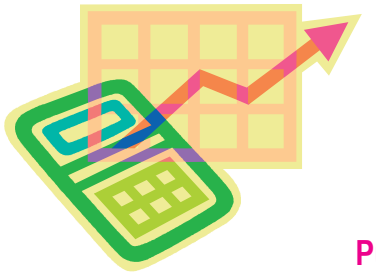

HEALTH CARE TECHNICAL UPDATE

Publisher: Workplace and Medical Services **Issue No:** 5 **Date:** April / May 2006

IN THIS ISSUE

How to Withdraw a Request for Medical Dispute Resolution

The Health Care Technical Bulletin is published to reduce or eliminate the need to file for medical dispute resolution by providing educational information to all parties. The information in this publication may also help to resolve part or all of a dispute currently pending with the Division of Workers' Compensation (DWC). If the issue(s) in a dispute is resolved before the dispute has been processed by DWC, the requestor may withdraw an individual CPT code in dispute or the entire dispute. It is important that the requestor formally withdraw the dispute (or the portion of the dispute that has been settled), by notifying Medical Dispute Resolution in writing by email at MDRInquiry@tdi.state.tx.us or by letter addressed to Division of Workers' Compensation, Medical Dispute Resolution, MS-48, Austin, Texas 78744. The letter of withdrawal can also be faxed to (512) 804-4811. In addition, a dispute can be withdrawn by calling (512) 804-4812.

Withdrawing disputes that have been resolved allows DWC staff to concentrate on unresolved disputes. In addition, withdrawing disputes that have been resolved can prevent being billed for medical dispute resolution services by DWC. The requestor and/or the respondent to a medical dispute can be billed up to $50.00 per hour when that party has violated law or DWC rules.

Billing and Reimbursement for CPT Code 97150

The description of Current Procedural Terminology (CPT) code 97150 contains the following information:

1. This is the CPT code for therapeutic procedure(s) for a group of 2 or more individuals.
2. CPT code 97150 should be billed only once per day for each member of the group.
3. The therapeutic procedures described by CPT code 97150 involve constant attendance of the physician or therapist, but by definition do not require one-on-one patient contact by the physician or therapist.

Since CPT code 97150 is *not* a "timed" code, only one unit of CPT code 97150 may be billed and reimbursed per day, regardless of how much time an individual spent in group therapeutic procedures. In addition, CPT code 97150 is in the range of physical medicine and rehabilitation codes that may require preauthorization. Once preauthorization has been given, the insurance carrier cannot withdraw the approval and the medical treatment or service cannot be denied payment for medical necessity.

Billing and Reimbursement for TENS Units

A treating doctor may prescribe a transcutaneous electrical nerve stimulator (TENS) unit when medically necessary to treat a compensable injury involving chronic, intractable pain or acute post-operative pain. Unlike other electrical neuromuscular stimulators, which directly stimulate muscles and/or motor nerves, the TENS unit decreases the perception of pain and/or stimulates the release of endorphins by passing an electrical current through electrodes on the skin.

Below is a summary of Texas workers' compensation reimbursement and HCPCS coding for TENS units:

Rental Reimbursement

Reimbursement for rental of a TENS unit covers the TENS unit rental and supplies, such as electrodes and batteries.

Purchase Reimbursement

- Reimbursement for purchase of a TENS unit covers lead wires plus one month of supplies, including electrodes, conductive paste/gel, and batteries.
- Report HCPCS code E0720 for a two-lead TENS and E0730 for a four-lead TENS.
- For reimbursement of a battery charger and additional replacement supplies,_including electrodes, conductive paste/gel, tape/other adhesive and adhesive remover, skin preparation materials, and batteries (9-volt or AA, single use or rechargeable), report the single comprehensive HCPCS code A4595. (Do not report the individual HCPCS codes A4556, A4558, or A4630.)
- For each month of supplies, report one unit of HCPCS code A4595 for a two-lead TENS or two units of HCPCS code A4595 for a four-lead TENS.
- For replacement lead wires, report one unit of HCPCS code A4557 for two lead wires going to two electrodes, and report two units of A4557 if all four lead wires of a four-lead TENS need to be replaced.
- For a conductive garment, when medically necessary for a patient to use a TENS unit, report HCPCS code E0731.

