PROCEDURAL GUIDANCE on HOSPITAL and FACILITY REIMBURSEMENT UNDER INDIANA'S WORKERS COMPENSATION PROGRAM
Effective for procedures rendered on and after July 1, 2014 in hospitals and January 1, 2023 for other medical facilities

I. Hospitals Reimbursed Under Medicare's Prospective Payment System

A. Hospital Inpatient Prospective Payment System

Inpatient Acute Care Hospitals are paid according to the Inpatient Prospective Payment System set up by CMS. Under this system, a hospital is paid a fixed amount for each patient discharged in a particular treatment category or Diagnosis Related Group (DRG).

The hospital will prepare and submit its claim for inpatient payment on the UB-04 (CMS- 1450) as follows:

(1) The hospital shall submit its claim for payment on a UB-04 form (if the claim is submitted on paper) or in an 837I claim transmission (if the claim is submitted electronically).

(2) For a claim for inpatient services or items, the hospital shall enter charges from the hospital specific charge description master (CDM) for services and items that correspond to physicians' orders in addition to routine sterile and non-sterile supplies. The CDM contains the revenue code (cost center), the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes and the charge for the service or item. The HCPCS is divided into two principal subsystems, referred to as level I and level II. Level I of the HCPCS is comprised of CPT (Current Procedural Terminology); a numeric coding system maintained by the American Medical Association (AMA). Level II HCPCS codes are maintained by CMS. Revenue codes define the area of service and are maintained by the National Uniform Billing Committee (NUBC). CPT and HCPCS codes are not required on an inpatient claim.

(3) The hospital's medical record coders shall code the inpatient claim using ICD-9 diagnosis and procedure codes based on physicians' orders, progress notes and discharge summary. When ICD-9 coding has been completed, the hospital will determine whether the UB-04 claim is ready for billing. The hospital will use ICD- 10 billing and procedure codes upon being required to do so for the Medicare program.

(4) The hospital shall submit UB-04 claims (along with the hospital's Medicare provider number if the number is not included in the UB-04 form) to an employer; an employer's insurance carrier; or through an electronic claims transmission vendor as it would submit a claim to the Medicare Program.

(5) When transmitted and received by the payer, the inpatient claim is "grouped" according to the ICD-9 (or, as noted above, ICD-10) diagnoses and procedures codes listed on the UB04 claim form utilizing the Medicare Severity Diagnosis Related Grouper (MS DRG). The diagnoses codes are grouped to determine the MS DRG. The MS DRG Grouper may be purchased from commercial vendors. Updates to the Grouper occur in October of each year, and as needed based on any changes implemented by the CMS during the year.

(6) The Medicare Inpatient Prospective Payment Pricer calculates each specific hospital's payment using the MS DRG relative weight, the hospital's specific wage index, and the federal base rate in addition to Medicare disproportionate share (for high- percentage of low-income patients) and indirect medical education (for approved teaching hospitals) add-ons if applicable to the hospital. Finally, for cases that exceed the cost threshold determined by the Pricer, an outlier payment is added to the base payment rate by the Pricer. The Inpatient PPS Pricer Software may be obtained free of charge from Medicare. The Pricer is updated on a quarterly basis. The Pricer software is available in a self-extracting executable format. The guidelines for downloading and executing the PPS PC Pricers are at the following web addresses:

https://www.cms.gov/WebPricer and

https://www.cms.gov/ipps-webpricer

(7) The Inpatient PPS Pricer must be set up for each hospital provider number. The MS DRG and admission and discharge dates are entered into the PC Pricer for calculation of the Medicare reimbursement.

(8) For purposes of paying the hospital's claim, the Medicare amount calculated under the process described above shall be multiplied by a factor of 2.0. The payment due a hospital shall not be reduced by any amount attributable to copayments, deductibles, or any other cost-sharing amount that may be required of a Medicare enrollee under the Medicare program.

(9) On a yearly basis, CMS releases proposed and final rule changes to the IPPS. Proposed and final rule changes are published in the Federal Register under the Department Health and Human Services in June and August, respectively. The effective date for any annual rule changes is the Federal Fiscal Year beginning October 1.

B. Hospital Outpatient Prospective Payment System

The hospital will prepare and submit its claim for outpatient payment on the UB-04 (CMS-1450) as follows:

(1) The hospital shall submit its claim for payment on a UB-04 form (if the claim is submitted on paper) or in an 837I claim transmission (if the claim is submitted electronically).

