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MEMORANDUM

FROM: **Workers Compensation Research Institute (WCRI)**

DATE: **November 10, 2020**

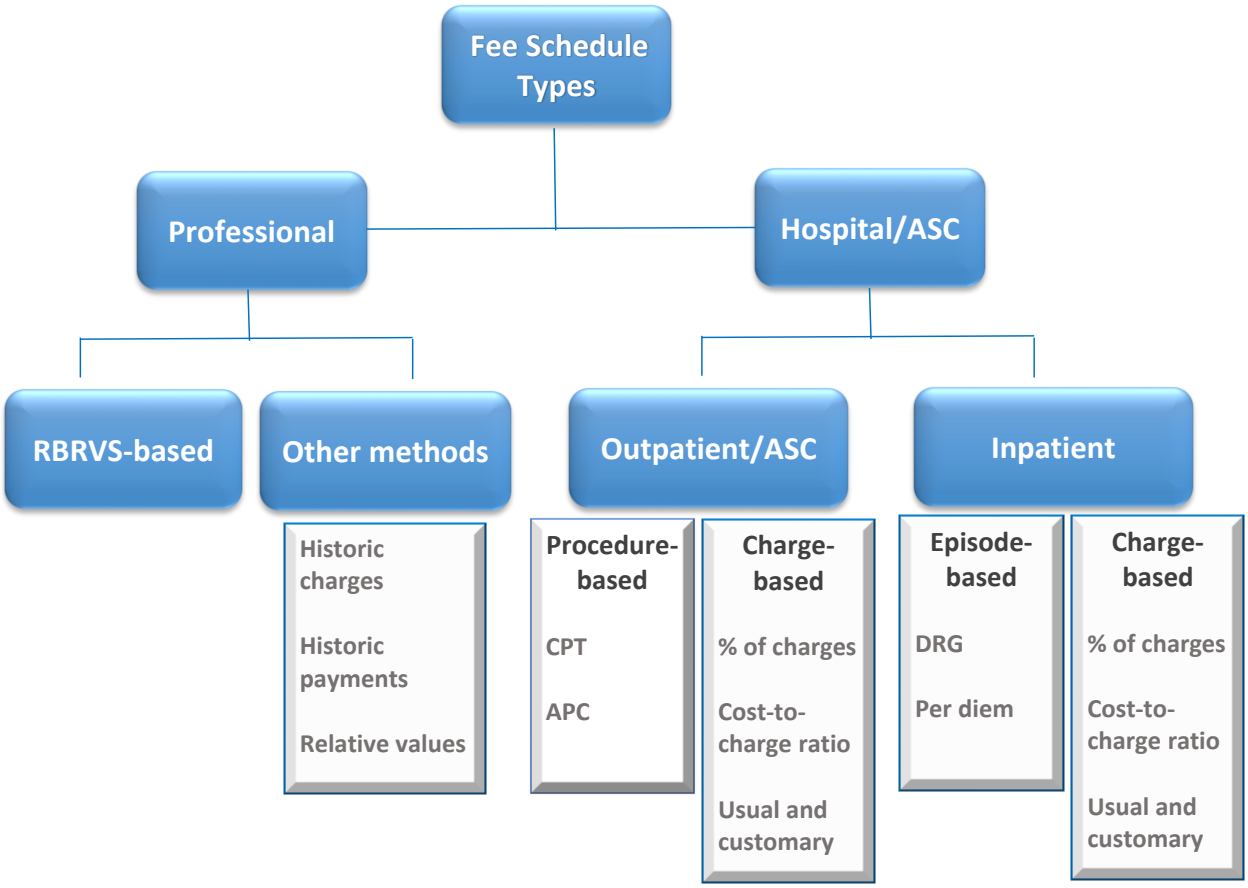
RE: **Medical fee schedules for hospital/ambulatory surgery center (ASC) services in workers' compensation**

This memorandum describes the elements of workers' compensation (WC) medical fee schedules for hospital services. Note that other elements of the fee schedules are described in the memorandum for professional services fee schedules. Throughout this document, we use the term *fee schedule* to refer to *workers' compensation medical fee schedules*. In the subsequent sections, we provide examples from many different states. The examples illustrate the variety in the methods used and the features of different methods.

