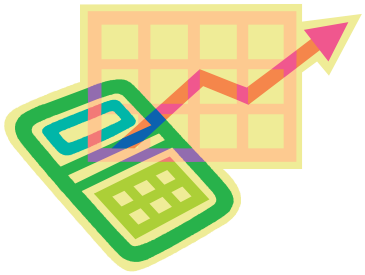

HEALTH CARE TECHNICAL UPDATE

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IN THIS ISSUE

What Is Meant by "Network," "Out-of-Network, " and "Non-Network"?

House Bill 7 (HB 7) has created significant changes in the Texas workers' compensation system, including provisions for formation of certified workers' compensation health care networks (WC networks). These WC networks apply only to medical services provided to the injured worker whose employer has elected to use a WC network for medical services related to a compensable injury. Disputes related to compensability, extent of injury, or carrier liability for the injury will continue to be handled under the Division of Workers' Compensation (DWC) claim dispute process. Also, pharmacies are excluded from participation in the networks [Tex. Ins. Code §1305.101(c)].

As a result of the new WC network provisions in HB 7, medical services provided to injured workers are now classified as "network," "out-of-network," or "non-network." Both ***network*** and ***out-of-network*** medical care involves medical services provided to an injured worker whose employer has elected to have workers' compensation medical benefits provided by a WC network certified by the Texas Department of Insurance. ***Non-network*** medical care, on the other hand, involves medical services provided to an injured worker whose employer has elected **not** to use a WC network. Following are some additional facts about each of these health care categories.

Network Services

When the employer elects to use a WC network for medical services, the injured worker must seek medical treatment from health care providers who have contracted with that WC network. Since the various WC networks are not required to have the same procedures and processes as one another, each WC network may have unique procedures and processes relating to preauthorization, change of treating doctor, treatment guidelines, etc. The WC networks are not required to use DWC medical forms. In addition, each WC network will address any medical necessity and fee disputes through their own particular internal medical dispute resolution processes.

Out-of-Network Services

Out-of-network medical care occurs when an employer elects to use a WC network and the injured worker lives within the WC network service area, **but the WC network does not have a particular provider or service available within the WC network.** In this circumstance, the treating physician must request and receive approval for an out-of-network referral from the WC network on behalf of the injured worker. The WC network must approve or deny the out-of-network referral within the time appropriate to the circumstances, but never later than 7 days after the request is made. For out-of-network medical services, the insurance carrier may reimburse services according to the DWC medical fee guidelines or, if the health care provider agrees to the network terms, the carrier may reimburse in accordance with the terms of the WC network contract for out-of-network services. **Under any circumstance, except in the case of an emergency, if the injured worker or doctor does not obtain approval from the WC network for the out-of-network medical care, the injured worker may be held**

personally liable for payment of this out-of-network medical care. Emergency services may be obtained from either WC network or out-of-network providers without referral and are not subject to these requirements.

Non-network Services

Non-network services involve medical care provided to an injured worker whose employer has workers' compensation insurance coverage **that is *not* through a WC network.** In these cases, medical care is provided, billed, and reimbursed in accordance with the process outlined in the Texas Labor Code and DWC rules for non-network care. DWC medical forms are used for non-network medical services. Also, medical services provided to injured workers must be obtained from or approved by a doctor on the DWC Approved Doctor List. The DWC will handle non-network fee disputes. Please note that DWC medical dispute resolution rules are currently being amended, particularly as they pertain to medical necessity disputes.

Change of Existing Claims From Non-Network to Network

Situation 1. Section 1305.103(c) of the Texas Insurance Code states that injured workers who live within the service area of a certified workers' compensation health care network (WC network) and who are being treated by a non-network provider for an injury that occurred **before** the employer elected to use a WC network must select a WC network treating doctor when notified by the carrier that health care services are now being provided through a WC network. The carrier is required to provide WC network notification and information to these previously injured workers as they provide to current employees who are subject to WC network requirements. The injured worker must select a treating doctor from the list of WC network treating doctors within 14 days of notification. If the injured worker does not select a treating doctor from the list of WC network treating doctors in 14 days, the WC network may assign a treating doctor to the injured worker. The injured worker may keep their current treating doctor if their current treating doctor agrees to the terms of the applicable WC network.

