Emerging Trends in Auto Related Medical Claims Payments
Or
UCR After Ingenix

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Agenda and Session Aims

Aim: Review Current Trends in UCR Concepts and Methods

- UCR Definitions and History
- The End of Ingenix UCR – Introduce FAIR Health
- Current UCR Type Physician Reimbursement Methods
  - FAIR
  - Medicare
  - Others
- The Future of UCR?
- Questions and Discussion

UCR – Definition and History

- Usual – Customary - Reasonable
- Not specifically defined in most states.

- Originated in Social Security Act of 1965. Inserted to placate AMA.
- Based on Charge Data
- Commonly implemented as a percentile of charge levels for a specific fee in a geographic area within a specified time period.
- Litigation disputes typically attack Reasonable aspect of a fee or a payment.

Definition and History
Why UCR

- A method of controlling and standardizing medical costs.
- A method for deterring aggressive medical billing practices and fraud
- A method for catching medical billing errors

UCR Definition and History

- Blue Shield Plans:
  - Check current charge against charge for previous year's (usual) 75th percentile in the area (customary), or justifiably higher because of a complicating factor (reasonable)
- Medicare
  - Adopted UCR methods as part of the Social Security Act (Medicare – 1965)
  - 1990s, increasing fees became distorted and unsustainable, moved to Resource Based Relative Value system
- Complaints:
  - Providers – claim UCR payments are skewed in favor of insurers.
  - Patients – complained about balanced billing

Definition and History
UCR Data Sources History

- 1990s
  - McGraw Hill
  - HIAA / PCHS
  - ADP
  - Ingenix
- 2000s
  - Ingenix
  - ADP
- 2009: The End of Ingenix
- 2010s
  - FAIR Health
  - Medicare based
  - Proprietary
  - ?

The End of Ingenix
What Happened

- On Oct 27, 2009, New York Attorney General Cuomo announced 'nationwide reform of the consumer reimbursement system for out-of-network health care charges'.
- This action found that the Ingenix MDR databases, commonly used to reimburse out-of-network physicians and hospitals, was systematically flawed.

Key Findings

1. Ingenix is owned by United Healthcare; the same insurance customers that used the data, which created a conflict of interest and incentive to skew the supplied data.
2. Ingenix UCR methodology was proprietary and inaccessible.
3. Attorney General Cuomo's findings led to several lawsuits which became combined in a class action in New York under ERISA, RICO and NY contract and deceptive practices law.

Other Payment Method Options

- Government Mandated: (Medicare, Medicaid, Worker's Comp), Personal Injury Protection (PIP)
- Contracted: (PPO, HMO, other provider agreements)

Side Note:

While the action was directed at Health Insurers, it turns out that Auto Insurers were also big users of the Ingenix's MDR and PCHS products.

Enter FAIR Health

- Established in 2009 as part of the settlement
- Formed with the objective to:
  - Take over and improve the database
  - Bring transparency, objectivity and reliability
- Mandate:
  - Establish an independent database of charge information with support from academic experts
  - Develop a free website to educate consumers
  - Create a research platform for policymakers and researchers

UCR Methodologies

Determining Usual, Customary, and Reasonable

- Percentile of Billed Charges
- Percentage of Medicare
- Multiple of Cost
- Multiple of Commercial (HMO, PPO etc.) Allowed Charges

