Hundredth Legislature - First Session - 2007
Committee Statement
LB 588

Hearing Date: February 12, 2007
Committee On: Business and Labor

Introducer(s): (Business and Labor Committee)
Title: Change the workers' compensation hospital fee schedule and payment of providers

Roll Call Vote – Final Committee Action:

	Advanced to General File
X	Advanced to General File with Amendments
	Indefinitely Postponed

Vote Results:

6	Yes	Senators Cornett, Lathrop, McGill, Rogert, Wallman, White
	No	
	Present, not voting	
1	Absent	Senator Chambers

Proponents:	**Representing:**
Dallas Jones	Nebraska Worker's Compensation Equity and Fairness, NFIB, Nebraska State Chamber
Charlie Burhan	Liberty Mutual
Don Cleasby	Property Casualty Insurers Assoc.
Ron Sedlacek	Nebraska Chamber of Commerce
Dick Johnson	Associated Builders and Contractors
Daniel R. Fridrich	Werner Enterprises

Opponents:	**Representing:**
Scott Wooton	Alegent Health
Brad Sher	Bryan LGH Medical Systems

Neutral:	**Representing:**
Kevin Conway	Nebraska Hospital Association
Korby Gilbertson	NCCI

Summary of purpose and/or changes:

Explanation of amendments, if any: The committee amendment rewrites the entire bill and makes the following changes.

LB 588 contains three significant changes to workers compensation. First, the bill establishes a prospective payment system for in-patient hospital services, which will provide consistency and produce savings for employers and payors. The fee schedule proposed within the bill is largely based on the payment method used by Medicare. The bill takes into account the differences between each hospital by incorporating their hospital specific Medicare rate and then increases that amount by 40%.

Second, the bill provides "prompt payment" language so that hospitals will be reimbursed in a more timely manner. Finally, the bill includes LB 77 as amended by committee. It provides that certain injured employees may be reimbursed according to their loss of earnings capacity, rather than according to the schedule set in statute. This third component is intended to ensure that at least a portion of those savings created by the new hospital fee schedule will be passed along to the injured worker.

Section by Section Summary

Section 1 amends 48-120 to provide that reimbursement for in-patient hospital worker's compensation claims *for hospitals located in or within twenty miles of a metropolitan class or primary class city and those hospitals with fifty-one or more licensed beds* shall be according to the new fee schedule set forth in section 2.

Section 2 creates the framework for a schedule of fees for in-patient hospital services and stays to be administered by the Workers' Compensation Court. Such fee schedule will be referred to as the Diagnostic Related Group inpatient hospital fee schedule (DRG Fee Schedule) and will be based on federal Medicare reimbursement.

Subsection 2 defines each term used in the computation of the DRG Fee Schedule.

Current Medicare Factor: means a hospital-specific dollar amount which is known and updated on a regular basis. The Current Medicare Factor is a base rate established by the Centers for Medicaid and Medicare through information provided by each hospital. It includes ad-ons for: wage indices, percentage of low income patients served, medical education costs associated with the hospital and a national calculation of average capital costs and operating costs which is geographically adjusted.

Current Medicare Weight: is a value which represents the resources required by hospitals, on average, to provide care to patients in that DRG compared to the resources required for other DRGs. These weights are determined by the Centers for Medicaid and Medicare, are universal for all hospitals and are updated and published at least on an annual basis in October of each year.

Diagnostic Related Group (DRG): means a universal code and description assigned under Medicare to each type of injury. Similar injuries are grouped into the same Diagnostic Related Group. DRG's are updated and published by the Centers for Medicaid and Medicare at least on an annual basis in October of each year.

Workers' Compensation Factor: means the Current Medicare Factor multiplied by 140%. (Medicare + 40%)

Subsection 3 directs the Compensation Court to include at least 38 of the most frequently used DRG's in the DRG Fee Schedule with the goal of covering at least 90% of all inpatient hospital workers' compensation claims in the state. DRG 462, which stands for rehabilitation shall not be included within the DRG Fee Schedule.

Subsection 4 sets forth the computation necessary to establish the DRG Fee Schedule.

The basic reimbursement for each DRG is the Worker's Compensation Factor multiplied by the Current Medicare Weight.

For those "outlier" cases that require unusual expense to treat, the bill provides additional compensation. For outlier cases there is a stop loss threshold. The stop loss threshold is a dollar amount which is three times the basic DRG reimbursement. When billed charges are greater than the stop loss threshold amount, hospitals will be reimbursed the basic reimbursement for that DRG plus 60% of the amount above the stop loss threshold.

For those charges less than the stop loss threshold, the hospital will be reimbursed the lesser of the basic DRG reimbursement or the actual billed charges.

Subsection 5 allows the compensation court to establish the rate of reimbursement for all other hospital stays or services not on the DRG Fee Schedule.

Subsection 6 directs the hospitals to assign a DRG to each workers compensation claim submitted for payment and allows the employer, insurer, or third party payor to audit that DRG assignment.

Subsection 7 directs the CEO of each hospital to certify their Current Medicare Factor to the administrator of the Comp Court by October 15 of each year.

Subsection 8 provides that each hospital and payor must report to the administrator of the compensation court the total number of times service for each DRG was provided and the number of times each DRG was reimbursed above the Stop Loss Threshold. This reporting requirement will help the court assess which DRGs should be included within the DRG Fee Schedule and to assess whether the fee schedule is working properly.

Subsection 9 gives the administrator of the court the authority to update the DRG codes, the weights, and the Current Medicare Factors on an annual basis to reflect the changes published by the Centers for Medicaid and Medicare. The Compensation Court may add or subtract DRGs from the DRG Fee Schedule on an annual basis in striving to cover at least 90% of the in-patient claims within the state.

Section 3 provides guidelines to ensure prompt payment for all workers compensation claims. Specifically a payor will have 15 days in which to notify the provider that the payor does not have all the information necessary to process the claim. If the payor fails to notify the provider

within that time frame, the claim is assumed to be complete and must be payed within 30 days. If the payor does not pay within 30 days, then the provider will be paid the full amount of billed charges rather than the discounted rate set by the compensation court.

Subsections 2 and 3 define "receipt" of a claim and "receipt" of payment. If sent electronically, receipt of a claim or payment is presumed to be on the date of the electronic verification. If the claim or the payment is sent by mail it shall be presumed to have been received 5 days after the post mark date.

Section 4 amends 48-121 to insert LB 77 with committee amendments into the bill. Currently, scheduled member injuries do not result in loss of earning capacity payments, but are paid according to the schedule. The language in the bill will allow a court to treat a combination of member impairments as a whole body injury and therefore can award the injured employee loss of earning capacity payments.

Two criteria must be met in order for the court to award loss of earning capacity for multiple member injuries: 1) a simple member disability alone does not accurately assess an employee's disability and 2) such disability results in at least a 30% loss of earning capacity.

Senator Abbie Cornett, Chairperson