

Minnesota Workers' Compensation DRG Evaluation Report



Research and Statistics

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Executive summary

This report is submitted by the Department of Labor and Industry (DLI) in compliance with a legislative mandate to evaluate Minnesota's new system for reimbursing hospitals for workers' compensation inpatient services. Specifically, Minnesota Statutes § 176.1362, subd. 7 requires DLI to produce a report by January 15, 2018 "analyzing the impact of the reforms under this section to determine whether the objectives have been met and whether further changes are needed."¹

As provided by the Legislature (Minn. Stat. §176.1362), on Jan. 1, 2016 Minnesota changed its system for paying for workers' compensation inpatient hospital services from a charge-based system to one based on Medicare's Inpatient Prospective Payment System (IPPS). In IPPS, a hospitalization is categorized – on the basis of principal diagnosis and primary treatment performed – into a Diagnosis-Related Group (DRG) and payment is then determined mainly from the DRG.² For this reason, IPPS – and other payment systems derived from it – are sometimes referred to as DRG systems. Minnesota's DRG system provides for payment at 200 percent of the Medicare level, not to exceed the charged amount, with provision for payment at 75 percent of charges in catastrophic (high-cost) cases and at 100 percent of charges for Medicare-designated Critical Access Hospitals.

In addition to the payment provisions, a central feature of the DRG statute is a set of requirements that take effect when certain conditions in the statute are met. These conditions – called the "sub. 4" conditions after the statutory section where they appear – are (1) that the hospital submits its charges to the insurer electronically, (2) that a DRG applies to the hospitalization, and (3) that the total charges in the case are less than the threshold for payment under the catastrophic provision. When these conditions are met, the insurer (1) must not require an itemization of charges or additional documentation to support a bill and (2) must, within 30 days of receipt, either pay the bill (with no reductions based on line-item review) or deny the entire bill on the basis that the condition for which the person is in the hospital is not work-related or that the hospitalization is not reasonably required.³

In framing the questions for this study, DLI took its guidance from the DRG statute and the policy discussions surrounding the framing of the statute. The study attempted to answer the following questions about the DRG system:

- Are insurers –
 - paying accurately under the new system;
 - following mandated timelines;
 - asking for documentation only as allowed by statute; and
 - denying payment only as allowed by statute?

- Are hospitals –
 - increasing their use of electronic billing under the DRG system; and

¹ The governing statute is in Appendix A.

² The types of softwares that perform these functions are known respectively as "grouper" and "pricer" softwares. Grouper softwares are available from private companies; the pricer software is available from the U.S. Centers for Medicare and Medicaid Services.

³ The insurer may do a post-payment audit with line-item review under certain conditions (see p. 3).

- following the mandated timeline for providing documentation in the event of a post-payment audit?⁴
- Has timeliness of payment improved under the DRG system?
- Have disputes decreased under the DRG system?
- Have inpatient hospital payments decreased under the DRG system?

To speak to these questions, DLI conducted a survey of insurers (including self-insurers) and hospitals in the summer of 2017, asking both respondent groups identical questions about a sample of individual workers' compensation inpatient hospitalizations that occurred in the second halves of 2015 and 2016 – periods before and after the new system took effect. The survey also asked two open-ended questions to gain additional information. In all, 72 insurers, 32 self-insurers, and 40 hospitals submitted data on at least one inpatient case in at least one of the two survey periods.⁵ The sample included data on 1,034 individual cases, approximately evenly distributed between the two years and between insurer and hospital reporters.⁶

These are the principal findings from the survey:

- (1) **Hospital use of electronic billing.** The use of electronic billing by hospitals increased substantially between the two report periods as reported by both insurers and hospitals. Hospitals reported a higher percentage of cases with electronic billing for 2016 (80 percent) than did insurers (59 percent) (Figure 5).
- (2) **Insurer requests for itemization or additional documentation.** When the “sub. 4” conditions were met for the 2016 cases, the insurer requested itemization or additional documentation in 8 percent of cases, as reported by insurers, or 20 percent of cases as reported by hospitals (Figure 7). There was not a statistically significant decrease between 2015 and 2016 in the percentage of cases with requests for itemization or additional documentation, as reported by either insurers or hospitals (Figure 8).
- (3) **Prompt action.** When the “sub. 4” conditions were met for the 2016 cases, the insurer took prompt statutory action (payment or denial within 30 days in accordance with statute) in 41 percent of cases as reported by hospitals and 83 percent of cases as reported by insurers (Figure 9). Both insurers and hospitals reported a modest increase in timeliness of action (payment or denial within 30 days) between 2015 and 2016 (Figure 10).
- (4) **Line-item denials.** When the “sub. 4” conditions were met for the 2016 cases, line-item denials were reported in 4 percent of cases by insurers and 2 percent by hospitals (Figure 11). Both insurers and hospitals reported statistically significant decreases in the percentage of cases with line-item denials between 2015 and 2016 (Figure 12).
- (5) **Bill-level payment reductions.** Between 2015 and 2016, the frequency of bill-level payment reductions dropped by 9 percentage points as reported by insurers and 13 point as reported by hospitals, statistically significant in both cases (Figure 13).

⁴ The sample size of the responses to the DLI survey (see below) was too small to speak to this question.

⁵ The data did not identify individual claimants.

⁶ Of these cases, 258 were instances where the same hospitalization was reported by both an insurer and a hospital. In all, both insurers and hospitals reported on more than 600 cases each. See Figure 3, p. 6.

- (6) **Disputes.** Both insurers and hospitals reported dispute rates of 3 percent for their 2016 cases. For hospitals, this represented a decrease from their reported 10-percent dispute rate for 2015⁷ (Figure 15).
- (7) **Insurer sharing of DRG information.** Hospitals reported that in 35 percent of their 2016 cases, they did not know the DRG the insurer used to pay the bill (Figure 17).
- (8) **Accurate payment.** For 2016 cases, where the statutory basis of payment was the DRG, the final payment was within 5 percent of the correct amount (as determined by DLI) 82 percent of the time as reported by insurers and 76 percent of the time as reported by hospitals. Where the final payment was not within 5 percent of the correct amount, there were equal tendencies toward over-payment and under-payment as reported by hospitals, but a somewhat greater tendency toward underpayment as reported by insurers, though this was statistically insignificant (Figure 18).
- (9) **Payment-to-charge ratio.** As reported by insurers, the ratio of the average final payment to the average total charge dropped from 83 percent to 72 percent from 2015 to 2016; as reported by hospitals, this ratio dropped from 84 percent to 70 percent (Figure 19).

Cost effects. DLI estimated the effect of the change to the DRG system on total inpatient hospital payments and on total workers' compensation system cost. It did this with three different data sources: (1) data from a large insurer, (2) data from the DLI survey, and (3) data from the Minnesota workers' compensation Medical Data Call.⁸ The first two data sources produced estimates that the DRG system (as opposed to keeping the prior system) reduced total inpatient hospital payments by 13 to 16 percent and total workers' compensation system cost by 0.7 percent to 0.8 percent, or \$11.8 to \$14.5 million a year. The third data source produced the estimate that the DRG system reduced total inpatient hospital payments by 9 percent and total workers' compensation system cost by 0.5 percent, or \$8.1 million a year (Figure 22).

To summarize these findings:

- (1) The survey results support the conclusion that, overall, the DRG system has increased administrative efficiency in workers' compensation inpatient hospital reimbursement, although there is still room for further improvement. It is not possible to quantify the cost savings from increased administrative efficiency.
- (2) The survey results indicate that payments are largely accurate under the DRG system.
- (3) Three different estimates of the effect of the DRG system on inpatient hospital payments indicate reductions ranging from 9 to 16 percent. The corresponding reductions in total workers' compensation system cost range from an estimated 0.5 percent to 0.8 percent, or \$8.1 to \$14.5 million a year.

The insurer and hospital responses to the open-ended questions touched on several areas; prominent among these were (1) frequency of PC-Pricer updates, (2) limitation of reimbursement to the charged amount, (3) use of preferred-provider arrangements, and (4) electronic funds transfer. See Section H (pp. 27-28) for further discussion and Appendix B (p. 35) for the verbatim responses.

⁷ Survey respondents were instructed to indicate that the payment was disputed if it was the subject of a dispute certification request, medical request, or claim petition filed with the Department of Labor and Industry.

⁸ This is a data-collection program of the National Council on Compensation Insurance (NCCI), which Minnesota participates in through the Minnesota Workers' Compensation Insurers Association (MWCIA). The MWCIA shares the data (de-identified) with DLI.

On the basis of the study results, DLI does not recommend legislative changes. However, it has identified three general areas for further review: electronic transactions, prompt action, and statutory basis of payment. This review may require additional records or information from insurers and hospitals. DLI is planning to develop training to address all areas illuminated by the study where there may be noncompliance with or lack of knowledge of statute or rule on the part of insurers or hospitals or their representatives.

DLI anticipates that as insurers and hospitals become more familiar with the new system, they will continue to build on improvements they have made.

Contents

Executive summary..... i

A. Introduction 1

B. Minnesota’s DRG provisions 3

C. Broad study questions 4

D. Data sources 4

E. Survey response rate..... 5

F. Survey results – individual case data..... 7

G. Cost effects 24

H. Insurer and hospital comments in response to open-ended questions 27

I. DLI recommendation – no additional DRG legislation currently needed..... 28

J. Areas for further DLI review and research..... 29

K. DLI training..... 29

L. Conclusion..... 30

Appendix A: Minnesota workers’ compensation DRG statute..... 32

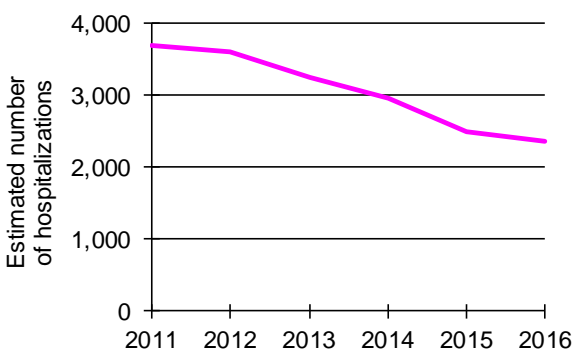
Appendix B: Verbatim insurer and hospital responses to open-ended questions 35

A. Introduction

Inpatient hospitalizations are an important but declining component of workers' compensation medical care in Minnesota. As shown in Figure 1, the estimated total number of hospitalizations declined from 3,690 in 2011 to 2,370 in 2016, a 36-percent decrease. By comparison, the total number of workers' compensation paid indemnity claims was essentially flat during the same period, ranging from an estimated 21,200 to 22,200 a year.⁹ From 2011 to 2016, the hospitalization rate declined from an estimated 15.6 per 100 paid indemnity claims to 10.4.¹⁰ For 2016, inpatient hospitalizations accounted for an estimated 15.3 percent of total workers' compensation medical cost and 5.3 percent of total workers' compensation system cost.¹¹

Figure 1

Estimated number of workers' compensation inpatient hospitalizations, 2011-2016 [1]



Year of discharge	Estimated number of hospitalizations
2011	3,690
2012	3,610
2013	3,250
2014	2,960
2015	2,500
2016	2,370

1. Estimated by DLI with data from the Workers' Compensation Medical Data Call, housed at the Minnesota Workers' Compensation Insurers Association and made available to DLI. Since the Medical Data Call does not include self-insurers or smaller insurers, figures from the Medical Data Call were projected to population totals using data on total workers' compensation medical costs reported in the Medical Data Call and tabulated from other sources by DLI.

Until January 1, 2016, Minnesota workers' compensation had a charge-based system for reimbursing hospitals for inpatient services. The statute provided that "large" hospitals (those with more than 100 beds) were reimbursed at 85 percent of their usual and customary charge for inpatient services, and that

⁹ Paid indemnity claims are claims with paid indemnity benefits – cash benefits that compensate for wage-loss or permanent partial disability. The numbers given are by injury year and projected to full maturity.

¹⁰ These figures are stated by year of hospitalization. The denominator is a weighted average of claims for years prior to the hospitalization year, where the weights reflect the distribution of time from injury to hospitalization. The average claim duration at hospitalization for 2011 to 2016 was 3.1 years, with 10 percent of cases at 10 or more years. Source: Minnesota Workers' Compensation Medical Data Call, from which data is made available to DLI via the Minnesota Workers' Compensation Insurers Association.

