TDI-DWC Fast Facts

Preauthorization, Concurrent Review, and Voluntary Certification (Rule 134.600)

As of May 2, 2006

What is preauthorization?

Preauthorization is prospective approval of health care based solely on medical necessity. Preauthorization is obtained from an insurance carrier by the requestor or injured worker **before** the health care is provided. Preauthorization and concurrent review are mandated by the Texas Workers' Compensation Act, §413.014 and §408.0042, as amended in 2005.

Which treatments and services require preauthorization?

Health care for an emergency **does not** require preauthorization. **The non-emergency health care requiring preauthorization includes the following:**

1. Inpatient hospital admissions including the principal scheduled procedure(s) and the length of stay.
2. Outpatient surgical or ambulatory surgical services (see "Surgical Services"below).
3. Spinal surgery.
4. All non-exempted work hardening and non-exempted work conditioning programs (see "Who is exempt from preauthorization and concurrent review?").
5. Physical and occupational therapy services rendered on or after December 1, 2005.
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 unless the service is part of a preauthorized or Division exempted returned-to-work rehabilitation program.
8. Unless otherwise specified, a repeat individual diagnostic study, with a reimbursement established in the current *Medical Fee Guideline* of greater than $350 or without a reimbursement rate in Medical Fee Guideline.
9. All durable medical equipment (DME) with billed charges greater than $500 per item (either purchase or expected cumulative rental).
10. Chronic pain management / interdisciplinary pain rehabilitation.
11. Drugs not included in the Division's formulary (**when closed formulary rules are adopted**).
12. Treatment and services that exceed or are not addressed by the Commissioner adopted treatment guidelines protocols and are not in a treatment plan preauthorization by the carrier (**when rules are adopted**).
13. Required treatment plans (**when rules are adopted**).
14. Any treatment for an injury or diagnosis that is not accepted by the carrier following the treating doctors examination to define the compensable injury (**when rules are adopted**).

Surgical services

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

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

A surgical service is a medical treatment or service that the American Medical Association classified in the Surgery Section of the CPT codes.

Rules about injury or diagnosis not accepted by carrier; drugs not in closed formulary; and treatment guidelines and protocols are under development.

Additional rules regarding the treating doctor's examination to define the compensable injury; medical dispute resolution; a closed formulary; and treatment guidelines and protocols are in development, but have not been adopted. Requests for preauthorization for those treatments or services should not be submitted or accepted until the pertinent rules are adopted or amended.

Physical and Occupational Therapy Services

Physical therapy and occupational therapy generally require preauthorization. When rendered between December 1, 2005 and May 2, 2006 preauthorization is not required for the first two visits following an examination if the treatments are rendered within the first two weeks following the date of injury or a surgical intervention previously approved by the insurance carrier.

When rendered on or after May 2, 2006, preauthorization is not required for the first six visits following an examination when the treatments are rendered within the first two weeks following the date of injury or a surgical intervention previously approved by the insurance carrier.

Note: <u>All</u> medical services that do not require preauthorization are subject to retrospective review for medical necessity by the carrier . This includes the evaluation and six PT/OT visits.

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What is concurrent review?

Concurrent review is a review of ongoing health care to determine if an extension of previously preauthorized health care is medically necessary. **The health care requiring concurrent review for an extension includes the following:**

1. Inpatient length of stay.
2. All non-exempted work hardening or non-exempted work conditioning programs.
3. Physical and occupational therapy services.
4. Investigational or experimental services or use of devices.
5. Chronic pain management / interdisciplinary pain rehabilitation.
6. Required treatment plans (**when rules are adopted**).

What is voluntary certification and how does it work?

Voluntary certification is an option for a requestor and carrier to voluntarily discuss health care. The carrier may elect to certify (approve) or agree to pay for **health care that does not require preauthorization.** A carrier that voluntarily certifies treatments, treatment plans or pharmaceutical services may not dispute the certified treatments, services, or medicine at a later date even if there is a final adjudication of non-compensablity or unrelatedness to the compensable injury. **Denials of voluntary certification are not subject to "prospective" dispute resolution.** Health care for which voluntary certification is denied and treatment subsequently rendered is subject to "retrospective" dispute resolution for medical necessity.

