Medical Dispute Resolution Newsletter

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Retrospective Denial of Preauthorization: Issues and Procedures

Medical Dispute Resolution (MDR) has established procedures and policies to assist the parties involved in claims where the preauthorized treatment/service(s) is approved initially, and then later (retrospectively) denied by the insurance carrier (carrier) as not medically necessary. When preauthorization is obtained, the health care provider (HCP) or injured worker receives verification from the carrier that the requested treatment/service(s) is medically necessary. A complete list of treatment/services requiring preauthorization may be found in Rule 134.600(h), Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.

MDR receives requests for medical dispute resolution where preauthorization has been properly obtained, the treatment/service(s) has been rendered, and then the claim is denied, retrospectively, by the carrier for medical necessity. ***Rule 133.301(a), Retrospective Review of Medical Bills, clearly states that once preauthorization is granted, medical necessity has been established and if the claim is denied retrospectively for medical necessity, the carrier is in violation of this rule.*** The carrier may deny the claim for reasons other than medical necessity if applicable, such as those stated in Rule 133.301(a)(1-9). However, the carrier commits a violation if they deny the preauthorized services for the stated reason of medical necessity.

Health Care Provider (HCP): If the HCP receives a retrospective denial for preauthorized services, they should first send a request for reconsideration to the carrier. MDR recommends that when a HCP sends the request for reconsideration, they include a copy of the preauthorization approval and a letter referencing TWCC Rule 133.301(a). This will serve as a reminder to the carrier that they have already provided preauthorization for the service(s) in question and are liable for payment. If the carrier continues to deny the claim, the HCP should turn to MDR for assistance.

The MDR process requires that the HCP complete a Medical Dispute Resolution Request / Response (DWC Form-60) and include a copy of the preauthorization approval. A preauthorization number alone is not acceptable. As the requestor, you must include copies of the initial preauthorization request and approval, the denial of payment received from the carrier, the reconsideration request sent to the carrier (Rule 133.304(k)-(m)), the denial received in response to the reconsideration request, and a statement of the medical treatment/service(s) in dispute. For detailed instructions on how to request medical dispute resolution, you may refer to Rule 133.307, Medical Dispute Resolution of a Medical Fee Dispute. Please ***note***, if there are additional issues involved with the medical dispute other than a retrospective denial of preauthorized services for medical necessity, (i.e., fee, extent, duplicate billing, etc.), the dispute is not eligible for the process described in this article until all other issues are resolved.

Insurance Carrier (carrier): When a Medical Dispute Resolution Request / Response (DWC Form-60) has been filed on a specific claim, the designated carrier will be notified via phone by a MDR representative first. It is important to note that the insurance carrier can often avoid a dispute with the use of the correct reason codes and a detailed explanation for the denial. To ensure compliance with Rule 133.304(c), Medical Payments and Denials, the stated reason for denial should be detailed, specific, and accurate. The use of the correct codes and a detailed explanation helps the health care provider understand the carrier's position on the disputed service (you may not deny preauthorized health care as "not medically necessary"). Please ***note***, that when a carrier issues a preauthorization approval, it establishes the medical necessity of treatment/service(s) that can not be rescinded retrospectively, not even with a peer review.

Again, Commission Rule 133.301(a) states that treatment/service(s) that is preauthorized cannot be denied retrospectively for medical necessity. If there is

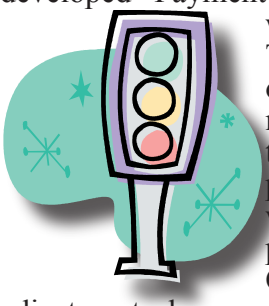
no resolution after a MDR representative contacts the carrier by phone, MDR may issue an order for payment. The claim may then be referred to the Compliance and Practices division for review.

By understanding the preauthorization and denial rules and procedures, we can all better serve the injured worker and provide compensation justly and expediently. Please direct your questions regarding the retrospective denial of preauthorized services to Medical Dispute Resolution at (512) 804-4812.

