TITLE 28. INSURANCE

PART 2. TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

CHAPTER 134: BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES AND PAYMENTS

SUBCHAPTER B: MISCELLANEOUS REIMBURSEMENT
AMEND: §134.110

SUBCHAPTER F: PHARMACEUTICAL BENEFITS
AMEND: §134.502

SUBCHAPTER G: PROSPECTIVE AND CONCURRENT REVIEW OF HEALTH CARE
AMEND: §134.600

1. INTRODUCTION

The Texas Department of Insurance (Department), Division of Workers' Compensation (Division) adopts amendments to §134.110, concerning Reimbursement of Injured Employee for Travel Expenses Incurred; §134.502, concerning Pharmaceutical Services; and §134.600, concerning Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care. These sections are adopted with changes to the proposed text published in the November 1, 2013, issue of the *Texas Register* (38 TexReg 7611). There was not a request for a public hearing submitted to the Division.

In conjunction with this adoption order, the Division is adopting amendments to 28 TAC §133.2, concerning Definitions; §133.240, concerning Medical Payments and Denials; §133.250, concerning Reconsideration for Payment of Medical Bills; and §133.305, concerning MDR (medical dispute resolution) - General. The adoption of amendments to §§133.2, 133.240, 133.250, and 133.305 are also published in this issue of the *Texas Register*.

In response to comments on the proposal, the Division made non-substantive changes to proposed §134.600(h). The Division moved the phrase "issue an adverse determination on each request" from the end of the sentence to the middle and deleted "received by the insurance carrier" for clarity. In addition to the changes made as a result of comments, the Division made non-substantive changes including adding the word "the" and the phrase "of the health care services" to §134.600(o)(4) to be consistent with §133.240(q) and §133.250(k). None of the changes made in this adoption to the proposed text materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

In addition, the Division adopts non-substantive changes throughout the text of §§134.110, 134.502 and 134.600. These non-substantive changes include revising references from "carrier" to "insurance carrier" in §134.502; adding the term "utilization" between the terms "concurrent" and "review" in §134.600; renumbering subsections for clarity; changing the capitalization of the words "Division" and "Department" ; and deleting the word "Texas" from the phrase "Texas Labor Code" to conform to current agency style.

2. REASONED JUSTIFICATION

These amendments are necessary to implement House Bill 4290, 81st Legislature, Regular Session, effective September 1, 2009, which revises the definitions of "adverse determination" and "utilization review" in Insurance Code Chapter 4201 to include retrospective reviews and determinations regarding the experimental or investigational nature of a service.

These amendments are also necessary for the Division to comply with the requirement of Labor Code §402.00114 to regulate and administer the business of workers' compensation in Texas and ensure that Labor Code Title 5 and other laws regarding workers' compensation are executed.

Under Labor Code §402.00116, the Division is required to administer and enforce Labor Code Title 5, other workers' compensation laws of this state, and other laws applicable to the Division.

In accordance with Government Code §2001.033(a)(1), the Division's reasoned justification for these rules is set out in this order, which includes the preamble. The entire adoption order is part of the reasoned justification for the new sections. The following paragraphs include a detailed, section-by-section description and reasoned justification of all of the amendments necessary to harmonize the amendments with 28 TAC §§19.2001 – 19.2017 (Subchapter U), concerning Utilization Reviews for Health Care Provided Under Workers' Compensation Coverage published in the February 15, 2013, issue of the *Texas Register* (38 TexReg 892). Harmonization of these adopted sections with Subchapter U is beneficial because consistency benefits both system participants and injured employees. The adopted amendments to §§134.110, 134.502, and 134.600 are also important for reasons set out in the adoption order of Subchapter U.

The Division adopts these amendments to: (1) define and incorporate current procedural requirements concerning "adverse determinations" and "reasonable opportunity" and (2) reference the requirements for compliance with 28 TAC §19.2009, concerning Notice of Determinations Made in Utilization Review. The adopted amendments to §134.110 implement Labor Code §408.004 and §408.0041. Labor Code §408.004(c) pertains to medical examinations that injured employees may be required to submit to and requires insurance carriers to pay for those examinations and the reasonable expenses incident to the employees submitting to those examinations. Labor Code §408.0041(h) requires insurance carriers to pay for designated doctor examinations described in Labor Code §408.0041(a), (f), and (f-2), unless it is otherwise prohibited by law, and the reasonable expenses incident to the employee in submitting to the examination.

Section 134.110 addresses **Reimbursement of Injured Employee for Travel Expenses Incurred**. Amended §134.110(a) adds a new paragraph (2) that provides that an injured employee may request reimbursement from the insurance carrier if the injured employee has incurred travel expenses when the distance traveled to attend a designated doctor examination, required medical examination, or post designated doctor treating or referral doctor examination is greater than 30 miles one-way. Amended §134.110(a)(2) is necessary to implement Labor Code §408.004 and §408.0041. Labor Code §408.004(c), in part, requires insurance carriers to pay for certain required injured employee medical examinations and the reasonable expenses incident to the employees submitting to those examinations. Labor Code §408.0041(h), in part, requires insurance carriers to pay for certain designated doctor examinations and the reasonable expenses incident to the employee in submitting to the examination.

Amended §134.110(a)(2) is also necessary to align with 28 TAC §126.6 and §126.17, concerning Required Medical Examination and Guidelines for Examination by a Treating Doctor or Referral Doctor After a Designated Doctor Examination to Address Issues Other Than Certification of Maximum Medical Improvement and the Evaluation of Permanent Impairment, respectively. Title 28 TAC §126.6 requires injured employees to submit to required medical examinations and requires insurance carriers to pay for reasonable travel expenses incurred by the employees in submitting to required medical examinations, as specified in 28 TAC Chapter 134 concerning Benefits--Guidelines for Medical Services, Charges, and Payments. Title 28 TAC §126.17 requires the insurance carriers to reimburse injured employees for all reasonable travel expenses as specified in 28 TAC Chapter 134, Subchapter B, concerning Miscellaneous Reimbursement. Amended §134.110(a)(2) is necessary to reimburse injured employees for travel expenses incurred for post designated doctor treating or referral doctor examinations more than 30 miles away.

