

THREE-MEMBER PANEL

2013 BIENNIAL REPORT



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INTRODUCTION

The Legislature enacted Senate Bill 108 in 2002 and included a charge to the Three-Member Panel, Section 440.13(12)(e), F.S., to assess the adequacy of medical reimbursement, access to care, and other aspects of the health care delivery in Florida's workers' compensation system. Beginning in 2003 and biennially thereafter, the Three-Member Panel has presented, to the Speaker of the House of Representatives and to the President of the Senate, a report on ways to improve the Florida workers' compensation health care delivery system. Over the years, the reports have offered recommendations in a number of areas where efficiencies might be realized and where impediments to cost containment, access to care, and effective regulatory oversight could be abated or eliminated.

The Panel's initial report was the predicate for a number of the medically related reforms that were subsequently enacted during the 2003 legislative session; these reforms were contained in Senate Bill 50A (SB 50A). The central theme of the 2005 Biennial Report was to illustrate the inefficiencies in the administration of the medical services program. The cause for the then existing administrative inefficiencies were stated to be "structural in nature", while other causes were presented as being a matter of divergent priorities and management issues resulting from two agencies sharing responsibility for one program. As a result of the Panel's recommendation, the Agency for Health Care Administration's Workers' Compensation Medical Services Unit (now referred to as the Office of Medical Services) was transferred, by way of an interagency agreement, to the Department of Financial Services-Division of Workers' Compensation (DFS-DWC) in November 2005.

The Panel's 2007 Biennial Report advanced the dialogue of the challenges in the administration of the medical services program under the tenuous auspices of the aforementioned interagency agreement. This paved the way for the Legislature's July 1, 2008 transfer of the Medical Services Unit to the DFS-DWC. The 2009 Biennial Report reaffirmed a number of the Panel's earlier recommendations and proposed ongoing monitoring to determine the need for future reform measures. The 2011 Biennial Report presented four principal topics. The topics were electronic medical billing (E-billing); prescription medications, physician dispensing, and drug repackaging; practice parameters and protocols of treatment; and the Florida Uniform Permanent Impairment Rating Schedule. These topics resulted in four recommendations to the Legislature.¹

The 2013 Biennial Report is organized into five primary topics. The first topic, *Physician Dispensing: Repackaged Drugs* augments and refreshes salient points from the Panel's 2011 Biennial Report relating to physician dispensing and repackaged drugs and includes a discussion of some of the more noteworthy initiatives that have transpired in the approximately two year interim. The second topic, *Outpatient Hospital Reimbursement*, provides a discussion of the current outpatient reimbursement methodology, the concept of usual and customary charges, and a proposed alternative to the current outpatient reimbursement methodology. The third topic, *Inpatient Hospital Reimbursement*, includes a discussion of the current inpatient reimbursement methodology and a proposal for an alternative Diagnosis

¹ The Panel's recommendations are on page 19 of the 2011 Biennial Report.

Related Groups (DRG) based reimbursement methodology. These initial three topics represent cost containment opportunities for the Legislature. The fourth topic, *Health Care Provider Certification*, discusses the current provider certification process and proposes its elimination. The fifth and final topic, *Health Care Provider Reimbursement Dispute Process*, looks at the current statutory language that addresses the timeline for resolving reimbursement disputes and suggests changes to the statute. The last section, *Conclusions and Recommendations*, summarizes the topics and recommendations for each substantive topic.

PHYSICIAN DISPENSING: REPACKAGED DRUGS

Florida's Office of Insurance Regulation (OIR) recently approved a 6.1 percent rate increase to become effective January 1, 2013 for workers' compensation insurance rates in Florida. The decision was founded on evidence submitted to the OIR by the National Council on Compensation Insurance (NCCI) in their rate filing, and during testimony offered by NCCI in the October 4, 2012 rate hearing.

This most recent rate increase was attributed to a variety of cost factors that occurred in the workers' compensation marketplace. Notwithstanding this most recent premium rate increase, Florida's workers' compensation rates remain 56 percent below the rates that existed prior to enactment of the 2003 legislative reform measures. However, the rate reductions that resulted from the 2003 reforms have been fully achieved as the OIR has approved a premium rate increase in each of the last three years (7.8 percent in 2010, 8.9 percent in 2011, and the current 6.1 percent increase in 2012).²

The issues of physician dispensing and repackaged drugs have been broadly discussed and written about because of their interconnectivity in terms of reimbursement for dispensed medications on a drug by drug basis and because of their aggregate impact on medical spending. NCCI identified physician dispensing of repackaged drugs as a driver of premium costs. Since 2008, more than 95 percent of the reimbursement dollars spent on repackaged drugs, in Florida, has been the result of physician dispensing; and, in 2011 97.9 percent of the dollars spent was the result of physician dispensing.³

A by-product of repackaging/relabeling has been that the average unit price of a repackaged drug can be many times that of the drug in its non-repackaged form.⁴ At the hearing on the 2012 rate filing, NCCI provided testimony that workers' compensation rates could decline by 1.1 percent if Florida addressed its physician drug dispensing issue⁵.

² Florida workers' compensation rates declined for seven successive years prior to the recent trend.

³ See [Florida Department of Financial Services, Division of Workers' Compensation, 2012 Results and Accomplishments](#), at page 117.

⁴The per unit markup can be as much as 679% according to the NCCI testimony provided at the August 18, 2011 workers' compensation premium rate hearing. This same testimony was again provided at the November 16, 2011 Three-Member Panel meeting.

⁵ NCCI also testified that another 5.5 percent rate decline could be achieved if expenditures for out-patient hospital care, in-patient hospital care, and ambulatory surgery centers (ASC) are addressed.

Several states (such as Arizona, Colorado, Georgia, and South Carolina) have implemented price caps and other regulatory tools to address the reimbursement disparity between repackaged and non-repackaged drugs. In some instances states have implemented an outright ban on physician dispensing⁶ and the use of repackaged drugs. For the last several years, numerous legislative solutions have been attempted in order to create price symmetry between the reimbursement of repackaged drugs and non-repackaged drugs. House Bill 5603 was passed during the 2010 legislative session; however, then-Governor Crist subsequently vetoed the bill. More recently, during the 2012 legislative session both the Florida Senate and the Florida House of Representatives considered legislation that would have addressed payments for repackaged drugs in much the same manner as some other states that have taken up this issue. Senate Bill 668 and House Bill 511 would have, in their original form, limited reimbursement for repackaged or relabeled drugs to an amount that would not exceed the reimbursement otherwise payable if the drug had not been repackaged or relabeled. Neither of these bills passed the Legislature.⁷ Advocates of physician dispensing argued that placing price caps on reimbursement for repackaged drugs would cause physicians to stop dispensing drugs and to stop accepting workers' compensation patients. Additionally, some have argued that patients could face delays when prescriptions are filled at pharmacies.

A July 2012 study released by the Workers Compensation Research Institute (WCRI) titled *Physician Dispensing in Workers' Compensation* shows that doctors in California have continued to dispense drugs since 2007 when a cap on prices was put into effect. The report also showed that physicians have begun dispensing non-repackaged drugs and charging prices on par with the prices charged by their retail pharmacy counterparts.⁸

To be clear, this section is not a commentary on the practice of physician dispensing. It is to bring focus to the fact that the current statutory benchmark of reimbursing prescription drugs at the Average Wholesale Price has led to a pricing environment that is not conducive to the self-execution of the workers' compensation system and does not provide reimbursement clarity and uniformity, which is a detriment to the payers and payees. The result has been a dramatic increase in the number of petitions for reimbursement dispute

⁶ Massachusetts, New York, Texas, Montana, and Utah have prohibited physicians from dispensing drugs as a matter of general law.

⁷In the last half of 2012, NCCI completed an analysis of the SB 668 and HB 511 proposal to revise reimbursement for repackaged or relabeled drugs. The NCCI analysis (Appendix A) includes a brief description of the proposal and provides an analysis of the resulting cost impacts which would ensue if the proposed changes were made effective in Florida.

⁸ The WCRI study cited that in states like Florida and Illinois, physician dispensed drugs have been priced between 60 and 300 percent more than what is charged by pharmacies. The WCRI report purports to have analyzed more than 758,000 claims involving more than seven days of lost-time from work. WCRI represents that it looked at nearly 5.7 million prescriptions from Arizona, Arkansas, California, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Louisiana, Maryland, Michigan, Minnesota, New Jersey, North Carolina, South Carolina, Pennsylvania, Tennessee, Virginia and Wisconsin. WCRI also looked at data from Massachusetts, New York and Texas, which generally prohibit physician dispensing. WCRI used data from claims arising in 2007 with all payments made through March 31, 2008. The study compared that data to injuries that occurred between Oct. 1, 2009, and Sept. 30, 2010, involving prescription costs paid through March 31, 2011.

filed by physicians in FY 2011/2012 (up 872% over FY 2010/2011 from 1,308 to 12,718, respectively) primarily due to disputes involving physician dispensed medication. Despite realigning existing staff resources to the reimbursement dispute process, the Division of Workers' Compensation will continue to be inundated with disputes unless a legislative and/or regulatory solution can be achieved that is acceptable to the various parties. Therefore, the Panel recommends that the Legislature consider amending section 440.13(12)(c), F.S., to create a new reimbursement benchmark that reduces the financial disparity between repackaged and non-repackaged drugs; provides a reasonable and standardized level of reimbursement to those parties that dispense prescription drugs; and minimizes future reimbursement disputes related to prescription drugs. Absent a legislative solution, the Panel recommends that the Division of Workers' Compensation explore regulatory options to achieve these goals.

HOSPITAL OUTPATIENT REIMBURSEMENT

Florida has a charge based system for reimbursing hospital outpatient services. Currently, these services are required to be reimbursed at 75 percent of “usual and customary charges” except as otherwise provided in Florida’s workers’ compensation statute⁹. The term “usual and customary charge” is not defined by Florida statute and its meaning can and does vary from state to state and among insurers.¹⁰ This ambiguity, in the intended meaning of the term, lead to divergent interpretations amongst stakeholders, which laid the foundation for the One Beacon Insurance v. Agency for Health Care Administration case¹¹. To summarize, the First District Court of Appeal ruled against AHCA in a medical reimbursement dispute relating to the appropriate construction of “usual and customary charges”. The Court determined that it was the intent of the Legislature to eliminate calculation of a “usual and customary charge” based on the fees of any one provider in favor of a calculation of such charge based on the average fees of all providers in a given geographical area. The Division’s attempt to comply with the Court’s ruling has resulted in three separate proposals to the Three-Member Panel over the last five years.

The Panel first considered testimony and comments regarding the proposed adoption of Medicare’s Outpatient Prospective Payment System (OPPS) in concert with payment adjustment factors¹² as the methodology for reimbursing hospitals 60 percent and 75 percent of usual and customary charges for outpatient services on June 19, 2008. This proposed reimbursement methodology was for the purpose of amending Rule 69L-7.501, F.A.C., and, represented the Division’s initial attempt to comply with section 440.13(12)(a), F.S., as interpreted through the One Beacon decision. After much controversy, several rule challenges, and unsuccessful negotiations, the Division returned to the Panel on December

⁹ Subsection 440.13(12)(a), F.S.

¹⁰ A discussion of the implications of an undefined “usual and customary charge” is provided in the Panel’s 2007 Biennial Report beginning at page 32 and concluding at page 39.

¹¹ The ruling is available at Florida’s First District Court of Appeal website:
<http://opinions.1dca.org/written/opinions2007/3-28-07/05-5459.pdf>

¹² Payment adjustment factors of 1.74 and 3.95, respectively, were established by analyzing claims data in the Divisions Medical Data Warehouse.

13, 2010, and requested the Panel's authorization to withdraw the then pending rule that would have incorporated Medicare's OPPS into the Florida Workers' Compensation Reimbursement Manual for Hospitals, 2006 Edition.¹³

At that same December 13, 2010 meeting, the Division announced that effective July 1, 2008, it began requiring Florida's workers' compensation carriers to report Current Physician Terminology (CPT) Code line level charge information for outpatient hospital bills. The Division further represented that it had continued to expand and improve the medical billing information that must be reported by carriers. Based in part on these facts the Division recommended that the Three-Member Panel authorize the Division to initiate the rule making process to amend the Florida Workers' Compensation Reimbursement Manual for Hospitals, 2006 Edition, to incorporate a schedule of maximum reimbursement allowances for hospital outpatient care. The schedule was based upon a CPT based methodology to determine what comprises a usual and customary charge for hospital outpatient service. The methodology created maximum reimbursement allowances based upon hospital charge data that was reported to the Division for certain CPT codes. The key components of the methodology were as follows:

- Use 18 months of bill data;
- Use a minimum threshold of 20 bills for development of an Maximum Reimbursement Allowance (MRA);
- Use the Medicare localities as adopted in the Florida Workers' Compensation Health Care Provider Reimbursement Manual;
- For those CPT codes that do not have an MRA, the services would continue to be reimbursed at either 75 percent or 60 percent of the hospital's billed charges depending on the nature of the service.

Again, the Division's attempts were met with opposition and after additional rule challenges and stalled negotiations; this rule making initiative was withdrawn on October 1, 2012.¹⁴

Most recently, the Division came before the Panel at its January 9, 2013 public meeting requesting permission to initiate rulemaking that would amend the Florida Workers' Compensation Reimbursement Manual for Hospitals, 2006 Edition, to incorporate a schedule of maximum reimbursement allowances for hospital outpatient care that is based upon yet another CPT based methodology. The most recent proposed methodology applies the same components as referenced for its predecessor with the following modifications:

- Applies an updated 18 months of bill data (January 1, 2011 through June 30, 2012);
- Establishes a single statewide reimbursement amount (per CPT code);
- Subjects the statewide reimbursement amounts to a wage index modification based on the urban area of the service.

NCCI estimates that the changes proposed above would result in an impact of -0.3% (-7 million dollars) on overall workers' compensation system costs in Florida. The NCCI

¹³ Rule 69L-7.501, F.A.C., was formally withdrawn on January 28, 2011.

¹⁴The Notice of Withdrawal appeared in volume 38/40 of the Florida Administrative Register, which can be viewed at the following web address:

<https://www.flrules.org/gateway/readFile.asp?sid=3&tid=12060706&type=1&file=69L-7.501.htm>

analysis of this proposed outpatient hospital reimbursement methodology is included in this Biennial Report as Appendix B.

The hope is that this most recently proposed outpatient hospital reimbursement methodology will be more durable than its forerunners in terms of its ability to withstand the challenges that history suggests will come during the rulemaking process. But, if it is not, then this current stalemate that has forestalled the last several attempts to update the hospital outpatient reimbursement MRAs will, in all likelihood, require the Legislature to define the term “usual and customary charge”. Any definition of the term would need to make all stakeholders aware of its intended meaning and when it is to be used in determining reimbursement for medically necessary treatment, care and attendance provided in an outpatient hospital setting. More preferable, the Panel would recommend removal of the statutory mandate in section 440.13(12)(a), F.S., that requires reimbursement for outpatient hospital services to be based on a percent of “usual and customary charges” and fix the reimbursement amounts to 120% or 140% of Medicare’s payments under its Outpatient Prospective Payment System.

A growing trend among states is to move away from charge based reimbursement and toward some other reimbursement methodologies that are more predictable and that offer greater opportunity for cost containment, while continuing to preserve access to high quality medical care. An example of such a state is Oregon.

The Oregon workers’ compensation system essentially uses Medicare’s OPSS with some fine-tuning. For example, all implants are separately payable at cost plus 10 percent; an implant is defined as an implantable device with a cost above \$100; only surgical codes (CPT codes 10021 through 69999) from Medicare’s hospital OPSS are used; the Medicare payment amount is reduced by the implant offset amount, if any (because implants are paid separately), then the reduced payment amount is multiplied by 1.1; any surgical code not listed in Medicare’s hospital OPSS is payable at 80 percent of the facilities billed charge¹⁵.

Additional examples of state workers’ compensation programs that utilize some form of the Medicare Outpatient Prospective Payment System are California, Colorado, North Dakota, South Carolina, Tennessee and Washington’s state fund. With the exception of Washington, which assigns a unique payment adjustment factor to each participating hospital, each state applies a single, statewide payment adjustment factor (PAF) to Medicare’s payment rates.

At its November 16, 2011 public meeting, the Three-Member Panel expressed its desire to evaluate the potential for cost savings that would result from implementing a fee schedule based on some percentage above Medicare’s Outpatient Prospective Payment System (OPSS). Implementing such a payment system would require legislative action. Therefore, in a December 9, 2011 letter to the Speaker of the Florida House of Representatives, Commissioner McCarty stated the case for the legislature to act. Recently, NCCI performed an analysis that presented two scenarios for the Panel to consider. The first scenario reflects overall impact on workers’ compensation system costs in Florida if payment rates for

¹⁵ This information was provided by Juerg Kunz, Medical Policy Analyst for the Oregon Workers’ Compensation Division.

hospital outpatient and ambulatory surgical center (ASC) services were equal to 120% of Medicare's OPPS. The second scenario reflects the overall impact on system costs if the payment rates were set to 140% of Medicare's OPPS (again for hospital outpatient and for ASC services). Each scenario projects a cost savings, -4.9% and -4.5%, respectively. The complete analysis is included as Appendix C.

HOSPITAL INPATIENT REIMBURSEMENT

The Florida workers' compensation law provides that the maximum reimbursement allowances for inpatient hospital care shall be based on a schedule of per diem rates to be approved by the Three-Member Panel no later than March 1, 1994.¹⁶ In the nearly two-decade interval, there have been surgical and non-surgical per diems that have changed very little over the years.

In Florida's workers' compensation program, the bulk of inpatient hospital services are paid according to the surgical or non-surgical per diem amount established by the Panel. The current Florida Workers' Compensation Hospital Reimbursement Manual contains the schedule of per diem rates.¹⁷ However, if the inpatient charges, excluding the charges for implants, exceed \$51,400 the hospital is reimbursed 75% of charges. Appendix D shows the number of inpatient bills that exceed the stop-loss amount.

The Three-Member Panel, at its November 16, 2011 public meeting, expressed its desire to look at the possibility of implementing a Diagnosis Related Group (DRG) system for the reimbursement of inpatient services. On this basis, the Department of Financial Services-Division of Workers' Compensation (DFS-DWC) was asked to gather information and report back to the Panel. Subsequently, DFS-DWC issued a Request for Qualifications (RFQ) seeking a quote from a vendor to provide consulting and analytical services for the purpose of evaluating Florida's current reimbursement allowances for inpatient services. The vendor was charged with proposing alternative reimbursement allowances that are reasonable, promote health care cost containment and efficiency with respect to the workers' compensation health care delivery system; and, that are sufficient to ensure the availability of such inpatient services to injured workers. Specifically, the vendor was asked to:

- Describe and list the various payment methodologies used by states to reimburse hospitals and Ambulatory Surgical Centers for workers' compensation inpatient services.
- Compare and contrast Florida's inpatient reimbursement methodology with those in other states.
- Provide a written report of the analysis and findings to the Division.
- Map the inpatient procedure codes from the Division's medical bill database to Medicare's Ambulatory Payment Groups.

¹⁶ Subsection 440.13(12)(a), Florida Statutes

¹⁷ The current surgical per diem for hospital inpatient services are: Surgical stay: \$3,304 per day; Non-surgical stay: \$1,960 per day. Inpatient services provided by a trauma center, licensed pursuant to s. 395.4025, F.S.: Surgical stay: \$3,305 per day; Non-surgical stay: \$1,986 per day.

Ultimately, the Division contracted with OptumInsight™ to perform this project and to present its findings to the Panel. The written report is attached to this Biennial Report as Appendix E. The report consists of two sections. The first section discusses the mapping and grouping process for inpatient claims. The second section provides an overview of Medicare's Inpatient Prospective Payment System (IPPS). Two additional items, one containing the claim level results of the grouping project and the other containing different analytic components of the grouping project, are discussed in the first section of the report. An additional document, which contains the current inpatient hospital reimbursement methodologies for various state workers' compensation programs, is included as Appendix F. This document does not offer any analysis of why a state has selected its inpatient hospital reimbursement method or what type of impact the payment method has had on medical claims cost or overall workers' compensation system costs. Nonetheless, it is a convenient reference tool for determining how inpatient hospital workers' compensation bills are currently being paid in other states. For example, California uses Medicare's IPPS which is a DRG payment methodology. The survey description is much more involved and can be reviewed for greater detail. Another example is Texas, which pays inpatient bills at 143% of the amount payable under Medicare's MS-DRG. Texas provides for outlier payments and establishes a different reimbursement methodology for inpatient stays of greater than 12 days. It is the Panel's recommendation that the Legislature remove the statutory mandate in s. 440.13(12)(a), F.S., that requires reimbursement for inpatient hospital services to be based on per diem and fix the reimbursement amounts to 120% or 140% of Medicare's payments under its Inpatient Prospective Payment System. Appendix G contains NCCI's cost analysis, which reflects an overall cost savings of -3.4% at 120% of Medicare and -3.0% at 140% of Medicare.

HEALTH CARE PROVIDER CERTIFICATION

At present, Florida's workers' compensation health care delivery system mandates health care provider certification for all physicians and recognized practitioners who wish to provide care to injured employees covered by Florida's workers' compensation law. Providers, except when providing emergency care, must be certified by the Department of Financial Services, Division of Workers' Compensation to be eligible for payment of services provided to injured employees.¹⁸ However, as it currently exists, health care provider certification offers no significant value to the workers' compensation system.

By way of background, the certification requirement was created pursuant to section 440.13(3)(a), F.S, when the Division of Workers Compensation created rule 38F-53, F.A.C., Health Care Provider Certification, which was adopted March 14, 1995. The adoption of this rule was in response to the 1993 statutory reform, which as a condition to eligibility for reimbursement, required health care providers to complete a Division-approved five-hour educational course related to workers' compensation. Explicitly, Section 440.13(3)(a), F.S., stated the subject areas of the required training were to include cost containment, utilization control, ergonomics and practice parameters. The only exception to completion of the five-hour course was if the health care provider was a participating member of an authorized

¹⁸ Pursuant to Subsection 440.13(3)(a), F.S.

