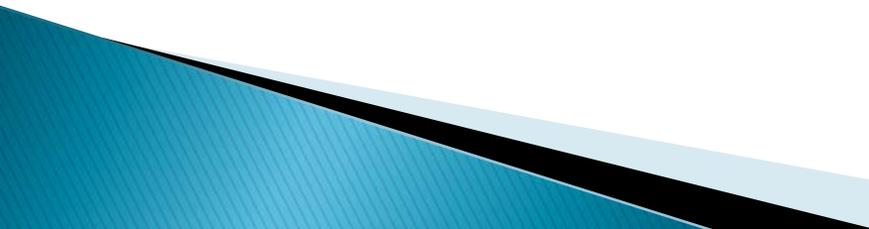


Workers' Compensation Legislative and Rules Update 2015

July 2015

Recent Legislative and Rulemaking Actions

- I. DRGs for hospital inpatient charges
 - II. Direct deposit by EFT
 - III. Electronic transactions
 - IV. DLI Workers' Compensation
Division modernization
 - V. Opioid rule
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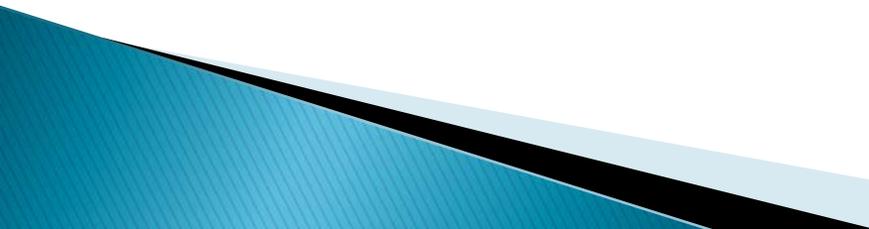
I. Inpatient DRG — Problems

Cost hikes. From 2006–2012 Minnesota hospital inpatient surgical costs increased 9.5% annually, which was faster than national average of 7.4%. During same period, MN non-hospital costs went up 4.5% annually, which was less than the national average of 5.5%

Inpatient DRG — Problems

Disputes. Between 1997–2013 total number of medical only claims declined 50%. But number of medical disputes increased and dispute rates rose by 71%. Other types of disputes (claim petitions, discontinuances, rehab, etc.) declined during same period.

Inpatient DRG — Problems

- ▶ Hospitals asserted that bill reviewers retained by payers made dispute resolution needlessly complex and lengthy.
 - ▶ Also, claimed payments took much longer, sometimes as much as several years after original billing. (Insurers disagreed.)
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Inpatient DRG — Background

- ▶ **Diagnostic Related Group.** Payments to hospitals are predetermined, based on patient's diagnosis instead of treatment charges.
- ▶ DRG system first used by Medicare in 1985. DRGs based on severity of diagnosis (MS-DRGs) were adopted in 2007.
- ▶ More than 750 MS-DRG codes.
- ▶ Other DRG systems exist, but Minnesota workers' compensation will use MS-DRG.

Inpatient DRG — Process

- ▶ Detailed negotiations over 10 months between Minnesota Hospital Association and Minnesota Insurance Federation, mediated by DLI, assisted by Optum Consulting. Data collected by parties and DLI.
 - ▶ Compromise agreement reached in late March.
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Inpatient DRG — Process

- ▶ Workers' Compensation Advisory Council business and labor representatives and legislators also played key roles. Approved compromise April 8, 2015.
 - ▶ Legislature passed and Governor signed compromise bill in May 2015 regular session.
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Inpatient DRG — Basics

(Minnesota Statutes 176.135–1362)

- ▶ Payments for inpatient services and supplies will be based on MS-DRG system for workers' comp patients discharged on or after Jan. 1, 2016.
- ▶ Maximum payment will be 200% of amount paid by Medicare for applicable DRG using the Medicare “PC Pricer” program. Replaces current standard of 85% of hospital’s “usual and customary” charge.
- ▶ Hospitals must bill same way they bill for Medicare. Billing must be within six months of either date of care or date provider learns insurer’s identity.

Inpatient DRG — Catastrophic High-cost Injuries

- ▶ **Catastrophic high-cost injuries.** If charges exceed \$175,000, payment will be 75% of hospital's usual and customary charge, instead of by DRG. These cases are 2.6% of all billings, but 18% of costs.
- ▶ Dollar amount for catastrophic injuries will be adjusted yearly by percentage change in average total charges per inpatient cases, based on hospital data reported to Health Department.