Existing subsection (g) of §134.110 is deleted because its effective date is no longer necessary.

Section 134.502 addresses **Pharmaceutical Services**. Amended §134.502(b) clarifies the existing requirement that doctors shall prescribe drugs in accordance with 28 TAC §134.530 and §134.540, concerning Requirements for Use of the Closed Formulary for Claims Not Subject to Certified Networks and Requirements for Use of the Closed Formulary for Claims Subject to Certified Networks, respectively. Title 28 TAC §134.530 and §134.540 were adopted effective January 17, 2011 (35 TexReg 11344).

Amended §134.502(d) changes the term "pharmacists" to the phrase "pharmacies and pharmacy processing agents" for consistency with Labor Code §413.0111, relating to processing agents. Amended §134.502(d) is also consistent with 28 TAC §133.307, concerning MDR of Fee Disputes, and 133.10, concerning Required Billing Forms/Formats. Title 28 TAC §133.307 allows qualified pharmacy processing agents to be requestors in medical fee disputes over the reimbursement of medical bills. Title 28 TAC §133.10 contains required billing forms and formats for pharmacies and pharmacy processing agents.

Amended §134.502(d) also changes the outdated citation from 28 TAC §134.800(d) to 28 TAC Chapters 133 and 134. Title 28 TAC §134.800 pertained to required billing forms and information prior to its repeal on May 2, 2006. Required billing forms and information are now codified in 28 TAC Chapter 133, concerning General Medical Provisions and 28 TAC Chapter 134, concerning Benefits--Guidelines for Medical Services, Charges, and Payments.

Amended §134.502(e) and (g) change the term "reasonableness or medical necessity" to "adverse determination" for consistency with the definition of the term "adverse determination" in Insurance Code §4201.002(1) and the injured employee's entitlement to all healthcare reasonably

required under Labor Code §408.021(a). Amended §134.502(e) and (g) also correspond with the definition for "adverse determination" in 28 TAC §19.2003(b)(1) and the definition in new §134.600(a)(1).

Amended §134.502(f) deletes the word "working" so that the prescribing doctor is required to provide a statement of medical necessity to the requesting party no later than the 14th calendar day after receipt of the request. This change is necessary because the provision of 14 working days delays the receipt of statements of medical necessity from prescribing doctors by pharmacy billing managers and pharmacy processing agents who are required to comply with timeframes contained in Division rules. System participants will be able to more easily monitor the timeframe to provide a statement of medical necessity under the rule for compliance purposes.

Amended §134.502(g) updates the citation from 28 TAC §133.304 to 28 TAC §133.240 because 28 TAC §133.304, concerning Medical Payments and Denials was repealed and re-codified as 28 TAC §133.240, concerning Medical Payments and Denials, in the April 28, 2006, issue of the *Texas Register* (31 TexReg 3544), effective May 2, 2006.

Section 134.600 addresses **Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care.** Amended §134.600 adds the term "utilization" between the terms "concurrent" and "review" in the title of §134.600 and in §134.600(a)(3), (a)(5), (a)(10), (c)(1)(C), (e), (f), (i)(2), (l), (o), (o)(2)(B), (q), (r), and (t) to conform to the term "concurrent utilization review" in 28 TAC §19.2003(b)(8).

Amended §134.600 adds new (a)(1) which defines "adverse determination" to correspond with the definition in 28 TAC §19.2003(b)(1). However, the definition of "adverse determination" in 134.600(a)(1) deviates from the statutory definition of "adverse determination" in Insurance Code §4201.002(1) concerning Definitions. The Division must exclude "experimental or investigational

services" from the definition of "adverse determination," because Labor Code §408.021 entitles an injured employee subject to either network coverage or non-network coverage to all medically necessary health care services, including experimental and investigational health care services. Pursuant to Insurance Code §4201.054(c), Labor Code Title 5 prevails if it conflicts with Insurance Code Chapter 4201. The Division also notes that experimental or investigational health care services for injured employees subject to non-network coverage must be preauthorized pursuant to Labor Code §413.014 and an adverse determination may not be issued solely because the health care is experimental or investigational.

Amended §134.600(a)(3) clarifies that concurrent utilization review is a form of utilization review to implement Insurance Code Chapter 4201 and to correspond with the definition for "concurrent utilization review" in 28 TAC §19.2003(b)(8).

Amended §134.600(a)(8) changes the definition of "preauthorization" in existing §134.600(a)(8) to correspond with the definition in 28 TAC §19.2003(b)(26).

Amended §134.600 adds new (a)(9) which defines "reasonable opportunity" to implement Insurance Code § 4201.206 and to correspond with 28 TAC §19.2003(b)(28).

Amended §134.600(e) adds the requirement that insurance carriers and utilization review agents comply with the requirements of 28 TAC §19.2012 to clarify the combined applications of 28 TAC §134.600(e), §19.2012, and Chapter 134, Subchapter F, concerning Pharmaceutical Benefits. Title 28 TAC §19.2002(b)(3) provides that if there is a conflict between Subchapter U, including §19.2012, and rules adopted by the commissioner of workers' compensation, the rules adopted by the commissioner of workers' compensation prevail. Amended §134.600(e) applies to insurance carriers and utilization review agents who are required to have and implement procedures when responding to requests for drugs that require preauthorization if the injured employee has received

or is currently receiving the requested drugs and the adverse determination could lead to a medical emergency. Amended §134.600(e) deletes the phrase "by the insurance carrier" because the Division recognizes that the party directly responding to requests for preauthorization may be the insurance carrier if the insurance carrier is a certified utilization review agent or the insurance carrier's utilization review agent.

