SUBCHAPTER E. Health Facility Fees
§134.402

1. INTRODUCTION. The Commissioner of Workers' Compensation (Commissioner), Texas Department of Insurance, Division of Workers' Compensation (Division), adopts amendments to §134.402 concerning Ambulatory Surgical Center (ASC) Fee Guideline. The amended section is adopted without changes to the proposed text as published in the October 26, 2007 issue of the *Texas Register* (32 TexReg 7667).

2. REASONED JUSTIFICATION. These amendments are necessary to maintain the stability of the ASC reimbursement rates during the period the Division develops a new ASC fee guideline in order to address new changes in Medicare's ASC reimbursement methodology.

These amendments do not apply to political subdivisions with contractual relationships under Labor Code §504.053(b)(2).

Labor Code §413.011 and §413.0511(b)(1), of the Texas Workers' Compensation Act (Act) require the Division to adopt health care reimbursement policies and guidelines that are:

(1) developed in consultation with the Division Medical Advisor;

(2) the most current reimbursement methodologies, models, values or weights used by the Centers for Medicare and Medicaid Services (CMS) in order to achieve standardization;

(3) fair and reasonable; and

(4) designed to ensure the quality of medical care; and achieve effective medical cost control.

The current version of §134.402 was based on the Medicare ASC reimbursement methodology in place at the time. That methodology established a set payment amount for each type of facility service that CMS determined would be reimbursed in an ASC setting. These services were divided into nine specific categories or ASC groups.

The reimbursement levels and fee guideline established in current §134.402 use the Medicare reimbursement structure as a baseline, or reference point, for the maximum allowable reimbursement calculations for services provided in an ASC health care facility.

However, the ASC fee guideline was not based solely on the Medicare reimbursements. Commercial market payments were also considered. The adoption of the ASC payment adjustment factor (PAF) of 213.3% was based upon due consideration of all of the statutory requirements for fee guidelines.

At the time of the adoption of the Division's ASC fee guideline, outpatient hospital and ASC payments were not standardized in the Medicare system, or in the market in general.

Beginning in January of 2008, Medicare's new ASC fee schedule will move toward standardizing the reimbursement methodologies of outpatient hospital and ASC facilities by changing the ASC methodology to be more like that of the outpatient hospital reimbursement methodology.

Medicare's new ASC fee schedule will incorporate relative payment weights for groups of procedures with similar resource and clinical characteristics, based on the Ambulatory Payment Classifications that are key elements of the Medicare Outpatient Prospective Payment System. The list of procedures eligible for payment under the Medicare ASC payment system will be greatly expanded. In the Medicare system, reimbursement for high cost devices and surgically implanted devices will be included in the procedure reimbursement amount. This is a significant change and the current PAF in §134.402 is not compatible with this new methodology.

Currently, §134.402 provides for ASCs to be paid at 213.3% of the Medicare ASC reimbursement amount. In addition, §134.402 requires surgically implanted devices to be reimbursed separately at the amount actually paid for the device by the ASC.

Section 134.402 currently provides that coding, billing, reporting, and reimbursement of ASC facility services covered by the rule are to be accomplished by applying the Medicare policies in effect on the date a service is provided. This provision was included to prevent the Texas workers' compensation system from falling out of synchronization with Medicare and to achieve the standardization goals established in §413.011 of the Act.

However, with the significant changes in Medicare's ASC reimbursement system, if this provision of §134.402 remains in place, the result will be application of the 213.3% payment adjustment factor to the new Medicare ASC reimbursement system.

In some instances this may result in unreasonable reimbursements. If 213.3% is applied to the new methodology, the reimbursement for some typical workers' compensation ASC services would range between 199% to 362% of 2007 Medicare rates.

Reimbursement for CPT code 64476 (injection to the lumbar or sacral area, each additional level), could decrease from $710 to $663, or 199% of 2007 Medicare rates; and reimbursement for CPT code 29826 (shoulder arthroscopy), could increase from $1,088 to $1,848, or 362% of 2007 Medicare rates.

Some reimbursements for surgically implanted device intensive procedures would increase up to 5709% of the 2007 Medicare rates. For example, reimbursement for CPT code 61886 (implant of neurostimulator

arrays), could increase from $1,088 to $29,114, or 5709% of 2007 Medicare rates. Additional separate reimbursement of implantables as currently required by §134.402 would push this rate even higher.

The new reimbursement differentials could lead to shifting sites of service for financial rather than clinical reasons to the detriment of injured employees and the Texas workers' compensation system overall.

The Division needs time to reevaluate all of the data and information, and to analyze the effects of the new Medicare ASC reimbursement methodology on workers' compensation reimbursements. This will allow the Division to make the appropriate recommended transition to the new Medicare reimbursement methodology for ASCs. The ASC fee guideline can then be integrated into the Texas workers' compensation system in a manner that provides reasonable reimbursement for all services in the system.

