August 6, 2018

Clarissa M. Rodriguez, Chair
New York State Workers' Compensation Board
328 State Street
Schenectady, NY 12305

Dear Chairwoman Rodriguez:

The New York State Chiropractic Association and the New York Chiropractic Council support the Workers Compensation Board's (WCB) effort to increase medical fees under Workers' Compensation, and thus No-Fault, which have gone relatively unchanged since 1996. We applaud the patient-centered approach to this needed update that seeks to "improve injured workers' access to timely, quality medical care" and describes injured workers access to quality medical care as of the "utmost importance."[1] Being employers ourselves, who pay workers' compensation premiums, we also appreciate that cost of WC coverage for employer's factor into the proposed fee schedule.

While supporting the overall principles outlined by the WCB, the profession has several chiropractic specific concerns, which we wish to bring to your attention. We believe that there are aspects of the proposed fee schedule that will not facilitate the desired goals of access and quality medical care. Our comments seek to achieve fairness across professional disciplines as we feel this is essential to enhancing trust within the system and plays an essential role in ensuring quality care and access to the patient's chosen provider.

We offer the following comments and recommended changes to the proposed fee schedule:

1. Chiropractic Conversion Factor

We believe that a careful evaluation of relevant factors, such as costs associated with delivering services, education, expertise, etc., should be considered when developing conversion factors that ultimately determine reimbursement. We struggle to comprehend the manner in which the proposed conversion factors for chiropractic and other professions are being calculated. It appears that historical trends are being carried forward, which negatively skews the value of services rendered by Doctors of Chiropractic (DC). We encourage equal pay for comparable services, regardless of the provider, with the pay based on education, expertise, and practical experience. As you are aware, the profession has been supportive of the patient-centered approach of the Medical Treatment Guidelines. In a similar vein, we believe that the proposed Fee Schedule should also have a provider neutral application.

At face value, it is difficult to understand why a recommended procedure, such as therapeutic exercise or ultrasound, would have variant reimbursement rates when rendered by a physician, a physical therapist, or a chiropractor. It would seem that similar procedures, requiring the same equipment costs and maintenance, similar training and risk, and similar benefit to the patient, should be reimbursed with less disparity in the fee. We have great respect and appreciation for our physician and therapist colleagues but struggle to understand why the value of a service rendered by a doctor of chiropractic is reimbursed at a lower rate because of the conversion factor used.

The proposed conversion factor for doctors of chiropractic falls well below that of medical doctors and physical therapists. The Resource-Based Relative Value System (RBRVS) is commonly utilized throughout the insurance industry as a basis to determine reimbursement rates. According to RBRVS calculations, 55% of the value of a service is determined by the physical work component (as ascribed to each CPT code). The remaining 45% includes both practice and malpractice expenses. Since the majority of the value of any given service is based upon the service itself (without consideration of discipline), many carriers, such as the NYSHIP, utilize one standardized fee schedule for medical doctors, physical therapists and doctors of chiropractic on the same fee schedule.

For several decades, the Centers for Medicare and Medicaid Services (CMS) has established practice expense estimates based on current resource cost data, which is based upon input from the American Medical Association and other provider groups. CMS (formerly HCFA) publishes such information on an annual basis. In addition, CMS has readily available data, which portrays physician expenses by specialty. According to 2017 data utilized in 2018 calculations, the physician expenses per hour by provider type is as follows (limited to those who deliver physical medicine services)[2]:

General Practice	114.65
Chiropractic	76.03
Physical Therapist	68.47

The delivery of physical medicine services by each of these professions would require the purchase and use of comparable equipment and office space. Other factors to be considered when calculating reimbursement are education, intensity of services provided, such as a duty to diagnose, order and interpret advanced imaging and diagnostic testing, and malpractice premiums. If a fee schedule is to vary per provider discipline, these factors should be considered and valued appropriately as they are under the CMS calculation where chiropractors are below the reimbursement for a medical doctor but higher than the reimbursement for a physical therapist. This is further supported by the Federal Registry, which calculates the cost of rendering care amongst the professions.

Based on the information available to us as we prepared these comments, we cannot understand how the proposed conversion factor for chiropractic was determined. Continuing historic trends that determine a conversion factor with no consideration of essential factors is not acceptable.

