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Hospital Facility Fee Guidelines – Frequently Asked Questions

Frequently Asked Questions Regarding 28 T.A.C. §134.403, Hospital Facility Fee Guideline – Outpatient

1. What is the applicable date for §134.403, Hospital Facility Fee Guideline – Outpatient?

Rule 134.403, Hospital Fee Guideline – Outpatient applies to outpatient medical services provided by an acute care hospital on or after March 1, 2008.

2. Is there a direct link or directions on where to find the reimbursement rates for hospital outpatient facility fee reimbursement on the Trailblazer website?

There is no PC Pricer application for Outpatient PPS on the Trailblazer or CMS websites at this time. The files in the "Downloads" section of the CMS website contain the logic, rates, wage index, and off-set amounts used by the OPPS PRICER program to calculate APC rates. This information can be found as ZIP files at the following link: http://www.cms.hhs.gov/PCPricer/08_OPPS.asp#TopOfPage Commercial software is also available for purchase from vendors.

3. What instructions and education will be provided pertaining to the new hospital facility fee rules?

The Division is conducting seminars throughout the state to facilitate the implementation of these rules. The seminar education materials will be added to the Division's website, and additional educational materials may be developed as needed. The Division will continue to answer questions or clarify issues through the Medical Benefits email box, MedicalBenefits@tdi.state.tx.us, and will continue to summarize appropriate topics for inclusion in Frequently Asked Questions and posted on the agency website. **(NOTE: This answer also applies to Inpatient Facility Fee Guidelines.)**

4. Does §134.403, Hospital Facility Fee Guideline – Outpatient, apply to Ambulatory Surgical Centers?

No, the Ambulatory Surgical Center Fee Guideline is §134.402, Ambulatory Surgical Center Fee Guideline.

Frequently Asked Questions Regarding 28 T.A.C. §134.404, Hospital Facility Fee Guideline – Inpatient

5. What is the effective date for §134.404, Hospital Facility Fee Guideline – Inpatient?

Rule 134.404, Hospital Fee Guideline – Inpatient applies to inpatient medical services provided in an acute care hospital with an admission date on or after March 1, 2008.

6. Is there a direct link or directions on where to find the reimbursement rates for hospital inpatient facility fee reimbursement on the Trailblazer website?

The CMS Inpatient PPS Pricer software is released on a quarterly basis and calculates reimbursement for inpatient discharges. The CMS Inpatient PPS Pricer software is available as a ZIP file at the following website: http://www.cms.hhs.gov/PCPricer/03_inpatient.asp#TopOfPage

Commercial software is also available for purchase from vendors.

7. How are Inpatient Rehabilitation Facilities reimbursed?

Rules 134.403 and 134.404 are for outpatient and inpatient medical services provided in an acute care hospital. The DWC does not have a fee guideline for inpatient rehabilitation facilities; in the absence of a negotiated contract, those services would be reimbursed at fair and reasonable in accordance with §134.1.

8. How are Behavioral Health Service Facilities reimbursed?

Rules 134.403 and 134.404 are for outpatient and inpatient medical services provided in an acute care hospital. The DWC does not have a fee guideline for behavioral health service facilities; in the absence of a negotiated contract, those services would be reimbursed at fair and reasonable in accordance with §134.1.

Frequently Asked Questions Regarding Billing and Reimbursement For Both Outpatient and Inpatient Hospital Facility Fee Guidelines

General Information: Rules 134.403, Hospital Fee Guideline – Outpatient, and 134.404, Hospital Fee Guideline – Inpatient, have provisions that allow a facility to choose between inclusive or separate reimbursement for implantables on a case-by-case basis. The facility reimbursement is calculated as illustrated below:

Facility Reimbursement Calculation Guide

Hospital Facility Fee Guideline	Facility Reimbursement Multiplier When Separate Reimbursement for Implantables IS NOT Sought by the Facility	Facility Reimbursement Multiplier When Separate Reimbursement for Implantables IS Sought by the Facility or the Surgical Implant Provider
Rule 134.403 Facility Fee Guideline – Outpatient	**200%** of Medicare facility specific reimbursement amount and any applicable outlier payment	**130%** of Medicare facility specific reimbursement amount and any applicable outlier payment
Rule 134.404 Facility Fee Guideline – Inpatient	**143%** of Medicare facility specific reimbursement amount and any applicable outlier payment	**108%** of Medicare facility specific reimbursement amount and any applicable outlier payment

When the facility chooses to have implantables reimbursed separately, the facility or surgical implant provider is reimbursed at the lesser of:

1) Manufacturer's invoice amount or
2) Net amount (exclusive of rebates and discounts); plus
3) 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

A facility is responsible to communicate their choice as to separate reimbursement for implantables. Failure to communicate their choice might result in incorrect reimbursement to the hospital.

9. Please illustrate the mathematical calculation of reimbursement for implantables.

Implantable Reimbursement Example

For the purpose of a mathematical illustration, an injured employee received surgical services in an acute care hospital (outpatient or inpatient). The services during this admission included three implantable items. Each of the three implantable items had an invoice amount of $20,000 and a rebate of $2,500.

