ADVISORY NO. 477

TOPIC: AMENDMENTS TO PREAUTHORIZATION/CONCURRENT REVIEW

The Division adopted amendments to Rule 134.600 (Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) which will become effective on July 1, 2012. In the preamble, the Division explained that these changes clarify the implementation and application of this Rule and they were necessary to harmonize Rule 134.600 with other Division rules and procedures. These include Chapter 504 of the Texas Labor Code and certain provisions of Chapters 1305 and 4201 of the Texas Insurance Code.

This advisory highlights some, but not all, of those changes that are likely to have the greatest impact upon our clients.

Generally, a provider must seek preauthorization of treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines (The *ODG Treatment Guidelines*) or that are not in a treatment plan authorized by the carrier. This includes, *initial* diagnostic testing where such testing is inconsistent with the recommendations of the *ODG*.

Similarly, the amendments to subsections 134.600(a)(4), (p)(4), and (q)(2) clarify that a Division-granted exemption from preauthorization and concurrent review requirements for work hardening or work conditioning programs only extends to services that are consistent with the *ODG*.

The Division, however, amended the rule to specifically address the need for preauthorization of certain pharmaceuticals when such are inconsistent with the *ODG* and as such repeal the August 29, 2008, Memorandum from the Division's Medical Advisor, entitled "Use of Pharmaceuticals in the Texas Workers' Compensation System." In that Memorandum, the Medical Advisor stated: "System participants should continue using the ODG treatment guidelines and continue to seek preauthorization for treatment, including prescriptions, when services fall outside or in excess of the ODG treatment guidelines."

As amended, preauthorization is no longer required for drugs prescribed for claims under Rules 134.506 (Outpatient Open Formulary for Claims with Dates of Injury Prior to 9/1/11), 134.530 (Requirements for Use of the Closed Formulary for Claims Not Subject to Certified Networks), or 134.540 (Requirements for Use of the Closed Formulary for Claims Subject to Certified

Networks). The Division explained that this amendment is necessary because the recent amendments to Rule 134.506 and newly adopted Rules 134.530 and 134.540, which provide that drugs prescribed under either the Division's open or closed formulary only require preauthorization as provided by those sections.

Rule 134.600(u) provides that all utilization review must be performed by a carrier that is registered with, or a utilization review agent that is certified by, the Texas Department of Insurance to perform utilization review in accordance with Chapter 4201 Texas Insurance Code and Chapter 19 of Title 28 of the Texas Administrative Code.

Subsection (u) also provides that all utilization review agents or registered insurance carriers who perform utilization review must comply with section 504.055 of the Texas Labor Code (Expedited Provision of Medical Benefits for Certain Injuries Sustained By First Responder In Course and Scope of Employment) and subchapter U of Chapter 19 of Title 28 of the Texas Administrative Code. Section 504.055 applies to first responders who sustain a serious bodily injury and requires the political subdivision, the Division, and the carrier to give priority to an injured first responder's claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from the compensable serious bodily injury.

Rule 134.600(t) provides that the carrier shall maintain accurate records to reflect information regarding requests for preauthorization, or concurrent review approval/denial decisions, and appeals, including requests for reconsideration and requests for medical dispute resolution. The Division adopted this amendment to facilitate the agency's duties of monitoring, compilation, and maintenance of statistical data, review of insurance carrier records, maintenance of an investigation unit, and medical review as required by Chapter 414 of the Texas Labor Code, Enforcement of Compliance and Practice Requirements.

Rule 134.600(o)(1) extends the deadline for a requestor to submit a request for reconsideration after receiving denial of a preauthorization request from 15 working days to 30 days (meaning calendar day. See Rule 102.3(b)). This harmonizes this parallel requirement for network claims under section 1305.354 of the Texas Insurance Code, which provides requestors 30 days to submit a request for reconsideration.

Rule 134.600(o)(2) extends the deadline for a carrier to respond to a request for reconsideration of a denial of a preauthorization request. The deadline is extended from "within 5 working days of receipt of the request" to "as soon as practicable but not later than the 30th day after receiving a request for reconsideration. Rule 134.600(o)(3) also provides, however, that the carrier's reconsideration procedures shall include a provision that the period during which the reconsideration is to be completed shall be based on the medical or clinical immediacy of the condition, procedure, or treatment. In other words, the more immediate the medical condition,

procedure, or treatment, the sooner the carrier must respond to the request for reconsideration. These provisions harmonize Rule 134.600 with parallel provisions in Sections 1305.354 and 4201.359 of the Texas Insurance Code.

Although not contained in the amendments to Rule 134.600, the Division announced that it would be eliminating the DWC Form-062, Explanation of Benefits.