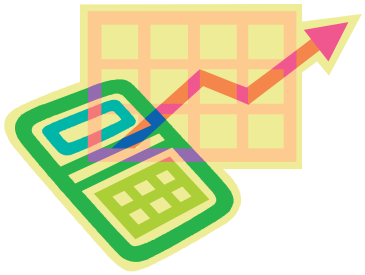

HEALTH CARE TECHNICAL UPDATE

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IN THIS ISSUE

CMS Announces 2006 Conversion Factor

The Centers for Medicare & Medicaid Services (CMS) uses a conversion factor (a dollar amount) to calculate reimbursement for professional medical services under the Medicare Physician Fee Schedule. The Division of Workers' Compensation (DWC) uses this CMS conversion factor, as required under the Medical Fee Guideline, Rule 134.202, along with a Relative Value Unit, a Geographic Practice Cost Index, and a DWC Multiplier (125% or 1.25) to calculate reimbursement for professional medical services in the Texas workers' compensation system.

The CMS conversion factor for calendar year 2006 is $36.1770, which is a reduction from the 2005 conversion factor of $37.8975. The DWC will use the new 2006 CMS conversion factor to calculate reimbursement for medical services provided to injured workers in the Texas workers' compensation system on or after January 1, 2006.

The U.S. Congress may enact legislation to change the 2006 conversion factor adopted by CMS. The Texas workers' compensation system will require use of the new conversion factor starting on the same date that Medicare requires it to be used.

1996 MFG: Invalid Billing Codes and Modifiers

A complete medical bill in the Texas workers' compensation system must contain valid billing codes as stated in the Division of Workers' Compensation (Division) Rule 133.1, Definitions for Chapter 133, Benefits--Medical Benefits. Correct billing codes include current Healthcare Common Procedure Coding System (HCPCS) Level I and II codes, modifiers, and current, Division-specific modifiers. These billing codes must be active and valid on the date a service is performed.

The Division is receiving dispute resolution requests on medical services that have been billed with modifiers from the 1996 Medical Feed Guideline (MFG). Division-specific modifiers contained in the 1996 MFG should not be referenced or utilized when billing for medical services provided on or after August 1, 2003. The current, valid list of Division-specific modifiers is located in the 2002 MFG, Rule 134.202(e)(9).

The most commonly billed, invalid (obsolete) Division-specific modifiers from the 1996 MFG include -EU, simultaneous electrical stimulation / ultrasound; -MP, manipulation; and -MT, muscle testing.

In the Texas workers' compensation system, invalid modifiers should be processed the same as invalid HCPCS codes. If a modifier is billed that is not active, not an effective modifier, or not a current, Division-specific modifier, the carrier should return the bill to the sender as an incomplete bill. If modifiers from the 1996 MFG are billed for dates of service on or after August 1, 2003, the insurance carrier should return the bill to the health care provider, as these are not valid billing codes and this would not meet the Division's definition of a complete medical bill under Rule 133.1.

It is important to note that incorrect billing is not the same as billing with invalid HCPCS codes and modifiers. A health care provider who bills a current billing code or modifier that is not appropriate for the services provided has not submitted an incomplete medical bill. An incomplete medical bill is when an invalid (obsolete) billing code and/or modifier is billed. Only bills that meet the true definition of an incomplete medical bill should be returned to the health care provider.

Reimbursement of Valid HCPCS Codes Without an Assigned Value

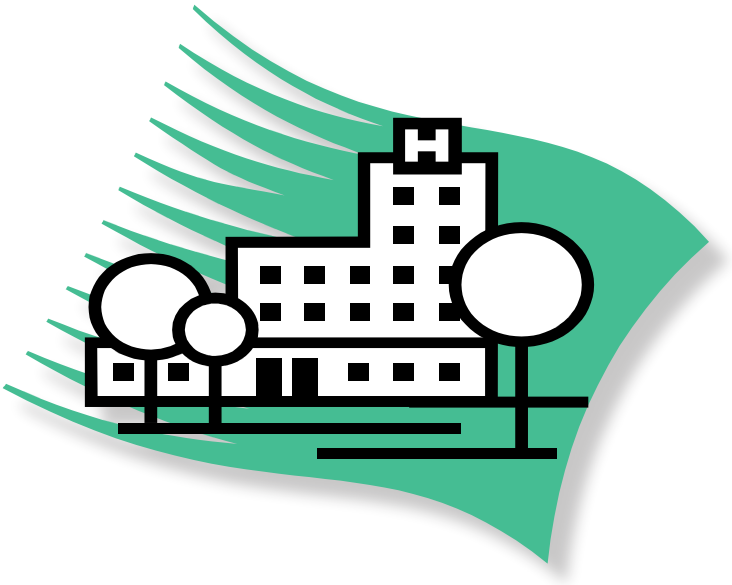
Insurance carriers (carriers) are responsible for correctly reimbursing medically necessary workers' compensation treatments and services. This includes when no reimbursement value for a Healthcare Common Procedure Coding System (HCPCS) code can be found in the Medicare Physician Fee Schedule Data Base or TrailBlazer fee calculator.

