Medical Dispute Resolution Newsletter

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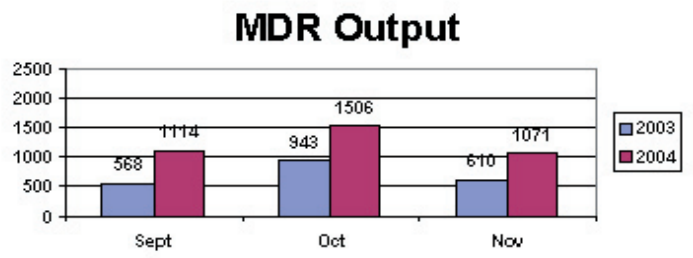
MDR Improvements

Newly implemented changes and open dialogue in the Medical Dispute Resolution (MDR) process have produced significant increases in the output of MDR disputes and evoked a "Dramatic change!" exclamation from Virginia Cullipher with Liberty Mutual. Virginia expressed great enthusiasm for the new changes and hopes to see continued improvements to the MDR system, which could result in fewer disputes proceeding to the State Office of Administrative Hearings (SOAH). The recent success in increasing the number of MDR requests completed has largely been due to the proactive monitoring of MDR processes and initiating open dialogue with injured workers, health care providers, and insurance carriers. The following chart reflects the increased output in completed requests:



Putting the human touch into the initial process of handling disputes is one of the changes to the MDR process that has evoked positive feedback and results from system participants. Through open dialogue with the parties involved in a dispute, simple oversights, such as, human error and basic misunderstanding have been discovered. By simply opening the channels of communication, the parties in a dispute develop a sense of involvement and commitment that brings progress and often, uncomplicated closure to disputes.

Vigilant attention and a proactive approach to monitoring disputes has fueled increased productivity within the MDR process and the opportunity for staff to better serve Agency customers. Closely monitoring MDR requests has revealed data that identifies potential abuse and specific areas where educational efforts can be directed. Educating injured workers, health care providers, and insurance carriers is a top priority for the MDR staff and the continued success of the MDR process.

With the active participation of our customers and system participants, we can continue to improve the MDR processes and response and resolution time to requests and inquiries. We welcome the opportunity to speak to and work with our customers and encourage any and all comments, questions, and suggestions to be directed to MDR's Customer Relations Representatives at 512-804-4817.

MDR Findings & Decision: A New Look

In the near future, you will notice that some of the Medical Dispute Resolution Findings and Decision forms are different than our usual format. We have designed a new template to provide you with the necessary information in these cases, in an easier to understand format. Instead of wading through eight to twelve pages of the same information you submitted in your request or response (and numerous references to Commission rules), you will see the decision on a simple two-page document.

We are piloting a new form to test this approach – allowing you to submit input on the form and for us to watch post-decision impact. Over the course of the next two months, we will be using this new template on selected retrospective fee disputes. If the pilot is successful, we will expand the use of the new template to other types of disputes. A copy of the "sample draft" of the MDR Findings and Decision form is located on pages 5 and 6 of this newsletter.

If you would like to provide feedback on the new Findings and Decision format , please send an email with your comments to medicalbenefits@tdi.state.tx.us.

Miscellaneous DME Code Denials

Are your physician and/or professional claims being denied when billing HCPCS code E1399, miscellaneous durable medical equipment? When billing miscellaneous durable medical equipment (DME), first determine if there is an alternative HCPCS Level II code that better describes the equipment being billed. If there is not, providers should include a **clear description** of the product being supplied, its brand name, manufacturer, catalog picture or description, catalog retail, and wholesale price or manufacturer invoice.

Without a clear description of the product or service being billed, the claim may be inappropriately reimbursed or denied because the carrier cannot determine what product is being billed. According to Rule 134.202(c)(6), "For products and services for which CMS or the Commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments." DME miscellaneous codes should be billed ***only*** if a more specific HCPCS code is unavailable.

In addition, when an insurance carrier reimburses miscellaneous DME charges, the carrier should provide an explanation on how they arrived at their reimbursement rate. According to Rule 133.304(i), when an insurance carrier pays a health care provider for services which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall: (1) develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement; (2) explain and document the method it used to calculate the rate of pay, and apply this method consistently; (3) reference its method in the claim file; and (4) explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement.