ANSI Claim Adjustment Reason Codes Replaced Payment Exception Codes on February 26, 2005

The Texas Workers' Compensation Commission (Commission) has moved toward the use of national standards for electronic transactions and adopted the IAIABC 837 format as the electronic file format for insurance carriers to report medical billing and payment information to the Commission. The American National Standards Institute (ANSI) electronic file formats were adopted as the national standard for health care transactions under the Federal Health Insurance Portability and Accountability Act (HIPAA). The International Association of Industrial Accident Boards and Commission (IAIABC) 837 electronic file format uses the ANSI standard 837 format for insurance carrier reporting of medical billing and payment information.

The Commission requires use of the ANSI Claim Adjustment Reason Codes (Reason Codes) and the related text descriptions instead of the Commission developed Payment Exception Codes (PEC) that were used on the TWCC-62. The TWCC-62, Explanation of Benefits (EOB), has been modified. The TWCC-62 is the form sent to a health care provider by an insurance carrier when a bill for medical services is paid, reduced, or denied. Reason Codes serve to communicate an adjustment when a medical bill or specific billed service was denied or paid differently than it was billed. There are more Reason Codes than there were PEC codes and they contain more detailed text descriptions for each individual code. This serves to assist the carrier in meeting the requirement of providing sufficient explanation to the health care provider in accordance with the Workers' Compensation Act and Commission rules.



Insurance carriers use Reason Codes on the TWCC-62 (EOB) to explain to health care providers the payment, denial, or reduction, of each line item charge on a medical bill. The Commission expects all participants to use the Reason Codes to explain the payment, denial, or reduction of a medical bill that is processed on or after February 26, 2005, and for reporting medical billing and payment information to the Commission in the IAIABC 837 format. The Commission will also use the Reason Codes for internal processes, such as Medical Dispute Resolution and compliance monitoring. The complete list of Reason Codes is provided on the Washington Publishing Company website at http://www.wpc-edi.com/codes/claimadjustment under "HIPAA" and "Code Lists."

The Commission is coordinating a request through the IAIABC to add eleven codes to the ANSI Claim Adjustment Reason Code list. These codes are specific to workers' compensation processing but are not unique to Texas. Codes W2-W12 appear at the end of the IAIABC 837 ANSI Claim Adjustment Reason Code Set spreadsheet which is posted on the Commission's website at http://www.tdi.state.tx.us/wc/information/ediguide/edi-guides.html. They are highlighted in blue and indicate "proposed new code" in the comments column. Insurance carriers should use these codes for medical bill processing, TWCC-62 (EOB) processing, and Medical Electronic Data Interchange (EDI) reporting on February 26, 2005. The Commission will announce the status of these codes if the ANSI committee who administers the ANSI Claim Adjustment Reason Code set adopts them. In the interim, they will be jurisdiction specific codes used for Texas workers' compensation Medical EDI reporting.

Insurance carriers may also use the ANSI Remittance Remark Codes or individual proprietary codes as secondary explanation codes when appropriate. The Remark Codes are located on the Washington Publishing Company website under "HIPAA" and "Code Lists." Additional information regarding the ANSI Remark Codes may be viewed in the Electronic Data Interchange (EDI) implementation guides on the Commission's website at http://www.tdi.state.tx.us/wc/information/ediguide/edi-guides.html.

The required fields, bar code, and form layout of the TWCC-62 (EOB) form are not changing. Bar codes are still a required element on the revised TWCC-62. Instructions pertaining to the standard requirements and placement of the bar code can be found in Advisory 2004-09, TWCC Forms Redesign Initiative, at http://www.tdi.state.tx.us/wc/news1/advisories/2004/ad2004-09.html. Questions regarding bar codes should be directed to Donna Cates at kathy.mcmaster@tdi.state.tx.us or (512) 804-4990, extension 301.

The PEC column heading on the TWCC-62 has been changed to reflect the use of ANSI Reason Codes and the form now references the Washington Publishing Company website for the complete list of Reason Codes. This list is dynamic. The list is updated three

times per year and the Commission will communicate accordingly with Texas workers' compensation system participants as the list is updated.

