# Medical Necessity Dispute Resolution Trends

# 2014-2020

Workers' Compensation
Research & Evaluation Group

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TDI Division of Workers' Compensation

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- other matters relevant to the cost, quality, and operational effectiveness of the workers' compensation system.

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# Acknowledgments

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Dr. Congying Sun managed the project, conducted the analyses, interpreted the results, and authored the report. Amy Lee provided methodological support, historical context, and co-authored the report. Researchers Botao Shi, Conrado Garza, and Hari Luintel provided valuable editorial comments.

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# Executive Summary

Generally, there are three types of medical disputes that can happen in the workers' compensation system:

- **fee disputes** - disputes over the amount of payment for an injured employee's medical services;
- **preauthorization disputes/concurrent review medical necessity disputes** - disputes about the medical necessity of future or current medical treatments that the insurance carrier denied; and
- **retrospective medical necessity disputes** - disputes about the medical necessity of treatments already provided and billed.

Independent Review Organizations (IROs) resolve medical disputes. IROs are made up of panels of doctors and other health care providers. TDI certifies IROs to resolve medical necessity disputes for both workers' compensation and group health claims. Most medical necessity disputes are between the health care provider and the insurance carrier's utilization review agent, but an injured employee may also ask for a medical necessity dispute if the dispute involves medical care that has not yet been provided (i.e., preauthorization or concurrent review disputes).

## Key Findings

**Frequency**: Medical necessity disputes have declined significantly since the 2005 legislative reforms.

**Network:** Non-network claims accounted for most of the medical necessity disputes filed from 2014 to 2020 (about 8 out of 10).

**Types of Medical Necessity Disputes:** More than 9 out of 10 medical necessity disputes were associated with preauthorization denials. More than half involved three types of services: surgery, radiology, and physical medicine services.

**Dispute Outcomes**: Most IRO decisions upheld the insurance carrier's utilization review denial. Those outcomes have not changed significantly since 2005.

**Timeliness**: Preauthorization and concurrent review disputes were resolved in an average of 18-20 days. The mean time frames to resolve past medical necessity disputes varied, but these disputes were extremely infrequent.

Once received, the IRO assigns the dispute to a doctor or other health care provider who has the training and experience appropriate for the type of medical care in dispute. The IRO must issue a written decision explaining whether the IRO agrees (i.e., "upholds") or disagrees with the insurance carrier's utilization review agent's decision to deny a medical service, along with a summary of the documentation reviewed, the clinical basis for the IRO's decision, and a summary of the IRO reviewer's qualifications. If the medical service in dispute involves a non-network claim, the IRO must take note of DWC's adopted treatment guidelines when reviewing the dispute. If the IRO does not follow the treatment guideline recommendations when deciding a dispute, the IRO must explain why in the written decision. Either party may appeal an IRO decision to a DWC administrative law judge and then to district court.

While the medical necessity dispute process has remained stable for more than 15 years, occasionally stakeholders raise concerns that the process results in unnecessary denials or delays of medical care for injured employees. Although TDI and DWC do not have data on the number and outcome of preauthorization and concurrent review requests for medical care, they are able to gauge the health of the

