

# The Department of Labor and Industry

## MEDICAL BILLS

Your responsibilities under the  
rules and current issues on  
processing and payment

# Outline

- Overview of the Rules (NOT INCLUDING THE TREATMENT PARAMETERS)

(A PARTIAL INDEX TOOL FOR CHAPTER 5221 RULES - Handout)

- Responsibilities of Providers
- Responsibilities of Payers (Insurers)
- Current Issues

# Premise

- Looking at the Rules on Fees for Medical Services a little differently.
- Ask not what are my rights but what are my responsibilities?

# Premise

- If you understand and comply with your responsibilities as a medical provider your rate of reimbursements should increase.

## SIMILARLY:

- If you understand and comply with your responsibilities as a payer (insurer) your defenses should succeed more often and litigation costs will likely decrease.

# Overview of the Rules

- Rules on Medical Reimbursement are found in Chapter 5221.
- Minn. Stat. 176.136 is the enabling statute.
  - Authority to establish rules for determining excessive charges including a “fee schedule.”
  - “Relative value units”- (RVU) for different services multiplied by a conversion factor.
  - Minn. Stat. 176.136 Subd.1b also provides for a “Limitation of Liability.”

# Purpose of Chapter 5221

“This chapter is intended to prohibit health care providers treating employees with compensable injuries from receiving excessive reimbursement for their services. This chapter also governs health care provider communication with parties; required reporting of medical, disability, and billing information under Minnesota Statutes, chapter 176; change of health care provider; and criteria for determining, serving, and filing maximum medical improvement.”

# Limitations on Reimbursement Dependent on Provider Type

- **Small hospitals** (100 or fewer licensed beds): **paid 100%** of usual and customary charge. (Minn. Stat. 176.136 Subd. 1b(a) and MN Rules 5221.0500 Subp. 2C)
- **Inpatient treatment at large hospitals** (more than 100 licensed beds): **paid 85%** of usual and customary charge. (Minn. Stat. 176.136 Subd. 1b(b) and MN Rules 5221.0500 Subp. 2B)

# Limitations on Reimbursement Dependent on Provider Type

- **Out-of-state provider** is limited to the payment that would be received under **work comp in their jurisdiction** where the treatment was provided. (Minn. Stat. 176.136 Subd. 1b(d)) (Treatment on or after May 1, 2008)
- **Nursing homes** participating in **medical assistance** and whose **rates** are **established** by Commissioner of **Human Services** are not subject to the 85 % limitation. (Minn. Stat. 176.136 Subd. 1b(c))
- **Independent medical examiners** - separate rule. (Minn. Stat. 176.136 Subd. 1c; see MN Rules 5219.0500)

# Limitations on Reimbursement Dependent on Provider Type

Any other medical provider is likely subject to  
Minn. Stat. 176.136 Subd.1a:

the relative value unit (RVU) multiplied by the  
conversion factor as itemized in MN Rules 5221.  
4030 – 4060. (Minn. Stat. 176.136 Subd. 1a. and  
MN Rules 5221.0500 Subp. 2A)

(This is what commonly is referred to as “the fee schedule.”  
This is where you find the treatment CPT codes covered in  
workers’ compensation, the RVU’s and conversion factors,  
etc.)

# Limitations on Reimbursement Dependent on Provider Type

- MN Rules 5221.0500 Subp. 2A refers to the “maximum amount” allowable for a service, article or supply.
- The maximum amount allowable is the lower of the fee schedule amount or your usual and customary charge.

# Limitations on Reimbursement Dependent on Provider Type

If you are a medical provider, (other than a large hospital providing inpatient services or a small hospital) your maximum fee is generally going to be the “fee schedule” amount (relative value unit x conversion factor).

# Limitations on Reimbursement Dependent on Provider Type

- However, if the CPT code is not in the “fee schedule” then the maximum fee is calculated differently.
- If the **CPT code** is not included in the workers’ compensation “fee schedule,” but is **unique to the Medicare Fee Schedule**, the maximum fee is **likely 85%** of the provider’s usual and customary charges. (MN Rules 5221.4020 Subp. 2C(7), (9), (11) ). (On the other hand, if the service is erroneously coded it may be in the fee schedule.)

