Medical Dispute Resolution Newsletter

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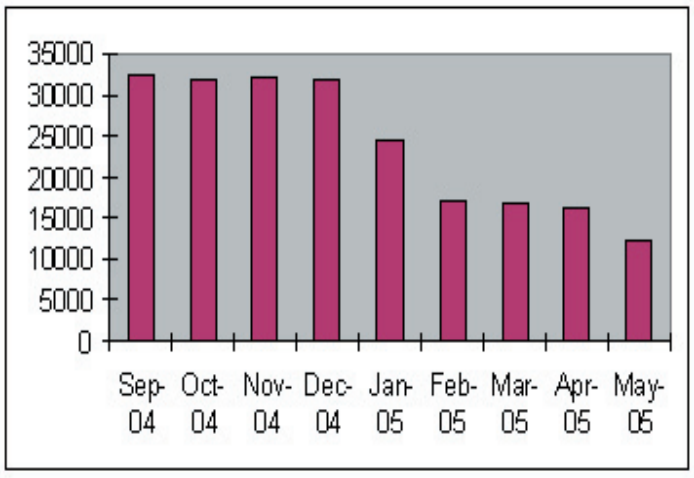
UPDATE: MDR Process Continues to Improve

Newly implemented changes and open dialogue in the Medical Dispute Resolution (MDR) process have produced significant increases in the resolution of MDR disputes resulting in a tremendous decrease in pending disputes. The recent success has been due to the proactive monitoring of MDR processes and initiating low-level dispute resolution through open dialogue with the injured workers, health care providers, and insurance carriers.

Texas workers' compensation system stakeholders have taken notice of the improved MDR processes and the reduction in pending disputes. Ron Nesbitt, a Dispute Analyst with Texas Mutual Insurance Company comments that, "The Low-Level Medical Dispute Resolution Process represents an innovative method for resolving disputes. The process is both efficient and cost-effective. . . a good example of what is right with the workers' compensation system in Texas." In addition, Mary Shields, Collections Manager with PRIDE, a health care provider, speaks of the, "Outstanding performance of the Medical Dispute Lower Level Resolution Team…saving cost to the carrier, provider, and the MDR system."

The number of pending disputes has decreased from 32,234 in September 2004 to 12,148 in May 2005. The following chart reflects the decrease in pending disputes.

Number of pending medical disputes Sept2004–May2005



Closely monitoring and grouping disputes by health care provider has revealed data that produces consistent decisions, facilitates the processing of large volumes of disputes, and identifies specific areas where educational efforts can be directed. With MDR's continued educational efforts and the active participation of our customers, we can continue to improve the MDR process and reduce response and resolution time to requests and inquiries.

We welcome the opportunity to speak to and work with our customers and encourage any and all comments, questions, and suggestions to be directed to MDR's Customer Relations Representatives at 512-804-4812. MDR representatives answer this line from 8:00 a.m. to 5:00 p.m., Monday through Friday.

MDR UPDATE!

Change of Treating Doctor and Certification of MMI

The filing of a TWCC-69, Report of Medical Evaluation, may terminate the injured worker's entitlement to temporary income benefits (TIB's), and also may establish entitlement to impairment income benefits and/or supplemental income benefits.

A TWCC-69 is filed when an injured worker reaches maximum medical improvement (MMI). MMI is the earlier of:

(A) the point in time when the injured worker's work-related injury or illness has improved as much as it is going to improve;

(B) 104 weeks from the date the injured worker became eligible to receive temporary income benefits; or

(C) the date determined by the Commission based on an extension of statutory MMI, as explained above in (B).

Some treating doctors are incorrectly certifying MMI and assigning an impairment rating following receipt of an approved TWCC-53, Request for Change of Treating Doctor, from the Commission. When a treating doctor receives written notice from the Commission that the injured worker is approved to change treating doctors, the previous treating doctor is required to send the injured worker's medical records to the new treating doctor. This is the only action that is required by the previous treating doctor. **The previous treating doctor should NOT certify MMI simply because they have received written notice that the Commission has approved a new treating doctor for the injured worker.**

Who Pays the Fee for an IRO Review of Medical Necessity?

