Texas Department of Insurance
Workers' Compensation Research and Evaluation Group

Medical Dispute Resolution and Complaint Trends

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7. Medical Dispute Resolution and Complaint Trends

One of the key goals of the workers' compensation system reforms laid out in HB 7 is that each injured employee "shall have access to a fair and accessible dispute resolution process."[1] The Sunset Advisory Commission, in its analysis of the former Texas Workers' Compensation Commission, noted that the medical dispute process prior to HB 7 was lengthy and lacked appropriate oversight and transparency in the regulation of Independent Review Organizations (IROs). IROs are panels of doctors who are certified by TDI to review medical necessity disputes. The Sunset Advisory Commission also recommended that the regulatory model for group health insurance should serve as a model for the workers' compensation system. As a result, HB 7 mandated a few changes: requiring that all IRO decisions meet certain statutory standards;[2] clarifying that TDI is not a party in the medical dispute; making the decision of the IRO binding pending appeal; and requiring that appeals of medical dispute decisions go directly to district court (removing the appeal of medical dispute decisions to the State Office of Administrative Hearings or SOAH).

On November 1, 2006, a Travis County District Court determined in HCA Healthcare Corp. v. Texas Department of Insurance and Division of Workers' Compensation, Cause No. D-1-GN-06-000176, that the medical dispute resolution process as revised by HB 7 did not provide due process to parties and determined that the removal of SOAH was facially unconstitutional. As a result, the 80th Legislature passed HB 724 in 2007, which requires appeals of non-network medical fee disputes (with disputed amounts not more than $2,000), all non-network preauthorization (medical necessity) disputes, and non-network retrospective medical disputes (with disputed amounts not more than $3,000) to be heard in a Contested Case Hearing (CCH) in TDI-DWC's local field offices.

During the 82nd Legislative session, the administrative appeal process for medical fee disputes underwent additional changes. Effective June 1, 2012, HB 2605 requires parties involved in an administrative appeal of a medical fee dispute decision to attempt resolution through a benefit review conference prior to requesting a CCH at SOAH. As an alternative to requesting a SOAH CCH, parties may now request binding arbitration. Additionally, HB 2605 allows TDI-DWC to recover the costs of SOAH CCH's from the non-prevailing party at SOAH, unless the non-prevailing party is the injured employee. If the parties to the dispute, which are generally the health care provider and the insurance carrier, are not satisfied with the SOAH appeal, either party may request

[1] See §402.021, Labor Code.

[2] Under HB 7, IRO decisions must contain all of the following elements: the qualifications of the doctor reviewer, a description of the clinical criteria used in making the decision, a list of the medical evidence reviewed, and an analysis and explanation of the decision. See §413.032, Labor Code.

judicial review.

It should be noted, however, that the medical fee dispute process is somewhat different for medical services provided in workers' compensation health care networks. Under HB 7, fee disputes that arise between health care providers and workers' compensation health care networks are resolved internally through the network's complaint process rather than by TDI-DWC.

In terms of medical necessity disputes, HB 2605 made several changes to align the process to appeal an IRO decision for network and non-network claims. After June 1, 2012, all appeals of IRO medical necessity decisions for network and non-network claims (as well as claims handled by political subdivisions who are delivering medical benefits under Section 504.053(b)(2), Texas Labor Code) are now handled through a CCH at TDI-DWC local field offices, regardless of the amount of money in dispute. Parties who are unsatisfied with the CCH decision may request judicial review.

This section of the report examines how the frequency, duration and outcomes of medical disputes have changed since the adoption of HB 7 in 2005. This section also examines the number of complaints received by TDI during this time, including complaints regarding the focal point of HB 7 – namely workers' compensation health care networks.