# Remember . . .

- If there is a zero RVU listed, the amount of reimbursement is NOT necessarily zero multiplied by the conversion factor!
- If there is a zero RVU, reimbursement may be limited to 85 % of the provider's usual and customary charge or the prevailing charge, whichever is less. You need to check the status code as well.
- You have to look at the status code for payment or coding instructions. Sometimes there is no payment allowed (because services have been bundled). (Minn. Stat. 176.136 Subd.1b(b))

# Minn. Stat. 176.136 Subd. 2

- Excessive charges for services are not payable and the health care provider cannot pursue a claim directly against the employee (or the employer or insurer).
- The **Health Care Provider** can file a **Medical Request** for amounts deemed excessive or the **employee** can pursue the claim as well.

# Excessive charges under the statute are those that:

- exceed the maximum charges allowable per Minn. Stat. 176.136 Subd. 1, 1a, 1b, or 1c;
  - For example: small hospitals (100 or fewer beds) get paid 100% of the hospital's usual and customary charge unless the charge is determined to be unreasonably excessive. (Minn. Stat. 176.136 Subd. 1b(a)).
- are for services that exceed the level, duration, or frequency that is excessive based on accepted standards;
- are for services outside scope of practice of provider/not recognized of therapeutic value; or
- are otherwise deemed excessive or inappropriate pursuant to the rules.

# Provider Responsibilities

- Submit your **usual and customary** charge.

*“No provider shall submit a charge for a service which exceeds the amount which the provider charges for the same type of service in cases unrelated to workers' compensation injuries.”* (MN Rules 5221.0700 Subp.1)

- Except for hospitals, **supply** copy of an **appropriate record** documenting the service and the relationship to the work injury. (MN Rules 5221.0100 Subp.1b and 5221.0700 Subp.2)
- Hospitals **must submit** appropriate **record** upon **request**. (MN Rules 5221.0700 Subp.2)

# Provider Responsibilities

Charges must be submitted to the payer directly by the health care provider actually furnishing the service, article, or supply and includes but is not limited to:

- Imaging, lab, or pathology not performed by the provider furnishing the test.
- Equipment, supplies, or medication not ordinarily kept in stock by the hospital or other health care provider.
- Services at a large or small hospital if the provider has an independent practice (except hospitals can charge for services by provider who receives base payment from hospital regardless of number of patients seen).
- Outpatient medications dispensed by licensed pharmacy.

## □ Buck-Ulrick v. Tri City Enterprises, slip op. (WCCA May 13, 2008)

- One of the very few cases regarding implants.
- The essence of the holding in this case was that the hospital was the provider that actually furnished the service or supply to the employee and was the proper billing party as opposed to the manufacturer.

# Provider Responsibilities

(MN Rules 5221.0700 Subp. 1 and 2)

- Charges must be submitted to the payer within 60 days from the date the health care provider knew the condition being treated was claimed by the employee as compensable under workers' compensation. Failure to submit within the 60 days is not a basis to deny but is a basis for disciplinary action against the provider under Minn. Stat. 176.103.
- Failure to submit claims within the time frames specified in Minn. Stat. 62Q.75, Subd. 3, may result in denial of payment.

# Provider Responsibilities

(Minn. Stat. 62Q.75 Subd. 3)

Prompt submission of bills is required (unless otherwise provided by contract or law):

- within six months from the date of service or the date the health care provider knew or was informed of the correct name and address of the responsible health plan company or third-party administrator, whichever is later ... applies to charges for workers' compensation.
- If no initial submission within six-months you may not be reimbursed. You can't collect from the recipient of the service or any other payer.