Preauthorization Disputes

In preauthorization medical necessity disputes, the carrier always pays for the Independent Review Organization (IRO) fee regardless of what the outcome of the prospective review is or who requested the IRO review. The health care provider (HCP) does not reimburse the IRO fee to the carrier even if the IRO determines that the requested services are not medically necessary. If the carrier does not pay the IRO fee, the carrier will be referred to Compliance and Practices for possible enforcement action.

Retrospective Medical Necessity Disputes

In retrospective medical necessity disputes where the requestor is a HCP, the requestor pays the IRO fee prior to the IRO review. If the requestor does not pay the IRO fee, the requestor will be referred to Compliance and Practices for possible enforcement action. If the IRO determines that the services in dispute were medically necessary, the Texas Workers' Compensation Commission (Commission) will order the carrier to pay for the services in dispute and refund the IRO fee to the requestor/HCP. If the IRO determines that the services in dispute were NOT medically necessary, the Commission will not issue an order to refund the IRO fee to the HCP. In addition, the Commission will not order for payment of the disputed services.

If the retrospective medical necessity dispute is appealed to the State Office of Administrative Hearings (SOAH) and SOAH upholds the IRO decision in the requestor's favor, the carrier is liable for payment of the disputed services. If SOAH overturns the IRO decision in favor of the carrier, the Commission then orders the requestor to refund the IRO fee to the carrier. In addition, the carrier is not liable for payment of the services in dispute.

In summary, in preauthorization medical necessity disputes, the carrier always pays the IRO fee. In retrospective medical necessity disputes, the requestor of the dispute pays the IRO fee up front. Following the IRO decision, responsibility for paying the IRO fee falls upon the non-prevailing party. The same is true following SOAH decisions. Any party who fails to pay the IRO fee when the fee is due will be referred to Compliance and Practices for possible enforcement action.

Case Management: Coordination of Return to Work

Coordination of return to work is comprised of team conferences or phone calls that serve to provide information regarding the capabilities and restrictions of the injured worker so that the employer may make appropriate employment decisions. The health care provider (HCP) is not expected to make employment decisions for the employer.

For example, a doctor prescribes a medication that may make the injured worker taking the medication sensitive to prolonged or excessive exposure to direct and/or artificial sunlight. The medication does not cause any additional restrictions of the injured worker's capability to perform tasks in their job description that do not involve prolonged or excessive exposure to direct and/or artificial sunlight. With this information, the employer can make appropriate work assignments for the injured worker that allows them to stay at work or return to work.

HCPs are allowed to bill and be reimbursed for team conferences and phone calls when coordinating return to work. The Medical Fee Guideline, Rule 134.202 (e)(5), describes the conditions under which these services may be billed and reimbursed. The return to work coordination must be with an interdisciplinary team. This team can include the employee, employer, and/or an assigned medical or vocational case manager. **The return to work coordination shall not be with employees of the coordinating HCP and must be outside of an interdisciplinary program, such as work hardening or work conditioning.**

Updated ANSI Reason Code Document

On June 3, 2005, the Texas Workers' Compensation Commission (TWCC) Medical Review Division updated and posted the TWCC ANSI Claim Adjustment Reason Code document containing direction on the use of the American National Standards Institute (ANSI) Claim Adjustment Reason Codes (reason codes). The ANSI reason codes are currently required for reporting on the TWCC-62, Explanation of Benefits (EOB) and in medical electronic data interchange (EDI) reporting.

The ANSI reason codes containing updated TWCC direction are highlighted in yellow. In addition, a column titled TWCC Statute (Law) and/or Rule has been added. This column is intended to assist stakeholders in identifying the potential law and rules that may apply to the various reason codes. **The law and rule citations provided are not an all-inclusive list.** There may be additional laws and rules that apply to each specific situation.

The ANSI reason code document is dynamic in nature and is intended to provide some guidance for the transition from the use of Payment Exception Codes (PEC) to the ANSI Claim Adjustment Reason Codes for bill processing and medical billing and payment data submission purposes. The updated document is posted on the TWCC website at http://www.tdi.state.tx.us/wc/thedivision.html under "What's New" and under "About the Commission" and "Medical Review." At the request of stakeholders, this document has been posted in Excel format to allow for sorting the data to meet stakeholder's business needs.

The updated ANSI reason code document is available for immediate use. TWCC will continue to monitor and make periodic updates to this document. Please direct any questions to the Medical Review Division at (512)-804-4812. This line is answered from 8 a.m. to 5 p.m., Monday through Friday.