Workers' Compensation Managed Care Arrangement (WCMCA) that would be responsible for supplying the required educational information to the health care provider. External vendors were allowed to provide the required training to prospective applicants for certification. In retrospect, the Division determined that the quality and focus of the training was often inconsistent with the stated goals of the statute, citing wide variations in content and interpretation from one course vendor to the next. Effective October 1, 2001, the statutory requirement for health care provider completion of the five-hour educational course was eliminated.¹⁹

Under the current provider certification process²⁰, when submitting an application for certification, providers must attest to the following criteria:

- No prior revocation, suspension or voluntary relinquishment of licensure within the past twelve months.
- No incidence of being placed on probationary status by a professional credentialing body within the past twelve months.
- No personal or facility conviction of a felony, crime or ethical violation within the past twelve months.
- No current decertification pursuant to the Rule 69L-29, F.A.C., Health Care Provider Certification.

The existing certification process does little to ensure that participating providers possess a better understanding of Florida's workers' compensation system and the metrics that are part of the workers' compensation law. Therefore, the Division has undertaken a significant rewrite of the existing Health Care Provider Certification Rule. The amended rule, which is set to take effect in the first quarter of 2013, will amend the current rule chapter to revise the process by which health care providers meet the minimum criteria for certification pursuant to section 440.13(3)(a), F.S.

In addition, the proposed amendment will introduce the "Florida Workers' Compensation Health Care Provider Certification Tutorial", a no-cost, on-line resource that implements an electronic certification process for health care providers that will enhance the efficiencies in the certification process. The tutorial has prompts and edits to ensure participation only by statutorily defined providers and offers a learning tool, which allows providers to progress through the tutorial at their own pace and to create and maintain their provider profile. The tutorial consists of an overview of the Florida workers' compensation system and the general administrative policies with which a health care provider must become familiar prior to certification and that will aid successful participation within the program.²¹

¹⁹ Effective July 1, 2002, HB 1643 transferred certain regulatory responsibilities under section 440.13, F.S., from the now disbanded Department of Labor and Employment Security to the Agency for Health Care Administration. At AHCA, Chapter 38F-53, F.A.C., became rule 59A-29, F.A.C.

²⁰ The Health Care Provider Certification Rule, Chapter 69L-29, F.A.C., was previously Chapter 59A-29, F.A.C., under the Agency for Health Care Administration.

²¹ The proposed rule amendment also deletes existing Rule(s) 69L-29.004, 69L-29.006, 69L-29.007, 69L-29.009 and 69L-29.011, F.A.C.

Although the recently revised, prospective iteration of the Health Care Provider Certification rule represents a significant improvement to the current rule, it is the Panel's recommendation that the Legislature eliminate the health care provider certification process performed by the Division.²² The criterion for certification would then become the standards used by Florida's Department of Health declaring all practitioners who are currently in good standing regarding their licensure to practice in their respective discipline and specialty as eligible to be authorized by carriers and to receive reimbursement for services rendered. This would increase the number of health care providers immediately eligible to see injured employees²³. In addition, it would reduce or reallocate resources currently devoted to maintaining a system that can be self executing.

HEALTH CARE PROVIDER REIMBURSEMENT DISPUTE PROCESS

The Department is responsible for resolving medical reimbursement disputes between health care providers and carriers. Disputes about compensability and medical authorization are addressed by Judges of Compensation Claims. Currently, providers are afforded 30 days from the receipt of notice of disallowance or adjustment of payment to file a dispute petition with the Department²⁴. The rule based tool for contesting a disallowed or adjusted payment is the Petition for Resolution of Reimbursement Dispute Form²⁵. Providers regularly file imperfect or incomplete petitions. When this occurs, the Department issues a Notice of Deficiency (NOD) to the provider in an attempt to seek corrections to the petition. These NODs must be tracked and resolved whether or not the provider submits a response.

Carriers that wish to participate in the dispute resolution process have 10 days from receipt of the petition to file a response; otherwise they waive all objections to the Department's determination²⁶. This short time period in which a carrier must respond to a provider's petition can result in a carrier's unintentional failure to respond or to timely respond.

The Department has 60 days from receipt of the petition to issue its determination²⁷. Prior to November 2011, the Department had received 150-200 petitions per month. For calendar year 2012 to date, the Department has received over 2,000 petitions per month. The average number of days to resolve a dispute has increased from roughly 24 days to over 81 days.

Therefore, the Panel is proposing that the Legislature amend section 440.13(7), F.S., using the following wording:

- (a) Any health care provider, ~~carrier, or employer~~ who elects to contest the disallowance or adjustment of payment by a carrier under subsection (6) must, within 45~~30~~ days after

²² This recommendation was also offered in the Panel's 2007 and 2009 Biennial Report, respectively.

²³ As of November 9, 2012, there are 38,800 certified health care providers in the DFS-DWC database, of which, 27,561 are physician providers. As of the same date, there are 60,352 medical doctors in the Florida Department of Health database.

²⁴ Subsection 440.13(7)(a), F.S.

²⁵ Rule 69L-31.003

²⁶ Subsection 440.13(7)(b), F.S.

²⁷ Subsection 440.13(7)(c), F.S.

receipt of notice of disallowance or adjustment of payment, petition the department to resolve the dispute. The petitioner must serve a copy of the petition on the carrier and on all affected parties by certified mail. The petition must be accompanied by all documents and records that support the allegations contained in the petition. Failure of a petitioner to submit such documentation to the department results in dismissal of the petition.

(b) The carrier must submit to the department within ~~3040~~ days after receipt of the petition all documentation substantiating the carrier's disallowance or adjustment. Failure of the carrier to timely submit the ~~requested~~ documentation to the department within ~~3040~~ days constitutes a waiver of all objections to the petition.

(c) Within ~~12060~~ days after receipt of all documentation, the department must provide to the petitioner, the carrier, and the affected parties a written determination of whether the carrier properly adjusted or disallowed payment. The department must be guided by standards and policies set forth in this chapter, including all applicable reimbursement schedules, practice parameters, and protocols of treatment, in rendering its determination.

It is the Panel's conviction that expanding the time limits as indicated above serves the threefold purpose of:

- 1) Encouraging parties to resolve medical reimbursement disputes outside of the statutory scheme by allowing negotiations to take place without the provider missing its deadline for filing a petition;
- 2) Ensuring that once a petition is filed, the carrier has ample time to respond to the petition; and,
- 3) Allowing the Department sufficient time to issue a determination no matter the volume of petitions received.

CONCLUSIONS AND RECOMMENDATIONS

In summary, this report discussed six topics and looked at how each might provide an opportunity for the Legislature to strengthen cost containment efforts and augment operational efficiencies. Therefore, the following recommendations are offered:

- 1) The Panel recommends that the Legislature consider amending section 440.13(12)(c), F.S., to create a new reimbursement benchmark that reduces the financial disparity between repackaged and non-repackaged drugs; provides a reasonable and standardized level of reimbursement to those parties that dispense prescription drugs; and minimizes future reimbursement disputes related to prescription drugs. Absent a legislative solution, the Panel recommends that the Division of Workers' Compensation explore regulatory options to achieve these goals.
- 2) Remove the statutory mandate in s. 440.13(12)(a), F.S., that requires reimbursement for outpatient hospital services to be based on a percent of "usual and customary charges" and fix the reimbursement amounts to 120% or 140% of Medicare's payments under its Outpatient Prospective Payment System; or, in the alternative;
- 3) If failing to adopt a change in the methodology for hospital outpatient reimbursement services, "usual and customary charge" will need to be defined in a manner so that all stakeholders are aware of its intended meaning and when it is to be used in determining reimbursement for medically necessary treatment, care and attendance provided in an outpatient hospital setting.
- 4) Remove the statutory mandate in s. 440.13(12)(a), F.S. that requires reimbursement for inpatient hospital services to be based on per diem and fix the reimbursement amounts to 120% or 140% of Medicare's payments under its Inpatient Prospective Payment System.
- 5) Eliminate the health care provider certification process performed by the Division. The criterion for certification would then become the standards used by Florida's Department of Health declaring all practitioners who are currently in good standing regarding their licensure to practice in their respective discipline and specialty as eligible to be authorized by carriers and to receive reimbursement for services rendered.
- 6) Amend section 440.13(7), F.S., to allow providers 45 days from receipt of a notice of disallowance or adjustment of payment to file a petition; allow carriers 30 days from receipt of a provider's petition to respond to the petition; and allow the Department 120 days from receipt of all documentation to issue a determination.

These recommendations provide a starting point for the Legislature as it considers any changes to the workers' compensation health care delivery system and its efforts to promote costs savings for Florida's employers, while ensuring that workers' compensation claimants have access to care to treat their injuries.



**ANALYSIS OF FLORIDA PROPOSAL
TO REVISE REIMBURSEMENT
FOR REPACKAGED OR RELABELED PRESCRIPTION DRUGS
EFFECTIVE UPON ADOPTION**

NCCI has completed an analysis of the proposal to revise reimbursement for repackaged or relabeled drugs. These changes were first proposed in House Bill (HB) 5603 (2010 session), then Senate Bill (SB) 1068 (2011 session) and later in HB 511/SB 668 (2012 session), none of which were enacted in Florida. This analysis includes a brief description of the proposal and provides an analysis of the cost impacts which would result if the proposed changes were made effective in Florida.

Cost Impact

NCCI estimates that the changes proposed to revise reimbursement for repackaged or relabeled drugs would result in an impact of -1.1% (-\$27.3M)¹ on overall workers compensation costs in Florida.

Summary of Proposed Change

The proposal addresses reimbursement for drugs that have been repackaged or relabeled. Under the proposal, reimbursements for such drugs would be limited to the Average Wholesale Price (AWP) per unit set by the original manufacturer of the drug, plus a \$4.18 dispensing fee. This proposal would not apply in situations where the employer or insurer has contracted for a lower reimbursement amount.

Currently, there are no limitations on the AWP for reimbursements of repackaged or relabeled prescription drugs. All prescription drugs are reimbursed at the AWP plus a \$4.18 dispensing fee, except in situations where the carrier has contracted for a lower amount.

Actuarial Analysis

In Florida, drug costs represent 15.1%² of workers compensation (WC) medical costs. Repackaged or relabeled drug costs represent 24.3%² of Florida's WC drug costs, or 3.7% (=24.3% x 15.1%) of medical costs. Non-repackaged drugs represent 11.4% (=15.1% - 3.7%) of medical costs.

In order to estimate the cost impact of this proposal, NCCI compared the paid amount of repackaged or relabeled drugs to the expected payment for drugs if they had been dispensed in

¹ Overall system costs are based on NAIC Annual Statement data as provided by A.M. Best including an estimate of self-insured premium. The estimated dollar impact of -\$27.3M is the percent impact displayed multiplied by A.M. Best 2011 written premium (preliminary) of \$1,794M for Florida plus an estimate of the self-insured premium from the Florida Division of Workers Compensation for 2011 of \$692M. This figure does not include the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs.

² Based on Florida Division of Workers' Compensation (DWC) data for Service Year 2011.



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their original packaging from the manufacturer (not repackaged or relabeled). A repackaged or relabeled indicator field from First Databank's *National Drug Data File™ (NDDF), Descriptive and Pricing Data*, was used to distinguish repackaged or relabeled drugs from the drugs dispensed in their original packaging from the manufacturer within the Florida Workers Compensation Data licensed to NCCI. **Since HB 7095, effective July 1, 2011, bans dispensing of Schedule II and Schedule III controlled substances by a physician, these drugs were omitted from the cost impact analysis.**

NCCI has assumed the difference between the current reimbursement for repackaged or relabeled drugs and the current reimbursement for the equivalent of these drugs that are not repackaged or relabeled, to be a reasonable estimate of the cost impact due to the proposed rule.

The current and proposed reimbursements for each repackaged or relabeled drug were calculated as follows:

$$\text{Current Cost} = \text{Average price per unit for repackaged or relabeled drug} \times \text{total units of repackaged or relabeled drug}$$

$$\text{Proposed Cost} = \text{Average price per unit for equivalent drug that is not repackaged or relabeled} \times \text{total units of repackaged or relabeled drug}$$

Where:

Units = Total number of pills per prescription

Average price per unit = Total paid divided by total units

The current and proposed reimbursements are summed over all the transaction-level data to obtain total current and total proposed costs. The estimated direct impact on drug costs is the ratio of total proposed costs to total current costs.

The impact on total prescription drugs due to the above proposals is summarized in the table below:

Type of Prescription Drug	Cost Distribution ²	Impact
Repackaged	24.3%	-45.1%
Non-Repackaged	75.7%	0.0%
Total Prescription Drugs	100.0%	-10.9%

² Based on Florida Division of Workers' Compensation (DWC) data for Service Year 2011.

CONTACT: LORI LOVGREN
Telephone: 561-893-3337
E-mail: Lori.Lovgren@ncci.com



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The above impact of -10.9% on total prescription drugs is then multiplied by the Florida percentage of medical costs attributed to prescription drug payments (15.1%²) to arrive at the estimated impact of -1.6% on medical costs. The resulting impact on medical costs is then multiplied by the percentage of Florida benefit costs attributed to medical benefits (68.4%³) to arrive at the estimated impact on Florida overall workers compensation system costs of -1.1% (-\$27.3M).

Additional Information

NCCI prepared a similar analysis for HB 5603 (2010 session) and SB 1068 (2011 session). Here is a comparison of estimates from each analysis:

		HB 5603 (2008 data)	SB 1068 (2009 data)	Current Analysis (2011 data)
(1)	Impact of Limiting AWP on Repackaged or Relabeled Prescription Drugs	-52.8%	-57.0%	-45.1%
(2)	Share of Repackaged or Relabeled Drug Costs to WC Drug Costs	23.5%	39.8%	24.3%
(3)	Share of WC Drug Costs to WC Medical Costs	12.8%	16.0%	15.1%
(4)	Impact on Medical Costs = (1) x (2) x (3)	-1.6%	-3.6%	-1.6%
(5)	Medical Costs as a percentage of Overall WC System Costs	68.9%	68.3%	68.4%
(6)	Impact on Overall WC System Costs = (4) x (5)	-1.1%	-2.5%	-1.1%

³ Based on NCCI Financial Call data from Policy Years 2009 and 2010 projected to 1/1/2013. This estimated date is subject to change depending on the effective date of this proposal.

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NCCI estimates that the proposed changes to the Florida Hospital Outpatient Fee Schedule developed by the Florida Division of Workers Compensation (FL DWC), with maximums that vary by statistical area, would result in an impact of -0.3% (-\$7M)¹ on overall workers compensation system costs in Florida.

Summary of Changes

Currently, reimbursement for workers compensation outpatient hospital services in Florida depends on the category of service as described below:

- **Category 1:** Any scheduled outpatient radiology or clinical laboratory services that are not performed in conjunction with a scheduled surgery shall be reimbursed by the schedule of maximum reimbursement allowance (MRA's) listed in Florida Workers' Compensation Health Care Provider Reimbursement Manual (FWCRM), 2007 Edition. In addition, outpatient physical, occupational, and speech therapy is reimbursable by the MRA listed in the FWCRM.
- **Category 2:** The maximum reimbursement level for scheduled outpatient surgeries is 60% of usual and customary charges (UCC). In addition, any scheduled radiology and clinical laboratory services performed in conjunction with, as defined as being performed on the day of or up to three days before a scheduled surgery, are also reimbursed at 60% of UCC.
- **Category 3:** All other outpatient procedures should be reimbursed at 75% of UCC.

The proposal seeks to reimburse hospital outpatient services under a Schedule of Maximum Reimbursement Allowance (MRA) that varies by procedure code and by statistical area within Florida. This schedule of MRA has been prepared by the Florida Division of Workers Compensation (FL DWC). Specifically under the proposal:

- **Category 1:** Reimbursement for hospital outpatient Category 1 procedures are proposed to be updated from the 2009 Medicare Resource Based Relative Value Scale (RBRVS) geographic-specific reimbursement levels to the 2012 Medicare RBRVS geographic-specific reimbursement levels.

¹Overall system costs are based on NAIC Annual Statement data as provided by A.M. Best including an estimate of self-insured premium. The estimated dollar impact of -\$ 7M is the percent impact displayed multiplied by A.M. Best 2011 written premium of \$1,794M for Florida plus an estimate of the self-insured premium from the Florida Division of Workers Compensation for 2011 of \$692M. This figure does not include the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs.

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- Category 2 and Category 3: These are subject to the proposed schedule of reimbursement. Procedures with no specified MRA shall continue to be reimbursed in accordance with the current fee schedule (60% of charges for Category 2 procedures and 75% of charges for Category 3 procedures)

Note that the actual language of the proposal was not provided to NCCI, and therefore the impact of this analysis may change depending on the implemented version of the proposal.

Actuarial Analysis

NCCI's methodology to evaluate the impact of medical fee schedule changes includes three major steps:

1. Calculate the percentage change in maximum reimbursements
 - a. Compare the prior and revised maximum reimbursements by procedure code and determine the percentage change by procedure code
 - b. Calculate the weighted average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights
2. Estimate the price level change as a result of the revised fee schedule
 - a. NCCI research by Frank Schmid and Nathan Lord (2012), "Impact of Changes to Physician Fee Schedules in Workers Compensation", suggests that a portion of a change in maximum reimbursements is realized on payments impacted by the change.
 - b. In response to a fee schedule decrease, NCCI research indicates that payments decline by approximately 50% of the fee schedule change.
 - i. The assumption for the percent realized for fee schedule decreases is 50%.
 - c. In response to a fee schedule increase, NCCI research indicates that payments increase by approximately 80% of the fee schedule change and the magnitude of the response depends on the relative difference between actual payments and fee schedule maximums (i.e. the price departure).
 - i. The formula used to determine the percent realized for fee schedule increases is $80\% \times (1.10 + 1.20 \times (\text{price departure}))$.
3. Estimate the share of costs that are subject to the fee schedule
 - a. The estimated share is based on a combination of fields, such as bill type and procedure code, as reported on the FL DWC detailed medical data, to categorize payments that are subject to the fee schedule.

The detailed medical transactions are obtained from the Florida Division of Workers Compensation (FL DWC) medical data management system reported on form DWC-90 for services performed between January 1, 2011 and December 31, 2011. This data is collected by



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the FL DWC from workers compensation insurance carriers and self-insured employers. The analysis of hospital outpatient services includes data reported with bill types 13x, 14x and 85x. There were approximately 160,000 bills included in the hospital outpatient analysis.

Hospital Outpatient Fee Schedule

In Florida, payments for hospital outpatient services represent 18.2%² of total medical payments. To calculate the percentage change in maximum reimbursements for hospital outpatient services, we calculate the percentage change in MRA for each procedure. The overall change in maximum reimbursements for hospital outpatient is a weighted average of the percentage change in MRA (proposed MRA/ current MRA) by procedure code weighted by the observed payments by procedure code. The current and proposed MRAs are calculated as follows:

Category 1 Procedures:

The facility MRAs under the current and proposed FWCRM were calculated using the following formulas:

MRA, Non-Surgical Services =

$$[(\text{Work RVU} \times \text{Work GPCI}) + (\text{Transitioned PE RVU} \times \text{PE GPCI}) + (\text{MP RVU} \times \text{MP GPCI})] \times$$
 Medicare Conversion Factor (CF) x 110%

Where: RVU = Medicare's Relative Value Unit for Physicians
 GPCI = Medicare's Geographic Practice Cost Index
 PE = Practice Expense
 MP = Medical Malpractice Insurance
 2009 Medicare CF = \$36.0666
 2012 Medicare CF = \$34.0376

GPCIs measure the resource cost differences by geographic area in the three components of the fee schedule—physician work, practice expenses (PE) (such as employee wages, rents, and medical equipment and supplies) and malpractice insurance (MP). Medicare specifies three GPCI localities for Florida. Locality 03 represents the greater Ft. Lauderdale (including West Palm Beach) area, locality 04 represents the greater Miami area, and locality 99 represents the rest of Florida. (Note the FWCRM uses the label "01/02" instead of "99" for the "rest of Florida" locality).

For purposes of estimating the impact, an average MRA is calculated for each medical procedure using the following geographic weights:

² Based on detailed medical data provided by FDWC for Service Year 2011.

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Locality 01/02: 60%
Locality 03: 25%
Locality 04: 15%

The weights are based on Florida population estimates by county through July 1, 2011 (Refer to <http://www.census.gov/popest/data/counties/totals/2011/index.html>). The facility and non-facility maximums for each procedure are the weighted average of the maximum reimbursement for each locality (after limiting the reimbursement to be no less than the 2003 MRA).

The overall weighted average percentage change in MRAs for hospital outpatient category 1 procedures is estimated to be +9.1%

Category 2 and 3 Procedures:

For each procedure code,

Current MRA = Current Charges x Trend Factor x Reimbursement %

Where Reimbursement % is 60% of UCC for Category 2 and 75% of UCC for Category 3

The charge for each medical transactional record was adjusted to reflect changes from past price levels to the price levels projected to be in effect on the estimated effective date of the hospital outpatient fee schedule (January 1, 2013). The trend factor is based on the U.S. hospital outpatient components of the medical consumer price index (MCPI) for the period 2012.

Service Year	Hospital Outpatient MCPI Change from July of previous year	Cumulative Trend Factor To 1/1/2013
2009	7.4%	
2010	6.1%	
2011	5.1%	1.094=(1.062 ^{1.50})

A trend factor of **1.094** is applied to hospital outpatient charges for Service Year 2011 to determine the projected charges at the January 1, 2013 price level (This estimated date is subject to change depending on the effective date of the proposal). The trend factor is based on the three-year average of the observed MCPI for 2009-2011 which is equal to 1.062 (= [1.074+1.061+1.051] /3). The trend period from the mid-point of 2011 to the estimated effective date of the revised hospital outpatient schedule 1/1/2013 (subject to change depending on the effective date of the proposal) is 1.50 years, resulting in a trend factor of 1.094 (=1.062^{1.50}).

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Proposed MRA (on or after 1/1/2013)

For each relevant procedure,

Proposed MRA = Proposed Statewide MRA x Normalized Geographical Adjustment Factor

Where the Statewide MRAs for Category 2 and Category 3 services and Normalized Geographical Adjustment Factors are provided by the FL DWC.

