Texas Ambulatory Surgery Center Society

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Texas Workers' Compensation ASC Fee Guidelines
Frequently Asked Questions

Effective September 1, 2008, the Texas Department of Insurance – Division of Workers' Compensation (TDI-DWC) will use a new fee schedule to reimburse ambulatory surgery centers (ASCs) for Texas workers' compensation cases. The new Texas workers' compensation fee guidelines will be based largely on the new Medicare ASC fee methodology. This comes as a result of the Texas Labor Code's requirement for the Texas workers' compensation ASC fee system to take into account changes to the Medicare ASC fee schedule.

The following is a summary of the highlights. Please contact TASCS Executive Director Bobby Hillert (Bhillert@texasascsociety.org | 214.728.7672 c) if you have any questions.

How will ASCs be reimbursed under this new workers' compensation system?

Under the new Texas workers' compensation system, ASCs will have several reimbursement options. The Texas workers' compensation ASC reimbursement rates are determined by using percentages (multipliers), 235 percent and 153 percent, multiplied by Medicare's fully implemented rate for ASC cases. A description of the new Medicare ASC rates can be found on page four of this questionnaire.

In addition to the multiplier, the other noticeable difference from the Medicare fee guidelines is that of the ability to reimburse implantables separately if a facility desires to do so. TDI-DWC recognized that Medicare does not always reimburse for the actual cost of an implantable. Therefore, TDI-DWC gives ASCs the option to be reimbursed for the actual cost (plus an added percentage for implantables under a certain cost). At a minimum, all implantables can be reimbursed for at least the cost under the new Texas workers' compensation reimbursement system.

The reimbursement options:

Surgery			
Non-device intensive		**Device intensive**	
1. No implants were Used or inclusive Reimbursement For implantable.	**2. Separate reimbursement for implantables is requested.**	**1. Inclusive reimbursement for implantables**	**2. Separate reimbursement for implantables is requested.**

REIMBURSEMENT FOR NON-DEVICE (cases with or without implants)

Two options:

- Medicare's geographically adjusted fully implemented ASC reimbursement amount multiplied by 235 percent.
- Or, if a separate reimbursement for an implant is desired, reimbursement is the sum of two parts:
    - Implant cost: The manufacturer's invoice amount or the net amount plus 10 percent or $1,000 per billed item add-on (whichever is less).
    - Medicare's geographically adjusted fully implemented ASC reimbursement amount multiplied by 153 percent.

REIMBURSEMENT FOR DEVICE INTENSIVE

The Texas workers' compensation system reimburses ASCs for "device intensive" procedures if they are cases that are defined by Medicare in Table 56 of CMS's final rule. Unlike Medicare, Texas workers' compensation gives ASCs the opportunity to receive separate reimbursement for the device. By giving ASCs an opportunity to receive separate reimbursement for the devices (plus an additional "add-on" portion), TDI-DWC is recognizing that Medicare does not always reimburse for the actual cost of an implantable.

Device intensive procedures are reimbursed as the sum of two parts:

- The sum of the ASC device portion.
- Medicare's geographically adjusted fully implmented ASC service portion multiplied by 235 percent.

If the facility requests separate reimbursement for a device, reimbursement for the device intensive procedure shall be:

- The sum of the manufacturer's invoice amount or the net amount plus 10 percent or $1,000 per billed item add-on, whichever is less. However, this cannot exceed $2,000 in add-on's per admission.
- Medicare's geographically adjusted fully implemented ASC service portion multiplied by 235 percent.

How does the "plus 10 percent" work?

The new Texas workers' compensation fee schedule allows ASC's to bill separately for the implant or device at invoice cost plus 10 percent. The "plus 10 percent" is what is capped at $1,000 per billed item and $2,000 per admission. That is, if multiple implantables are used, the add-on is capped at $2,000.

An ASC is responsible for communicating their choice regarding separate reimbursement for implantables. A carrier may audit the bill to seek verification of the amount certified. ASCs must include a certification regarding the actual cost of the implantables. The language: "I

hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

What numbers are needed to calculate the reimbursement?