¹¹ Workers' Compensation Medical Data Call (see note 2) and *Minnesota Workers' Compensation System Report, 2015* (Minnesota Department of Labor and Industry, February 2017), Figure 2.3 (p. 7).

“small” hospitals (with 100 or fewer beds) were reimbursed at 100 percent of charges for these services.¹² Many observers viewed this charge-based system – along with similar systems in other states – as giving rise to higher-than-necessary costs for quality medical care.¹³ This system also gave insurers incentive for large-scale line-item review of inpatient hospital bills, leading to increased disputes and administrative cost.

Because of these concerns, the 2015 Minnesota legislature provided for a new system of reimbursing hospitals for workers’ compensation inpatient services, which took effect on Jan. 1, 2016. This new system is based on Medicare’s Inpatient Prospective Payment System (IPPS). Under IPPS, payment is based on the principal diagnosis and treatment involved in a hospital stay. On the basis of these factors, the hospitalization is categorized into a Diagnosis-Related Group (DRG) and payment is then determined primarily from the DRG.¹⁴ For this reason, IPPS – and other payment systems derived from it – are sometimes referred to as DRG systems. IPPS only applies to non-Critical Access Hospitals.¹⁵ Minnesota’s DRG system provides for payment at 200 percent of the Medicare level, not to exceed the charged amount, with provision for higher payment in catastrophic cases.¹⁶

The fundamental idea in the DRG system is that payment for each DRG is determined by the average cost for cases in that DRG, not for a particular case. Some cases in each DRG cost more than average, some less; on average, the hospital receives adequate compensation for providing the necessary services for the cases it sees. Since payment is without regard to the particular services provided and billed for, the hospital has incentive to economize. Further, the insurer does not need to concern itself with the appropriateness of particular services and charges, so administrative costs and disputes are reduced. Medicare provides for highly expensive cases by means of an “outlier” provision.¹⁷

As part of the DRG statute, the legislature required the Department of Labor and Industry (DLI) to produce a report by January 15, 2018 evaluating the new system, specifically “analyzing the impact of the reforms under this section to determine whether the objectives have been met and whether further changes are needed.”¹⁸ This report is submitted in compliance with that requirement.

Section B of this report provides further description of Minnesota’s statutory provisions for its DRG system. Section C provides a list of study questions. Section D describes the survey used in the study. Section E describes response rates. Section F presents survey findings. Section G provides estimates of the effect of the DRG system on medical payments and on overall system cost. Section H summarizes insurer and hospital comments in response to open-ended survey questions and gives DLI responses. Section I discusses two recent changes in the DRG system designed to improve its operation. Section J indicates areas for further DLI review and research. Section K describes DLI’s plans for training to improve the system. Section L concludes. Appendix A contains Minnesota’s DRG statute. Appendix B contains verbatim insurer and hospital responses to the open-ended questions in the DLI survey.

¹² Minn. Stat. § 176.136, subd. 1b (2014).

¹³ *Report on Workers’ Compensation Reimbursement Methodologies* (prepared for DLI by CGI Federal, 2011).

¹⁴ The types of software that perform these functions are known respectively as “grouper” and “pricer” softwares. Grouper softwares are available from private companies; the pricer software is available from the U.S. Centers for Medicare and Medicaid Services.

¹⁵ “Critical Access Hospital,” U.S. Centers for Medicare and Medicaid Services (Medicare Learning Network), August 2017.

¹⁶ Further description is in Section B, p. 3.

¹⁷ The Medicare system accounts for geographic cost variation by means of a geographic wage index: a hospital’s reimbursement depends in part on the geographic wage index for its local area. Medicare also adjusts payment on the basis of other hospital characteristics. See “Acute Care Hospital Inpatient Prospective Payment System,” U. S. Centers for Medicare and Medicaid Services (Medicare Learning Network), December 2016.

¹⁸ Minn. Stat. § 176.1362, subd. 7.

B. Minnesota's DRG provisions

As previously indicated, Minnesota's DRG system provides for payment at 200 percent of the Medicare level, not to exceed the charged amount. Minnesota and other states with DRG systems for workers' compensation pay more than Medicare because of concern over the adequacy of Medicare payment levels.¹⁹

Minnesota's workers' compensation DRG system, like Medicare's system, only applies to non-Critical-Access Hospitals; Critical-Access Hospitals, which are generally smaller and located in nonmetropolitan areas, are reimbursed at 100 percent of charges.²⁰

To ensure adequate reimbursement in catastrophic cases, Minnesota provides that cases with charges above a threshold will be paid at 75 percent of charges. This threshold is adjusted for inflation and is currently \$196,021.

To ensure that the DRG system leads to administrative simplification, the Minnesota DRG statute provides that the insurer (or self-insurer) may not require itemization or additional documentation when the following ("sub. 4") conditions are met:²¹

- the hospital submits the bill electronically;
- a DRG applies to the hospitalization; and
- total charges in the case do not exceed the catastrophic threshold.

An exception is that the insurer may do a post-payment audit if it paid the bill within 30 days of receipt and there is an outlier (under the Medicare provision).

In addition, when the sub. 4 conditions are met, the insurer must take one of these actions within 30 days of bill-receipt:

- pay the bill according to the above provisions; or
- deny the entire hospitalization on the basis of (1) a denial of primary liability, (2) a denial that the hospitalization diagnosis is related to the work injury, or (3) a denial that the hospitalization is reasonably required for the condition in question.

Except when a post-payment audit is allowed, the insurer may not deny payment on the basis of bundling of services or on the grounds that a particular service is not reasonable and necessary.²²

Minnesota's DRG statute is in Appendix A.

¹⁹ See, for example, *2018 Almanac of Hospital Financial and Operating Indicators: A comprehensive benchmark of the nation's hospitals*, Optum 360, 2017; *Report to the Congress: Medicare Payment Policy*, Medicare Payment Advisory Commission, 2017; and "Underpayment by Medicare and Medicaid Factsheet," American Hospital Association, 2015.

²⁰ As of July 2017, Minnesota had 54 non-Critical-Access Hospitals and 78 Critical-Access Hospitals (Minnesota Department of Health).

²¹ These conditions are often referred to as the "sub. 4" conditions because of their numbering in statute (Minn. Stat. § 176.1362, subd. 4).

²² Bundling is a practice in which the insurer asserts that a service is properly viewed as part of another billed service and should therefore not be paid separately.

C. Broad study questions

In framing the questions for this study, DLI took its guidance from the DRG statute and the policy discussions surrounding the framing of the statute. The study attempted to answer the following questions regarding the DRG system:

- Are insurers –
 - paying accurately under the new system;
 - following mandated timelines;
 - asking for documentation only as allowed by statute; and
 - denying payment only as allowed by statute?
- Are hospitals –
 - increasing their use of electronic billing under the DRG system; and
 - following the mandated timeline for providing documentation in the event of a post-payment audit?²³
- Has timeliness of payment improved under the DRG system?
- Have disputes decreased under the DRG system?
- Have inpatient hospital payments decreased under the DRG system?

D. Data sources

Because existing data sources were inadequate to speak to most of the study questions (those pertaining to issues other than total payments), DLI administered a one-time data survey to both insurers and hospitals in Minnesota's workers' compensation system. To provide further evidence on total payments, DLI also employed data from a large insurer and from the Minnesota Workers' Compensation Insurers Association (MWCIA).²⁴ These two data sources are described in Section G in the context of the estimates regarding the effect of the DRG system on total payments.

To analyze the effect of the change to the DRG system, the DLI survey asked respondents to answer with respect to two time periods, before and after the DRG statute took effect. DLI decided to exclude the first six months under the DRG system recognizing that this was a transition period. Thus DLI selected July through December 2015 and July through December 2016 as the two study periods. The 2016 data also enabled DLI to study compliance with the DRG statute.

DLI conducted its survey during the summer of 2017 via email to insurers (including self-insurers) and hospitals. The insurer recipients were limited to those estimated to have at least one workers' compensation hospitalization in each of the second halves of 2015 and 2016.²⁵ The hospital recipients

²³ The sample size of the responses to the DLI survey (see below) was too small to speak to this question.

²⁴ MWCIA is Minnesota's workers' compensation data service organization and rating bureau.

²⁵ DLI estimated the number of workers' compensation hospitalizations for each insurer (including self-insurers) from the total number of hospitalizations (from Figure 1) and each insurer's share of total medical benefits paid, as reported annually to DLI. DLI estimated the number of hospitalizations for each hospital from the same total number of hospitalizations and each hospital's share of hospitalizations other than those paid for by private and major public insurers, as reported annually to the Department of Health.

were limited to non-Critical-Access Hospitals since those hospitals are the ones covered by the DRG system. In all, the survey was sent to 235 insurers, 145 self-insurers, and 49 hospitals. To limit the reporting burden, respondents were asked for data on only 50 percent of their cases for the two report periods, with a maximum of 30 cases per report period per respondent; this was done in a manner to promote randomness in case selection, an essential ingredient for producing representative (unbiased) results.²⁶ Insurer and self-insurer respondents were instructed to respond only for non-Critical-Access Hospital cases (those covered by the DRG system).

To analyze changes under the DRG statute and compliance with the statute, the survey requested data on the following items for individual hospital cases:

- admission dates;
- bill information (electronic submission, date received);
- basis of payment (DRG, catastrophic, charge-based, etc.);
- billed and allowed DRGs;
- charged and paid amounts (and payment date);
- denial reason and date;
- payment reduction reason;
- pre-payment documentation request;
- post-payment audit;
- hospital request for reconsideration; and
- dispute status.

The same information was requested from hospitals and insurers, to allow a comparison of responses.

In addition, both insurers and hospitals were asked open-ended questions inviting them to provide (1) any other information they deemed relevant to how well the DRG system has been working and (2) any changes they thought should be made to the system to improve its operation. Their verbatim answers to these questions are provided in Appendix B.

A copy of the survey instrument is available upon request from the Department of Labor and Industry.²⁷

E. Survey response rate

As previously indicated, the DLI survey was sent to 235 insurers, 145 self-insurers, and 49 hospitals. Of these, 72 insurers, 32 self-insurers, and 40 hospitals reported on one or more inpatient hospital cases for at least one of the two sample periods (Figure 2, p. 6).²⁸ These responding entities tended to be of larger-than-average size. Several insurer and self-insurer survey recipients, not shown in Figure 2, responded with an indication that they had no cases to report.

²⁶ Each reporting entity was instructed to report on cases with discharge dates from the 1st through the 15th of each month in each of the two six-month report periods. If an entity had more than 30 cases for the entirety of either six-month period, the reporting window in each month was correspondingly shortened to produce a target of 30 reportable cases for the six months. For example if an entity had 90 cases in total for the six months, it would have reported on cases with discharge dates from the 1st through the 10th of each month, causing about one-third, or 30 cases on average, to be included in the sample.

²⁷ Contact DLI Research and Statistics at (651) 284-5208.

²⁸ Survey respondents were asked to report individual cases if they had at least one reportable sample case in each of the two periods.

Figure 2**Number of entities sent survey and number reporting individual cases for 2015 or 2016 [1]**

Type of reporting entity	Number sent survey [2]	Number reporting individual cases [3]
Insurers [4]	235	72
Self-insurers [4]	145	32
Hospitals	49	40
Total	429	144

1. "2015" and "2016" denote discharges in the second halves of 2015 and 2016, respectively.
2. The entities sent the survey were those estimated to have at least one reportable case per six-month period in 2015 and 2016 (see note 26 in text).
3. The entities counted here are those that reported on at least one individual hospitalization. Many other entities responded that they had no cases to report.
4. In the remaining figures in this report, insurers and self-insurers are combined into a single category referred to collectively as "insurers".

In all, these reporting entities submitted data on 1,034 inpatient cases (Figure 3). These sample cases were fairly evenly distributed between the two years and between insurer and self-insurer reporters, on one hand, and hospital reporters, on the other. In the analysis of results, insurers and self-insurers are combined into one group labeled "insurers."

