DWC-06-0023

SUBCHAPTER G. Prospective and Concurrent Review of Health Care
§134.600

The Commissioner of the Division of Workers' Compensation, Texas Department of Insurance, adopts amendments to §134.600, concerning Preauthorization, Concurrent Review, and Voluntary Certification of Health Care. The adopted rule will replace the emergency rule adopted by the Commissioner of the Division of Workers' Compensation on November 3, 2005, published in the November 18, 2005 issue of the *Texas Register* (30 TexReg 7624), with an extension published in the March 10, 2006 issue of the *Texas Register* (31 TexReg 1539). The amended section is adopted with changes to the proposed text as published in the February 10, 2006 issue of the *Texas Register* (31 TexReg 812).

The amendments are necessary to implement portions of House Bill (HB) 7, enacted during the 79th Legislature, Regular Session, effective September 1, 2005. The amendments permit expedited compliance with statutory changes to the Labor Code as a result of changes to §413.014 and new §408.0042. The changes affected by HB 7 include revisions to Labor Code §413.014(c) which requires that rules adopted under this section require health care providers to seek preauthorization and concurrent review at a minimum for certain treatments including physical and occupational therapy, and creation of new Labor Code §408.0042(d), which requires health care providers to seek preauthorization of

treatments for any injury or diagnosis not accepted as compensable by the insurance carrier (carrier) following an examination by the treating doctor.

This adopted section does not apply to networks certified under Insurance Code Chapter 1305 or political subdivisions with contractual relationships under Labor Code §504.053(b)(2).

The adoption addresses several statutory requirements by incorporating the provisions of Labor Code §408.028, regarding pharmaceutical closed formularies, and §413.011, regarding treatment guidelines, protocols, and treatment plans, as well as amendments to §413.014 and new §408.0042. In addition, this adoption reflects the Division's efforts to coordinate this section with anticipated future Division rulemaking initiatives related to Chapter 137 (related to Disability Management) and rules pertaining to treatment guidelines and treatment plans.

A few changes are made to the proposed sections as published. However, none of the changes introduce new subject matter or affect additional persons other than those subject to the proposal as originally published. Throughout the rule, particularly in subsections (g) and (h), the Division makes editorial and grammatical changes for ease of reading and clarity as a result of public comment.

Subsections (a) through (f), (i), (j), (m) through (o), and (q) through (t) are adopted as proposed.

Adopted subsection (g) is changed from the proposal and addresses the need for preauthorization when an carrier requests a treating doctor examination to define the compensable injury as set forth in Labor Code §408.0042. This provision aids in the communication between parties and brings the denial of the preauthorization request to the forefront, which may foster earlier resolution of disputes. Subsection (g)(1)(B), which required a statement initialed by the injured employee acknowledging possible responsibility for charges related to the health care services provided if the injury/diagnosis is finally adjudicated as not being work-related, is deleted. This subsection was deleted because of concern that the provision could have a negative impact on injured employees and return to work outcomes. Additional language is added as a result of public comment to clarify the Division's intent for carriers to review requests pursuant to Labor Code §408.0042 for both issues of medical necessity and compensability. The carrier is required to address whether the requested treatment/service is medically necessary and whether the injury/diagnosis is related to the compensable injury. Regardless of the issue of compensability, it is important to the workers' compensation system that the issue of medical necessity be addressed when the care is needed as receiving early treatment promotes injured employees' prompt recovery and return to work. Paragraphs (4) and (5) of this subsection include additional language as proposed to clarify the proper venue for resolving issues

of either medical necessity or compensability. Subsection (g)(4) is added to clarify that the requestor or employee may file a compensability/extent of injury dispute upon receipt of a carrier's denial based on the determination that the injury/diagnosis was not compensable or work-related. New subsection (g)(5) is added to clarify that medical dispute resolution is the proper forum for denials based on medical necessity but not for denials in which the issue is compensability.

Subsection (h) is changed from proposal to clarify that carriers are required to approve or deny requests based solely on the medical necessity of the health care, except for requests submitted in accordance with subsection (g), which are related to §408.0042.

Adopted subsection (k) is changed from the proposal and provides an enforcement mechanism for carriers that fail to comply with any timeframe requirements of this section. Specific references to subsection (i) and (j) are removed to reinforce the importance of compliance with the section in its entirety, as well as with the timeframes stated in the section.

Subsection (p) is changed from the proposal at paragraph (9), which indicates that durable medical equipment in excess of $500 billed charges per item will require preauthorization.

General Comment: A commenter expressed a general assessment of the workers' compensation system as a whole as a result of HB 7 implementation efforts, including observations that the current system is already overloaded, underpaid, overworked, and breaking down at a rapid pace. The commenter additionally has some generalized observations about the basic tenets of the rule, but primarily focuses on the belief that the denial processes were discriminatory and arbitrary. The commenter states that the denial processes are not favorable towards chiropractic providers and are used as a delaying tactic to avoid payment.

Agency Response: The Division notes the commenter's concerns about the current system. The Division has taken many steps in an effort to develop a fair and effective preauthorization process to address the burdens of the current system and notes that an enforcement mechanism has been added to the rule to address inconsistencies in the process.

General Comment: A commenter states proper preauthorization requests are not being replied to within the mandated timeframe, and that carriers are not being compliant, and there seems to be a lack of enforcement.

