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TESTIMONY

Allowances for Spinal Hardware under California's Official Medical Fee Schedule

Issues and Options

BARBARA O. WYNN

CT-375

May 2012

Testimony presented before the California State Senate Labor and Industrial Relations Committee on May 9, 2012

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***Allowances for Spinal Hardware under California's Official Medical Fee Schedule
Issues and Options²***

**Before the Committee on Labor and Industrial Relations
California State Senate**

May 9, 2012

Chairman Lieu, Vice Chairman Wyland, and members of the Committee, thank you for the opportunity to appear before you today. The purpose of my testimony is to synthesize background information and findings from a series of RAND studies that have examined the appropriateness of the pass-through payment under the California Workers' Compensation Official Medical Fee Schedule (OMFS) for the costs of hardware and other instrumentation implanted during complex spinal surgery.

After providing background information on the relevant OMFS provision and the policy issues it raises, the report addresses the following questions:

- What is the number and cost of complex spinal surgeries performed on WC patients?
- How comparable are the costs of services provided to workers' compensation spinal surgery patients to those provided to Medicare patients?
- Is an OMFS allowance at 120 percent of the Medicare rate without a pass-through payment adequate to cover the estimated cost of providing services to WC patients?
- What considerations should be weighed in determining an appropriate allowance for spinal hardware and what are the strengths and weaknesses of potential options?

RAND researchers have examined issues related to the pass-through for the costs of hardware and instrumentation implanted during spinal surgery in several different studies since 2003. In our most recent study (Wynn et al., 2011), we used data from the Office of Statewide Health Planning and Development (OSHPD) for 2008 hospital stays. It is these analyses of 2008 OSHPD data that I describe in this testimony. Except where noted, our research was funded by the California

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Commission on Health and Safety and Workers' Compensation. The reports referenced at the end of my written testimony contain more detailed information on the data and methodologies that we used in our analyses. We would be happy to provide them as supplemental material.

Description of the OMFS Provisions

The Division of Workers' Compensation (DWC) in the Department of Industrial Relations maintains the OMFS for medical services provided under California's workers' compensation program. The OMFS establishes the maximum allowable fee for services unless the payer and provider contract for a different payment amount. The OMFS for inpatient care provided by acute-care hospitals is adapted from the Medicare payment system for these services. A predetermined maximum allowable fee is established for each admission based on the Medicare-severity adjusted diagnosis-related group (MS-DRG) to which the patient is assigned. The MS-DRG assignment takes into account such factors as the patient's principal diagnosis, comorbidities and complications, and surgical procedures. Each MS-DRG has a relative weight reflecting the average resources or costs for Medicare patients assigned to that MS-DRG relative to Medicare patients in other MS-DRGs. The OMFS standard allowance for a discharge is determined as the product of a hospital-specific composite rate times the MS-DRG relative weight times 1.20.³ In other words, the standard allowance is 20 percent higher than the amount Medicare would pay for the service. Additional allowances are made for discharges with atypically high costs and for the cost of hardware (implanted devices and instrumentation) used in complex spinal surgery. For complex spinal surgery, the additional allowance is for the cost of hardware and instrumentation used during the surgery. It is defined as documented paid costs net of discounts and rebates plus 10% for overhead up to \$250 and actual shipping and handling costs. The total allowance is 1.2 times the Medicare rate plus the allowance for hardware.

The underlying principle of DRG-based payment systems is that the allowance will exceed costs for some patients and will be less than costs for other patients but that, on average, the allowance will be sufficient to cover the costs of the inpatient stay and provide a reasonable rate of return. Generally, this principle applies to variation within a given type of stay (e.g., spinal surgeries) rather than variation across types of stays. Systematic underpayments for particular types of

³ The composite rate is a hospital-specific rate based on the Medicare standard payment rate adjusted for geographic differences in wages and, if applicable, the hospital's additional payments for teaching and for serving a disproportionate share of low-income patients.

Labor Code Section 5307.1(a) specifies that the maximum allowable fees shall not exceed 120 percent of the estimated aggregate fees allowed under the Medicare payment system. In establishing the OMFS, the AD adopted a 1.20 multiplier so that aggregate payments will approximate 120 percent of the Medicare allowable payments for comparable services.

stays could create potential access problems for workers compensation (WC) patients, while systematic overpayments could create incentives for unnecessary services.

