



# **REPORT ON WORKERS' COMPENSATION REIMBURSEMENT METHODOLOGIES**

December 12, 2012

State of Minnesota

Minnesota Department of Labor and Industry

**Pursuant to:**

**Master Contract T-Number 11ADA**

**Swift Master Contract Number 40490**

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# Agenda

- Introduction
- Study Overview
- Payment Systems Overview
- Study Area Findings
- MN-DLI Reimbursement Options

# Introduction

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# Study Overview

CGI was engaged to conduct a study of the various payment methods employed by Medicare, Medicaid and Workers' Compensation for 15 states for the following subject areas:

- Inpatient Hospital
- Small Hospitals
- Surgical Implants

# Study Overview

## Study focus: The payment for health care services

- Vulnerabilities are created when reimbursement is based on provider charge and is not managed via a fee schedule or case-based payment.
- While a fee schedule is a step towards managing the expense vulnerability, a case based payment system further extends the effort in closing that part of the system vulnerability.
- Even when fee schedule or case based systems are put into place, annual system maintenance and fee updates are necessary for the system to keep pace and maintain any system successes achieved.

# Study Overview

- The structure of the reimbursement systems reviewed for this study range from simple to very complex.
- Regardless of the primary payment mechanism, the associated policies and procedures that are implemented by the payer agency also affect payment.
- Payment policies and procedures such as prior authorization, visit limits, and case management impact total expenditures by the system as they can control utilization.
- That is to say, the effectiveness of a payment system is not defined purely by the primary payment mechanism but rather, by all approaches taken to cost control.

# PAYMENT SYSTEMS OVERVIEW

# Payment Systems Overview

## Health Insurance Reimbursement Goal:

- Pay providers for appropriately delivered services at a price level that is reasonable for the resources expended without disrupting patient access to care and the quality of care.
- Incentivize providers to deliver no more than the appropriate number of services to treat the condition.

# Payment Systems Overview – Types of Systems

## Charge based systems

- Usual and customary
- Discount on charges
- Cost and cost-plus

## Fee-for-service

- Case based patient classification systems
- Fee schedules

## Capitation

- Gatekeeper scenario

# Payment Systems Overview – Charge Based Methods

## Usual & Customary (UCR)

- Payment based on the average rate or charge in a related geographic area
- Actual payment may be at the UCR or some percentile of the UCR

## Discount on Charges

- A percentage of the claim charges is reimbursed
- Simple to administer payment

## Cost & Cost-Plus

- Requires the capture of cost information which can be complex
- Simple to administer payment

In general:

Payment = Service Charge x Percentage

# Payment System Overview – Fee for Service

## Case Based Patient Classification

- Patients are classified in a clinical and resource utilization perspective
- Example: diagnosis related groups (DRG)

