THE EFFECTIVE USE OF THE MEDICAL FEE SCHEDULE PRESENTATION

BY

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Mr. Miller is a litigator, concentrating his practice in handling workers' compensation claims, representing injured employees and defending employers, insurance companies, self-insureds and uninsured employers. In addition, his practice involves general insurance defense litigation including auto and personal injury litigation. Prior to forming Frankl Miller & Webb in 2004, Mr. Miller was a partner at Gentry Locke Rakes & Moore where he was the head of the workers' compensation practice area. He is currently a member of the Southwest Virginia Workers' Compensation Bar and the Virginia Association of Defense Attorneys. He received a bachelor's degree from Hampden-Sydney College and his law degree from the University of Virginia.

Ms. Schmersal is a worker's compensation paralegal, assisting injured workers as well as employers, claims administrators and insurers. She has worked in the workers compensation field for 7 years, spending 2 years as an adjuster before joining Frankl Miller Webb and Moyers as a paralegal in December 2014. Her experience, in both assisting injured workers and defending claims, benefits all of her clients by providing them with an understanding of all viewpoints and utilizing that knowledge to resolve their claims in the most direct and efficient way possible. She specializes in complex medical research as well as the preparation of medical cost projections and settlement evaluations. She holds a bachelor's degree in business administration from Campbell University in North Carolina.

I. Help! I need a number! (Forecasting medical costs before 2018)

A. Statewide Estimates

1. VHHA (Virginia Hospital & Healthcare Association)
2. VHI (Virginia Health Information)

B. Provider Price Transparency Lists

1. VCU
2. UVA
3. Carilion Clinic

C. National health pricing websites

1. Fairhealth

II. Leveling the Playing Field (the Implementation of the Medical Fee Schedule)

A. What it is

1. An outline of maximum fees for facilities and providers who provide treatment to injured employees

a) Does not eliminate contracts between the provider and the employer or carrier

b) The amount paid should be the lesser of the billed charge or the allowed fee listed for the service provided

c) If there is no contract or fee schedule provision for a particular service the Commission will determine the maximum fee to be paid by the employer or insurer, which will be effective until the service is incorporated into the fee schedule

(1) Maximum fee for new technology including implantable medical devices or items of medical equipment shall not exceed 130% of provider's invoiced cost

(2) Maximum fee for new procedure shall not exceed 80% of provider's charge for service

2. Applies to all treatment for dates of service January 1, 2018 and continuing

a) Date of injury does not impact applicability

3. Designed to reflect actual average costs for services including variation by medical community and procedure/service

a) 6 Medical Communities (aka Regions) instead of 23 planning districts

(1) Northern

(2) Northwest

(3) Central

(4) Eastern

(5) Near Southwest

(6) Far Southwest

4. Has some exclusions

a) All prescriptions & any DME sold by a retail provider

b) Traumatic injuries and burns

c) Air ambulances

d) Services provided under a written contract between the provider and the employer or carrier

5. Has two categories of hospital

a) Type One Teaching Hospital vs. Non-Type One

(1) To be a Type One Teaching Hospital the facility must have been state owned prior to January 1, 1996

(2) Only 2 Type One Teaching Hospitals in the Commonwealth

(a) UVA

(b) VCU

B. How it came to be

1. Developed in accordance with Chapters 279 & 290 (amended) of the 2016 Acts of Assembly and Chapter 478 of the 2017 Acts of Assembly

2. Approved on March 7, 2016

3. Developed by a regulatory Advisory Panel and the Commission's actuarial consultant, Oliver Wyman

4. Designed to achieve revenue neutrality

a) Eliminates pricing wars

(1) in which Provider A charges less to one employer and more to another; OR

(2) in which Provider A charges more than Provider B for the same service in the same community

C. What it can be used for

1. Accurately calculating medical costs for most procedures common to workers compensation

a) Except traumatic injuries and burns

2. Providing specific and detailed calculations to clients trying to assess their options and value a claim for settlement

a) Type One vs. Non-Type One

b) Conservative care vs. surgical care

3. Rebutting unrealistic demands from Claimants and their counsel

a) Ex. John demands $250,000 for medical treatment that the fee schedule only allows $72,000 for

III. Looking into the crystal ball (Projecting future expenses)

A. Step 1: Know your claimant

1. Age
   - *a) Any age-related issues*
     - (1) Slow wound healing
     - (2) Risks of anesthesia
     - (3) Lack of mobility/range of motion
2. Prior Medical History
   - *a) Pre-Existing Injuries*
     - (1) Previous injury to same body part
     - (2) Previous injury to alternate body part
       - *(a) Risk of compensable consequence*
   - *b) Prior Personal Injury and Workers Compensation Claims Previous injury to same body part*
     - (1) Type of Injury
     - (2) Last date of treatment
3. Chronic medical conditions
   - *a) Diabetes*
     - (1) Slow wound healing
     - (2) Weak skin/tissue at surgery site
     - (3) Hyper or hypoglycemia after surgery
   - *b) Hypertension*
     - (1) Risk of stroke or heart attack during surgery
     - (2) Risk of kidney problems during or after surgery
   - *c) COPD*
     - (1) Increased risk of complications from anesthesia
     - (2) Hypoxia
     - (3) Blood clots & pulmonary embolism
4. Current medications
   - *a) Blood pressure medications*
     - (1) Intraoperative hypotension
     - (2) Dehydration
   - *b) Diabetes medications*

(1) Diabetic ketoacidosis

c) *Blood thinners*

(1) Increased bleeding

(2) Risk of ischemia or thrombosis

B. Step 2: Know your provider

1. Conservative?

a) *Known for returning claimants to work promptly?*

b) *Willing to consider non-surgical methods first?*

c) *Surgery driven?*

2. Usual pattern for pre-surgical care

a) *PT*

b) *Injections*

c) *Prescriptions*

3. Usual pattern for post-surgical care

a) *Frequency of PT*

b) *Work restrictions*

c) *Release to full duty*

C. Step 3: Know your medical coding

1. DRG – Diagnosis Related Group

a) *6-digit alphanumeric code starting with DRG (ex. DRG469 – major joint replacement or reattachment)*

b) *Used for inpatient hospital procedures only*

c) *Does not include provider expenses*

2. CPT - Current Procedural Terminology

a) *5 digit all numeric code (ex. 99213 – midlevel office visit, established patient)*

b) *Can be used for both outpatient facility and all provider expenses*

3. HCPCS – Healthcare Common Procedure Coding System

a) *Usually a 5-digit alphanumeric code (ex. E0114 – crutches, underarm)*

b) *Commonly used for durable medical equipment & transportation*

D. Step 4: Know your basic expenses

1. Facility Expense

a) *Hospital (inpatient)*

b) *Hospital (outpatient)*

c) *Ambulatory surgery center*

2. Provider Expense

a) *Non-Surgeon*

b) *Surgeon*

(1) Co- Surgeon

(a) Necessary to perform distinct part of specific operative procedure

(b) Reimbursed at 62.5% of maximum allowed fee

(c) Ex: An otolaryngologist who performs the approach for an anterior cervical fusion before the spine surgeon performs the actual fusion