The OMFS pass-through payment is a deviation from standard Medicare rules that was originally established to ensure that WC patients have access to expensive hardware. Because a substantial portion (about 51 percent) of the Medicare rate used to determine the OMFS composite rate is for devices implanted during spinal surgery⁴ and the 1.20 multiplier used to determine the OMFS allowance already provides a cushion for the higher costs a hospital might incur in caring for a WC patient, an issue is whether the additional allowance is an unnecessary double allowance for hardware costs.

Aside from the double allowance issue, there are at least three other concerns about the current pass-through system for spinal surgery. First, a pass-through payment for hardware costs provides no incentive to use the least costly medically appropriate hardware. Second, the policy imposes an administrative burden to both payers and hospitals. Hospitals must locate invoices and determine the applicable costs and associated discounts and rebates for each patient. Often, multiple invoices are involved for a single WC patient, adding to the administrative burden. Third, the policy creates potential for abuse in reporting hardware costs, especially because payers cannot easily verify that the invoiced items were used only for the WC patient and that the reported costs are net of discounts and rebates. Typically, rebates are based on the total volume purchased from a given supplier and do not appear on the invoice. Further, the invoice reflects the amount the hospital was billed for the service and may include multiple-markups by suppliers to the amount the manufacturer charged for the item.

It is worth noting for policymakers how the additional allowance for hardware affects contracts between hospitals and payers. The purpose of the OMFS is to establish a reasonable and equitable payment for the services in the absence of a negotiated contract between payers and providers. However, it is common for hospitals to agree to a discounted rate from payers in return for patient volume. The additional allowance for hardware provides room for hospitals and payers to negotiate substantial discounts off the allowances for complex spinal surgeries. Fee discounting should not be a reason for setting excessive allowances. However, the effective date

⁴ Dalton, Kathleen, Sara Freeman, and Arnold Bragg, *Refining Cost to Charge Ratios for Calculating APC and MS-DRG Relative Payment Weights*, Research Triangle Park, N.C.: RTI International, 2008. As of October 31, 2008: http://www.rti.org/reports/cms/HHSM-500-2005-00291/PDF/Refining_Cost_to_Charge_Ratios_200807_Final.pdf

of any OMFS policy changes should be delayed to allow hospitals and payers time to renegotiate their contracts based on the revised OMFS policies.

Number and Cost of WC Inpatient Stays for Complex Spinal Surgery

In 2008, there were 5,055 complex spinal surgeries with total allowances of \$168 million before considering the additional pass-through allowances for the net costs of spinal hardware and instrumentation (Table 1). These stays account for nearly 40 percent of WC allowances for acute-care inpatient hospital stays used during spinal surgery. The OSHPD data do not have information that can be used to estimate the pass-through payments. If WC patients are assumed to have hardware costs that are comparable to the average spinal fusion patient, the pass-through payments would have totaled an estimated \$45 million. This estimate is likely to be an understatement given the incentives under the pass-through methodology to provide excessive hardware.

Table 1
Distribution of 2008 Workers' Compensation Discharges, by Medicare Severity-Adjusted
Diagnosis-Related Group Eligible for Pass-Through Payments

MS-DRG	Description	Number of Discharges	Estimated 2008 Total Allowances Net of Pass-through Payments (\$000s)	Percentage of Total Allowances Before Pass-through Payments	Relative Weights
	Spinal fusion except cervical	2,342	81,240	18.9	
459	With MCC	80	3,840		4.87
460	Without MCC	2,262	77,400		3.49
	Cervical spinal fusion	1,609	31,596	7.3	
471	With MCC	19	616		3.47
472	With CC	215	5,180		2.48
473	Without CC or MCC	1,375	25,800		1.94
	Combined anterior/posterior spinal fusion	818	47,850	11.1	
453	With MCC	45	3,650		8.43
454	With CC	320	19,500		6.58
455	Without CC or MCC	453	24,700		5.70
	Spinal procedures	240	5,621	1.3	
28	With MCC	16	711		4.23
29	With CC	92	2,590		2.84
30	Without CC or MCC	132	2,320		1.76
	Spinal fusion except cervical with spinal curve, malignancy, or infection diagnosis or 9+ fusions	46	2,513	0.6	
456	With MCC	3	206		6.77
457	With CC	24	1,320		5.47
458	Without CC or MCC	19	986		4.94
	All complex spinal surgeries	5,055	168,820		

Source: Wynn et al., 2011.

