Using Medicare as a Model for Hospital Fee Reimbursement

By Leann Lewis, Senior Business Consultant, Coventry Workers’ Comp

Executive Summary

As states began looking for ways to address medical cost containment in workers’ compensation, many considered Medicare as a model for fee schedule development. Some believe Medicare’s budget-neutral approach is an easy way to obtain cost savings; others believe that using an existing process that is maintained by the federal government means less resources needed in a given state agency; and some have no other method to approach cost containment outside of taking the same, hopefully proven, approach other jurisdictions have taken. Since 2014, eight jurisdictions passed laws, adopted rules, or considered switching to Medicare-based reimbursement for facility charges associated with work-related injuries.

Virginia and Florida considered and rejected Medicare-based reimbursement proposals in 2014.

Minnesota proposed legislation that would adopt Medicare-based pricing for inpatient facility bills and is considering adopting similar requirements for outpatient.

Alaska passed legislation that adopts Medicare-based pricing.

Tennessee, which already reimburses outpatient facility bills at Medicare-based rates, is considering adopting similar requirements for inpatient facility bills.

When contemplating the various medical benefit cost-driver categories, hospital charges are a natural focus for cost containment efforts because charges tend to be large for a single visit or stay. Often, workers’ compensation cost containment advisory groups spend significant time discussing reimbursement rates for services. The affect of pricing rules might not be included in the discussion at all. Setting rates is only one component of fee schedule development; requirements related to coding rules and billing policies can present distinct challenges and, left to interpretation by bill review organizations and payers, might result in unintended consequences. This whitepaper outlines the supplementary considerations rulemaking entities should consider when writing Medicare-based reimbursement rules.
**Inpatient Services**

In the context of workers’ compensation, there are three inpatient hospital bill topics that are often customized from Medicare to meet the needs of a particular jurisdiction. These topics are grouping, mandatory payment, and inpatient pass through.

### Grouping
Grouping is the process of combining various pieces of information into an output of a single code that explains what a hospital did to treat a patient, that code is used to determine payment.

### Mandatory Payment
Mandatory payment is the concept of reimbursement at fee schedule rates regardless of the billed charge. Sometimes, this means a hospital is paid more than it charged for a patient encounter.

### Inpatient Pass Through
For inpatient services, pass through is an estimate of Medicare bad debts, graduate medical expenses, and organ acquisition costs.

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**Case Study #1: To Group or Not to Group**

In the context of inpatient hospital bills, grouping is the process of combining various pieces of information into an output of a single code that explains what a hospital did to treat a patient. The Medicare payment for inpatient hospital services is primarily determined based on the output, specifically the medical severity diagnosis related group (MS-DRG) assigned to the bill. The MS-DRG is derived partly from the patient’s sex, age, and discharge status, but the diagnoses and procedures included on the UB04 are the most important criteria that impact MS-DRG assignment. These criteria are the ICD-9-CM diagnosis codes and the ICD-9-CM procedure codes.* The UB04 has the ability to capture up to 18 different diagnosis codes and six procedure codes. The diagnosis codes tell us the diseases or injuries for which the patient is being treated while the procedure codes tell us what medical procedures the hospital delivered to treat the injury or disease.

Many bill review systems include grouping software that determines the appropriate MS-DRG based on the diagnosis and procedure codes billed. Because there are various proprietary software systems that can perform this function, it’s possible that a bill review system would determine the MS-DRG code billed by the hospital is not correct.

*Note: ICD-9-CM procedure codes are published by the World Health Organization.

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**So what do you do now that you know this?**

There are three paths jurisdictions generally take:

If you ask ten people which option is best, you’ll probably get ten different answers.

1. **Require the bill reviewer to contact the hospital to obtain a correct MS-DRG or documentation that supports the billed MS-DRG**

2. **Allow the bill reviewer to return the bill to the hospital for corrected coding and/or additional documentation to support the MS-DRG billed**

3. **(“Right-Coding”) Allow the bill review company or payer to make payment based on their determination of the correct MS-DRG**

When writing rules, a review of existing regulations to understand what may already be in place is helpful. If the issue of right-coding has already been addressed, reiterate that fact in guidelines that apply to hospital bill review. As an example, California has language in the Labor Code that tells us right-coding is permitted as long as it’s done correctly:

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*Note: ICD-9-CM procedure codes are published by the World Health Organization.*
Case Study #2: Mandatory Payment

You may be wondering why Medicare would ever pay a hospital more than it is expecting to receive as payment. You may also be wondering why a hospital would ever charge less than it is expecting to be paid. To answer the first question, for inpatient and outpatient hospital services, Medicare’s rate setting methodology assumes that many payments will be less than what a hospital charges and some will be more, with the end result being a number that is budget-neutral. Budget-neutral means payments will not exceed tax revenues budgeted for Medicare spending for a particular institution in a given year. Of note is that this concept is not applicable to physician reimbursement. In other words, lesser of charges reimbursement does not apply to inpatient and outpatient bills.

