Medical Dispute Resolution Newsletter

Publisher: Medical Review Division **Issue No:** 3 **Date:** January 2005

IN THIS ISSUE

Cite the Source when Responding to a Medical Dispute

When supporting the billing or denial of charges in dispute on a Medicare policy or a National Correct Coding Initiative (NCCI) edit, the health care provider or insurance carrier should state the national or local Medicare policy or NCCI edit in effect on the date of service that supports their position in the dispute. For example, when responding to a fee dispute involving a "bundled" surgery code, the insurance carrier should clearly state which CPT code(s) is a component code and the specific comprehensive or greater CPT procedure code where the component code has been bundled

A complete medical bill requires a health care provider (HCP) to bill using correct billing codes from Commission fee guidelines that are in effect on the date(s) services are provided, unless the bill is a request for reimbursement by a person other than a HCP. For coding, billing, reporting, and reimbursement of professional medical services, the Texas Workers' Compensation system requires use of the Medicare program reimbursement methodologies, models, and values or weights in effect on the date a service is provided. To correctly bill and collect for services provided, a HCP should consider any Medicare policy or NCCI edit that affects the treatment or service provided. HCPs should expect that NCCI edits shall be applied when bills are submitted, processed, and reviewed.

If a HCP is not satisfied with the carrier's final action on a medical bill, they may request the carrier to reconsider their action. The HCP should provide a claim-specific, substantive explanation that enables the insurance carrier to understand their position and rebuts the carrier's reason for its action as indicated on the explanation of benefits. A generic statement that simply states a conclusion such as "insurance carrier improperly reduced the bill" or other similar phrases with no further description of the factual basis for the HCP's position, does not satisfy this requirement.

The carrier must conduct a series of retrospective examinations on a bill submitted by the HCP that are in compliance with the fee guidelines established by the Commission, such as the Medical Fee Guideline. Additionally, the explanation of benefits must include the correct payment exception codes required by the Commission and provide a sufficient explanation that allows the sender to understand the reason(s) for the carrier's action(s). Generic statements, such as "not sufficiently documented" or other similar phrases with no further description of the reason for the reduction or denial of payment, does not meet this requirement. To prevent miscommunication or a misunderstanding as to why charges are billed or denied, the HCP and/or insurance carrier should clearly state why the charges are billed or denied in a particular manner.

A **clear statement of the policy** being used by the HCP or carrier to support the billing for or the denial of charges improves the communication between all parties involved in resolving the dispute. In order to timely and accurately resolve disputes, the Commission's medical dispute resolution staff should be provided with the payment policy used by either party to the dispute in explaining their position in the dispute.

Release of Medical Information

In an effort to remain compliant with the Health Insurance Portability and Accountability Act (HIPAA), Health Care Providers (HCPs) continue to express concerns and have questions about releasing protected health information (1) when submitting bills and requests for medical dispute resolution, and (2) in connection with the TWCC-73 Work Status Report to the employer. The following information may be helpful to HCPs and other system participants with similar questions.

HIPAA permits health care providers who treat injured workers and are "covered entities" to disclose protected health information (PHI) to workers' compensation insurers, State administrators, employers

or *other* persons or entities involved in the workers' compensation system without the individual's authorization:

- As authorized and to the extent necessary to comply with laws relating to workers' compensation or similar programs established by law that provide benefits for work-related injuries or illness without regard to fault. 45 C.F.R. §164.512(l).
- To the extent state or other law requires disclosure. The disclosure must comply with and be limited to what the law requires. 45 C.F.R. §164.512(a).
- For purposes of obtaining payment for any health care provided to an injured or ill worker. 45 C.F.R. §164.502(a)(1)(ii).

Billing. In addition to 45 C.F.R §164.502(a)(1)(ii), Texas state law specifically authorizes a HCP to release PHI for the purposes of billing. Section 408.025 (d) of the Texas Workers' Compensation Act states, "A health care provider may disclose to the insurance carrier of an affected employer records relating to the diagnosis or treatment of the injured worker without the authorization of the injured worker to determine the amount of payment or the entitlement to payment." TWCC encourages HCPs to provide the necessary PHI information with their bills to prevent incorrect coding and billing, improper reimbursement, and unnecessary disputes.

