October 1, 2014

Robert E. Beloten, Chair
New York State Workers' Compensation Board
328 State Street
Schenectady, NY 12305

Dear Chairman Beloten:

The New York State Chiropractic Association and the New York Chiropractic Council would like to submit this document as our official response to the "Discussion Document for the New York State *Proposed* Workers' Compensation Medical Fee Schedule" that was released on July 28, 2014.

This document takes a look at each section of the discussion document with which we had a comment or a question. Our title headings mirror the headings used in the discussion document. If we are referencing any information from the discussion document, we have put that language in italics. If we have a comment regarding the section, we have noted it as a comment. Finally, if we have any questions regarding a section, we have indicated that it is a question and have put the questions in bold.

We understand the Medical Fee Schedule Discussion Document is only a discussion document and are optimistic that a mutually agreeable fee schedule can be achieved. It is noted that the WCB has produced this Medical Fee Schedule (MFS) Discussion Document to 'discuss in advance of a transition' the information contained within this document. The comments and questions below are meant for discussion and to open up dialogue, in the spirit of that goal.

The New York State Chiropractic Association and New York Chiropractic Council are also acutely aware that New York's No Fault system is required by statute to utilize the Workers' Compensation Fee Schedule. As such, any change made to the fee schedule will have a much broader implication, both with respect to the care received by the injured party, whether work-related, or related to a motor vehicle accident (which is beyond the responsibility of the WCB) as well as their treating provider.

First and foremost, while we understand the need to move to a standardized fee schedule (including the use of Relative Value Units in creating such a schedule), we feel it is inappropriate to assign Medicare's payment policies to other forms of insurance. As we have discussed at prior meetings, Medicare assigns responsibility for the payment of certain medically necessary services not covered by Medicare to the patient.

In the case of an injured worker, however, this assignment of payment is not permitted under Workers' Compensation law. As such, all services recommended and/or allowed by the applicable Medical

Treatment Guideline must be incorporated into any Fee Schedule recommended and adopted in the treatment of New York's injured workers. In addition, all services necessary for the care of individuals injured as a result of a motor vehicle accident must be incorporated within the medical fee schedule (irrespective of the Medical Treatment Guidelines which do not apply to No Fault injuries). Similarly, any service approved through the variance process must also be given consideration. Therefore, a provision should exist to allow for reasonable compensation for medically necessary and appropriate services.

Below are our specific comments regarding the each proposed section.

1.1 Statement of Purpose (Mission and Goals)

Mission Statement:
The New York State Workers' Compensation Board (the Board) protects the rights of employees and employers by ensuring the proper delivery of benefits to those who are injured or ill, and by promoting compliance with the law.

Comment: It is our belief that the Board also protects the right of the injured worker to seek care from an authorized treating provider of their choice. Therefore, it is our hope that the Board will work to ensure that the injured worker and their duly selected provider can work together for the proper delivery of entitled benefits.

1.2 Standard of Care

The fee schedule provides a precise description of and coding for services reimbursable under New York State Workers' Compensation System. It is the responsibility of the treating medical provider to provide medically necessary services within the scope of practice and to bill consistent with the Medical Fee Schedule, Medical Treatment Guidelines criteria and any other rules and regulations promulgated by the Board.

Question: What methodology does the WCB recommend which would allow the doctor of chiropractic to receive reimbursement for services which are consistent with the needs of the injured worker and recommended by the Medical Treatment Guidelines, but are not incorporated into the MFS Discussion Document?

Comment: The responsibility to render medically necessary care referenced above is dictated by the needs of our patients, embedded within our scope of practice, and mandated by the medical treatment guidelines. However, that responsibility conflicts with the proposed and modified Medical Fee Schedule (MFS), which excludes or restricts the billing of certain specific services we are required to perform.

A revised Fee Schedule must allow for the provision and equitable reimbursement of services rendered consistent with the applicable Medical Treatment Guideline(s), as allowed by each disciplines scope of practice and incorporated into the current fee schedule. To do less would be a disservice to the injured worker and appears discriminatory to a class of providers who are serving their patients in good faith.

3.2.1 Medical Treatment Guidelines

The fee schedule and all rules expressed within the fee schedule are subject to the general principles and recommendations contained in the MTGs.

