

Fee Schedule Guidelines

Outpatient Hospital

For use with the following code ranges: 00100-69990, 70010-79999, 80047-89398, 90281-99607, A0021-A9999, B4034-B9999, C1204-C9899, D0120-D9999, E0100-E8002, G0008-G9472, J0120-J9999, K0001-K0900, L0112-L9900, M0075-M0301, P2028-P9615, Q0035-Q9969, R0070-R0076, V2020-V5364, 0001F-9007F, 0019T-0391T, and comprehensive APCS 0039-0655

Notice

The five character numeric codes included in the North Dakota Fee Schedule are obtained from Current Procedural Terminology (CPT®), copyright 2014 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 2014 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).

The responsibility for the content of the North Dakota Fee Schedule is with WSI and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in North Dakota Fee Schedules. Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, and are not part of CPT, and the AMA does not recommend their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of North Dakota Fee Schedule should refer to the most current Current Procedural Terminology, which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply. CPT is a registered trademark of the American Medical Association.

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 (NDAC) that regulate medical services are **92-01-02-27 through 92-01-02-46**. The NDAC is accessible at the North Dakota Legislative Council web site:
<http://www.state.nd.us/lr/information/acdata/html/92-01.html>.

Table of Contents

Outpatient Hospital Pricing Methodology	4
Status Indicators	4
Calculation of the Reimbursement Rate	5
Limitations of the Outpatient Hospital Fee Schedule	5
Outpatient Hospital Payment Parameters	6
Outpatient Hospital Billing Requirements	9
Outpatient Hospital Reimbursement Procedures	12

North Dakota Workforce Safety & Insurance Outpatient Hospital Pricing Methodology

Outpatient Hospital Pricing Methodology outlines the methods used by Workforce Safety and Insurance (WSI) to determine the final rates represented on the Outpatient Hospital Fee Schedule. The Outpatient Hospital 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. Providers can access the complete Fee Schedule by visiting the Medical Provider Fee Schedule section of the WSI website: <https://www.workforcesafety.com/fee-schedules>.

Status Indicators

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

Indicator	Description	Pricing Methodology
B	Codes that are not recognized by WSI when submitted on an Outpatient Hospital Part B bill type (12x, 13x, 14x)	Not payable under the WSI Outpatient Hospital Fee Schedule. WSI may recognize an alternate code.
C	Inpatient Procedures	Not payable as an Outpatient Service; admit patient. Pricing is determined under WSI Inpatient Fee Schedule.
D	Discontinued Codes	Codes have been discontinued, effective beginning of calendar year.
E	Codes not Reportable in Outpatient Hospital	No payment is made for these codes.
G	Drug/Biological Pass-Through; Brachytherapy Sources	Pricing is determined based on the Medicare National Amount/Medicare Conversion Factor X WSI Conversion Factor, and paid at the published amount.
H	Corneal Tissue Acquisition and Device Pass-Through Categories and Hepatitis B Vaccine, provided in an outpatient hospital setting	Pricing is determined based on the invoice cost + 20%, when the services provided are in conjunction with a covered Outpatient Hospital procedure.
J	Services paid under the comprehensive APC	Pricing is determined based on 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	Pricing is determined based on the Medicare National Amount/Medicare Conversion Factor X WSI Conversion Factor, and paid at the published amount.
N	Bundled Code	Payment is bundled into the payment for other services.
O10	Laboratory services packaged when billed with another service that has a J, S, or T status indicator	Pricing is determined under the WSI Clinical Laboratory Fee Schedule. When paid at U&C under that fee schedule, WSI uses the U&C rate
S	Procedure or Service, Not Discounted When Multiple	Pricing is determined based on Medicare Assigned Weight X WSI Conversion Factor and paid at the published amount.
T	Procedure or Service, Multiple Procedure Reduction Applies	Pricing is determined based on Medicare Assigned Weight X WSI Conversion Factor and paid at the published amount.
Y	Non-Implantable Durable Medical Equipment	Not payable as an Outpatient Service. Pricing is determined under other WSI Fee Schedule.
Z	Services paid under other WSI fee schedules	Pricing is determined under other WSI Fee Schedule. When paid at U&C under that fee schedule, WSI uses the outpatient U&C rate.

