

# Delaware Workers Compensation Task Force

- March 7 2014



## Does it cost more to treat and injured worker?

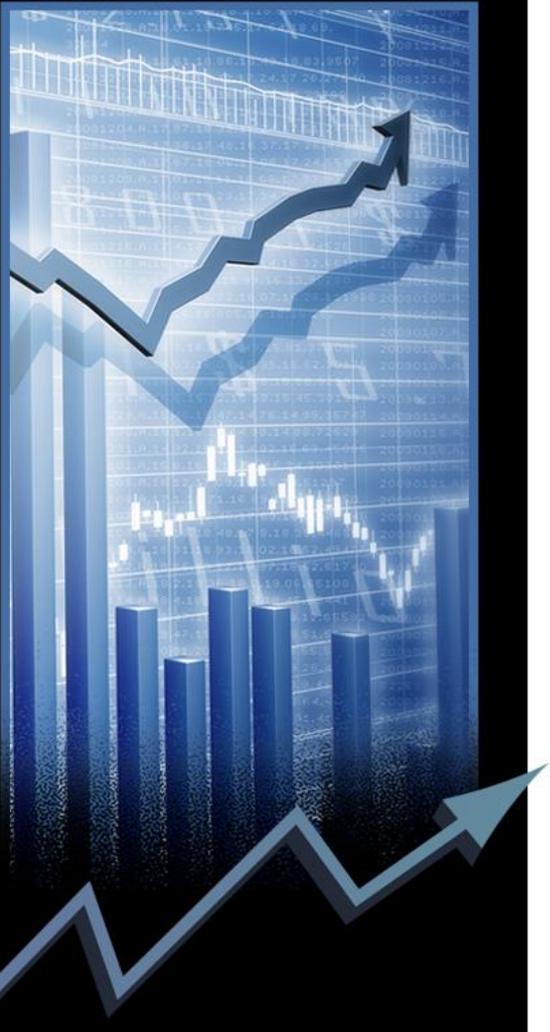
- *Is* care more expensive to provide?
- Why?
- Is a higher fee schedule than BC/BS or Medicare justified?
- Again, why?
- How much more?

# Comparison between BC/BS and Del. Workers Compensation

- Patient scheduling
- Office visits
- Form and paperwork requirements
- Claim processing
  - Time to process
  - Workforce requirements
  - Payment turn-around

# Patient Scheduling

- ❖ First State Orthopaedics (FSO) provided services to 2,591 Workers' Compensation patients and 10,368 BCBS patients in 2013
- ❖ Average BCBS office visit scheduling
  - Patient contacts front office
  - Front desk schedules and gathers patient demographic information along with insurance subscriber information
  - If no precertification is required, patient is scheduled. Average call time and workforce utilization **5-10 minutes**. **90%** of all office visit work does not require precertification
  - If precertification is required, patient transferred to that department, precertification done on-line with patient on phone and an **additional 5-10 minutes** is necessary



# Patient Scheduling

- ❖ Average Delaware Workers' Compensation office visit scheduling
  - Patient, employer or nurse case manager contacts front office
  - Front office transfers patient to specialized Workers' Compensation division within FSO to complete the call due to scheduling complexity to determine coverage
  - Staff must gather all information from caller such as:
    - Claim #
    - Body part being treated
    - Insurance adjuster contact
    - Employer contact information
    - Fax #'s for parties who require the Delaware Provider Form prior to scheduling the patient
  - Average call time 15-20 minutes. Average of 9 calls per visit scheduled to various parties. Patient scheduling time frame 60-135 minutes.



# Office Visit

- ❖ Average BCBS patient office visit  
**15-20 minutes**

- ❖ Average Delaware  
Workers'  
Compensation patient  
office visit 20-30  
minutes

- ❖ Pay is nearly the  
same as the  
complexity of visit  
the same. Very  
minor uptick for  
time.



