



RBRVS Fiscal Impact Study

Examining the Implications of Implementing an RBRVS-Based Fee Schedule for the Industrial Commission of Arizona

Final Report

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TABLE OF CONTENTS

1.0. Executive Summary.....	2
2.0. Project Description and Goals	3
2.1. Background of the ICA and Arizona Workers’ Compensation	3
2.2. Purpose of Study.....	4
2.3. RBRVS Features.....	4
2.4. Key Issues Facing the ICA	6
3.0. Project Approach	8
3.1. Research.....	8
3.2. Analysis	9
3.3. Recommendations.....	10
4.0. Data Collection and Program Review	11
4.1. Fee Schedules	11
4.2. National Council on Compensation Insurance Data	11
4.3. Literature Review	12
4.4. RBRVS Policy Options	13
5.0. Rate Analysis and Fiscal Impact	16
5.1. Assigning RVUs	17
5.2. Determining Ground Rules	18
5.3. Calculating Conversion Factors	18
5.4. Baseline Scenario.....	19
5.5. Multiple Conversion Factor Scenario	21
6.0. Recommendations	24
6.1. Adapting the RBRVS for the ICA Fee Schedule.....	24
6.2. Recommendations for Implementation.....	25

1.0. EXECUTIVE SUMMARY

The Industrial Commission of Arizona (ICA) contracted with Public Consulting Group, Inc. (PCG) to study the feasibility and fiscal impact of transitioning from the reimbursement methodology currently underpinning the Arizona Physicians' and Pharmaceutical Fee Schedule ("ICA Fee Schedule") to one based on the Resource-Based Relative Value Scale (RBRVS). The ICA fee schedule establishes reimbursement values for medical services provided to injured Arizona workers. In the schedule's present state, fees are established based a survey of reimbursement values in seven peer states. As the authority responsible for maintaining and updating the fee schedule the ICA is considering replacing the peer state survey with the RBRVS as the foundation of the rate structure. PCG was tasked with addressing the following questions:

- What is the economic impact of transitioning to an RBRVS reimbursement methodology for the basis of the ICA fee schedule?
- Is it feasible to implement an RBRVS-based fee schedule using Arizona-specific conversion factors?

To evaluate the feasibility of implementing an RBRVS-based fee schedule PCG studied the existing ICA fee schedule, placing it in the context of Arizona's workers' compensation program and broader trends in fee schedule design. A review of workers' compensation fee schedules and relevant literature was then conducted to analyze the policy implications of implementing an RBRVS-based fee schedule. PCG complemented this research with a series of quantitative analyses that formed the basis of the fiscal impact study and the accompanying recommendations. These analyses modeled reimbursements with RBRVS-based rates and compared the simulated expenditures to reimbursements according to the existing ICA fee schedule. PCG completed analyses for many different conversion factor scenarios to fully understand the fiscal implications of transitioning to an RBRVS-based reimbursement methodology.

As a result of both the policy and fiscal analysis, PCG finds that it would be feasible and advantageous for the Commission to institute an RBRVS-based reimbursement methodology as the foundation of the Arizona workers' compensation fee schedule. The RBRVS has emerged as the standard nationwide for fee schedule design, with 32 states using it as the basis of worker's compensation fee reimbursement. While a new rate structure would change many reimbursement values, these changes would not destabilize the workers' compensation program. Rather they would result in a robust fee schedule structure and payment distribution that is already familiar to providers. Additionally, an RBRVS-based fee schedule can benefit both the Commission and providers by reducing the administrative resources needed to update the reimbursement values, subsequently enabling the Commission to update all values on an annual basis, and to make the schedule more reflective of the Arizona market and more responsive to changing health care costs. It is PCG's recommendation that the ICA move forward with implementing an RBRVS-based reimbursement methodology.

2.0. PROJECT DESCRIPTION AND GOALS

The objective of this project was to evaluate the fiscal impact of implementing an RBRVS-based reimbursement methodology for the ICA fee schedule. As the ICA currently uses a different methodology to establish fees, PCG was hired to study the implications of transitioning to a new rate setting methodology based on the RBRVS. This section provides context for the project, as well as an introduction to the RBRVS as it relates to the ICA fee schedule.

2.1. Background of the ICA and Arizona Workers' Compensation

The ICA is the party responsible for administering the workers' compensation laws of the Arizona Workers' Compensation Act. These duties include developing and maintaining the ICA fee schedule, which establishes a schedule of fees to be charged for medical services provided to injured Arizona employees. This fee schedule applies to services provided by a variety of medical providers, including physicians, nurse practitioners, and physical therapists, among others. While the ICA fee schedule establishes fees for certain medical services, the values included are not maximum allowable charges. Providers and insurers are able to negotiate separate contracts regarding fees for medical services provided to covered Arizona workers.

The ICA fee schedule categorizes medical services using portions of the Current Procedural Terminology (CPT) of the American Medical Association (AMA), as well as the American Society of Anesthesiologists Association's 2011 Relative Value Guide, the latest version of the Academy of Orthopedic Surgeons Complete Global Service Data, and the 1995 and 1997 Documentation Guidelines for Evaluation and Management Services. The Commission reviews each service code every four years according to a predetermined annual review cycle, surveying the workers' compensation fee schedules from the states of Colorado, Nevada, New Mexico, North Carolina, Oregon, Utah, and Washington. Prior to 2015, each code was reviewed once every four years based on its service category. When under review, reimbursement rates for the codes under review are adjusted as needed according to the following methodology:

- Current Arizona values between the 75th and 100th percentile of the states surveyed are not adjusted;
- Current Arizona values over the 100th percentile of the states surveyed are reduced to the 100th percentile; and
- Current Arizona values below the 75th percentile are increased to the 75th percentile subject to the following:
 - Increases shall be capped at 25% unless and except as necessary to bring a current value up to the 50th percentile.

However, in the following situations this methodology does not apply:

- If the survey sample size is less than four, then the code may be identified as RNE (Relative Value Not Established) or BR (By Report), except if it involves the professional component "PC" of a value, in which case the PC value may be based on the current ICA PC to Total Value ratio;
- Codes specific to Arizona, the value of which may be determined through the hearing process; and
- Codes otherwise designated as BR.

2.2. Purpose of Study

In response to feedback from the provider and insurer community, in 2015 the Commission reviewed all service codes, and the Director of the Commission created an advisory committee to evaluate the current fee schedule methodology and identify any potential improvements to the process. This methodology committee reviewed the various methodologies employed by other states in the governance of their workers' compensation fee schedules and found that the length of time (4 years) required for a review of all codes in the fee schedule, as well as the reliance on other states to set fees, are issues for concern. In light of the substantial administrative burden that would be placed on the Commission if all codes were reviewed on an annual basis, the Commission considered the possibility of a transition to a reimbursement methodology that relies on the RBRVS fee schedules, which are used by Medicare and updated on a semi-annual basis. PCG was contracted to conduct a feasibility study for transitioning to an RBRVS-based fee schedule.

To complete the project, PCG performed an impact analysis of the transition from the existing Arizona fee schedule to an RBRVS reimbursement methodology using Arizona specific conversion factors. The objective of the study was to use current data to assess the economic and programmatic impact of implementing an RBRVS-based payment system. PCG's study methodology included the development of Arizona conversion factors such that the resulting RBRVS program is specific to the needs of the ICA and Arizona worker's compensation. The study designed and performed by PCG addressed the following objectives:

- What is the economic impact of transitioning to an RBRVS methodology using Arizona specific conversion factors?
- What are the strengths and limitations of implementing an RBRVS methodology?
- Recommendations to assist the Commission in making the policy decision of whether to transition to an RBRVS methodology that uses Arizona specific conversion factors.

