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MEDICAL FEE SAVINGS

INTRODUCTION

More than half of the worker' compensation costs in Louisiana are medical expenses. In a recent report by the Workers' Compensation Research Institute a large part of the employer's medical costs is due to excessive charges by hospitals and ambulatory surgery centers for outpatient services.
Our law firm has taken the lead in offering employers alternative methods of reducing their payments for outpatient bills:[1]

1. We have worked with a network of hospitals and ambulatory surgery centers (ASC) that have agreed to accept a reduced payment for outpatient services. Their bills are processed through our network, Contractual Payor Relief, LLC (CPR) and each bill payment is acknowledged by the facility as being accepted in full satisfaction of the bill.

2. If a hospital or ASC is not part of the network and refuses to negotiate a reasonable reimbursement, we provide the employer with a recommendation for payment that is significantly less than the amount that would be paid under the outpatient fee schedule. The recommendation is based on an analysis of the charges by our bill review expert who has access to data showing the actual costs reported by the hospital, their mark-up of those costs and the reimbursement the hospital receives from health insurers for the same services.

REPORTING OF RESULTS – Our clients receive a semi-annual and annual report showing the net savings [savings after deducting our fee] for both our network results and the net savings for reducing the outpatient bills from facilities that are not in the network.
One of our insurers received a report showing an annual savings of $ 1.5 Million. A self-insured group recently received a semi-annual report showing a savings of $778,000.

OUTPATIENT AND OUTLIER BILLING IN LOUISIANA : GOING ON THE OFFENSE

The Problem: The employee in Louisiana has the "choice of physician". The employer and its insurer are unable to control the selection of the facility where a surgery or treatment is to be performed. Without the leverage of selection needed to negotiate provider rates, employers and their insurers are required to reimburse providers in accordance with the medical reimbursement schedule established by the Office of Workers' Compensation. As a result, payments per claim for the medical care of injured workers in Louisiana were higher and growing faster than in most states, according to a study by the

Workers Compensation Research Institute (WCRI). In the 2018 WCRI study, Louisiana's outpatient charges are 77% higher than the national average.

In addition, payments for outpatient hospital care became a larger share of the total medical payments per claim, increasing from 29% in 2009 to 38% in 2016. According to the study, these results reflect the state's reimbursement approach. *"The fee schedule sets reimbursement for hospital outpatient services at 90 percent of billed charges. However, the workers' compensation statute calls for reimbursement based on the mean of usual and customary charges. The result of these conflicting provisions is considerable litigation."*

Statute Mandates "Mean of the usual and customary"

La. Rev. Stat. 23:1034.2 Reimbursement Schedule

Director of OWC shall establish and promulgate a reimbursement scheduled….

C (1) The reimbursement schedule shall include charges limited to the mean of the usual and customary charges….

When the Louisiana legislature established the medical reimbursement statute, it applied what appeared to be a reasonable standard for a fair reimbursement "mean of the usual and customary **charges**". This standard was appropriate for all medical providers **except** hospitals and ambulatory surgery centers (ASCs). While most businesses "charge" what they expect to be paid for a service, hospitals and ASCs have established what they call a chargemaster and apply artificially high amounts for various services which is then used in negotiating rates with health insurers.

Professor George Nation, III (Professor of Law and Business at Lehigh University) in a Pepperdine Law Review article explains this phenomenon as follows:

> Hospital list prices, contained in something called a chargemaster are insanely high, running ten times the amount that hospitals routinely accept as full payment from insurers. Moreover, the relative level of a particular hospital's chargemaster prices bears no relationship to either the quality of the services the hospital provides or to the cost of the services provided. The purpose of these fictitious list prices is to serve as a starting point or anchoring point for negotiations with third-party payers regarding the amount that they will actually pay the hospital for its goods and services.
>
> Ironically, there is widespread agreement, even on the part of many hospital administrators, that the prices reflected on chargemasters are ludicrously high and are set in an arbitrary and capricious manner. Hospital administrators often argue that this does not matter because no one really pays chargemaster prices. [Hospital Chargemaster Insanity: Heeling the Healers, Pepperdine Law Review, vol. 43 Issue 3, page 745.

The WCRI report and the experience of Louisiana employers and insurers clearly establish that the excessive charges for outpatient services have resulted in massive overpayments. While hospitals and ASCs are being reimbursed at 25% to 30% of billed charges by health insurers, Louisiana employers

are expected to pay 90%. The intent of the medical reimbursement schedule was to reduce the medical costs to the employer, not guarantee a payment that is 77% higher than the national average.

Purpose of Fee Schedule is to establish lowest charge for services

La. Admin. Code
Chapter 51 Medical Reimbursement Schedule

§5101 Statement of Policy
A. Intent of Medical Reimbursement Schedule (MRS) is to limit to the mean of the usual and customary charges all fees for medical services, supplies.
B. *(4)* …. Services must be coded and charged in the manner guaranteeing the lowest charge applicable.

