Medical Dispute Resolution Newsletter

Publisher: Medical Review Division **Issue No:** 8 **Date:** July 2005

IN THIS ISSUE

Failure to Pay IRO Fee - Actions and Consequences

Medical Dispute Resolution (MDR) has identified an unacceptable business practice by certain health care providers (HCP). Specifically, certain HCPs are requesting retrospective medical necessity disputes and then failing to pay the required Independent Review Organization (IRO) fee to the IRO. Even though an order for payment of the IRO fee has been issued and the HCP is facing potential administrative violations, the HCP fails to pay the IRO fee. This unacceptable business practice by some HCPs is costly. It results in substantial administrative processing by the insurance carrier (carrier), IRO, and Texas Workers' Compensation Commission (Commission).

To more effectively address this abuse and the negative impact this business practice has on the various parties involved, MDR will be taking stringent actions to change this improper business practice.

If a HCP fails to comply with an order to pay an IRO fee, MDR will take the following actions:

- **Refer the individual HCP to Compliance and Practices to enforce the order and for a potential administrative violation; and**
- **Dismiss any new submissions for retrospective medical necessity disputes by the HCP under Rule 133.308(r)(8), Medical Dispute Resolution by Independent Review Organizations.**

In the event that the HCP establishes a similar pattern in multiple cases, further enforcement actions will be considered and implemented. The Commission believes this approach will decrease the number of frivolous disputes filed and resolve some of the issues this improper business practice has created.

Invalid vs. Valid Billing Codes

In the Texas workers' compensation system, a complete medical bill must contain correct billing codes as stated in the Texas Workers' Compensation Commission (Commission) Rule 133.1, Definitions for Chapter 133, Benefits--Medical Benefits. Correct billing codes must be active, valid billing codes on the date a service is performed, such as those codes contained in the current American Medical Association (AMA) editions of the current procedural terminology (CPT), healthcare common procedure coding system (HCPCS), and international classification of diseases (ICD) ICD-9 guides.

An invalid billing code is a code that is no longer effective in a code set, such as the AMA's CPT, HCPCS, and/or ICD-9 guides. A billing code is considered an invalid code **ONLY** if the code is no longer a current, effective code in a billing code set. For example, the current billing code CPT 99080 may be billed in a situation where it is not appropriate. Billing CPT 99080 inappropriately does not make it an "invalid" code. If a true "invalid" code is billed, the insurance carrier should not process the bill, but return it to the sender as an incomplete bill.

A valid billing code is one that is effective in the AMA's CPT, HCPCS, and/or ICD-9 guides on the date a service is performed. Valid billing codes, even if they are billed inappropriately, should be processed by the carrier and not returned to the sender. For example, if a valid billing code is billed with an incorrect modifier, such as CPT 99214 with a –27 modifier, the medical bill should be processed. Modifier –27 is a valid modifier; however, in this example, it has been inappropriately billed with CPT 99214.

The Commission expects health care providers (HCP) to bill correctly and for the insurance carriers to try to correct the bill when they can and process bills correctly. The carrier can complete missing information already known to them and

or contained in their records, such as the date of birth, social security number, etc. **The carrier may return a bill when they cannot be completed with known information.** Carriers should **not** change a billing code reported by the HCP unless they contact the HCP to obtain the correct information to make the bill complete. If a carrier finds that a bill is incomplete due to an invalid code, they have the obligation under Commission Rule 133.300, Insurance Carrier Receipt of Medical Bills from Health Care Providers, to try to correct it. If it cannot be corrected, they must return the bill to the sender.

In the Texas workers' compensation system, invalid modifiers should be processed the same as invalid billing codes. If a modifier is billed that is not an effective modifier or a current Commission specific modifier, the carrier should return the bill to the sender as an incomplete bill. Medical bills containing billing codes, modifiers, and diagnoses that are no longer effective should not be processed by the carrier, but returned to the sender.