(2) For a claim for outpatient services or items, the hospital shall enter charges from the hospital specific charge description master (CDM) for services and items that correspond to physicians' orders in addition to routine sterile and non-sterile supplies. The CDM contains the revenue code (cost center), the CPT or HCPCS codes and the charge for the service or item. CPT and HCPCS codes are required on an outpatient claim.

(3) The hospital's medical record coders shall code the outpatient claim using ICD-9 diagnosis based on physicians' orders, progress notes and test results. When ICD-9 coding has been completed, the hospital will determine whether the UB-04 claim is ready for billing. The hospital will use ICD-10 billing and procedure codes upon being required to do so for the Medicare program.

(4) When the claim is ready for billing, the outpatient claim will be reviewed (or "scrubbed") for National Correct Coding Initiative (NCCI) and Medical Necessity (Local Coverage Determination and National Coverage Determination) edits. The NCCI edits will consider CPT and HCPCS coding (bundling and/or mutually exclusive). The Medical Necessity edits will look at ICD-9 codes (or, as noted above, ICD-10 codes) in relation to National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). NCCI edits are updated quarterly. NCDs and LCDs are updated periodically by CMS and the Medicare Administrative Contractors (MAC).

(5) After the outpatient claims are scrubbed, the hospital shall submit UB-04 claims to an employer; an employer's insurance carrier; or through an electronic claims transmission vendor as it would submit a claim to the Medicare Program.

(6) When outpatient claims are received by the payer, the payer will utilize the following Medicare fee schedules (which are updated on a yearly basis), in effect at the time the service or item was provided, to calculate the applicable outpatient reimbursement amount:

- the Ambulatory Payment Classification (APC) System;
- the Medicare Physician Fee Schedule used for payment of physical therapy, occupational therapy, speech therapy;
- the Medicare Clinical Laboratory Fee Schedule used for outpatient diagnostic laboratory services; and
- the Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule (DMEPOS) for outpatient orthotics and prosthetics.

(7) There is no PC Pricer application for Outpatient PPS at this time. The CMS files contain the logic, rates, wage index, and off-set amounts used by the OPPS Pricer program to calculate APC rates. Payment methodology is based on Outpatient Status Indicators. Outpatient Status Indicators are defined in Addendum D1 to the OPPS rules. Addendum D1 is updated yearly based on the OPPS Final Rule. Here is a link to Addendum D1:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/downloads/CMS1392P_Addendum_D1.pdf

(8) OPPS Addendum A and Addendum B are updated quarterly on the OPPS website. These addenda identify each CPT or HCPCS code status indicators, APC groups and OPPS national payment rate. Here is a link to Addendums A and B:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates

(9) For services or items paid based on APCs, the annual conversion factor (as set forth in the OPPS rules in effect at the time the service or item is provided) is multiplied by the APC relative weight and the specific hospital's wage adjustment. The APC relative weight is found in Addendum A and Addendum B. The wage index for calculating OPPS rates is the same wage index that can be found in the Inpatient PC Pricer Software that is updated each year.

(10) For diagnostic laboratory services, the Indiana Medicare Clinical Laboratory Fee Schedule for the specific CPT code reported on the claim is utilized for reimbursement for each service. The Medicare Clinical Laboratory Fee Schedule is updated yearly. Here is a link to the Fee Schedule:

https://www.cms.gov/medicare/medicare-fee-for-service-payment/clinicallabfeesched

(11) For outpatient orthotics and prosthetics, the Indiana Medicare DMEPOS Fee Schedule amount for the specific CPT/HCPCS codes reported on the claim is utilized for reimbursement of each service. The Medicare DMEPOS Fee Schedule is updated on a yearly basis. Here is a link to the Fee Schedule:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule

(12) For outpatient physical therapy, occupational therapy and speech therapy the Medicare Physician Fee Schedule amount for the specific CPT/HCPCS code reported on the claim is utilized for reimbursement of each service. Here is a link to the Fee Schedule:

https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched

(13) For more information on Payment under the OPPS, please see:

https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlngeninfo

(14) For purposes of paying the hospital's claim, the Medicare amount calculated under the process described above shall be multiplied by a factor of 2.0. The payment due a hospital shall not be reduced by any amount attributable to copayments, deductibles, or any other cost-sharing amount that may be required of a Medicare enrollee under the Medicare program.

(15) On a yearly basis, CMS releases proposed and final rule changes to the OPPS. Proposed and final rule changes are published in the Federal Register under the Department Health and Human Services in July and November, respectively. The effective date for annual rule changes is the beginning of the calendar year, January 1.

