Subchapter C - Medical Fee Guidelines
28 TAC §134.230

Subchapter G - Prospective and Concurrent Review of Health Care
28 TAC §134.600

1. INTRODUCTION. The Texas Department of Insurance, Division of Workers' Compensation (division) proposes amendments to 28 Texas Administrative Code (TAC) §134.230, *Return to Work Rehabilitation Programs*, and §134.600, *Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care*.

The proposed changes remove references to the preauthorization exemption for Commission on Accreditation of Rehabilitation Facilities (CARF) accredited programs related to Work Conditioning (WC) and Work Hardening (WH) services and provide a single reimbursement rate applicable to WC and WH services for all providers of these services, regardless of accreditation status. The proposed amendments do not affect, in any manner, the reimbursement rates applicable to Chronic Pain Management/Interdisciplinary Pain Rehabilitation or Outpatient Medical Rehabilitation Programs, regardless of CARF accreditation status.

WC and WH programs initially were utilized in the workers' compensation system in the mid-1990s. Both services are highly structured, goal-oriented individualized treatment programs designed to maximize the ability of injured employees to return to work (RTW). WC programs are a single disciplinary approach that use real or simulated work activities in conjunction with conditioning tasks. WH programs are interdisciplinary in nature designed to address the functional, physical, behavioral, and vocational needs of the injured employee.

Under the current version of §134.600, upon request, the Commissioner may grant an exemption to a CARF accredited WC or WH program from preauthorization and concurrent review requirements for those services. The current version of §134.230 provides that CARF accredited WC and WH programs receive the full Maximum Allowable Rate (MAR) for those services as a result of their accreditation. The preferential status of CARF accredited programs in terms of preauthorization requirements and reimbursement amounts was based on a general assumption that CARF accreditation would result in better outcomes, such as better cost effectiveness, shorter disability duration, and faster RTW.

Senate Bill (SB) 1494 of the 85th Legislative Regular Session amended Labor Code §413.014. Prior to the amendment, the statute required the commissioner to adopt rules to require preauthorization and concurrent review for WC or WH services provided by a health care facility not credentialed by an organization recognized by commissioner rules--the statute was interpreted to require that the commissioner recognize a credentialing organization. SB 1494 amended Labor Code §413.014(c)(2) to require pre-authorization and concurrent review for all WC and WH services. SB 1494 also added subsection (c-1) that gives the commissioner discretion to exempt from preauthorization and concurrent review WC and WH services "provided by a health care facility credentialed by an organization designated by commissioner rule." The proposed amendment to §134.600 reflects the commissioner's decision to exercise the discretion provided by Labor Code §413.014(c-1) to not designate a credentialing organization for preauthorization exemption.

As part of its FY 2017 Research Agenda, the Texas Department of Insurance Workers' Compensation Research and Evaluation Group (REG) updated a 2003 study conducted by its predecessor, the Research and Oversight Council on Workers' Compensation, that had analyzed the

impact of accredited and non-accredited work hardening/work conditioning programs. The REG published the results of that study, entitled "Outcome Comparisons of Return to Work Programs by Accreditation Status" in September 2017. To evaluate the effectiveness of the CARF accreditation, the REG's report compares the differences in utilization, cost, and outcome measurements associated with RTW rehabilitation programs by accreditation status.

Examining new injury claims from 2010 to 2013, the REG measured the impact of CARF accreditation on utilization, cost, and disability duration outcomes in RTW rehabilitation services. Using regression analysis, the REG controlled for the effects of external factors such as age, gender, network status, injury type, and injury severity. The results showed that there was no statistically significant difference in the disability duration measured by the length of temporary income benefits (TIBs) between accredited and non-accredited programs.

There were, however, significant differences in costs and utilization. For WH services, CARF accredited programs had lower utilization and higher costs than non-accredited programs. For WC services, CARF accredited programs had higher utilization and higher costs than non-CARF accredited programs.