The MS-DRG classification system takes into account the type of surgical procedures and the presence major complications and comorbidities (MCC), other complications and comorbidities (CC) or the absence of complications and comorbidities (no CC). The two highest volume types of surgeries are non-cervical (lumbar) and cervical spinal fusions. The relative weight for each MS-DRG is shown as a measure of relative costliness of the different types of stays. By type of surgery, MS-DRG 453 "Combined anterior/posterior spinal fusion" is the most costly. Within types of surgery, patients with MCCs are most costly and those with no CC are the least costly on average. A relatively small proportion of WC patients have MCCs.

A concern when the OMFS pass-through was initially established was that relatively few hospitals performed spinal surgery and that WC patients would not have access to spinal surgeries if these providers determined their allowances were inadequate. Technology has since diffused and the

number of hospitals performing spinal surgery has expanded. In 2008, 179 hospitals performed complex spinal surgeries qualifying for pass-through payments on WC patients. Half of these hospitals had fewer than ten WC discharges in the relevant MS-DRGs (Table 2). Eleven hospitals had 100 or more WC discharges for spinal surgery, and another 17 hospitals had 50–99 WC discharges.

Table 2
Number of Hospitals by Number of 2008 Workers' Compensation Discharges by MS-DRGs for Complex Spinal Surgeries

	Hospitals by Number of WC Discharges				Total Number of Hospitals
	>100	50–99	10–49	1–9	
MS-DRG					
Spinal except cervical	2	5	52	101	160
Cervical	1	2	47	97	147
Combined anterior/posterior spinal fusion		3	20	61	84
Spinal procedures or spinal neurostimulators			4	75	79
Spinal fusion except cervical with spinal curvature, malignancy, or infection diagnosis or 9+ fusions				25	25
All spinal surgeries	11	17	69	82	179

Source: Wynn et al., 2011

Comparative Costs of WC and Medicare Patients

One approach to determining the adequacy of the OMFS allowance is to contrast the resources required for Medicare and WC patients undergoing spinal surgery. If we observe that WC patients consume fewer resources than Medicare patients despite being reimbursed at 120 percent of the Medicare rate, we might conclude that an additional allowance for hardware costs is unnecessary. Using the 2008 OSHPD data, we compared device usage rates, total charges, and length of stay for WC and Medicare discharges. These are particular measures of resources required during a hospital stay but there are many other factors that determine the total resources hospitals devote to treating patients with complex spinal surgeries that are not accounted for in the comparison. We can count the number of unique implants that are used during spinal surgery but cannot determine the number of units that were used for each type of implant. We found that, on average, WC patients used more types of devices than Medicare patients use but that fewer vertebrae were fused (Table 3). We cannot tell from the OSHPD data the extent to which the use of more types of implanted devices reflects medically necessary differences in device utilization or the incentives created by the pass-through for excessive hardware usage.

Table 3
Comparison of the Number of Unique Types of Spinal-Surgery Implants, by Type of Spinal Fusion, for Workers' Compensation and Medicare Patients

Discharge	Noncervical Spinal Fusion		Cervical Spinal Fusion	
	WC	Medicare	WC	Medicare
Number of discharges	2,342	5,277	1,609	2,919
Unique types of implants per discharge	1.15	0.92	0.68	0.58
Percentage of patients with 2–3 vertebrae fused	88	80	84	72
Percentage patients with 4–8 vertebrae fused	10	19	14	27

Source: Wynn et al., 2011

In assessing the adequacy of the OMFS allowance, an important question is how a hospital's average cost for a WC spinal surgery case compares to the cost for a Medicare patient. We used the average charges for a spinal surgery inpatient stay as our measure of relative costliness and controlled for the MS-DRG to which the patient was assigned. Because hospital charges are substantially in excess of costs, average charges are not a measure of actual costs; however, they can be used to gauge the relative costliness of services across patient groups receiving similar services because the charges for individual items and services should be consistently imposed across all payers (with the actual payments for the services varying across payers). We found that despite the more-frequent use of spinal hardware for WC patients, WC patients had lower costs than comparable Medicare patients (Table 4). Average charges per Medicare discharge were 6 percent higher than the average charges per WC discharge (\$135,125 versus \$126,491). One reason WC patients are less costly is that they have a shorter length of stay than Medicare patients. The DRG-adjusted Medicare average length of stay was 16 percent higher (4.4 days versus 3.8 days). Both the average charge analysis and the length-of-stay analysis indicate that WC patients are less costly on average than Medicare patients, before considering that the OMFS allowance incorporates an extra 20-percent margin beyond the Medicare rates.