The study as carried out by PCG included the following subcomponents:

- Review of previous RBRVS transition impact studies and implementations in other states;
- Data collection process of all relevant claims, insurance and provider data;
- Development of a single Relative Value Unit (RVU) for each service code in the Arizona fee schedule;
- Development of Arizona specific conversion factors;
- Simulated payments under the proposed RBRVS reimbursement methodology;
- Assessment of fiscal impact of RBRVS transition; and
- Assessment of feasibility and challenges of RBRVS transition.

Together these analyses formed the basis for PCG's comprehensive evaluation of the economic and logistical feasibility of a transition from the current Arizona fee schedule to an RBRVS-based fee schedule, as described in this report.

2.3. RBRVS Features

The RBRVS was created for the Centers for Medicare & Medicaid Services (CMS) to form the basis of a fee schedule for physician reimbursement. It is based on the principle that payments for physician services should vary with the resources required to provide those services. An RBRVS-based fee schedule consists of reimbursement values arrived at by multiplying the resources required to perform a service, captured as Relative Value Units (RVUs), which are assigned to each service code and can be converted to fees using a dollar value conversion factor. Since the adoption of the RBRVS by CMS for the Medicare program in 1989, RBRVS-based fee schedules have proliferated in both public and private payer systems for they use resource requirements rather than costs or charges as the basis of reimbursement values. The basic structure of an RBRVS-based rate is:



The key component of a RBRVS system is the development of a single RVU for each service. This RVU is then applied to a conversion factor to determine a rate for a specific procedure. The advantage of this system is that by updating a single conversion factor, an entire fee schedule of rates can be updated while maintaining their relative value to one another. In the same way, different programs or geographical regions can use the same RVUs, but applying different conversion factors in order to reflect different acuity needs or budgetary constraints. This makes the RVU structure simple to update and highly adaptable from one setting to another—the same RVUs can be used across the country and over decades by applying specific local or periodic adjustments.

The most prominent RBRVS fee schedule is the Medicare Physician Fee Schedule (PFS), the fee schedule used by CMS to reimburse Medicaid physician cost. The PFS draws on RVUs created by the AMA, which are updated a minimum of once a year. At minimum, conversion factors are updated, and RVUs are updated as needed when the relative costs shift—because costs are relative to each other, simple multipliers like inflation may not impact the RVUs, but if malpractice expenses rise nationally compared to practice expense, or the cost of delivering a particular service reduces in cost due to technological improvements, the RVUs must be updated. The PFS is freely available through CMS and revised annually by the AMA, and so makes an excellent starting point for the construction of a payer-specific or program-specific RBRVS.

The RVU used in the CMS RBRVS system is the sum of three component RVUs, each of which reflects a distinct portion of the cost of delivering services. These are the Practice Expense (PE) RVU, which reflects the relative costs of maintaining a medical office, the Work RVU, which reflects the time and expertise of the medical professional delivering the service, and the Malpractice (MP) RVU, a relatively minor component which reflects the expense of malpractice insurance.

Each of the three components may be individually modified to reflect unique conditions as it impacts the different categories of expense. This is the sense in which the RVU system is “resource based.” Because the Medicare Physician Fee Schedule is used to derive the Medicare rates to be implemented in different health care markets across the United States, factors called Geographic Practice Cost Indices are also applied to adjust RVUs on a state by state or regional basis, allowing a single annual conversion factor to be used for most services. (Certain services, such as anesthesia, use distinct payment methodologies and conversion factors, while other services have discrete payments rather than Relative Value Units per procedure.) Similarly, the PFS records two distinct PE RVUs for

certain procedures—one for services delivered in a facility setting, and one for services delivered outside of this setting, which will generally have a higher practice expense.

2.4. Key Issues Facing the ICA

The RBRVS relies on certain key assumptions and methodologies in developing RVUs and determining which procedures will be reimbursed. Certain types of procedures do not have RVUs, use other methods of payment, or are included as part of a distinct service. Furthermore, because the RBRVS is designed to generate a single set of RVUs applicable to a large and diverse area, it is important to consider the scale at which geographic adjustments are made when adapting to a smaller region. There are four key issues which had to be considered and resolved:

Global Periods

Currently the ICA uses the global periods published in the most recent edition of Optum's Relative Values for Physicians. The global period defines the length of the post-operative period following a surgical procedure. The reimbursement rate for a procedure with a global period is designed to include all services related to the surgery, such as pre-operative visits, follow-up visits, and post-surgical pain management. Providers cannot bill separately for services related to the surgery that are delivered within the global period, as they are included within the "bundled" code.

CMS also publishes global periods for surgical procedures. However, in 2014 CMS proposed a final rule that would transition all surgical procedures with 10- and 90-day global periods to 0-day codes based on studies that showed physicians typically provide less follow-up care than is covered by global payments. 10-day codes would end in 2017 and 90-day codes would end in 2018. In the interim, CMS will revalue the codes so that they reflect only the value of pre- and intra-operative care and supplies, as well as evaluate the codes used in post-operative care to ensure payment adequacy. In light of these changes, as well as to maintain consistency and ease of transition, PCG's recommendations assume that the ICA will adopt the global periods defined by CMS under an RBRVS-based fee schedule.

Consultation Services

The ICA fee schedule and the PFS differ on payment policies for consultation services. Consultation services occur when a patient seeks out and receive an initial diagnosis for a problem. This description may also be applied to scenarios where a provider is asked to contribute a second opinion or confer on a diagnosis. Historically, Consultation has been treated as conceptually distinct from routine evaluation and management (E&M) provider visits, with distinct rates and separate codes. However, under the current RBRVS system, CMS uses E&M visit codes to reimburse for consultation services as well as routine E&M, and does not recognize the CPT codes previously used for consultation services and reimbursed individually. The additional costs related to consultation services specifically are distributed across the full volume of E&M codes, with the expectation that the costs will balance out in the aggregate. This is one form of a practice known as bundling, which combines similar services or services almost always found together by distributing costs for one service into payments for another.

The current ICA fee schedule provides separate reimbursement for those CPT codes that have been phased out of the PFS. In a transition to an RBRVS-based fee schedule, the ICA would need to address its consultation payment policy. Consultation codes have RVUs assigned to them as they were previously covered under the PFS, and it would be possible to develop reimbursement rates for them; however, the RVUs assigned to those codes will not be subject to review by the AMA in the future, potentially limiting the accuracy of the RBRVS-based fee schedule

as the RVUs become outdated. Further, the additional cost of consultations is factored into the existing rates for E&M procedures. Therefore, if higher values for consultations are used alongside these rates, the provider is in effect paid twice for consultations. PCG recommends that the ICA shift its approach to consultation codes in order to preserve the assumptions underlying the RBRVS system.

Pathology and Laboratory Reimbursement

The final key issue for ICA to consider is the reimbursement for Pathology and Laboratory codes. These codes are not included in the CMS RBRVS fee schedule, as they are frequently paid on a contractual basis. Instead, CMS maintains a separate fee schedule, the Clinical Diagnostic Laboratory Fee Schedule (CDL), which identifies state-specific rates for each procedure. For this reason, the ICA would not be able to shift these codes to the existing RBRVS basis. However, it is possible to back into an overall RVU amount for these procedures by using the current CMS conversion factor. By applying Arizona specific conversion factors to these RVU amounts, the ICA could scale the CDL rates to an appropriate Arizona-specific value. This is the approach PCG has used in its analysis.

3.0. PROJECT APPROACH

To complete this study successfully, and perform a comprehensive analysis of the impact of implementing an RBRVS methodology, PCG utilized a methodology comprised of three primary stages: research, analysis, and development of recommendations. A high-level overview of our project approach and methodology is provided in this section.

3.1. Research

The first elements of the study were grounded in research. PCG collected the quantitative and qualitative data necessary to review the existing ICA fee schedule and evaluate the application of the RBRVS in workers' compensation programs. PCG completed this research in three separate phases, each focusing on a specific aspect of the project.