ASC List of Medicare Approved Procedures

The Texas Workers' Compensation Commission (Commission) utilizes Medicare program reimbursement methodologies, models, and values or weights for coding, billing, and reporting payment policies in effect on the date a service is provided. As the Centers for Medicare & Medicaid Services (CMS) revises a component of the Medicare program, such as the ambulatory surgical center (ASC) list of Medicare approved procedures, the Commission shall require use of the revised list on the same effective date.

The CMS has proposed a rule that expands the number of procedures covered when furnished in an ASC. The proposed rule adds 67 procedures to the ASC list of Medicare approved procedures and deletes five from the existing list. The proposed rule was published in the *Federal Register on* May 4, 2005, and will become effective July 5, 2005. To view the proposed rule in its entirety, go to http://www.cms.hhs.gov/suppliers/asc/1478_42805.pdf.

The CMS is required to update the ASC list of Medicare approved procedures every two years. At this time, the CMS will be accepting comments on the proposed rule until July 5, 2005. If necessary, the CMS will publish a final rule responding to any comments at a later time.

Once the proposed ASC rule is adopted by the CMS, the changes will also be effective in the Texas workers' compensation system in accordance with Rule 134.402, Ambulatory Surgical Center Fee Guideline. In addition, the adopted changes should also be updated in the TrailBlazer Health ASC training manual, which may be accessed at http://www.trailblazerhealth.com/partb/tx/books.asp. The date the TrailBlazer training manuals are updated is indicated to the right of the manual under the "updated" title heading.

For more information on the changes to the ASC list of Medicare approved procedures or the CMS rule process, go to http://www.cms.hhs.gov/suppliers/asc.

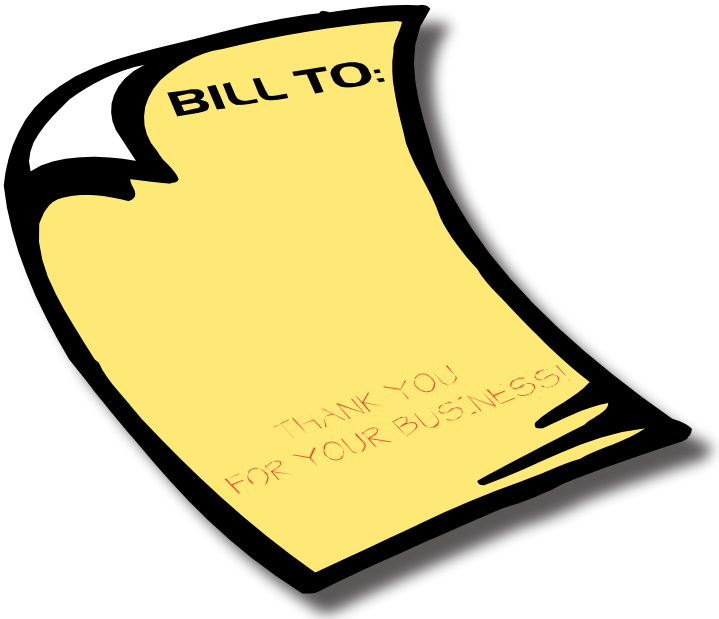
Billing for an IR when the Injured Worker is not at Clinical or Statutory MMI

ATTENTION DESIGNATED DOCTORS AND REFERRAL DOCTORS

If an injured worker is not at maximum medical improvement (MMI), do not assign an impairment rating (IR). In accordance with Rule 130.1 (c)(2), a doctor who certifies that an injured worker has reached MMI shall assign an impairment rating for the current, compensable injury using the rating criteria contained in the appropriate edition of the American Medical Association Guides to the Evaluation of Permanent Impairment. Rule 130.1, Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment, sets MMI as a prerequisite for assigning an IR.

Oftentimes, doctors indicate an injured worker has not reached MMI but assign an IR**. If an injured worker has not reached MMI, an IR should not be assigned.** The Medical Fee Guideline, Rule 134.202 (e)(6)(B)(i), states that if an examining (impairment rating) doctor, other than the treating doctor, determines MMI has not been reached; the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with subparagraph (C). Modifier "NM" should be billed with the CPT code to indicate the injured worker is not at MMI.

Unnecessary impairment ratings should not be conducted by the evaluator, billed by the evaluator, or reimbursed by the carrier. In addition, there is no seperate reimbursement for the TWCC-69.



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