The significant differences in costs were attributed to the medical fee guidelines that specify a 20 percent reduction in reimbursement for non-accredited programs. As a result of combined effects of different reimbursement rates and utilization, the average per claim cost of CARF accredited programs was higher than non-accredited programs by 12 percent ($667) in WH programs, and by 67 percent ($733) in WC programs. Despite the difference in average claim cost, there was no significant difference in the disability duration between claims at CARF accredited and non-accredited WC and WH programs. These results are similar to those in the 2003 study conducted by the Research and

Oversight Council. That study examined new claims of 1997 and 1998 injury years, covering services up to 2002, to evaluate the effects of CARF accreditation in programs. It found significant differences in utilization and costs, but no difference in disability duration outcomes in WH programs. Not only does there seem to be no significant difference in the outcomes based on entitlement to and payment of TIBs, the lack of differentiation seems to have held constant over a significant period of time.

Over time, there have been fewer CARF accredited programs registering with the division for exemption from preauthorization for WC and WH services. In 2003, there were 80 CARF accredited programs registered with the division. Of the 20 remaining CARF accredited WC and WH programs in Texas, 16 have registered for the exemption with the division. Historically, some CARF accredited programs have not applied for exemption from preauthorization and have preferred the certainty of establishing medical necessity through the preauthorization process prior to providing services, thereby eliminating the need for retrospective review of the services for medical necessity and removing a potential barrier to payment.

Based upon the REG report's findings regarding outcomes and the commissioner's discretion to not designate a credentialing organization for the purposes of the preauthorization exemption for WC and WH services granted to the commissioner by Senate Bill 1494, the proposed amendments to 28 TAC §134.600 remove the exemption status from CARF accredited programs.

The division is also proposing amendments to §134.230 to set a single reimbursement rate for WC services and WH services, regardless of a program's accreditation status, by removing the preferential reimbursement rate for CARF accredited WC and WH programs. In 1996 the Texas Workers' Compensation Commission determined that a financial incentive for CARF accreditation was appropriate. At the time, it was assumed that CARF accreditation assured program content,

which fostered an environment to create a program that increased the quality of rehabilitation services. Therefore, consideration was given to the financial and time investment necessary for a health care provider to meet CARF accreditation standards which was believed to justify a financial incentive for health care providers to obtain accreditation.

However, the results of two separate Texas Department of Insurance Workers' Compensation research studies found no statistically significant difference in disability duration measured by the length of TIBs between CARF accredited and non-CARF programs. The significant differences in per claim costs, utilization, and the effects of different reimbursement rates discussed above with respect to preauthorization are applicable to and were considered with respect to the reimbursement rate for WC and WH programs.

Based on the determination that the outcomes for accredited and non-accredited programs are similar, it is reasonable to conclude that reimbursement for these programs should be the same. Although the original adoption of the reimbursement differential recognized the expense and effort required for completion of the accreditation process, the underlying assumption was an expectation of enhanced program services and improved outcomes. Without any identifiable difference between them, there is no justification for paying a higher reimbursement rate for accredited programs that have not been proven to be superior to non-accredited programs. Consequently, the rationale for treating accredited and non-accredited programs in a disparate way is not supportable.

The reimbursement for all WC programs is proposed to be $28.80 per hour, and the reimbursement for all WH programs is proposed to be $51.20 per hour. These rates reflect 80% of the current MAR, the current reimbursement rates for non-network, non-CARF accredited WC and WH providers. These providers have been able to accommodate the current rates into their business

model. This seems to indicate that this rate is a reasonable fee within the market for these services. Currently, 75 percent of reimbursement for WC and WH services is paid at either the non-CARF accredited rate or through a certified network contract. Certified networks have also generally followed the division fee schedule for WC and WH services. This proposed change directly impacts approximately 25 percent of the total payments for WC and WH program services. Based on 2017 activity, this proposed change would potentially result in a system savings of approximately $200,000. Amendments to §134.230 also include several non-substantive changes for readability.

The division published an informal draft of these rules on its website on January 19, 2018. The division received and considered informal comments.

2. EXPLANATION.

Amended 28 TAC §134.230

The division proposes to restructure §134.230 for readability and to remove the preferential reimbursement rate for CARF accredited programs related to WC and WH services.

New §134.230(a) establishes the applicability of §134.230 by specifying that the section applies to services provided on or after September 1, 2018 by the Return to Work Rehabilitation Programs listed in the section. It establishes a delayed applicability date to facilitate implementation of the proposed rule.

New §134.230(a)(1) through (a)(4) list the types of programs the section applies to, including Work Conditioning/General Occupational Rehabilitation Programs; Work Hardening/Comprehensive Occupational Rehabilitation Programs; Chronic Pain Management; Interdisciplinary Pain Rehabilitation Programs; and Outpatient Medical Rehabilitation Programs.

