Medical Dispute Resolution Newsletter

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Checking the Status of a Request for Medical Dispute Resolution

Are you the requestor or respondent to a medical dispute and trying to check the status of a dispute filed with Medical Dispute Resolution (MDR)? The following information will assist you in obtaining timely and accurate updates on the status of a MDR.

To check on the status of a dispute, you may contact the Medical Dispute Resolution help line at 512-804-4812. MDR representatives answer this line from 8:00 a.m. to 5:00 p.m., Monday through Friday. When calling to check the status of your dispute, please have the MDR tracking number available.

Medical disputes are assigned a tracking number that is located in the upper right-hand corner of the dispute notification letter (MR-100) you received shortly after submitting your dispute to MDR. An example of a tracking number is "M5-05-0000-01." The four different types of MDR tracking numbers include M2, M4, M5, and M9.

- M2 - Prospective medical necessity dispute (preauthorization dispute)
- M4 - Fee dispute
- M5 - Retrospective medical necessity dispute or a "mixed issue" dispute which can be a fee and medical necessity dispute
- M9 - Non-jurisdiction dispute (A request for dispute resolution that has been rejected as it is incomplete or is outside the jurisdiction of MDR).

If a MDR tracking number is not available, you will need the Texas Workers' Compensation Commission (Commission) claim number, dates of service in dispute, and the requestor's name. If you do not have the MDR tracking number or TWCC claim number, you will need to provide the following:

- injured workers' name,
- injured workers' social security number,
- date of injury,
- date(s) of service(s) in dispute, and
- requestor's name.

Providing the above information to the MDR representative assisting you will help expedite your call in checking the status of your dispute and ensure the accuracy of the information you are provided.

If you receive a non-jurisdiction letter from the Commission where the MDR tracking number begins with an "M9," your request for dispute resolution has been denied and no active dispute exists. If you receive a non-jurisdiction letter (M9) due to missing information on your initial request, you must resubmit the entire dispute to MDR with the complete and correct information. If you receive a non-jurisdiction letter (M9) due to other unresolved issue(s), such as compensability, relatedness, or entitlement, these issues must be resolved through the local Commission field office handling the claim before MDR can proceed with your request for dispute resolution.

The status of a medical dispute filed with MDR will be reported as one of the following:

1. **"Filed and active"** - No decision has been reached.
2. **"Dismissed" or "M-9"** - The request for dispute resolution has been denied and no active dispute exists at the Commission.
3. **"Decision completed"** - The decision has been completed. If you are the requestor or respondent to a medical dispute and have not received your copy, the MDR representative will assist you.

Finding a MDR Decision Online

Do you need to find a Medical Dispute Resolution (MDR) decision on the Texas Workers' Compensation Commission (Commission) website? Following are step-by-step instructions on how to easily locate a MDR decision online by either the tracking number or the topic in dispute.

Step 1: Go to www.tdi.state.tx.us.

Step 2: In the upper right-hand corner of the web page, click on "Search."

Step 3: Review the search tips that state the following:

- for a basic search, enter keywords or phrases in the "Search For" box, separated by commas (e.g., designated doctor, spinal surgery)
- advanced options are not required for a basic search
- keywords may appear anywhere in the document, not just in titles
- **use the Limit Search Results drop-down list to restrict your search results to one of several pre-selected categories of information, such as advisories, medical dispute decisions or rules**
- use quotation marks (e.g., "prospective medical necessity") to search for an exact phrase
- use * as a wildcard (e.g., *retrospective medical necessity) to search for anything containing these words or this phrase.

Step 4: Enter your search topic or MDR tracking number.

Step 5: Click on the arrow at the end of the "limit search" drop down box and select "Medical Dispute Decisions."

Step 6: Click on "Find it!"

Step 7: Review the search results and revise your search criteria, if necessary.

State law requires the Commission to remove all identifying information of the injured worker; therefore, it is not possible to search for an MDR decision by the name of the injured worker. The names of the health care providers, insurance carriers, and independent review organizations (IRO) are included in MDR decisions posted online.

