RICHARD F. REYNOLDS
EXECUTIVE DIRECTOR

TEXAS
WORKERS' COMPENSATION COMMISSION
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-7551
(512) 804-4000

April 22, 2004

The Honorable Todd Staples, Chairman
Senate Select Interim Committee on Workers' Compensation
Texas Senate
P. O. Box 12068 – Capitol Station
Austin, Texas 78711

Dear Chairman Staples:

Thank you for the opportunity to again address the Senate Select Interim Committee on Workers' Compensation on April 29, 2004. Following is a list of the requests made in your letter of April 5, 2004, with a reference to the attachments provided as a response.

1) Charge 3: Study the impact of the Texas Workers' Compensation Commission's 2002 Medical Fee Guideline on access to quality medical care for injured workers and medical costs, including recommendations on whether the legislature should statutorily prescribe a methodology for calculating the workers' compensation conversion factor.

- A description of TWCC's studies and other information on the issue of access to medical care for injured workers, including:
  - the most recent numbers of doctors registered on the TWCC Approved Doctor List (ADL) in various areas of the state;
  - TWCC's ongoing and future plans to measure access to care issues, including measurement of whether doctors on the ADL are accepting new workers compensation cases;
  - identification of any regions of the state where access to care problems are significant, and TWCC's plans to address any such problems; and
  - any other issues TWCC believes are significant in assessing access to care;

  RESPONSE: See Section A (pages TWCC 01-10)

- An illustration of the impact of the 2002 TWCC fee guideline on reimbursement for the following medical services (a "before-and-after" type comparison with reimbursement under the 1996 guideline):
  - manipulations;
  - office visits;
  - spinal Magnetic Resonance Imaging (MRI) tests;
  - laminectomy;

- neuroplasty;
- work hardening and work conditioning; and
- needle electromyography (EMG)

RESPONSE: See Section B (pages TWCC 11-29)

- A description of any significant implementation issues TWCC has encountered with the 2002 medical fee guideline

  RESPONSE: See Section C (pages TWCC 30-32)

- A description of TWCC's ongoing fee guideline development or implementation efforts in other areas (i.e., hospitals, ambulatory surgical center, etc.)

  RESPONSE: See Section D (page TWCC 33)

TWCC Chairman Mike Hachtman may provide opening remarks at the April 29, 2004 hearing. Also, the following TWCC staff members will provide testimony to respond to the specific requests:

Dr. Bill Nemeth, Medical Advisor
Bob Shipe, Director Medical Review

If you have any questions or I can provide further information, please contact me at 804-4400 or Rhonda Myron, Director, Governmental Relations at 804-4252.

Sincerely,

Richard F. Reynolds
Executive Director

Attachments

SECTION A

A description of TWCC's studies and other information on the issue of access to medical care for injured workers.

With the institution of the new Approved Doctor List (ADL) in September of 2003, several dynamics have occurred leading to "perceived" access issues for injured workers (IW's) in the Texas Workers Compensation system. However, the Texas Workers Compensation Commission (TWCC) has no evidence of actual or persistent access problems other than those predicted as a result of these changes (such as the need for some IW's to change treating doctors (TD's) as a result of their TD's dropping out of the system).

Included in your package is a map, entitled "Number of Doctors Approved to Treat by Area", which reflects the number and geographic distribution of doctors who have been approved to provide treatment in the workers' compensation system as of 4/15/04. Following the map is a table entitled "Comparison of Specific MD Specialties – Previously Providing Service to More Than 18 Patients and ADL 2 Applications". The table is up-to-date through April 15, 2004, and it shows (by areas of the state) the specific medical specialties in comparison with the number of doctors in that specialty who provided care in that area in the past. These specialties were identified during implementation of the Approved Doctor List (ADL) because there were indications that these specialists would no longer participate in the workers compensation system – causing potential access problems.

Is there an access problem?

Currently 16,000 out of the 30,000 Doctors on the old ADL participate in the Texas workers' compensation system as members of the new ADL. The ADL has added an additional 557 Doctors since TWCC last reported to the Committee on March 25, 2004. The Approved Doctor List is rich with primary care and Family Medicine Doctors. Also, there are sufficient numbers of specialists available for specialty care.

The Texas Workers Compensation Commission (TWCC) has no evidence of actual or persistent access problems other than those predicted as a result of these changes (the need for some injured workers to change treating doctors (TD's) as a result of their TD's dropping out of the system.) In fact, when TWCC is advised of an area with possible access issues, the agency has evaluated the availability of access in

the particular area, and has found very few problems, other than some isolated individual instances.

With the institution of the new Approved Doctor List (ADL) in September of 2003, several dynamics have occurred leading to "perceived" access issues for injured workers (IW's) in the Texas Workers Compensation system. Although TWCC is not seeing a pervasive problem with newly injured workers having trouble finding "a" qualified Doctor in the Texas Workers Compensation system, some of these injured workers may be unable to access care through the initial Doctor(s) of their choosing or may be inconvenienced by having to drive some distance to access appropriate subspecialty care (a situation that existed prior to 9/1/03). However, there are sufficient providers available in the system to initiate appropriate care and make any specialty referrals as needed. While some areas of the state may have fewer choices than other areas, this is also true for other health care delivery systems in the state, such as group health coverage.

Additionally, several specialties, at this point, choose to participate in limited fashion only. For example, a recent survey of Texas orthopaedic surgeons done by the Texas Orthopaedic Association (published in March 2004) revealed that 2/3 of the orthopaedists took workers' comp patients: 1/3 took all comers, 1/3 were selective in their choice of patients, and 1/3 took no comp patients. This is nothing new – health care providers have always been selective as to which workers' compensation patients they choose to treat.

The most significant remaining issue in the TWCC system is that several very chronic complicated patients (not doing well, with little hope of recovery from chronic conditions) comprise the overwhelming majority of the population having difficulty with placement. This actual number of injured workers requiring placement help from Commission staff (charged with assisting in the identification of doctors for these complicated cases) thus far is 249 or 0.42 % (less than ½%) when compared with the almost 60,000 injuries reported in the system since September 1, 2003. Most of these IW's represent claimants who have long-standing chronic problems. Incidentally, most of these injured workers do have treating Doctors, but are looking for a change of treating doctor within the system. Due to the nature of these injured workers' problems and the difficulty in treating their complex chronic conditions, few doctors have the resources or will to undertake their treatment, as most of the applicable medical resources have already been used without success. Therefore, these injured workers stay unattached for days to weeks as many providers find it too challenging to engage such complex and seemingly hopeless patients. Again, this is not unique to the new ADL.

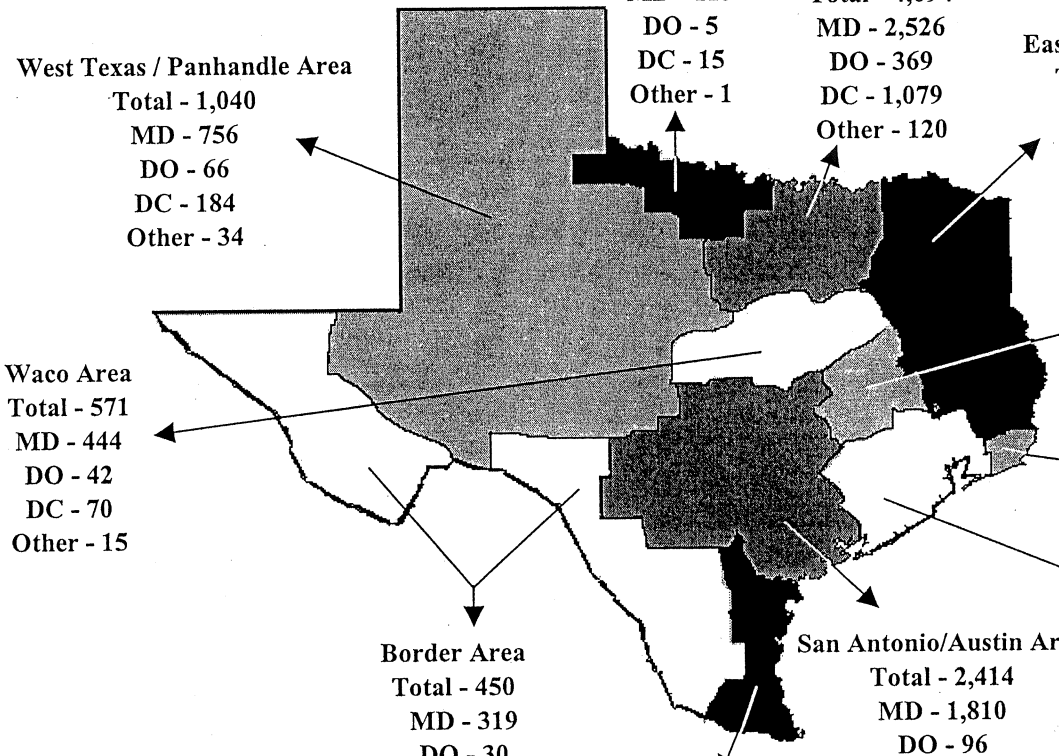
Overall, access to care in the current system is sufficient. There are injured workers who are unhappy with the choice of doctors available; however, as the system evolves, more injured workers will attach to treating doctors with much more ease as the referral pattern within the system (as is becoming evident) will have re-established itself. This phenomenon has been seen repeatedly when health maintenance organizations or preferred provider organizations are utilized in providing health insurance coverage. In addition, there are doctors or doctor groups, including specialists, who did not apply to be on the ADL before the September 1, 2003 date, but who are now applying and providing health care to injured workers, thereby increasing the choice available to injured workers.

