

CHAPTER 137. DISABILITY MANAGEMENT
SUBCHAPTER A. GENERAL PROVISIONS
§137.1
SUBCHAPTER B. RETURN TO WORK
§137.10
SUBCHAPTER C. TREATMENT GUIDELINES
§137.100
SUBCHAPTER D. REQUIRED TREATMENT PLANNING
§137.300

1. **INTRODUCTION.** The Commissioner of the Division of Workers' Compensation (Division), Texas Department of Insurance, adopts new §§137.1, 137.10, 137.100 and 137.300 concerning disability management including return to work, treatment guidelines, and treatment planning. The sections are adopted with changes to the proposed text as published in the September 1, 2006 issue of the *Texas Register* (31 TexReg 7090).

2. **REASONED JUSTIFICATION.** The new sections, as well as chapter and subchapter title changes, are necessary to implement changes as a result of House Bill (HB) 7, enacted by the 79th Legislature, Regular Session. Sections 137.1, 137.10, 137.100, and 137.300, are necessary to implement HB 7 amendments to Labor Code §413.011 that require the Commissioner of Workers' Compensation (Commissioner) to adopt by rule treatment guidelines that are evidence-based, scientifically valid, outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. The purpose of the treatment guidelines is to ensure the quality of medical care and to achieve effective medical cost control. HB 7 also amended Labor

Code §413.011 to require the Commissioner to adopt by rule return to work guidelines for the purpose of enhancing timely and appropriate return to work. HB 7 further amended Labor Code §413.018 to require the Commissioner by rule to provide for the periodic review of medical care provided in claims in which guidelines for expected or average return to work time frames are exceeded. The Commissioner also adopts the new titles of Chapter 137 and Subchapter B.

The Division posted an informal draft of the new sections relating to disability management on February 17, 2006, and invited public input, which included a stakeholder meeting on March 22, 2006. Prior to proposal, the Division considered the merits of various published return to work guidelines and treatment guidelines. Several stakeholder and work group meetings were held to discuss the disability management concept and rules related to guidelines. Meetings were also held with nationally recognized guideline publishers. During a March 23, 2006 meeting, representatives of the various guidelines made presentations to Division staff and workers' compensation system stakeholders regarding the development and use of their individual guidelines. The Division reviewed and evaluated these guidelines, received stakeholder input, and considered the recommendations of the Division's Medical Advisor and the former Texas Workers' Compensation Commission Medical Advisory Committee's Return to Work workgroup. Based on this review and input, the Division made the selection of the most current edition of *The Medical Disability Advisor, Workplace Guidelines for Disability Duration* (MDA), as the Division

return to work guideline, and the most current edition of the *Official Disability Guidelines-Treatment in Workers' Comp* (ODG), published by Work Loss Data Institute (WLDI), as Division treatment guidelines.

All system participants benefit from the adopted disability management rules because this chapter establishes a framework to foster, facilitate, and improve communications among injured employees, health care providers, employers, insurance carriers, and the Division by establishing treatment guidelines, planning benchmarks, and return to work goals and time frames. Disability management is a process designed to optimize health care and return to work outcomes for injured employees in an effort to avoid delayed recovery. The adoption of the disability management tools establish defined expectations for system participants. Clarity for system participants should result in fewer disputes and less intervention by the Division.

The MDA provides a basis for health care providers, insurance carriers, injured employees, employers, and the Division to objectively establish or develop return to work goals or a return to work plan, based on guideline established expectancies for disability duration, that include expected return to work time frames for the timely, safe and medically appropriate return of injured employees to productive work. Return to work guidelines establish a framework to foster, facilitate and improve communications among injured employees, health care providers, employers, insurance carriers and the Division regarding return to work goals, expected return to work time frames and proposed job duty

and activity modifications. Such communication is essential in returning injured employees to safe, medically appropriate and productive work.

The MDA provides reviewed and updated content. This publication provides disability duration estimates for normal recovery periods, and natural language descriptions of the most common illnesses and injuries of working people. In addition, MDA includes detail on co-morbidities to modify normal recovery periods. Features include: alphabetical listings of diagnoses and procedures; an alphabetical index; a medical code index; a glossary of terms; a section regarding management of medical absences; and diagnosis and procedure topics.

During the time between publication of editions, Reed Group, the publisher, collects information from the users of the MDA to improve and refine the guidelines. This development process includes data collection, topic identification, research and analysis of duration data and development of draft duration tables and manuscripts. The Reed Group's Medical Advisory Board's review and input regarding draft manuscripts is consolidated for publication of the final manuscript.

In evaluating the MDA guideline, the Division considered that the disability duration guidelines published by Reed Group are based on statistical analyses of actual outcome data. The MDA guidelines also integrate clinical judgment and experience, and clinical assessment of the minimum, optimum, and maximum expectancies of disability duration as the most constant variable in predicting a

length of disability. In developing the new edition of the MDA, the statistical data used was derived from an additional 1.65 million new disability cases between the years 2001 and 2003.

The Division treatment guidelines outline the frequency and extent of services presumed to be medically necessary and appropriate for a compensable injury. The ODG meets the provisions outlined in Labor Code §413.011(e) that require Division treatment guidelines to be evidence-based, scientifically valid and outcome-focused, and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care.

The ODG guidelines are evidence-based. Labor Code §401.011 (18-a) defines "evidence-based medicine" to mean "the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts, and treatment and practice guidelines in making decisions about the care of individual patients." The RAND Institute defined *evidence-based* and *peer-reviewed* to mean, at a minimum, a systematic review of literature published in medical journals included in the National Library of Medicine's MEDLINE. RAND, INSTITUTE FOR CIVIL JUSTICE and RAND HEALTH, *Evaluating Medical Treatment Guideline Sets for Injured Workers in California* xvi-xviii (2005), available at www.rand.org (RAND, *Evaluating Medical Treatment Guideline Sets for Injured Workers in California*). Finding that systematic reviews of the literature are standard and essential features of an evidence-based guideline

development process, RAND determined that ODG was evidence-based and peer-reviewed, criteria for inclusion in the RAND study of treatment guidelines.

The ODG evidence-based guidelines are linked directly to the evidence in the studies and references relevant to the specific treatment conclusion. The publication incorporates abstracts of studies with appropriate references and citations to the complete original research. This evidence is continuously updated by integrating the findings of new studies as they are conducted and released. The ODG treatment guidelines are well known throughout the health care and insurance industries and meet the criteria for inclusion in the National Guideline Clearinghouse (NGC) maintained by the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services. NGC requires a clinical practice guideline to meet the criteria for inclusion provided at www.guideline.gov/about/inclusion.aspx. For instance, the clinical practice guideline must contain systemically developed statements that include recommendations, strategies, or information that assists physicians, other health care practitioners, and patients in making decisions about appropriate health care for specific clinical circumstances. A clinical practice guideline must have been produced under the auspices of medical specialty associations, relevant professional societies, public or private organizations, government agencies at the Federal, State, or local level, or health care organizations. A clinical practice guideline developed and issued by an individual not officially sponsored or supported by one of the above types of organizations does not meet the inclusion

criteria for NGC. Corroborating documentation must have been produced and verified that a systematic literature search and review of existing scientific evidence published in peer reviewed journals was performed during the guideline development. A guideline will be included in NGC if corroborating documentation can be produced and verified detailing specific gaps in scientific evidence for some of the guideline's recommendations. Additional requirements for NGC inclusion are that the full text of the guideline must be available upon request in print or electronic format, in the English language, and the guideline must be current and the most recent version produced.

The ODG is comprehensive. Based on representations by WLDI, ODG covers conditions that represent over 99% of workers' compensation costs. The ODG allows health care providers and insurance carriers access to treatment information in one comprehensive and consistently organized source. This comprehensive approach enhances the usability of the guidelines and facilitates a consistent application of the guidelines in claims management systems and utilization review processes.

ODG contains prescreened links on their website to treatment resources concerning many workers' compensation conditions. The links are followed by a short description or excerpt from each of the website's contents, which will allow health care providers to quickly provide injured employees with personalized, patient-friendly information pertaining to recovery by printing the most relevant pages. This offers the patient information describing the injury, self-help

methods for speeding recovery and suggested therapies for regaining functionality and productivity.

The ODG guidelines are scientifically valid. ODG follows the steps integral to the process of creating evidence-based treatment guidelines. WLDI describes its methodology for formulating the ODG treatment guidelines in the Work Loss Data Institute, ODG Methodology Outline at www.odg-disability.com/methodology_outline.pdf. ODG includes a detailed document entitled *Appendix, ODG Treatment in Workers' Comp, Methodology Description Using the AGREE Instrument, 1571-1582* (2006). This Appendix provides an extensive explanation of how ODG Treatment meets each of the 23 criteria established by the *AGREE* instrument, including the quality domain describing the rigorous means of developing guidelines. The *AGREE* instrument is an appraisal instrument used to evaluate treatment guidelines after they have been developed. (RAND, *Evaluating Medical Treatment Guideline Sets for Injured Workers in California*, p. 29). The RAND study determined that ODG, and the other four guidelines studied, scored high in the rigor of development domain by clearly describing the methods used to search for evidence and formulate recommendations. (RAND, *Evaluating Medical Treatment Guideline Sets for Injured Workers in California* p. 32).

The ODG guidelines are outcome-focused. The information in ODG is a compilation of the current medical evidence that reflects the outcomes of new studies and clinical trials. This data is integrated into the guidelines to reflect

advances in medical technology, drug therapies, or alternative medicine techniques. Application of this information in a clinical setting has a positive impact in shaping injured employee return to work outcomes. The *ODG Foreword* notes that studies included in the ODG are focused on determining what is best for the injured employee. Additionally, the *ODG Foreword* reports the results of a study conducted in Ohio by CompManagement, Inc. The pilot study found that “following adoption of ODG statewide, results at CompManagement demonstrate[d] savings in medical costs of 64 percent, in lost days of 69 percent, and minimized treatment delays.”

Further, the ODG guidelines are designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care by providing clear data on optimum frequency and duration of treatments. The ODG treatment guidelines explain that claims should ideally be managed based on the details of the case using the “Procedure Summary.” The ODG Procedure Summary includes possible therapies and diagnostic methods, and provides a summary and reference to the most recent medical evidence with an indication of whether the procedure is recommended, not recommended, or under study. Within a Procedure Summary, ODG provides guidelines for instruction that include specific utilization review criteria often presented in an algorithmic format. Quality and timely care in workers’ compensation cases have become synonymous with overall cost containment. The level of cost containment is directly proportional to the degree of over-utilization of medical treatment

currently experienced within the system. Therefore, ODG satisfies the statutory requirement for adoption of treatment guidelines in the State of Texas.

Treatment planning promotes appropriate management of work-related injuries or conditions by the treating doctor. The treating doctor assumes an essential role in the coordination of care on behalf of an injured employee. In accordance with Labor Code §408.023(l) and §408.025(c), the responsibility of a treating doctor to effectively manage and maintain efficient utilization of health care is fulfilled through the process of treatment planning. Treatment planning fosters a framework for the treating doctor to facilitate and improve communications among injured employees, health care providers, employers, insurance carriers, and the Division. The Division expects the treatment planning process to lead to consensus between the treating doctor and insurance carrier regarding health care to be provided. In a situation where the referral doctor becomes primarily responsible for the employee's health care for a work-related injury, the injured employee may complete and submit a change of doctor form to the Division requesting that the referral doctor become the treating doctor in accordance with Labor Code §408.022, and §§126.9 (relating to Choice of Treating Doctor and Liability for Payment) and 180.22 (relating to Health Care Provider Roles and Responsibilities). If the referral doctor agrees to become the treating doctor and the Division grants the employee's request to change treating doctors, the "new" treating doctor will assume the responsibility of treatment planning.