Chapter 27 Utilization Review Procedure

§2701
A.2. It is also deemed in the best interest of all of the parties in the system that fees for services reasonably performed and billed in accordance with the MRS should be promptly paid. Not paying or formally contesting such bills by filing LDOL WC 1008 (Disputed Claim for Compensation) within 60 days of the date of receipt of the bill may subject the carrier/self-insured employer to P&A.

§2701 (4)…Services must be coded and charged in the manner guaranteeing the lowest charge applicable.

Chapter 25 Surgeries & Hospital Charges

The Fee Schedule establishes a per diem schedule for inpatient surgical rates and non-surgical based on stay over 2 days. Rates dependent on area of State where facility located. [Also provide for outliers to allow hospital to recover for acute care causing unusually high charges.]

OUTPATIENT hospital and surgery centers are exception to the mandated establishment of maximum payment based on mean of usual and customary

Outpatient Hospital and Ambulatory

NOTE: OWC Director did not follow mandate in WC Act La. Rev. Stat. 23:1034.2 to establish fee scheduled for hospital outpatient and ambulatory surgery.

WHY? In 1992 when Medical Reimbursement Schedule was created, outpatient billing was lower than inpatient. Therefore, the OWC Director gave only passing attention to putting limits on outpatient charges.

§2507 Outpatient Reimbursement

Outpatient hospital and ambulatory surgery services will be reimbursed at covered charges less a 10% discount.

Section 2507 of the Hospital Reimbursement Schedule is the provision that hospitals and surgery centers rely on to demand full payment at 90% of whatever they decide to bill the employer.

However, the Utilization Rules suggest that outpatient services should be "less costly":

§2713 Ambulatory Surgery

A. *Ambulatory Surgery refers to a program which recommends that specific procedures be performed on an outpatient basis. The program is designed to reduce unnecessary hospitalization and to shift care to less costly settings if medically appropriate.*

Are there any limits to the outpatient charges for hospital or surgery centers?

Yes – Case Law has held that they must be "Reasonable Charges"

Hospital and ASC has the duty to prove its charges are "reasonable."
Outlier Case: *Johnson Bros. Corp. v. Thibodaux Reg. Med. Center*, (La. App. 1st Cir. 9/28/01) 809 So.2d 430.

Court in *Johnson Bros.* cited *§5115 Surgery Guidelines* held that the hospital charges must be "reasonable'. Simply showing that their excessive charges are uniform (same charge for everyone) is not evidence of "reasonable" charges. Reversing the implant charges (300% over invoice) the court cited the provisions in *§5115* and found that 20% over invoices "reasonable" for implants.

Outpatient Case – Charges must be "reasonable". Manuel *v. River Parish Disposal, Inc.*, 96-302 (La. App. 5th Cir. 10/01/96), 683 So2d 791,795; *Avenue Surgical Suites v. JoEllen Smith Convalescent Center*, (La. App. 4th Cir 5/18/11) 66 So.3d 1103; *First Choice Surgery Center v. Fresh Pickin Mkt.*, (La. App. 1st Cir. 5/17/12), 102 So.3d 795.

Louisiana Supreme Court – Several recent decisions by the Louisiana Supreme Court declared that the cost of medical services was an important consideration of the legislature. Thus, the physician dispensed medication was unreasonable as the dispensed medicine was two to eight times more expensive than medicines obtained through the employer's insurer [*Lafayette Bone & Joint Clinic v. La. United Bus. SIF*, 2015-2137 (La. 06/29/16), 194 So. 3d 1112]. *Burges v. Sewerage & Water Board of New Orleans,* 2016-2267 (La. 6/29/17), 225 So. 3d 1020, in addition to ruling that the employer has choice of pharmacy, the Court noted that even if the charges are within the amount set forth in the reimbursement schedule, they may be deemed unreasonable or not "usual and customary".

OUTLIERS

An often overlooked and overpaid hospital claim is the demand for outlier status for hospital stays over two days. These are initially paid based on either the surgical or non-surgical per diem. If

implants are on the bill, the employer will pay the per diem in addition to 20% over the cost of the implants. The hospital will then send the payor an appeal or a request for reconsideration making a demand for 85% of the billed charges less the per diem already paid. The basis for this demand is found in Section 2519 of the reimbursement schedule. The intent of this provision is to recognize that there are special cases in which the hospitals costs are more than contemplated under the per diem reimbursement and should be reimbursed beyond the limits of the per diem.

The regulations recognize certain hospitalizations as qualifying as "automatic outliers". These include Aids, myocardial infarction and severe burns. For all other cases, the provider has the burden to establish that the case is atypical in nature due to case acuity causing unusual high charges when compared to the provider's usual case mix. The criteria used to determine if outlier status may be considered include those bills which are greater or equal to $100,000, or the non-surgical admission charges are greater than or equal to $75,000, or the average per day charge is 1.75 times the applicable per diem rate. If the hospitalization qualifies for outlier, the regulations provide for payment of 85% of billed charges.

