Payment Policy

Outpatient Hospital

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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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Outpatient Hospital Payment Methodology

Workforce Safety & Insurance shall reimburse outpatient hospital services using the O*utpatient Hospital Fee Schedule* in conjunction with the *Outpatient Hospital payment status indicators* and the *Outpatient Hospital payment parameters*.

Workforce Safety & Insurance will update the Outpatient Hospital Fee Schedule conversion factor each year based on the hospital Market Basket increase published by CMS in the Outpatient Prospective Payment System final rule. Appropriate adjustments will be made for ambulatory payment classification (APC) weight changes (if necessary).

Outpatient Hospital Fee Schedule

The payment amounts on the WSI Outpatient Hospital Fee Schedule are based on the following:

- For those outpatient hospital services that are paid on a fee schedule basis (Status Indicator Z); payment will be based on the appropriate **WSI Fee Schedule** amount in force at the time the service is rendered.

- Payment for all other outpatient hospital services is made based on the formula:

WSI Conversion Factor X HCPCS Weight

- Prior to 2008, the WSI Outpatient Hospital conversion factor was set at 165% of the national Medicare Conversion factor as published in the final OPPS rule each year. For 2008 and succeeding years, the conversion factor will be based on the prior year's conversion factor times the hospital Market Basket increase published by CMS in the OPPS final rule. Appropriate adjustments will be made for ambulatory payment classification (APC) weight changes (if necessary). The following are the WSI Outpatient Hospital conversion factors for each year beginning in 2008:

2013	$120.54
2014	$123.55
2015	$127.13

- The HCPCS weight is the Medicare weight as indicated in the listing of HCPCS codes in the final OPPS rule published in the Federal Register each year (commonly known as "Addendum B").
  - Where Addendum B contains a HCPCS code with a payment amount but no weight, the weight is computed by taking the Medicare payment amount divided by the Medicare conversion factor.
  - Where Addendum B contains a payable HCPCS code with no payment amount or weight (i.e., pass through devices paid at cost), the WSI payment will be made at reasonable cost based on a submitted invoice.

The only services that are considered for payment under the WSI Outpatient Hospital Fee Schedule are those that can be identified by a valid HCPCS code. The payment for all other services is packaged into the payment for payable HCPCS codes. The WSI Outpatient Hospital Fee Schedule contains all HCPCS codes (Level I and Level II codes), their respective payment status indicators, descriptions, weights, and payment amounts.

Workforce Safety & Insurance

Outpatient Hospital Payment Parameters

The following payment parameters more fully define the Outpatient Hospital payment system and provide detail as to how the amounts on the WSI Outpatient Hospital Fee Schedule are applied during the claims adjudication processes. Since the payments on the WSI Outpatient Hospital Fee Schedule are based largely on Medicare's OPPS methodology, WSI has adopted many of the OPPS payment parameters. However, some differences between the Medicare OPPS and the WSI Outpatient Hospital Fee Schedule parameters exist.

- **Effective Date** – The Outpatient Hospital Fee Schedule was implemented in January 2004

- **Annual/Quarterly Updates** – The Outpatient Hospital Fee Schedule will be updated in January of each year and will be effective for the calendar year. However, any delay by Medicare in publishing the hospital Market Basket increase, in updating its weights, or both, will cause a corresponding delay in the update of the WSI conversion factor and weights. Quarterly updates for HCPCS codes and weights provided by Medicare will be incorporated into the WSI Outpatient Hospital Fee Schedule.

- **Prospective Payments** – Services with extensive packaging will be paid at the amount indicated on the WSI Outpatient Hospital Fee Schedule, regardless of the billed charge amount. These services are identified with status indicators of S, T and V.

- **"Lesser Of" Payments** – Services without extensive packaging will be paid at the "lesser of" the amount indicated on the WSI Outpatient Hospital Fee Schedule or the billed amount. These services are identified with status indicators of G, K, X and Z.

- **Packaging** – WSI has incorporated the same packaging methodology as the Medicare OPPS with the exception of observation services and composite APCs.

- **Comprehensive APCs** – WSI has incorporated the same packaging and payment methodology for Comprehensive APCs as the Medicare OPPS.

