WORKERS' COMP

# BOOT CAMP

Training

PART 2

2025

# PREAUTHORIZATION, MEDICAL NECESSITY, >>>>> and <<<<< UTILIZATION REVIEW


TDI Division of Workers' Compensation

# Day 4

WORKERS' COMP
BOOT CAMP
Training
PART 2
2025

PREAUTHORIZATION, MEDICAL NECESSITY, >>>>> and <<<<< UTILIZATION REVIEW

# Learning Objectives

- Learn what the statutes and rules say about medical necessity.
- Know the non-network treatment guideline and how it works.
- Understand the preauthorization process.


# The Preauthorization Process:
## Utilization Review and Medical Necessity

**Division of Workers' Compensation**
**2025**

# Disclaimer

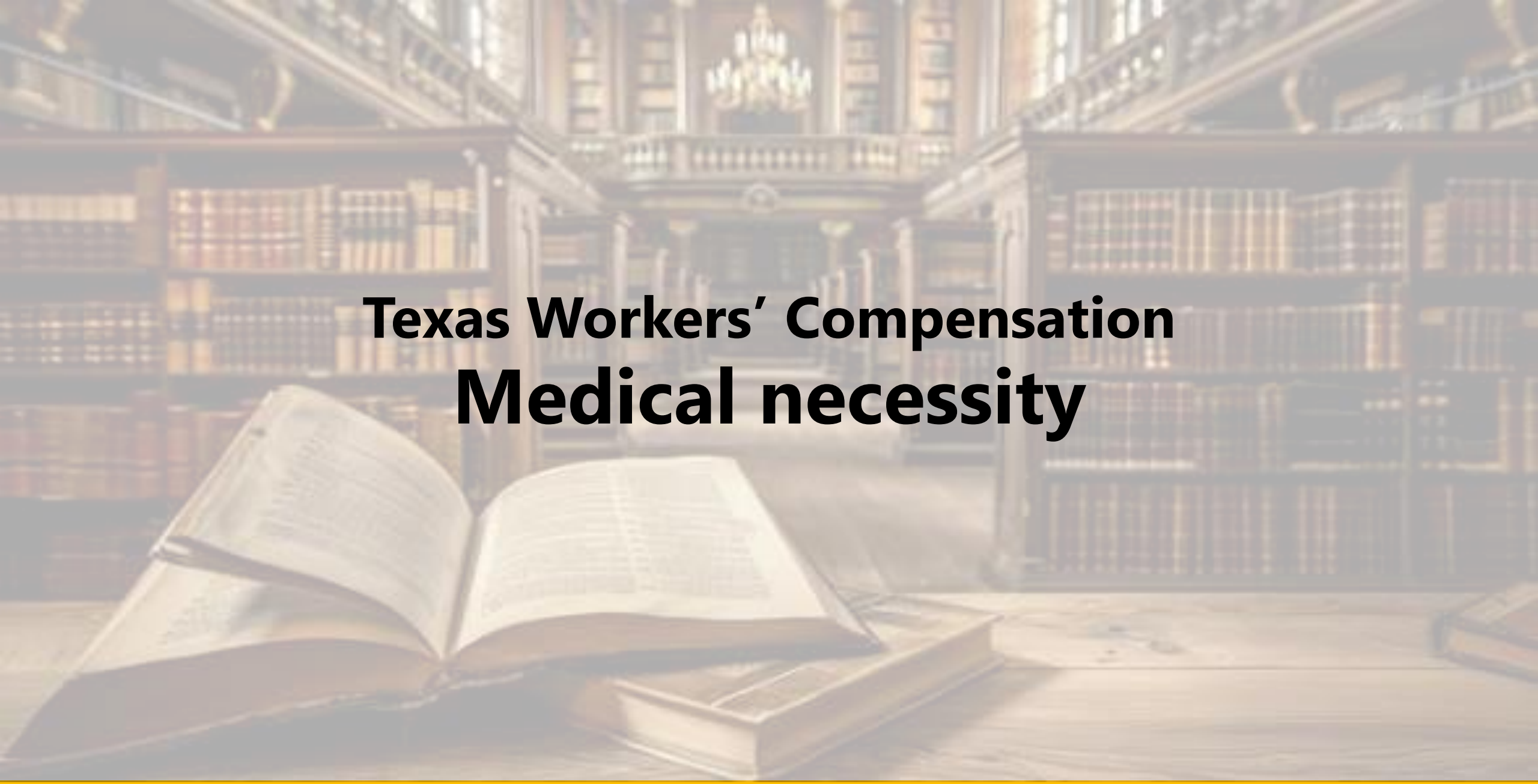
This presentation is for educational purposes only and provides general information. It is not a substitute for a full review of statutes and rules.

System participants are responsible for knowing and complying with the applicable sections of the Texas Insurance Code (Insurance Code), Texas Labor Code (Labor Code), and Texas Administrative Code (TAC).

Any opinions expressed by the speakers are personal and do not constitute or reflect any statement of policy by the Texas Department of Insurance, Division of Workers' Compensation (DWC).

# Overview

- Medical necessity in workers' compensation.
- Medical services requiring preauthorization.
- Preauthorization and utilization review (UR) process.
- Independent review process.
- DWC resources.



# Texas Workers' Compensation
# Medical necessity

# Medical Necessity Statutes

Labor Code Section (Sec.) 408.021.
Entitlement to Medical Benefits

All health care reasonably required to:

- Cure or relieve the effects naturally resulting from the compensable injury;
- Promote recovery; or
- Enhance the ability of the employee to return to or retain employment.

# Medical Necessity Statutes

Labor Code Sec. 401.011. General Definitions

Health care reasonably required means:

- Clinically appropriate.
- Effective for the injury.
- Provided with best practices consistent with evidence-based medicine.
- If evidence is not available, it must be consistent with generally accepted standards of medical practice recognized in the medical community.

# Medical Necessity Statutes

Labor Code Sec. 413.017. Presumption of Reasonableness

Insurance Code Sec. 1305.304. Guidelines and Protocols

The following medical services are presumed to be reasonable:

- Medical services consistent with medical policies (treatment guidelines).
- Medical services that the insurance carrier approves through UR.

# Medical Necessity Statutes

Insurance Code Sec. 1305.304. Guidelines and Protocols

Labor Code Sec. 413.011. Reimbursement Policies and Guidelines; Treatment Guidelines and Protocols

Treatment **guidelines** must be:

- Evidence-based.
- Scientifically valid.
- Outcome-focused.
- Designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care.

# Treatment Guideline Non-Network

28 TAC Sec. 137.100. Treatment Guidelines

***Official Disability Guidelines (ODG) – Treatment in Workers' Compensation***

(excluding the return-to-work pathways) 