Number of Doctors Approved to Treat by Area

Out-of-State Total - 1,715
Medical Doctor (MD) - 1,446
Doctor of Osteopathy (DO) - 81
Doctor of Chiropractic (DC) - 173
Other - 15

Approved Doctor List (ADL) Total - 15,971

In-State Total - 14,256
Medical Doctor (MD) - 10,195
Doctor of Osteopathy (DO) - 774
Doctor of Chiropractic (DC) - 2,869
Other - 418



Wichita Falls Area
Total - 136
MD - 115
DO - 5
DC - 15
Other - 1

Dallas Area
Total - 4,094
MD - 2,526
DO - 369
DC - 1,079
Other - 120

West Texas / Panhandle Area
Total - 1,040
MD - 756
DO - 66
DC - 184
Other - 34

East Texas Area
Total - 780
MD - 553
DO - 44
DC - 147
Other - 36

Bryan/College Station Area
Total - 220
MD - 170
DO - 12
DC - 31
Other - 7

Waco Area
Total - 571
MD - 444
DO - 42
DC - 70
Other - 15

Beaumont Area
Total - 249
MD - 186
DO - 21
DC - 39
Other - 3

Houston Area
Total - 4,034
MD - 3,013
DO - 98
DC - 805
Other - 118

San Antonio/Austin Area
Total - 2,414
MD - 1,810
DO - 96
DC - 449
Other - 59

Border Area
Total - 450
MD - 319
DO - 30
DC - 92
Other - 9

Valley Area
Total - 806
MD - 585
DO - 40
DC - 156
Other - 25

Data as of April 15, 2004

Note: *Doctors approved to provide treatment who practice in other states or other countries are not included in the statewide or regional totals. Some doctors may practice in multiple areas; therefore, the sum of areas are not the same as the statewide totals.*

TWCC-04

Comparison of Specific MD Specialties - Previously Providing Service to More Than 18 Patients and Those With ADL 2 Credential

Commission Field Office Region	# of MD/Specialists Providing Service to GT 18 Patients 2001	2002	# of MD/Specialists Approved as ADL2 4/15/2004	% of 2002 Providers
Dallas				
Neurology	24	25	29	116%
Neurological Surgery	25	23	22	96%
Occupational Medicine	9	7	28	400%
Orthopedic Surgery	119	118	105	89%
Physical Medicine and Rehab	29	31	60	194%
Fort Worth				
Neurology	15	15	11	73%
Neurological Surgery	16	16	19	119%
Occupational Medicine	2	3	19	633%
Orthopedic Surgery	81	80	76	95%
Physical Medicine and Rehab	16	16	37	231%
Denton				
Neurology	6	5	12	240%
Neurological Surgery	4	2	7	350%
Occupational Medicine	2	2	13	650%
Orthopedic Surgery	58	63	55	87%
Physical Medicine and Rehab	10	10	18	180%
Total Dallas Area				
Neurology	45	45	49	109%
Neurological Surgery	45	41	46	112%
Occupational Medicine	13	12	46	383%
Orthopedic Surgery	258	261	220	84%
Physical Medicine and Rehab	55	57	100	175%
Tyler				
Neurology	4	5	9	180%
Neurological Surgery	16	15	10	67%
Occupational Medicine	6	5	13	260%
Orthopedic Surgery	51	51	47	92%
Physical Medicine and Rehab	17	15	23	153%
Lufkin				
Neurology	3	3	1	33%
Neurological Surgery	2	2	0	0%
Occupational Medicine	0	0	0	N/A
Orthopedic Surgery	11	11	8	73%
Physical Medicine and Rehab	2	2	4	200%
Total East Texas Area				
Neurology	7	8	10	125%
Neurological Surgery	18	17	10	59%
Occupational Medicine	6	5	13	260%
Orthopedic Surgery	62	62	55	89%
Physical Medicine and Rehab	19	17	26	153%

Comparison of Specific MD Specialties - Previously Providing Service to More Than 18 Patients and Those With ADL 2 Credential

Commission Field Office Region	# of MD/Specialists Providing Service to GT 18 Patients 2001	2002	# of MD/Specialists Approved as ADL2 4/15/2004	% of 2002 Providers
Beaumont				
Neurology	3	5	6	120%
Neurological Surgery	5	5	5	100%
Occupational Medicine	0	0	7	N/A
Orthopedic Surgery	18	17	20	118%
Physical Medicine and Rehab	5	5	8	160%
Houston East				
Neurology	0	0	54	N/A
Neurological Surgery	2	2	32	1600%
Occupational Medicine	0	0	46	N/A
Orthopedic Surgery	15	13	194	1492%
Physical Medicine and Rehab	0	0	52	N/A
Houston West				
Neurology	54	52	15	29%
Neurological Surgery	38	35	7	20%
Occupational Medicine	20	19	17	89%
Orthopedic Surgery	206	214	71	33%
Physical Medicine and Rehab	38	44	26	59%
Missouri City				
Neurology	1	2	9	450%
Neurological Surgery	0	0	3	N/A
Occupational Medicine	1	1	10	1000%
Orthopedic Surgery	14	13	34	262%
Physical Medicine and Rehab	2	2	11	550%
Total Houston Area				
Neurology	55	54	72	133%
Neurological Surgery	40	37	37	100%
Occupational Medicine	21	20	63	315%
Orthopedic Surgery	235	240	275	115%
Physical Medicine and Rehab	40	46	71	154%
Abilene				
Neurology	3	4	3	75%
Neurological Surgery	1	1	0	0%
Occupational Medicine	0	0	1	N/A
Orthopedic Surgery	13	13	14	108%
Physical Medicine and Rehab	0	0	2	N/A
San Angelo				
Neurology	2	2	1	50%
Neurological Surgery	3	3	2	67%
Occupational Medicine	0	0	0	N/A
Orthopedic Surgery	9	9	4	44%
Physical Medicine and Rehab	0	0	0	N/A

Comparison of Specific MD Specialties - Previously Providing Service to More Than 18 Patients and Those With ADL 2 Credential

Commission Field Office Region	# of MD/Specialists Providing Service to GT 18 Patients 2001	2002	# of MD/Specialists Approved as ADL2 4/15/2004	% of 2002 Providers
Amarillo				
Neurology	1	1	2	200%
Neurological Surgery	7	5	6	120%
Occupational Medicine	1	1	3	300%
Orthopedic Surgery	16	17	13	76%
Physical Medicine and Rehab	6	6	7	117%
Lubbock				
Neurology	2	1	4	400%
Neurological Surgery	3	4	7	175%
Occupational Medicine	2	2	5	250%
Orthopedic Surgery	28	31	23	74%
Physical Medicine and Rehab	2	2	7	350%
Midland/Odessa				
Neurology	1	2	3	150%
Neurological Surgery	4	3	2	67%
Occupational Medicine	1	1	2	200%
Orthopedic Surgery	18	18	18	100%
Physical Medicine and Rehab	4	4	3	75%
Total West Texas Panhandle Area				
Neurology	9	10	13	130%
Neurological Surgery	18	16	17	106%
Occupational Medicine	4	4	10	250%
Orthopedic Surgery	84	88	69	78%
Physical Medicine and Rehab	12	12	18	150%
San Antonio				
Neurology	16	17	23	135%
Neurological Surgery	17	16	16	100%
Occupational Medicine	7	8	21	263%
Orthopedic Surgery	100	102	103	101%
Physical Medicine and Rehab	18	19	37	195%
Austin				
Neurology	10	10	12	120%
Neurological Surgery	7	6	7	117%
Occupational Medicine	5	5	22	440%
Orthopedic Surgery	61	62	61	98%
Physical Medicine and Rehab	12	10	21	210%
Victoria				
Neurology	2	2	2	100%
Neurological Surgery	2	2	0	0%
Occupational Medicine	0	0	5	N/A
Orthopedic Surgery	8	8	11	138%
Physical Medicine and Rehab	1	2	1	50%

Comparison of Specific MD Specialties - Previously Providing Service to More Than 18 Patients and Those With ADL 2 Credential