(2) Assistant Surgeon

(a) Physician who actively assists operating surgeon

(b) Reimbursed at 20% of maximum allowed fee

(c) Ex: A physician's assistant, nurse practitioner or clinical nurse specialist who assists the primary surgeon

c) *Radiologists*

3. Anesthesia

a) *Base Units*

(1) Established by American Society of Anesthesiologists

b) *Time Units*

(1) Based on length of procedure

c) *Modifying Units*

(1) QK – multiple anesthesia procedures concurrently

(2) QX – nonphysician anesthetist with direction from physician

(a) Reimbursed at 50% of maximum allowed fee

(3) QY – certified registered nurse anesthetist

(a) Reimbursed at 50% of maximum allowed fee

4. Durable Medical Equipment

5. Transportation

E. Step 5: Know your treatment dates

1. Prior to 2014

a) *Community Standard method*

2. Between January 1, 2018 and December 31, 2019

a) *Commission's 2018 Medical Fee Schedule*

3. After January 1, 2020

a) *Commission's 2020 Medical Fee Schedule*

F. Step 6: Know where to look

1. Anesthesia codes

2. CPT codes

3. DRG codes

4. HCPCS codes

IV. Putting it all together (Calculating Medical Costs with the Fee Schedule)

A. Keeping It Simple

1. Enter the partial zip code for the location where the treatment occurred
2. Enter the year the treatment was provided in
   a) *Only applies to dates of service on or after January 1, 2018*
3. Select the type of service
   a) *Hospital Inpatient*
      (1) Acute
      (2) Rehab
   b) *Hospital Outpatient*
   c) *Ambulatory Surgery Center*
   d) *Professional Services*
      (1) Anesthesiologist
      (2) Surgeon
         (a) *14 categories of surgeons*
         (b) *Listed on page 11 of the 2020 Ground Rules*
      (3) Non-Surgeon
   e) *Physical Medicine & Rehabilitation Services*
      (1) Physical Therapy
   f) *Osteopathic & Chiropractic Manipulative Treatment*
   g) *Acupuncture*
   h) *Dental*
   i) *Ambulance*
      (1) Ground transport only
      (2) Set rate per mile
      (3) Maximum Fee established for certain trips
   j) *S Codes*
      (1) Specific procedure codes that don't fit into other categories
4. Select a modifier (if listed on the bill)
5. Select code type
   a) *Hospital Inpatient – DRG Code*
   b) *Hospital Outpatient – DRG or CPT or HCPCS*
   c) *Ambulatory Surgery Center – DRG or CPT*

d) Professional Services – CPT or HCPCS

e) Physical Medicine & Rehabilitation Services – CPT or HCPCS

f) Osteopathic & Chiropractic Manipulative Treatment – CPT

g) Acupuncture – CPT

h) Dental – HCPCS

i) Ambulance – HCPCS

j) S Codes – HCPCS

6. The Reference Tool will search the Fee Schedule for you

a) Will provide the following information:

(1) Maximum Fee

(2) Base Units (for Anesthesia)

(3) Multi-surgery reduction

(a) Applies if multiple procedures are performed on a single surgical site

(4) Bilateral surgery reduction

(a) Applies if the same procedure is performed on bilateral body parts

B. Feeling Confident

1. Download the Fee Schedule PDF from the Commission's Website

2. Using the magnifying glass in the upper left corner search the document for the CPT code or HCPCS code related to the Claimant's treatment

3. Triple check yourself:

a) Right Section

(1) Keeping a copy of the Table of Contents on hand makes this much easier!

b) *Right Region*

(1) See Page 8 of the 2020 Medical Fee Schedule Ground Rules for a color-coded map

c) *Right Code*

C. Things to Remember

1. Not every CPT code or HCPCS code is listed in the fee schedule

a) If a code is not listed in the Fee Schedule payment for the service cannot be automatically denied.

(1) Ex: CPT Code: 80305 – Drug screen was not listed in the 2018 Fee Schedule

b) If a code is not listed, the Ground Rules of the Fee Schedule state that the Insurer shall pay no more than 80% of the billed amount.

2. Is your local hospital on par with the care a Claimant would receive at UVA or VCU?

a) Type One Teaching Hospitals are billed at a significantly higher rate than non-Type One Hospitals.

3. Non-Physician Providers are paid based on coding just like Physicians

a) This group includes:

(1) Physician's Assistants

(2) Nurse Practitioners

(3) Physical Therapists

(4) Occupational Therapists

(5) Speech Therapists

D. Type One vs. Non-Type One comparison

1. Type One includes only UVA and VCU
2. Non-Type One is every other hospital in the Commonwealth

E. Ultra Conservative care for cervical spine injury

1. Office visits
2. Physical therapy
3. Prescriptions (not calculated/not managed under fee schedule))

F. Conservative Care for cervical spine injury

1. Office visits
2. Physical therapy
3. Facet injections
4. Prescriptions (not calculated/not managed under fee schedule)

G. Surgical Care for cervical spine injury

1. Office visits
2. Facility expense
3. Surgeon expense
4. Assistant surgeon expense
5. Anesthesia

V. Questions

THE EFFECTIVE USE OF THE MEDICAL FEE SCHEDULE

Calculating exposure in workers' compensation settlements by accurately valuing future medical expenses

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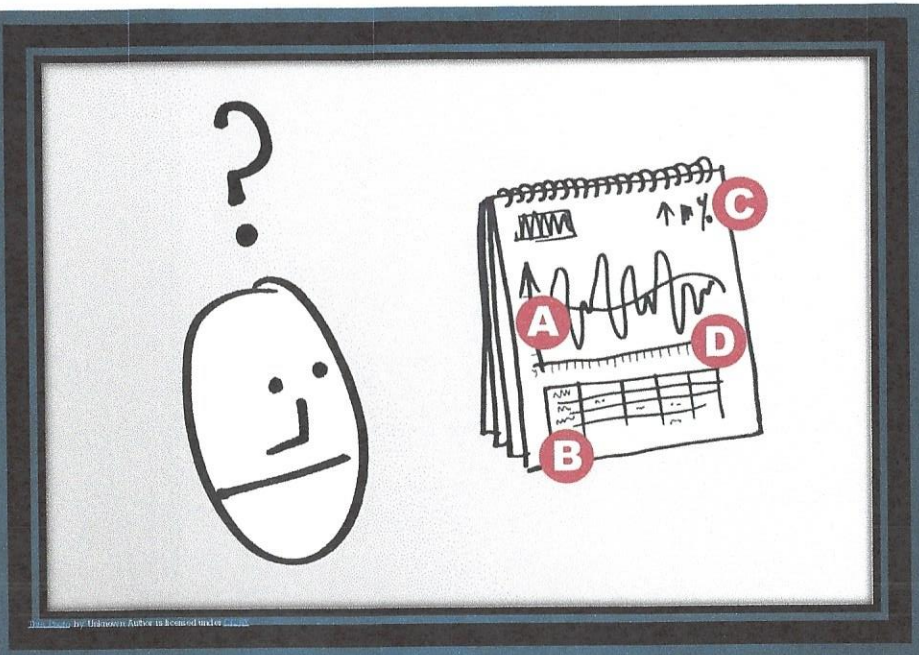
Johanna Schmersal



