Ethan Landy, JD| Office of General Counsel

In developing this presentation, the Department of Labor and Industry (DLI) has made every effort to accurately reflect the 2018 legislation, which is codified as Minnesota Statutes § 176.1364. The statutory language controls in the event of a difference between this presentation and the statute.

Background

About the HOFS

- The workers’ compensation hospital outpatient fee schedule (HOFS) is codified as Minnesota Statutes, § 176.1364
- The HOFS establishes payment for hospital outpatient surgical, emergency room, and clinic services using:
  - Addenda A and B from Medicare’s Outpatient Prospective Payment System (OPPS); and
  - Corresponding payment “status indicators” that Medicare assigns to each HCPCS code
- The HOFS includes only outpatient services with either a “J1” or “J2” status indicator for the specific HCPCS code

HOFS Resources

- The HOFS table, instructions, and other important information can be found on DLI's website at: www.dli.mn.gov/business/workers-compensation/work-comp-medical-fee-schedules-hofs

Applicability

- The HOFS went into effect for services provided on or after October 1, 2018
- The HOFS applies to **all** hospital outpatient services, except for services provided by hospitals designated by Medicare as Critical Access Hospitals
  - Outpatient (or inpatient) services at a Critical Access Hospital are paid at the hospital's usual and customary charge, unless the commissioner or a compensation judge determines the charge is unreasonably excessive. *Minn. Stat. 176.136, subd. 1b(a).*

Payment Amounts

- Payment amounts for services in the HOFS, as established according to the statutory requirements, are divided into two categories:
  - Non-critical access hospitals with 100 or fewer licensed beds; and
  - Hospitals with more than 100 licensed beds
- Payment amounts are set in the fee schedule, and **are payable regardless of the amount charged**
- Every Oct. 1, the HOFS payment rate table will be updated

How to Use the HOFS

Minnesota Hospital Outpatient Fee Schedule payment rates

for October 1, 2018 - September 30, 2019

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CPT is a registered trademark of the American Medical Association.

HCPCS Code	Short description	Status indicator	Minnesota payment rate: Hospitals with more than 100 licensed beds	Minnesota payment rate: Non-critical-access hospitals with 100 or fewer licensed beds
0071T	Us leiomyomata ablate <200	J1	$5,704.76	$10,727.41
0072T	Us leiomyomata ablate >200	J1	$5,704.76	$10,727.41
0101T	Extracorp shockwv tx hi enrg	J1	$6,639.65	$12,485.41
0102T	Extracorp shockwv tx anesth	J1	$6,639.65	$12,485.41
0184T	Exc rectal tumor endoscopic	J1	$10,777.18	$20,265.78

Initial Questions

- To pay a bill under HOFS, first determine the following:
  - What type of hospital is the bill from?
  - Does the bill include **at least one** service with a J1 status indicator (SI)?
  - If not, does the bill include **any services** with a J2 SI?

Bills with at least one “J1” service

- For bills with **one** J1 service, payment would be the HOFS amount in the payment table.
  - If there is **more than one** J1 service, the service with the highest HOFS amount is paid at 100% of that amount and any other service with a J1 status indicator is paid at 50% of its HOFS amount
- All other services are packaged into payment for the J1 service(s), and no separate payment is made
  - *Exception*: Implantable devices with an “H” status indicator

Bills with services with a J2 SI (and no J1)

- For bills with services with a J2 SI, and **no services with a J1 SI**:
  - Each service with a J2 SI is paid at listed HOFS amount
    - *Exception*: If there are 8 or more units of G0378, Observation services, per hour, on the bill then the APC 8011 rate in the HOFS table would apply. Payment for all other services on the bill, including services with a J2 SI, is packaged into this amount.

Bills with services with a J2 SI (and no J1), cont.