Inpatient DRG — Smaller Hospitals

Critical access hospitals (CAHs). Hospitals certified by Medicare as CAHs will be paid at 100% of usual and customary charges instead of by DRG. CAHs must have 25 or fewer inpatient beds, provide emergency care and meet other Medicare requirements.

Minnesota has 79 such hospitals. They treat lesser work injuries, some may have only one to two workers' compensation cases annually.

Outliers

- ▶ To protect hospitals from large losses, additional payments are made for unusually costly cases called outliers. (The outlier payment does not apply when charges exceed the \$175,000 workers' compensation threshold.)
- ▶ Outliers are identified by comparing their charges to a *fixed-loss* amount, a nationwide number, set annually by Medicare.
- ▶ The *cost to charge ratio* is annually set by Medicare for each hospital based on cost reports.

Outliers

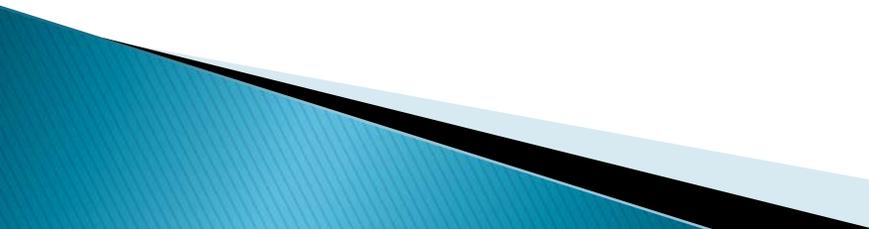
- ▶ The outlier payment is calculated using the hospital's reported charges, the hospital's own cost to charge ratio, the appropriate MS-DRG payment and the fixed loss amount.
 - ▶ Hospitals are paid 80% of calculated costs for most outliers, but 90% for burn cases.
 - ▶ *See addendum for an example of calculating outlier payment.*
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Inpatient DRG — Payments

When DRG applies and hospital submits electronic bill:

- ▶ Insurers may not require additional documentation.
 - ▶ Line item bill adjustments not allowed, except when post-payment audit is permitted.
 - ▶ Payer must, within 30 days, deny entire bill or pay bill in full (200% of Medicare payment amount).
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Inpatient DRG — Post-payment audits

- ▶ Audits only permitted when bill is paid within 30 days *and* payment included “outlier” amount (which is payment over DRG amount allowed for more expensive cases).
 - ▶ Audits must be initiated within six months of payment.
 - ▶ Following audit, 4% interest must be paid by insurer if it owes more or 4% by hospital if it was overpaid.
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Inpatient DRG — Study

- ▶ DLI must perform study analyzing impact of reforms. Due by Jan. 15, 2018.

Inpatient DRG — Rulemaking

- ▶ DLI allowed expedited rulemaking to implement DRG. Expect to use only if there is an unanticipated Medicare change or issues not addressed by new law.

Rulemaking for Outpatient Charges

- ▶ DLI also allowed rulemaking to adopt prospective payment (DRG-type) system for payment of treatment by hospital outpatient or ambulatory surgical centers.
 - ▶ Will not be needed if parties agree to legislation to be enacted during 2016 legislative session.
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II. Direct Deposit by EFT for Injured Workers (Minn. Stat. 176.221)

- ▶ When requested by injured worker, insurer or employers must deposit indemnity payments with bank, credit union or savings association by electronic funds transfer.
- ▶ Insurers must do so within 30 days of receiving employee's request if EFT arrangement exists with the bank.
- ▶ Insurer must make effort to establish EFT within two weeks of request if it doesn't already have an arrangement with the bank. (Jan. 1, 2016).

III. Electronic Health Care Billings

(Minn. Stat.176.135 subd. 7a)

- ▶ Proposed in response to joint DLI/MDH industry-wide symposium in November 2014.
- ▶ Payers must place on website or otherwise provide specific information that providers need to submit an e-bill, including:
 - payer ID number;
 - reporting claim numbers on the e-bill;
 - clearinghouse name; and
 - contact information.

(Jan. 1, 2016)

Electronic Health Care Billings

(Minn. Stat.176.135 subd. 7a)

- ▶ Payers must provide specific information so providers can match the payment to bill (Sept. 1, 2015).
- ▶ Providers must submit attachments with the e-bill electronically, using a specific national standard (July 1, 2016).
 - DLI will provide online training and materials to assist payers and providers implement the new attachment standard.

