

# WORKING P A P E R

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## Payments For Burn Patients Under California's Official Medical Fee Schedule For Injured Workers

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## SUMMARY

The OMFS inpatient fee schedule is adapted from the Medicare payment system for inpatient services furnished by acute care hospitals. A pre-determined maximum allowable fee is established for each admission based on the diagnosis-related group- or DRG- to which the patient is assigned. The DRG assignment takes into account factors such as the patient's principal diagnosis, co-morbidities, and surgical procedures. Each DRG has a relative weight reflecting the average resources or costs required by patients assigned to the DRG relative to patients in other DRGs. There are eight DRGs for burn cases. The FY03 relative weights indicate the most resource intensive burn DRG (DRG 504 Extensive Third Degree Burns with Skin Graft) is almost 21 times more costly than the least resource intensive DRG (DRG 511 Non-Extensive Burns without Complications or Comorbidities or Significant Trauma).

The OMFS standard allowance for a discharge is determined as the composite rate<sup>3</sup> x DRG relative weight x 1.20. Additional allowances are made for discharges with atypically high costs, or outliers. The additional allowance for burn cases equals 90 percent of the difference between the estimated costs for the discharge and the standard payment for the DRG plus an outlier threshold.

This study updates analyses from a 2003 RAND report<sup>4</sup> examining Official Medical Fee Schedule (OMFS) payments for workers' compensation burn discharges from acute care hospitals. Until January 1, 2004, burn cases were exempt from the OMFS maximum allowable fees for inpatient hospital care. The 2003 RAND report concluded that the fees should be adequate using a Medicare-based fee schedule. SB 228 (Alarcón 2003) ended the exemption for burns cases. The California Hospital Association has raised concerns regarding losses being incurred by hospitals for workers' compensation burn cases. Pending legislation<sup>5</sup> would re-institute the OMFS exemption for inpatient

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<sup>3</sup> 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 serving a disproportionate share of low-income patients.

<sup>4</sup> Barbara O. Wynn, *Adopting Medicare Fee Schedules: Considerations for the California Workers' Compensation Program*, Santa Monica, CA: RAND, MR-1776-ICJ, 2003.

<sup>5</sup> AB 935 (Koretz).

stays involving extensive burns. The OMFS would continue to apply to non-extensive burn discharges.

This study examines the adequacy of OMFS maximum allowable fees for inpatient burn cases by addressing two questions:

- How do the costs of caring for injured workers compare to the costs for Medicare patients in the burn DRGs?
- How do OMFS allowances for burn DRGs compare to the estimated costs of caring for injured workers?

We used 2003 administrative and financial data from the California Office of Statewide Health Planning and Development to compare the estimated costs per discharge for CA workers' compensation patients and Medicare patients. The underlying assumption is that if the estimated costs for the workers' compensation patients are less than 120 percent of the costs for Medicare patients, the OMFS payments for burn discharges should be sufficient.<sup>6</sup> The 20 percent reflects the 1.20 multiplier that is intended to compensate for any higher costs that workers' compensation patients might incur and to provide a reasonable margin on treating injured workers.

Our comparative analysis of Medicare and workers' compensation burn cases shows that on average workers' compensation patients are less costly than Medicare patients and have a shorter length of stay. The DRG-mix adjusted Medicare cost per discharge is about 12% higher than the cost per discharge for workers' compensation patient and the average length of stay is 7% longer. The comparison suggests that the 1.20 multiplier to the Medicare payment rate should be sufficient to assure that OMFS payments on average for burn cases are substantially more than the cost of providing care. This does not mean that the payment for every workers' compensation discharge will be higher than the costs for that patient. The DRG system is built on a system of averages, where some discharges are more costly than others, and the goal is to assure that on average the payment is adequate. Further, the outlier policy is designed to protect hospitals from large financial losses on extraordinarily high cost cases. However,

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<sup>6</sup> For purposes of this study, we equate the OMFS allowances to payments for injured workers. The actual payments may differ from the OMFS allowances because of contractual arrangements between the hospital and the employer (or payer).

as discussed below, our payment simulations raise some potential concerns that warrant further consideration.

The second aspect of our study was to simulate what payments would have been under the OMFS if the Medicare-based fee schedule had applied in 2003 and to compare the simulated payments to estimated costs. To estimate costs, we applied an overall cost-to-charge ratio to the total charges in the administrative data for each workers' compensation burn case. Hospital charging practices affect the accuracy of the cost estimate. First, hospitals have different charge structures for the services they provide and there are limitations on the extent to which this can be taken into account. In theory, a hospital's charges should be consistently related to its costs. An overall cost-to-charge ratio reflects the hospital's average markup across all services, but there can be substantial differences in hospital markups for particular types of services. We are limited to using an overall cost-to-charge ratio for this analysis and do not have the detailed charge information needed to know how a particular hospital's average markup (or cost-to-charge ratio) for burn discharges compares with its markup for other services.

The results are sensitive to the cost-to-charge ratios that are used to estimate costs but suggest that if 1.20 times the Medicare rates had been used to pay for burn discharges in 2003, total OMFS payments would have exceeded estimated costs. The aggregate payment-to-cost ratio would have been 1.09 using an OSHPD overall cost-to-charge ratio for all hospital services and 1.33 using a cost-to-charge ratio for Medicare inpatient services. While neither statistic is definitive given the limitations of the methodology, they lend further support to a conclusion that in general the DRG-based payments seem to be working for the OMFS. While the aggregate payment-to-cost ratio across all DRGs is above 1.0, there is considerable variation among the DRGs:

- The payment-to-cost ratios for the three most resource intensive DRGs are well above 1.0. Nevertheless, DRG 504 is of some concern because it requires intensive specialized care at substantial cost. The estimated average cost for DRG 504 discharges is \$151,269, nearly 4.5 times the next costliest DRG. The DRG allowance may be considerably higher or lower than the cost a particular case. A hospital may not have sufficient volume to average out a large gain or loss on its patients in this DRG.