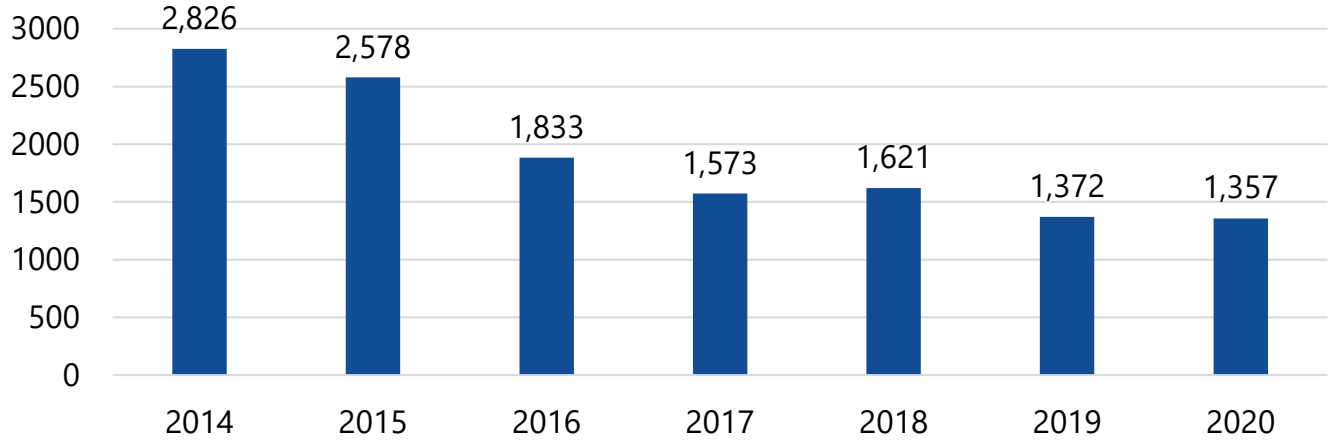
workers' compensation utilization review process by tracking the number and outcome of medical necessity disputes that health care providers' and injured employees' request. This report provides an overview of medical necessity dispute trends over the last few years.

## Frequency of Medical Necessity Disputes

Previous DWC Biennial Reports have shown that health care providers or injured employees filed significantly fewer medical disputes after the 2005 legislative reforms (House Bill 7, 79th Legislature).[1] Several factors contributed to this decline, including fewer workers' compensation claims filed, the adoption of health care networks in 2006, and DWC's adoption of evidence-based treatment guidelines in 2007.[2]

From January 2014 to December 2020, health care providers and injured employees filed a total of 13,210 medical necessity disputes. About 550 health care providers submitted 80 percent of these disputes. Figure 1.1 shows that medical necessity disputes declined since 2005 and this trend has continued in recent years. In 2014, DWC received 2,826 medical disputes. By 2020, that number fell to 1,357 (a reduction of about 52 percent).

**Figure 1.1: Total Number of Medical Necessity Disputes, 2014-2020**

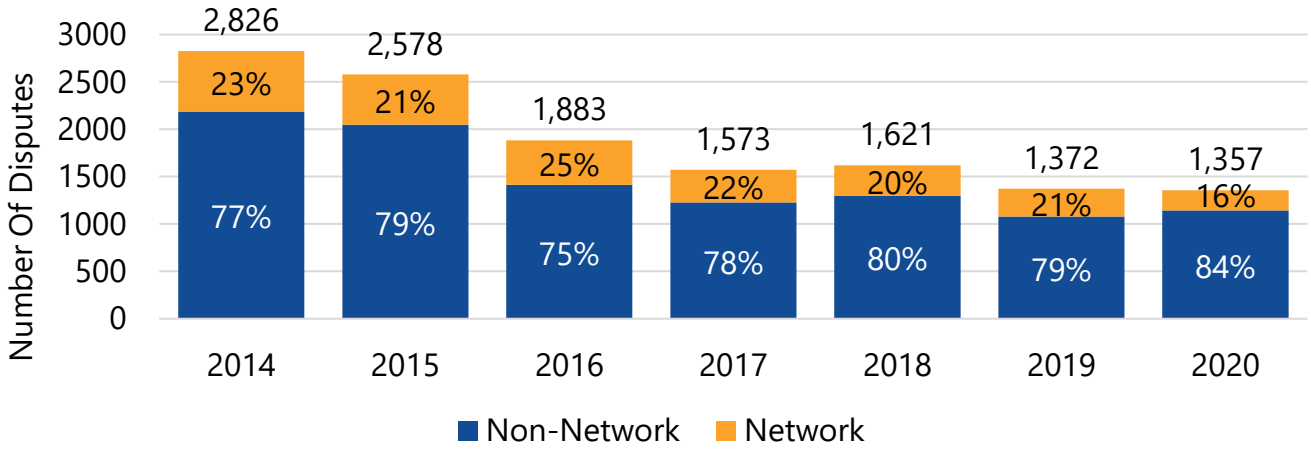



Source: Texas Department of Insurance and the Workers' Compensation Research and Evaluation Group, 2021.