New §134.230(b) states that Return to Work Rehabilitation programs should meet the specific program standards listed in the CARF Standards Manual. This language has not changed substantively from current §134.230--it has just been reorganized for readability.

New §134.230(c) has been added to provide the definition of Work Conditioning and Work Hardening in terms of CARF manual definitions. This language has not changed substantively from current §134.230--it has just been reorganized for readability.

New §134.230(c)(1) has been added to require the appropriate program modifier when billing for WC or WH services. This language has not changed substantively from current §134.230--it has just been reorganized for readability.

New §134.230(c)(2) stipulates the CPT code for WC by billed time and the reimbursement rate of $28.80 per hour and details regarding prorating billing and reimbursement increments of less than an hour. This new section combines the requirements in current §134.230(2)(A) and (B). The only substantive changes from the current §134.230 are the deletion of the "CA" modifier and the provision of a single reimbursement rate to reflect $28.80 for all providers of WC services. These changes are necessary based on the determination that CARF accredited and non-accredited programs have similar patient outcomes for WC services and should receive the same reimbursement rate, as detailed above.

New §134.230(c)(3) stipulates the CPT code for WH by billed time and the reimbursement rate of $51.20 per hour and details regarding prorating the billing and reimbursement of increments of less than an hour. This new section combines the requirements in current §134.230(3)(A) and (B). The only substantive changes from the current §134.230 are the deletion of the "CA" modifier and the provision of a single reimbursement rate to reflect $51.20

for all providers of WH services. These changes are necessary based on the determination that CARF accredited and non-accredited programs have similar patient outcomes for WH services and should receive the same reimbursement rate, as detailed above.

New §134.230(d) has been added to provide the billing and reimbursement amounts for Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs and Outpatient Medical Rehabilitation Programs. This language has not changed substantively from current §134.230--it has just been reorganized for readability.

New §134.230(d)(1) provides the percentage of MAR allowed for Chronic Pain programs for CARF and non-CARF accredited programs. This language has not changed substantively from current §134.230--it has just been reorganized for readability.

New §134.230(d)(2) has been added to provide coding requirements for CARF accredited and non-CARF accredited programs providing Chronic Pain services, the MAR amount of $125 per hour and details regarding prorating the billing and reimbursement of increments of less than an hour. This language has not changed substantively from current §134.230--it has just been reorganized for readability.

New §134.230(d)(3) has been added to provide coding requirements for CARF accredited and non-CARF accredited Outpatient Medical Rehabilitation Programs and sets MAR amount of $90 per hour and details regarding prorating the billing and reimbursement of increments of less than an hour. This language has not changed substantively from current §134.230--it has just been reorganized for readability.

New §134.230(e) has been added to provide an effective date for the section. It establishes a delayed effective date to help allow for ease of implementation of the proposed rule.

Amended 28 TAC §134.600

There have been no changes to §134.600(a)(1) - (4).

Amended §134.600(a)(5) has been deleted to remove the exemption from preauthorization for WC and WH services for division exempted CARF accredited programs. The remaining subsections, (a)(6) - (11), have been renumbered accordingly without substantive amendment. This change is necessary to effectuate the decision to no longer recognize a credentialing organization for exemption from preauthorization requirements for WC and WH services. This decision is based on the REG report's findings regarding outcomes and the commissioner's discretion to not recognize a credentialed health care facility as exempt from the preauthorization requirement for WC and WH services, discussed in detail above.

Amended §134.600(p)(4)(A) and (B) have been deleted to remove reference to exempted WC or WH services. This change is necessary to effectuate the decision to no longer recognize a credentialing organization for exemption from preauthorization requirements for WC and WH services. This decision is based on the REG report's findings regarding outcomes and the commissioner's discretion to not recognize a credentialed health care facility as exempt from the preauthorization requirement for WC and WH services, discussed in detail above.

Amended §134.600(q)(2)(A) and (B) have been deleted to remove reference to exempted WC or WH services. This change is necessary to effectuate the decision to no longer recognize a credentialing organization for exemption from preauthorization requirements for WC and WH services. This decision is based on the REG report's findings regarding outcomes and the commissioner's discretion to not recognize a credentialed health care facility as exempt from the preauthorization requirement for WC and WH services, discussed in detail above.