If you are searching for an MDR decision with the MDR tracking number, the first two digits of the MDR tracking number indicate the type of medical dispute. The types of medical disputes and identifying prefixes include:

- M2 – Prospective medical necessity dispute (preauthorization dispute)
- M4 –Fee dispute
- M5 – Retrospective medical necessity dispute or a "mixed issue" dispute which can be a fee and medical necessity dispute

To find a MDR decision by MDR tracking number only, go to the left navigation bar of the Commission website and click on "Dispute Decisions." Next, scroll down to the appropriate category of dispute. The disputes are listed sequentially within the dispute categories.

If the MDR decision you are seeking is not posted on the website, the decision may not be completed. To check on the status of a dispute, you may contact the Dispute Resolution help line at 512-804-4812. MDR representatives answer this line from 8:00 a.m. to 5:00 p.m., Monday through Friday. Please see the article titled *Checking the Status of a Request for MDR* contained in this issue of the MDR Newsletter.

Request for Reconsideration of a Medical Bill

The Texas Workers' Compensation Commission (Commission) rules contain two request for reconsideration processes. One is for preauthorization and the other is for medical bills.

The reconsideration process for medical bills is a series of steps that health care providers (HCP) must follow when resubmitting bills to carriers following either; (1) the denial of a bill or (2) the receipt of a reduced payment amount. Commission rule 133.304(k) states that if the sender of a medical bill is dissatisfied with the carrier's final action on the bill, then the sender of the bill may request reconsideration from the insurance carrier. The definition of "reconsideration" in Commission rule 133.1 provides that resubmitting a bill is limited to a one-time second review of the bill for payment by the carrier in accordance with rule 133.304(k). After the second review by the carrier has been completed, a health care provider may then proceed to Medical Dispute Resolution.

Although Commission rule 133.304 does not denote a specific time frame for requesting reconsideration, it details the process through which HCPs may seek to informally resolve a billing dispute with a carrier prior to the parties proceeding to Medical Dispute Resolution. As Medical Dispute Resolution is the HCP's only recourse to appeal the carrier's response to reconsideration, the request for reconsideration must be accomplished in a timely manner so that the HCP meets the one-year time frame for requesting Medical Dispute Resolution.

Billing for Unnecessary Range of Motion Impairment Ratings

The March 2005 edition of the Medical Dispute Resolution Newsletter addressed billing and reimbursement for impairment ratings (IR). The two methods discussed are the range of motion (ROM) versus diagnostic related estimate (DRE) method when assigning an IR in accordance with the American Medical Association (AMA) "Guides to the Evaluation of Permanent Impairment," Fourth Edition.

For certain body areas, such as the back, the DRE method for assigning an IR is primarily used. The DRE method determines the IR for a back injury by placing the injury into one of seven DRE categories. If there is no clear category into which the injury falls, the ROM method may be used to provide evidence (referred to as discriminators) to assist the evaluator in placing the injury into a specific category.

If the evaluator must use the ROM method to obtain a correct IR of a DRE area, the evaluator should bill and be reimbursed for performing the ROM method. Although the evaluator is reimbursed at the ROM rate in this situation, the evaluator is not reimbursed for both the DRE and the ROM amounts.

When the DRE method is used to assign an IR, the reimbursement is $150 for each body area, up to a maximum of three body areas. If the ROM method is used to assign an IR, the reimbursement is $300 for the first body area and $150 for each additional body area, up to a maximum of three body areas.

Disputes have been filed with the Texas Workers' Compensation Commission where the ROM method was unnecessarily used in a DRE area. If the ROM method is needed as a discriminator, the narrative report describing how the IR was calculated should include information indicating why the ROM method was necessary as a discriminator. The evaluator should not use the ROM method in a DRE area if it is not required as a discriminator. Unnecessary use of the ROM method should not be billed by the evaluator or reimbursed by the carrier.

When is Medical Necessity not an Issue?

Most medical services that do not require preauthorization or concurrent review and have not been voluntarily certified are subject to retrospective review for medical necessity by the insurance carrier. Certain services should not be denied as not medically necessary. These include, but are not limited to:

1. **Commission ordered examinations** such as designated doctor examinations, return to work (RTW) examinations, evaluation of medical care (EMC) examinations, and prospective review of medical (PRM) care examinations.

2. **Carrier requested examinations** such as required medical examinations, designated doctor examinations, RTW examinations, and EMC examinations.

3. **Case management services**, especially when the health care provider is coordinating with the employer, injured worker, and/or an assigned medical or vocational case manager to discuss return to work options for the injured worker.

