Fee Schedule Guidelines

Clinical Laboratory

WSI
North Dakota Workforce Safety & Insurance

January 2020

Notice

The five character numeric codes included in the North Dakota Fee Schedule are obtained from Current Procedural Terminology (CPT®), copyright 2019 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physicians. The five character alphanumeric codes included in the North Dakota Fee Schedule are obtained from HCPCS Level II, copyright 2018 by Optum360, LLC. HCPCS Level II codes are maintained jointly by The Centers for Medicare and Medicaid Services (CMS), the Blue Cross and Blue Shield Association (BCBSA), and the Health Insurance Association of America (HIAA).

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The WSI Fee Schedule is not a guarantee of payment. The fact that WSI assigns a procedure or service a HCPCS code and a payment rate does not imply coverage by WSI, but indicates the maximum allowable payment for approved services. Services represented are subject to provisions of WSI including: compensability, claim payment logic, applicable medical policy, benefit limitations and exclusions, bundling logic, and licensing scope of practice limitations.

Any changes made to Pricing Methodology are subject to the North Dakota Public Hearing process. WSI reserves the right to implement changes to the Payment Parameters, Billing Requirements, and Reimbursement Procedures as needed. WSI incorporates all applicable changes into the relevant Fee Schedule Guideline at the time of implementation, and communicates these changes in Medical Providers News, available on the WSI website at www.workforcesafety.com/news/medical-providers. WSI reviews and updates all Fee Schedule rates on an annual basis, with additional updates made on a quarterly basis when applicable.

For reference purposes, the sections of the North Dakota Administrative Code (N.D.A.C.) that regulate medical services are **92-01-02-27 through 92-01-02-46**. The complete N.D.A.C. is accessible on the North Dakota Legislative Council website: http://www.legis.nd.gov/agency-rules/north-dakota-administrative-code.

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Clinical Laboratory Pricing Methodology

Clinical Laboratory Pricing Methodology outlines the methods used by Workforce Safety and Insurance (WSI) to determine the final rates represented on the Clinical Laboratory Fee Schedule. The Clinical Laboratory Fee Schedule uses the applicable procedure codes and descriptions as defined by the Healthcare Common Procedure Coding System (HCPCS), their respective payment status indicators, and payment amounts. In accordance with North Dakota Administrative Code 92-01-02-29.2, any provider who renders treatment to a claimant under the jurisdiction of WSI is reimbursed according to the rates assigned in the WSI Fee Schedule. A provider may access the complete Clinical Laboratory Fee Schedule and other resources referenced within this document by visiting the Medical Provider section of the WSI website: www.workforcesafety.com.

Status Indicators

WSI assigns one of the following status indicators to each HCPCS code within the Clinical Laboratory Fee Schedule:

Indicator	Description	Pricing Methodology
A	Active Code	Service is payable under the applicable WSI Fee Schedule.
B	Packaged Code	Service is not separately payable. Payment is packaged into the payment for another service.
C	Custom Priced Code	Service is payable using usual and customary or WSI-negotiated rates.
D	Discontinued Code	Service is not payable. Code was discontinued effective beginning of the calendar year.
P	Excluded Code	Service is not payable under the WSI Fee Schedule.

Calculation of the Reimbursement Rate

For HCPCS codes assigned a status indicator “A”, WSI applies the following formula to determine the maximum allowable reimbursement rate:

Medicare Clinical Laboratory Fee Schedule Rate for ND X 250%

Annual Updates

WSI updates the Clinical Laboratory Fee Schedule annually based on the rate changes published by The Centers for Medicare and Medicaid (CMS).

Limitations of the Clinical Laboratory Fee Schedule

The payment rates listed on the Clinical Laboratory Fee Schedule indicate the maximum allowable payment for approved services only. The fact that a procedure or service is assigned a HCPCS code and a payment rate does not imply coverage by WSI, but indicates the maximum allowable payment for approved services. The final payment rate may be impacted by the payment parameters and billing requirements enforced by WSI. A provider is encouraged to carefully review WSI’s Payment Parameters, Billing Requirements, and Reimbursement Procedures to avoid unneccesary delays and denials of payment.