Calculation of the Reimbursement Rate

For HCPCS codes assigned a status indicator of “G”, “J”, “K”, “S”, “T” or “V”, WSI applies the following formula to determine the maximum allowable reimbursement rate:

HCPCS Weight X WSI Conversion Factor

For 2016, the Conversion Factor is \$130.18.

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”). WSI calculates the conversion factor based on the prior year’s conversion factor times the Hospital Market Basket increase published by The Centers for Medicare and Medicaid Services (CMS) in the Outpatient Prospective Payment System (OPPS) final rule.

- Where Addendum B contains a HCPCS code with a payment amount but no weight, WSI computes the weight 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), WSI payment is payment based on the invoice cost plus 20%. WSI identifies these services with an “H” status indicator.

Annual Updates

WSI updates the Outpatient Hospital Fee Schedule annually based on the Hospital Market Basket increases and HCPCS weights published by CMS. Any delay by CMS 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. WSI also incorporates the quarterly updates published by CMS into the Outpatient Hospital Fee Schedule.

Limitations of the Outpatient Hospital Fee Schedule

The payment rates listed on the Outpatient Hospital 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. Providers are encouraged to carefully review WSI’s Payment Parameters, Billing Requirements, and Reimbursement Procedures to avoid unnecessary delays and denials of payment.

North Dakota Workforce Safety & Insurance

Outpatient Hospital Payment Parameters

Outpatient Hospital 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- Most Outpatient Hospital services require prior authorization. Providers should refer to the [Utilization Review Guide](#) for information on which services require authorization and the steps required to obtain authorization. Providers may access this information by visiting the Medical Provider Authorization section of the WSI website:
<https://www.workforcesafety.com/medical-providers/authorization>

Bilateral Surgery Payment (50)- WSI utilizes Medicare's bilateral surgery payment adjustments for services assigned a status indicator "T" when billed with Modifier 50. WSI issues payment for the primary bilateral procedure at 150% of the fee schedule rate. If a bilateral procedure is a secondary procedure, the service is reimbursed at 75% of the fee schedule rate.

WSI does not apply bilateral procedure discounting to those procedures identified with status indicator "S".

Comprehensive APCs- With the exception of observation services, WSI utilizes the same packaging and payment methodology for Comprehensive APCs as the Medicare OPPS.

Distinct Procedural Services (59)- WSI reimburses for distinct procedural services at 100% of fee schedule, with the appropriate multiple procedure discounts.

Discontinued Procedure Discounting (73, 74, 52)- For services billed with modifier 73, if the procedure code is the highest weighted code, WSI prices it at 50% of the Outpatient Hospital Fee Schedule rate. If the procedure code is not the highest weighted code, WSI prices it at 25% of the Outpatient Hospital Fee Schedule rate.

WSI prices procedures billed with modifiers 74 and 52 as if no modifier were present (i.e., with normal multiple procedure discounting).

Modifier Usage- WSI does not require all of the modifiers required by the Medicare OPPS. WSI permits the appropriate use of OPPS modifiers.

Multiple Procedure Discounting- WSI applies multiple procedure discounting to codes identified with status indicator "T". If the procedure code is the highest weighted code, WSI prices it at 100% of the Outpatient Hospital Fee Schedule rate. If the procedure code is not the highest weighted code, WSI prices it at 50% of the Outpatient Hospital Fee Schedule rate.

WSI does not apply multiple procedure discounting to those procedures identified with status indicator "S".

Observation Services- WSI does not apply the comprehensive APC methodology to observation services. Providers must bill these services in hourly increments with HCPCS code G0378. WSI allows observation stays of 48 hours or less. WSI will initially deny hours of observation over 48, but providers may appeal these denials with evidence of medical necessity. WSI bundles the payment for HCPCS code G0379 (direct admit to observation) into the payment for G0378.

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

Outpatient Laboratory- WSI reimburses outpatient laboratory codes with a “O10” Status Indicator separately under the following circumstances:

- A hospital receives a specimen only and the patient does not present to the hospital.
- A patient presents to the hospital; however, lab tests are the only services provided during the encounter.
- Lab tests are unrelated to the reason the patient has presented to the hospital, and a physician other than the physician providing the services for which the patient presented to the hospital for orders the labs. Use of the L1 modifier is required under this circumstance in order to receive separate reimbursement.