2015 Workers' Compensation Legislation

- ▶ This is only an overview of the 2015 workers' compensation statutory amendments. The complete law is available online at www.revisor.mn.gov/laws/?year=2015&type=0&doctype=Chapter&id=43.
- ▶ It will be codified in Minn. Stat. chapter 176 at www.revisor.mn.gov/statutes/?id=176.

IV. Workers' Compensation Division Modernization

- ▶ DLI's Workers' Comp Division's IT system is more than 20 years old and needs updating.
- ▶ Just completed initial scoping phase. Hope to have RFP ready by January.
- ▶ \$4M was appropriated for FY16; \$6M for FY17; and \$3M each for FY18 and FY19.
- ▶ Will be added to assessment over next few years. Will not result in an increase in assessments for insurers and self-insurers, but they will not decrease as much.

(Ch. 1, art 1, sec 5, subd 2, 2015 Special Sess.)

V. Opioid Rules (Minnesota Rules part 5221.6110*)

- ▶ Opioid use for injured workers has greatly grown over the past 15 years. A 2014 study by WCRI showed 66% of nonsurgical work comp claimants with more than 7 days lost work time, who were given prescriptions for their injuries, received opioids. Six % of those were considered long-term users.
- ▶ After several years of consultation with the MSRB, input from affected parties and then proper procedural steps, DLI opioid rules became effective July 13, 2015.

*This is an overview only; the actual rules are available online at www.dli.mn.gov/PDF/docket/5221_6020_8900TrtmPar_2.pdf.

Opioid Rules

- ▶ Apply only to oral or skin patch (not injected opioids) when prescribed to be taken daily for at least 90 days.
- ▶ Require pain, function, risk assessments before starting.
- ▶ Selection criteria include: 1) all other reasonable medical treatment options have been exhausted; 2) patient can't maintain function without long-term use of opioids; 3) patient does not have a current substance use disorder; and 4) patient not using illegal substances.

Opioid Rules

Require:

- ▶ Written treatment contracts between the patient and health care provider.
 - ▶ Ongoing monitoring — increases with dosage or if patient is at high risk for dependency or abuse.
 - ▶ Referrals to specialists (required if patient is at high risk for dependence or abuse).
 - ▶ Documentation in the medical record.
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Opioid Rules

Insurer can deny payment for opioid treatment if first:

- ▶ Sends a copy of rules to patient and provider.
- ▶ Gives provider 30 days to initiate plan for compliance.

Opioid Rules

If patient has been on daily opioids for at least 90 days when rules became effective, provider must, within three months of insurer's notice:

- ▶ Assess patient's current pain and function.
 - ▶ Develop treatment plan consistent with rules.
 - ▶ Complete written contract with patient.
 - ▶ Initiate monitoring.
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Questions?



Addendum

Example of calculating outlier payment for a costly nonburn hospital case*

Basic facts needed

Hospital's charges	\$150,000
Usual MS-DRG payment	\$ 21,000
Hospital's cost to charge ratio**	.40
Fixed loss threshold***	\$ 24,758

To qualify for an outlier payment, the hospital's charges must exceed the usual MS-DRG payment by more than the fixed loss threshold.

Step One. Add MS-DRG payment to fixed loss threshold (\$21,000 + \$24,758). Result is \$45,758.

Step Two. Multiply hospital's charges by cost to charge ratio (\$150,000 x .40). Result is \$60,000.

Addendum

Step Three. Step Two result minus Step One result ($\$60,000 - \$45,758$). Result is $\$14,242$.

Step Four. Eighty percent of Step Three result ($\$14,242 \times .80$). Result is $\$11,393$.

Step Five. MS-DRG + Step Four result ($\$21,000 + \$11,393$). Total payment to hospital will be $\$32,393$.

Note: If this had been a burn case, Step Four would have been calculated $\$14,242 \times .90$ and the result would be $\$12,817$. The total payment from Step Five would have been $\$33,817$.

Addendum

- ▶ *This is a simplified example. More detailed information about calculating an outlier payment is online at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/outlier.html.
 - ▶ **Determined by Medicare for each individual hospital based on cost reports. Sometimes a statewide cost of charge ratio is used if Medicare is unable to determine individual one.
 - ▶ ***Annually determined by Medicare. The same number applies to every U.S. hospital receiving Medicare payments.
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