- **Multiple Procedure Discounting** – WSI has incorporated the same multiple procedure discounting methodology as the Medicare OPPS.

- **Bilateral & Discontinued Procedure Discounting** – WSI has incorporated the same payment adjustments for bilateral procedures and discontinued procedures as the Medicare OPPS.

- **Wage Adjustments** – WSI's conversion factor is not wage adjusted.

- **Outlier Payments** – WSI did not incorporate any outlier provisions into the Outpatient Hospital Fee Schedule.

- **Partial Hospitalization** – WSI will not pay for partial hospitalization services per se. All psychiatric services provided to hospital outpatients will be paid as outpatient mental health services.

- **Observation Services** – WSI will pay for valid observation services. These services must be billed in hourly increments with HCPCS code G0378. Observation stays of 48 hours or less will be allowed. Hours of observation over 48 will be initially denied but can be appealed by the provider. WSI will not make separate payment for HCPCS code G0379 (direct admit to observation). The payment for G0379 is bundled into the payment for G0378.

- **Services Paid At Cost** – There are several codes for services that are paid at cost. The hospital will be required to submit an invoice for these services. These services will be paid at cost plus 20%.

- **New Codes with no Payment** – New codes that have not been assigned a payment amount by Medicare (either through the APC system or through the Medicare Part B fee schedules) will be paid at 85% of billed charges.

- **CCI Edits** – WSI will use the same set of CCI edits as the Medicare OPPS.

- **Modifier Usage** – WSI will not require all of the modifiers required by the Medicare OPPS. Those modifiers required by WSI are: 25, 50, 52, 59, 73, 74, 76, 77, 78 and 79. The presence of other OPPS modifiers on the UB-04 claim form is permitted.

- **Provider-Based Clinics** – WSI will not recognize clinics as provider-based. All services of a type typically performed in a physician's office are to be billed on a CMS 1500 claim form. There are two exceptions to this policy:
    - An Urgent Care center that is located next to an Emergency Department, that shares a common registration or triage area with the Emergency Department, and bills a facility fee to all payers; and
    - a Pain Clinic located within the hospital's main building
    - Bill services in the urgent care centers with Revenue Code 456 or 516 and services in the Pain Clinics with Revenue Code 511.

- **Replacement Device Offsets** – WSI will incorporate Medicare's device offset methodology for those instances where replacement devices are provided at either no cost by the manufacturer or where the hospital received a credit of 50 percent or more of the estimated cost of the new replacement device. WSI will use the offset percentages published by Medicare when determining the appropriate payment reduction cap for those procedures involving replacement devices.

  Hospitals must bill using value code FD and the amount of the device credit received when a device is replaced at either no cost or at an amount that is 50 percent or more of the cost of the original device.

- **Pass Through Device Offsets** – WSI will incorporate Medicare's pass-through device offset methodology. WSI will use the offset percentages published by Medicare when determining the appropriate amounts for those procedures involving pass-through devices.

- **Packaged Drug Offsets** – WSI will not incorporate Medicare's "Threshold Packaged" and "Policy Packaged" drug offsets.