## Fee Schedule

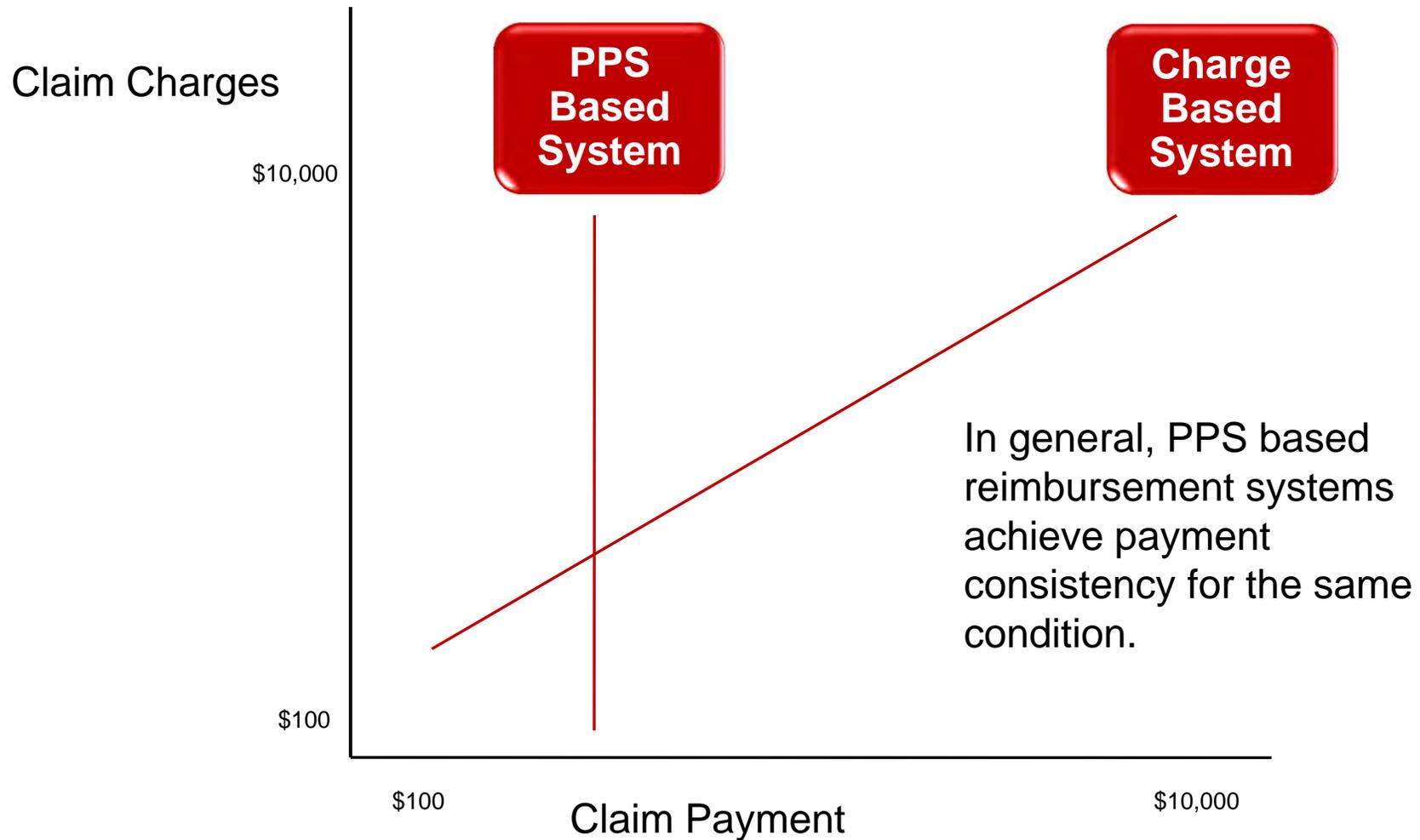
- Predetermined payment rates for all of the potential services to be bought

Payment calculation can be complex depending on how the reimbursement system is defined.

# Payment System Overview – Capitation

- Capitation relies on a primary gatekeeper who coordinates all of the beneficiaries care and in return, receives a set payment per person, per month.
- The gatekeeper is also responsible for the reimbursement to other providers for care not provided by the gatekeeper.

# Payment Systems Overview



*Diagnosis: Pneumonia*

# Payment Systems Overview

## Charge Based Payment

- Pro: simple to administer
- Con: providers are incentivized to provide more services than what may be necessary as payments are received for every billed service
- Con: may lead to claim detail line item denial

## Fee-for-Service: Fee Schedule

- Pro: predetermined payment rates permits better expense forecasting
- Pro: enhances the ability to identify what is being purchased and at what price
- Con: requires other payment policies in order to influence resource utilization
- Con: may lead to claim line item denial

## Fee-for-Service: Case Based

- Pro: predetermined payment rates permits better expense forecasting
- Pro: enhances the ability to identify what is being purchased
- Pro: incentivizes providers to provide an appropriate amount of services as reimbursement is not increased by billing more services
- Con: can be complex if designed to be

## Capitation

- Pro: most extreme control of resource expenditures
- Con: complex to design and administer
- Con: not a commonly used method

