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MEMORANDUM

FROM: **Workers Compensation Research Institute (WCRI)**

DATE: **November 2020**

RE: **Medical fee schedules for professional services in workers' compensation**

This memorandum describes the elements of workers' compensation (WC) medical fee schedules for professional services. Throughout this document, we use the term *fee schedule* to refer to *workers' compensation medical fee schedules*. In the subsequent sections, we provide examples from different states. The examples illustrate features of different methods and the variety in the methods used. Questions addressed in this memorandum:

1. What is a fee schedule?
2. Which types of providers are covered?
3. What are the bases of fee schedules?
4. Are fee schedules statewide or regional?
5. How are procedures not listed in the fee schedule reimbursed?
6. What are methods for updating fee schedules?
7. How are fee schedules and subsequent changes implemented?
8. Other considerations?
9. How did Illinois, Indiana, and Virginia implement fee schedules?
10. How does WCRI research help states measure the impact of fee schedule implementation or changes?

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1. What Is a Fee Schedule?

A fee schedule is a list of maximum allowable reimbursement amounts for medical procedures and treatments (determined by the classification of the CPT/HCPCS[1] code guide). Typically, fee schedules limit payments to providers of medical services to the lower of the billed charge or the rate in the fee schedule. Many states allow deviation from the fee schedule when other contractual agreements between payors and medical providers exist, including network agreements.

Fee schedules are the most direct policy tool to regulate prices. Other policy tools—treatment guidelines, utilization review, and managed care—regulate medical utilization rather than medical prices. Fee schedules are designed to control medical cost growth over time, to increase the consistency of procedure definitions and allowable rates, and to reduce disputes over medical payments.

As of 2018, 45 states used fee schedules. States that most recently introduced fee schedules are Virginia (for services effective January 1, 2018) and Indiana (hospital services effective July 1, 2014).

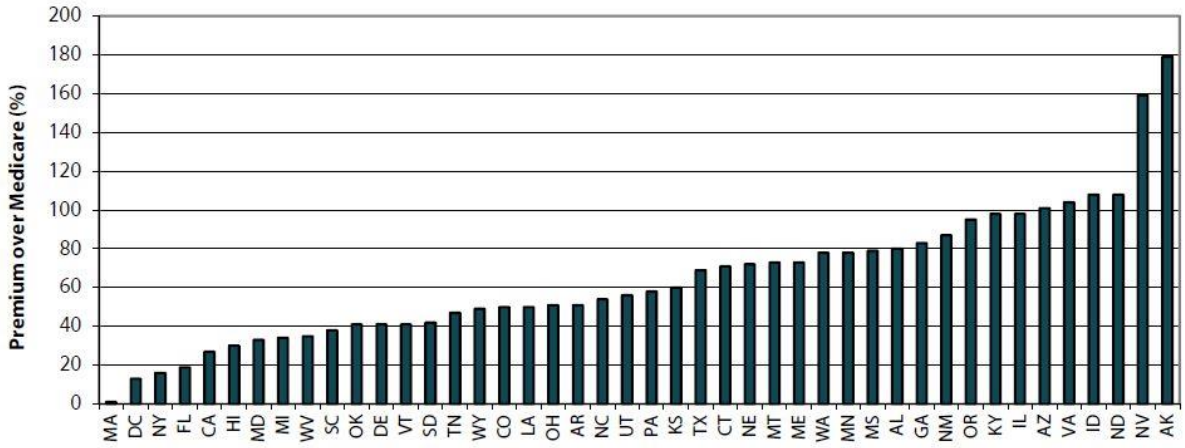
[1] CPT: Current Procedural Terminology. HCPCS: Healthcare Common Procedure Coding System is a registered trademark of the American Medical Association.

Number of Jurisdictions With WC Fee Schedules as of 2018				
	Professional	**Hospital Outpatient**	**Hospital Inpatient**	**Ambulatory Surgery Center**
With fee schedule	**45**	**43**	**44**	**42**
No fee schedule	IA, IN, MO, NJ, NH, WI	AZ, DC, IA, MO, NH, NJ, UT, WI	AZ, DC, IA, MO, NH, NJ, WI	AZ, DC, IA, IN, MO, NH, NJ, UT, WI

In states with fee schedules, the below chart compares the state's fee schedule rates to the Medicare rates in that state.

DESIGNING WORKERS' COMPENSATION MEDICAL FEE SCHEDULES, 2019

Figure 2 Workers' Compensation Premium over Medicare, February 2019



Notes: California, Delaware, Florida, Illinois, New York, Pennsylvania, Texas, and Virginia have distinct fee schedules for different parts of the state. For each, a single statewide rate was created by averaging the different sub-state fee schedules using the percentage of employed persons in each sub-state region as weights. Medicare establishes distinct sub-state fee schedules in 14 states. For each, a single statewide rate was created using the same procedure. Rhode Island has different billing codes for physical medicine and does not establish rates for the majority of the codes. An overall rate is not established for Rhode Island as physical medicine is the largest component of the marketbasket and excluding it significantly biases the results. For more details, see the technical appendix.