For further information on billing and reimbursement for TENS Units, consult Chapter 41 of the Palmetto DMERC Manual at:
www.palmettogba.com/palmetto/Providers.nsf/(Docs)/85256D580043E754852566C2006AA01F?OpenDocument.

Billing and Reimbursement for a Treating Doctor Attending a RME

Rule 134.5, Treating Doctor Attendance at a Medical Examination Under a Medical Examination Order, was recently amended, renumbered, and renamed as rule 134.100, Reimbursement of Treating Doctor for Attendance at Required Medical Examination. While there were some minor changes to the rule when it was amended, the billing and reimbursement requirements for the treating doctor attending a required medical examination (RME) remained the same and are as follows:

1. The amount of reimbursement is $100 per hour and is limited to four hours of reimbursement for time. If the time attending the RME is expected to exceed four hours, the doctor must obtain prior approval from the insurance carrier.

2. The reimbursement is limited to the time required to travel from the doctor's usual place of business to the place of the examination. In addition, it includes the duration of the examination and the time required to return from the examination location to the doctor's usual place of business (departure point). The travel shall be by the most direct route. This time does not include time spent for meals or other elective activities engaged in by the doctor.

3. The reimbursement shall be calculated in quarter hour increments with any amount over 10 minutes to be considered an additional quarter hour.

When billing for this service, a doctor may use a HCPCS level 1 code such as "unusual travel" and submit documentation to assist the insurance carrier to determine the accurate amount to reimburse the doctor. Such information would give the departure and arrival points, and information to establish the time spent traveling to and from the RME appointment. The information to show the time spent may include the time of departure to attend the RME appointment, the time of arrival at the RME appointment, how long the RME examination took, and the time of return from the RME appointment.

HCPCS Code Changes for ASCs

The DWC ambulatory surgical center (ASC) fee guideline, rule 134.402, requires ASCs to use Medicare policies for coding, billing, reporting, and reimbursing facility services. The Medicare policies that apply are those in effect on the date the service was provided.

ASCs should note that, effective January 1, 2006, Centers for Medicare & Medicaid Services (CMS) changed its approved ASC Healthcare Common Procedure Coding System (HCPCS) list by adding and deleting several codes. Therefore, when coding and billing facility services provided to injured workers, ASCs need to use the applicable HCPCS code updates.

For a list of the deletions and additions to the ASC List of Approved Procedures, go to www.cms.hhs.gov/MedlearnMattersArticles/downloads/MM4082.pdf.

Medical Fee Guideline Training Module

The DWC medical fee guideline (MFG), rule 134.202, does not include a catalog-like list of CPT codes and associated reimbursement values. This is a change from the format of the no longer effective 1996 Medical Fee Guideline.

However, a helpful, explanatory MFG Online Training Module is available at the DWC web site under "Seminars & Education" and "Medical Fee Guidelines Training." Here is a direct link: www.tdi.state.tx.us/wc/mr/mfgmodule.pdf. This module contains the current MFG as well as instructions for calculating medical fee reimbursement amounts. In addition, the MFG Online Training Module has been updated to reflect the latest change in the 2006 Medicare conversion factor.

"Submit" Means "Sent"

The Texas Labor Code, section 408.027, and Division rule 133.20 require a health care provider to submit a medical bill by the 95th day following the date of service or forfeit their right to reimbursement. The term "submit" is used in the same manner as the term "sent."

Rule 102.4(h) provides the following instructions to determine when documents are sent:
(h) Unless the great weight of evidence indicates otherwise, written communications are deemed to have been sent on:

(1) the date received if sent by fax, personal delivery, or electronic transmission or

(2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, **the latter of the signature date** on the written communication **or the date it was received minus five (5) days.** If the date received minus five (5) days is a Sunday or a legal holiday, the date deemed sent is the previous day which is not a Sunday or a legal holiday.

Here are a few examples:

(1) A medical bill is deemed to have been submitted on the date received, if sent by fax, personal delivery, or electronic transmission:
   (a) If a carrier receives a *faxed* medical bill from a health care provider (HCP) on May 29, 2006, the bill is deemed to have been submitted on May 29, 2006 (unless the great weight of evidence indicates otherwise).
   (b) If a carrier receives a medical bill *by personal delivery* on May 29, 2006, it is deemed to have been submitted on May 29, 2006 (unless the great weight of evidence indicates otherwise).

