176.1364 WORKERS' COMPENSATION HOSPITAL OUTPATIENT FEE SCHEDULE.

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given them.

(b) "Addendum A" means the addendum entitled "OPPS APCs for CY 2018," or its successor, developed by the Centers for Medicare and Medicaid Services (Medicare) for use in the Medicare Hospital Outpatient Prospective Payment System (OPPS) system under Code of Federal Regulations, title 42, part 419, as may be amended from time to time.

(c) "Addendum B" means the addendum entitled "OPPS Payment by HCPCS Codes for CY 2018," or its successor, developed by the Centers for Medicare and Medicaid Services (Medicare) for use in the Medicare Hospital Outpatient Prospective Payment System (OPPS) system under Code of Federal Regulations, title 42, part 419, as may be amended from time to time.

(d) "HCPCS code" means a numeric or alphanumeric code included in the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System. A HCPCS code is used to identify a specific medical service.

(e) "Hospital" means a facility that is licensed by the Department of Health under section 144.50.

(f) "HOFS" means the workers' compensation hospital outpatient fee schedule established under subdivision 3.

(g) "Insurer" includes workers' compensation insurers and self-insured employers.

(h) "Services" includes articles, supplies, procedures, and implantable devices provided by the hospital with the service. Services are identified by a code described in subdivision 3.

Subd. 2. **Applicability.** (a) This section only applies to payment of charges for hospital outpatient services if the charges include a service listed in the workers' compensation hospital outpatient fee schedule established by the commissioner under subdivision 3. If the charges do not include a service listed in the HOFS, payment shall be:

(1) the liability for each service that is included in the workers' compensation relative value fee schedule as provided in section 176.136, subdivision 1a, and corresponding rules adopted by the commissioner to implement the relative value fee schedule; or

(2) the liability as provided in section 176.136, subdivision 1b, paragraphs (b) and (c), for each service that is not included in the workers' compensation relative value fee schedule.

(b) This section does not apply to outpatient services provided at a hospital that is certified by Medicare as a critical access hospital. Outpatient services provided by these hospitals shall be paid as provided in section 176.136, subdivision 1b, paragraph (a).

Subd. 3. **Hospital outpatient fee schedule (HOFS).** (a) Effective for hospital outpatient services on or after October 1, 2018, the commissioner shall establish a workers' compensation hospital outpatient fee schedule (HOFS) to establish the payment for hospital bills with charges for services with a J1 or J2 status indicator as listed in the status indicator (SI) column of Addendum B and the comprehensive observation services Ambulatory Payment Classification (APC) 8011 with a J2 status indicator in Addendum A. The commissioner shall publish a link to the HOFS in the State Register before October 1, 2018, and shall maintain the current HOFS on the department's website.

(b) The amount listed for each of the procedures in the HOFS as described in paragraph (a) shall be the relative weight for the procedure multiplied by a HOFS conversion factor that results in the same overall payment for hospital outpatient services under this section as the actual payments made in the most recent 12-month period available before October 1, 2018. The commissioner must establish separate conversion factors to achieve the same overall payment for noncritical access hospitals of 100 or fewer licensed beds and hospitals with more than 100 licensed beds. The commissioner shall establish the two conversion factors according to the requirements in clauses (1) to (4) in consultation with insurer and hospital representatives.

(1) The commissioner shall obtain a suitable sample of de-identified data for Minnesota workers' compensation outpatient cases at Minnesota hospitals for the most recently available 12-month period. The commissioner may obtain de-identified data from any reliable source, including Minnesota hospitals and insurers, or their representatives. Any data provided to the commissioner by a hospital, insurer, or their representative under this subdivision is nonpublic data under section 13.02, subdivision 9.

(2) The sample must be divided into a data set for hospitals over 100 licensed beds, and 100 or fewer licensed beds, excluding critical access hospitals.

(3) For each data set the commissioner shall:

(i) calculate the total amount of the actual payments made in the most recent 12-month period available before October 1, 2018, adjusted for inflation to July 2018; and

(ii) apply all of the payment provisions in this section to each claim including, as applicable, payment under the relative value fee schedule or 85 percent of the hospital's usual and customary charge under section 176.136, subdivisions 1a and 1b, to determine the total payment amount using the Medicare conversion factor in effect for the OPPS in effect on July 1, 2018.

(4) The commissioner shall calculate the Minnesota conversion factor to equal the Medicare conversion factor multiplied by the ratio of total payments under clause (3), item (i), divided by the total payments under clause (3), item (ii).

(c) For purposes of this section:

(1) the relative weight is the amount in the "relative weight" column in Addendum B and Addendum A for comprehensive observation services;

(2) references to J1, J2, and H status indicators; Addenda A and B; APC 8011; and HCPCS code G0378 includes any successor status indicators, addenda, APC, or HCPCS code established by the Centers for Medicare and Medicaid Services.

(d) On October 1 of each year, the commissioner shall adjust the HOFS conversion factors based on the market basket index for inpatient hospital services calculated by Medicare and published on its website. The adjustment on each October 1 shall be a percentage equal to the value of that index averaged over the four quarters of the most recent calendar year divided by the value of that index over the four quarters of the prior calendar year.

(e) No later than October 1, 2021, and at least once every three years thereafter, the commissioner shall update the HOFS established under this subdivision by incorporating services with a J1 or J2 status indicator, and the corresponding relative weights, listed in the Addenda A and B most recently available on Medicare's website as of the preceding July 1. If Addenda A and B are not available on Medicare's website on the preceding July 1, the HOFS most recently published on the department's website remains in effect.