The Active/Inactive indicator reflects the status of the ANSI Claim Adjustment Reason Codes for version 4010. For the purposes of this implementation, inactive status is for the named version 4010 and all subsequent versions. Please ***note*** that version 4010 is the applicable EDI reporting version in the Texas workers' compensation system and on the TWCC-62. If the ANSI indicates a code in version 4010 as inactive, it is not used for this implementation of the IAIABC 837. "Inactive status" is not related to workers' compensation or applicability of the code to Texas workers' compensation.

The revised TWCC-62 is posted on the Commission's website. ***Request for approval of alternate TWCC-62 forms will no longer be required if the proprietary EOB, whether initial or reconsideration, contains all required fields prescribed by the Commission.***

The Medical Electronic Data Interchange (EDI) project establishes the foundation for electronic medical billing and reimbursement. Additional information and details on the EDI project and IAIABC 837 implementation are located on the Commission's website under the Business Process Improvement division at http://www.tdi.state.tx.us/wc/information/ediguide/edi-guides.html.

Billing and Reimbursement for Case Management

Case management in the Texas workers' compensation system consists of either team conferences or telephone calls with an interdisciplinary team that may include the employer. Although the treating doctor is primarily responsible for case management, a referral provider, such as a physical therapist or surgeon to whom the injured worker has been referred, may initiate communication, bill, and be reimbursed for case management.

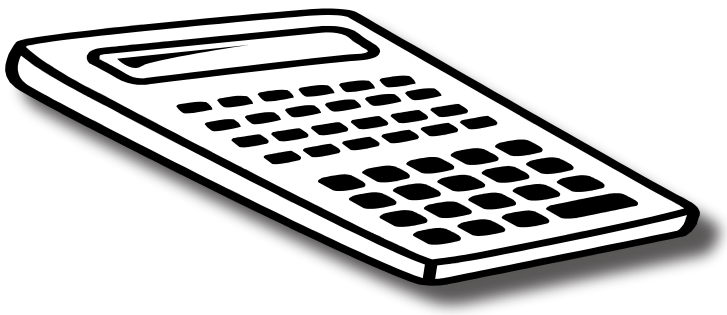
The health care provider (HCP) must bill using the CPT code that reflects the appropriate level of team conference or phone call when billing for case management services. The case management service must include coordination with an interdisciplinary team. Members of the interdisciplinary team shall not be employees of the coordinating HCP and the coordination must be outside of an interdisciplinary program, such as work hardening or chronic pain mangement.

Documentation of the coordination must include the name and specialty of each individual attending the team conference or engaged in a phone call. Team conferences and phone calls should be triggered by a documented change in the condition of the injured worker and performed for the purpose of coordination of medical treatment and/or return to work for the injured worker. Contact with one or more members of the interdisciplinary team more often than once every 30 days shall be limited to:

- the development or revision of a treatment plan;
- altering or clarifying previous instructions;
- coordinating the care of employees with catastrophic or multiple injuries requiring multiple specialties; or
- coordinating with the employer, employee, and/or an assigned medical or vocational case manager to determine return to work options.

Case management services are not assigned a specific maximum allowable reimbursement (MAR) by either the Centers for Medicare and Medicaid Services (CMS) or the Texas Workers' Compensation Commission (Commission). Therefore, the insurance carrier (carrier) should reimburse the case management services at an amount that is based on nationally recognized, published studies; published commission medical dispute decisions; or values assigned for services involving similar work and resource commitments. Two examples of such publications include, "The Essential RBRVS" published by Ingenix and the "2005 Physicians Fee & Coding Guide" published by MAG Mutual Healthcare Solutions.

If the health care provider is dissatisfied with the case management reimbursement amount from the carrier, they may request reconsideration by the carrier and, if necessary, file for medical dispute resolution. ***In resolving a fee dispute over the reimbursement amount for case management, a clear statement of the reasoning being used by the HCP or carrier to support their position concerning the amount billed or paid for case management services, improves the communication between all parties.*** In order to timely and accurately resolve these disputes, the Commission's medical dispute resolution staff should be provided with the reasoning used by either party to the dispute in explaining their position in the dispute.



