ICIS SAYS…

The Industry Claims Information System (ICIS) currently encompasses transaction-level data on more than 3.5 million California workers' compensation claims contributed by large and midsize national and regional insurers and self-insured employers for claims with dates of injury from 1993 through 2004. This "data warehouse" was built by CWCI and resides on a relational database platform at CWCI's Executive Offices. The data warehouse was built to meet the changing and expanding research and analysis requirements of the workers' compensation industry and the CWCI's membership.

The value of data depends on its practical applications. The Institute often relies on ICIS to generate "hard numbers" that can be used to advance the public policy debate on a wide variety of workers' compensation issues and concerns. In many cases, ICIS is the first and only source for this much needed empirical data. The following ICIS Report provides a preliminary look at changes in outpatient surgery payments following the adoption of an outpatient surgery facility fee schedule in January 2004.

ICIS SAYS: Early Returns on Workers' Comp Medical Reforms: Part 1.

Changes in Outpatient Surgery Payments Following Adoption of the Outpatient Surgery Facility Fee Schedule

by Alex Swedlow
California Workers' Compensation Institute

Background: Prior to the enactment of recent reforms, outpatient surgery facility fees in the California workers' compensation system were unregulated, and the amounts paid to outpatient surgery centers varied widely. A 2002 study conducted by Kominsky and Gardner[1] documented that the California's workers' compensation system was paying significantly higher fees for comparable procedures than federal health care programs such as MediCare. In response to these findings, in September 2003, California lawmakers enacted SB 228. Among the cost-saving provisions of this bill were amendments to Labor Code Section 5307.1(c), mandating that the state adopt a workers' compensation outpatient surgery facility fee schedule for services rendered on or after January 1, 2004. Under the revised statute, maximum facility fees for services performed in ambulatory surgical centers may not exceed 120 percent of the Medicare fee for the same services performed in a hospital outpatient facility.

The Rating Bureau estimated total outpatient costs for 2004 work injuries of $2.0 billion, and estimated that the new schedule could net annual savings of 41 percent or $800 million for accident year 2004, not including any changes in utilization that might occur. In addition, the Bureau estimated the outpatient surgery fee schedule could reduce future outpatient costs on pre-2004 claims by approximately $2.4 billion.

Research Goal: The goal of this analysis was to compare the average amounts paid under the new outpatient surgery facility fee schedule to the average payments for the same services prior to adoption of the schedule.

[1] Kominsky and Gardner, Inpatient Hospital Fee Schedule and Outpatient Surgery Study, California Commission on Health and Safety and Workers' Compensation, February 2002.

ICIS Data: The data required for this analysis consisted of average outpatient surgical facility fees paid to hospitals and free standing surgical facilities for commonly used outpatient surgical procedures:

1) before adoption of the outpatient surgery facility fee schedule (2001 dates of service); and
2) after the adoption of the schedule (2004 dates of service).

Each outpatient surgery facility fee used in the 2004 sample met the following criteria:

- The procedure was subject to the Medicare fee schedule;
- The procedure was the sole/primary procedure on a service date and not influenced by any cascade rule[2] discounts;
- The average payment for the procedure was profiled in Kominsky and Gardner's 2002 outpatient surgical facility study.

Prior to 2004, outpatient facility fees in California workers' compensation were not subject to a fee schedule, and payers negotiated usual and customary (U&C) pricing for these services. For this study, the Institute downloaded information on medical fee schedule amounts and other fee schedule rules and regulations from the Medicare and DWC websites,[3] and obtained data on average outpatient surgery facility payments for 2001 dates of service from Appendix C of the Kominsky and Gardner Report. To account for medical inflation, the 2001 payment data was adjusted to 2004 levels by applying a medical consumer price index factor compiled by the Bureau of Labor Statistics.[4]

The Institute then used ICIS to compile a data set of 5,474 paid outpatient surgical facility procedures with 2004 dates of service for which workers' compensation insurers and self-insured employers paid a total of $6.1 million. After calculating the average payment for each procedure, the analysts compared the 2004 results to the inflation-adjusted 2001 average payment data for the same procedures from the Kominsky and Gardner study and noted the percentage change.

Results

The analysts found 239 distinct outpatient surgical codes common to both the 2001 and the 2004 samples, with a majority of the outpatient facility services concentrated among a relatively small number of codes. The table below lists the top 20 outpatient surgical procedures common to both time periods, ranked by the total number of procedures in the 2004 claim sample. Together, these 20 procedures accounted for 62 percent of the outpatient surgical services paid under the new schedule. The table also shows the inflation-adjusted average payments for the outpatient facility procedures rendered in 2001, and the average fees paid for the same each procedures in 2004 (after adoption of the fee schedule). The percentage difference (i.e. the amount saved under the new schedule) is listed in the far right column.

[2] In cases where multiple procedures are performed on the same date, the Out-Patient Surgical Facility Fee schedule allows 100% of the allowed payment for the highest priced procedure and 50% of the allowed payment for all other procedures.

[3] For more information: Medicare's Out-Patient Hospital Fee Schedule www.cms.hhs.gov/providers/hopps
Out-Patient Hospital Fee Schedule Labor Code Section 5307.1
Out-Patient Hospital Fee Schedule California Code of Regulations 9789.30-9789.38

[4] The analysis used a 3-year compounded Medical Consumer Price Index of 1.151 (BLS 2005).