(1) Each time the HOFS is updated under this paragraph, the commissioner shall adjust the conversion factors so that there is no difference between the overall payment under the new HOFS and the overall payment under the HOFS most recently in effect, for services in both HOFSs.

(2) The conversion factor adjustments under this paragraph shall be made separately for each hospital category in paragraph (b).

(3) The conversion factor adjustments under this paragraph must be made before making any additional adjustment under paragraph (d).

(f) The commissioner shall give notice in the State Register of the adjusted conversion factor in paragraph (d) no later than October 1 annually. The commissioner shall give notice in the State Register of an updated HOFS under paragraph (e) no later than October 1 of the year in which the HOFS becomes effective. The notice must include a link to the HOFS published on the department's website. The notices, the updated fee schedules, and the adjusted conversion factors are not rules subject to chapter 14, but have the force and effect of law as of the effective date published in the State Register.

(g) Beginning October 1, 2023, to October 1, 2025, the commissioner shall adjust the conversion factors calculated under this subdivision to result in the following:

(1) for services effective October 1, 2023, a three percent overall reduction in total payments for hospital outpatient services;

(2) for services effective October 1, 2024, a three percent overall reduction in total payments for hospital outpatient services; and

(3) for services effective October 1, 2025, a four percent overall reduction in total payments for hospital outpatient services.

Subd. 4. **Payment under the hospital outpatient fee schedule.** (a) Services in the HOFS, and other hospital outpatient services provided with or as part of service in the HOFS, are paid according to paragraphs (b) and (c).

(b) If a hospital bill includes a charge for one or more services with a J1 status indicator, payment shall be as provided in this paragraph.

(1) If the bill includes a charge for only one service with only a J1 status indicator, payment shall be the amount listed in the HOFS for that service, regardless of the amount charged by the hospital.

(2) If the bill includes charges for more than one service with a J1 status indicator, the service with the highest listed fee in the HOFS shall be paid at 100 percent of the listed fee. Each additional service listed in the hospital outpatient fee shall be paid at 50 percent of the listed fee. Payment under this clause shall be based on the applicable percentage of the listed fee, regardless of the amount charged by the hospital.

(3) If the bill includes an additional charge for a service that does not have a J1 status indicator listed in the HOFS, no separate payment is made for the additional service. Payment for the additional service, including any service with a J2 status indicator, is packaged into and is not paid separately from the payment amount listed in the HOFS for the service with the J1 status indicator. Implantable devices are paid separately only as provided in subdivision 5.

(4) The insurer must not deny payment for any additional service packaged into payment for a service listed in the HOFS on the basis that the additional service was not reasonably required or causally related to an admitted work injury.

(c) If a hospital bill includes one or more charges for services with a J2 status indicator, and does not include any charges for services with a J1 status indicator, payment shall be as provided in this paragraph.

(1) Except for services packaged into an observation service as provided in clause (4), payment for each service with a J2 status indicator shall be the amount listed in the HOFS, regardless of the amount charged by the hospital.

(2) If a service without a HCPCS code is billed with a service with a J2 status indicator, payment is packaged into the payment for the J2 service.

(3) Payment for drugs with a HCPCS code is separate from payment for the service with the J2 code as provided in this clause.

(i) If the drug is delivered by injection or infusion, payment for the drug is packaged into payment for the injection or infusion service.

(ii) If the drug is not delivered by injection or infusion, payment for the drug is paid at the Medicare Average Sales Price (ASP) of the drug on the day the drug is dispensed. No later than October 1, 2018, and October 1 of each subsequent year, the commissioner must publish on the department's website a link to the ASP most recently available as of the preceding July 1. If no ASP is available, the most recently posted ASP linked on the department's website remains in effect.

(4) If a bill includes eight or more units of service with the HCPCS code G0378 (observation services, per hour), and there is a physician's or dentist's order for observation, payment shall be the amount listed in the HOFS for the comprehensive observation services Ambulatory Payment Classification 8011, regardless of the amount charged by the hospital. All other services billed by the hospital, including other services with a J2 status indicator, are packaged into the payment amount and are not paid separately from the payment amount listed in the fee schedule for HCPCS code G0378.

(5) For any other service on the same bill as the service with a J2 status indicator, payment shall be as provided in subdivision 2, paragraph (a).

Subd. 5. **Implantable devices.** The maximum fee for any service in the HOFS includes payment for all implantable devices, even if the Medicare OPPS would otherwise allow separate payment for the implantable device. However, separate payment in the amount of 85 percent of the hospital's usual and customary charge for an implantable device is allowed if the implantable device:

(1) has an H status indicator in Addendum B;

(2) is properly charged on a bill with a service with a J1 status indicator in the HOFS; and

(3) is properly billed with another HCPCS code, if required by Medicare's OPPS system.

The commissioner shall update the HOFS each October 1 to include any HCPCS codes that are payable under this section according to the Addendum B most recently available on the preceding July 1.

Subd. 6. MS 2022 [Repealed, 2023 c 51 art 4 s 2]

Subd. 7. **Rulemaking.** The commissioner may adopt or amend rules, using the authority in section 14.386, paragraph (a), to implement this section. The rules are not subject to expiration under section 14.386, paragraph (b).

History: *2018 c 185 art 2 s 1; 2023 c 51 art 4 s 1*