Billing and Reimbursement for an Impairment Rating: ROM vs. DRE

When an injured worker (IW) reaches clinical or statutory maximum medical improvement (MMI), the IW may be assigned an impairment rating (IR). Impairment ratings are assigned using the Fourth Edition of the American Medical Association (AMA), "Guide to the Evaluation of Permanent Impairment" (the Guides). The AMA Guides use two methods to assign an IR, range of motion (ROM) and diagnostic related estimate (DRE).

The 2002 Medical Fee Guideline (MFG), Rule 134.202(e)(6)(D), sets reimbursement for the assignment of IRs based on the method used to assign the IR. It is not possible to identify which method was used to determine the IR by reading only the CPT code. In order to reimburse the health care provider appropriately and determine which method was used to assign the IR, the insurance carrier (carrier) must read the narrative report attached to the Report of Medical Evaluation (TWCC-69) describing the calculation of the IR. If the ROM method was used in a DRE area, the narrative report should contain an explanation stating why the ROM method was necessary and how the ROM methodology assisted in calculating the IR.

When utilizing the ROM method to assign an IR, the reimbursement is $300 for the first body area and $150 for each additional body area, up to a maximum of three body areas. If the DRE method is used to assign an IR, the reimbursement is $150 for each body area, up to a maximum of three body areas.

Some body areas, such as the back, primarily use the DRE method for assigning an IR. The DRE method determines the IR for a back injury by placing the injury into one of seven categories. If there is no clear category into which the injury falls, the ROM method may be used to provide evidence, (referred to as discriminators), to assist the evaluator in placing the injury into a specific category.

The use of the ROM method in a DRE area has resulted in some misunderstandings over what the correct reimbursement should be in these instances. If the evaluator must use the ROM method to obtain a correct IR of a DRE area, the evaluator should bill and be reimbursed for performing the ROM method. Although the evaluator is reimbursed at the ROM rate in this situation**,** the evaluator is not reimbursed both the DRE and the ROM amounts.

Additional information regarding the billing and reimbursement guidelines for determining MMI and assigning an IR can be found in Advisory 2004-01, Billing and Reimbursement for Maximum Medical Improvement (MMI) and Impairment Rating (IR) Services, at http://www.tdi.state.tx.us/wc/news1/advisories/2004/ad2004-01.html.

Reimbursement for Licensed Surgical Assistants (LSA)

According to Medicare Part B payment policies for non-physician practitioners, there is no direct reimbursement for non-physician, licensed surgical first assistants, certified first assistants, and/or surgical technicians. However, the Medical Fee Guideline (MFG), Rule §134.202(a)(4) states that specific provisions contained in the Texas Workers' Compensation Act (Act), or Commission rules shall take precedence over any conflicting provision adopted by CMS. Section §413.011(c) of the Act states that the fee guidelines may not be interpreted in a manner that would discriminate in the amount or method of payment or reimbursement for services prohibited by Section 3(d), Article 21.52 of the Texas Insurance Code.

Reimbursement for state licensed surgical assistants (LSA) is protected by Section 3(d), Article 21.52 of the Texas Insurance Code; however, certified first assistants and surgical technicians are not. State licensed surgical assistants may be reimbursed 85 percent of 16 percent of the physicians' fee schedule when performing medically necessary assistance at surgery services.

Medicare payment policies require the use of the "AS" modifier when billing for assistant-at-surgery services performed by a clinical nurse specialist, physician assistant, or nurse practitioner. Therefore, this Medicare policy should be utilized in the Texas workers' compensation system when billing for assistant-at-surgery services by a state licensed surgical assistant.

The Commission's Advisory 2003-11, Medical Fee Guideline, 28 TAC §134.202, clarifies this concept by stating that a payment policy used in the Medicare program must not be utilized for Medical Fee Guideline purposes if it will result in discrimination that is specifically prohibited in Section 3(d), Article 21.52 of the Texas Insurance Code.