760-753-9992
800-488-5548
www.mcg.com/odg

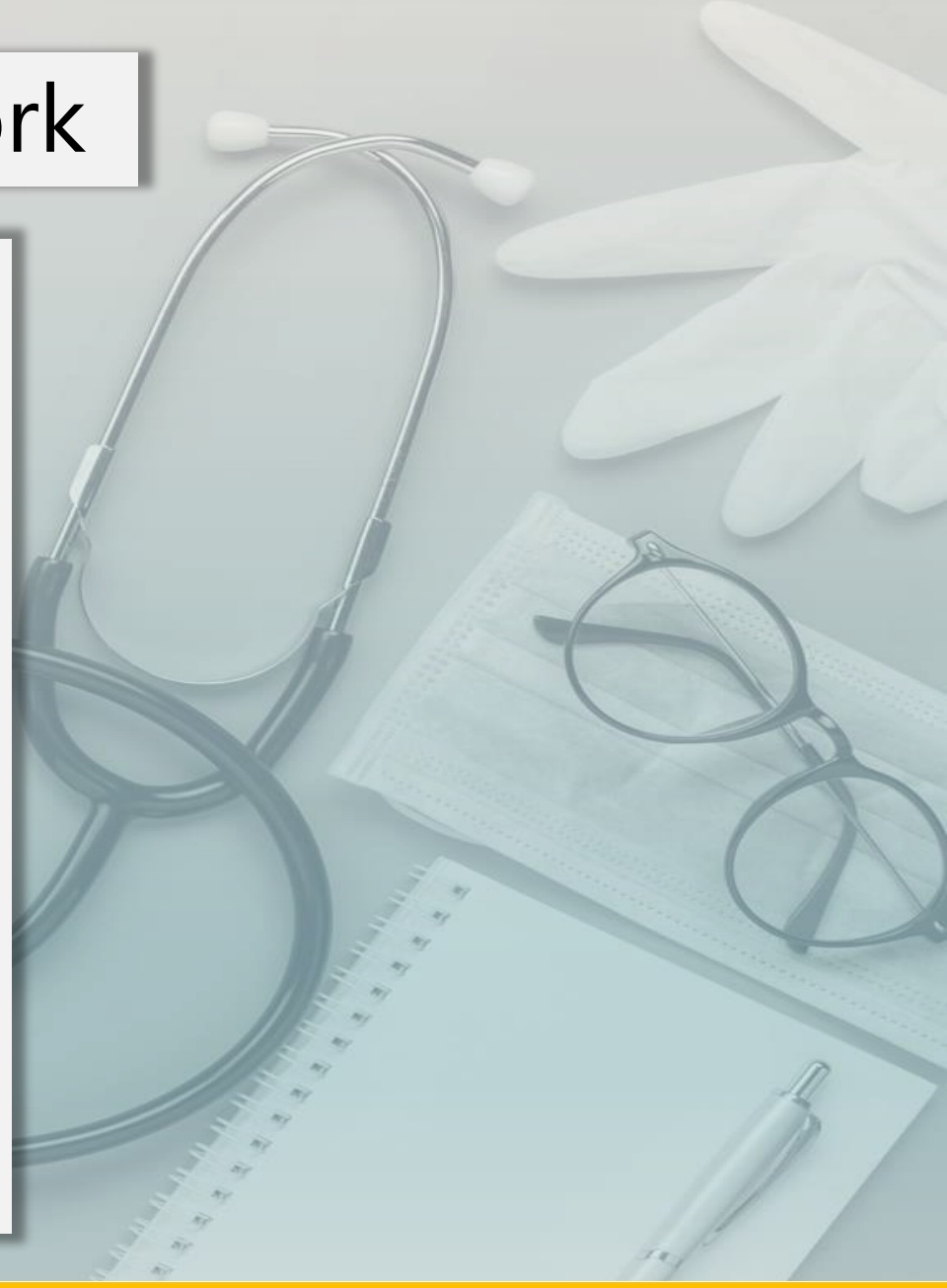
Network claims – refer to network treatment guidelines.
28 TAC Sec. 10.83. Guidelines and Protocols

# Treatment Guideline Non-Network

**ODG online treatment guideline:**

You can search by:

- Keyword or codes
  - ✓ Diagnosis
  - ✓ Types of treatment
- Treatment tab – filters
  - ✓ Recommendation status
  - ✓ Category
  - ✓ Body system
- Medical evidence summaries

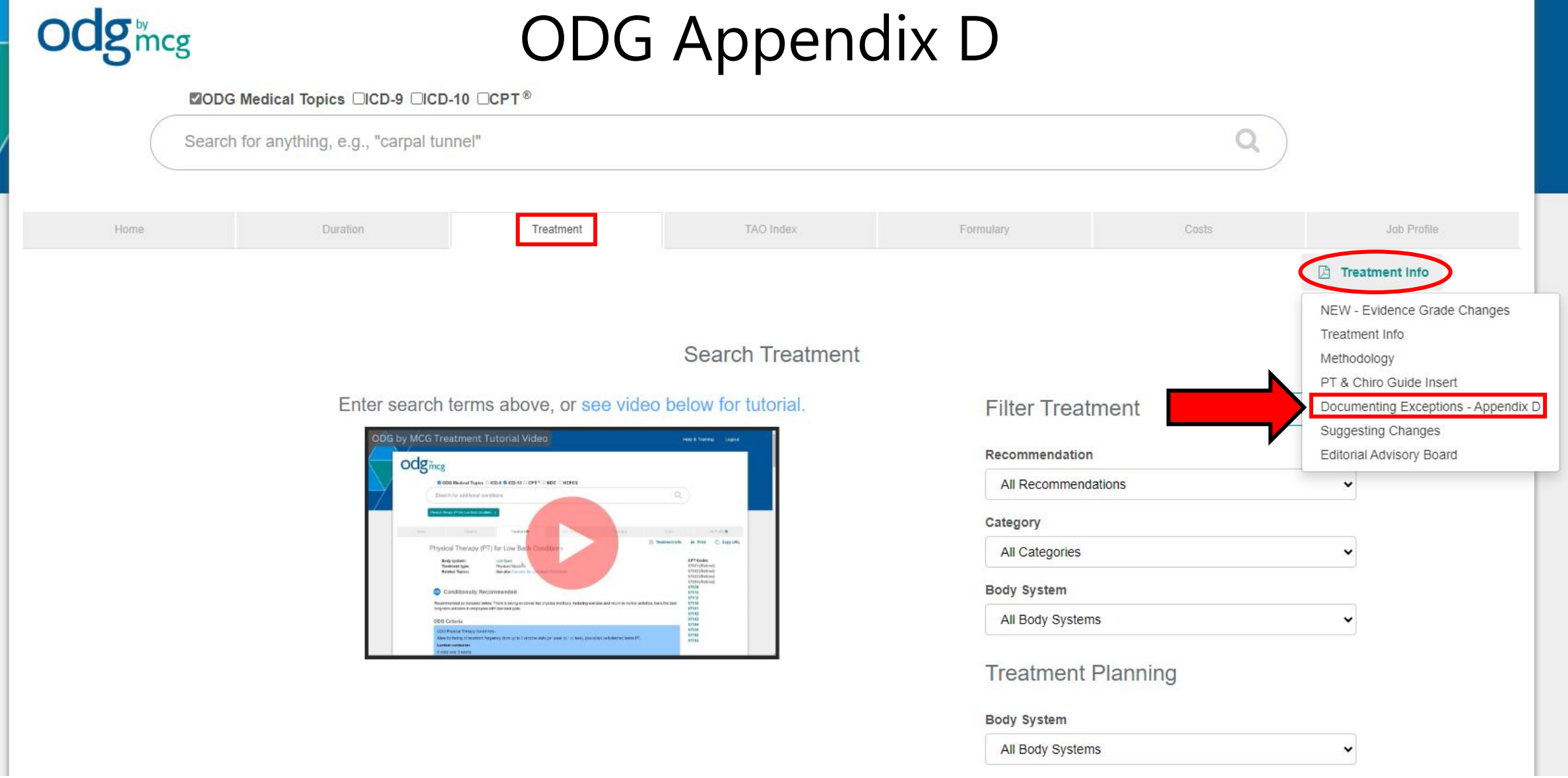


# Documenting Exceptions - Appendix D in the ODG for Non-Network

The ODG provides instructions on documenting exceptions to the treatment guideline for:

- Documenting treatments that are not recommended. This requires more extensive and detailed documentation.
- Explaining extenuating case-specific circumstances.
- Providing clear and reasonable documentation justifying treatments outside of the guidelines.

