Workers' Compensation Hospital Outpatient Fee Schedule

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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





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



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

1	Α	В	C	D	E	F
1		Minnesota Hospital Outpatient Fee	Schedule payme	nt rates		
2		for October 1, 2018 - Sept	ember 30, 2019			
4				Minnesota p	ayment rate	
5	HCPCS Code	Short description	Status	Hospitals with more than 100 licensed beds	Non-critical- access hospitals with 100 or fewer licensed beds	
7	Note: If you	u landed here by way of a search engine (or of	ther) link, be advi	ised that this fi	le contains	
8	materials o	copyrighted by the American Medical Associati	ion. You are not a	authorized to d	ownload	
9	these mate	erials unless you read, agree to and abide by th	he provisions of t	he copyright s	tatement.	
10	Read the c	opyright statement now (you will be linked bac	ck to here).			
12	The five-ch	paracter codes included in the Hospital Outpati	ient Fee Schedul	e (HOFS) are	obtained	
13	1.1	nt Procedural Terminology (CPT®), copyright				
14	(AMA). CP	T is developed by the AMA as a listing of desc	criptive terms and	l five-characte	r identifying	
15	codes and	modifiers for reporting medical services and p	procedures.			
17	The respon	nsibility for the content of HOFS is with DLI an	nd no endorsemen	nt by the AMA	is intended	
18	or should b	e implied. The AMA disclaims responsibility i	for any conseque	nces or liabilit	y attributable	
19	or related t	o any use, nonuse or interpretation of informa	tion contained in	HOFS. Fee so	hedules,	
20	relative val	ue units, conversion factors and/or related con	mponents are not	assigned by t	he AMA, are	
21		CPT, and the AMA is not recommending their		-		
22		edicine or dispense medical services. The AM		-		
23		ed herein. Any use of CPT outside of HOFS s				
24		Terminology which contains the complete and	d most current lis	ting of CPT co	des and	
25	descriptive	terms.				
27	CPT is a re	egistered trademark of the American Medical A	Association.			
29	0071T	Us leiomyomata ablate <200	J1	\$5,704.76	\$10,727.41	
30	0072T	Us leiomyomata ablate >200	J1	\$5,704.76	\$10,727.41	
31	0101T	Extracorp shockwv tx hi enrg	J1	\$6,639.65	\$12,485.41	
32	0102T	Extracorp shockwv tx anesth	J1	\$6,639.65	\$12,485.41	
33	0184T	Exc rectal tumor endoscopic	J1	\$10,777.18	\$20,265.78	

Initial Questions

- To pay a bill under HOFS, first determine the following:
 - OWhat type of hospital is the bill from?
 - ODoes the bill include at least one service with a J1 status indicator (SI)?
 - olf 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:
 - OEach 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







Example 1: J1 service

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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 <u>a</u> 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



1 A	B Minnesota Hospital Outpatient F	C C	D	E	F	G	H	1	J	K	L	M	N	0	Р	Q	R	
1			ent rates					1		2								
2	for October 1, 2018 - S	September 30, 2019																_
4			Minnesota p	ayment rate														
HCPCS 5 Code	Short description	Status indicator	Hospitals with more than 100 licensed beds	Non-critical- access hospitals with 100 or fewer licensed beds														
827 49421	Ins tun ip cath for dial opn	J1	\$7,307.15	\$13,740.60														
828 49423	Exchange drainage catheter	J1	\$3,582.82	\$6,737.26														
829 49426	Revise abdomen-venous shunt	J1	\$7,307.15	\$13,740.60														
830 49436	Embedded ip cath exit-site	J1	\$3,582.82	\$6,737.26														
831 49440	Place gastrostomy tube perc	J1	\$3,582.82	\$6,737.26														
832 49441	Place duod/jej tube perc	J1	\$3,582.82	\$6,737.26														
833 49446	Change g-tube to g-j perc	J1	\$3,582.82	\$6,737.26														
834 49491	Rpr hern preemie reduc	J1	\$11,266.81	\$21,186.48														
835 49492	Rpr ing hern premie blocked	J1	\$7,307.15	\$13,740.60														
836 49495	Rpr ing hernia baby reduc	J1	\$7,307.15	\$13,740.60														
837 49496	Rpr ing hernia baby blocked	J1	\$7,307.15	\$13,740.60														
838 49500	Rpr ing hernia init reduce	J1	\$7,307.15	\$13,740.60														
839 49501	Rpr ing hernia init blocked	J1	\$7,307.15	\$13,740.60														
840 49505	Prp i/hern init reduc >5 yr	J1	\$7,307.15	\$13,740.60														
841 49507	Prp i/hern init block >5 yr	J1	\$7,307.15	\$13,740.60														
842 49520	Rerepair ing hernia reduce	J1	\$7,307.15	\$13,740.60														
843 49521	Rerepair ing hernia blocked	J1	\$7,307.15	\$13,740.60														
844 49525	Repair ing hernia sliding	J1	\$7,307.15	\$13,740.60														
845 49540	Repair lumbar hernia	J1	\$11,266.81	\$21,186.48														
846 49550	Rpr rem hernia init reduce	J1	\$7,307.15	\$13,740.60														
847 49553	Rpr fem hernia init blocked	J1	\$7,307.15	\$13,740.60														
848 49555	Rerepair fem hernia reduce	J1	\$7,307.15	\$13,740.60														
849 49557	Rerepair fem hernia blocked	J1	\$7,307.15	\$13,740.60														
850 49560	Rpr ventral hern init reduc	J1	\$7,307.15	\$13,740.60														
851 49561	Rpr ventral hern init block	J1	\$7,307.15	\$13,740.60														
852 49565	Rerepair ventrl hern reduce	J1	\$11,266.81	\$21,186.48														
	Table 1 +		A	*** *** **					÷ •									