As of 2018, 45 states use fee schedules. States that most recently introduced fee schedules are Virginia (for services effective January 1, 2018), and Indiana (for hospital services effective July 1, 2014).

Number of Jurisdictions With WC Fee Schedules as of 2018				
	Professional	**Hospital Outpatient**	**Hospital Inpatient**	**ASC**
With fee schedule	**45**	**43**	**44**	**42**
No fee schedule	IA, IN, MO, NJ, NH, WI	AZ, DC, IA, MO, NH, NJ, UT, WI	AZ, DC, IA, MO, NH, NJ, WI	AZ, DC, IA, IN, MO, NH, NJ, UT, WI

In this memorandum, we focus on the most common fee schedules for hospital services. The diagram below summarizes common methods for computing fee schedule amounts.



Key:
APC: Ambulatory payment classification
ASC: Ambulatory surgery center
CPT: Current Procedural Terminology
DRG: Diagnosis-related groups
RBRVS: Resource-based relative value scale

How the Hospital Fee Schedule Is Determined

Hospital Outpatient/Ambulatory Surgery Centers (ASC)

There are two main methods for reimbursing hospitals and ASCs for outpatient care:

1. **Procedure-based.** This method includes reimbursements based on CPT/HCPCS[1] codes or Ambulatory Payment Classification (APC) groups.
    - The CPT/HCPCS approach assigns reimbursement amounts by procedure.
    - APC is part of the Medicare *Outpatient Prospective Payment System* (OPPS). All services paid under OPPS are classified into groups called APCs. Services in each APC are similar clinically and in terms of the resources they require. The Centers for

[1] CPT: Current Procedural Terminology. HCPCS: Healthcare Common Procedure Coding System is a registered trademark of the American Medical Association.

Medicare & Medicaid Services (CMS) has established a payment rate for each APC. Note that under this type of payment system, reimbursements for certain services (for instance, office visits and physical medicine) are not covered; they are paid under the RBRVS system.

2. **Charge-based.** This method includes percent of billed charges, *cost-to-charge* ratio, and usual and customary rates. Each of these methods reimburses the provider explicitly for the services billed.
    - **Percent of charges.** This method for reimbursing hospital services is based on hospital-level charge information. The hospital charge represents the amount that hospitals billed for services, but does not reflect how much hospital services actually cost or the specific amounts that hospitals received in payment. In some cases, system stakeholders may be interested in seeing how hospital charges translate into actual costs. *Cost-to-charge* ratio methodology enables this conversion.
    - ***Cost-to-charge* ratio.** Hospital-specific *cost-to-charge* ratio is based on all-payor cost. Cost information is obtained from the hospital accounting reports collected by CMS. The maximum payment for hospital services is calculated by multiplying the actual charge by the *cost-to-charge* ratio (see the example from Michigan below). Although the *cost-to-charge* methodology contains a charge element in calculating the reimbursement amount, in general hospitals do not have an incentive to increase the charges over time (unless the cost is growing too) because this may affect their *cost-to-charge* ratio in the next year. In contrast, the *percent of charge* methodology may create incentives for hospital providers to increase the charges over the years and as a result, this may lead to steady growth in actual payments.
    - **Usual and customary.** Two examples of how usual and customary can be specified are: (1) as a prevailing charge among providers, and (2) as an individual facility's usual and customary charge. The usual and customary amount is typically derived from the amount charged to all payors or the community in which the service was rendered, rather than from only workers' compensation claims. Note that usual and customary rates are not specifically defined in many states. Some states may use external databases (for instance, Fair Health) to define usual and customary.

Number of States Using Each Hospital Outpatient/ASC Reimbursement Method (not exclusive)						
	Procedure-based		Charge-based			Other
	CPT	APC	% of Charges	Cost-to-charge ratio	Usual and Customary	
Hospital Outpatient	13	11	12	5	4	5
ASC	9	18	12	1	3	4

Notes:
Some states use a combination of methods and may appear in more than one column in the table.
"Other" includes states with charge-based methods with some modification.