2. Which Types of Providers Are Covered?

The majority of fee schedules cover medical services for all types of providers: physicians, hospital inpatient and outpatient, ambulatory surgery centers (ASCs), physical and occupational therapists (PT/OTs), chiropractors, pharmacy, and durable medical equipment. Often there are separate fee schedules for ambulance services, anesthesia, or other specific types of services or providers.

This memorandum summarizes common methods for designing fee schedules for *professional* services. We use the term *professional* services to refer to physicians, physical and occupational therapists, including chiropractors, and other practitioners (for instance, nurse practitioner and physician's assistant).

A description of the structure of fee schedules for *hospital* services is provided in a separate

document. Fee schedules for hospital services are designed to cover hospital outpatient, ASCs, and inpatient services. They typically use methods based on episodes of care, but can also include specific payment amounts for particular procedures, or payments as a fixed percentage of charges.[2]

3. What Are the Bases of Fee Schedules?

The most common basis to set fee schedule rates for professional services is to use the *resource-based relative value scale* (RBRVS) by the Centers for Medicare & Medicaid Services (CMS). Other methods use historical charges or actual payments, and alternatives of the Medicare relative value units.

Number of Jurisdictions With Fee Schedules For Professional Services	
CMS RBRVS-based	Other methods
31	14

CMS RBRVS-BASED

In 1992, CMS implemented a standardized provider payment schedule in which differences in payments by service type and by geographic area were based on differences in the cost to providers. The RBRVS system evaluates medical procedures or services in terms of the provider's time, technical expertise, practice expenses, and professional liability insurance expenses, and assigns a relative value unit (RVU) for that procedure or service. In general, the more complex the procedure, e.g., knee arthroscopy versus office visit, the higher the RVU. CMS then adjusts the RVU based on geographical area by applying the Geographic Practice Cost Indices (GPCI) to arrive at the Total RVU. Once the Total RVU is determined, a conversion factor is applied in order to monetize that relative value and set the fee schedule rate. Below are two examples from the Minnesota Medicare fee schedule:

Examples from Minnesota (CMS locality 620200) Medicare amount in 2019

CPT 99213: Established patient office visit

RVU Components	RVU	GPCI	Total RVU (RVU x GPCI)	WC Monetary Conversion Factor	Medicare Amount (Total RVU x monetary conversion)
Physician work	0.97	1.000	0.9700	n/a	n/a
Practice expense (nonfacility)	1.05	1.011	1.0616	n/a	n/a
Professional liability insurance	0.07	0.362	0.0253	n/a	n/a
Total	n/a	n/a	**2.0569**	**$36.0391**	**$74.13**

CPT 29827: Arthroscopic rotator cuff repair

RVU Components	RVU	GPCI	Total RVU (RVU x GPCI)	WC Monetary Conversion Factor	Medicare Amount (Total RVU x monetary conversion)

[2] Episode of care methods: Centers for Medicare & Medicaid Services *ambulatory payment classification* and *diagnosis-related groups.*

Physician work	15.59	1.000	15.5900	n/a	n/a
Practice expense (nonfacility)	12.24	1.011	12.3746	n/a	n/a
Professional liability insurance	2.53	0.362	0.9159	n/a	n/a
Total	n/a	n/a	**28.8805**	**$36.0391**	**$1,040.83**

Minnesota WC fee schedule rate in 2020 (October 2020 – September 2021)

CPT Codes	Medicare Total RVU In 2019	WC Monetary Conversion Factor	WC Fee Schedule Amount
CPT 99213	2.0569	$70.86	**$145.75**
CPT 29827	28.8805	$70.86	**$2,046.47**

Additionally, because RBRVS valuations may not be optimal for workers' compensation reimbursements, most states that use the RBRVS system have made adjustments by modifying the RVU or the monetary conversion factor or by simply applying a WC-specific multiplier (or percentage) over the Medicare rate.

WC maximum amount = Total RVU x Monetary conversion factor x Multiplier

The goal of all these adjustments is to create a premium over the Medicare rate. There are two main reasons why states apply a premium over Medicare. First, providers may need compensation for the extra time and effort to manage WC patients. Second, a state may want to create its own pattern of relative fees across medical services, i.e., increase rates for primary care (office visits and physical medicine) relative to rates for specialty care (radiology and surgery). Modifications can be made as follows:

Total RVU: By design, CMS RVUs are not state-specific; rather they are procedure-specific. In the RBRVS system, the geographic adjustment is region-specific and applied to all procedures. As a result, for the purposes of workers' compensation, some states modify the RVU or the geographic component of it. In addition, states may decide to use different versions and years of the CMS RVU files. States using non-Medicare RVUs are discussed in the next section.

