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Chapter One. Introduction

Background

California's workers' compensation (WC) system provides medical care and wage-replacement benefits to workers suffering on-the-job injuries and illnesses. An injured worker is entitled to receive all medical care reasonably required to cure or relieve the effects of his or her injury. The term "payer" refers to the entity that is paying for medical care provided to an injured worker. It is usually a commercial insurer that provides WC coverage to an employer or a self-insured employer.

Ambulatory surgical centers (ASCs) are freestanding facilities where surgeries are performed on patients who are discharged within 24 hours, most often without a one-night stay. ASCs must meet health and safety standards established by the Medical Board of California (MBC) for physician-owned ASCs and by the California Department of Public Health (CDPH) for ASCs that are not physician owned. ASCs that are approved for participation in the Medicare program must meet additional standards. There are approximately 1,600 ASCs operating in California, the majority of which are physician owned.

The Division of Workers' Compensation (DWC) in the Department of Industrial Relations (DIR) is responsible for administration of the WC program. The Division maintains an Official Medical Fee Schedule (OMFS) for medical services provided under California's WC program. The OMFS establishes the maximum allowance for services furnished to injured workers unless the payer and provider contract for a different payment amount. The OMFS allows facility fees for surgical services performed in an ASC that is either licensed, accredited by an organization recognized by the MBC, or certified for participation in the Medicare program. Labor Code §5307.1 requires that the OMFS for ASC services be based on the Medicare fee schedule for hospital outpatient surgery. The Medicare fee schedule includes only services that the Centers for Medicare & Medicaid Services (CMS) has determined can be safely performed in the outpatient setting on Medicare beneficiaries. Medicare maintains a listing of "inpatient only" surgical procedures that are not covered in the outpatient setting. A procedure is classified as "inpatient only" either because of its invasive nature, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the typical patient who requires the procedure.

The OMFS rules extend the "inpatient only" policy to surgical procedures performed on injured workers but also permit a payer to authorize payment for an "inpatient only" procedure in an ambulatory setting at an agreed-upon rate when medically appropriate. High-volume "inpatient only" procedures for the WC patient population include hip and knee replacements,

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single-level spinal fusions involving insertion of instrumentation, an autograft, or multi-level cervical spinal fusions.

Senate Bill 863 (approved September 19, 2012) aimed to improve California's WC system by introducing new cost-saving efficiencies as well as increasing benefits to injured workers. Section 74 of Senate Bill 863 contained two provisions affecting OMFS ASC facility allowances. First, the Labor Code §5307.1(c) limitation on aggregate ASC facility allowances was reduced from 120 percent to 80 percent of the fee paid by Medicare for comparable services performed in a hospital outpatient department.[3] The revised allowance reflects the lower cost structure for ambulatory surgery performed in ASCs relative to hospitals. Second, DIR is required to study the feasibility of establishing an ASC facility allowance for an "inpatient only" procedure that would be set at 85 percent of the Medicare fee schedule amount for the procedure when it is performed on an inpatient basis. Medicare makes a predetermined per discharge payment for inpatient services based on the Medicare-severity-adjusted diagnosis-related group (MS-DRG) to which the patient is assigned. The MS-DRG payment covers the average cost of all services provided by the hospital during an inpatient stay. For surgical procedures, this would include the operating and recovery costs, room and board costs, and any ancillary costs for diagnostic tests, drugs, or medical supplies. If feasible and appropriate, shifting certain surgical procedures from the more expensive inpatient setting to the less expensive ASC setting would produce cost savings for employers and expand worker choice regarding where surgical services are provided.

Purpose

DIR asked RAND to examine the feasibility and appropriateness of including "inpatient only" procedures on the OMFS for ASC facility fees and to consider what the appropriate ASC facility allowance would be for an "inpatient only" procedure. DIR asked RAND to consider the following questions:

- What policy considerations should be addressed in allowing certain "inpatient only" services to be performed in ASCs?
- Which "inpatient only" services can be safely performed in the ASC setting for WC patients?
- If an OMFS rate were set for "inpatient only" services that are performed in an ASC, what multiplier to the Medicare inpatient rate or other fee schedule methodology should be considered? What are the projected cost savings with the use of this multiplier?

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[3] Medicare maintains a separate fee schedule for ASCs. The Medicare ASC payment levels are approximately 56 percent of the payment rates for comparable hospital outpatient services (MedPAC, 2013). The SB 863 provision reduces the OMFS allowances for ASC facility services from the same level as hospital outpatient services (120 percent of Medicare rates) to 67 percent of the OMFS allowances for hospitals. However, the ASC allowances are still about 143 percent of the amounts payable under the Medicare fee schedule for ASC services.

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- How applicable are ASC findings to the hospital outpatient department setting? What are potential implications regarding services to be allowed and the fee schedule to be used?

Approach and Methods

We used a combination of interviews, literature review, and data analysis to address the study questions. We started our review with two underlying policy questions: Do the health and safety requirements for ASCs provide adequate patient safeguards for performing higher risk surgeries that are typically performed in an inpatient setting? And what factors does Medicare consider in assessing whether a procedure can be safely performed in an outpatient setting?