For additional information on the requirements for billing miscellaneous DME products and supplies, please refer to the Issue 40, Spring 2002 DMERC Medicare Advisory, which also provides a list of miscellaneous codes that require the documentation described above, and Issue 42, Autumn 2002 DMERC Medicare Advisory. These advisories are available on the Palmetto GBA website at http://www.palmettogba.com.

Specific questions regarding the HCPCS coding of durable medical equipment may be directed to the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) at (877) 735-1326.

Referral by an ADL Doctor to a Non-ADL Doctor

Beginning September 1, 2003, the Texas Workers' Compensation Act and Commission Rule 180.20(a) require a doctor to be on the Approved Doctor List (ADL) or be granted a temporary exception in order to provide treatment to an injured worker and receive payment for medical care services provided to injured workers. Some treating doctors have referred injured workers to doctors who are not on the ADL. A doctor who is not on the ADL or who has not been granted a temporary exception from the requirement to be on the ADL, is not authorized to receive reimbursement for treating the referred, injured worker.

To verify if a doctor is on the ADL, you may access the ADL online at www.tdi.state.tx.us. Under TXCOMP, in the left navigation bar of the homepage, click on "Find a Doctor." Then click on "TXCOMP." Place the cursor on main menu, and then click on "Locate Doctor." You can search for a doctor by name, city, county, or specialty. Directly underneath the "specialties" option, check the box "Approved to Provide Treatment." By checking this box, your search will result in only those doctors who are approved to treat injured workers in the Texas workers' compensation system. If you do not check the "Approved to Provide Treatment" box, your search will result in all doctors being displayed, including those who are **NOT** approved to treat injured workers in the Texas workers' compensation system. If you do not have access to the Internet, you may contact Customer Assistance at 1-800-252-7031 and request a list of Commission approved doctors in your area, which can be mailed or faxed to you.

It is also important for an injured worker to verify that the doctor providing treatment for their work-related injury is on the ADL so that the doctor will receive reimbursement for the medical care services they provide.

Due to a non-ADL doctor not being authorized to receive reimbursement for medical care services provided to an injured worker, the non-ADL doctor also could not file a fee dispute for non-payment with the Commission. Treating doctors should refer injured workers to doctors who are on the ADL or who have been granted a temporary exception in order to treat the referred, injured worker. To verify if a temporary exception from the ADL has been granted to a specific doctor, you may search for a doctor on TXCOMP as described above and then contact an ADL management team representative at 1-888-489-2667, option 1, to confirm if a doctor has been granted a temporary exception.

For additional information concerning reimbursements involving non-ADL doctors, please see Advisory 2003-12, http://www.tdi.state.tx.us/wc/news1/advisories/2003/ad2003-12.html

