Legislative Update- Bills passed by the Texas Legislature and DWC Rules implementing the Legislation

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A. Legislation enacted by the 80th Texas Legislature

The Office of Injured Employee Counsel (OIEC) was established March 1, 2006 as a result of House Bill (HB) 7 during the 79th Texas Legislature. In December 2006, the OIEC issued a report to the 80th Legislature recommending legislation on a number of subjects. Included in the recommendations were: (1) enhancements to the return-to-work pilot program for small employers, (2) require all peer reviews to be performed by health care providers licensed in Texas, (3) authorize Benefit Review Officers to issue interlocutory orders at or up to 3 days after a benefit review conference, and (4) allow Ombudsmen access to an injured employee's medical records at no cost. Commissioner of Insurance Mike Geeslin also issued a report to the 80th Legislature in December 2006, recommending legislation on a number of subjects. Included in his recommendations were: (1) allow the penalty provisions in the Penal Code to apply to workers' compensation fraud, (2) authorize The Texas Department of Insurance to regulate Third Party Administrators, and (3) allow group health carrier who bill the injured worker in error to bill to the workers' compensation carrier even when the bill is submitted later than 95 days from the date the service was provided. As shown below, a number of these recommendations were enacted into law.

H.B. 34. This bill makes it an administrative violation for an insurance adjuster, case manager, or other person who has authority under the Texas Workers' Compensation Act to request performance of a service affecting the delivery of benefits to an injured employee or who actually performs such a service, including peer reviews, required medical examinations or case management, if the insurance adjuster, case manager, or other authorized person offers to pay, pays, solicits, or receives an improper

inducement relating to the delivery of benefits to an injured employee; or improperly attempts to influence the delivery of benefits to an injured employee, including through the making of improper threats. H.B. 34 is effective for violations committed on or after September 1, 2007.

H.B. 472. Amends Texas Insurance Code Chapter 4151 and requires third party administrators performing administrative services in connection with workers' compensation benefits to obtain a certificate of authority from the Texas Department of Insurance. The bill amended the definition of administrator to include persons collecting premiums or adjusting or settling claims for workers' compensation benefits, and expands the regulatory requirements for administrators. The amended definition also adds delegated entities and workers' compensation networks that administer claims for an insurer. The law adds an exemption for affiliates that are acting as administrator on behalf of a certified self insurer.

H.B. 473. Amends the Texas Labor Code to allow for deviation from fee guidelines by informal or voluntary network contracts and lists specific information that informal and voluntary networks are required to provide to the Texas Department of Insurance, Division of Workers' Compensation. This bill requires informal and voluntary networks to be certified as workers' compensation health care networks under Texas Insurance Code Chapter 1305 no later than January 1, 2011. This bill took effect on September 1, 2007, except for the provision regarding all carriers and certified networks which is effective as of January 1, 2011. This bill also reinstated the authority of the Benefit Review Officer to consider a request for interlocutory order for the payment or suspension of benefits, allows the opposing party the opportunity to respond

before issuance of the interlocutory order, and allows the Benefit Review Officer to issue an interlocutory order if determined to be appropriate. Of interest is the fact that Senate Bill 1169 authorizes the Subsequent Insurance Fund to reimburse insurance carriers for the overpayment of benefits paid as a result of a designated doctor's opinion that is later reversed or modified.

H.B. 724. Perhaps the most significant of the bills passed by the 80th Legislature. This bill restored the right to a hearing in medical disputes. Parties to a medical necessity or medical fee dispute now have an opportunity to administratively appeal a medical dispute resolution decision to either a contested case hearing (CCH) held by the Division of Workers' Compensation (DWC) or the State Office of Administrative Hearings (SOAH). An appeal to DWC is allowed for retrospective medical necessity disputes where the amount billed does not exceed $3,000, medical fee disputes in which the amount of reimbursement sought does not exceed $2,000, and prospective and concurrent medical necessity disputes. An appeal to SOAH is allowed for disputes where the dollar amounts in dispute exceed those allowed for CCH. This new appeal process applies to medical disputes that are currently pending for adjudication by DWC; that may be remanded to the DWC; or that may arise on or after September 1, 2007. The law became effective September 1, 2007. This bill also provided a reimbursement procedure for an accident or health insurer to recover amounts paid for health care services provided to an injured employee from the workers' compensation carrier in cases where an injury is determined to be compensable. Accident or health insurers may access dispute resolution for disputes over a failure to respond to or a reduction or denial of a reimbursement request. The law is effective for compensable injuries that occur after September 1,

