ADVISORY NO. 405
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TOPIC: NEW MEDICAL DISPUTE RESOLUTION RULES POSTED

The new Medical Dispute Resolution Rules are available on the DWC website at: http://www.tdi.state.tx.us/wc/rules/adopted/adopted.html. TDI/DWC has also published a "Fast Facts" regarding MRD Fee Disputes at http://www.tdi.state.tx.us/wc/mr/documents/ffmfdr.pdf.

New Rule 133.308 governs all network and non-network, prospective and retrospective medical necessity disputes filed on or after January 15, 2007. It is important to recognize that medical necessity disputes (and IROs) are regulated by TDI, not DWC, as of that date. DWC will continue to regulate and decide medical fee disputes under Rule 133.307.

A summary of significant changes are as follows:

An "adverse determination" is a prospective or retrospective denial of medical necessity by a URA. [133.305(a)(1)]. As noted elsewhere, DWC and TDI consider a retrospective medical necessity denial EOB an adverse determination. Your current EOB forms will still be used for retrospective denials. Continue to use the currently available ANSI denial codes for medical necessity. TDI has indicated it is working on new ANSI codes that will include instructions to the recipient on requesting an IRO. Until we receive the new ANSI codes, there is currently no such instructions proscribed for the EOB. While there are adverse determination templates issued by TDI to URAs, these are for health insurance claims. TDI has not yet issued such templates for workers' compensation claims. Your URA should continue to use its current formats, subject to the notice noted below, until further instruction from TDI.

In the meantime, any adverse determination from your URA or any medical necessity denial EOB should include a copy of the LHL009 (Request for IRO), or instructions on where to obtain the form. TDI has indicated informally that in lieu of attaching the LHL009, the URA/Carrier may give instructions for obtaining the form from the TDI website [http://www.tdi.state.tx.us/company/iro_requests.html] and the physical address [HWCN Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, TX 78714-9104] and instructions for obtaining an electronic version provided by the Carrier (if you so choose). Note that the form previously used (LHL403) is no longer available on the TDI website, and is replaced by the LHL009 for purposes of workers' compensation cases.

The Division has posted new versions of Rules 133.305, 133.307 and 133.308 regarding Medical dispute resolution, effective for requests for medical dispute resolution on and after January 15, 2007. The old rules 133.305, 133.307 and 133.308 have been repealed, but remain

effective for medical dispute requests filed before January 15, 2007.

These instructions were addressed in FO&L Advisory 404 regarding TDI Bulletin #'s B-0046-06, B-0047-06 and B-0048-06. The Bulletins implied that a copy of the LHL009 had to accompany each adverse determination. Conspicuously absent from the Bulletins was a reference to retrospective denials of medical necessity on an EOB. Since publication of the Bulletins and FO&L Advisory 404, both DWC and TDI have informally expressed the intent to require the inclusion of a copy of the LHL009 or instructions regarding where and how to obtain the form (as noted above) with all medical necessity adverse determinations, including EOBs. In other words, DWC and TDI consider an EOB an "adverse determination," to which the Bulletins apply.

The Bulletins and FO&L Advisory 404 also addressed the Online IRO Request Form.

A change in policy regarding carrier refund requests creates a real trap for healthcare providers. The old rules required the carrier to initiate medical dispute resolution for refund requests. The new rules place that burden on the provider.

Under TEX. LAB. CODE § 408.0271 [effective, and applicable to payments for "inappropriate" care] and Rule 133.260 [effective for DOS on or after 5/1/06], a carrier has 240 days from the date of service to request a refund when it determines that "inappropriate" healthcare services were previously reimbursed or when an overpayment was made. The provider has 45 days to respond to the refund request by issuing a refund or by "appealing" the request (equivalent to a request for reconsideration). The Carrier then has 45 days to respond by accepting the provider's position or maintaining the refund request. This is the point of departure from prior practice.

The sequence of disputes has significantly changed. As before, compensability, liability, extent of injury and medical necessity disputes have to be resolved before a fee dispute will be addressed. Under the new rules a fee disputed is not just abated pending resolution of these predicate issues. Now, a fee dispute cannot even be filed until final resolution of these other issues, and will be dismissed if it is filed prematurely. Rules 133.305(b), 133.307(e)(3)(G) and (H), and 133.308 (h).

As before, a request for dispute resolution must be filed within one year or the date of service. However, the new rules allow a fee dispute to be filed more than one year after the dates of service if such predicate issues as compensability, liability, extent of injury or medical necessity exist. In such case, the medical fee dispute request must be filed not later than 60 days after receipt of the final decision on the predicate issue(s). Rule 133.307(b)(1)(B)(i) and (ii).

What happens to an IRO Request (medical necessity dispute) when there are pending compensability, liability and extent of injury disputes is not clear. The prior rule 28 TAC § 133.308(f)(7)(repealed) expressly required the abatement of the IRO request pending final resolution of compensability, liability and extent disputes. Unfortunately, that language was not carried forward into new Rule 28 TAC § 133.305(h) or 133.308 (31 TexReg 10314, December 22, 2006). However, the Division is given discretion to dismiss IRO requests, and that may be a viable option. At this time, we do not have an answer from TDI whether IRO Requests will go forward, will be dismissed or will be abated pending final resolution of these other disputes.

The Division has enhanced its oversight of medical fee discount contracts. In the dispute process, the failure to supply a copy of the contract in support the party's position results is application by the Division of its own medical fee guidelines. The Division may also assess an administrative fee for resolving the dispute where the carrier purports to rely upon a contract provision but has not made the contract available upon request or where the contract (contrary to DWC-TDI policy) purports to also direct or manage healthcare in the absence of network certification. Rule 133.305 (c)(3) and (4).

The new rules acknowledge statutory changes that allow a qualified pharmacy processing agent to participate in the dispute process. Rules 133.307(b)(1) and (c)(2)(H); 133.308(e)(1)(A) and (2)(A).

The basic medical fee dispute process remains essentially the same. The Requestor still uses the DWC-60 to request fee dispute resolution. Now the request must include not only copies of the bills submitted for reconsideration, but the original bills as well. The requirements for carrier's responses, including discussions of supporting DWC/TDI/CMS rules, policies and guidelines remain the same. FO&L's processes for reporting and responding to medical fee disputes will not materially change. However, we will take advantage, where possible, of the new provision which acknowledges the Division's authority to raise new issues in the dispute process even though the carrier had not previously raised the issue in its EOBs. See Rule 133.307(e)(2).

New Rule 133.307(f) regarding the appeal of the Division's fee decision is somewhat problematic. The appeal is governed by TEX. GOV'T CODE § 2001.176 which requires the petition be filed in Travis County District Court "not later than the 30th day after the date on which the decision. . . is final and appealable." Typically, agency and court decisions are final and appealable when signed or issued. However, the new rule may be interpreted to be in conflict with legislative requirements as it requires the petition to be filed no later than 30 days after the decision is received by the appealing party. As a precaution FO&L recommends such a judicial appeal of a medical dispute decision be filed within 30 days of the date of issuance/signing of the decision.

The medical necessity dispute process had materially changed and is discussed in FO&L Advisory 404.

One consequence of a carrier's loss of a medical necessity dispute is that any peer review report utilized to deny the services may not be used for subsequent denials for the same services in that case. In such a case, a carrier would be better served by obtaining a new, updated peer review anyway.