Following publication of the proposed new sections in the *Texas Register* on September 1, 2006, the Division held a public hearing on October 5, 2006, and received comments suggesting changes to the sections as published. In response to comments made at the hearing and written comments from interested parties, the Commissioner is adopting these sections with some changes to the proposal as published. Throughout the adopted sections, the Division has made editorial and grammatical changes for clarity. The adopted sections should be read in conjunction with Labor Code §§413.011 and 413.018, and other statutes and sections as applicable.

§137.1. In subsection (a), as a result of commenters questioning whether the proposed rules apply to every claimant or only when there is a finding that the injured employee is at risk for delayed recovery, the Division deleted the proposed term *at risk for* and substituted the phrase *to avoid* to indicate that all injured employees not subject to a certified workers' compensation network are included in the disability management concept in order to avoid delayed recovery. In subsection (d), in response to a few comments to include provisions of §133.308 (relating to Medical Dispute Resolution by an Independent Review Organization) the Division deleted language regarding scientific medical evidence and the submission of documentation for dispute resolution as those criteria would be duplicative of the requirements of §133.308.

§137.10. In subsection (a), in response to a comment to clarify that system participants should not reference the treatment information in the MDA, the

Division added the phrase “excluding all sections and tables relating to rehabilitation, (MDA), published by the Reed Group, Ltd.,” to clarify that the use of the MDA is limited to the disability duration values as guidelines for the evaluation of expected return to work time frames. In subsection (e), in response to comments questioning the potential use of MDA to reduce or deny benefits, the Division changed the language to indicate that, in accordance with Labor Code §409.022, Division return to work guidelines may not be used as the sole justification or the only reasonable grounds for reducing, denying, suspending, or terminating income benefits to an injured employee. In subsection (f), in response to a comment questioning the standard for evidence-based medicine in establishing disability durations for diagnoses not included in the guidelines, the Division added language to clarify that for diagnoses or injuries not addressed by the Division return to work guidelines, system participants shall apply the principles of evidence-based medicine to establish disability duration parameters and return to work goals. In subsection (g), in response to a comment requesting sufficient time to implement necessary system changes, the Division added an effective date of May 1, 2007, for consistency with §§137.100 and 137.300.

§137.100. In subsection (a), in response to a comment requesting clarification to exclude ODG return to work references when using the ODG treatment guidelines, the Division added language to indicate exclusion of the ODG return to work pathways. In subsections (a), (d), and (f), in response to comments requesting clarification of the relationship between treatment guidelines,

treatment planning, and preauthorization, the Division added language to clarify that treatments or services may be provided if preauthorized in accordance with §134.600 (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) or §137.300. In response to comments requesting the deletion of proposed subsection (d) which provided for preauthorization requests for care within the guidelines, the Division removed the permissive language and re-numbered the subsections. In subsection (f), in response to comments requesting clarification of the relationship between treatment guidelines, treatment planning, and preauthorization, the Division revised the subsection to clarify the treatment planning process. In subsection (h), in response to comments requesting a sufficient time frame for the effective date of implementation, the Division changed the date of the applicability of this rule to May 1, 2007.

§137.300. In response to many comments concerning treatment planning, the Division added the term *Required* prior to *Treatment Planning* in the section title to duplicate terminology used in §134.600. In subsection (a), in response to a comment recommending a substitution of the term *reasonably* for *all*, the Division added *reasonably* prior to the term *all*. In the same subsection, in response to comments questioning the duration of a treatment plan, the Division deleted the phrase *specified period of time* and added language clarifying that treatment plans shall include treatments and services *for a minimum of 30 days*.

In response to commenters' concern regarding when treatment plans are required, the Division added language in subsection (a)(1) establishing that treatments and services anticipated to exceed or not included in Division treatment guidelines or Division treatment protocols will require treatment planning if *the treatment or service will be provided after the greater of: (A) 60 days from the date of injury; or (B) the optimum days listed in §137.10 of this title (related to Return to Work Guidelines)*. In subsection (a)(2), the Division added the phrase *or Division protocols* after the term *Division treatment guidelines*. Also in subsection (a)(2), in response to a comment recommending the deletion of the reference to return to work guidelines since the lack of a diagnosis being included in the Division's return to work guidelines is not relevant when addressing the appropriateness and medical necessity of health care in the Texas Workers' compensation system, the Division deleted the phrase *or Division return to work guidelines*. In subsection (b), in response to requests from commenters for the removal of permissive language allowing preauthorization requests through treatment planning for care that is within the treatment guidelines, the Division deleted the phrases *treating doctor may submit a treatment plan* and *to the insurance carrier for approval*. In the same subsection, the Division added the phrases *a treatment plan is not required* and *unless the treatments or services are submitted as part of a treatment plan in accordance with subsection (a) of this section* to clarify that a treatment plan for care within the guidelines is not required unless the treatments or services are

submitted as part of a comprehensive treatment plan to indicate all of the care the injured employee will receive. In response to comments requesting clarification about treatments and services on the preauthorization list versus treatment planning, the Division added language in subsection (c) to clarify that specific treatments and services listed in §134.600 may be submitted for preauthorization through a health care provider by following the requirements of §134.600. However, subsection (c) clarifies that even if a treatment or service is on the preauthorization list in §134.600, a health care provider must coordinate with the treating doctor to submit a treatment plan if any of the requirements of §137.300(a) apply. In subsection (d), in response to comments concerning the responsibilities of treating doctors and health care providers in the treatment planning process, the Division added the phrase *and identifies services that require a treatment plan pursuant to subsection (a) of this section, the health care provider shall confer with the treating doctor to develop the required treatment plan in accordance with subsection (a) of this section*, and removed the phrase *the health care provider shall submit the treatment plan to the treating doctor for submission to the insurance carrier*. In accordance with Labor Code §§401.011(42), 408.021(c), 408.023(j), and 408.025(c), and in response to comments regarding the responsibilities of a treating doctor in the treatment planning process, the Division added new subsections (e) and (f) to clarify that the treating doctor serves as the focal point for health care provided to an injured employee by health care providers that are not the treating doctors. Subsection

(e) provides that the treating doctor shall confer with the health care providers, insurance carriers, employers, or injured employees as necessary to develop the treatment plan. The treatment plan is required to include the identity and contact information of the health care providers involved in the delivery of health care proposed in the treatment plan. Subsection (f) states that the treating doctor shall inform the parties identified in subsection (e) of the approval or denial of the treatment plan. In subsection (g), in response to comments requesting a sufficient time frame for the effective date of implementation, the Division changed the date of the applicability of this rule to May 1, 2007.

3. HOW THE SECTIONS WILL FUNCTION. The title of Chapter 137 is changed to "Disability Management" to better encompass all of the adopted subchapters and rules, in addition to future rulemaking initiatives under the umbrella of the disability management philosophy. In addition, the title of Subchapter B is changed to "Return to Work" to broaden the scope of the rules contained in this subchapter. Chapter 137 is divided into four subchapters: General Provisions; Return to Work; Treatment Guidelines; and Treatment Planning.

Section 137.1 describes disability management as a process designed to optimize health care and return to work outcomes for injured employees to avoid delayed recovery in the Texas workers' compensation system. This section explains how disability management tools should be applied in the workers'

compensation system. This section also addresses the relationship between these tools and other utilization review or adjudication processes.

Section 137.10 identifies the most current edition of *The Medical Disability Advisor, Workplace Guidelines for Disability Duration* (MDA), excluding all sections and tables relating to rehabilitation, as the Division return to work guidelines for the evaluation of expected or average return to work time frames. The section provides information on how to obtain a copy of the return to work guidelines. The section provides that the Division return to work guidelines are presumed to be a reasonable length of disability duration. The section specifies the use of the return to work guidelines by health care providers, insurance carriers, injured employees, and employers. The section permits the consideration of co-morbid conditions, medical complications, or other factors that may influence medical recoveries and disability durations as mitigating circumstances when establishing return to work goals or revising expected return to work durations and goals. The section states that disability durations in the guidelines are not absolute values and do not represent specific periods of time at which an injured employee must return to work; instead, the values represent points in time at which additional evaluation may occur if an injured employee has not experienced a full medical recovery and returned to work. The section establishes that for all diagnoses and injuries not addressed by the Division return to work guidelines, system participants are required to establish disability duration parameters in accordance with the principles of evidence-based

medicine. Further, the section prohibits an insurance carrier from using the return to work guidelines as the sole justification or the only reasonable grounds for reducing, denying, suspending, or terminating income benefits to an injured employee. This section is effective on or after May 1, 2007.

Section 137.100 identifies the most current edition of the *Official Disability Guidelines – Treatment in Workers' Comp* (ODG), published by Work Loss Data Institute, as Division treatment guidelines, with the exclusion of the return to work pathways. The section requires health care providers to provide treatment in accordance with the Division treatment guidelines unless the treatment or service requires preauthorization in accordance with §134.600 or §137.300. The section provides information on how to obtain a copy of the Division treatment guidelines. The section provides that health care provided in accordance with the Division treatment guidelines is presumed reasonable and is also presumed to be health care reasonably required. The section also establishes that for health care not provided in accordance with the Division treatment guidelines, an insurance carrier is only liable for the costs of those treatments or services when provided in a medical emergency or if the treatments and services were preauthorized in accordance with §§134.600 or 137.300. The section allows the insurance carrier to retrospectively review health care provided within the Division treatment guidelines, and if appropriate, deny payment when the insurance carrier asserts that health care provided was not reasonably required. The section further requires an insurance carrier to support its assertion with documentation of

evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017. Section 137.100 informs health care providers that preauthorization in accordance with §134.600 or submission of a treatment plan in accordance with §137.300 may be required when proposed treatments and services exceed, or are not included, in the treatment guidelines. The section prohibits an insurance carrier from denying treatment solely because the diagnosis or treatment is not specifically addressed by the Division treatment guidelines or Division treatment protocols. The section applies to health care provided on or after May 1, 2007.

Section 137.300 requires treatment planning for certain circumstances. The section requires the identification of all reasonably anticipated health care treatment and services to be provided to the injured employee for a minimum of 30 days in a treatment plan. The section provides that treatment plans remain consistent with the principles of evidence-based medicine and health care reasonably required. The section further provides that when a treatment plan is required, a treating doctor shall submit the treatment plan for preauthorization. Section 137.300 states that when a health care provider identifies treatments and services that require preauthorization in accordance with §134.600, the treatments and services may be submitted for preauthorization by a health care provider in accordance with §134.600 unless the health care is submitted as part of a treatment plan in accordance with §137.300(a). Therefore, specific treatments and services listed in §134.600 may be submitted for preauthorization

through a health care provider by following the requirements of §134.600. However, the section provides that even if a treatment or service is on the preauthorization list in §134.600 a treatment plan is required if any of the criteria of §137.300(a) apply. The section provides that a treating doctor shall submit a treatment plan to the insurance carrier for preauthorization. The section specifies that if the health care provider is not the treating doctor and identifies services that require a treatment plan, the health care provider shall confer with the treating doctor to develop the required treatment plan. Section 137.300 provides that the treating doctor shall confer with the health care providers, insurance carriers, employers, or injured employees, as necessary to develop the treatment plan with the identity and contact information of the health care providers involved in the delivery of care proposed in the treatment plan. The section requires the treating doctor to inform the health care providers of the approval or denial of the treatment plan. Section 137.300 applies to health care provided on or after May 1, 2007.

