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For Insurance Carriers and Health Care Providers

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Time Frame for a Health Care Provider to Request Reconsideration of a Reduced or Denied Medical Bill

The Division of Workers' Compensation amended billing and reimbursement rules to be effective for dates of service on or after May 2, 2006. Sections of Rule 133.304, Medical Payments and Denials, were amended, renumbered, and named as rule 133.250, Reconsideration for Payment of Medical Bills.

New rule 133.250 outlines the process for the sender of a medical bill [generally a health care provider (HCP)] who is dissatisfied with an insurance carrier's final action on the bill to request reconsideration of the bill by the insurance carrier.

The HCP is required to submit the request for reconsideration of a reduced or denied medical bill no later than eleven months after the date of service. Further, a HCP is not permitted to submit a request for reconsideration until after either (1) the insurance carrier has taken final action on a medical bill or (2) the HCP has not received an explanation of benefits within 50 days from submitting the bill to the insurance carrier.

In addition, when submitting a request for reconsideration, the HCP must:

(1) Reference the original bill and include the same billing codes, date(s) of service, and dollar amount(s) as the original bill;

(2) Include a copy of the original explanation of benefits, if received, or documentation that a request for an explanation of benefits was submitted to the insurance carrier;

(3) Include any necessary and related documentation not submitted with the original medical bill to support the HCP's position; and

(4) Include a bill-specific, substantive explanation in accordance with rule 133.3, Communication Between Health Care Providers and Insurance Carriers, which provides a rational basis for modifying the denial or payment.

For dates of service prior to May 2, 2006, previous rule 133.304 did not specify a time frame within which the sender must request reconsideration of a reduced or denied medical bill. Therefore, for dates of service before May 2, 2006, a HCP may submit a request for reconsideration at any time and the carrier may pay additional amounts as appropriate at any time. **Requesting reconsideration does not extend the one-year medical dispute resolution deadline.** However, this one-year time frame does not prevent the HCP from requesting reconsideration or the carrier from paying additional amounts after the one-year time frame. Since medical dispute resolution is the HCP's primary recourse for appealing a carrier's response to a request for reconsideration, a request for reconsideration should be submitted in a timely manner.

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Insurance Carriers Are Still Required to Date Stamp Medical Bills

The Division of Workers' Compensation (DWC) recently amended the billing and reimbursement rules to be effective for dates of service on or after May 2, 2006. In addition to complying with new requirements established by recent changes in the Texas Labor Code, rules are being amended to reduce duplication within the rules.

For example, rule 133.300, Insurance Carrier Receipt of Medical Bills from Health Care Providers, was amended and renumbered as rule 133.200. Prior to amendment, rule 133.300(b) required insurance carriers to date stamp each medical bill and each individual document attached to the bill to indicate the date of receipt. However, this requirement duplicated a portion of rule 102.4(j), General Rules for Non-Commission Communications, which reads as follows:

> **(j) An insurance carrier, employer or health care provider that receives a written communication related to a workers' compensation claim shall date stamp or otherwise annotate the document indicating the date the written communication was received.**

A medical bill is a form of written communication and requires a date stamp.

Clarification of Preauthorization Requirements for Treatments and Services Provided On or After May 2, 2006

The recent amendments to rule 134.600, Preauthorization, Concurrent Review, and Voluntary Certification of Health Care, affect which treatments and services require preauthorization. Specifically, some were removed as individual items on the list of treatments and services requiring preauthorization, while others were entirely removed from the list. Also, three subsections of the list of treatments and services requiring preauthorization will not be effective until additional rules have been adopted.

Following is a summary of changes to 28 TAC §134.600. Preauthorization still may be required for items: a). When they exceed or are not addressed in adopted Division treatment guidelines; b). When they are included as part of a required treatment plan; or c). When they are provided for a treatment or diagnosis not accepted by the carrier as part of a compensable injury under 28 TAC § 126.14.

Treatments and services that require preauthorization under certain conditions:

1. **TENS units** were removed as separate items on preauthorization list due to duplication with other sections of the list. A TENS unit with billed charges in excess of $500 (either purchased or cumulative expected rental) are subject to preauthorization as durable medical equipment under rule 134.600(p)(9).

2. **Myelograms, discograms, or surface electromyograms** were removed from list as separate items, since they are diagnostic studies. If they are repeat individual diagnostic procedures with a reimbursement rate of greater than $350 as established by the current MFG, they are now subject to preauthorization under rule 134.600(p)(8).

