Texas Department of Insurance
Division of Workers' Compensation

FastFacts

Disability Management for Healthcare Providers

Disability management optimizes healthcare and return-to-work outcomes for injured employees through the use of treatment and return-to-work guidelines, and treatment planning. This serves the interests of all workers' compensation system participants by:

- providing injured employees appropriate medical treatment
- promoting principles of evidence-based medicine
- achieving greater accountability through communication
- establishing estimated return-to-work expectations
- improving the ability to monitor system outcomes

Effective dates for disability management components are as follows:

- Disability Management Rules apply to all claims with a date of injury occurring as of January 1, 1991.

- Treatment & Return to Work Guidelines are effective May 1, 2007 and are applicable to treatments and/or services provided as of this date.

The Treatment Planning rule was repealed on September 10, 2007.

Return to Work Guidelines

- The Medical Disability Advisor (MDA) provides minimum, optimum, and maximum expectancies (or averages) of return-to-work (RTW) time frames (disability duration) that are considered to be an expected length of disability duration.

- Treating doctors and other health care providers should consider factors that may influence medical recovery and disability durations, such as co-morbidity conditions and medical complications of the injured employee.

- MDA disability durations are not rigid time frames for when injured employees must return to work. Rather, they are points in time when the treating doctor should evaluate when the injured employee should be able to return to work and with what restrictions, if any.

- Return-to-work communications between the treating doctor and system participants should include proposed modifications to job duties and activities.

Treatment Guidelines

- The Official Disability Guidelines (ODG) provide data on the optimum frequency and duration of treatments.

- Healthcare provided in accordance with the ODG is presumed reasonable.

- The treating doctor is responsible for the appropriate coordination of health care and management of injured employees' claims. Healthcare providers (HCP), who are not the treating doctor, should maintain communications with the treating doctor at all times.

- HCPs must obtain preauthorization for treatment and services recommended by the ODG when the proposed treatment or service is on the preauthorization list.

- HCPs and Utilization Review Agents (URAs) retain the option to voluntarily certify any treatment or services recommended by the ODG and that are not on the preauthorization list.

- When proposed treatments and services exceed or are not included in the ODG, preauthorization is required.

- Any HCP may still submit preauthorization requests in accordance with §134.600.

Prospective Utilization Review

- The Official Disability Guidelines (ODG) provides data on the optimum frequency and duration of treatments.

- Health care provided in accordance with the ODG is presumed reasonable.

- Carriers/Utilization Review Agents (URA) must prospectively review treatment and services for medical necessity when the proposed treatment or service is on the preauthorization list.

- Healthcare providers (HCP) and URAs retain the option to voluntarily certify any treatment or services that are not on the preauthorization list.

- Treatment plans must include contact information for all HCPs involved in delivering the proposed healthcare so that the URA can contact the appropriate HCP if they need to discuss an adverse determination (a denial of a preauthorization request).

- For the transition to disability management, carriers should review treatment planning requests submitted prior to May 1, 2007, in order to avoid a lapse in provision of healthcare to the injured employee.

Retrospective Utilization/Bill Review

- Health care provided in accordance with the ODG is presumed reasonable.

- Carriers are not liable for treatments or services provided in excess of the ODG unless they were provided in a medical emergency or were preauthorized.

- Disability management rules take precedence over any conflicting payment policy provisions adopted or utilized by the Centers for Medicare and Medicaid Services.

- Carriers may retrospectively review and deny payment for treatment and services provided in accordance with the ODG, if they support the determination with documentation of evidence-based medicine that outweighs the presumption of reasonableness.

- Carriers may not deny treatment solely because it is not included in the ODG.

- When an adverse determination relating to medical necessity is disputed, an independent review organization (IRO) decision may override provisions of the disability management rules on a case-by-case basis.