HELP! I NEED A NUMBER

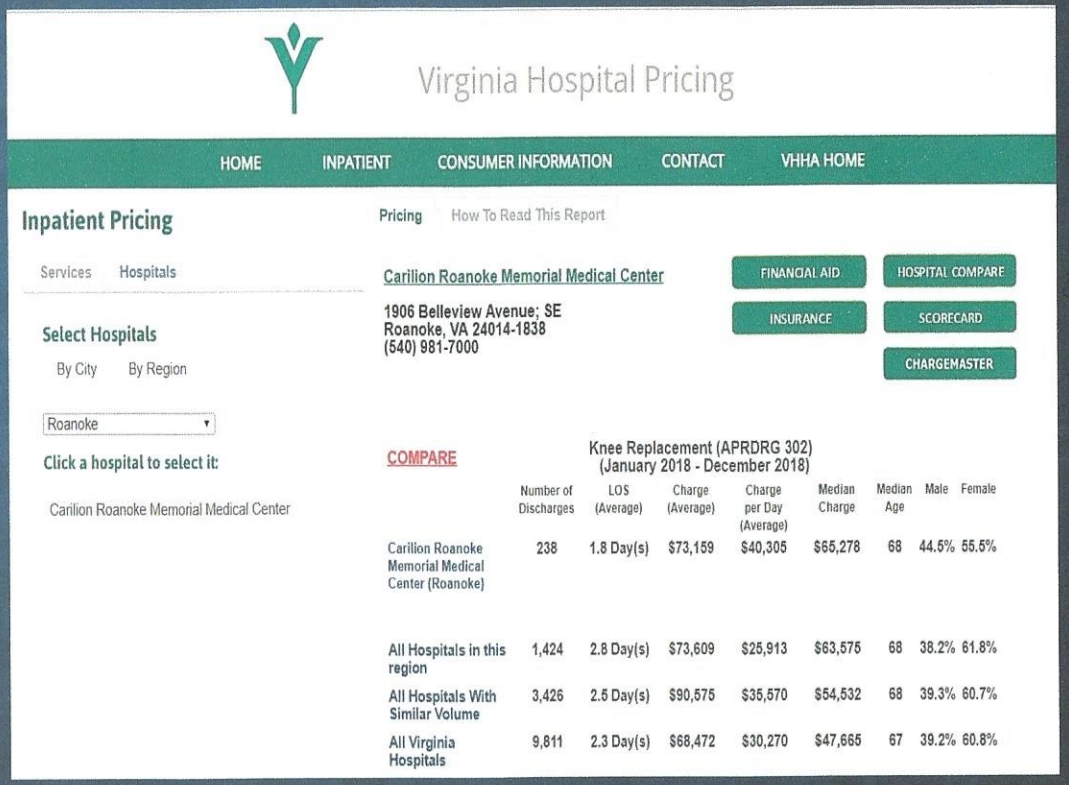
Forecasting medical expenses before January 1, 2018

VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION (VHHA)

www.vapricepoint.org

Limited service choices

Provides average expenses based on Association statistics



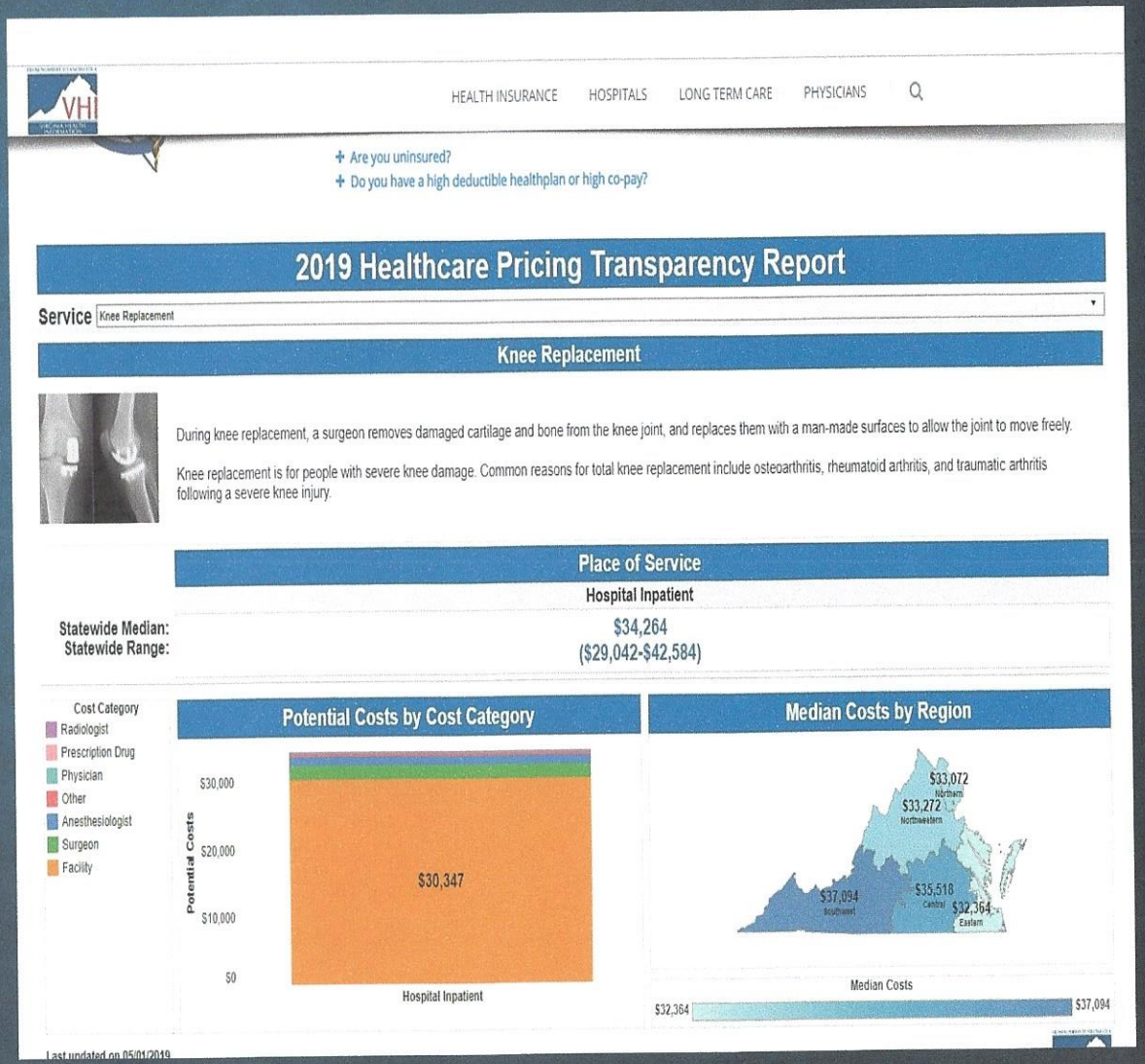
VIRGINIA HEALTH INFORMATION (VHI)