Medical Dispute Resolution. HCPs are permitted to disclose PHI for the purpose of medical dispute resolution because such disclosure is required by TWCC rule. Pursuant to Texas Labor Code §408.025, system participants are required to disclose to the Commission an injured worker's PHI that is necessary to process or adjudicate claims, or to coordinate care under the workers' compensation system.

TWCC-73 Work Status Report. A work status report is required at certain times pursuant to Rules 126.6(f), 129.5 and 130.110. The TWCC-73 provides limited, but generally sufficient, medical information from the doctor to the employer in a manner that will assist doctors and employers in complying with the various laws concerning release of information, while protecting the injured worker's medical privacy. The TWCC-73 is designed to provide work status and activity restrictions (Parts II and III), prescription medication information (block 20), high-level diagnosis information (block 21), and expected future medical care information (block 22) in a manner that is suitable with both HIPPA and OSHA requirements.

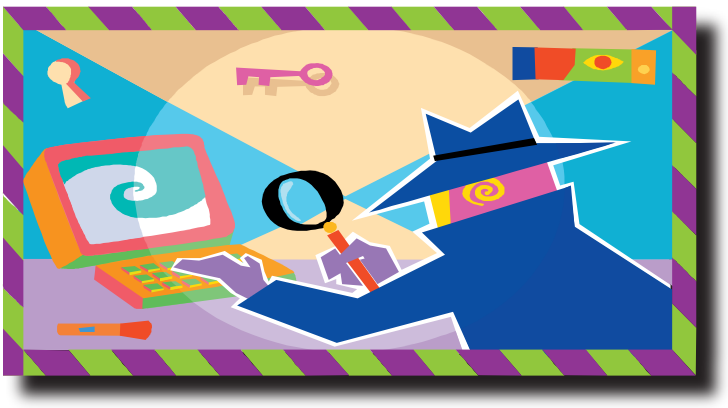
Work Assignments. An employer is responsible for making appropriate employment decisions and work assignments for their employees and for paying their employees correctly. The employer is entitled to work restrictions that impact the ability to perform certain duties safely and time and attendance information that may affect the injured workers' pay. Examples of this information include lifting restrictions, prescription medication that would impair the ability of the worker to operate machinery, and time away from work for medical appointments.

OSHA Compliance. Pursuant to 45 C.F.R §164.512(b)(v), HIPAA permits a HCP to disclose an injured worker's PHI to his or her employer so the employer can comply with it's obligations under OSHA if the HCP provides the injured worker with written notice of the disclosure.

The employer needs limited medical information that will allow the employer to comply with federal (OSHA) and state requirements concerning reporting work-related injuries. According to 29 C.F.R. §1904, employers are required to record work-related injuries or illnesses on the OSHA form 301, Injury and Illness Report, that result in one or more of the following: death, days absent from work, restricted work duties or transfer to another job, medical treatment beyond first aid, loss of consciousness, or diagnosis of a significant injury/illness by a physician or other licensed health care professional. For example, the employer does not need to know what medication was prescribed, but "yes" a prescription was written as the result of the work-related injury or illness as indicated in block 20 of the TWCC-73.

TWCC Privacy Provisions. The Texas Workers' Compensation Act requires the Commission to maintain the confidentiality of an injured worker's claim file, including information that could be used to identify an injured worker, with certain exceptions. See Texas Labor Code §§402.083-402.085, 402.092, and 411.034. The Commission is committed to protecting each injured worker's medical privacy.

For more information concerning HIPAA and the disclosure of workers' compensation information, please see Advisory 2003-05, Clarification on the HIPAA Privacy Rule and Disclosures to the Texas Workers' Compensation Commission, effective May 6, 2003.



