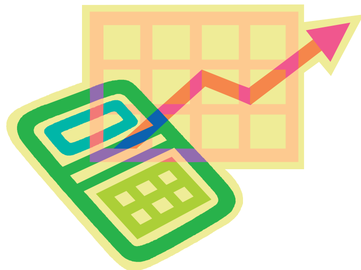

HEALTH CARE TECHNICAL UPDATE

Publisher: Medical Review **Issue No:** 1 **Date:** November 2005

IN THIS ISSUE: Top Ten Non-Network Questions

Page 1 Introduction to the New *Health Care Technical Update*
Page 1-2 Question 10: Preauthorization of Physical and Occupational Therapy Services
Page 2 Question 9: Timeframe for Requests for Reconsideration
Page 2-3 Question 8: After 95-Day Deadline, HCP Discovers Treatment Was for a Work-Related Injury
Page 3 Question 7: How to Count Days to Calculate Time Periods and Due Dates
Page 3 Question 6: Status of Approved Doctor List (ADL)
Page 3 Question 5: Insurance Carrier Payments to Address Block 33 of CMS-1500
Page 4 Question 4: Who Pays the IRO Fee for Resolving Medical Necessity Disputes
Page 4 Question 3: Status of the Medical Fee Guidelines
Page 4 Question 2: Status of Alternate Medical Dispute Resolution by Case Review Doctor Rule
Page 4 Question 1: New Requirements for Peer Review Doctors and Utilization Review Agents

Introduction to the New *Health Care Technical Update*

Greetings! A lot has happened since the last issue of the Medical Dispute Resolution (MDR) Newsletter. This summer the 79th legislature passed and Governor Rick Perry signed House Bill 7 (HB 7), which abolished the Texas Workers' Compensation Commission (TWCC) as of September 1, 2005. As a result, TWCC functions were merged with the Texas Department of Insurance (TDI) to form the new Division of Workers' Compensation (DWC).

The new *Health Care Technical Update (Update),* like its predecessor, the Medical Dispute Resolution (MDR) Newsletter, provides information to help reduce the number of medical disputes. In addition, the *Update* focuses on clarifying technical aspects of delivering health care to injured workers within the workers' compensation system in Texas.

This inaugural issue of the *Health Care Technical Update* uses a "Top Ten Questions" format to respond to the non-network related questions the DWC has most frequently received since the implementation of HB 7 on September 1, 2005. Please email any network questions you may have to WCnet@tdi.state.tx.us.

10. Which physical and occupational therapy services will require preauthorization before providing these services?

To implement portions of House Bill 7, the Commissioner of the Division of Workers' Compensation has adopted emergency amendments to rule 134.600 regarding preauthorization, concurrent review, and voluntary certification of health care. These amendments perform the following functions:

A) Substitute the term "Division" for "Commission"

B) Enable adoption of rules governing a treating doctor's examination to define the compensable injury, as required by Texas Labor Code section 408.0042(d)

C) Add specific physical and occupational therapy Healthcare Common Procedure Coding System (HCPCS) Level 1 codes to the list of non-emergency services requiring preauthorization

Any healthcare provider who uses the HCPCS codes outlined in the amended rule must obtain preauthorization before providing these services. Please note that initial evaluations and reevaluations are not included on the list of non-emergency services requiring preauthorization. In addition, any medical treatment that does not require preauthorization is subject to retrospective review for medical necessity by the insurance carrier.

The effective date for the emergency amendments to rule 134.600 is December 1, 2005. Therefore, physical and occupational therapy services provided on or after December 1, 2005, that meet the requirements of rule 134.600 will require preauthorization, even if the physical or occupational therapy services were initiated before December 1, 2005. The emergency amendments to rule 134.600 are posted on the Texas Department of Insurance, Division of Workers' Compensation website at www.tdi.state.tx.us/wc/rules/planning/preauth/dwcpreauthemergencyrule.pdf.

9. Is the timeframe for requesting reconsideration of a reduced or denied medical bill also 95 days from the date a carrier takes final action on a medical bill?