The overall weighted average percentage change in MRAs for hospital outpatient services for category 2 and category 3 procedures is estimated to be -9.2%

The table below summarizes the impacts by category:

Hospital Outpatient Categories	Distribution of Payments ²	Percent Change in MRAs
Category 1	5.0%	+9.1%
Category 2 and Category 3	66.0%	-9.2%
Payments with no Specific MRA	29.0%	0.0%
Overall Hospital Outpatient Payments	100.0%	-5.6%

The overall weighted percentage change in MRA for all hospital outpatient services is estimated to be -5.6% as shown above. Since the overall average maximum reimbursement for hospital outpatient services decreased, NCCI expects that 50% percent of the decrease in maximum reimbursements will be realized on hospital outpatient price levels. The impact on hospital outpatient payments, after the 50% offset, is -2.8%.

The above impact of -2.8% is then multiplied by the Florida percentage of medical costs that are attributed to hospital outpatient payments (18.2%²) to arrive at the impact of -0.5% on medical costs. The resulting impacts on medical costs is then multiplied by the percentage of Florida benefit costs attributed to medical costs (68.4%³) to arrive at the estimated impact on Florida overall workers compensation costs of -0.3% (-\$ 7M).

² Based on detailed medical data provided by FDWC for Service Year 2011.

³ Based on Policy Years 2009-2010 Financial Call data projected to 1/1/2013. This estimated date is subject to change depending on the date the changes become effective.

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The impacts due to the proposed changes in the outpatient fee schedule are summarized in the following table:

	Impact
(1) Impact on Hospital Outpatient Payments in Florida	-2.8%
(2) Hospital Outpatient Payments as a Percentage of Medical Costs in Florida ²	18.2%
(3) Impact on Medical Costs in Florida = (1) x (2)	-0.5%
(4) Medical Costs as a Percentage of Overall Workers Compensation System Costs in Florida ³	68.4%
(5) Total Impact on Overall Workers Compensation System Costs in Florida = (3) x (4)	-0.3%

² Based on detailed medical data provided by FDWC for Service Year 2011.

³ Based on Policy Years 2009-2010 Financial Call data projected to 1/1/2013. This estimated date is subject to change depending on the date the changes become effective.

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MAXIMUMS BASED ON MEDICARE PAYMENT RATES
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NCCI estimates that implementing a fee schedule based on 120% (Scenario 1) or 140% (Scenario 2) of Medicare's payment rates for Florida Hospital Outpatient and Ambulatory Surgical Centers (ASC) services will result in the following impact on overall workers compensation system costs in Florida:

	Scenario 1	Scenario 2
Overall Impact	-4.9% (-\$122M¹)	-4.5% (-\$112M¹)

Summary of Changes

Currently, reimbursement for workers compensation hospital outpatient services in Florida depends on the category of service as described below:

- Category 1: Any scheduled outpatient radiology or clinical laboratory services that are not performed in conjunction with a scheduled surgery shall be reimbursed by the schedule of maximum reimbursement allowance (MRA's) listed in Florida Workers' Compensation Health Care Provider Reimbursement Manual (FWCRM), 2007 Edition. In addition, outpatient physical, occupational, and speech therapy is reimbursable by the MRA listed in the FWCRM.
- Category 2: The maximum reimbursement level for scheduled outpatient surgeries is 60% of usual and customary charges (UCC). In addition, any scheduled radiology and clinical laboratory services performed in conjunction with, as defined as being performed on the day of or up to three days before a scheduled surgery, are also reimbursed at 60% of UCC.
- Category 3: All other outpatient procedures should be reimbursed at 75% of UCC.

For ASC services, the current reimbursement is based on either a MRA as outlined in Section XVI of FWCRM for ASC's (2006 Edition) or 70% of the charged amount when a MRA is not available.

¹Overall system costs are based on NAIC Annual Statement data as provided by A.M. Best including an estimate of self-insured premium. The estimated dollar impact of -\$122M and -\$112M is the percent impact displayed for each of the 2 scenarios multiplied by A.M. Best 2011 written premium of \$1,794M for Florida plus an estimate of the self-insured premium from the Florida Division of Workers Compensation for 2011 of \$692M. This figure does not include the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs.

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The proposal is to implement a medical fee schedule based on 120% (Scenario 1) or 140% (Scenario 2) of Medicare's payment rates for both hospital outpatient (Category 2 and Category 3) and ASC services. Reimbursement for hospital outpatient Category 1 procedures are proposed to be updated from the 2009 Medicare Resource Based Relative Value Scale (RBRVS) geographic-specific reimbursement levels to the 2012 Medicare RBRVS geographic-specific reimbursement levels.

Note that the actual language of the proposal was not provided to NCCI, and therefore the impact of this analysis may change depending on the implemented version of the proposal.

Actuarial Analysis

NCCI's methodology to evaluate the impact of medical fee schedule changes includes three major steps:

1. Calculate the percentage change in maximum reimbursement allowance (MRA)
 - a. Compare the prior and revised maximum reimbursements by procedure code and determine the percentage change by procedure code
 - b. Calculate the weighted average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights
2. Estimate the price level change as a result of the revised fee schedule
 - a. NCCI research by Frank Schmid and Nathan Lord (2012), "Impact of Changes to Physician Fee Schedules in Workers Compensation", suggests that a portion of a change in maximum reimbursements is realized on payments impacted by the change.
 - b. In response to a fee schedule decrease, NCCI research indicates that payments decline by approximately 50% of the fee schedule change.
 - i. The assumption for the percent realized for fee schedule decreases is 50%.
 - c. In response to a fee schedule increase, NCCI research indicates that payments increase by approximately 80% of the fee schedule change and the magnitude of the response depends on the relative difference between actual payments and fee schedule maximums (i.e. the price departure).
 - i. The formula used to determine the percent realized for fee schedule increases is $80\% \times (1.10 + 1.20 \times (\text{price departure}))$.
3. Estimate the share of costs that are subject to the fee schedule
 - a. The estimated share is based on a combination of fields, such as bill type and procedure code as reported on the detailed medical transactions to categorize payments that are subject to the fee schedule.

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The detailed medical transactions are obtained from the Florida Division of Workers Compensation (FL DWC) medical data management system reported on form DWC-90 for services performed between January 1, 2011 and December 31, 2011. This data is collected by the FL DWC from workers compensation insurance carriers and self-insured employers. The analysis of hospital outpatient services includes data reported with bill types 13x, 14x and 85x. There were approximately 160,000 bills included in the hospital outpatient analysis. The analysis of ASC services includes data reported with bill types 83x. There were approximately 27,000 bills included in the ASC analysis.

Hospital Outpatient

In Florida, payments for Hospital Outpatient services represent 18.2%² of total medical payments. To calculate the percentage change in maximum reimbursements for hospital outpatient services, we calculate the percentage change in MRA for each procedure. The overall change in maximum reimbursements for hospital outpatient is a weighted average of the percentage change in MRA (proposed MRA/ current MRA) by procedure code weighted by the observed payments by procedure code. The current and proposed MRAs are calculated as follows:

Category 1 Procedures:

The facility MRAs under the current and proposed FWCRM were calculated using the following formulas:

$$\text{MRA, Non-Surgical Services} = \frac{[(\text{Work RVU} \times \text{Work GPCI}) + (\text{Transitioned PE RVU} \times \text{PE GPCI}) + (\text{MP RVU} \times \text{MP GPCI})] \times \text{Medicare Conversion Factor (CF)} \times 110\%}{\text{Current MRA}}$$

Where: RVU = Medicare's Relative Value Unit for Physicians
GPCI = Medicare's Geographic Practice Cost Index
PE = Practice Expense
MP = Medical Malpractice Insurance
2009 Medicare CF = \$36.0666
2012 Medicare CF = \$34.0376

GPCIs measure the resource cost differences by geographic area in the three components of the fee schedule—physician work, practice expenses (PE) (such as employee wages, rents, and medical equipment and supplies) and malpractice insurance (MP). Medicare specifies three GPCI localities for Florida. Locality 03 represents the greater Ft. Lauderdale (including West Palm Beach) area, locality 04 represents the greater Miami area, and locality 99

² Based on detailed medical data provided by FDWC for Service Year 2011.

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represents the rest of Florida. (Note the FWCRM uses the label “01/02” instead of “99” for the “rest of Florida” locality).

For purposes of estimating the impact, an average MRA is calculated for each medical procedure using the following geographic weights:

Locality 01/02:	60%
Locality 03:	25%
Locality 04:	15%

The weights are based on Florida population estimates by county through July 1, 2011 (Refer to <http://www.census.gov/popest/data/counties/totals/2011/index.html>). The facility and non-facility maximums for each procedure are the weighted average of the maximum reimbursement for each locality (after limiting the reimbursement to be no less than the 2003 MRA).

The overall weighted average percentage change in MRAs for hospital outpatient category 1 procedures is estimated to be +9.1%

Category 2 and 3 Procedures:

For each procedure,

Current MRA = Current Charges x Trend Factor x Reimbursement %

Where Reimbursement % is 60% of UCC for Category 2 and 75% of UCC for Category 3

The charge for each medical transactional record was adjusted to reflect changes from past price levels to the price levels projected to be in effect on the estimated effective date of the hospital outpatient fee schedule (January 1, 2013). The trend factor is based on the U.S hospital outpatient components of the medical consumer price index (MCPI) for the period 2012.

Service Year	Hospital Outpatient MCPI Change from July of previous year	Cumulative Trend Factor To 1/1/2013
2009	7.4%	
2010	6.1%	
2011	5.1%	1.094=(1.062 ^{1.50})

A trend factor of **1.094** is applied to hospital outpatient charges for Service Year 2011 to determine the projected charges at the January 1, 2013 price level (This estimated date is subject to change depending on the effective date of the proposal). The trend factor is based on the three-year average of the observed MCPI for 2009-2011 which is equal to 1.062 (= [1.074+1.061+1.051] /3). The trend period from the mid-point of 2011 to the estimated effective

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date of the revised hospital outpatient schedule 1/1/2013 (subject to change depending on the effective date of the proposal) is 1.50 years, resulting in a trend factor of 1.094 ($=1.062^{1.50}$).

Proposed MRA (on or after 1/1/2013)

For each relevant procedure,

Proposed MRA = Medicare Payment Rate * Proposed Multiplier + Outlier Amount (if applicable)
– Multiple Procedure Discounts (if applicable)

Where Proposed Multiplier = 120% (Scenario 1) and 140% (Scenario2)

The Medicare Payment Rate is based on October 2012 version of Medicare Hospital Outpatient Prospective Payment System (OPPS) publication.

The Medicare Payment Rate used in this analysis is the national Medicare payment rate adjusted by the average of all Florida hospital wage indices.

The outlier amount is based on Medicare Hospital Outpatient Prospective Payment System (OPPS) reimbursement rule. Under the Medicare rule, the outlier threshold is met when a hospital's cost of furnishing a procedure exceeds 1.75 times the Medicare Ambulatory Payment Classification (APC) rate and exceeds the APC payment rate plus a \$1,900 fixed-dollar threshold.

When this threshold is met, an outlier reimbursement is calculated as 50 percent of the amount by which the cost of furnishing the procedure exceeds 1.75 times the ASC payment rate. For this analysis, NCCI assumes that Florida would adopt the same outlier rule. The table below displays a **hypothetical example** of the calculation of the expected reimbursement on or after January 1, 2013 for an APC of 0128 (Echocardiogram with Contrast).

(1)	(2)	(3)	(4)	(5)	(6)
		= (2) x Cost-to-Charge Ratio	(i) 175% x (1) (ii) (1) + \$1,900	=0.5 x [(3) – 1.75 x (1)]	= (1) + (5)
120% of 2012 Medicare APC Payment Rate	Total Trended Charge Submitted at the bill level	Total Costs for OPPS procedure	Proposed Outlier Threshold	Proposed Outlier Payment	Total Proposed MRA
\$669	\$ 25,000	\$4,325	Threshold (i): \$1,171 Threshold (ii): \$2,569	\$1,577	\$2,246

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The Cost to Charge ratio (CCR) is obtained from Medicare and is calculated as the average of the Florida Statewide Urban and Rural CCRs ($0.173 = 0.5 \times (0.182 + 0.164)$).

The calculation for the proposed MRA also considers multiple procedure discounts. Under the Medicare OPSS reimbursement rule, multiple procedure discounts are allowed for multiple surgical procedures performed during the same operative session. Primary procedures (the procedure with the highest payment rate) would be reimbursed at 100% of the fee schedule amount, and secondary surgical procedures would be reimbursed at 50% of the fee schedule amount.

The overall weighted average percentage change in MRAs for hospital outpatient services for category 2 and category 3 procedures is estimated to be -62.8% (Scenario 1) and -57.8% (Scenario 2).

The table below summarizes the impacts by category:

Hospital Outpatient Categories	Distribution of Payments²	Scenario 1 Percent Change in MRAs	Scenario 2 Percent Change in MRAs
Category 1	5.0%	+9.1%	+9.1%
Category 2 and Category 3	83.7%	-62.8%	-57.8%
Payments with no Specific MRA	11.3%	0.0%	0.0%
Overall Hospital Outpatient	100.0%	-52.1%	-47.9%

As shown in the table above, the overall weighted percentage change in MRA for all hospital outpatient services is -52.1% (Scenario 1) and -47.9% (Scenario 2). Since the overall average maximum reimbursement for hospital outpatient services decreased, NCCI expects that 50% percent of the decrease in maximum reimbursements will be realized on hospital outpatient price levels. The impact on hospital outpatient payments, after the 50% offset, is -26.1% (Scenario 1) and -24.0% (Scenario 2).

The above impacts are then multiplied by the Florida percentage of medical costs that are attributed to hospital outpatient payments (18.2%²) to arrive at the impact on medical costs of -4.8% for Scenario 1 and -4.4% for Scenario 2. The resulting impacts on medical costs are then multiplied by the percentage of Florida benefit costs attributed to medical costs (68.4%³) to arrive at the estimated impact on Florida overall workers compensation costs of -3.3% (-\$82M) for Scenario 1 and -3.0% (-\$75M) for Scenario 2.

² Based on detailed medical data provided by FDWC for Service Year 2011.

³ Based on Policy Years 2009-2010 Financial Call data projected to 1/1/2013. This estimated date is subject to change depending on the date the changes become effective.

**ANALYSIS OF PROPOSED CHANGES TO THE FLORIDA
HOSPITAL OUTPATIENT AND ASC FEE SCHEDULE
MAXIMUMS BASED ON MEDICARE PAYMENT RATES
EFFECTIVE UPON ADOPTION**

Ambulatory Surgical Center (ASC) Analysis

In Florida, payments for ASC services represent 7.9%² of total medical payments. To calculate the percentage change in maximum reimbursements for ASC services, we calculate the percentage change in MRA for each procedure. The overall change in maximum reimbursements for ASC is a weighted average of the percentage change in MRA (proposed MRA/ current MRA) by procedure code weighted by the observed payments by procedure code. The current and proposed MRAs are calculated as follows:

Current MRA

For each relevant procedure,

Current MRA = Charges x Trend Factor x 70% OR Actual MRA if available

Proposed MRA

The proposed MRAs are calculated in an analogous manner to the hospital outpatient analysis, except that Medicare has no outlier provision under the ASC fee schedule.

The overall weighted average percentage change in MRAs for ASC services is -61.1% (Scenario 1) and -56.5% (Scenario 2).

Since the overall average maximum reimbursement for ASC services decreased, NCCI expects that 50% percent of the decrease in maximum reimbursements will be realized on ASC price levels. The impact on ASC payments, after the 50% offset, is -30.5% (Scenario 1) and -28.2% (Scenario 2).

The above impacts are then multiplied by the Florida percentage of medical costs that are attributed to ASC payments (7.9%²) to arrive at the impacts on medical costs of -2.4% for Scenario 1 and -2.2% for Scenario 2. The resulting impacts on medical costs is then multiplied by the percentage of Florida benefit costs attributed to medical costs (68.4%³) to arrive at the impacts on Florida's overall workers compensation system costs of -1.6% (-\$40M) under Scenario 1 and -1.5% (-\$37M) under Scenario 2.

² Based on detailed medical data provided by FDWC for Service Year 2011.

³ Based on Policy Years 2009-2010 Financial Call data projected to 1/1/2013. This estimated date is subject to change depending on the effective date of the proposal.

**ANALYSIS OF PROPOSED CHANGES TO THE FLORIDA
HOSPITAL OUTPATIENT AND ASC FEE SCHEDULE
MAXIMUMS BASED ON MEDICARE PAYMENT RATES
EFFECTIVE UPON ADOPTION**

The impacts are summarized in the table below:

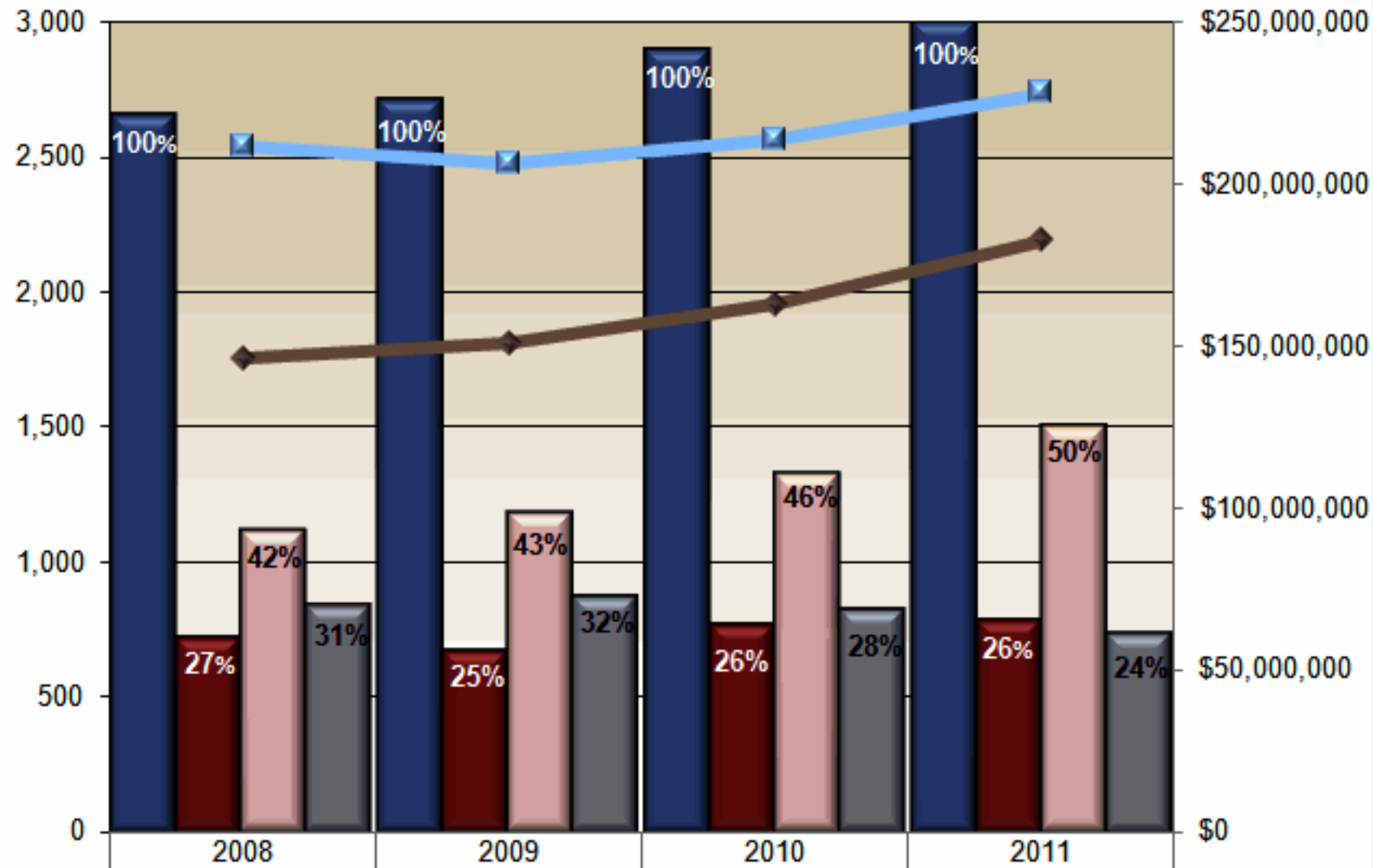
		Scenario 1	Scenario 2
(1)	Impact on Hospital Outpatient Payments in Florida	-26.1%	-24.0%
(2)	Hospital Outpatient Payments as a Percentage of Medical Costs in Florida ²	18.2%	18.2%
(3)	Impact of Hospital Outpatient Change on Medical Costs in Florida = (1) x (2)	-4.8%	-4.4%
(4)	Impact on ASC Payments in Florida	-30.5%	-28.2%
(5)	ASC Payments as a Percentage of Medical Costs in Florida ²	7.9%	7.9%
(6)	Impact of ASC Change on Medical Costs in Florida = (4) x (5)	-2.4%	-2.2%
(7)	Total Impact on Medical Costs in Florida = (3) + (6)	-7.2%	-6.6%
(8)	Medical Costs as a Percentage of Overall Workers Compensation System Costs in Florida ³	68.4%	68.4%
(9)	Total Impact on Overall Workers Compensation System Costs in Florida = (7) x (8)	-4.9%	-4.5%

² Based on detailed medical data provided by FDWC for Service Year 2011.

³ Based on Policy Years 2009-2010 Financial Call data projected to 1/1/2013. This estimated date is subject to change depending on the effective date of the proposal.

Inpatient Hospital Bills that Exceed \$51,400 Stop-Loss

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Total # of Inpatient Hospital Bills Received > Stop-Loss	2,654	2,710	2,899	3,004
# of Bills Without Implants > Stop-Loss	711	666	762	776
# of Bills With Implants > Stop-Loss After Excluding Implant Charges	1,113	1,177	1,323	1,501
# of Bills < Stop-Loss After Excluding Implant Charges	830	867	814	727
Amount Paid for All Inpatient Hospital Bills	\$211,855,514	\$206,266,586	\$213,791,230	\$228,064,193
Amt Paid All Bills > Stop-Loss With & Without Implants	\$146,116,016	\$150,923,003	\$162,908,431	\$182,697,921

Note: Only bills with payment amount >\$0 are included.