- Payment for drug charges on the same bill as a J2 (and no J1) service is as follows:
  - For drugs delivered by injection or infusion, payment is packaged into payment for the injection or infusion service and there is no separate payment of the drug;
  - Drugs not delivered by injection or infusion are paid at the Medicare Average Sales Price (ASP) on the date dispensed; and
  - If the drug is not delivered by injection or infusion and is not in the ASP, it is paid at 85% of the hospital's usual and customary charge

Bills with services with a J2 SI (and no J1), cont.

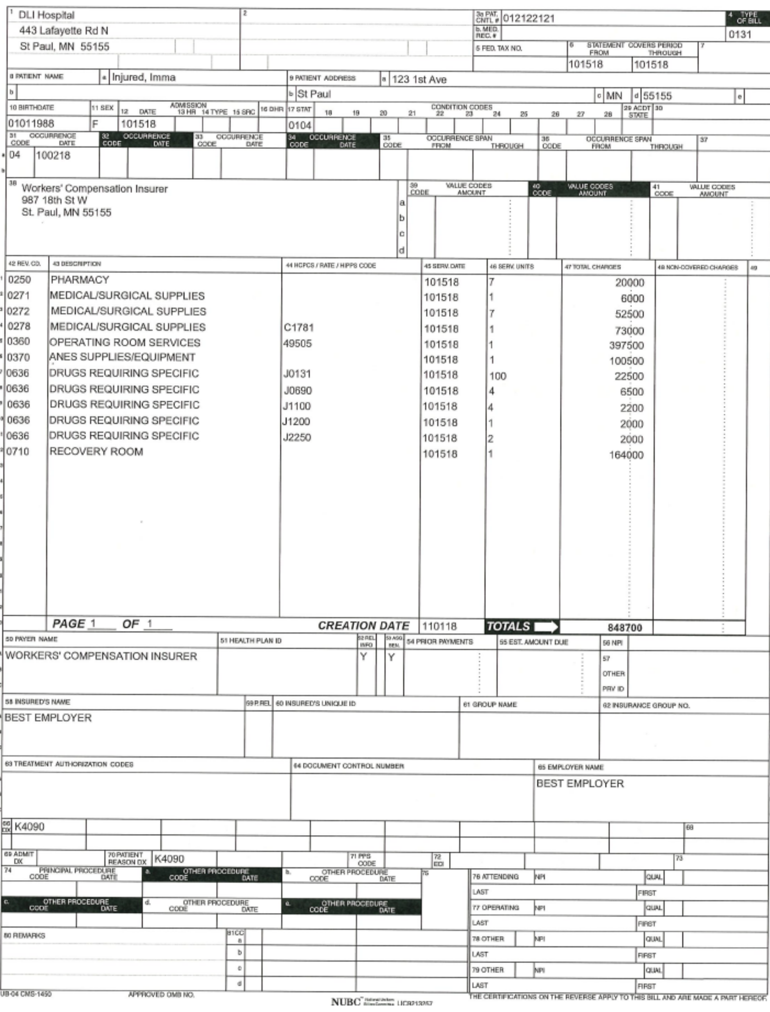
- Payment for services **without** a HCPCS code is packaged into payment for a service or services with a J2 SI (no separate payment)
- Payment for any other service on the same bill as a service with a J2 SI is paid according to the relative value fee schedule
  - Or, at 85% of a hospital's usual and customary charge if not included in the relative value fee schedule

Bills without a J1 **or** J2 service

- For bills that do not include any service listed in the HOFS:
    - If the service is covered by the relative value fee schedule, liability is as provided in the relative value fee schedule
    - If the service is **not** covered under the relative value fee schedule, it is paid at 85% of the hospital's usual and customary charge

