STATE OF NEW YORK
WORKERS'COMPENSATION BOARD
20 PARK STREET
ALBANY, NY 12207

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

DAVID P. WEHNER
CHAIRMAN

August 15, 2005

HOSPITAL INPATIENT FEE SCHEDULE
EFFECTIVE 1/01/2005 – 12/31/2005

Enclosed, please find the certification letter and schedules of initial hospital reimbursement rates for service rendered to patients covered under the Workers' Compensation Benefit Law, the Volunteer Firefighters' Benefit Law and the Volunteer Ambulance Workers' Benefit Law for the period January 1, 2005 through December 31, 2005.

The formula on which these rates are based was promulgated in accordance with Article 28 of the Public Health Law and reflect those provisions of the Health Care Reform Act 2003 (HCRA), as recently amended.

The January 1, 2005 rates, enclosed herein, are based upon the same inpatient reimbursable costs as those reflected in the 2004 inpatient rates promulgated on a statewide basis and certified on November 30, 2004, but also take into consideration the following changes:

1. Elimination of prospective rate adjustments contained in the 2004 rates, which were previously certified, and the development of revised prospective rate adjustments to reflect changes in rates prior to 2005 subsequent to that date.

2. Implementation of the initial 2004 trend factors, based upon the methodology as set forth in Article 2807-c(10) (c), which is 2.0%.

3. Implementation of 2003 actual capital costs and statistics, as submitted by hospitals in their 2003 Institutional Cost Report in lieu of budgeted capital costs and statistics. The major movable portion of these costs continues to be reduced by 44% in accordance with Article 2807-c of the Public Health Law.

4. Inclusion of the 2005 budgeted capital costs and statistics, as submitted by hospitals in their 2005 budgeted capital survey. This budgeted capital amount has been reduced by the percentage that the hospitals over-budgeted their 2003 capital costs in accordance with Article 2807-c(8) (f) of the Public Health Law.

5. Inclusion of updated indirect medical education information in the initial 2005 rates based upon the IME Survey submitted by hospitals for the period July 1, 2004 through June 30, 2005.

6. Implementation of the actual 2003 case mix adjustment for exempt units in accordance with part 86-1.64 of the Commissioner of Health's Administrative Rules and Regulations.

7. Implementation of the 2003 volume adjustment in the acute case payment and exempt unit rates for those facilities which qualify for such an adjustment in accordance with Part 86-1.64 of the Commissioner of Health's Administrative Rules and Regulations.

8. Inclusion of the above changes in the calculation of the group price for each respective year where appropriate.

Enclosures:

The following will briefly describe the enclosed rate schedules and backup documents contained in this package:

2005 Exempt Units and Hospitals Elements

This is a copy of hospitals specific data elements which have been used to formulate the revised rates of payment for each hospital. The following is a brief description of the elements on the schedule:

- Group Code – This is the group number to which a hospital has been assigned. Please note that the first page contains a description for each of the nine peer groups and note explanation.

- Exempt Hospitals and/or Units - A number 1 (one) in the column signifies that the facility has that type of approved unit. The next six columns list the exempt unit(s) for which the hospital has been approved and for which a discrete exempt unit per diem rate has been calculated. For facilities listed under the column headed Exempt Hospitals, please refer to the note on the first page (index) of the attachment for the type of hospital and the services provided.

2005 Diagnosis Related Groups

This enclosure provides specific information for each diagnosis related group (DRG) including DRG number, DRG description, per case and per day service intensity weights (SIW's), non-Medicare trimpoints and upstate/downstate group average lengths of stay. The per case SIW is to be applied to the blended cost per discharge to determine the inlier payment for an individual claim. The low and high trimpoints are needed to determine if the claim is an inlier, short stay or long stay claim depending on patient's acute length of stay. The group average length of stays (upstate/downstate) are used to divide the per case amount in the determination of the per diem for payment (when applicable). These DRG's are to be used for patients discharged on or after January 1, 2005.

Top 20 DRG's

Pursuant to the provisions of the Health Care Reform Act of 2003, services rendered to patients covered under the Workers' Compensation Benefit Law, the Volunteer Firefighters' Benefit Law, and the Volunteer Ambulance Workers' Benefit Law discharged January 1, 2005 and after are to be reimbursed the state governmental payor rate. Chapter 80 of the Laws of 1995 included a provision which impacts payments for the twenty most common diagnosis related groups (DRG's) (See "Top 20 DRG's" schedule). For inpatient claims that group into one of the DRG categories listed, reimbursement is at the lower of the hospital-specific blended cost per discharge or the weighted group average for the hospitals peer group. Those hospitals who are designated as rural and have opted for 100% hospital-specific reimbursement under Article 2807-c (6) are not subject to the Top 20 lower of payment system as described in Article 2807-c (5) of the Public Health Law.

Top 20 DRG rates based on the above adjustments have been calculated for the period January 1, 2005 through December 31, 2005. All payment formulas for Top 20 DRG's (Inliers, Short Stays, Transfers & High Costs) will use the rate amount listed in the Top 20 DRG column contained in the payment rate components listed on the Schedule entitled "Workers's Compensation and No Fault Hospital Case Payment Rates" (See Column 3).