# ODG Appendix D



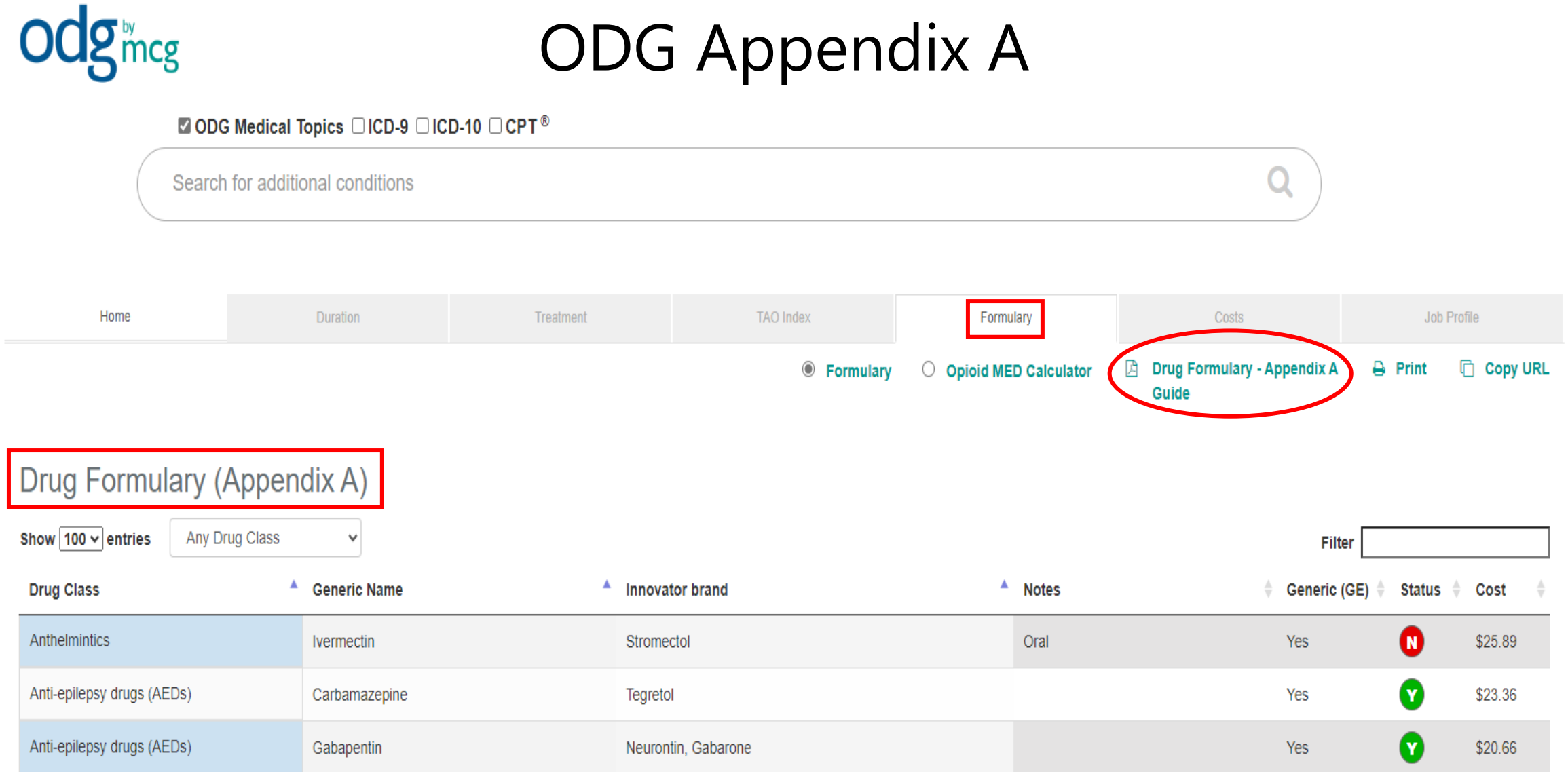



TDI Division of Workers' Compensation

# Drug Formulary - Appendix A in the ODG Network and Non-Network

Appendix A provides the list of “N” status drugs that require preauthorization and are not included in the DWC pharmacy formulary. The “N” drug list can also be found on DWC’s website.

# ODG Appendix A



## Non-Network and Network

# What medical services need preauthorization?

# What **non-network** medical services need preauthorization?

28 TAC Sec. 134.600. Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care

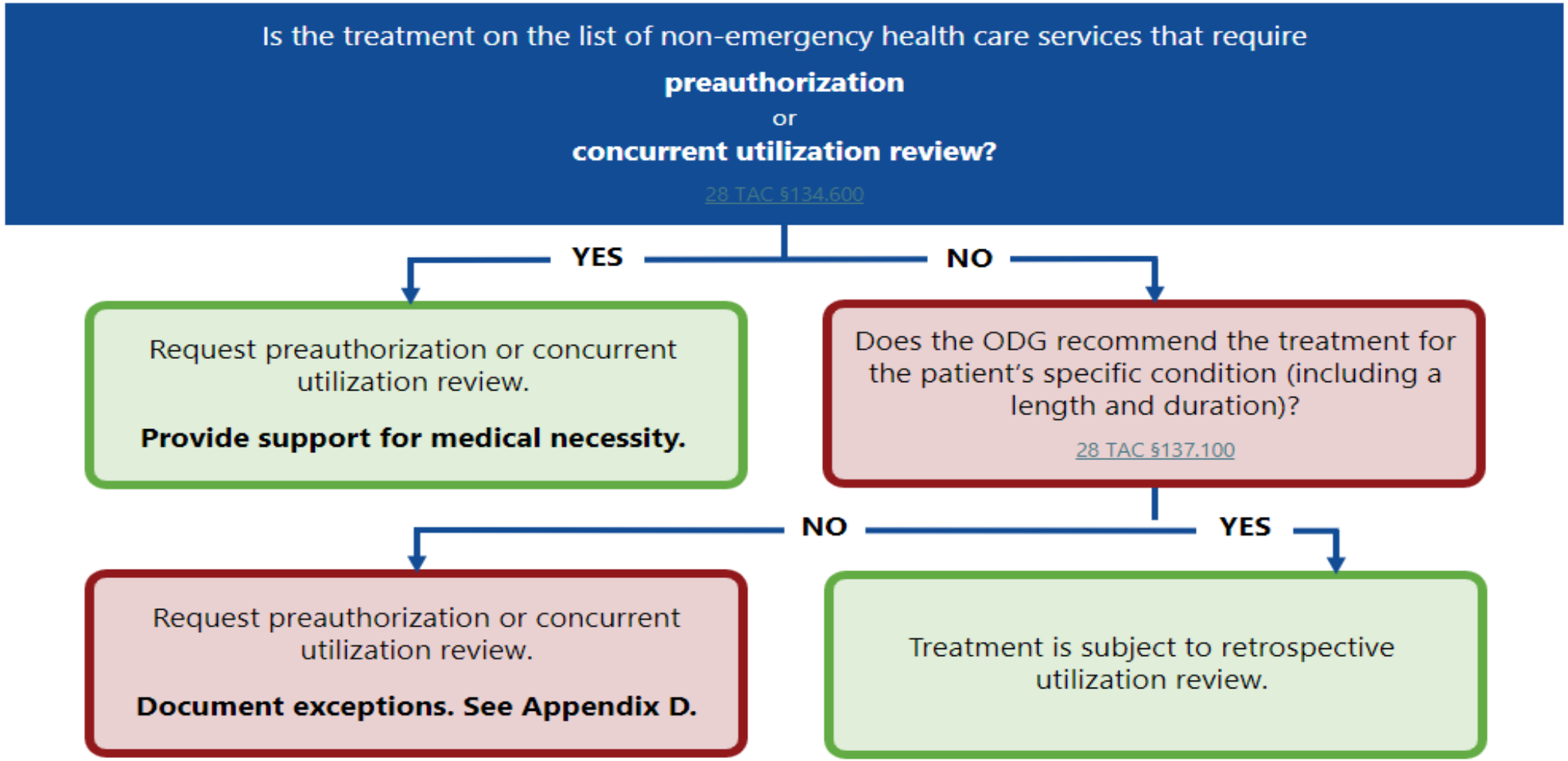
(non-network preauth rule)


List of nonemergency services (p)(1)-(12), including:

- Treatments and services that the ODG does not recommend or address.
- Drugs not included in the pharmacy formulary.