As for what hospitals charge, statutory requirements exist that stipulate hospitals must charge the same for treating a workers’ compensation patient as they would charge any other patient with a different type of payment source. In theory, the same services rendered to patients with similar circumstances should be billed at the same rate whether the payer is a group health payor, a workers’ comp payor, Medicare, or even when the patient is self-pay. Many jurisdictions have rules that explicitly prevent a medical provider from receiving payment at an amount greater than billed charge. Arkansas has a concise description that covers this situation:

An individual or entity reviewing an itemization of service submitted by a physician or medical provider shall not alter the procedure codes listed or recommend reduction of the amount of the payment unless the documentation submitted by the physician or medical provider with the itemization of service has been reviewed by that individual or entity. If the reviewer does not recommend payment for services as itemized by the physician or medical provider, the explanation of review shall provide the physician or medical provider with a specific explanation as to why the reviewer altered the procedure code or changed other parts of the itemization and the specific deficiency in the itemization or documentation that caused the reviewer to conclude that the altered procedure code or amount recommended for payment more accurately represents the service performed.

In contrast, Colorado only allows right-coding once the provider has been contacted:

Prior to modifying a billed code, the payer must contact the billing provider and determine if the modified code is accurate.

Lastly, jurisdictions with rules that require providers to submit complete and accurate bills typically expect the bill reviewer to return incorrectly coded bills to the hospital. Choosing an approach that is consistent with the jurisdiction’s view on how payers and providers should communicate is essential.

So what do you do now that you know this?

If a jurisdiction already has regulatory language that prohibits providers from receiving more reimbursement than what’s charged, this language should be reiterated in documents that outline Medicare-based pricing guidelines. This is an important consideration when a Medicare-based fee schedule includes a significant mark up. The volume of bills where payment is more than billed charge can increase exponentially if a large mark up of the Medicare allowable is adopted.
If there is no existing language providing guidance on payment as it relates to billed charges, it is important to give careful consideration to the potential downstream effects of implementing a mandatory payment guideline. Because the concept of mandatory payment has been around in workers’ compensation for some time, national payers should be able to accommodate this type of payment model. Regional payers and regional bill review companies that do not handle business where mandatory payment already exists may have more trouble incorporating this concept into their claims and pricing systems. It is common for payers to build edits into claims systems that reject payments if they are more than billed charge. This is an excellent precaution for many situations, but creates roadblocks when a fee schedule is mandatory. Modifying systems to accept payment recommendations that are greater than billed charge can be resource and time intensive.

Case Study #3: Inpatient Pass Through

Some hospitals receive funding from Medicare because of bad debts and direct medical education. These are called Medicare pass-through payments. Teaching hospitals receive regular payments to cover related costs, and bad debt related to treating Medicare patients is handled annually.¹

Because Medicare makes these payments directly to the hospitals, including them in workers’ compensation payments would mean the hospital is paid twice for pass-through items. The South Carolina Workers’ Compensation Commission clarified their intent to exclude inpatient pass-through payments in reimbursement in a letter dated December 22, 2009:

The Commission’s prospective Medicare plus forty percent payment policy does not allow payment for pass throughs. The pass-through costs in the PCPricer system represent Medicare patient costs, not costs associated with a workers’ compensation claim. In addition, the provider is reimbursed by Medicare for bad debts, organ acquisition costs for Medicare patients, and graduate medical education expenses on an annual basis, retrospective of the allowable expenses incurred in the previous year. Inclusion of these expenses in the calculation of the worker’s compensation claim using our prospective payment system would allow the provider to be reimbursed twice for the same expense.¹

So what do you do now that you know this?

It is important to consider whether these special payments should be excluded from or included in the workers’ compensation calculation. Payers and bill review companies will have completely different implementation needs depending on the choice made. In the example noted, the $4,635 pass-through payment is a small fraction of the overall payment, but considering the mark ups many jurisdictions provide for workers’ compensation payments, it could easily exceed $10,000 in additional medical payment.
Outpatient Services

Determining reimbursement for outpatient hospital services is more complex than the process for inpatient services because we have to look at individual line charges rather than just deal with the global reimbursement concept associated with inpatient billings. We’ll talk about single charges for multiple services, line-level payments that exceed line-level charges, total bill payments that are greater than total billed charges, and the inpatient only status indicator.

