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 this subdivision. 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.

(c) For patients discharged on or after May 31, 2017, payment for inpatient services, articles, and supplies must be calculated according to the PC-Pricer program identified on Medicare's Web site as FY 2016.1, updated on January 19, 2016.

(d) For patients discharged on or after October 1, 2017, payment for inpatient services, articles, and supplies must be calculated according to the PC-Pricer program posted on the Department of Labor and Industry's Web site as follows:

(1) No later than October 1, 2017, and October 1 of each subsequent year, the commissioner must post on the department's Web site the version of the PC-Pricer program that is most recently available on Medicare's Web site as of the preceding July 1. If no PC-Pricer program is available on the Medicare Web site on any July 1, the PC-Pricer program most recently posted on the department's Web site remains in effect.

(2) The commissioner must publish notice of the applicable PC-Pricer program in the State Register no later than October 1 of each year.

(e) The MS-DRG grouper software or program that corresponds to the applicable version of the PC-Pricer program must be used to determine payment under this subdivision.

(f) 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. The threshold amount in effect on the date of discharge determines the applicability of this paragraph.

(b) On January 1, 2017, 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. Beginning October 1, 2017, and each October 1 thereafter, the commissioner must adjust the previous threshold using the data available as of the preceding July 1. The commissioner must 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.

History: *2015 c 43 s 3; 2017 c 94 art 3 s 2,3*