**1999 HOUSE INDUSTRY, BUSINESS AND LABOR**

**HB 1333**

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1333

Industry, Business and Labor

❑ Conference Committee

Hearing Date Jan. 20, 1999

| Tape Number | Side A | Side B | Meter # |
|---|---|---|---|
| 2 | | x | 20.4 |
| | | | |
| | | | |
| Committee Clerk Signature Lisa Horner | | | |

Minutes:

HB 1333 Relating to worker's compensation medical and hospital fee schedules and worker's compensation managed care; and relating to worker's compensation medical and hospital fee schedules and worker's compensation managed care.

Chairman Berg opened the hearing on the bill.

Representative Reagan Pufall, Chief Operating Officer of the Workers Compensation Bureau testified in favor of the bill.

(see attached written testimony)

Questions and discussion followed. Representative Ekstrom asked where information on claim could be obtained. The response was that the information is at the bureau and is available for use. He went on to say that medical costs could better be controlled through this bill.

Chairman Berg closed the hearing on the bill.

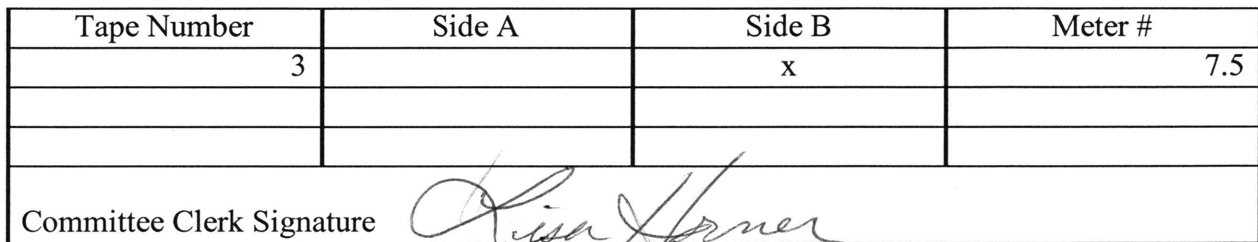
1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1333

House Industry, Business and Labor Committee

☐ Conference Committee

Hearing Date 1-26-99



| Tape Number | Side A | Side B | Meter # |
|---|---|---|---|
| 3 | | x | 7.5 |
| | | | |
| | | | |
| Committee Clerk Signature Lisa Horner | | | |

Minutes:

HB 1333

Chairman Berg opened the meeting on the bill.

Representative Kline moved to adopt the amendments, Second by Representative Severson

By voice vote, all yes, 0 no, motion carried

Representative Kline moved for do pass as amended, Second by Representative Brekke

By roll vote, 14 yes, 0 no, 1 absent

Representative Keiser will carry the bill

Chairman Berg adjourned the meeting on the bill.

FISCAL NOTE

(Return original and 10 copies)

Bill/Resolution No.: ______________ Amendment to: HB 1333

Requested by Legislative Council Date of Request: 1-29-99

1. Please estimate the fiscal impact (in dollar amounts) of the above measure for state general or special funds, counties, cities, and school districts.

**Narrative:**

See attached.

2. **State** fiscal effect in dollar amounts:

| | 1997-99 Biennium | | 1999-2001 Biennium | | 2001-03 Biennium | |
|---|---|---|---|---|---|---|
| | General Fund | Special Funds | General Fund | Special Funds | General Fund | Special Funds |
| Revenues: | | | | | | |
| Expenditures: | | | | | | |

3. What, if any, is the effect of this measure on the appropriation for your agency or department:

a. For rest of 1997-99 biennium: ______________

b. For the 1999-2001 biennium: ______________

c. For the 2001-03 biennium: ______________

4. **County, City, and School District** fiscal effect in dollar amounts:

| 1997-99 Biennium | | | 1999-2001 Biennium | | | 2001-03 Biennium | | |
|---|---|---|---|---|---|---|---|---|
| Counties | Cities | School Districts | Counties | Cities | School Districts | Counties | Cities | School Districts |

If additional space is needed, attach a supplemental sheet.

Date Prepared: 01-29-99

Signed J. Patrick Traynor

Typed Name J. Patrick Traynor

Department Workers Compensation Bureau

Phone Number 328-3856

## *NORTH DAKOTA WORKERS COMPENSATION BUREAU*
## *1999 LEGISLATION*
## ***SUMMARY OF ACTUARIAL INFORMATION***

***BILL DESCRIPTION*:** **Fee Schedules and Managed Care**

***BILL NO:*** **HB 1333**

***SUMMARY OF ACTUARIAL INFORMATION*:** The Workers Compensation Bureau, with the assistance of its Actuary, Glenn Evans of Pacific Actuarial Consultants, has reviewed the legislation proposed in this bill in conformance with Section 54-03-25 of the North Dakota Century Code.

The proposed legislation allows the Bureau to update its hospital and medical fee schedules through a simple notice and hearing process, rather than the lengthy administrative rulemaking process; and allows the Bureau to operate its managed care programs either with its own staff or through an outside service vendor.

***FISCAL IMPACT*:** Anticipate no rate or reserve level impact, however, the Bureau anticipates a cost savings can be achieved relating to the administration of certain components of its managed care program giving the flexibility to carry out these services internally rather than contracting with outside vendors for these services.

**AMENDMENT:** The proposed amendment clarifies that information compiled pertaining to specific health care providers is not public information.

The amendment will result in no change to the fiscal impact for the bill as introduced.

***DATE*:** **1-29-99**

## FISCAL NOTE

(Return original and 10 copies)

Bill/Resolution No.: HB 1333 Amendment to: ______

Requested by Legislative Council Date of Request: 1-13-99

1. Please estimate the fiscal impact (in dollar amounts) of the above measure for state general or special funds, counties, cities, and school districts.

   **Narrative:**

   See attached.

2. **State** fiscal effect in dollar amounts:

| | 1997-99 Biennium | | 1999-2001 Biennium | | 2001-03 Biennium | |
|---|---|---|---|---|---|---|
| | General Fund | Special Funds | General Fund | Special Funds | General Fund | Special Funds |
| Revenues: | | | | | | |
| Expenditures: | | | | | | |

3. What, if any, is the effect of this measure on the appropriation for your agency or department:
   a. For rest of 1997-99 biennium: ______
   b. For the 1999-2001 biennium: ______
   c. For the 2001-03 biennium: ______

4. **County, City, and School District** fiscal effect in dollar amounts:

| 1997-99 Biennium | | | 1999-2001 Biennium | | | 2001-03 Biennium | | |
|---|---|---|---|---|---|---|---|---|
| Counties | Cities | School Districts | Counties | Cities | School Districts | Counties | Cities | School Districts |

If additional space is needed, attach a supplemental sheet.

Date Prepared: 01-18-99

Signed [signature]

Typed Name J. Patrick Traynor

Department Workers Compensation Bureau

Phone Number 328-3856

# *NORTH DAKOTA WORKERS COMPENSATION BUREAU*
## *1999 LEGISLATION*
## *SUMMARY OF ACTUARIAL INFORMATION*

*BILL DESCRIPTION*: **Fee Schedules and Managed Care**

*BILL NO:* **HB 1333**

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The proposed legislation allows the Bureau to update its hospital and medical fee schedules through a simple notice and hearing process, rather than the lengthy administrative rulemaking process; and allows the Bureau to operate its managed care programs either with its own staff or through an outside service vendor.

*FISCAL IMPACT*: Anticipate no rate or reserve level impact, however, the Bureau anticipates a cost savings can be achieved relating to the administration of certain components of its managed care program giving the flexibility to carry out these services internally rather than contracting with outside vendors for these services.

*DATE*: **1-17-99**

## PROPOSED AMENDMENTS TO HOUSE BILL NO. 1333

Page 2, line 24, replace "regarding" with "compiled and analysis performed pursuant to a managed care program which relate to" and replace "and" with "or" and replace "medical" with "health care"

Page 2, line 25, replace "gathered or compiled the bureau is" with "are" and replace the second "is" with "are"

Page 2, line 26, after "inspection" insert "to the extent they identify a specific health care provider", replace "other than" with "except", after the first "to" insert "the specific health care provider," and after "employees" insert a comma

Renumber accordingly

This amendment will replace the underlined text on page 2, lines 24 through 27 with the following text: "Information compiled and analysis performed pursuant to a managed care program which relate to patterns of treatment, cost, or outcomes by health care providers are confidential and are not open to public inspection to the extent they identify a specific health care provider, except to the specific health care provider, bureau employees, or persons rendering assistance to the bureau in the administration of this title."

