Texas Department of Insurance
Division of Workers' Compensation
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Disability Management

Frequently Asked Questions (Revised 05/21/09)

Question 1:

What Disability Management guidelines were adopted?

The Division of Workers' Compensation (Division) adopted the current edition of MDA (Medical Disability Advisor, Workplace Guidelines for Disability Duration, published by the Reed Group, excluding all sections and tables relating to rehabilitation, as the Division's Return to Work Guidelines.

The Division adopted the current edition of the ODG (Official Disability Guidelines – Treatment in Workers' Comp, published by Work Loss Data Institute, excluding the return to work pathways, as the Division's Treatment Guidelines.

Question 2:

Should I obtain the MDA (Return to Work) and the ODG (Treatment) Guidelines?

Yes. The MDA book and online content are available from the Reed Group:
Toll-free: 866-889-4449
John Nelson: 303-404-6600 or jnelson@rgl.net
Barry Huxman: 303-407-0697 or bhuxman@rgl.net

The ODG book and online content are available from the Work Loss Data Institute at: http://www.worklossdata.com/texasform.htm.
The ODG book is issued annually and may not reflect changes made throughout the year. The online version is the most current.

Question 3:

Can insurance carriers use the MDA or ODG cost features to calculate payment to pay medical bills?

No. Reimbursement is based on the Division's fee guidelines; it is not based on MDA or ODG cost features.

Question 4:

Where can I get more information about the treatment and return to work guidelines?
To view the rules adopting the treatment and return to work guidelines, go to the Disability Management rules at the adopted rules page.

For more information about MDA, contact the Reed Group:
Toll-free: 866-889-4449
John Nelson: 303-404-6600 or jnelson@rgl.net
Barry Huxman: 303-407-0697 or bhuxman@rgl.net

For more information about ODG, click on the Work Loss Data Institute or call them at 760-753-9992.

Question 5:

Are the disability management rules applicable if the injury occurred prior to May 1, 2007?

Yes. The disability Management Rules apply to all claims with a date of injury on or after January 1, 1991. Treatment and Return to Work Guidelines are effective May 1, 2007 and are applicable to treatments and/or services provided as of that date.

Question 6:

Can an injured employee's income benefits be affected solely by the return to work guidelines?

No. Application of the return to work guidelines should not be the sole justification or the only reasonable grounds for reducing, denying, suspending, or terminating income benefits to an injured employee.

Question 7:

How will the health care provider know the injured employee's job classification to determine optimum days in the MDA?

The employee's job classification in the MDA is expressed in terms of Department of Labor job classifications. The definition of job classification is also found in the MDA. Through discussions with the injured employee and the employer, the doctor can determine the requirements of the injured employee's job and relate that information to the job classification provided in the MDA.

Question 8:

What happens if MDA fails to consider the complexities of a job or the specific requirements for returning to a job?

Although not every circumstance of a particular job is included in the MDA, broad categories related to the intensity of a job activity are included. The overarching disability management concept anticipates the use of MDA, not as an absolute representation of disability duration values, but as a benchmark to facilitate return to work planning and ultimately improve return to work outcomes. Further, the return to work guidelines provide the foundation for implementation of Labor Code §413.021(b), which includes job analysis, job modification and restructuring assessments.

Question 9:

How do the disability duration tables in the MDA apply when there are multiple diagnoses?

The treating doctor, employer and injured employee should refer to the appropriate duration tables for all diagnoses when developing a plan for return to work.

Question 10:

What happens when the treatment guidelines conflict with Medicare/CMS payment policies?

Rule 137.1(c) provides that the Disability Management Chapter takes precedence over any conflicting payment policy provision adopted or utilized by Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program.

Question11:

May an insurance carrier deny payment for treatment provided within the treatment guidelines?

Yes. All treatments and services provided within the treatment guidelines are subject to retrospective review. The carrier may deny payment for care determined not medically necessary even though the care was included in the guideline. The denial must be supported by evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017. In addition, any medical necessity disputes will be determined by an Independent Review Organization (IRO) in accordance with Labor Code §§413.031 and 413.032.

Question 12:

When do office visits require preauthorization?

Office visits do not require preauthorization but are subject to retrospective review of medical necessity. Although the ODG recommends office visits in the procedure summaries, there is not an established cap to limit medically necessary office visits.

Question 13:

How should health care professionals address treatments or services that exceed or are not included in the treatment guidelines?

All treatments and services that exceeds or are not included in the treatment guidelines requires preauthorization in accordance with §134.600.

Question 14:

Are treatment plans required?

Due to the repeal of Rule 137.300, treatment planning is not required until further notice. However, a doctor and an insurance carrier may agree to participate in voluntary certification of a treatment plan. The requirements for preauthorization of treatments and services as listed in Rule 134.600 remain in effect until further notice.

Question 15:

When the ODG treatment guidelines do not address treatment time per session, as does Medicare's Local Coverage Determination (LCD), would the preauthorization approval specify the length of treatment time?

No. Although length of time per treatment is not required in a preauthorization approval, specificity in preauthorization requests assists the reviewer in determining the medical necessity of the treatments or services requested and decreases the likelihood of a fee or medical necessity dispute.

Question 16:

May a treating doctor request a prospective review medical examination (PRME) of a proposed treatment that falls within the treatment guidelines?

No. The PRME rule (28 Texas Administrative Code §134.650) has been repealed as a result of the adoption of treatment guidelines. For further details, please click on News Release.

Question 17:

How do the Division treatment guidelines (Rule 137.100) interact with the Division preauthorization requirements (Rule 134.600)?

The preauthorization rule and the treatment guidelines work together to create four situations when preauthorization is required:

a. When the diagnosis is listed in the Treatment Guidelines and the treatment or service is on the preauthorization list
b. When the diagnosis is listed in the Treatment Guidelines but the treatment or service is not recommended, not listed, or exceeds the Treatment Guidelines in frequency or duration
c. When the diagnosis is not listed in Treatment Guidelines
d. When required by Commissioner order

To determine if preauthorization is required, health care providers should ask the following questions:

i. Is the diagnosis code listed in the treatment guidelines?
ii. Which treatments or services are recommended in the treatment guidelines?
iii. Does the recommended treatment or service require preauthorization as listed in Rule 134.600(p)-(q)?
iv. Does the treatment or service exceed the treatment guidelines in frequency or duration?

Question 18:

How should IROs apply these rules?

Independent Review Organizations (IROs) are required to consider the treatment guidelines when making decisions regarding non-network health care. IROs are required to fully explain and document their decisions in accordance with Labor Code §413.032. Additionally, §133.308 establishes that an IRO must indicate the specific basis for any decision that deviates from Division policies or guidelines.

Question 19:

Do the disability management rules apply to network claims?

No. These rules do not apply to claims within certified workers' compensation health care networks.

Question 20:

Do the disability management rules apply to Designated Doctors and doctors providing Required Medical Examinations?

Yes. Doctors who conduct these exams must take into account the ODG and MDA guidelines when evaluating injured employees.

Publication produced by the Texas Department of Insurance, Division of Workers' Compensation, Policy & Research, 7551 Metro Center Drive, Suite 100, Austin, TX 78744; 512-804-4800. This update is for educational purposes only and is not a substitute for the statute and Division rules.

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Last updated: 05/21/2009