These adopted sections do not apply to networks certified under Insurance Code Chapter 1305 pursuant to Labor Code §413.011(g) or political subdivisions with contractual relationships under Labor Code §504.053(b)(2).

4. SUMMARY OF COMMENTS AND AGENCY'S RESPONSE TO COMMENTS.

§134.650: Commenters recommend the simultaneous repeal of rule 134.650, as that rule undermines the effectiveness of the disability management process, utility of the treatment guidelines, and increase in medical costs to the system.

Agency Response: The Division disagrees that the simultaneous repeal of §134.650 is required at this time, and may consider this recommendation at a time after the implementation of treatment and return to work guidelines.

General: Commenter states that the success of the Division's ability to bring doctors back into the system is dependent on the treatment of legitimately injured employees within reasonable time frames, without hassles, as opposed to no treatment at all.

Agency Response: Based on numerous stakeholder meetings the Division understands that there are many factors that impact the willingness of health care providers to practice in the workers' compensation system. Administrative burdens are of particular importance. The Division's position is that implementation of the disability management rules and concept will provide a framework to improve treatment and return to work outcomes for injured employees. Administrative burdens should ultimately decrease through the consistent application of these tools.

General: Commenter encourages the Division to consider comments received on proposed rules in order to remove barriers to reimbursement for physicians.

Agency Response: The Division appreciates all commenters' recommendations and changes are made from proposal based on comments

received. The Division anticipates these rules will facilitate system operations and bring more certainty to the medical billing and reimbursement process.

General: Commenters support the adoption of return to work guidelines and in general support the concept of treatment guidelines and treatment planning. These rules should result in increased communication among system participants and improved return to work outcomes for injured employees. Another commenter states the proposed rules should contribute positively to the effective and efficient treatment of injured employees, reduce treatment and return to work disputes, and help foster prompt and appropriate return to work. A commenter specifically supports the goals and aims of the proposed rules. By emphasizing evidence-based guidelines, outcomes for all system participants can be optimized.

Agency Response: The Division appreciates the support.

General: Commenter recommends that treatment guidelines be implemented appropriately and used to improve health care delivery, and not be used improperly as a standard of care, or by agents to deny medically necessary care.

Agency Response: The Division anticipates health care providers and insurance carriers will integrate the disability management concepts to assure effective and efficient health care and promote early and appropriate return to work for injured employees. The Division agrees that the adopted guidelines only

establish benchmarks for use in the system. Individual claims may require more or less treatment, or more or less recovery time based on the specifics of the injury. The disability management rules recognize this and a variance from the guidelines should be supported by documentation. In addition, the Division believes that treatment guidelines alone do not establish the legal standard of care for a physician in Texas but may provide the courts with a benchmark by which to determine clinical conduct in the workers' compensation system. Further, Labor Code, §413.011(e) prohibits the denial of treatment solely on the basis that the proposed treatment is not specifically addressed by the treatment guidelines. The Division will monitor the use of the disability management tools by all system participants to assure compliance with the intent of HB 7.

General: Commenters opine that extensive education of system participants is required if the guidelines are going to be used as intended by their authors and the Division.

Agency Response: The Division agrees that education is an important component and is developing initiatives to educate system participants on the appropriate application of the rules and guidelines.

General: Commenter recommends that if TDI adopts both MDA and ODG guidelines it should make them available on the Division's website so that any updates are instantly accessible. MDA and ODG could obtain a user fee from

TDI for the use of their guidelines. Commenter expresses concern over the conflict of interest in adopting guidelines, then forcing the health care provider community to purchase the costly guidelines in order to have access to the information.

Agency Response: The Division is unable to pursue the recommendation as it is beyond the scope of this rulemaking activity. Further, no discussions took place with the vendors on this topic and no “user fee” funds are in the Texas Department of Insurance (TDI) budget.

General: Commenters recommend a single product, ODG, to be used by system participants because two guidelines create an undue financial burden on stakeholders.

Agency Response: The position of the Division is that despite the cost, the use of two products, MDA for the Division's return to work guidelines and ODG for the Division's treatment guidelines, best serves the needs of injured employees to facilitate early and appropriate return to work.

General: Commenter recommends independent review organization (IROs), who will determine medical necessity of treatment plans, be additionally trained at a designated doctor level so they understand the complexity of these claims and the rehabilitative potential of stay-at-work/return-to-work planning.

Additionally, commenter recommends consideration be given for using trained, matched health care providers in the discernment of treatment planning disputes.

Agency Response: The Division agrees that IROs should be completely familiar with the Division's adopted disability management rules. However, it is outside the scope of statutory authority to regulate IROs through the disability management rules. The Division disagrees with the recommendation regarding matching health care providers. Standards related to the prospective review or retrospective review of medical care are currently defined in the Insurance Code Article 21.58A and Division rules and no additional clarification is needed in these rules. In addition, Insurance Code, Article 21.58A includes the requirements for peer-to-peer reviews.

General: Commenters recommend that as disability management rules are implemented, adjustments must also be made to the general medical fee schedule. Commenter suggests designated doctors and IROs reimbursement be considered for adjustment. Commenter states this would allow for continued adequate access to quality health care providers.

Agency Response: The Division agrees and adjustments to §134.202 may be required as disability management concepts are fully integrated into the workers' compensation system. The responsibilities of treating doctors and the administrative complexity of the system play an important role in setting appropriate rates and assuring adequate access to health care providers. In

establishing the rate included in the Medical Fee Guideline, the Labor Code requires the Division to consider many factors. The disability management rules, as well as other Division rules, will play a significant role in future revisions to designated doctor reimbursement. IRO fees are set by Department of Insurance rules Chapter 12, Subchapter E, §12.401, §12.402, and §12.403, and are outside the authority of the Division and these disability management rules.

General: Commenter states that although citing Labor Code §413.021 as an effective statutory provision, the rules do not implement the provisions of §413.021(e) requiring the Division to adopt rules necessary to collect data on return to work outcomes to allow full evaluation to success and barriers to achieving timely return to work after an injury.

Agency Response: The Division agrees that these rules do not include a specific data collection component. The adoption of these rules, however, sets benchmarks for potential use in evaluation of various components of the workers' compensation system.

General: Commenters observe the proposal preamble states ODG covers 99% of conditions, but this does not mean ODG covers 99% of services delivered.

Agency Response: The Division agrees.

General: Commenter suggests the Division begin immediately working on either a pharmacy formulary or treatment protocol for pharmaceuticals, particularly narcotics.

Agency Response: The Division acknowledges the commenters' recommendation and is currently in the initial phase of rule making to develop a closed formulary. Additionally, the Division notes that ODG has begun to add pharmaceutical information to the treatment guideline.

General: Commenters recommend clarification between the appropriate usages of the two guidelines. The proposal preamble leaves the impression that the return to work guidelines may be used to identify medical care to be delivered, which should be the function of the treatment guidelines.

Agency Response: The Division agrees. The language is changed in §137.10 and 137.100 to clarify the use of the adopted guidelines.

General: Commenter supports the disability management concept. A commenter supports the combination of MDA and ODG guidelines since both provide an excellent evidence-based and useable system for benchmarking purposes in the Texas workers' compensation system. Commenter states this combination provides the highest level of well-documented, up-to-date, unbiased, and usable evidence-based guidelines for system use. Commenter states the rules provide enhanced communication between system participants at the

ultimate benefit of assuring that the injured employees of Texas receive prompt and appropriate health care.

Agency Response: The Division agrees with commenter's assessment of the disability management concept.

General: Commenters support the disability management system outlined in the proposed rules as resulting in increased communication among system participants and improved return to work outcomes for injured employees. A commenter further supports the emphasis of evidence-based guidelines, as outcomes for all system participants can be optimized.

Agency Response: The Division appreciates the supportive comments.

General: Commenter states these rules are designed to favor and increase the balance of power toward the insurance carrier, to the unreasonable detriment of the injured employee. Commenter also states that it is unfair to infer that injured employees are less motivated to get better or return to work when claims are carefully researched, it will be noted that there are systematic denials of necessary treatment. There is also systematic lack of cooperation on behalf of employers to provide work within the work restrictions by the treating doctor.

Agency Response: The Division disagrees. The disability management concept and rules are designed to provide a framework to enhance treatment and return to work outcomes for injured employees. The tools establish

benchmarks to facilitate communication between system participants and formulate return to work plans. The benchmarks establish starting points, which may be adjusted based on the specific circumstances of the claim.

General: Commenter states both return to work and treatment guidelines should be used only as guidelines and benchmarks, and not as a monitor for health care accuracy of reasonable and necessary treatments. All parties, insurance carriers, injured employees, the Division, IROs, designated doctors, required medical examinations, peer reviewers, and preauthorization, should be required and allowed to substantiate when a treatment or disability exceeds or reduces the recommendations in the guideline for that specific injury.

Agency Response: The Division agrees that the adopted guidelines establish benchmarks for use in the system. The Division anticipates that health care providers and insurance carriers will integrate the disability management concept to assure effective and efficient health care and promote early and appropriate return to work for injured employees. The Division will monitor the use of the disability management tools by all system participants to assure compliance with the intent of HB 7. Individual claims may require more or less treatment or more or less recovery time based on the specifics of the injury. It is the intent of the Division that a variance from the guidelines should be supported by documentation.

General: Commenter states to require use of these guidelines is excessive management, creates new costs, adds new barriers to creating a workable environment for quality health care and will not be an incentive to bring quality health care providers into the system. Parts of these rules contradict root causes for the passage of HB 7.

Agency Response: The Division disagrees. Uncertainty of expectations leads to confusion and frustration for all system participants. Disability management rules provide guidelines that create reasonable expectations about the operation of the workers' compensation system. These benchmarks lead to consistency and more certainty for all stakeholders.

General: Commenter is discouraged that anyone could be convinced that the new workers' compensation system is improving the way injured employees are taken care of in Texas and provides anecdotal examples of this concern.

Agency Response: Commenter's concerns are noted, however, commenter's concerns are not related to the adopted sections.

General: Commenter is in receipt of stakeholder comments recommending treatment protocols for pharmaceuticals and narcotics. Commenter indicates ODG addresses the various pharmaceuticals and summarizes the medical evidence and the resulting recommendations. In particular, there is detailed

information on opioids and other narcotics in the Chronic Pain Section, which include definitive patient selection criteria to be used by medical providers.

Agency Response: The Division acknowledges the Chronic Pain Section of the ODG.

General: Commenter notes that HB 7 indemnifies the insurance carrier for any aggravation or worsening of symptoms ascribed to any delay of treatment brought on by the insurance carrier's officious behavior. Commenter states that the rules permit penalizing physicians who bill their usual and customary fees rather than billing the amount specified by the medical fee guidelines. Commenter also notes that the proposed rules will repel physicians from entering into the system.

Agency Response: The Division acknowledges the commenter's concern regarding HB 7 and disagrees the rules penalize physicians who bill their usual and customary fees. Fee and reimbursement topics are generally outside the scope of these rules. The Division disagrees the adopted rules will deter physicians from the workers' compensation system. The Division believes adoption and implementation of the disability management concept and associated rules will increase communication opportunities for system participants, bring structure and certainty to the process, and ultimately decrease administrative burdens for system participants.

§137.1: Commenter recommends that the Division consider in its Performance Based Oversight initiative, the doctors who consistently do not follow the treatment guidelines, or are consistent outliers of the treatment guidelines.

Agency Response: The Division is developing standards relating to Performance Based Oversight through a process that includes stakeholders. The language in §137.1 is permissive and allows the use of treatment and return to work guidelines throughout the Division's programs. The Performance Based Oversight initiative is best suited to develop an integration of the guidelines into the evaluation standards.