Monetary conversion factor: In this approach, a premium over the Medicare rate is obtained by increasing the Medicare monetary conversion factors by a specific percentage. States often decide to use more than one monetary conversion factor depending on the type of service.

Multiplier: This is a WC-specific adjustment. In this approach a premium over the Medicare rate is obtained directly by applying a single (or multiple) percentage(s) over the Medicare rate.

Examples from states adjusting the RVU, monetary conversion factor, or applying multipliers

Michigan:

WC fee schedule amount = CMS RVU x **WC-adjusted GPCI** x **WC monetary conversion factor**

The monetary conversion factor for office visits, medicine, physical medicine, radiology, and surgical procedures was $47.66 in 2019. For comparison, the CMS monetary conversion factor in 2019 was $36.0391. The WC-adjusted GPCI is calculated using 60 percent of the Detroit area and 40 percent of the rest of the state's GPCI.

Minnesota:

WC fee schedule amount = CMS Total RVU x **several WC monetary conversion factors**

MN WC-specific monetary conversion factors: medical/surgical services ($70.86), physical medicine ($58.68), pathology/laboratory ($60.10), and chiropractic services ($50.70) from October 2020-September 2021.

Tennessee:
WC fee schedule amount = CMS Total RVU x monetary conversion factor x **several multipliers**
CMS monetary conversion factor for all services in 2020 = $36.0896 (as shown in the example above)
TN multipliers: chiropractic and PT/OT 1.3; general medicine 1.6; general surgery, radiology, and pathology 2; orthopedic and neurosurgery 2.75.

FEE SCHEDULES BASED ON OTHER METHODS

There are several other methods to compute fee schedule rates for professional services. These methods use historical charges, historical actual payments, and alternatives of the CMS relative values as the bases. Currently 14 states use these different methods.

Of the six states using relative values to calculate the reimbursement rates for professional services, three states use the Optum360 *Relative Values for Physicians.* The Optum360 relative value system is established by a survey of physicians in all specialties. Note that states using this type of relative value system still need to make a choice of the monetary conversion factor or other multipliers over the initial fee schedule amount. This approach is similar to the one described in the RBRVS model.

Number of States With Fee Schedule For Professional Services	
Based on Historical Charges/Payments	**Based on Relative Values**
8 **AL, IL, LA, MA, NM, RI, VT, VA**	**6** **HI, KY, NV, NY, SD, WV**

Examples from states using historical charges/payments
Illinois: 2006 maximum reimbursement rates were originally set at 90 percent of the 80th percentile of health care provider charges from 2002 to 2004.
Virginia: State-specific WC data in 2014 and 2015. The rates were designed to reflect historical payments for services provided to treat WC injuries.

Examples from states using relative values
Kentucky: Relative value system based on historical data from Fair Health commercial database; applied a single factor for all service types.
Nevada, South Dakota, and Wyoming: Relative values from *Relative Values for Physicians* (RVP) published by Optum360; applied multiple factors depending on the service type.

South Dakota WC fee schedule rates in 2019

CPT Codes	RVP In 2019	Monetary Conversion Factor	WC Fee Schedule Amount
CPT 99213	9.00	$8.00	**$72.00**
CPT 29827	21.80	$100.80	**$2,197.44**

Nevada WC fee schedule rates in 2019

CPT Codes	RVP In 2019	Monetary Conversion Factor	WC Fee Schedule Amount
CPT 99213	9.00	$11.43	**$102.87**
CPT 29827	21.80	$234.44	**$5,306.99**

Examples from states that switched to CMS RBRVS

Arizona, California, North Carolina, and Texas: Arizona in 2016, California in 2012, North Carolina in 2017, and Texas in 2008.

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4. Are Fee Schedules Statewide or Regional?

Most states have one fee schedule for the entire state. Eight states have regional fee schedules. This decision might be based on whether higher prices address access-to-care issues in particular areas of the state.

	Number of States With Regional Fee Schedules for Professional Services				
1 region	2 regions	3 regions	4 regions	6 regions	8 regions
37	DE	FL	IL, NY, PA	VA	CA, TX

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5. How Are Procedures Not Listed in the Fee Schedule Reimbursed?

Some medical procedures and treatments may not be assigned a fee schedule rate, due to, for example, a new service (procedure code); services not covered by Medicare but used in WC; an insufficient number of services to determine a usual and customary or charged-based amount; or codes omitted due to less frequent updates of the fee schedule (e.g., if it is tied to an older edition of a CPT/HCPCS book or RVU/RVP).