www.vhi.org/healthcarepricing

One statewide median cost

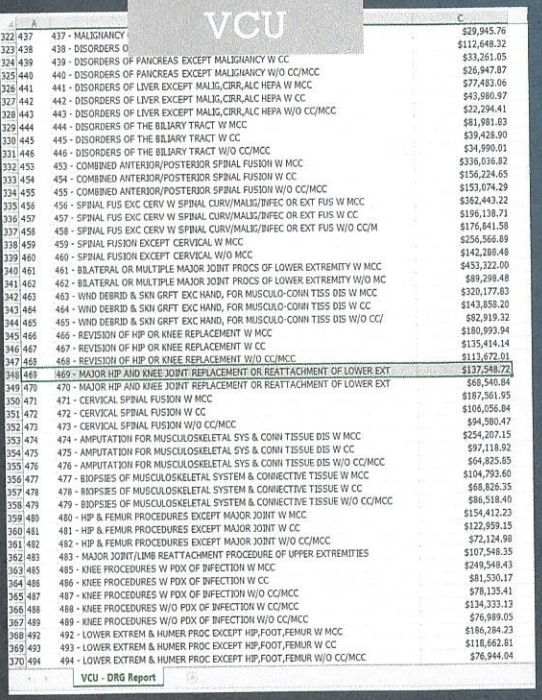
One statewide cost range

One estimated cost per region



PROVIDER PRICE TRANSPARENCY LISTS

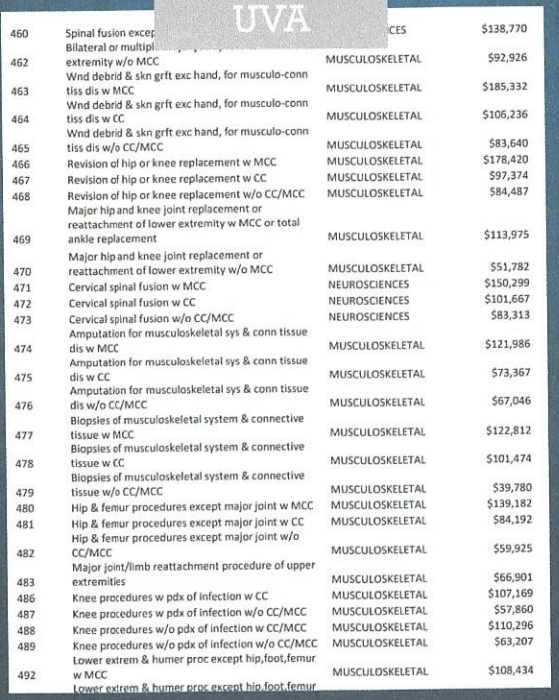
VCU



	A		C
322	437	437 - MALIGNANCY	$29,945.76
323	438	438 - DISORDERS O	$112,648.32
324	439	439 - DISORDERS OF PANCREAS EXCEPT MALIGNANCY W CC	$33,261.05
325	440	440 - DISORDERS OF PANCREAS EXCEPT MALIGNANCY W/O CC/MCC	$26,947.87
326	441	441 - DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W MCC	$77,483.06
327	442	442 - DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W CC	$43,980.97
328	443	443 - DISORDERS OF LIVER EXCEPT MALIG,CIRR,ALC HEPA W/O CC/MCC	$22,294.41
329	444	444 - DISORDERS OF THE BILIARY TRACT W MCC	$81,981.83
330	445	445 - DISORDERS OF THE BILIARY TRACT W CC	$39,428.90
331	446	446 - DISORDERS OF THE BILIARY TRACT W/O CC/MCC	$34,990.01
332	453	453 - COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	$336,036.82
333	454	454 - COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	$156,224.65
334	455	455 - COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	$153,074.29
335	456	456 - SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W MCC	$362,443.22
336	457	457 - SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W CC	$196,138.71
337	458	458 - SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W/O CC/M	$176,841.58
338	459	459 - SPINAL FUSION EXCEPT CERVICAL W MCC	$256,566.89
339	460	460 - SPINAL FUSION EXCEPT CERVICAL W/O MCC	$142,288.48
340	461	461 - BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	$453,322.00
341	462	462 - BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MC	$89,298.48
342	463	463 - WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	$320,177.83
343	464	464 - WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	$143,858.20
344	465	465 - WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/	$82,919.32
345	466	466 - REVISION OF HIP OR KNEE REPLACEMENT W MCC	$180,993.94
346	467	467 - REVISION OF HIP OR KNEE REPLACEMENT W CC	$135,414.14
347	468	468 - REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC	$113,672.01
348	469	469 - MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXT	$137,548.72
349	470	470 - MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXT	$66,540.84
350	471	471 - CERVICAL SPINAL FUSION W MCC	$187,561.95
351	472	472 - CERVICAL SPINAL FUSION W CC	$106,056.84
352	473	473 - CERVICAL SPINAL FUSION W/O CC/MCC	$94,580.47
353	474	474 - AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC	$254,207.15
354	475	475 - AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC	$97,118.92
355	476	476 - AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC	$64,825.65
356	477	477 - BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	$104,793.60
357	478	478 - BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	$68,826.35
358	479	479 - BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	$86,518.40
359	480	480 - HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	$154,412.23
360	481	481 - HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	$122,959.15
361	482	482 - HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	$72,124.98
362	483	483 - MAJOR JOINT/LIMB REATTACHMENT PROCEDURE OF UPPER EXTREMITIES	$107,548.35
363	485	485 - KNEE PROCEDURES W PDX OF INFECTION W MCC	$249,548.43
364	486	486 - KNEE PROCEDURES W PDX OF INFECTION W CC	$81,530.17
365	487	487 - KNEE PROCEDURES W PDX OF INFECTION W/O CC/MCC	$78,135.41
366	488	488 - KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	$134,333.13
367	489	489 - KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC	$76,989.05
368	492	492 - LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W MCC	$186,284.23
369	493	493 - LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W CC	$118,662.81
370	494	494 - LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W/O CC/MCC	$76,944.04

