

Hospital Inpatient Reimbursement Methodology

BWC Rate Year 2021

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# **Introduction**

Prompt, effective medical care makes a big difference for those injured on the job. It is often the key to a quicker recovery and timely return-to-work and quality of life for injured workers. Thus, maintaining a network of hospitals to provide appropriate care is an important element to ensure the best possible recoveries from workplace injuries. It also ensures access to quality, cost-effective service. Access for injured workers, and employers, means the availability of quality, cost-effective treatment provided on the basis of medical necessity. It facilitates faster recovery and a prompt, safe return to work.

Part of ensuring access to quality medical care requires the Ohio Bureau of Workers’ Compensation (BWC) to set fair reimbursement rates for inpatient services provided to injured workers. Inpatient reimbursement rates for BWC are established via Ohio Administrative Code (OAC) rulemaking process. Specifically, BWC’s hospital inpatient reimbursement methodology is detailed in. [OAC 4123-6-37.1](http://codes.ohio.gov/oac/4123-6-37.1). The rule describes the three methods BWC utilizes to reimburse hospitals for inpatient services provided to injured workers covered under the state fund. The rule also details reimbursement options for self-insuring providers.

This document was developed to help BWC customers to understand the background of BWC’s hospital inpatient reimbursement methodologies and to understand how BWC utilizes Medicare’s data and reimbursement methodologies as a basis for the majority of our hospital inpatient bills. Additionally, this document detail specific changes adopted by BWC for the hospital inpatient reimbursement methodology, as published yearly in rule. BWC’s inpatient reimbursement rule rate year is effective for inpatient discharge dates beginning February 1 each year and ending January 31 of the following year.

# **Overview of Inpatient Reimbursement Methodologies**

## A. Definition of Inpatient Services

An injured worker is considered to be an inpatient when the physician issues a formal order for admission to the hospital as detailed in [OAC 4123-6-01](http://codes.ohio.gov/oac/4123-6-01v1). ***It should be noted that BWC’s definition of inpatient services differs from Medicare.*** This level of care is typically required for the most severely injured and ill workers, as they require more intensive procedures and care levels. Injured workers may be admitted to a hospital on an emergency basis, such as for injuries requiring immediate surgical intervention or to treat severe infections. Additionally, inpatient care may be required for some non-emergent care, such as invasive surgical procedures like spinal fusions and certain joint replacements.

## B. BWC Hospital Types

[OAC 4123-6-01](http://codes.ohio.gov/oac/4123-6-37.1) defines hospitals as an institution that provides facilities for surgical and medical diagnosis and treatment of bed patients under the supervision of staff physicians and furnishes twenty-four hour-a-day care by registered nurses. BWC’s enrollment and certification requirements for hospitals are defined in [OAC 4123-6-02.2](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS). BWC enrolls eligible hospitals under four different hospital provider types:

* Acute care hospital – provider type 34
* Drug detoxification per diem hospital – provider type 35
* Psychiatric hospital – provider type 36
* Rehabilitation hospital – provider type 37

A single hospital may be enrolled with BWC under more than one provider type if they have separate and distinct units that qualify for separate enrollment. For example, an acute care hospital (provider type 34) may also have a separate and distinct psychiatric unit that would be separately enrolled a psychiatric hospital (provider type 36).

It is important to note that differences in provider type may affect reimbursement. The next section of this document details the different reimbursement methodologies and how the provider type impacts which methodology is used.

## C. BWC Inpatient Methodologies

BWC utilizes three different methodologies for reimbursing hospitals for inpatient services. The table below lists each reimbursement methodology, its corresponding BWC hospital type and IPPS eligible or IPPS exempt status. Each of these methodologies is further detailed within this document.

|  |  |  |
| --- | --- | --- |
| **Methodology** | **BWC Methodology Description** | **BWC Enrollment Type and**  **Medicare IPPS Status** |
| 1 | Medicare IPPS-based methodology | Type 34 – Acute care hospital and Medicare IPPS eligible |
| 2 | IPPS-exempt methodology | Type 34 – Acute care hospital and Medicare IPPS exempt hospital or unit  Type 36 – Psychiatric hospital  Type 37 – Rehabilitation hospital |
| 3 | All-inclusive per diem payment | Type 35 – Detox hospital\* |

\*Note - Provider type 35 is applicable to inpatient detox services only, as provided in accordance with Rule 4123-6-21.7, *Utilization of opioids in the subacute or chronic phases of pain treatment for a work-related injury or occupational disease*. All other services shall be billed under other hospital provider types.

## D. Determining the Appropriate Inpatient Reimbursement Methodology

A key step in processing inpatient bills is to determine which of the aforementioned three methodologies should be used. The methodology utilized is determined by the BWC provider type under which the hospital is enrolled and/or by hospital’s IPPS or IPPS-exempt status with Medicare.

Medicare designates hospitals as IPPS eligible or IPPS exempt. IPPS eligible hospitals are hospitals that Medicare reimburses under their IPPS methodology. BWC also reimburses these hospitals under the IPPS-based methodology. IPPS exempt hospitals are facilities that meet criteria to be designated by Medicare as IPPS exempt. These are certain:

* Cancer hospitals
* Children’s hospitals
* Long term acute care hospitals
* Psychiatric hospitals
* Rehabilitation hospitals
* Hospitals outside the 50 states, the District of Columbus or Puerto Rico
* And others, as noted in the Code of Federal Regulations.

For additional details on hospitals that are excluded from Medicare’s IPPS methodology, please see [42 CFR §412.23 - Excluded hospitals: Classifications](https://www.govinfo.gov/content/pkg/CFR-2015-title42-vol2/pdf/CFR-2015-title42-vol2-sec412-23.pdf).

IPPS exempt hospitals are reimbursed by Medicare differently than IPPS. BWC does not follow the Medicare reimbursement methodologies for IPPS exempt facilities. Instead, BWC reimburses those hospitals under our own IPPS exempt methodology, which is further detailed in this document (See Methodology 2).

