Medical Dispute Resolution Newsletter

Publisher: Medical Review Division **Issue No:** 5 **Date:** April 2005

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Hospital Stop-Loss Disputes

At the request of the Commissioners in the January 20, 2005, Public Meeting, the Texas Workers' Compensation Commission (Commission) Medical Review Division (Division) has completed an evaluation on the application and interpretation of the Hospital Stop-Loss Reimbursement (stop-loss) Method described in the Acute Care Inpatient Hospital Fee Guideline, Rule 134.401, as used in medical fee disputes. The evaluation involved intense review of the proposed and adopted versions of Rule 134.401, (including preambles); a random sampling of current dispute files to examine charges, costs, and concerns; and consultation with legal staff.

The stop-loss method is to be used for "unusually costly services" as established in Rule 134.401(c)(6). The explanation in subsection (A) of this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission (or hospital stay) must: (1) not only exceed $40,000 in total audited charges, but (2) also involve "unusually extensive services."

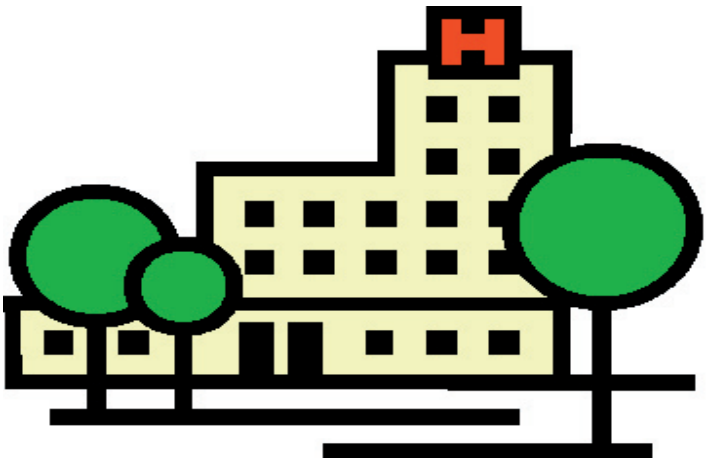
When the Commission initially adopted Rule 134.401 in 1997, approximately three percent of Texas workers' compensation hospital stays met the stop-loss threshold of $40,000. The charges associated with these hospital stays represented 17 percent of all billed hospital inpatient charges (excluding trauma cases). These few hospital stays were presumed to represent stays that involved unusually extensive services.

In reviewing current data for 2004, more than 28 percent of Texas workers' compensation hospital stays met the stop-loss threshold. The charges associated with these hospital stays represent more than 65 percent of all billed hospital inpatient charges (excluding trauma cases). **This significant increase of inpatient hospital stays exceeding the $40,000 stop-loss threshold between 1997 and 2004 indicates that a hospital charge of $40,000 or more is no longer, by itself, a good indicator that a hospital stay involves unusually extensive services.**

When a medical dispute is filed, it is now necessary for the Commission to examine whether unusually extensive services were provided during the hospital stay. In reviewing hospital stop-loss disputes, we will first verify if the total audited charges exceed $40,000. If so, we will determine whether or not the hospital stay involved unusually extensive services on a case-by-case basis. Our staff will review the submitted documentation to see if there was anything out of the ordinary (unusual) for the hospital stay, such as complications, infections, or multiple surgeries.

When appropriate, we may also compare the length of stay or similar information with the results of statistical surveys or other evidence-based guidelines. Lastly, we may seek clarification and an opinion from our medical staff for other specific hospital stays. We will apply the stop-loss method to the reimbursement determination only in situations that meet both eligibility criteria. Otherwise, we will apply the per diem rate and carve-out methodology (implants at cost plus 10 percent) described in Rule 134.401(c).

The Division will continue to work on replacing the existing hospital fee guideline with a Medicare based methodology consistent with more recent statutory requirements.



Reimbursement for the Report of Medical Examination

The Report of Medical Examination (TWCC-69) is prepared and submitted as a result of a Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examination. The reimbursement for the completion of a TWCC-69 is included in the reimbursement for the MMI/IR examination.

The Medical Fee Guideline, Rule 134.202(e)(6), states that the reimbursement for MMI/IR examinations includes, "the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets." As a result, there is not a separate reimbursement for completing the TWCC-69.

Third Party Settlements (What Advisory 2004-02 Really Means)

The Texas Workers' Compensation Act permits injured workers or their legal beneficiaries to seek the recovery of damages from a liable third party for a compensable injury or death. The workers' compensation insurance carrier may pursue a third party action in the name of the injured worker or the legal beneficiary if no such action is taken by the injured worker or beneficiary.