Number and Timeframe to Resolve Medical Disputes

Generally, there are three types of medical disputes raised in the workers' compensation system:

- fee disputes (which may include a dispute over the application of the TDI-DWC's fee guidelines or a dispute over the fee for a service that is not covered in TDI-DWC's fee guidelines);
- preauthorization disputes[3] (i.e., disputes regarding the medical necessity of certain medical treatments and services that were denied prospectively by the insurance carrier); and
- retrospective medical necessity disputes (i.e., disputes regarding the medical necessity of medical treatments and services that have already been rendered and billed by the health care provider).

[3] Section 413.014, Labor Code and 28 TAC §134.600 include a list of medical treatments and services that require preauthorization by the insurance carrier before they can be provided to an injured employee. Workers' compensation health care networks are not subject to these preauthorization requirements and may establish their own lists of medical treatments and services that require preauthorization. See §1305.351, Insurance Code.

Declining claim frequency, the creation of workers' compensation health care networks in 2006, the adoption of TDI-DWC's medical treatment guidelines in 2007 and the TDI-DWC's adoption of new professional, inpatient and outpatient hospital and ambulatory surgical center fee guidelines in 2008 have resulted in fewer medical disputes being filed with TDI. As Table 7.1 indicates, approximately 13,257 medical disputes were received by TDI in 2005, compared with 7,596 in 2010 and 7,795 in 2011.[4]

Table 7.1: Number and Distribution of Medical Disputes Submitted to TDI-DWC, by Type of Medical Dispute, 2002-2011 (as of October, 2012)

Year Dispute Received	Pre-authorization	Fee Disputes	Retrospective Medical Necessity Disputes	Total
2002	15%	58%	27%	8,906
2003	11%	70%	19%	17,433
2004	13%	60%	27%	14,291
2005	13%	68%	19%	13,257
2006	16%	70%	14%	9,706
2007	27%	72%	1%	8,810
2008	22%	75%	3%	12,244
2009	24%	74%	2%	12,293
2010	41%	58%	1%	7,596
2011	35%	63%	2%	7,795

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2012.

Additionally, the percentage of medical disputes associated with preauthorization denials has increased from 13 percent of all medical disputes in 2005 to 35 percent in 2011, while the percentage of retrospective medical necessity disputes has declined steeply from 19 percent in 2005 to 2 percent in 2011, which is most likely the result of the adoption of TDI-DWC's medical treatment guideline rule in May 2007. This rule requires preauthorization for all medical services that are outside of the guideline's recommendations in addition to the existing preauthorization requirements laid out in TDI-DWC's preauthorization rule – 28 TAC §134.600.

In an effort to more closely align the process for resolving workers' compensation medical necessity disputes with the process for resolving these same types of disputes in the group health system, TDI-DWC adopted a rule in January 2007 to streamline the intake of medical disputes, including preauthorization and retrospective medical necessity

[4] From August 2008 to August 2009, one health care provider filed approximately 6,000 pharmacy fee disputes against one insurance carrier. TDI-DWC upheld a great majority of these disputes in favor of the insurance carrier (approximately 60 percent of all fee disputes decisions made during those years), and the requestor eventually withdrew all the disputes during the appeal process.

disputes. Part of that process streamlining included requiring the insurance carrier's utilization review agent to send all of the medical evidence used to make the medical necessity decision to the IRO assigned by TDI directly instead of sending multiple copies to TDI to compile for the IRO's review. Another part of this process was to align internal TDI processes for assigning IROs so that IROs for workers' compensation disputes are now assigned by TDI instead of TDI-DWC and are assigned within 24 hours of the receipt of an IRO request. Additionally, fewer incoming fee disputes, combined with TDI-DWC's efforts to improve the efficiency of fee dispute resolution have resulted in more timely resolution of fee disputes.

As a result of TDI's process improvement efforts, the mean and median timeframes to resolve a medical dispute have declined significantly since 2005 for all dispute types (see Table 7.2). The average preauthorization dispute duration fell from 59 days in 2005 to 20 days in 2011 (a 66 percent decrease); the average fee dispute duration fell from 335 days in 2005 to 120 days in 2009 (a 64 percent decrease), but has increased to 197 days in 2011; and the average retrospective medical necessity dispute duration decreased from 123 days in 2005 to 31 days in 2011 (a 75 percent decrease).