Services without assigned fee schedule rates are sometimes reimbursed *by report* or fixed percentage of amount charged as indicated in regulations. *By report* means that the procedure has not been assigned a maximum amount, and requires a written description. States have different rules regarding what type of information should be included in the report (such as the rules for justifying charges based on variations from a similar procedure). Often, *by report* is reimbursement at a fixed percentage of billed charges. Among the states with a fee schedule for professional services, between 79 and 96 percent of medical payments were for services with assigned fee schedule rates.[3]

Note that some states may use the Optum360 *The Essential RBRVS* gap-fills, in addition to the RBRVS-

[3] Fomenko and Liu, 2019.

based fee schedule. Gap-fill relative values are developed for procedure codes not valued or included in RBRVS. Gap-fills are generated by Optum360 using information from other CMS files and their internal relative value scales.

Examples from states with procedures not listed in the fee schedule

Illinois: Payments are based on 53.2 percent of charges.

Pennsylvania, South Dakota, Tennessee, and Virginia: Payments are based on 80 percent of charges.

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6. What Are Methods for Updating Fee Schedules?

All elements of a fee schedule are subject to revision over time:

- the particular set of procedure codes listed, including the edition of the CPT/HCPCS coding book (published by the American Medical Association [AMA]);
- relative value units, including, for instance, the edition of the RBRVS or Optum360 relative values used;
- monetary conversion factors;
- state-specific multipliers; and
- inflation adjustments.

The Medicare RBRVS system is regularly reviewed and updated by CMS; the same applies to RVP published by Optum360 and the CPT/HCPCS coding book published by AMA. Regardless of the basis of the fee schedule (Medicare or non-Medicare), states may still have a process for incorporating those updates. Many states have a routine process for updating their fee schedule periodically, while some states have a more complex legislative or rulemaking process. It is common practice for the WC state agency to publish notice of proposed fee schedule changes on their website. Often the process involves a public hearing. After the end of the comment period, fee schedule changes are reviewed and adopted by the state agency. In some states, the final rules must undergo a review by a special legislative committee or by the Office of the Attorney General, as part of the rulemaking process.

Examples from states with periodic changes in their fee schedules, and a special rulemaking/legislative process

Florida: The Three-Member Panel is statutorily required to annually update the fee schedules. However, Florida also requires legislative ratification for fee schedule updates.[4] The most recent update in the professional fee schedule took effect in 2016 when Florida adopted 2014 Medicare rates; the prior version of the fee schedule used 2008 Medicare rates.

Massachusetts: The most recent update in the professional fee schedule was in 2009. One reason is that in Massachusetts the Executive Office of Health and Human Services (EOHHS), a state agency separate from the Department of Industrial Accidents (DIA), has statutory authority to establish WC fee schedule rates.

Michigan: Fee schedules (procedure codes, monetary conversion factors, and other changes made by Medicare) are typically updated annually. The state agency submits proposals to the Office of Regulatory Reinvention for approval. Following a hearing, the proposed rules are filed with the Joint Committee on Administrative Rules for approval.

One method of updating fee schedules is to index the fee schedule rates to changes in inflation. The most

[4] As of 2010, Florida added a requirement that state agencies (including the WC agency) must prepare a statement of estimated regulatory costs if a rule is expected to increase regulatory costs by more than $200,000 within one year of implementation. This rule also applies for WC fee schedule changes in excess of $200,000.

commonly used inflation factors are the Bureau of Labor Statistics Consumer Price Index (CPI) for *medical care*, the CPI for *all items*, and the CPI for *a specific region;* statewide average weekly wages (SAWW); and the Medicare economic index. Note that the CPI for all items and the CPI for medical care may include goods and services not relevant to workers' compensation. The CPI for all items may have a tendency to be lower than the CPI for medical care. In contrast, the use of SAWW may be more specific to the state, but may also lead to higher or lower changes over time than the general inflation.

Examples from states with annual inflation adjustments

Illinois: Consumer Price Index for All Urban Consumers, All Items (1982-84=100) for the 12-month period ending on August 31 of the previous year.

Maryland and Texas: Medicare Economic Index.

Pennsylvania: Statewide average weekly wages.

Virginia (biannual update): Consumer Price Index for All Urban Consumers for medical care for the South region.

Examples from states using alternative RVU and periodic changes in their fee schedules

Nevada: Uses the most recently published edition of the *Relative Values for Physicians* by Optum360. The administrator of the fee schedule annually reviews and approves the changes.

South Dakota: Uses the 2018 edition of the *Relative Values for Physicians* with periodic updates. Note that when a state agency proposes to increase a fee in a rule, the agency must provide a fund balance condition statement to justify the fee increase (SDCL 1-26-4.8).

Wyoming: Uses the 2019 edition of the *Relative Values for Physicians*. The WC Division updates the fee schedules and the rules each year to adopt the most recent edition of the *Relative Values for Physicians*.