Case Study #4: Multiple Outpatient Surgery Codes, One Charge

Although not a universal practice, hospitals sometimes bill for multiple surgical procedures performed in a single patient encounter with total charges bundled into one line. A patient might have two arthroscopic procedures performed and, instead of billing separate amounts for each code, the hospital combines the charge for both services onto one line. This is of particular interest to jurisdictions considering Medicare as a base for workers’ compensation fee schedule values because, historically, work comp payers have disregarded line items on outpatient hospital bills that do not have a fee. Concurrently, bill review systems and processes have not consistently been built to consider services billed without a charge. In order to ensure accurate and consistent reimbursement of outpatient billings, jurisdictional guidance must specifically address this topic.

Analysis of one of the largest jurisdictions in Coventry’s book of business for a six-month period resulted in 151 outpatient facility bills where hospitals billed at least two surgical codes and at least one of the charge lines for the billed surgical codes had no fee. This represents approximately 0.4% of all outpatient bills for this particular jurisdiction, a relatively small number, but is a challenge that can result in erroneous payment recommendations and delays in processing if not specifically addressed in regulations. These are actions that can result in fines or penalties in some jurisdictions, making it important that all parties understand the details of these requirements.

In the following example, a facility is billing for services related to a shoulder arthroscopy. The first surgical code, 29824, includes a charge of $9,500. The secondary surgical code, 29826, has no charge documented on the UB-04.

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*Note: CPT codes are published by the American Medical Association.*

The Medicare Claims Processing manual details Medicare’s approach to determining reimbursement for this type of billing. As far back as 2003, CMS’s OPPS Pricer included instructions to determine reimbursement for surgical procedures billed under a packaged concept or without a fee. An abridged version of that approach using the bill example is included in this paper, and we will use the date-appropriate version of Medicare’s Addendum B to obtain reimbursement information for the surgical codes billed. The only services from this example that will have a corresponding Medicare reimbursement rate are those services billed with CPT codes. The pharmacy, supply, anesthesia, physical therapy, and recovery room fees are essentially ignored because they are not billed with CPT detail.
As documented in the relevant sections of Addendum B, the CMS payment rate for the surgical codes is $2,111.62 and status indicator T applies for each. CMS addendum D1 tells us that a multiple procedure reduction applies to codes with status indicator T.

If the value for one of the two services were higher than the other, the multiple procedure reduction would apply to the lowest valued procedure. In this example, the discount applies to the second procedure billed. The total payment of $3,167.43, $2,111.62 for 29824 plus half of $2,111.62 for 29826, is the CMS rate. Typically, a jurisdiction would then add a geographical adjustment factor and a mark up percentage to arrive at the workers’ compensation value.

As you can see in this example, capturing the code with zero charge is critical to determine correct reimbursement as well as associated coding rules.

**So what do you do now that you know this?**

Texas provides an example where rules define how payment should be made when the fee schedule rate is higher than the charge for the services:

> **Regardles of billed amount, reimbursement shall be...the maximum allowable reimbursement (MAR) amount.**

To eliminate any chance for misunderstanding, it is helpful to add clarification that this logic is applicable at the line level as well as at the bill level, if that is the actual intent, which is true in Texas.

In contrast, Tennessee follows Medicare reimbursement for individual services on outpatient hospital billings, but does not allow total bill reimbursement to exceed total charges. Reimbursement is limited to:

> **The lesser of the provider’s bill, a contracted amount, or the maximum allowable per the MFS [which] should be determined based on the entire bill rather than a line-by-line basis.**

Based on clarification received from the Tennessee Division of Workers’ Compensation, we know that the intent of this direction is to ensure total reimbursement does not exceed total charges and this methodology does not apply to individual services. Another way to explain this requirement is to state that reimbursement for individual lines may exceed the line-level charge, but the total bill reimbursement may not exceed the total bill charge.

Additional considerations associated with Texas’ approach to reimbursement are outlined in the next case study.

### Case Study # 5: Payment Greater Than Charge, Lines and Bills

Taking the previous case study one step further, what if the hospital charged an amount less than the fee schedule rate for one of the two services? For illustrative purposes, let’s suppose the hospital billed $2,000 for each procedure.

If you recall from the inpatient scenarios discussed earlier, Medicare’s payment rates are adjusted by several factors and conditions, but the hospital’s actual charge for the service is not one of those factors. Medicare’s goal is to maintain budget-neutrality and that process has nothing to do with how much a hospital decides to charge for treating patients. In our example, the Medicare reimbursement would exceed the charge for the first procedure, but the total reimbursement for both surgeries would still be less than the hospital’s charge.
Since Medicare’s payment is made without regard to the hospital’s charge, Medicare would cut a check for $3,167.43. If this scenario appeared for a Texas workers’ compensation claim, the payer would be responsible for $6,334.86 because rules require a 200% mark up of Medicare’s rate. Since this is less than the overall charges of $29K, we don’t have to worry about the total payment being greater than the total billed charge.

Modifying our example a little bit more, let’s assume the hospital billed without the supplies, anesthesia, recovery room, and physical therapy services that we saw on the original bill. In that situation, we’d have an example of total payment exceeding total charge because the marked up fee schedule rate is about $2,300 more than billed charges.

