ADVISORY NO. 366
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TOPIC: 2002 MEDICAL FEE GUIDELINES AND MEDICARE

TWCC adopted a new *Medical Fee Guideline (MFG)* in 2002. Rule 134.202. This became effective on September 1, 2003. The New *MFG* adopts the Centers for Medicare and Medicaid Services (CMS formerly HCFA) payment policies with some exceptions.

General Rule:

As a general rule, for services covered under the *MFG*, carriers should follow Medicare payment policies. The *MFG* does not apply to prescription drugs, hospitals, and/or ambulatory surgical centers. With respect to the medical services covered under the *MFG*, there are four separate issues: Bundling, Efficacy, Utilization and Coverage. This advisory addresses them separately. Furthermore, specific provisions in the Workers' Compensation Act take precedence over any conflicting provision utilized by Medicare. 134.202(a)(4). The operative word in the rule is the word "specific." To the extent the Act or the rules clearly require payment for specific services, then payment is due and should not be contested because the Medicare policy handles it differently.

Bundling:

Medicare payment policies prohibit unbundling of charges. Some of the separate charges that we may see are improperly unbundled. The most frequent example is cold packs. Those are included as a part of the physician office services. If Medicare treats this as an unbundled charge, the service will be separately identified as a "B" status code. These codes are always bundled into payment for other services. These are not medical necessity issues; these are bundling or fee issues and are denied for that reason. These should rarely result in dispute resolution. When denying this charge, use payment code "G" and "Y."

Efficacy:

Medicare will identify certain treatments that are not medically effective. For those services, carriers should deny payment as an unnecessary treatment. An example of a treatment determined by Medicare to be medically ineffective is phonophoresis. LMRP *Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal Diseases and or Injuries*, Y-13B-R5. When denying phonophoresis or any other service deemed by Medicare to be medically ineffective, use payment exception code "Y" along with "U" or "V." (Note that the instructions for using the "Y" denial code require its use along with another code. In other words, CMS policies do not stand alone. Medical necessity is the ultimate standard).

Utilization:

Although there is no longer a TWCC treatment guideline, and although Rule 134.202 adopts a *fee* guideline, contained within the Medicare payment policies are protocols that restrict

the number of treatments that may be provided for selected illness.

For example, CMS prescribes utilization guidelines for certain CPT codes involving passive therapy. For the first four weeks, Medicare pays for a maximum of sixteen sessions, and for the second four weeks, after updating a treatment plan, it prescribes a maximum of twelve sessions. LMRP *Physical Medicine and Rehabilitation for Orthopedic and Musculoskeletal Diseases and or Injuries*, Y-13B-R5. Depending on the severity of the patient's condition, the usual treatment session is 30 - 45 minutes. Y-13B-R5. For a range of diagnosis codes involving neurological injuries, a usual session would not exceed two hours LMRP *Physical Medicine and Rehabilitation for Neurologic Injury* – Y-148-R5.

The policies noted: "claims that indicate therapy has exceeded eight weeks will be reviewed with specific attention to clinical justification and medical necessity of the procedures ordered by the attending physician." Accordingly, Medicare may pay for more than eight weeks of PT, but only if medical necessity was documented. Medicare recognizes that further treatment may be appropriate, but in most cases, it should be self-directed:

> It is expected that patients undergoing rehabilitation therapy for musculoskeletal injuries in the absence of neurologic compromise will transition to self-directed physical therapy within two months. The contractor recognizes variability in strength, recovery time, and the ability to be educated, and allows for a recertification for additional therapy, as long as adequate medical documentation by the supervising physician is recorded in the medical record and the patient continues to demonstrate progress. It is expected that at the two-month interval those patients undergoing will be transitioned to fully self-directed care modalities directed towards mobilization and strengthening. Only the more refractory cases requiring additional therapy are expected to continue beyond this point and additional documentation of necessity and medical certification by the supervising physician is required.

Y-13B-R5.

Accordingly, this is an example of a policy that effectively constitutes a Medicare treatment guideline. Like any guideline, it is a guide only. It does not mean that Medicare would not pay more when documented. Likewise, the TWCC Medical Fee Guideline recognizes that exceptions to Medicare policies may be appropriate from time to time. TWCC determinations are to be made by an IRO on a case-by-case basis. The Commission will monitor IRO decisions to determine whether Commission rule-making action would be appropriate with respect to recurring issues. Rule 134.202(a)(4).