§137.1(a): Commenter questions whether the proposed rules apply to every claimant, or only when there is a finding that the injured employee is at risk for delayed recovery.

Agency Response: The Division clarifies that the disability management philosophy applies to all injured employees not subject to a certified workers' compensation network. Because the proposed term *at risk* was not clear, it is deleted in subsection (a). The phrase *to avoid delayed recovery* is substituted as it indicates that avoiding delayed recovery is appropriate for any injured employee.

§137.1(a): Commenter recommends adding standards to the rule for making determinations as to which employees are at risk for a delayed recovery. The

Division should identify the decision maker of an injured employee's at risk status. Commenter further recommends the Division develop training and testing for doctors to demonstrate medical expertise in determining at risk status. Commenter states that without at risk standards the determination would be a subjective assessment that has the ability to undermine the disability management process.

Agency Response: The Division agrees that there is confusion regarding the term "at risk." With the deletion of this term, there is no need to define or identify the criteria for being "at risk." All injured employees are included in the disability management concept in order to avoid delayed recovery.

§137.1(b): Commenters recommend the term "shall" be used in place of "may" to clarify that the Division will use the tools for all of the stated purposes. Commenters question the propriety and effectiveness of achieving better return to work and medical outcomes if the use of the guidelines by the Division remains permissive and not mandatory. One commenter states that if the Division renders a decision or takes an administrative action contrary to its guidelines, then the Division should explain, in writing, the facts that justify the Division's deviation from its guidelines.

Agency Response: The Division declines to make this change. Adopted subsection (b) pertains to the integration of these tools by the Division throughout all of its processes and, as such, regulatory language is not required here. The

Division will consistently apply the criteria in this subsection, but will maintain its independent duty to provide for exceptions as needed in order to accomplish the intent of HB 7 and other statutory provisions.

§137.1(d) and (b): Commenter states the guidelines should not be used to grade or assess the quality of any practitioner.

Agency Response: The Division disagrees that the guidelines require the grading or assessing of quality of a particular health care provider. However, Division activities relating to quality and performance may integrate standards including the benchmarks established by guidelines into the evaluation process of system participants.

§137.1(d): Commenter states the treatment guidelines should not be considered to carry presumptive weight in any decision of denial or recommended treatments.

Agency Response: The Division disagrees that treatment guidelines should not carry presumptive weight since it would be contrary to the provisions of §413.017(1) and §413.011(e) of the Labor Code and would impede implementation of HB 7.

§137.1(d): Commenter suggests defining “scientific medical evidence” or otherwise a doctor may submit scientific medical evidence only to have the

insurance carrier say it is not, which would not allow any variance from the guidelines.

Agency Response: The Division agrees that the use of “scientific medical evidence” is confusing or could lead to confusion between insurance carriers and health care providers. Consequently, the language has been deleted.

§137.1(d): Commenter supports this provision as written. The provision establishes the importance of medical policies for the workers' compensation system and should not be overridden by IRO decisions, which are made on a case-by-case basis.

Agency Response: The Division agrees.

§137.1(d): Commenters urge the Division to retain proposed rule language of §133.308(n)(1)(G) that requires the IRO to explain the specific basis for recommending treatment as that proposed rule relates to this subsection. To avoid confusion, commenters recommend duplicating language in proposed rule 133.308(n)(1)(G) that requires an IRO decision that is contrary to adopted treatment guidelines or protocols to provide the specific basis for the variance. Another commenter recommends rule inclusion that should the IRO determine a variance from the treatment guidelines, the IRO must reference scientifically based medical evidence, or the lack of efficacy of similar treatment previously provided to the claimant to support any variance from a treatment guideline, to

include the lack of efficacy of similar treatment as previously provided to the claimant.

Agency Response: The Division agrees that the IRO decisions should be fully explained and documented in accordance with applicable IRO rules. However, the Division disagrees that additional references to the IRO process are required in this section.

§137.1(d): Commenters state that while a medical necessity IRO decision may take precedence over adopted treatment guidelines, it would be incongruent with the presumption created by the statute as to the treatment guidelines to allow an IRO to simply ignore the treatment guidelines, or to know which citations are credible.

Agency Response: The Division agrees that Labor Code §413.017 provides that Commissioner adopted medical policies are presumed reasonable. However, these adopted sections do not provide for an IRO to ignore treatment guidelines and Division rule 133.308 establishes the criteria for an IRO decision that deviates from Division policies or guidelines.

§137.1(d): Commenter recommends added language to read, "In a medical necessity dispute, insurance carriers, health care providers and injured employees should submit scientific medical evidence 'based on appropriately peer-reviewed, double-blinded and fully vetted data' that establishes that a

variance from the adopted treatment guidelines or treatment protocols is reasonably required to cure and/or relieve the injured employee from the effects of the compensable injury.” The commenter states this would further define “scientific medical evidence” and answer the questions as to which citations are credible and who determines the veracity of the citations. Commenter further states this would assist a non-medically trained hearing officer to ensure the highest and most prevailing standard of care.

Agency Response: The Division disagrees that the recommended language to define scientific medical evidence is necessary. Language regarding requirements of documentation to be submitted in a medical necessity dispute has been deleted because this criterion would be duplicative of the requirements of §133.308 and would also be confusing.

§137.1(d): Commenter recommends changing the term “should” to “shall” so that the rule reads, “In a medical necessity dispute, insurance carriers, health care providers and injured employees ‘shall’ submit scientific evidence that establishes...” Commenter further recommends that subsection (d) be revised, written in plain language so that the case-by-case basis is made clearer.

Agency Response: The Division disagrees with commenter’s recommended language substitution or need for revision. This language in the subsection has been deleted because the specific requirements of the IRO process are included in §133.308 and such language is confusing and is not necessary in this section.

§137.10: Commenter believes the addition of a case management function is missing, but necessary in this rule proposal. Commenter recommends the payor reimburse the doctor for this case management function, which would include employer contacts and negotiated stay-at-work/return-to-work plans.

Agency Response: The Division disagrees that the basic form of medical case management is not addressed as the Division notes this is the role of the treating doctor in the workers' compensation system. These rules enhance the ability of the treating doctor to fulfill the requirements of §408.025 and §408.021 of the Labor Code by requiring increased communication between referral providers and the treating doctor for claims requiring treatment planning. The coordination of that comprehensive plan is the responsibility of the treating doctor. The Division acknowledges that case management services referred to in §413.021 of the Labor Code have not yet been proposed. The Division intends future rule-making activities to address this form of case management services as well as other components of the disability management chapters and rules. Case management activities are currently addressed in §134.202, however, adjustments to the Medical Fee Guideline may be required as disability management concepts are fully integrated into the workers' compensation system.

§137.10: Commenter states stakeholders should be equally accountable for the employees' return to work and encourages the Division to consider educating employers about their responsibilities for accepting injured employees back to work.

Agency Response: The Division agrees that all system participants have a responsibility to encourage and facilitate return to work. The Division provides focused educational efforts with employers emphasizing return to work through seminars, publications, and website information. The Division believes these rules provide tools to enhance the exchange of information between system participants to develop more effective return to work plans and improve return to work outcomes.

§137.10(a) Commenter supports the adoption of the MDA Guidelines for the following reasons: MDA is accepted globally as an industry standard; MDA guidelines are scientifically valid and evidence based; MDA uses the best available external evidence based on 5 million records of observed data by those managing the injury or illness and/or paying the claim; MDA guidelines dramatically reduce lost time days; MDA creates a mechanism for communication between health care providers and patients whereby everyone starts on the same page; MDA sets recovery expectations for patients and gives health care providers a framework for counseling and guiding patients regarding return to work expectations; and MDA uses the best available external evidence

based on 5 million records of observed data by those managing the injury or illness and/or paying the claim. Another commenter supports adoption of the MDA return to work guidelines even though not everything will require the values noted, and some issues will require more.

Agency Response: The Division appreciates the support of the MDA as the Division's return to work guidelines.

§137.10(a): Commenter states the rule seems to mandate the use of return to work guidelines when it is or could be detrimental toward the claimant; however, the guidelines are optional when they could be detrimental toward the insurance carrier.

Agency Response: The Division disagrees that the return to work guidelines are biased against a claimant or optional for insurance carriers. The guidelines are benchmarks to facilitate communication between system participants and formulate return to work plans. The benchmarks establish starting points, which may be adjusted based on the specific circumstances of the claim.

§137.10(a): Commenter believes MDA, as a return to work guideline, is not designed to reduce excessive or inappropriate medical care.

Agency Response: The Division agrees that the return to work guidelines are not directly designed to reduce excessive or inappropriate medical care. However, early and appropriate return to work directly impacts the need for, and

types of, medical care provided to injured employees. Ultimately, this early intervention impacts system costs.

§137.10(a): Commenter is concerned that MDA does not take into consideration the complexity of the job and the job specific requirements for return to work. Commenter states this will cause a huge problem in outcomes if the insurance carriers deny treatment without considering all of the factors involved in the injury, diagnosis, as well as the complexity of the job and the requirements for return to work.

Agency Response: The Division disagrees. Although not every circumstance of a particular job is included in the MDA, broad categories related to the intensity of a job activity are included. As previously stated, these guidelines are a tool to develop return to work plans and set benchmarks. They provide the foundation for implementation of §413.021(b) of the Labor Code, which include job analysis, job modification and restructuring assessments.

§137.10(a): Commenter opines that the rules significantly impinge on the ability of health care providers to treat those injured employees who do not improve on the arbitrary, rigid schedule.

Agency Response: The Division disagrees. Medical care provided in the workers' compensation system is still controlled by the basic premise of an injured employee's entitlement to certain benefits, including medical benefits.

These rules facilitate treatment planning and return to work planning and allow for development of those plans based on the injured employee's specific situation and medical needs.

§137.10(a): Commenters recommend the Division be required to apply the return to work guidelines and question the propriety and effectiveness of achieving better return to work and medical outcomes if the Division's use of the return to work guidelines remains permissive and not mandatory. A commenter recommends the rules should create a presumption in favor of the disability guidelines adopted and any decision by a hearing officer or the Appeal Panels that is at variance with the disability guidelines should be explained as to why such variance is appropriate in the particular case. Additionally, interlocutory orders should not be issued for payment of temporary income benefits (TIBS) in a case where the requested disability is inconsistent with the disability guidelines

Agency Response: The Division declines to make these changes because it is inconsistent with Division policy. Division policy is that guidelines are intended to develop benchmarks for treatment while also considering the specific situations and medical needs of injured employees. Adopted subsection (a) pertains to the use of MDA by system participants, and as such, prescriptive language for the Division is not required. The Division will consistently apply the criteria in this subsection, but will maintain its independent duty to provide for exceptions as needed in order to accomplish the intent of HB 7 and other statutory provisions.

The Division notes the section permits system participants and the Division to consider an injured employee's co-morbid conditions, medical complications, or other factors that may influence medical recoveries and disability durations as mitigating circumstances when establishing return to work goals or revising expected return to work durations and goals. Disability durations in the guidelines are not absolute values and do not represent specific periods of time at which an injured employee must return to work; instead, the values represent points in time at which additional evaluation may occur if an injured employee has not experienced a full medical recovery and returned to work. Therefore, the suspension of an injured employee's TIBS is not mandatory if the injured employee's disability duration is inconsistent with the return to work guidelines.

§137.10(a): Commenter recommends identifying triggers in the return to work guidelines to initiate the requirement for treatment planning such as ODG's "at risk" date, which is suitable for this purpose. Commenter further opines that MDA's optimum number of days will result in well over 50% of cases being forced into treatment planning.

