Payment Policy

Inpatient Hospital

01/01/2015

1600 E Century Ave Ste 1
PO Box 5585
Bismarck ND 58506-5585
701-328-3800
800-777-5033
www.workforcesafety.com

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Disclaimer Language

The fact that a procedure or service is assigned a HCPCS code and a payment rate does not imply coverage by WSI, but indicates only how the procedure or service may be paid if covered by the program. The existence of a procedure code on this list is not a guarantee that the code is covered.

For reference purposes, the sections of the North Dakota Administrative Code that regulate medical services are **92-01-02-27 through 92-01-02-46**. The NDAC can be viewed at the North Dakota Legislative Council web site: http://www.state.nd.us/lr/information/acdata/html/92-01.html

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Workforce Safety & Insurance

Inpatient Hospital Payment Methodology

WSI will update the Inpatient Hospital Fee Schedule base rate each year based on the hospital Market Basket increase published by Medicare in the Inpatient Prospective Payment System final rule. Appropriate adjustments will be made for DRG weight changes (if necessary). If a separate Market Basket is published for capital costs, that update will be applied to the capital portion of the base rate. If a separate Market Basket is not published for capital costs, the operating cost update will be applied to both the operating portion and the capital portion of the base rate.

The outlier target for each year is set at an amount equal to 10% of the estimated DRG plus outlier payments. Estimated DRG payments are based on claims paid between January 1 and September 30th of the current year. When determining the outlier target and threshold, those cases where the actual outlier payments were greater than $100,000 will be eliminated from the database of claims. The following year's conversion factor is multiplied by the following year's weights to arrive at estimated DRG payments.

Based on the same claims database and a marginal payment factor of 80%, the current year's outlier threshold is raised or lowered until anticipated outlier payments equal 10% of total DRG payments plus anticipated outlier payments. The outlier threshold is rounded to the nearest $500.
Outlier Threshold for year 2012 is $90,000.

Inpatient Acute and Acute Psychiatric Services

Workforce Safety & Insurance (WSI) shall reimburse inpatient acute and acute psychiatric services as follows:

- Inpatient acute and acute psychiatric services are reimbursed by Diagnosis Related Group (DRG)
- A WSI specific rate (conversion factor) will be computed using the information published each year in the Federal Register and will be effective for the following calendar year. The formula for establishing the WSI rate is:

  WSI Conversion Factor:
  Operating Cost Portion of Rate **(+)** Capital Cost Portion of Rate **(=) WSI DRG Rate (**conversion factor)**; *for 2015 the CF is $8,710.00***.

  WSI DRG Payment Amount:
  WSI DRG Rate **(X)** Medicare's MS-DRG weights (published each year in the Federal Register) **(=) WSI DRG Payment Amount**

  The Operating Cost portion of the rate will be updated each year based on the operating cost hospital market basket published by Medicare each year in the Inpatient Prospective Payment System final rule. The Capital Cost portion of the rate will be updated each year based on the capital cost hospital market basket update published by Medicare each year in the Inpatient Prospective Payment System final rule. If a separate market basket is not published for capital costs, the operating cost update will be applied to the capital portion of the rate.

- WSI will make no adjustments to this formula for wage index or GAF factors, disproportionate share hospitals (DSH), indirect medical education/graduate medical education (IME/GME) or other Medicare pass-through amounts.

- WSI will make no adjustments to this formula in relation to the Hospital Quality Initiative program, the Hospital Value Based Purchasing program, the Hospital Readmission Reduction Program or other special Medicare programs.

- WSI will incorporate Medicare's New Technology Add-On payments at 1.2 times the Medicare payment amount.

- If necessary, WSI will make adjustments to the WSI conversion factor to account for aggregate weight changes.