Commission Field Office Region	# of MD/Specialists Providing Service to GT 18 Patients 2001	2002	# of MD/Specialists Approved as ADL2 4/15/2004	% of 2002 Providers
Total San Antonio/Austin Area				
Neurology	28	29	35	121%
Neurological Surgery	26	24	22	92%
Occupational Medicine	12	13	38	292%
Orthopedic Surgery	169	172	168	98%
Physical Medicine and Rehab	31	31	51	165%
Bryan/College Station				
Neurology	2	2	1	50%
Neurological Surgery	2	2	3	150%
Occupational Medicine	0	0	1	N/A
Orthopedic Surgery	15	14	16	114%
Physical Medicine and Rehab	1	2	5	250%
Waco				
Neurology	7	6	8	133%
Neurological Surgery	5	6	6	100%
Occupational Medicine	0	0	4	N/A
Orthopedic Surgery	28	26	29	112%
Physical Medicine and Rehab	3	4	8	200%
Wichita Falls				
Neurology	4	4	5	125%
Neurological Surgery	3	3	3	100%
Occupational Medicine	0	0	1	N/A
Orthopedic Surgery	7	8	7	88%
Physical Medicine and Rehab	0	0	3	N/A
Corpus Christi				
Neurology	6	6	4	67%
Neurological Surgery	4	3	1	33%
Occupational Medicine	1	2	9	450%
Orthopedic Surgery	28	30	28	93%
Physical Medicine and Rehab	4	4	8	200%
Weslaco				
Neurology	8	6	11	183%
Neurological Surgery	8	8	10	125%
Occupational Medicine	0	0	7	N/A
Orthopedic Surgery	23	26	35	135%
Physical Medicine and Rehab	3	4	7	175%

Comparison of Specific MD Specialties - Previously Providing Service to More Than 18 Patients and Those With ADL 2 Credential

Commission Field Office Region	# of MD/Specialists Providing Service to GT 18 Patients 2001	2002	# of MD/Specialists Approved as ADL2 4/15/2004	% of 2002 Providers
Total Valley Area				
Neurology	14	12	15	125%
Neurological Surgery	12	11	11	100%
Occupational Medicine	1	2	13	650%
Orthopedic Surgery	51	56	62	111%
Physical Medicine and Rehab	7	8	14	175%
El Paso				
Neurology	3	3	3	100%
Neurological Surgery	9	8	11	138%
Occupational Medicine	2	2	7	350%
Orthopedic Surgery	31	34	42	124%
Physical Medicine and Rehab	5	4	9	225%
Laredo				
Neurology	1	1	3	300%
Neurological Surgery	0	0	0	N/A
Occupational Medicine	0	0	3	N/A
Orthopedic Surgery	6	7	8	114%
Physical Medicine and Rehab	0	0	5	N/A
Total Border Area				
Neurology	4	4	6	150%
Neurological Surgery	9	8	11	138%
Occupational Medicine	2	2	9	450%
Orthopedic Surgery	37	41	49	120%
Physical Medicine and Rehab	5	4	13	325%
Totals on the ADL**				
Neurology	178	179	228	127%
Neurological Surgery	183	170	193	114%
Occupational Medicine	59	58	82	141%
Orthopedic Surgery	964	985	1008	102%
Physical Medicine and Rehab	178	186	279	150%

*** ADL totals count doctors according to the specialty type they have designated as "primary," and doctors practicing in more than one field office area are counted only once.*

Medical Quality Review
of
Health Care Providers
April 14, 2004

Providers Reviewed: 71
Providers Under Review: 41

NO.	STATUS	MDs	DOs	DCs	OTHER
14	No Action Recommended	11	0	2	1
5	Letter of Concern	3	1	0	1
5	Warning Letter	1	0	3	1
3	Agreements/Restrictions	1	0	2	0
20	Denied Admission*	11	2	7	0
8	Denials/Removals Pending	7	1	0	0
13	Other Actions Pending	8	0	5	0
3	No Application for New ADL[1]	2	0	1	0
71	**TOTAL**	**44**	**4**	**20**	**3**

- Above actions include 12 Designated Doctor reviews
  - 3 Letters of Concern / 1 Designated Doctor Removal

*One (1) Temporary Restraining Order and one (1) Temporary Injunction in place.

Medical Quality Review of Insurance Carriers

Insurance Carriers Reviewed: 4
Insurance Carriers Under Review: 9

There were no actions recommended against insurance carriers as a result of the four (4) insurance carrier reviews. However, a Letter of Concern was sent to a doctor and a treatment facility as a result of information found during the insurance carrier review. Those actions are reflected in the table above.

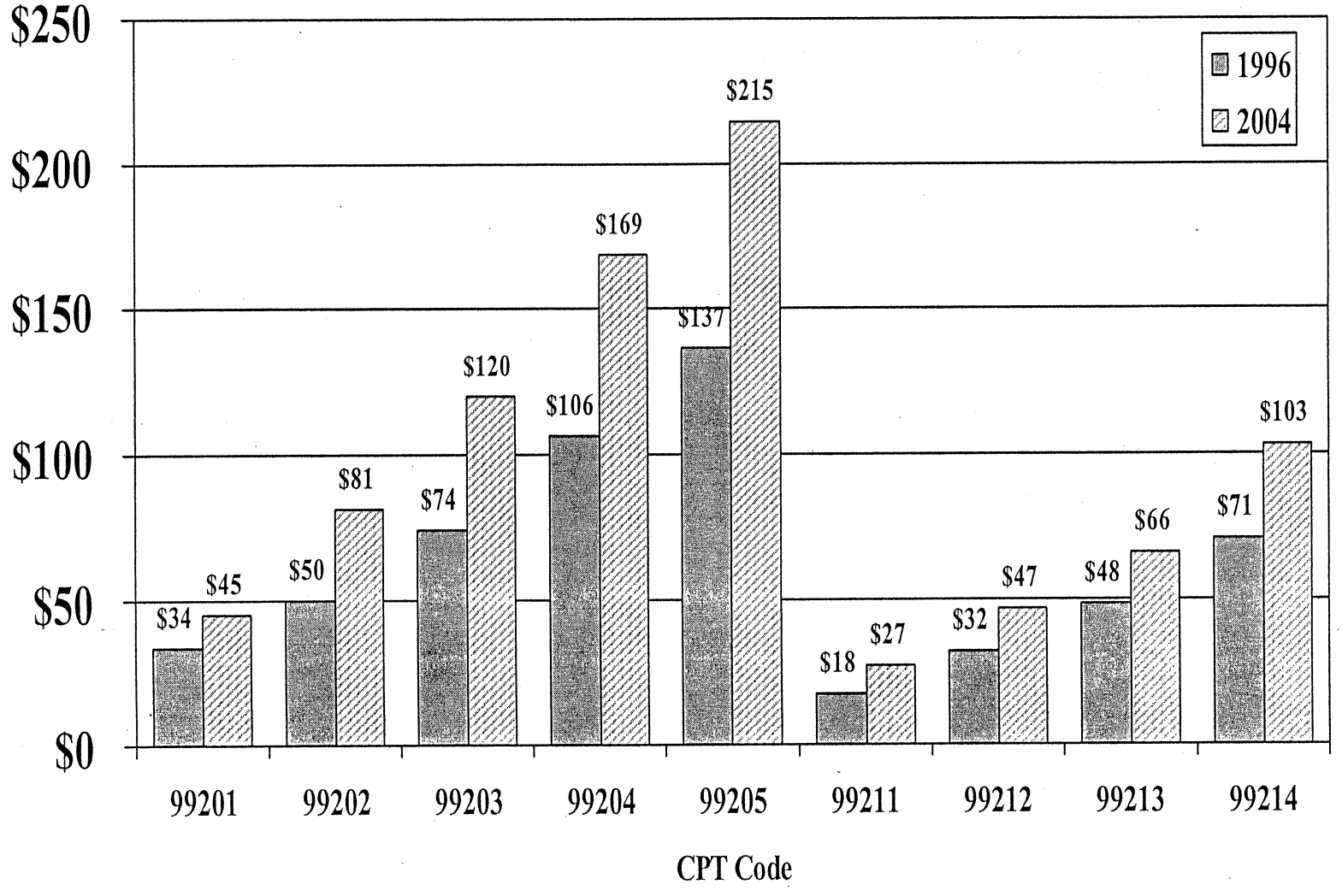
Additional Actions – Administrative Removals

NO.	STATUS	MDs	DOs	DCs	OTHER
36	ED Removals – Final Notice	30	5	0	1
8	ED Removals – Notice of Intent	7	1	0	0
0	Commissioner Removals	0	0	0	0
44	**TOTAL**	**37**	**6**	**0**	**1**

[1] MQRP review completed prior to implementation of ADL and provider has not applied for admission to the ADL.

