DEPARTMENT OF LABOR AND INDUSTRY

Designated contact employee training

The following overview and FAQs represents required training for workers' compensation designated contacts about new legislation passed in 2018. After you have read the overview and FAQs, you need to verify you completed the training via the designated contact portal.

Workers' compensation 2018 legislation – hospital outpatient fee schedule (HOFS) and ambulatory surgical center (ASC) payments

The following is an overview of Articles 2, 3 and 4 of the 2018 workers' compensation legislation.

> Article 2 establishes a workers' compensation hospital outpatient fee schedule using Medicare's Outpatient Prospective Payment System as a framework.
>
> Article 3 establishes billing, payment and dispute-resolution requirements for services provided by a hospital under Article 2 and by an ambulatory surgical center under Article 4.
>
> Article 4 establishes payment provisions for workers' compensation treatment provided by ambulatory surgical centers.

Note: This provides only an overview of the legislation related to the HOFS and ASC payments. The actual language of the legislation, which provides more detail, is at www.revisor.mn.gov/laws/?id=185&year=2018&type=0.

Answers to frequently asked questions begin on page 7.

Article 2 – Hospital outpatient fee schedule

Article 2 establishes a workers' compensation hospital outpatient fee schedule for payment of workers' compensation hospital outpatient surgical, emergency room and clinic services using Medicare's OPPS as a framework.

Section 1. Workers' compensation hospital outpatient fee schedule. (Will be codified as Minnesota Statutes § 176.1364.)

> **Subdivision 1. Definitions –** Paragraphs (a) to (h) define terms used in the proposal, including Medicare OPPS tables, called Addenda A and B, which are used to determine the workers' compensation HOFS amounts. Addenda A and B include a list of hospital service codes and descriptions and the Medicare relative weight for each service.

Subd. 2. Applicability –

Paragraph (a) – This section only applies to payment of hospital outpatient charges if they are listed in the hospital outpatient fee schedule established by the commissioner. If a hospital's charges do not include a service in the HOFS, it is paid according to the relative value fee schedule. If it is not covered by the relative value fee schedule, it is paid at 85 percent of the hospital's usual and customary charge.

Paragraph (b) – The HOFS does not apply to Medicare-certified critical access hospitals, which are paid as provided in Minn. Stat. § 176.136, subd. 1b (a): 100 percent of the critical access hospital's usual and customary charge, unless the commissioner or compensation judge determines the charge is unreasonably excessive.

Subd. 3. Hospital outpatient fee schedule –

Paragraph (a) – The commissioner must establish the HOFS amounts for services with a J1 or J2 status indicator in Addendum B of Medicare's OPPS and the comprehensive observation services Ambulatory Payment 5 Classification 8011 in Addendum A. The commissioner must publish a link to the HOFS in the *State Register* before Oct. 1, 2018, and place the HOFS on the Department of Labor and Industry's (DLI's) website.

Paragraphs (b) and (c) – These paragraphs establish the formula for calculating the payment amounts for services in the HOFS.

- The relative weights for the services with a J1 and J2 status indicator in Addenda A and B are multiplied by separate dollar conversion factors for: non-critical access hospitals of 100 or fewer licensed beds; and hospitals with more than 100 licensed beds.
- The commissioner must establish the conversion factors, in consultation with insurers and hospitals, using the process described in paragraph (b), so that the overall payment under the HOFS for the two hospital categories is the same as under the law in effect before the HOFS becomes effective.

Paragraph (d) – This paragraph describes how the HOFS conversion factors are adjusted annually, based on the market basket index published on Medicare's website.

Paragraph (e) – This paragraph describes the process for updating the HOFS in 2021 and at least every three years thereafter.

Paragraph (f) – This paragraph specifies how the commissioner must provide, by each Oct. 1, notice in the *State Register* of adjustments to the conversion factors and HOFS amounts in paragraphs (d) and (e). The notice must include a link to the updated HOFS published on DLI's website.

Subd. 4. Payment under the hospital outpatient fee schedule –

Paragraph (a) – This paragraph describes the scope of payment under the HOFS according to paragraphs (b) and (c).

Paragraph (b) – This paragraph describes the comprehensive payment when a bill includes one or more services with a J1 status indicator.

- If the bill includes charges for one service with a J1 status indicator, payment is the amount listed in the HOFS for that service, regardless of the amount charged.