*Office visits do not require preauthorization.

# Typical non-network treatment/preauthorization decisions



# What **network** medical services need preauthorization?

- Medical services outlined in the contract between the network and the health care provider.*
- Drugs not included in DWC's pharmacy formulary.

*Check your network contract for both medical services requiring preauthorization and for the preauthorization process.

# **Non-Network** and **Network** Pharmacy Preauthorization Requirements

**28 TAC Sec. 134.600(p)(11). drugs not included in the applicable DWC formulary require preauthorization.**

## Preauthorization not required

**Closed Formulary**

Includes **all** FDA approved drugs

**Excludes**

## Preauthorization required

- Drugs with status "N." (Appendix A).
- Investigational or experimental drugs.
- All prescription drugs created through compounding.

## Utilization review regulations

# What is utilization review?

# Utilization Review Regulation Network Claims

Insurance Code Chapter 1305. Workers' Compensation Health Care Networks and Chapter 4201. Utilization Review Agents

28 TAC, Part 1
Chapter 19. Licensing and Regulation of Insurance Professionals
Subchapter U. Utilization Reviews for Health Care Provided under Workers' Compensation Insurance Coverage

Chapter 10. Workers' Compensation Health Care Networks
Subchapter F. Utilization Review and Retrospective Review

# Utilization Review Regulation
# Non-Network Claims

Insurance Code Chapter 4201. Utilization Review Agents

28 TAC, Part 1
Chapter 19. Licensing and Regulation of Insurance Professionals
Subchapter U. Utilization Reviews for Health Care Provided under Workers' Compensation Insurance Coverage

28 TAC, Part 2
Chapter 134. Benefits--Guidelines for Medical Services, Charges, and Payments
Subchapter G. Prospective and Concurrent Review of Health Care

# Utilization Review

Review of the medical services for medical necessity and appropriateness.

A certified utilization review agent (URA) conducts the review.

# Utilization Review

**Insurance Code Sec. 4201.101.**
**Certificate of Registration Required**

Only Texas Department of Insurance (TDI)-certified URAs may conduct a UR.

(Adjusters who are not certified or registered URAs may not conduct a UR.)

# Utilization Review

**28 TAC Sec. 180.1. Definitions**

A physician performing a UR must hold the appropriate credentials.

- They must be of the same or similar specialty as the physician who requested the medical service and have a Texas license.
- Dentists and chiropractors must be appropriately licensed.

# Utilization Review

Adverse determination (denial) is a determination that medical services provided or proposed to be provided are not medically necessary or appropriate.

**Note:** Adverse determinations do not include a denial due to the failure to request preauthorization.

# Prospective utilization review

# Non-network preauthorization process

# Initial Preauthorization Request

**28 TAC Sec. 134.600., Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care**
**"non-network preauth rule"**


The requester or injured employee should include:

- The name of the injured employee.
- The specific health care.
- The number of treatments and specific timeframe to complete them.
- Information to substantiate medical necessity.

**Note:** There is no specific DWC preauthorization form.

(continued)

# Initial Preauthorization Request


The requester or injured employee should include:

- A phone and fax number.
- The name of the requester and professional license number or National Provider Identifier (NPI), or the name of the employee if the injured employee is requesting preauthorization.
- The name, license number, or NPI of the health care provider who will render the service, if different.
- The facility name and NPI (if being done in a facility).
- The estimated date of proposed health care.

# Initial URA Response to Preauthorization

The insurance carrier (URA) must either approve or issue a denial within three working days of receiving the request.

Also, the URA must send a written notification within one working day of the decision to both the:

- Injured employee (and representative).
- Requester.

# Initial URA Response to Preauthorization


**Preauthorization Approval or Denial**


The URA must either approve or issue a denial on each request based solely on the medical necessity, regardless of:

- Unresolved issues of compensability, extent of the compensable injury, or relatedness to the compensable injury.
- The insurance carrier's liability for the injury.
- The fact that the injured employee has reached maximum medical improvement.

# Initial URA Response to Preauthorization-Approval


The URA's approval response should include:

- The specific health care.
- The approved number of health care treatments and specific timeframe to complete the treatments.
- **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.**
- The preauthorization approval number.

# Can the URA withdraw or change any elements of the preauthorization request?

Once a medical service has been preauthorized:

- The approval may not be withdrawn by the URA or insurance carrier.
- The URA may not condition or change any elements of the initial request on the approval, **unless the health care provider and insurance carrier mutually agree** (in writing).

# Does preauthorization guarantee payment?

Yes and no, once a medical service has been preauthorized:

- An insurance carrier **may not deny** retrospectively for medical necessity.
- However, an insurance carrier **may deny** preauthorized medical services for other reasons:
  - Compensability, extent, or relatedness.
  - Billing and coding issues.

Labor Code Sec. 413.014. Preauthorization Requirements; Concurrent Review and Certification of Health Care

# Initial URA Response to Preauthorization-Denial (Adverse Determination)

**28 TAC Sec. 19.2003. Definitions**

Adverse determination--A determination by a URA that the medical services provided or proposed to be provided to an injured employee are not medically necessary or appropriate.

Does not include:

- Denial of medical services due to the failure to request prospective or concurrent utilization review.
- Determination that medical services are experimental or investigational.

# Initial URA Response to Preauthorization-Denial (Adverse Determination)

An adverse determination must contain:

- The principal reasons for adverse determination.
- The clinical basis for adverse determination.
- A description of the procedure for filing a complaint with TDI.
- The professional specialty and Texas license number of the physician, doctor, or other health care provider that made the adverse determination.

# Initial URA Response to Preauthorization-Denial (Adverse Determination)

An adverse determination must contain:

- The procedure for the URA's complaint/appeal system.
- The source of the screening criteria and treatment guideline used.
- A notice of the independent review process.
- The LHL009, *Request for a Review by an Independent Review Organization* form or a way to get the LHL009 form.

# Preauthorization Denials and Peer Review Reports

## 28 TAC Sec. 180.28. Peer Review Requirements, Reporting, and Sanctions

Peer review reports used to deny a preauthorization request must document the objective medical findings and evidence-based medicine that supports the opinion, including:

- The peer reviewer's name and Texas license.
- A summary of qualifications.
- A list of all medical records and documents reviewed.
- A summary of clinical history.
- An explanation of the peer review decision.

# Preauthorization Denials and Peer Review Reports

**28 TAC Sec. 133.308. MDR of Medical Necessity Disputes**

Insurance carrier's use of a peer review report after an independent review organization (IRO) decision:

If the IRO decision overturns an insurance carrier denial where a peer review report was used, the peer review report must not be used for subsequent medical necessity denials of the same medical service.

# Can an insurance carrier deny all future medical care?


**Labor Code Sec. 415.002. Administrative Violation by Insurance Carrier**

An insurance carrier or its representative commits an administrative violation if they make a statement **denying all future medical care** for a compensable injury.

# Before Issuing an Adverse Determination

The URA must:

- Afford the health care provider a reasonable opportunity to discuss the plan of treatment for the injured employee with a physician, dentist, or chiropractor licensed in Texas.

- Provide the URA's telephone number.

# Before Issuing an Adverse Determination

The URA must make at least one documented good-faith attempt to contact the health care provider that provides a reasonable opportunity:

- To discuss the services under review with the URA.
- During normal business hours.
- Before issuing a preauthorization adverse determination (no less than one working day).

# Health Care Provider and URA Discussion Pending Adverse Determination


The discussion must include, at a minimum:

- The clinical basis for the URA's decision.
- A description of documentation or evidence, if any, that **the health care provider of record can submit** on appeal, which might lead to a different UR decision.

# Requester's Appeal of an Adverse Determination (Reconsideration Request)

A formal process by which an injured employee (or rep) or health care provider of record may request reconsideration of an adverse determination.

