**ADVISORY NO. 418**
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**TOPIC: DIVISION HEARS TESTIMONY ON HOSPITAL FEE GUIDELINES**

The lines were sharply drawn between hospital and business interests during public testimony over the Division of Workers' Compensation's proposed hospital fee guidelines. On November 12, 2007, Commissioner of Workers' Compensation Albert Betts, Jr., heard testimony from witnesses representing a variety of stakeholder interests on the hospital fee guideline rules.

The proposed rules apply reimbursement methodologies that reflect current Medicare prospective payment practices, including an outlier methodology to replace the current charge-based stop-loss methodology.

The rules propose two different payment adjustment factors (PAFs) for inpatient and outpatient admissions. For inpatient hospital reimbursement, the Division has recommended 143 percent of Medicare reimbursement as the default PAF, and 108 percent for any diagnosis related group (DRG) involving surgically implanted devices that are requested to be paid separately. For outpatient hospital reimbursement, the Division has recommended 200 percent of Medicare reimbursement as the default PAF, and 130 percent for any ambulatory payment classification (APD) involving surgically implanted devices that are requested to be paid separately.

The rules propose that implantables, when billed separately, should be limited to an add-on reimbursement rate of 10 percent of the invoice cost or $1000, whichever is less.

The position of some hospital stakeholders was typified by the testimony of Dan De La Garza, CEO of Renaissance Health Care Systems, who told the Commissioner that inpatient admissions should be reimbursed at between 175 percent to 200 percent of Medicare or 140 percent of Medicare where implants are requested to be paid separately.

Charles Bailey, M.D., speaking on behalf of the Texas Hospital Association, criticized the rule's DRG reduction for shorter lengths of stay. Dr. Bailey predicted that most hospitals would not use the implantable carve out option. He also requested that the Division reinstate into its reimbursement calculation any costs that hospitals suffer because they are teaching hospitals, or by virtue of their bad debts.

Ron Luke, speaking on behalf of the Texas Association of Business, argued that the rules' proposals to carve out implantables for an alternate billing methodology should be discarded because it was unnecessary, potentially in violation of the labor code, and because the methodology would facilitate perceived improper business practices. Essentially, Mr. Luke contended that the carve out provisions would fail to facilitate effective medical cost control, as

required by the statute. TAB argued that the Division should set a single PAF of 120 percent of Medicare reimbursement for both inpatient and outpatient billing.

The Insurance Council of Texas, represented by Steve Nichols, urged the Division to abandon the carve out approach and set separate, single PAFs for inpatient and outpatient reimbursement, respectively.

Because a large number of medical fee disputes and court appeals have resulted from the absence of a fee guideline for hospital outpatient services and from controversies regarding interpretation of the stop-loss provisions of the current acute care inpatient hospital fee guideline (§134.401), the Division has stated that it anticipates that the number of fee disputes related to hospital services will decrease with the adoption of Medicare based hospital outpatient and inpatient fee guidelines. Such a decrease in fee disputes was the experience with implementation of §134.402 of this title (relating to Ambulatory Surgery Center Fee Guideline).

The Division believes that aggregate medical costs will increase under the rules, because the new guidelines establish a reimbursement methodology benchmarked to Medicare and reflective of the current economic indicators of health and the fair and reasonable standard established by the statute. Reimbursement for inpatient hospital stays will increase, according to DWC statements while reimbursement for outpatient services could decrease slightly.

The agency has recognized that there will be initial start-up costs for some carriers to convert their automated system to a Medicare based methodology. Carriers operating in other states with a Medicare-based reimbursement methodology may not incur these costs. These costs are difficult to quantify since each carrier has unique processing systems and internal controls. For hospitals, the reimbursement method used by Medicare is relatively simple and has been in use for some time. The administrative cost for hospitals to convert to this reimbursement system should be small.

The proposed rules are scheduled to take effect for any hospital services provided on or after March 1, 2008. The rules do not apply to professional medical services billed by a provider not employed by the hospital, except for a surgical implant provider and are not applicable to services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305.

**Texas Department of Insurance**
**Division of Workers' Compensation**
**Summary of Rule Proposals**

**Rules**
§134.403 Hospital Facility Fee Guideline – Outpatient
§134.404 Hospital Facility Fee Guideline – Inpatient

**Purpose of the Rules**
The proposed rules include §134.403, a new outpatient hospital fee guideline. The Division has not previously promulgated rules for hospital outpatient fees. The lack of a fee schedule leads to fee disputes over fair and reasonable reimbursement for these services.

The proposed rules also include §134.404, a new inpatient hospital fee guideline. The proposed rule applies reimbursement methodologies that reflect current Medicare prospective payment practices, including an outlier methodology to replace the current charge-based stop-loss methodology.

Both new proposed rules include language to comply with the requirements of the Labor Code §413.011, which includes using the Medicare system as a framework for the billing and reimbursement methodology and establishing standardized formats used in the group health and Medicare systems. Additionally, the rules will provide more consistent, structured reimbursement, which should result in a decrease in medical fee disputes.