Date: 1-25-99
Roll Call Vote #: 1

# 1999 HOUSE STANDING COMMITTEE ROLL CALL VOTES
## BILL/RESOLUTION NO. 1333

House Industry, Business and Labor Committee

☐ Subcommittee on ______
or
☐ Conference Committee

Legislative Council Amendment Number ______

Action Taken: do pass as amended

Motion Made By: Klein

Seconded By: Brekke

| Representatives | Yes | No | Representatives | Yes | No |
|---|---|---|---|---|---|
| Chair - Berg | ✓ | | Rep. Thorpe | | |
| Vice Chair - Kempenich | ✓ | | | | |
| Rep. Brekke | ✓ | | | | |
| Rep. Eckstrom | ✓ | | | | |
| Rep. Froseth | ✓ | | | | |
| Rep. Glassheim | ✓ | | | | |
| Rep. Johnson | ✓ | | | | |
| Rep. Keiser | ✓ | | | | |
| Rep. Klein | ✓ | | | | |
| Rep. Koppang | ✓ | | | | |
| Rep. Lemieux | ✓ | | | | |
| Rep. Martinson | ✓ | | | | |
| Rep. Severson | ✓ | | | | |
| Rep. Stefonowicz | ✓ | | | | |

Total (Yes) 14 No 0

Absent 0

Floor Assignment Keiser

If the vote is on an amendment, briefly indicate intent:

## REPORT OF STANDING COMMITTEE

**HB 1333: Industry, Business and Labor Committee (Rep. Berg, Chairman)** recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (14 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). HB 1333 was placed on the Sixth order on the calendar.

Page 2, line 24, replace "regarding" with "compiled and analysis performed pursuant to a managed care program which relate to", replace "and" with "or", and replace "medical" with "health care"

Page 2, line 25, replace "gathered or compiled by the bureau is" with "are" and replace the second "is" with "are"

Page 2, line 26, after "inspection" insert "to the extent the information and analysis identify a specific health care provider", replace "other than" with "except", after the first "to" insert "the specific health care provider,", and after "employees" insert an underscored comma

Renumber accordingly



(1) LC, (2) DESK, (3) BILL CLERK, (4-5-6) COMM

1999 SENATE INDUSTRY, BUSINESS AND LABOR

HB 1333

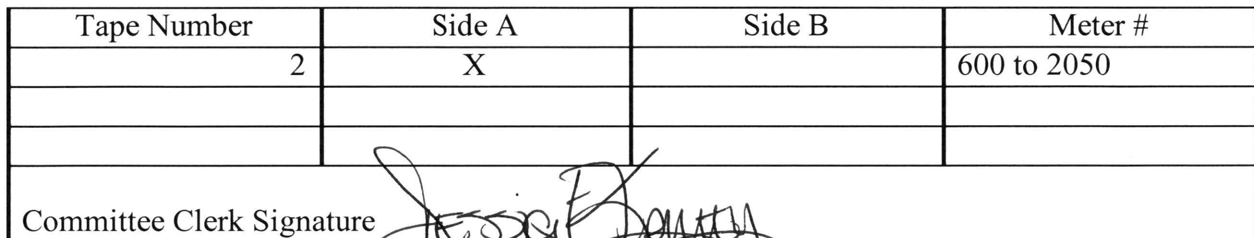
1999 SENATE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HOUSE BILL 1333

Senate Industry, Business and Labor

❑ Conference Committee

Hearing Date MARCH 3, 1999



| Tape Number | Side A | Side B | Meter # |
|---|---|---|---|
| 2 | X | | 600 to 2050 |
| | | | |
| | | | |
| Committee Clerk Signature | | | |

Minutes:

SENATOR MUTCH: opens the hearing on HOUSE BILL 1333

REAGAN PUFFAL: see testimony on bill, developing fee schedules for paying workers compensation claims. Problems caused by this inadequate fee schedule. Current law will not allow us to keep the fee schedules up to date. Relative value for physicians. Conversion packets that will allow the Bureau to get paid for their services and how much they are going to pay the claimant. Updated once every year. Our fee schedule needs to be updated at least once a year to keep up with the changes in the medical world. Work becoming rules on the fee schedules. This bill will fix the fee schedule and keep it up to date.

SENATOR THOMPSON: what is chapter 28 section 32

REAGAN PUFFAL: part of the century code that deals with administrative rule making.

SENATOR THOMPSON: thank you

SENATOR MUTCH: you are exempt from establishing rates for your employers

REAGAN PUFFAL: that is correct, this is the same language that is currently in the law relating to our premium schedule. Second part of bill relates to manage care. This is an area where previous medical and the bureau was not really moving to incorporate manage care techniques, Legislature in acted laws to get the bureau moving. Law required the bureau to contract with outside agencies to perform managed care services. 2 aspects, bill review: review to make sure that the bill is treatment for a work related illness. Utilization review, certain kinds of services where physicians have to get permission in advance to perform a service. Managed care is not well liked in this business. Eliminating certification for some employers and others who are to expensive will have to keep pre certification. Keep costs low or to prevent over utilization. Doing work in house to save money and bring bill review in house we could save allot of money. FTE authorization

SENATOR SAND: trust on both sides and everyone winning and compliment to bureau.

REAGAN PUFFAL: thank you!

SENATOR MUTCH: bills are going up all the time

REAGAN PUFFAL: person we hired is saving us money

SENATOR MUTCH: does this mean that you don't always pay the full amount.

REAGAN PUFFAL: Under the old fee schedule, we pay to much for some services and to little for others

SENATOR MUTCH: some provider doesn't wish to accommodate our needs because they are underpaid

REAGAN PUFFAL: if they treat injured workers and the fee schedule meeting the market value

SENATOR MUTCH: complaints from hospital and how much they are getting paid

REAGAN PUFFAL: that was a terrible problem up until currently but we were not current when the new computer program was installed.

SENATOR KREBSBACH: to what extent do you include discounts

REAGAN PUFFAL: we don't pay quite as much as some providers but do pay more than others

SENATOR MUTCH: need for concern about an assignment

REAGAN PUFFAL: 85% of medical bills within 30 days. Two years ago we were only paying 30% of medical bills in 30 days. Some bills are delayed

SENATOR MUTCH: any further questions

STEVE LATHAM: support of the bill. pass due notices from the doctor or the hospital and we are supporting managed health care in this health care bill. Step in the right direction

MOTION: conclude the hearing for the day.

Senator Thompson motioned for a do pass committee recommendation on HB1333. Senator Heitkamp seconded his motion. The motion carried with a 7-0-0 vote.

Senator Klein will carry the bill.

SR404099

Date: 3/3

Roll Call Vote #: 1

**1999 SENATE STANDING COMMITTEE ROLL CALL VOTES**
**HOUSE BILL/RESOLUTION NO. 1333**

Senate INDUSTRY, BUSINESS AND LABOR COMMITTEE Committee

☐ Subcommittee on ______
or
☐ Conference Committee

Legislative Council Amendment Number ______

Action Taken DO PASS

Motion Made By THOMPSON Seconded By HEITKAMP

| Senators | Yes | No | Senators | Yes | No |
|---|---|---|---|---|---|
| Senator Mutch | X | | | | |
| Senator Sand | X | | | | |
| Senator Krebsbach | X | | | | |
| Senator Klein | X | | | | |
| Senator Mathern | X | | | | |
| Senator Heitkamp | X | | | | |
| Senator Thompson | X | | | | |
| | | | | | |
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| | | | | | |

Total (Yes) 7 No 0

Absent 0

Floor Assignment KLEIN

## REPORT OF STANDING COMMITTEE

**HB 1333, as engrossed: Industry, Business and Labor Committee (Sen. Mutch, Chairman)** recommends **DO PASS** (7 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1333 was placed on the Fourteenth order on the calendar.

1999 TESTIMONY

HB 1333

**House Bill No. 1333**

**Fifty-sixth Legislative Assembly**
**Before the House Industry, Business, and Labor Committee**
**January 20, 1999**
**Testimony of Reagan Pufall**
**Regarding Medical Fee Schedules and Managed Care**

Mr. Chairman, Members of the Committee:

My name is Reagan Pufall. I am the Chief Operating Officer and General Counsel for the Workers Compensation Bureau and I am here to testify in support of 1999 House Bill No. 1333.

This Bill amends sections 65-02-08, 65-02-20, and 65-02-21, and repeals sections 65-02-19 and 65-05-07.1, of the North Dakota Century Code.

This Bill amends laws relating to two aspects of workers compensation medical services: First, the procedure followed by the Bureau in adopting and updating fee schedules for medical and hospital services; and second, how the Bureau obtains managed care services.

