

**AN EXAMINATION OF THE  
MEDICAL DISPUTE RESOLUTION  
PROCESS IN TEXAS**

**Research and Oversight Council  
on Workers' Compensation**

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## **Acknowledgments**

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## Executive Summary

A primary goal of the Texas Workers' Compensation Act of 1989 (Senate Bill 1) was to deliver fair compensation to injured workers while minimizing lengthy and costly litigation. The timely resolution of medical disputes between insurance carriers and injured workers/treating doctors is an important factor in the delivery of quality and cost-effective medical treatment. While there is strong evidence that the new system has achieved major successes, there are areas of concern.

Despite impressive cuts in the duration of time for resolving medical disputes, an overwhelming majority of health care providers and carriers believe the timeframe is still too long. In addition, disputes over medical treatment and fees continue to place significant demands on the process. For example, the 1997 court invalidation of the TWCC *Acute Care Inpatient Hospital Fee Guideline* added an additional 25,000 fee disputes to the already challenged system. Further, many system participants, especially providers, choose to “write off” disputable cases rather than enter a dispute process they consider time-consuming and therefore cost-prohibitive. This study examines the prevailing issues around the medical dispute process as it applies to non-hospital disputes. The goal is to explore opportunities and policy options for enhancing system efficiency.

Key findings include:

- The timeframes for resolving medical disputes are significantly below 1993 levels.
- As dispute resolution timeframes fall, the rates of increase and total number of disputes tend to rise. Efficiency in the dispute resolution process may lead to more disputes.
- Actual medical disputes make up less than 1 percent of all initial medical reimbursement denials and reductions. This suggests that current dispute levels may represent just the tip of the iceberg.
- The success rate of informal medical dispute resolution ranges from 80 to 96 percent.

- Initial denials and reductions of health care providers' bills by insurance carriers totaled over \$200 million for the past three years.
  
- Over 70 percent of all medical bills initially denied or reduced by insurance carriers for the past three years were based on the following three reasons:
  - payments were reduced to "Fair and Reasonable" rates;
  - bills submitted to insurance carriers were not accompanied by adequate Documentation of Procedures (DOP) when required; and
  - treatments requiring pre-authorization (under TWCC Rule 134.600) from the insurance carriers were performed without prior approval.

The medical dispute resolution process has achieved substantial progress in reducing dispute timeframes and ensuring timely delivery of necessary medical treatment in disputed cases. Increased efficiency may have lowered the barriers to more disputes in the future. To protect the efficiency gains of the past six years, it may be necessary to examine options for dispute prevention at the same time that process improvements continue to be implemented.



## **Section I: Introduction**

### **Background**

A primary goal of the Texas Workers' Compensation Act of 1989 (Senate Bill 1, effective January 1, 1991) was to provide injured workers with fair and timely compensation in the form of medical and income benefits, while minimizing the cost of lengthy litigation. Crucial to this effort is the efficient and effective resolution of disputes between the system's participants through an informal rather than a formal process.

This legislative intent can be considered a success. Informal income benefit dispute resolution hearings fell from 60,000 under the old law to 28,554 in 1998.<sup>1</sup> Medical disputes, which comprise only a small portion of all the informal disputes at the Texas Workers' Compensation Commission (TWCC), have also seen improved trends.<sup>2</sup> Ten years after the passage of the reform act and eight years after it went into effect, the length of time to resolve medical disputes has fallen dramatically, and a great majority of injured workers receive their medical and income benefits in a timely manner.<sup>3</sup>

### **The Medical Dispute Process**

The medical dispute resolution process is a multi-tiered administrative system designed to minimize costly, time-consuming litigation between health care providers, insurance carriers, and injured workers.

The three types of workers' compensation medical disputes are:

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<sup>1</sup> See Research and Oversight Council, *Before and After Workers' Compensation Reform in Texas* (1999).

<sup>2</sup> Texas Workers' Compensation Commission, *Dispute Resolution Information System (DRIS)* (1997).

<sup>3</sup> The 1997 court invalidation of the TWCC *Acute Care Inpatient Hospital Fee Guideline* added an additional 25,000 fee disputes to the system. The scope of this study is limited to non-hospital medical disputes. See Research and Oversight Council on Workers' Compensation, *An Examination of Strengths and Weaknesses of the Texas Workers' Compensation System* (1998), p. 22 for a discussion of the hospital fee disputes.

1. Pre-authorization dispute – when an insurance carrier denies a health care provider’s request for pre-authorization of certain treatments. The Pre-authorization rule, which covers 16 groups of treatments, tests, and services, was designed as a cost-containment mechanism to minimize unnecessary treatments.<sup>4</sup>
  
2. General Fee dispute – when:
  - a carrier denies or reduces a health care provider’s fees; or
  - a service requiring pre-authorization is conducted without an approval; or
  - a disagreement arises over a carrier’s determination of whether the cost of a medical treatment already performed is “fair and reasonable.”
  
3. Medical Necessity dispute – when a carrier denies payment on the grounds that the treatment, test, or service was not medically necessary.

The timely resolution of medical disputes contributes to the delivery of quality medical treatment. A pre-authorization dispute actually delays medical treatment pending the outcome of the dispute. Indirectly, problems with the medical dispute resolution process may discourage some health care providers from participating in the workers’ compensation system in the first place.

Some indicators suggest that the medical dispute resolution system has had significant success since its inception in 1991. For example, the TWCC *System Data Report* as of December 1998 shows that in each year since 1995, less than 1 percent of all medical bills processed in the system resulted in the filing of a medical dispute. In addition, a great majority (over 80 percent) of the disputes entering the administrative medical dispute resolution process are resolved without utilizing the formal appeals system. Also, the average timeframe for resolving medical disputes has seen a steady decline, especially from 1994 to 1997 (see Figure 1). However, after decreasing in 1996 and 1997, the total number of

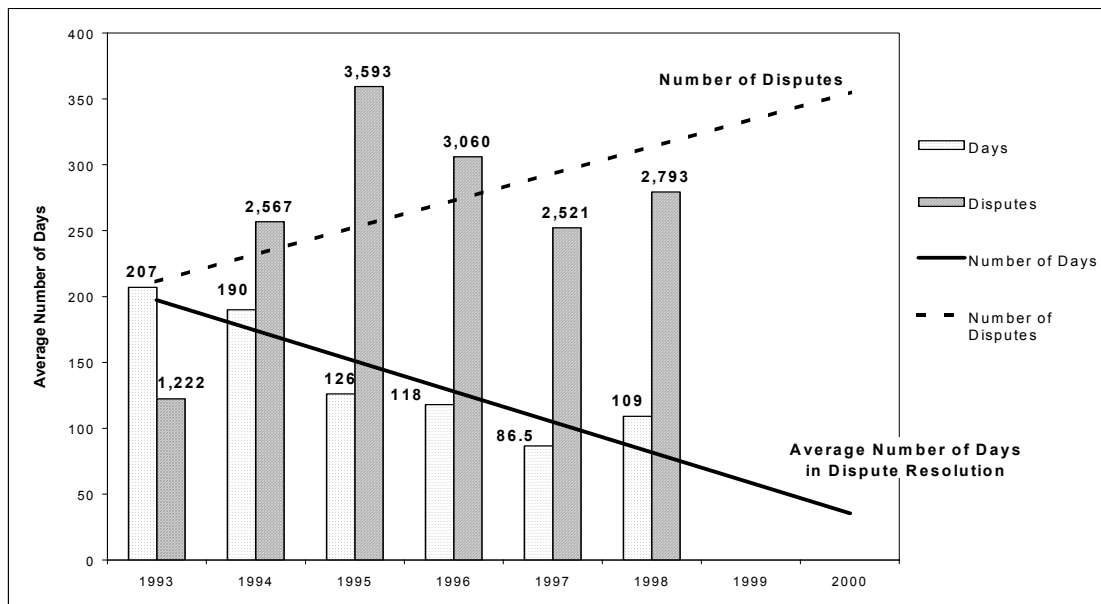
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<sup>4</sup> See Texas Workers’ Compensation Commission Pre-authorization Rule 134.600. A new pre-authorization rule has been proposed (Rule 134.601) which would reduce the number of treatments, tests, and services

disputes considered<sup>5</sup> is on the rise again. As of June 1999, TWCC has already completed 2,061 medical disputes.<sup>6</sup>

Interestingly, during the years showing the most dramatic progress in reducing the duration for dispute resolution, the number of medical disputes rose significantly. Between 1993 and 1995 when the average number of days to resolution fell by an average of 40 percent for the three dispute types, the total number of disputes almost tripled (see Figure 1). The weighted-average number of days for the three dispute types fell from 207 in 1993 to 126 days in 1995, while the total number of medical disputes completed by TWCC rose from 1,222 in 1993 to 3,593 in 1995.<sup>7</sup>

**Figure 1**  
**Medical Dispute Trends: Actual and Projected Number of Disputes Considered and Timeframe to Dispute Resolution, 1993-2000**



Source: Texas Workers' Compensation Commission, *System Data Report*, as of December 1998. The 2,793 disputes for 1998 may include a number of hospital fee disputes.

requiring pre-authorization from sixteen groups to five.