# Provider Responsibilities

(MN Rules 5221.0700 Subp. 2)

- Subp. 2a: Charges for all services, articles, and supplies must be submitted on a *CMS 1500 form* (except for hospital and pharmacy).  
[www.cms.hhs.gov/cmsforms/downloads/CMS1500805.pdf](http://www.cms.hhs.gov/cmsforms/downloads/CMS1500805.pdf)
- Subp. 2b-d discusses the format the bill should take.
- It must be filled out per Minn. Stat. [62J.52](#) and directions in the "Minnesota Standards for the Use of the CMS 1500 Claim Form" manual adopted by Department of Health per Minn. Stat. [62J.61](#).

# Provider Responsibilities

(MN Rules 5221.0700 Subp. 2)

- Hospitals are different. They must submit itemized charges on the uniform billing claim form UB-92 (CMS 1450). (The most current CMS form is UB-04.) It must be filled out according to Minn. Stat. [62J.52](#) and the "Minnesota UB-92 manual" published by the Minnesota Hospital Association.
- When the UB-92 (or UB-04) form provides only summary information, an itemized listing of all services and supplies provided during the inpatient hospitalization must be attached to the UB-92 form.

# ALERT:

Electronic billing is right around the corner and the “proper billing format” issues will be different now.

# Provider Responsibilities

(MN Rules 5221.0700 Subp. 3)

- Use professional judgment to assign the correct approved billing code, and any applicable modifiers.
- The codes come from the CPT, HCPCS, NDC, or UB-92 (UB-04) manual in effect on date of service.

# Payer Responsibilities

(MN Rules 5221.0600)

No later than 30 calendar days after receiving the bill the payer *shall*:

- **pay** (the charge or any portion of the charge that is not denied);
- deny (all or a portion of a charge) on the basis that:
  - the injury is non-compensable (Minn. Stat. 176.135 Subd. 6(1));
  - the charge is excessive (Minn. Stat. 176.135 Subd. 6(2) and MN Rules 5221.0500 Subp. 1 and 2); and/or
  - charges were not submitted on appropriate billing form (MN Rules 5221.0700);
- **request** specific additional information to determine whether the charge or the condition is compensable<sub>25</sub>

# Denial of Primary Liability

- Payers must advise health care providers in writing if there is a denial of primary liability. (MN Rules 5221.0600 Subp. 4)
- A denial of primary liability allows the bills to be submitted to other insurers.
- *If a dispute exists as to **whether an employee's injury is compensable** and the employee is otherwise covered by an insurer or entity pursuant to chapters 62A, 62C, 62D, 62E, 62R, and 62T, that insurer or entity shall pay any medical costs incurred by the employee for the injury up to the limits of the applicable coverage.* (Minn. Stat. 176.191 Subd. 3)

# Payer Responsibilities

(MN Rules 5221.0600 Subp. 4)

Within 30 days of receiving charges payer must provide **written notification** to the employee and provider:

- Basis for denial of all or part of a charge determined not to be for a compensable injury;
- Basis for denial or reduction of each charge;
- Denial of charge for failure to submit on prescribed form; and/or
- Request for appropriate record to allow for proper determination.

# Payer Responsibilities

(MN Rules 5221.0600 Subp. 4)

*“The payer shall specify the applicable rule, part, and subpart in this chapter supporting its denial or reduction of a charge. A general statement that a service or charge ‘exceeds the fee schedule or treatment parameters’ is not adequate notification.”*

# What is a proper request for specific additional information?

## MN Rules 5221.0600

- Bill review companies have argued an explanation of benefits (EOB) form constitutes a request for more information and the 30 day period to pay or deny does not start running until they receive more information.
- EOB statements frequently cite a reason for denial. An EOB may be specific enough to provide a basis for reduction or denial. However, an EOB itself is not a request for an appropriate record or specific information under the rules.