## I. FEE SCHEDULES

### A. Background on the Development of Medical Fee Schedules

In 1943 the Legislative Assembly enacted a law directing the Bureau to adopt fee schedules for the payment of medical and hospital services to injured workers:

> All fees and claims for legal, medical, and hospital services rendered under this Act to any claimant shall be in accordance with schedules of fees adopted or to be adopted by the Commissioners of the Workmen's Compensation Bureau and subject to the approval of such Commission.
>
> Session Laws 1943, chapter 274, section 10, now codified in section 65-02-08.

However, from 1943 to 1991, the Bureau did not adopt fee schedules. In 1991 the Legislative Assembly took steps to compel the creation of fee schedules. The legislature created section 65-05-07.1, which provided that if the Bureau did not adopt fee schedules, it would have to implement a statutorily mandated fee schedule equal to 110% of the Medicare fee schedule. The legislature also added language to 65-02-08 requiring that any fee schedule be approved by the Interim Committee on Administrative Rules before it could become effective. Subsequently, the Bureau did adopt fee schedules for medical and hospital services.

The current leadership of the Bureau recognizes that fee schedules are a necessary part of any modern, responsible medical payment system. We also strongly believe that those schedules must be well-crafted and kept continually up-to-date. A poorly structured or outdated fee schedule creates substantial burdens for the medical community, the injured workers receiving treatment, and the Bureau itself.

Unfortunately, in the past the Bureau's fee schedules were not kept updated. The medical fee schedule that was created in 1992 remained largely unchanged until 1998, except for an adjustment for inflation in 1994. By 1998, the schedule was badly outdated. Because of the creation of new medical treatments and changes in medical billing procedures, the schedule covered only about 45% of medical services. The schedule was also cluttered with many treatment codes no longer used by the medical community. Furthermore, the amounts paid for many services no longer matched their true costs. The Bureau was substantially overpaying for some services while substantially underpaying for others.

In 1998, the Bureau replaced that medical fee schedule with a new schedule. The new schedule covers about 90% of medical services, brings North Dakota payments more in line with those of neighboring states, and increases payments to medical providers by 8.9% overall. It is also less expensive to administer. The schedule was developed with input from professional medical associations in North Dakota, and incorporates current national industry standards for medical bill payment.

However, this fee schedule will also quickly become outmoded and burdensome if it is not continually updated. This bill will permit the Bureau to regularly update its fee schedules, so the Bureau will never again be in the position of imposing an inequitable, unwieldy, and inaccurate fee schedule on North Dakota's medical providers.

## B. How Fee Schedules Work

A fee schedule has three major components: codes, values, and conversion factors. All three must be regularly updated to keep the schedule current.

### 1. CPT Codes

Codes for medical services are called "CPT codes." CPT stands for "Current Procedural Terminology." CPT code manuals are published annually by the American Medical Association. Each medical service that a medical provider can perform for a patient is identified by a code number and a brief description. These CPT codes are used universally throughout the country by medical providers and payers.

As an example, attached to this testimony as Attachment 1 is a page from the AMA's CPT manual, showing the CPT codes for surgery to "release" nerves from scar tissue. Code number 64718 is used when a surgeon releases a nerve from blockage where the nerve passes through an opening in the bone at the elbow. Code number 64721 is

used when a surgeon releases a nerve where it passes through an opening in the bone at the wrist called the carpal tunnel.

### 2. Relative Value Units

Values for these services are provided by a publication called the St. Anthony Relative Values for Physicians Fee Schedule. This publication assigns a certain number of value "units" to each CPT code, showing the relative expense of each service compared to the others. These units are not dollars, but provide a comparison of the cost of different services. A service assigned 10 units costs about twice as much as a service with 5 units regardless of where it is provided, even though both those services may be more expensive in one city or state than in another. Attached to this testimony as Attachment 2 is a page from the St. Anthony manual providing values for the surgical procedures to release nerves from blockage at the elbow and at the carpal tunnel. CPT 64718 (release at elbow) is assigned 11 value units. CPT 64721 (release at carpal tunnel) is assigned 8.4 value units. This reflects that the elbow surgery is more complex, and therefore more costly, than the carpal tunnel surgery.

### 3. Conversion Factors

A payer of medical bills anywhere in the country can create a fee schedule based on CPT codes and relative value units by setting "conversion factors" to turn the value units into dollar amounts. Conversion factors will be set lower in areas of the country where medical costs are low, and higher in areas where medical costs are high. This is now the most widely used approach in creating medical fee schedules.

The new fee schedule adopted by the Bureau in 1998 follows this approach. It was determined that the appropriate conversion factor for surgical procedures for the level of medical costs in North Dakota is 80.15. Therefore, the maximum fee for CPT 64718 (release at elbow) is 11 value units times 80.15, which equals $881.65. The maximum fee for CPT 64721 (release at wrist) is 8.4 value units times 80.15, which equals $673.26. Attached to this testimony as Attachment 3 is a page from the Bureau's fee schedule, showing these maximum fees for these procedures. (Note that the printed fee schedule contains only the procedures most commonly billed to the Bureau.)

This approach is accurate, fair, and flexible. Both the American Medical Association and St. Anthony are widely respected and accepted authorities in the areas of CPT codes and relative values. As they update their codes and values, any fee schedule that incorporates those codes and values will also be updated, so long as those changes are adopted into the schedule as they are issued.

## B. Keeping the Fee Schedule Up-To-Date

The AMA updates the CPT codes annually each January. New code numbers are added for new procedures, old outdated code numbers are removed, and other code numbers are changed. Medical providers use the latest version of the CPT manual,

with the new and changed codes. If the Bureau would not update its fee schedule annually, it would get out of step with the medical providers because it would not be using the updated codes used by the providers in their billing statements. Providers would try to bill for services using new or changed codes that would not be in the fee schedule, which would lead to confusion and delay. Therefore, it is important that the Bureau be able to update its fee schedule promptly each year to incorporate the CPT changes.

St. Anthony updates its relative value units five to six times per year. These updates assign value units to new CPT procedures and adjust existing value units to reflect changes in medical practice, technology, and procedures. Ideally, the Bureau would update its fee schedule with each St. Anthony update. At a minimum, the fee schedule must be updated at least annually to incorporate the five or six changes to the relative value units that occurred during the preceding twelve months. The Bureau will also have to periodically adjust its conversion factors to keep them in line with medical costs in the region.

### C. Why This Bill is Needed

Current law makes it impossible for the Bureau to keep its medical fee schedule truly up-to-date, because the Bureau is required to follow the administrative rulemaking process to update its fee schedules. The rulemaking process is set forth in sections 28-32-01 through 28-32-03.3 of the Century Code. The Bureau followed that process in adopting its new fee schedule in 1998.

A timeline of the rulemaking process for the adoption of the 1998 medical fee schedule is attached to this testimony as Attachment 4. It shows that it took eight months to go through the rulemaking process before the new fee schedule took effect, from February 6 to October 1, 1998. Actually, the process could have taken even longer than that. It was fortunate that there happened to be a meeting of the Interim Administrative Rules Committee scheduled for July, which turned out to be perfect timing. An additional month or more could easily have been added to the process if the Committee's schedule had been different. Also, note that this process could only begin after all the work of preparing the new fee schedule had been completed. The fee schedule had to be in its final form before the publication notices could be sent out.

To provide good service to injured workers and medical providers, the Bureau will have to update its fee schedule at least annually, after the American Medical Association publishes its new CPT codes each January. This update would also incorporate all of the changes to the relative value units issued by St. Anthony during the preceding year. Based on our experience with the adoption of the 1998 fee schedule, under current law those updates would not take effect until the following October. This means that our CPT codes will always be almost a year behind the rest of the medical community, and some of our relative value units will be almost two years out of date. This is an unacceptable business practice. This is the kind of laggard performance that makes people bemoan state agencies. The Bureau is committed to providing excellent service

to injured workers, and to being an excellent partner with North Dakota's medical community. This Bill will aid the Bureau in achieving those goals in the area of its fee schedules.

Section 1 of this Bill will allow the Bureau to update its fee schedules through a faster notice and hearing process, rather than having to follow the full-blown eight month rule making process. The Bureau has been using this faster notice and hearing process for a number of years to update its schedule of premium rates. Premium rate making is governed by section 65-04-01(3) of the Century Code. In 1995, the Legislative Assembly amended that statute to permit the Bureau to amend its rate schedule through a simple public hearing process, rather than through the administrative rule making process in chapter 28-32. The 1995 amendment states:

> Before the effective date of any premium rate change, the bureau shall hold a public hearing on the rate change. Chapter 28-32 does not apply to a hearing held by the bureau under this subsection.

The Bureau has used this faster process to update its premium rate schedule four times since 1995, each time reducing overall rates by an average of 7.35% per year. This same language is now being adopted in slightly modified form in this Bill to also apply to the medical fee schedule. The medical fee schedule is similar to the premium rate schedule. Both contain tables of dollar values that must be regularly adjusted according to certain formulas in order to stay current in light of changing circumstances.