Step 1 – Determine the BWC provider type on the bill

1. If the hospital billed with BWC provider type 34, then proceed to Step 2 below.
2. If the hospital billed with BWC provider type 35, then payment is calculated under methodology 3 (detox hospital per diem methodology).
3. If the hospital billed with BWC provider type is 36 (psychiatric hospital) or 37 (rehabilitation hospital), then payment is calculated under methodology 2 (IPPS-exempt methodology).

Step 2 – Determine if the hospital is IPPS eligible or IPPS exempt

1. If the hospital is IPPS-eligible under Medicare, then payment is calculated under methodology 1 (IPPS-based methodology).
2. If the hospital is IPPS-exempt under Medicare, then payment is calculated under methodology 2 (IPPS-exempt methodology).

# **Methodology 1: BWC Reimbursement for Medicare IPPS-Eligible Hospitals**

|  |  |  |
| --- | --- | --- |
| **Methodology** | **BWC Methodology Description** | **BWC Enrollment Type and**  **Medicare IPPS Status** |
| 1 | Medicare IPPS-based methodology | Type 34 – Acute care hospital and Medicare IPPS eligible |

## A. Background

For the majority of inpatient services provided to Ohio’s injured workers, hospitals are paid under a modified version of Medicare’s inpatient prospective payment system (IPPS) methodology. A key benefit of the IPPS methodology is that all facilities experience consistent and equitable reimbursement for services rendered during the effective period. Further, under the prospective payment system, providers are encouraged to practice cost containment. Rates being established in advance provide facilities the data they can use to determine the best mix of their resources to achieve established budget goals without foregoing the provision of quality services.

The IPPS methodology is utilized by Medicare and certain private health insurance companies to pay for hospitalizations using a Medicare severity diagnosis-related group (MS-DRG or abbreviated, “DRG”) payment system. This system utilizes both patient or case-specific data and also hospital-specific data to calculate reimbursement. Find the Medicare IPPS fact sheet with payment formula descriptions [here.](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AcutePaymtSysfctsht.pdf) Some of the key concepts of IPPS are summarized below.

1. **Medicare Severity Diagnosis Related Groups (MS-DRGs)**

A patient’s diagnoses, procedures performed during the admission and other case-specific data elements to classify the episode of care into a MS-DRG group. These group classifications, and associated relative weights, are one of the factors used to calculate the Medicare reimbursement rate. There are over 700 different MS-DRGs. Examples of MS-DRGs are: 472 – cervical spinal fusion with complication or co-morbid condition; and 467 – revision of hip or knee replacement with complication or co-morbid condition.

1. **Hospital-Specific Impacts**

Under this methodology, numerous hospital-specific factors also impact the Medicare reimbursement rate. These factors include but are not limited to the physical location of the facility; the hospital’s compliance with the quality data reporting program; hospital quality performance measures and cost-to-charge ratios (CCR).

Hospital quality performance programs include but are not limited to the Value Based Purchasing Program, Hospital Acquired Conditions Program, Hospital Readmissions Reduction Program, etc. The facility’s quality performance in these programs may result in penalties and/or rewards based on hospital performance. Medicare publicly reports the hospital-specific data used to calculate reimbursement with the proposed and final rules and in the inpatient provider specific files.

1. **Fixed Payment for Episode of Care**

Another important aspect of this methodology is that the hospital is paid a fixed amount for the episode of inpatient care, regardless of how much money it actually spends treating the patient. If a hospital can effectively treat a patient for less money than Medicare pays it for the episode of inpatient care, then the hospital makes money on that hospitalization. If the hospital spends more money caring for the patient than Medicare gives it for the episode of care, then the hospital loses money on that hospitalization. This is the reason why occasionally under this methodology, hospital inpatient bills will be paid at a rate that is higher than the charges.

1. **Payment Deviations for Patient Transfers**

Medicare’s IPPS includes payment deviations for transfer cases and post-acute transfer cases. Transfer cases occur when a patient is transferred from an IPPS hospital to another IPPS hospital. Post-acute transfers occur when a patient is transferred from an IPPS hospital to a non-IPPS hospital, skilled nursing facility or under the care of home health services for certain MS-DRGs.

1. **High Cost Outlier Cases**

This Medicare methodology also contains a provision to help protect hospitals from large losses due to extraordinarily high-cost cases. This is referred to as an outlier add-on payment. To receive an outlier payment, the cost of a case must exceed the sum of the hospital’s applicable MS-DRG payment and a fixed loss threshold that is set at yearly by CMS. This fixed loss threshold acts similar to a deductible in a typical insurance policy. After a hospital reports exceeding this threshold for an individual case, Medicare pays the hospital 80 percent of its costs above that threshold as an outlier payment (90 percent for burn MS-DRGs 927, 928, 929, 933, 934 and 935).

1. **Outpatient Services Treated as Inpatient Services**

Another provision of the Medicare methodology details when outpatient services should be billed as inpatient services. This is also known as the “3-day (or 1-day) payment window.” Under the payment window policy, a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a beneficiary's inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic services and admission-related outpatient non-diagnostic services that are furnished to the beneficiary during the 3-day (or 1-day) payment window. The law makes the policy pertaining to admission-related outpatient non-diagnostic services more consistent with common hospital billing practices and makes no changes to the existing policy regarding billing of outpatient diagnostic services.  Hospitals and managed care organizations should follow this Medicare IPPS policy, which is detailed in the [Medicare Claims Processing Manual, Chapter 3](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf).

1. **Disproportionate Share Payments**

Adjustments are made in the Federal portion of the operating cost MS-DRG payment to increase payments to hospitals serving a disproportionate share of low-income patients.

1. **Indirect Medical Education**

An adjustment is also provided to the Federal rate for indirect costs of medical education of interns and residents. Medicare calculates this on a per discharge basis.