Amended §134.600(g)(3) deletes the phrase "medical necessity and/or" to correspond with the definition of "adverse determination" in Insurance Code §4201.002(1) and Subchapter U. Amended §134.600(g)(3) – (5), (h), (i), (m), (o), (o)(1) – (2), (o)(5), and (t) add the term "adverse determination" to conform to Insurance Code §4201.002(1) and Subchapter U and delete the outdated terminology referring to denials.

Additionally, amended §134.600(g)(3), (g)(4) and (g)(5) make non-substantive changes of the term "injury/diagnosis" to "injury or diagnosis." Section 134.600(g)(3) requires that if denying the request, the insurance carrier shall indicate whether it is issuing an adverse determination, and/or whether the denial is based on an unrelated injury or diagnosis in accordance with §134.600(m) of this section.

Amended §134.600(g)(4) allows the requestor or injured employee to file an extent of injury dispute upon receipt of an insurance carrier's response which includes a denial due to an unrelated injury or diagnosis, regardless of whether an adverse determination was also issued. Amended §134.600(g)(4) is necessary for consistency with the definition of the term "adverse determination" in Insurance Code §4201.002(1) and to correspond with 28 TAC §19.2003(b)(1).

Amended §134.600(g)(5) provides that requests which include a denial due to an unrelated injury or diagnosis may not proceed to medical dispute resolution based on the denial of unrelatedness. However, requests which include the dispute of an adverse determination may

proceed to medical dispute resolution for the issue of medical necessity in accordance with §134.600(o) of this section. Amended §134.600(g)(5) is necessary for consistency with the definition of the term "adverse determination" in Insurance Code §4201.002(1) and to correspond with 28 TAC §19.2003(b)(1).

Amended §134.600(h) requires the insurance carrier to "either approve or issue an adverse determination on each request based solely on the medical necessity of the health care required to treat the injury ..." for consistency with the definition of the term "adverse determination" in Insurance Code §4201.002(1) and to correspond with 28 TAC §19.2003(b)(1).

Amended §134.600(i) requires the insurance carrier to contact the requestor or injured employee within the required timeframes by telephone, facsimile, or electronic transmission with its decision to approve the preauthorization or concurrent utilization review request; issue an adverse determination on the request; or deny the request under §134.600(g) because it relates to an unrelated injury or diagnosis. Amended §134.600(i) is necessary for consistency with the definition of the term "adverse determination" in Insurance Code §4201.002(1) and to correspond with 28 TAC §19.2003(b)(1). Amended §134.600(i)(1) – (2) delete the word "within" and add the language "within the following timeframes" for clarification.

Amended §134.600(j) requires the insurance carrier to send written notification of the approval of the request; adverse determination on the request; or denial of the request under §134.600(g) because of an unrelated injury or diagnosis. Amended §134.600(j) is necessary to update the terminology in §134.600(j) to correspond with the definition for "adverse determination" in Insurance Code §4201.002(1) and 28 TAC §19.2003(b)(1).

Amended §134.600(l)(4) adds a fourth requirement for insurance carrier approvals, which requires insurance carriers to include the insurance carrier's preauthorization approval number in its

approval of a preauthorization request. Section 134.600(l)(4) provides that the preauthorization approval number must conform to the standards described in 28 TAC §19.2009(a)(4). Amended §134.600(l)(4) is necessary to align the requirements of this section with the medical billing requirements in 28 TAC Chapter 133, Subchapters B and G, concerning Health Care Provider Billing Procedures; and Electronic Medical Billing, Reimbursement, and Documentation; respectively, which require the inclusion of a preauthorization number on medical bills, if applicable.

Amended §134.600(m) requires insurance carriers to comply with 28 TAC §19.2010 and afford requestors a reasonable opportunity to discuss the clinical basis for the adverse determination prior to the insurance carrier issuing the adverse determination. Further, the notice of adverse determination must comply with the requirements of 28 TAC §19.2009 and include a plain language description of the complaint and appeal process. Amendments to §134.600(m) are necessary to streamline the requirements and harmonize with Insurance Code §4201.456 and 28 TAC §§19.2010 and 19.2009. These conforming changes enable the monitoring of whether a reasonable opportunity for discussion was offered and the collecting of information on peer-to-peer discussion results to ensure compliance with utilization review requirements.

Amended §134.600 deletes existing (m)(1) - (5) which outlined the elements that were required to be included in a denial of medical necessity. The requirements in existing §134.600(m)(1) are no longer necessary because the notice of adverse determination must comply with the requirements of 28 TAC §19.2009(b). Subsection (m) continues to provide that if preauthorization is denied based on Labor Code §408.0042 because the treatment is for an injury or diagnosis unrelated to the compensable injury, the notice of adverse determination must include notification to the injured employee and health care provider of entitlement to file an extent of injury dispute in accordance with 28 TAC Chapter 141 concerning Dispute Resolution--Benefit Review Conference.

Amended §134.600(o) provides that if the initial response to preauthorization or concurrent utilization review is an adverse determination, the requestor or injured employee may request reconsideration orally or in writing. Amended §134.600(o) is necessary to conform with Insurance Code §1305.354, concerning Reconsideration of Adverse Determination. Further, amended §134.600(o) conforms to the requirement that a request for reconsideration under §134.600(o) constitutes an appeal for the purposes of 28 TAC §19.2011. The term "appeal" is defined in 28 TAC §19.2003(b)(2). Further, requests for reconsideration must be made in accordance with the requirements of amended §134.600(o) and 28 TAC §19.2011.

Amended §134.600(o)(3) adds a reference to 28 TAC §19.2011 to clarify an insurance carrier's reconsideration procedures must also comply with 28 TAC §19.2011.

Amended §134.600(o)(4) requires insurance carriers that are questioning the medical necessity or appropriateness of the health care services to comply with the requirements of 28 TAC §19.2010 and §19.2011, including the requirement that the insurance carrier afford the requestor a reasonable opportunity to discuss the proposed health care with a doctor or, in cases of a dental plan with a dentist, or in cases of a chiropractic service with a chiropractor, prior to the issuance of an adverse determination on the request for reconsideration. This change is necessary to clarify the combined application of §134.600(o)(4), and 28 TAC §19.2010 and §19.2011 to insurance carriers and utilization review agents.