3. **Bone growth stimulators** were removed as separate items on the list because of duplication with other sections of the preauthorization rule. Based on amended rule 134.600(p)(1)-(3), an implantable bone growth stimulator is subject to preauthorization if specified as part of a surgical procedure. An external bone growth stimulator with billed charges in excess of $500 is subject to preauthorization as durable medical equipment under rule 134.600(p)(9).

Treatments and services that no longer require preauthorization:

1. Chemonucleolysis
2. Nursing home, convalescent, residential, and all home health care services and treatments
3. Chemical dependency or weight loss programs
4. Outpatient medical rehabilitation

Treatments and services that will not require preauthorization until additional rules are adopted:

1. (p)(11) drugs not included in the Division's formulary
2. (p)(12) treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier
3. (p)(13) required treatment plans

A table listing new rules being written and current rules being amended is located at http://www.tdi.state.tx.us/wc/rules/planning/ruleschart.html.

NOTE: ANY TREATMENT OR SERVICE THAT DOES NOT REQUIRE PREAUTHORIZATION IS SUBJECT TO RETROSPECTIVE REVIEW FOR MEDICAL NECESSITY BY THE INSURANCE CARRIER UNLESS: (1) THE CARRIER VOLUNTARILY CERTIFIES THAT TREATMENT OR SERVICE OR, (2) THE TREATMENT OR SERVICE IS FOR AN EMERGENCY, AS DEFINED IN RULE 133.2(3).

Billing and Reimbursement for Return-To-Work Rehabilitation Programs

The following chart may assist you with correct billing and reimbursement for return-to-work rehabilitation programs. The complete rule for billing and reimbursing these services is 134.202(e)(5) at the following link: http://info.sos.state.tx.us/pls/pub/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=2&ch=134&rl=202 .

For coding, please reference a commercial CPT code book. Note that, for the first four items in the chart below, the code for the first two hours is different from the code for each additional hour. Also note that the last four items in the chart all use the same CPT code.

Program Type (CARF title for program)	**Modifier 1**	**Modifier 2 (Use only if CARF Accredited)**	**Maximum Allowable Reimbursement (MAR)**
Work Conditioning (General Occupational Rehabilitation Program)	WC		$28.80 per hour
Work Conditioning (General Occupational Rehabilitation Program) CARF Accredited	WC	CA	$36.00 per hour
Work Hardening (Comprehensive Occupational Rehabilitation Program)	WH		$51.20 per hour
Work Hardening (Comprehensive Occupational Rehabilitation Program) CARF Accredited	WH	CA	$64 per hour
Outpatient Medical Rehabilitation	MR		$72 per hour
Outpatient Medical Rehabilitation CARF Accredited	MR	CA	$90 per hour
Chronic Pain Management/ Interdisciplinary Pain Rehabilitation	CP		$100 per hour
Chronic Pain Management/ Interdisciplinary Pain Rehabilitation CARF Accredited	CP	CA	$125 per hour

1. Units of less than 1 hour shall be prorated by 15-minute increments.

2. A single 15-minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes. Start and stop times are recommended to avoid dispute regarding time spent in the program.

Application of Facility and Non-Facility Reimbursement Rates

When calculating reimbursement for health care provider professional services in accordance with the Division Medical Fee Guideline, rule 134.202, two reimbursement amounts can often be found in the Centers for Medicare and Medicaid (CMS) resources—**facility and non-facility.** The place of service (POS) code (box #24B on the CMS-1500 billing form) is useful to determine if the place of service is facility or non-facility.

Facility reimbursement applies when the professional service is performed in a hospital [inpatient (POC 21), outpatient (POC 22), or emergency room (POC 23)]; ambulatory surgical center (POC 24); or skilled nursing facility (POC 31) setting. **Non-facility** reimbursement applies when the professional service is performed in a health care provider's office (POC 11) or any place of service other than those listed above under facility reimbursement.

How Workers' Compensation Health Care Network and Non-Network Contracts Affect Processing of Medical Fee Disputes

Generally, the Division of Workers' Compensation (DWC) does not have jurisdiction (legal authority) to process a medical fee dispute when the health care is provided under a certified network or non-network contract that covers amounts or fees for reimbursement of workers' compensation services involved in the fee dispute ("w/c fee contract"). Conversely, DWC can process a fee dispute when there is not a w/c fee contract. If the fee contract existence is in question, Medical Dispute Resolution will verify that a fee contract exists.