Agency Response: Because the term *at risk* in proposed §137.1(a) is not clear, it is deleted and the phrase to *avoid delayed recovery* is substituted as it indicates that avoiding delayed recovery is appropriate for any injured employee. The use of a return to work guideline as a trigger for treatment planning is not addressed in §137.10, but is addressed in adopted §137.300. Treatment

durations and other considerations outlined in §137.300 clarify the requirements for treatment planning. Since duration is not the only consideration in the treatment planning process, it is unlikely that 50% of the cases will require treatment planning.

§137.10(a): Commenter outlines the differences in the sources of data used to develop MDA and ODG return to work guidelines. Commenter states that by adopting MDA the state of Texas can rest assured it is working with the best evidence-based return-to-work guideline available.

Agency Response: The Division appreciates the support of the Division's selection of MDA as the Division's return to work guidelines.

§137.10(b): Commenter recommends clarifying language including that the rule does not apply to claims subject to workers' compensation under health care networks under Chapter 1305 of the Insurance Code.

Agency Response: The Division acknowledges the commenter's concern regarding the applicability of the adopted disability management rules to health care networks, however, the Division declines to make the modifications to the rule that reiterates the provisions of HB 7 and the sections of the Labor and Insurance Codes. Labor Code, §413.011 (g) provides that rules adopted relating to disability management do not apply to claims subject to workers' compensation networks. Workers compensation networks are required to adopt

their own treatment guidelines, return-to work guidelines, and individual treatment protocols, pursuant to Insurance Code, §1305.304. Based on the specificity of the Labor Code and Insurance Code provisions, it is the Division's opinion that it is unnecessary to restate such provisions in the adopted rules.

§137.10(b): Commenter recommends that if the Division adopts two separate guidelines as proposed, one for return to work and one for treatment guidelines, further clarification should be made that treatment information in the MDA should not be used by system participants.

Agency Response: The Division agrees. Language is added to §137.10 and §137.100 to clarify the use of the adopted guidelines.

§137.10(c): Commenter recommends using "optimum" time frames as provided in MDA for each specific diagnosis and job description; and, commenters recommend adding language, "optimum disability duration identified in the ..." or "maximum duration and job classification clarification". Commenter states it is more reasonable for all system participants to adopt the "optimum" disability duration as the statistical norm (benchmark), rather than assuming that disability will reach the accepted "maximum" in all situations.

Agency Response: The Division disagrees with the use of the MDA "optimum" time frames as a disability duration benchmark as the return to work standard for each specific diagnosis and job description, and thus disagrees with suggested

language addition. While the disability duration tables provide benchmark information on expected lengths of disability, the values do not represent the absolute minimum or maximum lengths of disability at which an individual must or should return to work. Rather, they represent important points in time at which, if full recovery has not occurred, additional evaluation should take place. These values are designed to allow individual differences in recovery time based on the numerous variables that impact disability duration. System participants should consider many factors including the diagnosis, any age-related complications, medications, return to work facilitations, availability of modified, alternate or transitional duty, job duty demands, managed disability programs, and employer's workplace factors when evaluating readiness for return to work.

§137.10(c): Commenter suggests defining "reasonable." Commenter states that this provision requires that the guidelines shall be presumed reasonable. Commenter questions the standard for overturning this presumption. Commenter further inquires whether the presumption disappears or shifts upon a showing to the contrary.

Agency Response: The Division disagrees with commenters' recommendation to further define "reasonable." In establishing the guidelines, the Reed Group collected data on more than 3.5 million workplace absence cases from multinational companies and governmental organizations to compile the normative database for the Fourth Edition. The database consists of actual

workplace absence data from a wide range of industries and geographic locations. In order to represent the most objective, accurate, and reliable view of disability duration, Reed Group's data set includes organizations that manage disability as well as those without case management services. The Division clarifies that a "standard for overturning the presumption of reasonableness" is not necessary in this rule since the disability durations are not absolutes or an end in themselves. The disability durations are benchmarks for establishing or re-assessing goals, or are the basis for a designated doctor examination, case management or a referral to vocational rehabilitation. These values do not represent the minimum or maximum lengths of disability at which an individual must or should return to work. Rather, if full recovery has not occurred, they represent important points in time that may indicate that further evaluation and planning is appropriate. The values are designed to allow individual differences in recovery time based on the numerous variables that impact functional restoration, and as such should be used as a communication tool for the insurance carrier, health care provider, injured employee and employer to discuss the patient's progress or any need to extend the established values.

§137.10(c): Commenter supports the Division's adoption of the MDA as a guideline for providing disability duration expectancies. Commenter recommends a rule requirement that a health care provider submit supporting documentation when a return to work goal for an injured employee differs from the MDA chart

estimation for the employee's particular injury. Commenter further recommends that the rule require that the health care provider identify the basis for a determination of job classification, i.e., employee, employer, or job analysis. Commenter believes that an employee's estimation of the kind of work the employee performs is not, in fact, always what is documented in the employer's job analysis. These recommendations are necessary since the MDA guidelines are not "absolute values" and do not address how to calculate a co-morbid or complicating factor's impact on the expected duration of a disability, and a standard calculation cannot be applied.

Agency Response: The Division declines to make the modifications to the rule for reasons previously stated that not every circumstance of a particular job is included in the MDA, and broad categories related to the intensity of a job activity are included. These guidelines are a tool to develop return to work plans and set benchmarks. They provide the foundation for implementation of §413.021(b) of the Labor Code, which includes job analysis, job modification and restructuring assessments.

§137.10(c)(2): Commenters state the rules are silent and fail to specify consideration of the guidelines by designated doctors, benefit review officers and hearing officers when determining disputes of return to work disability length issues, which may result in confusion. The insurance carrier's use of the return to work guidelines is unnecessarily and inappropriately limited to a basis of

requesting a designated doctor appointment, or referral to rehabilitation, regardless of prior findings on those same appointments or referrals. This renders any presumption moot. Though proposed rule 137.1(b) specifically permits the Division to use Chapter 137 rules as tools in income benefit disputes, the specificity of 137.10(c) fosters potential conflict. Commenters recommend requiring the designated doctor to presume that the Division's return to work guidelines provide a reasonable length of disability duration, and if the designated doctor finds disability beyond the period of time outlined in the guidelines, then the designated doctor should identify the medical facts that justify a longer duration of disability; or, offer scientific medical evidence that establishes a variance. Commenter recommends the presumption of some other evidence, such as treatment guidelines, be considered when ascertaining whether a designated doctor's report on MMI is entitled to presumptive weight when the two are in conflict. Commenters recommend that the Division should be required to presume that its guidelines provide a reasonable length of disability duration and should be used by the Division in resolving disputes. Further, if the Division resolves a disability dispute by finding that the employee is entitled to temporary or supplemental income benefits for a time in excess of the expected length of disability duration, then the Division should explain how the facts of the claim justify a greater period of lost time. A commenter states the designated doctor should be required to presume that the return to work guidelines provide reasonable length of disability duration, and if the designated

doctor finds disability beyond the period of time outlined in the guidelines, then the designated doctor should identify the medical facts that justify a longer duration of disability. Commenter recommends that if a designated doctor increases or lessens an injured employee's return to work period he should specify his reasoning.

Agency Response: The Division disagrees that the provisions of (c)(2) restrict the insurance carrier's use of the guidelines. The overarching disability management concept anticipates the use of MDA as a benchmark, and not an absolute, to facilitate return to work planning and ultimately improve return to work outcomes. Further, commenters are directed to subsection (e) of this section, which provides flexibility for the application of the guidelines to a particular injury. The Division agrees that the designated doctor decisions should be fully explained and documented in accordance with rules pertaining to the roles and function of designated doctors. However, it is the Division's opinion that no additional references to the designated doctor responsibilities are required in this section.

§137.10(c): Commenter recommends new paragraphs (4) and (5) be added to this subsection that identify how the Division intends to use the return to work guidelines: "(4) Division Medical Advisor and Medical Quality Review Panel in order to review performance of doctors on the Approved Doctor's List and other health care providers; and (5) Division Contested Case Hearing Officers and

Appeals Panel in deciding benefit disputes involving issues of existence and duration of disability.”

Agency Response: The Division declines to make the recommended additions since the requested provisions are already included with the use of disability management tools as outlined in §137.1(b). The Division policy is to consistently apply the disability management tools, and to also maintain its independent duty to provide for exceptions as needed in order to accomplish the intent of HB 7 and other statutory provisions.

§137.10(d): Commenter states it is improper to claim that co-morbidity may be considered; instead, co-morbidity must be considered.

Agency Response: The Division declines to make a change, as co-morbidities will not always be present in each individual case. However, the Division clarifies that system participants should consider all factors including any applicable co-morbidity, diagnosis, any age-related complications, medications, return to work facilitations, availability of modified, alternate or transitional duty, job duty demands, managed disability programs, and employer's workplace factors when evaluating readiness for return to work.

§137.10(d): Commenter supports language in the subsection and states in real life patients often present with multiple diagnoses, which complicates their

treatment and may extend their disability. This fact needs to be taken into account and explicit reference in the rule is a good idea.

Agency Response: The Division appreciates the supportive comment related to subsection (d).

§137.10(d): Commenters recommend clarifying “other factors” as the term is vague, undefined (e.g., not just subjective complaints of pain) and subject to variance in interpretations and applications. Commenter recommends that other factors considered should specifically include objective, documented medical findings of sufficient quality to overcome the return to work guidelines’ presumption of reasonableness.

Agency Response: The Division declines to further define factors that system participants may need to consider as mitigating circumstances when setting return to work goals or revising expected return to work durations and goals. Specificity in this area could potentially hinder communication efforts and limit the ability to fully consider and implement a return to work plan.

§137.10(d): Commenter recommends deletion of subsection (d) because the presence of co-morbid conditions are already addressed in the return to work guidelines, and there is no need to specifically account for such conditions in the rule.

Agency Response: The Division acknowledges that although co-morbidities are already addressed in the guidelines, there may be situations where consideration of other, unlisted co-morbidities may be appropriate. Failure to identify and consider those co-morbidities could lead to a delayed recovery, which is contrary of the expressed purpose of the disability management concept as provided in §137.1(a).

§137.10(e): Commenter suggests MDA guidelines be used in the context of the users' experience and judgment, and should not be used to tell the doctor what to do or not do. No injured employee should be denied payment based on the guidelines.

Agency Response: The Division agrees that the guidelines are a tool to be used to enhance the knowledge of system participants concerning return to work time frames. Return to work planning should integrate the disability management tools as well as the experience and judgment of the system participants. The Division also agrees with commenter that return to work guidelines should not be the sole justification for granting or denying income benefits to an injured employee. Subsection (e) has been changed to further clarify this provision.

§137.10(e): Commenters support the provisions of subsection (e) and especially referencing that the insurance carrier may not use the guidelines to reduce or deny income benefits. Commenter recommends adding the phrase "health care

benefits.” Another commenter supports this provision that prevents the return to work guidelines from being used as a justification to reduce or deny injured employees’ income benefits.

Agency Response: The Division clarifies subsection (e) is changed to indicate that Division return to work guidelines should not be used as the sole justification or the only reasonable grounds for reducing, denying, suspending, or terminating income benefits to an injured employee. The Division declines to add the recommended language because the MDA does not address medical care.

§137.10(e): Commenters recommend that while the rule could state that an insurance carrier may not use the guidelines as the *sole* (emphasis added) basis for suspension or refusal to initiate benefits, the rule should favor claim management decisions that are based upon guidelines that the Division specifically states are scientifically based.

