May 19, 2023

Deb Outwater
Department of Labor and Economic Opportunity
Workers' Compensation Agency
P.O. Box 30016
Lansing, MI 48909
Email: WCINFO@michigan.gov

RE: Health Care Services Rule Set 2022-42 LE

Dear Ms. Outwater,

Healthesystems is a pharmacy and ancillary benefit manager supporting workers' compensation insurance carriers, third-party administrators, and self-insured employers in the state of Michigan. We appreciate the opportunity to submit comments in favor of the proposed changes to the Health Care Services Rule Set 2022-42 LE. Additionally, we would like to recommend changes regarding dispense fees to practitioners for potential consideration in the next annual rule set update.

Dispense Fees to Practitioners

We would like to express our appreciation to the Workers' Compensation Agency for their attention to the state-specific code WC700, which is utilized for billing dispense fees. We fully support the proposed removal of this code from all relevant sections of the rules. Most providers are unaware that they need to bill a separate line for dispense fee using these state-specific codes, as they are not commonly used in standard billing practices. Furthermore, it is worth noting that other states have not adopted policies that require a separate code for dispense fees. Instead, many payers typically incorporate reimbursement for dispense fees into the average wholesale price (AWP) calculation for the drug billed with national drug code (NDC) number.

In relation to dispense fees, we would like to propose a change for the Agency's consideration in the next rule set update. Currently, according to rule R 418.10912 (Billing for Prescription Medications), practitioners or healthcare organization, excluding inpatient hospitals, are eligible for one dispense fee reimbursement per prescription drug within a 10-day period, except for over the counter (OTC) drugs. Our recommendation is that practitioners or healthcare organization should not be reimbursed for the dispense fee when dispensing any type of medication. This is because they already receive compensation for their services at the time of the office visit within their professional billing codes (Evaluation and Management CPT). These codes encompass all services provided to the patient at the place of service, including the review of currently prescribed medications and any new medications prescribed. Additionally, the dispense fee is intended to cover professional services offered by a pharmacist for dispensing medication and any overhead costs associated with maintaining and operating a pharmacy.

To avoid double reimbursement, several states, such as Alabama, Idaho, Mississippi, Tennessee, and others, have implemented policies that prohibit physicians from receiving dispensing fees. Considering

that the MI Health Care Services rules already prohibit practitioners or healthcare organizations from billing dispense fees for OTC medications, we encourage the Agency to also consider disallowing dispense fees for all prescription medications. This change would effectively eliminate unnecessary costs to system stakeholders.

We recognize the efforts the Agency has taken to ensure a fair and balanced workers' compensation system. We are grateful for the chance to express our support for this proposal and provide recommendations for future rule developments. Thank you for considering our recommendation, and we welcome any questions or comments you may have.

Sincerely,

*Tiffany Grzybowski*

Tiffany Grzybowski
Analyst, Advocacy and Compliance
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**Optum Workers' Compensation and Auto No-Fault**
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P: 1-833-486-7886
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May 24, 2023

LEO/WDCA
Attention to: Deb Outwater
Via email: WCINFO@michigan.gov

**RE: Proposed amendments to Workers' Compensation Health Care Services (HCS) rule set**

Optum Workers' Compensation and Auto No-Fault (Optum) appreciates the opportunity to provide written comments to the Workers' Disability Compensation Agency (WDCA) on proposed amendments to the Workers' Compensation Health Care Services (HCS) rule set. We specifically write in support of removal of the existing state-specific "WC-700" medication dispensing fee billing codes.

The HCS rules currently reference distinct state-specific dispensing fee codes to be used by providers when billing for certain categories of medications. These codes are WC700-G and WC700-B for generic drugs and brand name drugs, respectively, and WC700-T for commercially manufactured topical medications. We noticed the HCS Manual also still briefly references use of WC700-C for custom, non-sterile compounds.

Thanks to prior rule amendments, the above-mentioned codes are currently required except for when the NCPDP Workers' Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) is used for billing by an outpatient pharmacy. Previously, that exception was not in place. In prior comments, we wrote to recommend these codes be removed for billing by pharmacies, and we again thank the WDCA for making that prior change.

With this current rule-making, we are appreciative of the WDCA's proposal to go further than that and remove the use of these codes altogether. We support this removal, believing that these proprietary codes are unnecessary and often add administrative costs and burden to the system for both providers and payers.