# Payment Systems Overview

	Charge-Based		Fee-for-Service		Capitation
	Charge	Cost	Case-Based	Fee Schedule	Capitation
<b>Admin Complexity (payment calculation)</b>	Simple	Simple	Moderate to Complex	Simple to Moderate	Simple
<b>Admin Complexity (system maintenance)</b>	Moderate based on allowed charge definition	Moderate to Complex based on allowable costs and level of detail	Moderate to Complex based on payment policies	Simple to Moderate	Complex due to capitation rate setting
<b>Utilization Control</b>	None – a separate function	None – a separate function	High – the payment system influences resources	Low – a separate function	High
<b>Timely Claim Processing</b>	Barrier if line item review undertaken	Barrier if line item review undertaken	Low risk of barrier as case-based systems utilize extensive claim editors	Barrier if line item review undertaken	Low risk of barrier
<b>Common Providers Covered</b>	All providers	Only providers with cost report information	Hospital providers	All providers	Physician gatekeeper

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# INPATIENT HOSPITAL



# Inpatient Hospital - Methods

## % of Charge (POC)

- Predetermined discount applied to claim charges
- Expressed as either a discount from charges or a cost-based percent of charges
- Much debate about what costs really are in hospital cost reporting

## Per Diem

- Predetermined payment rate applied per day of stay
- Medical, surgical, and obstetrical per diems are typically created
- Length of stay needs to be managed

## Diagnosis Related Group (DRG)

- Predetermined payment per case
- System components are weights, provider rates, supporting policies such as outlier, transfer
- Aligns payment with patient severity/resource consumption
- Widely used
- Permits benchmarking against other payers

**Comparison of Inpatient Payment Methods: WC to Medicaid**

<b>State</b>	<b>Worker's Compensation</b>	<b>Medicaid</b>	<b>Additional Information</b>
<b>Minnesota</b>	% Charge	CMS-DRG	
<b>California</b>	MS-DRG (120% of Medicare Excludes Cancer, Children's & CAH)	Per Diem & Per Discharge as contracted	WC: Implants carved out of outlier; reimbursed 110% of cost if elected
<b>Florida</b>	Per Diem	Per Diem with Peer Rates (DRG in FY2013)	WC: Implants at 160% of cost MCD: Implants not included in outlier calculation
<b>Illinois</b>	MS-DRG (some POC for low volume/unstable)	CMS-DRG v12	
<b>Iowa</b>	Charges	CMS-DRG v24	
<b>Louisiana</b>	Lesser of charge or Per Diem	Per Diem with Peer Rates	WC: Implants – 120% of cost MCD: Implants – fee schedule with prior authorization
<b>Maryland</b>	APR-DRG	APR-DRG	
<b>Massachusetts</b>	% of Charge (State regulates charges)	Case Mix Adjusted Cost based Per Diem (case mix based on APR- DRG)	
<b>Michigan</b>	Cost Based	MS-DRG (custom weights)	
<b>Nebraska</b>	MS-DRG (only WC related DRGs available)	AP-DRG (CCR for carveouts)	WC: Implants paid at 125% if costs & charges > \$10,000
<b>North Carolina</b>	75% of Charges	Per Diem – Rehab MS-DRG	
<b>North Dakota</b>	MS-DRG (No DSH/IME)	APR-DRG	
<b>Tennessee</b>	Per Diem (Lesser of charge or Per Diem; declining per diem)	100% Managed Care	WC: Implants at cost and not part of outlier calculation
<b>Washington</b>	AP-DRG	AP-DRG	
<b>Wisconsin</b>	Varies by WC Managed Care Insurer	MS-DRG with AP-DRG for neonates	
<b>Wyoming</b>	Usual & Customary Charges	Level of Care (LOC) for general; Per diem for rehab	WC: Implants at 130% of cost