Treatment of work-related injuries or conditions should be in accordance with any applicable Medical Treatment Guidelines adopted by the Chair. If there is a conflict between the fee schedule, ground rules and the MTG recommendations, the MTG will prevail. With limited exceptions that are clearly identified in the MTG, treatment that is consistent with the MTG general principles and recommendations is preauthorized regardless of the cost of the treatment. Treatment that is: 1.) in excess of MTG frequency and duration recommendations; 2.) is not consistent with MTG recommendations; or 3.) is not addressed in the MTG, is not authorized unless the payer or Board has approved a variance.

Question: How does one bill for a service recommended by the Medical Treatment Guidelines, and when that service is medically necessary in the care of an injured worker, do the Medical Treatment Guidelines prevail (e.g., CPT codes covered for one provider type, but not for another) over the Medical Fee Schedule?

Comment: Since a conflict exists between the MTG recommendations and the proposed MFS, with respect to services which are not listed for reimbursement within the Chiropractic section, this would imply that the MTGs prevail and DCs should be reimbursed. Please confirm that services rendered consistent with the terms of the medical treatment guidelines will be incorporated into the next draft of the Fee Schedule. For example: 97110, 97035 as included in the physical medicine section of the MFS Discussion Document, as well as Table 1, Table 2 and Appendix D.

3.2.8 Medical Testimony

The proposed fee schedule uses the CPT code for medical testimony with New York State regulatory maximum values.

Whenever the attendance of the injured employee's treating chiropractor or treating psychologist is required at a hearing, such chiropractor or psychologist shall be entitled to an attendance fee of $300.00 for one case at one hearing point. If such chiropractor or psychologist shall also testify in other cases at the same hearing point on the same day, he or she shall be entitled to an attendance fee of $150.00 for each additional appearance, but in no case shall such aggregate fees for testimony at the same hearing point on the same day exceed $900.00. Refer to the Workers' Compensation Law Handbook for a complete explanation of the reimbursement for medical and psychological/neuropsychological testimony.

Question: Why would an MD or podiatrist be entitled to a significantly higher fee for testimony when the services provided by each are essentially the same?

Comment: This rule stipulates that an MD or Podiatrist would be entitled to $400 for the first case at a hearing, and $200 for each additional case, up to $1200 maximum. These amounts are reduced by 25% when such service is performed by a DC. Certainly the training and preparation required to perform this service is comparable amongst professionals.

A comparison between the educational requirements of DC's and MD's reveals not only significant overlap in educational requirements to obtain each degree, but the number of classroom hours were actually greater (4485 classroom hours towards a DC degree vs 4248 classroom towards obtaining an MD degree[1]) to obtain a DC degree than an MD degree. Only when each discipline specializes is financial disparity is encountered. Since the service is the same for all three disciplines, how was the 25% reduction determined?

[1]Ref: Chapman-Smith, D. The Chiropractic Profession. NCMIC Group Inc. 2000.

3.2.13.2 Physical Medicine Utilization

The proposed fee schedule maintains the existing ground rule limiting physical medicine services. Physical medicine services in excess of 12 treatments, or after 45 days from the first treatment, require documentation that includes physician certification of medical necessity for continued treatment, progress notes, and treatment plans. This documentation should be submitted to the payer as part of the claim. For conditions and injuries covered by the Medical Treatment Guidelines, E/M documentation requirements and the frequency and duration recommendations set forth in the MTG supersede this ground rule.

Question: Does this section conflict with the current timeframes already in place? Does this provision apply to all authorized treating providers, since physical medicine treatment and procedures are not limited to a particular profession, either by definition or within the current MTGs?

Comment: This section may conflict with some of the timeframes already in place.

3.2.13.5 Multiple Physical Medicine Procedures and Modalities

When multiple physical medicine procedures and/or modalities are performed on the same day, reimbursement is limited to 1.5 RVUs or the amount billed, whichever is less. The following codes represent the physical medicine procedures and modalities subject to this rule: ***[see table 2]***

Question: Since physical medicine services are not specialty specific (either by CPT code definition, or Medical Treatment Guidelines definition), please confirm that this section also applies to doctors of chiropractic as is currently the case.

Question: Are the RVU caps listed above and elsewhere in the document the Work RVU or Total RVU? Would the 1.5 RVU cap (X) the conversion factor = maximum reimbursement / visit?

Comment: Again, physical medicine services can be rendered by a variety of authorized treating providers, including but not limited to doctors of medicine, doctors of chiropractic, doctors of podiatric medicine, physical therapists and occupational therapists. As such, this rule should apply to all authorized treating providers who render medically necessary care consistent with the applicable Medical Treatment Guideline(s).