3. FISCAL NOTE. Mr. Matthew Zurek, Executive Deputy Commissioner for Health Care Management, has determined that for each year of the first five years the proposed amendments will be in effect, there will be no fiscal impact to state or local governments as a result enforcing and administering the proposal. There will be no measureable effect on local employment or the local economy as a result of the proposal.

4. PUBLIC BENEFIT AND COSTS. Mr. Zurek has also determined that, for each year of the first five years amended §134.230 and §134.600 are in effect, there will be a number of public health benefits. Requiring preauthorization of all WC and WH services provide greater consistency and administrative clarity for insurance carriers. Uniformity in the preauthorization requirements will also give providers more certainty in the claims process because lack of medical necessity will be removed as a reason for a retrospective health care services denial. Similarly, uniform preauthorization requirements for WC and WH services will help improve the quality of health care for injured employees because those services will have been determined to be medically necessary. Employers will also benefit when injured employees receive timely, appropriate care which facilitates return to work, and may realize indirect benefits through decreased premiums as a result of decreased medical benefit and indemnity costs through improved delivery of health care. The division anticipates the proposed amendments will facilitate the appropriate use of WC and WH services in the Texas workers' compensation system, resulting in improved quality of care, improved return-to-work outcomes, and fewer disputes.

Mr. Zurek anticipates that there will be costs to comply with §134.600. WC and WH services provided by the 16 exempted CARF accredited programs are currently subject to retrospective review for medical necessity. However, if the proposed amendments are adopted, these medical necessity reviews would be conducted prospectively. If the usage pattern remains unchanged, there will be

approximately 300 preauthorization requests for WC and WH claims from previously division exempted CARF accredited programs in the first 12 months after the rule becomes effective. The potential cost for the preauthorization of previously exempted claims would be 300 preauthorization reviews multiplied by $120 per review (a standard industry estimated average cost for preauthorization reviews is $60 - $120 per review). Thus, the fiscal impact could be as much as $36,000 in the first year. Assuming no change in utilization of WC and WH services at CARF accredited programs that were previously exempted from preauthorization, the cost over the first five years of amended §134.600 could be as much as $180,000. Ultimately, the net costs to insurance carriers for preauthorization of these claims will be the difference between the new preauthorization costs less the existing retrospective review costs. These costs are unique to the individual business practices of each insurance carrier as each utilizes unique retrospective review procedures. The 16 CARF accredited programs that are currently exempt from the preauthorization requirement for WC and WH services may incur a minimal administrative cost associated with requesting preauthorization as a result of the proposed amendments.

In addition, Government Code §2001.0045 requires a state agency to offset any costs associated with a proposed rule by: (1) repealing a rule imposing a total cost that is equal to or greater than that of the proposed rule; or (2) amending a rule to decrease the total cost imposed by an amount that is equal to or greater than the cost of the proposed rule. The proposed amendments will impose a cost to CARF accredited providers of WC and WH services and insurance carriers. However, Government Code §2001.0045(c)(6) states that the section does not apply to a rule that "is necessary to protect the health, safety, and welfare of the residents of this state." The division has determined that the proposed amendments are necessary to ensure WC and WH services provided

to injured employees are medically necessary and appropriate, which will protect injured employees' health safety and welfare. Additionally, Government Code §2001.0045(c)(9) states that the section does not apply to a rule that "is necessary to implement legislation, unless the legislature specifically states this section applies to the rule." Labor Code §413.011(a) requires the commissioner to adopt health care reimbursement policies and guidelines. The division has also determined that the proposed amendments are necessary to implement that statutory command. As a result, Government Code §2001.0045 does not apply to the proposed amendments and the division is not required to offset costs.

5. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS.

In accordance with Government Code §2006.002(c), the division has determined that adoption of the proposed amendments may have a direct, adverse economic impact on insurance carriers and CARF accredited programs providing WC and WH services who qualify as small or micro-businesses, as well as rural communities who may be self-insured insurance carriers. The division's cost analysis and resulting estimated costs in the Public Benefit and Cost Note, above, is equally applicable to small and micro-businesses, and also rural communities. Because the division has determined that the proposed amendments may have an adverse economic impact on small and micro-businesses and rural communities, this proposal contains the required economic impact statement and regulatory flexibility analysis.