4. **Correctly filed Commission required reports**

5. **Treating doctor certification of maximum medical improvement and assignment of an impairment rating.**

These services are required through the provisions of the Texas Workers' Compensation Act or Rules of the

Texas Workers' Compensation Commission and are not subject to dispute for medical necessity. The fee for these medical services may be reduced according to medical fee guidelines or contract terms, but should not be denied for lack of medical necessity.

Billing for Medical Fee Dispute Resolution Services

The Medical Dispute Resolution Section 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. If the health care provider does not bill in accordance with the act and rules or the carrier audits a bill in a manner that is inconsistent with the act and rules, the Texas Workers' Compensation Commission (Commission) will issue a bill for the cost of adjudicating the fee dispute to the party or parties who violated the act or rules.

Many parties to a dispute are under the impression that if the fee dispute is rendered in their favor, the Commission will not bill them. That is not necessarily true. If during the process of adjudicating the fee 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 following is a partial list of situations in which a party to a medical fee dispute could be billed for medical dispute resolution services:

Health Care Providers

- Unbundling charges
- Incorrect CPT code (up-coding)
- Incorrect modifiers
- Billing for services not rendered
- Duplicate billing

Insurance Carriers

- Clearly incorrect or improper reduction or denial or reason code on an EOB
- Changing CPT codes without the agreement of the health care provider (down-coding)
- Paying less than an established MAR without a contract

In addition, actions such as billing for services that were not provided, may indicate fraud and will be referred to the Compliance and Practices Division.

Valid Modifiers

Reporting valid modifiers on a medical bill is essential for complete and accurate medical bill processing in the Texas workers' compensation system. Oftentimes, invalid modifiers reported on a medical bill delay the appropriate processing of the reported charges.

To assist health care providers in reporting current and valid modifiers, following is a list of resources where valid modifiers may be located:

- American Medical Association CPT 2004 Book, Appendix A
    - Valid for dates of service 1/1/2004 – 12/31/2004
- American Medical Association CPT 2005 Book, Appendix A
    - Valid for dates of service 1/1/2005 – 12/31/2005
- Ingenix Coding Assistant
- TWCC Medical Fee Guideline, Rule §134.202 (e)(9), Commission Modifiers and Rule 129.5 (i), Work Status Reports
- TrailBlazer Health Modifier Overview Training Manual
    - http://www.trailblazerhealth.com/partb/books/modifieroverview.pdf
- TrailBlazer Health Specialty Training Manuals
    - http://www.trailblazerhealth.com/partb/tx/books.asp

Please note, as modifiers are added, updated, or deleted by the Centers for Medicare & Medicaid Services (CMS), the Texas Workers' Compensation Commission will adopt the applicable additions, updates, and deletions.

NCCI Edits: Products and Resources

The National Correct Coding Initiative (NCCI or CCI) edits are a key component in successfully applying the coding, billing, and reporting payment policies in effect on the date a service is provided as required by the Medical Fee Guideline (rule 134.202) and the Ambulatory Surgical Center Fee Guideline (rule 134.402). On page six is a chart of several resources for NCCI edits designed to clarify how to use and apply NCCI edits. This list is not exhaustive or all-inclusive, but is a starting point to find resources to use in dealing with NCCI edit practices. An Internet search directed to "CCI edits" will unveil hundreds of useful resources. Some resources will require WinZip software. The Texas Workers' Compensation Commission does not endorse or recommend any software. When selecting software, the purchaser should select software that meets their specific business needs.

National Correct Coding Initiative (NCCI)