Figure 3**Numbers of reported cases compared with population cases, 2015 and 2016**

	Number of reported cases		
	Year of hospital discharge [1]		Total
	2015	2016	
Cases reported by an insurer only [2]	184	181	365
Cases reported by a hospital only	203	208	411
"Common cases" -- reported by both an insurer and a hospital [3]	127	131	258
Total unique cases	514	520	1,034
Insurer total [4]	311	312	623
Hospital total [5]	330	339	669
Estimated number of population cases [6]	1,230	1,170	2,400
Estimated sampling rate -- insurers [7]	25%	27%	26%
Estimated sampling rate -- hospitals [8]	27%	29%	28%

1. "2015" and "2016" denote discharges in the second halves of 2015 and 2016, respectively.
2. "Insurers" includes insurers and self-insurers.
3. These are instances where the same hospitalization was reported by both an insurer and a hospital.
4. This is the sum of cases reported by an insurer only and those reported by both an insurer and a hospital.
5. This is the sum of cases reported by a hospital only and those reported by both an insurer and a hospital.
6. This is estimated from Figure 1 for each six-month period (second halves of 2015 and 2016) assuming the downward trend shown in Figure 1 was also occurring within each year.
7. This is the insurer total number of sample cases divided by the estimated number of population cases.
8. This is the hospital total number of sample cases divided by the estimated number of population cases.

In analyzing the data, it was possible to identify cases where the same hospitalization was reported by both an insurer and a hospital.²⁹ There were 258 of these “common cases” for the two years combined. Insurers and hospitals each reported more than 300 cases for each of the two years, including the common cases for both types of reporting entities.

There were an estimated 1,230 population cases for the second half of 2015 and 1,170 for the second half of 2016. Given these figures, the estimated sampling rate was 25 percent or somewhat higher depending on the type of reporting entity and the report period. It is important to note that this sampling rate partly reflects the fact that DLI only asked respondents for an average of 50 percent of their cases with a maximum of 30 per report period (see pp. 4,5 and note 26).³⁰ Although this was done in part to reduce the reporting burden, it was also done to improve data quality, given the likelihood that reporting entities would put more effort into each reported case if the number of reported cases was reduced. Moreover, the specification of a sampling mechanism by DLI (p. 5, note 26) may well have promoted random sample selection by reducing the likelihood that reporting entities, to reduce their workload, would themselves have selected a subsample of cases to report if they had been asked to report on all of their cases.

F. Survey results – individual case data

The presentation of results in this section takes account of all cases reported by insurers and hospitals, both the common cases and others cases. Throughout, findings are presented separately for both types of reporters for comparative purposes. For each finding, mention is made of extent to which the differences between insurer and hospital reporters persist when only the common cases are considered.

All results pertaining to differences between years or between reporting entities (insurers and hospitals) are subject to tests of statistical significance. Statistical significance is a measure of whether a given result is strong enough to have been unlikely to arise from random variation in the data. In this report, the criterion for statistical significance is 10 percent. This means that a result is deemed statistically significant if there is no more than a 10 percent chance that it would have arisen solely from random variation in the data.

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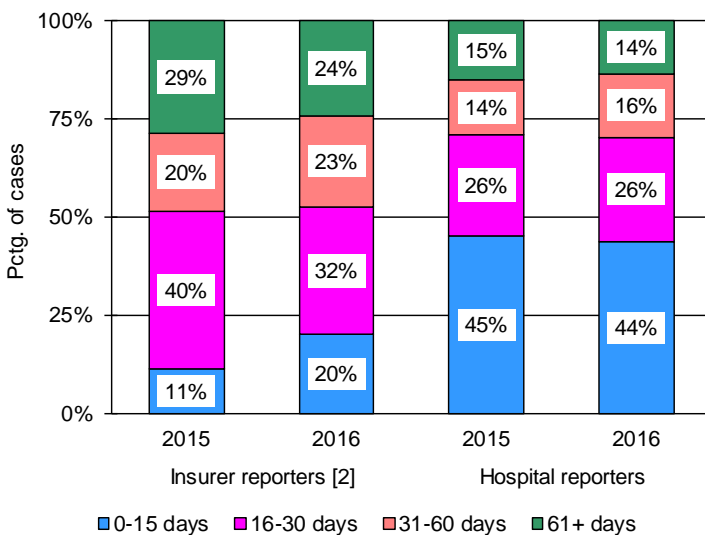
²⁹ These cases were identified using data reported by both insurers and hospitals on the hospital identity, dates of hospitalization, and other dates in the case. Claimant data was not reported in the survey.

³⁰ In other words, if all insurers and hospitals had reported on all of their reportable cases, the sampling rate would have been less than 50 percent.

Time to bill submission

The starting point in the reimbursement process is the hospital’s submission of the bill to the insurer. Insurers were asked when they (or a representative) received the bill from the hospital (or its representative); hospitals were similarly asked when they (or a representative) submitted the bill to the insurer (or its representative). The survey results indicate that the hospital (or its representative) initially submitted the bill to the insurer (or its representative) anywhere from a few days to more than 60 days after the hospital discharge (Figure 4). Given the phrasing of the question, the responses from the two entities would theoretically be the same. However, hospitals reported a substantially shorter time to bill submission that did insurers. For example, for 2016, the time to bill submission was 15 days or less in 44 percent of cases as reported by hospitals but in only 20 percent of cases as reported by insurers. The difference between the two groups was statistically significant, and substantially more than the few days the bill would take to travel in the mail if this form of submission was used. At the upper end of the distribution, for 2016, 14 percent of hospitals and 24 percent of insurers reported a time span of more than 60 days from discharge to bill submission. DLI plans further analysis of the discrepancy in reporting between insurers and hospitals.

Figure 4
 Number of days from hospital discharge to submission of bill, 2015 and 2016, insurer and hospital reporters [1]



1. This is the number of days from discharge to when the hospital (or its representative) sent the bill to the insurer (or its representative). "2015" and "2016" denote discharges in the second halves of 2015 and 2016, respectively.
 2. "Insurers" includes insurers and self-insurers.
- * The difference between insurer and hospital reporters is statistically significant for both years. The difference between years is statistically significant for insurer reporters only.

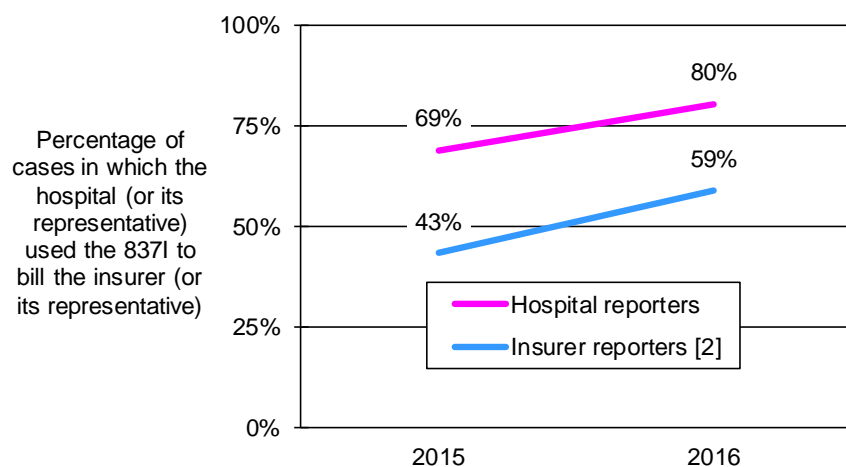
(In the common cases, there is still a strong tendency for the hospitals to report a shorter lag time than the insurers, although the difference between the two reporter types is statistically significant for 2015 only.)

Use of electronic billing

As of July 15, 2009, all Minnesota medical providers and payers are required to use electronic billing and remittance advice transactions.³¹ For inpatient services, the required form is the 837I electronic format established by the American National Standards Institute. This requirement is apart from Minnesota's workers' compensation DRG statute, but the DRG statute provides an incentive. As described in Section B above, when the statutory "sub. 4" conditions are met, the insurer is prohibited from doing line-item review, and must either pay or deny the bill according to the statutory requirements with 30 days of receipt. Filing the bill electronically is one of the sub. 4 conditions.

The survey asked whether the hospital (or its representative) used the 837I format to bill the insurer (or its representative). The responses to this question were different for the two years and for insurer and hospital reporters (Figure 5). For 2016, the 837I was used in 59 percent of cases as reported by insurers and 80 percent as reported by hospitals. Both types of entities reported an increase between 2015 and 2016. All of these differences were statistically significant. One possible reason for this is a practice referred to in anecdotal reports, wherein insurers (or their third-party administrators) ask their clearinghouses to "drop bills to paper" because the insurer is not equipped to handle the electronic format.³² DLI plans further analysis of the discrepancy in reporting between insurers and hospitals.

Figure 5
Hospital use of electronic billing (837I format), 2015 and 2016, insurer and hospital reporters [1]



1. "2015" and "2016" denote discharges in the second halves of 2015 and 2016, respectively.

2. "Insurers" includes insurers and self-insurers.

* The differences between reporter types (for each year) and between years (for each reporter type) are all statistically significant.

(In the common cases, the difference between reporter types persists and remains statistically significant for both years.)

³¹ Minn. Stat. §§ 62J.536, subd.1 and 176.135, subds. 7 and 7a.

³² Clearinghouses receive electronic billing data from a health care provider, check for errors, and then pass the data to the payer's clearinghouse, which then verifies that the data is in a compatible format for the payer's software or computer system to accept and process. After the bill is processed, the payer's clearinghouse sends an electronic remittance advice (explanation of benefits) to the hospital's clearinghouse, which then forwards it to the hospital.

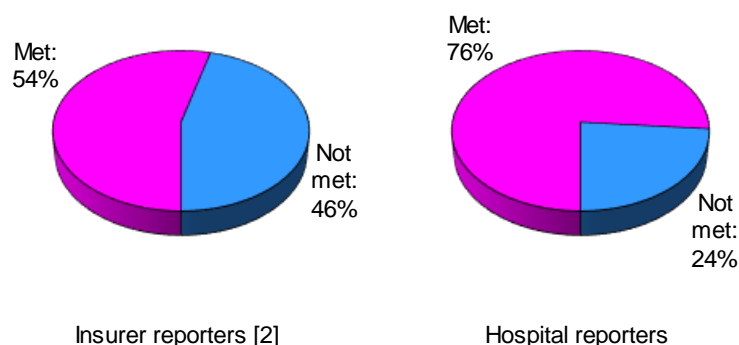
Frequency of sub. 4 conditions being met

Since the sub. 4 conditions trigger requirements for insurer behavior under the DRG statute, it is of interest to see how often these conditions were met for 2016. Using information reported by insurers and hospitals, DLI determined the sub. 4 conditions to have been met or not met for reported 2016 cases. Following statute, three pieces of information were used for this: (1) whether the reporting entity reported a valid DRG for the case to DLI, (2) whether the hospital billed the insurer via the 837I electronic format, and (3) whether the case was “catastrophic” because of having charges greater than the catastrophic threshold.³³

As reported by insurers, the sub. 4 conditions were met in 54 percent of the 2016 cases; as reported by hospitals, 76 percent; this difference was statistically significant (Figure 6). As reported by both insurers and hospitals, lack of use of the 837I format by the hospital was by far the principal reason for the sub. 4 conditions not being met; it was far less common for a valid DRG not to apply to the case or for the case to be a catastrophic one.³⁴

Figure 6

Frequency with which the sub. 4 conditions were met, 2016, insurer and hospital reporters [1]



1. See text for explanation of sub. 4 conditions. The sub. 4 conditions were deemed to be met or not met on the basis of data reported in the survey to DLI. "2016" denotes discharges in the second half of 2016.
 2. "Insurers" includes insurers and self-insurers.
- * The difference between insurer and hospital reporters is statistically significant.

(In the common cases, the difference between reporter types remains and is statistically significant.)

³³ See Section B, p. 3.

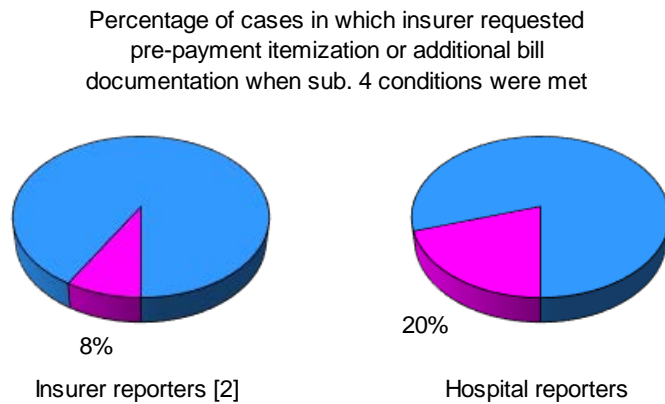
³⁴ For insurer reporters, the reasons for the sub. 4 conditions not to be met were as follows: the 837I (electronic report format) was not used, 91 percent; a DRG did not apply to the case, 11 percent; the case met the catastrophic threshold, 8 percent. For hospital reporters, the respective percentages were 13 percent, 83 percent, and 10 percent. (The respective percentages add to more than 100 percent because more than one category might apply.) A DRG was assumed to apply to the case if the survey respondent reported a valid DRG for the case.