Section 3 of this Bill repeals section 65-05-07.1 of the Century Code. That is the law that was enacted in 1989 mandating a statutory fee schedule based on the Medicare schedule if the Bureau failed to adopt a fee schedule of its own. Now that the Bureau has adopted a modern, effective fee schedule, this statute is no longer needed.

### D. Scope of the Bill

The Bureau is developing a new fee schedule for hospital services also. As with the medical fee schedule, the current hospital fee schedule has become badly outdated. The current fee schedule pays for inpatient services on a "per day" basis, and on a "cost to charge ratio" basis for outpatient services. The per day charge and the cost to charge ratio are different for every hospital in the state. The hospitals are very concerned about the fact that different facilities are paid significantly different amounts for performing the same services.

In developing the new hospital fee schedule, the Bureau is working closely with an advisory group whose members represent the North Dakota Hospital Association and individual hospitals across the state, to ensure that the new fee schedule will allow for an effective and responsive bill payment process. Development is expected to be complete in late February, at which time the rule making process to implement the new schedule will begin. However, under the current rule making process, the new fee schedule will not become effective until at least October.

The new hospital fee schedule will pay for inpatient services based on the Diagnostic Related Group (DRG) approach, in which payment is based on the patient's primary diagnosis at discharge. This is a widely accepted approach to inpatient reimbursement. Hospitals are familiar with the DRG system, and it allows them to effectively plan and manage their operations by knowing what payment they will receive for treating various conditions. The Bureau and advisory group are still exploring which new approach to follow for payment of outpatient services.

As with the medical fee schedule, the new hospital fee schedule will need to be regularly updated to keep current with changes in medical practices, costs, procedures, and technology. For example, advances in medical technology or techniques can substantially increase or decrease the expense of treating a given condition, and these changes must be incorporated into the fee schedule.

This Bill will also make it easier for the Bureau to further expand the coverage of its fee schedules. For example, the Bureau is working on expansions of the medical fee schedule to cover the cost of prescription drugs, which is the fastest growing component of workers compensation medical costs, and the cost of purchasing medical equipment such as wheelchairs or knee braces.

The faster notice and hearing process provided in section 1 of the Bill will apply to the schedules themselves, including the CPT codes, descriptors, Relative Value Units, conversion factors, dollar amounts, DRG's, and ASC categories with modification factors. It will also apply to the text in the fee schedules setting forth the scope and the proper use and application of the schedules. However, it will not apply to the medical service policies that are set forth in the Bureau's administrative rules on medical services, which are found in sections 92-01-02-27 through 92-01-02-47 of the North Dakota Administrative Code. Amendments to those rules will still be done through the administrative rule making process in chapter 28-32.

This concludes my testimony relating to fee schedules. I will now address managed care services.

## II. MANAGED CARE

As was outlined above, in 1991 the Legislative Assembly enacted a law compelling the Bureau to adopt medical and hospital fee schedules, to help control the rapidly rising medical costs that were contributing to the Bureau's growing unfunded liability at that time. Also in 1991, the legislature enacted three additional statutes, sections 65-02-19, -20, and –21, requiring that the Bureau take the further step in controlling medical costs of contracting for managed care services.

## 1. What is "Managed Care"?

The term "managed care" includes all procedures designed to monitor and control the frequency and cost of medical services. Two major components of managed care are utilization review and bill review.

### A. Utilization Review

Utilization review is the part of managed care that occurs before medical treatment is provided. By administrative rule the Bureau has designated certain medical services as being subject to utilization review. This means that a medical provider must get prior authorization before performing the service in order for it to be covered under workers compensation. This process of prior authorization is called "pre-certification." Services that must be pre-certified include inpatient hospital admissions, non-emergency surgery, imaging procedures such as an MRI or CT scan, and physical therapy or chiropractic treatment beyond an initial "window period." For example, in response to a request that an expensive imaging procedure be authorized, the physician might be asked to try treating the condition with a conservative treatment such as physical therapy first, to see whether the injury will respond to treatment without the need for expensive testing. During 1999, the Bureau pursue new initiatives in the area of utilization review, including the development of a "physician profiling" program, with the goal of making utilization review significantly less burdensome for most medical providers. Section 2 of this Bill contains a provision to ensure that the confidentiality of medical providers will be protected in that process.

### B. Bill Review

Bill review occurs after the medical treatment has been provided, and the medical facility has sent a bill for that treatment to the Bureau for payment. Bill review includes several steps. First, for every bill the Bureau receives, the Bureau also receives the medical records on the services being billed. Those records are reviewed to ensure the bill is for treatment for the work injury covered by the Bureau. For example, if the work injury was a broken leg, and the medical records showed that the treatment being billed was an office visit to treat the flu, the bill for that office visit would be denied. Second, bills can also be reviewed for correct coding. As was outlined above, there is a CPT code for virtually every type of medical service. A bill auditor can review the medical records to ensure that the correct CPT code was used. If the records show that the wrong code was used, the service can be re-coded and paid at the fee schedule rate under the correct code. The Bureau has just recently begun to develop this aspect of bill review. The third and final step is to apply the appropriate fee schedule to each medical bill, to ensure the maximum fee for the service is not exceeded.

### C. "Outside" Managed Care Firms

The laws enacted in 1991 require that the Bureau hire outside companies to perform managed care services, and that has been done. The Bureau currently has contracts with two firms, one to perform bill review and the other to perform utilization review. Both companies offer contracted managed care services on a nationwide basis.

Bill review services are performed by employees of the bill review firm located on-site at Bureau headquarters in Bismarck under the supervision of a Minneapolis branch office. This company has been performing bill review for the Bureau since August, 1997, under a contract covering the 1997-99 biennium. In many respects, the bill review program has been quite successful. For example, the firm has developed automated bill review software that allows about 20% of incoming medical bills to be authorized for payment by computer without ever being examined by a bill review nurse, generating significant savings of time and money.

Also, through dramatic improvements in our own internal systems and by working in partnership with the bill review firm, the Bureau has achieved substantial improvements in the payment of medical bills. In previous years, the Bureau did not pay medical bills in a timely manner, which was a serious issue disrupting the Bureau's key partnership with the medical community. Great progress has been made in this area in recent years. Medical bill payment was added to the Bureau's performance measurement system in June of 1997. At that time the Bureau was paying only 39% of medical bills within 30 days after they were submitted. By December, 1997, that was increased to 64% of bills paid within 30 days, and by December, 1998, the Bureau paid 85% of medical bills within 30 days of the date the bills were submitted.

## 2. Why this Bill is Needed

There is a concern regarding the cost of bill review services. During the early stages of the managerial and leadership reforms at the Bureau since 1994, the Bureau was focused on overhauling its own internal processes, to resolve serious performance and service problems in its core operations. By the end of 1997, the Bureau had addressed the most pressing internal performance issues and was achieving substantial improvement in key areas. At that point, attention was turned to a wide range of other opportunities for improvement, including a review of the services being provided by our outside service vendors. During the 1997-98 fiscal year, the Bureau paid an average of $76,150 per month to the bill review vendor. It was determined that if the Bureau could hire its own staff to perform bill review services, the program could be operated at a cost of about $38,500 per month, for a savings of $37,650 per month or $451,800 per year.

In recent months, the Bureau has renegotiated its contract with the bill review vendor to reduce the cost of the program. The vendor has been a positive and willing partner in

these renegotiations. As a result, the cost of the service has been reduced while at the same time the vendor has begun providing additional services at no extra charge. Even with these changes in the contract, however, the Bureau believes it could still achieve savings of about $250,000 per year by performing the work in-house. The Bureau has recently hired an individual with a high level of expertise in bill review who could implement and manage an in-house bill review program that would generate substantial cost savings while meeting or exceeding the performance provided by the outside vendor.

There are two barriers preventing the Bureau from performing bill review in-house. The first barrier is that sections 65-02-19, -20, and -21 specifically require that the Bureau contract the services with an outside vendor. This Bill will remove that requirement by amending sections 65-02-20 and -21 and repealing section 65-02-19. If this Bill is enacted, the Bureau will have the option of either continuing to contract with an outside vendor or bringing the work in-house.

The second barrier is that the Bureau does not have any FTE positions or salary dollars available for hiring its own bill review staff. The Bureau is exploring an alternative solution using an employee leasing or contracting arrangement. Under this approach, the bill review program would be managed by the Bureau's in-house bill review expert, who would supervise a staff of leased or contracted bill reviewers. The bill reviewers would track the claims for which they perform bill review, with the cost then treated as an allocated loss adjustment expense.