# Provider Responsibilities re: Payer's Proper Request

Must comply within seven working days with payers' proper written requests for existing medical data regarding services provided, the patient's condition, the plan of treatment, and other issues pertaining to the payer's determination of compensability or excessiveness. (MN Rules 5221.0700 Subp. 4)

# Denial as Excessive

(MN Rules 5221.0500 Subp. 2)

- A payer is not liable for excessive health care provider charges.
- A payer's liability is limited as provided by the "fee schedule" and if that is inapplicable, payment is limited to 85% of the provider's usual and customary charge or 85% of prevailing charge for similar treatment – whichever is lower.

# What is an Excessive Charge?

(MN Rules 5221.0500 Subp. 1)

- A. charge wholly or partially **duplicates** another charge;
- B. charge **exceeds** current **usual and customary** charge;
- C. **code not reflective of** actual service;
- D. does **not comply** with the **treatment standards**;
- E. service performed by **prohibited provider** (Minn. Stat. 176.83, 176.103, 176.1351, and 256B.0644);

# What is an Excessive Charge?

(MN Rules 5221.0500 Subp. 1)

- F. the service, article, or supply is **not usual, customary, and reasonably required for the cure or relief** of the effects of a compensable injury or is provided at a level, duration, or frequency that is excessive based on accepted standards;
  
- G. service, article, or supply was delivered in **violation of the federal Medicare anti-kickback statutes/regulations**;

# What is an Excessive Charge?

(MN Rules 5221.0500 Subp. 1)

- H. where approval for change of doctor required by part 5221.0430 for the provider submitting and approval has not been obtained from the payer; or
- I. service outside scope of practice of particular provider or not generally recognized within the particular profession of the provider as of therapeutic value for the specific injury or condition.

# Current Issue: Excessive Charges

- Bill review companies have denied or reduced charges for services they believe should be “bundled.”
- Using the term “bundled” may lead to some confusion.

# Four scenarios where you might see “bundling” or “bundled”

- Under Status Codes
  - This is acceptable usage.
- Outpatient Limitation for Medical/Surgical Facility Fee (MN Rules 5221.4033)
  - Certain services and supplies are included in any facility fee. “Bundling” should not be used to describe disputes over separate billing that arise under this rule.
- Global Surgical Package (MN Rules 5221.4035)
  - Similarly, disputes that arise over the components to be included in a global surgical package should not be referred to as “bundling.”
- Duplicative Charges
  - Cite the specific rule. (MN Rules 5221.0500 Subp. 1A)

# What is not bundling?

- There may be concepts similar to “bundling” in the global surgical package (MN Rules 5221.4035) and for services included in the facility fee for ambulatory surgical centers and hospital outpatient surgical centers (MN Rules 5221.4033).
- However, those are not where the rules actually refer to bundling.

# Indicators

(MN Rules 5221.4030, 5221.4040, 5221.4050, and 5221.4060)

- Columns 1 to 12 are necessary to determine the maximum fee under the “fee schedule.”
- Column 1 is the CPT/HCPS code.
- Column 3 identifies the status of the code.

# Bundled Codes

- “B” status is a “bundled” code.
- “P” status also indicates a “bundled” or excluded code. (MN Rules 5221.4020 Subp. 2C(8))

# Bundled Codes: “B” Status

Payment for covered services are always bundled into payment for other services. There is no separate payment even if an RVU is listed. Payment is subsumed by payment for the services to which they are incident. (MN Rules 5221.4020 Subp. 2C(2))

Example: a telephone call from a hospital nurse regarding care of a patient.

# Bundled Codes: “P” Status

- If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. An example is an elastic bandage furnished by a physician incident to physician service. (MN Rules 5221.4020 Subp. 2C(8)(a))

# Bundled Codes: “P” Status

- If the item or service is covered as other than incident to a physician service, such as colostomy supplies, it may be paid for separately.
- If the item or service is not provided incident to the services of a licensed provider, the maximum fee for the service is governed by any listed positive RVU (or if zero by MN Rules 5221.0500 Subp. 2B-2F). (MN Rules 5221.4020 Subp. 2C(8)(b))

# Bundled Codes

By definition “bundling” normally reduces the cost because the services are included in the base charge.