**Comparison of Inpatient Payment Methods: WC to Medicaid**

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Florida	Per Diem	Per Diem with Peer Rates (DRG in FY2013)	WC: Implants at 160% of cost MCD: Implants not included in outlier calculation			
Illinois	MS-DRG	CMS-DRG v12				
Iowa	<p>The comparison above shows us that:</p> <ul style="list-style-type: none"> <li>• 40% (6/15) WC agencies and 73% (11/15) of Medicaid agencies follow a DRG system</li> <li>• 20% (3/15) WC agencies and 13% (2/15) Medicaid agencies follow a per diem system</li> <li>• 33% (5/15) WC agencies and no Medicaid agencies follow a percent-of-charge or cost based system</li> <li>• 33% (5/15) WC and Medicaid agencies follow a DRG based system within the same state</li> <li>• 13% (2/15) WC and Medicaid agencies follow a per diem based system within the same state</li> <li>• 40% (6/15) WC and 13% (2/15) Medicaid agencies have special handling of surgical implants outside of the primary inpatient payment system</li> </ul>					
Louisiana						th prior authorization
Maryland						
Massachusetts						
Michigan						
Nebraska						sts & charges >
North Carolina						
North Dakota						
Tennessee				MS-DRG (No DSH/IME) Per Diem (Lesser of charge or Per Diem; declining per diem)	100% Managed Care	WC: Implants at cost and not part of outlier calculation
Washington				AP-DRG	AP-DRG	
Wisconsin	Varies by WC Managed Care Insurer	MS-DRG with AP-DRG for neonates				
Wyoming	Usual & Customary Charges	Level of Care (LOC) for general; Per diem for rehab	WC: Implants at 130% of cost			

# Inpatient Hospital – Diagnosis Related Groups (DRG)

Characteristic	MS-DRGs v28 (CMS – Maintained by 3M)	APR-DRGs v28 (3M and NACHRI)
<b>Overall approach and treatment of complications and co-morbidities</b>	Intended for use in Medicare population. Includes 335 base DRGs, initially separated by severity into “no CC”, “with CC” or “with major CC”. Low volume DRGs are then combined.	Structure unrelated to Medicare. Includes 314 base DRGs, each with four severity levels. There is no CC or major CC list; instead, severity depends on the number and interaction of CCs.
<b>Number of DRGs</b>	746	1,258
<b>Newborn DRGs</b>	7 DRGs, no use of birth weight	28 base DRGs, each with four severity levels (total 112)
<b>Psychiatric DRGs</b>	9 DRGs; most stays group to “psychoses”	24 DRGs, each with four severity levels (96 total)
<b>Payment Use by Medicaid</b>	MI, NH, NM, OK, OR, SD, WI, NC	<u>Operational:</u> MA, MD, MT, NY, PA, RI, SC <u>Planned:</u> CA, CO, IL, MS, ND, TX
<b>Payment use by Workers Comp</b>	CA, IL, ND (all 3 are planning to move to APR-DRG)	MD
<b>Payment use by other payers</b>	Commercial plan use	BCBSMA, BCBSTN (analysis purposes only)
<b>ICD-10 Ready</b>	Yes	Yes
<b>Other users</b>	Medicare, hospitals	Hospitals, AHRQ, MedPAC, JCAHO, various state “report cards”
<b>Other uses</b>	Used as a risk adjustor in measuring readmissions. Used to reduce payment for hospital acquired conditions	Used as a risk adjustor in measuring mortality, readmissions, complications

# Inpatient Hospital – Diagnosis Related Groups (DRG)

	A	B	C	D	E	F	G	H	I
1	<b>TABLE 5.—LIST OF MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS (MS-DRGS), RELATIVE WEIGHTING FACTORS, AND GEOMETRIC AND ARITHMETIC MEAN LENGTH OF STAY—FY 2013</b>								
2	MS-DRG	FY 2013 Final Rule Post-Acute DRG	FY 2013 Final Rule Special Pay DRG	MDC	TYPE	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
359	459	Yes	No	08	SURG	SPINAL FUSION EXCEPT CERVICAL W MCC	6.5390	7.3	9.1
360	460	Yes	No	08	SURG	SPINAL FUSION EXCEPT CERVICAL W/O MCC	3.8783	3.1	3.6
361	461	No	No	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W MCC	4.9062	6.4	7.7
362	462	No	No	08	SURG	BILATERAL OR MULTIPLE MAJOR JOINT PROCS OF LOWER EXTREMITY W/O MCC	3.3745	3.5	3.8
363	463	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W MCC	5.4443	10.9	15.1
364	464	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W CC	2.9406	6.5	8.2
365	465	Yes	No	08	SURG	WND DEBRID & SKN GRFT EXC HAND, FOR MUSCULO-CONN TISS DIS W/O CC/MCC	1.8802	3.9	5.0

Relative Values, Average Length of Stay, and High-Cost Outlier Threshold and Percentage for APR-DRG Grouper Version 27  
Effective For Dates of Discharge On Or After July 1, 2010 Following Implementation of APR-DRG  
Inpatient Fee-for-Service