Examples from states using different reimbursement methods:

Illinois (CPT-based): The hospital outpatient and ASC fee schedule rates are listed by type of

procedure (CPT), but they differ between ASCs and hospital outpatient departments depending on the region where the service was provided. Illinois has four fee schedule regions for ASCs and 14 for hospital outpatient services. Note that this fee schedule includes radiology, pathology and laboratory, and physical medicine and rehabilitation, as well as surgical services performed in a hospital outpatient setting that were not performed during an emergency room encounter or inpatient hospital admission.

Indiana (APC-based for hospitals, charge-based for ASCs): Hospital outpatient services are based on CMS APC groups (initially set at 200 percent of CMS rates). The reimbursement for services provided by ASCs is not covered by the hospital fee schedule. For ASC services in a defined community, payments are based on charges made by medical service providers at the 80th percentile in the same community for like services or products.

Louisiana (charge-based): Payments are based on 90 percent of billed charges. However, the WC statute calls for reimbursement based on the average of usual and customary charges.

Tennessee (APC-based): Tennessee uses the same approach to reimburse providers for surgery performed in hospital outpatient departments and ASCs. Payments are based on Medicare APC with rates set at 150 percent of the Medicare amount for listed procedures. For unlisted procedures, payments are based on 80 percent of the charges. For purposes of workers' compensation reimbursement to ASCs, the facility must be an approved Medicare ASC. Other outpatient services like diagnostics, laboratory, and physician services use a nonfacility provider fee schedule.

Michigan (*cost-to-charge* ratio):

- The Health Care Services Division of the Workers' Disability Compensation Agency publishes hospital ratios annually. The agency calculates ratios for each hospital based on the most recent fiscal year financial statement of patient revenue and operating expenses submitted to the Michigan Department of Health and Human Services. The WC agency calculates each hospital's *cost-to-charge* ratio by dividing the hospital's total operating expenses by the total patient revenue; the individual hospital ratios are then published.
- The reimbursement amount is calculated as

  Hospital charges x Hospital cost-to-charge ratio x 107% (or 110%)
- 107 percent is used for properly submitted bills within 30 days; 110 percent is used for properly submitted bills after 30 days.

Montana (group health rates): The Department of Labor and Industry obtains price information from each of the top five largest commercial insurers and group health third-party administrators in the state. The Department computes an average reimbursement rate. The statute guarantees the confidentiality of the individual insurer's price information.

HOSPITAL INPATIENT

There are two main methods for reimbursing hospitals for inpatient care:

1. **Episode-based.** This reimbursement approach includes *per diem* and *diagnosis-related groups (DRG).* These methods reimburse the provider at a flat rate, either per day or by DRG for all services provided during the inpatient stay.
   - ***Per diem* rate** covers all procedures and services used to treat the patient each day during the inpatient stay.
   - **DRGs** are part of the Medicare *Inpatient Prospective Payment System* (IPPS). This system

categorizes cases into *medical severity diagnosis-related groups* (MS-DRGs). Cases are separated into relatively homogenous groups with similar resource consumption and length of stay. DRGs incorporate the principal diagnosis, secondary diagnoses, procedures performed, and the age, sex, and discharge status of the patient. Reimbursement is based on a flat rate per DRG for all services needed to treat the patient.

2. **Charge-based.** Reimbursement is based on percent of billed charges, *cost-to-charge* ratio, per procedure, and usual and customary rates. Each of these methods reimburses the provider explicitly for the services billed. Unlike episode-based approaches, charge-based rates are not intended to be all inclusive.

Number of States Using Each Hospital Inpatient Reimbursement Method (not exclusively)					
Episode-based		Charge-based			Other
DRG	Per Diem	% of Charges	Cost-to-charge Ratio	Usual and Customary	
17	10	10	7	2	5

Notes:
Some states use a combination of methods and may appear in more than one column in the table.
"Other" includes states with charge-based methods with some modification.

Note that multiple methods are often used to reimburse for hospital inpatient care depending on the type of hospital, hospital size, location, or admission type. Most states also include a cost outlier provision (stop-loss) to allow additional payments in unusually costly—typically severe—cases. Some states also allow for separate reimbursement of durable medical equipment, supplies, and implants. To illustrate this point we are using Illinois and Minnesota as examples.