APPENDIX E



Florida Department of Financial Services,
Division of Workers' Compensation,
Bureau of Monitoring & Audit

Project Title

**Mapping Inpatient Bills to Diagnosis Related Groups and
Providing a Written Report**

Date

Dec. 4, 2012

Contact

Eric Anderson
Senior Consultant
OptumInsight
9200 Worthington Rd. Suite 300
Westerville, OH 43082
T 937-342-8561
eric.anderson@optum.com

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Executive Summary

OptumInsight is pleased to present this report to the Division of Workers' Compensation, Bureau of Monitoring and Audit.

The project encompassed several requirements:

- Map Florida's inpatient workers' compensation inpatient medical bills with dates of service in calendar years 2011 and 2010 and their respective procedure and diagnosis codes to Medicare's Diagnosis Related Groups.
- Provide a written report (this report with attachments) that includes:
 - An overview of Medicare's inpatient payment system.
 - A list of states that utilize Medicare's inpatient payment system for workers' compensation inpatient services, which includes a summary of the various components that comprise each state's respective payment rates. A description of the supplemental data sources used for the mapping process.
 - An explanation of the methodology used to complete the mapping process.
 - A description of obstacles in the mapping process and the respective implemented or proposed solutions.

Deliverables

- This document comprises two sections. In the first section, we will discuss the mapping and grouping process for inpatient claims. In the second section, we provide an overview of Medicare's Inpatient Prospective Payment System.
- A Microsoft Excel workbook which contains the claim level results of the grouping project.
- A second, supporting, Microsoft Excel workbook which contains various analytics components of the grouping project. These are discussed in the first section of this report.
- A third Microsoft Excel workbook which contains the state workers' compensation survey information.

Key Definitions

Some common terms used throughout this report and in the accompanying spreadsheets:

Acute Care Hospital: A general, short-stay hospital. Medicare pays acute care hospitals under the Inpatient Prospective Payment System (IPPS).

Bed Size: Bed counts are based on staffed beds, not licensed beds.

Base rate or conversion factor: Somewhat analogous to the conversion factor in a physician setting. The base rate times the relative weight provides a base payment amount.

Charge: What a hospital charges for a service.

CMI: Case Mix Index. A measure of how complex a hospital's patients are. The Case Mix Index is calculated by summing the relative weights of each claim and then dividing by the number of claims. The national median Medicare CMI is around 1.45. Workers' Compensation Case Mix Indexes are often somewhat higher than Medicare's rate around 1.6-1.7. A hospital with complex cases will have a CMI around 1.8 or more. CMI is tied to a particular version of the DRG weighting system.

Cost: The cost for a hospital to perform a service.

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Critical Access Hospital (CAH): Small, rural hospitals which meet certain Medicare requirements. Medicare pays Critical Access Hospitals 102% of their cost of providing a service. Because of the more favorable rules for CAHs, approximately 1,400 hospitals have converted to Critical Access status during the last three or four years.

DRG (or MS-DRG): Diagnosis Related Group. A system developed at Yale University in the early 1980s which groups related hospital admissions based on diagnosis codes, surgical procedures and patient demographics. Patients within the same MS-DRG should generally have similar resource utilization. Medicare adopted the MS-DRG system as a mechanism for paying inpatient claims. There are several DRG systems in common use; Medicare's is one. Optum sells its own APS-DRG system. 3M Corp. also develops and markets APR-DRGs, and several entities have their systems. Because the systems vary, it is important to understand which DRG system is referenced as well as which version.

DSH, DSHPCT or Disproportionate Share: This measures the number of low income patients served by a hospital. Medicare makes an extra payment for hospitals with a high DSH to help cover the likelihood of unpaid copayments and deductibles.

ICD-9(-CM): International Classification of Diseases, Version 9 with Clinical Modification. ICD-9 codes describe a patient's diagnosis and treatment. There are two types of ICD-9 codes: Diagnosis can be thought of as the patient's symptoms while Procedure codes are treatment (often surgical) provided. Historically, Medicare has allowed up to the first nine diagnosis codes and the first six procedure codes. The ICD-9 codes are used to make a DRG assignment.

Hospital Acquired Condition (HAC): A condition or diagnosis acquired after a patient was admitted to the hospital. An example might be a secondary infection a patient acquired following surgery. Under Medicare's IPPS rules, Medicare will not allow certain hospital acquired condition to increase the severity level of the MS-DRG assignment which would normally result in a higher payment. The hospital acquired condition requirement is relatively new and Medicare continues to make changes to the condition list and the requirements. See also the POA (Present on Admission) discussion.

IPPS or Inpatient Prospective Payment System: Medicare's methodology of paying most acute care hospitals for inpatient admissions. The IPPS rules follow the federal fiscal year, i.e. October 1 through September 30.

Medicare Cost Report: A report, required to be filed at least annually, with Medicare disclosing a hospital's cost for providing services. Large, and often complex, Medicare Cost Reports are public record although finding data on a particular hospital requires specialized skills in data management. The Medicare Cost Report is filed as a part of the Health Cost Report Information System and the terms HCRIS and MCR are often used interchangeably to mean the same thing.

Medicare Percent or MCR_PCT: How many of a hospital's patients are Medicare-covered patients. This number shows how dependent a hospital is on the Medicare payment system.

Medicare Provider Number: A six-character number used to identify a Medicare participating hospital. The first two characters identify the state (Florida is 10) while the third/fourth digit identifies the type of hospital. A "0" is an acute care hospital, a "13" identifies a critical access hospital.

OP RCC (Operating Ratio of Cost to Charge): The amount it costs a hospital to perform a service divided by the amount a hospital charges for the service. A corresponding ratio is the hospital's markup ratio. Multiplying a hospital's charge by the RCC provides an estimate of the hospital's cost of the service.

POA (Present on Admission) Indicator: This indicator is a part of the UB-04 form submission. It is a flag indicating whether a particular diagnosis code was present on admission or whether the condition after the patient was admitted. The POA indicators are used to determine whether the particular diagnosis code was a hospital acquired condition and thus exempt from increasing the severity level of the MS-DRG grouping. POA indicators are fairly recent (2010) and not all payers/claims processors require them.

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Relative weight: A method of weighting DRGs by the financial impact of caring for a patient. Historically, Medicare used charges amounts to establish the weighting scale. However, beginning with 2008, Medicare plans to move to a cost-based system. Relative weights are recalibrated at least annually.

Severity: A measure of how ill or complicated a patient's case is. Often, in workers' comp discussions, this is used as a substitute for the charge amount. However, medical severity and financial severity have an imperfect link. Patient A maybe more severely ill, medically, than Patient B, but is not necessarily more expensive to care for. Severity in this context refers to an assignment of a higher-weighted MS-DRG.

Wage Index: A Medicare calculated number indicating employee wage costs. The national wage index is set at 1.0. A 0.90 wage index would be 90 percent of the national rate. The Medicare wage index is calculated from Medicare Cost Reports.

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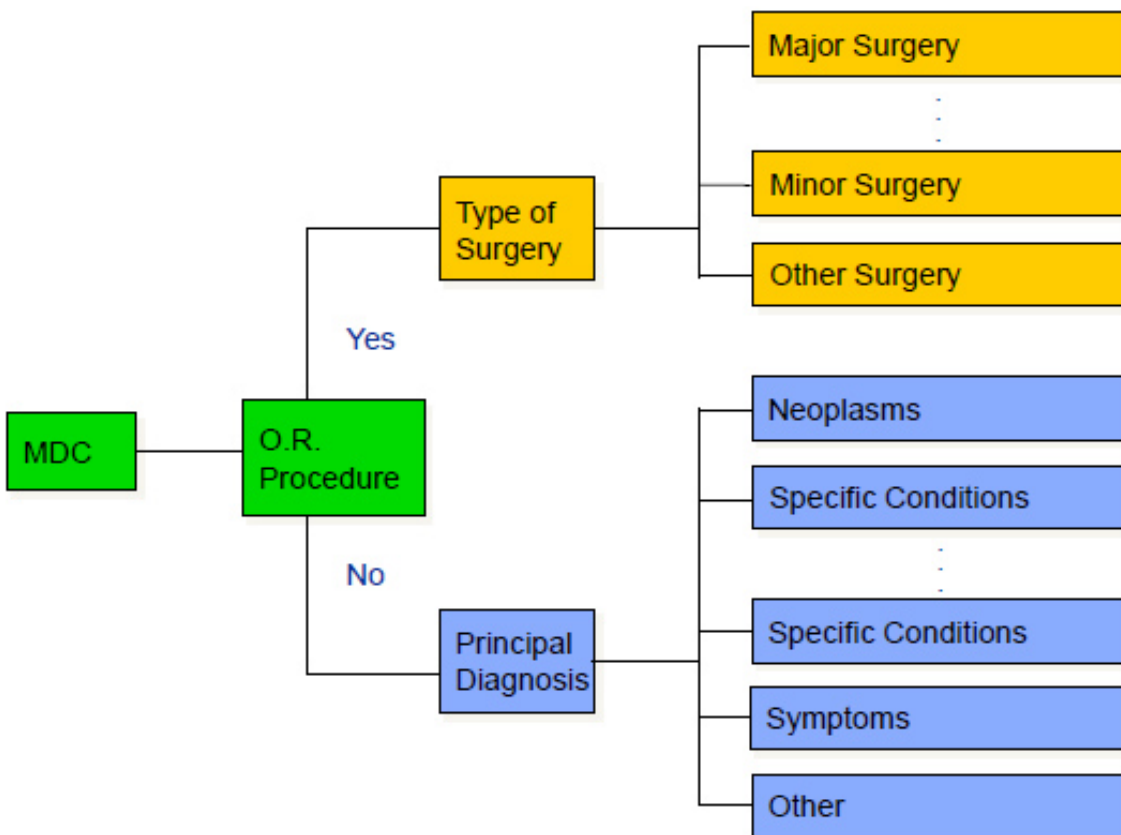
Mapping and Grouping Project

The Division supplied us with 19,272 claims for the grouping project. We develop, sell and support Optum EASYGroup software, a software program designed to group and price claims under Medicare (and other) PPS systems.

Determining Medicare's payment for any claim consists of two components.

First, the claim is "grouped" or assigned to an MS-DRG. Then, after the assignment, various payment factors determine Medicare's payment for the claim.

Basic DRG Model



The basic grouping model is straightforward enough. The grouper software first looks to see if a claim involves a transplant. If it does, the claim is assigned appropriately based on that.

Next, the grouper looks at the primary diagnosis code. This diagnosis code results in an assignment to a Major Diagnostic Category (MDC). MDCs are very broad categories covering multiple MS-DRGs and are usually aligned by body system such as circulatory or orthopedic.

In the next step, the grouper looks at whether there is a surgical code present. If so, the grouper looks for additional surgical codes to determine the complexity of the surgery. The software also looks for complicating diagnosis codes to make an MS-DRG assignment.

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If no appropriate surgical code is present, the grouper looks at the additional diagnosis codes to determine severity level. In general, Medicare has three levels for MS-DRGs: those with no complications, with complications and with major complications.

Once the MS-DRG assignment is made, the reimbursement component of the software looks at hospital-specific factors and uses them to determine the hospital's payment. (Payment methodology is covered in the second section of this report.)

A grouping and pricing for an analytics project such as this one requires a slightly different configuration than for real-time claim payments. From an analytics perspective it is often important to understand how the data may vary over the study period. A single point of reference facilitates comparisons to other systems by removing some of the data variability. Accordingly, we used the following rules:

- Claims dated (discharge) 10/1/2008 and after were all grouped to MS-DRG Version 28 with 10/1/2010 rates. (This is the fiscal year 2011 rates as rates follow the federal fiscal year.) Through the course of a year, hospitals may have several different payment rates. While these often do not differ by much, there are some variances. The decision to use 2010 rates will be discussed later in this section. Using 2010 grouping and pricing rules may somewhat understate the 2011 Medicare payments by 1 to 2 percent.
- Claims were assumed to have present on admission indicators present, i.e., all diagnosis codes were present on admission. In a small number of cases, present on admission can affect some MS-DRG assignments. However, because the POA (present on admission) data was incomplete, it was assumed that all indicators were present. This decision may slightly favor a higher weighted MS-DRG assignment (and payment).
- Where facilities could not be clearly identified, claims were excluded.
- Assume discharge date +3 days from admit. Discharge date was not in the original data. This would understate transfer cases and potentially overstate payments. On an overall basis, it's unlikely to be significant.
- Assume all discharges are to home. Discharge location was not present. Unless the length of stay was one day, this would not affect the MS-DRG assignment or payment.

Table 1 shows the breakout of claims processing.

Table 1	# of Claims
Total Claims	19,272
Non-Acute Care Hospital Claims	2,101
Claims Before 2010	47
Acute Care Claims Before 2010	1
Claims Eligible for Grouping	17,170

Table 2 Non Acute Care Claims Breakout	# of Claims
Critical Access Hospital Claims	33
Inpatient Rehabilitation Facility	835
Inpatient Psychiatric Facility	48
Other*	1,185
Total Non-Acute Records	2,101

As Table 2 illustrates, the 2,101 claims that were not grouped and priced fell out for several reasons:

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- Critical Access Hospitals are not paid under Medicare’s IPPS but rather on a cost-plus basis, There were 33 claims in this category.
- Inpatient Rehabilitation and Psychiatric Facilities are paid under a different payment method. However, rehabilitation and psychiatric subunits within an acute care setting are generally paid under IPPS rules.
- About half of the non-grouped/priced claims could not be identified based on the NPI (National Provider Identifier) on the claim. Because NPIs can be assigned by subunits within facilities or other types of facilities, we theorize that few, if any, of these non-identified claims are actually acute care facility claims.

During the data discovery/discussion process, Division staff explained that current Division data requirements only required submission of the primary diagnosis code. Secondary diagnosis codes and procedure codes are not currently required.

Secondary diagnosis codes along with primary and secondary procedure codes are important to the MS-DRG assignment process. While the primary diagnosis code can be sufficient for an initial assignment, the other codes are used to refine the MS-DRG assignment.

Absence of codes could lead to a lower-weighted MS-DRG assignment.

We suggested to the Division that in order to measure this possible assignment issue we should also group additionally available data.

Optum purchases inpatient claim data from the Florida Agency for Health Care Administration (AHCA). This data consists of every hospital admission and includes the payer type as a part of the data. From this data, Optum was able to extract 17,151 workers’ compensation claims for 2009 and 2010. (Optum had not yet processed the 2011 AHCA data the time of this project.) The AHCA data was known to be complete in that both secondary diagnosis codes along with primary and secondary procedure codes are required to be reported.

It was decided that the AHCA workers’ compensation claims should also be processed in parallel with the Division’s data to determine whether MS-DRG assignments were being affected by potentially missing codes.

The 2010 grouping and payment rules were used because 2010 data was the common dataset between Division data and AHCA data.

Table 3: CMI All Years	Data	Total Claims	Case Mix Index
ALL	Division WC Data	17,151*	1.56
ALL	AHCA Data	16,792	1.79
MED	Division WC Data	9,109	0.90
MED	AHCA AP Data	6,386	0.94
SURG	Division Data	8,042	2.30
SURG	AHCA AP Data	10,406	2.31

* This is lower than in Table 1 as not every claim could be grouped, i.e. 19 claims had an invalid diagnosis code which prevented grouping assignment.

Case Mix Index is an important tool for data comparison. Each MS-DRG has a relative weight. The case mix index is the sum of the relative weights of the claims divided by the total number of claims. What Table 3 shows is that the case mix index for medical and surgical claims comes very close to matching between the Division’s data and the AHCA data. The AHCA is a bit higher in both cases, but not significantly so.

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The overall case mix index, though, is considerably different between the two datasets. This difference is because of volume differences. Surgical cases represent 62% of the total claims for AHCA while surgical claims are only 47% of the division's data.

We looked, first, at seeing whether the year offset accounted for the difference. The AHCA data is for 2009 and 2010 while the division data encompassed 2010 and 2011.

Table 4 shows the case mix index broken out by year. The Division's data hovers around 1.56 while the AHCA data comes in around 1.80. The overall CMI differences between the data persist.

Table 4: CMI by Calendar Year	Year	CMI
Division WC Data	2010	1.565
	2011	1.566
	2012	1.512
AHCA Data	2009	1.767
	2010	1.811

Next, we investigated procedure/surgical code assignment frequency.

Table 5: Frequency of primary procedure code	Count	Not Present	Present
Division WC Data	7,209	41.96%	58.04%
AHCA WC Data	4,140	24.64%	75.36%
Optum National WC Data	23,342/123,282	18.94%	81.06%

Table 5 only examines 2010 data as it was present for both groups. A primary procedure code was present in 58% of the Division's data while it was present 75% of the time in the AHCA data. As a reliability check, we looked at how frequently a primary procedure code was present in any of Optum's All Payer database. Of the 123,282 workers' compensation claims in this data, a primary procedure code was present 81% of the time. This is an even higher rate than the AHCA data.

Table 5 tends to support the hypothesis that Division data is sometimes lacking primary/secondary procedure codes which generally would result in a claim being assigned to a typically higher-weighted MS-DRG.

As a point of reference, the 0.23 CMI difference between Division data and AHCA data translates into roughly a \$25 million difference in total payments.

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Inpatient Prospective Payment System Overview

At its simplest, Medicare's inpatient prospective payment system is a single calculation:

$$\text{MS-DRG relative weight} \times \text{base rate (conversion factor)} = \text{payment amount}$$

But no system affecting thousands of hospitals and millions of claims can ever be that simple. The annual rules update runs a thousand or more double-spaced pages. As new treatments come along, as political waves in Washington ebb and flow, the IPPS methodology continues to change and evolve in response.

Before diving into IPPS mechanics, it's helpful to understand context, where Medicare sees itself going and some the issues it is attempting to solve. While there are many, three from a workers' compensation perspective clearly stand out:

- **Value based purchasing.** Value based purchasing is Medicare's effort to move away from a pure fee for service system and to begin to reward providers for providing quality, efficient care.
- **ICD-10 conversion.** Currently, inpatient claims are coded using ICD-9 diagnosis and procedure codes. Medicare plans to implement a new system, ICD-10, beginning Oct. 1, 2014. This conversion is a massive undertaking and it could have a dramatic impact on inpatient claims payment. The new coding requirements are more involved, and depending on the final code assignments, claims are likely to undergo some shifting between MS-DRGs. This affects payments.
- **Charge compression.** While this isn't on most lists, the charge compression issue has a considerable impact especially on workers' compensation systems using Medicare's methodology. In a nutshell, charge compression refers to Medicare's calculation of costs. For expensive implantable devices, Medicare's current methodology underestimates costs and thus underpays device-intensive MS-DRGs. Since many workers' compensation claims involve implantable devices, this issue impacts state systems. Medicare has said it hopes to address the issue with the 2014 rule.

Before beginning, the other important thing to know about IPPS is that it spans the federal fiscal year, not the calendar year. That means the new rules and payments go into effect on October 1 each year and run through September 30.

A CAUTIONARY NOTE

Although the basics of Medicare's IPPS payment methodology are relatively straightforward, there are numerous exceptions, formulas and variances. A challenge is simplifying the process so a casual observer can follow the process but at the same time not leaving out something meaningful.

Each of the topics that follow is more complicated than the simplified explanation that follows. We've tried to balance clarity and simplification with completeness. Additionally, Medicare sometime makes payment policy adjustments throughout the year.

IPPS PAYMENT OVERVIEW

Most of what follows is adopted from Medicare's Medicare Learning Network IPPS Payment Sheet. Medicare also issues a preliminary IPPS rule each April and then releases its final rule in July or August. Although long, both the preliminary and final rules contain valuable information. Medicare's website has a landing page specifically for IPPS updates and changes. It is here:

<http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/index.html>

Generally, hospitals receive Medicare IPPS payment on a per discharge or per case basis for Medicare beneficiaries with inpatient stays. Related therapeutic outpatient department services provided within three days prior to admission are included in the payment for the inpatient stay and may not be separately billed.

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Discharges are assigned to diagnosis-related groups (DRG), a classification system that groups similar clinical conditions (diagnoses) and the procedures furnished by the hospital during the stay.

Medicare reviews MS-DRG definitions annually to “ensure that each group includes cases with clinically similar conditions that require comparable amounts of inpatient resources.” On October 1, 2007, a new DRG system called Medicare Severity (MS-DRG) was implemented. Medicare says MS-DRGs are designed better account for severity of illness and resource consumption. There are three levels of severity in the MS-DRGs based on secondary diagnosis codes:

1. MCC – Major Complication/Comorbidity, which reflect the highest level of severity;
2. CC – Complication/Comorbidity, which is the next level of severity; and
3. Non-CC – Non-Complication/Comorbidity, which do not significantly affect severity of illness and resource use.

The IPPS per-discharge payment is based on two national base payment rates or “standardized amounts:” one that provides for operating expenses and another for capital expenses. These payment rates are adjusted to account for:

- The costs associated with the beneficiary’s clinical condition and related treatment relative to the costs of the average Medicare case (i.e., the DRG relative weight); and
- Market conditions in the facility’s location relative to national conditions (i.e., the wage index).

In addition to these adjusted per discharge base payment rates, hospitals can qualify for

- outlier payments for cases that are extremely costly
- additional payments per discharge for the indirect costs of graduate medical education (IME) if they train residents in approved graduate medical education (GME) programs
- additional payments for treating a disproportionate share of low-income patients
- and additional payments for the use of certain new technologies.

The steps for determining an IPPS payment are as follows:

1. The hospital submits a bill to the Medicare Administrative Contractor for each Medicare patient they treat. Based on the information on the bill, the case is categorized into a DRG.
2. The base payment rate, or standardized amount (a dollar figure), includes a labor-related and non-labor related share. The labor-related share is adjusted by a wage index to reflect area differences in the cost of labor.
3. The wage-adjusted standardized amount is multiplied by a relative weight for the DRG. The relative weight is specific to each of 747 DRGs (for FY 2011) and represents the relative average costs associated with one DRG.
4. If applicable, additional amounts will be added to the IPPS payment for hospitals engaged in teaching medical residents to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals, hospitals that treat a disproportionate share of low-income patients, cases that involve certain approved new technologies, and for high cost outlier cases.