With respect to non-pharmacy, professional provider bills (often physicians dispensing medications from their office), there are nationally recognized procedure codes (CPT and HCPCS) for identifying a medication dispensing fee charge on a medical bill. This makes codes specific only to one state and one line of insurance unnecessary.

Additionally, categorization of a billed medication as a brand, generic or topical drug can be, and is already today, achieved through submission of the drug product's National Drug Code (NDC) and use of third-party references commonly used by payers and their pharmacy benefit managers (PBMs) throughout the industry (regardless of state or insurance line). Other elements submitted on a bill (particularly for pharmacies) also help with categorization.

Thank you for your consideration of our written support comments. We look forward to working with the WDCA on this and other rule developments in the future. Please let us know if you have any questions or require any additional information related to our comments.

Sincerely,

Adam Fowler
Manager, Public Policy & Regulatory Affairs
Optum Workers' Compensation and Auto No-Fault
adam.fowler5@optum.com

May 24, 2023
Workers' Disability Compensation Agency
Rule Set 2022-42 LE
Lansing, MI 48909
RE: Support Memo – 2022-42 LE

Dear Michigan Department of Labor and Economic Opportunity,

I appreciate the chance to provide feedback on administrative rule set 2022-42 LE, regarding the removal of state-specific dispensing fee billing codes. I am writing on behalf of the American Association of Payers Administrators and Networks ("AAPAN") to provide comment on behalf of our members addressing the proposed rule. AAPAN is the leading national association of preferred provider organizations ("PPOs"), networks, pharmacy benefit managers, and administrators in workers' compensation. Through our members, we work on behalf of thousands of injured workers throughout the country, including in Michigan.

We offer our support for the proposed administrative rule changes for the following reasons:

There are nationally recognized procedure codes for identifying a dispensing fee charge on a medical bill. We agree that removing the state-specific codes would also remove a layer of redundancy in the systems used for properly identifying charges related to medical billing and reimbursement. Other elements submitted on a bill - particularly for pharmacies - also help payers with categorization for charges, which means that even with the absence of these state-specific codes, proper reimbursement for dispensing will still be able to happen seamlessly.

Second, the categorization of a billed medication as a brand, generic or topical drug can be, and is already today, achieved through submission of the NDC (National Drug Code) and the use of third-party references used by payers and PBMs (Pharmacy Benefit Managers). The removal of the state-specific codes allows for administrative fluidity and accuracy in ensuring proper reimbursement. These state-specific codes are unnecessary and often add administrative costs and burden to the system for both providers and payers. This burden or confusion can also, in extreme instances, impact injured workers' ability to access the care they need.

The proposed change to the regulatory system in Michigan will be a useful stride towards further ensuring access to medications for injured workers, with minimal burdens for practitioners and payers getting in the way. Removing these state-specific codes will make it easier for payors and practitioners to ensure proper and timely

reimbursement without confusion. For these reasons we cordially voice our support for the removal of these codes in administrative rules set 2022-42 LE.

We appreciate this opportunity to provide feedback on this important policy issue, and we offer our assistance should you have any questions on achieving this policy goal or our comments generally.

Sincerely,

Julian Roberts
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ALLIANCE FOR PHYSICAL THERAPY QUALITY AND INNOVATION

20 F Street NW, Suite #700
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**Via Electronic Submission**

May 24, 2023

Depart of Labor and Economic Opportunity
Workers' Compensation Agency
Attention: Deb Outwater
PO Box 30016
Lansing, MI 48909

**Re: Rule Set 2022-42 LE**

Dear Ms. Outwater:

This letter represents the collective comments of the Alliance for Physical Therapy Quality and Innovation (the "APTQI") to the Department of Labor and Economic Opportunity Workers' Compensation Agency regarding the above referenced Rule Set.

By way of introduction, we are among the nation's leading providers of outpatient rehabilitation care, and collectively our members operate over 380 outpatient clinical sites in Michigan. furnishing therapy services on an annual basis to tens of thousands of injured workers in the state. We are writing to express our concern regarding the proposed policy to apply reimbursement discounts to services provided by physical therapy assistants (PTAs) and occupational therapist assistants (OTAs) to injured workers whose care falls under Michigan's workers compensation regulations.