By removing the requirement that the Bureau contract with an outside vendor for managed care services, this Bill will make it possible for the Bureau to further develop the concept of reducing costs and improving performance by operating the bill review process in-house.

This Bill would also permit the Bureau to perform utilization review in-house. In fiscal year 1997-98, the Bureau paid $766,845 to an outside vendor to perform utilization review. Utilization review is an area of particular concern to the medical community. Many North Dakota medical professionals strongly object to submitting pre-certification requests to out-of-state reviewers. In fact, bills have been prepared for this legislative session requiring that insurers have utilization review performed by doctors licensed in North Dakota. The Bureau's utilization review is currently performed by employees of the contract vendor located in Minneapolis, Minnesota. The Bureau does not currently have the in-house expertise to operate its own comprehensive utilization review program. Any initiative to bring utilization review in-house would require prior approval by our Board of Directors, including the member representing the medical community, and close cooperation with the state's medical providers. However, by giving the Bureau the option of bringing all or part of utilization review in-house in the future, this Bill will allow the Bureau and its Board to work during the next biennium to develop a

mutually satisfactory utilization review program in partnership with North Dakota's medical community.

This concludes my testimony on House Bill No. 1333. I respectfully ask for this committee's favorable recommendation on this bill, and will be happy to answer your questions at this time.

## Destruction by Neurolytic Agent (eg, Chemical, Thermal, Electrical, Radiofrequency)

### Somatic Nerves

64600 Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch

64605 second and third division branches at foramen ovale

64610 second and third division branches at foramen ovale under radiologic monitoring

64612 Destruction by neurolytic agent (chemodenervation of muscle endplate); muscles enervated by facial nerve (eg, for blepharospasm, hemifacial spasm)

64613 cervical spinal muscles (eg, for spasmodic torticollis)

(For chemodenervation for strabismus involving the extraocular muscles, see 67345)

64620 Destruction by neurolytic agent; intercostal nerve

64622 paravertebral facet joint nerve, lumbar, single level

64623 paravertebral facet joint nerve, lumbar, each additional level

64630 pudendal nerve

64640 other peripheral nerve or branch

### Sympathetic Nerves

64680 Destruction by neurolytic agent, celiac plexus, with or without radiologic monitoring

## Neuroplasty (Exploration, Neurolysis or Nerve Decompression)

Neuroplasty is the decompression or freeing of intact nerve from scar tissue, including external neurolysis and/or transposition.

(For internal neurolysis requiring use of operating microscope, use 64727)

(For facial nerve decompression, see 69720)

64702 Neuroplasty; digital, one or both, same digit

64704 nerve of hand or foot

64708 Neuroplasty, major peripheral nerve, arm or leg; other than specified

64712 sciatic nerve

64713 brachial plexus

64714 lumbar plexus

➔ CPT Assistant Jun 97:11

64716 Neuroplasty and/or transposition; cranial nerve (specify)

64718 ulnar nerve at elbow

64719 ulnar nerve at wrist

64721 median nerve at carpal tunnel

(For arthroscopic procedure, see 29848)

64722 Decompression; unspecified nerve(s) (specify)

64726 plantar digital nerve

64727 Internal neurolysis, requiring use of operating microscope (list separately in addition to code for neuroplasty) (Neuroplasty includes external neurolysis)

## Transection or Avulsion

(For stereotactic lesion of gasserian ganglion, see 61790)

64732 Transection or avulsion of; supraorbital nerve

64734 infraorbital nerve

64736 mental nerve

64738 inferior alveolar nerve by osteotomy

64740 lingual nerve

64742 facial nerve, differential or complete

64744 greater occipital nerve

64746 phrenic nerve

(For section of recurrent laryngeal nerve, see 31595)

| UPD | CPT | DESCRIPTION | UNITS | FUD | ANES |
|---|---|---|---|---|---|
| | 64704 | nerve of hand or foot | 8.0 | 90 | 3 |
| | 64708 | Neuroplasty, major peripheral nerve, arm or leg; other than specified | 10.0 | 90 | 4 |
| | 64712 | sciatic nerve | 14.0 | 90 | 5 |
| | 64713 | brachial plexus | 13.0 | 90 | 6 |
| | 64714 | lumbar plexus | 13.0 | 90 | 6 |
| | 64716 | Neuroplasty and/or transposition; cranial nerve (specify) | 15.0 | 90 | 5 |
| | 64718 | ulnar nerve at elbow | 11.0 | 90 | 3 |
| | 64719 | ulnar nerve at wrist | 7.9 | 90 | 3 |
| | 64721 | median nerve at carpal tunnel | 8.4 | 90 | 3 |
| | | (For arthroscopic procedure, see 29848) | | | |
| | 64722 | Decompression; unspecified nerve(s) (specify) | 10.0 | 90 | 3 |
| | 64726 | plantar digital nerve | 4.8 | 90 | 3 |
| | 64727 | Internal neurolysis, requiring use of operating microscope (list separately in addition to code for neuroplasty) (Neuroplasty includes external neurolysis) | BR | — | — |
| | | (VALUE EQUAL TO 25% OF PRIMARY PROCEDURE) | | | |

## Transection or Avulsion

| UPD | CPT | DESCRIPTION | UNITS | FUD | ANES |
|---|---|---|---|---|---|
| | | (For stereotactic lesion of gasserian ganglion, see 61790) | | | |
| | 64732 | Transection or avulsion of; supraorbital nerve | 7.0 | 30 | 5 |
| | 64734 | infraorbital nerve | 7.0 | 30 | 5 |
| | 64736 | mental nerve | 10.0 | 30 | 5 |
| | 64738 | inferior alveolar nerve by osteotomy | 10.0 | 30 | 5 |
| | 64740 | lingual nerve | 5.0 | 30 | 5 |
| | 64742 | facial nerve, differential or complete | 10.0 | 30 | 5 |
| | 64744 | greater occipital nerve | 7.5 | 30 | 5 |
| | 64746 | phrenic nerve | 5.0 | 30 | 6 |
| | | (For section of recurrent laryngeal nerve, see 31595) | | | |



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### Neuroplasty (Exploration, Neurolysis or Nerve Decompression)

| Code | Service | Maximum Fee |
|---|---|---|
| 64718 | ulnar nerve at elbow | 881.65 |
| 64721 | median nerve at carpal tunnel | 673.26 |

### Neurorrhaphy

| Code | Service | Maximum Fee |
|---|---|---|
| 64831 | Suture of digital nerve, hand, or foot; one nerve | 464.87 |

## Eye and Ocular Adnexa

The following codes, service descriptions, and maximum fees apply to surgical procedures involving the eye and ocular adnexa.

### Eyeball

#### Removal of Foreign Body

| Code | Service | Maximum Fee |
|---|---|---|
| 65205* | Removal foreign body, external eye; conjunctival superficial | 56.11 |
| 65210* | conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating | 64.12 |
| 65220* | corneal, without slit lamp | 64.12 |
| 65222* | corneal, with slit lamp | 96.18 |

## Anterior Segment

### Cornea

#### Excision

| Code | Service | Maximum Fee |
|---|---|---|
| 65420 | Excision of transposition of pterygium; without graft | 400.75 |

CPT codes and descriptions only copyright © 1997 American Medical Association

**Attachment 4**

Testimony of Reagan Pufall
1999 HB 1333
House Industry, Business, and Labor Committee
January 20, 1999

(Before February 6, all work on the new fee schedule is completed and schedule is in its final form)

| | |
|---|---|
| Feb 6 | Publication of Notice sent to ND Newspaper Association |
| Feb 13 | Notice and Amendments sent to Legislative Council for publication |
| Feb 16, 17 23, and 24 | Notice published in ND major daily newspapers |
| March 1 | Legislative Council publishes Notice and Amendments |
| April 1 | Public hearing held |
| May 1 | Thirty day post-hearing comment period ends |
| May 18 | Request made to Attorney General for opinion, enclosing comments and Bureau response to comments |
| July 6 | Opinion received from Attorney General |
| July 29 | Special review by Interim Administrative Rule Committee in accordance with NDCC 65-02-08 |
| Aug 10 | Amended rules sent to Legislative Council for publication |
| Sept 1 | Amended rules published |
| Oct 1 | Rules become effective |

**Total time required for rulemaking process: eight months**

# Engrossed House Bill No. 1333

## Fifty-sixth Legislative Assembly
## Before the Senate Industry, Business, and Labor Committee
## March 3, 1999
## Testimony of Reagan Pufall
## Regarding Medical Fee Schedules and Managed Care

Mr. Chairman, Members of the Committee:

My name is Reagan Pufall. I am the Chief Operating Officer and General Counsel for the Workers Compensation Bureau and I am here to testify in support of 1999 Engrossed House Bill No. 1333. This bill was unanimously approved by the Workers Compensation Board of Directors, and was approved by the House of Representatives by a vote of 93 to 1.