With the adoption of Rule 134.202, Medical Fee Guideline (MFG), the Texas workers' compensation system began using Medicare coding, billing, reporting, and reimbursement methodologies, models, and values or weights for reimbursement of professional medical services provided on or after August 1, 2003. Reimbursement values for most HCPCS codes used in Texas workers' compensation may be found by using the Medicare Physician Fee Schedule Data Base or the fee calculator at www.trailblazerhealth.com under "Tools" and "Medicare Fee Schedule."

To reimburse health care providers for HCPCS codes for which neither the Centers for Medicare & Medicaid Services nor the Division of Workers' Compensation (DWC) has established specific reimbursement values, subsection 134.202(c)(6) of the MFG requires carriers to "assign a relative value, which may be based on nationally recognized published relative value studies, published (DWC) medical dispute decisions, and values assigned for services involving similar work and resource commitments." An amount assigned by the carrier that is consistent with the requirements of this rule is the maximum allowable reimbursement (MAR) for those services.

Preauthorization for ESIs, Facet, and Trigger Point Injections Performed in a Doctor's Office or Imaging Center

Non-emergency surgical services performed in an ambulatory surgical center or hospital outpatient surgical department require preauthorization, as stated in Rule 134.600(h)(2). Surgical services are those services listed in the surgery section of the Current Procedural Terminology (CPT) codes. Any service included in the surgery section of the CPT codes that is performed in a hospital outpatient surgery department, an outpatient surgical center, or an ambulatory surgical center requires preauthorization. However, surgical services such as epidural steroidal injections (ESI) and facet or trigger point injections, *when performed in a doctor's office or in an imaging center,* do **not** require preauthorization and **are** subject to retrospective review for medical necessity.



Note: A doctor's office is not licensed as a facility, such as an ambulatory surgical center or hospital; therefore, a doctor's office is not eligible for reimbursement of a facility fee. The current 2002 Medical Fee Guideline, Rule 134.202, does not provide for reimbursement of surgical services performed in a doctor's office. The doctor is reimbursed for professional services performed, but not a facility fee. The 1996 Medical Fee Guideline, which outlined when a doctor's office could bill and obtain reimbursement for a facility fee, **is not appropriate for medical services provided on or after August 1, 2003.**

January 2006 - HPSA and PSA Modifiers

The Medical Fee Guideline, Rule 134.202, adopts Medicare polices for coding, billing, reporting, and reimbursement of professional medical services in the Texas workers' compensation system. In accordance with Medicare policies, doctors who render and bill for medical services provided in a Health Professional Shortage Area (HPSA) are entitled to receive a 10 percent incentive payment. Currently, when billing for a HPSA, the services must include the –QB modifier for services provided in a rural HPSA; and the –QU modifier for services provided in an urban HPSA. The –QB and –QU HPSA modifiers will be effective through December 31, 2005.

Effective January 1, 2006, the modifier to bill for a HPSA, regardless of whether the HPSA is a rural or urban area, is –AQ. Do not bill HPSA modifiers –QB and –QU for dates of service on or after January 1, 2006.

Only doctors, as defined by the Texas Labor Code section 401.011(17), are eligible to receive the HPSA incentive payment in the Texas workers' compensation system. Non-physician practitioners, such as a certified registered nurse anesthetist or physical or occupational therapists, are not eligible for HPSA payments.