Existing §134.600(v) is deleted because its effective date is no longer necessary.

3. HOW THE SECTIONS WILL FUNCTION

Section 134.110 specifies the requirements for reimbursement of injured employees for travel expenses incurred by the injured employees, the travel rate that the expenses must be based on by

the insurance carrier, and the insurance carrier's responsibility to inform the injured employee of the right to request a benefit review conference if the insurance carrier does not reimburse the full amount requested.

Section 134.502 specifies requirements for the prescription of drugs by doctors and pharmaceutical services provided to injured employees, including submission of bills for pharmacy services, statements of medical necessity by prescribing doctors, and requirements for transmittal of the explanation of benefits (EOB) to injured employees and the prescribing doctor when the insurance carrier denies payment for medications.

Section 134.600 provides the requirements applicable to preauthorization, concurrent utilization review, and voluntary certification of health care. Section 134.600 also specifies the meaning of words and terms when used in Chapter 134, unless the context clearly indicates otherwise.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSES.

General

Comment: One commenter greatly appreciates and supports the changes because they offer enhanced clarity.

Agency Response: The Division appreciates the supportive comment.

Comment: One commenter states that the rules make utilization review more burdensome and expensive from an administrative standpoint, which is not the most effective way to satisfy the mandate to control medical costs in the workers' compensation system. The commenter thinks the rules should have been written to follow existing Division rule language and conform to the Labor Code.

Agency Response: The Division asserts that these rules are necessary to implement HB 4290. Insurance Code Chapter 4201, to the extent not in conflict with Labor Code Title 5 or Insurance Code Chapter 1305, and these provisions apply to workers' compensation utilization review. Additionally, these rules promote efficient regulation of URAs through the alignment of health and workers' compensation URA certification and registration requirements, utilization review timeframes, and utilization review standards. These rules also align utilization review timeframes and standards within workers' compensation for network and non-network claims.

Comment: One commenter suggests that the best way to conform the current proposed rule changes with Subchapter U is to incorporate the commenter's suggested changes to these proposed rules into Subchapter U.

The commenter objects to the references to other codes and rules and the cross-referencing to other sections of this title because they make it difficult to understand what these sections mean without consulting other material. The commenter recommends that the references be revised to specifically explain what the code or rule referred to actually means. The commenter states the proposed rules are lengthy and complex and they should be self-contained rather than reference other rule sections because this change would ensure that system participants can more readily determine their responsibilities under the rules.

Agency Response: The Division declines to make the suggested changes. Amendments to Title 28 Chapter 19, Subchapter U are outside the scope of the amendments to Chapter 134 included in this adoption. The Division declines to delete the references to other codes and rules because an entity that performs utilization review is required to comply with the cited rules and statutes, and inclusion of the entire text of other rules and statutes would be repetitive. The Division has determined that the rules are more streamlined and easier to understand by including cross-

references, and also provides notice to URAs that they are subject to the requirements in other rules and statutes.

§134.502

Comment: One commenter supports §134.502(b), which requires a physician who is prescribing drugs to prescribe the drugs in accordance with §134.530 and §134.540 (Closed Drug Formulary). The commenter supports this rule because it will promote the delivery of high quality health care that is reasonably required by the nature of the injury, is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence-based medicine or, if that evidence is not available, generally accepted standards of medical practice recognized in the medical community.

Agency Response: The Division appreciates the supportive comment and clarifies that amended §134.502(b) clarifies the existing requirement that doctors shall prescribe drugs in accordance with 28 TAC §134.530 and §134.540.

§134.600

Comment: Several commenters assert the definition of "adverse determination" in §134.600(a)(1) conflicts with Insurance Code §4201.002(1) and the standards for health care coverage in the Workers' Compensation Act. The commenters assert that Insurance Code §4201.054(c) mandates that Title 5 of the Labor Code prevails over Insurance Code Chapter 4201 when there is a conflict. The commenters assert Labor Code §408.021 states that the injured worker is entitled to "…all health care reasonably required by the nature of the injury as and when needed" and the term "health care reasonably required" is defined in Labor Code §401.011(22-a). The commenters assert the proposed language suggests that the standard for entitlement to workers' compensation medical treatment is "medically necessary or appropriate" which is not defined in the

Workers' Compensation Act and is subject to an interpretation that could differ from the statutory standard of "health care reasonably required." The commenters suggest deleting the words "medically necessary or appropriate" in the definition and inserting the words "reasonably required" in their place.

Agency Response: The Division declines to make the suggested changes. The phrase "medically necessary or appropriate" is consistent with the definition of "adverse determination" under the Insurance Code §4201.002, which defines "adverse determination" as a determination by a URA that health care services provided or proposed to be provided to a patient are not medically necessary or are experimental or investigational. Also, the phrase "medically necessary or appropriate" is used in 28 TAC §12.5(1), which defines "adverse determination" for purposes of independent review. Introducing the phrase "health care reasonably required" would result in inconsistent definitions of "adverse determination" in the context of utilization review and independent review.

Nothing may be construed to limit health care reasonably required under Labor Code §408.021. The Division's position is that, based on Labor Code §408.021, an injured employee under both network and non-network coverage is entitled to health care reasonably required by the nature of the injury as and when needed, including experimental and investigational health care services. For this reason, the Division clarifies that the term "adverse determination" does not include a determination that health care services are experimental or investigational.

Comment: Two commenters support §134.600(a)(9) which defines the term "reasonable opportunity."

Agency Response: The Division appreciates the supportive comments.

Comment: A commenter requests that one working day be further defined in §134.600(a)(9)(A) as at least a 24-hour period in order to give the provider sufficient time to respond to an inquiry from the URA because this change would help ensure that the conversation between the URA and the provider actually takes place.

