



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation

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Ambulatory Surgical Center Fee Guideline Frequently Asked Questions - Updated 2017

Questions Regarding 28 Texas Administrative Code (TAC) §134.402, Ambulatory Surgical Center Fee Guideline:

1. What is the applicability date for 28 TAC §134.402, Ambulatory Surgical Center Fee Guideline?

Services provided in an ambulatory surgical center apply on or after September 1, 2008.

2. What instructions and education are available for ambulatory surgical center fee guideline rules?

The Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) conducted seminars to facilitate the implementation of these rules. The seminar education materials are on the TDI-DWC website, and additional educational materials may be developed as needed. TDI-DWC will continue to answer questions or clarify issues through Medben@tdi.texas.gov, and will summarize appropriate topics in frequently asked questions and post updates on the TDI website. You can also call CompConnection for Health Care Providers at (800) 372-7713.

The amended ASC Fee Guideline is located on the TDI-DWC website at www.tdi.texas.gov/wc/rules/adopted/documents/aoasc0808.pdf

3. Is there a list of ASCs licensed in Texas?

Yes, at www.dshs.state.tx.us/facilities/find-a-licensee.aspx

4. Does the amended ASC fee guideline use the Center for Medicare and Medicaid Services (CMS) transitional reimbursement rates or the fully implemented reimbursement rates?

Yes, the adopted ASC fee guideline uses the fully implemented reimbursement rates.

5. What is the reimbursement methodology in the ASC fee guideline?

28 TAC §134.402, Ambulatory Surgical Center Fee Guideline, is based on Medicare ASC reimbursement and applies a specific Texas workers' compensation payment adjustment factor. The rule also has provisions that allow an ASC to choose separate reimbursement for implantables on a case-by-case basis. The ASC reimbursement is calculated as shown in Table 1:

Table 1

Surgical Procedure with Non-device Intensive Procedure	Surgical Procedure with Device Intensive Procedure
When no implants were used or when reimbursement for implantables is inclusive, reimbursement is 235% of Medicare's geographically adjusted fully implemented rate.	When reimbursement for implantables is not requested, reimbursement is 235% of service portion of Medicare's geographically adjusted fully implemented rate, plus the Medicare device portion.
When implants were used and separate reimbursement for implantables is requested, reimbursement is 153% of Medicare's geographically adjusted fully implemented rate, plus separately calculated reimbursement for implantables.	When separate reimbursement for implantable is requested, reimbursement is 235% of service portion of Medicare's geographically adjusted fully implemented rate, plus separately calculated reimbursement for implantables.

When the ASC chooses to have implantables reimbursed separately, the ASC 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-ons per admission.

6. What is the mathematical calculation of reimbursement for implantables?

Table 2 shows an Implantable Reimbursement Example

In this example, an injured employee received surgical services in an ambulatory surgical center. The surgical services included three implantable devices. Each device had an invoice amount of \$20,000 and a rebate of \$2,500.

Table 2

Category	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 items	\$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

7. How does an insurance carrier determine if the provider is requesting separate reimbursement for implantables?

To get a separate reimbursement for implantables, a provider must make the request using the shaded portion of CMS-1500/fields 24d - 24h as indicated in 28 TAC §133.10. The insurance carrier should review those fields to determine if the ASC or surgical implant provider is requesting separate reimbursement for implantables.

The following are examples of language that may facilitate communications:

1. Separate reimbursement for implantables not requested.
2. Separate reimbursement to ASC for implantables requested.
3. Separate reimbursement to Company X for implantables requested.
4. Separate reimbursement to ASC & Company X for implantables requested.

An ASC is responsible for communicating its choice regarding separate reimbursement for implantables and for providing documentation.

8. What are the insurance carrier’s options if the ASC does not include information requesting separate reimbursement for implantables?

If the bill does not include information requesting separate reimbursement, the insurance carrier should use the appropriate multiplier in question #5.

9. What are the insurance carrier’s options if the ASC does not include information requesting separate reimbursement for implantables, but the insurance carrier then receives a bill for implantables from a surgical implant provider?

Because separate reimbursement is the ASC’s choice, the insurance carrier would pay the ASC the appropriate multiplier that includes reimbursement for the implantable, but would deny the bill from the surgical implant provider.

10. If an ASC requests separate reimbursement for implantables, but does not provide documentation, what options are available to the insurance carrier?

- A. Contact the ASC to request the information to complete the bill.
- B. Deny the bill due to lack of documentation.
- C. Pay the ASC bill with the reimbursement calculated at the higher multiplier. The higher multiplier includes reimbursement for the implantable. The ASC may request reconsideration and provide documentation for the implantables.

11. An ASC 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 insurance carrier?

- A. Contact the surgical implant provider to request the information to complete the bill.
- B. Deny the bill due to lack of documentation.

12. 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 the source of the implantables.

13. The ASC Fee Guideline requires the use of ADDENDUM AA, *ASC Covered Surgical Procedures for CY 2008*, published in the *Federal Register* on November 27, 2007, or its successor. Where can I find that document?

For surgical procedures with a date of service in CY 2017 the ADDENDUM AA, *Final ASC Covered Surgical Procedures for CY 2017*, can be found at:

www.cms.gov/apps/ama/license.asp?file=/Medicare/Medicare-Fee-for-Service-Payment/ascpayment/downloads/CMS-1656-FC-2017-FR-ASC-Addenda.zip

14. Is the method for determining the facility reimbursement to a specific Ambulatory Surgical Center (ASC) for surgical procedures in CY 2009 and CY 2010 different from surgical procedures in CY 2008 when the fee guideline was adopted?