Billing and Reimbursing PTs, OTs, and Other Practitioners for Impairment Rating Testing

Range of motion, strength, and sensory testing required by the American Medical Association "Guides to the Evaluation of Permanent Impairment" to assign an impairment rating (IR) for a musculoskeletal area can be performed by health care practitioners other than a certifying doctor. While many of these testing practitioners are physical therapists or occupational therapists, other qualified practitioners can perform the required testing to assign an IR. A health care practitioner is an individual who is licensed to provide or render health care, or an unlicensed individual who provides or renders care under the direction or supervision of a doctor.

A practitioner who conducts IR testing for a certifying doctor must have completed the Texas Workers' Compensation Commission approved IR training within two years prior to evaluating an injured worker. The certifying doctor is required to be on the Approved Doctor List (ADL), IR doctor list, and designated doctor list, if applicable. Practitioners who conduct IR testing are not required to be on the ADL or IR doctor list. However, if the qualifications of the testing practitioner are questioned, the testing practitioner must be able to produce documentation indicating that they were appropriately qualified at the time the IR testing was performed. It is the responsibility of the certifying doctor to ensure the practitioner conducting IR testing meets all IR testing requirements. If either the certifying doctor or practitioner performing the IR testing does not meet all IR testing requirements, the IR evaluation is invalid and is not reimbursable by the insurance carrier.

While practitioners are allowed to perform IR testing, the testing practitioners are not allowed to certify maximum medical improvement (MMI) or to assign an IR. The certifying doctor is responsible for performing the MMI examination and assigning the IR.

If the certifying doctor performs the MMI examination and assigns an IR, but does not perform the testing of the musculoskeletal body area(s), then the certifying doctor should bill the appropriate MMI CPT code (treating doctor or other than treating doctor) with modifier "26." Reimbursement for the certifying doctor for the determination of MMI and assignment of an IR is 80% of the total maximum allowable reimbursement (MAR).

If a practitioner other than the certifying doctor performs the testing of the musculoskeletal body area(s), the practitioner should bill the appropriate **MMI CPT code used by the certifying doctor with modifier "TC."** Reimbursement for the testing practitioner for the determination of MMI and assignment of an IR is 20% of the total MAR.

Correct Use of the "VR" Modifier

Instructions for billing for the services required in Rule 130.3, Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment by a Doctor other than the Treating Doctor, are located in the Medical Fee Guideline (MFG), Rule 134.202(e)(6)(F). The MFG rule explains that, when a treating doctor reviews the certification of MMI and the assignment of an IR performed by another doctor, the treating doctor will bill using the "Work related or medical disability examination by the treating physician..." and CPT code with the modifier "VR" to indicate their review of the TWCC-69, Report of Medical Evaluation.

The reimbursement for this service is $50.00. The treating doctor who reviews a TWCC-69, as required by Rule 130.3, would bill CPT 99455 with a -VR modifier to be reimbursed $50 for reviewing the TWCC-69. **The only doctor who is allowed to bill and be reimbursed for CPT code and modifier 99455-VR is a treating doctor.**

"Splitting" Charges into Technical and Professional Components

The concept of splitting the reimbursement for a current procedural terminology (CPT) code into professional and technical components with the "26" and "TC" modifiers does not apply to all CPT codes. **One way to determine if the reimbursement for a CPT code can be split into professional and technical components is to complete the following steps:**

Step 1 Go to the website for TrailBlazer Health Enterprises, LLC, at www.trailblazerhealth.com.

Step 2 If you have already registered on this site, sign in. If you have not previously registered, you must register to use the site. There is no cost to use this website.

Step 3 In the menu on the left side of the screen under "Tools," click on Medicare Fee Schedule.

Step 4 Select the year of the fee schedule, your state (Texas), and locality in the appropriate windows.

Step 5 Enter the procedure code (CPT) and appropriate modifier, if applicable.

Step 6 Click on "Search."

Step 7 Scroll down the page showing the results of your search to the section titled "Professional / Technical Component."

Step 8 Click on the green block with a white question mark in the "Professional / Technical Component" section. A popup window will appear with text that indicates if the CPT code can be split into professional and technical components.