## B. Calculating Reimbursement

BWC utilizes the Medicare IPPS reimbursement rate as a basis for reimbursement for IPPS-eligible hospital inpatient services. BWC utilizes the Medicare editing, grouping and pricing provisions that are effective for Medicare on October 1 of each year, with exceptions noted in this document. Click [here](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS) to see the Medicare final inpatient rules by rate year.

The basic concepts of calculating DRG and outlier payments can be found in this section of this document. Because numerous data elements and complex formulas are used to determine the MS-DRG assignment and the calculation of the Medicare reimbursement rate, BWC purchases software to replicate the Medicare methodology. This software performs the bill editing, grouping and pricing functions detailed in the steps below. BWC currently purchases the software from nThrive, Inc.

1. **Perform Clinical Editing – (Medicare Code Editor)**

The software contains the Medicare Code Edits (MCE) which supports MS-DRG assignment and identify potential billing errors. In determining the appropriate MS-DRG for a Medicare patient, the age, sex, discharge status, principal diagnosis, secondary diagnosis, and procedures performed must be reported accurately to the grouper program. The logic of the grouper software assumes that this information is accurate and the grouper does not make any attempt to edit the data for accuracy. Only where extreme inconsistencies occur in the patient information will a patient not be assigned to a MS-DRG. Therefore, the MCE is used to improve the quality of information given to the grouper. The MCE addresses:

1. Code edits - Examines a record for the correct use of diagnosis and procedure codes. They include basic consistency checks on the interrelationship among a patient's age, sex, and diagnoses and procedures.
2. Coverage edits - Examines the type of patient and procedures performed to determine if the services where covered.
3. Clinical edits - Examines the clinical consistency of the diagnostic and procedural information on the medical claim to determine if they are clinically reasonable and, therefore, should be paid.
4. **Determine the MS-DRG assignment (Grouper software)**

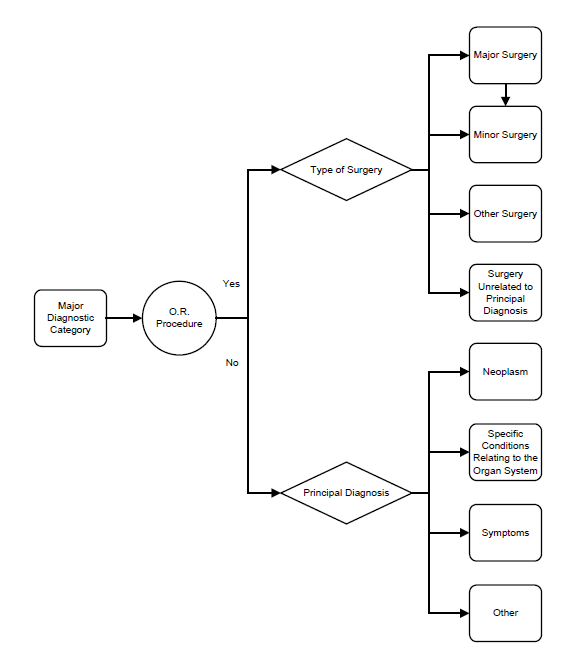
The software also contains the grouper logic to “group” or assign the appropriate MS-DRG number for each bill, using the data elements reported by the hospital. Various companies also offer electronic or paper manuals for purchase which allows the DRG assignment to be manually calculated.

One MS-DRG is assigned to each inpatient stay. The MS-DRGs are assigned using the principal diagnosis and additional diagnoses, the principal procedure and additional procedures, sex and discharge status. Secondary diagnoses that describe complications and co-morbid conditions (CC) or major complications and co-morbid conditions (MCC) can affect DRG assignment.

With some exceptions, all principal diagnoses are divided into one of 25 Major Diagnostic Categories (MDCs) that generally correspond to a single organ system. Examples of MDCs include:

* MDC 1 Diseases and Disorders of the Nervous System
* MDC 2 Diseases and Disorders of the Eye
* MDC 3 Diseases and Disorders of the Ear, Nose, Mouth and Throat

The section below describes the general steps the software uses to determine the correct MS-DRG.



Step 1 – Determine if the bill qualifies for a pre- major diagnostic category (MDC) MS-DRG.

Because some patient groups are extremely resource intensive, they are put into a separate group, before MDC assignment, based on the operating room (OR) procedure rather than principal diagnosis. This group is called pre-MDC MS-DRGs. The pre-MDC MS-DRGs include services such as organ transplants, bone marrow transplants and tracheostomy cases. If a procedure places a case into a pre-MDC, the MS-DRG is assigned outside of the MDC. For example, MS-DRGs 001 and 002, Heart Transplant or Implant of Heart Assist System, are assigned based on the procedure performed pre-MDC and the presence or absence of an MCC. The principal diagnosis is not taken into consideration. If the bill does not qualify for pre-MDC, go to step 2.

Step 2 – Determine the MDC.

Use the principal diagnosis to determine the MDC.

Step 3 – Determine if the bill contains an operating room (OR) procedure.

If a case is not assigned to a pre-MDC, patients are then classified by whether or not they had an OR procedure within each MDC. In some instances there are also non-OR procedures that may affect the MS-DRG assignment and may also be taken into consideration. There is a surgical hierarchy within each MDC and, in most instances, patients with multiple procedures are assigned to the most resource-intensive MS-DRG. An example of an MS-DRG assigned on the basis of an OR procedure is 470, Major Joint Replacement or Reattachment of Lower Extremity without MCC. If there was no OR procedure reported, go to step 4.

Step 4 – Use the principal diagnosis to determine DRG.