Recommendation

If variant conversion factors are to be implemented for different professions, there must be an adoption of an appropriate conversation factor for doctors of chiropractic that is based on relevant factors, such as costs associated with delivering services, education, expertise, malpractice rates, etc. Based on these factors and the CMS data, the conversion rate must be between the conversion factors of medical doctors and physical therapists.

2. Limitations – Ground Rule 10

We do not understand the intent of Ground Rule #10. "A chiropractor may only use CPT codes contained in the Chiropractic Fee Schedule for billing of treatment. A chiropractor may not use codes that do not appear in the Chiropractic Fee Schedule.[3]" This imposed limitation does not seem to serve patient access or quality of care.

All healthcare providers are obligated to provide medically necessary services that fall within their scope of practice. The New York Medical Treatment Guidelines (including the variance process) are considered to be the accepted guidelines in the treatment of New York's injured workers. This determines which treatment is considered authorized and billable. We cannot understand why a broad ground rule such as this is required on top of these existing standards. Nor is it evident why such a ground rule has only been applied to one discipline.

Recommendation

Remove Ground Rule #10 as it can negatively impact access to care when reimbursement is not available for a medically necessary service rendered consistent with the Medical Treatment Guidelines

If removing Ground Rule #10 is not an option, the other option would be to create one fee schedule for all WC treating providers. One of the strengths of the Medical Treatment Guidelines is that they are patient centered, and as such, uniformly apply to all treating providers equally. This same sentiment can be repeated for the entire Workers Compensation Fee Schedule, which would enhance trust, remove any unintended bias, ensure patient choice and access to the provider of a patient's choosing.

Recommendation

Adopt a single fee schedule that is applicable to all WC providers

3. Impairment Evaluation - 99243

We continue to have concerns about the level of disparity in reimbursement between chiropractic and physician services, including testimony and the permanency evaluation outlined by the C4.3 process. We recognize the WCB position that this is an issue of breadth of scope of practice. However, the level of disparity seems too great. We are aware of the physician's ability to comment on issues of medication and surgery as previously discussed (although a

doctor of chiropractic has an obligation to obtain and record such historical data and utilize that information in their medical decision making as defined by CPT codes and our scope of practice). However, these are not the primary determinants of impairment nor do they fully explain the complexity of each case. The examination performed, which would be billed as 99243, is to a large degree the same regardless of the provider. Furthermore, the completion of the C4.3 form requires the same exam and information, as well as understanding of the Impairment Guidelines.

Recommendation

Established a comparable fee for all authorized medical treating providers who render this exam and permanency determination

4. Reexaminations (99211-99214)

The proposed fee schedule allows for initial examination codes of 99201-99204, which are appropriately selected based on the nature and scope of the physical examination required by the injured worker's condition. For the examination of an established patient, only a single code of 99212 is listed. Reexamination of injured workers is an integral portion of the Medical Treatment Guidelines. While reexamination seeks to establish and document positive patient response, the complexity of a case determines the level of CPT code not provider discipline. More complex cases, which require a level 99203 or 99204 initial exam, typically require a similarly detailed reexamination as the patient recovers and approaches either pre-injury status or permanency.

Furthermore, the WCB's new CMS1500 initiative contains specific examination and documentation requirements. The performance of a 99213 level examination (and in some cases 99214) would be necessary to meet the requirements of this initiative. It must also be recognized that exacerbation as defined in MDO Bulletin 2012#1 require reexamination and detailed documentation. The degree and complexity of changes in the injured worker's health, medication, comorbidities, and social factors is not predictable or uniform. The complexity of evaluation and management is patient specific, regardless of discipline. As such, the availability of additional CPT codes for reexamination, which best represent the level of exam required, is appropriate and necessary.

Recommendation

Include examination codes 99211, 99212, 99213 and 99214 for use with established patients

5. Manipulation Under Anesthesia (MUA)

MUA services must be added to the chiropractic fee schedule. It is understood that MUA is not recommended by the Medical Treatment Guidelines. However, there are patients who benefit from skilled MUA from a highly trained provider. This is evident through approved variance requests. Removal of this code does not serve the best interests of the injured worker. Patients who benefit from MUA, with an approved variance, should be entitled to receive the

care. The current RVU listed on the medical fee schedule for manipulation of the spine requiring anesthesia, CPT code 22505, is 0.