The reimbursement methodology is the same for each year. However, because TDI-DWC rules require the use of the most current CMS weights, values, and measures, the CMS tables for a specific calendar year should be the source for data required to calculate reimbursement for services provided during that calendar year.

It is important to note that CMS sometimes finds it necessary to revise, rename, or reformat data required to calculate reimbursement.

15. What is a device intensive procedure?

Starting in 2017, the “device intensive” status is assigned to all surgical procedures with an individual HCPCS code-level device offset of greater than 40%.

Device-intensive procedures are identified in **ADDENDUM AA** with a payment indicator of J8 (device-intensive procedure paid at adjusted rate).

16. The ASC fee guideline states a reimbursement methodology for device intensive procedures. Is there a list of device intensive procedures?

TDI-DWC rules require use of the most current CMS weights, values, and measures, and the CMS tables for a specific calendar year should be the source for any data required to calculate reimbursements for services provided during that calendar year.

It is important to note that CMS sometimes finds it necessary to revise, rename, or reformat data required to calculate reimbursement.

For dates of service on or after January 1, 2017, the list of the device-intensive procedures for CY 2017 are listed in the ASC policy file labeled

“CY 2017 ASC Procedures to which the No Cost/Full Credit and Partial Credit Device Adjustment Policy Applies” (referred to as “ASC device adjustment file” below), available at:

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Policy-Files.html.

17. The ASC fee guideline requires the use of ADDENDUM B, Hospital Outpatient Prospective Payment System CY 2008, published in the Federal Register on Nov 27, 2007 or its successor to calculate the device portion of a device intensive procedure. Where can I find that document?

For dates of service on or after January 1, 2017, the device-intensive procedures for CY 2017 are listed in the ASC policy file labeled “CY 2017 ASC Procedures to which the No Cost/Full Credit and Partial Credit Device Adjustment Policy Applies” (referred to as “ASC device adjustment file” below), which is available via the Internet on the CMS Web site at:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Policy-Files.html>.

18. What are the steps for calculating the geographic adjusted reimbursement for an ASC?

A. Gather the information to calculate the geographical adjustment to the national ASC reimbursement amount:

- 1) National reimbursement for procedure (Addendum AA).
- 2) Statistical area number (White House/OMB Document).
- 3) Use the statistical area number to determine wage index (CMS-1392 pre-class wage index for ASC).

B. Perform geographical adjustment calculations

- 4) Divide the national reimbursement by 2.
- 5) Multiply half of the national reimbursement the wage index from Step 3.
- 6) Add half of the national reimbursement and wage adjusted half of the national reimbursement calculated in step 5. The sum of these two numbers is the geographic adjusted ASC reimbursement.

19. What are the steps for calculating reimbursement for a non-device intensive procedure when no implants were used?

A. Calculate the geographic adjusted ASC reimbursement for the procedure.

B. Multiply the geographically adjusted ASC reimbursement by the TDI-DWC payment adjustment factor, currently 235% (2.35).

20. What are the steps for calculating reimbursement for a non-device intensive procedure when implantables were used in the procedure but separate reimbursement for the implantables was not requested?

A. Calculate the geographic adjusted ASC reimbursement for the procedure.

B. Multiply the geographically adjusted ASC reimbursement by the TDI-DWC payment adjustment factor, currently 235% (2.35).

Note: In this scenario, reimbursement for the implantables is included in the basic reimbursement calculation.

21. What are the steps for calculating reimbursement for a non-device intensive procedure when implantables were used in the procedure and separate reimbursement for the implants was requested?

A. Calculate the geographic adjusted ASC reimbursement for the procedure.

B. Multiply the geographically adjusted ASC reimbursement by the TDI-DWC payment adjustment factor, currently 153% (1.53).

C. Calculate the separate reimbursement for the implantables (see FAQ #7).

D. Add B and C for the reimbursement of a non-device intensive procedure when implantables were used in the procedure and separate reimbursement for the implant is requested.

22. What are the steps for calculating reimbursement for a device intensive procedure when implantables were used in the procedure but separate reimbursement for the implantables was not requested?

- A. Calculate the geographic adjusted ASC reimbursement for the procedure.
- B. See the Table referenced in FAQ #16 to determine the “device offset” amount (percentage).
- C. Multiply the hospital outpatient prospective payment system amount by the device offset percentage to determine the device portion of the reimbursement calculation.
- D. Subtract the device portion from the geographically adjusted reimbursement to determine the service portion of the reimbursement calculation.
- E. Multiply the service portion by the TDI-DWC payment adjustment factor, currently 235% (2.35), to determine the TDI-DWC reimbursement for the service portion.
- F. Add the reimbursement for the device portion to the TDI-DWC reimbursement for the service portion. The sum is the total reimbursement for the procedure.

Note: In this scenario, reimbursement for the implantables is included in the basic reimbursement calculation.

23. What are the steps for calculating reimbursement for a device intensive procedure when implantables were used in the procedure and separate reimbursement for the implantables is requested?

- A. Calculate the geographic-adjusted ASC reimbursement for the procedure.
- B. See the Table referenced in FAQ #16 to determine the “device offset” amount (percentage).
- C. Multiply the hospital outpatient prospective payment system amount by the device offset percentage to determine the device portion of the reimbursement calculation.
- D. Subtract the device portion from the geographically adjusted reimbursement to determine the service portion of the reimbursement calculation.
- E. Multiply the service portion by the TDI-DWC payment adjustment factor, currently 235% (2.35), to determine the TDI-DWC reimbursement for the service portion.
- F. Calculate the separate reimbursement for the implantable(s) (see FAQ #7).
- G. Add the separated reimbursement for the implantables to the TDI-DWC reimbursement for the service portion. The sum is the total reimbursement for the procedure.

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