ASC Fee Disputes Prior to September 1, 2004: A Solution

Should the Texas Workers' Compensation Commission (Commission) order payment for the $22,000 billed by an Ambulatory Surgical Center (ASC) or agree with the $1,100 paid by an insurance carrier (carrier)? This simple question represents the historical dilemma we face with ASC medical fee disputes ***for services rendered prior to September 1, 2004***, which do not have an established fee guideline and must be reimbursed at a "fair and reasonable" amount. Neither the ASC billed charges nor the carrier's payment amount may represent the "fair and reasonable" reimbursement required by the Workers' Compensation Act (Act) and rules. ***ASC services provided after September 1, 2004 are reimbursed in accordance with Rule 134.402, Ambulatory Surgical Center Fee Guideline.***

Carriers have repeatedly argued that the total charges from ASCs are not "reasonable" to pay, referencing some of the comments made by ASCs during various hearings that they only receive a percentage of their charges from all payors, including group health and workers' compensation. On the other hand, ASCs have argued that an arbitrary payment of $1,100 by a carrier (based on an inpatient per diem rate) is not "fair" and does not reflect the actual costs of providing the services in their facility. In many cases, the actual "fair and reasonable" reimbursement seems to fall somewhere in the middle.

The primary driver of our medical dispute resolution actions is the Commission's fiduciary duty in resolving these fee disputes. Pursuant to Texas Labor Code § 413.031(b), our role in these cases is to adjudicate the "payment" given the provisions of the Act and rules. As we are not hearing officers or judges, we do not simply weigh "burden of proof" arguments. Instead, we must determine the "fair and reasonable" reimbursement amount that should be ordered for an individual fee dispute for services rendered prior to September 1, 2004. Therefore, we have to determine how to calculate these reimbursement amounts.

In February 2005, we began supplementing our previous approach to ASC dispute resolutions by applying a new methodology for those situations where an "all or nothing" order with either one party or another prevailing is not appropriate. We will continue to review the information outlined in Advisory 2003-09, Determining Fair and Reasonable Reimbursement for Ambulatory Surgical Center Care, but we will not stop there.

The supplemented ASC dispute resolution approach considers the documentation provided by all parties and involves up to three levels of analysis, depending on the facts of the individual case.

- ***File Review and Audit.*** At the first level, we review and consider all the information submitted to determine if either party has provided persuasive information that justifies the reimbursement amount they believe is "fair and reasonable." Documentation that would be viewed as "persuasive information" is outlined in Advisory 2003-09, Determining Fair and Reasonable Reimbursement for Ambulatory Surgical Center Care. If the information submitted strongly supports a specific reimbursement amount, we will issue an order consistent with that documentation. If not, the next two steps will be followed to determine the "fair and reasonable" reimbursement amount.

- ***Comparison with *Ingenix Range.*** If neither party's position is particularly persuasive, we will compare the disputed amounts with the range of reimbursement recommended through the Ingenix studies to determine an appropriate reimbursement amount (213.3% to 290% of Medicare for 2004 dates of service with appropriate adjustments for previous years). The selection of a specific reimbursement amount within the Ingenix range will depend on the information submitted by the parties. For example, if the carrier's position was not entirely persuasive, but was stronger than the ASC's position, we may select an amount at the lower end of the Ingenix range. On the other hand, if the surgery appears very complex, we may select a reimbursement amount at the higher end of the Ingenix range.

- ***Consensus on Order.*** After the Ingenix comparison is used, the staff member calculating the reimbursement amount will present the recommended decision to a team of selected staff for a final review. Initially, this team will consist of a staff member with ASC billing experience, a staff member with hospital billing experience, and a staff member with insurance adjusting experience. This team will consider the recommended reimbursement amount, discuss the facts of the individual case, and select the appropriate "fair and reasonable" reimbursement amount to be ordered in the final decision.