Program Review

In this phase PCG conducted a comprehensive review of the ICA fee schedule and Arizona workers' compensation program. These efforts began with the collection of current and past copies of the ICA fee schedule. PCG studied the guidelines for each service category and the rate setting methodology currently employed, and gained an understanding of the nuances of the ICA fee schedule. PCG also gathered information regarding the history and background of the fee schedule's development to place the current fee schedule in perspective with the larger system of reimbursement. Following these qualitative elements, PCG collected and conducted a preliminary analysis of aggregate claims data as a preliminary analysis of expenditure and utilization statistics in order to understand the quantitative aspects of workers' compensation in Arizona.

Survey of State Best Practices

Following the review of Arizona's policies for workers' compensation reimbursement PCG surveyed workers' compensation fee schedules across the country, cataloguing the spectrum of rate setting methods used by other state regulatory authorities to govern workers' compensation reimbursement. After the initial survey, PCG focused its efforts on the states currently referenced in the ICA's seven-state system and those states using an RBRVS-based reimbursement methodology. A more thorough understanding of the fee schedules from the seven reference states provided insight into the factors influencing the current ICA fee schedule, while a detailed review of RBRVS-based fee schedules yielded best practices in areas such as conversion factors, geographic adjustment, and other policies. Overall this phase of the project studied the nationwide landscape of workers' compensation reimbursement and utilization of RBRVS-based fee schedules.

Identification of Transition Requirements

In the final research phase PCG focused on Arizona's specific programmatic features and the factors that would need to be reconciled in a transition to RBRVS reimbursement. PCG obtained current and recent versions of the dominant RBRVS fee schedule, the PFS, as well as the CMS fee schedule governing pathology and laboratory services, the CLFS. With both the ICA and RBRVS fee schedules in hand, PCG conducted an in-depth comparison of the two, identifying key differences in reimbursement such as services covered and fee adjustment factors. This comparison, in conjunction with a scan of the Arizona payer and provider environment, pinpointed the features that would warrant additional attention when transitioning to an RBRVS-based fee schedule and require the Commission

to decide which RBRVS policies to adopt. Additionally, PCG synthesized research from all three phases to outline the steps needed to develop and maintain Arizona-specific conversion factors and researched economic indicators that could be used to update the conversion factors.

3.2. Analysis

The second stage of the project was comprised of analyzing the data collected and research conducted during the first part of this study. PCG conducted a series of analyses that evaluated both the feasibility of transitioning to an RBRVS-based fee schedule and the impact of such a transition. The results of these analyses formed the basis of the final recommendations included in this report.

Payment Policy Analysis

The first phase of analysis focused on payment policies. PCG examined the advantages and disadvantages of various RBRVS policy options, such as non-physician provider reimbursement and geographic adjustment guidelines, and evaluated their appropriateness to the ICA fee schedule based on characteristics of the workers' compensation system, specific needs of the Arizona stakeholder community, and current ICA policy. Following the development of preliminary payment policy recommendations, PCG reconciled the ICA fee schedule and the PFS, assigning RVUs to most non-AMA defined services included in the ICA fee schedule and applying best practices in workers' compensation reimbursement to those without comparable RVUs.

Development of Conversion Factors

In the second analysis phase PCG developed Arizona-specific conversion factors for a model RBRVS fee schedule. This analysis began with the development of a baseline conversion factor. Using utilization statistics and the 2015 ICA fee schedule, PCG calculated the single conversion factor, applied to all service categories aside from anesthesia, and conducted a preliminary fiscal impact analysis. The results of this preliminary analysis were then used to develop additional conversion factor scenarios designed to mitigate changes to reimbursement values resulting from the transition to an RBRVS-based system. These scenarios incorporated nationwide trends and best practices in RBRVS workers' compensation fee schedules, as well as addressed Arizona-specific characteristics identified during the baseline fiscal impact analysis and previous phases of the project.

Fiscal Impact Assessment

Following the development of a series of conversion factors, PCG conducted a fiscal impact assessment for each scenario. PCG simulated payments for each scenario, modeling reimbursements by applying the rates under each scenario to fiscal year 2014 utilization data. PCG also simulated payments using the same utilization data and applying the ICA fee schedule rates. To analyze the fiscal impact of each conversion factor scenario, PCG then compared the modeled RBRVS payments to the modeled ICA payments, looking at the distribution of payments across the system and the impact on each service category. With the results of these analyses PCG was able to identify a system with three conversion factors (Anesthesia, Surgery and Radiology, and All Other) as the optimal conversion factor system for use in a RBRVS-based fee schedule.

Cost-Benefit Analysis

The final phase of analysis was comprised of a comprehensive cost-benefit analysis. This analysis utilized all research collected and analyses completed prior to this point to examine the advantages, disadvantages, and

implications of implementing an RBRVS-based fee schedule. The cost-benefit analysis used the three conversion factor system identified in the fiscal impact assessment as the base of the assessment, exploring the costs and benefits of implementing that RBRVS fee schedule model for the Arizona workers' compensation system. Both the financial and policy implications of transitioning to this RBRVS-based reimbursement system were considered in this analysis.

3.3. Recommendations

The last stage of the project was the development of concrete, evidence-based recommendations to aid the Commission in making the policy decision of whether to move from the current reimbursement methodology, based on a seven-state survey, and instead implement an RBRVS-based reimbursement methodology as the foundation of the ICA fee schedule. PCG synthesized the many analyses and summaries developed throughout the project to determine the best course of action for the ICA. The project concluded with the writing of a final report which summarized PCG's research, findings, and recommendations.

4.0. DATA COLLECTION AND PROGRAM REVIEW

This section will describe results of the research phase of this study. Subsections 4.1 and 4.2 address the principle data elements used to construct PCG’s analysis, while subsection 4.3 discusses the qualitative materials referenced. This portion of the report concludes with subsection 4.6, a summary of PCG’s policy analysis and recommendations arrived at through the program review.

4.1. Fee Schedules

The ICA fee schedule was the starting point of the analysis, as it provides the “As-Is” picture of the current reimbursement framework. The 2015 fee schedule is divided into 10 sections based on service category. Each section includes the CPT or Arizona-specific codes for the services covered within that category, the applicable modifier(s), and the respective reimbursement value. Codes without a reimbursement value are noted as either ‘By Report’ or ‘Relative Value Not Established.’ The fee schedule also includes the specific guidelines governing reimbursement for each service category.

Additionally, PCG used the Physician Fee Schedule distributed by CMS. For this analysis, PCG used the Calendar Year 2015 Fee Schedule, downloaded from the CMS website. The PFS is based on RVUs produced, updated, and distributed by the AMA, and is most widely used source for RVUs. In addition to the main RBRVS file, PCG referenced the schedule of anesthesia base units and the Clinical Diagnostic Laboratory fee schedule, all for the same period.