<sup>5</sup> The TWCC *System Data Report* refers to completed disputes as disputes considered. Of the 3,862 disputes received in 1998, 2,793 have been completed. Disputes not yet completed are regarded as pending. Since outcomes are crucial to this study, the word “disputes” will refer to completed disputes.

<sup>6</sup> Texas Workers' Compensation Commission, *System Data Report*, as of June 1999.

<sup>7</sup> Ibid.

Note: The  $R^2$  was .88 for Average Number of Days, and .23 for Number of Disputes. This shows that the trend line is a more reliable predictor for Average Number of Days than for Number of Disputes.

The average number of days to resolve a medical dispute fell for five out of the six years shown, while the total number of disputes increased four out of those six years. The simple linear trend lines in Figure 1 point to more medical disputes and shorter dispute timeframes into the year 2000.

While the trend lines give general directions based on data from 1993, the trends show less certainty after 1995. An  $R^2$  of .23 for the number of disputes is a low predictive value, and suggests the existence of other significant factors driving the growth of disputes.

It is also worth noting that while the number of disputes completed may be driven by the number of disputes received, process efficiency and staff expertise may be stronger factors in explaining how an increasing number of cases are being closed in shorter timeframes. Further research is warranted to better understand this phenomenon. Crucial lessons may be drawn from the process improvements and the staff skill-sets utilized in the past six years.

This could also be indicative of an inverse relationship between the timeframes to dispute resolution and the number of medical disputes. If the timeframes to dispute resolution are considered by the disputing parties to be barriers to entering the process, then as the timeframes fall, more disputes would follow. Further research would be required to test the strength of this relationship between dispute resolution timeframes and the number of disputes.

Despite apparent improvements in the medical dispute resolution process, substantial dissatisfaction with the system still exists, especially among health care providers and insurance carriers. Testimony before the House Business and Industry Subcommittee on Workers' Compensation Insurance Carrier Practices (1998) raised several concerns from

system participants regarding the medical dispute resolution process, many of which were corroborated in recent studies by the Research and Oversight Council on Workers' Compensation (ROC):<sup>8</sup>

- The medical dispute resolution process is still too long.
- Health care providers face significant administrative overhead when considering filing a dispute.
- The process is cost-prohibitive for doctors to contest carrier denials/reductions.
- Too much paperwork is required of doctors, especially by carriers.
- Health care providers perceive that the dispute process is biased in favor of insurance carriers.
- Health care providers perceive that insurance adjusters, without medical expertise, are making medical decisions in the denial process.
- Health care providers and insurance carriers perceive that there is a lack of medical expertise in TWCC's dispute decision process.
- Health care providers say that carriers frequently deny payment of bills without adequate supporting documentation.

### **Report Objectives**

1. To present a comprehensive review of the medical dispute resolution process, as intended by legislation and in practice.
2. To answer the following questions:
  - a. How long is the dispute resolution process?
  - b. What factors influence the dispute resolution timeframe?
  - c. What factors contribute to the rate of medical disputes?

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<sup>8</sup> See Research and Oversight Council on Workers' Compensation, *Experiences of Doctors Who Practice in the Texas Workers' Compensation System* (1998); and *Survey of Texas Doctors Who Participate in the Workers' Compensation System* (1996).

- d. What is the ratio of cases resolved within the informal dispute resolution phase of the process?
- e. Does increasing efficiency in the medical dispute resolution process lead to increased utilization of the process?
- f. What are the patterns of medical reimbursement denials and reductions by carriers?
- g. What administrative, regulatory and legislative steps would:
  - minimize medical disputes?
  - increase dispute resolution efficiency by reducing dispute timeframe? and
  - minimize the need for medical reimbursement denials and reductions?

## **Section II: The Medical Dispute Resolution Process**

A request for medical dispute resolution (fee and medical necessity disputes) must be submitted to the TWCC Medical Review Division (Medical Review), no earlier than 60 days after the insurance carrier receives the bill from the health care provider, and no later than one calendar year after the treatment or service was rendered.<sup>9</sup> This request is submitted either through a Request for Medical Dispute Resolution form (TWCC-60) or as an informational letter accompanied by all the documents that are requested on the TWCC-60. Among the required documentation is proof of efforts between the parties to resolve the dispute. The TWCC-60 instructions require that a minimum of one phone call and one written appeal must be documented prior to completion and submission of the form.<sup>10</sup>

The party requesting the dispute (typically a health care provider or an injured worker) is referred to as the requestor. The responding party (typically the insurance carrier) is referred to as the respondent.<sup>11</sup> When a dispute request is submitted to Medical Review, the requestor must send a copy of the request including all required documentation by certified mail to the respondent. A dispute request is returned to the requestor by Medical Review along with an explanation letter if it is incomplete, is outside the allowable timeframe, or lacks clear reasons for the dispute.

The respondent has 30 days to file a response with TWCC or risks losing the dispute. The respondent must also send a copy of the response to the requestor. The response is expected to include a statement of the respondent's position regarding the dispute, along with appropriate medical summaries and peer review reports. Once all required documentation is received, the Medical Review Division reviews the dispute and issues a "Findings and Decision" to the disputing parties.

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<sup>9</sup> See Texas Workers' Compensation Commission Rule 133.305.

<sup>10</sup> See Texas Workers' Compensation Commission TWCC-60 (Rev. 3/93) form.

<sup>11</sup> In a small number of cases, carriers have been requestors with health care providers as respondents. In 1998, there were seven disputes filed by insurance carriers, two of which were withdrawn.

### **Appeals**

If TWCC's decision is appealed, a request for a formal hearing must be filed with the Chief Clerk of Proceedings at TWCC by the 20<sup>th</sup> working day after the decision is issued. Appeals are taken up in hearings under the Administrative Procedure Act (APA),<sup>12</sup> which is conducted by the State Office of Administrative Hearings (SOAH). SOAH decisions may be appealed by either party to district court.

In order to minimize the number of formal appeals, TWCC has implemented an administrative process called the Informal Resolution Conference (IRC), through which medical disputes can be resolved without a SOAH hearing. The IRC is a voluntary process that allows for confidential mediation by phone or in person. APA Proceedings Team mediators at TWCC serve as facilitators for the disputing parties. If a dispute remains unresolved after an IRC, it may proceed to a SOAH hearing.

### **Fees and Costs**

The Medical Review Division may charge a fee to review medical disputes at the rate of \$41 per hour of staff time, to be paid by the carrier or the health care provider, depending on which party was not in compliance with the fee guidelines and rules established by TWCC.<sup>13</sup> TWCC also assesses this fee against an insurance carrier found to have "unreasonably disputed a provider's charge." Injured workers participating in medical disputes as well as parties in pre-authorization disputes are never charged these fees. In the event that neither party was in non-compliance with existing rules, the fee is waived. In cases where peer reviews are required, additional fees, based on each specific case, are assessed. While the fees are imposed by statutory authority and collected for the General Revenue Fund, they may additionally serve as potential deterrents against unwarranted disputes.

In the past, Medical Review paid a fee to SOAH for conducting APA hearings. This requirement was temporarily suspended but if reinstated, as is expected to occur this coming

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<sup>12</sup> See *Texas Labor Code*, Chapter 413, Subchapter C.