# Separate Billing Allowed: Supplies provided as part of an office visit (MN Rules 5221.4020 Subp. 3)

Supplies provided during an office visit may be billed separately:

- surgical trays;
- injectable drugs and antigens;
- splints;
- casts used in treatment of fractures and dislocations;
- take-home supplies provided by HCP;
- orthotic devices (not including elastic stocking and bandages); or
- prosthetic devices replacing an internal body organ (foley catheter).

# The Rules require specificity to deny or reduce charges

The following statements on an EOB are not specific because they do not cite the rule and subpart as a basis for reducing or denying the charge.

- “Exceeds usual and customary”
- “Exceeds fee schedule”
- “Exceeds usual charges for geographic area”
- “Exceeds treatment parameters”

# Specificity

To deny or reduce charges you must cite the specific rule or rules that you are relying upon to reduce or deny charges.

# Basic Utilization Review Principles

- Bill review companies contract with payers (insurers) to process bills and are using **“basic utilization review principles.”**
- This is a process that payers are attempting to use to produce evidence of excessiveness.

# Current Issue: Prevailing Charge

- If a charge is not excessive under MN Rules 5221.0500 Subp. 1. (Recall that Subp. 1 of the rule defines excessive health care provider charges and states a payer is not liable for a charge that meets any of the nine listed conditions, as previously referenced.)
- Then you look to Subp. 2.

# Current Issue: Prevailing Charge

According to Subp. 2, a payer's liability is limited to either 85% of the provider's usual and customary charge" or 85% of the "prevailing charge" for similar treatment, whichever is lower.

# Usual and Customary Charge

- Defined as “the amount actually billed by the health care provider to all payers for the same service, whether under workers' compensation or not, and regardless of the amount actually reimbursed under a contract or government payment system.” (MN Rules 5221.0500 Subp. 2B(1))
- No provider shall submit a charge for a service which exceeds the amount which the provider charges for the same type of service in cases unrelated to workers' compensation injuries. (MN Rules 5221.0700 Subp. 1)

# Prevailing charge

Prevailing charge is defined as 75% of the usual and customary charges in the previous calendar year for each service, article, or supply if the database for the service meets all of the following criteria:

# Prevailing Charge: Database Requirements

- i. includes **only Minnesota providers**, with at least **three different, identifiable providers of the same provider type**, distinguished by whether the service is an inpatient hospital service, or an outpatient physician, pathology, laboratory, chiropractic, physical therapy or occupational therapy service, **or provider of other similar service, article, or supply;**

# Prevailing Charge: Database Requirements

- ii. there are at least 20 billings for the service, article, or supply; and
- iii. the standard deviation is less than or equal to 50 percent of the mean of the billings for each service in the data base or the value of the 75th percentile is not greater than or equal to three times the value of the 25th percentile of the billings.

# Current Case Law on Prevailing Charge

The current legal authority on prevailing charge is Lehto v. Community Memorial Hospital (WCCA Jan. 30, 2008)

(Summarily affirmed by the Minnesota Supreme Court (751 N.W.2d 585 (Minn. 2008))

- Three cases were consolidated involving the same provider and involving the issue of payment based on 85% of its usual and customary charges.

# Current Case Law on Prevailing Charge

- The payer (insurer) did not succeed in availing itself of the prevailing charge.
- Among other things, Judge Bonovetz found (and the WCCA affirmed) that computer screen abstracts of the bills were not adequate to meet the requirement of the rules.

# Current Case Law on Prevailing Charge

For data privacy reasons the Workers' Compensation Division is requiring redacted copies of actual billings (not computer screen abstracts).

# Conclusion

- Providers/Payers - become knowledgeable about the rules and your responsibilities.
- Providers/Payers - control what you can. Implement an internal program of compliance to ensure you are meeting your responsibilities.

# Conclusion

- Payers - be specific and cite the particular rules when denying or reducing a charge.
- Providers - maintain accurate and complete records and use the proper billing format.
- Last but not least - let's all try to communicate!