
**CURB
Meeting Minutes
May 16, 2012**

PRESENT

Board: Patricia Berry, MPH, Delores Burroughs-Biron, MD, David Butsch, MD, William Minsinger, MD, Richard Wasserman, MD, Michel Benoit, MD, John Mathew, MD, Norman Ward, MD

DVHA Staff: Michael Farber, MD (Medical Director, moderator), Bill Clark, Daljit Clark, Jennifer Herwood, Susan Mason

Hewlett Packard (HP) Staff: Barbara Beaty

Vermont Medical Society (VMS): Madeleine Mongan

Absent: Paul Penar, MD, Adam Kunin, MD,

HANDOUTS

- Agenda
- Draft minutes from 3/14/2012
- Cost Savings Report for Medsolutions
- CPT Detail Report: Vermont Medicaid 2011 Prior Auth Data
- VT Medicaid PCP vs Specialist Comparison Data
- VMS results from survey

CONVENE: Dr. Farber convened the meeting at 6:30 pm.

1.0 Introductions

2.0 Announcements – Dr. Michael Farber

Dr. Farber reports that some Board recommendations have come to fruition.

- PTOTST: The change to authorization after 8 visits for children will begin 7/1/12 with the goal of assuring appropriate care.
- Out of State Outpatient: Oversight will begin on 7/1/12, with the goal of keeping beneficiaries in state for services that can be equally provided in state.

Chiropractors: Dr. Farber reports that chiropractors are interested in receiving payment for more services. Last week they requested an opportunity to present their ideas to the CURB board. Dr. Farber was not certain that this was the right venue since the CURB focus is on overutilization. In the past they have wanted to be able to bill E+M codes. Dr. Farber reports that this is not allowed under regulation and federal law. They also want to be afforded the same number of services as the physical therapists. Chiropractors are allowed 10 visits without PA; [therapists are allowed 30 outpatient visits for adults

**CURB
Meeting Minutes
May 16, 2012**

without PA for combined PT, OT and ST]. Reconsideration is available for unusual and exceptional circumstances. Dr. Farber reports frequent requests for additional visits. Some are approved- for example, if the beneficiary has had a re-injury. Most problematic are the requests for visits for children; some as young as 6 weeks; some are for minor childhood injuries. Dr. Farber requests input.

Dr. Matthew: does not want to have the chiropractors present to CURB. He worked in the past with Dr. Monsey to review the literature in support of chiropractic care. There was no data to support many of the techniques used. They wanted to be considered primary care providers at that time.

Dr. Farber: suggests that CURB could ask the chiropractors what they wanted to present to CURB.

Dr. Butsch: approved this idea.

Dr. Benoit: felt that if there were no improvement after 10 treatments, there should be a review, given that they are themselves evaluating and then determining the treatment. There needs to be controls in place.

Dr. Minsinger: reported that MDs can't prescribe their own PT because this is a self-referral.

Dr. Farber remarked that it was of interest that no matter the condition, all the requests documented the presence of subluxation.

Dr. Minsinger reported that we are all subluxed to a certain degree, and that it is the amount that counts.

Dr. Burroughs-Byron felt that CURB may set a precedent by allowing the presentation, and perhaps instead the chiropractors could send literature for review.

Action: Dr. Farber will ask the chiropractors what they would like CURB to know.

Terms:

Dr. Farber reported that there are term limits in statute for committees. Randomly, 5 CURB representative's terms will end this summer, and 5 more next summer. A letter will be sent to the 5 whose terms are up this summer. He encouraged all representatives to renew their membership. The term limit is 3 years.

Dr. Benoit asks about the recruitment process.

Dr. Farber reports that he approaches resources such as the VMS, Dean Morin (UVM), and the VT AAP chapter. He may also look for individuals in a particular specialty. He encourages current representatives to make suggestions. He is looking for a diversity in terms of type of work experience. The candidate must be interested in the Medicaid program and in VT healthcare. The candidate does not have to be a physician.

Action: Letters will be sent out by DVHA; members receiving the letters are encouraged to renew their membership and/or to make recommendations for new candidates.

3.0 Review of Minutes:

Regarding previous minutes, Dr. Farber reported that there was one area of controversy. Dr. Penar had made a recommendation at the last meeting and there was a misunderstanding about whether the recommendation was for gold cards or the procedure

**CURB
Meeting Minutes
May 16, 2012**

Page 3

codes under review. Dr. Penar's recommendation was regarding a 2.5% denial rate; did the group understand this to apply to gold cards or procedure codes? The CURB board members who were present during the discussion had thought the recommendation applied to gold cards with the exception of Dr. Wasserman who could not recall.

Action: The minutes were approved.

4.0 Radiology Procedures and Utilization Controls – Bill Clark

Dr. Farber requests that the group provide DVHA a conclusion regarding the following issues:

- To decide a program to provide gold cards for good performance and/or:
- To determine whether certain procedure codes be eliminated from review.