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Clinical Laboratory Payment Parameters

Clinical Laboratory Payment Parameters outlines the rules for payment adopted by WSI. While WSI has adopted many of Medicare's rules for payment, WSI has developed a set of unique rules that are applied to the final payment of approved services. The complete payment parameters enforced by WSI are as follows:

Authorization- WSI does not require prior authorization for Clinical Laboratory services.

"Lesser of" Payments- The rates listed on the Clinical Laboratory Fee Schedule represent the maximum amount payable for services rendered. WSI pays the "lesser of" the billed charge or the Fee Schedule amount.

NCCI Edits- WSI incorporates all applicable NCCI edits.

Needle Stick/ Exposure Injuries- WSI allows for the payment of HIV and Hepatitis testing due to needle stick or exposure injuries. If the source patient is negative, WSI allows payment for repeat testing at 3 months from the date of injury. If the source patient is positive, WSI allows for the payment of repeat testing at 6 weeks and 3, 6, and 12 months from the date of injury.

Pathology- The WSI Clinical Laboratory Fee Schedule does not include pathology services. A provider should refer to the Medical Provider Fee Schedule for information on pathology services.

Payment Packaging- WSI packages the payment of HCPCS codes assigned a status indicator "B" into the pricing for other related services.

Pre-MRI Labs- WSI allows for payment of the following laboratory tests to check kidney function for contrast MRIs: creatinine, chemical panel, renal panel.

Pre-operative Labs- WSI allows for payment of the following routine pre-operative laboratory tests: CBC, chemical profile, urinalysis, PT, PTT, & lipids.

PT/PTT Labs- WSI allows for payment of the PT/PTT lab work for pre-injection services, pre-operative services, and post-operative services if the patient is on aspirin, coumadin, or warfarin.

Substance Testing- WSI allows for the payment of alcohol and/or substance testing under the following circumstances:

- Post-accident screening on the date of injury. A provider must complete and submit the results of a definitive screening, when a presumptive screening is positive, in order to be eligible for reimbursement.
- Cotinine testing at 6 weeks and 1 week prior to a spinal procedure
- Compliance testing as part of a chronic opiate treatment plan. For additional information, a provider should refer to WSI's Chronic Opioid Therapy Medical Policy and Ongoing Management of Opioids Treatment Guidelines.

WSI requires medical documentation show a positive presumptive test prior to allowing the reimbursement of definitive testing.

Tuberculosis Testing- WSI allows payment for tuberculosis testing at the time of exposure, as well as at 10 weeks from the date of exposure.

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Clinical Laboratory Billing Requirements

Clinical Laboratory Billing Requirements outlines the rules for billing adopted by WSI. WSI returns or denies inappropriately submitted bills. WSI notifies a provider of inappropriately submitted bills via a return letter or remittance advice. A provider must correct any returned bills prior to resubmission.

Bill Forms- A provider must submit medical bills for Clinical Laboratory services on a standard CMS 1500 form, UB-04 form, or via EDI.

Bill Form Submission- WSI offers the following options for bill submission:

Electronic Billing- A provider may submit medical charges via EDI through one of WSI's clearinghouses:

- **Carisk (fka iHCFA):** This option allows a provider to electronically submit professional (837p) and institutional (837i) charges along with supporting medical documentation. Contact Carisk EDI Support Services at 973-795-1641 (option 2) for additional information.
- **Noridian:** This option allows a provider to submit professional (837p) and institutional (837i) charges without medical documentation attachment. A provider must mail all supporting medical documentation to WSI at the address provided below or fax it to 701-328-3793. Contact Noridian EDI Support Services at 800-967-7902 for additional information.

