

MEMORANDUM

TO: Senator Douglas Racine, Chair, Committee on Health and Welfare
Representative Steven Maier, Chair, Committee on Health Care

FROM: Paul Harrington, Executive Vice President, Vermont Medical Society

RE: Act 61, Section 38, Workers' Compensation Workgroup Report

DATE: January 15, 2010

Pursuant to Section 38 of Act 61 (H.444), the Vermont Medical Society (VMS) was requested to convene a work group to study the provisions of sections 9418b through 9418f of Title 18 that currently apply to health insurance plans to determine whether some or all of these provisions should also apply to workers' compensation carriers.

18 V.S.A § 9418b dealing with PRIOR AUTHORIZATION;
18 V.S.A § 9418c dealing with FAIR CONTRACT STANDARDS;
18 V.S.A § 9418d dealing with CONTRACT AMENDMENTS;
18 V.S.A § 9418e dealing with MOST FAVORED NATION CLAUSES PROHIBITED;
and
18 V.S.A § 9418f dealing with RENTAL NETWORK CONTRACTS.

No later than January 15, 2010, the work group was requested to report its findings and recommendations to the house committee on health care and the senate committee on health and welfare. Consistent with the workgroup's charge, the report contains the following three recommendations:

Recommendation 1: The workgroup recommends that the provisions of sections 9418c through 9418f of Title 18 relating to contact standards should not apply to workers' compensation carriers at this time.

Recommendation 2: The Vermont Medical Society recommends that the General Assembly consider adding prior authorization provisions similar to those found in 18 V.S.A § 9418b to 21 V.S.A §640a in order to have prior authorization standards apply to both health insurers and workers' compensation carriers (note: the representative from the Department of Labor opposed the recommendation).

Recommendation 3: The workgroup recommends that the Vermont Department of Labor consider conducting a study involving medical providers, representatives of injured workers, insurance carriers and employers in order to develop and evaluate an evidence based medical treatment model for Vermont's worker's compensation system.

Please let me know if you have any questions or suggestions.

Act 61, Section 38

Workers' Compensation Workgroup Report

January 15, 2010

TO

The Senate Committee on Health and Welfare

And

The House Committee on Health Care

Act 61, Section 38, Report on Workers' Compensation January 15, 2010

Workgroup charge:

Section 38 of Act 61 (H.444) requests the Vermont Medical Society (VMS) to convene a work group to study the provisions of sections 9418b through 9418f of Title 18 that currently apply to health insurance plans to determine whether some or all of these provisions should also apply to workers' compensation carriers.

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No later than January 15, 2010, the work group is requested to report its findings and recommendations to the house committee on health care and the senate committee on health and welfare.

Problem Statement

Workers' compensation insurance in Vermont and nationally represents perhaps the first instance of universal health insurance coverage in this country. Enacted in the early 1900s, it mandates that employers provide both healthcare services and disability payments to workers injured in the workplace. Since it reimburses for healthcare services and disability payments for work-related injuries, workers compensation provides both similarities and differences for health care providers from traditional health insurance coverage.

One major difference for health care providers in dealing with health insurance companies, as opposed to workers compensation insurance carriers, is simply the large number of workers' compensation carriers. With only three major health insurance companies in Vermont (BCBSVT, MVP and CIGNA), compared to approximately 300 companies licensed in the state and 25 companies actively underwriting workers' compensation policies, providers face a greater deal of variation in claims processing practices based on the larger number of workers compensation insurance carriers.

A frequently cited problem for both hospitals and health care practitioners is the time and effort involved in obtaining reimbursement from workers' compensation carriers for healthcare services provided. One study indicated that the total orthopedic practice expense per episode of care was \$178 for a patient with health insurance and \$299 for a patient with the same condition

covered by workers' compensation.¹ And while payment for health care services through health insurance companies will typically be received within 30 days of submitting a bill, payments for the same services provided to a workers' compensation claimant may not be received for a much longer period of time. Although the reasons for delayed payment are varied they typically relate to determining that the healthcare services provided relate to a work-related injury, the need to deal with insurance adjusters and a lack of clarity regarding possible prior authorization requirements.

Workgroup process:

The workgroup held meetings on September 29th and October 27th at the offices of the Vermont Medical Society on Main Street in Montpelier. A large number of individuals, including physicians and other health professionals, regulators, representatives of workers compensation insurance carriers, representatives of injured workers and representatives of employers were notified of the meetings by e-mail (see Appendix B). In addition to the opportunity to participate in the meetings in-person, a conference call phone number was also made available for each meeting. While a representative from the National Council on Compensation Insurance (NCCI) participated in the workgroup, the NCCI does not take a position on this issue. They attended to observe and to provide information as requested.