4.2. National Council on Compensation Insurance Data

Finally, PCG used data from the NCCI to provide a utilization baseline used to model the impact of a change in rates. As the acting rating and statistical bureau for the Commission, the NCCI reports on workers’ compensation claims. The NCCI provided PCG with utilization data for 2012, 2013, and 2014. This data was PCG’s source for utilization in modeling the potential impact of the new fee schedule in comparison to the existing rates. It is aggregated by procedure code, across the state and without regard to practitioner type or modifier (other than pricing modifiers). For each paid procedure with a transaction count of five or greater, the NCCI reported the following metrics:

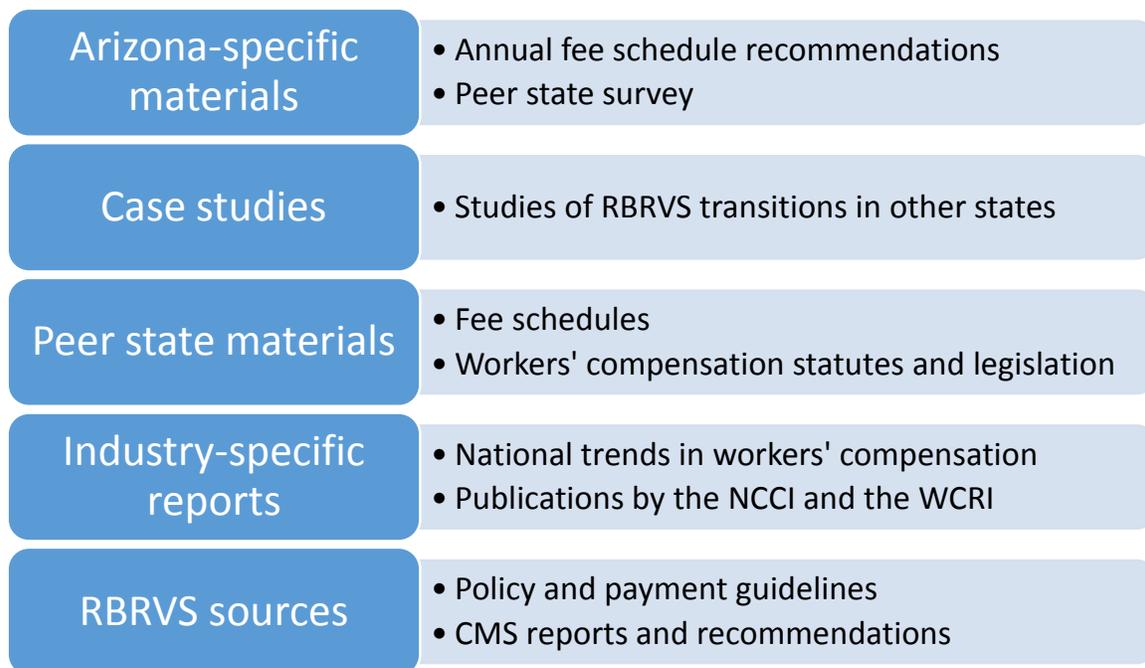
- Total payments;
- Total transaction volume;
- Average amount paid per code; and
- Payments at the 25th, 50th, and 75th percentiles.

PCG used the 2014 utilization statistics as the basis of our analysis. Because the vast majority of workers compensation medical services are not compensated at the maximum fee established in the fee schedule, the total payments actually received do not correspond to the modelled fiscal impact of the original fee schedule.

Additionally, the NCCI publishes annually a Medical Data Report. The Medical Data Report tallies the distribution of medical costs by service category, most frequently used services, and most expensive services according to amount paid. PCG referenced the Medical Data Report to inform determinations about policy options and priorities within the fee schedule and RBRVS system.

4.3. Literature Review

In addition to quantitative data, PCG conducted a review of relevant literature and other sources regarding workers' compensation reimbursement, the RBRVS, and implementing RBRVS-based fee schedules. The information referenced included sources such as state statutes and legislation governing workers' compensation programs and reports authored by the Worker's Compensation Research Institute analyzing trends in workers' compensation reimbursement. The types of sources collected during the literature review can be grouped into five categories. These are explained in the following figure, along with examples of the type of material collected, with examples of each:



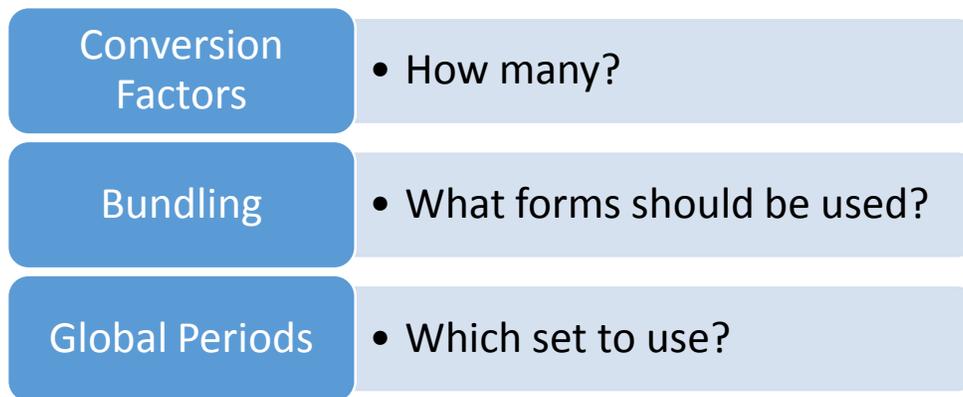
The materials gathered as a part of the literature and resource review informed PCG's analysis of payment policies and was the backbone of the identification of best practices. By focusing on sources within the aforementioned five categories PCG was able to examine the issue of workers' compensation reimbursement and RBRVS-based fee schedules from all angles. Arizona-specific materials such as the annual fee schedule recommendations and summary of action publications issued by the ICA provided context for the current ICA fee schedule and the provider and payer environment.

Examining fee schedules and impact studies from other states enabled PCG to identify trends in workers' compensation fee schedule design and RBRVS implementation and to understand the specific policies behind the data and reports published by organizations such as the Workers Compensation Research Institute and the NCCI. PCG found that using the RBRVS as the basis of a workers' compensation physician fee schedule is a standard practice across the country. Of the 44 state workers' compensation programs with physician fee schedules, 32 use

the RBRVS as the basis of reimbursement.¹ Additionally three states, including Arizona, are in the process of either studying or adopting the RBRVS as the basis of their rate structure; the New York Worker’s Compensation Board proposed transitioning to the RBRVS and the Nevada Division of Industrial Relations was advised to transition to the RBRVS.

4.4. RBRVS Policy Options

The RBRVS is an attractive basis for fee schedule design in part due to the flexibility it provides. The structure provides regulatory authorities with the ability to adopt policies which best suit their specific program. From the number of conversion factors used to the fee adjustment factors implemented, with an RBRVS-based fee schedule the ICA can choose which RBRVS policy options to apply. These options are summarized in the following figure, and are explained in depth in the remainder of the section.



Conversion Factors

As noted above, RBRVS-based fee schedules use conversion factors to monetize the RVUs and arrive at a rate for each service. All RBRVS-based fee schedules surveyed use at least two conversion factors: one for anesthesia services, and one for all other physician services. RVUs for anesthesia services are not comparable to RVUs for other physician services, requiring the use of a separate conversion factor to normalize reimbursement rates. However, within the scope of non-anesthesiology physician services, some fee schedules use a single conversion factor across all services while others use a series of conversion factors applied to different groupings of services. The PFS uses only one conversion factor and applies it to all non-anesthesiology services included under the PFS. As of 2012, seven states with RBRVS-based workers’ compensation fees schedules used a single conversion factor for physician services, while 23 used multiple conversion factors to set reimbursement rates.

Despite the additional administrative burden, it is best practice to use a set of multiple conversion factors. There are many advantages to using multiple conversion factors to set reimbursement rates within an RBRVS-based fee schedule. First, it addresses the difference in cost of service categories that may not be reflected within the RVUs

¹ The 31 states with RBRVS-based workers’ compensation physician fee schedules are: AK, AR, CA, CO, CT, DE, FL, HI, ID, IN, KS, KY, MD, ME, MI, MN, MS, MT, NC, NE, ND, OH, OK, OR, PA, SC, TN, TX, UT, WA, and WV.

assigned to each service code. Many states found that applying a single conversion factor across all non-anesthesia services did not produce reimbursement rates that adequately mimicked amounts previously paid under previous reimbursement systems. Instead, it is best practice to use multiple conversion factors in order to adapt the fee schedule to the program's needs and create a responsive and flexible fees schedule. PCG found that a multiple conversion factor system using the following service category groupings is most appropriate for Arizona:

- Surgery and Radiology;
- Evaluation & Management, General Medicine, Physical Medicine, Pathology and Laboratory, and Special Services

Using conversion factors tailored to service categories ensures that payments reflect the variation of costs found within the full spectrum of medical services. Second, multiple conversion factors provide the statutory authority or payer with more flexibility regarding the update of reimbursement rates. If an increase in cost of medical supplies disproportionately affects surgical services, for example, then the conversion factor can be updated proportionally. Finally, using multiple conversion factors can provide for a smoother transition to RBRVS-based reimbursement. It is easier to minimize or avoid large increases or decreases in reimbursement in certain service areas when using many conversion factors; a single conversion factor system is more likely to have an uneven impact across specialties.