2001 vs. 2004 Outpatient Surgery Facility Fees -- Top 20 Procedures

TOP 20 PROCEDURES (BY COUNT)	# OF PROCEDURES '04 SAMPLE	% OF PROCEDURES '04 SAMPLE	INFLATION-ADJUSTED AVG PAYMENT '01	AVG PAYMENT '04	% CHANGE '01 - '04
62311 – Inject spine lumbral sacral (cd)	654	11.9%	$935	$373	-60.1%
64721 – Carpal tunnel surgery	341	6.2%	$1,721	$983	-42.9%
29826 - Shoulder arthroscopy/surgery	318	5.8%	$2,959	$3,044	2.8%
29881 - Knee arthroscopy/surgery	301	5.5%	$2,921	$1,758	-39.8%
64483 - Inj foramen epidural lumbral sacral	266	4.9%	$821	$452	-45.0%
64475 - Inj paravertebral lumbral sacral	181	3.3%	$1,002	$443	-55.8%
49505 – Hernia, Init reduction	165	3.0%	$2,444	$1,616	-33.9%
29877 - Knee arthroscopy/surgery	158	2.9%	$2,521	$1,511	-40.1%
29880 - Knee arthroscopy/surgery	127	2.3%	$2,995	$1,693	-43.5%
62310 – Inject spine c/t	122	2.2%	$895	$354	-60.5%
20680 - Removal of support implant	111	2.0%	$1,908	$1,102	-42.3%
29823 - Shoulder arthroscopy/surgery	104	1.9%	$2,696	$1,069	-60.3%
26418 – Repair finger tendon	83	1.5%	$1,308	$855	-34.6%
20610 – Drain/inject, joint/bursa	75	1.4%	$452	$121	-73.3%
29876 - Knee arthroscopy/surgery	74	1.4%	$2,950	$1,390	-52.9%
29888 - Knee arthroscopy/surgery	68	1.2%	$3,553	$3,242	-8.8%
26055 – Incise finger tendon sheath	65	1.2%	$1,305	$798	-38.9%
29848 – Wrist endoscopy/surgery	59	1.1%	$2,078	$1,945	-6.4%
25115 - Remove wrist/forearm lesion	57	1.0%	$1,617	$1,200	-25.8%
64719 – Revise ulnar nerve at wrist	51	0.9%	$1,706	$816	-52.2%
Grand Total (All 239 Procedures)	**5,474**	**100%**	**$1,834**	**$1,120**	**-38.9%**

After adjusting for medical inflation and mix of medical procedures, the results showed that across all procedures in the sample, average outpatient surgery facility fee payments fell 38.9 percent from an inflation-adjusted average of $1,834 in 2001 to $1,120 in 2004.

Due to differences in Medicare fee schedule rates, savings percentages varied widely among the top 20 procedures. Changes in average payments ranged from a 2.8 percent increase (procedure 29826 - Shoulder arthroscopy/surgery) to a decrease of 73.3 percent (procedure 20610 - Drain/inject, joint/bursa). Among the most common outpatient surgical procedures, average payments under the schedule fell 60.1 percent for lumbral sacral spinal injections (procedure code 62311); 42.9 percent for carpal tunnel surgery (procedure code 64721); and 39.8 percent for knee arthroscopy surgery (procedure code 29881).

The average adjusted total reduction of 38.9 percent across all 239 procedures identified in the analysis clearly shows that the schedule has been effective in reducing outpatient surgery facility fees in California workers' compensation.

Note:
Table 1 provides snapshots of medical payments for the top 20 outpatient surgery facility procedures taken at a single point in time. The estimated savings in this analysis represent an initial measurement on one facet of medical services and should not be taken as the definitive statement on overall medical cost reductions in the California workers' compensation system. While it is clear from the data that the average amount paid for outpatient surgery facility procedures has fallen significantly, it is too early to tell if these savings will stand the test of time, or if the costs will simply reemerge in the future. Projecting healthcare cost savings is a tricky business due to the rapid pace of change in reimbursement rules, benefit design, medical innovation and patient preferences. Projections based on one aspect of medical cost, such as surgical facility fees, are also susceptible to multiple external variables, including:

- the changing mix of procedures with different savings yields;
- geographic adjustment factors for facilities;
- cascade pricing rules for multiple procedures on the same day; and
- shifts from outpatient surgery to inpatient admissions and/or utilization effects from other medical treatment intervention.

CWCI will continue to track short and longer term effects of recent medical reforms on reimbursements as well as utilization levels, and release the results in future studies.

The Research Series: Early Returns on Workers' Comp Medical Reforms – Changes in Medical Cost & Utilization

This analysis is the first in a 6-part series in which the Institute will track short- and long-term effects of fee schedules, utilization management and other workers' compensation medical cost drivers and cost containment strategies included in the 2002–2004 legislative reforms. The series will cover the following topics:

Part 1. Outpatient Surgery Fee Schedule
Part 2. Physical Therapy and Chiropractic Manipulation Cost and Utilization
Part 3. Physician Services Fee Schedule
Part 4. Pharmacy Fee Schedule Changes
Part 5. Utilization of Medical Services
Part 6. Inpatient Hospital Fee Schedule Changes

As noted above, the next report in the series will measure the initial effects of the 2002-2004 California workers' compensation reforms on the utilization and cost of physical therapy and chiropractic manipulation.