Agency Response: The Division will consistently apply the criteria in this subsection, but will maintain its independent duty to provide for exceptions as needed in order to accomplish the intent of HB 7 and other statutory provisions.

§137.10(e): Commenter justifies that to preclude the insurance carrier from considering the adopted disability guidelines in assessing the doctor’s credibility as to disability, is to limit the range of evidence in a manner inconsistent with articulated legislative intent. Commenter further suggested that the insurance

carrier should be able to refuse to initiate, or suspend, benefits on the basis of disability guidelines. If the claimant disagrees, as proving disability is the claimant's burden, the claimant can request a designated doctor to address the issue. Another commenter asserts it is proper for the insurance carrier and the Division to consider the guidelines as a useful tool in deciding if existing medical opinions and claim investigation support the ongoing disability.

Agency Response: As previously stated, the Division clarifies that designated doctors, IROs and other hearing officers' decisions should be fully explained and documented in accordance with rules pertaining to their roles and functions in the workers' compensation system. However, it is the Division's opinion that no additional reference is required in this section. The Division agrees that the adopted return to work guidelines are a valid benchmark in assessing an injured employee's ability to return to work. However, language was added to this subsection to clarify that an insurance carrier may not use the return to work guidelines as the sole justification or the only reasonable grounds for reducing, denying, suspending, or terminating income benefits to an injured employee.

§137.10(e): Commenter recommends that the rule should specify that benefit reductions or denials should not be based solely on the return to work guidelines, as there is no statutory prohibition to consider the return to work guidelines in making benefit determinations. Commenter further opines the limitations placed

on return to work guidelines usage appear to be in conflict with §413.011(f) of the Labor Code.

Agency Response: The Division agrees and subsection (e) is changed to clarify that return to work guidelines should not be the sole justification or the only reasonable grounds for reducing, denying, suspending, or terminating income benefits to an injured employee. The Division disagrees that the limitations related to the use of the guidelines for denial of benefits conflicts in any way with §413.011(f) of the Labor Code. Subsection (e) allows the use of the guidelines to deny benefits, but prevents their use as an arbitrary standard without consideration of other factors.

§137.10(e): Commenters support and agree that the MDA published by the Reed Group is based on statistical analysis of actual outcome data and return to work outcomes for workers' compensation should fall in line with that summary.

Agency Response: The Division appreciates the supportive comment related to subsection (e).

§137.10(f) Commenter recommends alternate language that substitutes "may" for "shall," because commenter states it would be impossible for system participants to be able to comply with the mandatory requirements of this rule since at the present time there does not exist evidence-based medicine that

addresses disability duration parameters and return to work goals for all diagnoses or injuries that are not addressed by the MDA.

Agency Response: The Division declines to make the recommended change, but recognizes that as proposed, system participants may not be able to fully comply with the requirements. The language is changed to clarify that in instances not addressed by the Division return to work guidelines, the principles of evidence-based medicine are to be applied to establish return to work goals.

§137.100: Commenter states that litigation is pending against the WLDI in federal court. Commenter provides documentation of the complaint and states that the plaintiff alleges breach of contract in connection with a royalty agreement, breach of a confidentiality agreement, and conversion of confidential business information. Commenter takes no position on the merits.

Agency Response: Based on the documentation provided by the commenter, the Division disagrees that the complaint against WLDI is relevant to the disability management rules. The thrust of the allegations concerns a contract dispute not relevant to the disability management rules adopted by the Division.

§137.100: Commenter supports the concept of treatment guidelines and treatment planning as they are the focus of these proposed rules for workers' compensation reform. Commenter states that the appropriate use of the treatment guidelines is more important than which treatment guidelines are

adopted. When used appropriately, treatment guidelines can be an effective tool to control utilization and inappropriate health care.

Agency Response: The Division appreciates the supportive comments pertaining to treatment guidelines and treatment planning.

§137.100: Commenter states agreement with the Federal Aviation Committee's conclusion that evidence-based medicine, selected or implemented without clinical experience, is very dangerous.

Agency Response: The Division agrees that clinical expertise is an important consideration in the effective application of treatment guidelines. The Division anticipates health care providers in the Texas workers' compensation system will integrate their expertise with the adopted treatment guidelines so that effective and efficient medical care is provided to injured employees in order to improve return to work outcomes.

§137.100: Commenter states that the proposed rule is significantly better than the pre-proposal rule that provided an un rebuttable presumption that all treatment in the treatment guidelines is reasonable and necessary without regard to the particular facts of the individual case.

Agency Response: The Division appreciates the comment and acknowledges the change was made from pre-proposal drafts as a result of system stakeholders' input.

§137.100: Commenter states that monthly or quarterly updates sound appealing, but is inconsistent with evidence-based medicine. Continuously updated guidelines present a moving target for treating physicians and reviewers, requiring continuous retraining and inefficiency. Commenter opines that the literature seldom produces an article so compelling that it alters an evidence-based guideline. Commenter states that it takes a number of studies carried out in different settings by different investigators to convince guideline developers that a finding is valid.

Agency Response: The Division disagrees that the continual updating of treatment guidelines is inconsistent with evidence-based medicine. Labor Code, §401.011(18-a) contemplates the use of *current* scientific and medical evidence to assist health care providers in making decisions about the care of employees with work-related injuries by defining “evidence-based medicine” to mean “the use of *current* best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed literature and other current scientifically based texts, and treatment and practice guidelines in making decisions about the care of individual patients.” One resource reports that “without current best evidence, a clinical practice risks becoming rapidly out of date, to the detriment of patients.” David L. Sackett, William M.C. Rosenberg, J.A. Muir Gray, R. Brian Haynes, and W. Scott Richardson, *Evidence Based Medicine: What It Is and What It Isn't*, British Medical Journal 312 (7023), 13

January, 71-72 (1996). Another reference provides that regular updating of reviews is necessary in order to ensure the accuracy of the information since “a print review article is out of date as soon as it is published.” Lisa A. Bero, Ph.D, *Evaluating Systematic Reviews and Meta-Analyses*, Journal of Law and Policy 570, 578 (2006). Based on the findings of new studies as they are released, the Division believes it is appropriate for WLDI to review the ODG treatment guidelines and make necessary revisions due to its frequent review of the scientific medical literature, survey data analysis, and expert panel validation.

§137.100: Commenters express concern regarding ODG’s disclaimer language that states the treatment guidelines are not to be used as cookbook medicine for rendering medical advice, and the final opinion regarding treatment and the ability of a patient to return to work rests with the physician treating the patient. Another commenter states that ODG does not consider the complexity of the job, job requirements for return to work, or other medical problems that may effect healing and/or complications related to the diagnosis/injury. It is very important that all of these things must be considered in a treatment guideline.

Agency Response: The Division notes commenters’ concerns. The Division anticipates health care providers’ ability to use these tools, and the treatment guidelines as a framework to develop treatment for injured employees. The health care provider must consider care above or below the guidelines consistent with the unique factors associated with an injury. The rules anticipate certain

care outside or inconsistent with the treatment guidelines be managed through treatment planning as coordinated with the preauthorization process.

§137.100: Commenter is concerned that insurance carriers and peer review doctors will utilize the synopsis of the outline for care without utilizing the entire ODG guidelines, which only benefits the payors.

Agency Response: The Division notes the commenter's concern. Injured employees continue to be entitled to all health care reasonably required by the nature of their compensable injury when necessary as established by Labor Code §408.021. Section 137.100 (a) provides that health care providers shall provide treatment in accordance with the current edition of ODG unless the treatment(s) or service(s) require preauthorization in accordance with §134.600 or §137.300. The Division will monitor the use of the disability management tools by all system participants to assure compliance with the intent of HB 7.

§137.100: Commenters state that the Federal Agency for Healthcare Research and Quality (AHRQ) does not investigate the evidence-based credibility of guidelines accepted for inclusion in the National Guideline Clearinghouse. Another Commenter provides that AHRQ does not permit guideline listing to be used for promotional purposes.

Agency Response: The Division agrees that AHRQ does not review information contained in an individual guideline's content. However, the intent of

the National Guideline Clearinghouse is to make evidence-based clinical practice guidelines available to health care professionals after meeting the criteria for inclusion. The Division acknowledges that inclusion of a guideline in the National Guideline Clearinghouse does not constitute an endorsement by AHRQ or any of its contractors of the guideline. The Division does not agree that a guideline included in the National Guideline Clearinghouse is prohibited from disclosing its inclusion in the database and providing the criteria for inclusion.

§137.100: Commenter recommends spine injuries be addressed separately. Commenter additionally recommends a separate law that incorporates American Association of Orthopedic Surgeons (AAOS) and North American Spine Society (NASS) algorithms for spine injury and includes updates of those algorithms.

Agency Response: The Division declines to develop rules that separately address spinal injuries and believes the ODG sufficiently addresses spinal injuries. The disability management concept provides for the treatment of spinal injuries through the references provided in the treatment guidelines, treatment planning and preauthorization. The Division clarifies that amendments to the Labor Code would need to occur through the legislative process and not through the agency's rule making authority.

§137.100: Commenter's opinion is that ODG treatment guidelines fail to take into consideration the full complexities of the spine and ODG provides overly

simplistic recommendations that fail to recognize the multiple factors involved in the extensive decision-making process prior to performing spinal surgery.

Agency Response: The Division believes the ODG sufficiently addresses spinal injuries. The Division agrees that identifying and recommending appropriate treatment can involve a complex decision making process. Prior to any spinal surgery, the ODG should be followed. If spinal surgery is medically necessary, then preauthorization must be obtained before the service is provided, as required by Labor Code §413.014. Preauthorization for spinal surgery is required whether the care is in accordance with or outside the treatment guidelines.

§137.100: Commenter states that there is potential that patients may be denied the necessary and appropriate care based on the guidelines alone, and not the accepted treatment standards that carry a greater degree of validity and scientific merit than a guideline.

Agency Response: The Division notes the commenter's concern. Injured employees continue to be entitled to all necessary health care as established by Labor Code §408.021. The Division anticipates that health care providers and insurance carriers will integrate the disability management concepts to assure effective and efficient health care and promote early and appropriate return to work for injured employees. The Division will monitor the use of the disability management tools by all system participants to assure compliance with the intent of HB 7.

§137.100 Commenter recommends the Division not adopt the ODG treatment guidelines in their current form, as further up-to-date work is needed by ODG that recognizes already proven treatment methodologies.

Agency Response: The Division disagrees. The Labor Code requires the Commissioner to adopt treatment guidelines for use in the workers' compensation system. The ODG is the best match for the system at this time. ODG reviews new information and studies as they become available and integrates these references into the online version on an ongoing basis. Additionally, a health care provider may submit treatments and services not included in the adopted treatment guidelines for preauthorization by the insurance carrier.

§137.100: Commenter states this rule is an inflexible restraint on the patient's ability to receive appropriate care and it ignores the uniqueness of each patient, co-morbid conditions, medical complications or other factors. Commenter states this rule envisions cookie-cutter treatment for all injured employees regardless of their individual abilities to recover or return to work.

Agency Response: The Division disagrees. The Division anticipates health care providers' ability to use these tools, and the treatment guidelines as a framework to develop treatment for injured employees. The health care provider must consider care above or below the guidelines consistent with the unique

factors associated with an injury. The rules anticipate certain care outside or inconsistent with the treatment guidelines be managed through treatment planning as coordinated through the preauthorization process. Injured employees continue to be entitled to all necessary health care as established by Labor Code §408.021. The Division will monitor the use of the disability management tools by all system participants to assure compliance with the intent of HB 7.