Agency Response: The Division acknowledges the commenter's concerns. New subsection (k) clarifies that there is an enforcement mechanism to assure that preauthorization requests are processed in an efficient and effective manner.

In order for the Division to take action, a complaint must first be received by the Division for investigation.

General Comment: A commenter recommends language be added to clarify the preauthorization rule does not apply to services rendered to employees participating in a workers' compensation network under Chapter 1305.

Agency Response: The Division declines to make this change as Labor Code §504.053 already addresses this situation. The Division attempts to avoid unnecessary repetition of statutory language; however, this clarification is added elsewhere in this adoption preamble.

(a) and (p)(5)(C): Commenters recommend definitions for medical necessity and surgical interventions. Commenters recommend that language be added to clarify that a surgical intervention is a surgery previously preauthorized by the carrier under subsections (p)(1), (2), and (3).

Agency Response: The Division declines to add definitions for these terms as it is believed that the terms are so widely used in the industry as to have a plain, commonly accepted meaning. Additionally, the Division declines to make the recommended change to subsection (p)(5)(C) because the language addition is not necessary.

(a)(1): Commenters recommend the definition of ambulatory surgical services be changed to reference the definition in §134.402. Commenters state this would provide necessary clarification of services that are included on the list under subsection (p)(2).

Agency Response: The Division declines to make this change. The term "ambulatory surgical services" is not defined in §134.402 (relating to Ambulatory Surgical Center Fee Guideline). Therefore, reference to §134.402 is not appropriate in this definition.

(a)(4): Commenters recommend language to clarify services provided by Division exempted programs is subject to retrospective review for the purposes of reimbursement by the carrier.

Agency Response: The Division clarifies that services subject to preauthorization and concurrent review are not subject to retrospective review. Conversely, exempted work hardening/work conditioning programs, as defined by subsection (a)(4), that do not require preauthorization or concurrent review are subject to retrospective review.

(b): Commenters recommend clarification regarding the prevailing provision if §134.600 conflicts with services requiring treatment plans.

Agency Response: The Division clarifies that subsection (b) as proposed resolves conflicts between Division-adopted treatment guidelines and this

section. Treatments and services covered within the treatment guidelines will continue to require preauthorization or concurrent review if they are included on the lists in subsection (p) or (q). The Division will monitor the situation for future rulemaking initiatives in the establishment of Chapter 137 (relating to Disability Management) and other applicable rules pertaining to treatment guidelines and treatment plans.

(e): Commenters recommend retaining the proposed deleted language that references a carrier's agent to include utilization review agents.

Agency Response: The Division declines to make the suggested change because carriers are allowed to use carrier's agents and utilization review agents in many processes pertaining to workers' compensation, not just in the preauthorization and concurrent review processes. The term "carrier agent" is defined in Chapter 133 (relating to General Medical Provisions), and the definition includes a utilization review agent.

(f) and (f)(2): A commenter recommends CPT codes be included in the components of a request, which improves a carrier's ability to approve treatments more quickly. Another commenter states carriers should not require health care providers to specify CPT codes as well as require the exact number of codes in each visit because a treatment plan is fluid and changes daily based on a patient's response to previous therapy.

Agency Response: The Division maintains that the preauthorization and concurrent review processes should focus on the delivery of health care or treatment provided to return the injured employee to work. While including CPT codes in preauthorization and concurrent review requests may be helpful to some carriers, such codes are not necessary in determining the medical necessity of the treatment or services. The Division notes that requiring such codes for the preauthorization and concurrent review processes would result in additional administrative burdens for providers and insurance carriers. Mandating specific CPT codes is likely to result in rigid and cumbersome preauthorization and concurrent review processes in which requests are unintentionally denied due to unnecessary administrative requirements.

(f): Commenters recommend an additional "shall" be included to provide clarification to the requestors as to their expected participation in the workers' compensation system.

Agency Response: The Division declines to make this change because the term "shall" is already included in the requirements of subsection (f).

(f): A commenter recommends language that allows injured employees to seek preauthorization be deleted from the rule because all health care should be coordinated with the treating doctor.

Agency Response: The Division declines to change the rule to limit the requestor to the treating doctor. The requirement of the Labor Code at §413.014 allows the claimant or health care provider to request preauthorization, and the rule language is consistent with the statutory requirement.

(f)(2): A commenter recommends adding language to decrease confusion by specifying "the maximum number of units of specific healthcare treatments."

Agency Response: The Division declines to incorporate the recommendation because this terminology was previously contained in subsection (e)(2) and has not been reported by system participants as confusing or difficult to apply. Additionally, the Division notes that the commenter's specific language recommendation may cause confusion.

(g): Commenters have concerns about the language that allows a health care provider to receive preauthorization approval based on medical necessity, yet be denied payment for the treatment or service from a workers' compensation carrier due to a compensability challenge. Commenters recommend either this issue be reconsidered and changed or develop a new rule to address situations where the health care provider is denied payment due to a determination that the injury is non-compensable or not work-related. A recommendation is made that would hold carriers accountable for preauthorized services and require carriers to coordinate benefits with the injured employee's group health.