We believe this new approach will help ensure a consistent, logical, and sound basis for determining the "fair and reasonable" reimbursement amount that is due in ASC fee disputes for services rendered prior to September 1, 2004. Each case will be reviewed individually and the final determination will be based on the facts of the specific situation, consistent with the requirements of the Act and rules. While either party may still appeal these decisions to the State Office of Administrative Hearings, we hope this new "fair and

reasonable" approach addresses both parties' concerns and reduces the need for subsequent litigation.

In June 2001, the Commission entered into a professional services agreement with Ingenix, Inc., (Ingenix), a professional firm specializing in actuarial and health care information services, to assist the Commission in developing new fee guidelines which would address fees for health care provided by facilities, including ASCs. Ingenix developed reimbursement ranges from a weighted average of Medicare and commercial market reimbursement amounts.

Amendments to ASC Fee Guideline are Adopted

At the February 17, 2005, Public Meeting, Commissioners adopted amendments to the Ambulatory Surgical Center (ASC) Fee Guideline, Rule §134.402. The purpose of the ASC rule amendments is to address information received by the Texas Workers' Compensation Commission (Commission) subsequent to the April 2004 adoption of this rule concerning impacts of the new ASC rule guideline on participants in the Texas workers' compensation system.

Since the initial adoption of the ASC Fee Guideline, effective for dates of service rendered on September 1, 2004, and after, ASCs have expressed concerns regarding the various components of the rule and their relationship to the overall reimbursement. These concerns included site of service limitations tied to the ASC List of Medicare Approved Procedures and implant reimbursement.

Following are the highlights of the amended ASC Fee Guideline.

- ***Establishes an effective date of April 1, 2005, for the amended rule.***

- ***Establishes a list of additional procedures that are not on the ASC List of Medicare Approved Procedures, including CPT codes and respective payment grouping (e.g., Medicare Group 1-9) as assigned by the Commission. The additional procedures are:***

  A. 11750-Excision of nail and nail matrix, partial or complete, (e.g., ingrown or deformed nail) for permanent removal (Group 1).
  B. 11760-Repair of nail bed (Group 1).
  C. 20552-Injection(s); single or multiple trigger point(s), one or two muscle(s) (Group 1).
  D. 20526-Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel (Group 1).
  E. 27599-Unlisted procedure, femur or knee (Group 1).
  F. 29873-Arthroscopy, knee, surgical; with lateral release (Group 3).
  G. 29999-Unlisted procedure, arthroscopy (Group 4).
  H. 63030-Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, lumbar (including open or endoscopically-assisted approach) (Group 6).
  I. 64405-Injection, anesthetic agent; greater occipital nerve (Group 1).
  J. 64999-Unlisted procedure, nervous system (Group 1).

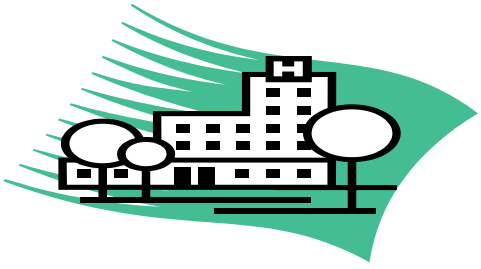
- ***Allows certain other procedures to be performed in an ASC by prospective agreement between the insurance carrier, health care providers, and ASC.***

- ***Allows separate reimbursement for surgically implanted, inserted, or otherwise applied devices at the manufacturer's invoice cost, less rebates and discounts. This reimbursement is in addition to the facility group case rate at the 213.3% payment adjustment factor.***

- ***Contains provisions concerning insurance carrier audit of ASC accounting practices related to invoicing of surgically implanted devices.***

Bills for dates of service from September 1, 2004, through March 31, 2005, are to be processed in accordance with the original ASC Fee Guideline. Bills for dates of service on or after April 1, 2005, will be processed in accordance with the amended ASC Fee Guideline.

The amended ASC Fee Guideline Rule §134. 402 with adoption preamble is located on the Commission's website at http://www.tdi.state.tx.us/wc/rules/adopted/134_402preamble.pdf.



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