2007. In addition, the definition of "Legal Beneficiary," in death benefits case was amended to add an "eligible parent" to the list of legal beneficiaries eligible for death benefits where there are no other legal beneficiaries.

H.B. 886. Amends the Texas Labor Code's small employer return-to-work pilot program. This bill gives small employers the option of submitting a preauthorization plan to DWC for workplace modifications to accommodate an injured employee's return to work. An approved modification plan guarantees that expenses incurred will be reimbursed to the small employer unless the modifications differ materially from the employer's proposal. Small employers may be financially compensated up to $2,500 for the cost of the workplace modifications. This bill became effective May 15, 2007.

H.B. 888. This bill enacted one of the Office of Injured Employee Counsel's (OIEC) legislative recommendations. It allows an Ombudsman to request and receive from health care providers at no cost to OIEC the medical records of an injured employee. The insurance carrier must reimburse the health care provider for the cost of the medical records. The law became effective June 15, 2007.

H.B. 1003. Amends Texas Labor Code Section 413.031 and provides that, notwithstanding Texas Insurance Code Section 4202.002 relating to the independent review organization (IRO), an IRO that uses doctors to perform reviews of health care services provided under the Texas Labor Code or Texas Insurance Code Chapter 1305, may only use doctors licensed in Texas. The definition for an IRO as used in the Labor Code is the same as in Insurance Code Chapter 1305. The law is effective for reviews of health care services provided under a claim for workers' compensation benefits that are conducted on or after September 1, 2007.

H.B. 1005. This bill amends the Texas Labor Code to clarify that a healthcare provider who fails to submit a medical bill within 95 days after the services are provided to the injured employee does not forfeit the right to reimbursement if the provider submits proof that the bill was timely filed with a group accident and health insurer or a Health Maintenance Organization that issues coverage under which the injured employee is covered or a workers' compensation insurance carrier other than the carrier liable for the reimbursement; or, the commissioner of workers' compensation determines that the failure to timely submit the medical bill resulted from a catastrophic event. The provider must submit the claim to the correct insurer within 95 days of being notified of the erroneous submission. This law applies to a claim for payment related to health care services rendered on or after September 1, 2007.

H.B. 1006. Amends the Texas Labor Code and the Texas Insurance Code to require that utilization review agents and insurance carriers use doctors licensed in Texas for performing utilization review or review conducted under the Workers Compensation Act or Texas Insurance Code Chapter 1305. The bill provides that the definitions for "credentialing" and "retrospective review" in Texas Labor Code Chapter 401 are the same as in Texas Insurance Code Chapter 1305, and that the definitions for "utilization review" and "Utilization Review Agent" are the same as in Texas Insurance Code 4201.

H.B. 2004. This bill requires that doctors performing peer review, utilization review, independent review, required medical examination or as a designated doctor must be certified in the specialty appropriate to the care the injured employee is receiving. The bill further requires that providers reviewing dental or chiropractic services must be

licensed in these specific areas. The bill also provides that a member of the medical quality review panel, other than a chiropractor, reviewing a workers' compensation case must also be certified in a specialty appropriate to the care the injured employee is receiving. The law became effective September 1, 2007 and applies only to reviews of health care service provided under a claim for workers' compensation benefits that are conducted on or after that effective date.

S.B. 458. Amends the definition of "health care" found in Texas Labor Code Section 401.011 to include the fitting, training, change or repair of a "prosthetic" or "orthotic" device. "Prosthetic" and "orthotic" are defined terms in this bill. The bill also amends the Texas Insurance Code relating to workers' compensation health care networks to add a reference to the Labor Code definition of those devices.