The rule amendments will continue the use of reimbursement structures and amounts at the Medicare ASC 2007 rates for services provided on January 1, 2008 through August 31, 2008. This will maintain the stability of the ASC reimbursement rates during the period a new ASC fee guideline utilizing the new Medicare ASC methodology is being developed and assure system participants of a timeline for implementation of the new Medicare methodologies.

3. HOW THE SECTIONS WILL FUNCTION. The adopted amendment to §134.402(a)(2) states that the section shall not apply to facility services provided by an ASC on or after September 1, 2008.

The adopted amendments to §134.402(a)(3) change a reference from "Texas Workers' Compensation Commission (commission)" to "Texas Department of Insurance, Division of Workers' Compensation (Division)" and changes "commission" to "Division."

The adopted amendment to §134.402(a)(4) adds the words "except as provided in subsection (b) of the section" to a provision in the paragraph that requires use of revised Medicare components for compliance with the section.

The adopted amendment to subsection (a)(4) also changes "commission" to "Division."

The adopted amendments to §134.402(b) insert the word "and" between the words "billing" and "reporting," and also removes the words "and reimbursement."

The adopted amendment to subsection (b) also removes the words "reimbursement methodologies, models, and values or weights including its" and the word "payment." The adopted amendment to subsection (b) also adds the requirement that for reimbursement of facility services covered in the rule, Texas workers' compensation system participants shall apply the reimbursement provisions of the section and the Medicare program reimbursement

methodologies, models, and values or weights that were in effect on the earlier of the date a service is provided or December 31, 2007.

The adopted amendment to §134.402(e)(3)(D) changes "commissioner" to "Division."

The adopted amendments to §134.402(f) change a reference from "§133.302 and §133.303 of this title (relating to Preparation for an Onsite Audit and Onsite Audits)" to "§133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill)" and changes the reference to §133.307 of this title from "(relating to Medical Dispute Resolution of a Medical Fee Dispute)" to "(relating to MDR of Fee Disputes)."

4. SUMMARY OF COMMENTS AND AGENCY'S RESPONSE TO COMMENTS.

Comment: Several commenters supported the proposal to freeze the Ambulatory Surgical Center (ASC) reimbursement methodology and rates based on the Medicare system in effect on December 31, 2007.

Agency Response: The Division appreciates the support.

Comment: A commenter stated that the system would be better served by "getting it right," and suggested deletion of the September 1, 2008 date in the rule.

Agency Response: The Division agrees that it is important to make appropriate rule amendments; however, the Division declines to make the change. Although time is needed to reevaluate all of the data and information, and to analyze the effects of the new Medicare ASC reimbursement methodology on workers' compensation reimbursements, the Division's proposed plan is to accomplish the appropriate transition to the new Medicare reimbursement methodology by September 1, 2008. In addition, by establishing a specific timeline, workers' compensation system participants are able to plan ahead for the necessary adjustments.

Comment: Several comments were made relating to recommendations for future rulemaking on ASC reimbursement methodology and rates. The comments urged the Division to immediately proceed with development of a permanent rule, to form an ASC Fee Guideline Workgroup, to be careful to follow CMS and Texas Legislative standards when drafting the permanent ASC rule, to build on the outpatient hospital fee guideline reimbursement structure, to be aware that Medicare reimburses ASC's at 65% of the rate paid for outpatient hospital services, to adopt a permanent rule by September 1, 2008, and if not, to continue the freeze until it is adopted.

Agency Response: Although the comments are outside the scope of this rulemaking, they will be considered as plans for future rulemaking on ASC.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.

For: The Boeing Company, Zenith Insurance Company, Insurance Council of Texas, Office of Injured Employee Counsel, Property Casualty Insurance Association of America, Texas Mutual Insurance Company.

Against: None.

6. STATUTORY AUTHORITY. The amendments are adopted under the Texas Labor Code §§408.021, 413.002, 413.007, 413.011, 413.012, 413.013, 413.014, 413.015, 413.016, 413.017, 413.019, 413.031; 413.0511, 402.0111, and 402.061. Section 408.021 entitles injured employees to all health care reasonably required by the nature of the injury as and when needed. Section 413.002 requires the Division to monitor health care providers, insurance carriers and claimants to ensure compliance with Division rules. Section 413.007 sets out information to be maintained by the Division. Section 413.011 mandates that the Division by rule establish medical reimbursement policies and guidelines. Section 413.012 requires review and revision of the medical policies and fee guidelines at least every two years. Section 413.013 requires the Division by rule to establish programs related to health care treatments and services for dispute resolution, monitoring, and review. Section 413.014 requires preauthorization by the insurance carrier for health care treatments and services. Section 413.015 requires insurance carriers to pay charges for medical services as provided in the

statute and requires that the Division ensure compliance with the medical policies and fee guidelines through audit and review. Section 413.016 provides for refund of payments made in violation of the medical policies and fee guidelines. Section 413.017 provides a presumption of reasonableness for medical services fees that are consistent with the medical policies and fee guidelines. Section 413.019 provides for payment of interest on delayed payments refunds or overpayments. Section 413.031 provides a procedure for medical dispute resolution. Section 413.0511 requires the Medical Advisor to make recommendations regarding the adoption of rules and policies to develop, maintain, and review guidelines as provided by §413.011. Section 402.00111 provides that the Commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Section 402.061 provides that the Commissioner of workers' compensation has the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

7. TEXT.

§134.402. Ambulatory Surgical Center Fee Guideline.