<sup>13</sup> See Texas Workers' Compensation Commission Rules 133.305 and 134.1.



year, could create increased budgetary concerns for TWCC. Successful resolution of appeals at the IRC phase rather than at a SOAH hearing represents a cost saving to TWCC.<sup>14</sup>

## **Outcomes**

### **Informal Dispute Resolution Rate**

A crucial performance measure to determine the success of the medical dispute resolution process is the percentage of cases resolved informally by TWCC rather than at a SOAH hearing. This measurement:

- indicates the degree to which the medical dispute resolution process meets the legislative intent, and
- demonstrates the effectiveness of the process in reducing costly litigation.

From May of 1998 to April of 1999, the rate at which disputes were resolved informally fluctuated between 80.5 percent and 96.7 percent.<sup>15</sup> This represents a significant success rate for the informal resolution of medical disputes at TWCC.

### **SOAH Appeals**

Appeals to SOAH tend to compound the timeframe associated with medical disputes. Appeals to SOAH for pre-authorization disputes took 111 days on average in 1997.<sup>16</sup> In contrast, the average timeframe for completing a pre-authorization dispute at Medical Review was 41 days. This meant that injured workers whose pre-authorization disputes were appealed to SOAH waited five months on average before a treatment approval could be obtained.

SOAH decisions may further contribute to the general perception that the medical dispute resolution process is biased in favor of insurance carriers. While TWCC's informal medical

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<sup>14</sup> This is calculated as an estimated cost avoidance total, based on the average amount billed by SOAH for APA hearings.

<sup>15</sup> Texas Workers' Compensation Commission, Medical Dispute Resolution Information System (MDRIS), as of June 1999.

<sup>16</sup> This timeframe represents the date that the appeal was filed with SOAH to the date that the decision was rendered. Texas Workers' Compensation Commission, 1998.

dispute outcomes ranged between 49 and 61 percent in favor of insurance carriers, SOAH's decisions ranged from 70 to 81 percent in their favor.<sup>17</sup>

#### Disputes as a Percentage of All Medical Services Billed

As previously noted, total medical disputes raised to TWCC make up less than 1 percent of all medical bills submitted to TWCC. While one dispute may represent multiple treatments over multiple service dates, each dispute represents a single injured worker. Since data are not readily available to determine the average number of treatments per dispute, for this study it is useful to look at the ratio of disputes to medical bills and treatments.

Over the past three years, total medical bills averaged 3.36 million per year and total medical disputes to TWCC averaged 2,790 per year. In other words, medical disputes comprised .08 percent of all medical bills, or eight disputes per 10,000 medical bills.

This extremely small percentage may suggest that the Texas workers' compensation system as a whole is operating at peak efficiency. Yet, while resolving medical disputes is crucial to ensuring timely and cost-effective delivery of necessary treatments to injured workers, it also imposes a significant administrative burden on TWCC.

To determine whether there are any discernable patterns to medical disputes, it is useful to view these disputes within their dispute types. In the following sections, we will look at disputes in terms of growth patterns, dispute timeframes, dollar amounts, and contributing factors.

#### Growth of Disputes by Dispute Types

As described previously, there are three general types of workers' compensation medical disputes:

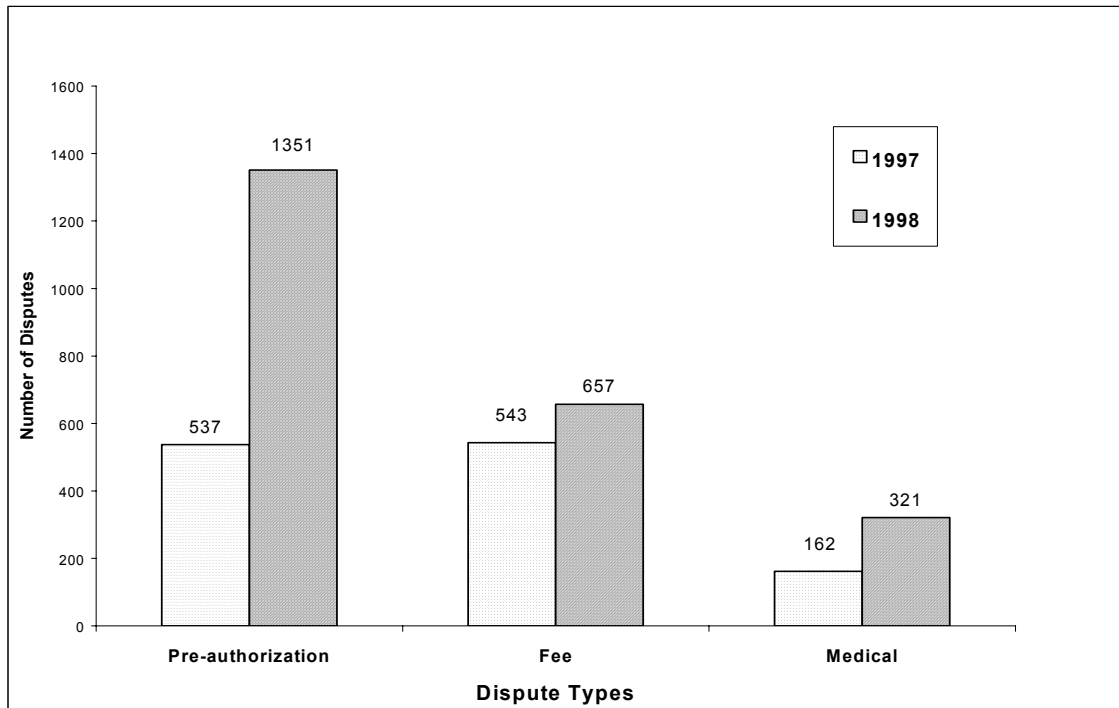
- Pre-authorization;
- Fee; and
- Medical Necessity.

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<sup>17</sup> Texas Workers' Compensation Commission, APA Dispute Resolution Information System (APADRIS), 1998.

After an overall 15 percent drop from 1996 to 1997, all three dispute-types are on the increase.<sup>18</sup> Pre-authorization disputes show the most significant increase, growing by 150 percent from 1997 to 1998 (see Figure 2). The 1999 total for pre-authorization disputes may well exceed the 1998 level of 1,351, since the mid-year total is already 764 disputes.

**Figure 2**  
**Distribution of Completed Workers' Compensation Medical Disputes, 1997-1998**



Source: TWCC Medical Dispute Resolution Information System (MDRIS) database, as of June 1999.

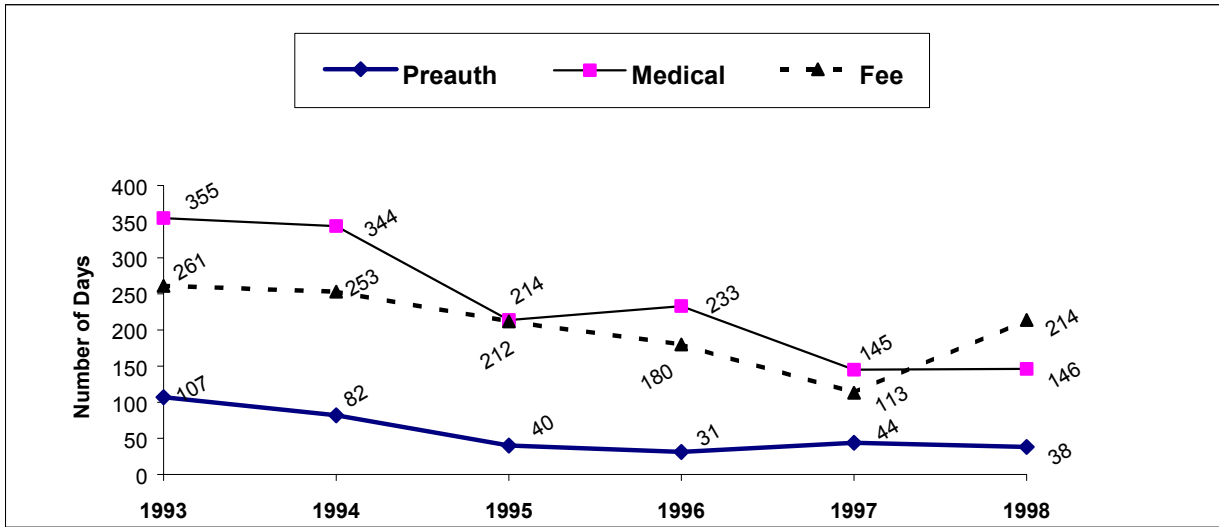
Note: The total number of medical disputes completed for January-June of 1999 is already 2,061 for all three dispute-types.