Workers' Compensation (1/01/05 – 12/31/05)

This is a printout of all rates of payment and their specific component parts which have been approved by OHSM for Workers' Compensation claims, and are to be used to make payments for inpatient hospital services.

The printout lists hospitals by NYPHRM region and contains the following data:

- Columns 1 through 10: Contains the revised rate components needed to calculate payments to a hospital for general acute care services for which reimbursement is governed by the per case methodology. These include inlier payments, short stay and transfer payments, long stay payments and high cost payments. A further explanation of columns which have changed from previous publications is as follows:

- Column 1 – Long Stay Group Neutral Cost/Discharge: This column should be utilized to calculate the long stay outlier payment for all applicable claims.

- Column 2 – Blended Case Mix Neutral Rate: This column combines the blended case mix neutral rate per discharge and base year malpractice case mix neutral cost per case listed separately in prior publications. This amount should be combined with the prospective adjustment amount reported in either Column 12 or 13 dependent upon the payor, workers' compensation or no-fault, respectively. The appropriate SIW should be multiplied times this combined amount to obtain a weighted rate per discharge.

- Column 3 – Top 20 DRG Rate: This column should be utilized in place of the Column 2 amount for all claims whose DRG assignment listed in the Top 20 DRG listing previously discussed. This amount should be combined with the applicable prospective rate adjustment from Column 12 or 13 prior to the application of the SIW.

- Column 4 – Capital Cost Rate Per Case: This column is similar to prior publications except that the current figure includes the Efficiency Cost Reduction Adjustment. This amount should be combined with the applicable prospective adjustment from Column 14 or 15 dependent upon the respective payor.

- Column 5 – Public Goods Pool Surcharge: This surcharge should be applied to the sum of the weighted rate per discharge (including prospective adjustments) plus the capital cost rate per case (including prospective adjustments). This surcharge is applicable for payors who have previously elected and been approved to pay the Public Goods Pool directly.

- Column 6 – Additional Public Goods Pool Surcharge: This additional surcharge of 24.00% should be added to the Column 5 amount of 8.85% to total 32.85%. This amount should be applied to the sum of the weighted rate per discharge (including prospective adjustments) plus the capital cost rate per case (including prospective adjustments) and included in the payment to the hospital. **This additional surcharge is only applicable to those payors who have not elected to pay the Public Goods Pool directly and have received approval for this arrangement by the Department of Health.**

- Columns 7 and 8: The capital per diem is to be utilized in the calculation of short stay and transfer payments for the respective payor.

- Columns 9 and 10: This SPARCS rate add-on is applicable to the per case or per diem payment respectively.

- Column 11: For those patients whose inpatient hospitalization at an acute level is no longer necessary, the case payment legislation authorizes payment of an alternate level of care rate. This column contains an alternative level of care per diem payment for each respective hospital. The appropriate public goods pool surcharge should be applied to this payment.

- Columns 12 through 17: These prospective adjustments reflect the net adjustments to the Worker's Compensation rates for periods 1988 through 1996 plus the Medicaid rate for the period January 1, 1997 through December 31, 2004. These prospective adjustments include the applicable rate differentials (5% or 13%) for the affected rate years for the respective payors. The adjustments are to be included in the applicable inlier and outlier payment calculations as detailed in this correspondence.

- Column 18: The high cost charge converter is the hospital specific inpatient ratio of cost to charges. This ratio is to be applied to total covered hospital inpatient charges for a specific claim to reduce charges to cost in the determination of high cost outlier payments.

- Column 19: The overall non-Medicare case mix is to be utilized in the determination of specific claim's eligibility as a high cost outlier.

- Column 20: Pure group price the for long stay test is the pure group price of the 2003 rates which is to be used in the calculation of the greater of high cost and long stay test to determine which payment to use.

- Columns 21 through 30: Per diem rates and components for hospitals which are totally exempt from the per case reimbursement system.

- Columns 31 through 40: Per diem rates and components for hospitals with a approved psychiatric exempt unit.

- Columns 41 through 50: Per diem rates and components for hospitals with an approved AIDS exempt.

- Columns 51 through 60: Per diem rates and components for hospitals with an approved Alcohol Rehabilitation exempt unit.

- Columns 61 through 70: Per diem rates and components for hospitals with an approved Drug Rehabilitation exempt unit.

- Columns 71 through 80: Per diem rates and components for hospitals with an approved Epilepsy exempt unit.

- Columns 81 through 90: Per diem rates and components for hospitals with an approved other exempt units.

- Columns 91 through 100: Per diem rates and components for hospitals with an approved Medical Rehabilitation exempt unit.

Workers' Compensation Retro-Payment Rate Schedules:

This schedule contains rates for hospitals for rate periods prior to January 1, 2005 as listed on the attached schedule.

Sample Payment Calculation Worksheets:

These schedules have been prepared to answer many questions that are received as to how to calculate the various different payments for the Workers' Compensation claims. These schedules correspond to the columns of the Workers' Compensation rates schedule enclosed.

Sincerely,

David P. Wehner
Chairman

Attachments