Agency Response: The Division acknowledges the commenters' concerns but has no jurisdictional authority to regulate health care outside the workers' compensation system. The Labor Code mandates that carriers participating in the workers' compensation system are required to pay for health care only if the injury is compensable. Addressing the issue of medical necessity as it arises is important to encourage early treatment and promote injured employees' prompt recovery and return to work. If an injury or diagnosis is deemed not compensable or is not a work-related injury, the health care providers are extended the same collection opportunities as every other health care provider not in the workers' compensation system. The Division notes that the health care provider is in the most appropriate position to collect on the health care services rendered since the health care provider has a direct relationship with the injured employee and has specific knowledge of the health care services rendered. Requiring a workers' compensation carrier to coordinate collection of payment from a group health carrier or injured employee for health care services not related to a compensable injury is likely to result in a negative financial impact to the workers' compensation carrier and increase overall costs in the system because it requires resources to be used for non-workers' compensation related activities. The Division is hopeful that newly promulgated §126.14 (relating to Treating Doctor Examination to Define Compensable Injury) may be used as a tool to communicate the limits of health care that may be provided in the workers'

compensation system. The Division will monitor the frequency of these occurrences and will continue to review this issue.

(g) and (h): Commenters recommend clarification be provided regarding subsections (g) and (h) as they seem to be in conflict. Subsection (g) implies denials may be based on medical necessity, unrelated injury/diagnosis, or both. Subsection (h) states the carrier shall review for both medical necessity and relatedness. In addition, subsection (h) appears in conflict with Labor Code §408.0042(d).

Agency Response: The Division notes clarification was needed regarding subsections (g) and (h). Therefore, subsections (g) and (h) have been changed to clarify that requests submitted in accordance with §408.0042 are required to be reviewed for both issues of medical necessity and relatedness. Regardless of the issue of relatedness, it is important to the workers' compensation system that the issue of medical necessity be addressed when the care is needed because receiving early treatment promotes injured employees' prompt recovery and return to work. In addition, it may also be a negative impact to the system if the diagnosis is ultimately compensable and the issue of medical necessity was not addressed.

(g): A commenter supports this subsection.

Agency Response: The Division appreciates the comment.

(g): A commenter recommends a carrier be prevented from denying payment for preauthorized services when the injury/diagnosis is not compensable or work-related unless the carrier has provided clear notice that the injury/diagnosis is in a compensability dispute.

Agency Response: The Division declines to change the rule. However, the Division clarifies that subsection (l)(3) establishes that an insurance carrier is required to include in an approval a notice of any unresolved dispute regarding the denial of compensability or liability or an unresolved dispute of extent or relatedness to the compensable injury. Additionally, the Division notes that Chapter 133 (relating to General Medical Provisions) addresses carriers' medical payment denials based on a non-compensable injury or when the condition for which the health care was provided was not related to the compensable injury. The Division notes the concern related to denials of payment for previously preauthorized care and will continue to review this issue.

(g)(1)(B): A commenter recommends the deletion of this subsection, which provides that the request contain an initialed statement by the injured employee. This requirement is unnecessary because §413.042 allows the health care provider to pursue a private claim against an injured employee if the injury is finally adjudicated as non-compensable or not work-related. The commenter further states that injured employees that are unable to pay for medical care may

be intimidated by medical cost and refuse health care even if the injury is finally adjudicated as compensable or work-related. This lack of care may result in a longer recovery period and negatively impact return to work outcomes.

Agency Response: The Division agrees with the commenter's recommendation and subsection (g) has been changed to delete this requirement.

(g)(1)(B): Commenter recommends a change to clarify in the injured employee's initialed statement that the injured employee may be liable "if the injury/diagnosis is finally adjudicated as not work-related."

Agency Response: The Division declines this recommendation and clarifies that subsection (g) has been changed to delete the required injured employee's initialed statement.

(g)(1)(B): A commenter states that the subsection does not indicate who is to retain a copy of the initialed statement and recommends a copy be provided to the injured employee. The commenter also recommends this statement be provided in a variety of languages.

Agency Response: The Division declines this recommendation and clarifies that subsection (g) has been changed to delete the required injured employee's initialed statement.

(h): A commenter states this subsection implies that the examination to define the compensability, rather than the treatment requested for a non-accepted diagnosis, requires preauthorization.

Agency Response: The Division notes clarification was needed and subsections (g) and (h) have been changed to clarify that requests submitted in accordance with Labor Code §408.0042 are required to be reviewed for both issues of medical necessity and compensability. The Division further clarifies that the examination to define the compensability does not require preauthorization and, the process is clarified by §126.14 (relating to Treating Doctor Examination to Define Compensable Injury).

(i): A commenter recommends adoption of preauthorization timeframes set forth in 28 TAC §10.102(e) - (g) in order to standardize preauthorization timeframes for both network and non-network services and also with HMOs under the Insurance Code.

Agency Response: The Division declines to change the rule to require a three calendar day timeframe as used in the workers' compensation network rules. No changes were proposed to the timeframes included in subsection (i), which prior to adoption were contained in subsection (f). The networks have the flexibility to design their preauthorization system through contracts with their health care providers in order to comply with the network timeframes. Preauthorization in the non-network workers' compensation system is established by this rule and not

subject to specific contractual negotiations between carriers and health care providers. Therefore, a three working day timeframe is more appropriate than the network timeframe.

(i): A commenter recommends the section allow pharmacists to dispense and be reimbursed for an emergency supply of a prescribed drug. This could be limited to three working days, which is consistent with a carrier's response time on a preauthorization request.