Figure 1.2 shows that non-network claims accounted for most of the medical necessity disputes (about 8 out of 10). The proportion of medical disputes for network claims was between 20 and 25 percent from 2014 to 2019, and then dropped to 16 percent in 2020. Although almost half of new workers' compensation claims are treated in networks,[3] network medical necessity disputes are less frequent since networks contract with health care providers and those contracts include requirements to follow the network's treatment guidelines and preauthorization requirements.

[1] See www.tdi.texas.gov//reports/dwc/documents/2020dwcbienlrpt.pdf.
[2] See 28 Texas Administrative Code Rule 137.100.
[3] See www.tdi.texas.gov/reports/wcreg/documents/netrc2020.pdf.

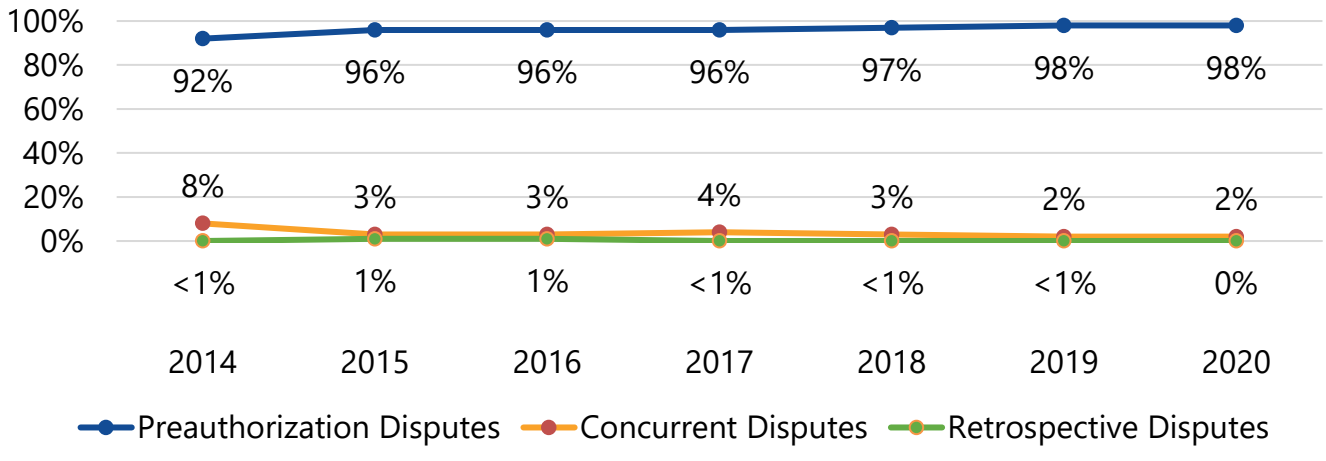
**Figure 1.2: Distribution of Medical Necessity Disputes by Network Status, 2014-2020**




Source: Texas Department of Insurance and the Workers' Compensation Research and Evaluation Group, 2021.

As Figure 1.3 shows, most medical necessity disputes in recent years (more than 9 out of 10) were associated with preauthorization denials. Concurrent review disputes declined (from 8 percent in 2014 to 2 percent in 2020), and retrospective medical necessity disputes only represented about 1 percent of medical necessity disputes. In 2020, health care providers and injured employees did not request any retrospective medical necessity disputes.