Paper Billing- A provider may submit bills in red and white paper format with supporting medical documentation to WSI at the following address:

PO Box 5585
Bismarck, ND 58506

Coding- A provider is required to bill using only current and appropriate HCPCS Level I (CPT) or HCPCS Level II codes for clinical laboratory services.

Medical Documentation- A provider must submit medical documentation to support all billed charges. WSI's Documentation Policies are available for detailed information on documentation requirements.

Medical Necessity- A provider is required to bill using the same medical necessity guidelines used for Medicare.

National Provider Identification (NPI)- WSI requires entities who are eligible for NPI to be registered with National Plan & Provider Enumeration System. When applicable, WSI requires a provider to include the NPI at both the rendering provider and billing provider levels.

Needle Stick/ Exposure Injuries- A provider must submit the bill for exposure source patient testing using the claim number of the injured worker, with modifier 22 appended to each line, separate from the bill for the exposure testing of the injured worker.

Substance Testing- A provider must utilize the current alphanumeric G codes created by Centers for Medicare and Medicaid Services (CMS).

Timely Filing- A provider must submit bills to WSI within 365 days of the date of service.

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Clinical Laboratory Reimbursement Procedures

Clinical Laboratory Reimbursement Procedures outlines how WSI communicates bill processing information and issues payment to a provider. In addition, it outlines WSI requirements for reimbursement. A provider is encouraged to follow WSI Reimbursement Procedures to prevent delays in the payment processing of medical charges submitted to WSI.

Provider Registration- Prior to reimbursement for treatment, a provider is required to register the applicable Billing NPIs with WSI by completing the Medical Provider Payee Registration form. For additional information, visit the Provider Registration section of WSI's website.

Payment Address- WSI issues payment to the Pay-to Address registered on the Medical Provider Payee Registration form, regardless of the address submitted on the bill form. To update a payment address, a provider must resubmit the registration form for each applicable Billing NPI.

Remittance Advice- WSI issues remittance advices for processed medical bills each Friday. The remittance advice includes important information about a medical charge, including: patient name, date of service, procedure billed, billed amount, paid amount, and remittance advice reason codes. A provider should refer to the How to Read the WSI Remittance Advice document for assistance with interpretation of the remittance advice. This reference includes a sample remittance advice, along with definitions for significant fields within the remittance advice. Contact customer service at 1-800-777-5033 with questions or to obtain a duplicate remittance advice.

Reason Codes- The WSI Remittance Advice Reason Codes document provides a comprehensive listing and description of the reason codes utilized by WSI. Each reason code identifies a cause for the adjudication of a medical charge and specifies whether a provider may bill a patient. When a reason code specifies a provider may bill a patient, WSI sends a "Notice of Non-Payment" letter to the patient informing them of their responsibility for the charge. In accordance with North Dakota Administrative Code 92-01-02-45.1, if a reason code does not state that a provider may bill a patient, the provider cannot bill the charge for the reduced or denied service to the patient, the employer, or another insurer.

Bill Status Inquiries- A provider must refer to the WSI Remittance Advice for bill status information when possible. WSI requests a provider allow 2 months from the date of bill submission prior to contacting WSI for bill status, which permits adequate time for bill receipt, bill processing, and payment and/or remittance advice mailing. WSI will not process requests for bill status inquiries of large volume or repetitive requests for the status of processed medical bills that do not meet the above requirements.

Overpayments- When an overpayment occurs on a medical bill, WSI will notify the provider of the overpayment in a letter. WSI allows 30 days from the date of the letter for a provider to issue the requested refund. If a provider does not issue the refund within 30 days of the date of the letter, WSI will withhold the overpayment from future payments.

Medical Services Disputes- North Dakota Administrative Code 92-01-02-46 provides the procedures followed for managed care disputes. A provider who wishes to dispute a denial or reduction of a service charge must submit the Medical Bill Appeal (M6) form, along with supporting documentation, within 30 days of the remittance advice issue date. WSI will not address a provider dispute submitted without the M6 form.

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