Partial Hospitalization- WSI does not pay for partial hospitalization services per se. WSI pays for all psychiatric services provided to hospital outpatients as outpatient mental health services.

Pass-Through Devices- WSI incorporates Medicare’s pass-through device offset methodology. WSI uses the offset percentages published by Medicare when determining the appropriate amounts for those procedures involving pass-through devices.

Prospective Payments- WSI pays outpatient hospital services with extensive packaging at the amount indicated on the WSI Outpatient Hospital Fee Schedule, regardless of the billed charge amount.

Provider-Based Clinics- WSI does not recognize clinics as provider-based. Providers must bill services of a type typically performed in a physician’s office on a CMS 1500 claim form, with the following exceptions:

- An Urgent Care center that is located next to an Emergency Department, which shares a common registration or triage area with the Emergency Department, and bills a facility fee to all payers. Facility charges for these services can be billed with Revenue Code 456 or 516
- A Pain Clinic located within the hospital’s main building. Providers may bill facility charges for these services with Revenue Code 511.

NCCI Edits- WSI incorporates all applicable NCCI edits.

New Codes with no Payment- WSI pays for new codes that Medicare has not yet assigned a payment for (either through the APC payment system or through the Medicare Part B Fee Schedules) at 85% of billed charges.

Packaged Drug Offsets- WSI does not incorporate Medicare’s “Threshold Packaged” and “Policy Packaged” drug offsets.

Packaged Procedures- WSI has adopted Medicare's packaging policies relating to Outpatient Hospital services. There are several HCPCS codes on the Outpatient Hospital Fee Schedule with a payment status indicator of "N". These are packaged services and a provider will not receive separate payment for them.

Repeat Procedure Modifiers (76,77,78,79)- Procedures with modifiers 76, 77, 78, or 79 are not subject to multiple procedure discounting and are be paid at the Outpatient Hospital fee schedule amount. These modifiers represent a return to the operating room or treatment area and indicate the reported procedures were not completed during the same operative session.

Replacement Device Offsets- WSI incorporates 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 uses 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.

Wage Adjustments- WSI does not wage adjust the conversion factor.

North Dakota Workforce Safety & Insurance

Outpatient Hospital Billing Requirements

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

Bilateral Surgical Procedures- Providers are required to bill bilateral surgical procedures on 1 line as a single unit, appended with the bilateral procedure modifier (50).

Bill Form- Providers must submit medical bills for outpatient services on a UB-04 form or via EDI.

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

Electronic Billing- Providers wishing to submit bills via EDI should contact Noridian EDI Support Services at 800-967-7902 for assistance.

Paper Billing- Providers may submit bills in red and white paper format only to WSI:
Workforce Safety & Insurance
PO Box 5585
Bismarck, ND 58506

Records- WSI does not consider payment for medical services without verification of the services rendered; therefore, providers must submit all relevant medical records to the address listed above. WSI denies medical bills received without supporting medical documentation.

Bill Status Inquiries- WSI will not process requests for bill status inquiries of large volume or repetitive requests for the status of processed medical bills. In addition, WSI requests that the provider allow two (2) months from the date of bill submission before inquiring on bill status. This allows adequate time for WSI to process the bill and for the provider to receive the remittance advice.

Coding- Providers are required to bill using only current and appropriate CPT and HCPCS Level II codes for medicine services.

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

Durable Medical Equipment- Providers may bill for Durable Medical Equipment (DME) items (as defined in the DME Payment Policy) on a UB-04 claim form or a CMS 1500 claim form with the appropriate modifiers. Providers must bill for separately payable supply items, not provided as part of an outpatient encounter, on a CMS 1500 claim form in order for WSI to issue payment based on the WSI DME fee schedule.

Fitness Center Services- When WSI approves an independent exercise program, facilities may bill for the fitness center services using WSI-specific code W0555 on a CMS 1500, or by submitting an invoice for the charges.

Inpatient Hospital vs. Outpatient Hospital Classification- WSI requires all providers to bill all patient stays of 24 hours or less as outpatient stays unless the surgical procedure performed has a status indicator of “C”. Providers must bill all patient stays for surgical services where the HCPCS code for the surgery has a status indicator of “C” (inpatient only) as inpatients, regardless of the length of the stay.