This Bill amends sections 65-02-08, 65-02-20, and 65-02-21, and repeals sections 65-02-19 and 65-05-07.1, of the North Dakota Century Code. It amends laws relating to two aspects of workers compensation medical services: First, the procedure followed by the Bureau in adopting and updating fee schedules for medical and hospital services; and second, how the Bureau obtains managed care services.

## I. FEE SCHEDULES

### A. Background on the Development of Medical Fee Schedules

In 1943 the Legislative Assembly enacted a law directing the Bureau to adopt fee schedules for the payment of medical and hospital services to injured workers:

> All fees and claims for legal, medical, and hospital services rendered under this Act to any claimant shall be in accordance with schedules of fees adopted or to be adopted by the Commissioners of the Workmen's Compensation Bureau and subject to the approval of such Commission.
>
> Session Laws 1943, chapter 274, section 10, now codified in section 65-02-08.

However, from 1943 to 1991, the Bureau did not adopt fee schedules. In 1991 the Legislative Assembly took steps to compel the creation of fee schedules. The legislature enacted section 65-05-07.1, which provided that if the Bureau did not adopt fee schedules, it would have to implement a statutorily mandated fee schedule equal to 110% of the Medicare fee schedule. The legislature also added language to section 65-02-08 requiring that any fee schedule be approved by the Interim Committee on Administrative Rules before it could become effective. Subsequently, the Bureau did adopt fee schedules for medical and hospital services.

The current leadership of the Bureau recognizes that fee schedules are a necessary part of any modern, responsible medical payment system. We also strongly believe that those schedules must be well-crafted and kept continually up-to-date. A poorly structured or outdated fee schedule creates substantial burdens for the medical community, the injured workers receiving treatment, and the Bureau itself.

Unfortunately, in the past the Bureau's fee schedules were not kept updated. The medical fee schedule that was created in 1992 remained largely unchanged until 1998, except for an adjustment for inflation in 1994. By 1998, the schedule was badly outdated. Because of the creation of new medical treatments and changes in medical billing procedures, the schedule covered only about 45% of medical services. The schedule was also cluttered with many treatment codes no longer used by the medical community. Furthermore, the amounts paid for many services no longer matched their true costs. The Bureau was substantially overpaying for some services while substantially underpaying for others.

In 1998, the Bureau replaced that medical fee schedule with a new schedule. The new schedule covers about 90% of medical services, brings North Dakota payments more in line with those of neighboring states, and increases payments to medical providers by 8.9% overall. It is also less expensive to administer. The schedule was developed with input from professional medical associations in North Dakota, and incorporates current national industry standards for medical bill payment.

However, this fee schedule will also quickly become outmoded and burdensome if it is not continually updated. This bill will permit the Bureau to regularly update its fee schedules, so the Bureau will never again be in the position of imposing an inequitable, unwieldy, and inaccurate fee schedule on North Dakota's medical providers.

### B. How Fee Schedules Work

A fee schedule has three major components: codes, values, and conversion factors. All three must be regularly updated to keep the schedule current.

#### 1. CPT Codes

Codes for medical services are called "CPT codes." CPT stands for "Current Procedural Terminology." CPT code manuals are published annually by the American Medical Association. Each medical service that a medical provider can perform for a patient is identified by a code number and a brief description. These CPT codes are used universally throughout the country by medical providers and payers.

As an example, attached to this testimony as Attachment 1 is a page from the AMA's CPT manual, showing the CPT codes for surgery to "release" nerves from scar tissue. Code number 64718 is used when a surgeon releases a nerve from blockage where the nerve passes through an opening in the bone at the elbow. Code number 64721 is

used when a surgeon releases a nerve where it passes through an opening in the bone at the wrist called the carpal tunnel.

### 2. Relative Value Units

Values for these services are provided by a publication called the St. Anthony Relative Values for Physicians Fee Schedule. This publication assigns a certain number of value "units" to each CPT code, showing the relative expense of each service compared to the others. These units are not dollars, but provide a comparison of the cost of different services. A service assigned 10 units costs about twice as much as a service with 5 units regardless of where it is provided, even though both those services may be more expensive in one city or state than in another. Attached to this testimony as Attachment 2 is a page from the St. Anthony manual providing values for the surgical procedures to release nerves from blockage at the elbow and at the carpal tunnel. CPT 64718 (release at elbow) is assigned 11 value units. CPT 64721 (release at carpal tunnel) is assigned 8.4 value units. This reflects that the elbow surgery is more complex, and therefore more costly, than the carpal tunnel surgery.

### 3. Conversion Factors

A payer of medical bills anywhere in the country can create a fee schedule based on CPT codes and relative value units by setting "conversion factors" to turn the value units into dollar amounts. Conversion factors will be set lower in areas of the country where medical costs are low, and higher in areas where medical costs are high. This is now the most widely used approach in creating medical fee schedules.

The new fee schedule adopted by the Bureau in 1998 follows this approach. It was determined that the appropriate conversion factor for surgical procedures for the level of medical costs in North Dakota is 80.15. Therefore, the maximum fee for CPT 64718 (release at elbow) is 11 value units times 80.15, which equals $881.65. The maximum fee for CPT 64721 (release at wrist) is 8.4 value units times 80.15, which equals $673.26. Attached to this testimony as Attachment 3 is a page from the Bureau's fee schedule, showing these maximum fees for these procedures. (Note that the printed fee schedule contains only the procedures most commonly billed to the Bureau.)

This approach is accurate, fair, and flexible. Both the American Medical Association and St. Anthony are widely respected and accepted authorities in the areas of CPT codes and relative values. As they update their codes and values, any fee schedule that incorporates those codes and values will also be updated, so long as those changes are adopted into the schedule as they are issued.

## B. Keeping the Fee Schedule Up-To-Date

The AMA updates the CPT codes annually each January. New code numbers are added for new procedures, old outdated code numbers are removed, and other code numbers are changed. Medical providers use the latest version of the CPT manual,

with the new and changed codes. If the Bureau would not update its fee schedule annually, it would get out of step with the medical providers because it would not be using the updated codes used by the providers in their billing statements. Providers would try to bill for services using new or changed codes that would not be in the fee schedule, which would lead to confusion and delay. Therefore, it is important that the Bureau be able to update its fee schedule promptly each year to incorporate the CPT changes.

St. Anthony updates its relative value units five to six times per year. These updates assign value units to new CPT procedures and adjust existing value units to reflect changes in medical practice, technology, and procedures. Ideally, the Bureau would update its fee schedule with each St. Anthony update. At a minimum, the fee schedule must be updated at least annually to incorporate the five or six changes to the relative value units that occurred during the preceding twelve months. The Bureau will also have to periodically adjust its conversion factors to keep them in line with medical costs in the region.

### C. Why This Bill is Needed

Current law makes it impossible for the Bureau to keep its medical fee schedule truly up-to-date, because the Bureau is required to follow the administrative rulemaking process to update its fee schedules. The rulemaking process is set forth in sections 28-32-01 through 28-32-03.3 of the Century Code. The Bureau followed that process in adopting its new fee schedule in 1998.

A timeline of the rulemaking process for the adoption of the 1998 medical fee schedule is attached to this testimony as Attachment 4. It shows that it took eight months to go through the rulemaking process before the new fee schedule took effect, from February 6 to October 1, 1998. Actually, the process could have taken even longer than that. It was fortunate that there happened to be a meeting of the Interim Administrative Rules Committee scheduled for July, which turned out to be perfect timing. An additional month or more could easily have been added to the process if the Committee's schedule had been different. Also, note that this process could only begin after all the work of preparing the new fee schedule had been completed. The fee schedule had to be in its final form before the publication notices could be sent out.

To provide good service to injured workers and medical providers, the Bureau will have to update its fee schedule at least annually, after the American Medical Association publishes its new CPT codes each January. This update would also incorporate all of the changes to the relative value units issued by St. Anthony during the preceding year. Based on our experience with the adoption of the 1998 fee schedule, under current law those updates would not take effect until the following October. This means that our CPT codes will always be almost a year behind the rest of the medical community, and some of our relative value units will be almost two years out of date. This is an unacceptable business practice. This is the kind of laggard performance that makes people bemoan state agencies. The Bureau is committed to providing excellent service

to injured workers, and to being an excellent partner with North Dakota's medical community. This Bill will aid the Bureau in achieving those goals in the area of its fee schedules.