If no OR procedure is performed, the case is classified into medical categories by the principal diagnosis. Medical categories include neoplasms, specific conditions related to the anatomical site, symptoms and other diagnoses. For example, MS-DRG 064, Intracranial hemorrhage or cerebral infarction with MCC, is assigned based on the principal diagnosis because no OR procedure is performed

Each DRG is assigned a relative weight based on the average amount of resources it takes to care for a patient assigned to that DRG. The average relative weight is 1.0. DRGs with a relative weight of less than 1.0 are less resource-intensive to treat and are generally less costly to treat. DRG’s with a relative weight of more than 1.0 generally require more resources to treat and are more expensive to treat. The higher the relative weight, the more resources are required to treat a patient with that DRG. This is why very serious medical situations, such as organ transplants, have the highest DRG weight.

The relative weight for a particular DRG can be found by downloading an Excel document provided by the Centers for Medicare and Medicaid Services:

1. Click [here](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS) to go to the Medicare final inpatient rules by rate year and select the appropriate year.
2. Scroll down to "Tables."
3. Download Table 5 for the list of DRGs and their relative weights.
4. **Determine the hospital-specific base rate (Pricer software)**

Each hospital has a base rate which is used to calculate reimbursement. The base payment rate is broken down into a labor portion and a non-labor portion. The labor portion is adjusted based on the wage index assigned to the hospital’s physical location.

1. **Calculate reimbursement (Pricer software)**

The software contains pricing logic to price bills according to the Medicare reimbursement rate for the correct rate year, using hospital-specific and case-specific data. Unless otherwise noted as BWC customizations in this document, BWC utilizes the pricing data effective for Medicare on October 1 of each year.

At a high level, the reimbursement is calculated by:

1. First multiplying the wage-adjusted standardized amount by the DRG weight.
2. Next, if applicable add the following adjustments:
   * Indirect medical education adjustments for teaching hospitals
   * Rural add-on
   * Disproportionate share uninsured patient’s adjustment; and
   * Cost outliers
3. And finally, adjusting that amount by hospital specific quality measures.

## C. BWC Customizations to the Medicare IPPS Methodology for Rate Year 2021

BWC applies several customizations to the Medicare IPPS methodology as noted below.

1. **Modification to Effective Dates**

Medicare’s IPPS rate year is effective for discharges from October 1 through September 30 of each year. BWC’s inpatient rate year is effective for discharges from February 1 through January 31 of each year. Since BWC does not adopt Medicare’s October 1 provisions until February 1 of the following year, bills with discharge dates between October 1 and January 31 of the following year require special handling:

1. These bills are processed using the software and policies in effect for the BWC rate year, which is different from the Medicare rate year. As such, these bills with discharge dates in this five month period continue to be edited, grouped and priced using the BWC rate year software.
2. In addition, bills for these dates of service which contain a new diagnosis code, procedure code or other data element (i.e. effective for Medicare on October 1 and after) cannot be processed using BWC’s current rate year software. Instead, managed care organizations (MCOs) are required to work with the hospital to cross-walk any new codes back to the previous year’s codes to allow the bill to be processed in our software.
3. **BWC Does Not Adopt Medicare’s Quarterly Updates**

The software effective for Medicare on October 1 of each year is utilized throughout BWC’s rate year. BWC’s rule allows the agency to adopt corrections detailed in Medicare’s correction notice rule. However, BWC does not recognize any other software or data updates made by Medicare throughout the rate year. For example, under IPPS, Medicare contractors are required to update a hospital’s provider specific payment data (in the Provider Specific File) every three months. BWC does not recognize these file updates. Instead, all provisions adopted by BWC on February 1 remain effective throughout the BWC rate year.

1. **Application to Non-Medicare Participating Hospitals**

[OAC 4123-6-37.1](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AcutePaymtSysfctsht.pdf) includes a provision for payment to hospitals that do not participate in Medicare (e.g. private “boutique” hospitals). The rule indicates that these hospitals are paid at the BWC IPPS-based methodology and it specifies the specific pricing factors used to calculate reimbursement. Currently there is only one hospital in Ohio that qualifies for this provision, Riverview Health Institute in Dayton, Ohio. Because these hospitals do not submit hospital-specific data to Medicare, the following data elements are utilized in the reimbursement calculations:

1. Click [here](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf) to go to the Medicare final inpatient rules by rate year and select the appropriate year.
2. Utilize the appropriate Final National Standardized Amounts based on the following factors which are in the Tables1A – 1E.
3. Identify the hospital’s wage index as either less than or equal to 1.0; or greater than 1.0:
   * 1. Identify the hospital’s physical location state;
     2. Identify the corresponding statewide average wage index for the state in Table 3.
     3. If the statewide average wage index is greater than 1, utilize table 1A. If the statewide average wage index is less than or equal to 1, utilize table 1B.
     4. Utilize the Final National Standardized Amounts for hospitals that did NOT submit quality data AND is NOT a meaningful EHR user.
4. Utilize the appropriate urban or rural operating statewide average operating CCR based on the hospital’s physical location and urban/rural designation as found in Table 8a.
   * 1. Using the county and state of the hospital’s physical location, identify the Core Based Statistical Area (CBSA), using the final rule Data File named *County to CBSA Crosswalk File and Urban CBSAs and Constituent Counties for Acute Care Hospitals File*.
     2. If a CBSA is listed for the county and state, then the hospital shall be designated as “urban.” If there is no CBSA listed for the county, then the hospital shall be designated as “rural.”
     3. Utilize the corresponding statewide average operating CCR for the state and urban/rural designation for payment calculation.
5. Utilize the appropriate urban or rural operating statewide capital CCR based on the hospital’s physical location and urban/rural designation as found in Table 8b.
6. DGME is not applied to non-Medicare participating hospitals.