S.B. 471. Amends the Texas Insurance Code to require the Commissioner of Insurance to establish by rule the information and reporting requirements that must be reported on workers' compensation claims and removes provisions specifying such information and requirements. It also authorizes the Commissioner to reduce or eliminate reporting requirements for insurance companies whose workers' compensation insurance business falls below a specific minimum premium volume established by the Commissioner.

S.B. 1627. This bill provides that a person who commits an offense of fraud under the Texas Labor Code Chapter 418 (Criminal Penalties) may be prosecuted under that chapter or any other applicable state law, including the Texas Penal Code. These changes became effective June 15, 2007.

B. DWC adopted rules

Disability Management. The Division of Workers' Compensation amended Rule 137.41 and adopted a new Rule 137.49. The adopted amendment to Rule137.41 incorporates the new Rule137.49 into the Disability Management rules that establish and set forth the terms, conditions, and requirements for the return to work pilot program. New Rule 137.49 establishes the procedures and requirements for the optional preauthorization plan whereby small employers may submit a proposal plan to the Division of Workers' Compensation that describes the workplace modifications and other changes that the employer proposes to make to accommodate an injured employee's return to work. This new rule also provides that if the Division of Workers' Compensation approves the employer's proposal, the Division of Workers' Compensation will guarantee reimbursement of the expenses incurred by the employer in implementing the modifications and changes from the return-to-work account.

Subsection (a) of new Rule 137.49 specifies who is eligible to apply for a guaranteed reimbursement of expenses from the return-to-work account. This subsection states that an "eligible employer," which is defined by Labor Code Section 413.022(a) (2) and Section 137.42(2), may apply for a guaranteed reimbursement of expenses. This subsection also states that an eligible employer may apply for a guaranteed reimbursement of "eligible expenses." "Eligible expense" is defined by Rule 137.42(3).

Subsection (b) of Rule 137.49 specifies how an eligible employer applies for a guaranteed reimbursement of expenses. This subsection requires the employer to submit to the Division a of Workers' Compensation properly completed Preauthorization Proposal Plan (DWC Form – 008) that includes a description of the proposed

modifications and changes, the estimated costs of those modifications and changes, and a copy of the Division of Workers' Compensation's "Work Status Report" from the injured employee's examining doctor.

Subsection (c) of Rule 137.49 provides that an incomplete proposal plan may be denied or returned to the employer for additional information while Subsection (d) provides that the Division of Workers' Compensation will make the Preauthorization Proposal Plan form available on the Division of Workers' Compensation's website.

Subsection (e) requires the return-to-work account administrator to review each submitted proposal plan in accordance with Rule 137.48. This subsection provides that the administrator may approve or deny the proposal plan in whole or in part or request additional information. The administrator must promptly notify the employer in writing of the approval or denial of the employer's proposal plan.

Subsection (f) sets out the process the employer must follow to obtain reimbursement while Subsection (g) requires the Division of Workers' Compensation to reimburse the employer the costs the employer incurred in making the approved modifications and changes. This subsection permits the Division of Workers' Compensation to deny reimbursement if the Division of Workers' Compensation determines that the modifications and changes differ materially from the proposal plan.

Medical Reimbursement. The Division of Workers' Compensation amended Rule 134.1 and adopted a new Rule 134.2. The amendments to Rule 134.1 were to address rule name changes. New Rule 134.2 allows the Commissioner of Workers' Compensation to identify areas of the state in which access to health care providers is less available (under served) and to adopt appropriate standards, guidelines, and rules

regarding the delivery of health care in those areas. In specifying workers' compensation underserved areas, the Division of Workers' Compensation utilized three criteria simultaneously: a ZIP Code that was not in a designated Medicare Health Professional Shortage Area (HPSA), a ZIP Code that had at least one Division approved request for a case-by-case exception to the appointment of a provider who was not on the Division's Approved Doctor List (ADL), and a ZIP Code that had no ADL provider listed. Using those three criteria, the Division has designated 122 of the 4,254 Texas ZIP Codes as eligible for a 10 percent incentive payment to providers who will treat workers ' compensation covered patients.

