Medical Dispute Resolution Newsletter

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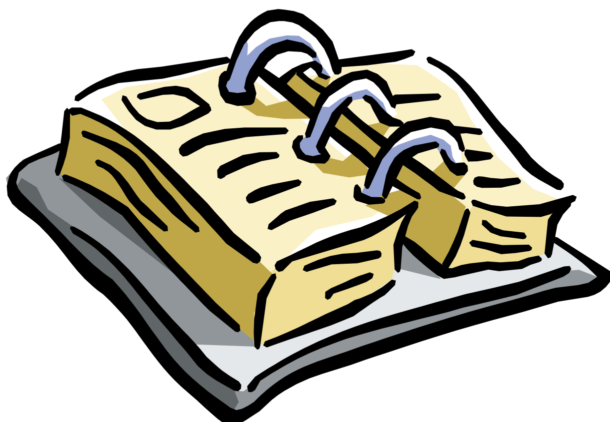
WELCOME

Welcome to the first issue of the Medical Dispute Resolution (MDR) Newsletter. The purpose of this informal publication is to provide helpful information that will facilitate the Medical Dispute Resolution process for all system participants. Through the MDR newsletter, we will provide noteworthy news on the medical dispute resolution process and tips for improving communication between disputing parties. We hope the information contained in this newsletter will prevent, or at least reduce, the occasions when it becomes necessary to file for Medical Dispute Resolution.

Timely Filing of the TWCC-60

The Medical Dispute Resolution Section cannot process the Medical Dispute Resolution Request/Response, form TWCC-60, if it is not filed timely. For retrospective medical necessity or fee disputes, the deadline for filing the TWCC-60 is one year after the date of service for the treatment or service in dispute. The health care provider must initiate and complete the initial billing and the request for reconsideration process in time to meet the one-year filing deadline for medical dispute resolution of a retrospective dispute.



TWCC Announces Effort to Improve Medical Dispute Resolution

In an aggressive effort to eliminate delays in processing requests for Medical Dispute Resolution, the Texas Workers' Compensation Commission has announced a new program to ensure the timely resolution of these disputes. The plan will increase the emphasis on low-level informal dispute resolution, expand quality assurance activities to eliminate unnecessary delays, and reduce administrative work that does not contribute to the dispute resolution process.

Processing medical necessity, preauthorization, and fee disputes has been challenging. Timely resolution of these disputes directly impacts the health care provided to injured workers and helps reduce the "hassle" factor for health care providers and insurance carriers. During the 2004 fiscal year, the Medical Review Division resolved more than 10,000 disputes with a very limited staff. While the staff size has not changed, the changes to internal processes and procedures will enable us to work many more disputes without incurring any additional cost to the state.

"This new proactive approach represents a team effort throughout the Medical Review Division, and these efforts already have had a positive effect on our outcomes," said Hilda Baker, Associate Director of Medical Review. "This approach allows the participants to become more involved in the system, giving them direct access to our dispute process, and becoming a part of the solution."

The Medical Review Division plans on providing system participants with information on the results of these efforts in December 2004.

Tips to Improve Filing for Medical Dispute Resolution

Resources on the Commission website, www.tdi.state.tx.us, to assist individuals filing for Medical Dispute Resolution include:

- Two slide show presentations explaining medical dispute resolution; http://www.tdi.state.tx.us/wc/dwc/divisions/mdr/mdrinfo.html
- A medical dispute resolution checklist to assist injured workers; and http://www.tdi.state.tx.us/wc/dwc/divisions/mdrchecklistie.html
- A medical dispute resolution checklist to assist health care providers. http://www.tdi.state.tx.us/wc/dwc/divisions/mdrchecklisthcp.html

Tip #1 When a party to a dispute is basing their position in a dispute on Medicare policy or a Correct Coding Initiative (CCI) edit, the party should state the national or local Medicare policy or CCI edit that supports their position. For example, when responding to a dispute involving the application of hot and cold packs, instead of stating, "Payment is denied based on Medicare payment policies," a better position statement would be, "Payment is denied based on CMS Program Memorandum AB-00-14 which states, 'Regardless of whether code 97010 is billed alone or in conjunction with another therapy code, payment is never made.'" This clear statement of policy improves the communication between all parties involved in resolving the dispute.