Example: Riverview Health Institute – RY 2021 Updates

|  |  |
| --- | --- |
| **Non-Medicare Participating Provider (Wage Index </= 1)** | |
| Labor - Related Standardized Amount | $3609.39 |
| Nonlabor - Related Standardized Amount | $2212.20 |
| Hospital Name | Riverview Health Institute |
| Hospital CBSA (Table 3) | 19430 |
| Wage Index (Table 3) | 0.9209 |
| Area Name (Table 3 CN) | Dayton, OH |
| Ohio Urban Operating Statewide Average CCR (Table 8a) | 0.231 |
| Ohio Capital Statewide Average CCR (Table 8b) | 0.022 |

1. **Modification to Cost-to-Charge Ratios (CCRs)**

For discharges beginning February 1, BWC utilizes the Medicare’s July 2020 CCRs in the pricing calculations which are derived from the July 2020 inpatient provider specific files (PSFs).

1. Inpatient PSF – INPpsf2007.xls
2. Inpatient Rehab PSF – IRFpsf2007.xls
3. Long Term Care PSF – LTCpsf2007.xls
4. Inpatient Psychiatric Facility PSF – IPFpsf2007.xls

For hospitals doing business with Ohio BWC in the past 18 months, the July 2020 inpatient hospital cost-to-charge ratios can be found on BWC’s Web site with OAC 4123-6-37.1 ([BWC's inpatient fee schedule](https://info.bwc.ohio.gov/wps/portal/bwc/site/provider/billing-and-reimbursement/find-a-fee-schedule/!ut/p/z1/tVJNb9swDP0r7cFHRaotJXZv3rC1KZIUQz7tyyDbsq1AllxZcdb--jFrCwxbM28oppNIkI_vPRKneIdTzXtZcSeN5griJB1_vY9mN7dTShbhahWReDONFovNOGBrH29_KfDDCYk_s-lydvPlnq0oTv-mn5x5MRnq3-AUp20uC5z4PM-jkPiI0YwhyjKCoqKgKKB0wq7GrCh5earOtWtdjZPsmF_kRjuh3YXQlZJd7RFIeqS1ppeFsBBKpaSuENcFskI22cF2ooEOj5QSchyVQqAur0VxUALfDdEFP307_zivgDR3NZK6NHh3dgrevTUFQOT-4SGNQcuJ_zeo-w9itiezBpb7o-AP2wNDKmWy50uKdRaEoNyKUlhhRwcL6dq5trv2iEdOXoyA8sjU0owq03vk2HYgwFjH1YuaTjrxs6bX31v4tenAmd9gcQI3Nzm7pSuKt70UR7zWxjbAfPmPJ3ZLhiaM3zlhAD54J3zbrNdNGDC1fwzInql-Vs4_BTS5658-zOPLy-96zKMN/dz/d5/L2dBISEvZ0FBIS9nQSEh/)). See the document titled “IPPS – Hospital Cost-to-Charge Ratios.” For hospitals not listed in that document, the tab labeled “How to Determine CCRs” in that document provides instructions on identifying hospital CCRs. The section below also describes this process.

1. **Hospitals without CCRs**

For hospitals that did not maintain Medicare CCRs and new hospitals, the Medicare 2021 urban or rural statewide average operating CCR is used to calculate reimbursement.

To assist self-insured employers in bill pricing, BWC provides a list of the inpatient CCRs for hospitals that are enrolled with BWC and have billed BWC within the last 18 months. If the hospital is not enrolled and actively billing, then the CCR will not be included in the document. In those cases, the self-insured employer can access the Medicare public files to identify the hospital’s inpatient CCR. The steps below indicate how to identify a hospital-specific CCR in the Medicare Inpatient Provider Specific Files.

Identifying the hospital-specific CCR in the Medicare Inpatient Provider Specific Files (IPSFs):

a. The hospital-specific Medicare CCRs for this methodology come from the July 2020 inpatient provider specific files (IPSF) in use by Medicare. There are four separate files used: inpatient, inpatient rehab, long term care and inpatient psychiatric facility. They can be found on the Medicare Web site: Home > Medicare > Prospective Payment Systems - General Information > Provider Specific Data for Public Use in SAS or text Format, or click on the following link:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/psf_text.html>

b. Select the appropriate provider specific file based on the hospital type. These IPSFs are to be used for the entire rate year for discharge dates beginning February 1, 2021. Subsequent Medicare IPSF updates should not be used.

c. Find the hospital using their numeric or alpha-numeric Medicare provider number, also known as the OSCAR number and/or the National Provider ID (NPI).

d. The CCR to be used in pricing the bill can be found under the column labeled “CCR.”

e. Next, multiply the CCR by 1.14 (i.e. 114% of cost). Please note, the final CCR used in this calculation shall be capped at .70.

Below is an example of a calculating the final CCR using an CCR of .359:

.359 x 1.14 = .409

f. The final CCR (.409) is then multiplied by the allowed billed charges to arrive at the appropriate reimbursement rate. Below is an example of the final calculation where the allowed billed charges are $5000:

$5000 x .409 = $2045

Identifying the CCR for a hospital not listed in the IPSFs:

Some hospitals will not be listed in the IPSFs (e.g. new hospitals that have not yet submitted a cost report, etc.). In that case, rule 4123-6-37.1 allows for reimbursement utilizing the appropriate urban or rural statewide average inpatient CCR instead of the hospital-specific CCR in the aforementioned calculation.

a. Identify the address for the physical location of the facility. Specifically, locate the correct county and state. A good resource for identifying the county is www.zipinfo.com.

b. Access the Medicare County to CBSA Crosswalk File and Urban CBSAs and Constituent Counties for Acute Care Hospitals File. Click [here](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS) to go to the Medicare final inpatient rules by rate year and select the appropriate year to find this file.

c. On the Excel tab labeled “Crosswalk,” find the county and state to determine if the facility county is located in a designated core based statistical area (CBSA). If the county is assigned to a CBSA record the CBSA number (it is 5 digits). This facility is an urban facility. If the field is blank, then it is a rural facility.

d. Access file 8A which is located in the IPPS Final Rule Homepage for the appropriate rate year. Click [here](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/psf_text.html) to go to the Medicare final inpatient rules by rate year and select the appropriate year to find this file. Choose the final rule and correction notice tables, and then choose the file Tables 8A, 8B and 8C. Open the excel file and use tab “8A OPER SWA”.