§137.100: Commenter states that adoption of ODG will not reduce excessive or inappropriate medical care and provides examples to support this position. Commenter opines that if the “Codes for Automated Approval” are used as presented without instruction for appropriate use, surgeries (for example, for carpal tunnel syndrome and discectomy), multiple imaging studies, and levels of service in excess of those proven effective would be automatically approved. Commenter believes such automated approval would render the utilization review process inoperative to a large extent and would mandate approvals without consideration of individual case information, as would occur when managing a patient clinically or when performing high quality utilization review. Commenter compares the ODG neurological criteria with *Hoppenfied’s Orthopedic Neurology* and Dermatome Maps to opine that the ODG criteria for lumbar discectomy is not generally accepted and could result in unnecessary surgery.

Agency Response: The Division disagrees that ODG is not designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. ODG provides clear data on optimum frequency and duration of treatments. The ODG treatment guidelines explain that claims should ideally be managed based on the details of the case using the "Procedure Summary." The ODG Procedure Summary includes possible therapies, diagnostic methods, and provides a summary with a reference to the most recent medical evidence with an indication of whether the procedure is recommended, not recommended, or under study. See, ODG at 14. Within a Procedure Summary, ODG provides guidelines for instruction that include specific utilization review criteria often presented in an algorithmic format. See, ODG at 16. "For surgical procedures that may be supported by high quality medical studies, ODG provides a decision matrix entitled 'ODG Indications for Surgery' TM that itemizes the decision-making process and patient selection criteria for successful outcomes from the surgery." *Id.* In addition, §134.600(p) requires preauthorization for outpatient surgical or ambulatory surgical services, spinal surgery, and certain repeat diagnostic studies to consider individual case information. Quality and timely care in workers' compensation cases have become synonymous with overall cost containment. The level of cost containment is directly proportional to the degree of over-utilization of medical treatment currently experienced in the system.

§137.100: Commenter states there are many areas where even ODG does not address specific diagnoses and interventions, particularly in the area of mental health and behavioral health care. Commenter consequently recommends the addition of language from §413.011(18-a) with explicit language that there will be many situations where ODG does not adequately address the service requested and other evidence-based guidelines and empirically based literature will need to be consulted.

Agency Response: The Division declines to make the recommended change. Treatments, services and diagnoses not specifically addressed in the treatment guidelines are addressed through the preauthorization or treatment planning processes and as such no additional language is necessary.

§137.100: Commenter states opposition to the Texas Department of Insurance's relegation of ACOEM as the proposed treatment guidelines and provides examples of the failure of the guidelines to assist health care providers in communicating with insurance carriers the care necessary for injured employees.

Agency Response: The Division clarifies that the ACOEM practice guidelines are not adopted as treatment guidelines for use in the non-network worker's compensation system. However, the Division notes that certified workers' compensation health care networks have the flexibility to utilize these or other guidelines according to their individual business practices.

§137.100: Commenter recommends the rules adopted by the Commissioner should amend the definition of “evidence-based medicine” to replicate the definitions provided in a position statement and defined by the AAOS (evidence-based practice; best research evidence; clinical expertise; and patient values).

Agency Response: The Division declines to make the recommended change as Labor Code §401.011(18-a) defines evidence-based medicine.

§137.100: Commenter states no evidence exists indicating that ODG will compromise an injured employee’s access to spinal surgery. Commenter also states that spinal surgeries will continue to go through the preauthorization process and can proceed to a review by an IRO if the insurance carrier denies preauthorization. Commenter states spinal surgery utilization is still a problem in Texas, as indicated by the Research and Oversight Council’s January 2001 report “Striking the Balance: An Analysis of the Cost and Quality of Medical Care in the Texas Workers’ Compensation System,” and will be addressed in an appropriate manner by adoption of the ODG treatment guidelines.

Agency Response: The Division agrees and clarifies that all spinal surgeries require preauthorization as established in §413.014 of the Labor Code. If a health care provider recommends spinal surgery, preauthorization is required in accordance with §134.600. The Division agrees that spinal injuries are a significant cost in the Texas workers’ compensation system and that ODG is a useful tool in managing spinal injuries.

§137.100: Commenter states that the insurance industry is cognizant of the Texas Labor Code provision that prohibits the denial of health care based solely on the treatment guideline adopted by the Division or on the basis that health care being proposed or that has been rendered either exceeds the treatment guideline or is not included in the guideline.

Agency Response: The Division notes that adopted §137.100(g), proposed as subsection (h), requires that the insurance carrier shall not deny treatment solely because the diagnosis or treatment is not specifically addressed by the Division treatment guidelines or Division treatment protocols.

§137.100: Commenter urges the Division not to include a provision stating that health care treatment is automatically preauthorized if it falls within the treatment guideline.

Agency Response: The Division agrees. Adopted §137.100(e), proposed as subsection (f), states that an insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017.

§137.100: Commenter recommends changes to ODG's treatment guidelines that adds the terms "electrical" to all references pertaining to "bone growth stimulators, " and adds "therapy" to the title relating to "Cold /Heat Pack" to read "Cold Therapy/Heat Pack."

Agency Response: The Division declines to make the change. Commenter's specific recommendations for changes in language in ODG or other Division adopted guidelines is best addressed with the publisher of the guidelines.

§137.100: Commenters state that the ratings given to a number of the abstracts in the low back chapter and a reference in the pain chapter from Kumar with regard to the use of spinal cord stimulation for failed back surgery syndrome (FBSS) are incorrect. Commenter provides that in most of the examples provided, studies were classified as randomized controlled trials (Type 2) but were actually either cohort studies or case series, while other studies were classified as systematic reviews (Type 1) but were actually narrative reviews or other forms of evidence. Commenter provides that ODG classified in error a case series by Kumar as a randomized controlled trial leading to the conclusion that spinal cord stimulators (SCS) are "recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated for FBSS and complex regional pain syndrome (CRPS) Type 1. Commenter believes more trials are needed to confirm whether SCS is an effective treatment

for certain types of chronic pain and states that appropriately reclassifying the Kumar article would remove the evidence in favor of SCS for FBSS. Commenter concedes that it is unknown the degree to which the classification errors found in the low back chapter exists in the other chapters of ODG and recommends identifying similar errors prior to using the stated information. Commenter further recommends ascertaining the degree to which search criteria identified all relevant articles, the credentials of those rating the articles, and whether the ratings were based solely on reading the abstracts or the entire article.

Agency Response: The Division believes the commenter has highlighted a unique strength of ODG. Each treatment guideline summary and subsequent recommendation in ODG is hyper-linked into the studies on which it is based, in abstract form, which have been ranked, highlighted and indexed. (See "ODG Methodology Outline" at www.odg-disability.com/methodology_outline.pdf.) This accountability and transparency in ODG lets users evaluate the strength of medical evidence behind guideline recommendations on their own. Then, if they disagree with the ODG rating of a study, the ODG interpretation of a study, or if they think ODG has overlooked a specific study, they are encouraged to provide their feedback to the ODG authors, and these comments are then reviewed and reflected in the guidelines as appropriate. The editorial effort behind *ODG Treatment* is an open process, and its success is based on its reputation for being (1) unique in taking evidence-based guidelines to their logical end point, with the conclusions linked directly to the evidence in the studies and references;

(2) continuously updated reflecting the findings of new studies as they are conducted and released so subscribers are always up to date; (3) comprehensive, covering all types of treatments and the relevant studies; and (4) independent and multidisciplinary in scope. (See "The Unique and Major Advantages ODG" at www.odg-disability.com/Advantages_of_Official_Disability_Guidelines.pdf.)

The Division disagrees that the rating studies on spinal cord stimulation are inaccurate. The only specific example produced by commenter says, "ODG classified in error a case series by Kumar as a randomized controlled trial." The link shown in the Pain Chapter under Spinal cord stimulators (SCS) listed as "(Kumar, 2006)" says, "Rating: 4a" (www.odg-twc.com/odgtwc/pain.htm#Kumar4). The rating level 4 is a Case Series and not a Controlled Trial (www.odg-twc.com/odgtwc/ExplanationofMedicalLiteratureRatings.htm). Commenter says that in "most" of the examples provided, studies were classified as Type 2, while other studies were classified Type 1. The Division does not agree with this assessment because there are a total of 41 studies cited under Spinal Cord Stimulation, and 6 received a Type 1 rating, while 8 received a Type 2 rating (less than 20% of the total, not qualifying as "most," see www.odg-twc.com/odgtwc/pain.htm - SCS References). Commenter said that more trials are needed to confirm whether spinal cord stimulation is an effective treatment for failed back surgery syndrome. The commenter's opinion is not unreasonable,

but ODG already limits the use of spinal cord stimulation to very unusual situations, since failed back surgery syndrome is the result of a failed spinal fusion, and ODG concludes, "Not recommended" for Fusion in the Low Back Chapter so ideally failed back surgery syndrome should almost never happen. Commenter recommends identifying "similar errors" prior to using ODG. The Division believes this is not an error and no "similar errors" have been identified. Commenter further recommends ascertaining the degree to which search criteria identified all relevant articles, the credentials of those rating the articles, and whether the ratings were based solely on reading the abstracts or the entire article. The evidence used for ODG is the complete article; however, ODG users have access to the abstract which serves as an article summary, and can help the user decide whether to review the complete article on their own. See "ODG Methodology Outline" at www.odg-disability.com/methodology_outline.pdf for a complete description of methodology.

§137.100: Commenter believes characterizing abstracts as evidence within the context of evidence-based medicine is inappropriate and potentially misleading. Abstracts are to be used as a guide to the evidence, but are not to be used in place of the evidence. Commenter states that the ODG chapter on pain and the use of spinal cord stimulators recommends trial stimulation supported by a link to the abstract. The user of ODG would assume from the statement and the link that the underlying medical study support trial stimulation. Commenter provides that the link on ODG is to an abstract for a protocol for a Cochrane Review and,

according to Cochrane, "a protocol is the rationale for the review," not the systematic review itself. Commenter states ODG does not provide a link to the actual systematic public study concluding the opposite of the ODG procedure summary that found "no data regarding the benefits of having a trial stimulation period." Commenter further states separate studies are not reaching different conclusions, but misuse of the very same study.

Agency Response: The Division disagrees with commenter's interpretation of ODG. According to ODG methodology the complete article is reviewed. ODG users have access to the abstract which serves as an article summary, and can help them decide whether to review the complete article on their own. See "ODG Methodology Outline" at www.odg-disability.com/methodology_outline.pdf for a complete description of methodology. The link at (Mailis-Gagnon-Cochrane, 2004) goes to a Cochrane systematic review (www.odg-twc.com/odgtwc/pain.htm - MailisGagnon) which says, "Mailis-Gagnon A, Furlan A, Sandoval J, Taylor R, Spinal cord stimulation for chronic pain, Cochrane Database Syst Rev. 2004;3:CD003783" and, "CONCLUSIONS: Although there is limited evidence in favour of SCS for Failed Back Surgery Syndrome and Complex Regional Pain Syndrome Type I, more trials are needed to confirm whether SCS is an effective treatment for certain types of chronic pain."

§137.100: Commenter states the representation that ODG covers conditions that represent over 99% of workers' compensation costs is a gross

overstatement. For comparison, a 2004 study by the California Workers Compensation Institute showed that for California data, 30% of claims had diagnoses that were too non-specific to apply guidelines, and 20% were trauma, primarily lacerations and fractures. *Evidence-Based Medicine & The California Workers' Compensation: A Report to the Industry*, California Workers' Compensation Institute, Harris, Swedlow, February 2004.