Recommendation

Add an appropriate RVU for CPT code 22505 and include of all applicable MUA codes on the chiropractic fee schedule:

- ***22505 Manipulation of the spine requiring anesthesia, any region***
- ***27197 Manipulation of the pelvis requiring anesthesia***
- ***27275 Manipulation of the hip requiring anesthesia***
- ***23700 Manipulation of the shoulder requiring anesthesia***

6. Electrodiagnostic Testing

There are several issues regarding electrodiagnostic testing as listed in the chiropractic fee schedule. We defer to our electrodiagnostic committee's comments for a full description of the issues here. Those comments are attached to this letter as Attachment A and B. Generally, we wanted to bring to your attention, an issue of updated versus older coding for nerve conduction study (NCS), an omission of necessary electromyography (EMG) codes and our concern for the value of the service. We also wanted to note that we appreciate that CPT codes 95907-95913 have since been added to the proposed fee schedule.

Recommendation

Add CPT codes 95885 - 95887 and adjust the RVUs to reflect the value of these services with similar increase in fees to other diagnostic procedures

7. Specialized Examinations (95831, 95851, 97750)

For some injured workers, the nature and extent of their injuries make it necessary and appropriate to measure and record specific range of motion (95831), or manual muscle testing (95851) values, and to include such data when reporting patient progress. Physical performance testing is also required in some cases (97750). The inclusion of these CPT codes become additionally important when the re-evaluation of the patient does not meet the threshold of an evaluation and management (e.g., 99212 or 99213) service.

Recommendation

Restore CPT codes 95831, 95851, and 97750.

8. Chiropractic Adjustment (98940, 98941, 98942)

The assigned RVU's for the codes 98940, 98941, 98942, which are specific to chiropractic manipulative therapy, are too low. The RVU's for these codes should be increased to conform with the higher level of education and training needed to perform these services, as well as for the other reasons stated in this letter.

Recommendation

Increase the RVU for CPT codes 98940, 98941, 98942 to match the level of training and education needed to use these codes

9. Durable Medical Equipment (DME)

The current proposed chiropractic fee schedule includes only code 99070. We understand the intent in use of this CPT code for customarily included supplies, but we are unclear as to the intent regarding DME for home use. If the intent is for all DME to be billed using this single code (99070), we strongly object. Supplying an invoice for all DME supplies was historically cumbersome and will again cause confusion and administrative burden for carriers, providers and the WCB. If the intent is for providers to bill using the established DME fee schedule, we recommend including a note to this point in the ground rules portion of the fee schedule.

Injured workers may need medical equipment quickly and efficiently to best address their condition, such as a TENS unit or cervical home traction (both of which are recommended within the Medical Treatment Guidelines). The HCPCS based DME fee schedule currently in place (use of the NYS Medicaid DME schedule) facilitates comprehension of the service provided, allows for comparison with the recommendations of the Medical Treatment Guidelines, and simplifies medical necessity review for services not recommended by the Guidelines. We hope that with a goal of improving access to care, availability and access of necessary DME, is not unnecessarily limited.

Recommendation

Clarify that the established DME fee schedule is available for providers

On behalf of the chiropractic profession, we thank you for the opportunity to comment. We hope that our comments are instructive and that our recommendations will be adopted in the final document. We believe that our recommendations will properly reimburse doctors of chiropractic while creating a balance of cost and quality patient care in the Workers Compensation system.

If you have any questions or comments concerning any of our recommendations, or need more information or data on any of the points we have made, we are happy to provide that information.

Sincerely,

Jason Brown, DC
President,
New York State Chiropractic Association

Joseph D. Baudille, DC
President,
New York Chiropractic Council

[1] http://www.wcb.ny.gov/content/main/SubjectNos/sn046_1058.jsp

[2] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1676-P.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending

[3] http://www.wcb.ny.gov/content/main/hcpp/MedFeeSchedules/GroundRules/Ground-Rules-Chiropractic.pdf

cc: Mary Beth Woods, Executive Director
Steven Smith, Deputy Executive Director