Situation 2. When the business relationship between an employer and a carrier is terminated, the carrier has the responsibility to pay wage replacement and medical benefits for compensable injuries that occurred during the time the employer purchased workers' compensation insurance from the carrier. Section 1305.005(b) of the Texas Insurance Code states, "An insurance carrier may establish or contract with a network certified under this chapter to provide health care services under the Texas Workers' Compensation Act." Carriers who are providing medical benefits for workers with compensable injuries that occurred on or after January 1, 1991, may choose to change the injured worker's health care from non-network to WC network if the injured worker lives in the WC network service area. To accomplish this change, the carrier must use a verifiable means to inform the injured worker that health care related to their work related injury must be obtained from a doctor on the WC network's list of treating doctors and confirm that the injured worker meets the service area requirements. The injured worker must select a treating doctor from the list of WC network treating doctors within 14 days. If the injured worker does not select a treating doctor from the list of WC network doctors in 14 days, the WC network can assign a treating doctor to the injured worker. If an agreement is reached between the current treating doctor and the applicable WC network, the injured worker may keep their current treating doctor.

Situation 3. There are times when a worker is no longer is employed by the employer where they were injured on the job and the carrier has the responsibility to pay wage replacement and medical benefits for a compensable injury. Section 1305.005(b) of the Texas Insurance Code states, "An insurance carrier may establish or contract with a network certified under this chapter to provide health care services under the Texas Workers' Compensation Act." Carriers who are providing medical benefits for workers with compensable injuries that occurred on or after January 1, 1991, may choose to change the injured worker's health care from non-network to WC network if the injured worker lives in the WC network service area. To accomplish this change, the carrier must use a verifiable means to inform the injured worker that health care related to their work related injury must be obtained from a doctor on the WC network's list of treating doctors and confirm that the injured worker meets the service area requirements. The injured worker must select a treating doctor from the list of WC network treating doctors within 14 days. If the injured worker does not select a treating doctor from the list of WC network doctors in 14 days, the WC network can assign a treating doctor to the injured worker. If an agreement is reached between the current treating doctor and the applicable WC network, the injured worker may keep their current treating doctor.

For additional information, please see Commissioner Bulletin B-0013-06, Subject: Carrier Responsibilities Concerning Workers' Compensation Health Care Networks, at the following link: http://www.tdi.state.tx.us/bulletins/2006/b-0013-06.html .

Situations When Workers' Compensation Network Injury Claims Are Subject to Non-Network Regulations

Health care for injured workers **within** certified workers' compensation networks (WC networks) must comply with both the Texas Insurance Code **and** applicable sections of the Texas Labor Code, and health care for injured workers **not** in WC networks falls solely under the Texas Labor Code. In addition, the interaction of various provisions of the Labor Code and the Insurance Code indicates that there are two situations in which health care delivery within a WC network falls under the non-network regulatory framework, i.e., under the Labor Code.

When an employer elects to use a WC network for medical services related to a compensable injury, the injured worker must seek medical treatment within the employer-designated WC network except in the following two types of situations:

1. **The insurance carrier determines that the injured worker does not live within the network service area.** Insurance Code, section 1305.005(b), states that, when a carrier contracts with a network, the employees "who live within the network's service area" are required to obtain medical treatment for a compensable injury within the network. In addition, subsection 10.62(e) of the WC network rules requires the injured worker to receive treatment from WC network providers during the pendency of a dispute regarding whether or not an injured worker "lives" within the service area.

2. **The injured worker has not received the required notification about network coverage.** Insurance Code §1305.005(h) states, "An insurance carrier…is liable for the payment of medical care under the requirements of Title 5, Labor Code, for an injured employee who does not receive notice until the employee receives notice of network requirements under this section."

Health care injury claims in the above two types of situations are covered by the Labor Code and Division of Workers' Compensation (Division) rules regarding non-network care rather than under the WC network contractual requirements. Although in these situations neither the injured worker nor the health care provider is likely to be aware of the network's internal contractual expectations and infrastructure, both parties do have access to the Division rules, forms and processes through the Division's website at www.tdi.state.tx.us/wc/indexwc.html.

Stakeholders involved in the situations explained above will be afforded the same rights as those in non-network claims. For example, injured workers may file change of treating doctor requests with the Field Offices, and health care providers may file for medical dispute resolution in the same manner as in other non-network claims. To ensure that the Division does not take action on network claims, Division staff will contact the insurance carrier to confirm the status of these claims before taking the requested action. Stakeholders are also strongly encouraged to verify the network or non-network status of injury claims to avoid problems during the claims management process.

Scope of Medical Practice Issues

Insurance carriers (carriers) are increasingly denying payment of medical bills based on type of license or scope of medical practice. Carriers are reminded that questions regarding whether or not a specific service is within the scope of practice of a particular health care provider's license are decisions for the appropriate licensing board, not the Texas Department of Insurance or the Division of Workers' Compensation (DWC). DWC will not substitute its judgment for that of the entity that is statutorily required to define the scope of practice of a particular type of medical license.