Agency Response: The Division declines to make the recommended change; however, §134.501 (relating to Initial Pharmaceutical Coverage) offers such provisions. Section 134.501 states that, for injuries which occur on or after December 1, 2002, the carrier shall pay for specified pharmaceutical services sufficient for the first seven days following the date of injury, regardless of issues of liability for or compensability of the injury that the carrier may have, if, prior to providing the pharmaceutical services, the health care provider obtains both a verification of insurance coverage, and an oral or written confirmation that an injury has been reported. The Division will monitor the situation for future rulemaking initiatives in the establishment of closed formularies pursuant to the Labor Code at §408.028.

(i): A commenter recommends adding language to require the carrier to contact both the requestor and the employee to approve or deny the request.

Agency Response: The Division appreciates the comment but clarifies that subsection (j) provides that the carrier communicate to the requestor and the employee regarding the carrier's response. The Division declines to make the suggested change because subsection (i) is a mechanism to expedite the preauthorization and concurrent review processes. Subsection (j) requires the carrier to provide written notification to the employee, employee's representative, and requestor. The Division believes that written notification to the injured employee is the most appropriate and clear method of communication in this circumstance.

(i): A commenter recommends the carrier response time to a surgery request should be extended to 15 days instead of three. The commenter states surgeries are unusual and are often known far in advance of the actual surgery date and URAs are generally not provided with the necessary medical records that are pertinent to the review of the surgical recommendation in such short timeframes. Such a provision would ensure inappropriate, and expensive treatment would not be provided, which would reduce costs.

Agency Response: The Division declines to make the rule change to extend the carrier's response time for recommended surgeries, as the three-day carrier response time has been in effect since 1997 and has not been widely reported by system participants as unduly burdensome. The Division feels that the three-day timeframe is appropriate for all parties and the time parameters provide sufficient

time to review the request without causing undue delay or interruption of treatment to the injured employee. Further, there is nothing in the rule prohibiting the health care provider from anticipating the surgical recommendation, and requesting the carrier allow the pertinent medical records be sent to the carrier in advance of the preauthorization request.

(m): A commenter recommends clarification on what a "reasonable opportunity" is in light of the fact physicians must communicate with physicians. This prohibits the carrier from meeting the three-day response timeframe.

Agency Response: The Division disagrees that clarification of reasonable opportunity is necessary as this terminology was previously contained in subsection (e)(2) and has not been reported by system participants as confusing or difficult to apply. The Division believes that this terminology is so widely used in the industry as to have a plain, commonly accepted meaning. Additionally, the three-day timeframe is believed to be appropriate to provide sufficient time to review and discuss the request without causing undue delay or interruption of treatment to the injured employee.

(m): A commenter recommends that the denial include both a description and source of the screening criteria utilized in making the denial.

Agency Response: The Division declines to add the suggested language because it does not offer additional clarity to the subsection. The Division notes

that either a description of the screening criteria used, or the source of the screening criteria is required by subsection (m).

(m): A commenter questions the deletion of previous subsection (m) regarding the rule's severability clause.

Agency Response: The Division removed the severability clause previously in the rule in an effort to more closely align its rules with Texas Department of Insurance rules. Additionally, the Division clarifies that the previous severability clause is unnecessary and provides no additional legal protection.

(m)(4): A commenter recommends rewording to establish plain language descriptions of the complaint and appeal process, and the deletion of the rest of the paragraph.

Agency Response: The Division declines to make this change because such a description is more appropriate in other Division rules. The Division intends to promulgate and amend existing rules regarding complaints and the appeal process. The Division notes that when a carrier denies the medical necessity of a service, the health care provider is entitled to the clinical basis for the denial, a description or the source of the screening criteria that were utilized as guidelines in making the denial, and the principle reasons for the denial.

(o)(1): A commenter recommends language to change the timeframe for reconsideration from 15 working days to 90 working days.

Agency Response: The Division declines to make the suggested change because such a lengthy period for reconsideration requests would unnecessarily prolong the preauthorization process and it is important to the workers' compensation system that the issue of medical necessity be addressed when the care is needed as injured employees' receiving early treatment promotes prompt recovery and return to work. In addition, an injured employee's medical condition could undergo a substantial change within 90 days. Such a change would necessitate the submission of a new request.

(o)(4): A commenter suggests that the treating doctor should have the ability to guarantee payment to his consultants for a second opinion and diagnostic studies to support a substantial change in condition.

Agency Response: The Division declines to make the suggested change because it would be unduly burdensome to the preauthorization and concurrent review process and increase costs to the system.

(o)(4): A commenter recommends clarification regarding the carrier's responsibility if there was no substantial change in the employee's medical condition.

Agency Response: The Division clarifies that the preauthorization process should again be afforded to the requestor if the requestor provides objective clinical documentation to support the requestor's assertion that a substantial change in medical condition has occurred relating to a previously denied preauthorization request. A substantial change is a fact-specific determination, which is determined on a case-by-case basis. A substantial change in condition might be supported by information contained in objective documentation, such as: current diagnosis; current symptoms; responsiveness to therapy to date; work status update; pertinent findings; and pertinent diagnostic testing. The carrier should consider these elements when making this determination during the reconsideration process.

(o): A commenter recommends subsection (k) regarding administrative penalty for non-compliance apply to this subsection as well.