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</table>

4000.00  3167.43

A payer in Texas would still cut a check for $6,334.86 because of the 200% mark up; however, in Tennessee, where the Medicare reimbursement is multiplied by 150%, a workers’ compensation payer would only cut a check for $4,000 because the regulations do not allow total bill payment to exceed total bill charges. Reimbursement of $6,334.86 is more than $2K beyond the total billed charge.

So what do you do now that you know this?
The most important consideration is to clearly outline what’s expected of payers when a line-level payment is more than what a hospital charged for the medical service as well as what should happen when the total reimbursement is more than the total charge. Keep in mind that the concept of paying more for a service than what a hospital charges may be foreign to some payers if Medicare-based hospital reimbursement is a new concept in a given jurisdiction.

Case Study #6: Inpatient Only Procedures
Because most Medicare patients are older, the amount of resources needed to perform some procedures is more complex than would be the case for much of the workers’ compensation population, an overall younger demographic. As a result, Medicare specifically identifies procedures that must be performed on an inpatient basis only. Even so, inpatient stays are usually more costly, complex, and even more dangerous than outpatient stays. Allowing reimbursement to outpatient facilities for services that Medicare defines as inpatient only may be beneficial to workers and reduce overall workers’ compensation costs.

Addendum B. Final OPPS Payment by APC Code for CY 2016
- **27704** Removal of ankle joint                    0041  29.6106  1  2000.00 2111.62 2111.62
- **27715** Repair of lower leg                      0063  97.0073 4 2328.40 845.68
- **27724** Repair of graft of fibula                0063  97.0073 4 2328.40 845.68
- **27725** Repair of lower leg                      0063  97.0073 4 2328.40 845.68
- **27726** Repair fibula nonunion                   0063  97.0073 4 2328.40 845.68
- **27727** Repair of lower leg                      0063  97.0073 4 2328.40 845.68
- **27730** Repair of fibula                        0063  97.0073 4 2328.40 845.68
- **27735** Repair of fibula                        0063  97.0073 4 2328.40 845.68
- **27740** Repair of leg                           0063  97.0073 4 2328.40 845.68
- **27745** Repair of leg                           0063  97.0073 4 2328.40 845.68
- **27750** Repair of fibula nonunion                0063  97.0073 4 2328.40 845.68
- **27755** Repair of lower leg                     0063  97.0073 4 2328.40 845.68
- **27760** Repair of lower leg                     0063  97.0073 4 2328.40 845.68

So what do you do now that you know this?
The challenge is, how do payers determine reimbursement when Medicare doesn’t? One possible approach to addressing this concern is to write regulations designating reimbursement for inpatient-only procedures at usual and customary rates. Tennessee allows for this exception, reimbursing inpatient-only procedures at 80% of billed charge. Other jurisdictions may not be keen to use a flat percent of charge for reimbursement of medical services that can be quite costly. When Indiana adopted Medicare-based reimbursement for hospital charges, they opted to allow payers and hospitals to pre-negotiate these services; however, without an accompanying pre-authorization requirement, it is debatable that many payers and providers know they should be proactively negotiating payment. California goes one step further and requires that the services be pre-authorized and the fee agreement be memorialized in writing. Other jurisdictions that recently adopted Medicare-based reimbursement did not address inpatient-only procedures at all.
OPPS Payment Status Indicators

CMS assigns payment status indicators to all outpatient services. Status indicators define whether a service is payable, discounted, or paid under a payment system other than the OPPS. You can think of them like modifiers if you are familiar with that concept for physician billings. Each procedure has a status indicator (modifier) that provides some information about how it should be billed and, sometimes, what should happen when it’s billed with other services. Addendum D1, which is included at the end of this paper, lists each status indicator along with its policy description. Many of the payment policies associated with addendum D1 are compatible with a workers’ compensation approach to facility reimbursement, but some warrant further attention.

- **Status indicator A**: services that are paid under a different Medicare fee schedule such as ambulance, clinical lab services, and others. Workers’ compensation systems should ensure regulatory language allows for use of these fee schedules, either by specifically referencing them or by stating that CMS payment status indicators are to be used as defined by CMS.

- **Status indicator B**: services not recognized by OPPS when submitted as outpatient services. Generally, these are codes that are more appropriately represented by other existing codes when billed for outpatient care. If Medicare’s policy for these procedures is accepted in a work comp system, facilities would need to rebill with appropriate codes in order to receive payment.

- **Status indicator C**: as of the January 2015 publication of addendum B, there are more than 1,700 services identified with status indicator C. They are inpatient services not payable when billed by an outpatient facility.