What are the requirements for the preauthorization request?

The requestor or injured worker must request preauthorization from the insurance carrier via the carrier's designated phone line, fax line, or email address. Preauthorization must be obtained before the health care is rendered. **The preauthorization request must include claim-specific information as well as the following:**

1. The specific health care requested;
2. The number of specific health care treatments (if applicable) and the specific period of time requested to complete the treatments;
3. The medical information to substantiate the medical necessity for the requested health care;
4. The accessible phone and fax numbers (and email address, if desired) for the carrier to use;
5. The name of the health care provider who will perform the requested health care; and
6. The facility name and estimated date of proposed health care.

Who is a requestor?

A requestor is the health care provider or designated representative, including office staff or a referral health care provider/ facility, who requests preauthorization, concurrent review, or voluntary certification.

Who may request preauthorization, concurrent review, or voluntary certification?

1. **Preauthorization —** requestor or injured worker
2. **Concurrent review —** requestor
3. **Voluntary certification —** requestor
4. **Reconsideration of denied preauthorization —** requestor or injured worker
5. **Reconsideration of denied concurrent review —** requestor

How should the carrier handle preauthorization and concurrent review requests?

Carrier responsibilities:

- **Must** designate accessible phone and fax numbers for use during normal business hours
- **May** designate an email address for use during normal business hours
- **Must** approve or deny a request by phone, fax, or email for:

  preauthorization — 3 working days
  concurrent review — 3 working days
  - **in-patient length of stay (LOS) — 1 working day**

- **Must** send written responses within **1 working day** of the decision to:

  Injured worker
  Worker's representative (if any)
  and
  Requestor (if not previously faxed or emailed)

- **Must** approve or deny a reconsideration request by phone, fax, or email for:

  preauthorization — 5 working days
  concurrent review — 3 working days
  - **in-patient length of stay (LOS) — 1 working day**

- **The carrier's failure to comply with time frame requirements is an administrative violation and should be treated as a denial by the requestor.**

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How should the carrier make its decision to approve or deny preauthorization or concurrent review requests?

The carrier must approve or deny requests for preauthorization or concurrent review based solely upon whether or not the proposed health care is medically necessary to treat the compensable injury.

Except when a treating doctor is requesting preauthorization following an exam to define the compensable injury, the carrier should not base its decision on any of the following:

1. Unresolved issues of compensability, extent of or relatedness to the compensable injury;
2. The carrier's liability for the injury; or
3. The fact that the worker has reached maximum medical improvement.

What should approvals and denials include?

If the carrier approves the request for preauthorization or concurrent review, the approval should include the following:

1. The specific health care approved;
2. The number of approved health care treatments and the specific period of time approved to complete the treatments and
3. Notice of any unresolved dispute(s) of compensability or liability, extent of, or relatedness to the compensable injury.

Once issued, a preauthorization or concurrent review approval may NOT be withdrawn.

If the carrier's decision is to deny the request for preauthorization or concurrent review, the carrier must give the requestor a reasonable opportunity to discuss the clinical basis for the denial with the appropriate doctor or health care provider performing the review **before** issuing the denial.

If the carrier denies the request for preauthorization or concurrent review, the denial must include the following:

1. The clinical basis for making the denial,
2. A description or source of screening criteria used as guidelines for the denial,
3. The principal reasons for the denial,
4. A plain language description of the complaint and appeal process. If the denial is based on a carrier not accepting a diagnosis or injury following a treating doctor examination to define the compensable injury, then notice must which notification to the injured employee and HCP of the entitlement to file an exent of injury dispute. See Chapter 141 of DWC rules.
5. After reconsideration of a denial, notification of the availability of an Independent Reviewer.

The carrier cannot change any element of the request unless mutually agreed to by the health care provider and the carrier. The agreement must be documented.

Does approval guarantee payment?