Agency Response: The Division declines to make the suggested change to the definition of the term "working day." "Working day" is consistent with Insurance Code §4201.002(16) which defines "working day" as "a weekday that is not a legal holiday" and is also consistent with 28 TAC §102.3, concerning Computation of Time, which states that "A working day is any day, Monday-Friday, other than a national holiday as defined by Texas Government Code, §662.003(a) and the Friday after Thanksgiving Day, December 24th and December 26th." A 24-hour period would conflict with the statutory definition and Division rules as one 24-hour period could cover more than one weekday that is not a holiday.

Comment: One commenter suggests a comma be added to §134.600(h) between the words "or" and "based."

One commenter seeks clarification of the meaning of §134.600(h).

Agency response: The Division declines to add a comma between the words "or" and "based" in §134.600(h). The Division agrees to a non-substantive change to clarify §134.600(h) by moving the phrase "issue an adverse determination on each request" and deleting "received by the insurance carrier" to clarify that the insurance carrier shall approve or issue an adverse determination on each request based solely on the medical necessity of the health care required to treat the injury.

Comment: One commenter suggests commas replace semicolons in §134.600(i).

Agency Response: The Division declines to make the suggested changes because the punctuation conforms to current agency style.

Comment: Two commenters think oral requests need to also be in writing to constitute an appeal for the purposes of §19.2011 in §134.600(o).

Agency Response: The Division declines to make the suggested changes. Amended §134.600(o) corresponds with Insurance Code §4201.355 which requires that within five working days from the date the utilization review agent receives the appeal, the agent must send to the appealing party a letter acknowledging the date of receipt and include a list of documents the appealing party must submit for review. Amended §134.600(o) also corresponds with Insurance Code §1305.354 which pertains to the reconsideration of adverse determinations by workers' compensation health care networks that requires that not later than the fifth calendar day after the date of receipt of the request, the network shall send to the requesting party a letter acknowledging the date of the receipt of the request that includes a reasonable list of documents the requesting party is required to submit. Further, Insurance Code §4201.354 requires that the procedures for appealing an adverse determination must provide that the adverse determination may be appealed orally or in writing and is consistent with the requirements of Insurance Code §1305.354 for workers' compensation network coverage. Amended §134.600(o) is necessary to align this proposed section with 28 TAC §19.2011(a)(3) which provides that an injured employee, the injured employee's representative, or the provider of record may appeal the adverse determination orally or in writing. This amendment is also consistent with 28 TAC §10.103 concerning Workers' Compensation Network Requests for Reconsideration.

Comment: Two commenters assert that the phrase in §134.600(o)(4) "where the insurance carrier is questioning" is too vague and not a workable standard.

One commenter suggests changing the language in §134.600(o)(4) to provide "In any instance where an insurance carrier has determined that the insurance carrier may issue an adverse determination…"

One commenter suggests replacing "In any instance where the insurance carrier is questioning" with the language "Prior to the issuance of an adverse determination relating to" in §134.600(o)(4). The commenter believes that whenever a carrier engages in any utilization review it is questioning the necessity or appropriateness of the health care services and this is the essence of utilization review. The commenter thinks that issuance of an adverse decision is a workable standard and it may make sense for a proposed rule to state that prior to issuing an adverse decision, a carrier shall give the provider a reasonable opportunity to discuss the services; however, triggering all these requirements merely because someone is questioning the appropriateness or necessity of services is too vague and represents a misunderstanding of the purpose of utilization review.

Agency Response: The Division declines to make the suggested change. New §134.600(o)(4) is consistent with Insurance Code §4201.206 which uses the phrase "who questions the medical necessity or appropriateness." It is also consistent with Subchapter U. The term "insurance carrier" is used because an entity that conducts utilization review in the workers' compensation system is required to comply with the applicable statutes and regulations to conduct utilization review. The Division recognizes that the party directly responding to a request for retrospective utilization review may be the insurance carrier if the insurance carrier is a certified utilization review agent or the insurance carrier's utilization review agent. Under the definition of agent in §133.2, the system participant who utilizes or contracts with an agent may also be responsible for the administrative violations of that agent.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.

For: CID Management

For, with changes: Office of Injured Employee Counsel, Property Casualty Insurers Association of America, Insurance Council of Texas, and American Insurance Association

6. STATUTORY AUTHORITY.

Amendments to §134.110 are adopted under Labor Code §§402.00111, 402.061, 408.004, and 408.0041.

Labor Code §402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code. Section 402.061 provides that the Commissioner of Workers' Compensation shall adopt rules as necessary for the implementation and enforcement of Title 5, Labor Code. Section 408.004 requires insurance carriers to pay for medical examinations that injured employees may be required to submit to and the reasonable expenses incident to the employees submitting to those examinations. Labor Code §408.0041 requires insurance carriers to pay for designated doctor examinations described in Labor Code §408.0041(a), (f), and (f-2), unless it is otherwise prohibited by law, and the reasonable expenses incident to the employee in submitting to the examination.

The amendments to §134.502 are adopted under the Labor Code §§402.00111, 402.00114, 402.00116, 402.061, 406.010, 408.021(a), 408.027, 408.028, 408.0281, 413.002, 413.011, 413.0111, 413.013, 413.017 and 413.031 and Insurance Code §4201.054.