Examples

Example 1: J1 service



1 DLI Hospital
443 Lafayette Rd N
St Paul, MN 55155

3a PAT. CNTL # 012122121
4 TYPE OF BILL 0131

6 STATEMENT COVERS PERIOD FROM 101518 THROUGH 101518

8 PATIENT NAME a Injured, Imma
9 PATIENT ADDRESS a 123 1st Ave b St Paul c MN d 55155

10 BIRTHDATE 01011988
11 SEX F
12 ADMISSION DATE 101518
17 STAT 0104

31 OCCURRENCE CODE 04 DATE 100218

38 Workers' Compensation Insurer
987 18th St W
St. Paul, MN 55155

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0250	PHARMACY		101518	7	20000	
0271	MEDICAL/SURGICAL SUPPLIES		101518	1	6000	
0272	MEDICAL/SURGICAL SUPPLIES		101518	7	52500	
0278	MEDICAL/SURGICAL SUPPLIES	C1781	101518	1	73000	
0360	OPERATING ROOM SERVICES	49505	101518	1	397500	
0370	ANES SUPPLIES/EQUIPMENT		101518	1	100500	
0636	DRUGS REQUIRING SPECIFIC	J0131	101518	100	22500	
0636	DRUGS REQUIRING SPECIFIC	J0690	101518	4	6500	
0636	DRUGS REQUIRING SPECIFIC	J1100	101518	4	2200	
0636	DRUGS REQUIRING SPECIFIC	J1200	101518	1	2000	
0636	DRUGS REQUIRING SPECIFIC	J2250	101518	2	2000	
0710	RECOVERY ROOM		101518	1	164000	
PAGE 1 OF 1		CREATION DATE	110118	TOTALS	848700	

50 PAYER NAME: WORKERS' COMPENSATION INSURER
52 REL. INFO: Y
53 ASG. BEN.: Y

58 INSURED'S NAME: BEST EMPLOYER

65 EMPLOYER NAME: BEST EMPLOYER

66 DX: K4090

70 PATIENT REASON DX: K4090

UB-04 CMS-1450 APPROVED OMB NO.

NUBC

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Example 1, cont.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0250	PHARMACY		101518	7	20000		
0271	MEDICAL/SURGICAL SUPPLIES		101518	1	6000		
0272	MEDICAL/SURGICAL SUPPLIES		101518	7	52500		
0278	MEDICAL/SURGICAL SUPPLIES	C1781	101518	1	73000		
0360	OPERATING ROOM SERVICES	49505	101518	1	397500		
0370	ANES SUPPLIES/EQUIPMENT		101518	1	100500		
0636	DRUGS REQUIRING SPECIFIC	J0131	101518	100	22500		
0636	DRUGS REQUIRING SPECIFIC	J0690	101518	4	6500		
0636	DRUGS REQUIRING SPECIFIC	J1100	101518	4	2200		
0636	DRUGS REQUIRING SPECIFIC	J1200	101518	1	2000		
0636	DRUGS REQUIRING SPECIFIC	J2250	101518	2	2000		
0710	RECOVERY ROOM		101518	1	164000		
	PAGE 1 OF 1	CREATION DATE	110118	TOTALS	848700		

Explanation of Example 1

- There is a J1 service on the bill – HCPCS 49505, Operating Room Services
  - This is the **only** J1 service on the bill. Do not be confused by the HCPCS **codes** that begin with the letter "J." That is not the same as a service with a J1 status indicator.
- The presence of the J1 service means you pay the amount in the HOFS table for that HCPCS code, as referenced earlier
  - Look on the HOFS table: **$7,307.15** for a hospital with more than 100 licensed beds, and **$13,740.60** for a hospital with 100 or fewer licensed beds
- All other services on this bill are not separately payable, and are packaged into the payment amount for the J1 service