# Forms and Paperwork Requirements

- 
- ❖ BCBS forms required - None
  - ❖ Delaware Workers' Compensation forms required
    - **Delaware Provider Form**
      - Provider forms are required at each new patient visit per Delaware 19 statute
      - The clinical staff fills out form out with restrictions
        - Clinical staff takes 5 minutes to fill out per patient
      - The form is then tasked to the Workers' Compensation support staff who downloads each form and faxes to the employer, adjuster or nurse case manager.
        - On average FSO sends 300 forms per week
        - Average time to process forms 2-3 minutes per form, per person in office (not clinical)
      - Staff then fields all calls from employers, adjusters, patients and nurses with questions, requests or comments.
        - Average time to process calls 5-10 minutes, per call

## Forms cont.

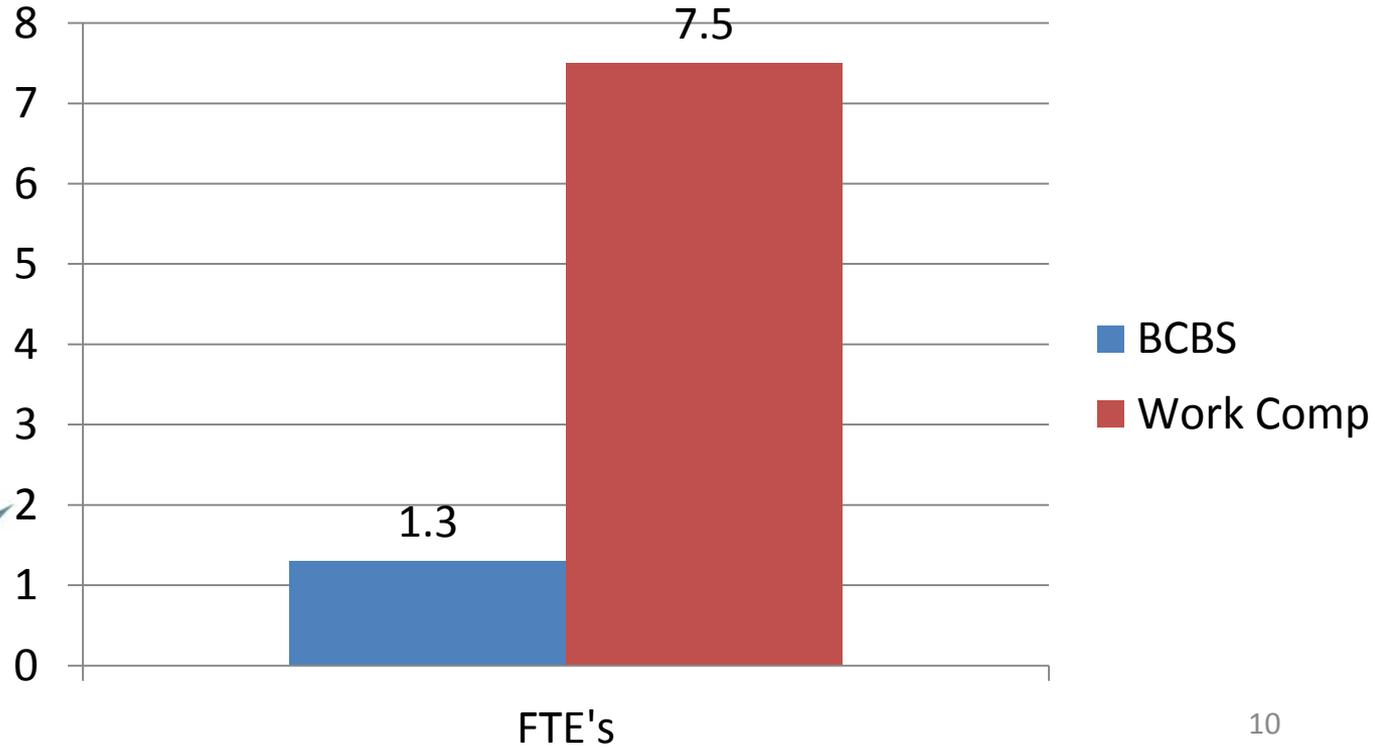
- While the forms have a fee of \$30 for each form, it is only paid on the first form, last form and any change of work status.
- We get paid on 12% of our forms filled out
- Forms are requested from employer, carrier, patient, attorneys and case managers for every visit
- It takes longer to tell everyone that we are not obligated to fill out forms for every visit than fill them out. So we do this work for free

