ADVISORY NO. 308
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TOPIC: NEW PREAUTHORIZATION RULE EFFECTIVE JAN 1, 2002

On November 15, 2001, the Commission significantly amended Rule 134.600, commonly referred to as the "Preauthorization Rule." The original rule, adopted in 1991, with the exception of one minor change, has remained essentially the same in the past ten years. The new Rule 134.600, re-titled Preauthorization, Concurrent Review, and Voluntary Certification, becomes effective **January 1, 2002**.

Besides a new title, the amended Rule 134.600 includes the mandated provisions from HB 2600 (the omnibus workers' compensation bill), adds definitions, decreases the required list of services requiring preauthorization, and adds data collection and reporting requirements. It also introduces two new concepts, concurrent review and voluntary certification, into the operational procedures of prospective review. This Advisory will review the amended rule emphasizing the changes for the insurance carrier population.

Definition of Terms

Subsection (a) defines six terms used in the remainder of the rule. Three terms, "ambulatory surgical center," "outpatient surgical services," and "preauthorization" are fairly self-explanatory. The term "concurrent review" is defined as a review of on-going health care where the service has already been prospectively approved. (An example is when an injured employee is admitted into the hospital with a preauthorized four-day stay. On the third day, the doctor requests an additional two days length of stay. The review of the request from the doctor is considered "concurrent review"). The other two words defined are "final adjudication" (the Commission's final decision on a dispute) and "requestor" (the person, including a referred provider, who may request the prospective reviews of preauthorization, concurrent review or voluntary certification).

When Carrier is Liable

Rule 134.600 (b) explains when the carrier is liable for the reasonable and necessary medical costs of the health care services. Subsection (b)(1) explains that liability is incurred when there is an emergency, when the carrier approves prospectively the services described in the preauthorization and concurrent review lists {Subsection (h) and (i)}, or when ordered by the Commission. Subsection (b)(2) states that carriers will also be liable for payment of services when a provider requests and the carrier approves voluntary certification.

Subsection (c) states that, even if the carrier approves the service as medically necessary, the carrier is not liable for the payment of the medical services if the Commission finds the injury to

be not compensable or if the health care was unrelated to the compensable injury. The preamble to the rule makes it clear that the carrier is not liable for payment of the preauthorized services pending final resolution of a compensability dispute.

Voluntary Certification

The concept of "Voluntary Certification" is described in §413.014 of the Labor Code (as amended by HB 2600) and is further explained in subsection (j) of Rule 134.600. This subsection of the rule states that the provider and the carrier may discuss treatment and treatment plans prospectively. The carrier may certify and agree to pay for the proposed treatment(s). {Voluntary Certification is approval of services that are not on the preauthorization list delineated in subsection (h)}. As noted previously, this certification subjects the carrier to liability of payment for the treatments. Subsection (j)(4) states further that if the carrier denies the certification and the provider performs the treatment proposed, that the medical care provided is subject to retrospective review.

Requirements for Requestors

Subsection (d) of Rule 134.600 states that designated telephone and facsimile numbers are required for preauthorization requests. It further states that the carrier may set up an e-mail address to receive requests from providers.

Subsection (e) explains the responsibility of the requestor in submitting the request for preauthorization or concurrent review. It states that preauthorization must be obtained prior to performing the service. If further services are necessary after the initial preauthorization approval, concurrent review should be requested prior to the end of the approved services. The request may be submitted to the carrier in any of the three ways listed in subsection (d) (telephone, fax, or e-mail). The requestor must include the specific health care services requested as listed in the preauthorization or the current review lists {Subsection (h) and (i)}, the number of treatments and/or the specific time period of care requested, medical information to substantiate the need for the care, the requestor's telephone and fax number, and name of the provider and facility where the service will be performed and an estimated date. (The requestor may also give an e-mail address for response from the carrier).