Informal Dispute Resolution Timeframes

The average timeframe for informally resolving medical disputes has fallen dramatically since 1993 (see Figure 3). However, during the years showing the most dramatic progress in reducing the duration of informal dispute resolution, the number of disputes rose significantly. From 1993 and 1996, while the average number of days to resolution fell by 32

to 70 percent for the three dispute types, the total number of medical disputes more than doubled, from 1,222 to 3,060.<sup>19</sup>

**Figure 3**  
**Average Number of Days to Complete Medical Disputes**  
**in the TWCC Administrative Dispute Resolution Process**



Source: Texas Workers' Compensation Commission, *System Data Report*, as of December 1998.

It is significant that pre-authorization disputes, which show the shortest average dispute resolution duration, also have the highest number of disputes and highest increase rates; while medical necessity disputes, which had the longest average dispute resolution duration until 1997, show the lowest number of disputes. A similar trend exists for the total number of disputes received. Pre-authorization and fee disputes, while exhibiting the two fastest timeframes for dispute resolution in 1997, had more disputes received (1,381 and 1,489 respectively) the following year than did medical necessity disputes (992 disputes received), which had the longest dispute resolution timeframe.<sup>20</sup>

<sup>18</sup> Texas Workers' Compensation Commission, Medical Dispute Resolution Information System (MDRIS) database, as of June 1999.

<sup>19</sup> Texas Workers' Compensation Commission, *System Data Report*, as of December 1998.

<sup>20</sup> Texas Workers' Compensation Commission Medical Dispute Resolution Information System (MDRIS), as of June 1999.

Since necessary medical treatment can often be held up pending the outcome of pre-authorization disputes, this dispute type receives priority over fee and medical necessity disputes. The average number of days to resolve pre-authorization and medical necessity disputes has stabilized since 1997, while the duration for fee disputes increased in 1998.

Longer timeframes for fee disputes may be the result of:

- a higher number of medical fee disputes as compared to the pre-1995 years;
- the influx of over 25,000 hospital fee disputes since 1997, due to the repeal of TWCC's *Acute Care Inpatient Hospital Fee Guideline*, which has placed increased demands on the Medical Review Division;<sup>21</sup> or
- inadequate staffing levels to process the increase in disputes received.

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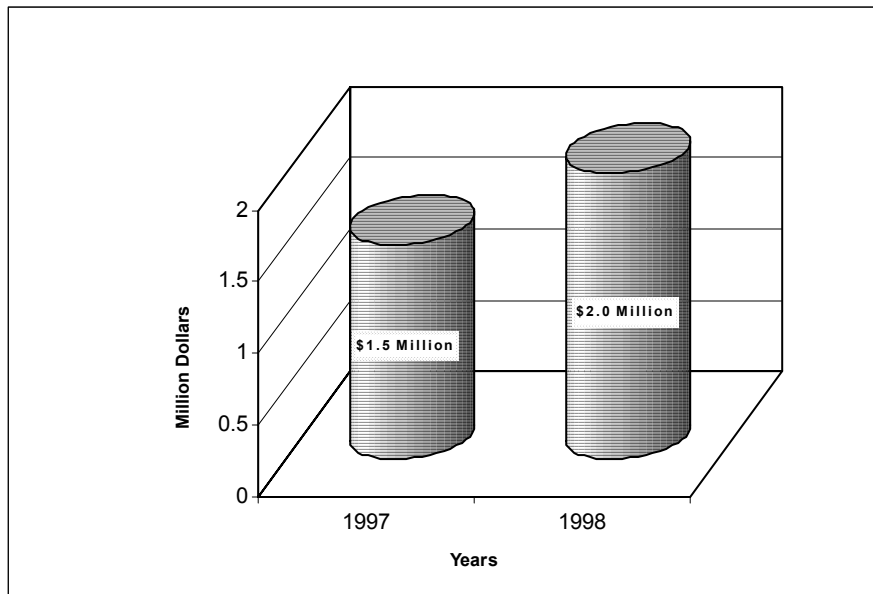
<sup>21</sup> See Research and Oversight Council on Workers' Compensation, *An Examination of Strengths and Weaknesses of the Texas Workers' Compensation System* (1998), p. 22; and *Biennial Report of the Research and Oversight Council on Workers' Compensation* (1998), p. 18.

### Disputed Amounts

The total dollars associated with medical disputes raised at TWCC is on the rise. This is a function of both the increasing number of medical disputes and the higher average dollar amount disputed. The total dollars disputed for medical necessity and fee disputes grew by 33 percent from \$1.5 million in 1997 to \$2 million in 1998 (see Figure 4).<sup>22</sup> Current data show that for the first six months of this year, the total is already 75 percent of the 1998 amount. At this rate, this year's total may well exceed \$3 million, twice the total amount disputed just two years ago.

Further, the average disputed amount for fee and medical necessity disputes is on a moderate climb, from \$2,066 per dispute in 1997 to \$2,224 for 1999. This could be explained by the increasing complexity of dispute cases handled by TWCC.

**Figure 4**  
**Total Dollar Amounts Disputed by Year**



Source: TWCC Medical Dispute Resolution Information System (MDRIS) database as of June 1999. The total amount for 1999 as of June 1999 is over \$1.5 million.

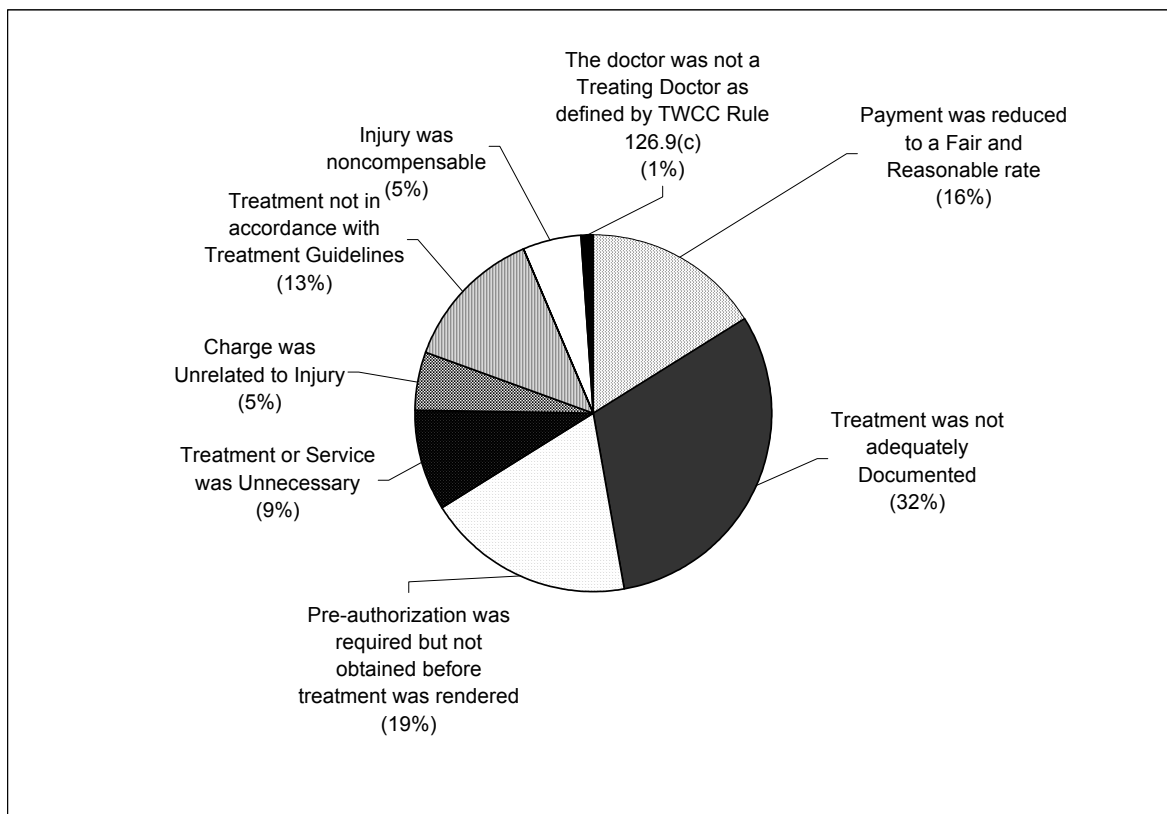
<sup>22</sup> Texas Workers' Compensation Commission, Medical Dispute Resolution Information System (MDRIS), as of June 1999. Since pre-authorization disputes are based on treatments not yet approved or rendered, no corresponding medical billing data are available to determine the total dollar value associated with pre-authorization disputes.