Preauthorization Time Line

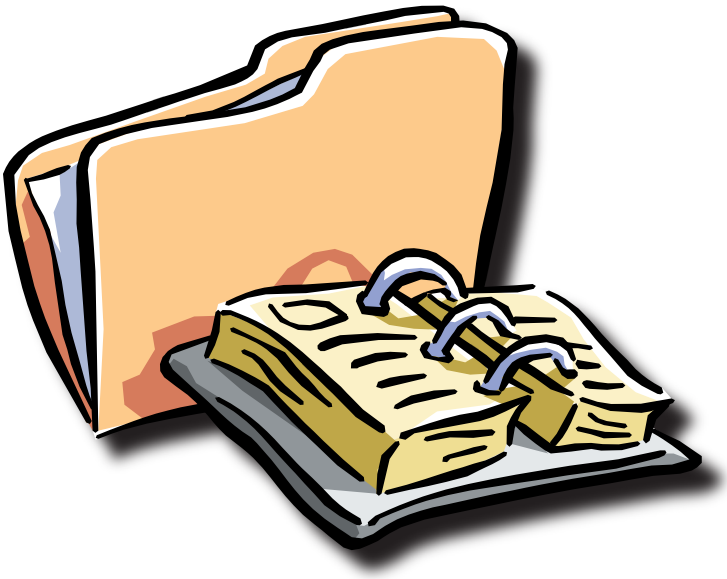
Medical dispute resolution requests related to preauthorization can be dismissed by the Texas Workers' Compensation Commission (the Commission) without action if the requestor (health care provider or designated representative, including office staff or a referral health care provider/health care facility) or injured worker does not follow the established time lines for disputes and reconsideration requests as stated in Rule 134.600, Preauthorization, Concurrent Review, and Voluntary Certification of Health Care and Rule 133.308, Medical Dispute Resolution by Independent Review Organizations.

If a preauthorization request is denied by the insurance carrier, the requestor or injured worker may request reconsideration of the denied health care within **15 working days** of receipt of a written denial.

If the request for reconsideration is denied in writing, the requestor or injured worker may appeal the denial by filing a dispute with the Commission using the TWCC-60, Medical Dispute Resolution Request/ Response form.

A prospective medical necessity (preauthorization) dispute resolution request is considered timely if the TWCC-60 form is filed with the Commission no later than the **45th calendar day after the date the carrier denied approval of the party's request for reconsideration** of the denied health care requiring preauthorization or concurrent review. Failure to timely file the dispute resolution request (TWCC-60) will result in dismissal of the request.

If a carrier does not respond to a health care providers' (HCP) request for reconsideration, the HCP may submit the reconsideration request to the Commission for a prospective medical dispute resolution.



How Liability, Compensability, and Extent Claim-Related Disputes Affect an MDR Dispute

Some health care providers (HCP) are unclear on the claim-related issues of liability, compensability, or extent (relatedness) of a work-related injury and how they affect a pending medical dispute. An insurance carrier (carrier) may deny a claim based on liability, compensability, or extent of injury. These claim-related dispute issues are rooted in establishing whether an injury or treatment of the injury is truly related to work.

A dispute arising from medical treatment provided for an alleged work-related injury cannot be processed by medical dispute resolution (MDR) until the claim-related issues of liability, compensability, and extent are resolved by final adjudication through the local Commission field office. Simply stated, all issues of liability, compensability, and extent must be resolved first. Then, and only then, can a medical dispute resolution be processed. However, a person or entity that fails to timely file a medical dispute resolution request waives their right to MDR. A request for MDR on a carrier denial or reduction of a medical bill is considered timely if it is filed with the Commission no later than one (1) year after the date(s) of service in dispute.

To help clarify the differences between liability, compensability, and extent, following is a definition for each of these terms.

Liability (Section 406.031) is defined, in part, as "an insurance carrier is liable for compensation for an employee's injury without regard to fault or negligence . . . and the injury arises out of and in the course and scope of employment."

Compensability (Section 401.011(10)) refers to "an injury that arises out of and in the course and scope of employment for which compensation is payable under" the Texas Workers' Compensation Act.