Example 2: J2 service

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Example 2, cont.

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42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 0320	RADIOLOGY DIAGNOSTIC	73140	101518	1	20000		
² 0460	EMERGENCY ROOM GENERAL	99283	101518	1	47500		
3							
4							
5							
6							
-		6.00					
<u> </u>						:	
8							
9							
10						:	
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18							
9							
20							
21							
12							
13	PAGE 1 OF 1	CREATION DATE	110118	TOTALS	67600		
50 PAYER NA					67500		L

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



A 1	B Minnesota Hospital Outpatient	C Fee Schedule payme	D nt rates	E	F	G H	-	J	K	L	M	N	0	Р	Q	R
6	for October 1, 2018 - S		int rates		-				2							
		September 30, 2019														
4			Minnesota p	ayment rate												
HCPCS 5 Code	Short description	Status indicator	Hospitals with more than 100 licensed beds	Non-critical- access hospitals with 100 or fewer licensed beds												
760 93615	Esophageal recording	J1	\$2,282.29	\$4,291.69												
761 93616	Esophageal recording	J1	\$2,282.29	\$4,291.69												
762 93618	Heart rhythm pacing	J1	\$2,282.29	\$4,291.69												
763 93619	Electrophysiology evaluation	J1	\$13,339.18	\$25,083.44												
764 93620	Electrophysiology evaluation	J1	\$13,339.18	\$25,083.44												
765 93624	Electrophysiologic study	J1	\$13,339.18	\$25,083.44												
766 93642	Electrophysiology evaluation	J1	\$2,282.29	\$4,291.69												
767 93650	Ablate heart dysrhythm focus	J1	\$13,339.18	\$25,083.44												
768 93653	Ep & ablate supravent arrhyt	J1	\$46,476.34	\$87,395.67												
769 93654	Ep & ablate ventric tachy	J1	\$46,476.34	\$87,395.67												
770 93656	Tx atrial fib pulm vein isol	J1	\$46,476.34	\$87,395.67												
771 99281	Emergency dept visit	J2	\$172.33	\$324.06												
772 99282	Emergency dept visit	J2	\$312.89	\$588.36												
73 99283	Emergency dept visit	J2	\$549.96	\$1,034.16												
774 99284	Emergency dept visit	J2	\$892.39	\$1,678.09												
775 99285	Emergency dept visit	J2	\$1,307.35	\$2,458.38												
776 99291	Critical care first hour	J2	\$1,841.46	\$3,462.74												
777 C9600	Perc drug-el cor stent sing	J1	\$26,381.73	\$49,609.10												
778 C9602	Perc d-e cor stent ather s	J1	\$40,211.93	\$75,615.87												
779 C9604	Perc d-e cor revasc t cabg s	J1	\$26,381.73	\$49,609.10												
780 C9606	Perc d-e cor revasc w ami s	J1	\$40,211.93	\$75,615.87												
781 C9607	Perc d-e cor revasc chro sin	J1	\$40,211.93	\$75,615.87												
782 C9734	U/s trtmt, not leiomyomata	J1	\$14,072.38													
783 C9739	Cystoscopy prostatic imp 1-3	J1	\$9,302.30	\$17,492.36												
784 C9740	Cysto impl 4 or more	J1	\$19,066.97	\$35,854.17												
785 C9741	Impl pressure sensor w/angio	J1		\$154,006.05												

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