For BWC rate year 2021, for Ohio hospitals, the statewide average CCRs are:

Urban: .231

Rural .344

e. Locate the state and urban or rural value based on the urban/rural determination made during the wage index CBSA assignment process (step c above).

f. Multiply this Medicare CCR by 1.14 (i.e. 114% of cost). Please note, the final CCR used in this calculation should be capped at .70.

g. The final CCR from step f above is then multiplied by the allowed billed charges to calculate the appropriate reimbursement rate.

1. **Application of Payment Adjustment Factor (PAF)**

As previously described in the DRG formula, BWC applies a payment adjustment factor (PAF) to inflate the Medicare DRG rate. The PAF is applied to the Medicare base payment rate. The PAF is not applied to any outlier add-on payment nor to the new technology add-on payment. For rate year 2021, the PAF is 1.127.

* 1. Application of PAF to Non-Outlier Bills

***MS-DRG reimbursement rate x 1.127 + new technology add-on payment (if applicable) = bureau reimbursement for hospital inpatient service***

* 1. Application of PAF to Outlier Bills

***BWC MS-DRG outlier reimbursement rate = (MS-DRG reimbursement rate x 1.127) + Medicare operating outlier amount + Medicare capital operating outlier amount + new technology add-on payment (if applicable)***

1. **Application of Direct Graduate Medical Education Per Diem Payment**

In addition to the indirect graduate medical education payment calculated by the pricer software, BWC reimburses eligible teaching hospitals a direct graduate medical education (DGME) add-on per diem payment for non-outlier cases reimbursed under this methodology. Bills that hit the Medicare high cost outlier threshold are not paid the DGME per diem. This payment covers costs for eligible teaching hospitals training of resident physicians. [OAC 4123-6-37.1](http://codes.ohio.gov/oac/4123-6-01v1) details the formula used to determine the per diem payment. [BWC's inpatient fee schedule](https://info.bwc.ohio.gov/wps/portal/bwc/site/provider/billing-and-reimbursement/find-a-fee-schedule/!ut/p/z1/tVJNb9swDP0r7cFHRaotJXZv3rC1KZIUQz7tyyDbsq1AllxZcdb--jFrCwxbM28oppNIkI_vPRKneIdTzXtZcSeN5griJB1_vY9mN7dTShbhahWReDONFovNOGBrH29_KfDDCYk_s-lydvPlnq0oTv-mn5x5MRnq3-AUp20uC5z4PM-jkPiI0YwhyjKCoqKgKKB0wq7GrCh5earOtWtdjZPsmF_kRjuh3YXQlZJd7RFIeqS1ppeFsBBKpaSuENcFskI22cF2ooEOj5QSchyVQqAur0VxUALfDdEFP307_zivgDR3NZK6NHh3dgrevTUFQOT-4SGNQcuJ_zeo-w9itiezBpb7o-AP2wNDKmWy50uKdRaEoNyKUlhhRwcL6dq5trv2iEdOXoyA8sjU0owq03vk2HYgwFjH1YuaTjrxs6bX31v4tenAmd9gcQI3Nzm7pSuKt70UR7zWxjbAfPmPJ3ZLhiaM3zlhAD54J3zbrNdNGDC1fwzInql-Vs4_BTS5658-zOPLy-96zKMN/dz/d5/L2dBISEvZ0FBIS9nQSEh/) includes a document with the DGME per diem reimbursement rate for all eligible hospitals.

1. The DGME per diem amounts are calculated using the Healthcare Cost Report Information System (HCRIS) files (CMS-2552-10). As noted in the rule, DGME is defined as:

***(Total approved amount for resident cost + total approved amount for allied health cost)/total inpatient days] = direct graduate medical education per diem***

1. BWC pulls the latest three years’ HCRIS files to obtain the above data elements and calculates the per diem rate for each hospital for each year. Three years of cost data are initially pulled since some hospitals may not have finalized cost reports for the latest year.
2. The latest year’s per diem rate for each hospital is used as the final DGME rate.
3. A payment adjustment factor of 1.127 is applied to the DGME per diem amount.
4. Formula

***DGME payment = DGME per diem rate x number of inpatient days x 1.127***

Example: An injured worker was admitted to Hospital A for 3 days. Hospital A’s DGME rate is $100 per day. The payment would be calculated as follows:

$100 x 3 days x 1.127 = $338.10

1. **BWC Does Not Follow Medicare’s 2- Midnight Rule**

As previously noted in this document, BWC’s definition of an inpatient bill is detailed in [OAC 4123-6-01](file://wghome1/a71374/Lisa's%20temp%20folder/IPPS%20-%20Determining%20Hospital%20Inpatient%20Cost-to-Charge%20Ratios). This BWC-specific definition does not follow the Medicare “2- midnight rule,” which maintains requirements for when an encounter may be billed as an inpatient service. See the [Medicare Claims Processing Manual Chapter 4](http://codes.ohio.gov/oac/4123-6-01v1) for additional details about the Medicare 2-midnight provision.

# **Methodology 2: BWC Reimbursement for Medicare IPPS-Exempt Hospitals**

|  |  |  |
| --- | --- | --- |
| **Methodology** | **BWC Methodology Description** | **BWC Enrollment Type and**  **Medicare IPPS Status** |
| 2 | IPPS-exempt methodology | Type 34 – Acute care hospital and Medicare IPPS exempt hospital or unit  Type 36 – Psychiatric hospital  Type 37 – Rehabilitation hospital |

## A. Background

This methodology is utilized to calculate reimbursement when a hospital is enrolled with BWC as a psychiatric hospital (type 36), a rehabilitation hospital (type 37) or an acute care hospital (type 34) that Medicare is IPPS exempt. While Medicare has their own methodologies for reimbursing these facilities, BWC does not follow Medicare’s policies for reimbursing these facilities.