- The following are reimbursed separate from the DRG payment:
    - Physician and mid-level practitioner professional services
    - Durable Medical Equipment (DME) for home use
    - Take home supplies (if allowable)
    - Take home drugs (if allowable)
    - CRNA services

- Outlier payments are calculated at 80% of charges in excess of an amount equal to the DRG payment plus any New Technology add-on payments plus an outlier fixed loss threshold. The outlier fixed loss threshold changes each year based on an **outlier target** that is established to maintain total outlier payments at 10% of total DRG plus outlier payments. If a claim reaches the outlier threshold, the formula for payment is:

  DRG Amount + ***New Technology Add On +*** (((Billed Charges – (DRG Amount + ***New Technology Add On +*** Threshold)) X .80); ***for 2015 the threshold will be $57,500.00***.

  The **outlier target** for each year is set at an amount equal to 10% of the estimated DRG plus outlier payments. Estimated DRG payments are based on claims paid between January 1st and September 30th of the current year. The following year's conversion factor is multiplied by the following year's weights to arrive at estimated DRG payments.

  Based on the same claims database and a marginal payment factor of 80%, the current year's outlier threshold is raised or lowered until the anticipated outlier payments equal 10% of total DRG payments plus anticipated outlier payments. The outlier threshold is rounded to the nearest $500.

  When determining the outlier target and threshold, those cases where the actual outlier payments were greater than $100,000 will be eliminated from the database of claims.

- Payment for transfers between acute facilities will be based on Medicare's existing transfer methodology. Transfers to post-acute settings are considered discharges and not transfers. The movement of patients from acute to post-acute settings will be monitored by the utilization review process. The methodology for payment of transfers is as follows:

DRG payment amount/GMLOS (Geometric Mean Length of Stay)	= per diem
1st day's payment	= 2 times the per diem
2nd and subsequent day's payments	= per diem amount up to the full DRG plus allowable outlier payments

- When a patient is discharged/transferred from an acute care hospital, and is readmitted to the same hospital on the same or subsequent calendar day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, the hospital will combine the original and subsequent stays onto a single claim.

  Services rendered by other entities during a combined stay must be included on the combined claim.

  When a patient is discharged from an acute care hospital and readmitted to a different acute care hospital on the same or subsequent calendar day for symptoms related to the prior stay's medical condition; the discharge hospital's claim will be paid under the current WSI transfer policy.

Inpatient Swing Bed Services

Inpatient Swing Bed Services – Skilled Level

- Skilled swing bed services will only be reimbursed to a hospital certified by Medicare to provide swing bed services and will require prior authorization.

- Payment for skilled swing bed services will be made based on 80% of billed charges.

- WSI makes its determination of skilled vs. non-skilled based on the level of care required by the patient and not based on Medicare's 100 days of coverage criteria. A three-day acute stay is not necessary to qualify for swing bed services.

Inpatient Swing Bed Services – Non-Skilled Level

- Non-Skilled swing bed services will only be reimbursed to a hospital certified by Medicare to provide swing bed services and will require prior authorization.

- Payment for non-skilled swing bed services will be made based on 80% of billed charges.

- WSI makes its determination of skilled vs. non-skilled based on the level of care required by the patient and not based on Medicare's 100 days of coverage criteria. A three-day acute stay is not necessary to qualify for swing bed services.

Rehabilitation Services

Inpatient Acute Rehabilitation Services – Distinct Unit

- Inpatient acute rehabilitation services provided in a distinct unit (i.e., separately certified by Medicare) will require prior authorization.

- Payment for inpatient acute rehabilitation services provided in a distinct unit (i.e., separately certified by Medicare) will be made based on 80% of billed charges.

Inpatient Long Term Acute Services

- Inpatient long term acute services (i.e., in a hospital or unit certified by Medicare as a long term acute hospital) will require prior authorization.

- Payment for inpatient long term acute services will be made based on 80% of billed charges.

Nursing Facility Services

Inpatient Skilled Nursing Services in a Skilled Nursing Facility

- Inpatient skilled nursing services provided in a skilled nursing facility will require prior authorization as well as analyst approval.

- Payment for skilled nursing services provided in a skilled nursing facility will be made at 100% of billed charges.

- WSI makes its determination of skilled vs. non-skilled based on the level of care required by the patient and not based on Medicare's 100 days of coverage criteria. A three-day acute stay is not necessary to qualify for swing bed services.

