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## **Please Note:**

- Study 1 focuses on **hospital and ambulatory surgical center** (ASC) fee schedules while Study 2 focuses on **professional** fee schedules.
- Table 3, 6, and 9 from Study 1 shows the workers' compensation fee schedule rates as a percentage **of** the Medicare rates, for hospital inpatient, outpatient, and ASC respectively.
- Table 3 from Study 2 shows the workers' compensation fee schedule rates as a percentage **above** the Medicare rates, for professional services.
- Table 3 from Study 2 includes all states with workers' compensation fee schedules for professional services as of July 2011, regardless of whether their fee schedules were based on Medicare or not. The states that actually based their fee schedules on Medicare are marked with **RBRVS** in column "Relative Value Scale Used" in Table 2 from Study 2.

**Table 3 Illustrative Inpatient Reimbursement Rates in Workers' Compensation as a Percent of Medicare in Each State for Common DRGs, by State, Current as of September 30, 2009**

DRG States	DRG 355	DRG 489	DRG 491	DRG 508	DRG 509	DRG 514	DRG 552
California	120%	120%	120%	120%	120%	120%	120%
Georgia <sup>a</sup>	133%	133%	133%	133%	133%	133%	133%
Illinois	264%	354%	240%	292%	229%	290%	239%
Mississippi	200%	200%	200%	200%	200%	200%	200%
Montana	134%	134%	134%	134%	134%	134%	134%
Nebraska <sup>b</sup>	149%	149%	149%	149%	n/a	149%	149%
North Dakota	138%	138%	138%	138%	138%	138%	138%
Ohio	120%	120%	120%	120%	120%	120%	120%
Oklahoma	49%	59%	50%	48%	43%	48%	48%
South Carolina	140%	140%	140%	140%	140%	140%	140%
Texas	143%	143%	143%	143%	143%	143%	143%
Washington <sup>c</sup>	81%	79%	78%	74%	n/a	89%	78%
West Virginia	135%	135%	135%	135%	135%	135%	135%

*Notes:* The rates presented are for a large hospital (200–900 beds) in a large city in each state. The DRGs presented are 355 (hernia procedures except inguinal & femoral without CC/MCC), 489 (knee procedures without prior diagnosis of infection without CC/MCC), 491 (back & neck procedure except spinal fusion without CC/MCC), 508 (major shoulder or elbow joint procedures without CC/MCC), 509 (arthroscopy), 514 (hand or wrist procedure, except major thumb or joint procedure without CC/MCC), and 552 (medical back problems without MCC).

<sup>a</sup> Workers' compensation rates presented for Georgia are taken directly from the Georgia Inpatient Hospital Payment Schedule. The Medicare rates for Georgia were calculated as that of a large hospital in a large city, as in other states.

<sup>b</sup> Worker' compensation rates presented for Nebraska are taken directly from the Nebraska DRG Fee Schedule. The Medicare rates for Nebraska were calculated as that of a large hospital in a large city, as in other states.

<sup>c</sup> Workers' compensation rates used in calculation in Washington are AP-DRGs. The following AP-DRGs were used for rate calculation (MS-DRG in parentheses): 160 (355), 222 (489), 758 (491), 224 (508), 232 (509), 229 (514), and 243 (552).

*Key:* AP-DRG: all patient diagnosis-related group; CC/MCC: co-morbidities and complications/major co-morbidities and complications; DRG: diagnosis-related group; MS-DRG: medical severity diagnosis-related group.

**Table 6 Illustrative Outpatient Reimbursement Rates in Workers' Compensation as a Percent of Medicare in Each State for Common APCs, by State, Current as of September 30, 2009**

APC (group) Workers' Compensation States	APC (CPT)				
	41 (29881)	42 (29826)	154 (49505)	208 (63030)	220 (64721)
California	120%	120%	120%	120%	120%
Colorado	155%	147%	153%	152%	154%
Hawaii	110%	110%	110%	110%	110%
Massachusetts <sup>a</sup>	59%	56%	59%	n/a	59%
Mississippi	110%	110%	110%	110%	110%
Montana	169%	169%	169%	169%	169%
South Carolina	140%	140%	140%	140%	140%
Tennessee	150%	150%	150%	150%	150%
Texas	200%	200%	200%	200%	200%
Washington	148%	148%	148%	148%	148%
West Virginia	135%	135%	135%	135%	135%

*Notes:* The rates presented are for a large hospital (200–900 beds) in a large city in each state. For all of the APC rates it is assumed that the hospital is not a sole community hospital and the rate was not reduced due to failure to meet Hospital Outpatient Quality Data Reporting Program (HOP QDRP) requirements. The codes used are: APC 41 (Level I arthroscopy, CPT code 29881), APC 42 (Level II arthroscopy, CPT code 29826), APC 154 (hernia/hydrocele procedures, CPT code 49505), APC 208 (laminotomies and laminectomies, CPT code 63030), and APC 220 (Level I nerve procedures, CPT code 64721).