The only the CPT codes that can have reimbursement separated into professional and technical components are the CPT codes which state that the professional / technical component can be split by use of the "26" and "TC" modifiers. Additionally, the Texas Workers' Compensation Commission specific CPT codes for certifying maximum medical improvement and assigning an impairment rating may be split into professional and technical components.

How an EOB Affects Medical Dispute Resolution

Including an Explanation of Benefits (EOB) with a medical dispute resolution (MDR) request is pertinent in determining the MDR track the request will follow. The dispute track a request for MDR may follow is determined by the American National Standards Institute (ANSI) claim adjustment reason code and/or proprietary or remittance remark codes reported with the denial. The three dispute tracks a MDR request may are:

- **Prospective Medical Necessity Dispute (M2)** - Medical services are preauthorized and then denied. These types of disputes are reviewed by an Independent Review organization (IRO) and currently do not require an EOB.
- **Medical Fee Dispute (M4)** – Medical services are billed and a dispute exists over the reimbursement amount or issue other than medical necessity. These types of disputes are reviewed by the Texas Workers' Compensation Commission Medical Dispute Resolution Officers.
- **Retrospective Medical Necessity Dispute (M5)** - Medical services are rendered and then denied for medical necessity. These types of disputes are reviewed by an Independent Review organization (IRO).

The initial screening of a dispute request results in the identification of the type of dispute submitted (M2, M4, or M5), a determination of the timeliness of the request, and verification that all required components for the dispute have been submitted. **Rule 133.307, Medical Dispute Resolution of a Medical Fee Dispute, pertains to medical fee disputes and refund requests. Among the components required for such a request is, "…a copy of each explanation of benefits (EOB) or response to the refund request relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB…"**

An EOB is an essential component in determining the type of dispute being submitted to MDR. Without an EOB, the Medical Review Division cannot verify if the dispute is a fee (M4) or medical necessity (M5) dispute. Each type of dispute has a distinctively different process. The likelihood that a MDR request is assigned to an incorrect dispute track increases when an EOB is not submitted with the request or carrier response. Reporting denial reasons alone on the TWCC-60, Medical Dispute Resolution Request / Response Table of Disputed Services, is subject to interpretation errors. **However, Rule 133.307 states in part that the respondent shall, within 14 days, "…provide any missing information required on the form, including absent EOB's not submitted by the requestor with the request…" In addition, Rule 133.308 states in part that the respondent shall supply "…Notices of adverse determinations of prospective or retrospective medical necessity, not provided by the requestor…"** Rules 133.307 and 133.308 were implemented in an effort to ensure that all medical dispute requests follow the appropriate dispute resolution track and all denial reasons are established for proper and timely dispute resolution.

Assigning a dispute to an incorrect dispute track does not speed up the resolution of a dispute. On the contrary, it increases the amount of time it takes to resolve a dispute and increases administrative costs for the requestor, respondent, and Medical Review Division.

Procedures Added to the ASC List

The Centers for Medicare & Medicaid Services (CMS) has revised the ambulatory surgical center (ASC) list of Medicare approved procedures. **Effective July 1, 2005, the CMS has added 66 healthcare common procedure coding system** (HCPCS) codes to the existing ASC list of Medicare approved procedures and removed five. The specific ASC HCPCS codes that have been added and removed from the ASC list may be viewed at http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3905.pdf. The updated and deleted ASC HCPCS codes are effective for services performed on or after July 1, 2005.

As the Texas Workers' Compensation Commission utilizes Medicare program reimbursement methodologies, models, and values or weights for coding, billing, and reporting payment policies, the changes to the ASC list of Medicare approved procedures are also effective in the Texas workers' compensation system on July 1, 2005.

Publication produced by the TWCC; Medical Review Division; Medical Benefits Services Section, 7551 Metro Center Drive, Suite 100, Austin, TX, 78744; (512) 804-4800. This newsletter is for educational purposes only and is not a substitute for the statute and Commission rules. (07/05)