State of South Carolina

1612 Marion Street
P.O. Box 1715
Columbia, S.C. 29202-1715

Tel: (803) 737-5700
Fax: (803) 737-5764
www.wcc.sc.gov

Workers' Compensation Commission

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To Workers' Compensation Insurance Carriers
Self-Insured Employers and Self-Insured Funds

A temporary injunction in litigation described below has ordered the South Carolina Workers' Compensation Commission, until further court action, from implementing the new payment system, Medicare plus forty percent, which took effect October 1, 2006 for ambulatory surgery centers. The Commission must therefore continue to use the payment methodology in effect prior to October 1, 2006 for any and all licensed ambulatory surgery centers until a determination by the Court following a hearing on the merits.

By way of background, on September 29, 2006, eight ambulatory surgery centers and the Ambulatory Surgery Association filed suit challenging the revised ambulatory surgery center maximum allowable payments established by the South Carolina Workers' Compensation Commission. That payment system became effective October 1, 2006 and limited payments to ambulatory surgery centers to no greater than 140% of the Medicare payment. A hearing was held on October 30, 2006 and on March 15, 2007 Circuit Court Judge Alison Renee Lee issued a temporary injunction restraining the Commission from implementing the reimbursement system for ambulatory surgery centers. At the Commission's request, Judge Lee provided for a thirty day stay of her order to give the Commission time to appeal the temporary injunction to the Court of Appeals.

The Commission appealed the temporary injunction and at the same time sought a stay of the injunction from a single judge of the Court of Appeals. That request for a stay was denied, and the Commission has now asked a full three-judge panel to consider staying the circuit court injunction. However, the thirty day stay permitted by the circuit court judge has now run out, and unless the stay is reinstated by an appellate court, the terms of the temporary injunction are now in effect.

As a result, the payment system for ambulatory surgery centers reverts back to the interim discount-to-charge method, that is, charges minus 12.1%, that was in effect prior

to October 1, 2006. It is important to note that this represents the maximum allowable payment, and insurance carriers and self-insured employers may negotiate lower prices.

It also is important to note that this system is voluntary: medical providers in most case are not required to provide care to workers' compensation patients. The employer/ insurance carrier has the right to select the treating provider and may negotiate lower payments. Ideally, the payment amount should be established when authorizing treatment. Payments cannot exceed the maximum allowable payment established by the Commission.

Since 2000, the number of workers' compensation cases in South Carolina treated at an ambulatory surgery centers has increased 121%. Over this same period of time charges have increased 314%. In addition, the Commission, in its bill review capacity, has seen an increase in the unbundling of procedures. Unbundling occurs when multiple procedure codes are billed for a procedure that is covered by a single comprehensive code. Because of the nature of our payment system, particularly for services which are paid on a discount-to-charge basis, substantial overpayment can result. The previous interim discount-to-charge system for outpatient services was inherently inflationary and resulted in prices substantially above the market rate as defined by what other major health insurance companies pay.

Plaintiffs have claimed that the new payment system was adopted in violation of the Administrative Procedures Act. They did not set forth any specific section of the APA that was violated, although in arguments and a brief presented at the hearing, asserted the decision of the Commission should have given "contested case" status. While the issue contested is a procedural one, no one has questioned the Commission's authority to establish prices. No hearing or decision has been made on the merits of the case. The case is before the Court of Appeals and we will keep you apprised as to its status.

This action only affects payments to ambulatory surgery centers, it does not affect payment to any other provider.

Background

On June 26, 2006 the South Carolina Workers' Compensation Commission approved revisions to its hospital inpatient and outpatient payment systems by adopting a prospective payment system for hospital inpatient, outpatient and ambulatory surgery center payments. Effective October 1, 2006, all inpatient and outpatient services, including procedures performed in ambulatory surgery centers, were to be paid at 140% of the Medicare payment, that is, the Medicare payment rate plus 40%.

These changes were based, in part, on the recommendation of the Commission's Hospital Advisory Committee. In a continuation of its efforts to assure that workers' compensation medical fee schedules adequately pay for services provided, ensure access to quality care and contain costs for business and industry, the South Carolina Workers' Compensation Commission reconvened the Hospital Advisory Committee in November 2004 to advise the Commission on what, if any, changes were necessary to improve the hospital inpatient payment system. The committee also was charged with making recommendations on the establishment of an outpatient fee schedule. The fourteen member Advisory Committee was composed of representatives of the hospital industry, medical association, property and casualty insurance carriers, a self-insured fund, business and industry, and State Government.

The full committee met six times over an eighteen month period to review the current system, review analysis conducted by staff, and to develop recommendations for improving the hospital inpatient and outpatient payment systems. A subcommittee consisting of six members from the full committee was formed in the summer of 2005 to further analyze data, including that provided by one hospital and two insurance companies, and to compare the existing payment system with Medicare.

The former hospital payment system for inpatient care was established in 1997 and was based on Medicare's diagnosis related groups (DRGs), a classification system which sorts inpatient claims into one of approximately 500 classifications. Each hospital discharge can be assigned to a DRG group based on the diagnoses, procedures performed, complications, co-morbidities, signs, and symptoms and discharge status. A DRG payment system is prospective in nature in that the price is set prior to services being rendered. Payment is based on the diagnosis related group the claim is assigned and determined by the resource needs for the average patient for that diagnosis group. Also included in this determination is length of stay and intensity of services. Patients within a given diagnosis related group will demonstrate similar resource consumption and length of stay patterns. The DRG classifications used were those developed by the Centers for Medicare and Medicaid Services for the Medicare program.

Services performed on an outpatient basis at a hospital or ambulatory surgical center were not subject to the DRG classification payment methodology. In 1996 when the current system was established by the Commission, Medicare was considering, but had not yet adopted, a prospective payment system for outpatient services. The 1997 amendments to the Commission's regulations provided that the Commission would develop a prospective payment system for outpatient hospital services and ambulatory surgical centers. The regulations also provided that until a prospective payment system was operational, the payments for hospital outpatient services and ambulatory surgical centers shall be set by the Commission based on a discount-to-charge basis.

The Commission expects the October 1, 2006 changes to establish prices that more closely reflect the cost of medical services, and to establish prices that are more competitive with those paid by large group health insurance companies – considering that workers' compensation provides for a single source of payment with little or no bad debt for compensable claims.

If you have any questions regarding these issues, please contact me at 803.737.5744.

Sincerely,

Gary R Thibault

Gary R. Thibault
Executive Director

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