3.3.1 Multiple Procedure Payment Reduction

The proposed fee schedule will adopt the CMS Medicare rule for Multiple Procedure Payment Reduction and apply the MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day for certain Physical Medicine codes, i.e., the MPPR may apply to multiple units as well as multiple procedures for Physical Medicine. The MPPR does not apply to add-on or bundled codes.

Question: Does the above rule applie to all disciplines, and are the payment reductions in this section utilized in conjunction with the RVU caps (e.g., as noted in section 3.2.13.5)?

Comment: Medicare's MPPR rules apply to physical medicine, regardless of the discipline of the professional rendering the service.

3.3.4 Chiropractic Services

The proposed fee schedule follows CMS Medicare's rules for Chiropractic Services with the following exceptions for Evaluation & Management, Medical Testimony, Permanency Evaluations, Physical Medicine and Radiology as described in the following paragraphs.

The guidance given below, as with the proposed fee schedule generally, is subject to the limitations and guidance provided in the MTGs.

Question: Is it the intent of the new fee schedule to limit the evaluation and management of a new patient? What is this proposal based upon?

Comment: Under the Evaluation and Management section, only one of five CPT codes is listed for a new patient examination: 99201. Only one of five CPT codes is listed for an established patient, 99212. The level of evaluation described by theses codes (based upon the key factors: problem focused history, examination and straight-forward medical decision making in both cases) is significantly less than that required to evaluate a typical injured worker – both in accordance with the medical treatment guidelines, and as required to adequately evaluate a patient prior to treatment. To limit the evaluation to this minimal level would be a disservice to the injured worker, and violate the mandated medical treatment guidelines.

An appropriate range of evaluation and management services for a typical 'new' injured worker as defined by the AMA's CPT guidelines, and those outlined in the Medical Treatment Guidelines would be 99202-99204. More complex cases (99205) are atypical in an outpatient setting, while minimal levels of evaluation (99201) are even scarcer when evaluating a patient who presents with a work-related injury. Please also note that CMS considers down-coding to be fraudulent. Mandated utilization of lower level E/M codes places the authorized treating provider in a predicament either to perform less of a service than that required and mandated, or provide the higher coded service required by the condition and bill fraudulently as dictated by the WC MFS. Neither can be required.

Question: What is the basis to limit the level of evaluation for permanency performed by a doctor of chiropractic to CPT code 99212?

Comment: The limitation of an established patient evaluation to CPT code 99212 also impacts the ability to perform the level of examination necessary to complete a C4.3. The level of examination necessary to perform such a service does not vary by specialty – either by patient requirements or in accordance with the Medical Treatment Guidelines.

Question: Is it the intent to limit the provision of active care procedures to only CPT code 97530 (eliminating 97110 and 97112)? If so, what would be the basis to limit active care to only one CPT code while others are recommended by the Medical Treatment Guidelines and covered by other professionals providing the same or similar service?

The discussion document states "*Chiropractors may bill the following physical medicine code for active therapy modalities in addition to spinal manipulation. This code is subject to the Multiple Physical Medicine Procedures and Modalities ground rule*." However, only CPT code 97530 is listed. No other active care CPT codes are listed, nor are any other passive procedures or modalities listed as noted in the physical medicine table 1, table 2, or Appendix D.

It is the provider's responsibility and requirement to select the CPT codes that best describe the services we render. When applied to physical medicine active procedures, the CPT code selected is based upon the *intent* of the service provided. Injured workers may require active care to increase their strength, endurance, range of motion, flexibility – in a manner consistent with the medical treatment guidelines. By definition, this requires the use of CPT code 97110. Furthermore, if the goals of care of the patient address reeducation of movement, balance, coordination, proprioception for sitting or standing, health care providers are required to utilize CPT code 97112. CPT code 97530 is utilized when performing dynamic activities to enhance functional performance – pushing and pulling for example. It is unclear why only one active care code has been recommended, while all 3 have their place in returning an injured worker to work and restoring their functional capabilities. It is further unclear why doctors of chiropractic do not have the ability to bill for these services, while providers of other disciplines may do so. Sections A10 and A11 of the Mid and Low Back Medical Treatment Guidelines incorporate all three of these active care codes (97110, 97112 and 97530) by the description of services recommended.