Tip #2 When filing prospective medical necessity (preauthorization) disputes, health care providers and injured workers must follow the timelines stated in Rule 134.600, Preauthorization, Concurrent Review, and Voluntary Certification of Health Care. A request for reconsideration must be filed with the carrier within **15 working days** of the receipt of the initial denial from the carrier. In addition, the health care provider or injured worker must file the request for medical dispute resolution with the Commission no later than the **45th day** after the receipt of the denial of the request for reconsideration by the carrier. The Medical Dispute Resolution section is unable to process prospective medical necessity dispute requests that do not meet these timelines.

The Commission also offers a Medical Dispute Resolution Helpline for system participants at (512) 804-4812.

Application of Hot and/or Cold Packs

For dates of service on or after August 1, 2003, in accordance with the *2002 Medical Fee Guideline** hot and/or cold pack application is a bundled service code and considered an integral part of a therapeutic procedure(s). Regardless of whether it is billed alone or in conjunction with another therapy code, additional payment should not be made. Payment is included in the allowance for another therapy service/procedure performed. Insurance carriers may deny hot and/or cold pack application using the Payment Exception Code "G" or "G" and "Y" and state that this service is global, integral, and/or a component of the primary procedure billed. Insurance carriers are encouraged to list the primary procedure code or Medicare payment policy in the explanation of benefits. **A request for TWCC medical dispute resolution for this service as either a fee dispute or a medical necessity dispute will not result in additional payment.**

*References: National Correct Coding Initiative Edits, Version 10.3 http://www.cms.hhs.gov/physicians/cciedits/ and TrailBlazer Local Coverage Determination Policy, Y-14.7. http://www.trailblazerhealth.com/lmrp.asp?lmrptype=tx&char=p

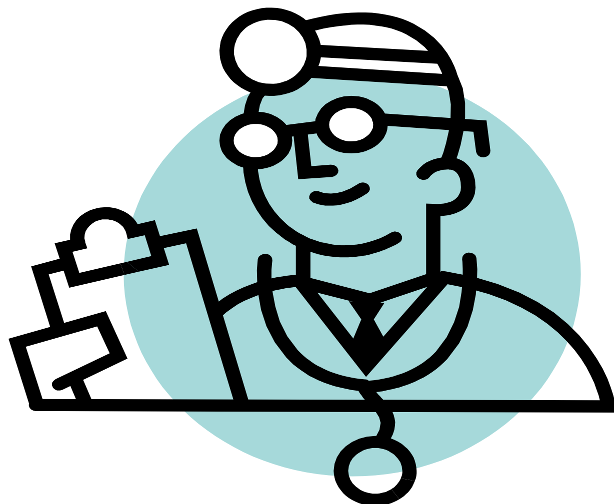
Alternate Medical Dispute Resolution (AMDR) Process

A temporary restraining order preventing the Texas Workers' Compensation Commission from implementing a new rule concerning a lower cost process to settle medical benefit disputes has been extended to December 17, 2004.

Commission Rule 133.309, Alternate Medical Necessity Dispute Resolution by Case Review Doctor, was adopted at the Commission's August 19, public meeting and provides the exclusive process for retrospective review of medical necessity disputes where the sum of disputed billed charges is less than $650. This rule would have been effective for requests filed with the Commission on or after October 1, 2004.

The implementation of the AMDR rule was restrained by an order signed on September 29, 2004, in the Travis County District Court, 345th Judicial District, as part of a lawsuit filed by the Insurance Council of Texas against the Commission. On October 13, the order was extended until December 17, 2004, or until a final decision is reached by the court on the lawsuit. A hearing on the plaintiffs' request for a permanent injunction is set for 9:00 a.m. on December 14, 2004.

Despite the extension of the restraining order, TWCC continues to build the Alternate Medical Dispute Resolution Case Review doctor list. Doctors on the Approved Doctor List (ADL) are encouraged to participate in this process and may do so by contacting Medical Dispute Resolution at 512-804-4812 or by email at amdr@tdi.state.tx.us.