The number of active fee disputes that needed to be resolved by TDI-DWC reached a peak of approximately 17,000 in August 2009. Issues involving previous inpatient hospital fee guidelines and previous pharmacy fee guidelines accounted for approximately 85 percent of those disputes. Litigation between health care providers and individual insurance carriers over the interpretations of these fee guideline rules prolonged the final resolution of many of these disputes; however, the combination of the aggressive adjudication of backlog disputes by TDI-DWC, the adoption of new professional and hospital fee guidelines effective March 2008, and the marked decrease in the volume of disputes have resulted in the resolution of over 11,000 backlog fee disputes since 2009. The number of new fee disputes received by TDI-DWC has decreased as well from approximately 12,000 new fee disputes in fiscal year 2007 to approximately 4,500 new fee disputes for fiscal year 2011.

The total number of active fee disputes that still need to be resolved by TDI-DWC as of October 19, 2012, was approximately 4,654 disputes. However, it should be noted that the number of medical necessity disputes filed with TDI also declined significantly during the same time period (see Table 7.1).

Table 7.2: Mean and Median Number of Days to Resolve Medical Disputes, by Type of Medical Dispute, 2002-2011 (as of October, 2012)

Year Dispute Received	Pre-authorization Disputes		Fee Disputes		Retrospective Medical Necessity Disputes	
	Mean	Median	Mean	Median	Mean	Median
2002	107	84	265	220	252	223
2003	58	48	582	592	205	168
2004	53	43	478	413	172	128
2005	59	53	335	184	123	79
2006	55	51	309	219	132	95
2007	22	21	205	193	32	26
2008	19	20	197	113	36	34
2009	20	20	120	87	36	37
2010	19	20	166	60	26	22
2011	20	20	197	122	31	27

Note: From August 2008 to August 2009, approximately 6,000 pharmacy fee disputes were received by DWC from one doctor against one insurance carrier. They were all subsequently upheld in favor of the insurance carrier

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2012.

Over the past few years, the proportion of medical disputes decided in favor of the insurance carrier or the health care provider has changed depending on the type of dispute (see Table 7.3). For fee disputes, decisions in favor of the health care provider decreased from 72 percent in 2005 to 37 percent in 2011. For retrospective medical necessity disputes, the percentage of decisions in favor of the insurance carrier increased sharply from 17 percent in 2006 to 76 percent in 2011. Since 2007, insurance carriers continue to prevail in approximately 75 percent of the decisions over preauthorization disputes.

While these dispute outcomes may suggest that insurance carriers are utilizing TDI-DWC's evidence-based treatment guidelines when making medical necessity decisions, and that IROs are also basing their medical necessity determinations on these treatment guidelines (as required by §413.031(e-1), Labor Code), they may also indicate that TDI needs to examine whether IROs are receiving all of the medical documentation relevant to the dispute from the insurance carrier.

Trends in Complaints Filed

While the number of workers' compensation claims decreased measurably since the passage of HB 7 in 2005, the number of complaints received by TDI-DWC has not generally followed the same trend. As Table 7.4 shows, the number of complaints has fluctuated during the past few years. While TDI-DWC received a total of 7,433 complaints in 2004, that number fluctuated between 3,820 in 2006 and 6,174 in 2011, the

second lowest number of disputes TDI-DWC received since 2006. Of those complaints closed in 2011, 2,390 (almost 39 percent) were "monitoring complaints," meaning that TDI-DWC did not investigate the complaint for a violation of the Act or Rules but did send a letter to the party that was the subject of the complaint asking them to resolve the complaint and reminding them of their compliance duties; 1,737 (almost 17 percent) were "unjustified," meaning that there was not a violation of the Act or Rules or a violation could not be substantiated; 1,040 complaints were "justified" complaints that were violations of the Act or Rules and warranted further investigation. The remaining complaints were closed in 2012 and not included in the overall closure numbers.[5]