References:

Hospital Outpatient PPS:

https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps

Outpatient PPS Pricer Code

https://www.cms.gov/OPPS-PricerCode

Outpatient Code Editor (OCE)

https://www.cms.gov/medicare/coding/outpatientcodeedit

II. Hospitals Reimbursed Under Medicare's Critical Access Hospital Program

Critical Access Hospitals (CAHs) are rural community hospitals that receive cost-based reimbursement as determined by Medicare. Cost is determined each year through a "cost report" submitted to the applicable Medicare Administrative Contractor (MAC). For Indiana, the MAC is Wisconsin Physicians Services (WPS). Based on its review of a CAH's cost report, the MAC determines for the CAH an interim rate for outpatient services and an interim per diem rate for inpatient stays. An interim rate letter (stating Medicare's interim reimbursement rate for outpatient services and items and Medicare's interim reimbursement rate for inpatient stays) is submitted to each CAH when completed by the MAC. When submitting a claim for reimbursement under Indiana's workers compensation program, a CAH will provide a copy of its interim rate letter to the workers compensation insurance carrier. The letter shall serve as the basis for the payer's payment to the CAH. The Medicare amount calculated under the CAH's interim rate letter shall be multiplied by a factor of 2.0. The payment due a hospital shall not be reduced by any amount attributable to copayments, deductibles, or any other cost-sharing amount that may be required of a Medicare enrollee under the Medicare program.

Indiana CAHs (35):

https://www.ihaconnect.org/about/indiana-hospitals/Pages/Rural-Health.aspx

III. Ambulatory Surgery Centers

The Ambulatory Surgery Center will prepare and submit its claim for payment for outpatient procedures as follows:

A. The facility shall submit its claim for payment on a UB-04 form (CMS-1450 if the claim is submitted on paper) or in an 837I claim transmission (if the claim is submitted electronically).

B. For a claim for outpatient services or items, the ASC shall enter charges from the ASC specific charge description master (CDM) for services and items that correspond to procedures billed. The CDM contains the revenue code (cost center), the CPT or HCPCS codes and the charge for the service or item. CPT and HCPCS codes are required on an outpatient claim.

C. The ASC's medical record coders shall code the ASC claim using ICD-10 diagnosis based on physicians' orders, progress notes and test results. When ICD-10 coding has been completed, the ASC will determine whether the UB-04 claim is ready for billing. The ASC will use ICD-10 billing and procedure codes upon being required to do so for the Medicare program.

D. When the claim is ready for billing, the ASC claim will be reviewed (or "scrubbed") for National Correct Coding Initiative (NCCI) and Medical Necessity (Local Coverage Determination and National Coverage Determination) edits. The NCCI edits will consider CPT and HCPCS coding (bundling and/or mutually exclusive). The Medical Necessity edits will look at ICD-10 codes (or, as noted above, ICD-10 codes) in relation to National Coverage Determinations (NCD) and Local Coverage Determinations (LCD). NCCI edits are updated quarterly. NCDs and LCDs are updated periodically by CMS and the Medicare Administrative Contractors (MAC). *CMS has adopted the physician version of NCCI edits**

E. After the ASC claims are scrubbed, the ASC shall submit UB-04 claims to an employer; an employer's insurance carrier; or through an electronic claims transmission vendor as it would submit a claim to the Medicare Program.

F. When ASC claims are received by the payer, the payer will utilize the Medicare ASC payment rates (which are updated on a quarterly basis), in effect at the time the service or item was provided. The payment rates can be found at: https://www.cms.gov/medicare/medicare-fee-for-service-payment/ascpayment/11_addenda_updates

- Payment indicators adopted by Medicare used in calculating reimbursement can be found in addendum DD1 of the ASC Approved HCPCS Code and Payment Rates found at the link above.
- Reimbursement will be based on the most current ASC rates published by Medicare on the date of service.
- Unlisted Codes may be denied unless facility provides appropriate comparable code or reimbursement is negotiated.

G. For purposes of paying the ASC's claim, the Medicare amount calculated under the process described above shall be multiplied by a factor of 2.0. The payment due an ASC shall not be reduced by any amount attributable to copayments, deductibles, or any other cost-sharing amount that may be required of a Medicare enrollee under the Medicare program.

H. On a yearly basis, CMS releases proposed and final rule changes to the OPPS. Proposed and final rule changes are published in the Federal Register under the Department Health and Human Services in July and November, respectively. The effective date for annual rule changes is the beginning of the calendar year, January 1.

References:

https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare/medicare-ncci-policy-manual

* CMS uses OCE (Outpatient Code Editor) edits for Hospital Outpatient claims. These help to identify incorrect or outdated coding.

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