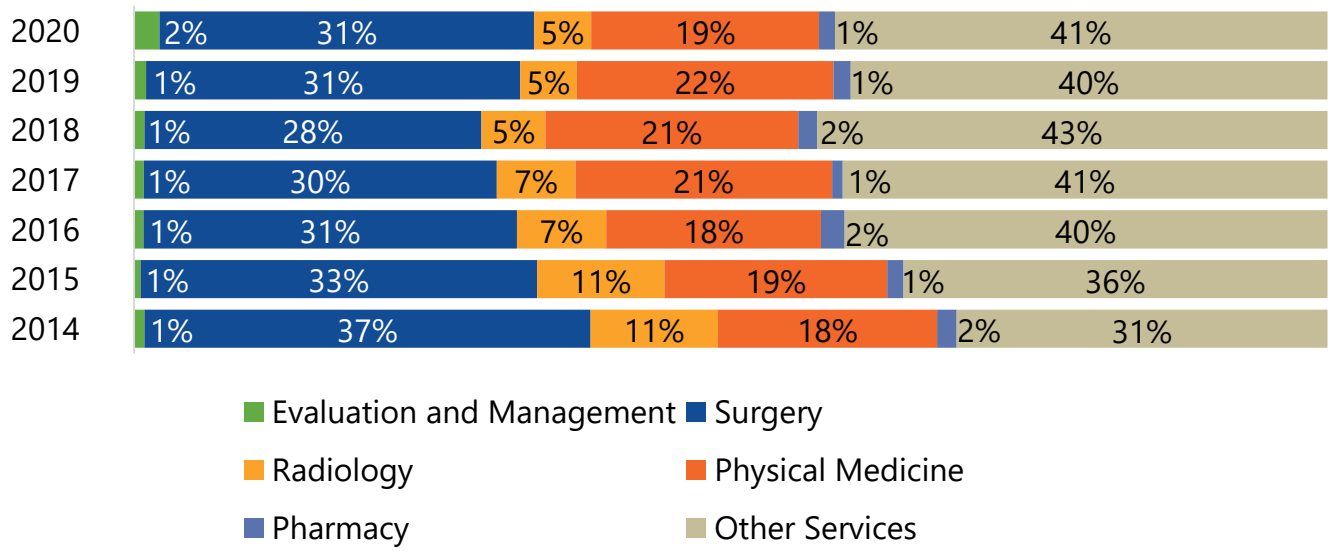
**Figure 1.3: Distribution of Medical Necessity Disputes by Type of Medical Dispute, 2014-2020**




Source: Texas Department of Insurance and the Workers' Compensation Research and Evaluation Group, 2021.
Note: Percentages may not always add up to 100 percent due to rounding.

Figure 1.4 shows that more than half of the medical necessity disputes involved three types of services: surgery, radiology, and physical medicine services. Overall, these percentages varied slightly from 2014 to 2020. Only 1 or 2 percent of disputes involved evaluation and management services (i.e., office visits) and pharmacy. The small number and percentage of pharmacy disputes is notable, given that DWC adopted a pharmacy closed formulary in 2011 that requires preauthorization for any "not-recommended" or "N drugs" before they can be dispensed to injured employees. In 2018, DWC also adopted rules that added all compounded prescription medications to the list of prescription drugs that require preauthorization.

**Figure 1.4: Distribution of Medical Necessity Disputes by Type of Service, 2014-2020**




Source: Texas Department of Insurance and the Workers' Compensation Research and Evaluation Group, 2021.
Note: "Other services" includes anesthesia, pathology and laboratory, and other services.
Note: Percentages may not always add up to 100 percent due to rounding.