Insurer requests for documentation when sub. 4 conditions were met

One of the requirements for insurers when the sub. 4 conditions are met is that they must not request itemization or additional documentation from the hospital. However, for 2016 cases where the sub. 4 conditions were met, hospitals reported that the insurer requested itemization or additional documentation 20 percent of the time; insurers themselves reported 8 percent; this difference was statistically significant (Figure 7).

Figure 7

Insurer requests for documentation when sub. 4 conditions were met, 2016, insurer and hospital reporters [1]



1. See text for explanation of sub. 4 conditions. The sub. 4 conditions were deemed to be met or not met on the basis of data reported in the survey to DLI. "2016" denotes discharges in the second half of 2016.
 2. "Insurers" includes insurers and self-insurers.
- * The difference between insurer and hospital reporters is statistically significant.

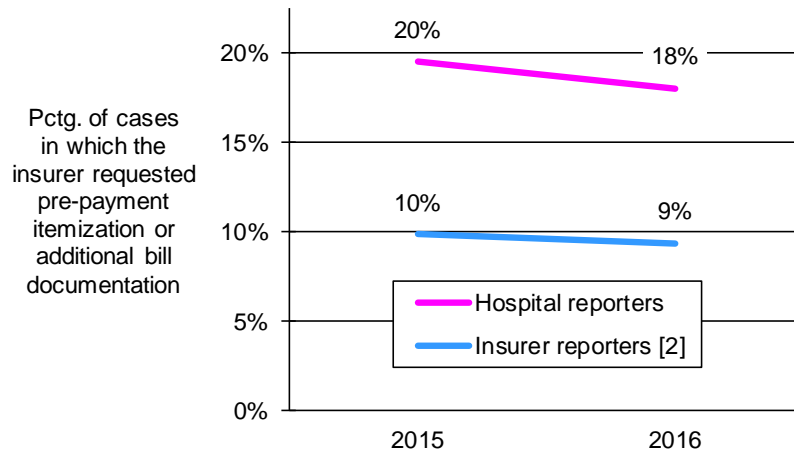
(In the common cases, the difference between reporter types is smaller (6 percentage points) and is no longer statistically significant.)

Insurer requests for documentation for 2015 and 2016

One of the goals of the DRG statute is to reduce administrative cost. One way this might occur would be a decrease in insurer requests for itemization or additional documentation. Figure 8 shows the frequency of such requests for both 2015 and 2016 without regard to whether the sub. 4 conditions were met (since they only apply to 2016). The results show small, statistically insignificant decreases for both reporter types. The difference between insurer and hospital reporters was statistically significant for both years.

Figure 8

Insurer requests for documentation, 2015 and 2016, insurer and hospital reporters [1]



1. "2015" and "2016" denote discharges in the second halves of 2015 and 2016, respectively. This figure is not limited to cases where the sub. 4 conditions were met.
 2. "Insurers" includes insurers and self-insurers.
- * The differences between reporter types (for each year) are statistically significant; the differences between years are not.

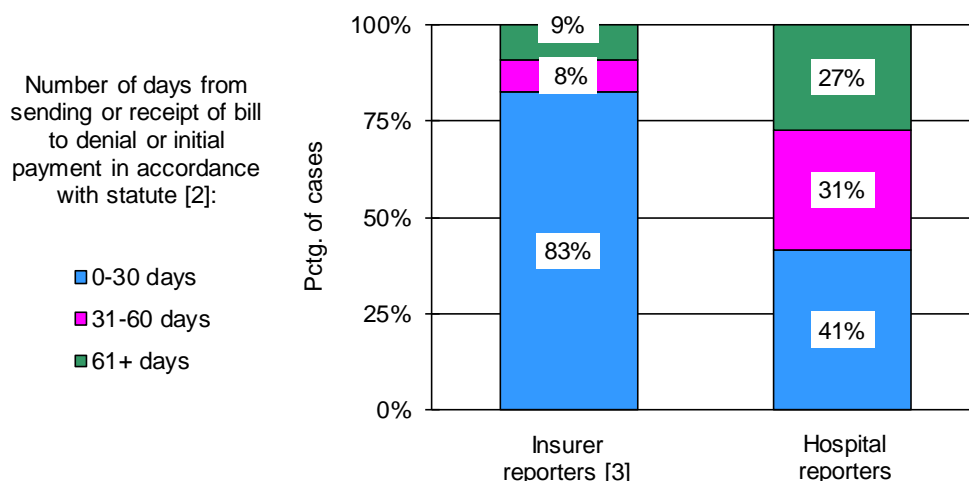
(In the common cases, the difference between reporter types remains but is statistically significant for 2015 only.)

Prompt statutory action when sub. 4 conditions were met

As previously indicated, the DRG statute provides that when the sub. 4 conditions are met, the insurer must either pay or deny the bill within 30 days of receipt in accordance with the statutory provisions.³⁵ Insurer and hospital reporters provided very different information regarding compliance with this requirement, which for convenience may be called “prompt statutory action” (Figure 9). According to insurer reporters, they took statutory action with 30 days of bill receipt 83 percent of the time; according to hospital reporters, this happened only 41 percent of the time. At the top end of the range, insurers indicated statutory action within 60 days 91 percent of the time, while hospitals indicated this occurred 73 percent of the time. The difference between the two reporter groups was statistically significant. DLI plans further analysis of the discrepancy in reporting between insurers and hospitals.

Figure 9

Prompt statutory action for 2016 cases meeting sub. 4 conditions, insurer and hospital reporters [1]



1. "2016" denotes discharges in the second half of 2016. See text for explanation of sub. 4 conditions.
 2. Sending or receipt of bill means the sending of the bill by the hospital (or its representative) to the insurer (or its representative), as reported by the hospital, or the receipt of the bill by the insurer (or its representative), as reported by the insurer. Denial in accordance with statute means, in a case where the sub. 4 conditions are met, a denial on the basis of primary liability, causation, or reasonableness and necessity of hospitalization or treatment. Payment in accordance with statute means, in a case where the sub. 4 conditions are met, payment made at 200 percent of the Medicare DRG amount for the hospital concerned.
 3. "Insurers" includes insurers and self-insurers.
- * The difference between reporter types is statistically significant.

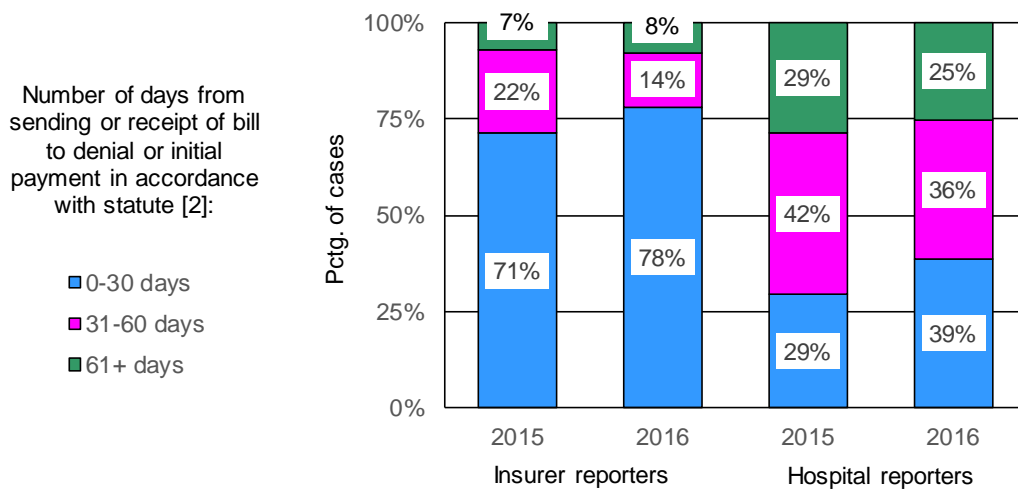
(In the common cases, a major difference remains between insurer and hospital reporters and is statistically significant.)

³⁵ See note 2 in Figure 9.

Prompt action for 2015 and 2016

As with insurer requests for documentation, it is of interest whether the time periods of bill payment or denial changed between 2015 and 2016. Figure 10 shows this timeline for the two years without regard to whether the sub. 4 conditions were met (since they only apply to 2016) and without regard to whether the bill payment or denial was in compliance with statute. As reported by hospitals, the frequency of cases with payment or denial within 30 days increased from 29 percent to 39 percent between 2015 and 2016; as reported by insurers, this frequency increase from 71 to 78 percent. The change was statistically significant for both insurer and hospitals reporters. As in the previous figure, there is a large, statistically significant difference between insurer and hospital reporters for each year.

Figure 10
Prompt action, 2015 and 2016, insurer and hospital reporters [1]



1. "2015" and "2016" denote discharges in the second halves of 2015 and 2016, respectively. This figure is not limited to cases where the sub. 4 conditions were met.
 2. Sending or receipt of bill means the sending of the bill by the hospital (or its representative) to the insurer (or its representative), as reported by the hospital, or the receipt of the bill by the insurer (or its representative), as reported by the insurer.
 3. "Insurers" includes insurers and self-insurers.
- * The differences between reporter types (for each year) and between years (for each reporter type) are all statistically significant.

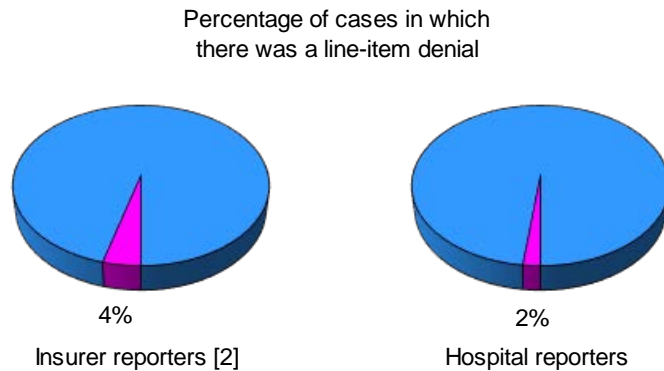
(In the common cases, a statistically significant difference remains between the reporter types for both years.)

Line-item denial when the sub. 4 conditions were met

Where the sub. 4 conditions were met in 2016, the incidence of line-item denials was small for both reporter types – 4 percent for insurer reporters and 2 percent for hospital reporters (Figure 11).

Figure 11

Line-item denial where sub. 4 conditions were met, 2016, insurer and hospital reporters, [1]



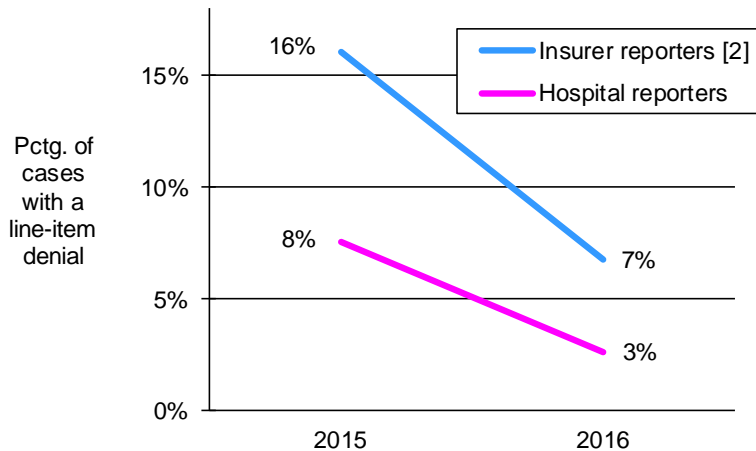
1. See text for explanation of sub. 4 conditions. The sub. 4 conditions were deemed to be met or not met on the basis of data reported in the survey to DLI. "2016" denotes discharges in the second half of 2016.
 2. "Insurers" includes insurers and self-insurers.
- * The difference between insurer and hospital reporters is not statistically significant.

(In the common cases, the difference between insurer and hospital reporters is not statistically significant.)

Line-item denial for 2015 and 2016

Given the requirement that insurers not do line-item denials when the sub. 4 conditions are met, it is of interest to know whether these denials decreased between the two years. As shown in Figure 12, the data indicates they did. Between 2015 and 2016, the percentage of claims with line-item denials decreased from 16 to 7 percent as reported by insurers and from 8 to 3 percent as reported by hospitals; both decreases were statistically significant.