Cases: *Gray Insurance Co. v. St Charles General Hospital*, 96-1637 (La. App. 1st Cir. 6/20/97), 696 So. 2d 577. The court noted that the bill averaged more than 1.75 times the applicable per diem rate, so it met the threshold requirement for appeal, but it held that in order to qualify for outlier status the hospital had the burden to prove the case was "atypical in nature due to case acuity causing unusually high charges when compared to the provider's usual case mix." The court found that the hospital did not meet its burden of proof. Outlier status was also denied to the hospital in *Winn Dixie Louisiana v. HCA Management Services and Tulane-Lakeside Hospital*, 08-1154 (La. App. 5th Cir. 4/28/09), 13 So. 3d 217 and in *Crescent City Surgical Care Center Facility, LLC v. Beverly Industries, LLC and the Gray Insurance Company*, 14-0552 (La. App. 4th Cir. 3/25/15), 162 So. 3d 1254.

HOW CAN WE HELP YOU AVOID PAYING UNREASONABLE CHARGES?

1. We have agreements with hospitals and ambulatory surgery centers in Louisiana. You send us the bill and if the facility is one that is part of our group the facility will sign an agreement for each bill stating that they will accept a payment that is less than the 90% for outpatient and 85% for outliers. The agreed rates range from 60% to 75% of billed charges. Thus, you pay less than the 90% for outpatient and 85% for outliers without the risk of an award of penalties and attorney fees.

2. If the facility is not part of our group or is not willing to negotiate, we can recommend to you a "reasonable" reimbursement. We have a bill review expert who has access to the CMS (Medicare) data which shows the costs for the hospital's services (diagnostics, anesthesia, surgical procedures etc.) as well as data showing what the hospital accepts from health insurers for these services. The CMS data also will show what is the usual and customary charges for a particular surgery.

3. We will also assist you in controverting physical therapy and diagnostic bills that are issued by a hospital as "outpatient" charges but should only be paid under the fee schedule. The difference in the reimbursements for such charges is usually a fraction of the amount you would pay as an "outpatient" charge.

Procedures for Controverting Outpatient Bills

1. Identify outpatient bills to be controverted. Not all outpatient bills are worth the time and expense to challenge. Using the criteria discussed above, the adjuster should set aside the outpatient bill for review. This must be done BEFORE the bill is submitted to the fee review company (most fee review vendors will automatically recommend payment of 90% of the charges). The bill would be sent to us, and after consultation with our fee review expert we will make a recommendation regarding whether to challenge the bill. While it is sent to us for analysis, the adjuster should request the itemization from the hospital/surgery center as well as any implant and supply invoices.

2. If the bill is deemed worthy of challenging, we will recommend specific amounts that should be paid (such as implants and facility fee based on multiple procedure reductions or reductions based on comparative data (usual and customary charges).

3. All the above must be done within 60 days of receipt of the bill to avoid penalties and attorney fees [see §2701 (2) Chapter 27. Utilization Review Procedures].

4. If the provider does not accept the payment, we anticipate the hospital/surgery center will send the TPA a request for reconsideration. Send us the request for reconsideration and we will respond to the request with an explanation regarding the reason for the payment. The next step in the process is either the facility accepts the payment or files a 1008 to recover the "underpayment". After filing responsive pleadings to the suit, we would issue written discovery and depositions of the hospital/surgery center's billing personnel.

5. The goal of this procedure is to either reach an amicable settlement with the provider or have the Judge affirm the recommended reduction of the outpatient charges.

How does this procedure differ from past experiences in outpatient litigation?

1. In the past the employer may have simply not paid the outpatient bill by claiming that it was not reasonable or paid some lower amount without any real data to support the reduction. This usually resulted in the provider filing a 1008 against the employer for the "underpayment" plus a demand for penalties and attorney fees. *Our procedure involves the payment of a **reasonable** amount based on CMS data and we may also recommend filing suit against the provider to controvert the bill.*

2. In the past, the provider's attorney would have his legal fees paid out of the recovery of the "underpayment" with an award of penalties and attorney fees. *Under our procedures where we recommend payment of a "reasonable" reimbursement, the provider must pay an attorney to litigate the "underpayment" since the award of penalties and attorney fees is only granted to the provider if there is a finding that the payment was not "reasonable".*

3. The reductions in the outpatient bills under our system are based on the full application of the Medical Reimbursement Schedule as it was intended to be used to establish a "reasonable" reimbursement to the provider (using the multiple procedures provisions, rejecting charges for items that are clearly covered in the fee schedule, comparing charges to national, regional, and local data showing similar services and demanding itemization of all charges).

4. The advantage of this procedure is that the employer/TPA is in full control of what bills re to be challenged.

If you would like to discuss this program in greater detail contact Denis Juge at our office at 504-831-7270 or send him an email at djuge@jugefirm.com