Consultation and Other Forms of Bundling

As described above, in 2010, Medicare stopped recognizing the CPT codes traditionally used for consultation services. Instead, consultation services were bundled under evaluation and management visit (E&M) codes. While RVUs for consultation services are published as part of the PFS, they are marked as "I", invalid for Medicare purposes. (This is different from many other bundled services, as discussed below.) Physicians may code for the consultations using the CPT, for record keeping, but consultations are not individually reimbursed by CMS under the Medicare program. In order to compensate for the lost consultation payments, CMS increased the RVUs for E&M codes accordingly.

We have noted that a transition to CMS rules would change how physicians are compensated, and education on the new bundling of rates will be important for continuity of reimbursement. The advantage of bundling consultation codes, as with other forms of bundling, is that it simplifies payment and removes the incentive to bill individually for actions which are, in practice, all part of a single course of treatment. In cases where physicians use one code or the other, it can also reduce ambiguity about which CPT code should be used, leading to more uniform and consistent coding.

Physicians may see and defend a real distinction between what they code as a consultation and what is coded as an E&M visit, in terms of time spent and effort expended, and argue that this distinction is worth compensation. Because a state workers' compensation program does not have the leverage or reach of a Federal program, transmitting and enforcing the new guidelines may be problematic. Other state workers' compensation programs have approached this issue in a variety of ways. Many states, including Oregon, New Mexico, and North Carolina, continue to compensate consultation as distinct from E&M visits. Other states, such as California, have chosen to follow CMS practice, a compromise position, as seen in Colorado, is to establish a single fee that can be paid for either the consultation code or the corresponding E&M code, but not both at once. This increases latitude for the provider, but reduces the consistency of the coding and does not meaningfully preserve a distinction between the two codes.

The conflation of consultation codes with the E&M visit codes is only one instance of the concept generally referred to as “bundling.” Bundled codes are traditionally labelled a “B” in the Medicare physician fee schedule, and broadly speaking are used for actions or services which may be distinct enough to warrant recording as a service delivered, but not to require an independent reimbursement. The most common example of a bundled code is a follow-up phone call between the provider and a patient, although there are many others.

As noted above, the advantage of bundling consultation codes, as with other forms of bundling, is that it simplifies payment and removes the incentive to bill individually for actions which are, in practice, all part of a single course of treatment. Trying to granularly pay for each phone call or each step of a routine examination increases administrative burden and creates opportunities to game the system. Instead, rates for individual actions are folded into an overall rates, such as a comprehensive E&M visit rate.

Virtually all physician fee schedules observe some form of bundling, either explicitly or by excluding the bundled codes from the fee schedule altogether. However, a given program’s choices for which codes to bundle may or may not align with the defined Medicare bundled codes. Unlike consultation codes, Medicare bundled codes do not have published RVUs, so if the program chooses to individually reimburse a code Medicare labels as bundled, it will be necessary to develop a distinct RVU. PCG has generally recommended that ICA observe the bundling principles used by CMS.

Global Periods

As described above, a global period is a period of time starting with a surgical procedure during which follow-up services which comprise normal post-operative care bundled into the surgery fee. The motivation for this bundling is similar to other bundled services, as described above, but different in that the bundling is only active for a limited time following the initial procedure. The PFS indicates an appropriate global period for all surgical procedures. Not all services are eligible to be bundled; only those which are part of the normal post-operative care of the surgery. In some cases, modifiers may be used to distinguish a new service from one that is part of the previous procedure.

The list below outlines examples of the types of procedures which are usually not bundled under the global surgical fee:

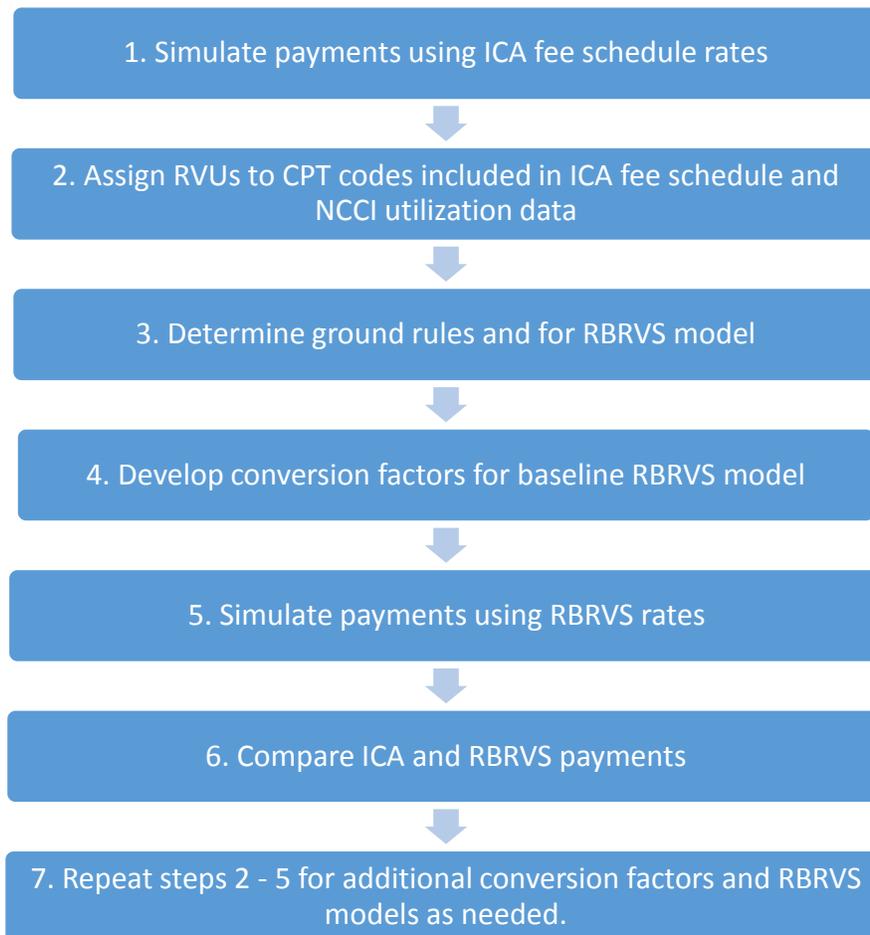
- Consultations;
- New patient evaluation and management (E&M) services;
- An E&M service the day before or the day of a major surgical procedure only if the initial decision to perform the surgery was made during that visit. Modifier -57 must be attached to the E&M code to indicate decision for surgery;
- Splinting and casting supplies.

State workers’ compensation programs do not necessarily observe the global observation period, especially if they do not generally try to bundle codes otherwise. New Mexico and North Carolina do not include global periods in the fee schedules, for examples, while Oregon and Washington, use the Medicare global periods directly.

Observing global periods introduces additional complexity into the claims processing and payment process. RVUs for the bundled services do exist, as the services are generally valid for payment outside of the global period. However, the global surgical codes are designed to incorporate the cost of all necessary post-operative care, so if PFS rules for global procedures are not followed, the CMS RVUs for these procedures may be higher than necessary. PCG recommends that ICA observe the global periods used by CMS.