- **Status indicator E**: codes that are not payable by Medicare due to statutory or other exclusions. This category encompasses a variety of services ranging from drug screens, health panels, and vaccinations to evaluation and management procedures, transportation, and dental services. The January 2014 publication of addendum B includes more than 1,400 codes with status indicator E. Most of these services would not be provided to a patient during an outpatient stay and should instead be associated with a physician office visit. Work comp systems should consider if Medicare’s policy makes sense for injured workers.

- **Status indicator H**: pass-through device paid based on cost. There are typically very few codes, often less than 10 out of thousands, that qualify for this separate payment. For 2015, there are only two procedures identified with this status indicator. Jurisdictions that carve out payment for implants might want to consider how to handle pass-through devices to avoid double payment.

- **Status indicator J1**: brand new for 2015, composite services that are packaged. Payment for services in the same family are packaged together. Bundling/packaging are familiar concepts in workers’ compensation so these may not warrant special consideration, but it is helpful to know that there are multiple ways Medicare identifies packaged services.

- **Status indicator M**: similar to status indicator B codes, these are services that Medicare does not reimburse when provided in an outpatient setting. The majority of services that fall into this group are category II codes, those specifically created by AMA to describe clinical components associated with evaluation and management services or G codes, which are temporary codes representing procedures and services that do not exist in CPT. As with status indicator E codes, cost containment may be better when provided during a physician office visit.

- **Status indicator Q1-Q2**: packaged codes where one payment is made for multiple, interdependent services.

- **Status indicator Q3**: composite diagnostic services that may be packaged together when multiple services are billed.

- **Status indicator Y**: non-implantable durable medical equipment that is paid through another mechanism. Medicare requires these to be billed on a CMS-1500 form as DME.
Outlier

An outlier is an additional payment made for unusually expensive cases that is added to the DRG payment. Medicare’s intent in paying more money for unusually expensive cases is to ensure access to high quality care for very sick patients. For inpatient services, Medicare identifies cases as outliers when the actual costs exceed a threshold amount that is set annually. When the combined operating and capital costs of a case exceed the outlier threshold, the hospital receives additional payment.

So what do you do now that you know this?

Because workers’ compensation entities also want to ensure access to care for injured workers, making allowances for additional payment to cover the costliest care may be needed. This concern should be balanced with adopted mark ups. If, for example, payment is 200% of the Medicare allowance, does it make sense to pay another 200% of an extra outlier reimbursement? What if there are carve-out services, such as implants – should those services be subtracted at some point in the payment calculation used to determine whether an outlier threshold has been met?

Inpatient/Outpatient Crossover Issues

Case Study # 7: Implants

Implants are commonly carved out from Medicare’s typical reimbursement methodology and customized for workers’ compensation. The genesis of this somewhat industry standard carve out is hazy. It’s possible that many believe Medicare doesn’t pay separately for implants, but in fact, they do. To explain how this works, let’s look at the life of an actual device or implant.

C1749, an implantable endoscope/colonoscope device, was identified as new technology by Medicare in October 2010.
Texas has a unique, added condition related to implant reimbursement. Texas requires hospitals to tell payers whether they want separate implant reimbursement. When they do want separate payment, the mark up for the rest of the charges is smaller at 108% of Medicare for inpatient and 130% of Medicare for outpatient services. Similarly, if the hospital doesn’t request separate payment for implants, services are paid at 143% of Medicare for inpatient and 200% of Medicare for outpatient.

For a few years, Medicare made separate payment for this code, beyond the amount paid to hospitals for associated services. As hospitals reported billing data about this code and the associated surgical services, Medicare began to learn that more resources were required to provide services that included C1749 and eventually increased payment rates for the surgical codes. They also changed the status indicator for the device/implant to N, meaning payment is always packaged.

Medicare-based reimbursement/
implants not separately paid
It is important for jurisdictions
to consider the balance between
cost containment and availability of quality care for injured workers when deciding on the best approach to rulemaking that affects payment of implants.
Adoption Schedule

This is probably one of the simplest things to address, but is often completely overlooked during rulemaking. Medicare has very specific timelines for adoption of updates to rates for institutional charges. Inpatient updates happen on a fiscal year basis, which is every October. Outpatient changes occur on a calendar year basis, with revisions scheduled every quarter. Each of these payment systems may have ad-hoc updates to deal with errors as well.

So what do you do now that you know this?

All rules should explicitly outline the expectation for incorporating Medicare changes, whether it's meant to happen once a year in January or some other date that makes sense for the workers' comp agency affected. Alternatively, rules could point to adoption on Medicare's schedule, to include ad-hoc correction notices. Tennessee opted to use Medicare updates as published:

Unless otherwise indicated herein, the current, effective Medicare procedures and guidelines are hereby adopted and incorporated as part of these Rules as if fully set out herein and effective upon adoption and implementation by the CMS.

