Hospital outpatient fee schedule (HOFS) – errors on bills with no J1 services

Payment errors	Correct payment practice
Category 1: Incorrect payment rates	
The insurer paid: • for a non-J2 service at the amount of the line charge; • for a non-J2 service at 85% of the line charge where the payment should have been determined differently; • the overall bill at the amount of the total charge; • the overall bill at 85% of the total charge; or • more than the HOFS rate for a J2 service.	• Payment for hospital outpatient bills do not depend on the amount charged. Payment must follow the provisions in Minnesota Statutes § 176.1364, subdivision 4. • If a bill does not contain a J1 service, payment for each service with a HOFS J2 status indicator is the amount listed in the HOFS for that service, regardless of the amount charged. However, there is an exception for comprehensive observation services.[1] • When other services are included on a bill with a J2 service (and there is no J1 service), payment depends on the type of service. Refer to Minn. Stat. § 176.1363, subd. 4 (c), or the flowchart available on the DLI website at www.dli.mn.gov/sites/default/files/pdf/fees_HOFS_decision_J2.pdf, for payment instructions for other services. • If there is a J2 service and no J1 service, the only hospital outpatient services payable at 85% of the hospital's usual and customary charge are non-J2 services that do not fall under another provision of Minn. Stat. § 176.1364, subd. 4 (c), and are not covered under the relative value fee schedule.

[1]If the bill includes eight or more units of the HCPCS code G0378 (hospital observation, per hour) and there is a physician or dentist order for this service, payment is the amount listed in the HOFS for Ambulatory Payment Classification (APC) 8011 (comprehensive observation service) regardless of the amount charged. Payment for all other services on the bill, including additional J2 services, is packaged into the HOFS amount for APC 8011.

Category 2: Payment for specific service types	
The insurer: • made zero payment for one or more services where the service was not denied on the basis of primary liability, causation, or reasonableness and necessity; • paid for a service without an HCPCS code; • paid for injection or infusion material along with the injection or infusion service; or • where there were eight or more units of G0378, paid for a service or services other than G0378.	• Every service on a bill with one or more J2 services (and no J1 services) must be paid, unless it is a drug packaged into an injection or infusion service or a service with no HCPCS code, or there are eight or more hours of comprehensive observation services (HCPCS code G0378) ordered by a physician or dentist. • No provision in the HOFS allows for nonpayment for a nonpackaged service, unless that service is denied on the basis of primary liability, causation, or reasonableness and necessity. • Under Minn. Stat. § 176.1364, subd. 4 (c)(2), a service without an HCPCS code that is included on a bill with a service with a J2 service is packaged into payment for the J2 service. • Under Minn. Stat. § 176.1364, subd. 4 (c)(3), payment for a drug that is delivered by injection or infusion is packaged into payment for the injection or infusion service.
Category 3: Awareness of fee schedule requirements and updates	
The insurer: • used the prior year's HOFS amount to pay for a J2 service; • used the relative-value fee schedule to pay for a J2 service; • used the payment rate for the wrong hospital size for a J2 service; • used the prior year's relative-value fee schedule; or • paid for the wrong number of units of service.	• Insurers must make sure they are using the correct fee schedule tables and appropriate columns when paying hospital outpatient bills. • All fee schedules, including the HOFS table and relative value fee schedule table, are updated each Oct. 1 on the Department of Labor and Industry (DLI) website. DLI can provide these tables in Excel format on request. • The HOFS includes two payment rates for each service – one for non-critical access hospitals with 100 or fewer licensed beds and another for hospitals with more than 100 licensed beds. • The insurer must pay the rate associated with the size of the hospital providing the service. DLI's website includes a link to the Minnesota Department of Health provider directory, which lists the number of beds at each Minnesota hospital. See www.dli.mn.gov/business/workers-compensation/work-comp-medical-fee-schedules-hofs.

Category 4: Resource based relative value fee schedule (RBRVS) related errors	
The insurer: • paid for a facility service related to a surgical procedure according to the RBRVS; • paid half the RBRVS payment for a single diagnostic imaging service; • failed to apply the multiple-procedure discount for diagnostic imaging services; • failed to limit the RBRVS payment to the charged amount; or • paid 42.5% of charge for a second procedure instead of following multiple-procedure requirements.	• Under Minn. Stat. § 176.1364 certain services provided with a J2 are paid according to the RBRVS in Minnesota Rules parts 5221.4005 to 5221.4061. • DLI posts the RBRVS tables on its website at www.dli.mn.gov/business/workers-compensation/work-comp-medical-fee-schedules-rbrvs. • Under Minn. R. part 5221.4010, the employer's liability for services covered by the RBRVS is limited to the fee schedule amount or the provider's usual and customary fee for the service, whichever is lower.[2] • The RBRVS covers professional fees, not facility fees. • If a service is listed in the RBRVS, this does not necessarily mean that the billed charge is covered under that schedule. For example, a hospital outpatient facility will often bill for a facility service (for example, an operating room) related to a surgical procedure by using the procedure's CPT code even though it is a facility service. If the service is billed by the facility, it is most likely a facility service and not a professional service. Look at the revenue code on the bill for more guidance. • If a service is not paid under another provision of the HOFS and is not covered under the RBRVS, it is paid at 85% of the hospital's usual and customary charge. • Other specific RBRVS provisions, such as multiple procedure discounting in Minn. R. 5221.4035, subp. 5, may apply to services on the bill.

[2]Unless the maximum fee is adjusted under Minn. R. part 5221.4035, 5221.4051 or 5221.4061.