Workforce Safety & Insurance

Payment Status Indicators for the Outpatient Hospital Fee Schedule

Indicator	Service	Status
A	Services furnished to a hospital outpatient that are paid under a separate Workforce Safety & Insurance fee schedule or payment system.	WSI Fee Schedule or other Payment System – DMEPOS, Ambulance. Items should not be billed on an outpatient hospital claim.
B	Codes that are not recognized by WSI when submitted on an Outpatient Hospital Part B bill type (12x, 13x, and 14x)	Not paid under the WSI Outpatient Hospital Fee schedule. An alternate code that is recognized by WSI may be available.
C	Inpatient Procedures	Not Payable as an Outpatient Service; Admit Patient; Bill as Inpatient.
D	Discontinued Codes	Deleted Effective Beginning of Calendar Year
E	Non-Covered Items and Services, Codes not Reportable in Outpatient Hospital Settings	Not Paid by WSI or when Performed in a outpatient hospital setting.
F	Corneal tissue acquisition	Paid at Reasonable Cost plus 20% Based on Submitted Invoice.
G	Drug/Biological Pass-Through; Brachytherapy Sources	Priced by: Medicare National Amount/Medicare Conversion Factor X WSI Conversion Factor. Paid at the lesser of the billed charge or the fee schedule amount.
H	Device Pass-Through Categories	Paid at Reasonable Cost plus 20% Based on Submitted Invoice.
J	Services paid under the comprehensive APC	Priced by: Medicare assigned weights X WSI Conversion Factor. Complexity adjusted for secondary and add-on codes. Per encounter payment includes all services except those with status indicators of F, G, or H.
K	Non Pass-Through Drugs and Biologicals; Therapeutic Radiopharmaceutical Agents; Blood and Blood Products	Priced by: Medicare National Amount/Medicare Conversion Factor X WSI Conversion Factor. Paid at the lesser of the billed charge or the fee schedule amount.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine & Hepatitis B Vaccine	Not Paid by WSI.
N	Items and Services Packaged into Prospective Payment Amounts	Not Separately Payable. Packaged Into Payment for Other Services.
P	Partial Hospitalization	Not Paid by WSI. Payment Made for Each Code as an Outpatient Mental Health Service.
S	Procedure or Service, Not Discounted When Multiple	Priced by: Medicare Assigned Weight X WSI Conversion Factor. Paid at the Published Amount Regardless of the Charge Amount.
T	Procedure or Service, Multiple Procedure Reduction Applies	Priced by: Medicare Assigned Weight X WSI Conversion Factor. Paid at the Published Amount Regardless of the Charge Amount.
V	Clinic or Emergency Department Visit	Priced by: Medicare Assigned Weight X WSI Conversion Factor. Paid at the Published Amount Regardless of the Charge Amount.
X	Ancillary Service	Priced by: Medicare Assigned Weight X WSI Conversion Factor. Paid at the Lesser of the Billed Charge or the Fee Schedule Amount.
Y	Non-Implantable Durable Medical Equipment	WSI Fee Schedule or other Payment System – DMEPOS items should not be billed on a hospital outpatient claim.
Z	Services paid under other WSI fee schedules	WSI Fee Schedule Payment – Lab, PT, OT, ST, Prosthetics & Orthotics, Certain Medical & Radiology Services. If the service is paid at U&C under that fee schedule, it will be paid at the same U&C amount for the OPH Fee Schedule

Workforce Safety & Insurance

Multiple Procedure & Bilateral Procedure Discounting

No Modifier
For "T" status procedures when no modifier is attached to the line. If the code is the highest weighted code use:

Fee Schedule Amount X Units X ((1 + .5 (units-1))/ units)

If the code is **not** the highest weighted code use:

Fee Schedule Amount X Units X.5

With these formulas it won't matter if a procedure that is performed multiple times is billed on one line with multiple units or on multiple lines with one unit each.

Repeat Procedure Modifiers
Any "T" status procedure with a modifier of 76, 77, 78, or 79 is **not** subject to multiple procedure discounting and should be paid at the fee scheduled amount. These modifiers represent a return to the OR or treatment area and indicate the procedure was not done during the same operative session.

Bilateral Modifier
If modifier 50 is attached to a procedure code and the procedure code is the highest weighted code use:

Fee Schedule Amount X Units X ((1+.5)/units)

If modifier 50 is attached to a procedure code and the procedure code is **not** the highest weighted code use:

Fee Schedule Amount X Units X.5 ((1+.5)/units)

With these formulas it won't matter whether a bilateral procedure is billed on one line with a unit of one or on one line with units of two. However, the formulas won't work if a bilateral procedure is billed on two lines. Therefore, it is required that providers bill bilateral procedures on one line with a modifier of 50 and either one or two units.

Discontinued Procedure Modifiers
If modifier 73 or 52 is attached to a procedure code and the procedure code is the highest weighted code use:

Fee Schedule Amount X Units X (.5/units)

If modifier 73 or 52 is attached to a procedure code and the procedure code is **not** the highest weighted code use:

Fee Schedule Amount X Units X .5(.5/units)

If modifier 74 is attached to a procedure code, the charge will pay as if no modifier were present (i.e., with normal multiple procedure discounting).

Workforce Safety & Insurance

Billing Requirements

The major WSI billing requirements for outpatient hospital services are as follows:

- Line item date of service billing is required for all lines containing valid HCPCS codes.