Based on a report run on September 22, 2017 on Texas-licensed insurance carriers' December 31, 2016 annual statements to the Texas Department of Insurance, department records show there are 10 insurance carriers writing workers' compensation and excess workers' compensation business in Texas with total national premiums (workers' compensation and other lines

of business) of less than $6 million. There are 20 CARF accredited programs in Texas. The division assumes that some of those CARF accredited programs that provide WC and WH services likely qualify as small and micro-businesses and/or are located in rural communities. According to the United States Census Bureau, Texas has scores of municipalities with a population of less than 25,000.

There will be no difference in the cost of compliance between a large, small, or micro-business as a result of the proposed amendments. However, CARF accredited programs providing non-network WC and WH services will have a potential reduction in income as a result of the proposed amendments. In fiscal year 2017, there were approximately 300 non-network injured employees who received WH or WC services at a CARF accredited facility with a total claim reimbursement amount of $1,016,317.37. Assuming no changes in utilization, CARF accredited programs providing non-network WC and WH services will have an approximate reduction in revenue of $200,000 from these services, in the first year, as a result of the proposed rule. The actual impact on a facility offering WC and WH services depend on the volume of services provided and the specific facility's business practices. Network CARF accredited programs will continue to be reimbursed at the negotiated contract rate for WC and WH services which may be higher or lower than the MAR established by the division's rule. To alleviate the adverse economic impact that the proposed amendments may have on small or micro-businesses or rural communities, the division considered: (i) not adopting the proposed amendments; (ii) implementing different requirements or standards for the affected small and micro-businesses and rural communities; and (iii) exempting small and micro-businesses and rural communities from the requirements of the proposed amendments. Under Government Code §2006.002(c-1), an agency is required to consider alternative regulatory methods only if the

alternative methods are consistent with the health, safety, and environmental and economic welfare of the state. The division has determined that the proposed amendments substantially contribute to the health, safety, and welfare of the state by ensuring that injured employees are receiving care that is medically necessary and appropriate.

Under Labor Code §408.021(a), an injured employee is entitled "to all health care reasonably required by the nature of the injury as and when needed" and "to health care that cures or relieves the effects naturally resulting from the compensable injury; promotes recovery; or enhances the ability of the employee to return to or retain employment." The purpose of the proposed amendments is to ensure that WC and WH services prescribed to injured employees are medically necessary and efficacious, and any variance in the requirements would defeat that purpose. Therefore, because this rulemaking is necessary to protect the health, safety, and welfare of the residents of this state, the division has determined that there are no regulatory alternatives to its proposal which will sufficiently protect the health, safety, and environmental and economic welfare of the state.

6. GOVERNMENT GROWTH IMPACT STATEMENT. Government Code §2001.0221 requires that a state agency prepare a government growth impact statement describing the effects that a proposed rule may have during the first five years that the rule would be in effect. The proposed amendments will not create or eliminate a government program and will not require the creation or elimination of existing employee positions. The proposed amendments will not require an increase or decrease in future legislative appropriations to the division and will not result in an increase or decrease in fees paid to the division.

The proposed amendments do not create a new regulation because the existing WC and WH rules include preauthorization requirements for non-CARF accredited programs. The proposed

amendments build on existing regulation and require that all WC and WH services be preauthorized before they are provided. Currently, only 16 CARF accredited programs have requested and received an exemption from preauthorization for WC and WH services. Therefore, the proposed amendments expand an existing regulation.

The proposed amendments increase the number of individuals subject to the rule's applicability. The division anticipates that the proposed amendments will positively affect the state's economy by ensuring that only medically necessary WC and WH services are prescribed to injured employees. This increased certainty that prescribed WC or WH services will serve their intended purpose should result in increased resolution of work-related injuries and, therefore, improved return-to-work outcomes.

7. TAKINGS IMPACT ASSESSMENT. The division has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

8. REQUEST FOR PUBLIC COMMENT. If you want to comment on the proposal, submit your written comments by 5:00 p.m. CST on June 4, 2018. A request for a public hearing must be sent separately from your written comments. Send written comments to rulecomments@tdi.texas.gov or by mail to Maria Jimenez, Texas Department of Insurance, Division of Workers' Compensation, Office of General Counsel, MS-4D, 7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645. If a hearing is held, the division will consider written comments and public testimony presented at the hearing.