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7. How Are Fee Schedules and Subsequent Changes Implemented?

New fee schedules and fee schedule changes can be introduced all at once, or in stages.

Examples from states that used a phased-in approach

California: In 2012, Senate Bill 863 required the Administrative Director of the Division of WC to adopt a new physician fee schedule based on the Medicare RBRVS. Prior to that, California used their own fee schedule. Starting in January 2014, the implementation consisted of four phases, with the last change implemented in January 2017.

Illinois: Fee schedules became effective on February 1, 2006. Between 2006 and 2009, more detailed hospital outpatient and ASC fee schedules were developed and became effective on February 1, 2009. Between 2006 and 2009, reimbursements for hospital outpatient and ASC services were based on 76 percent of charges.

North Carolina: In 2013, House Bill 92 required the Industrial Commission to develop hospital and provider fee schedules based on Medicare payment methodologies. Hospital and ASC fee schedule changes were introduced in each year between 2015 and 2017. Prior to the changes, payments were based on 79 percent of charges.

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8. Other Considerations?

There is wide variation in the way states use Medicare payment systems as well as different layers of complexity in their WC fee schedules:

- Some states closely follow Medicare instructions, billing, and coding changes, while other states may choose not to adopt all Medicare changes.

- States with a non-Medicare-based fee schedule often use the CMS Medicare Severity-Diagnosis Related Group (MS-DRG) system for inpatient services, including more than one method of reimbursement.

Additional questions to consider:

- How do WC payments relate to other payors in the system, such as auto insurers, Medicare, and commercial insurers? What is the possibility for claims shifting to or from WC?[5]
- Are there particular areas in the state with a shortage of medical professionals and potential access-to-care issues for workers with injuries?
- What is the input of the local medical community regarding WC payment policies?
- What are the advantages and disadvantages of establishing a state-specific fee schedule versus adopting some or all elements of already developed payment systems used by other payors?

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9. How Did Illinois, Indiana, and Virginia Implement Fee Schedules?

In this section, we discuss the experience of three states—Illinois, Indiana, and Virginia. Illinois and Indiana are neighboring states. Illinois adopted a non-Medicare-based fee schedule and made large revisions to the fee schedule five years after its initial introduction in 2006. Indiana implemented a Medicare-based fee schedule for hospital services only. Virginia is the most recent state to introduce a WC fee schedule, which is non-Medicare based.

In each state, we outline the reasons for introducing a fee schedule, the design and implementation process, and the post-fee-schedule review process. We have used evidence from publicly available official documents, state agency annual reports, and articles citing the experience of stakeholders.

Illinois fee schedules became effective February 1, 2006

Main objectives

- The 2005 law (HB 2137, Public Act 094-0277) introduced major reforms in Illinois. Among many provisions, the legislation created medical fee schedules. The reforms intended to make Illinois more competitive for jobs and businesses. In 2005, a governor's office press release stated that Illinois companies pay 40 percent more for workers' compensation than neighboring states Michigan, Wisconsin, and Indiana.[6] Policy discussions indicated that Illinois ranked among the highest in the country on WC insurance premium rates, indemnity, and medical costs.[7]
- Regarding the medical fee schedules, the governor's office press release stated that indexing medical fee schedules to the general Consumer Price Index (CPI-U) is expected to save Illinois businesses millions of dollars annually.[6]

Design and implementation

- The 2005 legislation created a Medical Fee Advisory Board. The purpose of the Board is to advise the Illinois WC Commission on the establishment of fees for medical services and the accessibility of medical treatment.

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[5] See WCRI research:
Do Higher Deductibles in Group Health Plans Increase Injured Workers' Propensity to File for Workers' Compensation? (Fomenko and Gruber, 2019);
Do Higher Fee Schedules Increase the Number of Workers' Compensation Cases? (Fomenko and Gruber, 2016).

[6] Office of the governor, July 20, 2005. Gov. Blagojevich signs landmark workers' compensation reforms.

[7] Illinois Workers' Compensation Commission FY2005 Annual report.