- An appeal may be submitted orally or in writing.
- The appeal must be within 30 days of receipt (non-network) or 30 days after the date of denial (network).

# Requester's Appeal of Adverse Determination (Request for Reconsideration)

Address the reasons for the denial in your request by considering:

- The definition of medical necessity.
- The applicable treatment guidelines or screening criteria.
- Documenting exceptions, if applicable.
- Any information that may be missing.
- Not missing deadlines!

# URA Response to Appeal (Request for Reconsideration)

The URA must respond to an appeal (request for reconsideration):

- As soon as practicable, but not later than the 30th day after receiving the appeal (request for reconsideration); or
- Within three working days after receipt for concurrent utilization review, except for the health care listed in 28 TAC Sec. 134.600(q)(1)., which is due within one day.

# Request for an Independent Review Organization (IRO)

If the URA's response to the appeal (request for reconsideration) remains an adverse determination, a requester may request an IRO to review it.

**Non-network:** no later than the **45th calendar day after receipt** of the insurance carrier's denial of an appeal.

**Network:** not later than the **45th day after the date of denial** of a reconsideration.

# Can the requester start the preauthorization process over?

Resubmission of preauthorization for the same medical services is only permitted when:

- There is a substantial change in condition; or
- Clinical prerequisites have been met, if applicable.

# Non-network preauthorization/concurrent review process

## Preauthorization request

### Request preauthorization or concurrent review

28 TAC §134.600
28 TAC Chapter 19

### URA response to request

Must approve issue or adverse determination within:

- **Three working days** of receiving a preauthorization or concurrent utilization review request.
- **One working day** of receiving a concurrent utilization review for inpatient length of stay request.

Before issuing an adverse determination, the URA must give the requester reasonable opportunity to discuss the clinical basis of the adverse determination:

- No less than **one working day** before issuing an adverse determination.
- Before issuing a concurrent or post-stabilization review adverse determination.

28 TAC §§19.2003 and 19.2010

Must send written notice of approval or adverse determination to the requester within **one working day** of the decision.

## Appeal request

### Request appeal of adverse determination

Must request appeal:

- Orally or in writing.
- Within **30 days** of receiving a written adverse determination.

**Note:** Injured employees with a life-threatening condition, or a request for medical interlocutory order are entitled to immediate review by an IRO and are not required to comply with the procedures for an appeal to the insurance carrier.

28 TAC §19.2011

### URA response to request

A second peer reviewer must approve or deny:

- As soon as practicable but within **30 days** of receiving a preauthorization appeal request.
- Within **three working days** of receiving a concurrent utilization review appeal request.
- Within **one working day** of receiving a concurrent utilization review for inpatient length of stay appeal request. The period to complete the appeal must be based on the medical or clinical immediacy of the condition, procedure, or treatment.

## IRO request

### Request independent review (LHL009)

Must request review by an IRO:

- By filing an LHL009 form with the URA.
- Within **45 calendar days** after receiving the URA's denial of appeal (non-network) or within **45 days** after the date of denial (network).

**Note:** There is no cost for an independent review, except for non-network retrospective reviews.

28 TAC Chapter 12
28 TAC §133.308

URA – utilization review agent
IRO – independent review organization

# Network preauthorization/concurrent review process

## Preauthorization request

### Request preauthorization or concurrent review

Insurance Code Chapter 1305
28 TAC Chapter 10
28 TAC Chapter 19

### URA response to request

Must approve issue or adverse determination within:

- The time appropriate to the delivery of services and condition of the patient, **not exceeding one hour** of receiving a post-stabilization treatment or life-threatening condition request.
- **Twenty-four hours** of receiving a concurrent hospitalization review request.
- **Three working days** of receiving all other preauthorization or concurrent review requests.

Before issuing an adverse determination, the URA must give the requester reasonable opportunity to discuss the clinical basis of the adverse determination:

- No less than **one working day** before issuing an adverse determination.
- Before issuing a concurrent or post-stabilization review adverse determination.

Must send written notice of approval or adverse determination to the requester within **one working day** of the decision. When sending adverse determination for life-threatening conditions, the URA must notify the requester of the availability of independent review.

Insurance Code §1305.353
28 TAC §§10.101, 19.2003, 19.2009

## Appeal request

### Request appeal of adverse determination

Must request appeal:

- Orally or in writing.
- Within **30 days** of receiving a written adverse determination.

**Note:** Injured employees with a life-threatening condition, or a request for medical interlocutory order are entitled to immediate review by an IRO and are not required to comply with the procedures for an appeal to the insurance carrier.

Insurance Code §1305.354
28 TAC §19.2011

### URA response to request

**Preauthorization**

Must approve or deny as soon as practicable but within **30 days** of receiving the preauthorization approval request.

**Post-stabilization treatment, life-threatening conditions, and continued stays for hospitalized employees**

Must approve or deny:

- Based on the medical or clinical immediacy of the condition, procedure, or treatment.
- Within **one calendar day** of receiving all necessary information to complete the reconsideration.

28 TAC §10.101

## IRO request

### Request independent review

Must request review by an IRO:

- By filing an LHL009 form with the URA.
- Within **45 days** after the date of denial.

**Note:** There is no cost for an independent review, except for non-network retrospective reviews.

Insurance Code §1305.355
28 TAC Chapter 12
28 TAC §§10.104, 133.308

URA – utilization review agent
IRO – independent review organization

## IRO requests

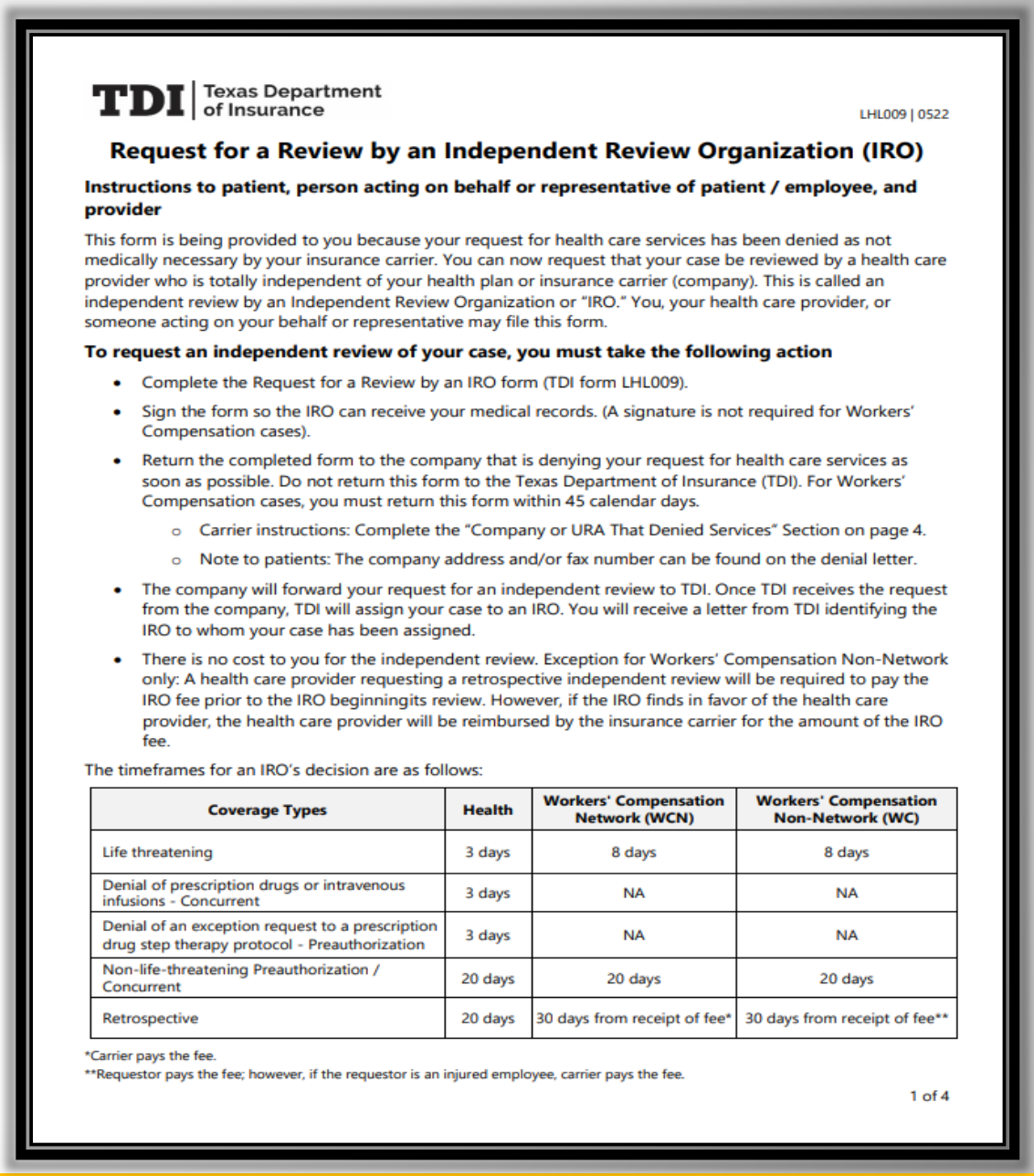
# Request for review by an IRO (LHL009 Form)

