State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-NINTH SESSION

H. F. No. 2193

04/13/2015 Authored by Albright, Mahoney and Baker
The bill was read for the first time and referred to the Committee on Commerce and Regulatory Reform
04/21/2015 Adoption of Report: Re-referred to the Committee on Rules and Legislative Administration
05/06/2015 Adoption of Report: Placed on the General Register
Read Second Time

A bill for an act

relating to workers' compensation; adopting recommendations of the workers' compensation advisory council regarding inpatient hospital payments; authorizing rulemaking; requiring a report; amending Minnesota Statutes 2014, section 176.136, subdivision 1b; proposing coding for new law in Minnesota Statutes, chapter 176.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2014, section 176.136, subdivision 1b, is amended to read:

Subd. 1b. **Limitation of liability.** (a) The liability of the employer for treatment, articles, and supplies provided to an employee while an inpatient or outpatient at a ~~small hospital~~ Critical Access Hospital certified by the Centers for Medicare and Medicaid Services shall be the hospital's usual and customary charge, unless the charge is determined by the commissioner or a compensation judge to be unreasonably excessive. ~~A "small hospital," for purposes of this paragraph, is a hospital which has 100 or fewer licensed beds.~~

(b) The liability of the employer for the treatment, articles, and supplies that are not limited by subdivision 1a ~~or~~, 1c ~~or~~, paragraph (a), or section 176.1362 shall be limited to 85 percent of the provider's usual and customary charge, or 85 percent of the prevailing charges for similar treatment, articles, and supplies furnished to an injured person when paid for by the injured person, whichever is lower. On this basis, the commissioner or compensation judge may determine the reasonable value of all treatment, services, and supplies, and the liability of the employer is limited to that amount. The commissioner may by rule establish the reasonable value of a service, article, or supply in lieu of the 85 percent limitation in this paragraph. A prevailing charge established under Minnesota Rules, part 5221.0500, subpart 2, must be based on no more than two years of billing data immediately preceding the date of the service.

(c) The limitation of liability for charges provided by paragraph (b) does not apply to a nursing home that participates in the medical assistance program and whose rates are established by the commissioner of human services.

(d) An employer's liability for treatment, articles, and supplies provided under this chapter by a health care provider located outside of Minnesota is limited to the payment that the health care provider would receive if the treatment, article, or supply were paid under the workers' compensation law of the jurisdiction in which the treatment was provided.

EFFECTIVE DATE. This section is effective for billing and payment of inpatient hospital services, articles, and supplies provided to patients discharged on or after January 1, 2016.

Sec. 2. **[176.1362] INPATIENT HOSPITAL PAYMENT.**

Subdivision 1. **Payment based on Medicare MS-DRG system.** (a) Except as provided in subdivisions 2 and 3, the maximum reimbursement for inpatient hospital services, articles, and supplies is 200 percent of the amount calculated for each hospital under the federal Inpatient Prospective Payment System developed for Medicare, using the inpatient Medicare PC-Pricer program for the applicable MS-DRG as provided in paragraph (b). All adjustments included in the PC-Pricer program are included in the amount calculated, including but not limited to any outlier payments.

(b) Payment under this section is effective for services, articles, and supplies provided to patients discharged from the hospital on or after January 1, 2016. Payment for services, articles, and supplies provided to patients discharged on January 1, 2016, through December 31, 2016, must be based on the Medicare PC-Pricer program in effect on January 1, 2016. Payment for inpatient services, articles, and supplies for patients discharged in each calendar year thereafter must be based on the PC-Pricer program in effect on January 1 of the year of discharge.

(c) Hospitals must bill workers' compensation insurers using the same codes, formats, and details that are required for billing for hospital inpatient services by the Medicare program. The bill must be submitted to the insurer within the time period required by section 62Q.75, subdivision 3. For purposes of this section, "insurer" includes both workers' compensation insurers and self-insured employers.

Subd. 2. **Payment for catastrophic, high-cost injuries.** (a) If the hospital's total usual and customary charges for services, articles, and supplies for a patient's hospitalization exceed a threshold of $175,000, annually adjusted as provided in paragraph (b), reimbursement must not be based on the MS-DRG system, but must instead be paid at 75 percent of the hospital's usual and customary charges.