- The development of the fee schedule rates was contracted to True Course Medical Data Analysis & Claims Services, LLC (in 2011 the company was acquired by Health Systems International).
- Fee schedule amounts were initially set at 90 percent of the 80th percentile of what health care provider charges had been between 2002 and 2004. The hospital inpatient fee schedule was initially created using data from the Illinois Department of Public Health. During the negotiations, labor representatives opposed a Medicare-based fee schedule, fearing that the lower Medicare payments would hurt workers' access to care. Instead, stakeholders agreed on a unique fee schedule based on historical charges between 2002–2004 (charge data was used because payment data is usually proprietary and unavailable).[8]
- Illinois introduced per-procedure (CPT-based) fee schedules with different amounts for each of the following: *professional*, *hospital outpatient,* and *ASC* services (the ASC fee schedule was created in 2009).
- A key element of the fee schedule is that all rates are updated annually with the changes in the CPI for all urban consumers (CPI-U).
- Since the effective date in 2006, the fee schedule has undertaken many changes, with the most significant change in 2011 when fee schedule rates were reduced by 30 percent for all medical services. A short summary of fee schedule development is provided here:[9]
    - **2006**: IL implemented medical fee schedules for professional and hospital services, effective February 1, 2006
    - **2006–2009**: Services provided by hospitals and licensed ASCs defaulted to 76 percent of charges (POC76)
    - **2009**: Per-procedure fee schedule introduced for hospital outpatient and services provided by licensed ASCs, effective February 1, 2009
    - **2009**: Hospital inpatient services paid using MS-DRG coding system, effective June 30, 2009
    - **2011**: Fee schedule rates reduced by 30 percent for all services effective September 1, 2011; POC76 default was reduced to POC53.2
    - **2011:** Facilities that are either licensed or accredited included in the ASC fee schedule
    - **2006–2012**: Fee schedule rate calculated for each of 29 geozips (regions based on first 3 digits of zip code)
    - **2012**: Number of fee schedule regions reduced to 4 for professional services and 14 for hospital services (regions are based on county), effective January 1, 2012
    - **2013**: 16,000 CPT codes assigned with fee schedule amounts, effective October 1, 2013; prior to that POC53.2 was used
    - **2014**: Fee schedule amount increased for some evaluation and management (office visits) codes, effective July 16, 2014
- The National Council on Compensation Insurance, Inc. (NCCI) estimated that the 2006 fee schedules would reduce system costs by 2 percent.[10]
- Five years after the implementation of the fee schedules, the Illinois governor stated that workers'

[8] Illinois Workers' Compensation Commission. Report to the governor and general assembly on the Illinois workers' compensation medical fee schedule. January 1, 2010.

[9] Illinois Workers' Compensation Commission. *History of the fee schedule developments*.

[10] WorkCompCentral.com. *Lawmakers approve Illinois fee schedule rule*. June 14, 2006.

compensation medical fees in Illinois were significantly higher than the median of other states.[11] Policy discussions also centered on high costs of WC premiums in Illinois and dissatisfaction with the modest cost savings from the 2006 reforms.[12] Effective September 1, 2011, HB 1698 (Public Act 97-18) reduced the fee schedule rates by 30 percent for all medical services.

- Milliman estimated that Illinois reforms are expected to result in an 8.5–12.75 percent decrease in workers' compensation costs; medical payments would decrease 5–7 percent. The overall decrease means a $255–380 million reduction in WC costs.[13]
- NCCI estimated that a 30 percent reduction in the fee schedule rates would lower medical payments by 14 percent; the impact on the overall system costs would be a 7 percent decrease.
- One unintended consequence of the 30 percent fee schedule reduction was that it affected actual prices paid in a disproportionate way—fee schedule rates for evaluation and management (E&M) dropped below Medicare rates in Illinois; for all other services, fee schedule rates remained higher than Medicare in Illinois. In 2014, the Illinois WC Commission increased fee schedule amounts for some office visit codes to Medicare levels in Illinois.[14] Policy discussions regarding E&M reimbursements have continued up to date.

Post-implementation review process

- According to the WC Commission report to the governor and general assembly on the Illinois workers' compensation medical fee schedule, and WC Commission annual reports:[15]
  - The fee schedule saved money by reducing the growth of Illinois' medical costs, without harming workers' access to medical care. The fee schedule rates are adjusted each year with the changes in the general CPI-U. Between 2006 and 2010, the CPI-U increased 15 percent compared with 20 percent in the CPI for medical care. While perspectives vary on the savings produced, there was an agreement among the stakeholders that the growth rate of medical costs was significantly reduced as a result of the fee schedule. The report also cited findings from NCCI and WCRI research.
  - Business representatives expressed concern that the fee schedule is too generous. The law was expected to yield a 6.5 percent cost savings through the fee schedule as well as other provisions. Some of these savings may have not materialized.
  - A charge-based fee schedule presented at least two issues: 1) it created some anomalies in the fee schedule (Illinois introduced 29 regional fee schedules), and 2) it made the administration of the fee schedule difficult (for instance, when Medicare changed its hospital inpatient system from DRG to MS-DRG codes, it took the Commission a year and a half to promulgate rules, recalculate the bills, and adapt to the change). The large number of regional fee schedules increased the administrative

[11] The Illinois Turnaround Agenda.

[12] Lucci, M., Illinois Policy. Illinois remains uncompetitive after 2011 workers' compensation changes.
Illinois Workers' Compensation Commission. FY2010 Annual Report.

[13] Paczolt, M. Milliman. 2011. *Illinois reforms expected to result in 8.5%-12.75% decrease in workers' compensation costs*.