If a third party action is taken, the workers' compensation insurance carrier is entitled to a lien on any recovery from the third party for past income and medical benefits paid on the claim. The amount recovered must first be used to reimburse the workers' compensation insurance carrier for income and medical benefits that have been paid on the claim. If the amount recovered exceeds the amount paid by the workers' compensation insurance carrier, the injured worker or their beneficiary is entitled to the excess amount. However, by Law, the excess is then treated as an advance against the injured workers' future income and medical benefits. The excess must be exhausted prior to the workers' compensation insurance carrier resuming payment of income and medical benefits owed on the claim. Therefore, the injured worker is responsible for paying the remaining amounts for future income and medical benefits which the injured worker is entitled to receive from the excess recovery.

The excess of a third party recovery is reduced by the amount of the injured workers' income benefits as the income benefits accrue. The injured worker is also required to pay medical benefits from the excess recovery. Health care providers must continue to submit requests for preauthorization and their medical bills to the workers' compensation insurance carrier as required by the Texas Workers' Compensation Commission (Commission) rules. The workers' compensation insurance carrier is responsible for responding to requests for preauthorization and adjusting the medical bills received as required by Commission rules.

Once the medical bills are adjusted, the workers' compensation insurance carrier should submit the medical bills and required explanation of benefits to the injured worker so that the injured worker may promptly pay the adjusted amount to the health care provider. This will allow the workers' compensation insurance carrier to determine when they are required to resume payment of benefits by subtracting the adjusted bill amounts and amounts of any additional benefits due from the remaining excess third party recovery.

Medical necessity and medical fee disputes must continue to be handled through the Medical Dispute Resolution (MDR) process according to Commission rules.

Invalid Modifiers Effective On or After Dates of Service 8-1-03

The Texas Workers' Compensation Commission (Commission) Medical Fee Guideline (MFG), Rule 134.202(b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided." Oftentimes, modifiers are reported that are no longer valid or not applicable to the date of service in question.

Many of the modifiers from the 1996 Medical Fee Guideline were **not** retained in the 2002 Medical Fee Guideline that is effective for dates of service on or after August 1, 2003. Modifiers from the 1996 MFG that were **not** retained in the current MFG (Rule 134.202(e)(9)) are considered invalid. For example, a requestor may bill for muscle testing with CPT code 97750 and modifier -MT. According to Rule 134.202(e)(9), this modifier is invalid for dates of service on or after August 1, 2003.

The invalid modifiers most commonly reported through medical dispute resolution are -MT and -EU. The -MT and -EU modifiers are invalid for medical services provided on or after August 1, 2003. Medical Dispute Resolution (MDR) may bill $50.00 per hour per case review if the health care provider does not bill in accordance with the Law and Commission rules.

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If the requestor bills for an invalid modifier and it is forwarded to medical dispute resolution, the requestor will be billed if the requestor is in violation of law or rules.

When an insurance carrier audits a medical bill, they shall reference the appropriate MFG based on the date when the service(s) was provided. If a service is billed with a modifier that is no longer valid in the Texas workers' compensation system, they may deny the service with American National Standards Institute (ANSI) Claim Adjustment Reason Code B18 that states, "Payment denied because this procedure code/modifier was invalid on the date of service or claim submission." Please note, this does not apply to modifiers that are active, valid AMA or Commission specific modifiers.

The definition for a complete medical bill is detailed in Rule 133.1(a)(3)(C) which states that a complete medical bill "includes correct billing codes from Commission fee guidelines in effect on the date of service." In addition, a list of Commission-specific modifiers is located in the MFG, Rule 134.202(e)(9), that health care providers shall utilize in addition to the applicable modifiers prescribed by Medicare policies.

The Centers for Medicare & Medicaid Services (CMS) modifiers may be found in the TrailBlazer Health Modifier Overview training manual at http://www.trailblazerhealth.com/partb/books/modifieroverview.pdf and in TrailBlazer specialty training manuals such as Surgery and Anesthesia. In addition, current 2005 modifiers may be viewed in the Appendix A section of the American Medical Association's Current Procedural Terminology (CPT) 2005 manual. As the CMS updates and/or deletes modifiers, the Commission will also require the addition or deletion of the affected modifiers.

For additional information on the MDR billing process, please refer to the December 2004 issue of the Medical Dispute Resolution Newsletter at http://www.tdi.state.tx.us/wc/dwc/divisions/mdr/04-12mdrnews.pdf.

Reimbursement for HPSAs and PSAs

Health Care Professional Shortage Area (HPSA) and Physician Scarcity Area (PSA) incentive payments are reimbursed in the Texas workers' compensation system. The 2002 Medical Fee Guideline (MFG), Rule 134.202, adopted Medicare Part B payment policies for professional services provided in the Texas workers' compensation system. As of August 1, 2003, the 2002 MFG adopts the most current Medicare payment policies, as they are effective with Medicare. HPSA payments became effective in the Texas workers' compensation system beginning with dates of service August 1, 2003. PSA payments became effective in the Medicare Part B and Texas workers' compensation system on January 1, 2005.

A HPSA payment is a 10 percent incentive payment paid only to doctors who provide professional services within the geographic boundaries of an urban or rural HPSA, as designated by Medicare. A HPSA payment is based on the location where the service is performed. The HPSA geographic areas are published in the Trailblazer Medicare Part B newsletters at http://www.trailblazerhealth.com/partb/tx/index.asp, as well as, on the CMS website at http://www.cms.hhs.gov/providers/hpsa/#psa.