DRG	Severity of Illness	Description	Relative Value	Average Length of Stay	High-Cost Outlier	
					Threshold	Percentage
0320	1	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES	0.8020	2.03	24,000	80%
0320	2	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES	1.4386	4.47	24,000	80%
0320	3	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES	2.6150	8.73	24,000	80%
0320	4	OTHER MUSCULOSKELETAL SYSTEM & CONNECTIVE TISSUE PROCEDURES	7.1594	17.48	24,000	80%
0321	1	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP	1.3945	1.59	24,000	80%
0321	2	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP	1.8953	2.71	24,000	80%
0321	3	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP	3.8021	7.45	24,000	80%
0321	4	CERVICAL SPINAL FUSION & OTHER BACK/NECK PROC EXC DISC EXCIS/DECOMP	6.3717	17.09	24,000	80%

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# SMALL HOSPITALS



# Small Hospitals

- Small hospitals were defined as 100 beds or less
- Mix of hospitals:
  - Critical Access (25 beds or less)
  - Small Rural
  - Sole Community
  - Rural Referral Center
- Mix of payment methods

# Small Hospitals

Comparison of Small Hospital Payment Methods: WC to Medicaid			
State	Worker's Compensation	Medicaid	Additional Information
Minnesota	100% Charge	DRG + 15%/20%	
California	Follows Medicare	Separate Schedule	
Florida	No Separate Distinction	No Separate Distinction	
Illinois	No Separate Distinction	No Separate Distinction	MCD: Peer group rates for IP
Iowa	Charges	Cost	
Louisiana	Location – not size	IP: Per Diem OP: 110% Cost	
Maryland	No Separate Distinction	Revenue Regulated	
Massachusetts	No Separate Distinction	Cost w/incentives	
Michigan	No Separate Distinction	No Separate Distinction	
Nebraska	Bed size & location	IP: Cost OP: 97.5% Charge	
North Carolina	Cost	Cost	
North Dakota	No Separate Distinction	No Separate Distinction	
Tennessee	No Separate Distinction	Managed Care	TN Medicaid is fully managed care to 3 primary payers whose information is largely private.
Washington	CAH – OP=POC	CAH – Cost No other distinction	
Wisconsin	No Separate Distinction	Cost	
Wyoming	No Separate Distinction	Increase in Standard Rate	

- 67% (10/15) WC and 27% (4/15) Medicaid agencies make no separate distinction with regard to pricing for small hospitals
- Inpatient Medicaid reimbursement, if any modification is made for small hospitals, it is typically handled through a provider base rate but they do not have a separate reimbursement mechanism from the primary system.
- Washington recognizes only CAHs for special consideration

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# SURGICAL IMPLANTS

# Payment Systems Overview – Surgical Implants

- Surgical implants are specific devices used and implanted into the body.
- Often are very expensive with only a few manufacturers creating the device.

# Payment Systems Overview – Surgical Implants

Comparison of Surgical Implant Payment Methods: WC to Medicaid			
State	Worker's Compensation	Medicaid	Additional Information
Minnesota	% Charge	No Separate Payment	
California	No Separate Payment	Invoice	
Florida	Hosp: Invoice + 60% ASC: Invoice + 50%	Cochlear Implants – Invoice	
Illinois	Invoice + 25%	Via outlier calculation	
Iowa	Charge	Fee Schedule	
Louisiana	Physician: Invoice + 20%	Fee Schedule	
Maryland	No Separate Payment	No Separate Payment	
Massachusetts	No Separate Payment	IP: Cost OP: No separate payment	
Michigan	Invoice + % (varies)	No Separate Payment	
Nebraska	Invoice + 25% if > \$10k	IP – No separate payment OP – Cost	
North Carolina	No Separate Payment	Fee Schedule	
North Dakota	No Separate Payment	Fee Schedule	
Tennessee	> \$100 = Invoice + 15% up to \$1,000	Managed Care	BlueCare: included in case rates unless contracted otherwise
Washington	IP/OP: No Separate Payment ASC – Invoice	No Separate Payment	
Wisconsin	Managed Care	Prior Auth	
Wyoming	> \$1,000 – Invoice + 30%	No Separate Payment	