1. Determine your statistical area number – http://www.whitehouse.gov/omb/bulletins/fy2008/b08-01.pdf
2. Find the CMS geographically adjusted wage index associated with your statistical area – Go to the http://www.cms.hhs.gov and search for "CMS-1392 pre class wage index for ASC." The download is titled: "FY 2008 Pre-reclass Wage Index for Use in Calculating Payments Effective for Services Furnished Beginning January 1, 2008 Under the Revised ASC Payment System [ZIP, 14KB]
3. For device-intensive surgeries, you will need ASC Table 56 to determine the rates. Go to http://www.cms.hhs.gov and search for "ASC Table 56." The download the file titled "CMS-1392-FC ASC Preamble Tables [ZIP, 14KB]. This will provide you with the APC offset percentage.

Examples of Texas Workers' Compensation ASC Reimbursement

The following are several examples of how an ASC could be reimbursed under the new Texas workers' compensation system. The code and Medicare reimbursement rates are included in the examples.

For non-device intensive surgeries, determine the following information:

1. Determine the national fully implemented reimbursement for CPT 64721 from Addendum AA.
2. Determine the statistical area using the OMB chart at: http://www.whitehouse.gov/omb/bulletins/fy2008/b08-01.pdf
3. Search the CMS Web site for: CMS-1392 pre class wage index for ASCs.

Non-device intensive: No implants

Example: 64721 – Carpal Tunnel Surgery ($747.36 fully implemented rate from CMS Addendum AA) in Abilene, Texas.

First, find the geographically adjusted fully implemented Medicare rate:

- The CMS wage index for Abilene, Texas is .7958.
- The CMS wage index is applied to half of the national reimbursement amount.

1. $747.36/2 = $373.68
2. $373.68 x .7958 = $297.38

3. $373.68 + $297.38 = **$671.06 (geographically adjusted fully implemented Medicare rate)**

$671.06 (geographically adjusted fully implemented Medicare rate)
x 235% (TX workers' compensation multiplier)

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$1,576.99 TX workers' compensation reimbursement

Non-device intensive: Implants (two possible ways to bill this)

Example: 29888 – Arthroscopy Aided ACL ($1,892.32 fully implemented rate from CMS Addendum AA)

First, find the geographically adjusted fully implemented Medicare rate:

- The CMS wage index for Abilene, Texas is .7958.
- The CMS wage index is applied to half of the national reimbursement amount.

1. $1,892.32/2 = $946.16
2. $946.16 x .7958 = $752.95
3. $946.16 + $752.95 = **$1,699.11 (geographically adjusted fully implemented Medicare rate)**

Option A: Use the Medicare reimbursement amount only

$1,699.11 (geographically adjusted fully implemented Medicare rate)
x 235% (TX workers' compensation multiplier)

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$3,992.91 TX workers' compensation reimbursement

Option B: Bill the device cost separately
Step 1: Determine the implantable billed separately:

$1,000 (implantable cost hypothetical)
+ $100 (10 percent of implant or $1,000; whichever is less)

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$1,100 Cost of implantables
Step 2: Determine the service portion:

$1,699.11 (geographically adjusted fully implemented Medicare rate)
x 153 % (TX workers' compensation multiplier rate for implantables billed separately)

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$2,599.64 (TX workers' compensation service portion)

3. Add steps 1 and 2 together = **$3,699.64 TX workers' compensation when implantables are billed separately**

For device intensive reimbursement, one must determine two steps:

- Device portion
- Service portion

Table 56 contains the "device offset" percentage to determine the device portion.

Device intensive (two possible ways to bill the device)
Example: 64553: Implant neuroelectrodes

Option A: Use the Medicare reimbursement amount only

Step 1: Determine the device portion:
$11,767.07 (geographically adjusted rate)
x .8057 (from Table 56)

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$9,480.73 (the device portion)

Step 2: Determine the service portion by subtracting the device portion from the total reimbursement:

$11,767.07 (geographically adjusted rate)
- 9,480.73 (device portion)

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$2,286.34 (service portion)

Step 3: Determine the TX workers' compensation reimbursement for the service portion:

$2,286.34 (Medicare service portion rate)
x 235% (TX workers' compensation multiplier)

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$5,372.90 (TX workers' compensation service reimbursement)

Step 4: Add the TX workers' compensation service reimbursement to the reimbursement for the device portion:

$5,372.90 (TX workers' compensation service reimbursement)
+ 9,480.73 (Reimbursement for the device portion)

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$14,853,63 (TX workers' compensation reimbursement for device intensive not requiring separate reimbursement)

Option B: Bill the device invoice cost separately

$10,500.00 – Hypothetical implantable cost

Step 1: Find the service portion of the Medicare geographically adjusted ASC reimbursement ($2,286.34 from the previous example).