Medical Fee Guidelines. Rather than modifying the 2002 Medical Fee Guideline two new Rules 134.203 and 134.204 were adopted to create a separation of the conversion factors for Medicare-based fee schedules from workers' compensation specific services and reimbursements that are currently combined in the 2002 Medical Fee Guideline. New Rule 134.203 relates to medical fees for reimbursements predominantly based on conversion factors and Medicare. New Rule 134.204 relates to medical fees for reimbursement of workers' compensation specific codes, services, and programs that are specific to the Texas workers' compensation system. The new Rules apply to medical services provided on or after March 1, 2008, and contain changes that allegedly provide for fair and reasonable reimbursement in the current health care market. Rule 134.202 will remain in effect for reimbursements related to professional medical services provided between August 1, 2003 and March 1, 2008.

The Division of Workers' Compensation claims that with two separate Rules, any future amendments will be easier for the Division to of Workers' Compensation to

change and for system participants to implement. New Rule 134.203 relates to medical fees for reimbursements predominantly based on conversion factors and Medicare. New Rule134.204 relates to medical fees for reimbursement of workers' compensation specific codes, services, and programs that are supposedly needed in the Texas workers' compensation system but are not as dependant on the Resource-Based Relative Value Scale(s) (RBRVS) and Medicare methodologies.

New Rule 134.203 adopts two conversion factors. The two conversion factors were established in consultation with the Division of Workers' Compensation Medical Advisor pursuant and in consideration of the amendments made by House Bill 7 in 2005. The conversion factor of $52.83 for calendar year 2008 is to be used for all professional service categories, with the exception of surgical procedures when performed in a facility setting, such as a hospital or an ambulatory surgical center (ASC). This "non-facility" conversion factor is based on the Medicare Economic Index (MEI) used by CMS to develop its adopted 2008 conversion factor. Texas Labor Code Section 413.011 requires that reimbursement be fair and reasonable although there are some who contend this new Rule does not provide for such.

The second conversion factor of $66.32 for calendar year 2008 is to be used for surgical procedures when performed in a facility setting, such as a hospital or ASC. This conversion factor is based on the average reimbursement differential between reimbursement rates for surgical services and overall services of those state workers' compensation systems using the Resource Based Relative Value Scale (RBRVS) as listed in Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2006 (Workers' Compensation Research Institute, 2006). This $66.32 conversion factor also

takes into consideration the alleged limited availability of health care providers with the specialized expertise necessary to provide those services. The Division of Workers' Compensation relied up a report by the Texas Medical Association in their 2006 Survey of Texas Physicians Research Findings, there has been a dramatic loss of access to surgical specialties by injured employees since the adoption of Rule134.202.

Performance Based Oversight. The Division of Workers' Compensation adopted new Rule180.19 concerning performance-based oversight (PBO). The Division of Workers' Compensation was criticized for its last PBO report. The new Rule provides that there will be three regulatory tiers – high, average, and poor. Placement in a tier is determined by reviewing the assessed participant's degree of compliance and success in meeting the key regulatory goals relative to other assessed participants. What this supposedly means is there will be a bell curve to rate the system participants. The rule also provides what incentives will be offered to those entities placed into a regulatory tier (including those specifically listed in Texas Labor Code §402.075(f)) as required for the high performers, and those available to system participants regardless of tier placement. The assessments s will be conducted at least once each biennium.

Hospital Facility Fee Guidelines. The Division of Workers' Compensation adopted a new Outpatient Hospital Fee Guideline and its third Inpatient Hospital Fee Guideline. The current Inpatient Hospital Fee Guideline is found in Rule 134.401. New Rule 134.403 contains the Outpatient Hospital Fee Guideline and new Rule134.404 contains the Inpatient Hospital Fee Guideline. These new guidelines are referred to as Hospital Facility Guidelines.

New Rule134.403 provides an outpatient hospital fee guideline, which uses the Medicare system as a framework for the billing and reimbursement methodology and establishes standardized formats used in the group health and Medicare systems. New Rule 134.404 provides a new inpatient hospital fee guideline that applies reimbursement methodologies that reflect current Medicare prospective payment practices, including a Medicare-based outlier methodology to replace the previous charge-based stop-loss methodology.