Another approach some jurisdictions take is to require updates only as the agency directs, which is a perfectly acceptable option, but does require the agency to distribute announcements and updates in a way that payers and bill review companies are quickly notified. The important thing is for rules to be very clear about what Medicare files are appropriate for use so hospitals and payers are using the same source data.

Pricing Policies or Reimbursement Rules

A topic frequently omitted from workers' compensation guidelines that use Medicare's rates as a base for reimbursement is when to and when not to use Medicare's pricing policies or reimbursement rules. Medicare has hundreds of rules that govern payment. Many of these would have no bearing on treatment for a workers' compensation claim, but some are appropriate to think about in the context of cost containment. It is important to explicitly outline expectations for use of pricing policies. The National Correct Coding Initiative (NCCI) edits and information from the Medicare Learning Network (MLN) are the main areas where Medicare provides direction on pricing policies or reimbursement rules.
National Correct Coding Initiative (NCCI)

Updated quarterly, National Correct Coding Initiative edits are a set of rules developed by CMS that address incorrect coding of outpatient facility (and individual practitioner services, although that is outside the scope of this paper) that would result in erroneous payment. In the past, edits were subcategorized and available from multiple rationale-based lists, but consolidation has happened over the years and all outpatient edits are available in one format, split into multiple Excel lists to accommodate the sheer amount of content. The NCCI file includes all procedure combinations never permitted as separately payable services or only separately payable when specific conditions are met. Edit rationale includes mutual exclusivity, standards of practice, more extensive procedure, and even CPT-based criteria.  

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</tr>
<tr>
<td>44132</td>
<td>44203</td>
<td></td>
<td>20130101</td>
<td>*</td>
<td>0</td>
<td>Sequential procedure</td>
</tr>
<tr>
<td>44132</td>
<td>44203</td>
<td></td>
<td>20030101</td>
<td>*</td>
<td>0</td>
<td>Sequential procedure</td>
</tr>
<tr>
<td>44132</td>
<td>G0272</td>
<td></td>
<td>20040331</td>
<td>1</td>
<td>0</td>
<td>Misuse of column two code with column one code</td>
</tr>
</tbody>
</table>

Column 1 lists the procedure against which the codes in column 2 are bundled, exclusive, sequential, and so on. Some codes have hundreds of accompanying codes in column 2. The sample above is a particular code with only a handful of column 2 codes. You can see that CMS gives specific instructions as to whether separate payment is ever allowed in the second to last column titled, “Modifier” column. When the 0 indicator is present, the column 2 code never receives separate payment when billed with the column 1 code. When the 1 indicator is present, separate payment is sometimes permitted and modifiers are used to tell the payer that special circumstances are documented to support that separate payment.

So what do you do now that you know this?

The use of NCCI edits in workers’ compensation is very common across the industry. The most important thing payers need to know when implementing Medicare-based reimbursement for the first time is the frequency to make those changes. Medicare publishes updates quarterly so jurisdictions should consider how that schedule fits with existing regulations. Payers and bill review companies may have different capabilities for updating NCCI edits. Updating systems on a quarterly basis could pose a hardship for some, while others may have challenges maintaining separate versions of the NCCI tables. Talking to stakeholders about potential problems with NCCI table maintenance, from medical providers to payers to bill review entities, is vital.
Coventry | July 2015 | Using Medicare as a Model for Hospital Fee Reimbursement

Transmittals and Medicare Learning Network (MLNs)

Medicare publishes transmittals to communicate everything from communications to Medicare Administrative Contractor (MACs), annual final rule changes to small, ad-hoc corrections. Rule changes are made available in easy-to-understand language through MLNs. In 2014 521 MLNs were posted, and so far in 2015, 189 MLNs have been published. Medicare also creates an index categorized by subject where readers can peruse the various documents.

So what do you do now that you know this?

Most importantly, including clear language in regulations that directs payers and bill review companies to either use Medicare’s rules or not is needed. If Medicare-based reimbursement is being adopted and will be part of existing regulations, instructions clarifying that jurisdictional rules and regulations take precedence are helpful. Texas addresses possible conflicts with this:

> Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers’ Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program.

For outpatient services, only Critical Access Hospitals (CAHs) are excluded from the Prospective Payment Systems (PPS). Many jurisdictions exclude CAH from fee schedules all together. On the inpatient side, there are more types of facilities that either are not included in any type of PPS or have their own Prospective Payment System methodology. Inpatient psychiatric, inpatient rehabilitation, long-term care, and skilled nursing facilities all have a reimbursement system separate from IPPS.

So what do you do now that you know this?

Understanding existing regulation is the first key. If some of these facility types are already addressed, then reiterating or pointing to those regulations when drafting inpatient and outpatient rules ensures payers will know where they can go to find answers. If jurisdictions intend to include Medicare’s reimbursement methodology for non-IPPS and non-OPPS bill types, this expectation must be clearly stated. It is unusual for workers’ compensation to outline reimbursement rules for these special facilities so giving as much lead time as possible for payers to prepare is essential.

