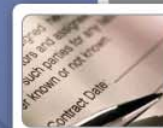


FAIRPAY insights\$

Finding the fair cost of care



Closing the Door
on Provider Fee
Disputes

P2



Savings Opportunity:
Hospital-Caused
Errors

P3



Update: Data Source
Integrity

P3

MEDICARE PAYMENTS EVEN MORE OUT-OF-LINE

2008'S SUCCESSES

*A message from Richard Leonardo,
President, FAIRPAY Solutions*

The first annual edition of Insights has historically been our opportunity to recap the prior year and this will serve as no exception. Reflecting on the fourth quarter of '08 (our last edition) and wrapping up the first quarter in '09, I can't thank you enough for continually entrusting us with your business. 2008 proved to be a record year in both bill volume and client savings. With only a few weeks left in Q1 '09, it doesn't appear to be letting up; we are currently experiencing the largest bill volume quarter since our inception.

However, volumes processed and dollars saved only detail part of the story. Our clients' book of bills experienced the same net savings in '08 as it did in '07 at 53%, with provider pushback declining to 12% and giveback finishing off the year at 6%. Although the number of provider inquiries declined, the aggressiveness of the tactics was amplified in certain jurisdictions. This is not a surprise when considering that in November, The New York Times reported that "62% of the hospitals surveyed reported flat to declining admissions versus the prior year" and Health Strategies recently reported that workers' comp represents 2% of a hospital's charges but 16% of their profits. It appears that in '09 commercial payers will continue to be the target of much of the cost shifting, especially if Medicare reimbursements get cut.

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On Wednesday, February 25th, in a background briefing, President Obama unveiled the first set of proposals to overhaul the way Medicare pays for medical services. The proposal includes over \$25 Billion in reductions to hospital payments.

Two proposals of how Medicare will significantly change how it pays hospitals are completely alien to workers' compensation payers:

1) Medicare will be paying a bundled payment, which includes all hospital inpatient and outpatient services, plus physician fees, imaging and lab and other ancillary services. Take-home DME and medicines may also be included. This all-inclusive bundled payment, determined by the "care episode," has long been advocated by Peter Orszag, Mr. Obama's point-person on Medicare payment reform.

2) Medicare will stop paying if the patient needs to be readmitted to the hospital.

These changes add to a growing array of Medicare reasons to deny payment to hospitals, some of which include: new edit rules, additional coverage limit rules and payment denials for hospital-caused infections.

On top of this, the hospital industry has been pointing out for several years that Medicare does not adequately pay

for costs that are of especial concern for workers' compensation. Some of which are:

- Medicare does not adequately pay hospitals for their costs of implants. This has been validated by independent researchers in studies funded by Medicare.¹
- Medicare does not adequately pay for higher-cost cases. The data on this is incontrovertible – Medicare is underpaying hospitals for higher cost inpatient cases ("outliers") by several Billion dollars a year versus the statutory requirement for Medicare to pay 5%-6% of its total inpatient payments for "outliers." Many workers' compensation surgeries exceed Medicare's outlier thresholds, according to a recent independent analysis of state data.² These underpayments are another reason to not base workers' compensation hospital payments on Medicare's ever-changing fee schedules.

With Medicare sharply reducing payments, get ready *now* for hospitals to begin charging much more for workers' compensation patients!

¹ K. Dalton. "A Study of Charge Compression in Calculating DRG Relative Weights." RTI, prepared for Centers for Medicare & Medicaid Services, January 2007.

² M. Malloy & H. Midkiff, "The Relativity of DRG Weights: Evaluating the Appropriateness of Using Medicare DRG Relative Weights for Non-Medicare Patient Populations," January 5, 2009. J. Taylor and Associates whitepaper.

2008'S SUCCESSSES

A message from Richard Leonardo,
President, FAIRPAY Solutions

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2008 also saw several product innovations at the direct request of our clients. We built a small LTAC database at one reinsurer's request, a TPA encouraged the implementation of front-end negotiation for LTACs, a carrier client motivated us to begin front-end negotiating 1st party auto bills, several clients prompted the negotiation of sendbacks, and two of the large box retailers have encouraged the creation of a liability solution. We are grateful for your willingness to allow us to engage in other medical repricing business solutions and have begun the widespread sharing of the early results during stewardships. Please continue to challenge us to produce repricing alternatives.

As we approach the close of the stewardship season, we are indeed experiencing unprecedented times with the Dow approaching 6500, unemployment exceeding 8% nationally, GM talking about going bust, and Citigroup trading at roughly a \$1.00. It could be so easy to allow ourselves to be distracted, even paralyzed, by these circumstances, but thankfully 140 plus million workers are still heading off to the workplace each day. We are more thankful that you, our clients, have entrusted us with a record number of bills thus far in Q1. We look forward to continually maximizing your savings and exceeding your expectations.

Respectfully,

Rich

▣ MAKING A DIFFERENCE

FAIRPAY is grateful to have received so many wonderful notes from our customers about our holiday gift donation, on behalf of our clients and staff, to the Freedom Calls Foundation. Helping military parents serving overseas stay in touch with families at home is a terrific thing to support.

FAIRPAY knows this compassion for others is consistent with what we see in our clients: an abiding focus on caring for injured workers. You inspire us to bring you more resources to help you in your mission of transforming these lives.

Thank you for your continued business partnership which allows us to assist those in our community every year.

For more information on the Freedom Calls Foundation, please visit their website at www.freedomcalls.org.