Following the pandemic, more than 20% of physical therapy and occupational therapy professionals left their profession. This has created an acute labor shortage among rehabilitation professionals to provide care to injured workers and assure that the labor force in Michigan is productive and injury-free. This reduction in the workforce has resulted in labor costs increasing by more than 10% in the Michigan market. Retaining staff has become tremendously challenging, particularly within rural markets and for specialty services like hand therapy. Additional cuts in reimbursement would further challenge providers' ability to provide care to the injured worker population given the challenges of finding and retaining staff with these high labor costs.

Furthermore, to decrease opioid prescriptions in all settings, there must be appropriate reimbursement and access to a broad range of pain management and treatment services, including non-pharmacological alternatives to opioids, such as physical therapy. Opioid prescription guidelines issued by the Centers for Disease Control and Prevention (CDC) in 2016 reinforce this notion, describing non-pharmacological treatments such as physical therapy as low-risk options which can "ameliorate chronic pain." The guideline goes on to say physical therapy,

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among other pain treatments, often incur lower annual costs than opioid-based therapies, making physical therapy not only less conducive to risk, but also more cost-effective. With all these

findings, physical therapy clearly has the potential to play a crucial role in establishing non-medication-based treatment alternatives to opioids. It is essential to recognize this value and assure that injured workers in Michigan have access to physical therapy.

APTQI is requesting the agency reject this proposal in order to preserve access to care for the injured worker in Michigan. We would welcome a meeting to provide additional insights on this proposed policy change. This meeting can be held at your convenience at a location of your convenience. We look forward to your response.

I can be reached at 713-824-6177 or by email at npatel@aptqi.com.

Sincerely,

Nikesh Patel, PT, DPT
Executive Director
APTQI
npatel@aptqi.com

May 24, 2023

Department of Labor and Economic Opportunity
Workers' Compensation Agency
Administrative Rules for Workers' Compensation Health Care Services (HCS)
Rule Set 2022-42 LE

LEO/WDCA Attention to: Deb Outwater
PO Box 30016, Lansing, MI 48909
WCINFO@michigan.gov

Dear Ms. Outwater,

The Michigan Chapter of the American Physical Therapy Association (APTA MI) is writing to express our disagreement with the proposed application of the proposed CO/CQ modifiers and subsequent fee reduction of 15% per the CMS guidelines when those modifiers are used.

We believe that this is a flawed policy at the CMS level and APTA at the national level is continuing our discussions with CMS to reverse or mitigate the damage that has been done by this flawed policy. Specifically the AMA CPT 'always' therapy codes already account for the utilization of assistants in the calculation of the business expense as a part of the RVU process. Therefore, the Association continues to assert that it is a flawed policy because the practice expense values for physical medicine CPT codes already have been reduced to avoid duplication during the valuation process. Certain efficiencies that occur when multiple therapy services are provided in a single session were explicitly taken into account when relative values were established for these codes

In addition this reduction in payment can interfere with the provision of high quality care and access to care, with an additional potential to impact patient safety. This is trying to achieve cost savings from a skilled professional performing their job vs. looking at imaging or other specialty care. Rural areas and underserved populations could also be impacted due to a possible limitation of services.

Services provided by PT and OT assistants requires supervision of the PT /OT professional, equipment, administrative support, etc. without a reduced cost by the company providing the service. To suggest a reduction in reimbursement is a direct contradiction to the expected service provided and hinders the ability to deliver that service.

Finally, now that the Worker's compensation fee schedule is tied to the CMS fee schedule, depending on the individual practice and its patient and payer mix, the proposed payment cuts may

reduce payment for services to that which it may be below the provider cost per visit. In fact CMS cuts via sequestration, MPPR reductions and CO/CQ modifier applications, have some practices netting less per visit than they did 15 years ago.

So on behalf of all Physical Therapists in the state of MI, APTA MI asks you to strongly reconsider implementing the CMS CO/CQ modifier process or at the very least consider discussion with APTA MI a more appropriate di minimis standard for when the CO/CQ modifier would be applied. Thank you for your time in reviewing this letter. Please feel free to reach out to us if you have any questions or if there is anything we can further clarify.

Sincerely,

Edward Mathis, PT, DPT
President

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