Across the country, using Medicare as a basis for determining workers’ compensation payments for hospital services has increased over the years. Customization varies widely, from only adding a mark up on Medicare’s rate to carving out and specially handling multiple components of reimbursement. Before adopting the Medicare model for hospital reimbursement, it is important for jurisdictions to consider their cost containment goals as well as thoroughly communicating specifics of payment requirements to payers.

If you have questions or need further information, please contact your Coventry account manager.
<table>
<thead>
<tr>
<th>Status Indicator</th>
<th>Item/Code/Service</th>
<th>OPPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example:</td>
<td>Not paid under OPPS. Paid by MACs under a fee schedule or payment system other than OPPS. Services are subject to deductible or coinsurance unless indicated otherwise.</td>
</tr>
<tr>
<td></td>
<td>• Ambulance Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Separately Payable Clinical Diagnostic Laboratory Services</td>
<td>Not subject to deductible or coinsurance.</td>
</tr>
<tr>
<td></td>
<td>• Separately Payable Non-Implantable Prosthetics and Orthotics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Physical, Occupational, and Speech Therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Diagnostic Mammography</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Screening Mammography</td>
<td>Not subject to deductible or coinsurance.</td>
</tr>
<tr>
<td>B</td>
<td>Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).</td>
<td>Not paid under OPPS. May be paid by MACs when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS. An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.</td>
</tr>
<tr>
<td>C</td>
<td>Inpatient Procedures</td>
<td>Not paid under OPPS. Admit patient. Bill as inpatient.</td>
</tr>
<tr>
<td>D</td>
<td>Discontinued Codes</td>
<td>Not paid under OPPS or any other Medicare payment system.</td>
</tr>
<tr>
<td>E</td>
<td>Items, Codes, and Services:</td>
<td>Not paid by Medicare when submitted on outpatient claims (any outpatient bill type).</td>
</tr>
<tr>
<td></td>
<td>• For which pricing information is not available</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Not covered by any Medicare outpatient benefit category</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Statutorily excluded by Medicare</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Not reasonable and necessary</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Corneal Tissue Acquisition; Certain CRNA Services and Hepatitis B Vaccines</td>
<td>Not paid under OPPS. Paid at reasonable cost.</td>
</tr>
<tr>
<td>G</td>
<td>Pass-Through Drugs and Biologicals</td>
<td>Paid under OPPS; separate APC payment.</td>
</tr>
<tr>
<td>H</td>
<td>Pass-Through Device Categories</td>
<td>Separate cost-based pass-through payment; not subject to copayment.</td>
</tr>
<tr>
<td>J1</td>
<td>Hospital Part B services paid through a comprehensive APC</td>
<td>Paid under OPPS; all covered Part B services on the claim are packaged with the primary &quot;J1&quot; service for the claim, except services with OPPS SI=F,G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.</td>
</tr>
<tr>
<td>K</td>
<td>Nonpass-Through Drugs and Nonimplantable Biologicals, Including Therapeutic Radiopharmaceuticals</td>
<td>Paid under OPPS; separate APC payment.</td>
</tr>
<tr>
<td>L</td>
<td>Influenza Vaccine; Pneumococcal Pneumonia Vaccine</td>
<td>Not paid under OPPS. Paid at reasonable cost; not subject to deductible or coinsurance.</td>
</tr>
<tr>
<td>M</td>
<td>Items and Services Not Billable to the MAC</td>
<td>Not paid under OPPS.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>N</td>
<td>Items and Services Packaged into APC Rates</td>
<td>Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.</td>
</tr>
<tr>
<td>P</td>
<td>Partial Hospitalization</td>
<td>Paid under OPPS; per diem APC payment.</td>
</tr>
</tbody>
</table>
| Q1 | STV-Packaged Codes | Paid under OPPS; Addendum B displays APC assignments when services are separately payable.  
(1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator “S,” “T,” or “V.”  
(2) In other circumstances, payment is made through a separate APC payment. |
| Q2 | T-Packaged Codes | Paid under OPPS; Addendum B displays APC assignments when services are separately payable.  
(1) Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator “T.”  
(2) In other circumstances, payment is made through a separate APC payment. |
| Q3 | Codes That May Be Paid Through a Composite APC | Paid under OPPS; Addendum B displays APC assignments when services are separately payable.  
Addendum M displays composite APC assignments when codes are paid through a  
(1) Composite APC payment based on OPPS composite-specific payment criteria.  
(2) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services. |
| R | Blood and Blood Products | Paid under OPPS; separate APC payment. |
| S | Procedure or Service, Not Discounted When Multiple | Paid under OPPS; separate APC payment. |
| T | Procedure or Service, Multiple Procedure Reduction Applies | Paid under OPPS; separate APC payment. |
| U | Brachytherapy Sources | Paid under OPPS; separate APC payment. |
| V | Clinic or Emergency Department | Paid under OPPS; separate APC payment. |
| Y | Non-Implantable Durable Medical Equipment | Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC. |
Inpatient Prospective Payment System (IPPS):
the system of payment for acute care hospital inpatient stays under Medicare Part A (hospital insurance) based on prospectively set rates.