To understand the origin of medical necessity and fee disputes, the next section examines the denial and reduction of medical bills by insurance carriers.

### Section III: Denials and Reductions of Medical Bills

With the exception of pre-authorization disputes, all other medical disputes arise from disagreements over compensation of medical bills submitted by doctors. Providers bill insurance carriers for payments after treatments are rendered. Upon receiving a medical bill, the carrier conducts a review of the bill to determine the appropriateness of the medical treatment and the charge. A decision is then made to pay the bill in full, reduce the bill, or deny payment of the bill. This process is referred to as “retrospective review.” The justifications for reductions and denials are explained by denial codes required by TWCC to describe the rationale for partial payment and non-payment of medical bills. Figure 5 shows the relative distribution of initial reimbursement denials and reductions based on denial codes.

**Figure 5**  
**Reasons Given by Insurance Carriers for Initial Denials and Reductions of Medical Bills in 1998**



Source: TWCC Medical Forms database, as of June 1999.



### Resubmitted Bills

Statewide, the initial denial or reduction rate by insurance carriers for all Texas workers' compensation medical bills averaged 14.3 percent in 1997 and 15.9 percent in 1998.<sup>23</sup> Insurance carriers that exceeded the average initial denial rate had rates ranging from 16.3 percent to 37.6 percent. However, these initial denial rates may not accurately represent the final result of all bills that are denied or reduced. There are indications that perhaps up to 30 percent of initially denied bills are routinely resubmitted by health care providers. In some cases, insurance carriers reconsider and pay previously denied bills if resubmitted with a written appeal and adequate documentation.

With such a potentially significant resubmission rate for initially denied or reduced bills, the real percentage of denied/reduced bills may be considerably lower than the 15.9 percent cited for 1998. The denial/reduction rate for an insurance carrier could be the combined result of efficient auditing of inappropriate billings as well as improper denials.

Data are unavailable to accurately assess the degree to which health care providers challenge payment denials/reductions with written appeals outside of TWCC, or the degree to which they are satisfactorily resolved.

### Denials and Reductions: Frequencies and Dollar Amounts

While less than 1 percent of all bill denials and reductions ended in medical disputes in 1996, the disputed dollar amount was 3.4 percent of the denied/reduced dollar amounts for that year. It is therefore reasonable to conclude that as much as 96.6 percent of the initial dollar amount denied or reduced by insurance carriers goes unchallenged in the medical dispute resolution process. In the past three years, over \$200 million in medical charges were either reduced or denied on initial bill submissions without a medical dispute at TWCC.<sup>24</sup>

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<sup>23</sup> Texas Workers' Compensation Commission, Medical Forms database, as of June 1999.

<sup>24</sup> Ibid.

While it is difficult to determine the final outcome of all denied or reduced bills from the available data, it is from this pool of bills that most disputes (other than pre-authorization disputes) arise. When these denials or reductions are disputed, they are categorized as either fee or medical necessity disputes.

As Figure 5 shows, the three codes used most frequently by insurance carriers to deny or reduce bills are:

1. necessity of treatment not documented;<sup>25</sup>
2. pre-authorization not obtained before rendering treatment;<sup>26</sup> and
3. medical bills reduced to “Fair and Reasonable” amount.

These three groups consistently dominate the denial codes, totaling 2.6 million, or about 70 percent of all denials and reductions during the past three years.

“Fair and Reasonable” denials/reductions, when charges are reduced to fair and reasonable rates, have been on the decline in recent years, falling from over 300,000 services in 1996 to under 200,000 (16 percent of all denials) in 1998.<sup>27</sup> The total dollar amount for these “Fair and Reasonable” denials/reductions fell from \$10.6 million to \$6.3 million during the same period (see Figure 6). Another feature of denials is the payment ratio, which is the percentage of original charges submitted by the health care provider that are paid by the insurance carrier. The payment ratio for “Fair and Reasonable” denials/reductions remained stable at around two-thirds from 1996 to 1998 (see Table 1).

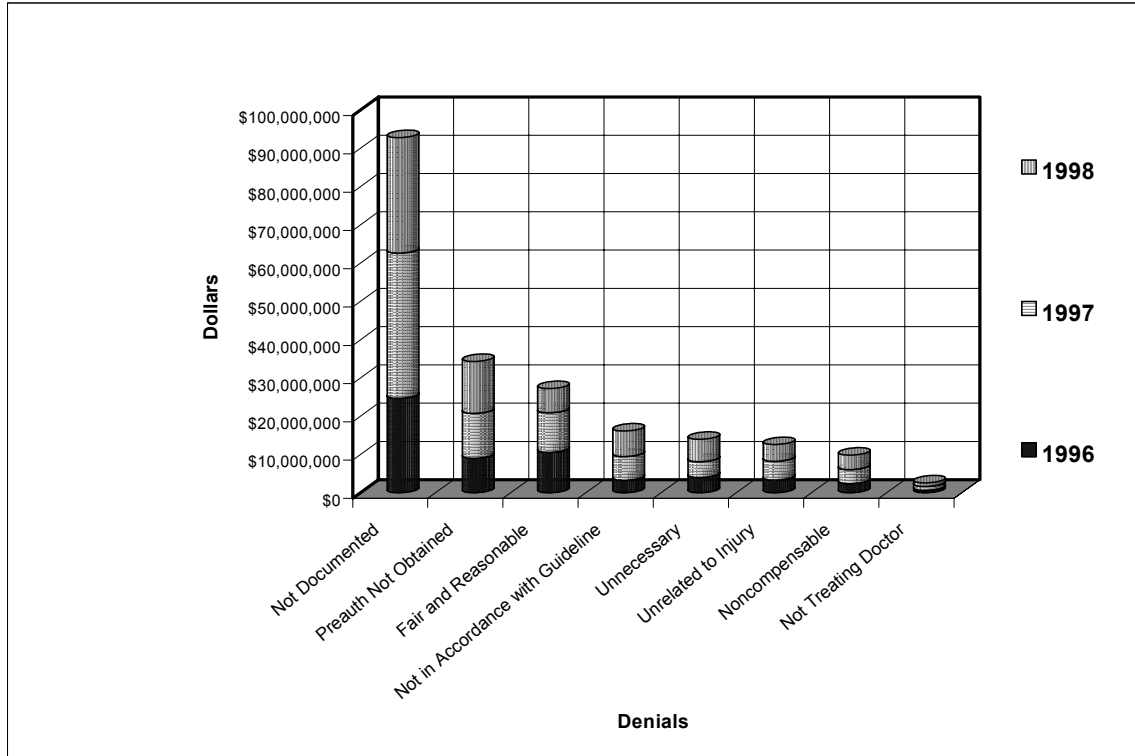
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<sup>25</sup> Payment for certain treatments is determined by Documentation of Procedure (DOP) when no maximum allowable reimbursement (MAR) is specified in the TWCC 1996 *Medical Fee Guideline*. Without adequate DOP a health care provider’s bill may be denied or reduced.

<sup>26</sup> As previously noted, a dispute based on this denial becomes a fee dispute arising from a treatment rendered without pre-authorization.

<sup>27</sup> Where documentation of procedures (DOP) is supplied for treatments not covered by a maximum allowable reimbursement, the payment should be at the fair and reasonable rate.