Carrier's Responsibilities

Subsection (f) explains the carrier's responsibility in the preauthorization and concurrent review process. (These responsibilities do not relate to voluntary certification). Subsection (f)(1) states that the carrier should approve or deny the preauthorization or concurrent review request solely

on the medical necessity of the service as it relates to the injury. The carrier should not take into account unresolved issues of compensability, extent of or relatedness (to the compensable injury), liability for the injury, or if maximum medical improvement has been reached. Subsection (f)(2) states, prior to issuance of a denial, the carrier should give reasonable opportunity for the requestor to discuss the reasons for a denial with the appropriate reviewing provider.

Subsection (f)(3) is an important subsection of the rule because it lays out the time frames for granting approval or issuing a denial for a preauthorization or concurrent review request. The time frame for preauthorization is three working days, the same as the current rule. The time frame for a concurrent review request response is also three working days, except if the request is for an additional length of stay for an inpatient setting. In the case for additional length of inpatient stay, the response is due one working day after receipt of the request. The response to the provider can be communicated by telephone, facsimile, or by e-mail.

Subsection (f)(4) states that within one working day of the notification required under subsection (f)(3), the carrier must send written notification to the employee, employee's representative and to the requestor. (If the response to the requestor was submitted initially by fax or e-mail, this notification to the requestor is not necessary).

Subsection (f)(5) describes the information required with the approval of preauthorization or concurrent review. The approval should include the specific health care approved, the number of treatments and/or time frame approved, and a notice explaining any unresolved compensability, liability, extent of injury, or unrelatedness to the compensable injury disputes.

Subsection (f)(6) describes the information submitted with a denial. It should include the description or source of screening criteria and plain language notifying the employee of the right to timely request reconsideration.

Requests for Reconsideration

Subsection (g) discusses a request for reconsideration of a denial. Who may make a request for reconsideration differs depending upon if it is for preauthorization (the employee or requestor may request) or it is for concurrent review (only the requestor may request reconsideration). This request for reconsideration should be made within 15 days of a written denial from the carrier.

Subsection (g)(2) describes the time frames for the carrier to respond to a request for reconsideration. There are three different time frames: five working days if the request is for a preauthorization denial, three working days if the request is for a concurrent review, and one

working day if it is for an added length of stay for an inpatient hospital admission.

Subsection (g)(3) states that the requestor or employee may appeal a reconsideration denial by filing a dispute as in accordance with §413.031 of the Labor Code and Rule 133.305. Subsection (g)(4) explains that, if a service has been denied at the Independent Review Organization (IRO) level, that a request for preauthorization for the same service can only be filed if there is a substantial change in the injured employee's condition.

Services Subject to Preauthorization

Subsection (h) of Rule 134.600 describes the treatments and services that will require preauthorization. The table below compares the current preauthorization list and the changes in this list with the amended rule, effective January 1, 2002. By reviewing the table, it is apparent that the preauthorization list has changed through addition, deletion and revision of the required treatments and services. The major changes are deletion of physical therapy and occupational therapy, exemption of accredited working hardening/work conditioning programs, inclusion of medical rehabilitation programs, and addition of spinal surgery and investigational or experimental services and devices. (There is no list of treatments and services specified for "investigational or experimental services or devices").

As noted, work hardening and work conditioning programs will be exempt from preauthorization if they are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and if they submit documentation to the Commission proving the accreditation. Since CARF does not classify programs as work conditioning and work hardening, the accreditation held by the provider must be for general occupational rehabilitation and/or comprehensive occupational rehabilitation (work conditioning and work hardening, respectively). The Commission will provide a list of the facilities exempted from preauthorization on their website. A facility is not exempted from preauthorization until they have submitted their documentation to the Commission and the TWCC has exempted the preauthorization requirement. (There are approximately 25 facilities in the state of Texas that may apply for this exemption).

Subsection (h)(9) describes CARF accreditation as noted in the previous paragraph. It also states that at the end of one year, all programs, regardless of accreditation, will be subject to preauthorization and concurrent review.

Subsection (k) states that preauthorization requirements may be increased or decreased for specific health care providers or individual claims in accordance with the mandates of §408.0231(b)(4) of the Labor Code.