Base Payment Rate: includes the labor and non-labor related portions of the IPPS reimbursement rate. The labor-related share is geographically adjusted. Hospitals located in Alaska and Hawaii receive an additional labor-related adjustment. This value is multiplied by the MS-DRG rate.

Cost to Charge Ratio (CCR): derived from cost reports hospitals send to CMS, CCR is the difference between a facility’s costs to provide services and the fees charged for those services. Cost-to-charge ratios are a percent value, i.e. 0.238.

Disproportionate Share Hospital (DSH): add-on included in IPPS reimbursement when a hospital facility treats a high percentage of low-income patients.


Indirect Medical Education (IME) Adjustment: add-on included in IPPS reimbursement when a hospital facility is an approved teaching hospital.

Inpatient Pass-Through: estimate of Medicare bad debts, graduate medical expense, and organ acquisition costs.

Medicare Severity Diagnosis Related Group (MS-DRG): sometimes called DRG, the code assigned to an inpatient stay representing treatment provided; MS-DRG is determined by the ICD-9 diagnosis and procedure codes, patient age, sex, and discharge status.

Outlier: unusually expensive case with costs above a fixed-loss cost threshold amount.

Sole-Community Hospital: rural hospital.

Value-based Purchasing (VBP): incentive payments that hospitals receive for meeting performance measures defined by CMS.

Wage Index: the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.
**Outpatient Prospective Payment System (OPPS):**
the system of payment for acute care hospital outpatient stays under Medicare Part B (medical insurance) based on prospectively set rates.

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### Payment based on complexity of service

<table>
<thead>
<tr>
<th>CF</th>
<th>CF</th>
<th>APC relative weight</th>
</tr>
</thead>
</table>

### Geographic adjustment

<table>
<thead>
<tr>
<th>60% labor related</th>
<th>40% non-labor related</th>
</tr>
</thead>
</table>

### Measures relative resources of services

### Hospital wage index

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**Special Exceptions**

- If the patient is exceptionally costly:
  - Payment + High cost outlier

- If a rural SCH:
  - Payment × 1.071

- If a cancer or children’s hospital eligible for transitional outpatient payment:
  - Payment + Transitional outpatient payment; final payment determined at cost settlement

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**Addendum A**: Medicare table that lists, by APC: group title, status indicator (SI), relative weight, payment rate, national unadjusted copayment, minimum unadjusted copayment; published quarterly.

**Addendum B**: Medicare table that lists, by procedure code: short descriptor, status indicator (SI), APC, relative weight, payment rate, national unadjusted copayment, minimum unadjusted copayment; published quarterly.

**Addendum C**: Medicare table listing procedures by APC group to include status indicator (SI), relative weight, payment rate, national unadjusted copayment, and minimum unadjusted copayment.

**Addendum D1**: Medicare table that lists the OPPS payment status definitions for each status indicator (SI); revisions published as payment policies change.

**Addendum E**: Medicare table that lists procedures payable when performed as inpatient services only. These services are included in addenda A and B with status indicator C.

**Addendum M**: Medicare table listing procedures that are payable at composite rates. In order to determine payment amount, refer to the value of the composite APC assignment on addendum C.

**APC Group**: ambulatory payment classification group; a system for grouping outpatient services provided by hospitals based on similarity of costs and clinical indications.

**Composite Rate**: a method of paying one rate for multiple services typically performed together. Most commonly found with diagnostic procedures.

**Multiple Procedure Rule**: paying a lesser amount for subsequent surgical procedures.

**National Correct Coding Initiative (NCCI)**: coding methodology developed by Medicare to support correct coding and address incorrect coding that could lead to incorrect payments. Edits are based on CPT and other industry standards.

**Packaged**: the concept that some supplies and/or services are required to perform a medical procedure and therefore included in the procedure and not separately payable.

*Tables as provided in the Medicare Learning Network Payment System Fact Sheet Series – Hospital Outpatient Prospective Payment System*
About Leann Lewis

Leann Lewis is one of the industry’s leading subject matter experts in workers’ compensation medical fee schedules. With more than 20 years of experience in the medical bill review arena, she has built a solid foundation of knowledge related to the complexities and variety of rules and regulations in the marketplace. Leann is a graduate of Lipscomb University with a Master’s of Health Care Informatics.

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