

Trends in Provider Billing

Workers' Compensation
Cost Containment

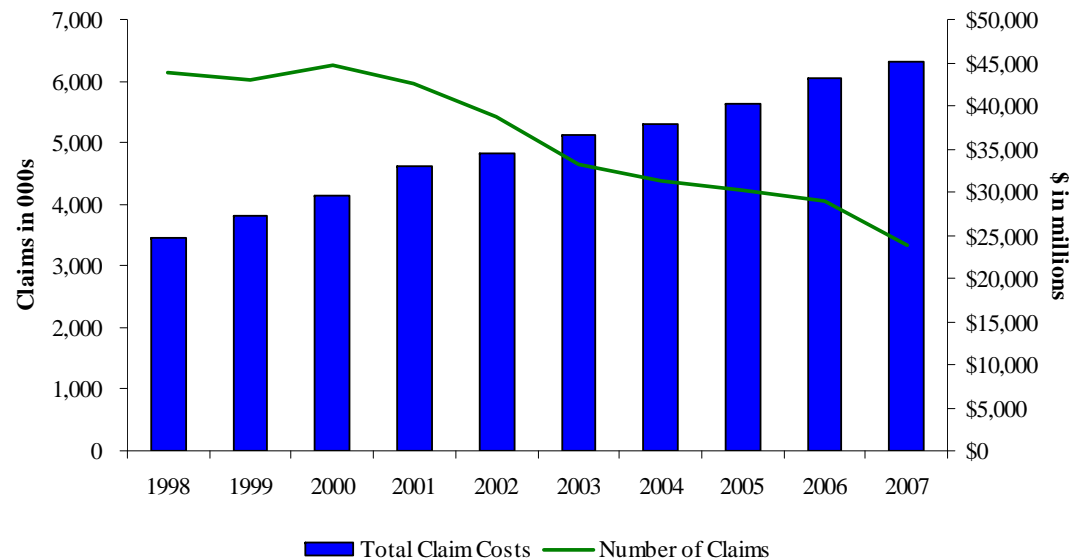
Finding the
fair cost of
healthcare[®]

Work Comp Claims vs. Costs

Despite claim volume decreasing due to a shift from a manufacturing-based economy to a service-based economy, Workers' Compensation costs continue to rise given:

- Medical cost inflation and cost shifting
- Increasing use of more complex (i.e. high priced) procedures
- Increasing utilization (i.e. more procedures, more testing)

Workers' Comp Claims Volume vs. Costs



Source: National Association of Insurance Commissioners (NAIC) and National Council on Compensation Insurance (NCCI).