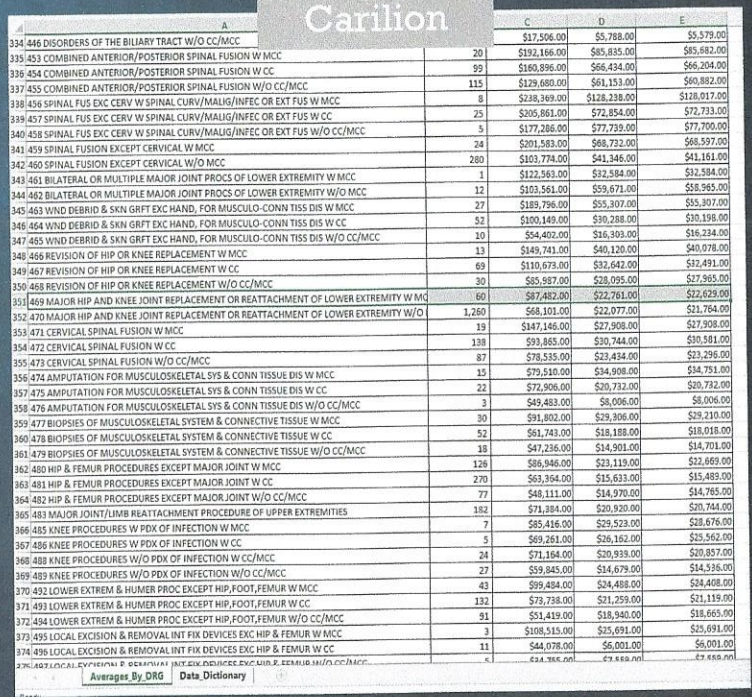
VCU - DRG Report

UVA



460	Spinal fusion excep	CES	$138,770
462	Bilateral or multipl extremity w/o MCC	MUSCULOSKELETAL	$92,926
463	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w MCC	MUSCULOSKELETAL	$185,332
464	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w CC	MUSCULOSKELETAL	$106,236
465	Wnd debrid & skn grft exc hand, for musculo-conn tiss dis w/o CC/MCC	MUSCULOSKELETAL	$83,640
466	Revision of hip or knee replacement w MCC	MUSCULOSKELETAL	$178,420
467	Revision of hip or knee replacement w CC	MUSCULOSKELETAL	$97,374
468	Revision of hip or knee replacement w/o CC/MCC	MUSCULOSKELETAL	$84,487
469	Major hip and knee joint replacement or reattachment of lower extremity w MCC or total ankle replacement	MUSCULOSKELETAL	$113,975
470	Major hip and knee joint replacement or reattachment of lower extremity w/o MCC	MUSCULOSKELETAL	$51,782
471	Cervical spinal fusion w MCC	NEUROSCIENCES	$150,299
472	Cervical spinal fusion w CC	NEUROSCIENCES	$101,667
473	Cervical spinal fusion w/o CC/MCC	NEUROSCIENCES	$83,313
474	Amputation for musculoskeletal sys & conn tissue dis w MCC	MUSCULOSKELETAL	$121,986
475	Amputation for musculoskeletal sys & conn tissue dis w CC	MUSCULOSKELETAL	$73,367
476	Amputation for musculoskeletal sys & conn tissue dis w/o CC/MCC	MUSCULOSKELETAL	$67,046
477	Biopsies of musculoskeletal system & connective tissue w MCC	MUSCULOSKELETAL	$122,812
478	Biopsies of musculoskeletal system & connective tissue w CC	MUSCULOSKELETAL	$101,474
479	Biopsies of musculoskeletal system & connective tissue w/o CC/MCC	MUSCULOSKELETAL	$39,780
480	Hip & femur procedures except major joint w MCC	MUSCULOSKELETAL	$139,182
481	Hip & femur procedures except major joint w CC	MUSCULOSKELETAL	$84,192
482	Hip & femur procedures except major joint w/o CC/MCC	MUSCULOSKELETAL	$59,925
483	Major joint/limb reattachment procedure of upper extremities	MUSCULOSKELETAL	$66,901
486	Knee procedures w pdx of infection w CC	MUSCULOSKELETAL	$107,169
487	Knee procedures w pdx of infection w/o CC/MCC	MUSCULOSKELETAL	$57,860
488	Knee procedures w/o pdx of infection w CC/MCC	MUSCULOSKELETAL	$110,296
489	Knee procedures w/o pdx of infection w/o CC/MCC	MUSCULOSKELETAL	$63,207
492	Lower extrem & humer proc except hip,foot,femur w MCC	MUSCULOSKELETAL	$108,434
	Lower extrem & humer proc except hip,foot,femur		

Carilion



	A		C	D	E
334	446 DISORDERS OF THE BILIARY TRACT W/O CC/MCC		$17,506.00	$5,788.00	$9,579.00
335	453 COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W MCC	20	$192,166.00	$85,835.00	$85,682.00
336	454 COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W CC	99	$160,896.00	$66,434.00	$66,204.00
337	455 COMBINED ANTERIOR/POSTERIOR SPINAL FUSION W/O CC/MCC	115	$129,680.00	$61,153.00	$60,882.00
338	456 SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W MCC	8	$238,369.00	$128,238.00	$128,017.00
339	457 SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W CC	25	$205,861.00	$72,854.00	$72,733.00
340	458 SPINAL FUS EXC CERV W SPINAL CURV/MALIG/INFEC OR EXT FUS W/O CC/MCC	5	$177,286.00	$77,739.00	$77,700.00
341	459 SPINAL FUSION EXCEPT CERVICAL W MCC	24	$201,583.00	$68,722.00	$68,597.00
342	460 SPINAL FUSION EXCEPT CERVICAL W/O MCC	280	$103,774.00	$41,346.00	$41,161.00
343	461 BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	1	$122,563.00	$32,584.00	$32,584.00
344	462 BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC	12	$103,561.00	$59,671.00	$58,965.00
345	463 WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	27	$189,796.00	$55,307.00	$55,307.00
346	464 WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	52	$100,149.00	$30,288.00	$30,198.00
347	465 WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	10	$54,402.00	$16,303.00	$16,234.00
348	466 REVISION OF HIP OR KNEE REPLACEMENT W MCC	13	$149,741.00	$40,120.00	$40,078.00
349	467 REVISION OF HIP OR KNEE REPLACEMENT W CC	69	$110,673.00	$32,642.00	$32,491.00
350	468 REVISION OF HIP OR KNEE REPLACEMENT W/O CC/MCC	30	$85,987.00	$28,095.00	$27,965.00
351	469 MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W MC	60	$87,482.00	$22,761.00	$22,629.00
352	470 MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O	1,260	$68,101.00	$22,077.00	$21,764.00
353	471 CERVICAL SPINAL FUSION W MCC	19	$147,145.00	$27,908.00	$27,908.00
354	472 CERVICAL SPINAL FUSION W CC	138	$93,865.00	$30,744.00	$30,581.00
355	473 CERVICAL SPINAL FUSION W/O CC/MCC	87	$78,535.00	$23,434.00	$23,296.00
356	474 AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W MCC	15	$79,510.00	$34,908.00	$34,751.00
357	475 AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W CC	22	$72,906.00	$20,732.00	$20,732.00
358	476 AMPUTATION FOR MUSCULOSKELETAL SYS & CONN TISSUE DIS W/O CC/MCC	3	$49,483.00	$8,006.00	$8,006.00
359	477 BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W MCC	30	$91,802.00	$29,306.00	$29,210.00
360	478 BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W CC	52	$61,743.00	$18,188.00	$18,018.00
361	479 BIOPSIES OF MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE W/O CC/MCC	18	$47,236.00	$14,901.00	$14,701.00
362	480 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W MCC	126	$86,946.00	$23,119.00	$22,669.00
363	481 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	270	$63,364.00	$15,633.00	$15,489.00
364	482 HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W/O CC/MCC	77	$48,111.00	$14,970.00	$14,765.00
365	483 MAJOR JOINT/LIMB REATTACHMENT PROCEDURE OF UPPER EXTREMITIES	182	$71,384.00	$20,920.00	$20,744.00
366	485 KNEE PROCEDURES W PDX OF INFECTION W MCC	7	$85,416.00	$29,523.00	$28,676.00
367	486 KNEE PROCEDURES W PDX OF INFECTION W CC	5	$69,261.00	$26,162.00	$25,562.00
368	488 KNEE PROCEDURES W/O PDX OF INFECTION W CC/MCC	24	$71,164.00	$20,933.00	$20,857.00
369	489 KNEE PROCEDURES W/O PDX OF INFECTION W/O CC/MCC	27	$59,845.00	$14,679.00	$14,536.00
370	492 LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W MCC	43	$99,484.00	$24,488.00	$24,408.00
371	493 LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W CC	132	$73,738.00	$21,259.00	$21,119.00
372	494 LOWER EXTREM & HUMER PROC EXCEPT HIP,FOOT,FEMUR W/O CC/MCC	91	$51,419.00	$18,940.00	$18,665.00
373	495 LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W MCC	3	$108,515.00	$25,691.00	$25,691.00
374	496 LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W CC	11	$44,078.00	$6,001.00	$6,001.00
375	497 LOCAL EXCISION & REMOVAL INT FIX DEVICES EXC HIP & FEMUR W/O CC/MCC	5	$24,765.00	$7,559.00	$7,559.00

Averages_By_DRG | Data_Dictionary

vcuhealth.org/locations/vcu-medical-center/billing-and-insurance/price-transparency
uvahealth.com/services/billing-insurance/pricing
carilionclinic.org/pricing#standard-charges-by-diagnosis-related-group-drg