Labor Code §402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code. Section 402.00114 requires the division to regulate and administer the business of workers' compensation in

this state and ensure that Labor Code, Title 5 and other laws regarding workers' compensation are executed. Section 402.00116 requires the commissioner of workers' compensation to administer and enforce Labor Code Title 5, other workers' compensation laws of this state, and other laws applicable to the division. Section 402.061 provides that the Commissioner of Workers' Compensation shall adopt rules as necessary for the implementation and enforcement of Title 5, Labor Code. Section 406.010 authorizes the division to adopt rules necessary to specify the requirements for carriers to provide claims service and establishes that a person commits a violation if the person violates a rule adopted under this section. Section 408.021(a) states that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Section 408.027 establishes the timeframe for a health care provider's claim submission, the timeframes for an insurance carrier's processing of a claim including requests for additional documentation and audit, the reimbursement during the pendency of an audit, and the applicability of §408.027 to all delivered health care. Section 408.028 requires health care practitioners providing care to an employee to prescribe any necessary prescription drugs in accordance with the applicable state law. Section 408.028(b) requires the commissioner by rule to adopt a closed formulary under Labor Code §413.011 and requires the rules adopted to allow an appeals process for claims in which a treating doctor determines and documents that a drug not included in the formulary is necessary to treat an injured employee's compensable injury. Labor Code §408.028(f) requires the commissioner by rule to adopt a fee schedule for pharmacy and pharmaceutical services that will provide reimbursement rates that are fair and reasonable, assure adequate access to medications and services for injured workers, minimize costs to employees and insurance carriers, and take into consideration the increased security of payment afforded by Labor Code Title 5. Labor Code §408.0281 provides prescription medication or services may be

reimbursed in accordance with the fee guidelines adopted by the commissioner or at a contract rate in accordance with that section.

Section 413.002 requires the division to monitor health care providers, insurance carriers, independent review organizations, and workers' compensation claimants who receive medical services to ensure compliance with division rules relating to health care, including medical policies and fee guidelines. Section 413.011 requires the commissioner to adopt health care reimbursement policies and guidelines. Section 413.0111 requires that rules adopted by the commissioner for the reimbursement of prescription medications and services must authorize pharmacies to use agents or assignees to process claims and act on the behalf of the pharmacies under terms and conditions agreed on by the pharmacies. Section 413.013(1), (2) and (3) require the division by rule to establish a program for prospective, concurrent, and retrospective review and resolution of a dispute regarding health care treatments and services, a program for the systematic monitoring of the necessity of the treatments administered and fees charged and paid for medical treatments or services including the authorization of prospective, concurrent or retrospective review under the medical policies of the division to ensure the medical policies and guidelines are not exceeded, and a program to detect practices and patterns by insurance carriers in unreasonably denying authorization of payment for medical services requested or performed if authorization is required by the medical policies of the division. Section 413.017 establishes a presumption of reasonableness of medical services consistent with the medical policies and fee guidelines adopted by the division and medical services that are provided subject to prospective, concurrent, or retrospective review and required by the medical policies of the division and that are authorized by an insurance carrier. Section 413.031 entitles a party, including a health care provider, to a review of a medical service provided or for which authorization of payment is sought if a health care provider has been denied payment, paid a

reduced amount for the medical service rendered, or denied authorization for the payment for the service required or performed if authorization is required or allowed by Labor Code Title 5 or division rules.

Insurance Code §4201.054 provides that Chapter 4201 applies to utilization review of a health care service provided to a person eligible for workers' compensation medical benefits under Title 5, Labor Code; the commissioner of workers' compensation shall regulate as provided by Chapter 4201 a person who performs utilization review of a medical benefit provided under Title 5, Labor Code; Title 5, Labor Code, prevails in the event of a conflict between Chapter 4201 and Title 5, Labor Code; and the commissioner of workers' compensation may adopt rules as necessary to implement §4201.054.

The amendments to §134.600 are adopted under the Labor Code §§402.00111, 402.00114, 402.00116, 402.061, 408.021, 408.027, 413.013, 413.014, and 413.031; and Insurance Code §4201.456 and §4201.054.

Labor Code §402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code. Section 402.00114 requires the division to regulate and administer the business of workers' compensation in this state and ensure that Labor Code, Title 5 and other laws regarding workers' compensation are executed. Section 402.00116 requires the division to administer and enforce Labor Code Title 5, other workers' compensation laws of this state, and other laws applicable to the division. Section 402.061 provides that the Commissioner of Workers' Compensation shall adopt rules as necessary for the implementation and enforcement of Title 5, Labor Code. Section 408.021, in part, entitles an employee who sustains a compensable injury to all health care reasonably required by the nature of the injury as and when needed and specifically entitles the employee 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. Section 408.027 provides requirements for payment of health care providers by insurance carriers and requires the commissioner to adopt rules as necessary to implement the provisions of §408.027 and §408.0271. Section 413.013(1), (2) and (3) require the division by rule to establish a program for prospective, concurrent, and retrospective review and resolution of a dispute regarding health care treatments and services, a program for the systematic monitoring of the necessity of the treatments administered and fees charged and paid for medical treatments or services including the authorization of prospective, concurrent or retrospective review under the medical policies of the division to ensure the medical policies and guidelines are not exceeded, and a program to detect practices and patterns by insurance carriers in unreasonably denying authorization of payment for medical services requested or performed if authorization is required by the medical policies of the division. Section 413.014 provides, in part, that division rules adopted under this section must provide that preauthorization and concurrent review are required at a minimum for any investigational or experimental services or devices. Section 413.031 entitles a party, including a health care provider, to a review of a medical service provided or for which authorization of payment is sought if a health care provider has been denied payment, paid a reduced amount for the medical service rendered, or denied authorization for the payment for the service required or performed if authorization is required or allowed by Labor Code Title 5 or division rules.

Insurance Code §4201.054 provides that Chapter 4201 applies to utilization review of a health care service provided to a person eligible for workers' compensation medical benefits under Title 5, Labor Code; the commissioner of workers' compensation shall regulate as provided by Chapter 4201 a person who performs utilization review of a medical benefit provided under Title 5, Labor Code;

Title 5, Labor Code, prevails in the event of a conflict between Chapter 4201 and Title 5, Labor Code; and the commissioner of workers' compensation may adopt rules as necessary to implement §4201.054. Section 4201.456 provides that subject to the notice requirements of Insurance Code, Chapter 4201, Subchapter G, before an adverse determination is issued by a specialty utilization review agent who questions the medical necessity or appropriateness, or the experimental or investigational nature, of a health care service, the agent shall provide the health care provider who ordered the service a reasonable opportunity to discuss the patient's treatment plan and the clinical basis for the agents determination with a health care provider who is of the same specialty as the agent.