- If the bill includes charges for more than one service with a J1 status indicator, payment for the service with the highest listed fee is 100 percent of the listed fee; each additional service in the HOFS is paid at 50 percent of the listed fee.

- No separate payment is made for charges for additional services on the bill, except for implantable devices paid as provided in subdivision 5.

Paragraph (c) – This paragraph describes payment for a bill with one or more services with a J2 status indicator, and no J1 service.

- Payment for each service with a J2 status indicator is the amount listed in the HOFS, regardless of the amount charged.

- Payment for services without a Healthcare Common Procedure Coding System (HCPCS) code that are billed with a service with a J2 status indicator is packaged into the payment for the J2 service.

- Payment for drugs with a HCPCS code delivered by injection or infusion is packaged into payment for the injection or infusion service. Payment for drugs not delivered by injection or infusion is the Medicare 6 Average Sales Price (ASP) of the drug when dispensed. The commissioner must publish on DLI's website a link to the ASP most recently available as of the preceding July 1.

- If a bill includes eight or more units of service with HCPCS code G0378 (observation services, per hour) and there is a physician's or dentist's order for observation, payment is the amount listed in the HOFS for Ambulatory Payment Classifications 8011, regardless of the amount charged. All other services billed by the hospital are packaged into the payment amount for code G0378.

- For other services on the same bill as the service with the J2 status indicator, payment is the amount allowed by the relative value fee schedule or, if not covered by the RVFS, 85 percent of the hospital's usual and customary charge.

Subd. 5. Implantable devices – Payment for implantable devices is included in the maximum fee for services in the HOFS, except that an implantable device with a H status indicator in Addendum B

that is billed with a J1 service is paid at 85 percent of the hospital's usual and customary charge. The HOFS must be updated each year to include any HCPCS codes payable under this section.

Subd. 6. Study – The commissioner must conduct a study of the HOFS and report to the Workers' Compensation Advisory Council (WCAC) by Jan. 15, 2021. Based on the results of the study, WCAC must consider if there is a minimum 80 percent compliance with timeliness and accuracy of payments. The WCAC must also consider additional statutory amendments, including but not limited to a maximum 10 percent reduction in payments under the HOFS and an increase in indemnity benefits to injured workers.

Subd. 7. Rulemaking – The commissioner has rulemaking authority under section 14.386 if needed to implement the law.

Effective date: Article 2, section 1, is effective for hospital outpatient services provided on or after Oct. 1, 2018.

Article 3: Outpatient billing, payment and dispute resolution

Article 3 establishes billing, payment and dispute-resolution requirements for the hospital outpatient fee schedule (in Article 2) and ambulatory surgical center payment provisions (in Article 4).

Section 1. Minn. Stat. § 176.136, subd. 1b, Limitation of liability.

Paragraph (a) – This eliminates payment at 100 percent of the hospital's usual and customary charge for outpatient services provided by non-critical access hospitals of 100 or fewer licensed beds.

Paragraph (b) – All non-critical access hospitals are paid 85 percent of the hospital's usual and customary charge if the outpatient charges are not covered by 176.1363 (the ASC fee schedule in Article 4) or 176.1364 (the HOFS in Article 2).

Paragraph (e) – The prevailing charge as a basis to reduce a payment to an ASC under section 176.1363 or a hospital as defined in section 176.1364 is repealed.

Paragraph (f) – "Inpatient" is defined as a patient admitted to a hospital by order of a physician or dentist for purposes of chapter 176 (the workers' compensation law). The hospital must provide documentation of the order if requested by the employer.

Effective date: Article 3, section 1, is effective for hospital outpatient services provided on or after Oct. 1, 2018.

Section 2. Outpatient billing, payment and dispute resolution. (Will be codified as Minn. Stat. § 176.1365.)

Subdivision 1. Scope – Section 2 applies to billing, payment and dispute resolution for services provided by an ASC under Article 4 (Minn. Stat. § 176.1363) and by a hospital under Article 2 (Minn.

Stat. § 176.1364). “Insurer” includes a self-insured employer and “services” is as defined in section 176.1364.

Subd. 2. Outpatient billing, coding and prior notification –

Paragraph (a) – For services governed by Articles 2 and 4, hospitals and ASCs must bill insurers using the same codes, formats and details required for billing Medicare.

Paragraph (b) – All charges for ASC or HOFS services must be submitted on the appropriate electronic transaction required by the workers’ compensation law. ASCs must submit charges on the electronic 837P form. ASCs must not bill for services and items that are included in the facility fee under federal ASC regulations; Minnesota Rules 5221.4033, subp. 1a, Governing facility fees, does not apply to ASCs.