[14] Illinois Workers' Compensation Commission. Medical Fee Advisory Board minutes of the meeting held on July 16, 2014.

[15] Illinois Workers' Compensation Commission. January 1, 2010. Report to the governor and general assembly on the Illinois workers' compensation medical fee schedule.
Illinois Workers' Compensation Commission. FY2009 Annual Report.

and technical burdens.

- Reflecting the 2011 fee schedule changes:[16]
    - Insurers reported a 19 percent decrease in total loss costs between 2011 and 2015. Illinois had the largest decrease in premiums among all the states, dropping from the fourth highest to the seventh highest between 2012–2014.
    - Since 2012 the premium insurance rates in Illinois for both the voluntary and assigned risk market decreased 17 percent.
    - The governor's office press release stated reforms savings of $450 million.
    - External studies found a large decrease in medical payments per claim in Illinois. There was little change in utilization, meaning providers did not provide more services to make up for the lost income.
    - The fee schedule achieved the goal of limiting future increases in prices paid to the annual changes in the CPI-U. Between 2006 and 2018, the average prices paid for professional services grew in line with the annual CPI-U updates—about 1–2 percent per year.

Indiana hospital fee schedule became effective July 1, 2014

Main objectives

- To contain hospital reimbursement costs, which were a major cost driver in the state's workers' compensation system.[18]

Design and implementation

- HEA 1320 (HB 1320) as of 2013 created a fee schedule for hospital services (both inpatient and outpatient). The bill also made other changes related to reimbursement for drugs and implants. Provisions of this legislation increased indemnity benefits paid to workers with injuries.

- The Indiana General Assembly Interim Study Committee on Insurance reviewed different aspects of fee schedule development, such as how to create the fee schedule—using the Medicare model, contracting a consulting company, or using commercial rates provided under group health insurance. The Committee also collected testimony from providers, payors, and lobbyists on medical reimbursements, and then concluded hearings and issued a report.[19]

- Stakeholders agreed that the Medicare-plus system is the most feasible model for a fee schedule. The method is used in other states, and insurers and hospitals are familiar with how it operates. In addition, the Medicare fee schedule should provide stability and predictability to the workers' compensation system.[20]

- Reimbursement rates for hospital services were set at 200 percent of Medicare's facility reimbursement rate. Note that rates are calculated separately for inpatient and outpatient services. For inpatient services, the rate is set at 200 percent of the Medicare Inpatient

[16] Illinois Workers' Compensation Commission. FY2014 Annual Report.
Governor Quinn Announces Historic Workers' Compensation Rate Reductions, July 30, 2017.
[17] State of Illinois Department of Insurance. Workers' compensation insurance oversight report 2017.
State of Illinois Department of Insurance. Workers' compensation insurance oversight report 2019.
[18] WorkCompCentral.com. Lawmaker Wants Hospital Fee Schedule Choices by Dec. 1. October 24, 2012.
[19] Indiana General Assembly Interim Study Committee on Insurance. Meeting Minutes in 2013.
[20] WorkCompCentral.com. Lawmaker Wants Hospital Fee Schedule Choices by Dec. 1. October 24, 2012.
WorkCompCentral.com. PCI Urges Gov. Pence to Sign Hospital Fee Schedule Bill. May 2, 2013.
Indiana General Assembly Interim Study Committee on Insurance. Meeting Minutes September 4, 2013.

Prospective Payment System (IPPS).[21] For outpatient services, the rate is set at 200 percent of the Medicare Outpatient Prospective Payment System (OPPS).[22] There is no fee schedule for professional and ASC services. Payments to these providers are based on the 80th percentile of charges in the same community for similar services or products.[23]

- An actuarial analysis by the NCCI estimated that the fee schedule could reduce medical costs by 3.7 percent. An analysis by the Indiana Compensation Rating Bureau estimated that the bill would decrease WC costs by $5–16 million, or 0.7–2.3 percent. Indiana's Legislative Services Agency estimated the bill would reduce payors' payments to hospitals by $38 million a year.[24]

Post-implementation review process

- Most of the information available about fee schedule effects in Indiana comes from WCRI research.
- After 2014, a major concern among stakeholders was that ASCs were not included in the fee schedule. In 2018, the average ASC facility payment per claim continued to be among the highest of the study states, and was growing. Between 2015 and 2018, ASC facility payments per claim grew 5 percent per year. Note that in the years prior to the introduction of the hospital fee schedule (2008–2012), growth rates for ASC and hospital outpatient facility payments per claim were similar, at about 10 percent per year. In February 2020, HB 1332 passed the House. The bill, if it becomes law, would limit ASC reimbursements to 220 percent of Medicare.