(c) If a carrier receives a medical bill *by email* on May 29, 2006, the bill is deemed to have been submitted on May 29, 2006 (unless the great weight of evidence indicates otherwise).

(2) A medical bill is deemed to have been submitted on the date postmarked if sent by mail via United States Postal Service regular mail:

(a) If a carrier receives a medical bill *by regular mail with a* May 29, 2006, *postmark on the envelope,* the bill is deemed to have been submitted on May 29, 2006 (unless the great weight of evidence indicates otherwise).
(b) If on June 2, 2006, a carrier receives *by regular mail a medical bill without an accompanying envelope,* and the bill was signed on May 29, 2006, the bill is deemed to have been submitted on May 29, 2006 (unless the great weight of evidence indicates otherwise).

(c) If on June 2, 2006, a carrier receives *by regular mail a medical bill without an accompanying envelope,* and the bill has no signature, the bill is deemed to have been submitted five (5) days before June 2, 2006, counting as follows:
1 – June 1; 2 – May 31; 3 – May 30; 4 – May 29; 5 – May 28
Since May 28, 2006, is a Sunday, the bill is deemed to have been submitted on May 27, 2006 (unless the great weight of evidence indicates otherwise).

Determination of when a medical bill was *submitted* (or when any written communication was *sent*) **is made in terms of the method of communication and when the bill (or other communication) was *received.*** While this method of determining when a bill was submitted may sound confusing, it actually simplifies the determination of the submission date, as the above examples show.

Rulebook Supplement 2006-02 Containing Medical Billing, Reimbursement and Preauthorization Rules Available Online

Rulebook Supplement 2006-02 containing rules recently adopted by the Commissioner of Workers' Compensation is available online from the Texas Department of Insurance (TDI), Division of Workers' Compensation. The supplement can be printed from the TDI website at http://www.tdi.state.tx.us/wc/rules/tableofcontents/supplements.html.

To purchase a hard copy of the rulebook supplement or a complete set of the Texas Workers' Compensation Act and Division Rules, contact the Division's Publications Section at 512-804-4240.

Rulebook Supplement 2006-02 contains new and amended rules published in the Texas Register on April 28, 2006 and are effective for dates of service on or after May 2, 2006:

A "Rule Development Process" chart that lists rules that are currently under development is available at the DWC web site at the following link: http://www.tdi.state.tx.us/wc/rules/planning/ruleschart.html

Clarification of Preauthorization for Bone Growth Stimulators Effective for Dates of Service on or after May 2, 2006

In the recent amendments to rule 134.600, Preauthorization, Concurrent Review, and Voluntary Certification of Health Care, bone growth stimulators were removed as separate items on the list of treatments, and services that require preauthorization. Bone growth stimulators were removed as separate items because of duplication with other sections of the preauthorization rule. Based on amended rule 134-600(p)(1)-(3), an implantable bone growth stimulator would be preauthorized as part of a surgical procedure. The exact reference would depend on the place of service of the surgery and/or type of surgery. An external bone growth stimulator with billed charges in excess of $500 would be preauthorized as durable medical equipment under rule 134.600(p)(9).

Use Only Adopted, Effective Rules

When using Division rules, system participants must use only rules that have been adopted and that are in effect for the date when a medical service or treatment is provided. Medical dispute resolution requests are not accepted if they are based on rules that were not adopted or that were not in effect on the date the disputed medical service was provided.

During the rule development process, the Division website contains links to pre-proposal draft rules and proposed rules, which are rules that have not been adopted. These non-adopted rules are made available to give stakeholders/ the public any opportunity to provide comments or suggestions before rules are finalized and adopted.

Links from the Division website to any pre-proposal draft rules and proposed rules can be found under "Rules" and "Rule Development Process." From the chart, an interested party may select "Pre-Proposal Draft on the Internet" or "Rule as Proposed for Public Comment."

A rule is adopted only after the commissioner has signed the rule and the rule has been published in the Texas Register as a public policy. For links to adopted Division rules on our website, select "Rules" and "HTML…"

When Health Care Providers May File as Subclaimants to Compensability Disputes or Extent of Injury Disputes

The Section 413.042 of the Texas Labor Code prohibits a health care provider (HCP) from billing an injured worker (IW) or the IW's private health insurance for medical services related to an on-the-job injury or illness unless the Division of Workers' Compensation (DWC) or a court has determined that the injury or illness is non-compensable.