Paragraph (c) –

- ASCs, hospitals and insurers must comply with existing workers’ compensation rules governing prior notice to the insurer and the insurer’s response. Prior notice may be provided by the hospital, ASC or surgeon.
- For purposes of the rule that requires notice to insurers of a non-emergency inpatient hospitalization, “inpatient” has the meaning as provided in section 176.136, subd. 1b (d) (which requires an order from a physician or dentist).

Paragraph (d) – ASC or hospital bills must be submitted as required by Minn. Stat. § 176.135, subds. 7 and 7a, and within the time period required by Minn. Stat. § 62Q.75, subd. 3. Insurers must respond to the initial bill as provided in Minn. Stat. § 176.135, subds. 6 and 7a. Copies of records or reports related to charges are separately payable as provided in section 176.135, subd. 7 (a).

Subd. 3. ASC or hospital request for reconsideration; insurer response; time frames –

Paragraph (a) – An ASC or hospital’s request for reconsideration of an insurer’s payment denial or reduction must be submitted to the insurer in writing within one year of the EOR or EOB.

Paragraph (b) – The insurer must respond in writing to the reconsideration request within 30 days and must respond to the issues raised by the ASC or hospital in its request.

Subd. 4. Insurer request for reimbursement of overpayment; time frame – A payer that determines it has overpaid an ASC or hospital must request reimbursement in writing to the ASC or hospital within one year of the date of the payment.

Subd. 5. Medical request for administrative conference; time frame to file –

Paragraph (a) – An ASC or hospital must notify the payer of intent to file a medical request for an administrative conference at least 20 days before filing and a payer must notify an ASC or hospital of its intent to file a medical request at least 20 days before filing.

If the medical request is permitted by Minn. Stat. § 176.136, subd. 2 (which allows health care providers to file a medical request with DLI only for disputes about whether the charge was excessive or treatment was reasonable and necessary), the ASC, hospital or insurer must file the medical request with DLI within one year after the:

- initial EOR or EOB if the ASC or hospital does not request reconsideration;
- date of the insurer's response to the ASC or hospital's request for reconsideration; or
- insurer's request for reimbursement of an overpayment under subdivision 4.

Paragraph (b) – Paragraph (a) does not prohibit an employee from filing a medical request for assistance or claim petition for payment denied or reduced by the insurer. The ASC or hospital may not bill the employee for the denied or reduced payment when prohibited by the workers' compensation law.

Subd. 6, Interest – Paragraphs (a) and (b) state interest at an annual rate of 4 percent is payable to an ASC, hospital or insurer for amounts that are underpaid or overpaid.

Effective date: Article 3, section 2, is effective for services provided on or after Oct. 1, 2018.

Article 4: Ambulatory surgical centers

Article 4 establishes payment provisions for workers' compensation treatment provided by ambulatory surgical centers.

Section 1. Ambulatory surgical center payment. (Will be codified as Minn. Stat. § 176.1363.)

Subdivision 1. Definitions – This provides definitions of terms used in the proposal, including ASC, conversion factor and Medicare Ambulatory Surgical Center Payment System (ASCPS). The definition of ASCPS also describes the Medicare ASCPS Addenda (AA, BB and DD1), which provide the payment rate and weight for specific services, and payment provisions in the Medicare ASCPS.

Subd. 2. Payment for covered surgical procedures and ancillary services based on the ASCPS –

Paragraph (a) – Payment to an ASC shall be the lesser of:

- the ASC's usual and customary charge for all services, supplies and implantable devices; or
- the Medicare ASCPS payment times a multiplier of 320 percent.
  - The 320 percent must be adjusted on July 1 of every year if the conversion factor (dollar multiplier) for the service is less than 98 percent of the conversion factor in effect on the previous July 1, according to a specific formula.
  - The amount payable includes payment for all implantable devices.

– The 320 percent is annually adjusted; starting July 1, 2019, the conversion factor is less than 98 percent of the conversion factor in effect the previous July 1.

Paragraph (b) – Payment is effective for surgical procedures from Oct. 1, 2018, through Sept. 30, 2019, and must be updated each Oct. 1 based on the ASCPS addenda AA, BB and DD1 most recently available from Medicare's website as of the previous July 1 and the corresponding Medicare claims processing manual. If Medicare has not updated the ASCPS addenda, the addenda identified in the notice most recently published by the commissioner in the *State Register* shall remain in effect.