Agency Response: The Division agrees with the recommendation to extend the administrative penalties for non-compliance to all subsections containing timeframes. The rule now reflects this recommendation. Additionally, the Division clarifies that it is the Division's intention to monitor system participants regarding compliance with timeframes.

(p): A commenter is concerned with the deletion of some of the services (durable medical equipment, diagnostic services) from the list of services that require

preauthorization. The commenter believes this will result in over-utilization and increased costs and recommended this be re-evaluated.

Agency Response: The Division clarifies that durable medical equipment and repeat individual diagnostic studies have been retained, and are in subsection (p), paragraphs (8) and (9) of this section.

(p): Commenters recommend clarification on how subsections (p)(12)-(14) shall be coordinated with the other list items.

Agency Response: The Division clarifies that the purpose of subsection (b) is to resolve conflicts between Division-adopted treatment guidelines and this section. Treatments and services covered within the treatment guidelines will continue to require preauthorization or concurrent review if they are included on the lists in subsection (p) or (q). Treatments and services not covered within the treatment guidelines and not specifically included on the lists in subsection (p) or (q) will require preauthorization per subsection (p)(12). The Division anticipates that treatments and services specifically listed in subsection (p) or (q) may be included in required treatment plans. The Division will consider and monitor the situation relative to future rulemaking initiatives in the establishment of Chapter 137 (relating to Disability Management) and rules pertaining to treatment guidelines and treatment plans. In addition, subsection (p)(14) requires treatment for an injury or diagnosis that is not accepted by the carrier pursuant to Labor

Code §408.0042 and §126.14 of this title to be preauthorized. Subsection (g) specifically addresses requests submitted in accordance with subsection (p)(14).

(p): A commenter supports the inclusion of chronic pain management/interdisciplinary pain rehabilitation, discograms, and repeated diagnostic examinations over $350 on the list of services requiring preauthorization.

Agency Response: The Division appreciates the comment. However, the Division clarifies that discograms are not on the list of non-emergency health care requiring preauthorization unless it is a repeat individual diagnostic study.

(p)(5): A commenter recommends statutory support for the rationale for the six physical/occupational visits allowed by the rule be clearly delineated in the preamble. Another commenter states the Division has no authority to create this exception in the absence of expressed legislative intent. The commenter recommends the exception should be the same as the three working days the carrier has to respond instead of two weeks.

Agency Response: The Division clarifies that preauthorization is required for physical therapy and occupational therapy services as mandated by §413.014. The allowance of a short period where preauthorization is not required in order to avoid a delay in treatment for an injured employee is not contrary to that requirement. It is appropriate for the details of the preauthorization process to be

specified in this rule, including when the requirement begins. Pursuant to §413.011(g), the Commissioner may adopt rules that are designed to promote appropriate health care at the earliest opportunity after the injury to maximize injury healing and improve stay-at-work and return-to-work outcomes. Section 402.061 authorizes the Commissioner to implement and enforce the Texas Workers' Compensation Act. This implementation requires the Act to be viewed as a whole to ensure the goals of the Act are achieved.

In addition, physical therapy and occupational therapy services provided during this initial period are subject to retrospective review. Therefore, the carrier is not obligated to pay for such services if they are not medically necessary.

(p)(5): A commenter recommends physical and occupational therapy evaluations be included because an evaluation without treatment has been extremely disruptive and cumbersome for providing continuous care.

Agency Response: The Division declines to make this change because the Labor Code §413.014 requires the commissioner's rules under that section to specify physical and occupational "therapy" are to be preauthorized. An evaluation is not therapy; and, an evaluation may occur that does not result in physical/occupational therapy services being medically necessary.

(p)(5): A commenter states that there is no reason post-surgery physical/occupational therapy cannot be requested at the time of the surgical request or simultaneously with the surgery itself.

Agency Response: The Division agrees that it is feasible to request physical and occupational therapy at the time of the surgical request or simultaneously with the surgery itself. This section does not prevent this from occurring; in fact, subsection (p)(13) encourages such foresight through requiring preauthorization of treatment plans.

(p)(5)(B): A commenter asks whether Health Care Procedural Coding System (HCPCS) Level II temporary codes for physical and occupational therapy services in a home setting apply to only HCPCS Level II codes S9129 and S9131 or if the temporary codes also include G0151 and G0152.

Agency Response: The Division clarifies that both sets of temporary codes referenced by the commenter for physical and occupational therapy services in a home setting are included in Level II temporary codes pursuant to subsection (p)(5)(B) and require preauthorization and concurrent review processing.

(p)(5)(B): Commenters recommend language changes to subsections (p)(5)(B) to include "procedures/professional services" as well as temporary codes. Commenters state this change would include all G-codes, including electronic

stimulators, and S-codes, including home care training, that may be provided as physical and occupational therapy services.

Agency Response: The Division declines to make this change as Labor Code §413.014 requires the commissioner's rules adopted under that section to require preauthorization and concurrent review of physical and occupational therapy services. The Division, after extensive review and input by system stakeholders via an emergency rule, and a pre-proposal rule draft, believes physical and occupational therapy services are adequately identified as adopted in this subsection, and not necessarily identified as everything a physical or occupational therapist is allowed to do within their practice act. However, the Division clarifies that temporary G-codes specifically listing services of physical/occupational therapists in a home health setting require preauthorization in accordance with subsection (p)(5)(B).

