CLIENT NEWSLETTER

RDG THE LAW OFFICE OF RICKY D. GREEN, PLLC

April 5, 2012

Dear Reader,

The Division sent out a memorandum dated April 3, 2012 regarding adopted amendments to preauthorization, concurrent utilization review and voluntary certification of health care. The amended rules were adopted on March 26, 2012 and become effective on July 1, 2012. The Division stated, ""With the adoption of these amendments, which include paper explanation of benefits requirements, the (DWC) will eliminate the DWC Form-062, Explanation of Benefits."

One of the most important of the new provisions (New §134.600(u)) reiterates the Division's requirement that all peer review doctors either be utilization review agents or work for a company that is a utilization review agent.

Some of the other adopted amendments include the following:

- An amendment to §134.600(a)(4) clarifies that a division-granted exemption for work hardening or work conditioning programs from preauthorization and concurrent review requirements only extends to services that are consistent with the Division's treatment guidelines.

- An amendment to §134.600(f) provide that requests for preauthorization must now also include the name of the injured employee; the name of the requestor and requestor's professional license number or national provider identifier, or injured employee's name if the injured employee is requesting the preauthorization; the name and professional license number or national provider identifier of the health care provider who will render the health care if different than the requestor; and the facility name and the facility's national provider identifier, if applicable.

- An amendment to §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.

- An amendment to §134.600(o)(2) extends the deadline for an insurance 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."

- An amendment to §134.600(o)(3) provides that "[i]n addition to the requirements in this section, the insurance 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."

Continued…

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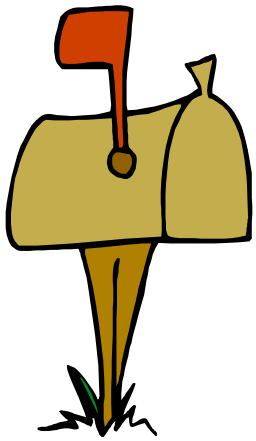
- An amendment to §134.600(o)(5) provides that a request for preauthorization for the same health care can only be resubmitted when the requestor provides objective clinical documentation to support a substantial change in the injured employee's medical condition or objective clinical documentation that demonstrates that the injured employee has met clinical prerequisites for the requested health care that had not been met before submission of the previous request.

- An amendment to §134.600(p)(4) provides that preauthorization is required for all work hardening or work conditioning services if the proposed services are requested by a non-exempted work hardening or work conditioning program or by a division exempted program if the services will exceed or are not addressed by the division's treatment guidelines. The amendment also provides that the preauthorization requirement of subsection (p)(12) does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits).

- An amendment to §134.600(q)(2) provides that concurrent review is required for all work hardening or work conditioning services if the proposed services are requested by a non-exempted work hardening or work conditioning program or by a Division exempted program if the services will exceed or are not addressed by the Division's treatment guidelines as described in subsection (p)(12).

- An amendment to §134.600(t) provides that an insurance carrier must maintain accurate records to reflect information regarding requests for reconsideration and requests for medical dispute resolution, in addition to information regarding requests for preauthorization or concurrent utilization, review approval/denial decisions, and appeals.

- A new §134.600(u) provides that "[for] the purposes of this section, all utilization review must be performed by an insurance 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 Insurance Code, Chapter 4201 and Chapter 19 of this title."



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