Step 2. Calculate the TX workers' compensation reimbursement for the service portion:
$2,286.34
x 235% (TX workers' compensation multiplier)
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$5,372.90 (TX workers' compensation reimbursement for the service portion)

Step 3: Calculate the separate reimbursement for implantables:

- $10,500 x 10% = $1,050.00
- $10,500 + $1,000* = **$11,500.00 (Separate reimbursement for implantables)**
- $1,000 is less than 10% of $10,500.

Step 3: Add the TX workers' compensation reimbursement for the service portion to the reimbursement for the device portion:

$5,372.90 (TX workers' compensation reimbursement for service portion)
+11,500.00 (implantable reimbursed separately)
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$16,872.90 (TX workers' compensation reimbursement)

What are the new Medicare ASC fee guidelines?

The Medicare ASC payment rates can be found at: http://www.cms.hhs.gov/ascpayment/.

CMS's August 2, 2007 final rule established a revised Medicare payment system for ASCs (effective January 1, 2008). It added approximately 790 additional ASC procedures in calendar year (CY) 2008 that CMS would reimburse in addition to the nine ASC groups that Medicare previously reimbursed. The Texas workers' compensation system recognized these same nine ASC groups as well prior to the new Medicare fee guidelines rule.

In addition, this new fee schedule for ASCs based the ASC rates in part on the rates that Medicare pays hospital outpatient departments (HOPDs).

CMS provided a four-year transition to the fully implemented revised ASC rates. They will be based on a blend of the CY 2007 ASC payment rates and the revised ASC payment rates:

- 75/25 in CY 2008, also includes the fully implemented rate
- 50/50 in CY 2009

- 25/75 in CY 2010
- 100 percent of the revised ASC payment rates in CY 2011

In the CY 2008 OPPS/ASC final rule, CMS estimated that ASCs should be paid about 65 percent of the OPPS payment rate for the same procedures in a HOPD. For example: Standard Medicare ASC payment rate for most ASC covered surgical procedures is calculated by multiplying the ASC conversion factor ($41.401 for CY 2008) by the ASC relative payment weight set (based on the OPPS relative payment weight) for each separately payable procedure.

How will Medicare pay for devices?

For the device dependent ambulatory payment classifications (APCs), CMS develops estimates of the "device offset percentage," the proportion of the procedures' costs that are attributable to the cost of the device. CMS identifies the covered surgical procedures for which the device offset percentage of the APC under the OPPS is greater than 50 percent of the APCs median cost and designates those surgical procedures as device intensive. CMS pays the same amount for the device-related portion of the procedure under the revised ASC payment system as under the OPPS for HOPDs. However, in the Medicare system payment for the service portion of the ASC rate will be adjusted by the ASC conversion factor.

For example, if the OPPS payment for a device intensive procedure is $7,000 and the device offset percentage is 75 percent, the device portion is $5,250 ($7,000 x 0.75 = $5,250). The remaining $1,750 ($7,000 - $5,250 = $1,750) is the service portion of the procedure, the non-device cost that the facility incurs when the device is implanted. Under the revised ASC payment system, CMS will pay the same amount for the device portion of the procedure ($5,250) as under the OPPS, but will adjust the service portion to approximately 65 percent of $1,750, or $1,137 ($1,750 x 0.65 = $1,137).

Thus, the Medicare ASC rate will be calculated by adjusting the OPPS service portion by the Medicare ASC conversion factor and that will be added to the full device portion of the OPPS rate to establish the full Medicare ASC payment rate for the procedure. Using the example, the resulting ASC reimbursement would be $6,387 ($5,250 + $1,137 = $6,387).

Source: Texas Department of Insurance – Division of Workers' Compensation (TDI-DWC)

The information included in this white paper is provided for informational discussion purposes and is not intended to serve as legal advice.