9. STATUTORY AUTHORITY. The amendments are proposed under Labor Code §402.00111, *Relationship Between Commissioner of Insurance and Commissioner of Workers' Compensation; Separation of Authority; Rulemaking*, §402.00116, *Chief Executive,* §402.00128, *General Powers and Duties of Commissioner,* §402.061, *Adoption of Rules*, §403.014(c)(2), *Preauthorization Requirements; Concurrent Review and Certification of Health Care*, §504.053(b)(2), (c), *Election,* §413.011, *Medical Services and Fees,* §413.012, *Medical Policy and Guideline Updates Required,* §413.017, *Presumption of Reasonableness,* §413.0511, *Medical Advisor*; and Insurance Code §1305.351, *Utilization Review* and §1305.153 *Notice of Certain Utilization Review Determinations; Preauthorization Requirements.*

Labor Code §402.00111 requires the commissioner of workers' compensation to exercise all executive authority, including rulemaking authority, under Title 5 of the Labor Code. Labor Code 402.00116 requires the commissioner to administer and enforce the Texas Workers' Compensation Act and other workers' compensation laws of this state and laws granting jurisdiction or applicable to the division or commissioner. Labor Code §402.00128 requires the commissioner to conduct the daily operations of the division and implement division policy. Labor Code §402.061 requires the commissioner of workers' compensation to adopt rules as necessary for the implementation and enforcement of the Texas Workers' Compensation Act.

Labor Code §413.014(c)(2) requires preauthorization and concurrent review for work-hardening or work-conditioning services. Labor Code §504.053(c) provides that if a political subdivision or pool provides medical benefits to injured employees in accordance with §504.053 (b)(2), then Chapter 413 (including preauthorization lists and fee guidelines), except for §413.042 does not apply. Labor Code §413.011 requires the commissioner to adopt fee guidelines, that those

guidelines to be fair and reasonable, and designed to ensure quality of medical care and to achieve effective medical cost control. Labor Code §413.012 requires medical policies and fee guidelines to be reviewed and revised at least every two years to reflect fair and reasonable fees and to reflect medical treatment or ranges of treatment that are reasonable or necessary at the time the review and revision is conducted. Labor Code §413.017 provide that medical services that are consistent with the division's medical policies and fee guidelines are presumed reasonable. Labor Code §413.0511 requires the division's medical advisor to make recommendation regarding the adoption of fee guidelines. Insurance Code §1305.351 provides that the preauthorization requirements of Labor Code §413.014 and the commissioner of workers' compensation rules do not apply to health care provided through a workers' compensation network. Insurance Code §1305.153 provides that the amount of reimbursement for services provided by a network provider is determined by the network/provider contract and that approved out-of-network providers shall be reimbursed as provided by the WC Act and the division's applicable rules.

10. TEXT.

§134.230. Return to Work Rehabilitation Programs.

(a) This section applies to services provided on or after September 1, 2018 by the Return to Work Rehabilitation Programs listed: [~~The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation~~

~~of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or insurance carrier.~~]

(1) Work Conditioning/General Occupational Rehabilitation Programs; [~~Accreditation by the CARF is recommended, but not required.~~]

[~~(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the maximum allowable reimbursement (MAR).~~]

[~~(B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR.~~]

(2) Work Hardening/Comprehensive Occupational Rehabilitation Programs; [~~For division purposes, General Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Conditioning.~~]

[~~(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT code 97545 with modifier "WC." Each additional hour must shall be billed using CPT code 97546 with modifier "WC." CARF accredited programs shall add "CA" as a second modifier.~~]

[~~(B) Reimbursement shall be $36 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.~~]

(3) Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs; and [~~For division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.~~]

[~~(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT code 97545 with modifier "WH." Each additional hour shall be billed using CPT code 97546 with modifier "WH." CARF accredited programs shall add "CA" as a second modifier.~~]

[~~(B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.~~]

(4) Outpatient Medical Rehabilitation Programs. [~~The following shall be applied for billing and reimbursement of Outpatient Medical Rehabilitation Programs.~~]

[~~(A) Program shall be billed and reimbursed using CPT code 97799 with modifier "MR" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited programs add "CA" as a second modifier.~~]

[~~(B) Reimbursement shall be $90 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.~~]

[~~(5) The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs.~~]

[~~(A) Program shall be billed and reimbursed using CPT code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited programs shall add "CA" as a second modifier.~~]

[~~(B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.~~]

(b) A Return to Work Rehabilitation program should meet the specific program standards listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual that include the active participation by the injured employee, employer, and payor or insurance carrier in recovery and return to work planning.