**Figure 6**  
**Total Dollars Denied/Reduced by the Reasons Given by Insurance Carriers, 1996-1998**



Source: TWCC Medical Forms database, as of June 1999.

Denials and reductions based on inadequate documentation increased from 333,000 in 1996 to 380,000 (32 percent of all denials) in 1998. The payment ratio for this denial is low. As seen in Table 1, as little as 4 percent of the charges are paid when inadequate documentation is cited as the denial/reduction reason. Inadequate documentation accounted for \$92 million in denials/reductions from 1996 to 1998.

**Table 1**  
**Percentage of Charges that are Paid by Denial/Reduction Codes, 1996-1998**

<b>Denial Type</b>	<b>1996</b>	<b>1997</b>	<b>1998</b>
Injury Noncompensable	22%	14%	7%
Charges Reduced to a "Fair and Reasonable" Rate	65%	67%	67%
Treatment Not in Accordance with Guidelines	11%	39%	51%
Not Documented	4%	5%	6%
Doctor Not a Treating Doctor as Defined by TWCC	1%	1%	1%
Pre-authorization Required but Not Obtained	4%	1%	1%
Treatment Unnecessary	13%	5%	6%
Charges Unrelated to Injury	4%	3%	2%

Source: TWCC Medical Forms database, as of June 1999.

Overall, the most significant decrease in payment ratios was for “Noncompensable” denials (from 22 percent to 7 percent), used when an injury is not considered work-related.

The steepest increase in payment ratios was for “Not in Accordance with Guideline” denials (from 11 percent to 51 percent). This represents an almost five-fold increase in the payment ratio of this denial code. At the same time, the prevalence of the “Not in Accordance with Guideline” denials has more than tripled since 1996 (from 50,000 to over 159,000), making it the fourth most frequently used denial code (13 percent of all denials) in 1998.

As with the “Not in Accordance with Guideline” code, improper or low usage of medical treatment guidelines could explain the increase in some dispute types. The relationship between medical treatment/fee guidelines and disputes is discussed below.

#### Medical Treatment Guidelines and Disputes

The proper usage of medical treatment and fee guidelines by health care providers and insurance carriers is an essential component of any effort to minimize disputes resulting from denials/reductions of medical bills. In December 1998, the ROC conducted a survey to determine the usage level of TWCC’s medical treatment guidelines. The survey participants were selected because of their heavy participation in the Texas workers’ compensation system.<sup>28</sup>

The results showed that 27 percent of the health care providers and 16 percent of the insurance carriers surveyed either did not have any of TWCC’s medical treatment guidelines in their offices or did not know whether their utilization review agents had copies of the guidelines. Interestingly, one-third of the medical doctors<sup>29</sup> who responded to the survey did not have any of the treatment guidelines. Based on the percentage of health care providers who had copies of the treatment guidelines in their offices and the percentage of health care

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<sup>28</sup> See Research and Oversight Council on Workers’ Compensation, “Usage of Medical Treatment Guidelines,” *Texas Monitor* 4, No. 1 (1999), and the full report, *Workers’ Compensation Medical Treatment Guidelines in Texas* (1999). The health care providers surveyed had completed TWCC’s Designated Doctor training in 1997.

providers who used the guidelines at least “sometimes” in their treatment of injured workers, the study estimated that less than half (46 percent) of health care providers who take workers’ compensation cases actively use the TWCC medical treatment guidelines in their practice. The study also reported that, overwhelmingly, insurance carriers (82 percent) believe that they should be allowed to dispute medical treatments that fall within the parameters of the TWCC medical treatment guidelines. However, only 20 percent of the health care providers agreed with this statement.

This survey underscores two potential contributors to medical disputes:

- the low usage of TWCC’s medical treatment guidelines by insurance carriers and the most active health care providers; and
- the disparity in medical treatment and medical control philosophies between insurance carriers and health care providers regarding the role of the treatment guidelines in the system.

While a similar survey on the usage of fee guidelines in Texas has not been done, it is conceivable that disparity in attitudes between insurance carriers and health care providers over fee guideline usage (especially in the interpretation of denial/reduction codes) would also lead to medical disputes.

#### Bill Reduction as a Savings to the Workers’ Compensation System

In addition to the denial codes discussed above, medical bills may also be reduced according to the TWCC *Medical Fee Guideline*.<sup>30</sup> The Maximum Allowable Reimbursement (MAR) in the fee guideline sets limits on the amount insurance carriers are required to pay for medical treatments. When a billed amount exceeds the MAR, the insurance carrier is required to reduce that bill to the MAR amount. This reduction is discussed separately because it is considered more of a saving to the system than a disputable denial. It represents the difference between the “usual and customary” amount billed and the amount allowed. The

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<sup>29</sup> Medical doctors comprise one of six treating doctor types recognized by TWCC. The remaining five are dentists, optometrists, chiropractors, podiatrists, and doctors of osteopathic medicine.

total savings attributed to the 1996 *Medical Fee Guideline* in 1998 was over \$103 million.<sup>31</sup> It is unlikely that this bill reduction could be the source of fee disputes at TWCC.

TWCC encourages health care providers to charge their “usual and customary” fees instead of the MAR. This information is essential in monitoring charge trends, and is therefore critical in designing future fee schedules.

#### Dominant Characteristics and Trends in the Medical Dispute Resolution System

The above discussions on dispute types and denial rates suggest the following dominant characteristics of the medical dispute resolution system:

- Medical disputes make up significantly less than 1 percent of all medical treatments and services provided in the Texas workers’ compensation system. Approximately eight out of every 10,000 workers’ compensation medical services provided in the State of Texas end in a medical dispute at TWCC.
- Approximately 15 percent of all workers’ compensation medical bills in 1998 were either denied or reduced by insurance carriers. The total dollar value of the denials/reductions was \$70 million. Bill denials/reductions by insurance carriers may be the source of most fee and medical necessity disputes.
- The denial/reduction rate may be lower since an indeterminate number of previously denied and reduced bills are being re-evaluated and paid when resubmitted with written appeals.
- The number of disputes tends to increase as the timeframe for resolving disputes decreases.

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<sup>30</sup> See the Texas Workers’ Compensation Commission, *Medical Fee Guideline* (1998).

<sup>31</sup> Texas Workers’ Compensation Commission, *System Data Report*, as of December 1998.

- Most medical disputes are based on disagreements over pre-authorization and documentation.

The discussion so far has been based on statistical trends from the medical dispute resolution and the medical billing databases. However a critical component to this study is input from the primary participants in the system -- health care providers and insurance carriers. Their perceptions of the medical dispute process will be explored in the following section.

## **Section IV: Perceptions of Insurance Carriers and Health Care Providers**

Within the past three years, the ROC has conducted several surveys of system participants. In each case, the goal was to gather opinions and perceptions that could provide useful insight into the strengths and weaknesses of the system. These perceptions have become valuable resources in developing legislative and regulatory initiatives aimed at improving the system. Both insurance carriers and health care providers have contributed meaningful insights that are specifically relevant to this study of the medical dispute resolution process.