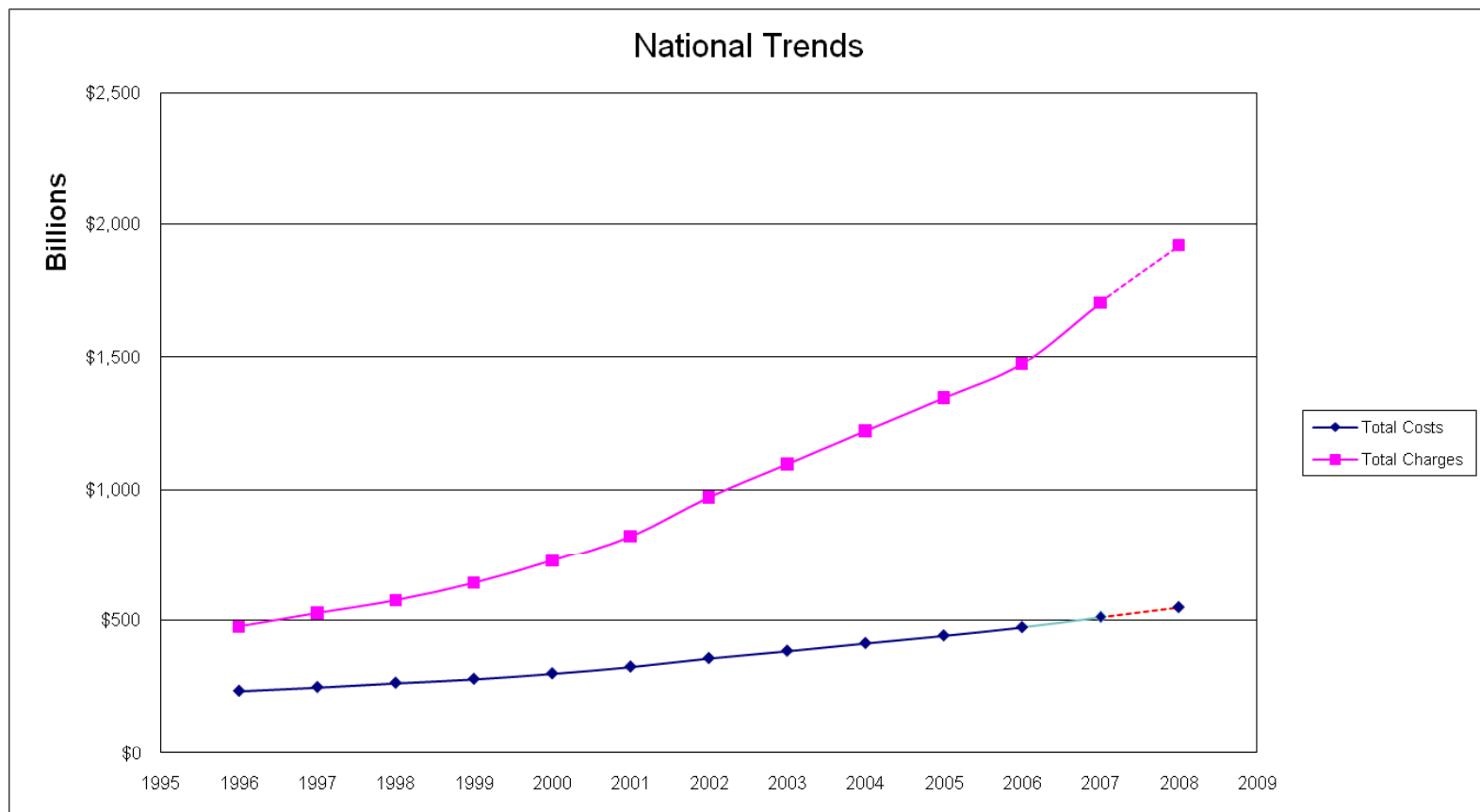
Hospital Charges

Hospital charges do not systematically reflect hospital costs due to:

- Different markups for different departments
- Higher markups for certain services
- Higher markups for Outpatient services
- Charge optimization (to improve reimbursement by specific types of payers and managed care)
- Charge compression (lower markups for higher cost items)
- Cost Shifting – with increasing government and payer scrutiny on group health medical costs, providers are “cost shifting” to workers’ compensation payers, and ultimately employers, to make up the shortfall

Hospital Charge Trends

Relative *charges* may not accurately proxy relative *costs*



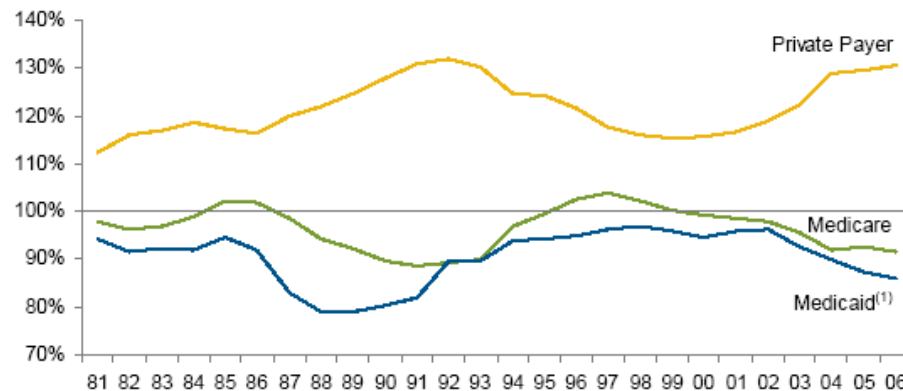
Source: Actual cost and charge data reported by hospitals to CMS.

Hospitals Need to Increase Reimbursement from Private Payers

- Medicare and Medicaid paying less than average costs
- Uncompensated care (uninsured/indigent) to Undercompensated care
- Private payers shrinking

TRENDWATCH CHARTBOOK 2008
Trends in the Overall Health Care Market

Chart 4.6: Aggregate Hospital Payment-to-cost Ratios for Private Payers, Medicare, and Medicaid, 1981 – 2006



Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2006, for community hospitals.
(1) Includes Medicaid Disproportionate Share payments.

