WORKING
PAPER

Inpatient Hospital Services

An Update on Services Provided Under California's Workers' Compensation Program

BARBARA O. WYNN

WR-629-CHSWC

January 2009

Prepared for the Commission on Health, Safety and Workers' Compensation

This product is part of the RAND Center for Health and Safety in the Workplace and RAND Health working paper series. RAND working papers are intended to share researchers' latest findings and to solicit informal peer review. They have been approved for circulation by the RAND Center for Health and Safety in the Workplace and RAND Health but have not been formally edited or peer reviewed. Unless otherwise indicated, working papers can be quoted and cited without permission of the author, provided the source is clearly referred to as a working paper. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors.
RAND® is a registered trademark.

CENTER FOR HEALTH AND SAFETY IN THE WORKPLACE
A Study by the RAND Institute for Civil Justice and RAND Health

SUMMARY

This working paper examines changes in the number and type of discharges and maximum allowable fees under the California Workers' Compensation (WC)Official Medical Fee Schedule (OMFS) for inpatient hospital services from 2003-2005. The paper is part of an on-going study evaluation the impact of the changes in Labor Code provisions affecting medical care provided injured workers. The study's final report will include an analysis of inpatient data through 2007 and integrate the inpatient findings with findings from an analysis of ambulatory surgery data from 2005 (the first year such data are available from OSHPD) - 2007.

Effective January 2004, the OMFS was revised to provide for annual updates for acute care inpatient stays based on the Medicare payment system with an additional pass-through for the cost of devices and instrumentation used during complex spinal surgery. In the aggregate, OMFS allowances are limited to 120 percent of Medicare payments for comparable services. The OMFS was also expanded to include facility fees for ambulatory surgery (without a pass-though for spinal hardware). The Labor Code required that specialty hospitals become subject to the OMFS effective January 1, 2005; however, this provision has not been implemented. In addition to the OMFS changes, other significant changes were made during the study period with potential impacts on the utilization of inpatient hospital services. These included the adoption of medical treatment guidelines as presumptively correct medical treatment (effective March 23, 2004) and the requirement that injured workers of employers with medical provider networks use network providers throughout the course of their treatment (effective January 1, 2005).

The analyses reported in this paper use transaction-level data on WC hospital discharges during 2003-2005 available from the California Office of Statewide Health Planning and Development (OSHPD). Key findings include the following:

- There was a 9.6% decrease in the number of WC inpatient hospital stays. While the number of stays declined, the mix of inpatient stays remained relatively stable. The changes in the volume and mix of inpatient services are attributable to a number of factors and cannot be attributed directly to the legislative changes affecting hospital inpatient care.
- The estimated payment per discharge increased 5.0 percent. However, the increase would have been higher if the OMFS had not been updated. The 2004 OMFS revisions increased the allowances for acute care stays, but these higher allowances were more than offset by the elimination of the OMFS exemptions for certain high cost stays in acute care hospitals.
- The combination of the decrease in discharges and increase in average payment resulted in an estimated 5.1 reduction in aggregate payments. Actual payment information is not available in OSHPD data. The estimate assumes payment levels consistent with the OMFS allowances for acute care hospital stays and at 90 percent of charges for OMFS-exempt stays. Because hospital charges are substantially higher than costs, payers may have contracted with hospitals to pay for exempt services at a lower rate.
- The overall estimated average payment-to-cost ratio for acute care inpatient stays was 1.09 in 2005. It is likely to increase beginning in 2008 with Medicare refinements to better account for difference in patient severity in determining payment.
- In 2005, charges for WC stays in specialty hospitals totaled $67 million. Stays in rehabilitation hospitals and units of acute care hospitals accounted for nearly $49 million of this amount.

The paper raises several concerns that warrant monitoring and consideration of changes in OMFS policies. The Administrative Director of the Division of Workers' Compensation has discretionary authority that could be used to address most of these issues.

- There is wide variation in the payment-to-cost ratios across different types of acute care stays that could adversely affect the provision of appropriate inpatient care. This issue should be re-

examined after the Medicare severity refinements are fully implemented. The AD has authority to adjust fees within an aggregate limit.

- The pass-through for the cost of hardware used during complex spinal surgery is problematic and should be re-evaluated. The average payment-to-cost ratios for inpatient stays affected by this provision are higher than average *before* the pass-through payments are taken into consideration. There are also inconsistencies in the Labor Code regarding which surgical procedures are "complex" and eligible for the pass-through. Further, the pass-through creates an incentive to shift less complex spinal surgeries from outpatient to inpatient settings.
- The Medicare-severity refinements should improve payment accuracy; however, they may also lead to unwarranted payment increases caused by coding improvement rather than a real change in patient mix. If warranted, the AD's authority to adjust the OMFS allowances within the overall 120 percent of Medicare limit could be used to adopt a lower percentage add-on to account for the effect of coding improvements.
- Because hospital charges are substantially higher than costs, payors are at risk for unnecessary expenditures as long as specialty hospitals- particularly rehabilitation facilities - remain exempt from the OMFS. The AD has authority to adopt Medicare-based fee schedules for specialty hospitals; however, further analysis is needed to determine whether the Medicare methodologies are appropriate for the WC patient population. Also, the administrative burden of expanding the OMFS to small-volume specialty hospitals may outweigh potential cost savings.