Table 4
Comparison of Workers' Compensation and Medicare Discharges, Charges, and Length of Stay by MS-DRG Groupings for Complex Spinal, 2008

MS-DRG	Worker's Compensation				Medicare			
	Discharges		Mean Charges (\$) ^a	Mean Length of Stay (days)	Discharges		Mean Charges (\$) ^a	Mean Length of Stay (days)
	Number	Percent-age of Total			Number	Percent-age of Total		
Spinal fusion except cervical								
459 With MCC	80	—	229,380	8.9	423	—	228,403	9.7
460 Without MCC	2,262	—	133,184	4.2	4,854	—	136,769	4.5
	2,342	46.3	136,493	4.3	5,277	49.4	143,943	4.9
Cervical spinal fusion								
471 With MCC	19	—	135,648	7.2	315	—	174,337	9.2
472 With CC	215	—	91,898	2.7	764	—	116,054	4.5
473 Without CC or MCC	1,375	—	75,624	1.9	1,840	—	83,228	2.5
	1,609	31.8	78,496	2.1	2,919	27.3	101,352	3.7
Combined anterior/posterior spinal fusion								
453 With MCC	45	—	361,613	11.7	203	—	386,221	12.9
454 With CC	320	—	205,531	5.6	439	—	252,181	7.2
455 Without CC or MCC	453	—	175,372	4.4	351	—	180,018	4.7
	818	16.2	197,295	5.3	993	9.3	254,159	7.5
Spinal procedures or spinal neurostimulators								
28 With MCC	16	—	207,489	11.6	239	—	199,318	12.8
29 With CC or Neurostimulator	92	—	106,432	4.3	336	—	118,082	7.4
30 Without CC or MCC	132	—	62,129	2.9	327	—	67,329	3.8
	240	4.7	88,840	4.0	902	8.4	121,391	7.5
Spinal fusion except cervical with spinal curvature, malignancy, or infection diagnosis or 9+ fusions								
456 With MCC	3	—	386,205	13.0	126	—	361,076	15.1
457 With CC	24	—	236,436	6.8	318	—	232,378	7.6
458 Without CC or MCC	19	—	184,464	5.0	157	—	183,405	5.2
	46	0.9	224,737	6.5	601	5.6	246,569	8.6
All spinal-surgery MS-DRGs	5,055	100	126,491	3.8	10,692	100.0	145,888	5.3
DRG-adjusted averages			126,491	3.8			135,125	4.4

^a Weighted average using WC number of discharges.

NOTE: Due to rounding, some numbers do not sum to 100.

Source: Wynn et al., 2011

While the comparative cost analysis suggests the additional allowance is unnecessary, it rests on an assumption that Medicare-based rates appropriately reflect the costs of care and provide a reasonable rate of return. There are concerns that Medicare's relative weights for the MS-DRGs for spinal surgery do not fully account for device costs because hospital's tend to have a higher mark-up on low cost items than high cost items such as devices (called "charge compression"). Medicare anticipates addressing this shortcoming through improved data effective October 1, 2013.

Adequacy of OMFS Allowance Without the Pass-through for Hardware

Another approach to evaluating the adequacy of the OMFS allowance is to examine the ratio of estimated allowances to estimated costs for each type of spinal surgery. An allowance-to-cost ratio of 1.05 indicates, for example, that estimated allowances are 5 percent more than the estimated costs and are, on average, adequate to cover the costs. We estimated the ratios for spinal surgeries in 2008.⁵ The allowances exclude the pass-through amount, so these results essentially provide information about the adequacy of allowances if the pass-through mechanism were to be eliminated. Table 5 displays the estimated allowance-to-cost ratios for all complex spinal-surgery MS-DRGs. We observe considerable variation across MS-DRGs, with allowance-to-cost ratios for procedures with major complications tending to be lower. For the two most common types of spinal fusion, the estimated allowance-to-cost ratio was less than 1.0 (lumbar spinal fusion = 0.93, cervical spinal fusion = 0.95), indicating that some continued allowance for spinal hardware may be warranted (Table 5) for these two types of surgery. An additional allowance may not be necessary after the undervaluation of device costs in Medicare's payment rates for spinal surgery is addressed.