<sup>a</sup> Massachusetts' outpatient workers' compensation rates are equal to the ASC workers' compensation rates for surgeries.

*Key:* APC: ambulatory payment classification; CPT: Current Procedural Terminology.

**Table 9 Illustrative Ambulatory Surgical Center Reimbursement Rates in Workers' Compensation as a Percent of Medicare in Each State for Common APCs, by State, Current as of September 30, 2009**

APC (group) Workers' Compensation States	APC (CPT)				
	41 (29881)	42 (29826)	154 (49505)	208 (63030)	220 (64721)
California	120%	120%	120%	n/a	120%
Colorado	353%	407%	358%	n/a	337%
Hawaii	110%	110%	110%	n/a	110%
Maryland	125%	125%	125%	n/a	125%
Massachusetts <sup>a</sup>	130%	150%	132%	n/a	125%
Michigan <sup>a, b</sup>	142%	84%	135%	n/a	153%
Mississippi <sup>c</sup>	265%	192%	n/a	n/a	173%
Montana <sup>a</sup>	276%	335%	283%	n/a	265%
Nevada <sup>a, c</sup>	145%	85%	138%	n/a	148%
New Mexico	298%	362%	306%	n/a	286%
Ohio <sup>d</sup>	108%	108%	108%	n/a	108%
Oregon <sup>a, c</sup>	178%	104%	169%	n/a	192%
Pennsylvania	135%	80%	129%	n/a	146%
South Carolina	140%	140%	140%	n/a	140%
Tennessee	150%	150%	150%	n/a	150%
Texas	235%	235%	235%	n/a	235%
West Virginia	135%	135%	135%	n/a	135%

Notes: For all of the APC rates it is assumed that the rate was not reduced due to failure to meet Hospital Outpatient Quality Data Reporting Program (HOP QDRP) requirements. Also state level CBSAs were used to determine the wage index except for Massachusetts where the Boston-Quincy CBSA 14484 was used and Rhode Island where the Providence-New Bedford-Fall River, RI-M CBSA 39300 was used. The codes used are: APC41 (Level I arthroscopy, CPT code 29881), APC 42 (Level II arthroscopy, CPT code 29826), APC 154 (hernia/hydrocele procedures, CPT code 49505), APC 208 (laminotomies and laminectomies, CPT code 63030), and APC 220 (Level I nerve procedures, CPT code 64721).

<sup>a</sup> For workers' compensation rates, the state has its own grouping method or rates.

<sup>b</sup> For workers' compensation rates, the state uses the CMS 56-group ASC reimbursement method.

<sup>c</sup> For workers' compensation rates, the state uses the CMS 9-group ASC reimbursement method.

<sup>d</sup> For workers' compensation rates, the state's rate is 100% of the CMS transitional rates.

Key: APC: ambulatory payment classification; ASC: ambulatory surgical center; CBSA: core based statistical area; CMS: Centers for Medicare & Medicaid Services; CPT: Current Procedural Terminology; n/a: not applicable.