Paragraph (c) – The commissioner must annually, and no later than Oct. 1, give notice in the *State Register* of any adjustment to the multiplier under paragraph (a) and of the applicable Medicare addenda. The notice must identify and link to the applicable addenda.

Subd. 3. Payment for compensable surgical services not covered under ASCPS –

Paragraph (a) – If a compensable surgical procedure is not listed in the ASCPS addenda, payment is 75 percent of the ASC's usual and customary charge for the procedure with the highest charge. Subsequent unlisted procedures are paid at 50 percent of the ASC's usual and customary charge.

Paragraph (b) – If the service is listed in the ASCPS addenda, but a payment amount is not listed, or the payment indicator provides it is paid at reasonable cost or is contractor priced, payment is 75 percent of the ASC's usual and customary charge.

Subd. 4, Study – The commissioner must conduct a study analyzing the impact of the reforms, including timeliness and accuracy of payments, and recommend further changes if needed. The results must be reported to the WCAC and legislative leaders with jurisdiction over workers' compensation matters by Jan. 15, 2021.

Subd. 5, Rulemaking – The commissioner may adopt or amend rules to implement this section and the Medicare ASCPS for workers' compensation using the process in Minn. Stat. § 14.386, paragraph (a).

Effective date: Article 4, section 1, is effective for procedures and services provided by an ASC on or after Oct. 1, 2018, except subdivision 5 is effective the day following final enactment.

Frequently asked questions

The following frequently asked questions further address the changes, summarized above, to Minnesota's workers' compensation law approved by the Workers' Compensation Advisory Council and enacted by the Minnesota Legislature in 2018.

The legislation establishes new payment methodologies for outpatient medical services at a hospital or an ambulatory surgical center. It also clarifies billing, payment and dispute resolution for services at these entities. The legislation is effective for services provided by a hospital or ASC on or after Oct. 1,

2018. The Department of Labor and Industry will post additional information, including links to the Medicare ASC tables and a link to the HOFS, on its website once completed.

1. What providers are covered by the HOFS and ASC language?

The new hospital outpatient fee schedule applies to any hospital that is licensed by the Department of Health under Minn. Stat. § 144.50, *except* a hospital that is certified as a Critical Access Hospital by Medicare.

The ASC language covers facilities that are: certified as an ASC by Medicare; or licensed by the Department of Health as a freestanding outpatient surgical center that is not owned by a hospital.

2. When does the HOFS amount apply to charges for hospital outpatient services?

The fee schedule rates only apply if the charges include a service listed in the HOFS. If the charges do not include a service listed in the HOFS, payment is the amount under the relative value fee schedule in Minn. Stat. § 176.136, subd. 1a, or the liability provided in Minn. Stat. § 176.136, subd. 1b, paragraphs (b), (c) and (e), if it is not listed in the relative value fee schedule table.

3. Why are there two dollar-amounts for services in the HOFS?

The legislation requires that separate conversion factors be established for two categories: non-critical access hospitals of 100 or fewer licensed beds; and hospitals with more than 100 licensed beds.

The department will include a list on its website that specifies which payment category applies to specific hospitals.

4. How will I know if a service listed in the HOFS has a J1 or J2 status indicator?

The HOFS table on the DLI website will designate whether the service has a J1 or J2 status indicator. Services will be listed by their Healthcare Common Procedure Coding System code.

5. When will the HOFS and ASC addenda tables be available on the DLI website?

The legislation requires DLI to publish a link to the HOFS and notice of the applicable ASC addenda in the *State Register* by Oct. 1.

The department will post these links as soon as they are available; the target is early September 2018.

6. What other changes from this bill should I be aware for Oct. 1?

Non-critical access hospitals with 100 or fewer licensed beds are no longer paid at 100 percent of the usual and customary charge for outpatient services. These hospitals are now subject to the HOFS, as well as the relative value fee schedule in Minn. Stat. § 176.136, subd. 1a.

Additionally, the legislation repeals prevailing charge as a basis to reduce a payment to an ASC under Minn. Stat. § 176.1363 or a hospital for outpatient services under Minn. Stat. § 176.1364.

More information

If you have further questions about medical fee schedules, contact the Department of Labor and Industry's medical policy staff at 651-284-5052 or medical.policy.dli@state.mn.us.