For example, the Texas Board of Chiropractic Examiners (TBCE) has found that doctors of chiropractic can perform nerve conduction studies, provided the doctor has the knowledge and training to perform these tests in a safe and competent manner. (Please see TBCE position statement on nerve conduction studies at the following link: http://www.tbce.state.tx.us/FAQ/PDF/nerve_conduction.pdf .) The scope of practice of a doctor of chiropractic is in the jurisdiction of TBCE, and not the DWC. The validity of the tests and the interpretation of the nerve conduction studies are more closely tied to the level of training and experience, as well as the specific type of license held by the doctor. Carriers and other stakeholders with scope of practice concerns are encouraged to bring those matters to the attention of the appropriate licensing board. Carriers should not deny payment of a medical bill based on scope of practice interpretations.

Carriers have stated that their primary reason for denial of payment was that the services were not medically necessary. In such cases, carriers should deny payment of a medical bill based on the lack of medical necessity, not based on the doctor's license type. Medical necessity disputes will be sent to an independent review organization for resolution, provided that the payment is denied for lack of medical necessity and not solely because of a perceived scope of practice issue. By making a timely and appropriate identification of the proper reasons for denial, the carrier will ensure that the dispute resolution process appropriately handles a medical necessity or fee dispute.

Use of "Whole Procedure" and Technical Component Modifiers When Billing MMI and IR

When the possibility of a permanent impairment exists, a Division of Workers' Compensation (DWC) certified impairment rating (IR) doctor must perform a physical examination to determine maximum medical improvement (MMI) and assign an IR.

When the examining doctor performs the MMI examination and the range of motion, strength, or sensory testing required to assign an IR for the musculoskeletal body area(s), the doctor should bill using the appropriate MMI current procedural terminology (CPT) code with the component modifier –WP. Reimbursement is 100 percent of maximum allowable reimbursement (MAR).

Examining Doctor Determines MMI and Performs IR Testing
Examining Doctor Billing

Examining Doctor Role	CPT Code	Component Modifier	Reimbursement to Examining Doctor
Treating or referral doctor who has treated the injured worker.	99455	-WP **Note**: In addition to the component modifier, a "V" modifier is required to indicate the level of service.	100% of MAR
Doctor who has NOT treated the injured worker, such as a designated doctor, referral doctor or required medical examination doctor.	99456	-WP	100% of MAR

When the examining doctor performs the MMI examination and assigns the IR but does not perform the range of motion, strength, or sensory testing of the musculoskeletal body area(s), that doctor should bill using the appropriate MMI CPT code with the component modifier -26. In this instance, reimbursement to the examining doctor is 80 percent of MAR.

Examining Doctor Determines MMI and Refers IR Testing
Examining Doctor Billing

Examining Doctor Role	CPT Code	Component Modifier	Reimbursement to Examining Doctor
Treating or referral doctor who has treated the injured worker.	99455	-26 **Note**: In addition to the component modifier, a "V" modifier is required to indicate the level of service.	80% of MAR
Doctor who has NOT treated the injured worker, such as a designated doctor, referral doctor or required medical examination doctor.	99456	-26	80% of MAR

If a health care provider (HCP) other than the examining doctor performs the range of motion, strength, or sensory testing of the musculoskeletal body area(s), the HCP performing the testing should bill using the same MMI CPT code as that used by the examining doctor but with the component modifier -TC. In this instance, reimbursement to the HCP is 20 percent of MAR.

Examining Doctor Determines MMI and Refers IR Testing
Referred Health Care Provider Billing

Examining Doctor Role	CPT Code	Component Modifier	Reimbursement to Referred Health Care Provider
Treating or referral doctor who has treated the injured worker.	99455	-TC **Note**: In addition to the component modifier, a "V" modifier is required to indicate the level of service.	20% of MAR
Doctor who has NOT treated the injured worker, such as a designated doctor, referral doctor, or required medical examination doctor	99456	-TC	20% of MAR

When an examining doctor refers an injured worker to another HCP for range of motion, strength, or sensory testing of musculoskeletal body area(s), the bills from the two parties must be coordinated and billed appropriately. Failure to coordinate the CPT codes and modifiers for the examination and musculoskeletal testing may result in incorrect payment to one or both parties.

Parties Have 30 Days to Appeal a Medical Dispute in District Court

The Workers' Compensation Act (Act), section 413.031, provides that, after September 1, 2005, medical dispute decisions (except spinal surgery prospective decisions)* can no longer be appealed to the State Office of Administrative Hearings. Therefore, to appeal a medical dispute decision, a party must seek judicial review through Travis County District Court.