Inpatient Non-Skilled Nursing Services in a Skilled Nursing Facility

- Inpatient non-skilled nursing services provided in a skilled nursing facility will require prior authorization as well as analyst approval.

- Payment for non-skilled nursing services provided in a skilled nursing facility will be made at 100% of billed charges.

- WSI makes its determination of skilled vs. non-skilled based on the level of care required by the patient and not based on Medicare's 100 days of coverage criteria. A three day acute stay is not necessary to qualify for swing bed services.

Inpatient Services Provided by Out-of-State Providers

Inpatient services provided by out-of-state providers will be made based on the same parameters as for in-state providers. Payment to out-of-state providers will be subject to the grievance procedures already established by WSI.

Workforce Safety & Insurance

Inpatient Hospital vs. Outpatient Hospital Billing Policy

The following reflects the Workforce Safety & Insurance policy regarding whether a claim for hospital stays should be billed as outpatient claims or as inpatient claims

- All patient stays of 24 hours or less must be billed as outpatient stays unless a surgical procedure is performed that has a status indicator of “C”. **

- Outpatient (observation) stays may be greater than 24 hours but initial payment will be limited to 48 hours.
    - Providers may appeal the 48 hour cap if they believe they have documentation to support an extended observation stay

- All inpatient stays of 2 days or less will be reviewed.
    - Stays of less than 24 hours will be adjudicated as outpatient claims unless the claim contains a HPCPS code with a status indicator of “C” (inpatient only).
    - Stays of greater than 24 hours but less than 2 days will be reviewed to assure that acute care was rendered (based on the current WSI criteria). If no acute care was rendered, the claim will be returned to the provider for resubmission as an outpatient claim.

All patient stays for surgical services where the HCPCS code for the surgery has a status indicator of “C” (inpatient only) must be billed as inpatients, regardless of the length of the stay.

Workforce Safety & Insurance

New Technology Add On Payments

New Technology Description	Qualifying Criteria		Pmt Amount
Zenith Fenestrated Graft	Diagnosis: Procedure: NDC:	N/A 39.78 N/A	9,805.80
Voraxaze	Diagnosis: Procedure: NDC:	N/A 00.95 N/A	56,700.00
Argus II System	Diagnosis: Procedure: NDC:	N/A 14.81 N/A	86,434.50
Kcentra	Diagnosis **Exclusions**: Procedure: NDC:	286.0, 286.1, 286.2, 286.3, 286.4, 286.5, 286.7, 286.52, 286.53, 286.59 00.96 N/A	1,905.00
Zilver PTX	Diagnosis: Procedure: NDC:	N/A 00.60 N/A	2,046.30
CardioMEMS HF Monitoring System	Diagnosis: Procedure: NDC:	N/A 38.26 N/A	10,650.00
MitraClip System	Diagnosis: Procedure: NDC:	N/A 35.97 N/A	18,000.00
RNS System	Diagnosis: Procedure: NDC:	N/A 01.20 & 02.93 together N/A	22,170.00

Workforce Safety & Insurance

Provider Remittance Advice

WSI processes medical service billings weekly. A remittance advice is sent to the provider with the reimbursement check, providing information to the provider about the service, including the patient's name, date of service, procedure billed, submitted amount, and paid amount. The remittance advice also includes reason codes or explanation of benefits (EOB) codes, to explain any reductions in payment of a service or denial of payment.

Some EOB codes allow the patient to be billed for the denied charges, or for the balance of reduced charges. These instances are identified by the statement "CONTACT CLAIMANT FOR PAYMENT". When these EOB codes occur, WSI also sends a "NOTICE OF NON-PAYMENT" EOB to the patient regarding the reduced or denied charges, to inform the patient of their responsibility for the charges.

If an EOB code does not state the patient may be contacted for payment, any reduction or denial of services is not billable to the patient, the employer, or another insurer.

Copies of remittance advices can be obtained by calling 1-800-777-5033. You can access the list of our EOB codes on our website in the library section.