### **Length of Process**

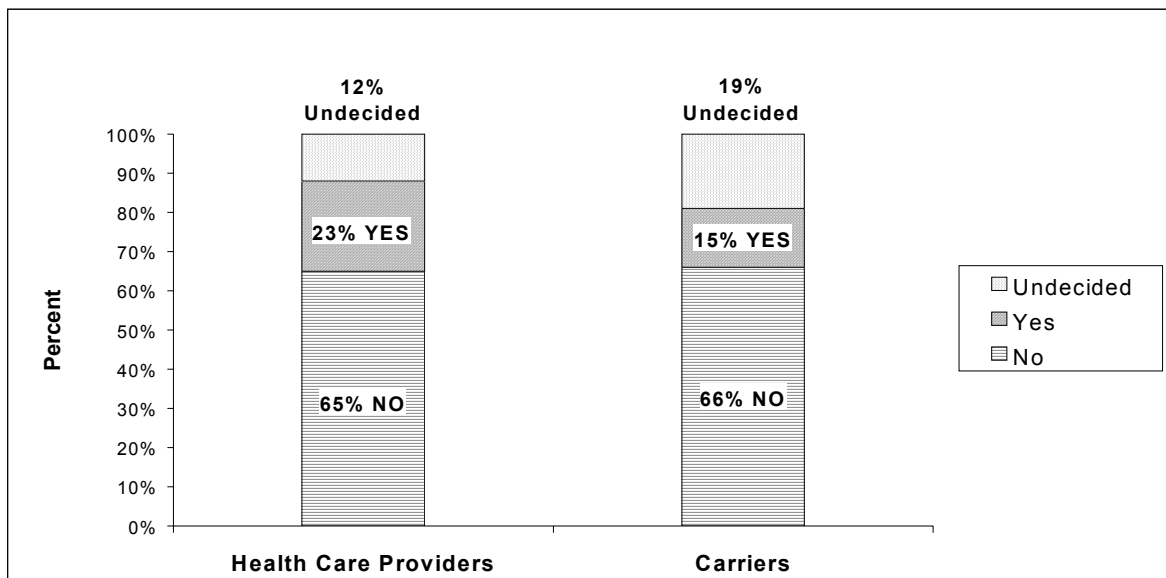
In 1998, the ROC surveyed insurance carriers, health care providers, injured workers, employers, and attorneys regarding their general attitudes towards the Texas workers' compensation system.<sup>32</sup> When asked to give their opinions on the medical dispute resolution system, two-thirds of the surveyed insurance carriers and health care providers felt that the length of the medical dispute process was unreasonable (see Figure 7). Approximately 90 percent of these participants believed that all medical disputes should be resolved within one to three months.

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<sup>32</sup> See Research and Oversight Council on Workers' Compensation, *An Examination of the Strengths and Weaknesses of the Texas Workers' Compensation System* (1998); and *Experiences of Doctors Who Practice in the Texas Workers' Compensation System* (1998).



**Figure 7**  
**Is the length of time it takes to currently resolve a workers' compensation medical dispute reasonable?**



Source: Research and Oversight Council on Workers' Compensation, *An Examination of the Strengths and Weaknesses of the Texas Workers' Compensation System* (1998).

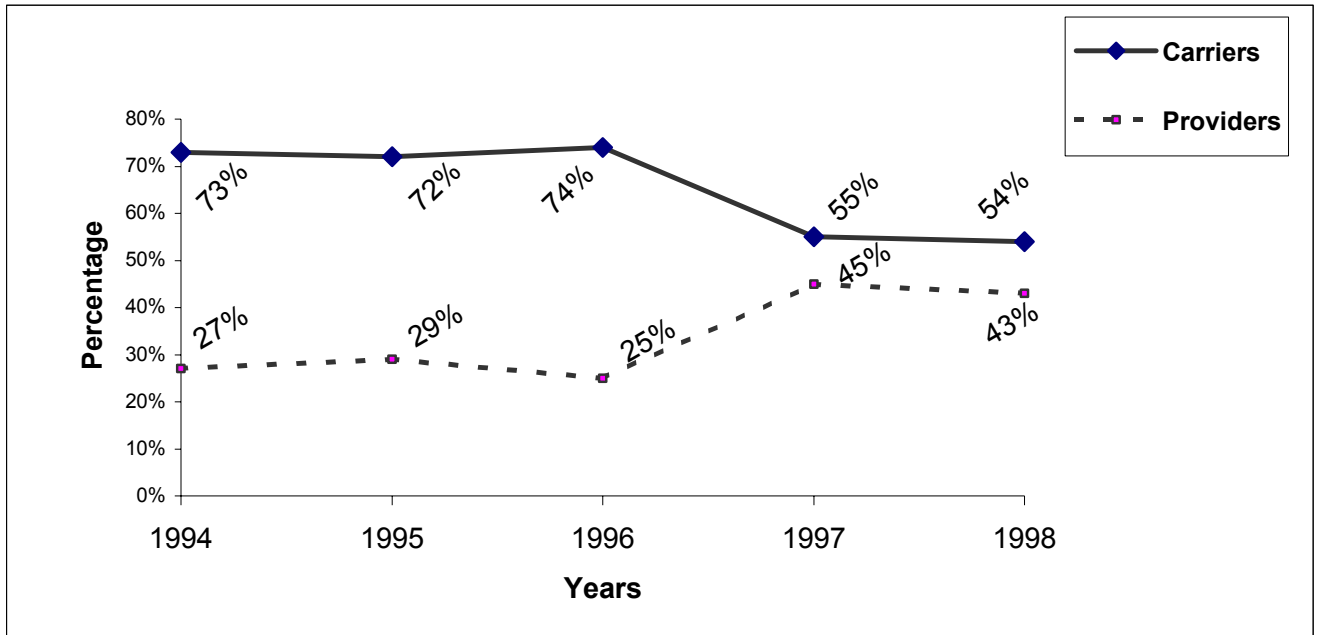
**Fairness of the Medical Dispute Resolution Process**

In terms of perceived fairness, TWCC's medical dispute resolution process received mixed scores. Less than half of the health care providers surveyed (47 percent), and slightly more than half of the insurance carriers (57 percent), felt that medical disputes are decided in a fair and reasonable manner by TWCC.<sup>33</sup> One would expect even lower numbers for providers and higher numbers for carriers given a breakout of dispute outcomes (see Figure 8). Insurance carriers prevailed in an overwhelming percentage of disputes between 1994 and 1996.<sup>34</sup> Since 1997, however, this margin has narrowed considerably.

<sup>33</sup> See Research and Oversight Council on Workers' Compensation, *An Examination of the Strengths and Weaknesses of the Texas Workers' Compensation System* (1998).

<sup>34</sup> See Texas Workers' Compensation Commission *System Data Report*, as of December 1998.

**Figure 8**  
**Prevailing Parties in the TWCC Administrative Medical Dispute Resolution Process**



Source: TWCC System Data Report, as of December 1998.

**Cost of Medical Dispute Resolution**

A major cost factor in the medical dispute resolution process is time. According to the 1998 survey of system participants, two-thirds of insurance carriers and health care providers felt that the length of time it takes to resolve a medical dispute is too long. More than half of the health care providers surveyed thought that the length of the medical dispute resolution process was not cost-effective and actually discouraged participation by health care providers.<sup>35</sup>

Health care providers testifying before the House Business and Industry (B&I) Subcommittee on Workers' Compensation Insurance Carrier Practices in 1998 said that they sometimes write off medical bills rather than dispute denials through TWCC. This assertion may also be supported by the fact that a great majority of denied and reduced bills currently go uncontested by medical providers.

<sup>35</sup> See Research and Oversight Council on Workers' Compensation, *An Examination of the Strengths and Weaknesses of the Texas Workers' Compensation System* (1998).

Nevertheless, 74 percent of the health care providers surveyed in 1998 felt that the trend was toward more disputes. This should alert TWCC administrators that any planned improvement in dispute resolution processing time may trigger increased participation by the contesting parties.

### **Pre-authorization and Documentation Issues in Denials and Disputes**

It was earlier established that issues involving pre-authorization and documentation tend to dominate disputes. This is also consistent with the findings on fee denials and reductions, where 51 percent of denied/reduced bills were related to either prior pre-authorization not received or inadequate documentation. In testimony before the House B&I Subcommittee in 1998, doctors testified that many pre-authorization disputes could be avoided if the treating doctor had an opportunity to speak with the utilization review agent about the proposed treatment. Further, 55 percent of the doctors surveyed in 1998 confirmed that they “rarely” or “never” receive a reasonable, written justification from an insurance carrier when a request for pre-authorization is denied.<sup>36</sup> Also, over half (54 percent) of the doctors surveyed said that insurance carriers “always” or “often” down-code or reduce fees for services without providing written justification.

Interestingly, the data examined previously in this study show that inadequate documentation from doctors was the primary justification used by insurance carriers over the past two years to initially deny or reduce payments (see Figures 5 and 6). Clearly, effective documentation requirements could significantly reduce the number of disputes as well as denials/reductions. Under new Texas Department of Insurance (TDI) Utilization Review Rules, denials of medical care or payments by insurance carriers require more detailed and documented justifications.<sup>37</sup>

Part of the documentation dilemma may be attributable to inefficient and redundant reporting practices on both the provider side and the carrier side. House Bill 2511 (76th Legislature) authorizes TWCC to create a task force to develop a plan for electronic reporting of

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<sup>36</sup> See Research and Oversight Council on Workers’ Compensation, *Experiences of Doctors Who Practice in the Texas Workers’ Compensation System* (1998).

information and financial exchanges at a system-wide level. The completion date for the plan is statutorily set for October 1, 2000.