⁵

We simulated the payment amounts using the OSHPD discharge records and each hospital's composite rate. We estimated costs by applying an overall cost-to-charge ratio derived from Medicare cost reports to the total charges on the OSHPD discharge record. There are limitations to using an overall cost-to-charge ratio because hospital markups vary across departments and within departments. We used an overall cost-to-charge ratio because we only had access to total charges in the OSHPD data; however, we increased the cost estimate to account for the effect of charge compression based on findings in Dalton et al., 2008.

Table 5
Average Allowances, Estimated Costs, and Allowance-to-Cost Ratios for MS-DRGs Eligible for Pass-Through Payments, 2008

MS-DRG	Description	Average OMFS Allowance (\$)	Estimated Average Cost (\$)	Allowance-to-Cost Ratio
	Spinal fusion except cervical	33,842	36,203	0.93
459	With MCC	46,112	59,590	0.77
460	Without MCC	33,410	35,381	0.94
	Cervical spinal fusion	19,168	20,245	0.95
471	With MCC	32,410	33,320	0.97
472	With CC	23,855	23,255	1.03
473	Without CC or MCC	18,246	19,588	0.93
	Combined anterior/posterior spinal fusion	58,351	53,194	1.10
453	With MCC	80,738	95,378	0.85
454	With CC	61,057	54,228	1.13
455	Without CC or MCC	54,266	48,398	1.12
	Spinal procedures	23,463	21,538	1.09
28	With MCC	44,444	45,880	0.97
29	With CC	28,188	26,892	1.05
30	Without CC or MCC	17,618	14,846	1.19
	Spinal fusion except cervical with spinal curve, malignancy, or infection diagnosis or 9+ fusions	54,653	59,526	0.92
456	With MCC	68,744	90,639	0.76
457	With CC	55,060	61,539	0.89
458	Without CC or MCC	51,914	52,072	1.00

Source: Wynn et al., 2011

To investigate whether the lower ratios were likely attributable to higher device costs, we performed an analysis for the Division of Workers' Compensation in which we compared the amounts implicit in the standard OMFS allowance for spinal hardware (before the pass-through) with the estimated WC spinal-hardware costs. Because information on WC-specific device costs is not readily available, we assumed that average WC implant costs are similar to the average for all patients. Our source for the average implant costs for all patients was a hospital survey reported in *Orthopedic News*. Because of the issues raised by the current pass-through methodology, this may be a more appropriate measure of the costs of medically necessary implants than one generated from a sample of invoices for California WC patients. Our estimate for the amount implicit in the OMFS rate is based on the amount implicit in the Medicare rate (on average, 51 percent of the standard rate) times 1.2. Table 6 shows the results of the analysis for the two most common types of spinal surgery. According to the *Orthopedic News* report, average device costs are much higher for noncervical spinal fusions than for cervical spinal fusions. For both types of surgery, however, the amount implicit in the OMFS allowance is less than the average cost based on the current Medicare rates.

Table 6
Comparison of Amounts Implicit in 2009 Standard Official Medical Fee Schedule Allowances for Spinal Surgery, with Estimated Average 2009 Implant Costs

Type of Spinal Fusion	Estimated Average Implant Costs (\$) ^a	Amount Implicit in the OMFS Standard Allowance (\$)	Difference (\$)
Noncervical	14,407	11,544	2,863
Cervical	5,960	5,350	610

^a *Orthopedic Network News*, Vol. 20, No. 4, October 2009.

Source: Wynn et al., 2011.

Potential Policy Options

In weighing potential options for refining the policy for spinal-hardware pass-through payments we considered the following objectives: (1) eliminate excessive allowances for hardware, (2) recognize that WC patients use more hardware than Medicare patients do, (3) provide incentives for efficient use of resources, (4) provide financial protection for atypically high-cost cases, and (5) reduce administrative burden and potential for abuse.

In Table 7, we summarize our assessment of four basic policy options: 1) retain the current pass-through policy, 2) eliminate the pass-through and treat complex spinal surgeries the same as other surgeries, 3) retain the current pass-through policy but reduce the OMFS multiplier to remove the implicit amount for hardware (e.g., reduce it to 0.6), and 4) eliminate the pass-through but provide an additional allowance for the difference between the estimated WC hardware costs and the amount implicit in the OMFS allowance (e.g., \$610 for cervical fusions in Table 6). The **+** indicates the policy is consistent with a particular objective, the **-** indicates it is contrary to the objective, and a **O** indicates it is partially consistent with the objective.