Bills with at least one “J1” service

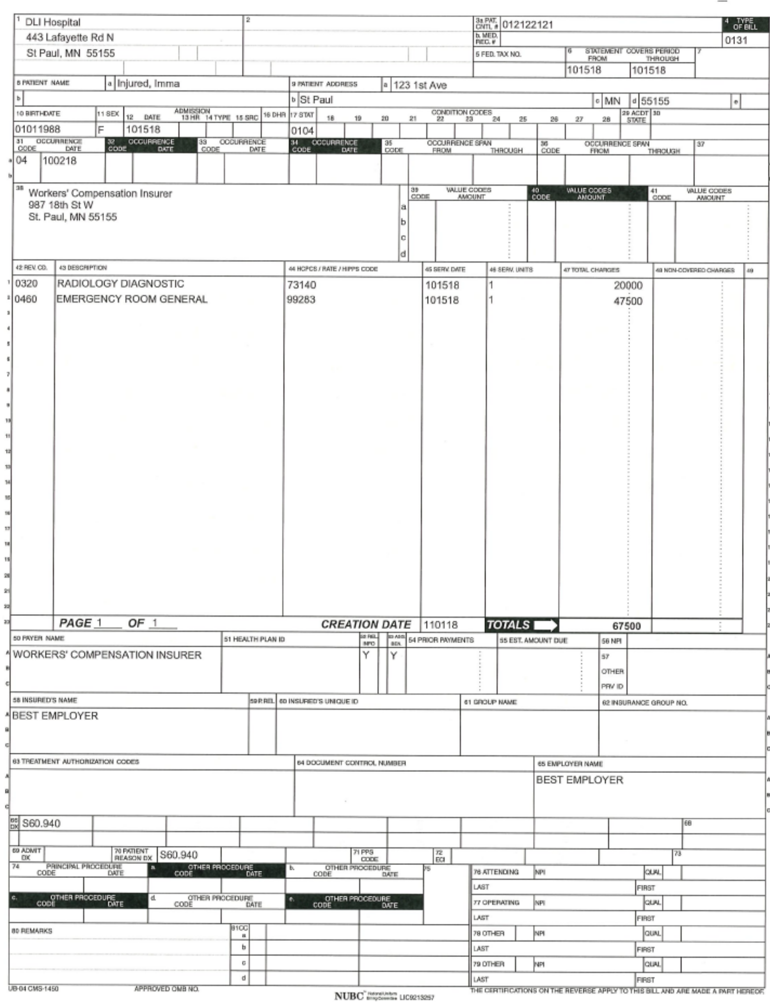
- For bills with **one** J1 service, payment would be the HOFS amount in the payment table.
  - If there is **more than one** J1 service, the service with the highest HOFS amount is paid at 100% of that amount and any other service with a J1 status indicator is paid at 50% of its HOFS amount
- All other services are packaged into payment for the J1 service(s), and no separate payment is made
  - *Exception*: Implantable devices with an “H” status indicator

Minnesota Hospital Outpatient Fee Schedule payment rates
for October 1, 2018 - September 30, 2019

HCPCS Code	Short description	Status indicator	Minnesota payment rate: Hospitals with more than 100 licensed beds	Minnesota payment rate: Non-critical-access hospitals with 100 or fewer licensed beds
49421	Ins tun ip cath for dial opn	J1	$7,307.15	$13,740.60
49423	Exchange drainage catheter	J1	$3,582.82	$6,737.26
49426	Revise abdomen-venous shunt	J1	$7,307.15	$13,740.60
49436	Embedded ip cath exit-site	J1	$3,582.82	$6,737.26
49440	Place gastrostomy tube perc	J1	$3,582.82	$6,737.26
49441	Place duod/jej tube perc	J1	$3,582.82	$6,737.26
49446	Change g-tube to g-j perc	J1	$3,582.82	$6,737.26
49491	Rpr hern preemie reduc	J1	$11,266.81	$21,186.48
49492	Rpr ing hern premie blocked	J1	$7,307.15	$13,740.60
49495	Rpr ing hernia baby reduc	J1	$7,307.15	$13,740.60
49496	Rpr ing hernia baby blocked	J1	$7,307.15	$13,740.60
49500	Rpr ing hernia init reduce	J1	$7,307.15	$13,740.60
49501	Rpr ing hernia init blocked	J1	$7,307.15	$13,740.60
49505	Prp i/hern init reduc >5 yr	J1	$7,307.15	$13,740.60
49507	Prp i/hern init block >5 yr	J1	$7,307.15	$13,740.60
49520	Rerepair ing hernia reduce	J1	$7,307.15	$13,740.60
49521	Rerepair ing hernia blocked	J1	$7,307.15	$13,740.60
49525	Repair ing hernia sliding	J1	$7,307.15	$13,740.60
49540	Repair lumbar hernia	J1	$11,266.81	$21,186.48
49550	Rpr rem hernia init reduce	J1	$7,307.15	$13,740.60
49553	Rpr fem hernia init blocked	J1	$7,307.15	$13,740.60
49555	Rerepair fem hernia reduce	J1	$7,307.15	$13,740.60
49557	Rerepair fem hernia blocked	J1	$7,307.15	$13,740.60
49560	Rpr ventral hern init reduc	J1	$7,307.15	$13,740.60
49561	Rpr ventral hern init block	J1	$7,307.15	$13,740.60
49565	Rerepair ventrl hern reduce	J1	$11,266.81	$21,186.48