At the first meeting, the workgroup reviewed its legislative charge and identified areas for additional research. During the second meeting the research findings were discussed and the following three recommendations were developed.

Recommendations:

Recommendation 1: The workgroup recommends that the provisions of sections 9418c through 9418f of Title 18 relating to contact standards should not apply to workers' compensation carriers at this time.

Based on its research and findings, the workgroup determined that contract standards are not a major source of concern for health care providers in their interactions with workers' compensation carriers, due to the general lack of contracts between health care providers and workers compensation carriers.

In 1995, the Vermont Department of Labor adopted Rule 40.000², a Workers Compensation Medical Fee Schedule. Since the medical fee schedule establishes the maximum allowable amount payable under workers compensation, the regulation may obviate much of the need for contracts relating to reimbursement for health services between workers compensation carriers and health care professionals.

¹ Brinker, M.R., O'Connell, D. P., The effect of payer type on orthopaedic practice expenses, The Journal of Bone and Joint Surgery, Inc., 2002: 1816-1822

² <http://labor.vermont.gov/Workers%20Compensation%20Rules/tabid/311/Default.aspx>

Recommendation 2: The Vermont Medical Society recommends that the General Assembly consider adding prior authorization provisions similar to those found in 18 V.S.A § 9418b to 21 V.S.A §640a in order to have prior authorization standards apply to both health insurers and workers' compensation carriers (note: the representative from the Department of Labor opposed the recommendation).

The legislative charge directed the workgroup to determine whether the current prior authorization requirements applying to health insurance companies in 18 V.S.A § 9418b should also apply to workers compensation insurance carriers.

Prior authorization provides that payment for medical treatment, hospitalization, or a prescription will only be made if the health insurance company has approved it in advance.

There are a number of states, such as Colorado³ and Alabama⁴ that spell out requirements for prior authorization in their workers' compensation regulations. The Mayo clinic participates in many states' Workers' Compensation programs and their website indicates if Mayo does participate, the provider should contact the Workers' Compensation carrier to determine if any prior authorization is required.⁵

Based on its research, members of the workgroup found there are instances when workers' compensation carriers in Vermont require that a prior authorization be received for medical services and supplies. In addition, there are instances when a healthcare provider will request that the workers compensation carrier issue a prior authorization before performing a medical procedure on an injured worker in order to ensure they will receive payment for the procedure.

As noted earlier, one problem is the difficulty in finding the right person to speak with the workers' compensation carrier to obtain prior authorization. One hospital department chair noted there many workers' compensation carriers operating in Vermont and sometimes it is difficult to determine who the adjuster is. Once they do find the correct person at the carrier they are often told that the prior authorization can take up to 30 days. This compares to health insurance carriers where they usually get prior authorization in one day because there are fewer carriers and the people at the health insurance carrier they need to call for prior authorization are usually known to the hospital.

The VMS drafted prior authorization legislation for inclusion in Title 21 §640a in order to provide similar standards and protections between health insurance companies and workers' compensation carriers (see Appendix A). Under the draft legislation, in most instances the worker's compensation insurance carriers would be required to pay medical bills for health care services for which prior authorization was required by and received from the insurance carrier.

In addition, an insurance carrier would be required to furnish, upon request from a health care provider, a current list of services and supplies requiring prior authorization and they would be

³ http://www.coworkforce.com/dwc/rules/WordVersions/Rule_18.asp

⁴ http://dir.alabama.gov/docs/law/wc_480-5-5-.31.pdf

⁵ <http://www.mayoclinic.org/billing-rst/#workers>

required to respond to a health care provider's request for prior authorization within seven business days from receipt of the provider's completed request. A representative of the American Insurance Association (AIA) indicated its lack of opposition to the draft legislation's seven-day requirement to respond to a pre-authorization request.

The VMS believes that setting reasonable prior authorization standards and time frames for workers compensation insurance carriers will further advance the goal of providing greater uniformity between insurance carriers and help advance administrative simplification. In addition, through the provision's inclusion of the ability of healthcare providers to request prior authorization for medical services it should help provide injured workers with more timely access to health care services.

However, the recommendation from the Vermont Medical Society on the need for prior authorization standards in Title 21 was not unanimous. J. Stephen Monahan, Director, Workers' Compensation & Safety Division, Vermont Department of Labor, expressed his opposition to having it addressed by inclusion in Vermont statutes, due to a concern the provision may dramatically increase the number of medical disputes that his division will be expected to handle, he feels they simply lack the manpower and resources to take on a host of new disputes.