Prospective Review of Medical Care (PRM) Not Requiring Preauthorization, Rule 134.650

New Rule 134.650 provides a process for the prospective review of medical care that does not require preauthorization, as outlined in Rule 134.600, Preauthorization, Concurrent Review, and Voluntary Certification of Health Care. The PRM process can reduce the instances when retrospective medical necessity disputes are filed by addressing medical necessity and issuing a medical interlocutory order as appropriate. The doctor proposing medical care, the injured worker, or the injured worker's representative can use the new PRM process. When an injured worker or their representative files for a PRM to review medical care that has been denied based on a peer review by the carrier, the injured worker or their representative may not have received a copy of the peer review from the carrier, to file with the TWCC-49. Carriers can improve the prospective review process by providing a copy of the peer review to the injured worker or their representative when a copy of the peer review is requested.

To learn more about the new PRM process, see the FAST FACTS information sheet at: http:/www.tdi.state.tx.us/wc/forms/index.html

Review by Compliance and Practices for Possible Administrative Violation

Some health care providers have filed a violation referral with the Compliance and Practices Division rather than file for medical dispute resolution. A review for potential violation by Compliance and Practices is not an alternative to medical dispute resolution. If a bill is retrospectively reduced or denied by a carrier, the fee dispute must first be addressed through the medical dispute resolution process. If the Medical Dispute Resolution process issues a finding and decision in favor of the health care provider and the insurance carrier owes the health care provider additional reimbursement or fails to abide by the Commission order, the health care provider may submit a violation referral to Compliance & Practices Division.

Billing for Maximum Medical Improvement (MMI) and Impairment Rating (IR)

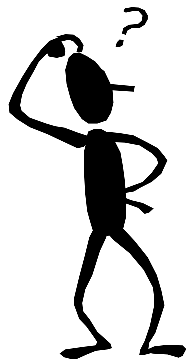
Rule 134.202, Medical Fee Guideline, establishes two methods to bill and to be reimbursed for conducting an impairment rating. One approach is the Diagnosis Related Estimate (DRE) model; the other approach is the Range of Motion (ROM) method. In those body areas where there are DRE standards, the DRE method is the preferred approach to rating impairment. However, there are times when the ROM method is used as a discriminator in a body area that is normally rated by the DRE model, such as the spine. When the ROM method is used in a body area that is normally rated by DRE model, the documentation of the impairment rating must support the reason the ROM method was used.

Additional information concerning billing and reimbursement for MMI and IR is contained in the following advisories:

Advisory 2004-01: Billing and Reimbursement for Maximum Medical Improvement (MMI) and Impairment Rating (IR) Services
http://www.tdi.state.tx.us/wc/news1/advisories/2004/ad2004-01.html

Advisory 2004-06: Billing for Commission Specific Services, CPT Codes, and Modifiers, Including Return to Work and Evaluation of Medical Care Examinations
http://www.tdi.state.tx.us/wc/news1/advisories/2004/ad2004-06.html

After filing the TWCC-60, early discussion between disputing parties (i.e. insurance carrier, health care provider, injured worker) regarding errors, such as preauthorized services and incorrect billing and coding, or omissions of medical documentation and claim forms, can result in prompt resolution of the dispute. For assistance or additional information, please contact Medical Dispute Resolution Officers Marjorie Clark at (512) 804-4817 or via email at marjorie.clark@tdi.state.tx.us, or Benita Diaz at (512) 804-4876, benita.diaz@tdi.state.tx.us.



Test your Trivia Knowledge: Can a medical fee dispute be filed with the Commission over the amount of payment for health care services provided to an injured worker that have been determined to be medically necessary and appropriate for treatment of the injured worker's compensable injury?

Answer: Yes, a medical fee dispute can be filed when a health care provider disputes a carrier's reduction or denial of a medical bill; an injured worker disputes a carrier's reduction or denial of a request for reimbursement of health care charges that the injured worker paid; a carrier disputes the health care provider's reduction or denial of the carriers request for a refund of payment for health care previously paid by the carrier (refund request dispute); or a health care provider disputes a refund order by the Commission that is issued pursuant to a Commission audit or review (refund order dispute).

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