DWC cannot process a fee dispute in the following two types of situations, since they both concern a w/c fee contract:

1. The health care in question was provided under a workers' compensation health care network contract (except for those services provided under Rule 134.1, Medical Reimbursement).

2. The health care was provided under a non-network contract between a HCP and an insurance carrier (or a carrier's authorized representative) that does not direct medical care but that does involve a w/c fee contract.

DWC can process a fee dispute regarding reimbursement for health care that does not concern a w/c fee contract. For example, when an authorized out-of-network doctor provides health care without agreeing to a network fee schedule, DWC can process the fee dispute.

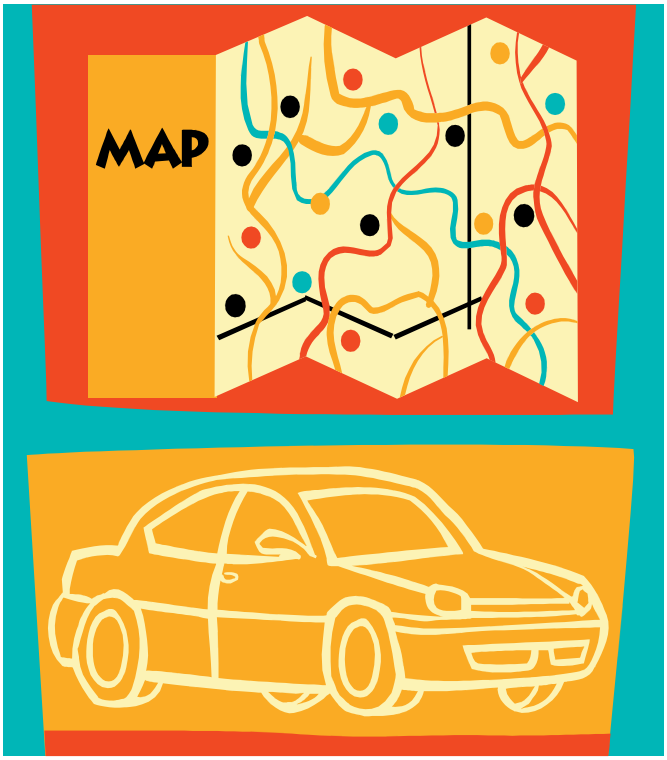
The following chart shows which fee disputes may be filed for resolution through the DWC medical dispute resolution process (middle column) and which fee disputes may be filed through the network complaint process (third column):

	Division of Workers' Compensation Medical Dispute Resolution Process	**Individual Workers' Compensation Health Care Network Complaint Process**
A medical fee dispute in a workers' Health care compensation *network*	NO	YES
A medical fee dispute involving a *non-network* contract with a fee schedule	NO*	NO*
A medical fee dispute involving a *non-network* contract without a fee schedule	YES	NO

* A fee dispute involving a non-network w/c fee contract is normally resolved through the contract resolution process in the contract or through judicial proceedings.

Employee's Request for Travel Reimbursement (Rule 134.110)

Rule 134.6, Travel Expenses Incurred by the Injured Employee, was recently amended and renumbered as rule 134.110. If an injured worker has to travel more than 30 miles one way from where they live in order to receive necessary medical care for their work-related injury or illness, they may request reimbursement for their travel expense from their employer's workers' compensation insurance carrier. To receive reimbursement, they must submit a DWC Form-48, Request for Travel Reimbursement, with documentation such as receipts within one (1) year of the date they incur the travel expenses.



The insurance carrier may deny the request for travel expense reimbursement if the injured worker could have received the same medical treatment within 30 miles of where they live. Reimbursement is based on the travel rate for state employees on the date the travel occurred, using the shortest reasonable route, from where they either live or work, depending on the place of departure. In addition, if the point where the travel began is not the injured worker's home or place of employment, then the reimbursement will be calculated from the closest of the employee's home, the place of employment, or the actual place where the travel began. Total reimbursement is based on round-trip mileage.

When the travel expenses reasonably include food and/or lodging, the carrier shall reimburse for the actual expenses based on the receipts provided and must not exceed the current rate of reimbursement paid to state employees when traveling. To obtain the current state rate reimbursement amounts, go to: http://www.window.state.tx.us/ and click on "Mileage Guide" on the left side of the home page. The insurance carrier will pay the expenses or notify the injured worker of the reasons for any reduction or denial of reimbursement in writing. If the injured worker disagrees with the insurance carrier's reduction or denial, they may contact Customer Assistance at 1-800-252-7031 to request a benefit review conference to resolve the dispute.

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