SECTION B

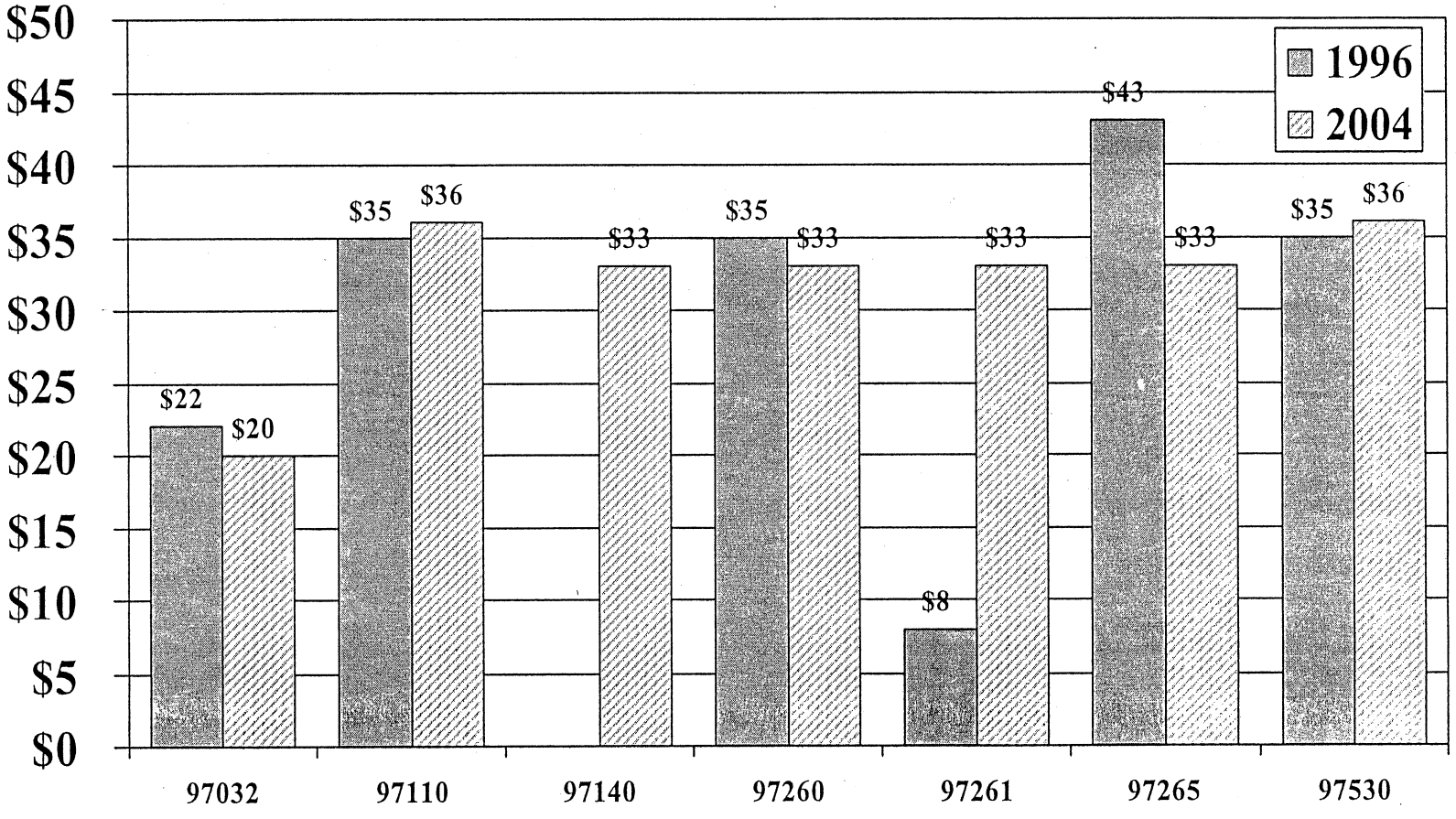
Maximum Allowable Reimbursement for Office Visits



CPT Code	Full Description
Evaluation /Management	
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordi
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making. Coun
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or coordination of ca
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coo
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordin
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making. Cou
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling

TWCC-12

Maximum Allowable Reimbursement for Physical Medicine Codes

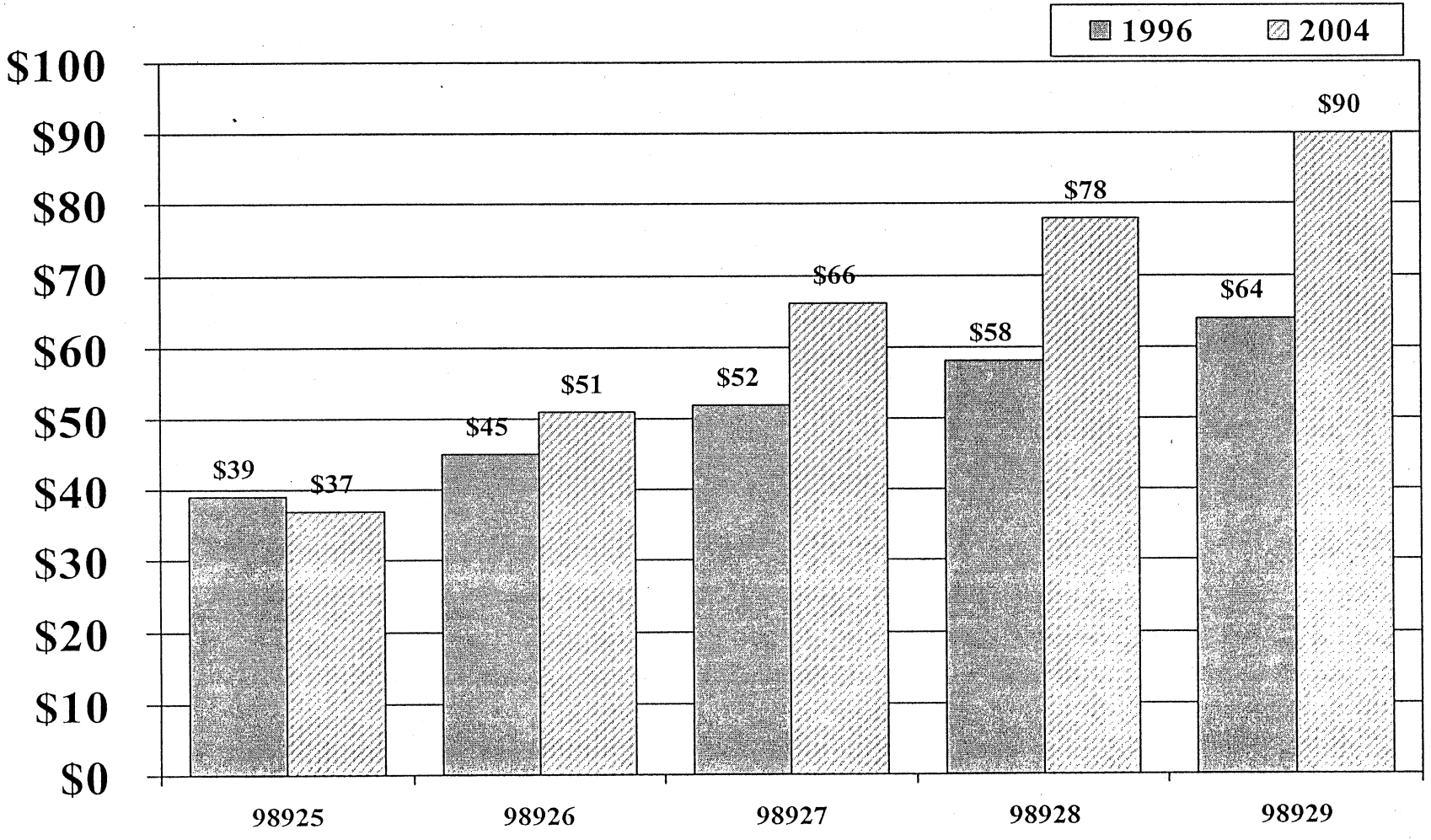


Physical medicine codes 97260, 97261 and 97265 were deleted in 1999 and replaced with 97140. This change did not become effective the Texas workers' compensation system until the implementation of the new fee guideline

CPT Code	Full Description
Physical Medicine	
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97260	Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist) (separate procedure) performed by physician; one area
97261	each additional area
97265	Joint Mobilization, one or more areas (peripheral or spinal)
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

TWCC-14

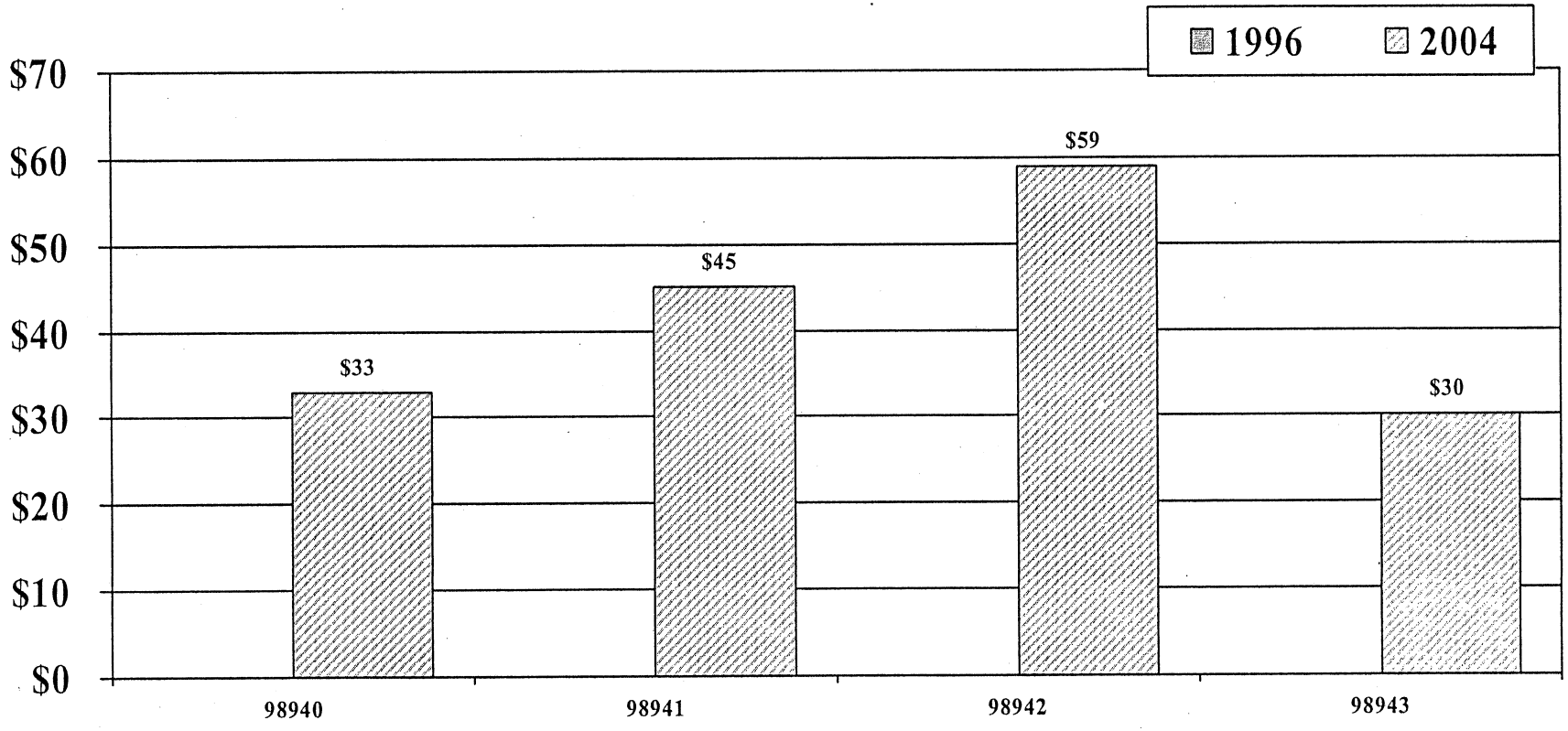
Maximum Allowable Reimbursement for Selected Osteopathic Manipulation Codes