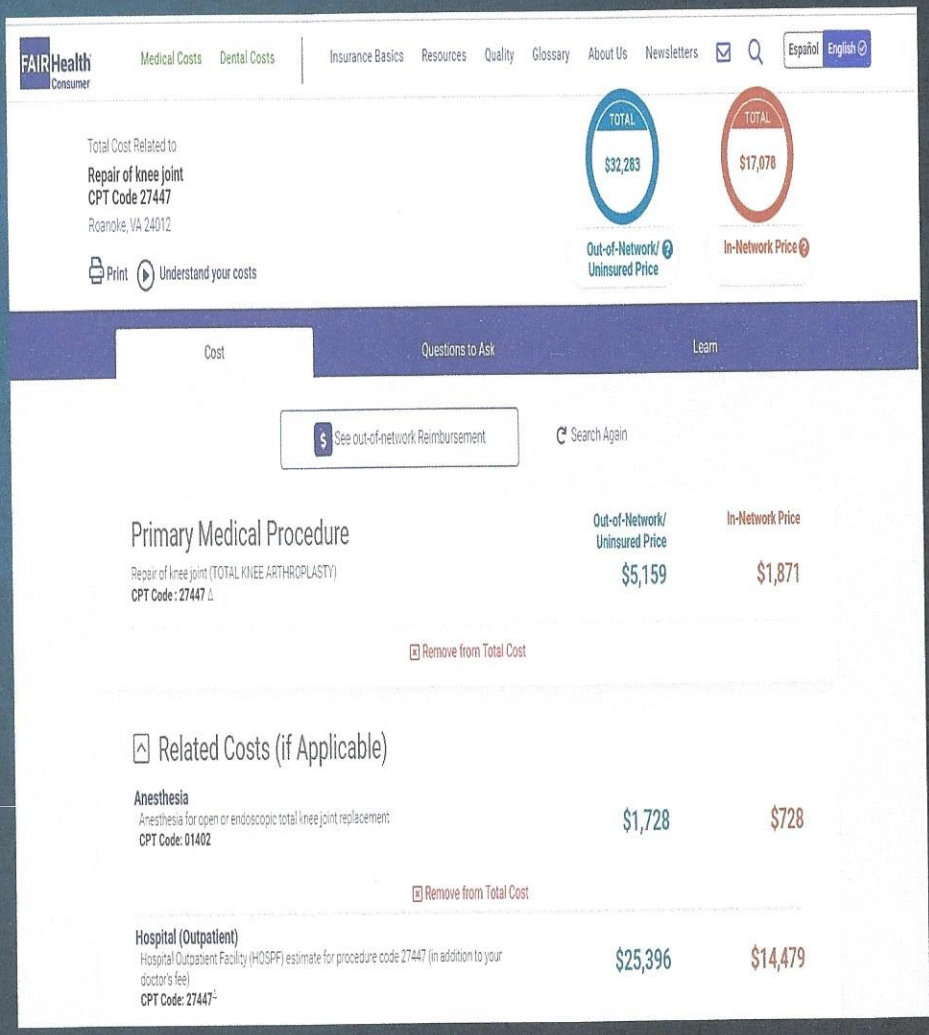
NATIONAL HEALTH PRICING WEBSITES

www.fairhealthconsumer.org/medical

Limited procedure choices

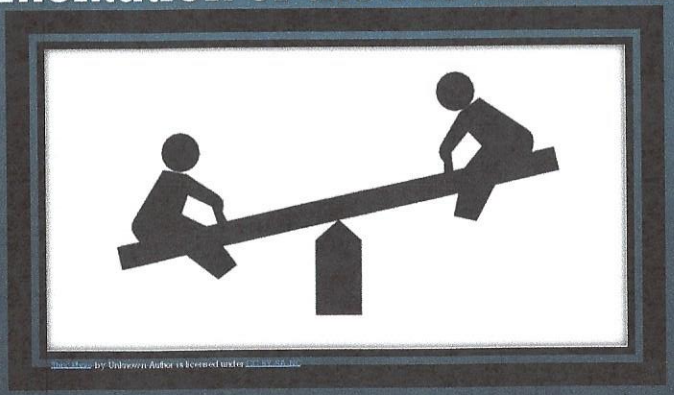
Based on zip code

Often based on private health insurance or Medicare payment rates



LEVELING THE PLAYING FIELD

The implementation of the Medical Fee Schedule



WHAT IS THE FEE SCHEDULE

- An outline of maximum fees for facilities and providers who provide treatment to injured employees
- Applies to all treatment for dates of service January 1, 2018 and continuing
- Designed to reflect actual average costs for services including variation by medical community and procedure/service
- Has specific exclusions
- Has two categories of hospitals

HOW IT CAME TO BE

- Developed in accordance with Chapters 279 & 290 (amended) of the 2016 Acts of Assembly and Chapter 478 of the 2017 Acts of Assembly
- Approved on March 7, 2016
- Developed by a regulatory Advisory Panel and the Commission's actuarial consultant, Oliver Wyman
- Designed to achieve revenue neutrality

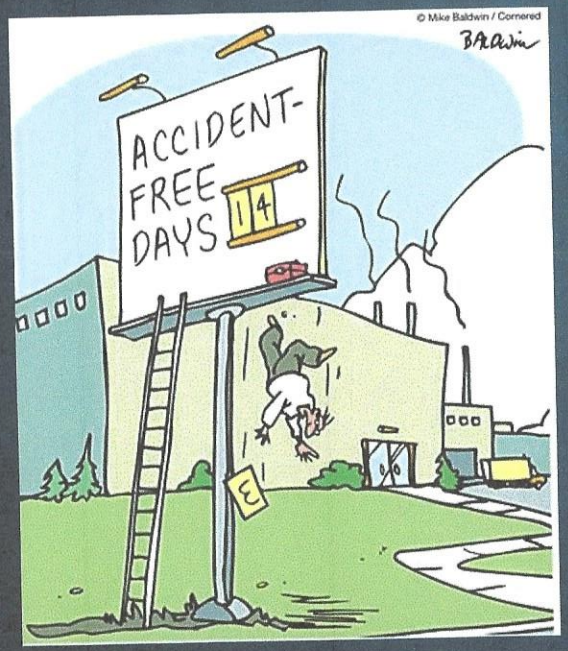
WHAT IT CAN BE USED FOR

- Accurately calculating medical costs for most procedures common to workers compensation
- Providing specific and detailed calculations to clients trying to assess their options and value a claim for settlement
- Rebutting unrealistic demands from Claimants and their counsel