Figure 12
Line-item denial, 2015 and 2016, insurer and hospital reporters



1. "2015" and "2016" denote discharges in the second halves of 2015 and 2016, respectively. This is not limited to cases where the sub. 4 conditions were met.
 2. "Insurers" includes insurers and self-insurers.
- * The differences between reporter types (for each year) and between years (for each reporter type) are all statistically significant.

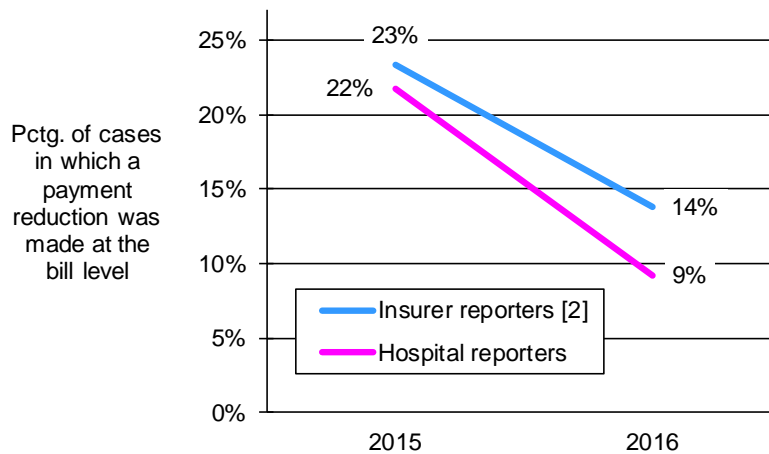
(In the common cases, the difference between reporter types persists but is not statistically significant.)

Bill-level payment reduction

As shown in Figure 13, the frequency of bill-level payment reduction (as opposed to line-item denials) by the insurer declined as reported by both insurers and hospitals. The decrease was 9 percentage points as reported by insurers and 13 points as reported by hospitals, statistically significant in both cases. A majority of the reductions concerned, for both years and reporter types, were because of arrangements with preferred-provider organizations (PPOs) or (sometimes in the case of hospital reporters) “claimed” PPO arrangements (data not shown here).

Figure 13

Bill-level payment reduction, 2015 and 2016, insurer and hospital reporters [1]



1. "2015" and "2016" denote discharges in the second halves of 2015 and 2016, respectively.
 2. "Insurers" include insurers and self-insurers.
- * The difference between years is statistically significant for both reporter types.

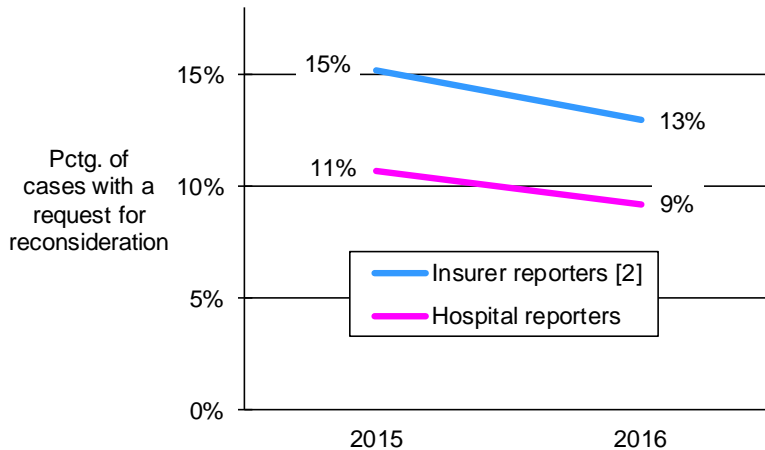
(In the common cases, the difference between reporter types is not statistically significant for either year.)

Requests for reconsideration

One indicator of friction cost is the degree to which hospitals request a reconsideration of payment by the insurer.³⁶ According to the results shown in Figure 14, both reporter types showed a 2-percentage-point decrease between 2015 and 2016 in the frequency of requests for reconsideration, although the difference between years was statistically insignificant for both reporter types.

Figure 14

Request for reconsideration, 2015 and 2016, insurer and hospital reporters



1. "2015" and "2016" denote discharges in the second halves of 2015 and 2016, respectively.
 2. "Insurers" includes insurers and self-insurers.
- * The difference between years is not statistically significant for either reporter type.
The difference between reporter types is statistically significant for 2015 only.

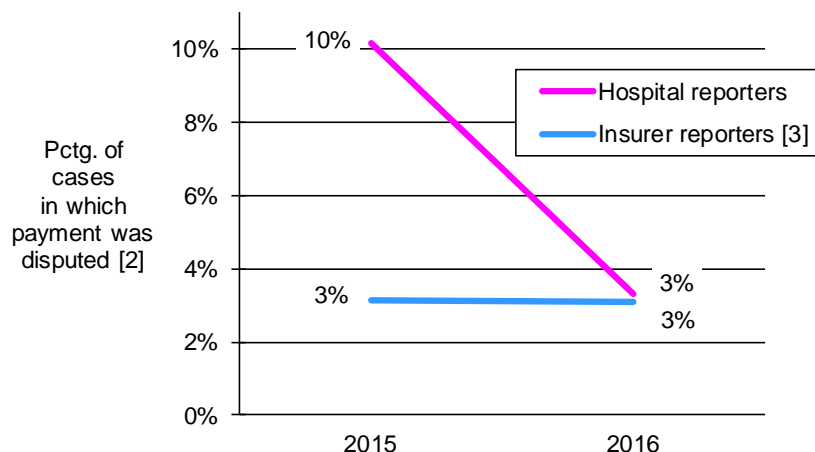
(In the common cases, the difference between reporter types persists but is not statistically significant.)

³⁶ A request of reconsideration is not a dispute as defined on the next page in the context of Figure 15.

Disputes

Another indicator of friction cost is the frequency of disputes. According to hospital reporters, the frequency of disputes declined from 10 percent of cases to 3 percent of cases between the two years (statistically significant), while according to insurer reporters it was the same for both years at 3 percent (Figure 15). Disputes here were defined as instances where a request for dispute certification, medical request, or claim petition regarding the bill was filed with DLI.³⁷

Figure 15
Dispute status, 2015 and 2016, insurer and hospital reporters [1]



1. "2015" and "2016" denote discharges in the second halves of 2015 and 2016, respectively.
 2. Respondents were instructed to indicate that the payment was disputed if it was the subject of a dispute certification request, medical request, or claim petition filed with the Department of Labor and Industry.
 3. "Insurers" includes insurers and self-insurers.
- * The difference between years is statistically significant for hospital reporters only.
The difference between reporter types is statistically significant for 2015 only.

(In the common cases, the statistically significant difference between reporter types for 2015 remains.)

³⁷ Dispute certification is a process required by statute in which, in a medical or rehabilitation dispute, DLI must certify that a dispute exists and that informal intervention did not resolve the dispute before an attorney may charge for services. A medical request is a form by which a party to a medical dispute requests assistance from DLI in resolving the dispute. The request may lead to efforts toward informal resolution by DLI or to mediation or an administrative conference at DLI or the Office of Administrative Hearings (OAH). A claim petition is a form by which the injured worker contests a denial of primary liability or requests an award of indemnity, medical or rehabilitation benefits. In response to a claim petition, OAH generally schedules a settlement conference or formal hearing.

Statutory basis of payment

As expected, the reported statutory basis of payment changed between 2015 and 2016 according to both insurers and hospitals (Figure 16). For 2016, insurers reported 85 percent of cases being paid under the DRG formula, while hospitals reported 75 percent. Both insurers and hospitals reported small but positive percentages of cases being paid at 100 percent or 85 percent of charges for 2016, suggesting that awareness of the new DRG system is not complete.³⁸ Significant percentages of hospitals for both years – 16 percent for 2015, 17 percent for 2016 – did not know how the insurer determined payment. Because of this unknown component for hospitals, the difference between insurer and hospital reporters was statistically significant for both years. DLI plans further analysis of the cases where hospitals reported they did not know the statutory basis of payment used by the insurer.

Figure 16

Statutory basis of payment, 2015 and 2016, insurer and hospital reporters [1]

Reported statutory basis of payment	Percentage of not-denied bills			
	Insurer reporters [2]		Hospital reporters	
	2015	2016	2015	2016
200 percent of DRG formula amount	3%	85%	0%	75%
75 percent of charges (catastrophic case)	0%	6%	0%	2%
100 percent of charges (small hospital)	11%	2%	19%	1%
85 percent of charges (large hospital)	82%	4%	65%	1%
Negotiated, PPO, or settlement	2%	1%	0%	0%
Other	2%	2%	0%	4%
Unknown	0%	0%	16%	17%

1. "2015" and "2016" denote discharges in the second halves of 2015 and 2016, respectively.

2. "Insurers" includes insurers and self-insurers.

* The differences between reporter types (for each year) and between years (for each reporter type) are all statistically significant.

(In the common cases, the statistically significant difference between reporter types remains for both years.)

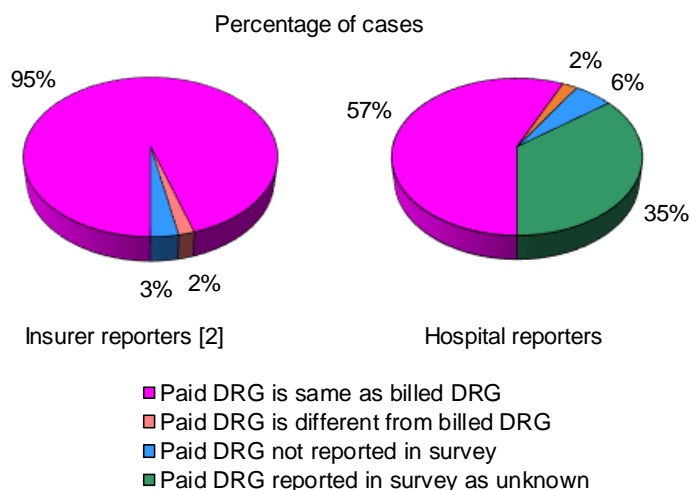
³⁸ As previously indicated, the survey was limited to non-Critical-Access Hospitals – those covered by the DRG statute. Some of these hospitals have 100 or fewer beds and were thus eligible for reimbursement at 100 percent of charges of inpatient services under the pre-DRG (pre-2016) statute. Hospitals with more than 100 beds were eligible for reimbursement at 85 percent of inpatient charges under the pre-DRG statute.

Billed vs. paid DRGs

Where the statutory basis of payment is the DRG formula, one possible source of dispute is disagreement between the hospital and the insurer about the appropriate DRG. The survey asked insurers and hospitals to indicate both the “billed” DRG (indicated by the insurer on the bill) and the “paid” DRG (used by the insurer to determine payment). Figure 17 shows, according to both types of reporters, how the billed DRG compared with the paid DRG for 2016 cases where the DRG formula was the basis of payment. As in the previous figure, there was a large “unknown” component for hospital reporters: in 35 percent of cases for 2016, the hospital did not know the DRG used by the insurer to determine payment, giving rise to a statistically significant difference between the two reporter groups. However, with the unknown and not-reported cases excluded, there was no statistically significant difference (data not shown in figure). DLI plans further analysis of the cases where hospital reporters indicated they did not know the DRG used by the insurer as the basis of payment.