## B. Calculating Reimbursement

BWC reimburses these hospitals at a percentage above their cost on a bill by bill basis.

Step 1 - For rate year 2021, the hospital cost for each bill is calculated by multiplying the allowed billed charges on the bill by the hospital’s July 2020 cost-to-charge ratio.

Step 2 - That cost figure is further multiplied by a payment adjustment factor or 1.14.

Step 3 - That resulting figure is capped at 70% of allowed charges if applicable.

1. **Formula**

***BWC IPPS-exempt reimbursement rate = Allowed billed charges x hospital-specific cost-to-charge ratio x 1.14, not to exceed 70% of the hospital’s billed charges.***

Example payment calculation:

Allowed billed charges = $5000

Hospital’s July 2020 CCR = .359

BWC PAF = 1.14

$5000 x .359 x 1.14 = $2046.30

Example payment calculation requiring 70% cap:

Allowed billed charges = $5000 (cap is 70% of charges or $3500)

Hospital’s July 2020 CCR = .650

BWC PAF = 1.14

$5000 x .650 x 1.14 = $3705.00

Payment is capped at $3500

1. **Cost-to-Charge Ratios (CCRs)**

Utilize the July 2020 hospital cost-to-charge ratios to calculate reimbursement:

1. Inpatient PSF – INPpsf2007.xls
2. Inpatient Rehab PSF – IRFpsf2007.xls
3. Long Term Care PSF – LTCpsf2007.xls
4. Inpatient Psychiatric Facility PSF – IPFpsf2007.xls

For hospitals doing business with Ohio BWC in the past 18 months, hospital cost-to-charge ratios can be found on BWC’s Web site with OAC 4123-6-37.1 ([BWC's inpatient fee schedule](https://info.bwc.ohio.gov/wps/portal/bwc/site/provider/billing-and-reimbursement/find-a-fee-schedule/!ut/p/z1/tVJNb9swDP0r7cFHRaotJXZv3rC1KZIUQz7tyyDbsq1AllxZcdb--jFrCwxbM28oppNIkI_vPRKneIdTzXtZcSeN5griJB1_vY9mN7dTShbhahWReDONFovNOGBrH29_KfDDCYk_s-lydvPlnq0oTv-mn5x5MRnq3-AUp20uC5z4PM-jkPiI0YwhyjKCoqKgKKB0wq7GrCh5earOtWtdjZPsmF_kRjuh3YXQlZJd7RFIeqS1ppeFsBBKpaSuENcFskI22cF2ooEOj5QSchyVQqAur0VxUALfDdEFP307_zivgDR3NZK6NHh3dgrevTUFQOT-4SGNQcuJ_zeo-w9itiezBpb7o-AP2wNDKmWy50uKdRaEoNyKUlhhRwcL6dq5trv2iEdOXoyA8sjU0owq03vk2HYgwFjH1YuaTjrxs6bX31v4tenAmd9gcQI3Nzm7pSuKt70UR7zWxjbAfPmPJ3ZLhiaM3zlhAD54J3zbrNdNGDC1fwzInql-Vs4_BTS5658-zOPLy-96zKMN/dz/d5/L2dBISEvZ0FBIS9nQSEh/)). Identify the appropriate rate year and the document labeled “IPPS – Hospital Cost-to-Charge Ratios.” For hospitals not listed in the document, the tab labeled “How to Determine CCRs” in that document provides instructions on identifying their CCRs. Also see Methodology 1 of this document for further information.

1. **Hospitals without CCRs**

For hospitals that did not maintain Medicare CCRs and new hospitals, the Medicare 2021 urban or rural statewide average operating CCR is used to calculate reimbursement. Instructions on finding these CCRs can be found on BWC’s Web site with OAC 4123-6-37.1 ([IPPS - Determining Hospital Inpatient Cost-to-Charge Ratios](file://wghome1/a71374/Lisa's%20temp%20folder/IPPS%20-%20Determining%20Hospital%20Inpatient%20Cost-to-Charge%20Ratios)). Also see Methodology 1 of this document for further information.

For BWC rate year 2021, for Ohio hospitals, the statewide average CCRs are:

Urban: .231

Rural .344

# **Methodology 3: BWC Reimbursement for Hospitals Treating Addiction**

|  |  |  |
| --- | --- | --- |
| **Methodology** | **BWC Methodology Description** | **BWC Enrollment Type and**  **Medicare IPPS Status** |
| 3 | All-inclusive per diem payment | Type 35 – Detox hospital |

## A. Background

[OAC 4123-6-21.7](http://codes.ohio.gov/oac/4123-6-21.7v1)*, Utilization of opioids in the subacute or chronic phases of pain treatment for a work-related injury or occupational disease,* became effective in October 2016. The rule permits reimbursement for detoxification treatment for opioid use disorder for an injured worker for eighteen months without having opioid use disorder allowed in the claim. Treatment may include a limited duration of inpatient treatment during a specific timeframe as detailed in the rule. A companion policy details additional limitations of this rule. The policy can be found on BWC’s Web site under [Provider Billing and Reimbursement Manual](https://info.bwc.ohio.gov/wps/portal/bwc/site/provider/billing-and-reimbursement/billing-reimbursement-manual/!ut/p/z1/tVLZUoMwFP0VfeCRJhLSUt_QUdtOl3HsIrw4gaaQDiQ0pFT9ei8u41rRccxTcpdzzzk3KETXKJSsEgkzQkmWwTsI2zeT7vCi13fx2JtOu9if97vj8bxN6MxBiw8FjtfB_jntXw0vLid06qLwJ_14z_FxU_8chSgsYrFEAe1y5iwjbpMOo7ZL244dHWFmxw4m1COc4Nitq2NpCpOiINrFB7GShktzwGWSiTK1MAQtXGhViSXX8BRZJmRiM7m0NRd5tNUlz6HjNfUubOdMbsG3QRNvMNbRo9NRAuyZSW0hVwpd7x33mvpyHKCJ9WYT-qCuVnRbN_yjvEXtY8PeHwu-WSxYlGQqemLvy4h44IXmK665bm01hFNjivLYwhau3WkB95ZKhWolqrLwrihBidKGZc-ySmH4W3Evt6_wU1WCRZ9gUQDfsbN3b0cuWlSC79BMKp0D86tf_r4ebprQ_uOEBnjyR_gin81yj9BsfUfwmmbVcDU6I24wqO5PRv7h4QN4xUhf/dz/d5/L2dBISEvZ0FBIS9nQSEh/), New/Revised/Updated Policies. The policy is titled BRM-07 *Opioid Use Disorder Treatment Coverage*.