Payments for Surgical Implants typically followed:

- No separate treatment from the primary payment system, or
- Carved-out of the primary payment system & reimbursed at invoice cost (+)

# MN-DLI REIMBURSEMENT OPTIONS

# Reimbursement Options – Study Findings Summary

Study Area	Workers' Compensation	Medicaid	Medicare
<b>Inpatient Hospital</b>	60% PPS 33% POC/Cost	86% PPS 0% POC/Cost	PPS
<b>Outpatient Hospital</b>	27% APC 27% POC 20% Fee Schedule	27% APC 0% POC 27% Fee Schedule 47% EAPG	OPPS based on APC
<b>Small Hospital</b>	67% No special treatment	27% No special treatment	Cost-based
<b>Ambulatory Surgery Center (ASC)</b>	40% Medicare ASC 27% POC/Chg 20% Fee Schedule	20% Medicare ASC 7% POC 47% Old Medicare ASC Groups	APCs for ASCs
<b>Anesthesia Providers</b>	87% RVU	87% RVU	RVU
<b>Surgical Implants</b>	13% POC/Chg 40% No Separate Pmt 47% Invoice plus 0% Fee Schedule	0% POC/Chg 33% No Separate Pmt 27% Invoice plus 27% Fee Schedule	No separate payment
<b>Key:</b> PPS – Prospective payment system POC – Percent-of-Charge APC – Ambulatory Patient Classification EAPG – Enhanced Ambulatory Patient Groups RVU – Relative Value Units			

# Reimbursement Option – Inpatient Hospital

CGI recommended direction: MS-DRGs

MS-DRG Reimbursement System Component	MN-DLI Decisions
<b>Obtain Supporting Data</b>	<ul style="list-style-type: none"> <li>• Obtain two years of claims data in order to evaluate the impact to the system that affects both payers and providers</li> <li>• Identify and evaluate cost data to be used in determination of outlier payments, and provider margin analysis</li> <li>• Identify inflation factors to be used to adjust claims data to current</li> </ul>
<b>Grouper</b>	<ul style="list-style-type: none"> <li>• Identify the version of MS-DRGs to begin implementation</li> <li>• Identify vendors to support grouping and pricing</li> </ul>
<b>DRG Weights</b>	<ul style="list-style-type: none"> <li>• Identify and evaluate Medicare DRG weights or the creation of custom DRG weights</li> <li>• Identify and evaluate charge-based or cost-based weights</li> </ul>
<b>Payment Policies</b>	<ul style="list-style-type: none"> <li>• Determine base rates</li> <li>• Identify supporting payment policies:               <ul style="list-style-type: none"> <li>○ Transfer policy</li> <li>○ Outlier policy</li> <li>○ Provider preventable conditions</li> <li>○ Readmissions</li> <li>○ Short stay policy</li> </ul> </li> <li>• Determine included and excluded inpatient services</li> </ul>
<b>System Maintenance</b>	<ul style="list-style-type: none"> <li>• Determine system update schedule and for which components</li> </ul>

# Reimbursement Option – Small Hospitals

- CGI recommended direction: Include in payment methodology for inpatient and outpatient hospitals
- The research shows that small hospitals are not exempt from prospectively set reimbursement systems.
- Small hospital reimbursement usually follows the payment system for the setting of the delivery of care. That is, no different treatment from the primary inpatient hospital reimbursement and the same is true for outpatient hospital reimbursement.
- CGI recommends that small hospitals be blended into any new inpatient or outpatient hospital reimbursement changes.
- Options exist with regard to creating an add-on payment in addition to the prospective payment system but this is a matter of policy.

# Reimbursement Option – Surgical Implants

## CGI recommended direction:

- Include surgical implant reimbursement in the primary payment methodology for inpatient, outpatient, and ASCs if a prospectively based system is implemented. If no change is made to those systems, then reimbursement for surgical implants should be established at invoice cost.
- Surgical implants are subject to substantial price inflation and have been the latest hot topic in healthcare publications due to the increasingly high utilization of devices.
- By removing the exposure to the payment based on provider charge, the expense associated with the device payment will result in less exposure to price inflation from the provider.

# Questions & Wrap up



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