Key Components of UCR

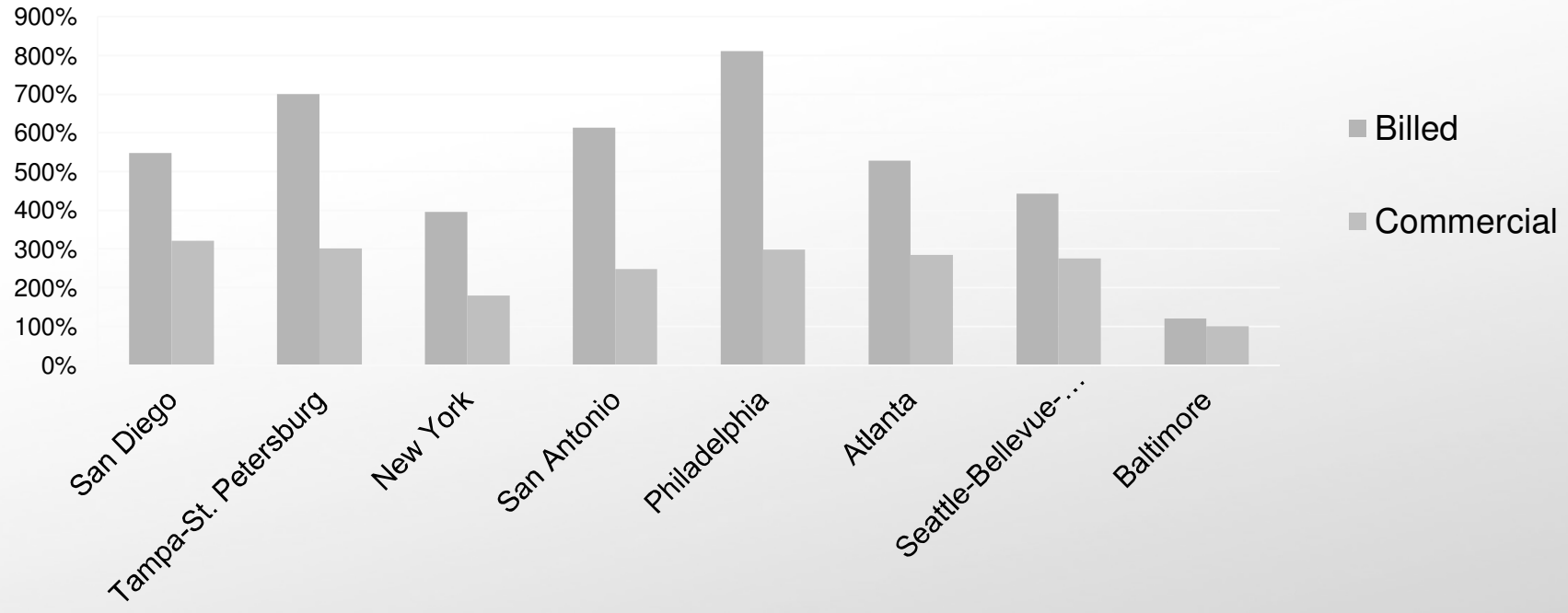
- Underlying Data Sources
- Selecting a Percentile
- Geographic Areas
- Statistical Methods
  - Direct Calculation
  - Blending
  - Filling Gaps and Holes
  - Values for New Codes

Hospital Billed Charge Levels

Billed Charges and Commercial Reimbursement relative to Medicare

Based on 2008 Medicare hospital outpatient data.

Commercial values shown are estimates.



Data Source – Medicare 5% Sample

- Publically Available
- Credible Data Source
  - Hospital Outpatient: Over 27 million service lines used
  - Professional: Over 73 million service lines used
- Complete HCPCS/CPT coding

Medicare Payment Areas Sample - Texas

Hospital Outpatient – MSA

- Houston – Sugar Land
  - 10 counties
- San Antonio
  - Atascosa County
  - Bandera County
  - Bexar County
  - Comal County
  - Guadalupe County
  - Kendall County
  - Medina County
  - Wilson County

Physician – Texas Carrier Locality

- Brazoria
- Dallas
- Galveston
  - Galveston County only
- Houston
- Beaumont
- Fort Worth
- Austin
- Rest Of State

Determining the relationship between Medicare Fees and Billed Charges

- For each service line in the 5% Sample
  - Calculate the Billed per Unit
  - Assign Medicare Fee per Unit
  - Calculate Billed Ratio:

$$\text{Billed Ratio} = \frac{\text{Billed per Unit}}{\text{Medicare Fee per Unit}}$$

Provider	Place of Service	Service	Billed	Medicare Fee	Billed Ratio
A	Office	Chiropractic Manipulation	$43.00	$25.43	1.691
B	Office	Chiropractic Manipulation	$35.00	$25.43	1.376

Methodology – Calculating the Raw 80th Percentile Billed Ratio

- Calculated for each HCPCS/CPT Code and Area
- Area definitions based on Medicare payment areas
- Each service line counts as one observation
- The 80th percentile is set to the smallest Billed Ratio where at least 80% of the services have a lower Billed Ratio.

Example

	Description CPT-4 95861	Notes and Sources	Amount
A	Medicare Allowed Amount	From CMS Physician Fee Look-up Carrier 0090099	$106.77
B	80th Percentile Multiple – Direct calculation	Based on 151 billed charges in San Antonio, TX	3.044
C	80th Percentile Multiple – Regression Formula	Based on the regression formula	3.391
D	Number of CMS billed charges	From 2007 Five Percent Sample	151
E	Weighted Multiple (151/200 x B) + (49/200 x C)	Calculated	3.129
F	Base Year Recommended Fee (2007) x (E x A)		$334.08
H	Final Fee Recommendation for year 2012 Trended by 7%	Calculated	Fee 2007: 334.08 … Fee 2012: 468.57