When the rule was under development, several hospitals requested an all-inclusive per diem rate instead of the existing IPPS or IPPS exempt rates. BWC honored the hospitals’ requests and developed provider type 35 for detox per diem services. The per diem rates were developed with hospital input.

For these inpatient detox services, hospitals may opt to be paid under any of BWC’s three methodologies for inpatient services. The methodology used to calculate payment is determined by the BWC provider type and IPPS eligible or IPPS exempt status detailed in the Overview of Reimbursement Methodologies section of this document.

Facilities opting for the per diem rate must enroll as a provider type 35 and report the revenue codes listed on in Table 1 (below) in the Appendix of OAC 4123-6-37.1.

|  |  |  |
| --- | --- | --- |
| **Service** | **Revenue Code** | **Per Diem Rate** |
| Acute inpatient detoxification services | 0126 | $786 |
| Subacute inpatient detoxification services | 1002 | $597 |

## B. Calculating Reimbursement

Reimbursement is calculated by multiplying the per diem rate by the number of allowed inpatient days. Per diem rates are all-inclusive for all facility services. Reimbursement is made at the lesser of the total charges or the total calculated per diem payment. BWC provider type 35 is not eligible for any other method of inpatient reimbursement. For admissions unrelated to inpatient detox per diem services, the hospital must bill under provider type 34, 36 or 37.

Step 1 – Identify the per diem reimbursement rate for the revenue code billed.

Step 2 – Multiply the per diem reimbursement rate by the number of inpatient days of the admission. This is the fee schedule amount.

Step 3 – Reimbursement is made at the lesser of the billed charges or the BWC detox per diem reimbursement rate.

1. **Formula**

***BWC detox per diem reimbursement = detox per diem rate x number of inpatient days***

1. **“Lesser of” Provision**

Payment is made the lesser of the billed charges or the BWC detox per diem reimbursement amount.

# **Additional Resources**

**1. Provider Billing and Reimbursement Manual**

BWC’s Provider Billing and Reimbursement Manual (BRM) contains additional resources for customers regarding policies related to reimbursement of medical services. The [BRM](https://info.bwc.ohio.gov/wps/portal/bwc/site/provider/billing-and-reimbursement/billing-reimbursement-manual/!ut/p/z1/tVLZUoMwFP0VfeCRJhLSUt_QUdtOl3HsIrw4gaaQDiQ0pFT9ei8u41rRccxTcpdzzzk3KETXKJSsEgkzQkmWwTsI2zeT7vCi13fx2JtOu9if97vj8bxN6MxBiw8FjtfB_jntXw0vLid06qLwJ_14z_FxU_8chSgsYrFEAe1y5iwjbpMOo7ZL244dHWFmxw4m1COc4Nitq2NpCpOiINrFB7GShktzwGWSiTK1MAQtXGhViSXX8BRZJmRiM7m0NRd5tNUlz6HjNfUubOdMbsG3QRNvMNbRo9NRAuyZSW0hVwpd7x33mvpyHKCJ9WYT-qCuVnRbN_yjvEXtY8PeHwu-WSxYlGQqemLvy4h44IXmK665bm01hFNjivLYwhau3WkB95ZKhWolqrLwrihBidKGZc-ySmH4W3Evt6_wU1WCRZ9gUQDfsbN3b0cuWlSC79BMKp0D86tf_r4ebprQ_uOEBnjyR_gin81yj9BsfUfwmmbVcDU6I24wqO5PRv7h4QN4xUhf/dz/d5/L2dBISEvZ0FBIS9nQSEh/) can be accessed on BWC’s Web site.

**2. Clinical Edits for All Medical Bills**

Prior to pricing medical bills, MCOs’ and BWC’s bill processing systems apply general clinical editing to all incoming bills.

1. Claim Number Validation

BWC’s system ensures the claim number submitted on the bill corresponds to a valid injured worker claim number.

1. Provider Number Validation

BWC’s system validates that the provider number submitted on a hospital type bill corresponds to a hospital provider type.

1. Revenue Center Code Validation

Revenue code accepted by BWC are detailed in Table 2 of the Appendix of OAC 4123-6-37.1. Non-covered revenue codes are denied by BWC.

1. Diagnosis Validation

BWC’s system ensures the principal diagnosis on the inpatient bill meets one of the following criteria:

1. Allowed in the injured worker’s claim,
2. In the same diagnosis grouping [diagnosis grouping](http://codes.ohio.gov/oac/4123-6-37.1) as an allowed condition in the claim, or
3. The bill contains an override code applied by the MCO to indicate the diagnosis is not allowed in the claim, but the bill may be paid according to policy.
4. Duplicate Check

BWC’s system also checks for duplicate bills. If an incoming bill is a duplicate of a bill that is paid or in process, the incoming bill is denied.

1. **Medicare IPPS fact sheet with payment formula descriptions**

[Medicare IPPS Fact Sheet](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AcutePaymtSysfctsht.pdf)