These exceptions, however, should be judiciously granted. The TWCC is *required* to adopt Medicare policies and guidelines with "minimal modifications." 413.011(a). The TWCC is given authority under 412.011(f) to pass rules regarding medical necessity. To read those two statutes consistently, the TWCC rules should be consistent with Medicare policies to the extent possible – otherwise the modifications of the policy would not be "minimal."

Note that the TWCC preamble states:

> Medicare's payment policies largely define "main-stream medicine." These policies have been developed and refined over many years in the public area . . . . The Commission could not independently duplicate this work. The Texas Workers' Compensation system as a whole will benefit by bringing its payment policies and unit costs in line with mainstream medicine. The frequency distribution of services may differ between group health, Medicare and workers' compensation beneficiaries. *However, for a given medical service, there is no good reason why the payment policy should differ.*

[emphasis added]. 27 Tex.Reg. 4053.

In response to another comment, TWCC disagreed that medically necessary services should be defined through specific TWCC rules. TWCC responded that: "CMS policies establish a method of dealing with these services." 27 Tex.Reg. 4066. Even TMA, at one point in time, wrote the TWCC that carriers should not "only partially implement Medicare's rules." 27 Tex.Reg. 4069.

The *MFG* states that the system participants "shall apply" the Medicare program reimbursement methodology, including payment policies in effect on the date that the service is provided. 134.202(b). The express policy of the Legislature is medical cost containment, and the carrier is certainly within its rights to insist on a lower cost alternative. See e.g., 413.011(d) (provides that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.") and 413.011(g).

Note that on December 8, 2003, President Bush signed the Medicare Prescription Drug and Modernization Act of 2003. Section 624 of this Act reinstated a moratorium on the therapy dollar limits for calendar years 2004 and 2005. This section also included language to implement a moratorium on the Medicare therapy limits for the remainder of 2003 starting with the date of the enactment, December 8, 2003. Accordingly, the dollar caps of $1,590 (physical therapy) and $1,590 (occupational therapy) apply <u>only</u> to the period from September 1, 2003 through December 7, 2003. For now, the dollar cap limits do not apply to any other dates of service

through 2005. The utilization guideline for physical medicine is otherwise in effect.

Although the IRO should follow applicable Medicare utilization policies, they do have flexibility under the Act to find disputed services to be medically necessary for a particular patient under the patient's particular circumstances. Those decisions may be appealed to SOAH and litigated at that time. The IROs *should* follow the same payment policies and only override those policies in the event of demonstrated medical necessity.

In summary, carriers are required to follow the Medicare program, including, the limits on utilization as prescribed by Medicare. For physical medicine, the utilization limits are effectively a treatment guideline. *Unless the documentation supports otherwise, services outside these guidelines should be disputed.* For each of these cases, the provider or claimant may dispute our determination. In the event of a dispute, the matter will be referred to an IRO for resolution. We recommend that you use codes Y, along with U or V when denying these services.

Coverage:

Although Medicare limits coverage to medical services that are "safe and effective," there are some services that are medically effective and medically necessary, which are not covered by Medicare. See LMRP *Non-Covered Services* Z-14B-R1. These are cost based political decisions adopted to minimize the cost of the Medicare system. Accordingly, these services are not covered because of a choice, as opposed to a determination by Medicare that the service is not medically necessary or medically effective. Examples of noncovered medically necessary services are select lab tests, x-rays, hearing aids, etc. Chiropractic treatment of extremities is not covered by Medicare, but because extremity treatment is within the scope of chiropractic practice under Texas law, it is covered by Rule 134.202(a)(3). Similarly, work hardening is not covered by Medicare, but is covered by rule. 134.202(e)(5).

Medically necessary services that are not covered must be reimbursed, notwithstanding the fact that they would not be reimbursed under Medicare. See Rule 134.202 (a)(4) and 134.202(c)(6). Carriers must assign a relative value which may be based on nationally recognized published relative value studies, published medical dispute decisions, and values assigned for services involving similar work and resource commitments.'" 27 Tex.Reg. 4048. IRO and SOAH Decisions should further define the boundaries of medical necessity vs. coverage.

Further information is available at www.trailblazerhealth.com. This is an administrator of the Medicare program and they have a website with much more specific information covering many more pages. Other information is available on the TWCC web site. Most of this information should almost certainly be incorporated into reimbursement software that should be

commercially available. You should make sure that your medical bill vendor is aware of these changes.