Government Code §2001.036 provides, in part, that a rule takes effect 20 days after the date on which it is filed in the Office of the Secretary of State.

7. TEXT.

CHAPTER 134: BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES AND PAYMENTS
SUBCHAPTER B: MISCELLANEOUS REIMBURSEMENT
AMEND: §134.110

§134.110 ***Reimbursement of Injured Employee for Travel Expenses Incurred***

(a) An injured employee may request reimbursement from the insurance carrier if the injured employee has incurred travel expenses when:

(1) medical treatment for the compensable injury is not reasonably available within 30 miles from where the injured employee lives and the distance traveled to secure medical treatment is greater than 30 miles one-way; or

(2) the distance traveled to attend a designated doctor examination, required medical examination, or post designated doctor treating or referral doctor examination is greater than 30 miles one-way.

(b) The injured employee shall submit the request for reimbursement to the insurance carrier within one year of the date the injured employee incurred the expenses.

(c) The injured employee's request for reimbursement shall be in the form and manner required by the division and shall include documentation or evidence (such as itemized receipts) of the amount of the expense the injured employee incurred.

(d) The insurance carrier shall reimburse the injured employee based on the travel rate for state employees on the date travel occurred, using mileage for the shortest reasonable route.

(1) Travel mileage is measured from the actual point of departure to the health care provider's location when the point of departure is:

(A) the employee's home; or

(B) the employee's place of employment.

(2) If the point of departure is not the employee's home or place of employment, then travel mileage shall be measured from the health care provider's location to the nearest of the following locations:

(A) the employee's home;

(B) the place of employment; or

(C) the actual point of departure.

(3) Total reimbursable mileage is based on round trip mileage.

(4) When an injured employee's travel expenses reasonably include food and lodging, the insurance carrier shall reimburse for the actual expenses not to exceed the current rate for state employees on the date the expense is incurred.

(e) The insurance carrier shall pay or deny the injured employee's request for reimbursement submitted in accordance with subsection (c) of this section within 45 days of receipt.

(f) If the insurance carrier does not reimburse the full amount requested, partial payment or denial of payment shall include a plain language explanation of the reason(s) for the reduction or denial. The insurance carrier shall inform the injured employee of the injured employee's right to request a benefit review conference in accordance with §141.1 of this title (relating to Requesting and Setting a Benefit Review Conference).

CHAPTER 134: BENEFITS—GUIDELINES FOR MEDICAL SERVICES, CHARGES AND PAYMENTS

SUBCHAPTER F: MEDICAL PHARMACEUTICAL BENEFITS
AMEND: §134.502

§134.502 *Pharmaceutical Services*

(a) A doctor providing care to an injured employee shall prescribe for the employee medically necessary prescription drugs and over-the-counter medication (OTC) alternatives as clinically appropriate and applicable in accordance with applicable state law and as provided by this section.

(1) It shall be indicated on the prescription that the prescription is related to a workers' compensation claim.

(2) When prescribing an OTC medication alternative to a prescription drug, the doctor shall indicate on the prescription the appropriate strength of the medication and the approximate quantity of the OTC medication that is reasonably required by the nature of the compensable injury.

(3) The doctor shall prescribe generic prescription drugs when available and clinically appropriate. If in the medical judgment of the prescribing doctor a brand-name drug is necessary, the doctor must specify on the prescription that brand-name drugs be dispensed in accordance with applicable state and federal law, and must maintain documentation justifying the use of the brand-name drug, in the patient's medical record.

(4) The doctor shall prescribe OTC medications in lieu of a prescription drug when clinically appropriate.

(b) When prescribing, the doctor shall prescribe in accordance with §134.530 and §134.540 of this title (relating to Requirements for Use of the Closed Formulary for Claims Not Subject to Certified Networks and Requirements for Use of the Closed Formulary for Claims Subject to Certified Networks, respectively).

(c) The pharmacist shall dispense no more than a 90-day supply of a prescription drug.

(d) Pharmacies and pharmacy processing agents shall submit bills for pharmacy services in accordance with Chapter 133 (relating to General Medical Provisions) and Chapter 134 (relating to Benefits--Guidelines for Medical Services, Charges, and Payments.

(1) Health care providers shall bill using national drug codes (NDC) when billing for prescription drugs.

(2) Compound drugs shall be billed by listing each drug included in the compound and calculating the charge for each drug separately.

(3) A pharmacy may contract with a separate person or entity to process bills and payments for a medical service; however, these entities are subject to the direction of the pharmacy and the pharmacy is responsible for the acts and omissions of the person or entity. Except as allowed by Labor Code §413.042, the injured employee shall not be billed for pharmacy services.

(e) The insurance carrier, injured employee, or pharmacist may request a statement of medical necessity from the prescribing doctor. If an insurance carrier requests a statement of medical necessity, the insurance carrier shall provide the sender of the bill a copy of the request at the time the request is made. An insurance carrier shall not request a statement of medical necessity unless in the absence of such a statement the insurance carrier could reasonably support a denial

based upon extent of, or relatedness to the compensable injury, or based upon an adverse determination.

(f) The prescribing doctor shall provide a statement of medical necessity to the requesting party no later than the 14th day after receipt of request. The prescribing doctor shall not bill for nor shall the insurance carrier reimburse for the statement of medical necessity.

(g) In addition to the requirements of §133.240 of this title (relating to Medical Payments and Denials) regarding explanation of benefits (EOB), at the time an insurance carrier denies payment for medications for any reason related to compensability of, liability for, extent of, or relatedness to the compensable injury, or for reasons related to an adverse determination, the insurance carrier shall also send the EOB to the injured employee, and the prescribing doctor.

CHAPTER 134: BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES AND PAYMENTS
SUBCHAPTER G: PROSPECTIVE AND CONCURRENT REVIEW OF HEALTH CARE
AMEND: §134.600

§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.

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

(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.

(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.

(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.

(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.