Extent (relatedness) arises out of an established compensable claim for a work-related injury where the claim-related dispute concerns whether a body part or prescribed/provided treatment is related to the compensable claim.

Most often, these claim-related dispute issues, liability, compensability, and extent, are related, but raised independent of each other. Liability must be established first, and only then can compensability be considered. Extent stems from a dispute over the relatedness of the work-related injury to what has already been established as a compensable injury. In most cases, compensability issues that are raised are based largely on extent.

The preauthorization Rule 134.600(f)(5)(C), retrospective medical necessity Rule 133.308(f)(7), and fee dispute Rule 133.307(e)(2)(D) require medical disputes to be temporarily held until final adjudication of the extent issue has been determined. As a result, the MDR department has implemented a new process to assist requestors with successful completion of their dispute. All MDR files are closely reviewed to determine if the carrier has raised extent issues. Previously, upon determination of the existence of an extent dispute, the only notification requestors received was an automated (medical review) MR-106 letter explaining that a liability, compensability, or extent of injury dispute was raised by the carrier and notified the parties that the medical dispute was being held until the liability, compensability, or extent of injury issue was resolved. Currently, MDR staff contacts the affected parties to the claim-related dispute to explain the process. As the extent issue must be resolved through the local Commission field offices' claim-related dispute resolution process, requestors are asked to file a TWCC-45 to request a Benefit Review Conference (BRC). MDR staff will explain to a health care provider how to file as a sub-claimant to the claim-related dispute. For details on filing as a sub-claimant to a claim-related dispute, please refer to the MDR vs. Claim-Related Dispute Resolution article on page 3 of this newsletter.

Injured workers are not required to file a TWCC-45, but must contact their local Commission field office to request a BRC to be set on the extent issue. The extent issue may be adjudicated by an agreement at the BRC, by decision of the Hearing Officer at the Contested Case Hearing, or by the Appeals Panel. In any of these cases, MDR staff will monitor the claim-related dispute to assist the requestor with the resolution of the medical bill once the extent issue is finally adjudicated.

Questions regarding this new process may be directed to the MDR help line at 512-804-4812.

MDR vs. Claim-Related Dispute Resolution

A health care provider (HCP) participating in the Texas workers' compensation system may be involved in either a medical dispute (as a party to the dispute) or in a claim-related dispute (as a sub-claimant). In a typical medical dispute, the HCP and insurance carrier are the opposing parties. In most claim-related disputes (indemnity), the injured worker and insurance carrier are the opposing parties, and the HCP may choose to be a sub-claimant. **NOTE**: Unless the HCP requests sub-claimant status, they are **NOT** a party to a claim-related dispute and the Commission cannot provide the HCP with information concerning any claim-related dispute.

The two major types of disputes handled through the Commission's Medical Review Division are fee and medical necessity disputes. These disputes may be initiated by filing a TWCC-60, Medical Dispute Resolution Request/Response form.

Fee Disputes: The Commission reviews medical fee disputes, other than those involving refund orders issued by the Division of Compliance and Practices. Medical fee disputes involve the amount of payment for health care treatment/services that have already been provided to an injured worker and determined to be medically necessary. Regardless of the prevailing party, medical fee disputes may be subject to a dispute-processing fee by the Commission ***if*** the health care services are not billed and/or audited in a manner that is consistent with the law and rules. Please refer to the December 2004, issue of the *MDR Newsletter* for more information on processing fees charged for the resolution of a fee dispute at http://www.tdi.state.tx.us/wc/dwc/divisions/mdr/04-12mdrnews.pdf.

Medical Necessity Disputes: Medical necessity disputes, other than those involving refund orders issued by the Division of Compliance and Practices, are statutorily required to be reviewed by an Independent Review Organizations (IRO). Medical necessity disputes (except refund order disputes) reviewed by an IRO are subject to an IRO fee. The assessment of IRO fees is based on the Texas Department of Insurance's (TDI) two-tiered fee structure as established in TDI Rule 12.403. The Tier 1 IRO fee is $650 for disputes reviewed by a medical doctor (M.D.) or a doctor of osteopathic medicine (D.O.), while the Tier 2 IRO fee is $460 for disputes reviewed by a medical professional other than an M.D. or a D.O.