# Claims

- ❖ BCBS claim processing
  - FSO utilizes electronic claims processing
  - No required forms to be sent
  - Cost per claim to process **\$.005**
  
- ❖ Delaware Workers' Compensation claim processing
  - All claims must be sent paper and via mail
  - Forms required to be sent per claim
    - Delaware Provider Form
    - Office notes
    - Operative reports
    - Billable physician form(HCFA 1500)
    - FSO sends claims certified mail to establish insurance carrier accountability to ensure compliance with 30 day rule for UR/payment/denial
  - Cost per claim to process **\$10.27 for first submission only.**

# Full Time Equivalents (FTE's)

Required to Process Claims for 10,360 BC/BS patients, and  
2,591 WC patients

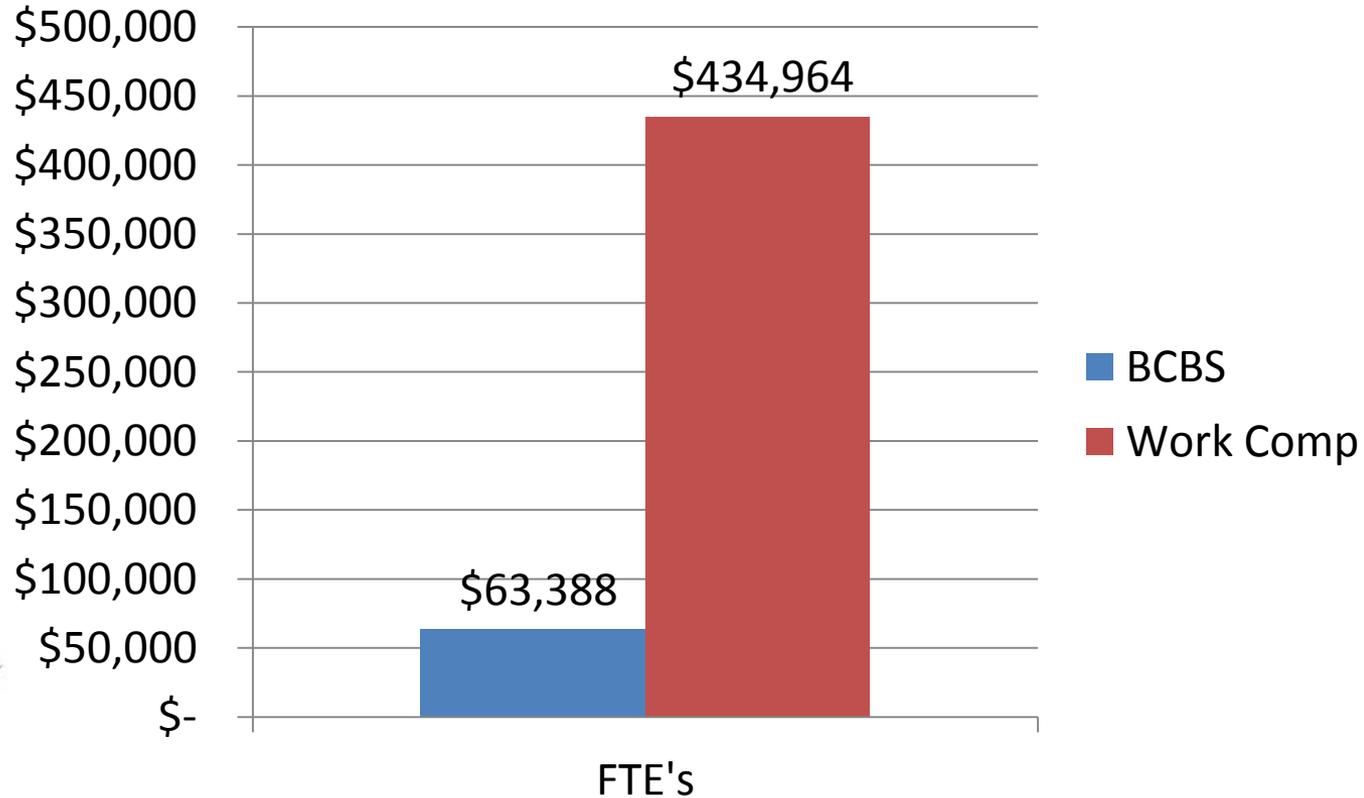




## Full Time Equivalents (FTE's)

- ❖ FSO employs 1.3 FTE's in non-clinical positions that were utilized to process BCBS claims for 10,360 patients in 2013. Their duties included
  - Claim submission, claim processing, collections and posting in EMR
  
- ❖ FSO employs 7.5 FTE's in non-clinical positions (to include 2 Registered Nurse Case Managers to process State of Delaware Worker's Compensation claims for 2,591 patients in 2013. Their duties included:
  - Claim submission
  - Claim processing
  - Claim collections and posting in Electronic Medical Record (EMR) System
  - Communicating with attorneys and paralegals, employers, and NCM's
  - Scheduling and organizing of depositions