- The payment-to-cost ratios for the less resource intensive DRGs are below 1.0. Of particular concern is DRG 507 Full Thickness Burn with Skin Graft or Inhalation Injury without CC or Significant Trauma. A significant portion of discharges assigned to this DRG has either low or high payment-to-cost ratios and there is an aggregate net loss for these discharges.
- When the DRGs for patients with non-extensive burns (DRGs 510 and 511) are dropped from the simulation, the aggregate payment-to-cost ratios increase. The allowances for the non-extensive burn DRGs may be more problematic than some of the DRGs for extensive burn cases that are being considered for exemption.

Most hospitals treating injured workers with burns have only one or two cases and should not be of particular concern. These hospitals do not treat the most resource intensive burn patients and their estimated average cost is low relative to hospitals that treat more resource-intensive patients. Any over- or underpayment for their burn discharges should average out with payments for discharges in other DRGs.

There are 12 hospitals that have five or more workers' compensation burn discharges. Four of the six hospitals with 5-20 discharges have net gains on their workers' compensation burn discharges. The two hospitals with net losses are safety net hospitals. One had substantial losses on DRG 504 discharges; the other hospital's losses were attributable to non-extensive burn discharges.

Only five hospitals have more than 20 workers' compensation burn discharges. It is this group of hospitals that would be most harmed if the OMFS allowances for burn discharges are inadequate. Four of the five hospitals had net gains on their workers' compensation burn discharges. One safety net hospital had net losses on both extensive and non-extensive burn discharges.

The 2003 data do not support an across-the-board OMFS exemption for extensive burn cases. An outright exemption is likely to add unnecessary administrative costs because of the need for case-by-case negotiations and to unreasonably high payments because of the role of charges determining the negotiated price. There are several alternatives to an exemption that warrant further consideration. Options 1 and 2 are

mutually exclusive. Options 3 and 4 narrow eligibility for special treatment and could be considered with either of the first two options or an exemption policy.

### **Option 1: Create a Pass-Through Formula**

The pass-through for hardware and instrumentation for spinal surgery is suggested as a precedent for exempting DRGs 504–509. However, there is an important distinction between a *pass-through* based on the costs of the hardware and an *exemption* that would rely on negotiated amounts between the hospital and the payor. The starting point for negotiated rates is typically a hospital's charges, which were more than three times cost in 2003 according to the OSHPD financial data.

One alternative would be to use the Medicare cost-to-charge ratio used to price outlier payments to estimate costs for the discharge and to set payment at a multiple of that amount, e.g., 1.20. Assuming that a hospital's cost-to-charge ratio in the FY05 Medicare PPS Impact File was .30, the payment for a burn patient with \$200,000 in total charges would be:

$$(\$200,000 \times .30) \times 1.20 = \$72,000$$

Relative to relaxing the outlier payment methodology (see Option 2), this option is likely to improve overall payment accuracy for burn discharges because it would reduce payments for relatively low cost discharges and increase payment for relatively high cost discharges. By eliminating the DRG payment for burn discharges, it would reduce incentives to provide services efficiently.

While all hospitals are likely to benefit from an exemption, the data suggest that most hospitals, including safety net hospitals, are operating with a net gain on workers' compensation burn discharges and might receive less payment under a pass-through policy than the OMFS. A variant of Option 1 would be to allow hospitals to elect prior to the beginning of the payment year whether they would be paid under Option 1 or the OMFS.

### **Option 2: Reduce the outlier threshold for burn cases.**

The outlier threshold is a hospital-specific amount (ranging from about \$35,000 to \$45,000) that hospitals must absorb before payments are made for unusually high cost cases. Reducing the threshold to a lower amount (e.g., \$10,000) would reduce a

hospital's financial loss on atypically high cost cases. This option would pay a higher amount for atypically high cost cases that are generating losses but hospitals would continue to incur some loss on these cases (the amount of the outlier threshold plus 10% of the remaining excess costs). It would continue to make the same payments for other cases. Relative to Option 1, it retains the PPS incentives for efficiency.

If Option 1 were adopted, consideration should be given to extending it to DRGs 510 and 511, which have a low payment-to-cost ratio. As is the case with the other relatively inexpensive burn DRGs, there are discharges in DRGs 510–511 with losses that do not qualify for outlier payments because of the high outlier threshold relative to costs.

### **Option 3: Limit special treatment to hospitals with burn intensive care units.**

Instead of providing special treatment under the OMFS on a DRG basis, only hospitals that have burn centers or burn intensive care units would qualify for special treatment. The option would assure that injured workers have access to these specialized units, which are the only hospitals likely to treat discharges in most extensive burn cases. This option would rely on the PPS averaging concept for hospitals with only a few relatively inexpensive burn discharges.

### **Option 4: Limit special treatment to DRGs 504–507**

DRGs 508–509 Full Thickness Burns Without Skin Graft are about as resource-intensive as non-extensive burns (DRGs 510 and 511). The pattern of payment-to-cost ratio do not suggest a need for these DRGs to be exempted or paid as a pass-through. While DRG 506–507 are also relatively inexpensive, the pattern-of-cost to charge ratios suggests special treatment might be warranted for discharges assigned to these DRGs.