IPPS PAYMENT SAMPLE CALCULATION

The preceding discussion provided an overview, but seeing a real-life example of a payment calculation helps solidify understanding. Medicare provides a PC Pricer tool that calculates a payment for any MS-DRG for any provider.

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```

INDRV112.exe - COBOL Text Window
      INPAT PRICER 2011.2 PSF 04/11 (DISCHRG 10/2010-9/2011)
PROVIDER> 100135 TALLAHASSEE MEMORIAL HEALTHCARE   PROU TYPE> 00 CEN-DIV> 3
EFF DATE> 20100901

      * OPERATING AMOUNTS *
PATIENT ID> 111-11-11111
DRG> 331
ADMIT DATE> 10/15/2010
DISCH DATE> 10/21/2010
FY BEG DATE> 10/01/2009
LEN OF STAY> 006
OUTLIER DAYS> 000
TRANSFER ADJ> 0.00000 NO
CHARGES AMT> $ .00
PASS THRU AMT + $128.94
NEW TECH AMT + $ .00
TOT OPER AMT + $9,466.23
TOT CAPI AMT + $697.96
*** TOTAL AMT = $10,293.13

      * CAPITAL AMOUNTS *
C-FSP> $633.23
C-HSP> $ .00
C-OUTLR> $ .00
C-DSH> $44.58
C-IME> $20.15
C-EXCEPT> $ .00
C-OLD-HH> $ .00
MA-HSP> $ .00

DRG WGT> 01.6267
GM ALOS> 04.8
AM ALOS> 05.3
WAGED SIZE> OTHER-URB
WAGED INDX> 00.8950
PR WAGED INDX> 00.0000
GEO/STD CBSA> 45220/45220
RECL CBSA> 45220 NO
OPER/CAP CCR> 0.277/0.017
NAT LABOR> 3201.75
NAT NLABOR> 1962.36
NAT FSP AMT> $4,827.93
INT/BED RATIO> 0.0674
CMI CPD AMT> $1,725.03
PAY CODE> B

      ***> 14 CALC AS DRG PAY - PERDIEM DAYS = OR > GM LOS
DRG DSC> MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC/MCC
MDC DSC> DISEASES & DISORDERS OF THE DIGESTIVE SYSTEM