**Table 3 Workers' Compensation Premium over Medicare, July 2011**

State	Overall	ER Services	E&M	Major Radiology	Minor Radiology	Neuro. Testing	Physical Medicine	Pain Mgmt. Injections	Major Surgery
Alabama	64	29	-2	281	274	33	59	27	276
Alaska	168	167	72	380	436	312	140	371	440
Arizona	58	100	14	144	115	106	48	53	206
Arkansas	56	39	42	111	120	48	43	117	131
California <sup>a</sup>	-1	24	-17	86	65	36	-14	-12	71
Colorado	40	137	29	141	101	48	17	59	120
Connecticut	68	66	47	115	114	90	23	139	279
Delaware <sup>b</sup>	109	180	32	205	221	116	87	244	384
Florida <sup>b</sup>	2	3	-7	4	-3	0	-1	52	28
Georgia	71	49	49	145	145	66	48	66	218
Hawaii	15	28	10	40	63	6	15	14	22
Idaho	115	112	117	162	172	125	50	170	346
Illinois <sup>b</sup>	136	211	33	340	379	207	108	261	443
Kansas	44	43	38	70	65	40	23	128	124
Kentucky	34	27	19	62	57	26	25	65	109
Louisiana	48	73	12	96	95	44	58	24	127
Maine	51	49	36	69	50	61	54	125	66
Maryland	31	26	26	26	26	26	27	33	67
Massachusetts	-1	-4	-10	-2	-7	-6	-25	16	126
Michigan	34	44	29	47	39	24	38	22	36
Minnesota	56	87	68	91	83	60	36	83	74
Mississippi	58	33	22	79	58	56	59	169	150
Montana	93	93	93	93	93	92	94	93	94
Nebraska	61	85	43	166	156	50	35	105	187
Nevada	91	118	18	373	293	94	74	63	326
New Mexico	54	58	22	436	149	56	40	73	133
New York <sup>b,c</sup>	15	86	-19	112	167	66	-3	-4	140
North Carolina	11	31	-16	136	118	5	-6	69	123
North Dakota	86	88	86	87	89	84	85	85	93
Ohio <sup>d</sup>	44	n/c	35	43	39	28	37	39	108
Oklahoma	29	40	4	125	76	53	14	58	132
Oregon	101	107	106	90	91	90	84	148	146
Pennsylvania <sup>b</sup>	27	26	-4	106	92	20	27	27	114
Rhode Island <sup>e</sup>	n/c	51	2	354	162	39	n/c	45	251
South Carolina	44	48	44	42	47	45	44	41	46
South Dakota	34	96	6	161	119	26	25	-22	137
Tennessee	83	124	79	124	124	79	48	124	208
Texas <sup>b</sup>	65	61	61	61	61	61	62	61	102
Utah	30	29	24	51	46	20	26	61	54
Vermont	53	50	8	165	126	64	53	95	175
Washington	63	62	62	63	63	62	63	64	62
West Virginia <sup>f</sup>	39	41	38	36	36	39	41	36	35
Wyoming	42	101	10	199	149	73	24	4	170

*Notes:* Positive numbers in this table reflect a percentage above the Medicare fee schedule levels for a state, and negative numbers in this table reflect a percentage below the Medicare fee schedule levels for a state. Illinois passed legislation introducing a 30 percent reduction in the fee schedule rates, effective September 2011. This recent legislative change is not reflected in this analysis. In addition, the West Virginia workers' compensation fee schedule had an annual update, effective July 1, 2011, that is not reflected in this study.

<sup>a</sup> California sets workers' compensation rates for 30 minutes per unit for a few physical medicine services. However, Medicare and the other states set rates for 15 minutes per unit for the same services. We estimated California rates for 15 minutes per unit for these services, based on DBE data.

*continued*

**Table 3 Workers' Compensation Premium over Medicare, July 2011 (continued)**

<sup>b</sup> Delaware, Florida, Illinois, New York, Pennsylvania, and Texas have distinct workers' compensation fee schedules for different parts of the state. For each, a single statewide rate was created by averaging the different sub-state fee schedules using the percentage of employed persons in each sub-state region as weights. Medicare establishes distinct sub-state fee schedules in 14 states. For each, a single statewide rate was created using the same procedure.

<sup>c</sup> In New York, the maximum number of relative value units reimbursed per physical medicine visit is capped. For instance, when multiple physical medicine procedures and/or modalities are performed on the same day, the reimbursement is limited to eight units. This additional dimension of the fee schedule regulation is not captured in the analysis due to the focus of the study on the service-level rather than visit-level reimbursement.

<sup>d</sup> Ohio does not establish rates for the emergency services included in the marketbasket. For Ohio, the overall rate is based on the fee schedule levels for the other seven service groups. For more detail, see the Technical Appendix.

<sup>e</sup> Rhode Island has different billing codes for physical medicine that we are unable to crosswalk to commonly used CPT codes. An overall rate is not established for Rhode Island, as physical medicine is the largest component of the marketbasket and excluding it significantly biases the results. For more detail, see the Technical Appendix.