The changes to the HPSA modifiers were published in July 2005 by the Centers for Medicare & Medicaid Services (CMS) under the Medlearn Matters section. The article pertaining to this change may be found at http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM3935.pdf .

Doctors who render and bill for medical services provided in a Physician Scarcity Area (PSA) continue to be entitled to a five percent incentive payment in 2006. When billing for a PSA, the services must include the –AR modifier.

CPT 97010: Hot and/or Cold Packs

Current procedural terminology (CPT) code 97010, application of hot or cold packs to one or more areas, is a bundled service code and considered to be an integral part of a therapeutic procedure(s). Reimbursement for CPT code 97010 is included in the reimbursement for the comprehensive therapeutic code. Additional payment should not be made for CPT code 97010.

According to the Medical Fee Guideline, Rule 134.202, Texas workers' compensation system participants shall apply Medicare program reimbursement methodologies, models, and values or weights in medical bill processing. The National Correct Coding Initiative edits are utilized by Medicare and therefore also apply in the Texas workers' compensation system.

The Division of Workers' Compensation (DWC) has received numerous dispute resolution requests where CPT code 97010 has been denied as not medically necessary. This is incorrect. As the application of hot and/or cold packs is a bundled service code, insurance carriers should process it as a bundled service code. The appropriate ANSI claim adjustment reason code (reason code) to report with CPT code 97010 is reason code 97; payment is included in the allowance for another service/procedure. CPT code 97010 should not be denied as not medically necessary.

Dispute resolution requests for CPT code 97010 denied as not medically necessary must be forwarded to an Independent Review Organization (IRO) for review and incur either the tier 1 $650 or tier 2 $460 IRO fee. Even if the IRO determines that the hot and/or cold pack application is medically necessary, additional payment is not due, as this is a bundled service code.

An article addressing the billing and reimbursement of hot and/or cold packs was previously published in the November 2004 edition of the Medical Dispute Resolution Newsletter. That article was published prior to the implementation of the reason codes, and it references Payment Exception Codes that are no longer active in the Texas workers' compensation system.

PT/OT Preauthorization and CPT Codes

The emergency amendments to Rule 134.600, Preauthorization, Concurrent Review, and Voluntary Certification of Health Care, utilizes the section titles of the Physical Medical and Rehabilitation section of the HCPCS Level Codes (CPT codes) and a CPT code descriptor to designate those physical therapy (PT) and occupational therapy (OT) services which are required to be preauthorized.

Rule 134.600, contains the instructions for the preauthorization process. These instructions apply to all health care requiring preauthorization and are not specific to any one category of health care. The items that must be contained in all preauthorization requests include the:

(A) specific health care for which preauthorization is sought;

(B) number of specific health care treatments and specific period of time to complete the treatments;

(C) medical information to substantiate the need for the recommended health care;

(D) accessible telephone and facsimile numbers of the health care provider who may also designate an electronic transmission (email) address for use by the carrier;

(E) name of the provider performing the health care; and

(F) facility name and estimated date of proposed health care.

Regarding PT/OT preauthorization, there are physical medicine services reflected in the AMA's CPT book that fall before, after and in-between those PT/OT services requiring preauthorization, but they themselves are not subject to preauthorization. For example, the physical medicine and rehabilitation evaluation and re-evaluation CPT codes; active wound care management; tests and measurements; medical nutrition therapy and acupuncture CPT codes do not require preauthorization. Only the modalities, both supervised and constant; therapeutic procedures (excluding work hardening and work conditioning); and unlisted physical medicine and rehabilitation procedure require preauthorization under the emergency amendments to Rule 134.600 (h)(15). The requirements for the preauthorizing work hardening and work conditioning remain in Rule 134.600 (h)(9) and are not changed by the emergency amendments.

The use of CPT codes is one way to identify the specific therapy treatments that are requested for preauthorization, however they are not the only way. The CPT code descriptors may be also be used. Submitting a request for "PT/OT for two weeks" is not specific enough for the insurance carrier or utilization review agent (URA) to identify the specific therapy services that are being requested for preauthorization. Clear communication is an important part of the preauthorization process. An unspecific request can lead to misunderstanding as to what was or what was not preauthorized. To make an informed decision about the medical necessity of the proposed PT/OT services; the carrier or URA needs sufficient information included in the request or, they may deny the preauthorization request when the three working day time frame has been exhausted.

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