Figure 17

Reported paid DRG as compared with billed DRG for cases where the statutory basis of payment is 200 percent of the DRG formula amount, 2016, insurer and hospital reporters [1]



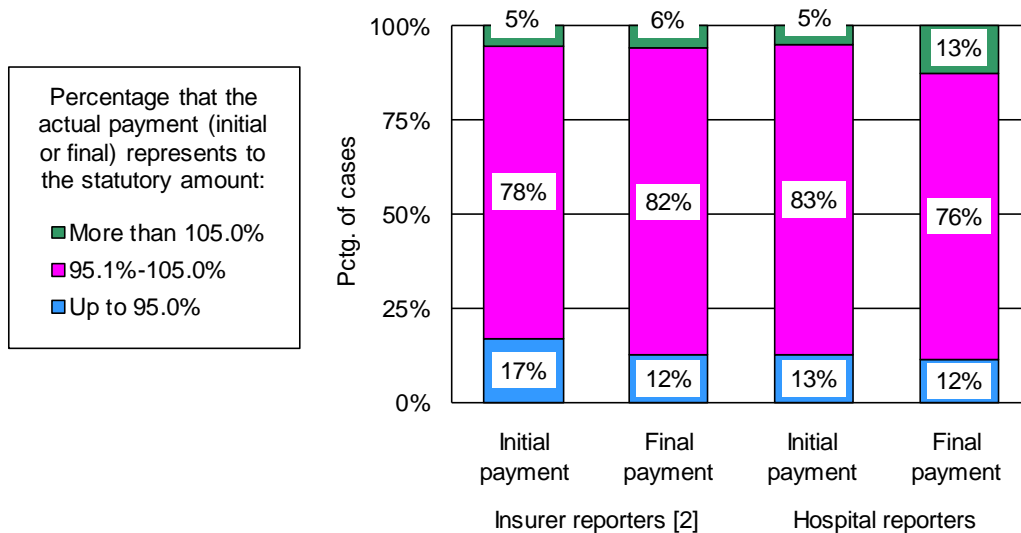
1. This figure is limited to cases where a valid billed DRG was reported, and excludes cases where a nonblank but invalid value was reported for the paid DRG. "2016" denotes cases with discharge dates in the second half of 2016.
 2. "Insurers" include insurers and self-insurers.
- * The difference between insurer and hospital reporters is statistically significant.

(For the common cases, the result is almost exactly the same as for all cases.)

Actual payments vs. statutorily correct amounts

A major question with respect to the new DRG system is the extent to which insurers are paying accurately or inaccurately. Figure 18 shows, according to insurers and hospitals, the reported initial and final payment amounts as a percentage of the statutorily correct amount.³⁹ DLI determined the statutory amount in each case using the reported paid DRG, the identity of the hospital, and the total charged amount in conjunction with Medicare’s PC-Pricer tool. Three ranges were established with respect to the ratio of the actual payment to the statutorily correct amount; these are shown in Figure 18. The comparison was performed both for the initial payment made by the insurer and for the final payment after any adjustments. A strong majority of cases were paid in the middle range, where the ratio of payment to the statutory amount (200 percent of the Medicare DRG formula amount, not to exceed charges) was from 95.1 percent to 105.0 percent. For the final payment, 82 percent of cases as reported by insurers and 76 percent as reported by hospitals were in this middle range. The results suggest a possible slight tendency toward a greater likelihood of underpayment than of overpayment (a greater percentage of cases in the lower range than the upper range). However, this did not hold for the final payment as reported by hospitals, and it was statistically significant only for the initial payment as reported by insurers.

Figure 18
Initial and final payments as percentage of statutory amount for 2016 cases where the reporting entity indicated that the statutory basis was the Medicare DRG, insurer and hospital reporters [1]



- "2016" denotes cases with discharge dates in the second half of 2016.
 - "Insurers" include insurers and self-insurers.
- * The only statistically significant difference is between the percentages above and below the middle range for the initial payment as reported by insurers.

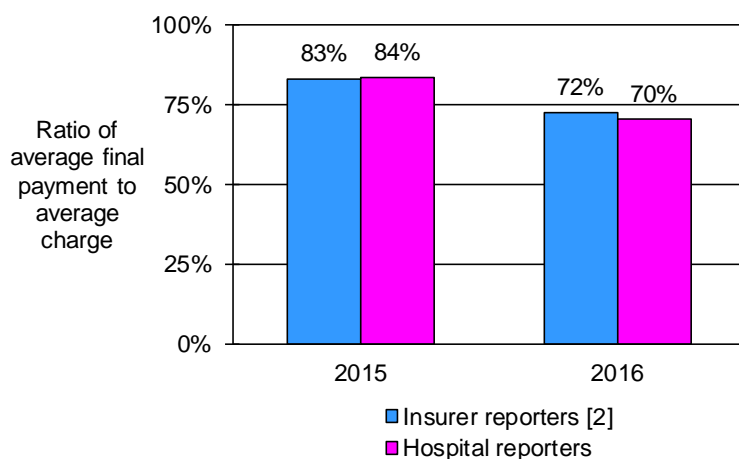
(In the common cases, the results are essentially the same, with no statistically significant difference between reporter types.)

³⁹ The comparison was done for all cases where the reported statutory basis of payment was other than 75 percent of charges under the catastrophic formula.

Ratio of average payment to average charge

Since the DRG system changed the mechanism of paying hospitals for inpatient services, it is of interest to consider the ratio of payments to charges in 2015 and 2016. Figure 19 shows the ratio of the average final payment to the average charge for insurer and hospital reporters for both years. For insurer reporters, this ratio decreased from 83 to 72 percent between the two years; for hospital reporters it decreased from 84 to 70 percent; both differences were statistically significant. In percent terms, the decreases were 12.8 percent and 15.7 percent, respectively.⁴⁰

Figure 19
Ratio of average final payment to average charge, 2015 and 2016, insurer and hospital reporters [1]



1. "2015" and "2016" denote discharges in the second halves of 2015 and 2016, respectively.
 2. "Insurers" includes insurers and self-insurers.
- * The difference between years is statistically significant for each reporter type.

(In the common cases, as in the cases shown here, there is a statistically significant difference between years but not between reporter types.)

⁴⁰ These are percent decreases rather than percentage-point decreases. For example, a decrease from 50 percent to 25 percent is a 25-percentage-point decrease but a 50-percent decrease.

G. Cost effects

One of the primary questions regarding the DRG system is its effect on total medical cost and ultimately on total workers' compensation system cost. DLI estimated this effect using three data sources: (1) data from a large insurer, (2) the DLI survey conducted in the summer of 2017, and (3) data from the Minnesota Workers' Compensation Insurers Association (MWCIA).

The first estimate employed data on Minnesota workers' compensation inpatient hospitalizations for 2013 to 2015 from the large insurer. DLI estimated payments for 2016 under Minnesota's DRG system using the reported DRG and charge data (projected to 2016) and compared these with the insurer's actual payments (projected to 2016). This gave an estimated 14.6-percent payment reduction attributable to the switch to the DRG system. This estimate pertains to non-Critical-Access Hospitals, which are the ones affected by the DRG statute.

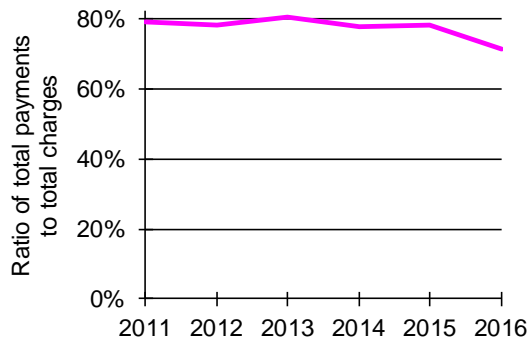
The second estimate comes directly from Figure 19. As previously noted, that figure shows percent decreases between 2015 and 2016 of 12.8 and 15.7 percent for insurer and hospital reporters, respectively. This estimate, like the first one, pertains to non-Critical-Access Hospitals only.

The third estimate is derived from Figure 20, which shows the ratio of average payments to average charges for inpatient hospitalizations for 2011 to 2016 for Minnesota insurers participating in the Workers' Compensation Medical Data Call.⁴¹ This ratio was in the range of 78 to 80 percent for 2011 to 2015 and dropped to 71 percent for 2016. The 71 percent for 2016 is 8.6 percent below the amount that would result if 2016 were projected from the 2011 through 2015 trend. Since individual hospitals cannot be identified in the Medical Call Data, the estimate pertains to all hospitals combined.

(continued on next page)

⁴¹ This is a data-collection program of the National Council on Compensation Insurance (NCCI), which Minnesota participates in through the MWCIA. MWCIA shares the data with DLI.

Figure 20
Medical call data: Ratio of total payments to total charges for insured inpatient hospital cases, 2011-2016 [1]



Year of discharge	Ratio of total payments to total charges
2011	79.2%
2012	78.2%
2013	80.2%
2014	77.5%
2015	78.3%
2016	71.3%

1. The Medical Data Call is a database of workers' compensation medical services, charges, payments, and related items housed at the Minnesota Workers' Compensation Insurers' Association (MWCIA). The data is reported by insurance companies. MWCIA performed the tabulations for this figure with programs developed by DLI. The payments and charges considered here are those involving hospital providers for inpatient services.

(continued on next page)

Figure 21 presents cost estimates from the three sources (see columns [a] and [b]). The estimates from the first two sources (lines 1 and 2) are close to each other. However, the estimate from the Medical Call Data (line 3) is of lower magnitude. The fact that this estimate (in contrast to the other two) pertains to all hospitals combined is only a small part of the reason for this. The reason for the divergence is uncertain, but it may occur in part because the Medical Data Call data encompass all of 2016, including in particular the first half of the year which was a transition period during which some insurers may not have promptly made the switch to the DRG system. Indeed, the DLI survey results presented in Figure 16 show that even in the second half of 2016, some insurers had not made the transition.

Figure 21
Estimated cost reduction from change to DRG system

	Estimated percent cost reduction				Estimated cost reduction amount, 2016 [3] [e]
	Workers' compensation inpatient hospital cost: non-critical-access hospitals [a]	Workers' compensation inpatient hospital cost: all hospitals [b]	Workers' compensation medical cost [1] [c]	Total workers' compensation system cost [2] [d]	
1. Estimates using data from a large insurer [4]	14.6%		2.2%	0.8%	\$13.5 million
2. Estimates from the DLI survey [5]					
a. As reported by insurers	12.8%		1.9%	0.7%	\$11.8 million
b. As reported by hospitals	15.7%		2.3%	0.8%	\$14.5 million
3. Estimate from the Medical Call data [6]		8.6%	1.3%	0.5%	\$8.1 million

- For lines other than line 3, this is equal to column [a] x 14.8 percent; the latter is the estimated percentage that workers' compensation payments to Minnesota non-Critical-Access Hospitals for inpatient cases represent relative to total workers' compensation medical payments. For line 3, this column is equal to column [b] x 15.3 percent; the latter is the estimated percentage that workers' compensation payments to all Minnesota hospitals for inpatient cases represent relative to total workers' compensation medical payments. The percentages are estimated with data from a large Minnesota workers' compensation insurer and from the Minnesota workers' compensation Medical Data Call.
- This is equal to column [c] x 35 percent; the latter is the estimated percentage that workers' compensation medical payments represent relative to total workers' compensation system cost ("Minnesota workers' compensation system report, 2015," Figure 2.3, p. 7, DLI, February 2017).
- This is equal to column [d] x DLI's estimated total workers' compensation system cost for 2016 of \$1.78 billion.
- The large insurer supplied data on inpatient cases for 2013 through 2015 including DRGs. See text.
- Estimated from the data in Figure 19. See note 40 in text.
- Estimated from the data in Figure 20. See note 40 in text.

As shown in column [c] of Figure 21, according to estimates 1 and 2, the decrease in workers' compensation medical cost from the switch to the DRG system ranges from an estimated 1.9 to 2.3 percent. The corresponding effect on total workers' compensation system cost is an estimated 0.7 or 0.8 percent. The total medical cost effect according to the Medical Call data is an estimated 1.3-percent reduction, and the corresponding effect on total system cost is an estimated 0.5 percent. The estimated cost-reduction amounts from the DRG system range from \$8.1 to \$14.5 million a year.

H. Insurer and hospital comments in response to open-ended questions

The DLI survey asked insurers and hospitals two open-ended questions to solicit their views on how the DRG system has been working and how, if at all, they would like to see the system changed. Three insurers and four hospitals responded to these questions. This section summarizes the insurer and hospital answers to these questions and provides DLI's responses. Appendix B contains the verbatim responses to the open-ended questions.

Issue: Frequency of PC-Pricer updates

Comment. Although Medicare updates its PC-Pricer quarterly, Minnesota updates its PC-Pricer annually. One hospital and two insurers reported issues pertaining to this difference and recommended more frequent updates of the Minnesota's PC-Pricer to minimize variations in reimbursement amounts and simplify claim processing.

DLI response. DLI discussed this matter with insurer and hospital representatives when developing the DRG statutory language. These representatives agreed there would be fewer errors if the effective PC-Pricer changed just once each year. To calculate payment under the DRG system, many insurers use proprietary software, which incorporates the Medicare PC-Pricer, rather than Medicare's actual PC-Pricer. The proprietary software may be updated partly in response to non-workers' compensation contracts between insurers and hospitals. Moreover, Medicare updates its PC-Pricer at various times throughout the year – sometimes quarterly and sometimes more often to make corrections. A system that would require using Medicare updates throughout the year would require insurers, hospitals, and DLI to continuously check the Medicare PC-Pricer for updates, modify any proprietary software accordingly, and change their Explanation of Benefit programs. This would increase disputes over what PC-Pricer is being used and whether payment is accurate.