(a) Applicability of this rule is as follows:

(1) This section applies to facility services provided by an ambulatory surgical center (ASC), other than professional medical services.

(2) This section applies to facility services provided by an ASC on or after September 1, 2004. The provisions of subsection (e)(2), (3), and (4), and subsection (f) of this section apply to facility services provided by an ASC on or after April 1, 2005. This section shall not apply to facility services provided by an ASC on or after September 1, 2008.

(3) Specific provisions contained in the Texas Workers' Compensation Act (Act) or Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this rule, shall take precedence over any conflicting provision adopted or utilized by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program. Exceptions to Medicare payment policies for medical necessity may be provided by Division rule. Independent Review Organization (IRO) decisions regarding medical necessity are made on a case-by-case basis. The Division will monitor IRO decisions to determine whether Division rulemaking action would be appropriate.

(4) Except as provided in subsection (b) of this section, whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions and orders for services rendered on or after the effective date of the revised component.

(b) For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare

program coding, billing, and reporting policies in effect on the date a service is provided with any additions or exceptions in this section. For reimbursement of facility services covered in this rule, Texas workers' compensation system participants shall apply the reimbursement provisions of this section and the Medicare program reimbursement methodologies, models, and values or weights that were in effect on the earlier of the date a service is provided or December 31, 2007.

(c) To determine the maximum allowable reimbursement (MAR) for a particular service, system participants shall apply the Medicare payment policies for these services and the Medicare ASC reimbursement amount multiplied by 213.3%.

(d) In all cases, reimbursement shall be the lesser of the:

(1) MAR amount regardless of billed amount; or

(2) facility's and payer's workers' compensation negotiated and/or contracted amount that applies to the billed service(s).

(e) Exceptions and modifications to the Medicare payment policies are as follows:

(1) Whenever Medicare requires a payment policy change to be retroactive, that change shall only apply to services provided on or after the date of that change.

(2) In addition to the ASC List of Medicare Approved Procedures, the following procedures will be reimbursed when provided in an ASC at the reimbursement rate provided by this section as if they were on that list (using the same Medicare group assignment values):

(A) 11750 - Group 1

(B) 11760 - Group 1

(C) 20552 - Group 1

(D) 20526 - Group 1

(E) 27599 - Group 1

(F) 29873 - Group 3

(G) 29999 - Group 4

(H) 63030 - Group 6

(I) 64405 - Group 1

(J) 64999 - Group 1

(3) If a service is not included on the ASC List of Medicare Approved Procedures or listed in subsection (e)(2) of this section, the insurance carrier (carrier), health care provider, and ASC may agree to an ASC setting as follows:

(A) The agreement may occur before, during, or after preauthorization.

(i) A preauthorization request may be submitted for an ASC setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request.

(ii) A preauthorization request or approval for a non-ASC facility setting may be revised to an ASC setting by written agreement of the carrier and the health care provider during or after preauthorization.

(B) The agreement between the carrier and the ASC must be in writing, in clearly stated terms, and include:

(i) the reimbursement amount;

(ii) any other provisions of the agreement; and

(iii) names, titles and signatures of both parties with dates.

(C) Copies of the agreement are to be kept by both parties.

(D) Upon request of the Division, the agreement information shall be submitted in the form and manner prescribed by the Division.

(4) The carrier shall reimburse all surgically implanted, inserted, or otherwise applied devices at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) actually paid for such device to the manufacturer by the ASC. Provider billing shall include a certification that the amount sought represents its actual cost (net amount, exclusive of rebates

and discounts). That certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

(f) A carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under subsection (e)(4) of this section properly reflects the actual cost standard contained in that subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested.

(g) Where any terms or parts of this section or its application to any person or circumstance are determined by a court of competent jurisdiction to be invalid, the invalidity does not affect other provisions or applications of this section that can be given effect without the invalidated provision or application.

8. CERTIFICATION. This agency certifies that the adopted sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on _____, 2007.

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Norma Garcia
General Counsel
Texas Department of Insurance,
Division of Workers' Compensation

IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that amendments to §134.402, concerning Ambulatory Surgical Center Fee Guideline, is adopted.

AND IT IS SO ORDERED.

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ALBERT BETTS
COMMISSIONER OF WORKERS' COMPENSATION
TEXAS DEPARTMENT OF INSURANCE

ATTEST:

_____
Norma Garcia
General Counsel

COMMISSIONER'S ORDER NO._____