Diagnosis Related Groups (DRGs) were adopted by CMS (at that time named the "Health Care Financing Administration") in the early 1980s for the reimbursement of hospital inpatient services, and this methodology is widely used by other payors. DRG groups are based on clinically similar diagnoses requiring similar amounts of resources. Each inpatient stay is grouped into a single DRG, and each stay is reimbursed at a predetermined per discharge rate for the DRG, regardless of billed amount or length of inpatient stay, though CMS makes adjustments called "outliers" to the reimbursement to reflect extraordinarily high cost cases. To determine outliers, the base payment rates are multiplied by individual DRG weights and adjusted for local market conditions, or geographic adjustments. Adjustments for local market conditions are accomplished through the wage index, the capital geographic adjustment factor, and the large urban add-on.

In setting the payment rates in the Outpatient Payment Prospective System (OPPS), CMS covers hospitals' operating and capital costs for the services they furnish. Ambulatory Payment Classifications (APCs) were adopted by CMS in August 2000, and the APC methodology is not as widely used by other payors. There are more than 808

APCs based on clinically similar items and services requiring similar amounts of resources. An outpatient visit may include multiple APCs, each APC having a predetermined rate. CMS determines the payment rate for each service by multiplying the APC relative weight for the service by a conversion factor. The relative weight for an APC measures the resource requirements of the service and is based on the median cost of services in that APC. CMS makes outlier adjustments to reflect unusually high cost cases. Additional payments to the facility are made for pass-through items based on hospital specific cost information (e.g., drugs and implantables). Some outpatient services (e.g., physical therapy, occupational therapy, durable medical equipment, and laboratory) are reimbursed using the Medicare physician fee schedules rather than being grouped into an APC.

Hospital services account for a significant portion of the medical benefits paid in the Texas workers' compensation system. Payments to hospitals for calendar year 2005 services totaled approximately $205 million, which represents approximately 20 percent of total medical payments. These payments were split relatively evenly between inpatient services ($93 million) and outpatient services ($111 million).

The Division of Workers' Compensation has adopted Payment Adjustment Factors (PAFs) for use in new Rule 134.403 and Rule 134.404. For the Inpatient Hospital Fee Guideline, the adopted PAFs are 143 percent and 108 percent of Medicare. The adopted PAFs for the Outpatient Hospital Fee Guideline are 200 percent and 130 percent of Medicare. Hospitals will have the option to choose the higher or lower PAF for each guideline. The higher PAF contemplates the inclusion of reimbursement for surgically implanted devices as a part of the DRG. If the hospital chooses the lower PAF,

the surgically implanted device(s) will be reimbursed separately at cost plus an administrative expense fee. The administrative expense fee is set at 10 percent or $1,000 per item add-on, whichever is less, but will not exceed $2000 in add-on's per admission. If the hospital is reimbursed the lower PAF, the cost of the surgically implanted device(s), including the administrative expense fee, will not be considered in determining eligibility for outlier payments.

If implants are reimbursed separately, then the administrative fee of $1000.00 or ten percent of the implant cost, per item add-on, which ever is less will be allowed. However the maximum implant administrative fee is limited to $2,000 per admission.

Health Facility Fees. The Division of Workers' Compensation has amended Rule 134.402, the Ambulatory Surgical Center (ASC) Fee Guideline. The current Rule134.402 provides for ASCs to be paid at 213.3% of the Medicare ASC reimbursement amount. In addition, Rule 134.402 requires surgically implanted devices to be reimbursed separately at the amount actually paid for the device by the ASC. Because of Medicare changes to how it reimburses ASCs, the current Rule could cause dramatic increases in ASC reimbursements.

The rule amendments continue the use of reimbursement structures and amounts at the Medicare ASC 2007 rates for services provided on January 1, 2008 through August 31, 2008.

C. DWC proposed rules

At the time this paper went to printing the Division of Workers' Compensation has proposed but not yet adopted new Medical Dispute Resolution Rules 133.305, 133.307, and 133.308. The proposed amendments incorporate administrative-level

hearings into the Division of Workers' Compensation Medical Dispute Resolution process as a step between medical dispute resolution (MDR) or independent review organization (IRO) review and judicial review in resolution of medical fee and medical necessity disputes. The proposed amendments also address licensing and professional specialty requirements for doctors performing reviews for IROs.