**Instructions are at the top of the form.**

**Do not send the form to TDI. Send it to the URA.**

If you have questions about the form, please contact:

- ✓ Managed Care Quality Assurance (MCQA): 512-676-6400
- ✓ MCQA toll free: 866-554-4926
- ✓ MCQA email: MCQA@tdi.texas.gov



TDI | Texas Department of Insurance

LHL009 | 0522

## Request for a Review by an Independent Review Organization (IRO)

**Instructions to patient, person acting on behalf or representative of patient / employee, and provider**

This form is being provided to you because your request for health care services has been denied as not medically necessary by your insurance carrier. You can now request that your case be reviewed by a health care provider who is totally independent of your health plan or insurance carrier (company). This is called an independent review by an Independent Review Organization or "IRO." You, your health care provider, or someone acting on your behalf or representative may file this form.

**To request an independent review of your case, you must take the following action**

- Complete the Request for a Review by an IRO form (TDI form LHL009).
- Sign the form so the IRO can receive your medical records. (A signature is not required for Workers' Compensation cases).
- Return the completed form to the company that is denying your request for health care services as soon as possible. Do not return this form to the Texas Department of Insurance (TDI). For Workers' Compensation cases, you must return this form within 45 calendar days.
  - Carrier instructions: Complete the "Company or URA That Denied Services" Section on page 4.
  - Note to patients: The company address and/or fax number can be found on the denial letter.
- The company will forward your request for an independent review to TDI. Once TDI receives the request from the company, TDI will assign your case to an IRO. You will receive a letter from TDI identifying the IRO to whom your case has been assigned.
- There is no cost to you for the independent review. Exception for Workers' Compensation Non-Network only: A health care provider requesting a retrospective independent review will be required to pay the IRO fee prior to the IRO beginningits review. However, if the IRO finds in favor of the health care provider, the health care provider will be reimbursed by the insurance carrier for the amount of the IRO fee.

The timeframes for an IRO's decision are as follows:

| Coverage Types | Health | Workers' Compensation Network (WCN) | Workers' Compensation Non-Network (WC) |
|---|---|---|---|
| Life threatening | 3 days | 8 days | 8 days |
| Denial of prescription drugs or intravenous infusions - Concurrent | 3 days | NA | NA |
| Denial of an exception request to a prescription drug step therapy protocol - Preauthorization | 3 days | NA | NA |
| Non-life-threatening Preauthorization / Concurrent | 20 days | 20 days | 20 days |
| Retrospective | 20 days | 30 days from receipt of fee* | 30 days from receipt of fee** |

*Carrier pays the fee.
**Requestor pays the fee; however, if the requestor is an injured employee, carrier pays the fee.

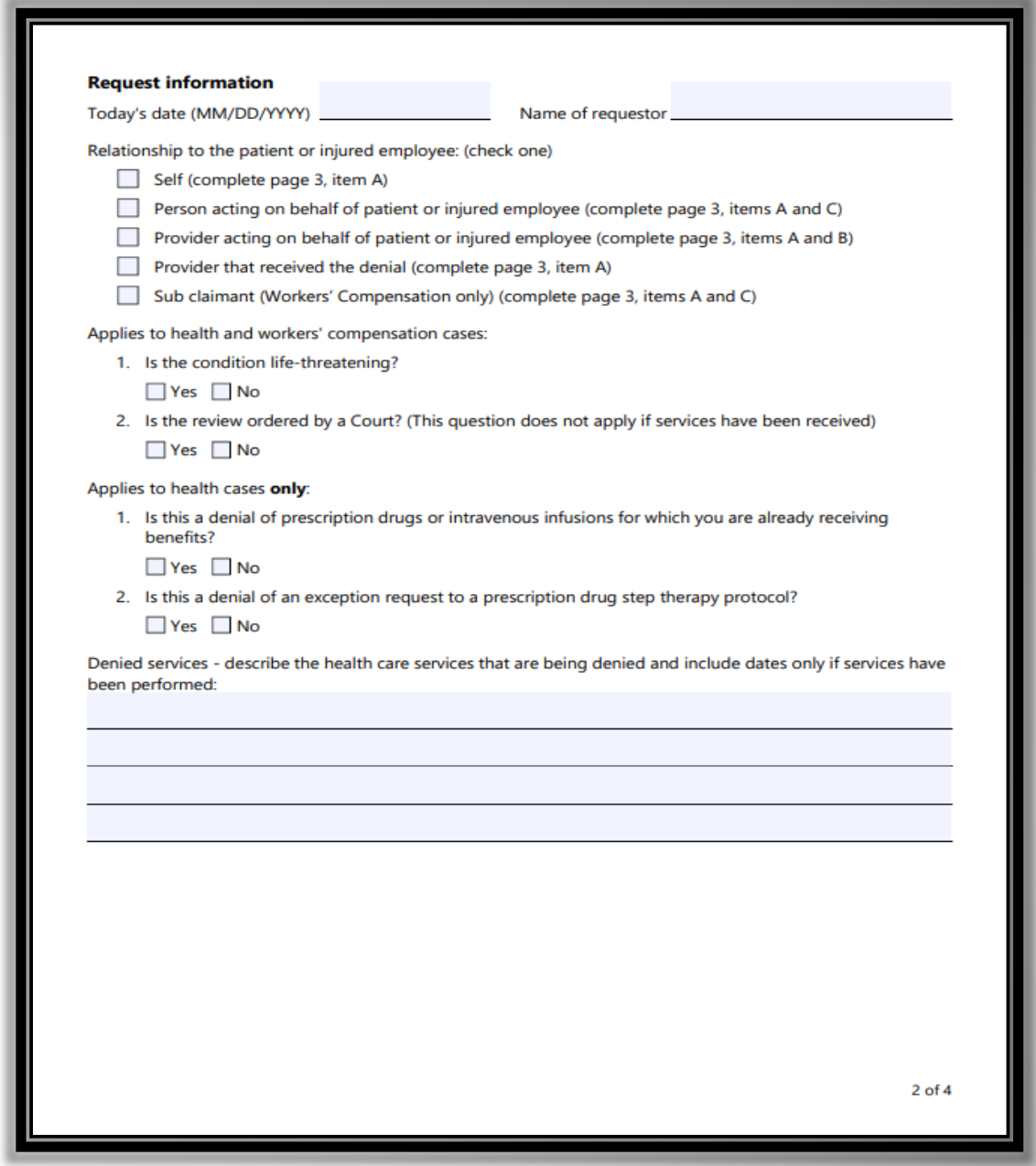
1 of 4

## Denied services:

Information on denied health care services is on the denial from the URA/insurance carrier. (It doesn't necessarily have to be CPT/HCPCS billing codes.)