Table 1

Example 2: J2 service



DLI Hospital
443 Lafayette Rd N
St Paul, MN 55155

3a PAT. CNTL #: 012122121
4 TYPE OF BILL: 0131
6 STATEMENT COVERS PERIOD FROM: 101518 THROUGH: 101518

8 PATIENT NAME: a Injured, Imma
9 PATIENT ADDRESS: a 123 1st Ave; b St Paul; c MN; d 55155

10 BIRTHDATE: 01011988
11 SEX: F
12 ADMISSION DATE: 101518
17 STAT: 0104

31 OCCURRENCE CODE: 04 DATE: 100218

38:
Workers' Compensation Insurer
987 18th St W
St. Paul, MN 55155

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
0320	RADIOLOGY DIAGNOSTIC	73140	101518	1	20000	
0460	EMERGENCY ROOM GENERAL	99283	101518	1	47500	
	PAGE 1 OF 1	CREATION DATE	110118	TOTALS	67500	

50 PAYER NAME: WORKERS' COMPENSATION INSURER
52 REL. INFO: Y
53 ASG. BEN.: Y

58 INSURED'S NAME: BEST EMPLOYER

65 EMPLOYER NAME: BEST EMPLOYER

67: S60.940
70 PATIENT REASON DX: S60.940

UB-04 CMS-1450 APPROVED OMB NO. NUBC LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Example 2, cont.

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0320	RADIOLOGY DIAGNOSTIC	73140	101518	1	20000		
0460	EMERGENCY ROOM GENERAL	99283	101518	1	47500		
	PAGE 1 OF 1	CREATION DATE	110118	TOTALS	67500		

50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL | 53 ASG | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI

Explanation of Example 2

- There is no J1 service on this bill. But, the emergency room service, HCPCS code 99283, is a J2 service
- As referenced earlier, this means the J2 service is paid at the HOFS rate.
  - Look on the HOFS table: **$549.96** for a hospital with more than 100 licensed beds, and **$1,034.16** for a hospital with 100 or fewer licensed beds
- Unlike the earlier example, other services on a bill with a J2 service may be separately payable
  - The radiology service on this bill is separately payable, and is paid at $48.01 according to the relative value fee schedule
  - Therefore, total payment is either **$597.97** or **$1,092.17**

Bills with services with a J2 SI (and no J1)

- For bills with services with a J2 SI, and **no services with a J1 SI**:
  - Each service with a J2 SI is paid at listed HOFS amount

Minnesota Hospital Outpatient Fee Schedule payment rates
for October 1, 2018 - September 30, 2019