<sup>f</sup> West Virginia sets the workers' compensation fee schedule to be 135 percent of Medicare using rounded, fully implemented RVUs. In 2011, Medicare was still using transitional RVUs, and Medicare does not round during the calculation. The result of these differences is that the 2011 workers' compensation premium over Medicare in West Virginia is not exactly 35 percent.

*Key:* CPT: Current Procedural Terminology; DBE: Detailed Benchmark/Evaluation database; E&M: evaluation and management; ER: emergency; Mgmt.: management; n/c: not comparable; Neuro.: neurological/neuromuscular; RVU: relative value unit.

**Table 2 Characteristics of Workers' Compensation Fee Schedules for Nonfacility Providers, July 2011**

Jurisdiction	Relative Value Scale Used	Conversion Factors (single or multiple) <sup>a</sup>	Last Update of Fee Schedule and/or Conversion Factors Covered as of July 1, 2011
Alabama	n/a	n/a	January 1, 2011
Alaska	n/a	n/a	December 31, 2010
Arizona	n/a	n/a	October 1, 2010
Arkansas	RBRVS	Multiple	January 1, 2011
California	OMFS RVU	Multiple	February 15, 2007
Colorado	RVP	Multiple	January 1, 2011
Connecticut	RBRVS	Multiple	July 15, 2010
Delaware	n/a	n/a	January 31, 2011
Florida	RBRVS	Multiple	February 4, 2009
Georgia	RBRVS	Multiple	April 1, 2011
Hawaii	RBRVS/HI RVU	Multiple	February 28, 2011
Idaho	RBRVS	Multiple	April 7, 2011
Illinois <sup>b</sup>	n/a	n/a	January 1, 2011
Kansas	RBRVS	Multiple	January 1, 2011
Kentucky	RBRVS	Multiple	March 4, 2011
Louisiana	n/a	n/a	March 20, 2001
Maine	RBRVS	Single	November 5, 2006
Maryland	RBRVS	Multiple	January 1, 2011
Massachusetts	n/a	n/a	April 1, 2009
Michigan	RBRVS	Single	December 8, 2010
Minnesota	RBRVS	Multiple	October 1, 2010
Mississippi	RBRVS	Multiple	October 1, 2010
Montana	RBRVS	Single	April 1, 2011
Nebraska	RBRVS	Multiple	June 1, 2010
Nevada	RVP	Multiple	February 1, 2011
New Mexico	n/a	n/a	December 31, 2010
New York	NY RVU	Multiple	December 1, 2010
North Carolina	n/a	n/a	May 3, 2011
North Dakota	RBRVS	Single	January 1, 2011
Ohio	RBRVS	Multiple	January 1, 2011
Oklahoma	RBRVS	Multiple	March 3, 2010
Oregon	n/a	n/a	April 1, 2011
Pennsylvania <sup>c</sup>	RBRVS	n/a	January 1, 2011
Rhode Island	n/a	n/a	July 1, 2008
South Carolina	RBRVS	Single	January 1, 2011
South Dakota	RVP	Multiple	June 19, 2008
Tennessee	RBRVS	Multiple	July 1, 2011
Texas	RBRVS	Multiple	July 1, 2011
Utah	RBRVS	Multiple	December 1, 2010
Vermont	n/a	n/a	January 1, 2011
Washington	RBRVS	Single	July 1, 2011
West Virginia <sup>d</sup>	RBRVS	Single	July 1, 2010
Wyoming	RVP	Multiple	January 1, 2011

<sup>a</sup> The column for single or multiple conversion factors does not refer to anesthesia, laboratory, or pathology services.

<sup>b</sup> Illinois passed legislation introducing a 30 percent reduction in the fee schedule rates, effective September 2011. This recent legislative change is not reflected in this analysis.

<sup>c</sup> In Pennsylvania, prior to January 1, 1995, the medical fees were capped at 113 percent of Medicare. Medical fee updates on and after January 1, 1995, are calculated annually based on the percentage changes in the statewide average weekly wage. These updates are effective on January 1 of each year, and they are cumulative. The 2011 fee schedule was updated by the percentage change in the statewide average weekly wage, which was 1.5 percent. This percentage change applies to all services rendered on or after January 1, 2011.

<sup>d</sup> The West Virginia workers' compensation fee schedule had an annual update, effective July 1, 2011, that is not reflected in this study.

Key: n/a: not applicable; OMFS: Official Medical Fee Schedule; RBRVS: Resource-Based Relative Value Scale (Medicare); RVP: Relative Values for Physicians; RVU: relative value unit.