Illinois:

- Trauma admissions for Level I and II trauma centers: payments are based on MS-DRG or 53.2 percent of charges if no assigned DRG
- Standard admission: MS-DRG or 53.2 percent of charges if no assigned DRG
- Rehabilitation hospitals: *per diem*
- Seven revenue codes (called *pass-through*) as defined in the regulations: 65 percent of charges
- Cost outlier provision: If the bill for the inpatient stay is 2.857 times the fee schedule amount per MS-DRG, the maximum for the cost outlier is the assigned DRG fee schedule amount plus 53.2 percent of the charges that exceeded that DRG amount. Note the *pass-through* revenue codes are deducted and paid separately at 65 percent of charges

Minnesota:

- All inpatient services: maximum payment is based on 200 percent of the CMS MS-DRGs
- Catastrophic, high-cost injuries: if the hospital's usual and customary charge exceeds a certain threshold, which is updated annually ($209,868 for discharges October 2019–September 2020), payment is based on 75 percent of hospital's usual and customary charges
- Critical access hospitals (total of 79): 100 percent of usual and customary charges

REFERENCES

WCRI reports

Coomer, N. 2010a. *Fee schedules for hospital and ambulatory surgical centers: A guide for policymakers*. Cambridge, MA: Workers Compensation Research Institute.

———. 2010b. *National inventory of workers' compensation fee schedules for hospitals and ambulatory surgical centers*. Cambridge, MA: Workers Compensation Research Institute.

Fomenko, O. 2013. *Comparing workers' compensation and group health hospital outpatient payments*. Cambridge, MA: Workers Compensation Research Institute.

Fomenko, O., and T. Liu. 2019. *Designing workers' compensation medical fee schedules, 2019.* Cambridge, MA: Workers Compensation Research Institute.

Fomenko, O., and R. Victor. 2013. *A new benchmark for workers' compensation fee schedules: Prices paid by commercial insurers?* Cambridge, MA: Workers Compensation Research Institute.

Rothkin, K., and R. Tanabe. 2018. *Workers' compensation medical cost containment: A national inventory, 2018.* Cambridge, MA: Workers Compensation Research Institute.

Additional sources by state

Indiana

Indiana General Assembly. *Indiana WC act*. Retrieved from http://iga.in.gov/legislative/laws/2019/ic/titles/022/#22-3.[i]

Illinois

Illinois Workers' Compensation Commission, *Illinois rules for treatment, effective 11/20/12*. Retrieved from https://www2.illinois.gov/sites/iwcc/Documents/Section7110.90--112012.pdf.[i]

Michigan

Workers' Disability Compensation Agency, Health Care Services Division. *Michigan cost-to-charge ratio method*. Retrieved from https://www.michigan.gov/leo/0,5863,7-336-94422_95508_26922-335659--,00.html.[i]

Department of Licensing and Regulatory Affairs, Workers' Compensation Agency. *Reference guide to calculate Michigan WC maximum allowable payments for evaluation and management, medicine, physical medicine, radiology and surgery*. Retrieved from https://www.michigan.gov/documents/wca/RBRVS_Methodology_643297_7.pdf.[i]

Louisiana

Louisiana Administrative Code, Title 40, Chapter 25, Section 2507. *Hospital outpatient reimbursement*.
Louisiana Revised Statutes, 23:1034.2 *Reimbursement schedule*.

Minnesota

Office of the Revisor of Statutes. *Minnesota hospital inpatient regulations*. Retrieved from https://www.revisor.mn.gov/statutes/cite/176.1362.[i]

Montana

Montana Code Payment of Medical, Hospital, and Related Services - Fee Schedules and Hospital Rates. 39-71-704 (b)(1). Retrieved from https://leg.mt.gov/bills/mca/title_0390/chapter_0710/part_0070/section_0040/0390-0710-0070-0040.html.[i]

Tennessee

Tennessee WC medical fee schedule overview. Retrieved from https://www.tn.gov/content/dam/tn/workforce/documents/injuries/TNMFS_Handbook_Jan2020.pdf.[i]

[i] All links have been accessed on November 6, 2020.