Section 1 of this Bill will allow the Bureau to update its fee schedules through a faster notice and hearing process, rather than having to follow the full-blown eight month rule making process. The Bureau has been using this faster notice and hearing process for a number of years to update its schedule of premium rates. Premium rate making is governed by section 65-04-01(3) of the Century Code. In 1995, the Legislative Assembly amended that statute to permit the Bureau to amend its rate schedule through a simple public hearing process, rather than through the administrative rule making process in chapter 28-32. The 1995 amendment states:

> Before the effective date of any premium rate change, the bureau shall hold a public hearing on the rate change. Chapter 28-32 does not apply to a hearing held by the bureau under this subsection.

The Bureau has used this faster process to update its premium rate schedule four times since 1995, each time reducing overall rates by an average of 7.35% per year. This same language is now being adopted in slightly modified form in this Bill to also apply to the medical fee schedule. The medical fee schedule is similar to the premium rate schedule. Both contain tables of dollar values that must be regularly adjusted according to certain formulas in order to stay current in light of changing circumstances.

Section 3 of this Bill repeals section 65-05-07.1 of the Century Code. That is the law that was enacted in 1989 mandating a statutory fee schedule based on the Medicare schedule if the Bureau failed to adopt a fee schedule of its own. Now that the Bureau has adopted a modern, effective fee schedule, that statute is no longer needed.

## D. Scope of the Bill

The Bureau is developing a new fee schedule for hospital services also. As with the medical fee schedule, the current hospital fee schedule has become badly outdated. The current fee schedule pays for inpatient services on a "per day" basis, and on a "cost to charge ratio" basis for outpatient services. The per day charge and the cost to charge ratio are different for every hospital in the state. The hospitals are very concerned about the fact that different facilities are paid significantly different amounts for performing the same services.

In developing the new hospital fee schedule, the Bureau is working closely with an advisory group whose members represent the North Dakota Hospital Association and individual hospitals across the state, to ensure that the new fee schedule will allow for an effective and responsive bill payment process. Development is almost complete, under the current rule making process, the new fee schedule will not become effective until at least October.

The new hospital fee schedule will pay for inpatient services based on the Diagnostic Related Group (DRG) approach, in which payment is based on the patient's primary diagnosis at discharge. This is a widely accepted approach to inpatient reimbursement. Hospitals are familiar with the DRG system, and it allows them to effectively plan and manage their operations by knowing what payment they will receive for treating various conditions. The Bureau and the advisory group are exploring which new approach to follow for payment of outpatient services.

As with the medical fee schedule, the new hospital fee schedule will need to be regularly updated to keep current with changes in medical practices, costs, procedures, and technology. For example, advances in medical technology or techniques can substantially increase or decrease the expense of treating a given condition, and these changes must be incorporated into the fee schedule.

This Bill will also make it easier for the Bureau to further expand the coverage of its fee schedules. For example, the Bureau is working on expansions of the medical fee schedule to cover the cost of prescription drugs, which is the fastest growing component of workers compensation medical costs, and the cost of purchasing medical equipment such as wheelchairs or knee braces.

The faster notice and hearing process provided in section 1 of the Bill will apply to the schedules themselves, including the CPT codes, descriptors, Relative Value Units, conversion factors, dollar amounts, DRG's, and ASC categories with modification factors. It will also apply to the text in the fee schedules setting forth the scope and the proper use and application of the schedules. However, it will not apply to the medical service policies that are set forth in the Bureau's administrative rules on medical services, which are found in sections 92-01-02-27 through 92-01-02-47 of the North Dakota Administrative Code. Amendments to those rules will still be done through the administrative rule making process in chapter 28-32.

This concludes my testimony relating to fee schedules. I will now address managed care services.

## II. MANAGED CARE

As was outlined above, in 1991 the Legislative Assembly enacted a law compelling the Bureau to adopt medical and hospital fee schedules, to help control the rapidly rising medical costs that were contributing to the Bureau's growing unfunded liability at that time. Also in 1991, the legislature enacted three additional statutes, sections 65-02-19, -20, and –21, requiring that the Bureau take the further step in controlling medical costs of contracting for managed care services.

## 1. What is "Managed Care"?

The term "managed care" includes all procedures designed to monitor and control the frequency and cost of medical services. Two major components of managed care are utilization review and bill review.

### A. Utilization Review

Utilization review is the part of managed care that occurs before medical treatment is provided. By administrative rule the Bureau has designated certain medical services as being subject to utilization review. This means that a medical provider must get prior authorization before performing the service in order for it to be covered under workers compensation. This process of prior authorization is called "pre-certification." Services that must be pre-certified include inpatient hospital admissions, non-emergency surgery, imaging procedures such as an MRI or CT scan, and physical therapy or chiropractic treatment beyond an initial "window period." For example, in response to a request that an expensive imaging procedure be authorized, the physician might be asked to try treating the condition with a conservative treatment such as physical therapy first, to see whether the injury will respond to treatment without the need for expensive testing. During 1999, the Bureau will pursue new initiatives in the area of utilization review, including the development of a "physician profiling" program, with the goal of making utilization review significantly less burdensome for most medical providers. Section 2 of this Bill contains a provision to ensure that the confidentiality of medical providers will be protected in that process.

### B. Bill Review

Bill review occurs after the medical treatment has been provided, and the medical facility has sent a bill for that treatment to the Bureau for payment. Bill review includes several steps. First, for every bill the Bureau receives, the Bureau also receives the medical records on the services being billed. Those records are reviewed to ensure the bill is for treatment for the work injury covered by the Bureau. For example, if the work injury was a broken leg, and the medical records showed that the treatment being billed was an office visit to treat the flu, the bill for that office visit would be denied. Second, bills can also be reviewed for correct coding. As was outlined above, there is a CPT code for virtually every type of medical service. A bill auditor can review the medical records to ensure that the correct CPT code was used. If the records show that the wrong code was used, the service can be re-coded and paid at the fee schedule rate under the correct code. The Bureau has recently begun developing this aspect of bill review. The third and final step is to apply the appropriate fee schedule to each medical bill, to ensure the maximum fee for the service is not exceeded.

C. "Outside" Managed Care Firms

The laws enacted in 1991 require that the Bureau hire outside companies to perform managed care services, and that has been done. The Bureau currently has contracts with two firms, one to perform bill review and the other to perform utilization review. Both companies offer contracted managed care services on a nationwide basis.

Bill review services are performed by employees of the bill review firm located on-site at Bureau headquarters in Bismarck under the supervision of a Minneapolis branch office. This company has been performing bill review for the Bureau since August, 1997, under a contract covering the 1997-99 biennium. In many respects, the bill review program has been quite successful. For example, the firm has developed automated bill review software that allows about 20% of incoming medical bills to be authorized for payment by computer without ever being examined by a bill review nurse, generating significant savings of time and money.

Also, through dramatic improvements in our own internal systems and by working in partnership with the bill review firm, the Bureau has achieved substantial improvements in the payment of medical bills. In previous years, the Bureau did not pay medical bills in a timely manner, which was a serious issue disrupting the Bureau's key partnership with the medical community. Great progress has been made in this area in recent years. Medical bill payment was added to the Bureau's performance measurement system in June of 1997. At that time the Bureau was paying only 39% of medical bills within 30 days after they were submitted. By December, 1997, that was increased to 64% of bills paid within 30 days, and by December, 1998, the Bureau paid 85% of medical bills within 30 days of the date the bills were submitted.

**2. Why this Bill is Needed**

There is a concern regarding the cost of bill review services. During the early stages of the managerial and leadership reforms at the Bureau since 1994, the Bureau was focused on overhauling its own internal processes, to resolve serious performance and service problems in its core operations. By the end of 1997, the Bureau had addressed the most pressing internal performance issues and was achieving substantial improvement in key areas. At that point, attention was turned to a wide range of other opportunities for improvement, including a review of the services being provided by our outside service vendors. During the 1997-98 fiscal year, the Bureau paid an average of $76,150 per month to the bill review vendor. It was determined that if the Bureau could hire its own staff to perform bill review services, the program could be operated at a cost of about $38,500 per month, for a savings of $37,650 per month or $451,800 per year.

In recent months, the Bureau has renegotiated its contract with the bill review vendor to reduce the cost of the program. The vendor has been a positive and willing partner in

these renegotiations. As a result, the cost of the service has been reduced while at the same time the vendor has begun providing additional services at no extra charge. Even with these changes in the contract, however, the Bureau believes it could still achieve savings of about $250,000 per year by performing the work in-house. The Bureau has recently hired an individual with a high level of expertise in bill review who could implement and manage an in-house bill review program that would generate substantial cost savings while meeting or exceeding the performance provided by the outside vendor.

There are two barriers preventing the Bureau from performing bill review in-house. The first barrier is that sections 65-02-19, -20, and -21 specifically require that the Bureau contract the services with an outside vendor. This Bill will remove that requirement by amending sections 65-02-20 and -21 and repealing section 65-02-19. If this Bill is enacted, the Bureau will have the option of either continuing to contract with an outside vendor or bringing the work in-house.