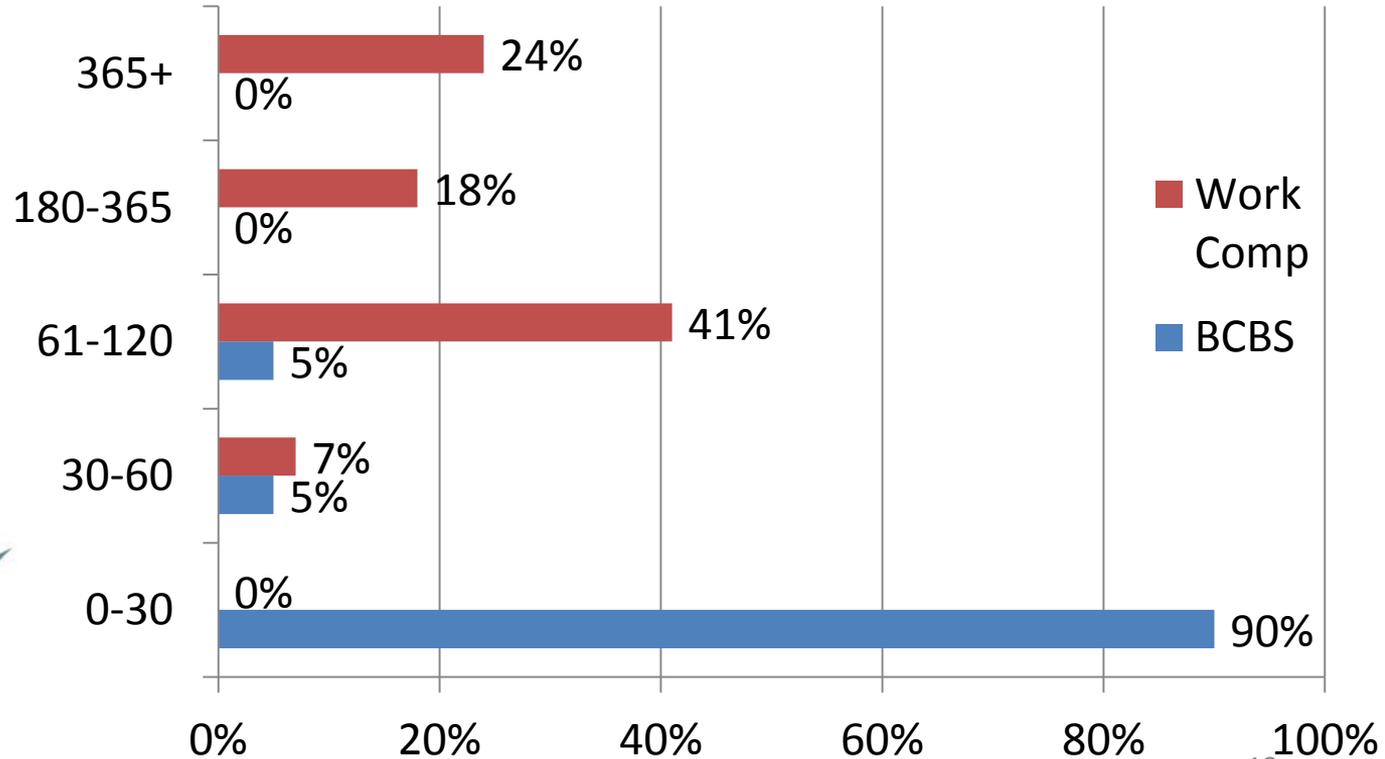
# Full Time Equivalent (FTE) Cost



\*\* Computed at \$17 hr. at 2080 hrs. annual for office staff and \$33.65 hr. at 2080 hrs. for NCM's . Includes \$13,400 for full time annual benefits

# Claim Processing – Days for Payment

Receipt on Clean Claim Submissions



# Claim Processing : Days for Payment Receipt on Clean Claim Submissions

- ❖ FSO wording from BCBS contract
  - BCBS agrees to adjudicate **90%** of clean claims within 14 calendar days, **95%** of clean claims within 30 calendar days and **99%** of clean claims with 60 calendar days
  - FSO staff confirms above methodology as accurately being adhered to by BCBS
- ❖ Delaware Statute requires all Workers' Compensation insurance carriers to pay a clean claim with **30 days** of receipt of claim
  - FSO instated a mandatory certified mail claim submission policy to hold carriers to the **30 day** time line
  - Prior to this policy the average Delaware Workers' Compensation claim was resubmitted **42%** of the time
  - FSO has a less than **1%** payment remittance in **30 days** from claim submission
  - Less than **50%** of original claims are paid in full or paid correctly within **120 days** per the State of Delaware Workers' Compensation fee schedule
  - More than **30%** of all claims submitted end in some form of litigation that takes payment submission well beyond 1 year
  - **16%** of all claims submitted are eventually denied coverage after extensive litigation and all services<sup>14</sup> rendered, and are non-recoverable by FSO. Total loss of



# Complexity Cascade

- There is a continuum of difficulty getting paid that increases with the cost of the services.
- Carriers fight a lot less for a \$150 office visit than they do for a \$10,000 surgery.
- Our Workers Comp practice is roughly 50% office visit based, 5% percent injections and 40% surgery (by revenue)
- In general, we collect more percentage wise from office visits than injections and much more than surgery.
- The numbers quoted on previous slides are an average, but the default rate is much higher for surgical services than office visits.

## Additional Payment Difficulties

- We Currently have over 100 Workers Compensation Carriers built into our system.
- Liberty Mutual alone has 20 different companies processing payments
- Many claims use Third Party Administrators to further complicate matters.