Reimbursement for Implantables

	Item #1	Item #2	Item #3	Total
Net Amount for Implantable Item	$20,000	$20,000	$20,000	$60,000
Rebates or Discounts	-$2,500	-$2,500	-$2,500	-$7,500
Adjusted Net Amount for Implantable Item	$17,500	$17,500	$17,500	$52,500
Add-on of 10% or $1,000, Whichever is Less	$1,000*	$1,000*	$0**	$2,000
Total Computed reimbursement for Implanted Item(s)	$18,500	$18,500	$17,500	$54,500

*$1,000 is less than 10% of $17,500.
**The $2,000 "cap" for this admission was met by implants #1 and #2.

10. How is a payer to determine whether the provider is requesting separate reimbursement for implantables?

To determine if the facility or surgical implant provider is requesting separate reimbursement for implantables, the payer should review the codes that are billed, the amounts that are billed, and the documentation that is provided. The health care provider is not required to submit separate bills for facility charges and implantables.

Although not specified by rule, the Division suggests that health care providers communicate their intentions in billing notes that may be included in box #80 of the UB-04 or in Loop 2300 of the 837-I. In addition, the payer may contact the facility or surgical implant provider to ask if separate reimbursement for implantables is requested.

While not required by Division rules, the following are examples of language for the billing notes that will facilitate communications between the billing facility and the insurance carrier:

1) Separate reimbursement for implantables not requested
2) Separate reimbursement to hospital for implantables requested
3) Separate reimbursement to Company X for implantables requested
4) Separate reimbursement to Hospital & Company X for implantables requested

11. What are the payer's options if the facility does not include any information requesting separate reimbursement for implantables?

If the bill from the facility does not include any information requesting separate reimbursement for implantables, the payer should calculate reimbursement with the appropriate higher multiplier.

12. What are the payer's options if the facility does not include any information requesting separate reimbursement for implantables but the payer then receives a bill for implantables from a surgical implant provider?

Since separate reimbursement is the election of the facility, the payer would pay the facility the appropriate higher multiplier that includes reimbursement for the implantable, but would deny the bill from the surgical implant provider.

13. What documents should be included with an acute care hospital facility bill?

Rules 133.10, 133.20, and 133.210 work with the acute care facility fee guidelines to outline the following documents for a hospital bill:

1) A bill on the standard forms used by the Centers for Medicare and Medicaid Services. The bill must include the correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service.
2) An itemized statement of charges.
3) Appropriate hospital records.
4) A copy of the operative report if the surgical services rendered on the same date for which the total of the fees established in the current Division fee guideline exceeds $500.
5) While not specified by rule, if implantable items are used during the admission and separate reimbursement is requested, an invoice for implanted items will expedite processing the bill.
6) If implantable items are used during the admission and separate reimbursement is requested, a certification that the amount billed for the implanted items represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable.

Notes: All information submitted on required billing forms must be legible and completed in accordance with Division instructions. In addition, a carrier can request additional documentation if necessary to process a bill.

14. If a facility requests separate reimbursement for implantables, but the facility does not provide documentation, what options are available to the payer?

The options are:

A. Contact facility to request the information to complete the bill.
B. If the required documents are not provided, deny the bill due to the lack of documentation.
C. Pay the facility bill with the reimbursement calculated at the appropriate higher multiplier. The higher multiplier includes reimbursement for the implantable. The facility may request reconsideration and provide the documentation for the implantables.
D. Pay the facility bill with the reimbursement calculated at the lower multiplier and do not reimburse for implantables. The hospital may request reconsideration and provide the documentation for the implantables.

15. A facility indicates separate reimbursement for implantables and agrees to allow the surgical implant provider to bill for the implantables. The surgical implant provider does not provide documentation. What options are available to the payer?

The options are:

A. Contact surgical implant provider to request the information to complete the bill.

B. If the required documents are not provided, deny the bill due to the lack of documentation.

16. Is the $2,000 add-on cap for implantables increased if the bills for implantables come from different surgical implant providers?

No, the $2,000 add-on cap for implantables is per admission, not per the source of the implantables.

17. If a carrier receives a bill and the facility uses revenue code 278, is it to be implied that the facility is NOT billing separately for the implants?

The hospital facility fee guideline does not provide any assumptions regarding revenue codes. To determine if the facility or surgical implant provider is requesting separate reimbursement for implantables, the payer should review the codes billed, the amounts billed, and the documentation provided.

Although not specified by rule, the Division suggests that providers communicate their intentions in billing notes that may be included in box #80 of the UB-04 or in Loop 2300 of the 837-I. In addition, the payer may call the facility or surgical implant provider to ask if separate reimbursement for implantables is being requested.

18. Where are the Division instructions for completing a medical bill?

The Division's *Texas Clean Claim & eBill Workers' Compensation Companion Guide* is located at the following link: http://www.tdi.state.tx.us/wc/ebill/index.html

19. If the hospital does not put a Medicare number on an inpatient or outpatient facility bill, how should these bills be handled?

The facility is required to have their National Provider Identifier (NPI) number on medical bills; they are not required to have their Medicare number on the bills. The carrier must crosswalk (reference) the NPI number to the Medicare number. The National Plan & Provider Enumeration System crosswalk (registry search) is available at the following link: https://nppes.cms.hhs.gov/NPPES/Welcome.do