Virginia fee schedule became effective January 1, 2018

Main objectives

- One objective was to increase certainty in pricing, and reduce disputes about medical fees.[25] Prior to the introduction of the fee schedule, about 2,000 medical fee disputes were filed annually with the Virginia WC Commission.[26] Medical payments were based on the prevailing community rate for 15 different regions. As a result, medical fee disputes were often litigated.
- Another objective was to achieve revenue neutrality by provider type and medical community by developing a fee schedule that reflected average historical reimbursement rates based on actual WC payments in Virginia in 2014 and 2015. The law cited below required that the fee schedule produce overall reimbursements to providers in the same category of providers in the same medical community that are equal to the amounts that were paid during calendar years 2014 and

[21] IPPS: Inpatient Prospective Payment System. Categorizes cases into diagnosis-related groups (DRGs). The DRGs form a manageable, clinically coherent set of patient classes that relate a hospital's case mix to the resource demands and associated costs experienced by the hospital. DRGs incorporate the principal diagnosis; secondary diagnoses; surgical procedures; and age, sex, and discharge status of the patient.

[22] OPPS: Outpatient prospective payment system. The CMS has implemented the OPPS under Medicare for reimbursement for hospital outpatient services at most hospitals. All services paid under the OPPS are classified into groups called APCs. Services in each APC are similar clinically and in terms of the resources they require. The CMS has established a payment rate for each APC.

[23] Worker's Compensation Board of Indiana Guidelines and Procedural guidance.

[24] WorkCompCentral.com. ICRB Summarizes New Law, Posts $2 Fee Suggestions. July 16, 2013.
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[25] WorkCompCentral.com. *Medical fee schedules nearing implementation.* November 29, 2017.

[26] Virginia workers' compensation commission Annual Reports, various years. See the references.

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Design and implementation

- Chapters 279 and 290 (amended) of the 2016 Acts of Assembly and Chapter 478 of the 2017 Acts of Assembly set the statutory framework for creating a fee schedule.
- The Virginia WC Commission, Advisory Panel, and *Oliver Wyman Actuarial Consulting* were involved in the development of the fee schedules.[28] The data underlying the fee schedule includes information provided by NCCI (data collected through the medical data call), claims supplied by medical providers and facilities, and self-insured employers.
- Discussions among stakeholders took place in 2016 and 2017. In January 2017, the Advisory Panel approved the draft version of the medical fee schedule. During January–February 2017, stakeholders were able to test, analyze, and provide feedback on the draft. In April 2017, the WC Commission approved the final version of the fee schedule. There were several iterations between Oliver Wyman, the Advisory Panel, and the WC Commission regarding revisions of the fee schedule prior to the final version.
- Fee schedule rates were calculated for seven distinct types of providers within six geographic regions.[29]
- The Virginia WC Commission established a Medical Fee Services Department for the administration of the fee schedule and for resolving medical fees disputes before proceeding to a hearing.
- In 2017, NCCI estimated that the implementation of the fee schedule would result in an overall 1.9 percent decrease in WC system costs in Virginia. The ultimate impact on medical costs would be a 2.8 percent decrease.[30]

Post-implementation review process

- According to the Virginia WC Commission annual reports in 2018 and 2019:[31]
    - The Medical Fee Services Department reviewed more than $600,000 in disputed charges for medical services in 2018. This led to the resolution of 49 percent of disputes without referral to the judicial docket.
    - The annual reports show that provider-filed claims in 2018 and 2019 were 6–7 percent of all filed claims to the WC Commission; in prior years, this percentage varied between 4 and 5 percent.
    - The 2019 Annual Report cited that external studies confirmed a decrease in medical payments per claim.

[27] Oliver Wyman. 2017. Overview and methodology of the Virginia workers' compensation medical fee schedules.
[28] Ibid.
[29] Ibid.
[30] NCCI Analysis of the implementation of the Virginia medical fee schedules effective January 1, 2018
[31] Virginia Workers' Compensation Commission. Annual 2018 Report.
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10. How Does WCRI Research Help States Measure the Impact of Fee Schedule Implementation or Changes?

- WCRI Benchmarking studies (*CompScope™ Medical Benchmarks*, *Medical Price Index for WC,* and *Designing Medical Fee Schedules*) inform the policy discussions regarding reimbursement to providers (fee schedule comparisons and actual payments) and how the state compared with other study states on medical payments, prices, and utilization
- Provides a baseline for monitoring changes following the implementation of the fee schedule
- Provides insight into the impact of the reforms and provides a context for evaluating future changes
- Examines the following questions:
    - How long did the impact of the reforms last?
    - Did the reforms address the key medical cost drivers in the system?
    - What are the key metrics to monitor to see if the reforms had the intended effect?
    - In what areas may the state continue to experience issues (for instance, higher-than-typical medical payments) and how might the state determine if mid-course corrections are needed? Were there any unintended consequences?

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