- In general, non-recurring services can be billed separately from the monthly claims for recurring services.

- Multiple outpatient hospital encounters on the same day (i.e., the patient leaves the hospital and returns later in the day for other services) can be combined into one bill for that date of service or can be billed on separate claims. However, all services during an encounter with the hospital must be billed on the same claim.

- Units of service must match the description of the HCPCS code. If the same service is performed more than once on the same day, it may be reported on the claim as one line with multiple units or on multiple lines with one unit each.

- Surgical HCPCS codes must be billed with units that equal the number of times the procedure was performed as indicated by the code's description.

- Multiple surgical procedures must be reported on subsequent lines. Only the first line is required to have a charge. Subsequent lines may be reported with a unit of 1 and zero charges. However, a hospital may attach charges to each line of a multiple surgery claim if it wishes to do so.

- When a procedure is performed bilaterally, the appropriate code HCPCS code should be reported on one line with the bilateral modifier (50) attached.

- When an operative session is terminated either prior to or subsequent of the administration of anesthesia (modifiers 73 or 74), only the planned procedure(s) may be reported on the claim. Any claim with a 73 or 74 modifier that contains more than 1 "T" status procedure code will be reviewed. WSI may request records to substantiate multiple planned procedures.

- Revenue codes for which there is no valid HCPCS code reportable may be combined into one line (per revenue code) indicating total units and total charges. Typically, these revenue codes are 25X, 26X, 27X, 28X, 37X, 39X, 56X, 62X, 70X, 71X, 72X, 81X, and 942. If the hospital wishes to bill a valid HCPCS code under one of these revenue codes (e.g., a pass through device "C" code with revenue code 278), that line must stand-alone and have a date of service attached to it.

- Self-administrable drugs may be billed in the covered column on the UB-04 claim form. The claimant is not responsible for self-administrable drugs. These drugs are packaged for WSI purposes unless the fee schedule indicates a separate payment for them.

- A limited supply of take home drugs may be included as covered on the claim. Since take home drugs are considered packaged, the hospital is advised to limit the drugs to an amount that will last the claimant until a pharmacy is available.

- Hospitals will need to use HCPCS code G0378 on all claims containing charges for valid observation services. Observation services must be billed in hourly increments in order for the hospital to receive proper payment. Only revenue code 762 may be used to bill for valid observation services.

- Hospitals billing for Urgent Care centers that are located next to the Emergency Department and share a registration or triage area with the Emergency Department and bill a facility fee to all payers can bill a facility fee. These fees should be billed with Revenue Code 456 or 516 and an appropriate procedure code or an appropriate non-emergency E&M code.

- Hospitals billing for Pain Clinics located within the main hospital building can bill a facility fee. These fees should be billed with Revenue Code 511 and an appropriate HCPCS code.

- Phase III cardiac rehab services and fitness center services, where approved, are to be billed on a separate claim. These services do not have a valid HCPCS code but will be paid outside of the outpatient hospital fee schedule if billed on a separate claim. These services should be billed with revenue code 994.

- Services for automatic phone dialing devices such as “Lifealert or “Lifeline,” where approved, are to be billed on a separate claim form. These services do not have a valid HCPCS code but will be paid outside of the outpatient hospital fee schedule if billed on a separate claim. These services should be billed with revenue code 999.

- Professional fees cannot be billed on the UB-04 claim form. All professional services must be billed on the CMS 1500 claim form. This includes CRNA services. Professional fees billed on an UB-04 claim form will be “line item denied” (revenue codes 96X, 97X & 98X).

- All Durable Medical Equipment (DME) items must be billed on a CMS 1500 claim form with the appropriate modifiers. Revenue Code 29X will not be payable on a UB-04 claim form. All supplies billed on a UB-04 claim form will be packaged into the payable services provided on that date (except for pass through devices). Separately payable supply items, not provided as part of an outpatient encounter must be billed on a CMS 1500 claim form in order to be paid by the WSI DMEPOS fee schedule.

- Orthotics (HCPCS codes L0000-L4999) and Prosthetics (HCPCS codes L5000-L9999) may be billed on either the UB-04 claim form with revenue code 274 or on the CMS 1500 claim form. Payment is based on the existing WSI medical fee schedule amounts in either case.

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

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.