LOOKING INTO THE CRYSTAL BALL

6 Tips for projecting future medical expenses

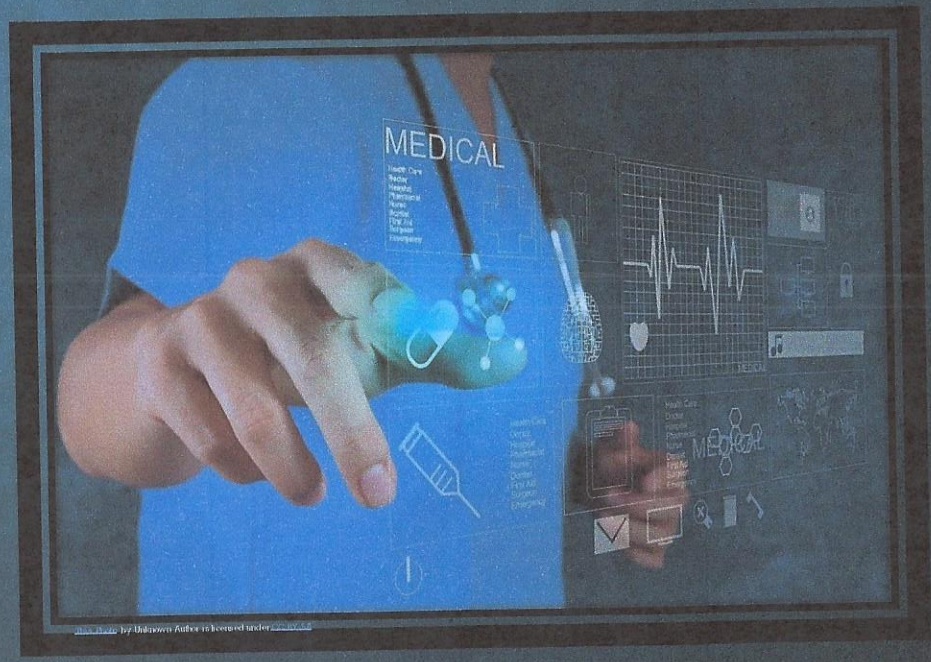
KNOW YOUR CLAIMANT



- Age
  - Risk of age related issues such as:
    - Slow wound healing
    - Risks of Anesthesia
    - Lack of mobility/range of motion
- Prior medical history
  - Pre-Existing Injuries
  - Prior Claims
- Chronic medical conditions
  - Diabetes
  - Hypertension
  - COPD
- Current medications
  - Blood pressure medications
  - Diabetes medications
  - Blood Thinners

KNOW YOUR PROVIDER

- Conservative or Claimant friendly
  - Do they consider non-surgical methods first?
  - Are they surgery driven?
  - Are they known to keep patients out of work or get them back to work quickly?
- Usual pattern for pre-surgical care
- Usual pattern for post-surgical care
  - Frequency of PT
  - Work Restrictions
  - Release to Full



KNOW YOUR MEDICAL CODING

- DRG CODES – DIAGNOSIS RELATED GROUP
  - 6-digit alphanumeric code starting with DRG
  - Used for inpatient hospital procedures
  - Does NOT include provider expenses
- CPT – CURRENT PROCEDURAL TERMINOLOGY
  - 5 digit all numeric code
  - Can be used for both outpatient facility expenses and provider expenses
- HCPCS – HEALTHCARE COMMON PROCEDURE CODING SYSTEM
  - Usually a 5 digit alphanumeric code
  - Commonly used for durable medical equipment and transportation

KNOW YOUR BASIC EXPENSES

- FACILITY EXPENSE
  - Inpatient Facility
  - Outpatient Facility
- PROVIDER EXPENSE
  - Surgeon
  - Non - Surgeon
- ANESTHESIA
  - Base Units
  - Time Units
- DURABLE MEDICAL EQUIPMENT
- TRANSPORTATION
  - Air
  - Ground

KNOW YOUR TREATMENT DATES

- Is the date of service before January 1, 2018?
  - Use the community standard method.
- Is the date of service between January 1, 2018 and December 31, 2019?
  - Use the Commission's 2018 Medical Fee Schedule
- Is the date of service after January 1, 2020?
  - Use the Commission's 2020 Medical Fee Schedule

KNOW WHERE TO LOOK

- Anesthesia codes
  - www.anesthesiabilling.org
- CPT codes
  - www.correctcodechek.decisionhealth.com
  - coder.aapc.com
- DRG codes
  - findacode.com/code-set.php?set=DRG
  - icd10data.com/ICD10CM/DRG
- HCPCS codes
  - coder.aapc.com/hcpcs-codes/
  - hcpcs.codes/search

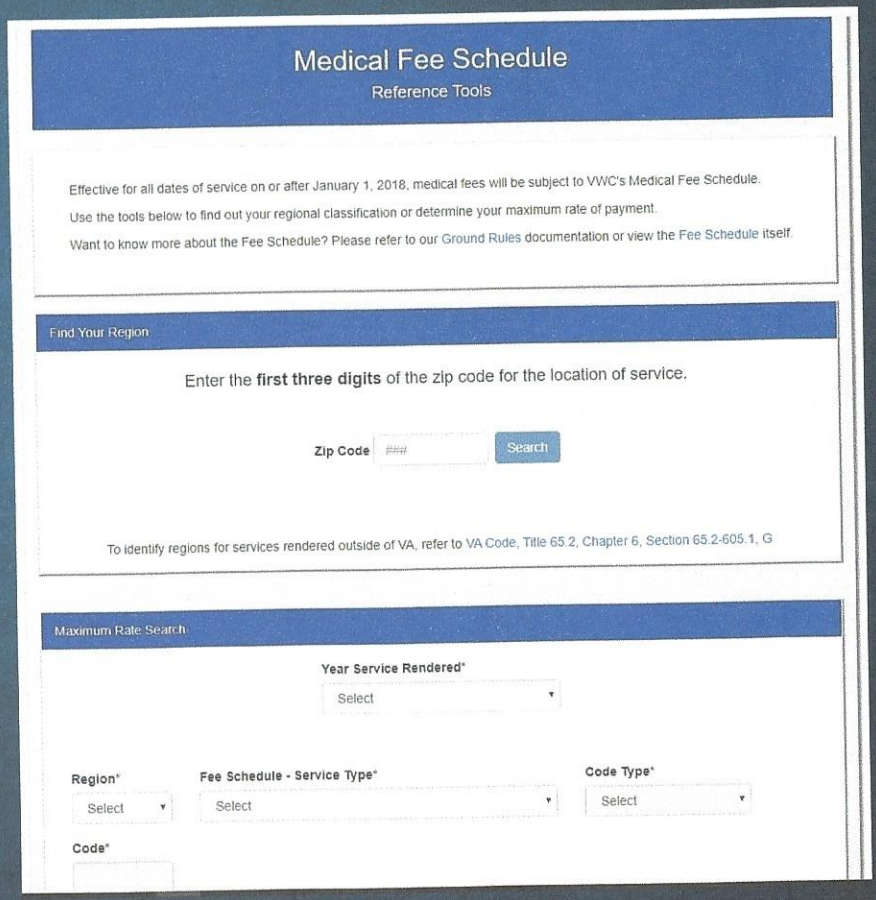
PUTTING IT ALL TOGETHER

Calculating Medical Costs with the Fee Schedule

KEEPING IT SIMPLE

Using the Commission's Reference Tool

- Enter the partial zip code for the location where treatment occurred
- Enter the year that treatment was provided in
- Select the type of service
- Select a modifier (if needed)
- Select code type
- The Reference Tool will search the fee schedule for you