5.0. RATE ANALYSIS AND FISCAL IMPACT

This section describes the methods used to complete the fiscal impact analyses. PCG conducted these analyses with the objective of arriving at an accurate estimate of the impact of implementing an RBRVS reimbursement methodology and of creating RBRVS models appropriate for the Arizona workers' compensation system. To do so, PCG used a methodology that can be summarized in seven steps:



PCG followed this process to complete the rate analysis and fiscal impact evaluation. Subsections 5.1, 5.2, and 5.3 describe in detail the methods used to assign RVUs, determine ground rules, and calculate conversion factors while subsections 5.4 and 5.5 describe the results of the fiscal impact analyses. PCG used the most recent utilization data available, that from October 1, 2013 through September 30, 2014, the 2015 ICA fee schedule rates, and the January 2015 version of the PFS. These datasets were chosen for accuracy; the January update of the PFS would be the most appropriate set of RVUs to use for an annual update based on the Commission's fee schedule review calendar and to achieve an "apples to apples" comparison PCG used the 2015 ICA rates as well.

5.1. Assigning RVUs

An RBRVS-based fee schedule hinges on the assignment of RVUs for each service code. The RVUs are supposed to reflect the resources required for each service and create a relationship between the CPT codes that reflects the relative resource needs of each service. PCG assigned RVUs to all codes included in the NCCI utilization data that would potentially be included in the fiscal impact analysis. PCG began this process by assigning RVUs to all codes with values published in the January 2015 PFS. After this step, the codes remaining were either Arizona-specific codes, CPT codes without published RVUs, or codes not included in the PFS. Collectively this group of codes are known as “gap codes” for they represent a gap between the RBRVS and ICA policies.

To assign RVUs or alternate reimbursement methodologies to the gap codes, PCG used give different tactics: (1) find RVUs published in other fee schedules, (2) calculate RVUs based on maximum allowable reimbursement, (3) crosswalk to comparable CPT codes with assigned RVUs, and (4) “pass through” the existing method of reimbursement. These methods were used successively, moving from most to least true to the principles of the RBRVS.

1. RVUs in the Office of Workers’ Compensation Programs Fee Schedule

The Federal Department of Labor’s Office of Workers’ Compensation Programs (OWCP) fee schedule supplied RVUs for all gap codes assigned using this method. The OWCP uses the same scale as the PFS, and ICA gap codes found in the OWCP could simply be assigned the OWCP RVUs without any further modification. As the OWCP is specific to workers’ compensation, PCG was able to assign RVUs to some frequently utilized service codes such as 99456 (Disability examination) through this method.

2. Calculated Using Maximum Allowable Rates

The second method used to assign RVUs to gap codes involved backing into RVUs from a maximum allowable Medicare reimbursement amount. As discussed in subsection 2.4 CMS reimburses most pathology and laboratory services through the Clinical and Diagnostic Laboratory (CDL) fee schedule. The CDL publishes rates specific to each state. Dividing the Arizona rate by the current CMS conversion factor delivers RVUs for that specific service code. PCG used this method to assign RVUs to the vast majority of ICA gap codes, deriving RVUs for 256 CPT codes this way.

3. Crosswalk to Comparable CPT Code

Another process PCG used to assign RVUs to gap codes is known as crosswalking. Crosswalking assigns RVUs by matching CPT codes with existing RVUs to gap codes with analogous procedures, levels of intensity, and physician skill. This method was used for code 90882 (Environmental manipulation). Crosswalking can be applied to many service codes, but the resulting RVUs require additional maintenance if the source codes are updated on a different schedule or with different aims than the code in question.

4. Pass Through

PCG treated codes which could not readily be assigned RVUs through the other four methods as “pass through” codes. This means that it was assumed the codes would be reimbursed the same way in an RBRVS fee schedule as they are currently reimbursed under the ICA fee schedule. Most of the codes designated as pass through are used infrequently and were designated as ‘By Report’ or ‘Relativity Not Established’ in the ICA fee schedule.

5.2. Determining Ground Rules

“Ground rules” refer to the many policies that govern reimbursement for claims submitted under a fee schedule. The ground rules determine which claims are allowable and what the appropriate reimbursement is. For example, a claim submitted for a service performed by a nurse practitioner would receive different reimbursements from a fee schedule that includes a non-physician practitioner adjustment and from a second fee schedule that does not, regardless if the maximum allowable reimbursement is the same. Thus the fiscal implications of implementing an RBRVS-based reimbursement methodology vary greatly depending on the ground rules that are used in the model.

There are important differences in the ground rules currently used by the ICA and the PFS. These differences were discussed previously in section 2.4 “Key Issues Facing the ICA” as well as in section 4.4 “RBRVS Policy Options.” PCG analyzed these policies during the program review and was able to arrive at recommendations for many of them based on the research and data collected at that point in the study. To summarize, PCG recommends that with a RBRVS-based fee schedule the Commission:

- **Should** adopt the global periods defined by CMS rather than continue to use those published by Optum;
- **Should** transition to CMS policies regarding consultation codes;
- **Should not** use the Arizona CDL values for pathology and laboratory reimbursement; instead PCG recommends that RVUs be created using the method described in the previous section.

PCG was able to arrive at conclusions for these ground rules with the resources and data available to our team. However, determinations regarding other ground rules that influence a fiscal impact analysis require detailed claims data beyond what was available to PCG. The NCCI provided data aggregated by service code for all codes with five or greater units of utilization in a given year. The data distinguished codes by pricing modifiers but did not include statistical or surgical modifiers. Without the detailed information required to determine appropriate reimbursement for a claim, policies such as multiple procedure discounting and adjustments for co- and assistant surgeons could not be evaluated.

This limitation, along with the many service codes included in the ICA fee schedule that are advisable for a workers’ compensation system but not included in the PFS, led PCG to abide by the ICA ground rules in our fiscal impact analyses. For example, codes with a ‘B’ status code in the PFS, indicating that they would ordinarily be bundled and not paid individually according to the RBRVS ground rules, were allotted full reimbursement in our models. PCG finds that this approach is advantageous for the consistency it brings to the analyses, applying both workers’ compensation guidelines and rates and thus creating RBRVS models that are sufficiently tailored to the needs of the Arizona workers’ compensation system. This approach provided the most consistency

5.3. Calculating Conversion Factors

The objective of this study was to assess the feasibility and fiscal impact of implementing an RBRVS-based fee schedule with Arizona-specific conversion factor(s). To calculate a conversion factor, PCG first calculated payments based on 2014 workers’ compensation claims and the ICA rate, estimating the expected payments if all claims were paid according to the ICA rate. Second, PCG summed the total RVUs of the system by multiplying the assigned RVUs by the utilization for each service code. The third and final calculation simply divided the estimated payments by the total RVUs resulting in a dollar value per RVU, which is captured as the Arizona-specific conversion factor. This calculation can be summarized in the following equation:

$$\frac{\text{Total ICA Payments}}{\text{Total Utilized RVUs}} = \text{ICA Conversion Factor}$$

To calculate additional conversion factors PCG adapted the above process as needed. By restricting the summed payments and RVUs to the codes in question PCG calculated numerous conversion factors in order to develop an RBRVS model that was minimized disruption to the Arizona workers' compensation system. For example, to calculate a conversion factor for pathology services PCG used the following equation:

$$\frac{\text{ICA Pathology Payments}}{\text{Utilized Pathology RVUs}} = \text{Pathology Conversion Factor}$$

In addition to the baseline conversion factor calculation, PCG used an additional factor for the final RBRVS model. PCG developed conversion factors designed to moderate the payment redistribution effected by RBRVS reimbursement. As the baseline model resulted in large decreases in surgery and radiology reimbursement, PCG calculated a conversion factor model that capped any decrease at 20%. To do so, PCG used the following steps:

1. Desired surgery (S) and radiology (R) payments:

$$(\text{ICA Surgery Payments} + \text{ICA Radiology Payments}) \times 0.8 = \text{Goal RBRVS R-S Payments}$$

2. Develop radiology/surgery conversion factor using utilized RVUs:

$$\frac{\text{RBRVS R-S Payments}}{\text{R RVUs} + \text{S RVUs}} = \text{R-S Conversion Factor}$$

3. Calculate payments for non-radiology or surgery service categories:

$$\text{Total ICA Payments} - \text{RBRVS R-S Payments} = \text{Remaining Payments}$$

4. Develop conversion factor for other service categories:

$$\frac{\text{Remaining Payments}}{\text{Sum of Remaining RVUs}} = \text{All Other Conversion Factor}$$

By ensuring that the payments and RVUs used in each conversion factor calculation all come from the same pool of service codes PCG was able to create a series of conversion factors that moved beyond the baseline model and contributed to RBRVS models more appropriate for the program as a whole.