Partly because some insurers and hospitals were using the wrong version of the Medicare PC-Pricer, and partly because Medicare delayed updating its pricer for 2017 hospital discharges, the 2017 Legislature required DLI to update Minnesota's pricer every Oct. 1 with the most recently available Medicare version of the pricer as of the preceding July 1. In response to this 2017 legislation, insurers and hospitals now have one consistent PC-Pricer for calculating correct payment of workers' compensation hospital bills, which should address the confusion reflected in the comments.

As required by law, DLI makes the pricer available on its website. DLI will continue to work with parties to make sure that the PC-Pricer is accessible and usable. This includes reviewing the download instructions for accuracy and issuing additional instructions on how to use the pricer for medical payments.

Issue: Limitation of reimbursement to the charged amount

Comment: Some hospital commenters expressed confusion about whether payment under Minnesota's DRG system (200 percent of Medicare) is capped at the amount charged. These commenters noted that Medicare pays the amount specified by the PC-Pricer regardless of the amount charged. In Minnesota's system, since the formula payment is 200 percent of Medicare, the formula payment more often exceeds the charged amount than does the Medicare amount itself.

DLI response. The DRG statute does not state that payment "shall be" 200 percent of Medicare, but that "maximum reimbursement" for inpatient hospital charges is 200 percent of Medicare.⁴² The workers'

⁴² Minn. Stat. § 176.1362, subd. 1.

compensation law does not provide in any other circumstance for health care providers to receive *more than* the provider's charge, although in some cases the law provides an exact amount.⁴³

Issue: Preferred-provider arrangements

Comment: One hospital commented that payers use "silent" PPOs (arrangements with preferred-provider organizations) and that PPOs should be prohibited.

DLI response: PPOs involve a contract between a healthcare provider and an insurer. There is no need to prohibit these arrangements by statute because health care providers are not required to enter into them. Minnesota statute prohibits "shadow contracting" for workers' compensation medical benefits.⁴⁴ DLI advises that hospitals should ask payers to provide evidence of a PPO contract where one is asserted.

Issue: Electronic funds transfer

Comment: One hospital commented that electronic funds transfers (EFTs) should be required to coincide with the electronic "835" transmission (the insurer's explanation of benefits).

DLI response: DLI agrees that it should be straightforward for health care providers to match payment (whether or not by EFT) with the insurer's electronic explanation of benefits. This problem was addressed by a 2015 statutory change requiring that information provided "on or with the payment must be sufficient to allow providers to match the payment to specific bills."⁴⁵ DLI will address this concern in training as described below.

I. DLI recommendation – no additional DRG legislation currently needed

DLI does not propose any additional DRG legislation at this time. The DRG payment system is still young, and the trend for payment of inpatient hospital bills is one of increasing timeliness and decreasing disputes. The vast majority of DRG payments analyzed in the study were found to be within five percent of the statutory amount.

Two legislative provisions in 2017 (which took effect after the period covered by the survey) are expected to address concerns raised by insurers and hospitals.

First, as discussed above, DLI is now required to post a link and instructions to the specific PC-Pricer version required to be used to calculate payment, starting with discharges on or after Oct. 1, 2017.⁴⁶ Having one consistent PC-Pricer will standardize payments and will allow DLI to identify errors made by insurers and hospitals and to provide responsive training accordingly.

⁴³ See, for instance, Minn. Stat. § 176.1362, subd. 2, which states that payment for catastrophic injuries "*must ... be paid* at 75 percent of the hospitals usual and customary charges," and Minn. Stat. § 176.136, subd. 1b, which states that payment for small and critical access hospitals "*shall be* the hospital's usual and customary charges (emphasis added)." The relative value fee schedule and the pharmacy fee schedule in Minnesota Rules, chapter 5221 (which are also tied to federal fee schedules) provide that services are paid at the lower of the maximum fee established by the rules or the provider's actual charge.

⁴⁴ Minn. Stat. § 62Q.74.

⁴⁵ Minn. Stat. § 176.135, subd. 7 (e).

⁴⁶ Minn. Stat. § 176.1362, subd. 1.

Second, designated-contact legislation took effect on Nov. 1, 2017.⁴⁷ This requires all payers to register with DLI a contact person who must (1) be responsible for addressing problems relating to submission and payment of medical bills, (2) attend training provided by DLI, and (3) respond to DLI inquiries about problems related to submission and payment of medical bills within 30 days.

DLI is planning training on the basis of the study results as described in Section K.

J. Areas for further DLI review and research

On the basis of the study results, DLI has identified the following areas for further review. This review may require additional records or information from insurers and hospitals.

Electronic transactions. The use of electronic billing and explanation of reimbursement for health care, including in workers' compensation, has been a statewide requirement since 2009;⁴⁸ however, workers' compensation has lagged behind general health care in progress toward this goal. The survey produced different responses from insurers and hospitals regarding the percentage of claims submitted electronically as required by law. This is important because the insurer's 30 days to pay or deny charges begin when the insurer receives the hospital's electronic bill. DLI plans additional research on electronic transactions, including auditing files from common claims in the study (instances where the same claim was reported by both an insurer and a hospital), to compare the date of the hospital's submission with the insurer's receipt of the electronic bill. Examining these discrepancies will allow the department to understand why the reported information differs and propose solutions or training.

Prompt action. The survey produced starkly different responses from insurers and hospitals regarding the promptness of insurer action (payment or denial) when the sub. 4 conditions are met.⁴⁹ As with the use of electronic billing, DLI plans additional research, including auditing files from common claims, to provide greater understanding and to illuminate areas for training.

Statutory basis of payment. Both insurers and hospitals reported cases in 2016 that were paid at 100 percent or 85 percent of charges, suggesting that awareness of the DRG system is not complete. The study included a number of instances where hospitals stated that there was an "unknown" reason for a reduction in payment, and one hospital commented that it did not know the DRG under which the hospital was paid. DLI will review the survey data to determine why certain cases were not paid according to statute, and use the findings to recommend suggestions for future training to improve payment accuracy.

K. DLI training

DLI is planning to develop training to address all areas illuminated by the study where there may be noncompliance with or lack of knowledge of statute or rule on the part of insurers or hospitals or their representatives.

It should be noted that DLI, to help improve the accuracy and timeliness of inpatient hospital bill payment, has already prepared a video on the DRG system and use of the PC-Pricer, which is available on the DLI website.

⁴⁷ Minn. Stat. § 176.135, subd. 9.

⁴⁸ Minn. Stat. § 62J.526 and 176.135.

⁴⁹ The sub. 4 conditions are described on p. 3.

DLI's training will include, among other things, information about relevant tools currently in place, including a downloadable version of the current PC-Pricer and an insurance verification tool available on the DLI web site.⁵⁰

The DLI training will address (at minimum) the following areas in the DRG system brought to light either by the statistical findings or by insurer or hospital responses to the open-ended questions: (1) the conditions under which insurers may or may not request itemization or additional documentation, (2) the requirements for prompt action (payment or denial) and when they apply (3), the prohibition of line-item denials except under limited conditions, and (4) the requirement that insurers inform hospitals of exactly how they determine payment.

L. Conclusion

The study has attempted to answer these questions regarding the DRG system:

- Are insurers –
 - paying accurately under the new system;
 - following mandated timelines;
 - asking for documentation only as allowed by statute; and
 - denying payment only as allowed by statute?
- Are hospitals –
 - increasing their use of electronic billing under the DRG system; and
 - following the mandated timeline for providing documentation in the event of a post-payment audit?⁵¹
- Has timeliness of payment improved under the DRG system?
- Have disputes decreased under the DRG system?
- Have inpatient hospital payments decreased under the DRG system?

To speak to these questions, DLI conducted a survey in the summer of 2017 of insurers and hospitals covering periods before and after the DRG system took effect on January 1, 2016. The periods covered were the second halves of 2015 and 2016. For the question concerning cost, DLI used both the survey results and pre-existing data sources.

The principal findings of the study are as follows:

- **Electronic billing.** Hospital use of electronic billing has increased under the DRG system.
- **Insurer requests for itemization or additional documentation.** There was not a statistically significant decrease between 2015 and 2016 in the percentage of cases with requests for itemization or additional documentation, as reported by either insurers or hospitals. When the

⁵⁰ The PC-Pricer is available at www.dli.mn.gov/WC/PcPricer.asp. The insurance verification tool (www.inslookup.doli.state.mn.us) is important in light of hospital questions about how to verify workers' compensation coverage and obtain insurer information for submitting an inpatient claim. Providers can also obtain help in identifying the correct payer by calling the DLI workers' compensation hotline at 1-800-342-5354, option 3.

⁵¹ The sample size of the responses to the DLI survey (see below) was too small to speak to this question.

“sub. 4” conditions were met for the 2016 cases,⁵² the insurer requested itemization or additional documentation in 8 percent of cases, as reported by insurers, or 20 percent of cases as reported by hospitals.

- **Timelines of insurer action.** Both insurers and hospitals reported a modest increase in timeliness of action (payment or denial within 30 days) between 2015 and 2016.
- **Line-item denials.** Both insurers and hospitals reported statistically significant decreases in the percentage of cases with line-item denials between 2015 and 2016.
- **Bill-level payment reductions.** Both insurers and hospitals reported statistically significant decreases in the frequency of bill-level payment reductions between 2015 and 2016.
- **Disputes.** Both insurers and hospitals reported dispute rates of 3 percent for their 2016 cases. For hospitals, this represented a decrease from their reported 10-percent dispute rate for 2015.⁵³
- **Insurer sharing of DRG information.** Hospitals reported that in 35 percent of their 2016 cases, they were unaware of the DRG the insurer used to pay the bill.
- **Accurate payment.** For 2016 cases, where the statutory basis of payment was the DRG, the final payment was within 5 percent of the correct amount (as determined by DLI) 82 percent of the time as reported by insurers and 76 percent of the time as reported by hospitals. Where the final payment was not within 5 percent of the correct amount, there were equal tendencies toward over-payment and under-payment as reported by hospitals, but a somewhat greater tendency toward underpayment as reported by insurers, though this was statistically insignificant.
- **Payment-to-charge ratio.** As reported by insurers, the ratio of the average final payment to the average total charge dropped from 83 percent to 72 percent from 2015 to 2016; as reported by hospitals, this ratio dropped from 84 percent to 70 percent.
- **Cost effects.** Three different estimates of the effect of the DRG system on inpatient hospital payments indicate reductions ranging from 9 to 16 percent. The corresponding reductions in total workers’ compensation system cost range from an estimated 0.5 percent to 0.8 percent, or \$8.1 to \$14.5 million a year.

To summarize these findings:

- (1) The survey results support the conclusion that the DRG system has increased administrative efficiency in workers’ compensation inpatient hospital reimbursement, although there is still room for further improvement.
- (2) The survey results indicate that payments are largely accurate under the DRG system.
- (3) Three different estimates of the effect of the DRG system on inpatient hospital payments indicate reductions ranging from 9 to 16 percent. The corresponding reductions in total workers’ compensation system cost range from an estimated 0.5 percent to 0.8 percent, or \$8.1 to \$14.5 million a year.

DLI will conduct further research into areas where questions remain and will provide training in areas where the survey findings showed there to be noncompliance or lack of knowledge.

DLI anticipates that as insurers and hospitals become more familiar with the new system, they will continue to build on improvements they have made.

⁵² The “sub. 4” conditions are described on p. 3.

⁵³ Survey respondents were instructed to indicate that the payment was disputed if it was the subject of a dispute certification request, medical request, or claim petition filed with DLI.

Appendix A

Minnesota workers' compensation DRG statute

Downloaded from www.revisor.mn.gov/statutes/?id=176.1362 on November 30, 2017.

176.1362 INPATIENT HOSPITAL PAYMENT.

Subdivision 1. Payment based on Medicare MS-DRG system. (a) Except as provided in subdivisions 2 and 3, the maximum reimbursement for inpatient hospital services, articles, and supplies is 200 percent of the amount calculated for each hospital under the federal Inpatient Prospective Payment System developed for Medicare, using the inpatient Medicare PC-Pricer program for the applicable MS-DRG as provided in this subdivision. All adjustments included in the PC-Pricer program are included in the amount calculated, including but not limited to any outlier payments.