Mr. Monahan also believes the provision attempts to address a problem that really doesn't exist in the worker's compensation system at present. He stated " the provisions in 18 V.S.A § 9418b prescribe procedures that must be followed when a health insurer requires prior authorization, the information provided the work group was that no workers' compensation insurer has established any prior authorization requirements, so adding the language to title 21 creates the illusion doing something. It may confuse a claimant's, medical providers and others into thinking that they must get prior authorization, thereby delaying necessary treatment, or may cause worker's compensation insurers to implement prior authorization requirements where none were previously warranted."

Recommendation 3: The workgroup recommends that the Vermont Department of Labor consider conducting a study involving medical providers, representatives of injured workers, insurance carriers and employers in order to develop and evaluate an evidence based medical treatment model for Vermont's worker's compensation system.

While outside of the workgroup's legislative charge, J. Stephen Monahan, Director, Workers' Compensation & Safety Division, Vermont Department of Labor, suggested moving toward an evidence-based medical treatment model for the worker's compensation system. He indicated that several states that have adopted evidence based treatment protocols have successfully controlled medical costs, without denying injured worker's reasonable and necessary care, and generally producing favorable injured worker outcomes.

Dr Neil Haas also recommended adopting a common frame of reference for recognizing reasonable services. He believes that if there was a default for identifying reasonable service, there is less room for disagreement, and a clearer basis for expecting timely authorization and payment. Adopting a set of guidelines as presumptively correct can provide a common frame of reference. California, Texas, and other states have done this.

Background

Act 203 (H.887), the 2008 health care reform bill, implemented fair standards for provider contracts with insurers. It prohibits insurers from imposing retrospective denials of paid claims after 12 months, with certain exceptions relating to fraud or mistake. It prohibits insurers from arbitrarily changing the code on a billed claim in order to pay a lower reimbursement, with certain exceptions for fraud or mistake. Under 18 V.S.A § 9418b, the act requires insurers to make payment on claims where prior authorization was required and received, with certain exceptions for fraud or mistake.

Act 61 (H.444), the health care reform omnibus bill of 2009, contained numerous provisions, including reducing the time for both health insurers and workers' compensation carriers to pay claims, establishing contract standards for health plan contracts with physicians, and regulating rental networks.

Workers' Compensation:

Act 61 adds to Title 21 §640a new timely payment requirements of medical bills under a workers' compensation claim. Previously, these provisions were in Title 18 along with the provisions for timely payment of traditional medical bills. Act 61 reduces the amount of time an insurance carrier has to either pay the bill, or provide written notification to the injured employee, healthcare provider and Commissioner Department of Labor that the bill is contested, from 45 to 30 days, following receipt of a medical bill.

If the employer or insurance company denied the medical bill based on insufficient information to determine liability for payment, the bill requires the insurance carrier to pay or deny payment within 30 days after receiving additional information. The bill establishes a 12-percent annual interest rate for unpaid medical bills. The bill stipulates that a medical bill must be submitted in legible form with every field or data element relevant to the treatment completed and treatment coding that conforms to the criteria of the National Correct Coding Initiative.

The bill also allows the Commission of Labor to assess penalties against the employer or insurance carrier that fails to comply with provisions of sections and permits the Commissioner to refer to the BISHCA Commissioner if the insurance carrier neglects or fails to pay medical bills is required.

Act 61 also adds to Title 21 §640a protections against recoupment of payments to physicians by workers' compensation carriers and also prohibitions against down coding by these companies.

Health Insurer Contract Standards:

Act 61 made significant steps toward administrative simplification, improved transparency and greater balance in the relationship between health insurers and physicians by addressing:

18 V.S.A § 9418c dealing with FAIR CONTRACT STANDARDS and 18 V.S.A § 9418d dealing with CONTRACT AMENDMENTS:

Act 61 creates standards for contracts addressing contract amendments, disclosure of products covered by the contract, term of the contract, termination notice period, and mechanisms for resolving grievances. The bill also requires a summary disclosure form or executive summary of the contract to be included with contract and amendments as contracts are often more than 20 pages long. The summary will include key terms and the pages where they can be found as well as health plan contact information a practitioner can use to obtain additional information. Beginning July 1, 2009, summary provided on request within 60 days of request. Summary included in contracts entered or renewed on or after July 1, 2009. No later than July 1, 2014 for all other existing contracts.