5.4. Baseline Scenario

PCG began the fiscal impact analysis by developing a baseline model with a single, Arizona-specific conversion factor. Using one conversion factor for anesthesia services and a second for all other services is the method used by the PFS and how the RBRVS was designed to be used. The baseline model followed this set-up as well as the “ground rules” discussed in subsection 5.2. The conversion factors used in this model are included in Table 5.4a, while the modeled payments are included in Table 5.4b.

Table 5.4a. Conversion Factor Values, Baseline Scenario

Service Category	Conversion Factor
Anesthesia	\$58.10
All Other	\$68.83

Table 5.4b. Simulated Payments, Baseline Scenario

Service Category	Projected Payments	FY14 ICA Payments
Anesthesia	\$3,540,357	\$3,540,358
Evaluation & Management Services	\$45,349,718	\$36,697,306
Pathology & Laboratory	\$1,566,625	\$2,055,758
Surgery	\$26,975,767	\$34,799,444
Radiology	\$9,327,220	\$15,040,084
Physical Medicine	\$37,037,760	\$31,802,579
General Medicine	\$2,146,426	\$1,987,304
Special Services	\$184,392	\$203,949

In this scenario radiology would be the most affected, seeing a 38% decrease in total reimbursements when transitioning from the current ICA fee schedule to an RBRVS-based rate structure. E&M services would experience the largest increase in reimbursements, jumping 23% from the current reimbursements. Physical and general medicine services would also see an increase in total reimbursement, although of a smaller magnitude than E&M services. The largest dollar value decrease would come from reimbursement for surgical services, which sees a 22% decrease and is the third largest service category by total payments. Table 5.4c compares the distribution of payments under the simulated ICA system and the baseline RBRVS model.

Table 5.4c. Payment Distribution, Baseline Scenario

Service Category	RBRVS Payment Distribution	ICA Payment Distribution
Anesthesia	2.8%	2.8%
Evaluation & Management Services	37.0%	29.1%
Pathology & Laboratory	1.3%	1.6%
Surgery	22.0%	27.6%
Radiology	7.6%	11.9%
Physical Medicine	30.2%	25.2%
General Medicine	1.8%	1.6%
Special Services	0.2%	0.2%

Under a single conversion factor RBRVS fee schedule, E&M services would remain the largest service category but would have a much larger share of the total reimbursements. Surgical services reimbursement would comprise a smaller percentage of the overall total, moving from 27.6% of reimbursements to 22%. Physical medicine, like E&M services, would also comprise a larger portion of total reimbursements. The smallest service categories by reimbursement value (pathology and laboratory, general medicine, and special services) would remain relatively steady in terms of proportion of system-wide reimbursements. Additionally, PCG compared ICA payments to estimated Medicare reimbursements. The analysis calculated the modeled ICA and RBRVS payments as a percentage of anticipated Medicare payments. As shown in Table 5.4d, all service categories are well above the expected Medicare reimbursement, and payments are more balanced in their relationship to Medicare under the RBRVS model.

Table 5.4d. Payments as Percentage of Medicare Payments, Baseline Scenario

Service Category	Baseline RBRVS Payments	FY14 ICA Payments
Anesthesia	259%	259%
Evaluation & Management Services	188%	152%
Pathology & Laboratory	189%	138%
Surgery	193%	249%
Radiology	193%	311%
Physical Medicine	192%	164%
General Medicine	178%	165%
Special Services	111%	123%

5.5. Multiple Conversion Factor Scenario

The baseline model was developed to provide insight into the anticipated changes from an RBRVS transition and enable PCG to develop an RBRVS system suited to the needs of the ICA and Arizona workers' compensation. PCG explored many variations, grouping together different service categories in order to identify models feasible for implementation. After consulting with the ICA regarding the various options available PCG identified a multiple conversion factor scenario as most appropriate for use in the ICA fee schedule. This scenario uses one conversion factor for anesthesia services, one for surgery and radiology services, and a third for all remaining service categories within the ICA fee schedule. The baseline scenario indicated that surgery and radiology services had much higher reimbursement values relative to E&M and physical medicine services. To mitigate that effect, this model caps the reduction in combined surgery and radiology reimbursements at 20% while reducing overall payments by 2%. The conversion factors for this scenario are included in Table 5.5a.

Table 5.5a. Conversion Factor Values, 20% Scenario

Service Category	Conversion Factor
Surgery/Radiology	\$75.68
Anesthesia	\$56.94
All Other	\$63.97

The baseline fiscal impact analysis indicated that transitioning to an RBRVS fee schedule would disrupt the current distribution of reimbursements and decrease reimbursement for surgical and radiology services while increasing reimbursement for E&M services. Using a separate conversion factor for surgery and radiology services adds flexibility to the rate structure without sacrificing too much of the relativity, and the value, of the RBRVS. The results of the multiple conversion factor scenario are included in Table 5.5b.

Table 5.5b. Simulated Payments, 20% Scenario

Service Category	Projected RBRVS Payments	FY14 ICA Payments
Anesthesia	\$3,469,551	\$3,540,358
Evaluation & Management Services	\$42,179,001	\$36,697,306
Pathology	\$1,457,242	\$2,055,758
Surgery	\$29,619,717	\$34,799,444
Radiology	\$10,255,470	\$15,040,084
Physical Medicine	\$34,423,994	\$31,802,579
General Medicine	\$2,004,061	\$1,987,304
Special Services	\$178,688	\$203,949

As seen above, radiology payments see a larger reduction in reimbursement than surgical services relative to their size. Collectively payments to those two categories decreases by only 20%, which is smaller than the 38% reduction in radiology and 23% reduction in surgical services seen under the baseline scenario. Overall, in this model the changes are distributed more evenly across the largest service categories when compared to the baseline model. The E&M and physical medicine service categories still undergo an increase in total reimbursement, but with a smaller magnitude of change. Although pathology and laboratory services see a larger decrease in total reimbursement, the real value of that decrease is small as that service category comprises only 1.6% of payments in the simulated ICA scenario. The distribution of payments in this model can be seen in Table 5.5c.

Table 5.5c. Payment Distribution, 20% Scenario

Service Category	RBRVS Payment Distribution	ICA Payment Distribution
Anesthesia	2.8%	2.8%
Evaluation & Management Services	34.1%	29.1%
Pathology & Laboratory	1.2%	1.6%
Surgery	24.0%	27.6%
Radiology	8.3%	11.9%
Physical Medicine	27.9%	25.2%
General Medicine	1.6%	1.6%
Special Services	0.1%	0.2%

Compared to the distribution of payments in the ICA simulation, a greater proportion of reimbursements are going to the E&M and medicine categories, with a total of 63.6% of payments in contrast to a total of 55.9% of payments under the ICA fee schedule. This increase is paired with a decrease in the relative distribution of surgery and radiology services, which comprise 31.3% of total reimbursements in the 20% RBRVS scenario, down from 39.5%. That decrease reflects both the foundation of this model, a 20% reduction in surgery and radiology reimbursements, as well as the relationship between surgical and consultation service RVUs within the RBRVS. Non-specialist care has traditionally been undercompensated relative to specialist, and specifically surgical, services, which is one of the inequities that the RBRVS was created to address.