-----
U = VIEW THIS PROU  A = ADD PROU  B = CHANGE BILL  R = PRT REPORT  Q = QUIT  ENTER>
  
```

The screen above shows the result of such a calculation. Let's step through the key items.

What we're looking at is:

- Tallahassee Memorial (provider number 100135, at top of screen)
- MS-DRG 331, a major large and small bowel procedure without complications or major complications. The MS-DRG is the second element in the left-hand column.
- This admission occurred in October 2010 (underneath MS-DRG in left column), so it's using the FY 2011 calculations.

WAGE INDEX ADJUSTMENTS

The right-hand column contains information about the MS-DRG's relative weight (1.6267), the hospital's wage index (0.895).

CMS uses the Office of Management and Budget's Core Based Statistical Area definitions (with some modifications) to define each labor market area. The wage index is revised each year based on wage data reported by IPPS hospitals. Hospitals may request geographic reclassification if they believe that they compete for labor with a different area than the one in which they are located.

The wage index is applied to the labor-related portion or labor share of the operating base rate, which reflects an estimated portion of costs affected by local wage rates and fringe benefits. Additionally, the wage index is applied to the whole capital base rate. The current estimate of the national operating labor share is 68.8 percent, which is applied to hospitals with a wage index greater than or equal to 1.0. The national operating labor share is 62 percent for areas with a wage index less than 1.0.

For FY 2011, the national base rate was \$5,164.11. The hospital's adjusted rate, then, uses this formula:

$$(\$5,164.11 \times 62\% \times 0.895) + (\$5,164.11 \times 38\%) = \$4,827.93$$

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You'll see this amount near the bottom of the right-hand column. It's called NAT FSP AMT.

The FY2013 unadjusted operating base rate is \$5,348.76.

The FY2013 capital base rate is \$425.49

MS-DRG RELATIVE WEIGHTS

MS-DRG relative weights are based on the cost of providing the service. Hospitals are required to submit Medicare Cost Reports shortly after the end of their fiscal year. Large and complex, after working through a number of calculations and adjustments, a cost report allows Medicare to create a cost-to-charge ratio. With this cost to charge ratio, Medicare can then estimate the cost of any particular claim. In our example above, Medicare shows the overall operating cost to charge ratio for Tallahassee Memorial as 0.277. (It's about midway down in the right-hand column.)

So, if the hospital had billed \$30,000 for our sample claim, Medicare would have estimated it cost the hospital \$8,310 to provide the service.

$$(\$30,000 \times 0.277 = \$8,310)$$

After making various adjustments, Medicare averages the costs across the nation to determine the national average cost for each MS-DRG. It then indexes these costs to produce a relative weight for each MS-DRG.

For the current fiscal year, relative weights range from 0.1649 for a normal newborn (yes, there are babies covered under Medicare, these are often folks on disability) to 26.3441 for a heart transplant.

OPERATING AND CAPITAL PAYMENT AMOUNTS

Medicare divides payments into two broad categories: Operating and Capital as well as several additional add-ons. Operating pays for the cost of providing patient care, Capital covers the cost of the building and equipment.

As you may remember, the basic payment calculation is relative weight x base rate = payment. In this case,

$$1.6267 \times \$4,827.93 = \$7,853.59$$

The capital payment uses the same formula, but this screen does not show Tallahassee Memorial's capital rate, but it would be \$389.27. The resulting capital payment is \$633.23.

IME ADD-ON

Teaching hospitals or hospitals that train residents in approved medical, osteopathic, dental, or podiatry residency programs also receive IME adjustments to reflect the higher indirect patient care costs of teaching hospitals relative to non-teaching hospitals. The size of the IME adjustment depends on the hospital's teaching intensity. For operating payments, teaching intensity is measured by the hospital's number of residents trained per inpatient bed (i.e., the resident-to-bed ratio). In FYs 2008, 2009, and 2010, the operating IME adjustment increased per-case payments by 5.5 percent for approximately every 10 percent increase in the resident-to-bed ratio. In FY 2011, the rate is still 5.5 percent.

The IME add-on for operating was \$283.81 and for capital \$20.15.

DSH ADD-ON

Hospitals that treat a disproportionate share of low-income patients receive additional operating and capital payments. A hospital can qualify for the Medicare operating disproportionate share hospital (DSH) adjustment by using one of the following methods:

APPENDIX E

- Primary method – The hospital’s DSH patient percentage exceeds an amount specified in statute. The DSH patient percentage equals the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and Supplemental Security Income benefits and the percentage of total inpatient days attributable to patients eligible for Medicaid but not eligible for Medicare Part A.
- Alternate method (known as the Pickle methodology) – Large urban hospitals qualify for DSH if they can demonstrate that more than 30 percent of their total net inpatient care revenues come from State and local governments for indigent care (other than Medicare or Medicaid). For hospitals with a DSH patient percentage that exceeds 15 percent, operating DSH payments are based on a statutory formula. The DSH payment add-on rate is capped at 12 percent of base inpatient payments for rural hospitals with fewer than 500 beds and for urban hospitals with fewer than 100 beds. Rural Referral Center payments are based on a separate formula. Hospitals that qualify for a DSH payment under the Pickle methodology (i.e., they receive at least 30 percent of inpatient revenue from State and local government subsidies) have a 35 percent adjustment rate. Urban hospitals with 100 or more beds and all hospitals that receive at least 30 percent of inpatient revenue from State and local government subsidies are eligible for capital DSH payments (regardless of their DSH patient percentage). The capital DSH add-on payment is based on the empirically estimated cost effect of treating low-income patients.

The DSH payment add-ons were \$1,328.83 for operating and \$44.56 for capital.

OUTLIER PAYMENTS

To promote access to high quality inpatient care for seriously ill beneficiaries, additional payments are made for outlier or extremely costly cases. These cases are identified by comparing their estimated operating and capital costs to a fixed loss threshold. The fixed loss amount is set each year, which is adjusted to reflect labor costs in the hospital’s local market. The fixed loss amount changes, but is roughly around \$23,000. For FY 2011, the fixed loss amount was \$23,075.

Hospitals are paid 80 percent of their costs above their fixed loss thresholds and 90 percent of costs above the outlier threshold for burn cases. Outliers are financed by offsetting reductions in the operating and capital base rates (i.e., there is a reduction to the rates paid to all cases so that the amount paid as outliers does not increase or decrease estimated aggregate Medicare spending). The national fixed loss amount is established at the level that will result in estimated outlier payments equaling 5.1 percent of total payments for the Fiscal Year.

Our example did not trigger an outlier payment.

TRANSFER ADJUSTMENTS

In the left-hand column, there are several overall adjustments to the payment.

DRG payments are reduced when:

- The beneficiary’s LOS is at least one day less than the geometric mean LOS for the DRG;
- The beneficiary is transferred to another hospital covered by the Acute Care Hospital IPPS or, for certain MS-DRGs, discharged to a post-acute setting;
- The beneficiary is transferred to a hospital that does not have an agreement to participate in the Medicare Program (effective October 1, 2010); and The beneficiary is transferred to a Critical Access Hospital (CAH) (effective October 1, 2010).

The following post-acute care settings are included in the transfer policy:

- Long-term care hospitals;
- Rehabilitation facilities;

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- Psychiatric facilities;
- SNFs;
- Home health care when the beneficiary receives clinically related care that begins within three days after the hospital stay;
- Rehabilitation distinct part (DP) units located in an acute care hospital or a CAH;
- Psychiatric DP units located in an acute care hospital or a CAH;
- Cancer hospitals; and
- Children’s hospitals.

In our example, there was no transfer adjustment and it shows as \$0. (It’s underneath the Outlier Days entry.)

PASS THRU AND NEW TECHNOLOGY PAYMENTS

Pass thru amounts are calculated on a per diem basis while new technology amounts encompass new technology where the costs have not been included in the MS-DRG weight calculation.

THE TOTAL AND TOTAL BASE RATES

Adding the operating, capital payments along with the pass thru amounts and new technology produces a total page of \$10,293.13. You’ll see this amount in the lower left-hand corner of the screen.

Another way to look at this calculation – as some states do – is to consider a “total” effective base rate, not just a standardized amount. In this example, we could calculate the effective total base rate by dividing the total payment by the MS-DRG relative weight or:

$$\text{\$10,293.13} / 1.6267 = \text{\$6,327.61}$$

This process simplifies the calculation because the various individual factors can be blended together. When doing comparisons to Medicare payments, it’s vital to recognize whether the basic payment amount is being used or the total effective base rate.



Florida Department of Financial Services,
Division of Workers' Compensation,
Bureau of Monitoring & Audit

Survey of State Workers' Compensation
Inpatient Payment Methodologies

Date

October 25, 2012

Contact

Eric Anderson
Senior Consultant
OptumInsight
9200 Worthington Rd. Suite 300
Westerville, OH 43082
T 937-342-8561
eric.anderson@optum.com

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ALASKA

Type: WORKERS' COMPENSATION

Effective Date: 12/31/2010

Conversion Factor:

Type of stay	Per diem
Med/Surg	\$19,659.00
ICU/CCU	\$32,653.50
Updates/Wage Index:	CPI

Other Payment System Variations

Reimbursement is calculated based on a 24-hour stay. The inpatient medical and surgical per diem rate was calculated by taking the 90th percentile of relative and actual charge medical and surgical data across the entire state of Alaska. The per diems are broken into two different types of hospital stays: Medical/Surgical and ICU/CCU. Although hospital stays can be broken down into many categories, these two represent the most common stays in Alaska for workers' compensation. <http://labor.state.ak.us/wc/home.htm>

ALABAMA

TYPE: WORKERS' COMPENSATION

Effective Date: 8/1/2012

Payment methodology/updates:

Per Diem for each hospital

1.075 See description below

(c) Inpatient reimbursement shall be limited to the prevailing reimbursement as described in Rule 480-5-5-.04(3) for participating and nonparticipating hospitals or limited to the lesser negotiated rates for privately contracted hospitals pursuant to Code of Alabama. 1975 §25-5-314.

The formula for calculating a per diem payment amount shall be Per Diem Rate x Inpatient Days = Per Diem Amount. Any variations from a pure per diem payment methodology shall be controlled by the language of the agreement or statutory committee statement.

Schedule of maximum fees. If the total per diem prevailing rate of reimbursement amount is less than the product of the stop loss percentage time the total allowable charges, then the payment shall be the product of the stop loss percentage times the total allowable charges. Within 60 days from May 19, 1992, the Workers' Compensation Medical Services Board shall submit to the Governor an initial schedule of maximum fees for medical services covered by this article, which schedule shall become effective immediately upon submission to the Governor. The initial schedule of maximum fees shall be established by the board in the manner prescribed in this section. The fee for each service in the schedule shall be exactly equal to an amount derived by multiplying the preferred provider reimbursement customarily paid on May 19, 1992, by the largest health care service plan incorporated pursuant to Sections 10-4-100 to 10-4-115, inclusive, by a factor of 1.075, which product shall be the maximum fee for each such service. In addition the board may submit to the Governor for approval on or before January 31, 1993, a revised schedule of selected fees for medical services covered by this article, which fees shall not exceed the fees established in the initial schedule of fees by more than 2 1/2 percent. The revised schedule of fees, but not individual fees or separate portions thereof, shall be subject to acceptance or rejection by the Governor. If the revised schedule of fees is rejected by the Governor, it shall be referred to the board for further consideration and

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the initial schedule of maximum fees shall continue to be in effect until the Governor and the board reach agreement; provided, however, the schedule of maximum fees in effect on January 31, 1993, shall not be subject to further revision through this process.

<http://dir.alabama.gov/wc/2012FeeSchedules.aspx>

ARKANSAS (CMS)

TYPE: WORKERS' COMPENSATION

Effective Date: 8/1/2012

This Inpatient Hospital Fee Schedule is applicable for all inpatient medical, surgical, rehabilitation, and/or psychiatric services rendered in a hospital to injured workers under the **ARKANSAS WORKERS' COMPENSATION ACT**. This Inpatient Hospital Fee Schedule is established pursuant to **ARK. CODE ANN. 11-9-517 (1987)**.

I. GENERAL GROUND RULES

A. General Information

1. Reimbursements shall be determined for services rendered in accordance with this fee schedule and shall be considered to be inclusive unless otherwise noted.

2. Reimbursement for a compensable workers' compensation claim shall be the lesser of the hospital's usual and customary charges or the maximum amount allowed under the Inpatient Fee Schedule.

3. All inpatient hospital care must be reviewed under the PROFESSIONAL HEALTH CARE REVIEW PROGRAM required by COMMISSION RULE 30.

4. Inpatient hospitals shall be grouped into the following separate peer groupings:

PEER GROUP 1	HOSPITALS 1 - 49 BEDS
PEER GROUP 2	HOSPITALS 50 - 99 BEDS
PEER GROUP 3	HOSPITALS 100 - 199 BEDS
PEER GROUP 4	HOSPITALS 200 - 399 BEDS
PEER GROUP 5	HOSPITALS 400+ BEDS
PEER GROUP 6	REHABILITATION HOSPITALS
PEER GROUP 7	PSYCHIATRIC HOSPITALS

5. For each inpatient claim submitted, the provider shall assign a DIAGNOSIS RELATED GROUP (DRG) code from the attached listing which appropriately reflects the patient's primary cause of hospitalization. Reimbursement for a compensable workers' compensation claim shall be the lesser of the hospital's usual and customary charges or the maximum amount allowed under the Inpatient Fee Schedule.

CALIFORNIA

TYPE: WORKERS' COMPENSATION

Effective Date: 12/1/2011

Payment Methodology and Updates:

Update to the standardized amount. L.C. 5307.1(g)(1)(A)(i) provides that the annual inflation adjustment for inpatient hospital facility fees shall be determined 2. Composite Rate Calculation

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a. Update to the standardized amount. L.C. 5307.1(g)(1)(A)(i) provides that the annual inflation adjustment for inpatient hospital facility fees shall be determined solely by the estimated increase in the hospital market basket. Thus, in lieu of using the Medicare FY2012 rates to determine the updated OMFS amounts, the estimated increase in the hospital market basket was applied to the FY2011 OMFS rates.

b. OMFS rate for operating costs

i. Based on the Medicare Hospital Inpatient Prospective Payment System, all hospitals are paid the same standard rate for operating costs (based on the rate for hospitals located in large urban areas). The FY2011 rate was \$ 5,493.28 . The estimated increase in the market basket is 3.0%. The FY2012 standard rate under the OMFS is \$5,658.08 ($\$5,493.28 \times 1.03$).

ii. The Medicare Hospital Inpatient Prospective Payment System provides that if a hospital's wage index is less than or equal to 1.0, the labor-related share is .62 of the standard rate. If the wage index is greater than 1.0, the labor-related share is .688. The wage-adjusted standard rate is determined as follows:

The factors to determine composite rates are available on the CMS website at <http://www.cms.hhs.gov/AcuteInpatientPPS/>.

The public use file used to calculate the composite rates is entitled FY 2012 Final Rule - IPPS Impact File. The file contains wage data posted on the CMS website as of August 15, 2011.

2. Composite Rate Calculation

a. Update to the standardized amount. L.C. 5307.1(g)(1)(A)(i) provides that the annual inflation adjustment for inpatient hospital facility fees shall be determined solely by the estimated increase in the hospital market basket. Thus, in lieu of using the Medicare FY2012 rates to determine the updated OMFS amounts, the estimated increase in the hospital market basket was applied to the FY2011 OMFS rates.

COLORADO

TYPE: WORKERS' COMPENSATION

Effective Date: 8/12/2012

Payment Methodology and Updates:

Retrieve the relative weights for the assigned MS-DRG from the MSDRG table in effect at the time of discharge.

The Maximum Fee Allowance is determined by calculating:

(b) The following types of inpatient facilities are reimbursed at 80% of billed inpatient charges:

(1) Medicare certified Critical Access Hospital (CAH) (listed in Exhibit #3 of this Rule)

(2) Medicare certified long-term care hospital

(3) Colorado Department of Public Health and Environment (CDPHE) licensed rehabilitation

facility,

(4) CDPHE licensed psychiatric facilities that are privately owned.

(5) CDPHE licensed skilled nursing facilities (SNF).

(1) $(\text{MS-DRG Relative Wt} \times \text{Specific hospital base rate} \times 190\%) + (\text{trauma center activation allowance}) + (\text{organ acquisition, when appropriate})$.

(2) For trauma center activation allowance, (revenue codes 680-685) see 18-6(M)(3)(g).

(3) For organ acquisition allowance, (revenue codes 811-812) see 18-6(I)(3)(h).

DISTRICT OF COLUMBIA

TYPE: WORKERS' COMPENSATION

Effective Date: 1/1/2012

Conversion Factor: CMS @ 113%

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DELAWARE

TYPE: WORKERS' COMPENSATION

Effective Date: 1/29/2012

Payment Methodology and Updates:

CPI Update

Beginning on Oct. 31, 2012, each hospital and ambulatory surgical cent (ASC) in Delaware must submit bill-verification reports and will be paid 80% of current actual charges that will be averaged in some cases and adjusted by state auditors. The Health Care Advisory Panel will be required to review fees for hospitals and ASCs every three years.

FLORIDA

TYPE: WORKERS' COMPENSATION

Effective Date: 10/1/2007

Payment Methodology and Updates:

1. If the Total Gross Charges After Implant Carve-Out is \$51,400.00 or less, reimbursement shall be determined according to the Rule 69L-7.501, F.A.C. Effective 10/01/07 Florida Workers' Compensation Reimbursement Manual for Hospitals, 2006 Edition 9 following per diem allowances: Per Diem Schedule. For purposes of reimbursement under this Manual, surgical implant charges are those charges identified on the hospital billing form under Revenue Code 278. Reimbursement for surgical implants billed under Revenue Code 278, when charged for inpatient hospital services and supplies, Rule 69L-7.501, F.A.C. Effective 10/01/07 Florida Workers' Compensation Reimbursement Manual for Hospitals, 2006 Edition 9 following per diem allowances:

a. Inpatient services provided by hospital:

(1) Surgical stay: \$3,304.00 per day;

(2) Non-surgical stay: \$1,960.00 per day.

b. Inpatient services provided by a trauma center, licensed pursuant to s. 395.4025, F.S.:

(1) Surgical stay: \$3,305.00 per day; (2) Non-surgical stay: \$1,986.00 per day. Determination of whether inpatient services are surgical or non-surgical shall be based on the CMS-defined operative status for the ICD-9-CM primary procedure code reported by the hospital in the appropriate Form Locator on the hospital billing form in accordance with 69L-7.602, F.A.C

GEORGIA

TYPE: WORKERS' COMPENSATION

Effective Date: 4/1/2012

Payment Methodology and Updates:

MS-DRGs most current edition

Hospital Market Basket

Inpatient hospital maximum allowable reimbursement (MAR) totals are provided by MS-DRG in this schedule. As of the date of publication, the MS-DRG maximum allowable reimbursement is based upon the 2012 CMS relative weights multiplied by a base rate of \$8,406.57. Any MS-DRGs outside of this schedule will be reimbursed at 62.23 percent of charge. Reimbursement will be effective for the date of discharge. MS-DRG MARs represent payment in full, unless the outlier payment is applicable or a contract between a payor/provider is negotiated.

MS-DRGs 945 and 946 (Rehabilitation) are exempt from the Hospital Payment Fee Schedule. Reimbursements for inpatient rehabilitation should be negotiated by the facility and the payor, on a case-

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by-case basis, prior to services being rendered. If a payment rate has not been negotiated prior to services being rendered, the hospital will be reimbursed based on the MS-DRG payment schedule, which is calculated by multiplying the current relative weight of MS-DRG 945 or 946 and the current year's Georgia Workers' Compensation base rate of \$8,406.57, plus any applicable reimbursable outlier costs. Most MS-DRG payments will be at the base rate times the MS-DRG weight. However, to provide additional reimbursement where the Georgia Workers' Compensation Board deems the MS-DRG payment inadequate to cover the costs incurred by the facility, the Board has established an outlier payment for high-cost cases. Implantables are not subject to outlier reimbursement.

The outlier payment will be made according to the following formula:

Outlier Charge = Total Billed Charges – MS-DRG Payment – implants if applicable – 40,000.00

If Outlier Charge > 0, then Outlier Payment = 0.45 x Outlier Charge

If Outlier Charge is 0, then Outlier Payment = 0

For MS-DRGs 927, 928, 929, 933, 934, 935, 003 and 004, the outlier payment will be made according to the following formula:

Outlier Charge = Total Billed Charges – MS-DRG Payment – implants if applicable – 40,000.00

If Outlier Charge > 0, then Outlier Payment = 0.65 x Outlier Charge.

If Outlier Charge is 0, then Outlier Payment = 0

HAWAII

TYPE: WORKERS' COMPENSATION

Effective Date: 02/28/2011

Payment Methodology and Updates:

110% of Medicare

[If an] injury requires private care, intensive care, or isolation, as determined by the attending physician, in which case the prevailing private rates may be charged.

§12-15-53 Hospital services.

(b) Hospital charges for an injured employee shall be limited to the lowest room charge for the nature of the injury at the hospital where confined, except if the nature of the injury requires private care, intensive care, or isolation, as determined by the attending physician, in which case the prevailing private rates may be charged.

(c) Where an injured employee is treated in the emergency facility of a hospital, the allowable hospital charge for the use of the emergency room shall be the established emergency room charge for that particular hospital.

(d) All hospital charges shall be itemized when a bill is submitted. [Eff 1/1/96] (Auth: HRS §§386-21, 386-72) (Imp: HRS §386-21)

IDAHO

TYPE: WORKERS' COMPENSATION

Effective Date: 1- Apr

Payment Methodology and Updates:

CMS Table 5 MS-DRGs

Hospital Inpatient: MS-DRG

Table 5: List of MS-DRGs, Relative Weighting Factors (Effective January 1, 2012)

Table 5: List of FY13 MS-DRGs, Relative Weights (Effective October 1, 2012)

Hospital Outpatient & Ambulatory Surgery Centers (ASC) (Effective January 1, 2012)

Addendum B – Weights by CPT Code (CMS-1525-FC)

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Addendum D1 – Status Indicators

Hospital Inpatient: MS-DRG

a. Critical Access and Rehabilitation Hospitals. The standard for determining the acceptable charge for inpatient and outpatient services provided by a critical access or rehabilitation hospital is ninety percent (90%) of the reasonable charge. Implantable hardware charges shall be reimbursed at the rate of the actual cost plus fifty percent (50%). (1-1-12)

b. Hospital Inpatient Services. The standard for determining the acceptable charge for inpatient services provided by hospitals, other than critical access and rehabilitation hospitals, is calculated by multiplying the base rate by the current MS-DRG weight for that service. The base rate for inpatient services is ten thousand dollars (\$10,000). Inpatient services that do not have a relative weight shall be paid at eighty-five percent (85%) of the reasonable charge; however, implantable hardware charges billed for services without an MS-DRG weight shall be reimbursed at the rate of actual cost plus fifty percent (50%). (1-1-12)

i. Inpatient Threshold Exceeded. When the charge for a hospital inpatient MS-DRG coded service exceeds the sum of thirty thousand dollars (\$30,000) plus the payment calculated under the provisions of Subparagraph 032.02.b. of this rule, then the total payment for that service shall be the sum of the MS-DRG payment and the amount charged above that threshold multiplied by seventy-five percent (75%). Implantable charges shall be excluded from the calculation for an additional inpatient payment under this Subparagraph. (1-1-12)

ii. Inpatient Implantable Hardware. Hospitals may seek additional reimbursement beyond the MS-DRG payment for invoiced implantable hardware where the aggregate invoice cost is greater than ten thousand dollars (\$10,000). Additional reimbursement shall be the invoice cost plus an amount which is equal to ten percent (10%) of the invoice cost, but which does not exceed three thousand dollars (\$3,000). Handling and freight charges shall be included in invoice cost.

ILLINOIS

TYPE: WORKERS' COMPENSATION

Effective Date: 1-Feb

Payment methodology/updates:

MS-DRGs

CPI See website for fees.

B. Clearly Identifiable DRG

As reimbursement is based upon DRG, hospital providers must clearly identify the DRG in a manner consistent with this fee schedule. The DRG assignment will be made in a manner consistent with grouping practices used by the hospital when billing both government and private carriers (e.g., CMS Grouper Version 24.0). Hospitals shall list the DRG code on the UB-04.

C. DRG as a Global Reimbursement and Revenue Code Exceptions to Global Reimbursement

The DRG fee schedule amount reflects the maximum medical fee schedule amount for an entire inpatient hospital stay. There are, however, eight exceptions:

- 0274 (prosthetics/orthotics)
- 0275 (pacemaker)
- 0276 (lens implants)
- 0278 (implants)
- 0540 and 545 (ambulance)
- 0624 (investigational devices)
- 0636 (drugs requiring detailed coding)

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These charges are classified as pass-through charges and are paid at a rate of 65% of the charged amount. These revenue codes will not be covered under the DRG fee schedule amount. Once pass-through charges are identified and removed, all remaining charges are subject to the DRG fee schedule amount.

Charges billed under the above listed revenue codes shall be at a provider's normal rates under its standard chargemaster.

If the fee schedule amount defaults to 76% of charged amount, these rules will still apply. Remove all charges from the applicable revenue code line items and pay at 65% of charged amount: the remaining total charges will then be paid at 76%.

D. Cost Outliers

The Illinois Workers' Compensation Act recognizes that there are cases where the costs for treating an injured worker are unusually high in relation to other patients treated within the same as DRG. This fee schedule will use the following formula to determine if cost outlier payments should be made. If, after subtracting the pass-through revenue code charges, the balance of the bill is at least two times the fee schedule amount, the charged amount meets the definition of a cost outlier. The maximum fee schedule amount will be as follows: the pass-through revenue code charges are reimbursed at 65% of actual charge and the balance of the bill will be reimbursed at the fee schedule amount plus 76% of the portion of the charges that exceed the fee schedule amount. The pass-through revenue code charges shall be billed at the provider's normal rates under its standard chargemaster.

KANSAS

TYPE: WORKERS' COMPENSATION

Effective Date: 1/1/2012

Payment methodology/updates

MS-DRGS

5. COMPUTATION OF MAXIMUM ALLOWABLE REIMBURSEMENT: The Kansas Workers Compensation Schedule of Medical Fees that is current on the date of an inpatient discharge from the hospital, will define the levels of payment applicable to computation of the maximum allowable reimbursement. The maximum allowable reimbursement per inpatient stay shall be computed as follows:

MAXIMUM ALLOWABLE REIMBURSEMENT= Medicare MS-DRG (Version 27) Relative Weight X \$7200 (for Peer Group 1 Hospitals) or \$7000 (for Peer Group 2 hospitals).

CRITICAL ACCESS HOSPITALS AND PEER GROUP 3 HOSPITALS shall be reimbursed at billed charges less 15.0%.

All out- of-state hospitals except out-of-state critical access hospitals will be reimbursed at Peer Group 2 hospital level or Medicare MS-DRG Relative Weight X \$7000.

Out-of-state critical access hospitals shall be reimbursed at billed charges less 15%. Additionally, the rules that are contained within this fee schedule also apply to out-of-state hospitals.

6. STOP-LOSS METHOD:

a. PURPOSE AND APPLICATION: Stop-loss is an independent reimbursement methodology that will reimburse the hospital for unusually costly services rendered during treatment to an injured worker. No charge attributable to implantables or trauma activation fees shall be considered for purposes of determining eligibility for, and reimbursement under, stop-loss.

b. COMPUTATION OF THE MAXIMUM ALLOWABLE REIMBURSEMENT UNDER STOP-LOSS: To be eligible for the stop-loss payment, the total charges for the hospital inpatient stay, excluding

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charges attributable to implantables and trauma activation fees, must be at least Sixty Thousand Dollars (\$60,000.00), the minimum stop-loss threshold. If the total charges for the hospital inpatient stay equal or exceed the minimum stop-loss threshold, the total charges are then multiplied by seventy percent (70%) to determine the maximum allowable reimbursement excluding implantables (see Ground Rule 5 of these Ground Rules)and trauma activation fees (see Ground Rule 7 of these Ground Rules).