(p)(5)(C): Commenters recommend a change to reflect "six sessions" rather than "six visits" to eliminate the interruption of treatment for at least three days in order to obtain preauthorization. Some commenters recommend extending the timeframe to 30 days for which the delivery of physical and occupational therapy services need not require preauthorization and concurrent review. Some commenters state that the extension of this timeframe may result in decreased costs to the system and prevent delay in providing health care to the injured employee.

Agency Response: The Division declines to make the recommended change because the timeframe for physical and occupational therapy services needing preauthorization and concurrent review has been extended from two visits, as stated in the adopted emergency rule, to six visits as currently written in an effort to address concerns regarding cost in the system and to prevent delay in health care delivery to the injured employee.

(p)(5)(C): Commenters recommend the Division define "visit" with regard to physical and occupational session because such a clarification will enhance the communication between system participants, expedite the preauthorization and bill review processes, and minimize unnecessary disputes.

Agency Response: The Division declines to make this change. The Division believes that the term "visit" is so widely used in the medical field as to have a plain, commonly accepted meaning. The Division feels that defining such a term is unnecessary and may cause confusion amongst system participants.

(p)(9): Commenters recommend language specify that durable medical equipment in excess of $500 billed charges per item require preauthorization. Such a clarification will enhance the communication between system participants and expedite the preauthorization process.

Agency Response: The Division agrees to make the suggested change in an effort to enhance communication between system participants.

(p)(10): A commenter recommends Commission on Accreditation of Rehabilitation Facilities (CARF) accredited pain management programs not be required to obtain preauthorization and to be the same as CARF accredited work hardening/work conditioning programs.

Agency Response: The Division declines to make this change because pain management programs have been identified as items historically highly requested in the preauthorization process. Additionally, Labor Code §413.014 requires a preauthorization exemption for CARF accredited work hardening/work conditioning programs. The Labor Code does not include such a provision for pain management programs.

(p)(12): A commenter inquires about the screening criteria carriers will use to determine medical necessity for treatment/services not addressed by a Division treatment guideline.

Agency Response: The Division's future rulemaking initiative includes the establishment of Chapter 137 (relating to Disability Management). This chapter may include treatment protocols not addressed by treatment guidelines or treatment planning. Until these rules are fully implemented, the Division clarifies that carriers should continue to use their individually established screening criteria.

(p)(12) and (13): A commenter recommends that the section be revised to include a list of specific services because the current section is not descriptive enough.

Agency Response: The Division will take this comment into consideration and monitor the situation relative to future rulemaking initiatives in the establishment of Chapter 137 (relating to Disability Management) and applicable rules pertaining to treatment guidelines and treatment plans.

(q): A commenter recommends concurrent review apply only to inpatient length of stay as the remainder of the items on the list should not require a one-day turnaround. Other commenters recommend physical/occupational therapy be removed as the one-day turnaround is unrealistic for these types of treatments.

Agency Response: The Division declines to make this change and clarifies that per subsection (i)(2) a one-day turn around time applies only to inpatient stays and not all items on the concurrent review list.

(q)(3): Commenters state that any request for physical and occupational therapy services beyond the initial authorization that is above and beyond the initial six visits would be considered outside the current evidence-based treatment guidelines (i.e., Official Disability Guideline (ODG), American College of Occupational and Environmental Medicine (ACOEM)).

Agency Response: The Division will take this comment into consideration and monitor the situation relative to future rulemaking initiatives in the establishment of Chapter 137 (relating to Disability Management) and rules pertaining to treatment guidelines and treatment plans.

(r): A commenter recommends hospitals be given the ability to obtain preauthorization or verification of payment for any proposed service, not just those listed in subsection (p). The commenter also recommends that such services should not be subject to retrospective review of medical necessity.

Agency Response: The Division declines to make this change. The list of services requiring preauthorization is comprehensive, especially in relation to hospital services. Further, requiring preauthorization for more or all services that hospitals provide would be unduly costly to the system. Verification of payment is accomplished through receipt of an explanation of benefits in accordance with Chapter 133 (relating to General Medical Provisions).

(s): A commenter suggests limiting preauthorization controls to only individual doctors or individual workers' compensation claims. The commenter recommends that doctors be regulated by the Insurance Commissioner and not under the purview of the Division of Workers' Compensation.

Agency Response: The Division declines to make the suggested changes because it unnecessarily limits the regulatory authority needed by the Division to

enforce applicable statutory and rule provisions. The Division of Workers' Compensation is a division within the Texas Department of Insurance and is statutorily required to administer and operate the Texas Workers' Compensation System pursuant to §402.001(b) of the Labor Code, which includes the regulation of all system participants.

(t): Commenters recommend that the Division provide detailed clarification of how the list items should be reported in subsequent reporting requirements.

Agency Response: The Division utilizes notifications to inform participants of established forms and implementation periods. Notifications are disbursed with ample time to allow carriers to capture Division-required data. Additionally, the Division has granted extensions when appropriate to accommodate the needs of a carrier. The Division anticipates utilizing the same cooperative working relationships with carriers and other system participants for ongoing data collection efforts and consequently the Division declines the recommendation to specify by rule.

For: Medtronic.