Healthcare Reform

- Healthcare reform is focused on group health which accounts for about 97% of costs
- Providers are likely to “**cost shift**” to workers’ compensation
 - Providers’ cost structure is largely fixed, leading them to seek reimbursement from workers’ compensation patients
 - Newly insureds added to Medicaid which pays substantially less than hospital costs
 - Impact of excise tax on certain devices
 - Workers’ compensation is estimated to account for 1/50th of hospital revenue, but 1/6th of hospital profit

Hospitals Are Maximizing Comp Payments

- Hospital charges are outpacing hospitals' costs
- Medical bills make up 58% of total workers' compensation medical payments¹
- Workers' compensation is one of the very few FFS payers

¹ NCCI Chief Actuary, Dennis Mealy during the May 2010 NCCI conference.

Hospitals Are Maximizing Comp Payments

(continued)

- “Payment enhancement” by hospitals is rampant:
 - Inpatient & Outpatient “gaming” to bulk-up gross charges
 - Unbundling
 - Enhanced charge capture
 - Rate optimization
 - Aggressive charge-master increases
 - Intensification of services – especially ER, OR & ICU
 - Platform reverse engineering

Implications for Payers

- Many more high dollar hospital bills
- Even in fee schedule states, more hospitals are “gaming” their billings to get high payments
- Increasing gap between payments by health insurers and payments by workers’ compensation payers for similar hospital services

10 Things to Do Now

Reduce the payout on high dollar facility bills:

- #10 - Perform Charge Validation Analysis (CVA) on all your high dollar facility bills to counter hospitals' gaming
- #9 - For all high dollar facility bills, reprice to a reasonable payment amount

10 Things to Do Now *(continued)*

- #8 - Question services performed in hospitals & ASCs that can safely be done in a physician's office
- #7 - Reprice Implants to their real costs

10 Things to Do Now *(continued)*

#6 - For Inpatient bills that exceed the fee schedule stop-loss threshold, perform CVA and Market Value Pricing (MVP)

Corollary: Reprice to a level of reasonableness, when the fee schedule does not apply to an Inpatient bill

#5 - Implement a process to ID duplicate implants

10 Things to Do Now *(continued)*

- #4 - Counter DRG maximization, when the Inpatient fee schedule pays based on DRGs

- #3 - Optimize your PPO network for all hospital & ASC bills

10 Things to Do Now *(continued)*

- #2 - Negotiate repeat occurrence bills based on cost and prevailing rate data
- #1 - Counter unbundling, when the Outpatient fee schedule pays based on CPTs

Unbundling Case Study

- Hospitals realize that many payers use an APC grouper, so they add the CPT code to each line:
 - 500 - 250 (drugs) – 63030
 - 250 - 270 (supplies) – 63030
 - 6000 - 360 (surgical procedure) – 63030

Unbundling Case Study

- Your software platform could be recommending double payment:

Billed	Rev code	CPT code
– 500 – (2500)	250 (drugs)	– 63030
– 250 – (2500)	270 (supplies)	– 63030
– 6000 - (5000) -	360 (surgical procedure)	– 63030

Actual Owed – 5000

System Recommended – 10,000

Long Term Care Case Study

- Initially, RNs negotiated the Long Term Care (LTC) bills to an average reduction of 10% off billed charges
- Primary concerns were ensuring the patient received the highest quality of service and his family's concerns were addressed

Long Term Care Case Study *(continued)*

By evaluating the treatment plan, calculating the costs for the services provided and identifying what the provider typically accepts for payment:

- Each bill audited for gaps in service
- Average savings has exceeded 60%

Build Your Own Repricing Unit

- Multiple data points to establish a reasonable payment amount
- Tailor repricing methods to meet each state's legal requirements
- Payment recommendations that are consistent and defensible
- Equipped to handle provider pushback

Carriers vs. Employers

- FL Outpatient fee schedule proposal
 - Increased costs
 - Artificial revenue growth
 - Neither competitive advantage or disadvantage
 - Cost shift to employers
- Active lobbying effort
- Align with the right constituency