Dr. Farber stated that he felt there would be more provider acceptance for the gold card idea.

Bill Clark presented data demonstrating that for the first year of the radiology utilization program, there was a net savings of \$1.6 million, a PMPM savings of \$1.61; a savings of 32%. This savings met DVHA expectations. There was a \$2.1 million gross savings which included both MedSolutions and the contractor's fee.

Dr. Minsinger asked if there was any data comparing the savings for PET, CT and MRI; Bill reported that this was not currently available.

Dr. Minsinger reported that there are specific protocols to ensure proper decision making; his hospital, for example, reported that no PET scans should be ordered by primary care physicians.

Bill Clark reported that all criteria are posted on the website. Specialists that make referrals for PET scans have a higher approval rate than primary care physicians.

Dr. Farber reported that the criteria for PET scans are complex and include more that just for a diagnosis of cancer. Some are approved for staging and monitoring, also for certain noncancer related conditions such as brain lesions, staging for consideration of a heart transplant, and for solitary pulmonary nodules.

Dr. Wasserman mentioned the training effect that such protocols can support.

Bill reports that the cost savings is expected to level out; this is appropriate as we don't want to create barriers to care.

Dr. Minsinger asked if MedSolutions can tell if the beneficiary has had a previous MRI for the same condition.

Bill reported that MedSolutions can't tell, but that DVHA can through the edit/audit information, to determine if there has been overuse.

Dr. Matthew asked if ER's have a pass on this? He is concerned because there is a radiation risk with CT; this is especially concerning for the young.

Bill reported that they do. ER utilization is difficult to track; but we would want to bend the curve downward.

Dr. Minsinger suggested that there must be a DVHA billing data base that could be utilized to determine if there has been overutilization of radiology or testing.

**CURB
Meeting Minutes
May 16, 2012**

Page 4

Daljit Clark reported that sharing data can be an issue and timely access to data for the use of ERs is an issue.

Dr. Wasserman reported that the Health Exchange and sharable electronic records should help with this in the future.

Dr. Benoit felt that there should be some way established for hospitals to be able to connect the dots to avoid excess testing.

Bill Clark felt that ER utilization management would have to be done retroactively at this point. He recommends that these are great issues for future study.

Dr. Farber asked if the ER contacts the primary care MD before performing tests that may have been done previously.

Dr. Matthew replied that the PCP may not remember the specifics of each patient's case.

Dr. Butsch reports that the ER MDs try to look up old records and try to contact the PCPs.

Dr. Matthew supported the move toward electronic medical records for this purpose.

Dr. Burroughs-Byron asked if there was a way to tell how many ER tests show positive findings.

Daljit Clark reported that this would require chart review.

Bill Clark asked if all radiology reports are standardized.

Dr. Wasserman reported that many reports are in PDF format and thus not searchable.

Dr. Benoit raises the issue that there are now many small MRI units in MD offices, some produces poor quality images but can be rented and are billable. When these are performed, he often has to obtain another MRI with a superior imaging. He recommends that DVHA may want to consider not covering the cost of imaging from these small MRI units. He reported that there are some of these units in use in Vermont.

Dr. Burroughs-Byron wondered how often MRIs needed to be repeated because of these poorly functioning units.

Bill Clark reported that we would need to know if there was a standard for resolution; or we could limit the approved facilities.

Dr. Matthew and Dr. Burroughs-Byron reported on cases in Canada where poorly operating units produced poor images that were poorly interpreted resulting in many missed cases of breast cancers.

Dr. Minsinger reported that MDs need to send their patients to the proper facilities if their machines are not adequate for the level of imaging required.

Dr. Matthew reported that there was a financial incentive for physicians to have their own units.

There was a discussion about MRI spectroscopy. There was general agreement that the need for this test should be determined by the specialist, not the PCP.

Action: Dr. Farber will research this issue with other Medicaid and health insurers. DVHA does not want to pay for substandard MRIs.

Madeleine Mongan from VMS reported on a survey of 14 practices regarding the concept of the gold card. Responses included:

CURB
Meeting Minutes
May 16, 2012

- Administrative burden: 10-30 minutes per case
- Web-based systems are problematic because of frequent password changes
- If the PCP gets the authorization, they don't know if contrast is required.
- Responsive staff and access to the medical director
- Requests are usually granted
- Time 'on hold' was an issue
- Few concerns re: guidelines
- Low volume users should get an automatic pass
- Positive response for gold card
- One department felt that this was an extreme burden to their hospital.

Dr. Ward reported that there were problems related to the lack of an authorization: does the provider send the patient away or absorb the cost? A physician can order the study, but it is the radiology department that has to absorb the cost if the authorization hasn't been done.

Dr. Wasserman and Dr. Minsinger agreed that the hospital should not schedule the radiology appointment until they receive the prior authorization.