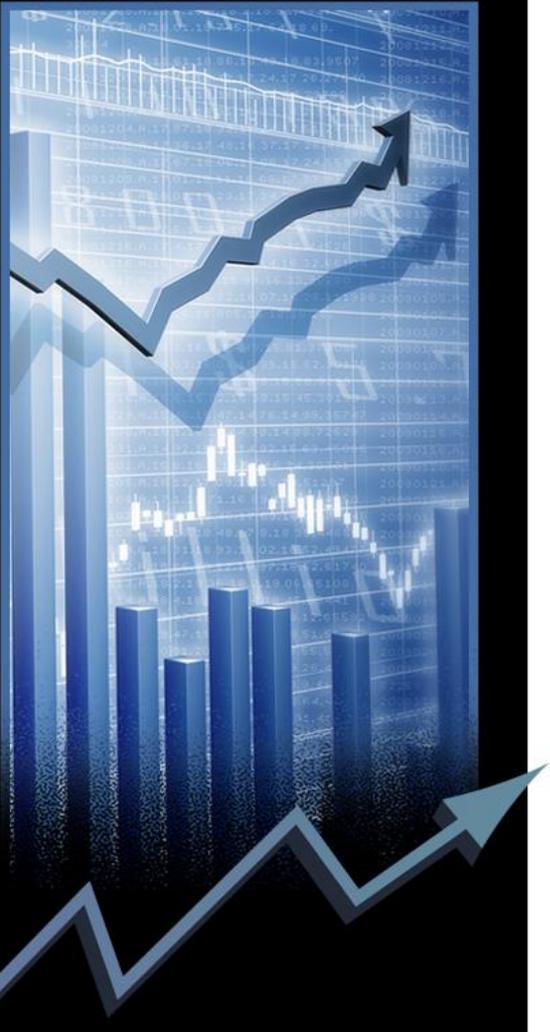


# Additional Legal

- FSO has filed over 600 petitions with the Industrial Accident Board to collect interest alone
- \$225,000 collected on statutory interest
- Over \$100,000 in legal fees
- Does not include filings over the actual bill
- All of this is a huge drain on FSO resources, IAB resources and carrier money. This cost is passed along in the form of rate increases to Delaware Businesses.

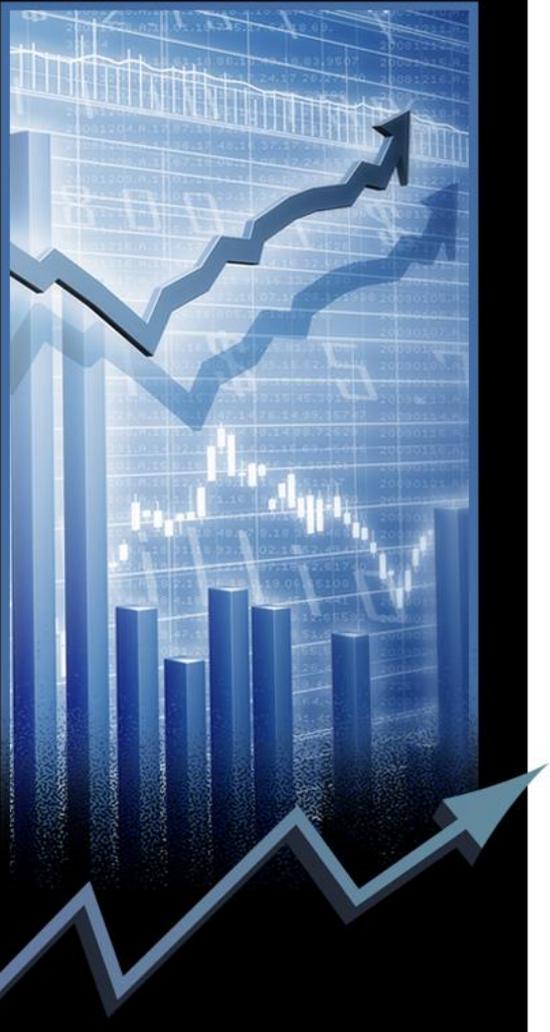
# WCRI presentation to Task Force 1/2014

- Are DE Health Care Prices Too High (Low)?
- If provider time/expense were identical, then hard to justify a differential
- If provider time/expense is higher for WC patients, differential is justified
- If higher in WC, does the difference justify the difference?



## How do we save money on medical to affect a positive rate change?

- Use our data from DCRB to inform savings. Decreasing costs on those that have raised fees outside medical cost containment.
- Bring outliers back in line. We did that in the past and had substantial results. Over the years providers have learned to work around the rules
- Preserve what is good in the system, and access to care
- Task force directed goals to HCAP
- Legislatively authorize HCAP to make the changes that are required. At this time we are not permitted to change the reimbursement methodology.