Table 7
Overview of Potential Policy Options for Spinal Hardware

Objective	(1) Retain current policy	(2) Treat same as other stays	(3) Continue pass-through but reduce the multiplier	(4) Eliminate pass-through but provide an additional allowance
Eliminate excessive payment for hardware	-	+	+	+
Recognize that WC patients use more hardware than Medicare patients do	+	O	+	+
Provide incentives for efficient use of resources	-	+	-	+
Provide financial protection for atypically high-cost cases	+	O	+	O
Reduce administrative burden and potential for abuse.	-	+	-	+

In several of our earlier studies, we discussed eliminating the pass-through payment and treating complex spinal surgery the same as other WC hospital stays. This option relies on the overall averaging concept underlying the DRG system used in the OMFS. Overall, WC patients tend to be younger and less costly than Medicare patients and the 1.2 multiplier provides an additional cushion for any higher costs that might be attributable to treating WC patients. Further, the OMFS incorporates financial protection for atypically high cost cases but does not provide as much financial protection as the pass-through for systematically higher hardware costs.

Based on our more recent analysis, some type of supplemental allowance for the higher hardware usage may be needed to assure that WC patients have continued access to medically appropriate spinal surgery and implants. The excessive allowance could be eliminated by continuing the pass-through but reducing the multiplier for the OMFS standard allowance to

remove the amounts attributable to device costs. The amounts that are implicit in the OMFS allowance for device costs vary across types of spinal surgeries, but on average are about 51 percent of the allowance. This suggests that the multiplier would need to be reduced to 0.60 to eliminate recognition of the hardware costs twice in the allowances. A continued pass-through increases payment accuracy and provides full financial protection by paying for actual hardware costs on a case-by-case basis. However, it continues the incentives to provide unnecessary and costly hardware and continues the administrative burden of filing and processing bills for hardware. If the pass-through were continued, it would be important to establish safeguards to reduce opportunities for abuse. In this regard, policies that should be considered include requiring the hospital to bill for all hardware, basing the allowance on the manufacturer's original invoice, and requiring hospital certifications regarding any discounts and rebates not reflected on the invoice.

The other option would be to create an additional allowance for the difference between the estimated average hardware costs and the amount implicit in the standard OMFS allowance. This option recognizes that WC patients have, on average, higher device costs than what has been built into the OMFS allowance but also provides incentives for efficient use of spinal hardware, reduces administrative burden and avoids time-consuming review of the invoices. By basing the add-on on average hardware costs, the payment is consistent with the underlying DRG averaging principle; however, it is not as accurate on a case-by-case basis. Hospitals would still have financial protection for atypically high cost cases but hospitals that systematically have above-average costs would be disadvantaged. Because the hardware costs vary by type of spinal surgery, the additional allowance should be determined by type of spinal surgery. An add-on payment- which would provide the same additional allowance to all hospitals performing the particular type of surgery- is preferable to an increase in the multiplier. The latter would provide different allowances based on hospital location and other characteristics that should not affect the amount a hospital pays for spinal hardware.

Recommendation

The RAND reports on the spinal hardware pass-through issue did not recommend a specific policy. With regard to the legislation under consideration, there are definite advantages to addressing the excessive allowance for hardware through a revision in the Labor Code that eliminates the pass-through provision. However, consideration should also be given to 1) delaying the effective date until the OMFS incorporates Medicare's rates that will be effective October 1, 2013 and 2) adding a provision authorizing an additional allowance for complex spinal surgeries without regard to the 120 percent limitation of aggregate allowances under the OMFS

for inpatient services if the administrative director of the Division of Workers' Compensation determines that the standard allowance is inadequate to maintain access to high quality medically appropriate spinal surgeries. Delaying the effective date would defer the change until the undervaluation of device costs in the Medicare relative weights is addressed and allow time for hospitals and payers to renegotiate their contracts. Adding a provision giving the administrative director discretionary authority to increase the allowance for complex spinal surgeries without regard to the 120 percent aggregate limitation safeguards against potential access issues if the amounts implicit in the OMFS standard allowances are not adequate after the Medicare relative weights for spinal surgeries are improved. Any additional allowance should be limited to the difference between average estimated costs for medically appropriate hardware and the amounts implicit in the OMFS standard allowance.

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