## Outcomes of Medical Necessity Disputes

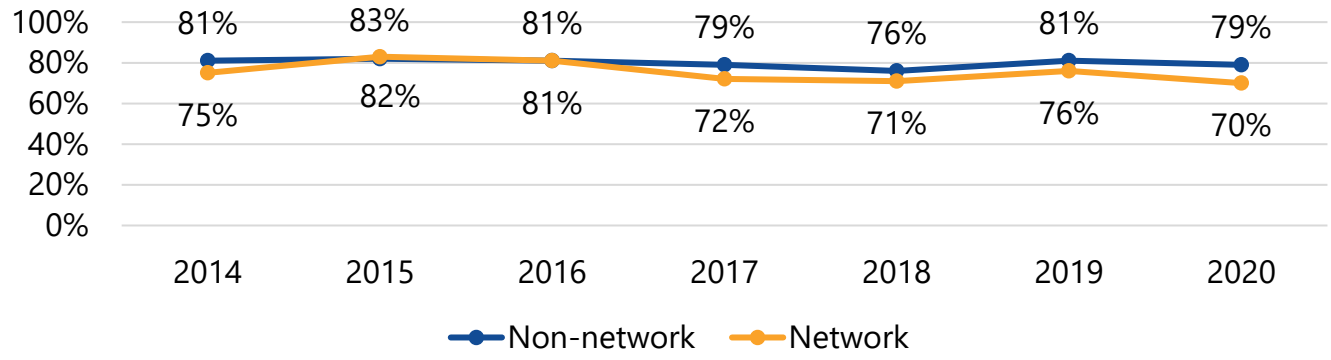
As part of the 2001 and 2005 legislative reforms, the Texas Legislature required the use of evidence-based treatment guidelines by health care providers and insurance carriers to help determine what medical services were appropriate for specific work-related injuries. This was an effort to promote high-quality medical care and reduce unnecessary friction between stakeholders. These treatment guidelines also served as the basis for DWC's statutorily required pharmacy formulary adopted in 2011 and 2013, which requires health care providers or injured employees to get preauthorization for any pharmaceutical drug that is excluded from DWC's pharmacy formulary.

Health care providers must follow DWC's adopted treatment guidelines when treating injured employees with non-network claims and the network's treatment guidelines when treating injured employees with network claims. Similarly, insurance carriers must follow these evidence-based treatment guidelines when processing preauthorization/concurrent review requests or reviewing medical bills (retrospective review).

As a result, most medical necessity disputes resulted in decisions that upheld the insurance carrier's utilization review denial (see Figure 2.1). This is because the Labor Code requires IROs to take note of DWC's adopted treatment guidelines when resolving disputes and to document in their decision why they diverged from the adopted treatment guideline. Although Figure 2.1 provides information about dispute outcomes from 2014 to 2020, these dispute outcomes have not changed significantly since 2005. In 2005, about 71 percent of preauthorization dispute decisions upheld the insurance carrier's utilization review denial.[4] In 2020, about 70 percent of disputes involving network claims and 79 percent of disputes involving non-network claims upheld the insurance carrier's utilization review decision. IROs tended to uphold the insurance carrier's utilization review decision more often for disputes involving non-network claims compared with network claims.

It should be noted that while the statute provides an opportunity to appeal an IRO decision to a DWC contested case hearing, few IRO decisions are appealed. In 2020, parties requested only 51 medical contested case hearings.

**Figure 2.1: Percentage of Network and Non-Network Disputes where the IRO Upheld the Insurance Carrier's Utilization Review Decision, 2014-2020**




Source: Texas Department of Insurance and the Workers' Compensation Research and Evaluation Group, 2021.