House Bill 7 created a change in medical billing requirements by establishing the deadline to submit a medical bill as 95 days after the date of service. This applies to medical services provided on or after September 1, 2005. A health care provider (HCP) who fails to meet this time line forfeits their right to reimbursement.

A request for reconsideration of a reduced or denied medical bill does not have a specific timeframe deadline. However, to be eligible for medical dispute resolution, reconsideration of a reduced or denied medical bill must be completed and form DWC-60 submitted within one year after the dates of service in dispute. The medical dispute resolution filing deadline is one year after the dates of service in dispute were provided.

Emergency rules relating to the 95-day medical billing requirement and other House Bill 7 requirements are posted on the Division of Workers' Compensation website at www.tdi.state.tx.us/wc/rules/planning/medbill/dwcproviderbillingemergencyrule.pdf and www.tdi.state.tx.us/wc/rules/planning/medbill/dwcauditsemergencyrule.pdf.

8. What is a health care provider's (HCP) recourse when a patient does not reveal that their treatment was for a workers' compensation injury until after the 95-day medical billing deadline has passed?

Section 413.042 of the Texas Workers' Compensation Act prohibits a HCP from pursuing a private claim against an injured worker. Therefore, a HCP cannot bill the injured worker or the injured worker's private health insurance for treatments related to a compensable injury.

A HCP, who after 95 days discovers that the medical treatments were related to an on-the-job injury, may file as a sub-claimant with the Division of Workers' Compensation (Division) local Field Office. Sub-claimant status allows the HCP to find out whether the Division or a court of law has finally adjudicated the on-the-job injury as non-compensable. According to Section 413.042(a)(1), "finally adjudicated" refers to a final, non-appealable decision issued by a benefit contested case hearing officer, the Appeals Panel, or a district court that the injury or a specific part of the injury is non-compensable.

If the on-the-job injury has been adjudicated as non-compensable or the treatments were administered to a part of the injured worker's body that is not part of the compensable injury, agency regulations do not prohibit the HCP from billing the injured worker or the injured worker's private health insurance. On the other hand, if the on-the-job injury is compensable, by law the HCP cannot bill the injured worker or their private insurance. This may leave the HCP with little recourse but to write off the charges.

To ensure correct and timely billing, it is essential that the health care provider's personnel who conduct the patient intake and registration process pointedly ask each patient if they have been injured on the job. Although this will not guarantee obtaining workers' compensation information from every patient, it will help in obtaining necessary information from those patients who assume the HCP knows they were injured on the job and from those patients who are waiting to be asked.

Emergency rules that include the 95-day medical billing requirement and other requirements from House Bill 7 are posted on the Texas Department of Insurance, Division of Workers' Compensation website at www.tdi.state.tx.us/wc/rules/planning/medbill/dwcproviderbillingemergencyrule.pdf and www.tdi.state.tx.us/wc/rules/planning/medbill/dwcauditsemergencyrule.pdf.

7. Since accurate counting of "days" is important for following workers' compensation laws and rules, how should we count days to accurately calculate time periods and due dates? Also, what date should we use if a due date falls on a non-working day?

Rule 102.3, Computation of Time, outlines how to calculate days to determine due dates and time periods. For your convenience, following is a brief paraphrase of rule 102.3.

A) What is a "day"? A "day" is a calendar day except when a rule specifies the term "working day" instead. A calendar day includes weekend days, holidays, and working days.

B) What is a "working day"? A working day is a weekday, Monday-Friday, with the following exceptions:

1) National holidays as defined by Texas Government Code §662.003(a)
2) The Friday after Thanksgiving
3) December 24th and December 26th
4) The days listed in 1) through 3) are not counted as working days.

C) How do we compute a period of days? To count a period of time measured by days:

1) Count by calendar days; that is, by including weekends, holidays, and working days.
2) Do not count the first day but do count the last day.

D) What date should we use when a due date or the last day of a time period falls on a non-working day? Unless otherwise specified, if the last day of any time period is not a working day, extend the time period to include the next day that is a working day.

Please consult rule 102.3 regarding computation of time for further requirements concerning counting days to accurately determine due dates and time periods.