Services Subject to Concurrent Review

Subsection (i) describes the list of health care requiring concurrent review. This list mirrors the majority of services that are on the preauthorization list {subsection (h)} that may need an extension of services. (Psychotherapy and biofeedback are listed in subsection (h), but were not included in the concurrent review list in subsection (i). Either of these services may require extensions such as described in a concurrent review definition. If an extension of these services were requested it should be treated as a preauthorization request).

New Reporting Requirements

Subsection (l) of rule 134.600 discusses the need for the carrier to maintain accurate records regarding preauthorization and concurrent review requests. Subsection (l)(1)(2) lists the information that the Commission may request from the carrier regarding these processes. By January 1, 2003, as described in subsection (l)(3) and (4), the Commission will prescribe a specific form and format that carriers will use to report, electronically, mandated information. After the form and format is prescribed, the report will be required every quarter.

Old Rule Transition to New Rule

Subsection (m) describes that preauthorization requests should be responded to in accordance with the rule in effect at the time of the request. It also provides for the severability of portions of the rule if there is a challenge to the rule. Subsection (n) states that the spinal surgery second opinion process will remain into effect as described in Rule 133.206 until this rule (134.600) becomes effective. Section (o) defines the effective date of this rule as January 1, 2002. Obviously, this rule demands immediate attention since the effective date is so near.

Current Rule 134.600	**Rule 134.600 Preauthorization List, Effective 01/01/02**

Preauthorization List	
Inpatient hospitalizations	Inpatient hospitalizations including principal scheduled procedure(s) and length of stay
Ambulatory surgical center care	Outpatient surgical and ambulatory surgical services as defined in subsection (a)
Transfers between facilities	This service deleted from new preauthorization list
Psychiatric or psychological therapy or testing unless as part of work hardening	All psychological testing and psychotherapy, repeat interviews, and biofeedback; except when any service is part of a preauthorized or exempt rehabilitation program
All external and implantable bone growth stimulators	No change from previous rule
All chemonucleolysis	No change from previous rule
All facet or trigger point injections	These services deleted from new preauthorization list
All nonemergency myelograms, discograms, or surface electromyograms	All myelograms, discograms, or surface electromyograms
Unless otherwise specified, repeat individual diagnostic study, with a fee established in the current Medical Fee Guideline of greater than $350 or documentation of procedure (DOP).	No change from previous rule
Video fluoroscopy	This service deleted from new preauthorization list
Radiation therapy or chemotherapy	This service deleted from new preauthorization list
Biofeedback except as part of work hardening program	Included with psychological testing on the list (see above)
Physical therapy or occupational therapy beyond eight weeks of treatment	This service deleted from new preauthorization list
Pain clinics	Rehabilitation programs to include outpatient medical rehabilitation and chronic pain management/interdisciplinary pain rehabilitation
Chemical dependency clinics, or weight loss clinics	Chemical dependency and weight loss programs

Current Rule 134.600 Preauthorization List	**Rule 134.600 Preauthorization List, Effective 01/01/02**
Work hardening, in excess of six weeks (limited to a one-time two-week extension)	Work hardening and work conditioning services provided in a facility that has not been approved for exemption by the Commission. For approval, facilities must submit documentation of current accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) to the Commission. A comprehensive occupational rehabilitation program or a general occupational rehabilitation program provided in a facility accredited by CARF constitute work hardening or work conditioning for purposes of this section. All work hardening or work conditioning programs, regardless of accreditation, will be subject to preauthorization and concurrent review on or after one year from the effective date of this sections. Commission exempted facilities are subject to Commission verification and audit, and the Commission will provide a list of the facilities approved for exemption on the TWCC website
Work conditioning, in excess of four weeks (limited to a one-time two-week extension)	Work conditioning listed with work hardening (see above)
All durable medical equipment in excess of $500 per item and all TENS units	All durable medical equipment (DME) in excess of $500 per item (either purchase or expected cumulative rental) and all transcutaneous electrical nerve stimulators (TENS) units
Nursing home, convalescent, residential, and all home health care services and treatments	No change from previous rule
All nonemergency dental services, including reconstructive dental or dental appliances	This service deleted from new preauthorization list
Not on previous preauthorization list	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
Not on previous preauthorization list	Spinal Surgery