For, with changes: Memorial Hermann Worklink; Riata Therapy Specialists, PLLC; Concentra Medical Center; Texas Medical Association; Work & Rehab; American Insurance Association; Denton Management Associates, LLC; GENEX Services, Inc.; Office of Injured Employee Counsel; State Office of Risk

Management; The Boeing Company; Texas Mutual Insurance Company; Texas Association of School Boards Risk Management Fund; TIRR Rehabilitation Center; Concentra Health Services; Midland Memorial Hospital; Fair Isaac Corporation; Insurance Council of Texas; Property Casualty Insurers Association of America; and individuals.

Against: Baker Chiropractic and Flahive, Ogden & Latson.

Neither for nor Against: CS Stars.

The amendments are adopted under Labor Code §§413.014, 408.0042, 402.00111 and 402.061. Section 413.014 requires that the Commissioner's preauthorization and concurrent review rules adopted under this section include at a minimum the list of services specified in that section. Section 408.0042(d) requires preauthorization of treatments for any injury or diagnosis not accepted as compensable by the carrier following a requested examination by the treating doctor. Section 402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Section 402.061 provides the Commissioner the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

§134.600. Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.

(a) The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

(1) Ambulatory surgical services: surgical services provided in a facility that operates primarily to provide surgical services to patients who do not require overnight hospital care.

(2) Concurrent review: a review of on-going health care listed in subsection (q) of this section for an extension of treatment beyond previously approved health care listed in subsection (p) of this section.

(3) Diagnostic study: any test used to help establish or exclude the presence of disease/injury in symptomatic persons. The test may help determine the diagnosis, screen for specific disease/injury, guide the management of an established disease/injury, and formulate a prognosis.

(4) Division exempted program: a Commission on Accreditation of Rehabilitation Facilities (CARF) accredited work conditioning or work hardening program that has requested and been granted an exemption by the Division from preauthorization and concurrent review requirements.

(5) Final adjudication: the Commissioner has issued a final decision or order that is no longer subject to appeal by either party.

(6) Outpatient surgical services: surgical services provided in a freestanding surgical center or a hospital outpatient department to patients who do not require overnight hospital care.

(7) Preauthorization: prospective approval obtained from the insurance carrier (carrier) by the requestor or injured employee (employee) prior to providing the health care treatment or services (health care).

(8) Requestor: the health care provider or designated representative, including office staff or a referral health care provider/health care facility that requests preauthorization, concurrent review, or voluntary certification.

(9) Work conditioning and work hardening: return to work rehabilitation programs as defined in Chapter 134 of this title (relating to Benefits – Guidelines for Medical Service, Charges and Payments).

(b) When Division-adopted treatment guidelines conflict with this section, this section prevails.

(c) The carrier is liable for all reasonable and necessary medical costs relating to the health care:

(1) listed in subsection (p) or (q) of this section only when the following situations occur:

(A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

(B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;

(C) concurrent review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or

(D) when ordered by the Commissioner; or

(2) per subsection (r) of this section when voluntary certification was requested and payment agreed upon prior to providing the health care for any health care not listed in subsection (p) of this section.

(d) The carrier is not liable under subsection (c)(1)(B) or (C) of this section if there has been a final adjudication that the injury is not compensable or that the health care was provided for a condition unrelated to the compensable injury.

(e) The carrier shall designate accessible direct telephone and facsimile numbers and may designate an electronic transmission address for use by the requestor or employee to request preauthorization or concurrent review during normal business hours. The direct number shall be answered or the facsimile or electronic transmission address responded to by the carrier within the time limits established in subsection (i) of this section.

(f) The requestor or employee shall request and obtain preauthorization from the carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this

section. The request for preauthorization or concurrent review shall be sent to the carrier by telephone, facsimile, or electronic transmission and, include the:

(1) specific health care listed in subsection (p) or (q) of this section;

(2) number of specific health care treatments and the specific period of time requested to complete the treatments;

(3) information to substantiate the medical necessity of the health care requested;

(4) accessible telephone and facsimile numbers and may designate an electronic transmission address for use by the carrier;

(5) name of the provider performing the health care; and

(6) facility name and estimated date of proposed health care.

(g) A health care provider may submit a request for health care to treat an injury or diagnosis that is not accepted by the carrier in accordance with Labor Code §408.0042.

(1) The request shall be in the form of a treatment plan for a 60 day timeframe.

(2) The carrier shall review requests submitted in accordance with this subsection for both medical necessity and relatedness.

(3) If denying the request, the carrier shall indicate whether the denial is based on medical necessity and/or unrelated injury/diagnosis in accordance with subsection (m).

(4) The requestor or employee may file an extent of injury dispute upon receipt of a carrier's response which includes a denial due to unrelated injury/diagnosis, regardless of the issue of medical necessity.

(5) Requests which include a denial due to unrelated injury/diagnosis may not proceed to medical dispute resolution based on the denial of unrelatedness. However, requests which include a denial based on medical necessity may proceed to medical dispute resolution for the issue of medical necessity in accordance with subsection (o).

(h) Except for requests submitted in accordance with subsection (g) of this section, the carrier shall approve or deny requests based solely upon the medical necessity of the health care required to treat the injury, regardless of:

(1) unresolved issues of compensability, extent of or relatedness to the compensable injury;

(2) the carrier's liability for the injury; or

(3) the fact that the employee has reached maximum medical improvement.