Line Item Billing- WSI requires line item date of service billing for all lines, with the exception of observation services.

Medical Necessity- Providers are required to bill using the same medical necessity guidelines as they use for Medicare.

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

Multiple Surgical Procedures- Providers must bill multiple surgical procedures on subsequent lines.

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 providers to include the NPI at both the rendering provider and billing provider levels.

Observation Services- Hospitals must use HCPCS code G0378 on all claims containing charges for valid observation services. Providers must bill observation services 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.

Orthotics and Prosthetics- Providers may bill for orthotics (HCPCS codes L0000-L4999) and Prosthetics (HCPCS codes L5000-L9999) on either the UB-04 claim form with revenue code 274 or on the CMS 1500 claim form. WSI pricing for these services is determined based on the existing WSI DME fee schedule amounts in either case.

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

Phase III Cardiac Rehab Services- Providers must bill Phase III cardiac rehab services on a separate claim. These services do not have a valid HCPCS code but WSI pays for them outside of the outpatient hospital fee schedule when billed on a separate claim. Providers must bill these services with revenue code 994.

Professional Fees- Providers cannot bill professional fees on the UB-04 claim form. Providers must bill all professional services 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).

Services without Valid HCPC Codes- Providers may combine revenue codes for which there is no valid HCPCS code reportable into one line.

Take-Home Drugs- WSI considers take-home drugs as packaged services and this service is not separately reimbursable.

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

Units of Service- The units of service must match the description of the HCPCS code. Providers must bill surgical HCPCS codes with units that equal the number of times the procedure was performed, as indicated by the code's description.

Urgent Care Centers- Hospitals may bill a facility fee for Urgent Care centers that are located next to the Emergency Department and share a registration or triage area with the Emergency Department when they bill a facility fee to all payers. Providers must bill these fees with Revenue Code 456 or 516 along with an appropriate procedure code or an appropriate non-emergency E&M code.

North Dakota Workforce Safety & Insurance

Outpatient Hospital Reimbursement Procedures

Outpatient Hospital Reimbursement Procedures outlines how WSI communicates bill processing information and issues payment to medical providers. In addition, it outlines the WSI's requirements for reimbursement. Providers are encouraged to familiarize themselves with WSI's Reimbursement Procedures to reduce repetition of bill processing information and delays in payment.

Provider Registration- Providers must register with WSI in order to receive reimbursement. Providers can register by completing and submitting a W9 form or the [Payee Registration and Substitute IRS Form W9](#).

Payment Address- WSI issues payment to the address as indicated on the applicable payment bill form. If WSI has not received a W9 or Payee Registration and Substitute IRS Form W9 with the address indicated on the bill form, WSI will not issue payment until WSI receives the W9 or Payee Registration and Substitute IRS Form.

Remittance Advice- WSI issues remittance advices for processed medical bills each week on Friday. Providers must refer to the remittance advice for bill status information. Information contained on the remittance advice includes patient name, date of service, procedure billed, submitted amount, and paid amount. The remittance advice also includes reason codes, which explain any reductions or denials of payment for a service. Providers in need of a duplicate remittance advice can request these by contacting our customer service department at 1-800-777-5033.

Reason Codes- Certain reason codes allow the provider to bill the patient for the denied charges, or for the balance of reduced charges. The [remittance advice reason codes](#) identify the cause for the determination and specifically state that the provider may bill the patient. When these reason codes occur, WSI also sends a "Notice of Non-Payment" letter to the patient informing them of their responsibility for the charges.

In accordance with [North Dakota Administrative Code 92-01-02-45.1](#), if a reason code does not state that a provider may bill the patient, the provider cannot bill the charges for reduced or denied services to the patient, the employer, or another insurer.

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 the 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 begin withholding the overpayment from future payments.

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

1600 E Century Ave, Suite 1
PO Box 5585
Bismarck, ND 58506-5585
701-328-3800
800-777-5033
Fax: 701-328-3820

www.workforcesafety.com

WSI's UR Department
701-328-5990
1-888-777-5871
Fax: 701-328-3820