Table 7.3: Percentage of Concluded Medical Disputes Decided in Favor of Insurance Carrier or Health Care Provider, by Type of Medical Dispute, 2002-2011 (as of October, 2012)

Year Dispute Received	Pre-authorization Disputes		Fee Disputes		Retrospective Medical Necessity Disputes	
	Carrier	Provider	Carrier	Provider	Carrier	Provider
2002	69%	31%	41%	59%	43%	57%
2003	77%	23%	32%	68%	33%	67%
2004	76%	24%	31%	69%	31%	69%
2005	71%	29%	28%	72%	17%	83%
2006	65%	35%	28%	72%	17%	83%
2007	77%	23%	19%	81%	72%	28%
2008	75%	25%	79%	21%	57%	43%
2009	78%	22%	92%	8%	65%	35%
2010	73%	27%	58%	42%	69%	31%
2011	77%	23%	63%	37%	76%	24%

Note 1: These dispute resolution outcomes were only calculated for disputes that had been concluded as of October 2012 – disputes that were withdrawn or dismissed were excluded from the analysis. Hospital disputes, disputes submitted without the DWC-60 form and disputes with incorrect jurisdiction were also excluded.

Note 2: From August 2008 to August 2009, approximately 6,000 pharmacy fee disputes were received by DWC from one doctor against one insurance carrier. They were all subsequently upheld in favor of the insurance carrier

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2012.

The most frequent types of complaints received by TDI-DWC in 2011 include complaints about communication issues (e.g., timely filing of required forms) complaints from health care providers about medical benefit s (e.g., prompt payment) and complaints regarding the failure of a system participant to attend a required exam or hearing.

[5] Complete results from TDI-DWC's System Monitoring and Oversight section are available at www.tdi.texas.gov/wc/pbo/index.html.

Table 7.4: Total Number of Complaints Received by the Texas Department of Insurance, Division of Workers' Compensation, January, 2004 – December, 2011

Complaint Year	2004	2005	2006	2007	2008	2009	2010	2011
Number of Complaints	7,433	5,883	3,820	6,715	8,621	6,516	6,808	6,174

Note: Complaint counts for 2005 and 2006 should be viewed with caution since these numbers are incomplete due to the transition of the functions of the former Texas Workers' Compensation Commission to the newly created Division of Workers' Compensation. During the transition, the Division's complaints were placed into TDI's existing complaint tracking system, which initially did not track complaints received through referrals from TDI-DWC field office staff. Complaints received through internal referrals are now tracked as part of the system.

Source: Texas Department of Insurance, Division of Workers' Compensation, 2012.

Overall, TDI[6] has received relatively few complaints about certified workers' compensation networks since 2005 (368 total complaints – of which approximately 30 percent were deemed justified) given that almost 327,373 injured employees have been treated in networks as of February 1, 2012. The most frequent types of complaints raised by health care providers were complaints about rejections of provider applications to participate in networks, complaints about network fees or payment of medical bills and complaints from providers who said they were improperly listed as being network providers.

The most frequent types of complaints raised by injured employees included complaints about the employer's failure to provide a copy of the network's requirements, complaints about the availability and/or types of network doctors who were willing to accept new patients, and concerns about not receiving an up-to-date and complete directory of network providers. Chapter 1305, Insurance Code, as well as TDI's network rules (Chapter 10 of the Texas Administrative Code) require certified networks to resolve complaints, including disputes over network fees, internally and to maintain a detailed complaint log that is subject to TDI's examination.

The administration of workers' compensation disputes and complaints is a critical component of TDI's mission. Since the adoption of HB 7 the number of complaints continues to fluctuate while the number of disputes has decreased and effective streamlining has led to steep reductions in the average durations to resolve disputes timeframes. TDI will continue to monitor disputes and complaints, and to improve processes where feasible.

[6] The TDI Managed Care Quality Assurance program certifies workers' compensation health care networks and resolves complaints filed about networks.