(b) Payment under this section is effective for services, articles, and supplies provided to patients discharged from the hospital on or after January 1, 2016. Payment for services, articles, and supplies provided to patients discharged on January 1, 2016, through December 31, 2016, must be based on the Medicare PC-Pricer program in effect on January 1, 2016.

(c) For patients discharged on or after May 31, 2017, payment for inpatient services, articles, and supplies must be calculated according to the PC-Pricer program identified on Medicare's Web site as FY 2016.1, updated on January 19, 2016.

(d) For patients discharged on or after October 1, 2017, payment for inpatient services, articles, and supplies must be calculated according to the PC-Pricer program posted on the Department of Labor and Industry's Web site as follows:

(1) No later than October 1, 2017, and October 1 of each subsequent year, the commissioner must post on the department's Web site the version of the PC-Pricer program that is most recently available on Medicare's Web site as of the preceding July 1. If no PC-Pricer program is available on the Medicare Web site on any July 1, the PC-Pricer program most recently posted on the department's Web site remains in effect.

(2) The commissioner must publish notice of the applicable PC-Pricer program in the State Register no later than October 1 of each year.

(e) The MS-DRG grouper software or program that corresponds to the applicable version of the PC-Pricer program must be used to determine payment under this subdivision.

(f) Hospitals must bill workers' compensation insurers using the same codes, formats, and details that are required for billing for hospital inpatient services by the Medicare program. The bill must be submitted to the insurer within the time period required by section 62Q.75, subdivision 3. For purposes of this section, "insurer" includes both workers' compensation insurers and self-insured employers.

Subd. 2. Payment for catastrophic, high-cost injuries. (a) If the hospital's total usual and customary charges for services, articles, and supplies for a patient's hospitalization exceed a threshold of \$175,000, annually adjusted as provided in paragraph (b), reimbursement must not be based on the MS-DRG

system, but must instead be paid at 75 percent of the hospital's usual and customary charges. The threshold amount in effect on the date of discharge determines the applicability of this paragraph.

(b) On January 1, 2017, the commissioner must adjust the previous year's threshold by the percent change in average total charges per inpatient case, using data available as of October 1 for non-Critical Access Hospitals from the Health Care Cost Information System maintained by the Department of Health pursuant to chapter 144. Beginning October 1, 2017, and each October 1 thereafter, the commissioner must adjust the previous threshold using the data available as of the preceding July 1. The commissioner must publish notice of the updated threshold in the State Register.

Subd. 3. Critical Access Hospitals. Hospitals certified by the Centers for Medicare and Medicaid Services as Critical Access Hospitals shall be reimbursed as provided in section 176.136, subdivision 1b, paragraph (a).

Subd. 4. Submission of information when payment is by MS-DRG. Except when a postpayment audit is allowed under subdivision 6, an insurer must not require an itemization of charges or additional documentation to support a bill from a non-Critical Access Hospital when all of the following requirements are met:

(1) the hospital must submit its charges to the insurer on the 837 institutional standard electronic transaction required by section 62J.536;

(2) an MS-DRG must apply to the hospitalization; and

(3) the hospital's total charges must be less than the threshold amount in subdivision 2, as annually adjusted.

Subd. 5. Prompt payment requirement when MS-DRG payment is made. (a) When the requirements in subdivision 4 have been met, the insurer must take one of the following actions within 30 days of receipt of the hospital's bill:

(1) pay the hospital's bill as provided in subdivision 1, with no reductions based on a review of charges for specific services, articles, or supplies; or

(2) deny payment for the entire hospitalization for one of the following reasons:

(i) the patient's workers' compensation injury claim is denied;

(ii) the diagnosis for which the patient was hospitalized is not related to the insurer's admitted workers' compensation injury; or

(iii) the hospitalization was not reasonably required to cure and relieve the employee from the effects of the injury under section 176.135 or rules adopted under section 176.83, subdivision 5.

(b) When the requirements of subdivision 4 are met, an insurer must not deny payment for one or more charges on the basis that the charge should have been bundled into another charge, or on the basis that a particular service, article, or supply was not reasonably required, except that the insurer may raise these issues during a postpayment audit under subdivision 6.

Subd. 6. Postpayment audits; records; interest. (a) The insurer may conduct a postpayment audit if both of the following requirements are met:

(1) the insurer paid the hospital's bill within 30 days according to the PC-Pricer program amount described in subdivision 1; and

(2) the amount paid according to the PC-Pricer program in subdivision 1 included an outlier payment.

(b) If an audit is permitted under paragraph (a), the insurer must request any additional records needed to conduct the audit within six months after payment. The records requested may include an itemized statement of charges. Within 30 days of the insurer's request, the hospital must provide the additional documentation requested. An insurer must not request additional information from a hospital more than three times per audit.

(c) An insurer must pay the hospital interest at an annual rate of four percent if it is determined that the insurer is liable for additional hospital charges following a postpayment audit. A hospital must pay the insurer interest at an annual rate of four percent if it is determined that the hospital owes the insurer reimbursement following the insurer's audit. Interest is payable by the insurer from the date payment was due under this section or section 176.135. Interest is payable by the hospital from the date the overpayment was made.

Subd. 7. Study. The commissioner of labor and industry shall conduct a study analyzing the impact of the reforms under this section to determine whether the objectives have been met and whether further changes are needed. The commissioner must report the results of the study to the Workers' Compensation Advisory Council and the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over workers' compensation by January 15, 2018.

Subd. 8. Rulemaking. The commissioner may adopt or amend rules using the authority in section 14.389, including subdivision 5, to: (1) implement this section and the Medicare Inpatient Prospective Payment System for workers' compensation; and (2) implement the Medicare Hospital Outpatient Prospective Payment System, or other fee schedule, for payment of outpatient services provided under this chapter by a hospital or ambulatory surgical center, not to take effect before January 1, 2017.

History: 2015 c 43 s 3; 2017 c 94 art 3 s 2,3

Appendix B

Verbatim insurer and hospital responses to open-ended questions

This appendix presents the verbatim insurer and hospital responses to the open-ended survey questions.

Insurer and self-insurer responses to open-ended questions

Question 1: *Please provide any information, other than what is provided in the structured data elements, that you believe relevant to how well Minnesota's DRG system for workers' compensation has been working. If you describe any issues that related primarily to the transition to the DRG system, please identify them as such.*

Response 1: During the transition we struggled with obtaining the correct pricing. The medical provider, our state contact and the bill review vendor were all coming up with different amounts. This is now resolved.

Response 2: From a vendor standpoint, matching an external party's software (PC Pricer), which is often out of date with actual Medicare pricing and *Federal Register* adoptions is a challenge. The vendor never knows what is actually in the pricing software and what bugs, data versions, and other problems might exist without significant effort to try to open up the program and peer into the files to attempt to see why the pricing does not align. Often times it is due to the tool not having the newest adoptions available yet, because the government is not programming the PC Pricer as a tool that is used for their reimbursement. The tool is an estimator and not guaranteed to be reflective of actual Medicare payments and what has been adopted into the *Federal Register*. From a payer standpoint, we could simply opt to flag the bills for review and manually price each bill to ensure 100 percent compliance to the statute, however, this poses challenges because of the date differences to pull the appropriate effective provider rates.

Response 3: We have seen a lack of documentation from the providers when initially submitting bills. This has caused delays in processing due to requests for supporting documentation.

Question 2: *What changes, in your opinion, should be made to Minnesota's DRG system for workers' compensation to improve its operation? Why do you think so?*

Response 1: Making sure the PC pricer tool as the newest adoptions available and having the tool be more than an estimator and be reflective of actual Medicare payments and what has been adopted into the *Federal Register*. These recommended changes are based on the above listed issues.

Response 2: More timely notification of updates to the pricer so that the bill review vendors can update the system in time for effective dates to prevent incorrect payments. I do not believe this is within Minnesota's control though.

Hospital responses to open-ended questions

Question 1: *Please provide any information, other than what is provided in the structured data elements, that you believe relevant to how well Minnesota's DRG system for workers' compensation has been*

working. If you describe any issues that related primarily to the transition to the DRG system, please identify them as such.

Response 1: DRG Transition Note – Even though not required, [hospital name] submits the Itemized Statement & Medical Records with every WC claim. We are unable to stop an electronic process for only certain payers. DRG Transition Issue – Using a specific timeframe CMS Pricer is difficult for automated systems. Most systems that calculate based on CMS, update with CMS' quarterly updates. Thus, it's difficult to justify variances in reimbursement. In turn, making it extremely difficult to appeal claims. Issue – Electronic EOBs & many EORs provide little to no information relative to how a claim has been priced (i.e. no DRG listed; non-Standard AUC Reason Codes, none or minimal Denial Reason explanations). Once again, making it extremely difficult to appeal reimbursement. DRG Transition Issue – When the new 200 percent of Medicare reimbursement was being proposed, there was no mention of reimbursement maxing at charges. Medicare does not "max at charge". Our analysis was based on 200 percent of Medicare. This has caused an additional reimbursement loss for [hospital name].

Response 2: Payers are sliding under silent PPOs to reduce reimbursement. Chasing down who they are paying under can be labor intensive.

Response 3: There are payers that are still not using the DRG reimbursement methodology.

Response 4: We have had some companies that have refused to process our claims without medical records and/or itemized charge statements. One of which we had to report. Our vendor, [vendor name], still requires us to send attachments with the claims, so, to meet their requirement, we attach a copy of the Minnesota Statute stating that we are not required to send any attachments ... The vendor will not make the change, because the payers have made this a requirement that [vendor name] must follow. So this causes extra work and delays. We have to appeal a large number of cases to get the correct payment still, the payers do not pay correctly as you will see in the data. It has gotten much better with claims processing in 2017 than it was last year. We have many issues with the electronic remits. Some payers will only send us denials on the electronic 835 remit, some payers do not/will not do EFT for payment, some payers we get paper checks and remits and 835 electronic files. There is no consistency on the timing of all of the above. Sometimes we get a remit and have wait 2-3 weeks before the money comes and vice versa

***Question 2:** What changes, in your opinion, should be made to Minnesota's DRG system for workers' compensation to improve its operation? Why do you think so?*

Response 1: Clarify the reimbursement calculation to determine 200 percent of Medicare fee schedule and provide a template to the payers so they are able to easily calculate the reimbursement with the appropriate facility factors. It appears that a lot of the work comp payers do not have systems that are capable of calculating the facility rate. Include the most current Medicare fee schedule in the reimbursement calculation to allow for simplicity of interpretation, and ease of claims processing. The Medicare fee schedule is updated quarterly and programmed in the billing system, it is not possible to hold the Medicare fee schedule static for work comp while applying the quarterly updates in the system for other payments. Also, please clarify if payment should be capped at 100 percent of charges, or if the 200 percent of Medicare should still apply regardless of charges. It is not clear if the payers should be paying the lesser of charges. If we are following Medicare methodology, there is no lesser of charges, the full reimbursement rate applies.

Response 2: Need to improve: 1. Electronic remittance process a. EFT and 835 Need to come at the same time 2. Need a better way to verify coverage and obtain the Workers comp Claim number so we

can submit to the claim. This causes a lot work trying to track down the W/C payer and capture the information needed to file the claim. Sometimes taking weeks to gather 3. The clearinghouses force us to send claims to the payer but use different payer IDs based on the employer. This creates a huge burden trying to map the claim to the correct contracted payer with correct clearinghouse ID. For example [vendor name] has XXX payer ID. We want to be able to submit the claim to the claims processor for the employer and have the claims processor map to the employer. So we have to manage a huge number of payer plans to account for this. For health care, they may have multiple products, employers, but we only submit to one payer ID.

Response 3: PPO agreements should be disallowed.

Response 4: There should be a mandate that all EOBs and EORs (whether electronic or paper) include the DRG in which the payer is basing their reimbursement, and Standard AUC Reason Codes with detailed explanations. This would reduce administrative burden and many phone calls for both provider and payer. There should be a mandate that appeals and responses include detailed reasons and explanations. [Hospital name] includes details in their appeals relative to how we calculate reimbursement and why we disagree with a payer's denial. Most often the response we receive (if any) is "paid correct, no further reimbursement warranted" or "no additional information has been provided to warrant a change in reimbursement". Once again, very time-consuming with no results; often forcing the filing of Medical Requests which adds to the expense of work comp.