(c) General Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Conditioning. Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening. Work Conditioning and Work Hardening must be billed and reimbursed as follows:

(1) The appropriate program modifier is required when billing for Work Conditioning and Work Hardening.

(2) The first two hours of each session of Work Conditioning must be billed and reimbursed as one unit, using CPT code 97545 with modifier "WC." Each additional hour must be billed using CPT code 97546 with modifier "WC." Reimbursement is $28.80 per hour. Units of less than one hour must be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(3) The first two hours of each session of Work Hardening must be billed and reimbursed as one unit, using CPT code 97545 with modifier "WH." Each additional hour must be billed using CPT code 97546 with modifier "WH." Reimbursement is $51.20 per hour. Units of less

than one hour must be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(d) Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs and Outpatient Medical Rehabilitation Programs must be billed and reimbursed as follows:

(1) The hourly reimbursement for a CARF accredited program is 100 percent of the maximum allowable rate (MAR). The hourly reimbursement for a non-CARF accredited program is 80 percent of the MAR.

(2) Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs must be billed and reimbursed using CPT code 97799 with modifier "CP" for each hour. The number of hours must be indicated in the units column on the bill. CARF accredited programs must add "CA" as a second modifier. The MAR is $125 per hour. Units of less than one hour must be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(3) Outpatient Medical Rehabilitation Programs must be billed and reimbursed using CPT code 97799 with modifier "MR" for each hour. The number of hours must be indicated in the units column on the bill. CARF accredited programs must add "CA" as a second modifier. The MAR is $90 per hour. Units of less than one hour must be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(e) This section will become effective September 1, 2018.

§134.600. ***Preauthorization, Concurrent Utilization 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) Adverse determination: A determination by a utilization review agent made on behalf of a payor that the health care services provided or proposed to be provided to an injured employee are not medically necessary or appropriate. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. An adverse determination does not include a determination that health care services are experimental or investigational.

(2) 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.

(3) Concurrent utilization review: a form of utilization review for 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.

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

[~~(5) 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 utilization review requirements except for those provided by subsections (p)(4) and (q)(2) of this section.~~]

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

(6)[~~(7)~~] 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)[~~(8)~~] Preauthorization: a form of prospective utilization review by a payor or a payor's utilization review agent of health care services proposed to be provided to an injured employee.

(8)[~~(9)~~] Reasonable opportunity: At least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with the utilization review agent during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination:

(A) no less than one working day prior to issuing a prospective utilization review adverse determination;

(B) no less than five working days prior to issuing a retrospective utilization review adverse determination; or

(C) prior to issuing a concurrent or post-stabilization review adverse determination.

(9)[~~(10)~~] Requestor: the health care provider or designated representative, including office staff or a referral health care provider or health care facility that requests preauthorization, concurrent utilization review, or voluntary certification.

(10)[~~(11)~~] Work conditioning and work hardening: return-to-work rehabilitation programs as defined in this chapter.

(b) – (o) (No change)

(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 work hardening or work conditioning services [~~requested by:~~

~~(A) non-exempted work hardening or work conditioning programs;~~ ~~or~~

~~(B) division exempted programs if the proposed services exceed or are not addressed by the division's treatment guidelines as described in paragraph (12) of this subsection~~];

(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 insurance 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 applicable division 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 insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits);

(13) required treatment plans; and

(14) any treatment for an injury or diagnosis that is not accepted by the insurance 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 utilization review for an extension for previously approved services includes:

(1) inpatient length of stay;

(2) all work hardening or work conditioning services [~~requested by:~~

~~(A) non-exempted work hardening or work conditioning programs;~~ ~~or~~

~~(B) division exempted programs if the proposed services exceed or~~ ~~are not addressed by the division's treatment guidelines as described in subsection (p)(12) of this section~~];

(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) – (u) (No change.)

11. CERTIFICATION. The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Issued at Austin, Texas, on April 20, 2018.

Nicholas Canaday III
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Texas Department of Insurance,
Division of Workers' Compensation