Finally, the payments under the 20% RBRVS model are still above expected Medicare reimbursements in all service categories. As shown in Table 5.5d, total payments for all major service categories are at least one and a half times the value of anticipated reimbursements if they were paid according to Medicare rates. For the two largest service categories by payment amount, E&M and Physical Medicine, total payments are 175% and 178% respectively of anticipated Medicare reimbursements. The redistribution of payments is also apparent in these numbers, as there is a smaller magnitude of difference in the RBRVS model than under the current ICA system. Whereas in FY14 the percentage of Medicare ranged from 123% to 311%, in the RBRVS model the range is only from 108% to 255%.

Table 5.5d. Payments as Percentage of Medicare Payments, 20% Scenario

Service Category	RBRVS Payments	FY14 ICA Payments
Anesthesia	255%	259%
Evaluation & Management Services	175%	152%
Pathology & Laboratory	175%	138%
Surgery	212%	249%
Radiology	212%	311%
Physical Medicine	178%	164%
General Medicine	166%	165%
Special Services	108%	123%

6.0. RECOMMENDATIONS

6.1. Adapting the RBRVS for the ICA Fee Schedule

Transitioning to an RBRVS-based reimbursement methodology presents many advantages to the Arizona workers' compensation program and the ICA. The RBRVS provides a principled and rigorously tested system of reimbursement that was developed specifically for medical services reimbursement. It bases reimbursement on the resources required to provide services rather than costs or other factors. Currently the ICA fee schedule is influenced by seven separate fee schedules. By adjusting the rates according to the fluctuations in the fee schedules surveyed, the current methodology does not provide for a coherent approach to rate development or fee schedule design and allows for imbalances in payment levels to develop. Based on the policies of the seven surveyed states, one service category may have very low payments relative to another. The risks associated with such a system include decreased provider participation due to inadequate reimbursement and inflated worker's compensation costs

In contrast, changes in RBRVS-based reimbursement affect the entire fee schedule due to the use of the relative value scale. That key feature of the RBRVS makes it easier for regulatory authorities to maintain fair and equitable reimbursement rates. The structure of the relative value scale and ease of update have made the RBRVS the national standard for worker's compensation fee schedule design. It forms the basis of fee schedules in 32 states, including four of the seven states currently surveyed by the ICA. Implementing an RBRVS-based fee schedule for Arizona workers' compensation would fairly distribute payments across service categories and reduce the administrative burden required to update the fee schedule. The potential shock of the initial payment redistribution would be mitigated by the fact that the ICA fee schedule is already partially linked to the RBRVS through the North Carolina, Oregon, Utah, and Washington fee schedules, all of which are based on the RBRVS. Table 6.1 summarizes the key implications of transitioning to an RBRVS-based reimbursement methodology.

Table 6.1. Effects of an RBRVS-based Reimbursement Methodology

- Align fee schedule with accepted national standard that is widely used Federal and State rate setting authorities
- Resolves inequities in the current rate structure and balances reimbursements across provider specialty
- Facilitates benchmarking and comparison to other workers' compensation fee schedules
- Reduces administrative burden of ICA's annual update and review
- Provides flexibility to tailor fee schedule to specific needs of Arizona workers' compensation program
- Increases some reimbursement rates while decreasing others, resulting in a more balanced distribution of payments across the system
- May impact provider participation in the worker's compensation program

It is the ease of updating an RBRVS-based fee schedule that is one of the most compelling reason to adopt it. The current method of review is time consuming and administratively burdensome. Collecting the seven fee schedules and manually adjusting the codes under review is a resource strain on the Medical Resource Office at the ICA.

Under an RBRVS-based fee schedule the Commission would be able to update all codes by simply adopting the RVUs published that year in the PFS and updating the conversion factor as needed based on economic and market indicators. The ICA would be able to review the entire fee schedule on an annual basis, rather than updating each code every four years, ensuring that the reimbursement values stay up to date and are competitive for providers.

RBRVS-based fee schedules can be adapted as easily as they are updated. The ICA would have more flexibility through an RBRVS reimbursement methodology to enact policy changes or address issues within the workers' compensation system. For example, should it become clear that there are issues with access to care for injured employees in certain parts of the state the ICA would be able to include a positive payment adjustment factor based on county or zip code to encourage providers to practice in that area. A final administrative benefit of the RBRVS is that it has been subject to extensive review and validation and is widely accepted as a standard basis for reimbursement values, from workers' compensation programs to private insurers.

Furthermore, as the RBRVS forms the backbone of the PFS, providers are accustomed not only to the rate structure and the relativity of reimbursement values but also to the associated payment policies and reimbursement adjustments used by CMS in Medicare reimbursement. Annual updates in reimbursement or billing policies are likely to be less disruptive and roll out more smoothly as providers are accustomed to the types of changes that regularly occur in RBRVS reimbursement, such as the addition or deletion of certain CPT codes. The smoother adoption of new policies by providers would diminish the ICA's administrative burden of maintaining the ICA fee schedule.

The RBRVS offers many benefits to the Commission and PCG recommends that the ICA implement an RBRVS-based reimbursement methodology for the workers' compensation fee schedule. While there are logistical hurdles to overcome in order to successfully implement a new reimbursement methodology, the result will be a more balanced fee schedule with a robust rate structure tailored specifically to Arizona workers' compensation. PCG believes the ICA can implement an RBRVS-based reimbursement methodology and does not require a transition period. To facilitate that successful transition, PCG has recommendations resulting from the analyses conducted in this study.

6.2. Recommendations for Implementation

Multiple Conversion Factor Model

It is PCG's recommendation that the Commission adopt an RBRVS model which uses one Arizona-specific conversion factor for surgery and radiology service codes, one conversion for all other service codes, and a third for anesthesia services. Our analysis finds that this model, when developed with a 20% reduction in combined surgery and radiology reimbursements, would optimize the advantages of the RBRVS by creating equity in reimbursement values across service categories and minimize the decreases in total reimbursement for radiology and surgery that would occur in a single conversion factor RBRVS system.

Global Periods

The ICA currently uses global periods published by Optum in the Relative Values for Physicians to govern pre- and post-operative lengths of care. At the moment CMS publishes another set of global periods that are applied to surgical codes in the RBRVS. However, beginning in 2017 CMS will begin to phase out bundled surgical packages and global periods. These changes will be reflected in altered RVU values for certain CPT codes. To prepare for

these changes and avoid inaccurate reimbursement stemming from applying Optum's global periods to individually paid services, PCG recommends the ICA adopt the CMS surgical global periods and accompany that change by adopting the CMS consultation code bundling policies, discussed later in this section.

Pathology and Laboratory Service Codes

The PFS does not assign RVUs to a majority of pathology and laboratory codes included in the ICA fee schedule. CMS instead reimburses these services using a separate fee schedule which publishes only the dollar value reimbursements. PCG recommends that the Commission develop RVUs for these service using the values published by CMS. Using a fee schedule based in dollar values sacrifices the flexibility afforded by the conversion factor system and would diminish the long-term relativity of the pathology and laboratory codes.

Consultation and Bundling Policies

In addition to the aforementioned advantages offered by an RBRVS-based fee schedule, another is its capacity to be used as a cost containment mechanism. The RVUs published in the PFS for consultation and E&M services are designed to create appropriate reimbursement values in a system which uses the bundling policies adopted by CMS, so a fee schedule which reimburses for both outdated consultation codes and current E&M services is likely to pay twice for the same set of services. In light of upcoming changes to surgical global periods and RVUs for associated services, PCG recommends that under an RBRVS-based fee schedule the ICA adopt the RBRVS bundling policies for consultation services to avoid excessive reimbursement rates. Implementing an RBRVS-based fee schedule without the tandem adoption of CMS consultation policies and surgical global periods would limit the effectiveness of the fee schedule at maintaining relativity and accurate reimbursement across services.



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