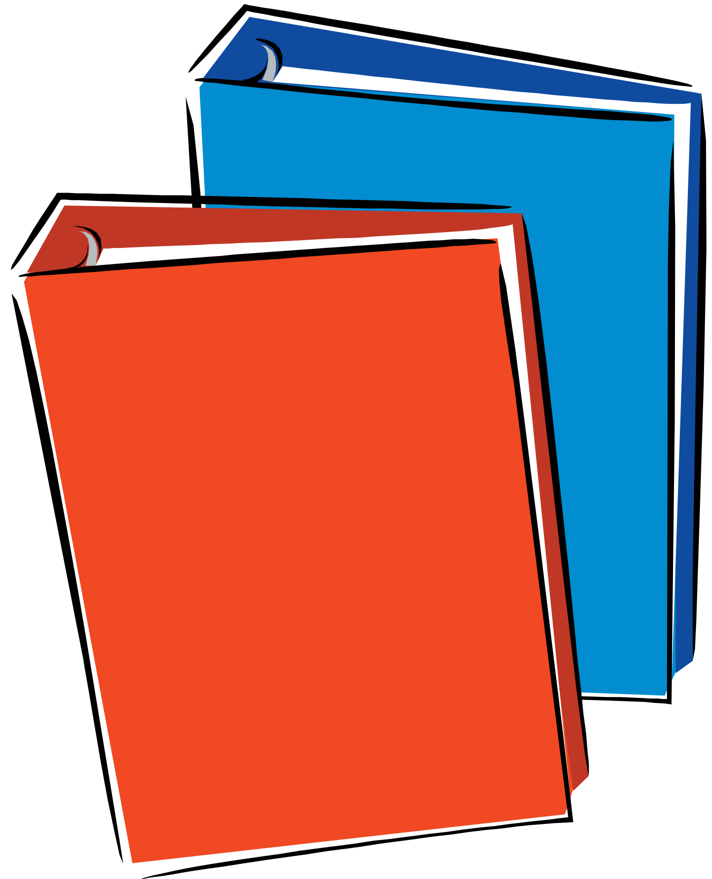
The Centers for Medicare and Medicaid Services (CMS) developed the NCCI to promote national correct coding methodologies and control improper coding that leads to inappropriate payment in Part B claims. The coding policies developed are based on:

- coding conventions defined in the American Medical Association's (AMA) Current Procedural Terminology (CPT) manual,
- national and local policies and edits,
- coding guidelines developed by national societies,
- analysis of standard medical and surgical practice, and
- review of correct coding practice.

The NCCI edits identify pairs of services that normally should not be billed by the same physician, for the same patient, on the same day. The NCCI includes two types of edits: comprehensive/ component edits and mutually exclusive edits.

- **Comprehensive/Component edits** identify code pairs that should not be billed together because one service is a component of the other (bundled).
- **Mutually Exclusive edits** identify code pairs that, for clinical reasons, are unlikely to be performed on the same patient, on the same day. For example, a mutually exclusive edit might identify two different types of testing that yield equivalent results.

Previously, the NCCI edits have been available to physicians and other providers on a paid subscription basis, but they are now available to anyone with a personal computer. The **NCCI edits are updated quarterly** and are posted at *cms.hhs.gov/physicians/cciedits/default.asp*



Name	*Website*	*Product*	*Cost*	*Description*	*Phone Number*
Centers for Medicare & Medicaid Services	www.cms.hhs.gov/physicians/cciedits.com	National Correct Coding Initiative Edits – Version 11.1 for Physicians (Effective April 1, 2005 – June 30, 2005)	Free, but requires WinZip software	This web page is aimed at providing information to providers on Medicare's National CCI edits, but will not address specific CCI edits. Includes links to NCCI Policy Manual for Part B Medicare Carriers (Updated Oct. 1 2004), Medicare Claims Processing Manual (Sec. 20.9), NCCI frequently asked questions (FAQs), NCCI Edits Program Transmittals, and a resource on where to submit concerns in writing regarding specific CCI edits.	Toll-free (877) 267-2323
TrailBlazer Health Enterprises, LLC	www.trailblazerhealth.com	Select "Notices" from the top navigation bar then enter "CCI edits" in the search line.	Free	This web page alerts health care providers to changes in the CCI edits on a quarterly basis. It includes a series of articles directed to the specific provider type(s) affected by the changes.	1-800-553-6847
Ingenix	www.ingenixonline.com	CCI Updateable Data File (Item #2976)	$399.95	Review of procedures for correct coding: Identifies reasons for an unbundled code, an excluded code, and more. Explanation of official edits: why a code should not be billed with another. Provides timely (quarterly) updates.	1-800-INGENIX (464-3649)
Wasserman Medical Publishers, Ltd.	www.correctcoder.com	Correct Coder for Edits PC/Windows application ($159 quarterly), on-line Web based application ($59 quarterly subscription), book ($119).	Varies	Products created to simplify the use of CCI.	1-800-669-3337

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