Furthermore, Section D.9a-e of the Mid and Low Back Medical Treatment Guidelines recommends various approaches to active care, which again may be described by a variety of CPT codes. As previously discussed with the Board, the current version of the Medical Treatment Guidelines often discuss the approach to patient care, but at times are not based upon CPT descriptions. This is a prime example of such.

Question: Why is there no provision for passive care?

Similarly, there is no provision in this Fee Schedule for passive care designed to facilitate progress towards active care (as noted in the various Medical Treatment Guidelines). Passive care may be a necessary component of patient care, particularly during the acute inflammatory stage of healing. The use of modalities for pain management and inflammation control when rendered in an evidenced based manner is similar in efficacy to the use of agents such as prescription analgesics, anti-inflammatories, narcotics, and over the counter medications, but with fewer side effects. Elimination of coverage for such services during the acute phase may result in increased dependency on other treatment options.

The potential side effects and best interests of the injured worker should be kept in mind when evaluating this decision. Passive procedures are already incorporated into the MFS Discussion

Document (Table 1, Table 2, and Appendix D), and as such should also be allow for injured workers (consistent with the appropriate Medical Treatment Guideline) and those who suffer injuries related to a motor vehicle accident when seeking such services from a doctor of chiropractic. To do less would be a disservice to the injured worker, potentially prolonging both temporary and permanent disability.

Will the following codes be payable to chiropractors when performed under the WC system after the proposed fiscal 2015 fee changes are instituted?

Current WC codes that Doctors of Chiropractic can currently perform and bill for under the 2014 NYS Workers Compensation Fee Schedule:
95903 Motor NCV
95904 Sensory NCV
95934 H-Reflex
95860 Needle EMG 1 extremity
95861 Needle EMG 2 extremities

New Codes recognized by Medicare/2015 NYS Comp Codes:
95907 NCV 1-2 nerves
95908 NCV 3-4 nerves
95909 NCV 5-6 nerves
95910 NCV 7-8 nerves
95911 NCV 9-10 nerves
95912 NCV 11-12 nerves
95913 NCV 13 or more nerves

Needle EMG codes recognized by Medicare/2015 NYS Comp Codes:
95885 Needle EMG each extremity limited muscles
95886 Needle EMG 5 muscles 1 extremity
95887 Needle EMG non extremity
95870 Needle EMG 4 muscles 1 extremity

SSEP and Evoked Potential codes:
95925: Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system.
95926: Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs

Comment: All physical medicine procedures (as defined by CPT definition, and incorporated in the Medicare RVUs) should be incorporated into the Chiropractic Services section of the medical fee schedule, consistent with the medical treatment guidelines and other areas of the MFS Discussion Document.

Based upon the NYS Chiropractic scope of practice, properly trained doctors of chiropractic have been legally permitted to perform and interpret electrophysiological evaluations for more than 25 years under the workers compensation system. It has also long been established that these services are reimbursable when performed by doctors of chiropractic.

4.2.2 Modifier Z2: Completion of the Doctor's Report of MMI/Permanent Impairment (Form C-4.3) Finding of Non-Schedule Loss (NSL) performed by a Chiropractor or Psychologist

The proposed fee schedule will adopt a new modifier, Z2, for the billing and payment of the completion of a Disability Exam performed by a Chiropractor or Psychologist.

When a chiropractor performs a complete evaluation for non-schedule loss of use for an injury within the chiropractor's scope of practice, and submits a timely and complete C-4.3 Form according to the latest NYS Workers' Compensation Impairment Guidelines and related form instructions the chiropractor may bill for the exam and completion of the form, using code 99212 with the New York specific Modifier Z2. Modifier Z2 can only be billed with code 99212 and will add $100 to the allowed reimbursement for code 99212.

Comment: We have several concerns when comparing reimbursement for the same/similar services rendered by an MD and a DC. The requirement to perform and submit a complete evaluation for a non-schedule loss of use is the same for an MD and DC. However, once again, a DC is reduced to the same level as a psychologist, a lower level degree. Although the evaluation of the same injured worker is the same/similar when rendered by an MD and DC, there is a two-fold impact to this rule:

1. An MD can bill a 99215 level of service, while a DC can only bill a 99212 level of service. The requirements needed to meet each level of E/M are well described and established. The MFS discussion document provides further guidance. This alone creates great disparity in the reimbursement level for the same/similar service. The CPT code defines the service, not the discipline performing it. Please note that the work value would remain the same (as defined by the CPT code), while the practice expense RVU and professional liability expense RVU would constitute any differential in services rendered between these two disciplines. Although the same evaluation is being performed, the 2014 RVU for CPT code 99212 is 0.48 vs. 2.11 for CPT code 99215.
2. When comparing the Z1 and Z2 modifier, an MD is entitled to an additional $200, while a DC performing this service is only entitled to an additional $100 for the same/similar service. From a practical perspective, a DC practicing in the 1320203 Medicare Locality (Poughkeepsie and NYS Suburbs) would receive approximately $145, while an MD billing at the 99215 level would receive approximately $350 for this service. This results in more than a 50% reduction when the same service is performed by a DC as when it is performed by a MD. It is recommended that the WCB consider use of CPT Code 99214 or 99215, as supported by the complexity of the case, and only one Modifier, Z1, be utilized to compensate providers for the additional elements and time necessary to perform and complete the C4.3 report.

5.2.2 Electric Stimulation Therapy

The proposed fee schedule no longer covers unattended electrical stimulation therapy.
Electrical stimulation therapy is now billed under code G02383 and is paid according to Medicare ground rules, which require that the therapy be "provided in a supervised manner."

Comment: The G0281-3 HCPCS were derived to provide more specificity to CPT code 97014 (unattended electrical stimulation), and to allow distinction when unattended stimulation is utilized for wound care.

Code G0283 is defined as Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care. According to CMS, it is classified as a "supervised" modality, even though it is labeled as "unattended." Consistent with Medicare rules, the MFS has eliminated CPT Code 97014. HCPCS code G0283 is to be utilized to reflect this service when rendered in a supervised manner.

To ensure this rule is not misunderstood, or inadvertently applied to individuals injured in a motor vehicle accident, we recommend the incorporation of the eliminated CPT code (consistent with section 3.4.2) resulting in the following minor modification in italics:

> The proposed fee schedule no longer covered unattended electrical stimulation therapy *as described by CPT code 97014*. Electrical stimulation therapy is now billed under code G0283 [typo correction] and is paid according to Medicare ground rules, which require that the therapy be "provided in a supervised manner."

Appendix A:

Board Guidance on Treatment Plan and Narrative Reporting Requirements

Comment: This section further supports the requirements to perform a higher level of evaluation and management service than that allowed for within this MFS discussion Document.

Appendix C:

Work Hardening/Conditioning Program Requirements

Evaluation Process: Initial screening evaluation is performed by the treatment team consisting of:
A) Physical Therapy and/or Occupational Therapy
PLUS
B) Psychology/Psychiatry and/or Vocational Rehabilitation, Chiropractor, or other providers suitable by scope of practice

Comment: The pre-admission requirement requires evaluation by a physical therapist or occupational therapists, but excludes the inclusion of a doctor of chiropractic, who possess all of the training and requirements to perform such pre-admission assessment as determined in the State Education Law. Please consider the incorporation of doctors of chiropractic along with physical therapists in section A, rather than section B.

Appendix F: Documenting Objective Improvement

Question: Since there are numerous validated outcome assessment tools readily available, some of which are more specific to a patient's condition, why was a new tool developed?

Comments: The use of outcome assessment instruments to direct and prioritize care, to monitor the patient's course of recovery, and to ensure that anticipated goals are met is well documented. The draft Patient Self-Documentation of Functional Changes provides an interesting method to seek objective functional status for multiple body regions, pre-injury, progressively and at discharge.

We would like the opportunity to participate in a pilot program with members of the WCB and other disciplines to see if we can further enhance this tool, and/or develop a list of readily available validated tools which health care professionals are already utilizing in their office which accomplish this same task.

Conclusion

In summary, the aforementioned is offered to foster dialogue between the Board and our profession, as intended by the MFS Discussion Document. We have incorporated several questions above which we would like to discuss to better understand the intent of the MFS, to ensure the rights of injured workers' are not compromised and to ensure that doctors of chiropractic are not being denied payment and coverage for services that we are authorized and trained to provide.

For the next version of the Medical Fee Schedule, we believe our mutual goal should be the inclusion of all services injured workers in the State of New York are entitled to receive, as recommended by the Medical Treatment Guidelines, and consistent with the Chiropractic scope of practice.

If you have any immediate comments or questions, please let us know. We are happy to provide more information or further clarification. We look forward to meeting with you in the near future.

Respectfully submitted,
The New York State Chiropractic Association and the New York Chiropractic Council