# Data collection committee update

- See following page

## **Update on Data Collection Committee**

SB 1 developed the medical data call to inform our medical charge decision making. It is only recently that we have had data to review that went back far enough to be useful. The most recent quarterly update was January 2014

What is critical is that our medical expenditures be reviewed by category. This allows us to assess whether the fee control measures put in place have worked. The table below shows some striking points. Most importantly, those services that were captured in our fee schedule, such as physician services, rehab and chiropractic have been singularly successful in controlling costs. Those categories outside the fee schedule, have had huge increases in costs.

The point of this review is to say that for the first time, we have actual cost data that lets us adjust our payment methodology to dramatically increase costs, and control those costs that have run up without much control.

DCRB produced data based on the total amount of money spent on services. The data below is a comparison of year over year changes. It utilizes 12 quarters of data, and has two complete years of changes.

The list below includes the category, total dollars spent and billed, and the average of the last 8 quarters of increases or decreases in amount paid for the service. They are presented in order with most costly total services at the top. Some services are broken down for clarity under the global taxonomy group.

<b>Taxonomy group</b>	<b>Dollars billed</b>	<b>Dollars paid</b>	<b>Amount of inc or dec</b>
Physician payment	\$87,796,000	\$63,867,000	6% decrease
Hospitals	\$55,302,000	\$44,480,000	18% increase
Prescription drugs	\$24,940,000	\$21,243,000	7.8% increase
Rehab services	\$22,998,000	\$17,885,000	5.9% increase
Ambulatory HCF	\$17,328,000	\$13,368,000	13% increase
Supplies	\$7,000,000	\$5,535,000	30% increase
Chiropractic	\$6,450,000	\$5,089,000	1.5% decrease
Laboratory	\$2,091,000	\$1,433,051	130% increase
Surgery /Subcategory	\$65,780,000	\$48,866,000	4% increase
Medicine office visit	\$20,186,000	\$14,065,000	3.3% increase
Radiology	\$18,502,000	\$12,749,285	0.94% increase
Med/Surg and implants	\$9,183,269	\$7,286,505	16% increase
Operating room services	\$4,287,000	\$3,360,000	18.8% increase

SPINE CARE DELAWARE ASC PAYMENT HISTORY

	Total Claim	Correct Payment	% Correct	Incorrect Payment	% Incorrect	Denied	% Denied
Insurance W/C Medicare	228 85	99 75	43.40% 88.20%	45 6	19.70% 7%	73 4	32% 4.70%
Aging:							
Insurance W/C Medicare	31-60 Days 144,930 (9.59%) 41,759 (17.6%)	61-90 Days 70,151 (4.6%) 14,903 (6.2%)	91-120 Days 89,898 (5.95%) 15,740 (6.6%)	121+ Days 1,064,504 (70.47%) 53,335 (22.49%)	Balance 1,510,670 237,116		

**Delaware Compensation Rating Bureau, Inc.**  
**Medical Data Call Detail Report<sup>1</sup>**  
**Type of Service Grouping Based on CPT, HCPCS and Revenue Codes**  
**Service Type: Evaluation & Management (CPT: 99201-99499)**  
**Third Largest by Dollars Paid Quarter 3, 2010 through Quarter 2, 2013**