- *Review of ASC health and safety standards.* We reviewed the health and safety requirements applicable to ASCs and assessed whether they provide adequate patient safeguards for performing higher risk procedures that are ordinarily performed as inpatient procedures. To do so, we assembled information from the CDPH on licensed ASCs, from the MBC on physician-owned ASCs, from CMS on Medicare-certified ASCs, and from the accrediting organizations on accredited physician-owned ASCs. We also gathered information on the number of ASCs by licensure, accreditation, and certification status. Finally, because so many California ASCs are physician owned, we reviewed the protections for patients under self-referral rules that apply when the surgeon has a financial interest in the ASC in which the procedure will be performed.
- *Review of Medicare criteria for "inpatient only" procedures.* We reviewed the criteria that Medicare uses to assess whether procedures can be safely performed in an ambulatory setting and adapted them for the WC patient population. We used this policy framework to guide our analyses of specific WC procedures and the conclusions we drew from the results.

We used the policy framework developed from our review of Medicare criteria for "inpatient only" criteria to guide our assessment of whether these procedures could be safely performed in an ambulatory setting on WC patients. We focused our assessment on a set of high-volume WC procedures that are Medicare "inpatient only" procedures that potentially could be performed in an outpatient setting. The data analyses included consideration of the extent to which the procedures are currently being performed in an ambulatory setting and the proportion of procedures performed on an inpatient basis that involve no more than a one-night stay. Following is an overview of how we approached each step in our assessment. A further explanation of our approach to analyzing each database is found in the relevant chapter of this report.

- *Identification of study procedures.* Medicare's 2013 "inpatient only" procedure list contains 1,734 procedures. To narrow the list to high-volume WC procedures that could potentially be performed safely in an ambulatory setting, we analyzed the 2011 medical administrative data from the California Workers' Compensation Information System

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(WCIS). We identified high-volume WC inpatient procedures with a relatively short average length of stay as potential candidates for inclusion on the OMFS for ASC facility allowances. Most of these procedures had been identified as procedures of interest by the California Ambulatory Surgery Association.

- *Determining whether study procedures are performed in ambulatory settings.* We used ambulatory surgery utilization data from the Office of Statewide Health Planning and Development (OSHPD) to investigate the extent to which the study procedures are being performed in ambulatory settings on WC patients as well as non-Medicare/Medicaid patients ages 18–64. Because the OSHPD ambulatory surgery data do not include physician-owned ASCs, we supplemented the OSHPD data with two additional sources: the 2011 WCIS and 2011 all-payer data on physician services obtained from FAIR Health, Inc., a commercial database of healthcare claims contributed by health plans. The WCIS and FAIR Health physician data elements include the setting in which surgical procedures are being performed in California. The services reported as being performed in an ASC in these data include physician-owned ASCs as well as the licensed ASCs that are captured in the OSHPD data.

To inform our discussion of potential policies and recommendations, we reviewed pertinent literature on performing selected procedures in an ambulatory setting and the policies used by other payers.

- *Literature review on selected procedures.* We reviewed the literature regarding the performance of three high-volume “inpatient only” services (multi-level spinal fusions with and without instrumentation, hip replacements, and knee replacements) in ambulatory settings. We note that Medicare already covers most single-level cervical and lumbar spinal fusions that do not involve instrumentation in a hospital outpatient setting and does not include these procedures on its “inpatient only” list. We were particularly interested in patient outcomes when the procedures are performed in ambulatory settings and whether there is an evidence base for prospective patient selection criteria.
- *Review of other WC program policies for “inpatient only” procedures.* We reviewed the policies that the federal and other state WC programs have adopted for covering and paying for Medicare “inpatient only” procedures in ambulatory settings. We also conducted semi-structured interviews with WC officials in other states.

In our final set of analyses, we explored the payment issues that would need to be addressed in setting an OMFS facility fee for “inpatient only” procedures that are performed in an ambulatory setting. To gauge the reasonableness and appropriateness of applying a 0.85 multiplier to the Medicare fee schedule, we reviewed how the Medicare rates are set and compared the estimated hospital cost of performing cervical spinal fusions on WC inpatients who require no more than a one-night stay with the estimated average cost for all WC inpatients assigned to the same MS-DRG. Because we concluded that the current policy is preferable to setting an OMFS fee schedule amount, we did not generate any savings estimates.

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Organization of This Report

The remainder of this report is organized as follows:

- Chapter Two discusses the pertinent requirements for state licensure, Medicare certification, and accreditation. Because most ASCs are physician owned, we also discuss the rules on physician self-referral. The underlying issue is whether there are sufficient safeguards against inappropriate referrals to an ASC for an "inpatient only" procedure. We also provide an overview of the ASC landscape in California by regulatory status.
- Chapter Three discusses Medicare's policies regarding "inpatient only" procedures and summarizes the policies adopted by a sample of other WC programs. These policies inform what criteria DIR might consider in deciding whether to remove certain procedures from the "inpatient only" list for WC patients.
- Chapter Four reports on our data analyses with respect to the "inpatient only" procedures. It identifies the high-volume WC procedures that are defined as "inpatient only". It presents the results from our investigation of the extent to which these procedures are already being performed in ambulatory settings and the proportion of WC patients who had the procedure on an inpatient basis who were discharged the same day or after a one-night stay.
- Chapter Five discusses the evidence from the medical literature regarding ambulatory surgery for hip and knee replacements and multi-level cervical fusions with instrumentation.
- Chapter Six discusses the issues that would need to be addressed in setting an OMFS facility allowance for "inpatient only" procedures performed in an ambulatory setting and potential OMFS fee schedule options.
- Chapter Seven discusses the study findings and provides our recommendations.

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