Filling in the Data Holes

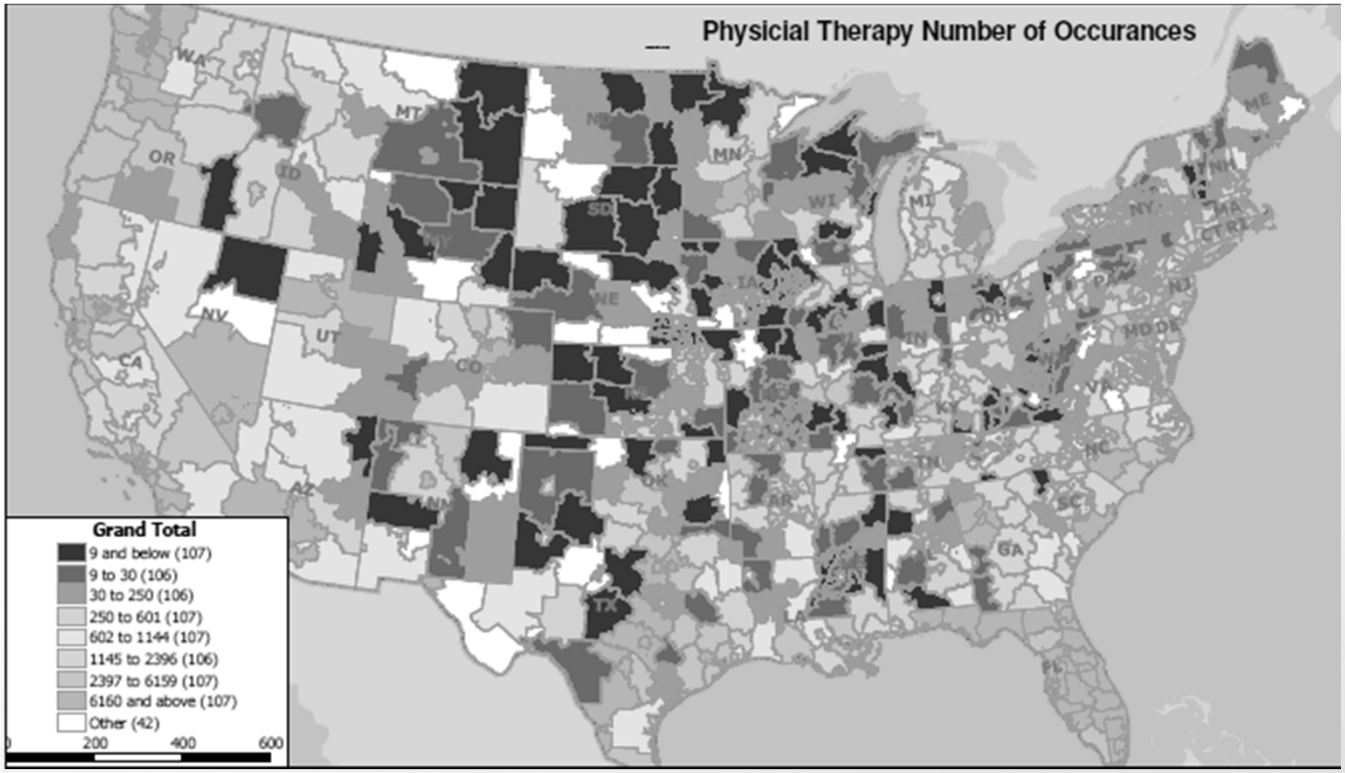
- Regression used to estimate the 80th Percentile Billed Ratio for each HCPCS/CPT code and Area combination.
- Separate regression run for Hospital Outpatient and Physician
- Regression Formula:

  Billed Ratio = Intercept * (HCPCS/CPT Effect) * (Area Effect)
- Examples:
- Professional Chiropractic Manipulation in San Antonio Texas

  Billed Ratio = 4.15 * 0.42 * 1.07 = 1.86
- Professional Hot/Cold Packs Therapy in San Antonio Texas

  Billed Ratio = 4.15 * 1.52 * 1.07 = 6.77

Why we need to fill in holes



Credibility Blending

- Credible data is not available for all HCPCS/CPT code and Area combinations
- Straight line credibility

$$Z = \text{Credibility} = \frac{\text{Observations}}{300}$$

- Final Billed Ratio =

  Z * (Raw Billed Ratio) + (1 - Z) * (Regression Result)

- Example:

  100 service lines, resulting in Z = 0.333

  Final Billed Ratio = 0.333 * (Raw Billed Ratio) + 0.667 * (Regression Result)

Developing the Payment Rate

- Payment Rate = Billed Ratio * Medicare Reimbursement
  - Billed Ratio is the final credibility blended estimate of the 80th percentile.
- Professional
  - Facility / Non-Facility
  - Technical (TC), Professional (26), and Global
  - Anesthesia base units
  - Bundled HCPCS
- Hospital Outpatient
  - Bundled Revenue Codes
  - Bundled HCPCS

Medicare Fee Schedules

Hospital Outpatient

- APC
- Lab
- DME
- RBRVS
- DME
- ASP (Drugs)
- Ambulance

The Future of UCR
Bringing Healthcare Payment Methods to Casualty Insurance

- The Term UCR will be dropped
- RBRVS based (National Healthcare)
- Fixed Fees (Prospective Payments)
- National Rental Network Contracts (PPO)
- Bundled Payments
- Tiered Provider Networks
- Published Fee Schedules

Questions?