## Patient/injured employee information:

If you don't know the DWC claim number, it's ok to leave it blank on the form.



**Request information**

Today's date (MM/DD/YYYY) _____ Name of requestor _____

Relationship to the patient or injured employee: (check one)

- ☐ Self (complete page 3, item A)
- ☐ Person acting on behalf of patient or injured employee (complete page 3, items A and C)
- ☐ Provider acting on behalf of patient or injured employee (complete page 3, items A and B)
- ☐ Provider that received the denial (complete page 3, item A)
- ☐ Sub claimant (Workers' Compensation only) (complete page 3, items A and C)

Applies to health and workers' compensation cases:

1. Is the condition life-threatening?
   ☐ Yes ☐ No
2. Is the review ordered by a Court? (This question does not apply if services have been received)
   ☐ Yes ☐ No

Applies to health cases **only**:

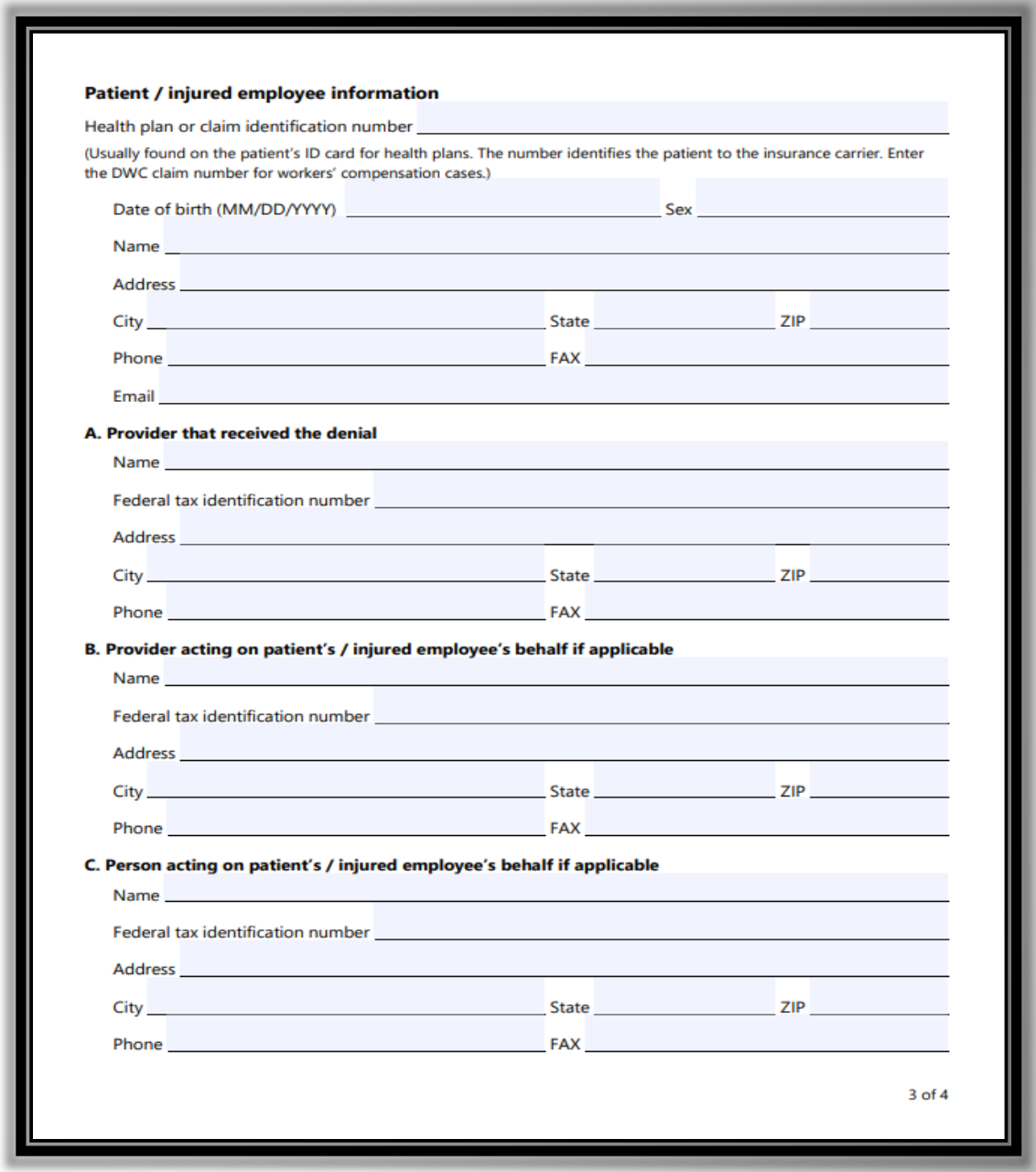
1. Is this a denial of prescription drugs or intravenous infusions for which you are already receiving benefits?
   ☐ Yes ☐ No
2. Is this a denial of an exception request to a prescription drug step therapy protocol?
   ☐ Yes ☐ No

Denied services - describe the health care services that are being denied and include dates only if services have been performed:

2 of 4

**Federal tax identification number:** If you don't know it, use N/A.

Only complete **B. Provider acting on patient's / injured employee's behalf** if it's different from A. Provider that received the denial.



**Patient / injured employee information**

Health plan or claim identification number _____

(Usually found on the patient's ID card for health plans. The number identifies the patient to the insurance carrier. Enter the DWC claim number for workers' compensation cases.)