An insurance carrier may dispute that the worker sustained a compensable injury or dispute that the condition medically treated is a part of the compensable injury. If the injured worker does not pursue a final resolution of such a dispute through the DWC, the HCP may not be able to collect payment for medical services rendered. In that event, the HCP may file for subclaimant status in order to pursue a final resolution of that dispute through the DWC as a subclaimant.

To qualify for subclaimant status, the HCP must have "(1) provided compensation, including health care provided by a health care insurer, directly or indirectly, to or for an employee or legal beneficiary; and (2) sought and been refused reimbursement from the insurance carrier" [Texas Labor Code, Section 409.009].

To file as a subclaimant, a HCP should submit a letter on business letterhead to the local DWC field office manager stating that they have provided health care to an injured worker, billed the insurance carrier, and been denied payment by the carrier and requesting subclaimant status for that particular claim. After a HCP provider has been granted sub-claimant status, the HCP can be provided information concerning claim-related disputes where the HCP provided service, sought payment, and was denied reimbursement.

List of Certified Workers' Compensation Health Care Networks and Network Applicants

House Bill 7 authorized Texas Department of Insurance (TDI) to begin certifying workers' compensation health care networks (WC networks) in January 2006 [Tex. Ins. Code, Sec. 1305.002].

A listing of certified workers' compensation health care networks is available on the TDI website under "Provider Networks" (upper left by star). Here is a link: www.tdi.state.tx.us/wc/wcnet/wcnetworks.html. Click on a WC network name for additional information, including the WC network's address, telephone number, attorney for service (if any), and service areas. Since additional WC networks will be added to this online listing as they become certified, please visit the website regularly for updates.

Workers' compensation system participants who wish to obtain names and contact information for health care networks currently engaged in the WC network certification process may submit an Open Records Request. Information on the procedure for submitting an Open Records Request is available at: www.tdi.state.tx.us/commish/legal/lcoprc1i.html.

How do Workers' Compensation Health Care Networks Affect Forms Commonly Submitted by Doctors?

Three of the forms commonly used in a doctor's office are the form DWC-53, Employee' Request for Change of Treating Doctor; the form DWC-73, Work Status Report; and the form DWC-69, Report of Medical Evaluation. The following chart illustrates the purpose of each form and the applicability of each form in workers' compensation health care network (WC network) and non-network situations.

Form Number	Form Title	Purpose of Form	Applicability to networks and non-network patients
DWC-53	Employee's Request for Change of Treating Doctor	This form is used by the employee when requesting a change of treating doctor in non-network situations.	Required ONLY for non-network WC patients. WC Networks can use this form or develop a form unique to the individual network.
DWC-73	Work Status Report	This form provides information to the employer and carrier regarding the current work status of the injured worker and work capabilities/restrictions from the doctor. In addition, the work status information on this form is used by the insurance carrier to know when to start or stop paying temporary income benefits (TIBS) to the injured worker.	Required for BOTH WC network and non-network injured employees.
DWC-69	Report of Medical Evaluation	This report is used to tell the insurance carrier when the injured worker has reached maximum medical improvement (MMI) and the percentage of impairment, if any, resulting from the compensable injury. This information is used by the carrier to know if it is necessary to pay impairment income benefits (IIBS) and the possibility of the need to pay supplemental income benefits (SIBS).	Required for BOTH WC network and non-network injured employees.

The FAST FACTS information sheet concerning medical forms used by all system participants was recently revised. The updated FAST FACTS includes information concerning the use of specific forms in certified workers' compensation network and in non-network situations. In addition, the rule references in the updated FAST FACTS have been revised due to the rules that went into effect on May 2, 2006. To view all FAST FACTS information sheets including FAST FACTS-Medical Forms, click on http://www.tdi.state.tx.us/wc/dwc/divisions/medrev.html#fastfacts .

Publication produced by the Texas Department of Insurance, Division of Workers' Compensation, Workplace and Medical Services, 7551 Metro Center Drive, Suite 100, Austin, TX 78744; (512) 804-4800. This update is for educational purposes only and is not a substitute for the statute and Division rules. 05/06)