HCPCS Code	Short description	Status indicator	Minnesota payment rate: Hospitals with more than 100 licensed beds	Minnesota payment rate: Non-critical-access hospitals with 100 or fewer licensed beds
93615	Esophageal recording	J1	$2,282.29	$4,291.69
93616	Esophageal recording	J1	$2,282.29	$4,291.69
93618	Heart rhythm pacing	J1	$2,282.29	$4,291.69
93619	Electrophysiology evaluation	J1	$13,339.18	$25,083.44
93620	Electrophysiology evaluation	J1	$13,339.18	$25,083.44
93624	Electrophysiologic study	J1	$13,339.18	$25,083.44
93642	Electrophysiology evaluation	J1	$2,282.29	$4,291.69
93650	Ablate heart dysrhythm focus	J1	$13,339.18	$25,083.44
93653	Ep & ablate supravent arrhyt	J1	$46,476.34	$87,395.67
93654	Ep & ablate ventric tachy	J1	$46,476.34	$87,395.67
93656	Tx atrial fib pulm vein isol	J1	$46,476.34	$87,395.67
99281	Emergency dept visit	J2	$172.33	$324.06
99282	Emergency dept visit	J2	$312.89	$588.36
99283	Emergency dept visit	J2	$549.96	$1,034.16
99284	Emergency dept visit	J2	$892.39	$1,678.09
99285	Emergency dept visit	J2	$1,307.35	$2,458.38
99291	Critical care first hour	J2	$1,841.46	$3,462.74
C9600	Perc drug-el cor stent sing	J1	$26,381.73	$49,609.10
C9602	Perc d-e cor stent ather s	J1	$40,211.93	$75,615.87
C9604	Perc d-e cor revasc t cabg s	J1	$26,381.73	$49,609.10
C9606	Perc d-e cor revasc w ami s	J1	$40,211.93	$75,615.87
C9607	Perc d-e cor revasc chro sin	J1	$40,211.93	$75,615.87
C9734	U/s trtmt, not leiomyomata	J1	$14,072.38	$26,462.19
C9739	Cystoscopy prostatic imp 1-3	J1	$9,302.30	$17,492.36
C9740	Cysto impl 4 or more	J1	$19,066.97	$35,854.17
C9741	Impl pressure sensor w/angio	J1	$81,899.22	$154,006.05

Table 1

Bills with services with a J2 SI (and no J1), cont.

- Payment for services **without** a HCPCS code is packaged into payment for a service or services with a J2 SI (no separate payment)
- Payment for any other service on the same bill as a service with a J2 SI is paid according to the relative value fee schedule
  - Or, at 85% of a hospital's usual and customary charge if not included in the fee schedule

Outpatient billing, payment, and dispute resolution

Billing requirements

- Hospitals and ASCs must bill workers' compensation insurers using the same codes, formats and details that are required for billing Medicare
    - Includes AMA CPT codes, Medicare's ASCPS, outpatient code editor, HCPCS codes, and the Medicare NCCI policy manual, webpage and tables
- ASCs must bill electronically in the 837P format; Hospitals must bill electronically in the 837I format
- Medical records must be attached to the 837P or 837I in the 275 format

Submission and payment

- Hospital and ASC bills must be submitted to payer within 6 months from the date of service or the date the correct payer is known, whichever is later
  (Minn. Stat. § 62Q.75, subd. 3)

- Insurers have 30 calendar days to pay, deny, or request additional information
  - (Minn. R. 5221.0600, subp. 4)

Reconsideration and reimbursement

- Hospitals and ASCs have one year from the date of the EOR or EOB to request that the insurer reconsider a payment denial or reduction
    - The reconsideration request must be in writing
    - The insurer has 30 calendar days to respond in writing to the request for reconsideration and address the issues raised in the request
- The insurer has one year from the date of the payment to request reimbursement for an overpayment

Medical requests at DLI

- Hospitals and ASCs must notify the insurer at least 20 days prior to filing a Medical Request with DLI for an administrative conference
- Insurer, hospital or ASC must file a Medical Request no later than the latest of:
  - One year after date of initial EOR or EOB if the hospital or ASC does not request reconsideration of a payment denial or reduction;
  - One year after date of insurer's response to a hospital or ASC request for reconsideration; or
  - One year after the insurer's request for reimbursement of an overpayment from a hospital or ASC

HOFS Resources

Who to contact

- Questions about the HOFS or any other fee schedule should be directed to DLI's Medical Policy staff at 651-284-5052 or medical.policy.dli@state.mn.us

QUESTIONS?

Thank You!

Ethan Landy

ethan.landy@state.mn.us

651-284-5302