Request Form: A Medical Dispute Resolution (MDR) is initiated by filing the TWCC-60 form, "Medical Dispute Resolution Request/Response," including the "Table of Disputed Services" which must include complete details of the charges and issue(s) in dispute.

Several resources available on the Commission's website, www.tdi.state.tx.us, to assist HCPs in 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 health care providers. http://www.tdi.state.tx.us/wc/dwc/divisions/mdrchecklisthcp.html

Claim-related disputes are handled at the Commission's local field office through the Commission's internal claim-related dispute resolution process, and may lead

to a more formal proceeding. Claim-related disputes, such as those involving compensability, extent of injury, or the carrier's liability for the claim, may directly affect the HCP as an insurance carrier may not pay medical bills for the claim in dispute.

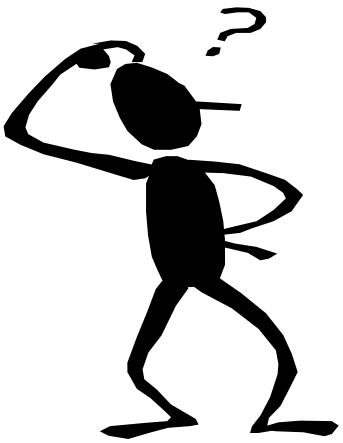
A HCP is prohibited from billing an injured worker or pursuing a private claim against an injured worker or an injured worker's private or group health insurance for charges on outstanding bills that have resulted from the dispute unless the Commission has finally adjudicated the injury as non-compensable.

The HCP may file as a sub-claimant by advising the local Commission field office in writing that they wish to become a sub-claimant to the claim. Once established as a sub-claimant, to resolve a claim-related dispute, the HCP must file a TWCC-45 to request a Benefit Review Conference (BRC). On the TWCC-45, the HCP must explain that they have outstanding charges and want the Commission to determine if the injured worker or carrier is responsible for paying for the health care rendered. The injured worker is in the best position to provide information to resolve a claim-related dispute, however, the HCP may do so as well.

In addition to disputes involving compensability, extent of injury, or the carrier's liability for the claim, there are other disputes that may affect the HCP which are also handled at the local Commission field office. These disputes include disputes of maximum medical improvement and/or impairment rating, designated doctor opinion, date of injury and/or notification of injury, supplemental income benefits (SIBS), and lifetime income benefits (LIBS).

An extensive discussion of medical fee and necessity disputes, claim-related disputes, and other disputes that may affect a HCP is located in Chapter 6 of the Approved Doctor List (ADL) level 2 Training Module at http://www.tdi.state.tx.us/wc/adltraining/adl-info.html.