CPT Code	Full Description
Osteopathic Manipulative Treatment	
98925	Osteopathic manipulative treatment (OMT); one to two body regions involved
98926	Osteopathic manipulative treatment (OMT); three to four body regions involved
98927	Osteopathic manipulative treatment (OMT); five to six body regions involved
98928	Osteopathic manipulative treatment (OMT); seven to eight body regions involved
98929	Osteopathic manipulative treatment (OMT); nine to ten body regions involved

TWCC-16

Maximum Allowable Reimbursement for Selected Chiropractic Manipulation Codes

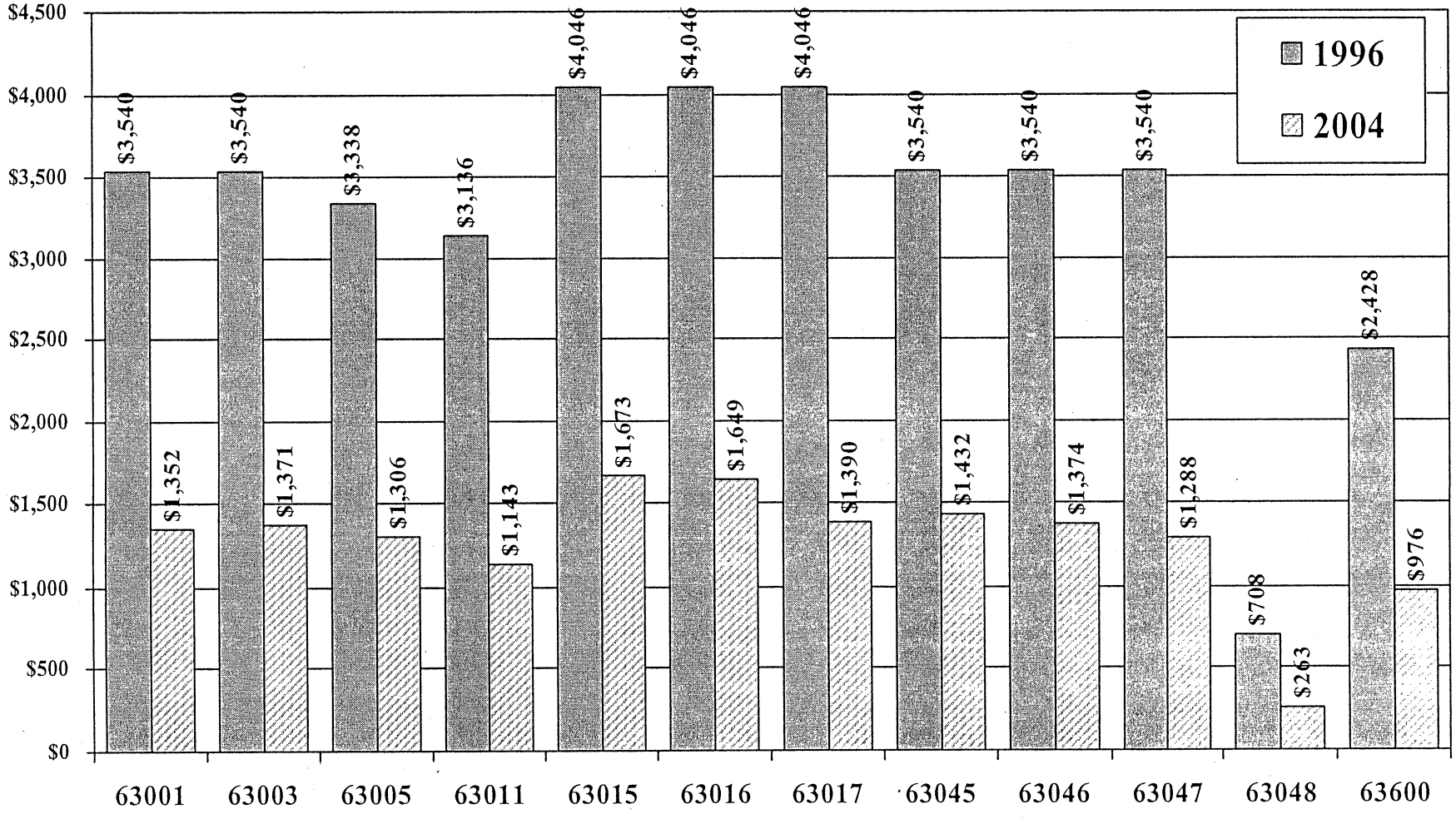


The 1996 Medical Fee Guideline used existing CPT codes with an assigned maximum allowable reimbursement. At that time chiropractic manipulation service CPT codes were unavailable, so chiropractors billed using office visit codes with an -MP modifier. Additional manipulations were billed using 97261, therefore we are unable to directly track chiropractic services by specific CPT codes. Current CPT codes adopted in the 2002 MFG allow for tracking of chiropractic manipulations by specific codes.

CPT Code	Full Description
Chiropractic Manipulative Treatment	
98940	Chiropractic manipulative treatment (CMT); spinal, one to two regions
98941	Chiropractic manipulative treatment (CMT); spinal, three to four regions
98942	Chiropractic manipulative treatment (CMT); spinal, five regions
98943	Chiropractic manipulative treatment (CMT); extraspinal, one or more regions

TWCC-18

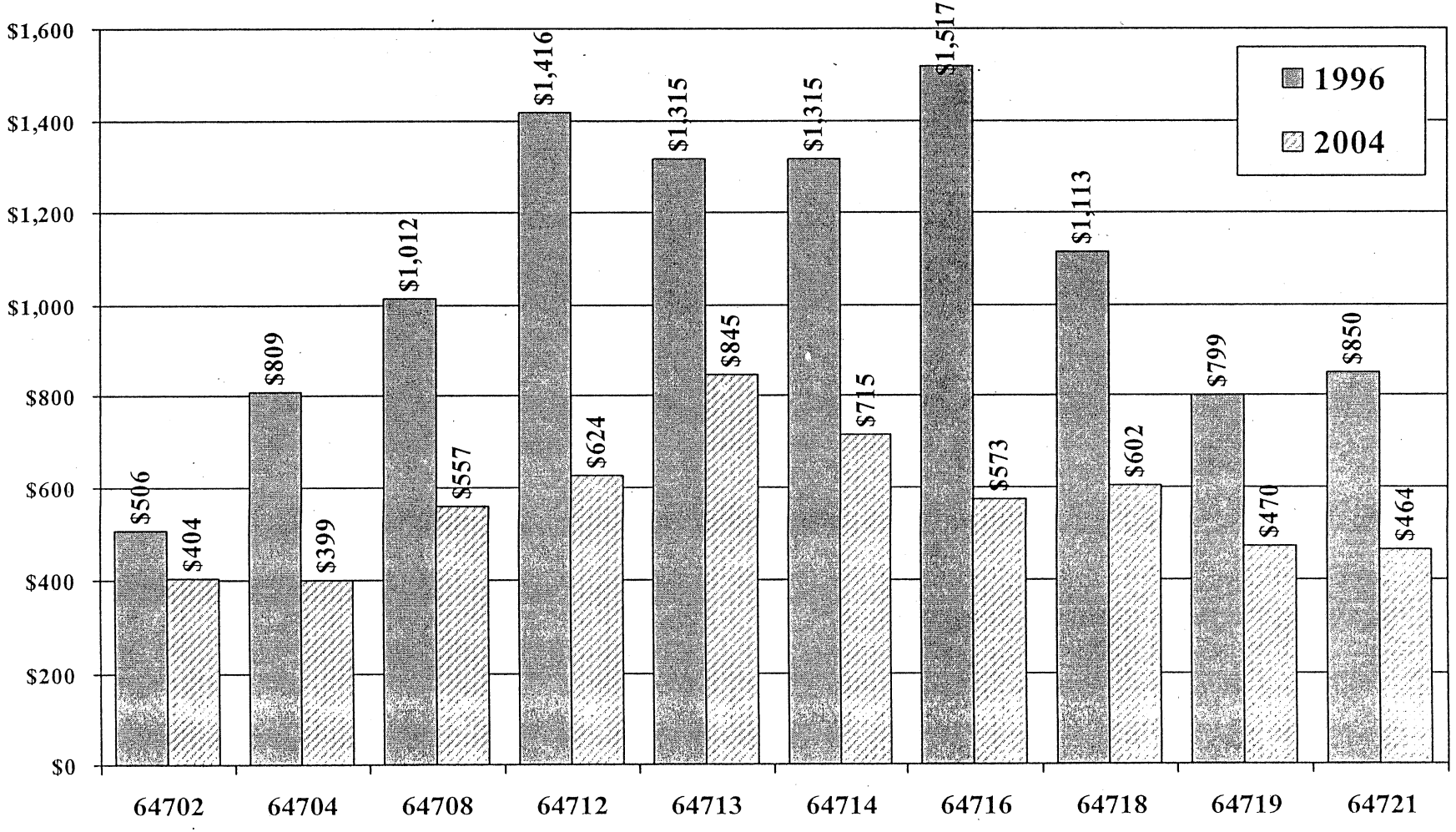
Maximum Allowable Reimbursement for Selected Laminectomy Codes