18 V.S.A § 9418e dealing with MOST FAVORED NATION CLAUSES PROHIBITED

The bill prohibits the use of “most favored nation” clauses in health care contracts, which are often used by health plans to prevent practitioners from granting better discounts to other health plans. Effective date: July 1, 2009.

18 V.S.A § 9418f dealing with RENTAL NETWORK CONTRACTS

The bill ensures oversight and accountability of rental networks by requiring them to register with BISHCA if they are not already licensed or registered. The bill also creates transparency requirements for rental networks and requires all parties to a rental network contract to comply with all of the terms of the underlying contract with the physician. As well, the health care practitioner must agree to this type of rental transaction in the underlying contract and a contracting entity or health plan engaging in this practice must:

Create a list – posted on its Web site and updated at least every 90 days – of third parties with access to the network and discounts;

Require the third party to identify the source of the contract discount on each remittance advice or explanation of payment form; and

Notify the third party of termination of the underlying contract and require the third party to cease claiming the discount or other contract rights after termination.

The bill prohibits “downstream rental” which occurs when an entity which itself obtained access to the network through a rental arrangement in turn rents the network to other entities. As contracts get farther and farther away from the original contract with the physician, many have found it becomes increasingly difficult to obtain prior authorization or correct payment problems. To date, Vermont is the only state that has banned such downstream rentals. Effective date: Jan. 1, 2010.

Appendix A.

Title 21 §640a. Medical bills; Payment; Disputes is amended to read:

* * *

(m) (1) Employers or insurance carriers shall pay medical bills for health care services for which prior authorization was required by and received from the employer or insurance carrier, unless:

- (A) Payment is with respect to an individual for whom the employer or insurance carrier is not liable as of the date the service was provided;
- (B) The employer or insurance carrier has a reasonable belief that fraud or other intentional misconduct has occurred;
- (C) The medical bill payment was incorrect because the health care provider was already paid for the health services identified in the medical bill;
- (D) The health care services identified in the medical bill were not delivered by the health care provider;
- (E) The medical bill payment is the subject of adjustment with another workers' compensation or health insurer;
- (F) The medical bill is the subject of legal action: or
- (G) If the services rendered differed from the services discuss when prior authorization was requested and received.

(2) An employer or insurance carrier shall furnish, upon request from a health care provider, a current list of services and supplies requiring prior authorization.

(3) An employer or insurance carrier shall respond to a health care provider's request for prior authorization within seven business days from receipt of the provider's completed request.

(4) If, after the service was provided, the employer or insurance carrier agrees the service provided was reasonable and necessary, lack of prior authorization for payment does not warrant denial of payment.

(5) Notwithstanding the provisions of subsection (m) of this section, nothing in this section shall be construed to prohibit an employer or insurance carrier from denying continued or extended coverage as part of concurrent review, or applying payment policies that are consistent with an applicable law, rule, or regulation.

Appendix B

Act 61, Section 38, Workers' Compensation Workgroup Distribution List:

Amy Mason	Primmer & Piper
Anthony Otis	Lobbyist
Bea Grause	Vermont Assoc. of Hospitals and Health Systems
Brian Calhoun, MD	
Cassandra LaRae-Perez	Primmer & Piper
Catherine Z. Davis	Lake Champlain Chamber of Commerce
Clare Buckley	Kimbell, Sherman and Ellis
Chris Rice	
Craig Fuller	Keller and Fuller
Dave Jillson	Practice Manager – Assoc. of Orthopaedics of VT
Don George	Blue Cross
Gerhild Bjornson, MD	CIGNA
Hunt Blair	OVHA
James Hester	Health Care Reform Commission
John Hollar	Downs Rachlin & Martin
Jonathan Wolff	Primmer & Piper
Lauren Parker	MBA Health Group
Lisa Stratton	State of Vermont
William Little	MVP
Lucie Garand	Downs Rachlin & Martin
Madeleine Mongan	VMS
Mary Lacaillade	State of Vermont
Mike Bertrand	BISHCA
Mike DelTrecco	Vermont Assoc. of Hospitals and Health Systems
Stephen Monahan	Vermont Department of Labor
Nelson S. Haas, M.D.	Physician
Pat Moulton Powden	Commissioner, Vermont Department of Labor
Peter Taylor	Vermont Dental Society
Carol Presley	Acadia
Rebecca Heintz	BISHCA
Rick Barrett	BISHCA
Michael Sirotkin	
Susan Besio	OVHA
Susan Gretkowski	NCCI