The second barrier is that the Bureau's appropriation does not include FTE positions or salary dollars for hiring its own bill review staff. The Bureau is exploring an alternative solution using an employee leasing or contracting arrangement. Under this approach, the bill review program would be managed by the Bureau's in-house bill review expert, who would supervise a staff of leased or contracted bill reviewers. The bill reviewers would track the claims for which they perform bill review, with the cost then treated as an allocated loss adjustment expense.

By removing the requirement that the Bureau contract with an outside vendor for managed care services, this Bill will make it possible for the Bureau to further develop the concept of reducing costs and improving performance by operating the bill review process in-house.

This Bill would also permit the Bureau to perform utilization review in-house. In fiscal year 1997-98, the Bureau paid $766,845 to an outside vendor to perform utilization review. Utilization review is an area of particular concern to the medical community. Many North Dakota medical professionals strongly object to submitting pre-certification requests to out-of-state reviewers. In fact, bills have been prepared for this legislative session requiring that insurers have utilization review performed by doctors licensed in North Dakota. The Bureau's utilization review is currently performed by employees of the contract vendor located in Minneapolis, Minnesota. The Bureau does not currently have the in-house expertise to operate its own comprehensive utilization review program. Any initiative to bring utilization review in-house would require prior approval by our Board of Directors, including the member representing the medical community, and close cooperation with the state's medical providers. However, by giving the Bureau the option of bringing all or part of utilization review in-house in the future, this Bill will allow the Bureau and its Board to work during the next biennium to develop a

mutually satisfactory utilization review program in partnership with North Dakota's medical community.

This concludes my testimony on House Bill No. 1333. I respectfully ask for this committee's favorable recommendation on this bill, and will be happy to answer your questions at this time.

## Destruction by Neurolytic Agent (eg, Chemical, Thermal, Electrical, Radiofrequency)

### Somatic Nerves

64600 Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch

64605 second and third division branches at foramen ovale

64610 second and third division branches at foramen ovale under radiologic monitoring

64612 Destruction by neurolytic agent (chemodenervation of muscle endplate); muscles enervated by facial nerve (eg, for blepharospasm, hemifacial spasm)

64613 cervical spinal muscles (eg, for spasmodic torticollis)

(For chemodenervation for strabismus involving the extraocular muscles, see 67345)

64620 Destruction by neurolytic agent; intercostal nerve

64622 paravertebral facet joint nerve, lumbar, single level

64623 paravertebral facet joint nerve, lumbar, each additional level

64630 pudendal nerve

64640 other peripheral nerve or branch

### Sympathetic Nerves

64680 Destruction by neurolytic agent, celiac plexus, with or without radiologic monitoring

## Neuroplasty (Exploration, Neurolysis or Nerve Decompression)

Neuroplasty is the decompression or freeing of intact nerve from scar tissue, including external neurolysis and/or transposition.

(For internal neurolysis requiring use of operating microscope, use 64727)

(For facial nerve decompression, see 69720)

64702 Neuroplasty; digital, one or both, same digit

64704 nerve of hand or foot

64708 Neuroplasty, major peripheral nerve, arm or leg; other than specified

64712 sciatic nerve

64713 brachial plexus

64714 lumbar plexus

➲ CPT Assistant Jun 97 11

64716 Neuroplasty and/or transposition; cranial nerve (specify)

64718 ulnar nerve at elbow

64719 ulnar nerve at wrist

64721 median nerve at carpal tunnel

(For arthroscopic procedure, see 29848)

64722 Decompression; unspecified nerve(s) (specify)

64726 plantar digital nerve

64727 Internal neurolysis, requiring use of operating microscope (list separately in addition to code for neuroplasty) (Neuroplasty includes external neurolysis)

## Transection or Avulsion

(For stereotactic lesion of gasserian ganglion, see 61790)

64732 Transection or avulsion of; supraorbital nerve

64734 infraorbital nerve

64736 mental nerve

64738 inferior alveolar nerve by osteotomy

64740 lingual nerve

64742 facial nerve, differential or complete

64744 greater occipital nerve

64746 phrenic nerve

(For section of recurrent laryngeal nerve, see 31595)

| UPD | CPT | DESCRIPTION | UNITS | FUD | ANES |
|---|---|---|---|---|---|
| | 64704 | nerve of hand or foot | 8.0 | 90 | 3 |
| | 64708 | Neuroplasty, major peripheral nerve, arm or leg; other than specified | 10.0 | 90 | 4 |
| | 64712 | sciatic nerve | 14.0 | 90 | 5 |
| | 64713 | brachial plexus | 13.0 | 90 | 6 |
| | 64714 | lumbar plexus | 13.0 | 90 | 6 |
| | 64716 | Neuroplasty and/or transposition; cranial nerve (specify) | 15.0 | 90 | 5 |
| | 64718 | ulnar nerve at elbow | 11.0 | 90 | 3 |
| | 64719 | ulnar nerve at wrist | 7.9 | 90 | 3 |
| | 64721 | median nerve at carpal tunnel | 8.4 | 90 | 3 |
| | | (For arthroscopic procedure, see 29848) | | | |
| | 64722 | Decompression; unspecified nerve(s) (specify) | 10.0 | 90 | 3 |
| | 64726 | plantar digital nerve | 4.8 | 90 | 3 |
| | 64727 | Internal neurolysis, requiring use of operating microscope (list separately in addition to code for neuroplasty) (Neuroplasty includes external neurolysis) | BR | — | — |
| | | (VALUE EQUAL TO 25% OF PRIMARY PROCEDURE) | | | |

## Transection or Avulsion

| UPD | CPT | DESCRIPTION | UNITS | FUD | ANES |
|---|---|---|---|---|---|
| | | (For stereotactic lesion of gasserian ganglion, see 61790) | | | |
| | 64732 | Transection or avulsion of; supraorbital nerve | 7.0 | 30 | 5 |
| | 64734 | infraorbital nerve | 7.0 | 30 | 5 |
| | 64736 | mental nerve | 10.0 | 30 | 5 |
| | 64738 | inferior alveolar nerve by osteotomy | 10.0 | 30 | 5 |
| | 64740 | lingual nerve | 5.0 | 30 | 5 |
| | 64742 | facial nerve, differential or complete | 10.0 | 30 | 5 |
| | 64744 | greater occipital nerve | 7.5 | 30 | 5 |
| | 64746 | phrenic nerve | 5.0 | 30 | 6 |
| | | (For section of recurrent laryngeal nerve, see 31595) | | | |



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### Neuroplasty (Exploration, Neurolysis or Nerve Decompression)

| Code | Service | Maximum Fee |
|---|---|---|
| 64718 | ulnar nerve at elbow | 881.65 |
| 64721 | median nerve at carpal tunnel | 673.26 |

### Neurorrhaphy

| Code | Service | Maximum Fee |
|---|---|---|
| 64831 | Suture of digital nerve, hand, or foot; one nerve | 464.87 |

## Eye and Ocular Adnexa

The following codes, service descriptions, and maximum fees apply to surgical procedures involving the eye and ocular adnexa.

### Eyeball

#### Removal of Foreign Body

| Code | Service | Maximum Fee |
|---|---|---|
| 65205* | Removal foreign body, external eye; conjunctival superficial | 56.11 |
| 65210* | conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating | 64.12 |
| 65220* | corneal, without slit lamp | 64.12 |
| 65222* | corneal, with slit lamp | 96.18 |

## Anterior Segment

### Cornea

#### Excision

| Code | Service | Maximum Fee |
|---|---|---|
| 65420 | Excision of transposition of pterygium; without graft | 400.75 |

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**Attachment 4**

Testimony of Reagan Pufall
1999 HB 1333
House Industry, Business, and Labor Committee
January 20, 1999

(Before February 6, all work on the new fee schedule is completed and schedule is in its final form)

| | |
|---|---|
| Feb 6 | Publication of Notice sent to ND Newspaper Association |
| Feb 13 | Notice and Amendments sent to Legislative Council for publication |
| Feb 16, 17 23, and 24 | Notice published in ND major daily newspapers |
| March 1 | Legislative Council publishes Notice and Amendments |
| April 1 | Public hearing held |
| May 1 | Thirty day post-hearing comment period ends |
| May 18 | Request made to Attorney General for opinion, enclosing comments and Bureau response to comments |
| July 6 | Opinion received from Attorney General |
| July 29 | Special review by Interim Administrative Rule Committee in accordance with NDCC 65-02-08 |
| Aug 10 | Amended rules sent to Legislative Council for publication |
| Sept 1 | Amended rules published |
| Oct 1 | Rules become effective |

**Total time required for rulemaking process: eight months**