CPT Code	Full Description
Laminectomy	
63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), one or two vertebral segments; cervical
63003	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), one or two vertebral segments; thoracic
63005	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), one or two vertebral segments; lumbar, except for spondylolisthesis
63011	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), one or two vertebral segments; sacral
63012	Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)
63015	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), more than 2 vertebral segments; cervical
63016	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), more than 2 vertebral segments; thoracic
63017	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or diskectomy, (eg, spinal stenosis), more than 2 vertebral segments; lumbar
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, cervical
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, lumbar (including open or endoscopically-assisted approach)
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; each additional interspace, cervical or lumbar (List separately in addition to code for primar
63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; cervical
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; lumbar
63043	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; each additional cervical interspace (List separately in addi
63044	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; each additional lumbar interspace (List separately in additi
63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; cervical
63046	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; thoracic
63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; lumbar
63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; each additional segment, cervical, thoracic, or lu
63600	Creation of lesion of spinal cord by stereotactic method, percutaneous, any modality (including stimulation and/or recording)

TWCC-20

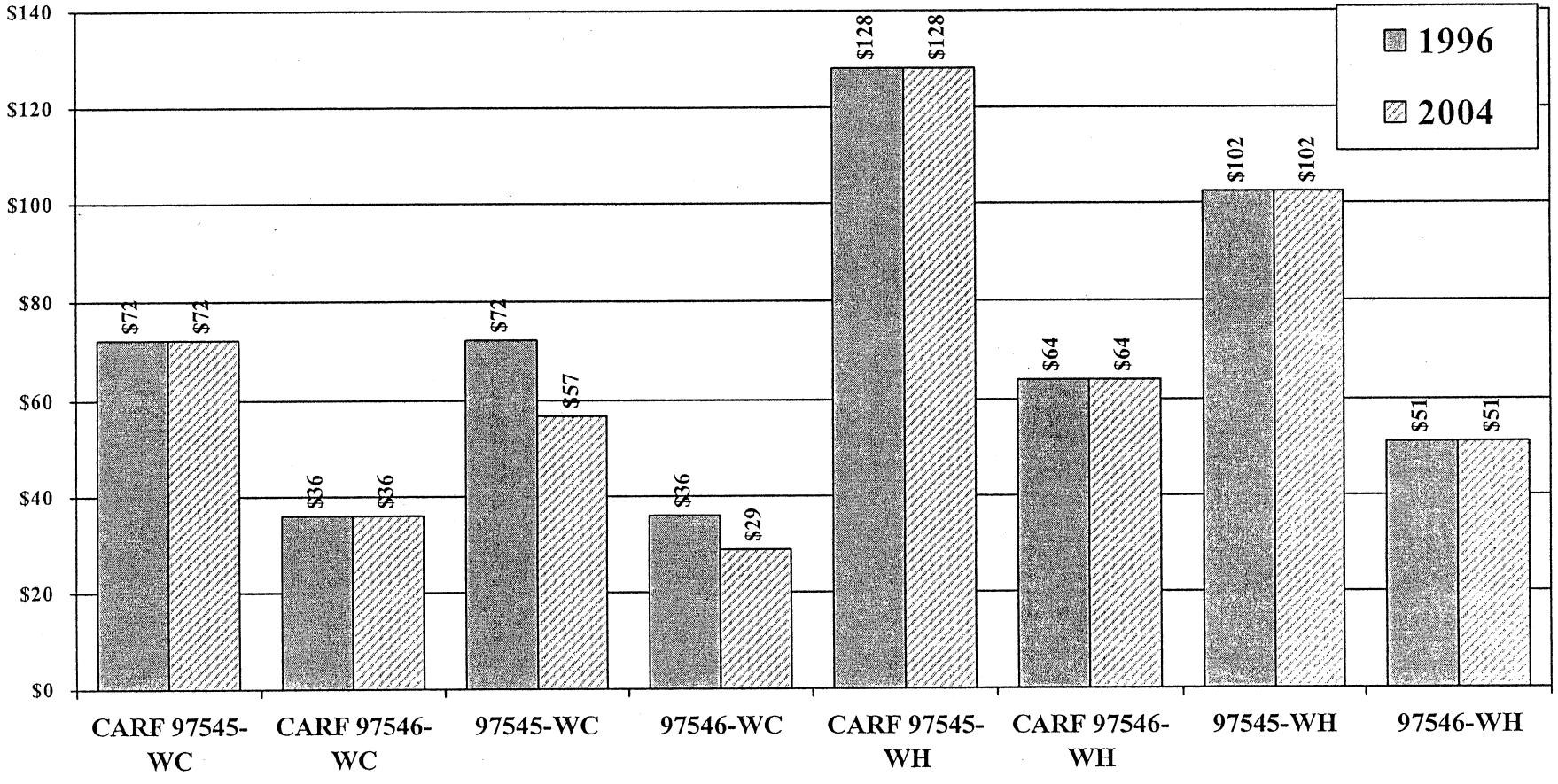
Maximum Allowable Reimbursement for Selected Neuroplasty Codes



CPT Code	Full Description
Neuroplasty	
64702	Neuroplasty; digital, one or both, same digit
64704	Neuroplasty; nerve of hand or foot
64708	Neuroplasty, major peripheral nerve, arm or leg; other than specified
64712	Neuroplasty, major peripheral nerve, arm or leg; sciatic nerve
64713	Neuroplasty, major peripheral nerve, arm or leg; brachial plexus
64714	Neuroplasty, major peripheral nerve, arm or leg; lumbar plexus
64716	Neuroplasty and/or transposition; cranial nerve (specify)
64718	Neuroplasty and/or transposition; ulnar nerve at elbow
64719	Neuroplasty and/or transposition; ulnar nerve at wrist
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel

TWCC-22

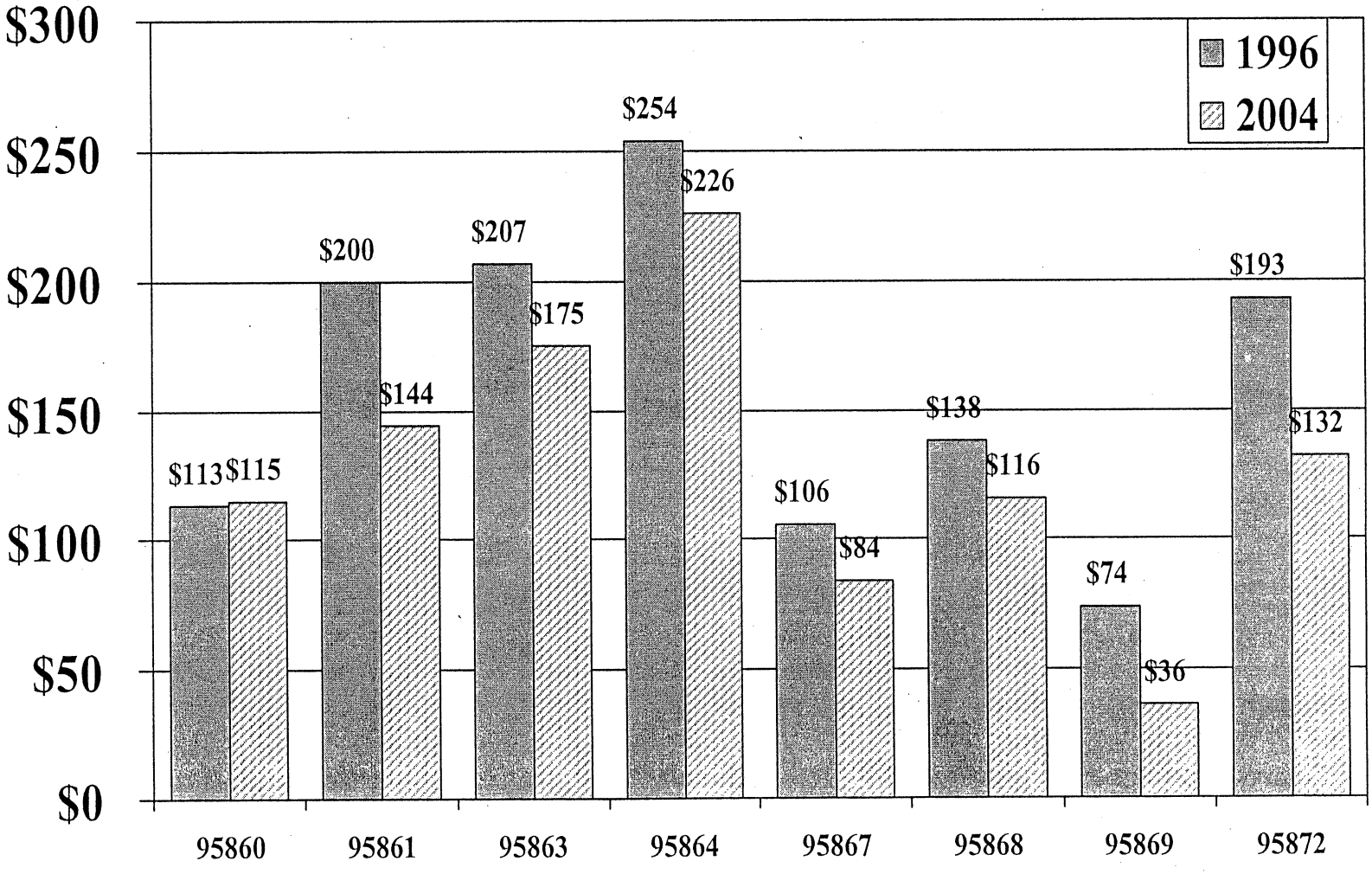
Maximum Allowable Reimbursement for Selected Work Conditioning and Work Hardening Codes



The 97545 code is billed as one unit for the first two hours, 97546 is billed one unit for each additional hour.

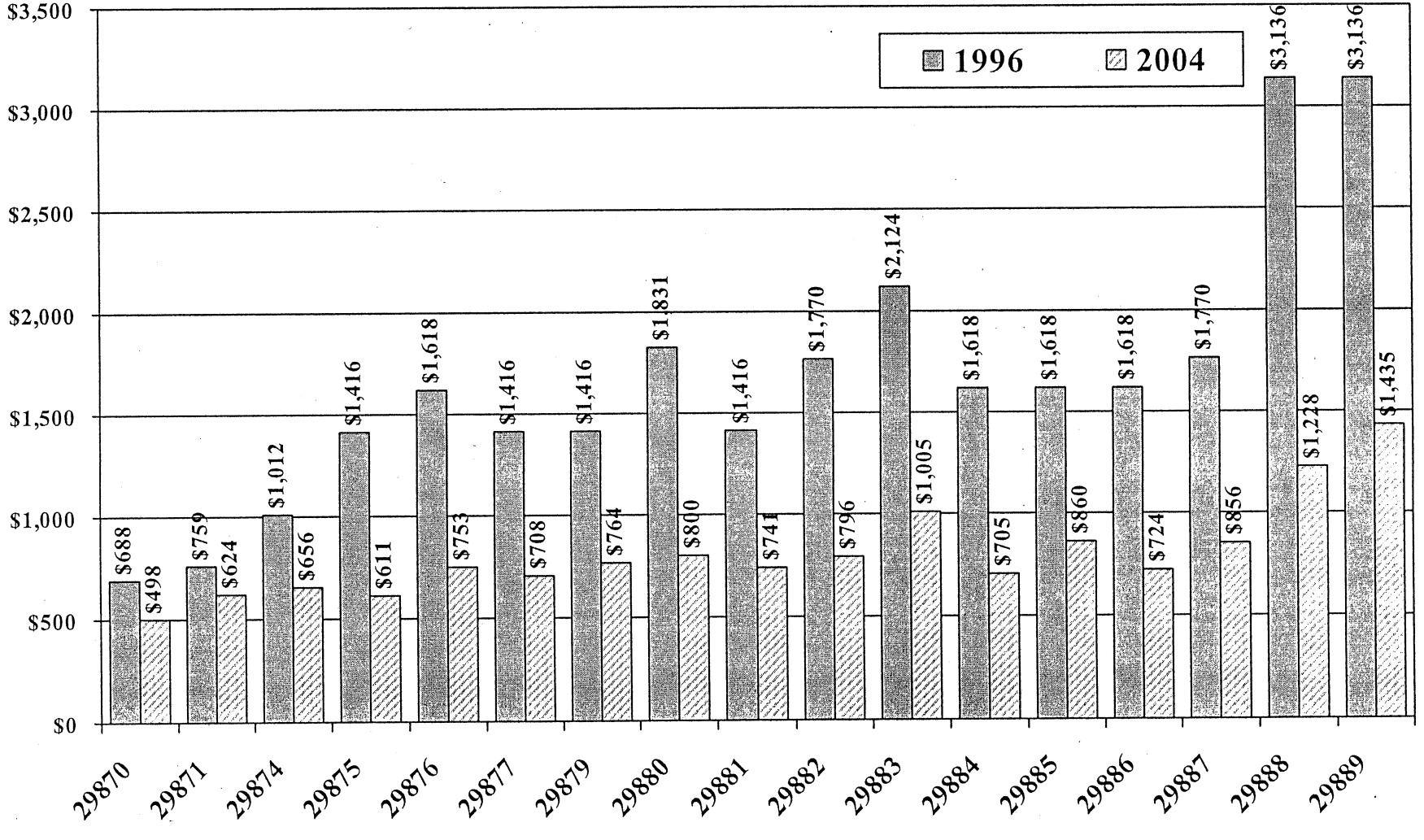
There was no accreditation price differential for work conditioning in the 1996 MFG.

Maximum Allowable Reimbursement for Selected Needle EMG Codes



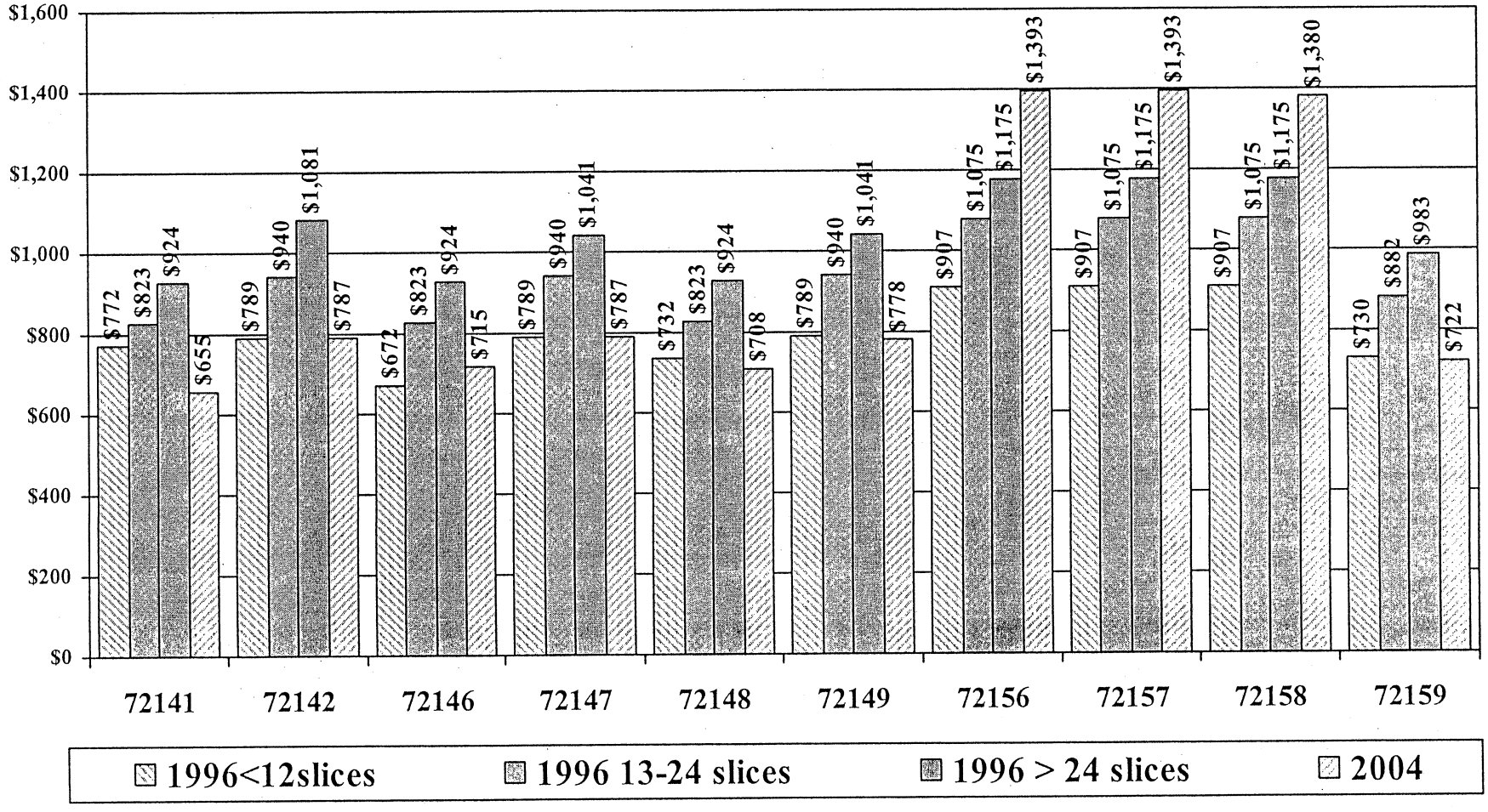
CPT Code	Full Description
EMG	
95860	Needle electromyography, one extremity with or without related paraspinal areas
95861	Needle electromyography, two extremities with or without related paraspinal areas
95863	Needle electromyography, three extremities with or without related paraspinal areas
95864	Needle electromyography, four extremities with or without related paraspinal areas
95867	Needle electromyography, cranial nerve supplied muscles, unilateral
95868	Needle electromyography, cranial nerve supplied muscles, bilateral
95869	Needle electromyography; thoracic paraspinal muscles
95872	Needle electromyography using single fiber electrode, with quantitative measurement of jitter, blocking and/or fiber density, any/all sites of each muscle studied