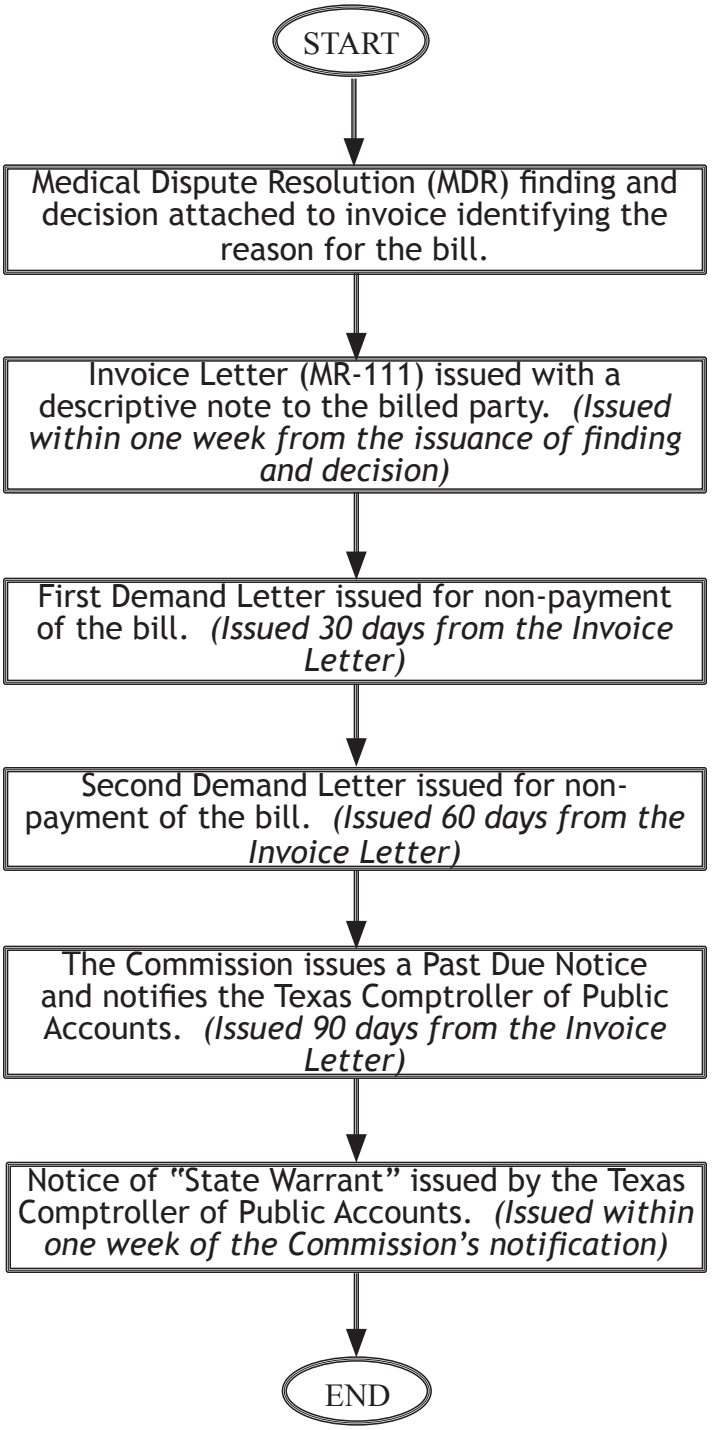
MDR Billing Process

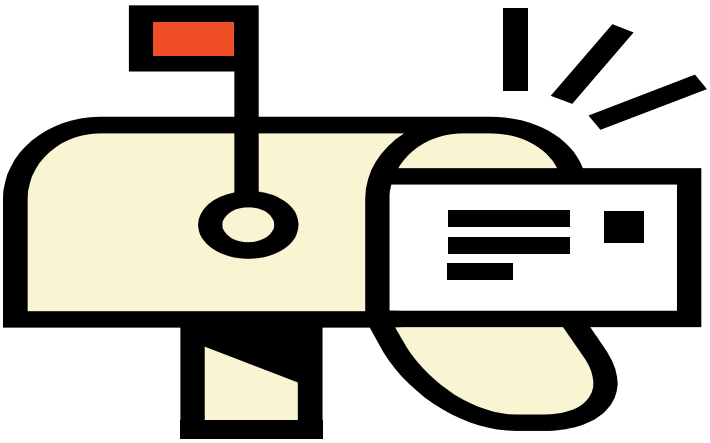
Confused about Medical Dispute Resolution's (MDR) billing process for fee disputes? Medical Dispute Resolution is authorized to bill $50 per hour (new fee amount as of November 1, 2004) per case review, according to Section 413.020(2) of the Texas Labor Code which authorizes the Commission to charge a dispute processing fee. Simply stated, if the health care provider does not bill in accordance with the law and rules or the carrier audits a bill in a manner that is inconsistent with the law and rules, the Commission will issue a bill for the cost of processing the fee dispute and rendering a finding and decision to the party who violated the law or rules. Many parties to a dispute are under the impression that if their fee dispute is rendered in their favor, they will not be billed by the Commission. That is not necessarily true. If during the process to adjudicate the dispute, it is determined that one or both parties have violated the Texas Labor Code or rules of the Commission in their processing of a bill, one or both parties will be billed accordingly. If neither party violates the Texas Labor Code or rules of the Commission, neither party will be billed.

The billed party will receive an Invoice letter (MR-111) from the Commission stating the amount to be paid to the Commission. System participants will notice a new change to this process. A note will be attached with the MDR Invoice identifying the reason for the bill. This note will reduce customer confusion and unnecessary calls to the Commission concerning the bill for the fee dispute.