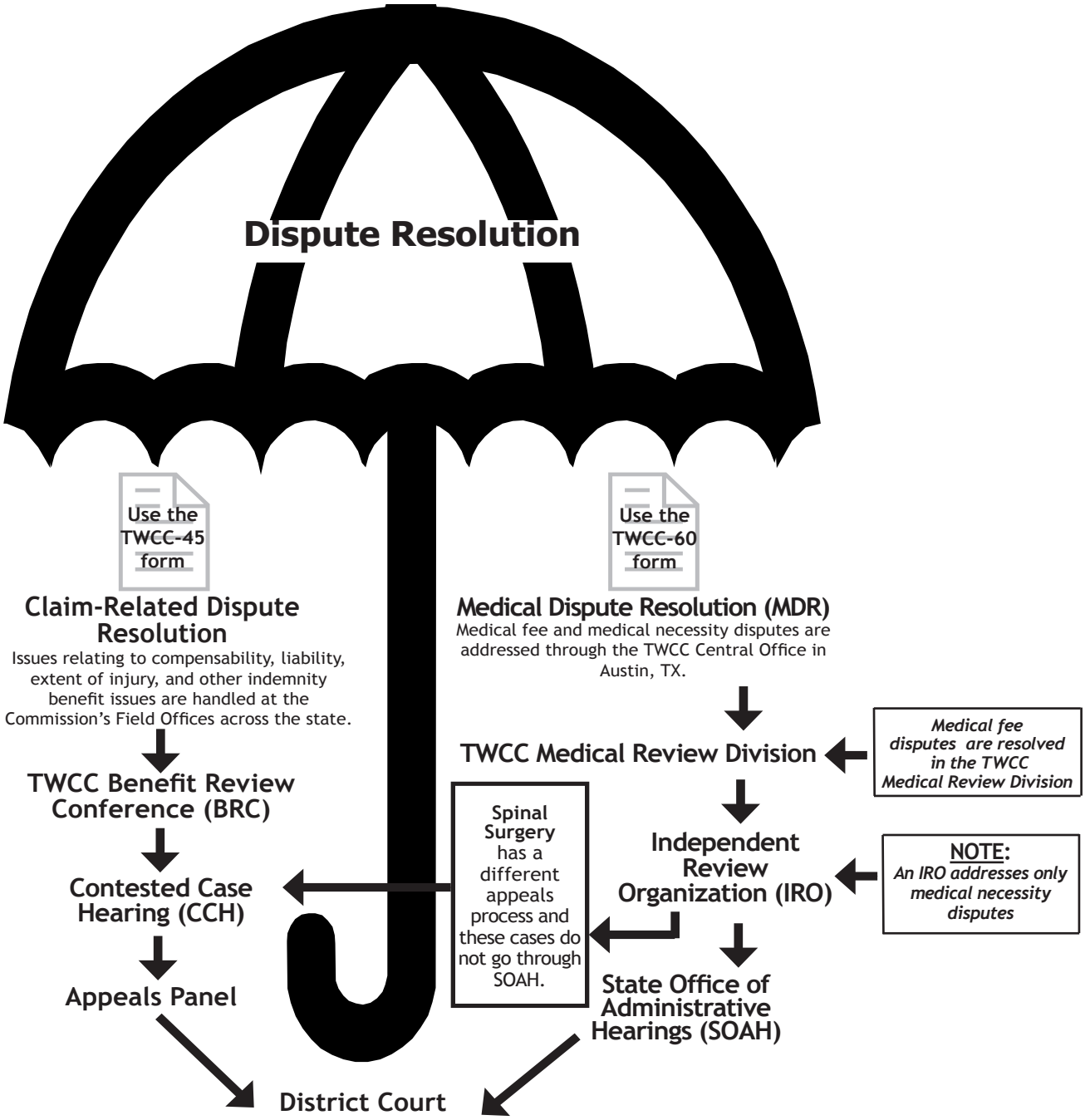
Please see an illustration of the Medical Dispute Resolution versus Claim-Related Dispute Resolution processes on page 6.



Test your Trivia Knowledge: When a health care provider (HCP) recommends medical treatment for an injured worker that does not require preauthorization, but the insurance carrier's peer review doctor states that no future medical care is necessary, what is the process to resolve the difference of medical opinions?

The Commission adopted rule 134.650, Prospective Review of Medical Care Not Requiring Preauthorization (PRM) that became effective on October 1, 2004. The PRM rule is designed to address situations where preauthorization is not required on the proposed medical care, but the HCP and carrier have reached an impasse on the injured worker's medical care. A PRM examination is performed by a PRM doctor. The PRM examination is intended to provide an unbiased opinion regarding whether the proposed treatment is medically necessary, and if at issue, whether the medical condition to be treated is causally related to the compensable injury. For additional information on this rule, please see the PRM FAST FACTS at http://www.tdi.state.tx.us/wc/forms/index.html or contact your local Commission field office for more information.

Medical Dispute Resolution (MDR) vs. Claim-Related Dispute Resolution



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. **(01/05)**