Activity Period	Number of Claims with Payment(s)	Number of Procedures <sup>2</sup>	Procedure Units	Medical Amount Charged	Medical Amount Paid	Average Procedures per Claim	Average Units per Procedure	Average Procedure Units per Claim	Average Payment per Procedure	Average Payment per Unit	Average Payment per Claim
Quarter 3, 2010	3,654	9,523	10,117	\$1,758,081	\$1,188,362	2.61	1.06	2.77	\$124.79	\$117.46	\$325.22
Quarter 4, 2010	3,700	9,369	9,399	\$1,673,036	\$1,180,000	2.53	1.00	2.54	\$125.95	\$125.55	\$318.92
Quarter 1, 2011	3,468	8,810	8,829	\$1,566,197	\$1,109,905	2.54	1.00	2.55	\$125.98	\$125.71	\$320.04
Quarter 2, 2011	3,499	9,134	9,175	\$1,802,983	\$1,138,765	2.61	1.00	2.62	\$124.67	\$124.10	\$325.45
Quarter 3, 2011	3,660	9,408	9,419	\$1,696,990	\$1,200,062	2.57	1.00	2.57	\$127.66	\$127.41	\$327.89
Quarter 4, 2011	3,721	9,294	9,328	\$1,704,993	\$1,196,572	2.50	1.00	2.51	\$128.75	\$128.28	\$321.57
Quarter 1, 2012	3,535	8,983	9,008	\$1,657,010	\$1,152,944	2.54	1.00	2.55	\$128.35	\$127.99	\$326.15
Quarter 2, 2012	3,678	9,478	9,521	\$1,751,458	\$1,223,537	2.58	1.00	2.59	\$129.09	\$128.51	\$332.66
Quarter 3, 2012	3,650	9,129	9,312	\$1,734,299	\$1,227,887	2.50	1.02	2.55	\$134.50	\$131.86	\$336.41
Quarter 4, 2012	3,552	8,669	9,448	\$1,635,469	\$1,141,254	2.44	1.09	2.66	\$131.65	\$120.79	\$321.30
Quarter 1, 2013	3,607	8,965	9,404	\$1,734,040	\$1,179,523	2.49	1.05	2.61	\$131.57	\$125.43	\$327.01
Quarter 2, 2013	3,466	8,590	9,524	\$1,572,074	\$1,126,768	2.48	1.14	2.83	\$131.17	\$114.70	\$325.10
Grand Total <sup>3</sup>	19,570	109,352	112,785	\$20,186,640	\$14,065,568	5.59	1.03	5.76	\$128.63	\$124.71	\$718.73

**Percent Change from Prior Year's Quarter**

Activity Period	Number of Claims with Payment(s)	Number of Procedures <sup>2</sup>	Procedure Units	Medical Amount Charged	Medical Amount Paid	Average Procedures per Claim	Average Units per Procedure	Average Procedure Units per Claim	Average Payment per Procedure	Average Payment per Unit	Average Payment per Claim
Quarter 3, 2011	0.16%	-1.21%	-6.90%	-3.48%	0.98%	-1.37%	-5.76%	-7.05%	2.22%	8.47%	0.82%
Quarter 4, 2011	0.57%	-0.80%	-0.76%	1.91%	1.40%	-1.36%	0.05%	-1.32%	2.22%	2.18%	0.83%
Quarter 1, 2012	1.93%	1.96%	2.03%	5.80%	3.68%	0.03%	0.06%	0.09%	1.88%	1.81%	1.91%
Quarter 2, 2012	5.12%	3.77%	3.76%	9.26%	7.44%	-1.28%	-0.01%	-1.29%	3.54%	3.55%	2.22%
Quarter 3, 2012	-0.27%		-1.14%	2.20%	2.32%	-2.70%	1.89%	-0.87%	5.45%	3.49%	2.50%
Quarter 4, 2012	-4.54%	-6.72%	1.29%	-4.08%	-4.62%	-2.29%	8.59%	6.11%	2.25%	-5.83%	-0.09%
Quarter 1, 2013	2.04%	-0.20%	4.40%	4.65%	2.31%	-2.15%	4.61%	2.31%	2.51%	-2.00%	0.26%
Quarter 2, 2013	-5.76%	-9.37%	3.18%	-4.53%	-7.91%	-3.83%	13.85%	9.49%	1.61%	-10.75%	-2.27%

*inc 3-20-20 per UR*

<sup>1</sup>Values not shown for cells containing data for single claim, employer or carrier.

<sup>2</sup>Count of Medical Data Call records, each representing a medical bill line item.

**Note:** The grand total of the claim count column will not equal the sum of the claim counts shown by line item. We identify individual claims as unique combinations of values in the following fields: claim number, carrier, policy number and effective date. Each line item then reflects the number of unique claims with one or more records included in the criteria for the line item, and the grand total reflects the overall number of unique claims with one or more records in the report. Since claims can contribute data to more than one line item, the line item claim counts do not, and in most cases cannot, sum to the overall report total.