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

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

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

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

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

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

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

(D) when ordered by the commissioner;

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

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

(e) The insurance carrier shall designate accessible direct telephone and facsimile numbers and may designate an electronic transmission address for use by the requestor or injured employee to request preauthorization or concurrent utilization review during normal business hours. The direct number shall be answered or the facsimile or electronic transmission address responded to within the time limits established in subsection (i) of this section. The insurance carrier shall also comply with any additional requirements of §19.2012 of this title (relating to URA's Telephone Access and Procedures for Certain Drug Requests and Post-Stabilization Care).

(f) The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent utilization review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent utilization review shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission and, include the:

(1) name of the injured employee;

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

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

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

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

(6) name of the requestor and requestor's professional license number or national provider identifier, or injured employee's name if the injured employee is requesting preauthorization;

(7) name, professional license number or national provider identifier of the health care provider who will render the health care if different than paragraph (6) of this subsection and if known;

(8) facility name, and the facility's national provider identifier if the proposed health care is to be rendered in a facility; and

(9) estimated date of proposed health care.

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

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

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

(3) If denying the request, the insurance carrier shall indicate whether it is issuing an adverse determination, and/or whether the denial is based on an unrelated injury or diagnosis in accordance with subsection (m) of this section.

(4) The requestor or injured employee may file an extent of injury dispute upon receipt of an insurance carrier's response which includes a denial due to an unrelated injury or diagnosis, regardless of whether an adverse determination was also issued.

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

(h) Except for requests submitted in accordance with subsection (g) of this section, the insurance carrier shall either approve or issue an adverse determination on each request based solely on the medical necessity of the health care required to treat the injury, regardless of:

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

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

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

(i) The insurance carrier shall contact the requestor or injured employee within the following timeframes by telephone, facsimile, or electronic transmission with the decision to approve the request; issue an adverse determination on a request; or deny a request under subsection (g) of this section because of an unrelated injury or diagnoses as follows:

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

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

(j) The insurance carrier shall send written notification of the approval of the request, adverse determination on the request, or denial of the request under subsection (g) of this section because of an unrelated injury or diagnosis within one working day of the decision to the:

(1) injured employee;

(2) injured employee's representative; and

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

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

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

(1) the specific health care;

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

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

(4) the insurance carrier's preauthorization approval number that conforms to the standards described in §19.2009(a)(4) of this title (relating to Notice of Determinations Made in Utilization Review).

(m) In accordance with §19.2010 of this title (relating to Requirements Prior to Issuing Adverse Determination), the insurance carrier shall afford the requestor a reasonable opportunity to discuss the clinical basis for the adverse determination prior to issuing the adverse determination. The notice of adverse determination must comply with the requirements of §19.2009 of this title and if preauthorization is denied under Labor Code §408.0042 because the treatment is for an injury or

diagnosis unrelated to the compensable injury the notice must include notification to the injured employee and health care provider of entitlement to file an extent of injury dispute in accordance with Chapter 141 of this title (relating to Dispute Resolution--Benefit Review Conference).

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

(o) If the initial response is an adverse determination of preauthorization or concurrent utilization review, the requestor or injured employee may request reconsideration orally or in writing. A request for reconsideration under this section constitutes an appeal for the purposes of §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determinations).

(1) The requestor or injured employee may within 30 days of receipt of a written adverse determination request the insurance carrier to reconsider the adverse determination and shall document the reconsideration request.

(2) The insurance carrier shall respond to the request for reconsideration of the adverse determination:

(A) as soon as practicable but not later than the 30th day after receiving a request for reconsideration of an adverse determination of preauthorization; or

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

(3) In addition to the requirements in this section and §19.2011 of this title, the insurance carrier's reconsideration procedures shall include a provision that the period during which

the reconsideration is to be completed shall be based on the medical or clinical immediacy of the condition, procedure, or treatment.

(4) In any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services prior to the issuance of an adverse determination on the request for reconsideration, the insurance carrier shall comply with the requirements of §19.2010 and §19.2011 of this title, including the requirement that the insurance carrier afford the requestor a reasonable opportunity to discuss the proposed health care with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively.

(5) The requestor or injured employee may appeal the denial of a reconsideration request regarding an adverse determination by filing a dispute in accordance with Labor Code §413.031 and related division rules.

(6) A request for preauthorization for the same health care shall only be resubmitted when the requestor provides objective clinical documentation to support a substantial change in the injured employee's medical condition or that demonstrates that the injured employee has met clinical prerequisites for the requested health care that had not been previously met before submission of the previous request. The insurance carrier shall review the documentation and determine if any substantial change in the injured employee's medical condition has occurred or if all necessary clinical prerequisites have been met. A frivolous resubmission of a preauthorization request for the same health care constitutes an administrative violation.

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

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

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

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

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

(t) The insurance carrier shall maintain accurate records to reflect information regarding requests for preauthorization, or concurrent utilization review approval or adverse determination decisions, and appeals, including requests for reconsideration and requests for medical dispute resolution, if any. The insurance carrier shall also maintain accurate records to reflect information regarding requests for voluntary certification approval/denial decisions. Upon request of the division, the insurance carrier shall submit such information in the form and manner prescribed by the division.

(u) For the purposes of this section, all utilization review must be performed by an insurance carrier that is registered with, or a utilization review agent that is certified by, the Texas Department of Insurance to perform utilization review in accordance with Insurance Code, Chapter 4201 and Chapter 19 of this title (relating to Agents' Licensing). Additionally, all utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Insurance Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in course and scope of employment.

8. CERTIFICATION.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on March

X

Dirk Johnson
General Counsel
Texas Department of Insurance,
Division of Workers' Compensation

IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that the amendments to 28 TAC §134.110, concerning Reimbursement of Injured Employee for Travel Expenses Incurred; §134.502, concerning Pharmaceutical Services; and §134.600, concerning Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care; are adopted.

AND IT IS SO ORDERED.

X

ROD BORDELON
COMMISSIONER OF WORKERS' COMPENSATION

ATTEST:

_X_____

Dirk Johnson
General Counsel

COMMISSIONER ORDER NO.