CLOSING THE DOOR ON PROVIDER FEE DISPUTES

Disclaimer: This article provides information meant only to be a guide to general principles of law. Information about the law is not legal advice – the application of information to individually specific facts and circumstances. This article is NOT LEGAL ADVICE. Each reader must consult his own legal counsel to interpret the law and any application of this information to his particular situation.

In these tough economic times, businesses are looking for nickels and dimes in every nook and cranny. Medical providers are no different. FAIRPAY has seen increasing numbers of reconsideration requests from providers who are conducting "audits" and seeking additional payment on bills where payment was accepted long ago. Many of our customers have been asking how long is too long, or, stated differently, when does the workers' compensation system say a provider is precluded from asserting a claim for additional payment?

The answer, of course, varies for each jurisdiction and is not always as clear cut as we might wish. Some states provide clear deadlines – which are known in the law as statutes of limitations – for providers to file a medical fee dispute as part of the state's workers' compensation statutes or regulations. In other states, the workers' compensation legislation is silent as to deadlines for filing such disputes, and an analogy must be made to other limitations statutes, such as the limitations periods for filing a civil contract claim. In some states, the limitations issue has been heavily litigated and is clear, and in other states, the situation is more murky and open to interpretation.

The other critical question relating to limitations is whether the state actually enforces existing legislation limiting the time for filing provider fee disputes. We have had good success in certain states in closing the door on provider fee disputes relating to FAIRPAY-reviewed bills after the stated limitations period. In Florida, for example, if the provider does not file a dispute within 30 days of receipt of the Explanation of Bill Review, the state routinely will deny further reimbursement. Similarly, in Wisconsin, the state regularly upholds its requirement that a provider must file a fee dispute within six months of its receipt of notice that payment has been reduced or disallowed.

The limitations periods for fee disputes vary widely; they can be as short as 21 days or as long as six years after payment is received. FAIRPAY carefully watches these limitations periods and regularly raises the issue through local counsel in fee disputes – another way that we help our clients achieve and maintain a savings level that is as high as possible.

UPDATE: DATA SOURCE INTEGRITY

The New York Times reported on January 15, 2009 that Ingenix has decided to exit the UCR database business and turnover its know-how to a non-profit organization that will be, going forward, an independent source of UCR databases. Ingenix's decision was made in response to allegations by New York's attorney general, Andrew Cuomo, that United Healthcare was underpaying out-of-network group health claims by using UCR data that was set too low.

Cuomo's original allegations were that, "Ingenix operates a defective and manipulated database that most major health insurers use to set the reimbursement rates for out-of-network medical expenses...two subsidiaries of United dramatically under-reimbursed their members for out-of-network medical expenses by using data provided by Ingenix." A press release by Cuomo on January 13, 2009 and Ingenix's comments reported in the New York Times make it clear that no facts emerged to substantiate these allegations for faulty UCR rates. Cuomo's office now claims that potential conflicts of interest are eliminated by having a university "create a new, independent database, not controlled by an insurer, to help determine fair and accurate reimbursement rates" as the basis for health insurers' out-of-network payments.

The new independent UCR database, to be developed and owned by a not-for-profit entity, will replace the Ingenix PHCS [ex HIAA] database as well as their MDR database. Though workers' compensation payers were not included in any of Cuomo's allegations, Ingenix has decided to get out of the UCR database entirely, including exiting the MDR database product that is used by workers' compensation payers. With the independent agency take over, United neatly eliminates the financial/legal costs of defending that Ingenix is not intentionally lowering its U&C data to reduce United's group health out-of-network costs. According to Ingenix, these databases gross less than \$25 million/year. United can easily recover that with lower litigation costs over this issue and setting group health out-of-network payment rates at 70% of what Medicare pays physicians.

We would expect little long-term turmoil over this for workers' compensation payers if the new non-profit competently develops the new UCR database. Additionally, there are several other UCR-type databases (e.g.: Wasserman, Captiva [ex Context], Comstock) that are available for use by workers' compensation regulators and payers.

SAVINGS OPPORTUNITY: ARE YOU OVER-PAYING FOR HOSPITAL-CAUSED ERRORS?

The average bill for patients that contracted an infection in the hospital is 5.5 times the bill for patients that did not get an infection! This staggering statistic was recently reported by the Pennsylvania Health Care Cost Containment Council:

Here is another "mind-blowing" statistic: a recently published study by Medicare's policeman, the OIG, reports 15 percent of inpatients suffered an adverse event while in the hospital.

The issue of the frequency and cost of hospital-caused errors has been out there for a few years. Now Medicare is cracking down by denying extra payment for certain types of hospital-caused errors. Many of the largest group health carriers, following Medicare's lead, are also denying payments for these.

FAIRPAY has developed sophisticated analytical tools that spot hospital-caused errors and infections and, where state regulations permit, screens out payments for hospital-caused errors. One of our most sophisticated analytical tools for performing this is our proprietary hospital-bill DNA profiling tool. Hospital bill DNA allows us to compare the actual charges billed for a DRG by every U.S. hospital against a 'fingerprint' of the typical charges for that DRG for that hospital. With this leading-edge tool, charges for hospital-caused errors are quickly identified.

Contact us if you also want this cost-saving scrubbing of your inpatient bills, with excessive charges for hospital-caused errors, too.

FAIRPAY SOLUTIONS' EVENTS 2009 SCHEDULE

- **April 19 - 23:**
RIMS Annual Conference
Orlando, Florida
Booth #207
- **May 14 - 15:**
NJ Self Insurers' Association
Spring Conference
Atlantic City, NJ
- **May 21 - 22:**
VT Workers' Compensation
Spring Conference
Burlington, VT
- **May 31 - June 2:**
PRIMA Annual Conference
Dallas, TX
Booth #408