Date of birth (MM/DD/YYYY) _____ Sex _____

Name _____

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

Email _____

**A. Provider that received the denial**

Name _____

Federal tax identification number _____

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

**B. Provider acting on patient's / injured employee's behalf if applicable**

Name _____

Federal tax identification number _____

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

**C. Person acting on patient's / injured employee's behalf if applicable**

Name _____

Federal tax identification number _____

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

3 of 4

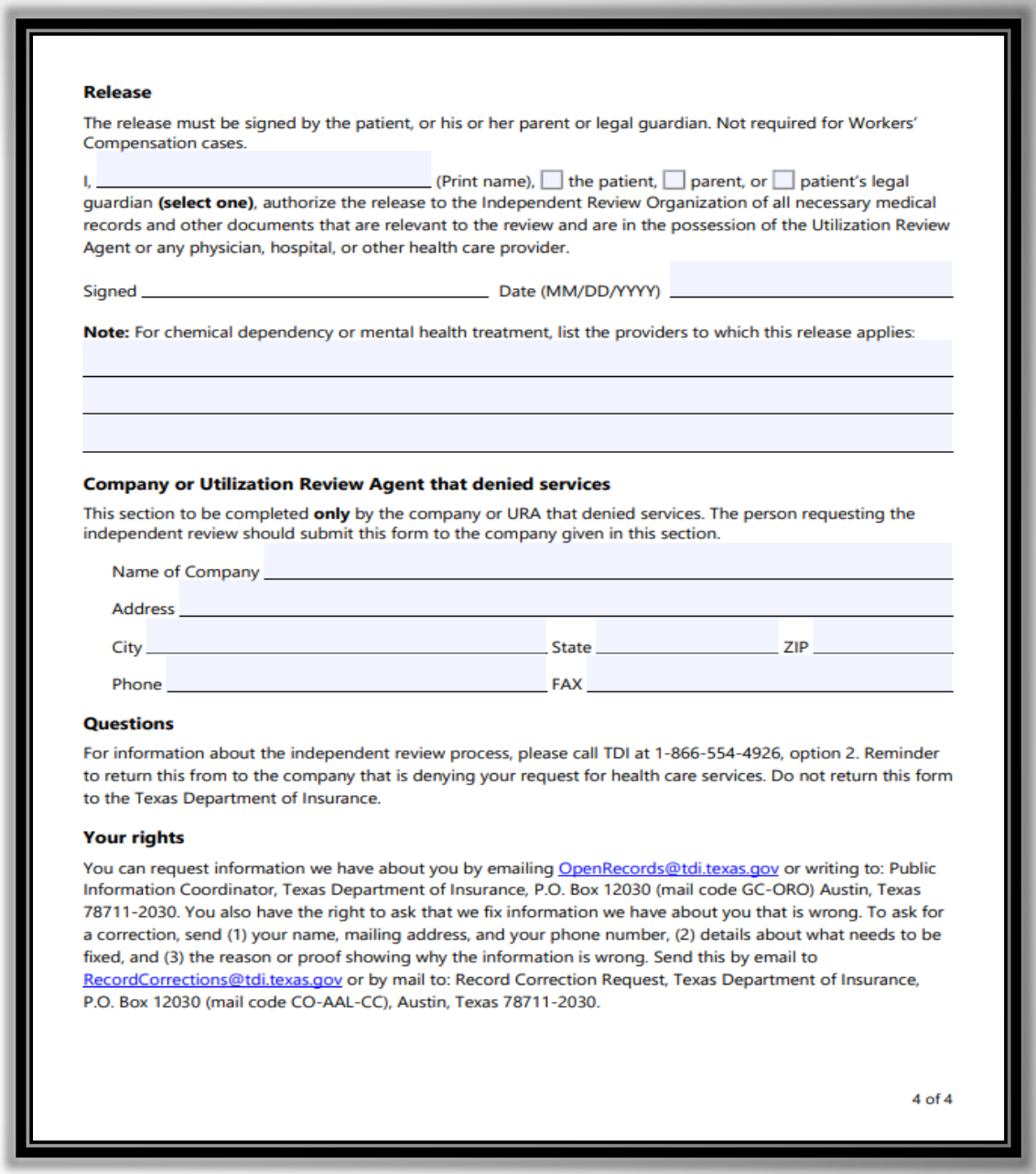
Release signature is not required for workers' compensation cases.

The **URA** completes the Company or Utilization Review Agent that denied services section.

The URA includes the LHL009 form with the denial.

The form can be mailed or faxed to the URA/insurance carrier **within 45 days of the second denial.**

The URA/insurance carrier submits the IRO request to MCQA next.



**Release**

The release must be signed by the patient, or his or her parent or legal guardian. Not required for Workers' Compensation cases.

I, _____ (Print name), ☐ the patient, ☐ parent, or ☐ patient's legal guardian **(select one)**, authorize the release to the Independent Review Organization of all necessary medical records and other documents that are relevant to the review and are in the possession of the Utilization Review Agent or any physician, hospital, or other health care provider.

Signed _____ Date (MM/DD/YYYY) _____

**Note:** For chemical dependency or mental health treatment, list the providers to which this release applies:

_____

_____

_____

**Company or Utilization Review Agent that denied services**

This section to be completed **only** by the company or URA that denied services. The person requesting the independent review should submit this form to the company given in this section.

Name of Company _____

Address _____

City _____ State _____ ZIP _____

Phone _____ FAX _____

**Questions**

For information about the independent review process, please call TDI at 1-866-554-4926, option 2. Reminder to return this from to the company that is denying your request for health care services. Do not return this form to the Texas Department of Insurance.

**Your rights**

You can request information we have about you by emailing OpenRecords@tdi.texas.gov or writing to: Public Information Coordinator, Texas Department of Insurance, P.O. Box 12030 (mail code GC-ORO) Austin, Texas 78711-2030. You also have the right to ask that we fix information we have about you that is wrong. To ask for a correction, send (1) your name, mailing address, and your phone number, (2) details about what needs to be fixed, and (3) the reason or proof showing why the information is wrong. Send this by email to RecordCorrections@tdi.texas.gov or by mail to: Record Correction Request, Texas Department of Insurance, P.O. Box 12030 (mail code CO-AAL-CC), Austin, Texas 78711-2030.

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# Independent Review Organization (IRO) process

### Request for independent review (LHL009)

Must request review by an IRO:

- By filing an LHL009 form with the URA.
- Within **45 calendar days** after receiving the URA's denial of appeal (non-network) or within **45 days** after the date of denial (network).

**Note:** There is no cost for an independent review, except for non-network retrospective reviews.

28 TAC Chapter 12
28 TAC §133.308

### URA notifies TDI of request for IRO

The URA must notify TDI within **one working day** after receiving the request.

### TDI assigns IRO and notifies parties

### IRO requests records

The URA submits required documentation to the IRO within **three working days** of receiving notification of IRO assignment.

The IRO may request additional information from either party and health care providers whose records are relevant to the review.

### IRO decision

The IRO must issue a decision within:

- **Eight days** after receiving a dispute for life threatening conditions.
- **Twenty days** after receiving a dispute for preauthorization or concurrent review.
- **Thirty days** after receiving the IRO fee for retrospective reviews.

These timeframes begin on the date the IRO receives the designated doctor report.

28 TAC §133.308

### Appeal of an IRO decision

To request a DWC contested case hearing, file a written appeal with DWC's Chief Clerk of Proceedings within **20 days** of receiving the IRO decision.

28 TAC Chapters 140 and 142
28 TAC §133.308

URA – utilization review agent
IRO – independent review organization

# Who pays IRO fees?

| Insurance Carrier Pays IRO Fee ($650 or $450) | Requester Pays IRO Fee |
|---|---|
| **All** preauthorization reviews. | |
| Network – retrospective reviews requested by health care provider. | Non-Network – retrospective reviews requested by health care provider (insurance carrier pays back if requester wins). |
| **All** retrospective reviews requested by injured employee. | |

## IRO decision appeal

# How do you appeal an IRO decision?

# Appeal of an IRO Decision Network and Non-Network

**28 TAC Sec. 133.308. MDR of Medical Necessity Disputes**

- Appeal of an IRO decision is through a contested case hearing (CCH).
- The IRO decision is not an agency decision, and neither the Texas Department of Insurance nor DWC is considered a party to an appeal.
- A benefit review conference is not a prerequisite to a CCH.

# Appeal of an IRO Decision

**28 TAC Sec. 133.308. MDR of Medical Necessity Disputes**

- Requests by first responders may be expedited.
- The IRO is not required to participate in the CCH.
- The appealing party has the burden of overcoming the decision by a preponderance of evidence-based medical information.

# Appeal of an IRO Decision

**28 TAC Sec. 133.308. MDR of Medical Necessity Disputes**

- Before the CCH, a party may send a letter of clarification to the chief clerk, but it may not ask the IRO to reconsider its decision.
- The administrative law judge will consider applicable treatment guidelines.

# What's after the hearing process?

If a party would like to appeal after all administrative remedies are exhausted:

- They may pursue judicial review outside of DWC.
- DWC is not a party.
- DWC may charge expenses to the requester for preparing documents for judicial review.

# Can a health care provider bill the injured employee after a decision on medical necessity?

## Labor Code Sec. 413.042. Private Claims; Administrative Violation

A health care provider may not pursue a private claim against a workers' compensation claimant for all or part of the cost of a medical service, **unless the injury is adjudicated as not compensable**.


**Note:** Services determined to not be medically necessary is not the same as the injury adjudicated as not compensable.


# Preauthorization Takeaways

You may not bill the injured employee if the medical service is determined to not be medically necessary. You may only be able to resubmit same preauthorization in very limited circumstances. You need to know:

- The definition of medical necessity.
- The applicable treatment guidelines or screening criteria.
- How to document exceptions, if applicable.
- Any information that may be missing.
- The deadlines.

# Recap

- Medical necessity in workers' compensation.
- Medical services requiring preauthorization.
- Preauthorization and utilization review (UR) process.
- Independent review process.
- DWC resources.

# Contact Us

CompConnection:
800-252-7031 option 3

compconnection@tdi.texas.gov