(i) The carrier shall contact the requestor or employee by telephone, facsimile, or electronic transmission with the decision to approve or deny the request as follows:

(1) within three working days of receipt of a request for preauthorization; or

(2) within three working days of receipt of a request for concurrent review, except for health care listed in subsection (q)(1) of this section, which is due within one working day of the receipt of the request.

(j) The carrier shall send written notification of the approval or denial of the request within one working day of the decision to the:

(1) employee;

(2) employee's representative; and

(3) requestor, if not previously sent by facsimile or electronic transmission.

(k) The carrier's failure to comply with any timeframe requirements of this section shall result in an administrative violation.

(l) The carrier shall not withdraw a preauthorization or concurrent review approval once issued. The approval shall include:

(1) the specific health care;

(2) the approved number of health care treatments and specific period of time to complete the treatments; and

(3) a notice of any unresolved dispute regarding the denial of compensability or liability or an unresolved dispute of extent of or relatedness to the compensable injury.

(m) The carrier shall afford the requestor a reasonable opportunity to discuss the clinical basis for a denial with the appropriate doctor or health care

provider performing the review prior to the issuance of a preauthorization or concurrent review denial. The denial shall include:

(1) the clinical basis for the denial;

(2) a description or the source of the screening criteria that were utilized as guidelines in making the denial;

(3) the principle reasons for the denial, if applicable;

(4) a plain language description of the complaint and appeal processes, if denial was based on Labor Code §408.0042, include notification to the injured employee and health care provider of entitlement to file an extent of injury dispute in accordance with Chapter 141 of this title (relating to Dispute Resolution—Benefit Review Conference); and

(5) after reconsideration of a denial, the notification of the availability of an independent review.

(n) The carrier shall not condition an approval or change any elements of the request as listed in subsection (f) of this section, unless the condition or change is mutually agreed to by the health care provider and carrier and is documented.

(o) If the initial response is a denial of preauthorization, the requestor or employee may request reconsideration. If the initial response is a denial of concurrent review, the requestor may request reconsideration.

(1) The requestor or employee may within 15 working days of receipt of a written initial denial request the carrier to reconsider the denial and shall document the reconsideration request.

(2) The carrier shall respond to the request for reconsideration of the denial:

(A) within five working days of receipt of a request for reconsideration of denied preauthorization; or

(B) within three working days of receipt of a request for reconsideration of denied concurrent review, except for health care listed in subsection (q)(1) of this section, which is due within one working day of the receipt of the request;

(3) The requestor or employee may appeal the denial of a reconsideration request regarding medical necessity by filing a dispute in accordance with Labor Code §413.031 and related Division rules.

(4) A request for preauthorization for the same health care shall only be resubmitted when the requestor provides objective clinical documentation to support a substantial change in the employee's medical condition. The carrier shall review the documentation and determine if a substantial change in the employee's medical condition has occurred.

(p) Non-emergency health care requiring preauthorization includes:

(1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;

(2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

(3) spinal surgery;

(4) all non-exempted work hardening or non-exempted work conditioning programs;

(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

(i) Modalities, both supervised and constant attendance;

(ii) Therapeutic procedures, excluding work hardening and work conditioning;

(iii) Orthotics/Prosthetics Management;

(iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and

(B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;

(C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:

(i) the date of injury, or

(ii) a surgical intervention previously preauthorized by the carrier;

(6) any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care;

(7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or Division exempted return-to-work rehabilitation program;

(8) unless otherwise specified in this subsection, a repeat individual diagnostic study:

(A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline, or

(B) without a reimbursement rate established in the current Medical Fee Guideline;

(9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);

(10) chronic pain management/interdisciplinary pain rehabilitation;

(11) drugs not included in the Division's formulary;

(12) treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier;

(13) required treatment plans; and

(14) any treatment for an injury or diagnosis that is not accepted by the carrier pursuant to Labor Code §408.0042 and §126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury).

(q) The health care requiring concurrent review for an extension for previously approved services includes:

(1) inpatient length of stay;

(2) all non-exempted work hardening or non-exempted work conditioning programs;

(3) physical and occupational therapy services as referenced in subsection (p)(5) of this section;

(4) investigational or experimental services or use of devices;

(5) chronic pain management/interdisciplinary pain rehabilitation; and

(6) required treatment plans.

(r) The requestor and carrier may voluntarily discuss health care that does not require preauthorization or concurrent review under subsections (p) and (q) of this section respectively.

(1) Denial of a request for voluntary certification is not subject to dispute resolution for prospective review of medical necessity.

(2) The carrier may certify health care requested. The carrier and requestor shall document the agreement. Health care provided as a result of the agreement is not subject to retrospective review of medical necessity.

(3) If there is no agreement between the carrier and requestor, health care provided is subject to retrospective review of medical necessity.

(s) An increase or decrease in review and preauthorization controls may be applied to individual doctors or individual workers' compensation claims, by the Division in accordance with Labor Code §408.0231(b)(4) and other sections of this title.

(t) The carrier shall maintain accurate records to reflect information regarding requests for preauthorization, or concurrent review approval/denial decisions, and appeals, if any. The carrier shall also maintain accurate records to reflect information regarding requests for voluntary certification approval/denial decisions. Upon request of the Division, the carrier shall submit such information in the form and manner prescribed by the Division.