When providing professional services in a HPSA area, the CMS-1500 claim form must show the physical location where the service(s) are provided in box number 32. In addition, the modifier QB should be reported for a rural area and QU should be reported for an urban area. HPSA payments are not paid for Texas Workers' Compensation Commission (Commission) specific services (Rule 134.202(e)), such as a Commission ordered, required medical examination (RME) of the injured worker.

Although anesthesia codes 00100 through 01999 do not appear on the Medicare Physician Fee Schedule Data Base (MPFSDB), medically necessary anesthesia services furnished within a HPSA area and billed with modifier AA, AD, GC, QK, or QY, are eligible for the HPSA incentive payment when an eligible doctor furnishes them within a HPSA area.

A PSA payment is a 5 percent incentive payment paid only for primary and specialty care doctors who are in a Medicare designated physician scarcity geographic area. Medicare automatically reimburses the PSA incentive payment without an identifying modifier, however, some service areas, require an AR modifier. **TWCC will require an AR modifier for all services that qualify for a PSA incentive payment. The purpose of the AR modifier in the Texas workers' compensation system is to easily identify services provided in a PSA area**.

Medicare reimburses HPSA and PSA incentive payments on a quarterly basis and on the amount actually paid for the services provided. Insurance carriers in the Texas workers' compensation system should reimburse those services that qualify for the HPSA and PSA incentive payments on a per line, per bill basis, and on the amount actually paid.

ANSI Claim Adjustment Reason Code Update

The Texas Workers' Compensation Commission (Commission/TWCC) has implemented the American National Standards Institute (ANSI) Claim Adjustment Reason Codes (reason codes) as part of the Commission's move toward using national standards for medical electronic data interchange (EDI) reporting. On March 15, 2005, the Medical Review Division (Division) published a document on the Commission's website providing direction on the use of the reason codes. This document may be viewed at Recommended Direction on Use of the ANSI Claim Adjustment Reason Code 3/15/05.

After additional review, the Division has updated the TWCC ANSI Claim Adjustment Reason Code document that provides direction on the use of the ANSI reason codes currently required for reporting on the TWCC-62, Explanation of Benefits (EOB), and medical EDI reporting. This list is available for immediate use. The reason codes containing updated TWCC direction are highlighted in yellow. The updated document is posted on the TWCC website at http://www.tdi.state.tx.us/wc/dwc/divisions/ANSIcode_direction.pdf.

ANSI Claim Adjustment Reason Codes are always the primary codes to report on the EOB and in medical EDI reporting. The TWCC Comments column provides direction specific to Texas workers' compensation medical bill processing. The Fee or Medical Necessity Dispute column indicates the dispute resolution track a disputed medical service will follow. Any additional text descriptions reported on an EOB may change the designated dispute resolution track. The complete ANSI Claim Adjustment Reason Code set is available on the Washington Publishing Company website at www.wpc-edi.com.

Please *note*, the proposed ANSI codes W2-W12 are active reason codes specific to workers' compensation and should be used for EOB and medical bill processing, and in medical EDI reporting to the Commission.

The ANSI reason codes replaced the Payment Exception Codes that were previously published on the TWCC-62. The ANSI reason codes do not create or replace any Laws or Commission rules.

Currently, the Division is working to assign the applicable Law(s) and/or Commission rule(s) to the reason codes that are applicable in the Texas workers' compensation system. This step will be helpful in assisting insurance carriers determine the applicable Law(s) and Commission rule(s) for a reason code when processing a payment, denial, or adjustment of billed medical services. In addition, it will assist health care providers in determining the applicable Law(s) and Commission rule(s) that were referenced for the payment, denial, and adjustment of the medical services they billed.

Updates to the reason codes will be published as necessary and communicated in the "What's New" and "Medical Review Division" sections of the Commission's website, as well as, via e-mail. Questions regarding the ANSI reason codes may be directed to Medical Review at (512) 804-4812.

Alternate Medical Dispute Resolution (AMDR) Update

District Court Judge Covington of the 345th District Court declared the Texas Workers' Compensation Commission (Commission) Rule 133.309, Alternate Medical Necessity Dispute Resolution by Case Review Doctor (AMDR), invalid on February 24, 2005. The AMDR rule was to be effective on October 1, 2004; however, District Court Judge Lowry issued a temporary restraining order that prevented the implementation of the AMDR rule. The AMDR rule addresses the concerns presented by the Texas Legislature as expressed in Section 413.031(m) of the Texas Labor Code by providing an alternate dispute resolution process for low-dollar disputes. Currently, the Commission is appealing Judge Covington's decision.

The Commission will continue to provide additional updates on the status of the AMDR rule in future editions of the Medical Dispute Resolution Newsletter.

TEXAS WORKERS' COMPENSATION COMMISSION

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. **(05/05)**