(b) Beginning January 1, 2017, and each January 1 thereafter, the commissioner must adjust the previous year's threshold by the percent change in average total charges per inpatient case, using data available as of October 1 for non-Critical Access Hospitals from the Health Care Cost Information System maintained by the Department of Health pursuant to chapter 144. The commissioner must annually publish notice of the updated threshold in the State Register.

Subd. 3. **Critical Access Hospitals.** Hospitals certified by the Centers for Medicare and Medicaid Services as Critical Access Hospitals shall be reimbursed as provided in section 176.136, subdivision 1b, paragraph (a).

Subd. 4. **Submission of information when payment is by MS-DRG.** Except when a postpayment audit is allowed under subdivision 6, an insurer must not require an itemization of charges or additional documentation to support a bill from a non-Critical Access Hospital when all of the following requirements are met:

(1) the hospital must submit its charges to the insurer on the 837 institutional standard electronic transaction required by section 62J.536;

(2) an MS-DRG must apply to the hospitalization; and

(3) the hospital's total charges must be less than the threshold amount in subdivision 2, as annually adjusted.

Subd. 5. **Prompt payment requirement when MS-DRG payment is made.** (a) When the requirements in subdivision 4 have been met, the insurer must take one of the following actions within 30 days of receipt of the hospital's bill:

(1) pay the hospital's bill as provided in subdivision 1, with no reductions based on a review of charges for specific services, articles, or supplies; or

(2) deny payment for the entire hospitalization for one of the following reasons:

(i) the patient's workers' compensation injury claim is denied;

(ii) the diagnosis for which the patient was hospitalized is not related to the insurer's admitted workers' compensation injury; or

(iii) the hospitalization was not reasonably required to cure and relieve the employee from the effects of the injury under section 176.135 or rules adopted under section 176.83, subdivision 5.

(b) When the requirements of subdivision 4 are met, an insurer must not deny payment for one or more charges on the basis that the charge should have been bundled into another charge, or on the basis that a particular service, article, or supply was not reasonably required, except that the insurer may raise these issues during a postpayment audit under subdivision 6.

Subd. 6. **Postpayment audits; records; interest.** (a) The insurer may conduct a postpayment audit if both of the following requirements are met:

(1) the insurer paid the hospital's bill within 30 days according to the PC-Pricer program amount described in subdivision 1; and

(2) the amount paid according to the PC-Pricer program in subdivision 1 included an outlier payment.

(b) If an audit is permitted under paragraph (a), the insurer must request any additional records needed to conduct the audit within six months after payment. The records requested may include an itemized statement of charges. Within 30 days of the insurer's request, the hospital must provide the additional documentation requested. An insurer must not request additional information from a hospital more than three times per audit.

(c) An insurer must pay the hospital interest at an annual rate of four percent if it is determined that the insurer is liable for additional hospital charges following a postpayment audit. A hospital must pay the insurer interest at an annual rate of four percent if it is determined that the hospital owes the insurer reimbursement following the insurer's audit. Interest is payable by the insurer from the date payment was due under this section or section 176.135. Interest is payable by the hospital from the date the overpayment was made.

Subd. 7. **Study.** The commissioner of labor and industry shall conduct a study analyzing the impact of the reforms under this section to determine whether the objectives have been met and whether further changes are needed. The commissioner must report the results of the study to the Workers' Compensation Advisory Council and the chairs and ranking minority members of the house of representatives and senate committees with jurisdiction over workers' compensation by January 15, 2018.

Subd. 8. **Rulemaking.** The commissioner may adopt or amend rules using the authority in section 14.389, including subdivision 5, to: (1) implement this section and the Medicare Inpatient Prospective Payment System for workers' compensation; and (2) implement the Medicare Hospital Outpatient Prospective Payment System, or other fee schedule, for payment of outpatient services provided under this chapter by a hospital or ambulatory surgical center, not to take effect before January 1, 2017.

EFFECTIVE DATE. Subdivisions 1 to 6 are effective for billing and payment of inpatient hospital services, articles, and supplies provided to patients discharged on or after January 1, 2016. Subdivision 8 is effective the day following final enactment.