Maximum Allowable Reimbursement for Selected Knee Arthroscopy Codes



CPT Code	Full Description
Arthroscopy, Knee	
29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
29871	Arthroscopy, knee, surgical; for infection, lavage and drainage
29874	Arthroscopy, knee, surgical; for removal of loose body or foreign body (eg, osteochondritis dissecans fragmentation, chondral fragmentation)
29875	Arthroscopy, knee, surgical; synovectomy, limited (eg, plica or shelf resection) (separate procedure)
29876	Arthroscopy, knee, surgical; synovectomy, major, two or more compartments (eg, medial or lateral)
29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)
29879	Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture
29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving)
29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving)
29882	Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)
29883	Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)
29884	Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure)
29885	Arthroscopy, knee, surgical; drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)
29886	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion
29887	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixation
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction

Maximum Allowable Reimbursement for Spinal MRI Codes



MRI's were billed as limited, standard and extended in the 1996 MFG. Coding requirements changed soon after the adoption of the 1996 MFG but were not implemented in the Tx. workers' compensation system until 8/1/2003.

CPT Code	Full Description
Spinal Magnetic Resonance Imaging	
72141	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material
72142	Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)
72146	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material
72147	Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)
72148	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material
72149	Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)
72156	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical
72157	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar
72159	Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s)

SECTION C

A description of any significant implementation issues TWCC has encountered with the 2002 medical fee guideline

Several complicating factors have arisen through the pre- and post-implementation of a Medical Fee Guideline consistent with the statutory provisions that the Commission's guidelines be based on the most current reimbursement methodologies, models, and values or weights used by the Centers for Medicaid/Medicare Services, including the applicable payment policies relating to coding, billing, and reporting.

Implementation Delay Due to Litigation. The Medical Fee Guidelines (MFG) currently in place were proposed on December 12, 2001 and included the Medicare payment policies and procedures, based on extensive input from stakeholders. After careful consideration of public comment received at a public hearing and through written testimony, the Commission adopted the new MFG in April 2002. The new MFG provided for a 125% Medicare conversion factor and included Medicare payment policies and procedures. The effective date for the new MFG was September 1, 2002.

Before the MFG was implemented, the Texas Medical Association and the AFL/CIO jointly sued and the court issued a temporary injunction preventing implementation and remanding the MFG to the Commission to either revise or readopt it. The Commission readopted the MFG in December 2002 with a supplemental preamble. The court issued a decision on June 11, 2003 upholding the adoption of the MFG and ordering an effective date of August 1, 2003. The quick implementation of the MFG after the court's decision was made more difficult by the fact that many system participants had waited for the court case to settle rather than becoming familiar with the Medicare system and developing processes and automated systems to function under the new MFG.

Post Implementation Issues. The 2002 MFG brought about significant changes in medical billing, reimbursement and utilization in the workers' compensation system. With its implementation, the four most significant issues Texas has faced have been (1) clarifying how to apply Medicare payment policies to a workers' compensation or occupational medicine environment; (2) converting to a very dynamic and extensive Medicare-related billing and reimbursement system; (3) reconciling the use of both Medicare payment policies and other treatment guidelines under consideration; and (4) defining how to best implement a system for electronic billing of medical services between the health care provider and the insurance carriers.

Medicare Payment Policies v. Medical Necessity. Some confusion remains concerning the applicability of Medicare payment policies in a workers' compensation setting because some of these policies conflict with the statutory provisions relating to the provision of "reasonable and necessary medical care" for workers' compensation claimants. Although some carriers would like simply to apply the Medicare payment policies in performing their bill review functions, the MFG and a clarifying advisory issued by the Commission establish that medical necessity takes precedence over Medicare payment policies for workers' compensation.

Understanding Medicare Policies and Guidelines. The learning curve for healthcare providers and insurance carriers who conduct other parts of their business in the Medicare arena has been relatively short. However, those providers and carriers whose business activities are primarily in workers' compensation have had a much more difficult time learning and understanding the ever-changing nature of Medicare. It appears that there are more health care providers and carriers who fall in the latter category than in the first.

Many workers' compensation carriers and health care providers who provided coverage and medical care in Texas generally had not performed bill processing in a Medicare-like environment. Implementation of the 2002 MFG has required these entities to train staff and implement programming changes to account for the Medicare-based guideline. To assist in these efforts, the Commission has produced educational information and identified resources for system participants to use in becoming familiar with and staying current on Medicare reimbursement policies.

Evidence of this learning curve can be seen through the types of disputes being filed through medical dispute resolution process. To date, the majority of fee disputes over medical care provided since August 1, 2003 have been the result of either the provider or insurance carrier not being familiar with the appropriate Medicare payment policies or billing codes. With education, it is the Commission's expectation that the number of medical fee disputes will diminish over time.

Treatment Guideline Reconciliation. When the Commission proposed adoption of a treatment guideline in October, 2001, the overwhelming request from stakeholders was to allow the Medicare payment policies to serve as treatment guidelines. As a result, the Commission withdrew the rule that would have adopted the use of treatment guidelines. With some time under the Medicare-based fee guideline, the Commission and many of the stakeholders have concluded that a treatment guideline is needed in addition to the Medicare payment policies. The Commission has contracted with a medical expert to assist in determining the interplay of the Medicare payment policies and treatment guidelines and to identify potential conflicts. This information will be used in developing new rules for the use of a disability management model for the delivery of medical care that will incorporate the use of treatment guidelines.

Electronic Billing for Medical Services. One of the common complaints of the Commission's implementation of a Medicare-based fee guideline is that it does not require a mechanism for electronic billing between the health care providers and the insurance carriers, as is the case with Medicare. In the Medicare system, the Centers for Medicare and Medicaid Services (CMS), contracts with two intermediaries to process bills in their ever-changing system. These two carriers specialize in Medicare payment policies and have software programs that are specifically designed and maintained using the most up to date Medicare policies. These automated tools allow for fewer disputes over billing and much shorter payment timeframes.

In the Texas workers' compensation system, there are over 250 workers' compensation carriers, and the additional bill review entities that may be under contract with the carriers, that need to be taken into consideration while determining how to incorporate electronic billing into the workers' compensation system. Furthermore, the need for documentation on whether the medical care being billed for is related to a compensable injury adds additional complication to the use of electronic billing in a workers' compensation environment. However, with the Spring 2005 implementation of a new, nationally recognized format for electronic submission of medical billing data to the Commission, carriers will be better positioned to make the necessary system modifications to allow for electronic billing from and remittance to the health care providers. The Commission is presently identifying options for adoption of full electronic billing from the health care providers to the insurance carriers and to the Commission.

SECTION D

A description of TWCC's on-going fee guideline development or implementation efforts in other areas (i.e., hospitals, ambulatory surgical centers, etc.)

Ambulatory Surgery Center Fee Guideline. On April 15th of this year, the Commission adopted the Ambulatory Surgery Center (ASC) Fee Guideline that set the payment adjustment factor at 213.3% of the Medicare ASC payment rate. The new rule uses the Medicare methodology for determining ASC reimbursement required by HB 2600 and provides standardization of coding, billing and reporting procedures by aligning the workers' compensation billing procedures with a those in the Medicare system.

Inpatient and Outpatient Hospital Fee Guidelines. In response to public input, all three facility fee guidelines have not been adopted at the same time. The current hospital in-patient fee guideline has been in effect since August 1, 1997. Although the Commission has not yet adopted a hospital out-patient guideline, we anticipate proposing a revised in-patient fee guideline and a new out-patient guideline in late 2004 or early 2005.

Pharmacy Fee Guidelines. Pharmacy fee guidelines that establish maximum allowable reimbursements for prescription drugs have been in effect since 1/3/02 and were amended in March 2004.