### **Impact of the Medical Dispute Resolution Process on Health Care Delivery**

While 76 percent of injured workers surveyed in 1998 by the ROC replied that they thought the current system ensured adequate and timely medical care, 46 percent felt that their insurance company tried to delay or deny some of their benefits.<sup>38</sup> Interestingly, 87 percent of health care providers in the same survey thought that medical disputes had negative impacts on patient care, while only 54 percent of insurance carriers agreed.

### **External Factors That May Impact Medical Dispute Resolution**

#### Competitive Pressures

Texas insurance carriers are under intense competitive pressures. Eighty-five percent of insurance carriers who responded to the 1998 survey said they believed the insurance industry is currently underpricing workers' compensation coverage to remain competitive, and 75 percent said that this would lead to higher premiums in the future.<sup>39</sup> Health care providers in the system cite competitive pressures as well, due to additional overhead requirements of workers' compensation cases that general health practitioners do not face.

#### Rising Costs

Insurance carriers in Texas are facing considerable threats to profitability. A significant number (57 percent) of insurance carriers surveyed said that the cost of handling workers' compensation claims is higher in Texas when compared to other states.<sup>40</sup> The average insurance company in Texas paid out more in administrative and claim costs (\$1.10 per dollar of premium received) than the national average of \$1.01.<sup>41</sup> In the face of fierce competition between 1994 and 1997, insurance carriers have also seen claim costs rise by 64 percent (from \$743 million to \$1.2 billion) while direct earned premium fell by 41 percent

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<sup>37</sup> See *Texas Insurance Code*, Article 21.58A.

<sup>38</sup> See Research and Oversight Council on Workers' Compensation, *An Examination of Strengths and Weaknesses of the Texas Workers' Compensation System* (1998).

<sup>39</sup> *Ibid.*

<sup>40</sup> *Ibid.*

<sup>41</sup> See Texas Department of Insurance, *Quarterly Legislative Report on Market Conditions*, 1993 – 1997.

(from \$2.8 billion to \$1.7 billion).<sup>42</sup> Further, recent studies show that medical costs in Texas may exceed the national average by as much as 80 percent.<sup>43</sup>

#### Impact on Bill Denials/Reductions and Dispute Resolution

Tight insurance market conditions characterized by increased competition, rising costs, declining premiums, and underpricing, could generate pressures for creative cost-cutting and revenue-enhancing measures.

The medical dispute resolution process appears vulnerable to such efforts. Currently, as much as 96 percent of all dollars denied or reduced go unchallenged by health care providers in the medical dispute resolution system. A random payment denial by an insurance carrier would therefore have a significant chance of not being disputed; and, if disputed by the health care provider, a 54 percent chance of prevailing in favor of the insurance carrier. Provider propensity to “write off” denials combined with the absence of effective deterrence against unwarranted denials by insurance carriers could have spillover effects for the medical dispute process. Conditions that encourage random bill denials and reductions are potential sources for increased fee and medical necessity disputes. Insufficient data exist to conclude whether similar patterns are present in pre-authorization disputes.

Improper billing practices by health care providers can also contribute to the denial and reduction rate of workers’ compensation bills in Texas. The denial/reduction rate could then be interpreted as the insurance carriers’ detection rate of inappropriate billings. What is unknown is the degree to which improper billing goes undetected.

Another contributor could be multiple interpretations of TWCC’s medical treatment and fee guidelines, leading to conflicts between legitimate provider billing practices and acceptable carrier reimbursement practices. In all likelihood, a combination of all three factors

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<sup>42</sup> Some of this decline in premiums can be attributed to the rise in the number of deductible policies as well as the reduction in frequency and severity of workplace injuries.

<sup>43</sup> See National Council on Compensation Insurance, *Annual Statistical Bulletin*, 1998 and 1999 editions; and the Research and Oversight Council on Workers’ Compensation, *Biennial Report of the Research and Oversight Council on Workers’ Compensation: December 31, 1998* (1999).

contributes to the number of medical disputes. Further research and auditing is necessary to quantify their relative impacts on the process.

## **Section V: Considerations for Improving the Medical Dispute Resolution Process**

There can be two approaches to improving the medical dispute resolution process: 1) increase the efficiency of handling disputes; and 2) minimize the occurrence of disputes in the first place. The following recommendations utilize both approaches:

1. Consider increasing TWCC's access to medical expertise. The advantages of TWCC's timely access to medical guidance could be substantial:
  - medical dispute decisions would have greater credibility and might be less likely to be appealed;
  - medical policy guidance could be more focused to reduce disputes before they occur;
  - arbitrary denials/reductions with inadequate justifications could decrease; and
  - the number of disputes could fall.
  
2. Consider allowing insurance carriers to pre-authorize comprehensive treatment plans. This would reduce the likelihood of pre-authorization disputes by gaining a single approval of a treatment plan in advance rather than a separate approval for each individual treatment. A treatment plan would be an agreed-upon program between the insurance carrier and the treating doctor that includes treatments and prescription medicines along with estimated costs. This approved plan would minimize the line by line review and approval process that can multiply the chances for medical disputes. If a proposed plan by a treating doctor is not acceptable to the insurance carrier, then TWCC may require that the medical advisor make the final determination. This recommendation could be implemented under TWCC Rule 134.600 or other existing law.<sup>44</sup>

Other possible areas for process improvements, based on findings from this review, might include:

- increase the use of Informal Resolution Conferences (IRCs), which have been shown to resolve medical disputes more quickly and at less cost than SOAH appeals;
- reduce medical dispute response time from current timeframes;
- increase staffing and training resources for TWCC’s Medical Dispute Resolution Section;
- impose additional penalties and interest for rules violations; and
- develop a complaint process specifically for dispute resolution issues.

Additional research is needed in these areas before more specific recommendations can be made. House Bill 3697, passed by the 76th Legislature, provides for a joint venture between the ROC and the Texas Workers’ Compensation Insurance Fund to conduct specific research on medical issues during the interim period prior to the next legislative session. This research will focus on the quality and cost-effectiveness of the current workers’ compensation health care delivery system, including medical provider treatment patterns and insurance carrier practices. Findings from these research initiatives can be used to help guide further improvements in the medical dispute resolution process.

### **Conclusion**

The medical dispute resolution process was established as an informal resolution system to reduce costly litigation and to help ensure effective and efficient delivery of medical treatment to injured workers. Some indicators suggest that TWCC’s Medical Review Division has had exceptional success with preventing and processing medical disputes: less than eight out of every 10,000 treatments end up in the medical dispute resolution system and the dispute timeframes have been reduced significantly since 1993.

Yet, most providers believe that the dispute process is cost-prohibitive, and as a result, write off most reduced and unpaid bills. More than 96 percent of all denials/reductions go undisputed. The insurance carriers believe the process is too long and imposes a costly administrative burden. All indications are that the result of shorter dispute timeframes would be an increase in the number of disputes TWCC must consider.

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<sup>44</sup> This recommendation was proposed in the ROC’s *Biennial Report of the Research and Oversight Council on Workers’ Compensation* (1998). It is also part of the proposed revision to the TWCC Pre-authorization Rule



The challenge for TWCC is to continue to make progress towards a realistic dispute timeframe without opening the floodgates to potential disputes. Additional increases in dispute workloads may necessitate a significantly larger staff to maintain past improvements in process efficiency. To be sustainable, internal improvements in the medical dispute resolution process should be accompanied by a comprehensive plan to minimize bill denials/reduction, and therefore prevent the occurrence of future medical disputes.

The proposed considerations for continuing to improve the medical dispute process and to minimize denials are by no means exhaustive. Further research may be required to explore additional opportunities for ensuring the continued success of TWCC's medical dispute resolution system.

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which is currently in the comment phase (Rule 134.601).