Barbara Beatty reported that the hospital in question does not schedule radiology until they receive the PA.

Bill Clark reported that provider perceptions are very important even if inaccurate.

Dr. Matthew inquires if we could have VT radiologists perform the reviews rather than pay MedSolutions for this.

Bill Clark reported that there are conversations about this issue.

Dr. Butsch feels that there is a burden on the PCP in obtaining the PAs.

Dr. Farber reported that in California, the person billing should be the one that must request the PA. This is the case in pharmacy as well, the PCPs have to get PA for nonpreferred drugs and yet they are not the ones billing for the drugs.

Dr. Matthew reported that he would prefer it if DVHA paid him for the time spent in the PA process with code 99213. He also suggests PA only for expensive drugs and not a \$4 script. He reported that the FQHC kept track and determined that \$250,000 was spent on pursuing prior authorizations.

Bill Clark reported that DVHA tries to be innovative but are limited financially.

Dr. Butsch also agreed that payment for the PA process was a great idea.

Dr. Farber queried: Should we have a gold card? Do risks outweigh the benefits?

Dr. Minsinger: There are political issues; some who use the gold card are trying to withdraw from the process.

Dr. Matthew reported that the legislature said it would happen with pharmacy but it never did. He inquired if MedSolutions got paid the same regardless of the gold card.

Bill Clark reported that they would get paid the same and they have a contract thru 12/31/12.

Dr. Minsinger recommended that the data suggests that PCPs not be able to obtain a gold card.

CURB
Meeting Minutes
May 16, 2012

Page 6

Dr. Wasserman recommended that high volume, low rejection provider be candidates for gold cards.

Dr. Minsinger wanted to be cautious about dividing physician practices into 'good' and 'bad' - he recommended considering random audits of all practices in the interest of fairness.

Dr. Wasserman asked if the MedSolutions criterion was publically available. Bill said yes, and Dr. Wasserman felt that even so, physicians don't always have the time to view the criteria.

Dr. Burroughs-Byron felt that the PA process was an opportunity for learning.

Madeleine Mongan reported that VMS support a gold card for imaging and DUR criteria.

Dr. Farber felt that gold carding seems to have usefulness and could be a positive public relations initiative for Medicaid. He asked for input re: Dr. Penar's idea of: volume of 50 per year with a 2.5 rejection rate. What is a reasonable number, denial rate, 1 year or greater?

Dr. Wasserman felt that we should look at the most common things, and determine what proportion of providers would qualify- a sensitivity analysis.

Dr. Farber said that we could look at various % rates.

Dr. Minsinger asked that we look at other states/insurances criteria for gold carding.

Daljit Clark reported that there is a private insurer who uses MedSolutions and uses a gold card system. They are now trying to get rid of the gold card because utilization was going up again.

Bill Clark suggested that the spot check idea might assist with that problem. He asked if the CURB was comfortable with denial for greater than or equal to 2.5% with referral rate of 100?

The group wanted more analysis.

Dr. Benoit suggested we start with the 12 providers that would initially qualify, and expand from there.

Dr. Matthew stated that we would need to know if a big chunk of the problem is in the ER.

Daljit Clark reported that there has been no increase or decrease in ER utilization.

Dr. Matthew reported that a situation arose where his office was billing for neurofeedback and then suddenly after 4 months, HP retrodenied.

Bill Clark asked for specifics. We would like to change the perception to Medicaid as a partner in health care.

Dr. Wasserman asked about what other states and insurances have done regarding gold carding.

Action: Dr. Farber will contact other Medicaids and insurances about their experiences with gold carding. Bill will obtain additional data for gold carding.

Procedure codes:

Dr. Farber asked for discussion about the issue of eliminating certain procedure codes from the authorization process. He reported that he foresaw problems because it is only a

**CURB
Meeting Minutes
May 16, 2012**

Page 7

partial solution. He also felt that radiologists should order the specific studies because they know the type of study that they need.

Dr. Benoit reported that there will be more and more protocols over time that physicians should stick to. He cited the uselessness of MRI in diagnosing tennis elbow. Certain ICD9 codes should send up a red flag.

Bill Clark reported that the criteria does require diagnosis codes.

Dr. Burroughs-Byron reported that if the ER MD orders a test, and they discover some issue, the patient is told, and they report it to the PCP which drives additional studies.

Dr. Farber asked if the group thought that looking at codes was fruitful.

Dr. Minsinger stated that it would be hard to make recommendations.

Dr. Matthew suggested paying for the time spent in acquiring PAs.

Dr. Burroughs-Byron recommended extra for management- like suboxone administrative fees.

Action: Dr. Farber will look into coding for management/administration.

Adjournment – CURB meeting adjourned at 8:20 PM

Next Meeting

July 10, 2012

Time: 6:30 PM – 8:00 PM

Location: Department of Vermont Health Access, Williston, VT