7. TRAUMA ALERTS AND ACTIVATION FEES: Trauma Revenue Codes can only be used by trauma centers/hospitals as licensed or designated by state or local government authority authorized to do so, or as verified by the American College of Surgeons. Only patients for whom there has been pre-hospital notification based on triage information by pre-hospital care givers who meet either state, local, or American College of Surgeons field triage criteria, or are delivered by interhospital transfers, and are given the appropriate team response can be billed a trauma activation charge. Trauma Center fees are not paid for Alerts . Activation Fees mean that a Trauma Team has to be activated, not just alerted. These fees are in addition to ER and inpatient fees. Trauma Center Activation fees are as follows:

- Level I \$3,000.00
- Level II \$2,500.00
- Level III \$1,000.00
- Level IV \$0.00

KENTUCKY

TYPE: WORKERS' COMPENSATION

Effective Date: 3/14/2011

Payment methodology/updates:

A hospital's base cost-to charge ratio shall be based on the latest cost report. The base cost-to-charge ratio shall be further modified to allow for a return to equity by multiplying the base cost-to-charge ratio by 132 percent except that a hospital with more than 400 licensed acute care beds as shown by the Cabinet for Health and Family Services. Designated Level I trauma center shall ha a return to equity by multiplying its base cost-to-charge ratio by 138 percent.

<http://www.labor.ky.gov/workersclaims/mscc/Pages/Physicians-Fee-Schedule.aspx>

LOUISIANA

TYPE: WORKERS' COMPENSATION

Effective Date: 7/1/2005

Payment methodology/updates

Medical and Surgical Per Diem		§2505. Hospital Inpatient Reimbursement
SMSA*	Medical per Diem	Surgical per Diem
Alexandria	\$1212	\$1628
Baton Rouge	\$1125	\$2015
Houma-Thibodaux	\$ 908	\$1697
Lafayette	\$1009	\$1655
Lake Charles	\$ 946	\$1645
Monroe	\$1050	\$1654
New Orleans	\$1186	\$2059
Nonmetropolitan	\$ 771	\$1570
Shreveport	\$1198	\$1629

*Please refer to Exhibit I for listing of hospitals within each SMSA.

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A. Reimbursement for inpatient hospital services will be limited to the lesser of covered billed charges or the per diem amount. The per diem rate assigned to the Standard Metropolitan Statistical Area in which the services are rendered will be applied to inpatient days by type of service, either medical or surgical.* The reimbursement amount will be reduced by charges for noncovered items and services.

NOTE: *The diagnosis/procedure code requiring the greatest resource consumption (severity) should be used to assign the correct category.

B. Using the following Per Diem Rate Schedule, the formula for calculating payment amount is:

Per Diem Rate x Inpatient Days = per Diem Amount

1. If billed charges > per diem amount, pay per diem amount less noncovered charges.
2. If billed charges < per diem amount, pay billed charges less noncovered charges.

Per Diem Rate Schedule

*Please refer to Exhibit I for listing of hospitals within each SMSA.

C. A provider formally approved by Medicare as a rural referral center will be recognized as such under these rules, and will be reimbursed under the same per diem rate as that of the SMSA assigned to the provider by the Medicare Geographic Classification Review Board.

http://www.laworks.net/Downloads/Downloads_OWC.asp

MASSACHUSETTS

TYPE: WORKERS' COMPENSATION

Effective Date: 9/1/2004

Payment methodology/updates:

41.03: Payment for Inpatient Services

(1) General. Payment for inpatient services is equal to the product of the PAF and the hospital's Charge for the service. The PAF shall be applied to all billed Charges that are payable under 114.1 CMR 41.00.

Payment is based on the applicable PAF and Charge effective on the date the service is provided.

(2) Rate Determination. The Division will determine a Hospital specific industrial accident Rate Year Payment on Account Factor (PAF) as follows:

(a) Calculation of PAF. The rate year PAF equals the lower of 1.0 or the Hospital's base year Private Sector Gross Patient Service Revenue (PSGPSR) minus its base year private sector contractual adjustments divided by its base year Private Sector Gross Patient Service Revenue (PSGPSR). Private sector revenues and contractual adjustments used in this calculation will be those reported in the DHC FP-403 cost report from Industrial Accident, Managed Care and Non-Managed Care payer groups.

Rate Year PAF = the lower of 1.0 or

$$\frac{\text{Base Year PSGPSR} - \text{Base Year Private Sector Contractual Adjustments}}{\text{Base Year PSGPSR}}$$

Payment on Account Factor (PAF). The percentage applied to total Charges for services rendered to an Industrial Accident Patient to calculate payment as determined in accordance with 114.1 CMR 41.03.

MARYLAND

TYPE: WORKERS' COMPENSATION

Effective Date: 3/23/2008

Payment methodology/updates

Per Diem is the same for each hospital

MS-DRGs MEI

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Maryland Health sets state rates please see for all the information
http://www.hscrc.state.md.us/hsp_Rates4.cfm

MAINE

TYPE: WORKERS' COMPENSATION

Effective date: December 2011

Payment methodology/updates

SECTION 3. INPATIENT FACILITY FEES

3.01 BILLING

Bills for inpatient services must be submitted on a CMS Uniform Billing (UB-04) form.

3.02 CRITICAL ACCESS HOSPITALS

Payments for inpatient services in a critical access hospital are based on the MS-DRG system. The payment is calculated by multiplying the base rate times the MS-DRG weight. The base rate for inpatient services at critical access hospitals is \$10,907.00.

3.03 ACUTE CARE HOSPITALS

Payments for inpatient services in an acute care hospital are based on the MS-DRG system. The payment is calculated by multiplying the base rate times the MS-DRG weight. The base rate for inpatient services at acute care hospitals is \$8,923.00.

3.04 MAXIMUM REIMBURSEMENT

Except as provided in subsections 3.05 and 3.06, acute care hospitals shall be paid the maximum allowable payment established in Appendix IV or its usual and customary charge, whichever is less, for inpatient services.

3.05 OUTLIER PAYMENTS

The threshold for outlier payments is \$75,000.00 plus the maximum allowable payment established in Appendix IV. If the outlier threshold is met, the outlier payment must be the maximum allowable payment plus the charges above the sum of the threshold and the maximum allowable payment multiplied by 75%. The total payment for the services is the outlier payment plus the maximum allowable payment.

3.06 IMPLANTABLES

Where an implantable exceeds \$10,000 in cost, acute care hospitals may seek additional reimbursement beyond the maximum allowable charge. Reimbursement is set at the actual amount paid plus 20% or \$500.00, whichever is less. When an acute care hospital seeks additional reimbursement pursuant to this rule, the implantable charge is excluded from any calculation for an outlier payment. Handling and freight charges must be included in the acute care hospital's invoiced cost and are not to be reimbursed separately.
<http://www.maine.gov/wcb/departments/omrs/omrs/mfs.htm>

MICHIGAN

TYPE: WORKERS' COMPENSATION

Effective Date: 10/1/2010

Payment methodology/updates

Cost to charge ratio

R 418.101101 Calculation and revision of payment ratio for Michigan hospitals.

Rule 1101. (1) The workers' compensation agency shall annually calculate and revise, under the provisions of 1969 PA 306, 24.201 et seq. MCL, the payment ratios for all Michigan hospitals. The calculation shall be made using a hospital's most recent fiscal year information that is submitted to the Michigan department of community health, medical services administration, preceding each annual calculation. The information used shall be that reported to the Michigan department of community health, medical services administration, on the hospital's statement of patient revenues and operating expenses, G2 worksheet. The

APPENDIX F

workers' compensation agency shall complete the payment ratio calculation between September 1 and October 1, or the earliest date when the figures are available from Michigan department of community health and shall annually publish the hospital ratio calculations in a separate manual effective for dates of service on or after the effective date of these rules.

(2) The workers' compensation agency shall calculate a hospital's cost-to-charge ratio by dividing each hospital's total operating expenses by total patient revenues as reported on the hospital's statement of patient revenues and operating expenses, G2 worksheet. Reimbursement for Hospital Facility Services A hospital shall bill facility services to the carrier in accordance with R 418.10922. The hospital is required to provide only the following records for a properly submitted bill:

Emergency Room record.

Anesthesia report (when billing anesthesiologists or CRNA services).

Physical Medicine services (PT, OT, Speech and Hearing evaluations and subsequent reports every 30 days).

The carrier may request any other records necessary for utilization review and pay for those records in accordance with R 418.10118. Once compensability has been determined, withholding payment for copies of related lab and x-ray reports is not appropriate.

Cost to charge ratios - http://www.michigan.gov/documents/wca/10_Hospital_Ratios_333598_7.pdf

MINNESOTA

TYPE: WORKERS' COMPENSATION

Effective Date: 10/1/2004

Payment methodology/updates

CPI update

Limitations on Reimbursement Dependent on Provider Type
Small hospitals

<http://www.dli.mn.gov/WC/PDF/WcMedSymp1a.pdf>

(100 or fewer licensed beds): paid 100% of usual and customary charge. (Minn. Stat. 176.136 Subd. 1b(a) and MN Rules 5221.0500 Subp. 2C)

Inpatient treatment at large hospitals (more than 100 licensed beds): paid 85% of usual and customary charge. (Minn. Stat. 176.136 Subd. 1b(b) and MN Rules 5221.0500 Subp. 2B) 256.969 PAYMENT RATES. Subdivision 1. Hospital cost index. (a) The hospital cost index shall be the change in the Consumer Price Index-All Items (United States city average) (CPI-U) forecasted by Data Resources, Inc. The commissioner shall use the indices as forecasted in the third quarter of the calendar year prior to the rate year. The hospital cost index may be used to adjust the base year operating payment rate through the rate year on an annually compounded basis.

(b) For fiscal years beginning on or after July 1, 1993, the commissioner of human services shall not provide automatic annual inflation adjustments for hospital payment rates under medical assistance, nor under general assistance medical care, except that the inflation adjustments under paragraph (a) for medical assistance, excluding general assistance medical care, shall apply through calendar year 2001. The index for calendar year 2000 shall be reduced 2.5 percentage points to recover overprojections of the index from 1994 to 1996. The commissioner of management and budget shall include as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11 annual

APPENDIX F

adjustments in hospital payment rates under medical assistance and general assistance medical care, based upon the hospital cost index.

Subd. 2b. Operating payment rates. In determining operating payment rates for admissions occurring on or after the rate year beginning January 1, 1991, and every two years after, or more frequently as determined by the commissioner, the commissioner shall obtain operating data from an updated base year and establish operating payment rates per admission for each hospital based on the cost-finding methods and allowable costs of the Medicare program in effect during the base year. Rates under the general assistance medical care, medical assistance, and MinnesotaCare programs shall not be rebased to more current data on January 1, 1997, January 1, 2005, for the first 24 months of the rebased period beginning January 1, 2009. For the rebased period beginning January 1, 2011, rates shall not be rebased, except that a Minnesota long-term hospital shall be rebased effective January 1, 2011, based on its most recent Medicare cost report ending on or before September 1, 2008, with the provisions under subdivisions 9 and 23, based on the rates in effect on December 31, 2010. For subsequent rate setting periods in which the base years are updated, a Minnesota long-term hospital's base year shall remain within the same period as other hospitals. Effective January 1, 2013, and after, rates shall not be rebased. The base year operating payment rate per admission is standardized by the case mix index and adjusted by the hospital cost index, relative values, and disproportionate population adjustment. The cost and charge data used to establish operating rates shall only reflect inpatient services covered by medical assistance and shall not include property cost information and costs recognized in outlier payments. (i) In addition to the reductions in paragraphs (b), (c), (d), (g), and (h), the total payment for fee-for-service admissions occurring on or after July 1, 2011, made to hospitals for inpatient services before third-party liability and spenddown, is reduced 1.96 percent from the current statutory rates. Facilities defined under subdivision 16 are excluded from this paragraph. Payments made to managed care plans shall be reduced for services provided on or after January 1, 2011, to reflect this reduction.

MISSISSIPPI

TYPE: WORKERS' COMPENSATION

Effective Date: 11/1/2012

Payment methodology/updates

INPATIENT SERVICES

FEE SCHEDULE UPDATE OCTOBER 1, 2012

The Mississippi Inpatient Base Rate as of October 1, 2012 is \$10,697.52. This base rate is used to calculate the reimbursement of a Mississippi Workers' Compensation inpatient hospital claim for all discharge dates on or after October 1, 2012.

The maximum reimbursement for an inpatient claim is determined by multiplying the Mississippi base rate times the current (FY 2012) MS-DRG relative weight. The most current DRG Relative Weight table is included with this update.

OUTLIER PAYMENTS

The formula for determining the outlier threshold for each facility remains the same but the Medicare outlier fixed loss threshold and the facility cost to charge ratios were revised October 1, 2012. Effective for discharge dates from and after October 1, 2011, the Medicare outlier fixed loss threshold is \$21,821.00.

The current hospital cost to charge ratio table can be found on the CMS website. However, a table showing the most current cost to charge ratios for Mississippi hospitals is also found on the [next page](#).

A table showing the historical summary of our Inpatient Base Rates and corresponding Medicare outlier threshold amounts since August 1, 2007 is also included.

MONTANA

TYPE: WORKERS' COMPENSATION

Effective date: 1/1/2010

APPENDIX F

Payment methodology/updates

165% of Medicare MS-DRGs

(h) The Base Rates and Conversion Formulas Established by the Department National Base Rates
Every year Medicare establishes a base rate for facilities providing Medicare services by utilizing technical calculations conducted using state and national data from large databases maintained by the Centers for Medicare and Medicaid Services (CMS).

Nationally, for Fiscal Year 2008, the Medicare inpatient operating base rate is \$4,990.60 for labor and supply costs, and a series of additional factors---often varying by region or issue---are used to further enhance the actual reimbursement rate set for a state, region within a state, or for an individual hospital. Taking a look at the future, CMS has just released a new proposed base rate number of \$5,099 for Fiscal Year 2009.

Montana Inpatient Base Rate = \$7,735

For Montana workers' compensation (WC) calculation purposes, Montana's base rate is established utilizing only some of the technical calculations conducted by the Centers for Medicare and Medicaid Services (CMS). The Department determined that, for the initial implementation of the new fee schedule, it will use the national operating base rate of \$4,990.60 but multiply it by 155 percent, or \$7,735, for hospital reimbursement for Montana. Building in an allowance for inplantables and outliers and the elimination of the wage index is estimated to bring the total rate to approximately 165% of the Medicare reimbursement rate.

Some available state-level studies for other states have identified a cost-shifting of Medicare payments of approximately 16 percent to the commercial sector, but appropriate data to compare Medicare expenditures to commercial insurance expenditures in our state were not available. Rather than put in place an unworkable reimbursement base rate, the Department is using its best projections to avoid problems in the short run, and meanwhile establishing required cost data collection and monitoring to better determine actual costs for the future.

One example of how the Montana base rate of \$7,735 is to be implemented is to look at a DRG medical service weighted at 3.35. The inpatient calculation formula would be \$7,735 base rate times the DRG weight of 3.35, which would result in a DRG reimbursement of \$25,912.

NORTH CAROLINA

TYPE: WORKERS' COMPENSATION

Effective Date: 2/1/2009

Payment methodology/updates

MS-DRGs

Beginning July 27, 2009, for service dates on and after that date, the following inpatient hospital billing band and outpatient and ambulatory surgical center reimbursement rates shall come into effect:

The lower end cap of the DRG band for reimbursement of inpatient hospital bills will be adjusted from 77.07% to 75% of charges for hospitals other than critical access hospitals. (Critical access hospitals are defined by federal law and are the smallest hospitals in the State, located in rural areas.)

The reimbursement rate for outpatient hospital bills will be adjusted from 95% of charges to 79% of charges for hospitals other than critical access hospitals. For critical access hospitals, the outpatient reimbursement rate will be reduced from 95% to 87% of charges.

The reimbursement rate for ambulatory surgical centers will be adjusted from 100% of charges to 79% of charges.

<http://www.ic.nc.gov/ncic/pages/feesec14.htm>

NORTH DAKOTA

TYPE: WORKERS' COMPENSATION

Effective Date: 1/1/2012

APPENDIX F

Payment methodology/updates

MS-DRGs

Inpatient Acute and Acute Psychiatric Services

Workforce Safety & Insurance (WSI) shall reimburse inpatient acute and acute psychiatric services as follows:

- Inpatient acute and acute psychiatric services are reimbursed by Diagnosis Related Group (DRG)
- A WSI specific rate (conversion factor) will be computed using the information published each year in the Federal Register and will be effective for the following calendar year. The formula for establishing the WSI rate is:

Operating Cost Portion:

92% of the total base rate for the 2008 calendar year. The percentage is based on the historical Operating cost/Capital cost base rate split for the 2008 calendar year.

The Operating Cost portion of the rate will be updated each year based on the operating cost hospital market basket published by Medicare each year in the Inpatient Prospective Payment System final rule.

Capital Cost Portion:

8% of the total base rate for the 2008 calendar year. The percentage is based on the historical Operating cost/Capital cost base rate split for the 2008 calendar year.

The Capital Cost portion of the rate will be updated each year based on the capital cost hospital market basket update published by Medicare each year in the Inpatient Prospective Payment System final rule. If a separate market basket is not published for capital costs, the operating cost update will be applied to the capital portion of the rate.

WSI Conversion Factor:

Operating Cost Portion of Rate (+) Capital Cost Portion of Rate (=) WSI DRG Rate (conversion factor)

WSI DRG Payment Amount: WSI DRG Rate (X) Medicare's MS-DRG weights (published each year in the Federal Register)

(=) WSI DRG Payment Amount

WSI will make no adjustments to this formula for wage index or GAF factors, disproportionate share hospitals (DSH), indirect medical education/graduate medical education (IME/GME) or other Medicare pass-through amounts.

If necessary, WSI will make adjustments to the WSI conversion factor to account for aggregate weight changes.

Outlier payments are calculated at 80% of charges in excess of an amount equal to the DRG payment plus an outlier fixed loss threshold. The outlier fixed loss threshold changes each year based on an outlier target that is established to maintain total outlier payments at 10% of total DRG plus outlier payments. If a claim reaches the outlier threshold, the formula for payment is:

$$\text{DRG Amount} + (((\text{Billed Charges} - (\text{DRG Amount} + \text{Threshold})) \times .80)$$

The outlier target for each year is set at an amount equal to 10% of the estimated DRG plus outlier payments. Estimated DRG payments are based on claims paid between January 1st and September 30th of the current year. The following year's conversion factor is multiplied by the following year's weights to arrive at estimated DRG payments.

<http://www.workforcesafety.com/medical-providers/feeschedule/displayFeeSchedule.asp?name=HospitalInpatient2012January.pdf>

NEBRASKA

TYPE: WORKERS' COMPENSATION

APPENDIX F

Effective Date: 12/15/2011

Payment methodology/updates

MS-DRGs

RULE 26

SCHEDULES OF FEES FOR

MEDICAL, SURGICAL, AND HOSPITAL SERVICES

A. The following Nebraska Workers' Compensation Court fee schedules, including the instructions, ground rules, unit values, and conversion factors set out in such schedules, are hereby adopted pursuant to section 48-120(1)(b) of the Nebraska Workers' Compensation Act. Reimbursement for medical, surgical, and hospital services provided pursuant to section 48-120 shall be in accordance with such schedules, except for services covered by the inpatient hospital fee schedules established in section 48-120.04, and except for services covered by contract pursuant to section 48-120(1)(d).

1. Schedule of Fees for Medical Services, effective June 1, 2010.

2. Schedule of Fees for Hospitals and Ambulatory Surgical Centers, effective January 1, 2012.

3. Schedule of Fees for Implantable Medical Devices, effective January 1, 2012.

Such schedules and the inpatient hospital fee schedules established in section 48-120.04 shall be available on the court's web site at <http://www.wcc.ne.gov>.

B. The Diagnostic Related Group inpatient hospital fee schedule established in section 48-120.04 shall include the following Medicare Diagnostic Related Groups, effective January 1, 2012:

3 92 300 465 491 514 607 902 935

26 93 301 467 492 516 638 903 945

27 101 309 468 493 517 641 904 946

28 103 310 470 494 536 700 906 948

29 113 312 472 496 552 781 907 955

30 156 329 473 497 554 812 908 956

41 176 354 475 500 556 853 909 957

52 184 378 476 501 558 856 914 958

74 193 390 480 502 561 857 917 964

82 200 392 481 504 563 858 918 982

83 201 442 482 505 566 862 921 989

84 206 454 483 507 574 863 922

86 208 455 484 508 581 864 923

87 241 459 486 511 602 871 927

89 282 460 489 512 603 872 928

90 299 464 490 513 605 885 929

NEW MEXICO

TYPE: WORKERS' COMPENSATION

Effective Date: 12/31/2011

Payment methodology/updates

67% of billed charges for new hospitals

11.4.7.9 PROCEDURES FOR ESTABLISHING THE MAXIMUM AMOUNT OF REIMBURSEMENT DUE

A. All hospitals shall be reimbursed at the hospital ratio itemized in the official WCA listing that becomes effective on December 31, 2011, for all services rendered from December 31, 2011 to December 31, 2012, except as provided in Subsection B of this temporary rule. Any new hospital shall be assigned a ratio of 67%.

(1) The assigned ratio is applied toward all charges for compensable services provided during a hospital inpatient stay, emergency department visit and outpatient hospital surgery.

(2) This ratio does not include procedures that are performed in support of surgery, even if performed on the same day and at the same surgical site as the surgery.

APPENDIX F

(1) Implants, hardware and instrumentation implanted or installed during surgery in the setting of a hospital shall be reimbursed at invoice cost times 1.25 plus shipping and handling for the implant or hardware and NMGR.T.

(2) The professional and technical charges for radiology and pathology/laboratory services provided in a hospital shall be paid at rates equivalent to those set forth in the most current version of the healthcare provider fee schedule. The hospital shall provide a detailed billing breakdown of the professional and technical components of the services provided, and shall be paid pursuant to the procedures set forth at Paragraph (7) of Subsection G of 11.4.7.9 NMAC of these rules.

C. All hospitals shall provide to the WCA:

(1) the most recent full year filing of their HCFA/CMS 2552 G-2 worksheet prepared on behalf of the organization, by February 1, 2012;

(2) any hospital may specifically designate this worksheet as proprietary and confidential; any worksheet specifically designated as proprietary and confidential in good faith shall be deemed confidential pursuant to NMSA 1978, Section 52-5-21 and the rules promulgated pursuant to that provision.

(3) Failure to comply may result in fines and penalties.

D. All provisions of 11.4.7 NMAC contrary to the provisions set forth in this temporary rule are deemed void and inoperative during the effective period of this rule.

DD. Maximum amount of reimbursement due means the maximum payment for any service that is the lesser of the contract amount or the amount appropriately calculated by one of the following official methods:

(1) the assigned ratio discount method which is the hospital's established usual and customary charge for compensable services multiplied by the assigned ratio, plus any applicable New Mexico gross receipts tax; or,

(2) the maximum allowable amount method which is the lesser of the usual and customary fee, the contract amount or the amount prescribed by the healthcare provider fee schedule, plus any applicable New Mexico gross receipts tax; <http://www.workerscomp.state.nm.us/pdf/rules/rule7.pdf>

NEVADA

TYPE: WORKERS' COMPENSATION

Effective Date: 2/1/2008

Payment methodology/updates

Per Diem

TRAUMA ACTIVATION FEE REIMBURSEMENT

NV00150 Trauma Activation Fee.....\$3,172.40

Requires notification of trauma team members at designated trauma hospitals in response to triage information received concerning a person who has suffered a traumatic injury as defined by NRS 450B.105. Trauma activation is based upon parameters set forth in NAC 450B.770 (Procedures for initial identification and care of patients deemed with trauma). Regardless of the disposition of the patient, all charges related to the appropriate care of the patient above and beyond the activation fee shall apply and are reimbursed per the Nevada Medical Fee Schedule.

HOSPITAL EMERGENCY DEPARTMENT FACILITY REIMBURSEMENT

Nevada Specific Codes:

NV00100 First hour for use of emergency facility.....\$150.77

NV00101 Each additional hour or fraction thereof for use of emergency facility.....\$ 75.41

Treatment and supplies provided by the emergency department are reimbursed separately.

If an injured employee is admitted to the hospital from the emergency department, the charges related to the care in the emergency department and the per diem rates for an inpatient who receives care at the hospital are billed and paid separately.

HOSPITAL REIMBURSEMENT

APPENDIX F

Nevada specific codes and payment:

NV00200 Medical-Surgical Intensive Care.....	\$2975.16
NV00400 Medical-Surgical Cardiac Care.....	\$2731.50
NV00500 Medical-Surgical Care.....	\$1809.33
NV00900 Burn Care.....	\$2731.50
NV00600 Psychiatric Care.....	\$1809.33
NV00700 Rehabilitation Care.....	\$1809.33
NV00550 Skilled Nursing Care Facility.....	\$1809.33

The per diem rate includes all services provided by the hospital including the professional and technical services provided by members of the hospital’s staff and other services ordered by the treating or consulting provider of health care. Charges for an inpatient’s use of an operating room must be included in the per diem rate for the hospital.

Rural hospitals receive an additional 10% over the established per diem rate. Hospitals in Clark County, Washoe County, and Carson City are not considered rural hospitals.

The insurer shall reimburse the hospital for orthopedic hardware, prosthetic devices, implants and grafts at the cost to the hospital, excluding tax and charges for freight, plus 20 percent, unless there is a written agreement between the insurer and hospital for a lower reimbursement.

The insurer shall reimburse the hospital for supplies and materials, including grafts and implants used in open-heart surgery at the cost to the hospital, excluding tax and charges for freight, plus 40 percent, unless there is a written agreement between the insurer and hospital for a lower reimbursement.

NEW YORK

TYPE: WORKERS’ COMPENSATION

Effective Date: 4/1/2004

Payment methodology/updates

PAS rates

2012 Medical Fee The Workers' Compensation Board has been advised by the Department of Health that the Ambulatory Surgery Rates for hospital based and free standing ambulatory surgery centers have been frozen at 2003 levels and accordingly, there is no updated fee schedule.

Section 54 of Part C, Chapter 58 of the Laws of 2005, provides in part, that ...rates in effect on March 31, 2003 as established in accordance with paragraph(e) of subdivision 2 of Section 2807 of the Public Health Law shall continue in effect for the period April 1, 2003 through September 30, 2006...

If you have any questions regarding this announcement, please contact the Department of Health, Bureau of Primary and Acute Care Reimbursement at 518-474-3267.

HOSPITAL INPATIENT FEE SCHEDULE EFFECTIVE 7/01/2003 – 12/31/2003

Enclosed, please find the certification letter and schedules of initial hospital reimbursement rates for service rendered to patients covered under the Workers’ Compensation Benefit Law, the Volunteer Firefighters’ Benefit Law and the Volunteer Ambulance Workers’ Benefit Law for the period July 1, 2003 through December 31, 2003.

The formula on which these rates are based was promulgated in accordance with Article 28 of the Public Health Law and reflect those provisions of the Health Care Reform Act 2003 (HCRA), which currently expires June 30, 2005.

The July 1, 2003 rates, enclosed herein, are based upon the same inpatient reimbursable costs as those reflected in the 2003 inpatient rates promulgated on a statewide basis and certified to you on April 15, 2003, but also take into consideration the following changes:

APPENDIX F

1. Inclusion of updated Indirect Medical Education (IME) information as a result of a new IME survey submitted by hospitals which provide actual information for the period July 1, 2002 through June 30, 2003 and projected information for the period July 1, 2003 through June 30, 2004.
2. Implementation of the final 2002 trend factor into the 2002 and 2003 rates in accordance with article 2807-c(10)(c) of the Public Health Law.