6. Is the Approved Doctor List (ADL) going away?

House Bill 7 contains a provision that abolishes the ADL on September 1, 2007, unless the Commissioner of the Division of Workers' Compensation waives the ADL requirements before that date. Doctors providing treatment in workers' compensation networks certified by the Texas Department of Insurance under section 1305 of the Texas Insurance Code do not have to be on the ADL to provide treatment to injured workers.

5. Is it true that as of September 1, 2005, insurance carriers have to make payments directly to the health care provider (HCP) named in block 31 and not to the name and address in block 33 of the CMS-1500?

No, the above statement is not true. Rather, insurance carriers should continue to make payments to the HCP *or* the HCP's billing service, whichever is named in block 33 of the CMS-1500. For instructions on completing the CMS-1500 Health Insurance Claim Form, please consult form DWC-67.

As indicated on form DWC-67, the name of the HCP performing the treatment or service goes in block 31; the location where the health care was rendered goes in block 32; and the name and address of *either* the HCP *or the billing service for the HCP* goes in block 33 of the CMS-1500.

4. Who pays the Independent Review Organization (IRO) fee for the resolution of medical necessity disputes?

The insurance carrier (carrier) pays the IRO fee for medical necessity disputes filed by injured workers. Injured workers never pay IRO fees. Following are the two types of medical necessity disputes involving IRO fees:

A. ***Prospective medical necessity disputes:*** The carrier pays the IRO fee in prospective medical necessity disputes (disputes involving preauthorization and concurrent review), including those involving injured worker reimbursements.

B. ***Retrospective medical necessity disputes:*** The requestor (usually the health care provider) pays the IRO fee when they submit documentation to the IRO. However, when the requestor is the prevailing party in a dispute, the carrier may be ordered to reimburse the IRO fee to the requestor.

3. Did any of the fee guidelines change on September 1, 2005, as the result of House Bill 7?

No. Existing fee guidelines will continue as the adopted fee guidelines for out-of-network services until amendment of any pertinent rules. You may find the current fee guidelines in the following rules:

134.202 Medical Fee Guideline
134.303 2005 Dental Fee Guideline
134.401 Acute Care Inpatient Hospital Fee Guideline
134.402 Ambulatory Surgical Center Fee Guideline
134.503 [Pharmacy] Reimbursement Methodology

Please note that these rules may be amended in the future as a result of the legislative requirement that the Division of Workers' Compensation (Division) adopt Centers for Medicare and Medicaid System (CMS) reimbursement methodologies, models, and values or weights. For example, rule 134.401 regarding the acute care inpatient hospital fee guideline will be amended to align it with standardized CMS reimbursement structures. Further, the Division is required to review each fee guideline every two years, which could also result in amendment of the existing fee guidelines.

2. What is the status of the Alternate Medical Dispute Resolution (AMDR) by a Case Review Doctor rule?

The AMDR rule 133.309 addresses the concerns expressed by the Texas Legislature that the cost of standard medical dispute resolution acted as a barrier to fair resolution of low-dollar fee disputes. Section 413.031(m) of the Texas Labor Code allowed the agency to adopt rules to implement an alternate dispute resolution process for low-dollar retrospective medical necessity disputes.

Although the AMDR rule was adopted to be effective on October 1, 2004, Travis County District Court Judge Lowry issued a temporary restraining order to prevent implementation of the AMDR rule and District Court Judge Covington subsequently ruled that the AMDR rule is invalid. The Division is appealing that decision. During the appeal, low-dollar retrospective medical necessity disputes will continue to be processed through the existing dispute resolution process.

1. After September 1, 2005, can peer review doctors make retrospective medical necessity determinations?

Yes. Peer review doctors can still make retrospective medical necessity determinations. The most significant change to the peer review process is that peer reviewer doctors must now be licensed in Texas [§408.0231(g)].

Note: In contrast to the above requirements for peer review doctors, utilization review agents (preauthorization companies) may use a doctor licensed in another state to perform reviews if these reviews are performed under the direction of a doctor licensed in Texas [408.023 (h)].

Publication produced by the TDI-DWC, Medical Review, 7551 Metro Center Drive, Suite 100, Austin, TX 78744-1609; (512) 804-4800. This update is for educational purposes only and is not a substitute for the statute and Division rules. (11/05)