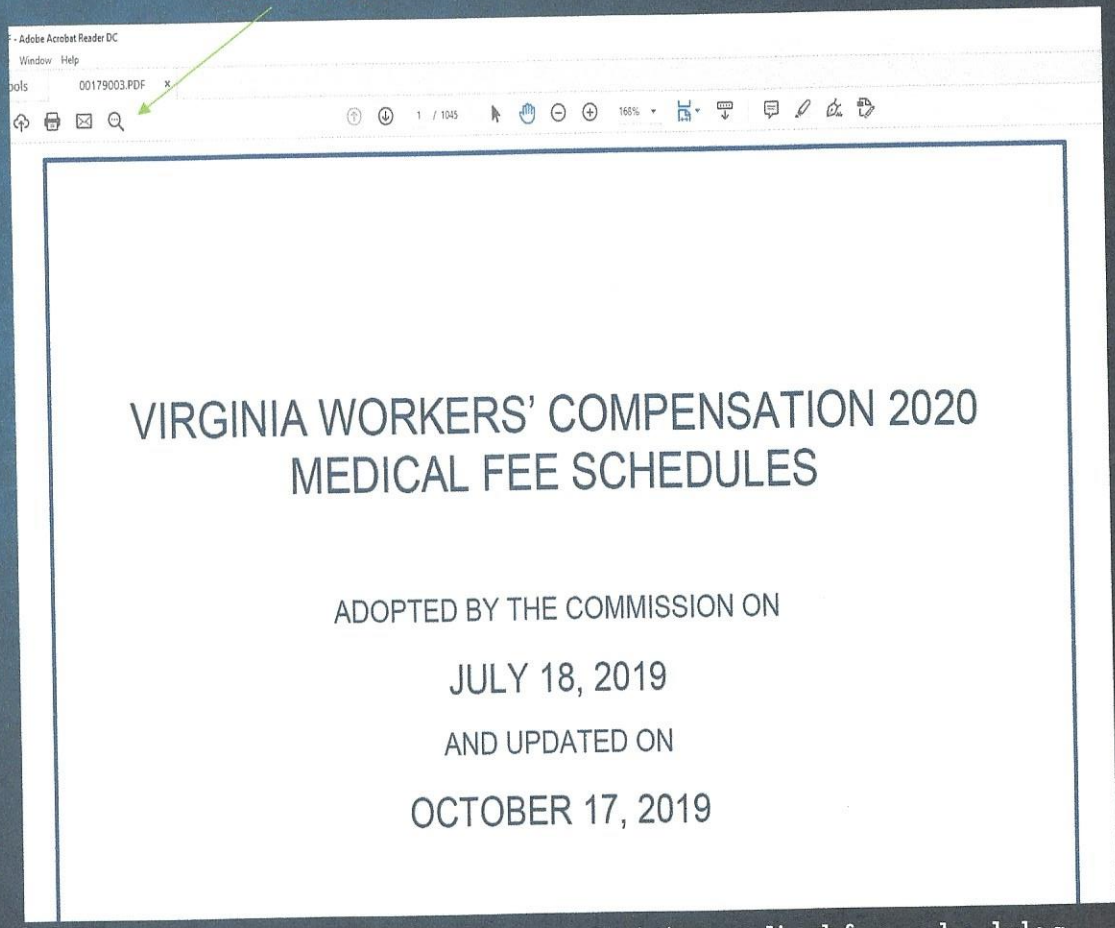


medicalfeeschedule.workcomp.virginia.gov

FEELING CONFIDENT

Searching the Fee Schedule On Your Own

- Download the Fee Schedule PDF from the Commission's Website
- Using the magnifying glass in the upper left corner search the document for the CPT code or HCPCS code related to the Claimant's treatment
- Triple check yourself:
  - Right section
  - Right code
  - Right region



workcomp.virginia.gov/content/virginia-medical-fee-schedules

THINGS TO REMEMBER

Not every CPT code or HCPCS code is listed in the fee schedule

If a code is not listed in the Fee Schedule payment for the service cannot be automatically denied.

If a code is not listed, the Ground Rules of the Fee Schedule state that the Insurer shall pay no more than 80% of the billed amount.

Is your local hospital on par with the care a Claimant would receive at UVA or VCU?

Type One Teaching Hospitals are billed at a significantly higher rate than non-Type One Hospitals

Non-Physician Providers are paid based on coding just like Physicians

This group includes providers like:

- Physician's Assistants
- Nurse Practitioners
- Physical Therapists
- Occupational Therapists
- Speech Therapists

Type One Vs. Non-Type One: What's the difference?

PRICING A TOTAL KNEE REPLACEMENT IN THE CHARLOTTESVILLE AREA

	UVA (Type One Teaching Hospital)	SENTARA MARTHA JEFFERSON (Non-Type One Teaching Hospital)
Facility Expense (DRG0469)	$82,202.00	$59,099.00
Surgeon (CPT Code: 27447)	$3,054.88	$3,054.88
Assistant Surgeon (20% of max value allowed for CPT Code: 27447)	$610.98	$610.98
Anesthesia (Base Units: 7; Time Units: 8)	$989.70	$989.70
TOTAL CHARGES	**$86,857.56**	**$63,754.56**

ULTRA CONSERVATIVE CARE FOR A CERVICAL SPINE INJURY

CPT Code		Cost Per	Cost over 15 Years
99213	Orthopaedic/Spine Surgeon office visits	$94.41	$1,416.15
99213	Physical Medicine & Rehabilitation office visits	$94.16	$1,506.56
99213	Pain Management office visits	$94.16	$4,143.04
72141	Cervical MRI without contrast	$913.58	$1,827.16
72040	Cervical X-rays (2 or 3 views)	$70.79	$1,061.85
97162	Physical Therapy (initial evaluation)	$143.61	$574.44
97164	Physical therapy (progress evaluation)	$66.55	$266.20
97164	Physical Therapy (discharge evaluation)	$66.55	$266.20
97110	Therapeutic exercises (2 units x 48 visits)	$101.62	$4,877.76
97140	Manual therapy (1 unit x 48 visits)	$45.68	$2,192.64
	Total Cost (not including prescriptions)		**$18,132.00**

CONSERVATIVE CARE FOR A CERVICAL SPINE INJURY

CPT Code		Cost Per	Cost over 15 Years
99213	Orthopaedic/Spine Surgeon office visits	$94.41	$1,416.15
99213	Physical Medicine & Rehabilitation office visits	$94.16	$1,506.56
99213	Pain Management office visits	$94.16	$4,143.04
72141	Cervical MRI without contrast	$913.58	$1,827.16
72040	Cervical X-rays (2 or 3 views)	$70.79	$1,061.85
64490	Injection, cervical or thoracic, w/ guidance, single level	$503.66	$15,109.80
64491	Injection, cervical or thoracic, w/ guidance, 2nd level	$268.82	$8,064.60
97162	Physical Therapy (initial evaluation)	$143.61	$574.44
97164	Physical therapy (progress evaluation)	$66.55	$266.20
97164	Physical Therapy (discharge evaluation)	$66.55	$266.20
97110	Therapeutic exercises (2 units x 48 visits)	$101.62	$4,877.76
97140	Manual therapy (1 unit x 48 visits)	$45.68	$2,192.64
	Total Cost (not including prescriptions)		**$41,040.20**

SURGICAL CARE FOR A CERVICAL SPINE INJURY

CPT Code		Cost Per	Total Cost
99214	Spine Center Pre-Operative office visit	$156.79	$627.16
99214	Spine Center Post-Operative office visit	$156.79	$940.74
DRG473	Cervical Spinal Fusion w/o complications	$45,294.00	$45,294.00
22551	Surgeon – Cervical Anterior Discectomy & Fusion	$3,811.51	$3,811.51
22554	Surgeon – Cervical Anterior Discectomy & Fusion (rev)	$3,434.81	$3,434.81
22853	Surgeon – Instrumentation	$1,274.36	$1,274.36
63081	Surgeon – Corpectomy	$3,747.33	$3,747.33
20931	Use of allograft	$133.09	$133.09
22551	Assistant – Cervical Anterior Discectomy & Fusion	$762.30	$762.30
22554	Assistant – Cervical Anterior Discectomy & Fusion (rev)	$686.96	$686.96
22853	Assistant – Instrumentation	$254.87	$254.87
63081	Assistant – Corpectomy	$749.47	$749.47
0670	Anesthesia (Base units: 13, Time units: 8)	$1,406.79	$1,406.79
	Total Cost (not including prescriptions)		**$63,123.39**

QUESTIONS?