**Hospital Fee Guidelines Research and Data**
During the development of these proposed rules, the Division reviewed and considered data from the following sources:
- Texas Health Care Information Council CY 2005 inpatient hospital data
- Data collected and submitted by the Texas Hospital Association
- Report from Research & Planning Consultants, LP – under contract with Texas Mutual Insurance Company and other carriers
- Report submitted by Renaissance Healthcare Systems, Inc.
- Hospital industry market and reimbursement information from the Medicare Payment Advisory Commission
- Texas workers' compensation data reported by insurance carriers and maintained by the Division
- Market based reimbursement information provided by Ingenix, Inc. – under contract with the former Texas Workers' Compensation Commission
- Milliman report analysis of payments for CY 2005 workers' compensation services as indexed to Medicare reimbursement – under contract with the Division
  1. Milliman estimated overall inpatient reimbursement at 115% of Medicare
     - Claims with charges < $40,000 reimbursed at approximately 66% of Medicare
     - Claims with charges > $40,000 reimbursed approximately 160% of Medicare
  2. Milliman estimated overall outpatient reimbursement at 186% Medicare
- Research of states with significantly Medicare-based reimbursement models are:

| Inpatient Medicare Reimbursement Model | Outpatient Medicare Reimbursement Model |
|---|---|
| California - 120% | California - 122% |
| North Dakota - 130% | North Dakota - 165% |
| Ohio - 115% | South Carolina - 140% |
| South Carolina - 140% | Tennessee - 150%, or facility's discretion to choose to bill and be reimbursed 150% of non-device portion of the APC[2] plus separate implantable reimbursement |

**Stakeholder Payment Adjustment Factor (PAF) Recommendation Ranges**
- Inpatient 100% to 170% of Medicare, separate reimbursement for implantables, carve-outs and stop-loss.
- Outpatient 100% to 275% of Medicare, separate reimbursement for implantables.

**Rule Highlights Reflecting Informal Comments**

- Include the reference to the most recently adopted and effective Medicare Outpatient or Inpatient Prospective Payment System (OPPS/IPPS) reimbursement formula and factors as published annually in the *Federal Register* rather than including the actual formula in the rule.
- For each rule proposed, two PAFs:
  1. For inpatient Medicare reimbursement - 143% as default PAF, and 108% for those DRGs[1] with surgically implanted devices requested to be paid separately;
  2. For outpatient Medicare reimbursement - 200% as default PAF, and 130% for those APCs[2] with surgically implanted devices requested to be paid separately.
- For implantables when billed separately, limits the add-on reimbursement to 10% of the invoice cost or $1,000, whichever is less.
- Defines and allows billing by a "surgical implant provider."
- Inpatient hospitals classified by Medicare as Sole Community Hospital, Medicare Dependent Hospital, or Rural Referral Center Hospitals are initially to be paid the proposed Maximum Allowable Reimbursement (MAR) amount in the rule. If the initial payment is less than the cost of the services in question, the hospital may request reconsideration, present documentation of any amount it would have been paid under the Medicare regulations in effect when the services were performed and the hospital shall be paid the difference as adjusted by the appropriate multiplier.

**Proposed Rule Application**

Actual examples of inpatient hospital fee disputes reflecting actual workers' compensation insurance carrier payments and re-priced to reflect Medicare reimbursement and reimbursement based on the proposed rules.

| Brief Descriptor of Diagnosis Related Groups (DRGs) – see DRG footnote | DRG Numbers | Hospital Billed Charges | Actual WC Insurance Carrier Payment | Re-Priced at Medicare DRG Payment | Proposed Payment @ 143% | Proposed Payment @ 108% + Implant |
|---|---|---|---|---|---|---|
| Post operative or post-traumatic infections w/ operating room procedure | 579 | $18,691 | $1,118 | $16,868 | $24,121 | no implant |
| Traumatic injury; age >17; w/o complications | 445 | $9,983 | $1,527 | $3,565 | $5,098 | no implant |
| Lower extremity & humerus procedure; except hip, foot, femur; age >17 w/o complications | 219 | $41,495 | $6,599 | $10,018 | $14,325 | $14,512 |
| Spinal fusion; except cervical, w/o complications | 498 | $104,304 | $45,561 | $25,861 | $36,982 | $53,367 |

**Estimated Fiscal Impact**

| Estimated Impact (in $Millions) | | | | |
|---|---|---|---|---|
| | Estimated 2005 Workers' Compensation Reimbursement | Estimated Projected Payments | Change | Projected Change |
| Inpatient | $ 93.35 | $ 120.50 | $ 27.14 | 29.1% |
| Outpatient | $110.12 | $ 105.39 | $ (4.72) | -4.3% |
| Estimated total hospital impact | $203.47 | $ 225.89 | $ 22.42 | 11.0% |
| Estimated total medical cost impact | $991.69 | $1,014.11 | $ 22.42 | 2.3% |

[1] DRG: Diagnosis Related Groups; approximately 536 DRG groups for CY 2007 are based on clinically similar diagnoses requiring similar amounts of resources; each inpatient stay is grouped into a single DRG, and each stay is reimbursed at a predetermined reimbursement rate per DRG.

[2] APC: Ambulatory Payment Classifications; more than 808 APCs based on clinically similar items and services requiring similar resources; an outpatient visit may include multiple APCs, each APC having a predetermined reimbursement rate.