3. Inclusion of the above changes in the calculation of the group price for each respective year where appropriate. This enclosure provides specific information for each diagnosis related group (DRG) including DRG number, DRG description, per case and per day service intensity weights (SIW's), non-Medicare trimpoints and upstate/downstate group average lengths of stay. The per case SIW is to be applied to the blended cost per discharge to determine the inlier payment for an individual claim. The low and high trimpoints are needed to determine if the claim is an inlier, short stay or long stay claim depending on patient's acute length of stay. The group average length of stays (upstate/downstate) are used to divide the per case amount in the determination of the per diem for payment (when applicable). These DRG's are to be used for patients discharged on or after January 1, 2003.

Top 20 DRG's

Pursuant to the provisions of the Health Care Reform Act of 2003, services rendered to patients covered under the Workers' Compensation Benefit Law, the Volunteer Firefighters' Benefit Law, and the Volunteer Ambulance Workers' Benefit Law discharged July 1, 2003 and after will be reimbursed the state governmental payor rate. Chapter 80 of the Laws of 1995 included a provision which impacts payments for the twenty most common diagnosis related groups DRG's (See Top 20 DRG's schedule). For inpatient claims that group into one of the DRG categories listed, reimbursement is at the lower of the hospital-specific blended cost per discharge or the weighted group average for the hospitals peer group. Those hospitals who are designated as rural and have opted for 100% hospital-specific reimbursement under Article 2807-c (6) are not subject to the Top 20 lower of payment system as described in Article 2807-c (5) of the Public Health Law. Top 20 DRG rates based on the above adjustments have been calculated for the period July 1, 2003 through December 31, 2003. All payment formulas for Top 20 DRG's (Inliers, Short Stays, Transfers & High Costs) will use the rate amount listed in the Top 20 DRG column contained in the payment rate components listed on the Schedule entitled Workers' Compensation and No Fault Hospital Case Payment Rates (See Column 3).

OHIO

TYPE: WORKERS' COMPENSATION

Effective Date: 1/1/2004

(C) Bureau fees for hospital inpatient services.

(1) Bureau fees for hospital inpatient services will be based on usual and customary methods of payment, such as prospective payment systems, including diagnosis related groups (DRG), per diem rates, rates based on hospital cost to charge ratios or percent of allowed charges.

(2) Except in cases of emergency, prior authorization must be obtained in advance of all hospitalizations. The hospital must notify the bureau, the injured worker's MCO, QHP, or self-insuring employer of emergency inpatient admissions within one business day of the admission. Failure to comply with this rule shall be sufficient ground for denial of room and board charges by the bureau, MCO, QHP, or self-insuring employer from the date of admission up to the actual date of notification. Room and board charges denied pursuant to this rule may not be billed to the injured worker.

<http://www.ohiobwc.com/downloads/blankpdf/OAC4123-6-37.pdf>

OKLAHOMA

TYPE: WORKERS' COMPENSATION

Effective Date: 1/1/2012

Payment methodology/updates

APPENDIX F

MS-DRGs

Inpatient Hospital Services

Ground Rules

MAXIMUM ALLOWABLE REIMBURSEMENT = [Total Audited Charges – (MS-DRG reimbursement per Ground Rule 3 x 50%)] x 65%.

For example,

MS-DRG 461

Billed charges = \$150,000

Implant Charges = \$25,000

Total Audited Charges = \$125,000

Since the total audited charges exceed the minimum stop-loss threshold, the MAR is calculated as follows:

MS-DRG reimbursement per Ground Rule 3 = 5.3985 x \$4,016.58 = \$21,683.51.

MAR = [\$125,000 – (\$21,683.51 x 50%)] x 65%

= (\$125,000 – \$10,841.76) x 65%

= \$114,158.24 x 65%

= \$74,202.86

For purposes of this calculation, audited charges do not include any charges for implantables since implantables are reimbursed separately under Ground Rule 4 of these ground rules.

6. PAYMENT DISPUTES: Nothing in these ground rules shall be construed to preclude a payer from challenging a provider's charges.

http://www.owcc.state.ok.us/PDF/2012%20Fee%20Schedule-%201-19-12%20edits_FINAL.pdf

OR TYPE: WORKERS' COMPENSATION 1/1/2012 Cost to charge ratios

http://www.cbs.state.or.us/wcd/rdrs/mru/fee_schedule.html This bulletin provides updated adjusted cost/charge ratios. Apply these ratios to hospital inpatient and outpatient services according to ORS 656.248 and OAR 436-009-0020. This bulletin replaces Bulletin 290 issued March 13, 2012.

PENNSYLVANIA

Type: Workers' Compensation

Effective Date: 1/1/2004

Payment methodology/updates

113% DRG

§ 127.110. Inpatient acute care providers—generally.

(a) Payments to providers of inpatient acute care hospital services shall be based on the sum of the following:

(1) One hundred thirteen percent of the DRG payment.

(2) One hundred percent of payments that are reimbursed on the prospective payment system, as listed in subsection (b).

(3) One hundred percent of pass-through costs. (4) One hundred percent of applicable cost outliers or 100% of applicable day outliers.

(b) In calculating the payment due, the following payments, which are reimbursed on a prospective payment basis by the Medicare Program, shall be multiplied by 100%:

(1) The prospective portions of capital-related costs relating to payments to the following:

(i) Fully-prospective hospitals.

(ii) Hold-harmless hospitals reimbursed at 100% of the Federal rate (100% hold harmless).

(iii) Blended hold-harmless hospitals.

(2) Direct medical education costs.

(3) Indirect medical education costs.

(c) In calculating the payment due, the following costs, which are reimbursed on a cost basis by the Medicare Program, shall be multiplied by 100%:

(1) The cost portions of capital-related costs relating to the following:

APPENDIX F

- (i) Blended hold-harmless hospitals.
- (ii) Capital-exceptional hospitals.
- (2) Paramedical education costs.
- (3) Cost outliers or day outliers.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.154 (relating to medical fee updates on and after January 1, 1995—inpatient acute care providers subject to DRGs plus add-on payments).

§ 127.111. Inpatient acute care providers—DRG payments.

(a) Payments to providers of inpatient hospital services, whose Medicare Program payments are based on DRGs, shall be calculated by multiplying the established DRG payment on the date of discharge by 113%.

(b) For discharges on and before December 31, 1994, the DRG payments, using the Medicare DRG methodology, shall be based on the most recently published tables of payments, relative values, wage indices, geographic adjustment factors, rural and urban designations and other applicable Medicare payment adjustments published in the Federal Register. The effective date for these changes under the Medicare Program shall also be the effective date for the changes under the act.

(c) If the amount of the DRG reimbursement changes during a patient's stay, the applicable reimbursement rate on the date of discharge shall be used to calculate payment under the act.

(d) If a patient was admitted prior to August 31, 1993, the act's medical fee caps may not apply.

Cross References

This section cited in 34 Pa. Code § 127.101 (relating to medical fee caps—Medicare); 34 Pa. Code § 127.154 (relating to medical fee updates on and after January 1, 1995—inpatient acute care providers subject to DRGs plus add-on payments).

§ 127.112. Inpatient acute care providers—capital-related costs.

(a) An additional payment shall be made to providers of inpatient hospital services for the capital-related costs reimbursed under the Medicare Part A Program.

(b) Hospitals, which have a hospital-specific capital rate lower than the Federal capital rate (fully-prospective), shall be paid for capital-related costs as follows: the hospital's capital rate, as determined by the Medicare intermediary, shall be multiplied by the DRG relative weight on the date of discharge.

(c) Hospitals, which have a hospital-specific capital rate equal to or higher than the Federal capital rate (hold-harmless), shall be paid for capital-related costs as follows:

(1) Hospitals paid at 100% of the Federal capital rate shall receive the Federal capital rate, as determined by the Medicare intermediary, multiplied by the DRG relative weight on the date of discharge.

(2) Hospitals paid at a rate greater than 100% of the Federal capital rate shall be paid on the basis of the most recent notice of interim payment rates as determined by the Medicare intermediary. Hospitals shall receive the new Federal capital rate multiplied by the DRG relative weight on the date of the discharge plus the old Federal capital rate as determined by the Medicare intermediary.

(d) Capital-exceptional hospitals, or new hospitals within the first 2 years of participation in the Medicare Program, shall be paid for capital-related costs as follows: the most recent interim payment rate for capital-related costs, as determined by the Medicare intermediary, shall be added to the DRG payment on the date of discharge. <http://www.pacode.com/secure/data/034/chapter127/chap127toc.html>

RHODE ISLAND

TYPE: WORKERS' COMPENSATION

Effective Date: 7/1/2012

Payment methodology/updates

Percent of charge

RHODE ISLAND WORKERS' COMPENSATION HOSPITAL RATES

The inpatient, emergency room and ambulatory surgery adjustments to charges are effective for all hospital services provided on or after July 1, 2012.

HOSPITAL CHARGES SHOULD BE MULTIPLIED BY THE APPROPRIATE PERCENTAGE LISTED BELOW.

APPENDIX F

Example: \$100.00 Butler Inpatient Charge x 50.00% Inpatient adjustments to charges

\$ 50.00 Amount Paid

Hospital Inpatient Adjustment to Charges

Adjustment to Charges

Butler 50.00%

KentCounty 41.94%

Landmark 37.30%

Memorial 50.60%

Miriam 41.89%

Newport 74.76%

Rhode Island 47.78%

RI Rehab Hospital 55.96%

Roger WMS. 56.45%

St. Joseph 45.33%

South County 59.23%

Westerly 62.79%

Women & Infants 45.65%

Rates are based on approved cost finding methodology and other statistical data furnished by each hospital through the Hospital Association of Rhode Island for the period indicated.

All other outpatient services are subject to the rules and rates of the Rhode Island Workers' Compensation Fee Schedule. <http://www.risingms.com/RIFee/2012%20Fee%20Schedules/Hospital%20Guidelines.pdf>

SOUTH CAROLINA

TYPE: WORKERS' COMPENSATION

Effective Date: 10/1/2006

Payment methodology/updates

MS-DRGs

PPS Capital Payment

<http://www.wcc.sc.gov/Documents/IMS/2007%20HPS%20Manual.pdf>

DRG Relative Weight x (Standard Federal Rate) x (GAF) x (Large Urban Add-on, if applicable) x (1 + DSH Adjustment Factor + IME Adjustment Factor)

PPS Operating Payment + PPS Capital Payment = Hospital Specific DRG Payment

Outlier Payment

1. Determine Costs:

Operating Costs = Billed Charges x Operating Cost to Charge Ratio

Capital Costs = Billed charges x Capital Cost to charge Ratio

2. Determine Outlier Threshold

Fixed Loss Threshold (Published in the Federal Register Final Rule for each year)

Determine Operating Cost-to-Charge Ratio to Total Cost-to-Charge Ratio (hospital specific) = (Operating CCR) / (Operating CCR + Capital CCR)

Calculate Operating Outlier Threshold = {[Fixed Loss Threshold x ((Labor related portion x CBSA wage index) + Non-labor related portion)] x Operating CCR to Total CCR} + PPS Operating Payment

Determine Capital Cost-to-Charge Ratio to Total Cost-to-Charge Ratio (hospital specific) = [Capital CCR] / (Operating CCR + Capital CCR)

Calculate Capital Outlier Threshold = (Fixed Loss Threshold x Geographic Adjustment Factor x (Large Urban Add-On, if applicable) x Capital CCR to Total CCR) + PPS Capital Payment

Determine Outlier Payment: Marginal Cost Factor 0.80 of the combined operating and capital costs in excess of the fixed-loss threshold
Outlier Payment = (Cost - Outlier Threshold) x Marginal Cost Factor

APPENDIX F

Calculate Outlier Payment for both operating and capital. Combined operating and capital costs for a case must exceed the combined threshold to qualify for an outlier payment.

The following information for the FY is found on the CMS website under Acute Inpatient PPS:

DRG Relative Weights: Acute Inpatient File for Download

www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp

Wage Index Tables: Acute Inpatient Wage Index Files

TENNESSEE

TYPE: WORKERS' COMPENSATION

Effective Date: 7/1/1905

Payment methodology/updates

IV. IN-PATIENT HOSPITAL FEE SCHEDULE

The In-patient Hospital Fee Schedule, Chapter 0800-2-19, is applicable for all inpatient hospital stays. These are defined as hospital stays which exceed 23 hours and the employee has been formally admitted. Different rules apply for outpatient services performed in a hospital setting. For these see Rule 0800-2-18-.07.

See Rule 0800-2-19-.02(6).

A. In-patient Hospital Services Are Reimbursed under a Per Day Methodology In-patient services are calculated under a per day or per diem basis, not under the Medicare DRG system. This is one of the areas in which the Tennessee Medical Fee Schedule differs from the Medicare basis used throughout most of the Fee Schedule Rules.

Reimbursement for a compensable workers' compensation claim shall be the lesser of the hospital's usual charges, the PPO or other contracted amount, or the maximum amount allowed under this In-patient Hospital Fee Schedule.

In-patient hospitals are grouped into the following separate peer groupings:

1. Peer Group 1 Hospitals 2. Peer Group 2 Rehabilitation Hospitals 3. Peer Group 3 Psychiatric Hospitals

See Rule 0800-2-18-.02(2)(b) and 0800-2-19-.01.

B. Maximum Allowable Reimbursement Amounts

The maximum per diem rates to be used in calculating the reimbursement rate is as follows:

Surgical Admissions - \$1,800.00 for the first seven (7) days; \$1,500.00 per day for each day thereafter. This includes Intensive Care (ICU) & Critical Care (CCU);

Medical Admissions - \$1,500.00 for first seven (7) days; \$1,250.00 per day for each day thereafter;

Rehabilitation Hospitals - \$1,000.00 for the first seven (7) days; \$800.00 per day thereafter;

Psychiatric Hospitals (applicable to chemical dependency as well) maximum allowable amount is \$700.00 per day.

D. Surgical implants

These shall be reimbursed separately and in addition to the per diem hospital charges pursuant to Rule 0800-2-18-.10 of the Medical Fee Schedule Rules. Additional reimbursement may be made in addition to the per diem for implantables (i.e. rods, pins, plates and joint replacements, etc.). Maximum reimbursement for implantables billed at \$100.00 or less per item shall be limited to eighty percent (80%) of billed charges. Maximum reimbursement for implantables over \$100.00 is limited to the hospital's cost plus fifteen percent (15%) of the invoice amount, up to a maximum of invoice plus \$1,000.00 per item. This is not cumulative. Implantables shall be billed using the appropriate HCPCS codes, when available. Billing for implantables which have an invoice amount over \$100.00 shall be accompanied by an invoice.

E. Non-covered charges

Non-covered items are: convenience items, charges for services not related to the work injury/illness services that were not certified by the payer or their representative as medically necessary.

F. Amounts in Addition to Per Diem Charges

The following items are not included in the per diem reimbursement to the facility and may be reimbursed separately. All of these items must be listed with the applicable CPT/HCPCS codes.

APPENDIX F

TEXAS

TYPE: WORKERS' COMPENSATION

Effective Date: 5/19/2012

Payment Methodology/Updates:

MS-DRGs 43% above Medicare

TITLE 28. INSURANCE Adopted Sections

Part 2. Texas Department of Insurance, Page 123 of 141 Pages

Division of Workers' Compensation

Chapter 134. Benefits-Guidelines for Medical Services, Charges, and Payments Medicare's reimbursement. Medicare DRGs, which adjust for severity and recognize the intensity of services for specific patients, will apply to services when these rules become effective. Establishing a different reimbursement methodology for cases with a length of stay greater than 12 days would realign the relative weights of the DRG methodology and be inconsistent with the prospective payment concepts of the Medicare system. Medicare reimbursement reflects average costs and length of stay, and in general is designed to cover costs and provide a profit for efficiently managed facilities. This concept extends to the outlier methodology. The 43 percent adjustment above Medicare reimbursement should provide some insulation for facilities in these cases. The payment adjustment factors provide further reimbursement to cover the costs of a lengthy stay. <http://www.tdi.texas.gov/wc/rules/adopted/documents/aorderhfg0108.pdf>

UTAH

TYPE: WORKERS' COMPENSATION

Effective Date: 7/1/2012

Payment Methodology/Updates:

§ R612-2-14 Hospital Fees Separate Fees covering hospital care shall be separate from those for professional services and shall not extend beyond the actual necessary hospital care. When it becomes evident that the patient needs no further hospital treatment, he/she must be discharged. All billings must be submitted on a UB92 form and be properly itemized and coded and shall include all appropriate documentation to support the billing. There shall not be a separate fee charged for the necessary documentation in billing for payment of hospital services. The documentation of hospital services shall include at a minimum the discharge summary. The insurance carrier may request further documentation if needed in order to determine liability for the bill.

<http://www.rules.utah.gov/publicat/code/r612/r612-002.htm#T14>

VERMONT

TYPE: WORKERS' COMPENSATION

Effective Date: 4/1/2009

Payment Methodology/Updates:

MS-DRGs

Medicare Hospital Manual Advisory Information

This manual is available at <http://www.cms.hhs.gov/Manuals/PBM/list.asp>. The manual provides instructions for implementation of the provisions of Title IVII of the Social Security Act and Medicare regulations particularly as they relate to hospital benefits.

Section 210 deals with covered inpatient hospital services. Section 210.4 contains the definition of a supply:

APPENDIX F

Supplies, appliances, and equipment which are ordinarily furnished by the hospital for the care and treatment of the beneficiary solely during his inpatient stay in the hospital are covered inpatient hospital services.

Rule 40.022(B) requires that durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) as defined under the Medicare program shall be reimbursed at 83% of billed charge and adjusted annually thereafter or 150% of cost whichever is less.

While hospitals are not required to submit invoices to carriers they are required to submit documentation which allows the carrier to make a reasonable determination of what the provider paid for the DMEPOS. This documentation includes but is not limited to copies of the order forms, copies of the catalog pages, order confirmation sheets, etc.

<http://labor.vermont.gov/InfoCenter/MedicalHealthCareProviders/tabid/151/Default.aspx>

WASHINGTON

TYPE: WORKERS' COMPENSATION

Effective Date: 7/1/2012

Payment Methodology/Updates:

POAC AP-DRG

Effective for Dates of Service on or After July 1, 2012 Facility Fee Schedule POAC, APC, & AP-DRG Rates July 1, 2012

POAC 2012 POAC Percentage Dollars Hospital Rates

Effective for Dates of Service on or After July 1, 2012

Refer to the Field Key for definitions Hospital Rates Page 1 Facility Fee Schedule

POAC, APC, & AP-DRG Rates July 1, 2012 Hospital Rates

Field Key:

Column Title Column Value

L&I Provider Number Number

Provider Name

City

Exempt

DRG

DRG-Spec

DRG-Teach

Inactive

POAC

2012 POAC Percentage Percentage

Dollars Dollars

2012 Payment Status

2012 APC Rate

2012 AP-DRG Base Rate

Hospital specific percent of allowed charge (POAC) factor

Hospital specific blended APC rate

Hospital is not paid using APC system

The hospital's rate which is multiplied by the AP-DRG relative weight

Hospital is not paid using AP-DRG system

Value Description

Provider number associated with the individual hospital

Hospital name

Washington State City where hospital is located

APPENDIX F

Hospital is exempt from either the inpatient or the outpatient or both prospective payment systems
Hospital inpatients are paid on a AP-DRG basis using statewide rate and
Hospital outpatients are paid using hospital specific blended APC rate
Hospital inpatients are paid on a AP-DRG basis using statewide rate and
Hospital outpatients are paid using hospital specific POAC rate
Hospital inpatients are paid on a AP-DRG basis using hospital specific rate and
Hospital outpatients are paid using hospital specific blended APC rate
Hospital is no longer active as an L&I provider
Hospital inpatients and outpatients are paid using hospital specific POAC
Refer to the Field Key for definitions Hospital Rates Page 2

2012 Payment Status

2012 APC Rate

2012 AP-DRG Base Rate

Hospital specific percent of allowed charge (POAC) factor

Hospital specific blended APC rate

Hospital is not paid using APC system

<http://www.lni.wa.gov/ClaimsIns/Files/ProviderPay/FeeSchedules/2012FS/fsHospRates.pdf>

WEST VIRGINIA

TYPE: WORKERS' COMPENSATION

Effective Date: 7/1/2012

Payment Methodology/Updates:

135% MS-DRGs

HOSPITAL INPATIENT SERVICES

For Critical Access Hospitals: 135% of the hospital-specific final Medicare per diem reimbursement for July 1 update prior to date of service* (rounded) = OIC Maximum Medical Reimbursement, rounded.

For Medicare Prospective Payment Hospitals: 135% of the hospital-specific final Medicare MS-DRG** core element*** reimbursement for July 1 update prior to date of service* (rounded) = OIC Maximum Medical Reimbursement, rounded.

* For date of service between July 1 through June 30, the reimbursement effective on the July 1 immediately prior to date of service would apply. For example, for a January 10, 2013 date of service, the Medicare reimbursement information effective on July 1, 2012 would apply.

** Grouper 29 used by Medicare on July 1, 2012

*** Core element reimbursement (per Medicare) = standardized amounts (basic payment); wage index; DRG relative weights; disproportionate share; indirect medical education; and outlier (if applicable).

WYOMING

TYPE: WORKERS' COMPENSATION

Effective Date: 1/1/2012

Payment Methodology/Updates:

Rates are based on a survey of hospital room rates and is updated yearly



ANALYSIS OF PROPOSED CHANGES TO THE FLORIDA HOSPITAL INPATIENT FEE SCHEDULE MAXIMUMS BASED ON MEDICARE PAYMENT RATES EFFECTIVE UPON ADOPTION

NCCI estimates that implementing a fee schedule for hospital inpatient services based either on 120% of Medicare (Scenario 1) or 140% of Medicare (Scenario 2) will result in the following impacts on Florida’s overall workers compensation system costs:

	Scenario 1	Scenario 2
Overall Impact	-3.4% (-\$85M)¹	-3.0% (-\$75M)¹

Summary of Changes

The Florida Division of Workers Compensation (FL DWC) proposes to adopt an inpatient hospital fee schedule based on Medicare’s Inpatient Prospective Payment System (IPPS) using either 120% of Medicare (Scenario 1) or 140% of Medicare (Scenario 2). Medicare’s IPPS system uses Medicare-Severity Diagnosis Related Groups (MS-DRGs) to group patients with similar clinical problems that are expected to require similar amounts of hospital resources.

Currently hospital inpatient services are reimbursed under a Per-Diem Schedule if Total Gross Charges (after implant carve-out) fall below a certain threshold. Otherwise, reimbursement is 75% of the Total Gross Charges.

Note that the actual language of the proposal was not provided to NCCI, and therefore the impact of this analysis may change depending on the implemented version of the proposal.

Actuarial Analysis

NCCI’s methodology to evaluate the impact of medical fee schedule changes includes three major steps:

1. Calculate the percentage change in maximum reimbursements
 - a. Compare the prior and revised maximum reimbursements by procedure code and determine the percentage change by procedure code
 - b. Calculate the weighted average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights

2. Estimate the price level change as a result of the revised fee schedule

¹Overall system costs are based on NAIC Annual Statement data as provided by A.M. Best including an estimate of self-insured premium. The estimated dollar impact of -\$85M and -\$75M is the percent impact displayed for each of the 2 scenarios multiplied by A.M. Best 2011 written premium of \$1,794M for Florida plus an estimate of the self-insured premium from the Florida Division of Workers Compensation for 2011 of \$692M. This figure does not include the policyholder retained portion of deductible policies, or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs.



**ANALYSIS OF PROPOSED CHANGES TO THE FLORIDA
HOSPITAL INPATIENT FEE SCHEDULE
MAXIMUMS BASED ON MEDICARE PAYMENT RATES
EFFECTIVE UPON ADOPTION**

- a. NCCI research by Frank Schmid and Nathan Lord (2012), "Impact of Changes to Physician Fee Schedules in Workers Compensation", suggests that a portion of a change in maximum reimbursements is realized on payments impacted by the change.
 - b. In response to a fee schedule decrease, NCCI research indicates that payments decline by approximately 50% of the fee schedule change.
 - i. The assumption for the percent realized for fee schedule decreases is 50%.
 - c. In response to a fee schedule increase, NCCI research indicates that payments increase by approximately 80% of the fee schedule change and the magnitude of the response depends on the relative difference between actual payments and fee schedule maximums (i.e. the price departure).
 - i. The formula used to determine the percent realized for fee schedule increases is $80\% \times (1.10 + 1.20 \times (\text{price departure}))$.
3. Estimate the share of costs that are subject to the fee schedule
- a. The estimated share is based on a combination of fields, such as bill type and procedure code as reported on the detailed medical transactions, to categorize payments that are subject to the fee schedule.

The detailed medical transactions are obtained from the Florida Division of Workers Compensation (FL DWC) medical data management system reported on form DWC-90 for services performed between January 1, 2011 and December 31, 2011. This data is collected by the FL DWC from workers compensation insurance carriers and self-insured employers. The analysis of hospital inpatient services includes data reported with bill types 11x, 12x, 18x, 21x, 22x, 23x, 81x and 82x. There were approximately 10,000 bills included in the hospital inpatient analysis.

Hospital Inpatient Fee Schedule

In Florida, payments for hospital inpatient services represent 17.2%² of total medical payments. To calculate the percentage change in maximums for hospital inpatient services, we compare the maximum reimbursements for each hospital inpatient bill under the current and proposed fee schedule.

The current maximum reimbursement allowance (MRAs) for each hospital inpatient bill is calculated as follows:

If total trended charges (excluding charges for implants) is \$51,400 or less,

² Based on detailed medical data provided by FL DWC for Service Year 2011



**ANALYSIS OF PROPOSED CHANGES TO THE FLORIDA
HOSPITAL INPATIENT FEE SCHEDULE
MAXIMUMS BASED ON MEDICARE PAYMENT RATES
EFFECTIVE UPON ADOPTION**

Current MRA = current per diem allowance x length of stay (LOS) + implant reimbursement

If total trended charges (excluding charges for implants) is greater than \$51,400,

Current MRA = total trended charges (excluding charges for implants) x 75% + implant reimbursement

To calculate the total trended charges, the charge for each medical bill was adjusted to reflect changes from past price levels to the price levels projected to be in effect on January 1, 2013. The trend factor used for these projections is based on the annual changes in the U.S. hospital inpatient component of the medical consumer price index (MCPI) using data from the U.S. Bureau of Labor Statistics.

The MCPI for the period 2009-2011 is as follows:

Service Year	Hospital Inpatient Component MCPI Change from July of previous year
2009	6.7%
2010	8.8%
2011	6.8%

The selected annual trend to project data beyond 2011 is the three-year average of the observed MCPI for 2009-2011 ($1.074 = (6.7\%+8.8\%+6.8\%)/3$). The trend period is based on the length of time from the date of service from each bill to January 1, 2013.

In order to estimate the implementation of a Medicare based fee schedule, NCCI relied on the analysis performed by OptumInsight (previously known as Ingenix) to map each hospital inpatient bill to a MS-DRG code, and to compute the proposed MRA under Medicare's IPPS for that MS-DRG code.

The overall change in maximum reimbursements for hospital inpatient services is a weighted average of the percentage change in MRA (proposed MRA/ current MRA) by bill weighted by the observed payments by bill. The table below summarizes the impact by category and by scenario:



**ANALYSIS OF PROPOSED CHANGES TO THE FLORIDA
HOSPITAL INPATIENT FEE SCHEDULE
MAXIMUMS BASED ON MEDICARE PAYMENT RATES
EFFECTIVE UPON ADOPTION**

Category	Distribution Of Payments	Impact Scenario 1	Impact Scenario 2
Bills currently subject to 75% of Charges	81.0%	-76.0%	-72.6%
Bills currently subject to Per-Diem	19.0%	+21.2%	+41.0%
Impact on Overall Inpatient Hospital Bills	100.0%	-57.6%	-51.0%

Since the overall average maximum reimbursement for hospital inpatient services decreased, NCCI expects that 50% percent of the decrease in maximum reimbursements will be realized on hospital inpatient price levels. The overall weighted average percentage changes in MRA after the 50% adjustment is -28.8% under Scenario 1 and -25.5% under Scenario 2.

The above impacts for hospital inpatient services are then multiplied by the Florida percentage of medical costs attributed to hospital inpatient payments (17.2%)² to arrive at the impact on medical costs. The resulting impacts on medical costs are then multiplied by the percentage of Florida benefit costs attributed to medical benefits (68.4%)³ to arrive at the estimated impact on Florida overall workers compensation costs.

The impact from the proposed changes to Florida Workers Compensation Hospital Inpatient Reimbursement is summarized in the following table:

		Impact Scenario 1	Impact Scenario 2
(1)	Impact on Hospital Inpatient Payments in Florida	-28.8%	-25.5%
(2)	Hospital Inpatient Payments as a Percent of Medical Costs in Florida ²	17.2%	17.2%
(3)	Impact on Medical Costs in Florida due to the proposed Hospital Inpatient Fee Schedule = (1) x (2)	-4.9%	-4.4%
(4)	Medical Costs as a Percentage of Overall Workers Compensation Benefit Costs in Florida ³	68.4%	68.4%
(5)	Impact on Overall Workers Compensation System Costs in Florida = (3) x (4)	-3.4%	-3.0%

² Based on detailed medical data provided by FL DWC for Service Year 2011

³ Based on NCCI Financial Call data from Policy Years 2009 and 2010 projected to 1/1/2013. This estimate date is subject to change depending on the effective date of the proposal.



**ANALYSIS OF PROPOSED CHANGES TO THE FLORIDA
HOSPITAL INPATIENT FEE SCHEDULE
MAXIMUMS BASED ON MEDICARE PAYMENT RATES
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Appendix

Type Of Stay	Current Per Diem	Current Stop-Loss Threshold
Surgical Non-Trauma	\$3,304.00	\$51,400.00
Non-Surgical Non-Trauma	\$1,960.00	\$51,400.00
Surgical Trauma	\$3,305.00	\$51,400.00
Non-Surgical Trauma	\$1,986.00	\$51,400.00