Parties have 30 days from the date the decision is final and appealable to initiate judicial review [Tex. Gov. Code, Sec. 2001.176]. The Division of Workers' Compensation does not have the authority to extend the statutory 30-day deadline to file with the Travis County District Court under any circumstance. Once a Finding and Decision concerning a medical dispute is rendered the 30-clock begins to run. If the requestor or the respondent contacts Medical Dispute Resolution (MDR), their file is not placed in any type of suspense pending a call from MDR. The clock continues to tick and 30 days means 30 days, regardless of whether they contacted MDR. Under subsection 413.031(k) of the Act, neither the Division nor the Texas Department of Insurance is considered to be a party to a medical dispute. In addition, the Division is not allowed to provide legal advice or assistance to parties seeking judicial review of a medical dispute.

*A party wishing to dispute a spinal surgery prospective decision must submit a request for a hearing in writing to the Division Chief Clerk of Proceedings. This written request must be received by the Division within 10 days of your receipt of the decision.

EOB/EOR Requirements

Insurance carriers are required to provide an explanation of benefits (EOB) or explanation of remittance (EOR) to a health care provider when processing their medical bills. The EOB/EOR must clearly communicate "how" (or why) the carrier paid, reduced, or denied the health care provider's charges. Under Division of Workers' Compensation (DWC) rules 133.304, 133.307, and 133.308, the insurance carriers must give timely and adequate denial reasons or else the carrier waives its right to have the denial reason considered in the medical dispute resolution process.

Carriers may use the DWC Form-62, Explanation of Benefits, or their own proprietary (alternate) form for EOB/EOR transactions. Prior approval of alternate EOB/EOR forms is not required by the DWC, as long as all of the required fields on the DWC Form-62 are included on the alternate form. Insurance carriers or other system participants who develop their own EOBs are not required to include a barcode on the EOB. The DWC Form-62 is available on the DWC website under the forms section at www.tdi.state.tx.us/wc/forms/index.html.

In February 2005, the Division of Workers' Compensation (DWC) stopped using DWC-specific Payment Exception Codes (PEC) on the EOB/EOR and began using the American National Standards Institute (ANSI) Claim Adjustment Reason Codes (ANSI reason codes). The ANSI reason codes are nationally utilized codes for health care transactions that are more specific and more abundant than the PECs. In addition, up to five ANSI reason codes may be reported for each line of billed medical services on the EOB/EOR. This allows carriers to provide a detailed explanation of how each billed line was processed.

A list of ANSI reason codes used in Texas is available at www.wpc-edi.com. The DWC's direction on utilizing these codes in the Texas workers' compensation system may be accessed at Texas Department of Insurance, Division of Workers' Compensation's Direction on Use of the ANSI Claim Adjustment Reason Codes 11/16/05 or through the www.tdi.state.tx.us website under "About the Division" and "Medical Review."

Return-to-Work Assistance for Small Employers and RTW New Poster

In February, the Division of Workers' Compensation announced a new Return to Work (RTW) pilot program authorized by the State Legislature that will reimburse eligible expenses that help injured employees return to work after a workplace injury. Eligible small employers with workers' compensation insurance who have two to 50 employees may be eligible for reimbursements for workplace modifications, special equipment, tools, furniture or devices, or other related costs to bring an injured employee back to work in a modified or alternate duty capacity. Reimbursement applications will be reviewed under newly adopted Chapter 137, Return to Work Pilot Program rules. Agencies of the State of Texas and political subdivisions of the State are not eligible to participate in the Small Employer Pilot Program.

The RTW Pilot Program for Small Employers will assist small employers in bringing employees back to work more quickly, which is beneficial for both the employee and the employer. An individual small employer may be reimbursed for up to $2,500 annually for eligible expenses. The pilot program is funded through August 31, 2008. Call (512) 804-5000 or email rtw.services@tdi.state.tx.us for more information or to obtain an application form. Additional information is also available on the TDI website at: http://www.tdi.state.tx.us/wc/dwc/divisions/rtw/documents/smlemplyrpilot.pdf

A bi-lingual English / Spanish poster that asks the questions: **Stay at Work or Return to Work?** and **If not, have you discussed returning to work with your doctor and employer?** is now available on the Division of Worker' Compensation website. The poster is free and may be downloaded and printed in color for employers' worksites or healthcare providers' offices. The poster is located on the website at: http://www.tdi.state.tx.us/wc/dwc/divisions/rtw/documents/rtwposter.pdf .

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