## Timeliness of Medical Necessity Disputes

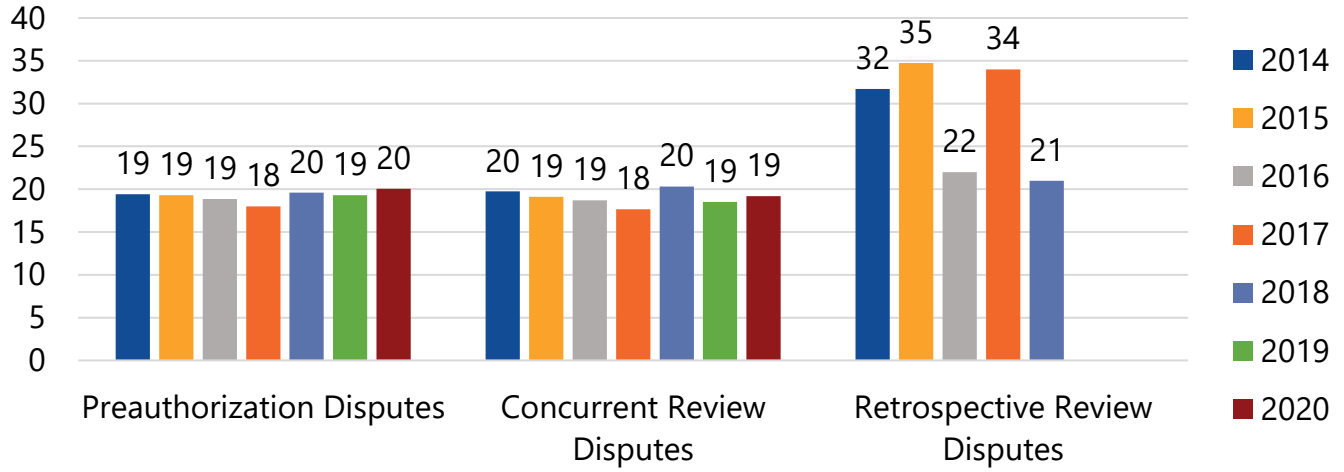
Texas Insurance Code Chapter 4202 and Texas Administrative Code §133.308 require IROs to resolve medical necessity disputes within specified time frames. IROs must resolve preauthorization and concurrent review disputes no later than 20 days from the date the IRO receives the dispute and no later than 30 days from the date the IRO receives the review fee when doing retrospective reviews of medical necessity. This analysis uses the date the IRO receives the dispute to measure timeliness for all types of medical necessity disputes, since the date the IRO receives the review fee is not captured in the data. Therefore, the

[4] See www.tdi.texas.gov/reports/wcreg/documents/biennial2018.pdf.

retrospective review disputes may actually be resolved timely depending on the date the IRO fee was received, even though the dispute timeframes exceed 30 days in this analysis.

Generally, IROs have met these time frames, especially for preauthorization and concurrent review disputes.[5] As Figure 3.1 shows, the mean time frame to resolve preauthorization and concurrent review medical necessity disputes was between 18 and 20 days. While the mean time frames to resolve retrospective medical necessity disputes varied over time, these disputes were infrequent. In 2016 and 2018, the average retrospective review dispute duration was close to 20 days, while in 2014, 2015, and 2017, the average dispute duration was above 30 days. IROs received three retrospective review disputes in 2019 but did not render a decision on them. No retrospective review dispute was filed in 2020.

**Figure 3.1: Average Number of Days to Resolve Medical Necessity Disputes by Type of Dispute**




Source: Texas Department of Insurance and the Workers' Compensation Research and Evaluation Group, 2021.
Note: Timeliness of medical necessity disputes was measured by taking the average number of days between the date the IRO received the dispute and the date the IRO rendered a medical dispute decision.

## Summary

This report presents baseline information about medical necessity dispute resolution trends in the Texas workers' compensation system. Overall, disputes continue to decline due to a variety of factors, including fewer claims, and the creation of networks and treatment guidelines. Most disputes involve preauthorization denials, and non-network claims account for most medical necessity disputes. IROs tend to uphold the insurance carrier's utilization review decision in most medical necessity disputes. The analysis also shows that medical necessity disputes are resolved timely – most within 19 or 20 days from the date the IRO received the dispute.

[5] The timeliness of resolving medical disputes in the system has also improved over time. In 2005 (pre-House Bill 7), the system resolved a preauthorization or concurrent review dispute in an average of 59 days and a retrospective medical necessity dispute in an average of 123 days.

There have been concerns raised by stakeholders about the effectiveness and value of the current utilization review process within the Texas workers' compensation system. While this report does not analyze the frequency and outcome of preauthorization and concurrent review requests or the percentage of medical services retrospectively denied for medical necessity reasons, this report does provide a snapshot of how these utilization review decisions fare once they have been disputed and reviewed by IROs. The downward trend of medical necessity disputes coupled with the consistency of IRO decisions on these disputes over time indicates that the utilization review process is not increasing system-wide friction among stakeholders. However, this does not mean that the utilization review process does not warrant consistent monitoring and improvement.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