Under Texas Labor Code Section 413.031(k), (k-1) and (k-2), a party is entitled to a hearing before the State Office of Administrative Hearings (SOAH) for retrospective medical necessity disputes in which the amount billed is greater than $3,000.00. A party aggrieved by a final decision of the SOAH may seek judicial review conducted in the manner provided for judicial review of a contested case under Chapter 2001, Subchapter G of the Texas Government Code. Texas Labor Code Section 413.0311 is applicable to a party to a medical fee dispute in which the amount sought in reimbursement does not exceed $2,000, a party appealing an IRO decision regarding determination of the retrospective medical necessity for a health care service for which the amount billed does not exceed $3,000, and a party appealing an IRO decision regarding determination of the concurrent or prospective medical necessity for a health care service.

Under proposed Rule 133.307 parties to fee disputes in which the amount of reimbursement sought by the requestor in its request is greater than $2,000.00 may request a hearing before SOAH. Proposed 133.307 provides that to request a contested case hearing before SOAH, a party shall file a written request for a SOAH hearing with the Division's Chief Clerk of Proceedings in accordance with Division of Workers' Compensation Rule 148.3. Proposed Rule 133.307 also requires the party seeking review of the MDR decision to deliver a copy of its written request for a hearing to all other

parties involved in the dispute at the same time the request for hearing is filed with the Division of Workers' Compensation.

Under proposed Rule 133.307 parties to fee disputes in which the amount of reimbursement sought by the requestor in its request is less than or equal to $2,000.00 dollars may appeal the MDR decision by requesting a contested case hearing held by the Division of Workers' Compensation. Proposed Rule 133.307 provides that to request a Division of Workers' Compensation contested case hearing, a written request for a Division of Workers' Compensation contested case hearing must be filed with the Division of Workers' Compensation's Chief Clerk of Proceedings no later than the 20th day after the date on which the decision is received by the appealing party. The request must be filed in compliance with the Division of Workers' Compensation rules; and that the party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute at the same time the request for a hearing is filed with the Division of Workers' Compensation.

Proposed Rule 133.307 allows requests for hearing to be submitted to a Division of Workers' Compensation location other than the Division of Workers' Compensation's Chief Clerk of Proceedings in Austin. Requests for hearing may be made at a local field office of the Division of Workers' Compensation. This filing with other Division of Workers' Compensation offices is only applicable to Division of Workers' Compensation conducted contested case hearings.

Proposed Rule 133.307 would also limit the evidence that could be considered at a Division of Workers' Compensation conducted contested case hearing to documentary evidence exchanged and to witnesses reasonably disclosed in said documentary evidence

during medical dispute resolution except upon a showing of good cause, and that parties may not raise issues regarding liability, compensability, or medical necessity at a contested case hearing for a medical fee dispute.

The proposed amendments to Rule 133.308 creates a new subsection (d), which specifies that an IRO doctor performing a review under Rule 133.308 shall be a doctor who is qualified by education, training and experience to provide all health care reasonably required by the nature of the injury to treat the condition until further material recovery from or lasting improvement to the injury can no longer reasonably be anticipated.

The proposed amendments to Rule 133.308 clarify that a requestor shall file a request for independent review with the insurance carrier that actually issued the adverse determination or the carrier's utilization review agent that actually issued the adverse determination no later than the 45th calendar day after receipt of the denial of reconsideration, and clarify that a carrier shall notify the Texas Department of Insurance (Department) of a request for independent review on the same day the request is received by the carrier or its utilization review agent.

Another proposed amendment to Rule 133.308 specifies that in a contested case hearing, a decision issued by an IRO carries presumptive weight that may only be overcome by a preponderance of evidence-based medical evidence to the contrary.

A public hearing will be held on February 4, 2008, to take public comment on the proposed medical dispute resolution rules but this author firmly believes the rules will adopted as proposed.