If the MDR bill from the Commission is not paid within 30 days, the Commission will mail the "First Demand" letter. After a total of 60 days, if the Commission does not receive payment for the billed amount, a "Second Demand Letter" will be mailed. After 90 days, the Commission will generate an internal "Past Due Notice" and notify the Texas Comptroller of Public Accounts. The billed party's account will be placed on "warrant hold" and the Comptroller will issue a Notice of State Warrant letter. A "warrant hold" means that a violating party will not be eligible to receive public monies from state or federal sources, including Medicare, until the MDR bill has been paid in full.

A billed party may issue a check directly to the Commission or sign a power of attorney over to the Texas Comptroller of Public Accounts. If a billed party does not respond to the warrant hold, the Texas Comptroller of Public Accounts will deduct payment from monies owed to the party and forward the monies to the Commission until the hold is satisfied. For more information regarding the MDR billing process, you may contact an MDR Accounts Receivable representative at 512-804-4884.





Rule 134.600 and the National Comprehensive Coding Initiative (NCCI) Edits

What is the effect of Rule 134.600, Preauthorization, Concurrent Review, and Voluntary Certification of Health Care on the National Correct Coding Initiative (NCCI) edits? Preauthorization, concurrent review, and voluntary certification do not affect the application of the NCCI edits. For instance, a health care provider (HCP) requests and receives a voluntary certification for four weeks of physical therapy. The approved voluntary certification request includes 10 CPT codes that will be performed during a four-week period. The approved request for the 10 CPT codes is subject to the NCCI edits. For example, when separately billing for a therapeutic procedure to one or more areas that is 15 minutes in duration, along with the application of hot or cold packs, the hot or cold pack application is bundled to the therapeutic procedure. In other words, the application of hot or cold packs is a component of the therapeutic procedure and payment for this item is included in the primary procedure code payment. To be properly reimbursed for services where preauthorization, concurrent review, or voluntary certification have been obtained, the HCP must provide and bill the services in a manner that is consistent with the NCCI edits.

Procedures should be reported with the CPT codes that describe the services performed most specifically and comprehensively. When viewing the NCCI tables, column 1 is the comprehensive (primary) code column, while column 2 is the component code column. Therefore, column 2 codes are components of the more comprehensive code in column 1. Unbundling occurs when multiple procedure codes are billed for a procedure that is covered by a single comprehensive code. The following is a sample NCCI edit chart for bundled services.

Examples from NCCI Edit Chart

Column 1	Column 2	NCCI Edit Modifier	NCCI Edit Modifier Legend
97039	99357	9	9=CPT code modifier not applicable
97110	62310	1	1=CPT code modifer allowed
97140	64405	1	
98940	95831	0	0=CPT code modifier not allowed

NCCI mutually exclusive edits, different from bundling edits, apply to pairs of codes and are also part of the NCCI. When viewing the NCCI tables for mutually exclusive edits, column 1 and column 2 represent a pair of procedure codes that cannot be reasonably performed in the same session. The NCCI edit "modifier" column indicates whether a CPT code modifier is allowed to report two code pairs not normally reported on the same day, but may be appropriate under certain circumstances.

Additional information on the NCCI edits may be obtained from the Centers for Medicare &Medicaid Services website at http://www.cms.hhs.gov/physicians/CCIedits/. Due to the size of the NCCI edit files, you will need the WinZip software to review the data contained in the NCCI edit files.

"Reasonable and Necessary"

At times, health care providers (HCP) contact an insurance carrier for pre-approval to perform a service or treatment that does not require preauthorization. Later, the carrier denies the claim and the HCP will contact the Commission stating that the carrier told them they would pay "reasonable and necessary" charges if they were related to the injured worker's compensable injury. The HCPs believe they have been given a form of pre-approval or voluntary certification when told that "reasonable and necessary" charges related to the injured worker's compensable injury would be reimbursed.

The statement, "We will pay for the reasonable and necessary medical treatment if it is related to the compensable injury…" as used by the carrier, is derived from the second paragraph of TWCC Advisory 98-06 http://www.tdi.state.tx.us/wc/news1/advisories/ad98-06.html, Confirmation of Coverage. This statement does NOT mean that the carrier has given pre-approval or voluntary certification. Simply stated, the phrase "reasonable and necessary" is an acknowledgment of the pre-approval request and an assurance that the charges, when billed, may be retrospectively reviewed for medical necessity as they are related to a compensable injury. The phase "reasonable and necessary" is not a pre-approval of any type and is not grounds for medical dispute resolution or for a referral for a compliance violation.

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