- If the injury is compensable, the carrier is liable for all reasonable and necessary medical costs of health care to treat the compensable injury.
- If preauthorization, concurrent review, or voluntary certification is approved for a compensable injury, the carrier is liable for payment; however, the payment amount may be subject to retrospective review.
- If preauthorization or concurrent review is approved for a claim that the carrier contests on the basis of liability, compensability, or extent of injury, approval does not guarantee payment unless the dispute is resolved in favor of the injured worker.
- Except for voluntary certification, the carrier is not liable if the injury is finally adjudicated as non-compensable or the treatment is not related to the compensable injury. Final adjudication means that the Division has issued a final decision or order that is no longer appealable by either party.

What are the carrier's record-keeping responsibilities?

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

How are "working days" calculated?

In accordance with Rule 102.3(a)(1), when "counting a period of time measured by days, the first day is excluded and the last day is included." For example, if the carrier receives a request on a Wednesday. The day of receipt does not count. The carrier must respond no later than the close of business on the following Monday (within 3 working days). Weekends and holidays are not considered "working days."

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What can the requestor or injured worker do if the carrier denies the request for preauthorization or concurrent review?

The requestor or injured worker may file a "Request for Reconsideration" with the carrier **within 15 working days** of receipt of a written denial.

The carrier must respond to a request for reconsideration of a denial for:

- **Preauthorization — within 5 working days**
- **Concurrent review — within 3 working days**
- **Extension of inpatient length of stay—within 1 working day** (see page 2).

If the response is a denial of preauthorization the requestor or injured worker may request reconsideration of the denied health care. If the response is a denial of health care requiring concurrent review, the requestor may request reconsideration of the denied health care.

If a reconsideration request is denied, the requestor or injured worker may appeal the denial by filing a dispute with Medical Dispute Resolution using form DWC-60, "Medical Dispute Resolution Request/Response." The dispute process is regulated by the Texas Workers' Compensation Act, §413.031 and Division-adopted rules 133.305, 133.307, and 133.308. Medical necessity disputes are forwarded to an Independent Review Organization (IRO).

When may a preauthorization request be resubmitted?

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

Resources

- For more information about DWC medical benefits laws, processes, rules and forms call DWC's Customer Services at (512) 804-4800 and select option 5.
- Many resources, including the Act, proposed and adopted rules and forms are available on the DWC website at www.tdi.state.tx.us. The Medical Fee Guideline Training Module is available at www.tdi.state.tx.us/wc/mr/mfg.html.
- To order a *Medical Fee Guideline*, the Act, or Division rules, please call the DWC Publications Department at (512) 804-4240 or print out and mail the order form under the "Publications Price List" heading on the DWC website, www.tdi.state.tx.us/wc/information/pubpricelist.html.

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Who determines what constitutes necessary medical information?

The requestor initially determines which medical information is necessary to substantiate the need for the recommended health care. The requestor then provides this information to the carrier at the time of the initial request by phone call, fax, or email. The carrier approves or denies the requested health care based on the medical information submitted.

May the carrier require additional information?

The carrier may **request** additional documentation, but the requestor is not required to submit it. The decision to approve or deny the request must be rendered within the set time frames and based on the medical documentation submitted. Further, the carrier is responsible for furnishing copies of all medical documentation to the preauthorization agent or company. The requestor does not need to resubmit documentation already provided to the insurance carrier.

Who is exempt from preauthorization and concurrent review Requirements?

Work hardening and work conditioning programs that:

1. are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), **and**

2. have requested and been approved for exemption by DWC

Documentation accompanying the request must reflect accreditation of a program in order to qualify for DWC exemption from preauthorization of that program. The programs eligible for exemption are:

- **General Occupational Rehabilitation Programs = work conditioning**
- **Comprehensive Occupational Rehabilitation Programs = work hardening**

See Advisory 2001-11 about DWC exemption from preauthorization and concurrent review. Submit documentation of current accreditation to request exemption from preauthorization to DWC at 7551 Metro Center Dr. Ste. 100, MS-43, Austin, TX 78744.

Exempted facilities are listed on the DWC website and are subject to Division verification and audit.