Agency Response: The Division acknowledges differences among treatment guidelines. Jeffrey S. Harris, MD, MPH, MBA, Alex Swedlow, MHSA, California Workers Compensation Institute, *Evidence-Based Medicine & The California Workers' Compensation System: A Report to the Industry*, 14-17 (2004) states that trauma and non-specific claims involve 51.7% of all California workers' compensation claims and 42.3% of total benefit costs, which the adopted state guidelines did not cover at the time of the report. Additionally, the 2004 report notes that guidelines for trauma injuries that include fractures, burns, and lacerations were not expressly developed for the adopted California state guidelines due to well-defined treatment pathways and anecdotal studies of less treatment variability. Based on the January 2004 report, a few of the primary diagnosis codes for non-specific claims that did not fit within the adopted California state guideline diagnostic criteria included 784.0-headache; 854.00-brain injury; 719.46-joint pain, lower leg, and 729.5-pain in limb. However, there are notable differences between California's adopted guidelines at the time of the reported study and the current ODG. For instance, specific treatment guidelines

are provided in ODG for injuries involving burns, the head, the leg, and pain. Given the differences between the guidelines, the fact that a similar study specific to ODG and workers' compensation injuries in the state of Texas has not been conducted, it is probable that the results would yield different comparative percentages. Although a specific study has not been conducted to validate WLDI's representations, the Division notes that ODG does cover all the major body parts likely to be involved in a workers' compensation injury. This comprehensiveness supports the conclusions that ODG addresses the overwhelming majority of workers' compensation medical costs.

§137.100: A commenter provides documentation which indicates that Lippincott Williams & Wilkins, the publisher of the Journal of Occupational and Environment Medicine (JOEM), has asked the Work Loss Data Institute to cease and desist from the use of JOEM abstracts and other JOEM publications because use of JOEM proprietary materials is unauthorized and must cease immediately, and because the Work Loss Data Institute is mischaracterizing the abstracts as evidence which is not the intended purpose of the JOEM abstracts.

Agency Response: It is the understanding of the Division that the abstracts are provided as a summary to assist the user in knowing which studies may be appropriate for review in order to evaluate the strength of the medical evidence behind the guidelines. The reported controversy between Lippincott Williams & Wilkins, and the Work Loss Data Institute, referred to by the commenter, is a

topic outside the scope of this rule making activity and does not affect the Division's choice of the ODG treatment guidelines.

§137.100: Commenter states that ODG listed treatment guidelines written by health care entities such as Blue Cross and Aetna as a high quality reference when such guidelines have never been considered evidence in any other treatment guideline. A high level systematic review only gives an article high quality weight when performed as a high quality randomized controlled trial.

Agency Response: According to the *WLDI Methodology Outline*, ODG prefers an article written in the English language that satisfies a certain criterion. WLDI ODG gives preference to evidence that is a systematic review of the relevant medical literature. WLDI considers an article that reports a randomized controlled trial or a controlled trial. WLDI also considers an article that reports a prospective cohort study or a retrospective study. WLDI further considers an article that reports a case control series involving at least 25 subjects in which the assessment of the outcome was determined by the person or entity independent from the persons or institution that performed the intervention, the outcome of which is being assessed. When there are limited studies available with the preferred criteria, it becomes necessary to review other studies, and rank the evidence alphanumerically from 1a to 10c based on the type of evidence (1-Systematic Review/Meta-Analysis, 2-Controlled Trial –Randomized (RCT) or Controlled, 3-Cohort Study-Prospective or Retrospective, 4-Case Control Series,

5-Unstructured Review, 6-Nationally Recognized Treatment Guideline from guidelines.gov, 7-State/Other Treatment Guideline, 8-Foreign Treatment Guideline, 9-Textbook, 10-Conference Proceedings/Presentation Slides). The evidence is further ranked by the quality within the type of evidence (a-High Quality, b-medium quality, and c-low quality) using the methodology in the second chapter of ODG. Generally, using the ODG alphanumeric methodology, treatment guidelines from health care entities such as Blue Cross and Aetna would receive a rating of 7 - State/Other Treatment Guideline which is lower than a rating of 1 - Systematic Review/Meta-Analysis or 2 - Controlled Trial – Randomized (RCT) or Controlled unless studies from a health insurance company were published in the peer-reviewed literature, in which instance such studies could receive a higher ranking. Further, whether a particular treatment is covered or not covered by health care insurance should be relevant to coverage decisions in workers' compensation.

§137.100: Commenter opines that ODG is overly comprehensive, including numerous low level studies.

Agency Response: The Division disagrees. WLDI gives prefers an article written in the English language that satisfies a certain criterion. WLDI gives preference to evidence that is a systematic review of the relevant medical literature. WLDI considers an article that reports a controlled trial-randomized or

controlled. WLDI considers an article that reports a cohort study, whether prospective or retrospective. WLDI considers an article that reports a case control series involving at least 25 subjects in which the assessment of the outcome was determined by the person or entity independent from the persons or institution that performed the intervention the outcome of which is being assessed. When there are limited studies available with the preferred criteria, it becomes necessary to review other studies, and rank the evidence alphanumerically from 1a to 10c based on the type of evidence (1-Systematic Review/Meta-Analysis, 2-Controlled Trial –Randomized (RCT) or Controlled, 3-Cohort Study-Prospective or Retrospective, 4-Case Control Series, 5-Unstructured Review, 6-Nationally Recognized Treatment Guideline from guidelines.gov, 7-State/Other Treatment Guideline, 8-Foreign Treatment Guideline, 9-Textbook, 10-Conference Proceedings/Presentation Slides). The evidence is further rated by the quality within the type of evidence (a-High Quality, b-medium quality, and c-low quality) using the methodology in the second chapter of ODG. According to David L. Sackett, William M.C. Rosenberg, J.A. Muir Gray, R. Brian Haynes, and W. Scott Richardson, *Evidence Based Medicine: What It Is and What It Isn't*, BMJ 312 (7023), 13 January, 71-72, "if no randomized trial has been carried out for [the] patient's predicament, we must follow the trail to the next best external evidence and work from there." Further, Lisa A. Bero, Ph.D, *Evaluating Systematic Reviews and Meta-Analyses*, Journal of Law and Policy 580 (2006), citing, Debra J. Cook et. al., *Should*

Unpublished Data Be Included in Meta-analyses? Current Convictions and Controversies, 269 JAMA 2749, 2749-53 (1993) reports that the “majority of methodologists and journal editors now believe that unpublished data should be included in systematic reviews, suggesting widespread belief that important data remain unpublished.”

§137.100: Commenter recommends an independent, in-depth assessment of proposed guidelines by qualified medical and epidemiologic professionals prior to adoption. Commenter further states that sales or vendor presentations in support of particular proposed guidelines do not generally provide the specificity, depth, and breadth of analysis necessary to assure maximum benefit for injured employees.

Agency Response: The Division disagrees that it has not thoroughly reviewed the adopted guidelines. Prior to proposal, the Division considered the merits of various published return to work guidelines and treatment guidelines. Several stakeholder and work group meetings were held to discuss the disability management concept and rules related to guidelines. In addition, meetings were held with guideline publishers. Representatives of various guidelines made presentations to Division staff and workers' compensation system stakeholders regarding the development and use of their individual guidelines. After reviewing and evaluating these guidelines and stakeholder input, as well as considering the recommendations of the Division's Medical Advisor and the former Texas

Workers' Compensation Commission Medical Advisory Committee's Return to Work workgroup, the Division selected the guidelines.

§137.100: Commenter recommends that clarification be made as to potential physician licensing and malpractice allegations if the doctor performs a procedure or treatment within the adopted treatment guidelines, specifically surgical discectomy. Commenter questioned whether doctors violate the standard of care in Texas if they follow the Division treatment guidelines.

Agency Response: The Division acknowledges the concern regarding a physician's compliance with a duty to follow the standard of care in the medical profession when treating an injured employee. The Division clarifies that all spinal surgeries require preauthorization in accordance with Labor Code §413.014 and preauthorization requests are evaluated for medical necessity on a case-by-case basis. The Division disagrees that treatment guidelines establish the standard of care for a physician in Texas. The WLDI discloses in its ODG treatment guidelines that it is "not engaged in rendering medical advice, legal, or professional advice. The final opinion regarding any medical condition and the ability of a patient to return to work should rest with the physician." According to medical literature, treatment guidelines do not establish legal standards for clinical care but may provide the courts with a benchmark by which to determine clinical conduct in the workers' compensation system. Brian Hurwitz, *How Does Evidence Based Guidance Influence Determinations of Medical Negligence?*,

329 BMJ 1028 (2004); Ash Samanta, M.D., L.L.B., Jo Samanta, B.A., Michael Gunn, L.L.B., *Legal Considerations of Clinical Guidelines: Will NICE Make A Difference?*, 96 Journal of the Royal Society of Medicine, 134 (2003). This perspective from the medical literature appears consistent with the legal precedence in Texas. In *Denton Regional Med. Ctr. v. Lacroix*, 947 S.W. 2d 941, 951 (Tex. App. Fort Worth 1997), the court held that although it may consider the hospital's internal policies and bylaws, as well as the Joint Commission on Accreditation of Health Care Organizations standards in determining the standard of care, those factors alone do not determine the standard of care. Therefore, it is the Division's opinion, that in using the treatment guidelines as only a benchmark for determining appropriate care, the physician must ultimately consider the individual circumstances and needs of the injured employee and act according to the applicable standards of care for his particular medical profession. The Division acknowledges that injured employees may require more or less treatment than provided in the treatment guidelines based on the specifics of the injury. The disability management rules recognize this and a variance from the guidelines should be supported by documentation.

§137.100: Commenter states it is incorrect that ODG is not evidence-based and that the methodology is flawed. Commenter includes an outline of ODG's methodology, which provides detail as to how ODG is created and remains evidence-based. Commenter additionally states that reviewers use actual

studies, not abstracts, to formulate the conclusions for the guidelines and abstracts are provided as an accommodation to the subscribers. Commenter states an observation has been made that the guidelines lack evidence-based medicine. Commenter notes that the summarizations in ODG can only be as good as the studies that have been conducted and are available. Consequently, ODG can only rely on what's being studied and what is being released in terms of results and outcomes based on evidence-based science. ODG reads the studies themselves; however, only the abstracts are provided because it would be impossible to include the entire studies in a book or a database. In addition, studies are sometimes not available for publication. Commenter states that ODG provides on its website a dynamic database that provides the most current updates of studies or clinical trials. Commenter further states system participants are encouraged to utilize ODG's web-based version because the print version does not include studies completed and released after the annual publication of the hard-copy ODG. In addition, ODG offers discounts for system participants who choose to subscribe to the ODG web version rather than the book version.

Agency Response: The Division acknowledges the comments regarding ODG.

§137.100: Commenters state that ACOEM guidelines are the only treatment guidelines under consideration that meet the statutory standard outlined in Labor Code §413.011(e), and recommends its sole adoption in the State of Texas. Commenters state that ACOEM practice guidelines are the highest quality and

most scientifically based and empirically validated guidelines currently available. Commenters further state that the ODG treatment guidelines do not meet the scientific principles for evidence-based medicine, therefore, not meeting the statutory tests of §413.011(e). A treatment guideline that references links to abstracts may appear to be evidence-based, but does not meet the Labor Code standard of being “scientifically valid.” Commenter provides that ODG does not follow most of the steps integral to the widely accepted evidence-based medicine process described in the referenced publications. Commenter further provides that ODG does not describe the expert review and consensus process used to make testing and treatment recommendations or a scheme for rating individual systematic reviews or the body of high quality evidence to support each recommendation. Commenter comments that ODG does not describe its process for a multidisciplinary review or for external review other than a reference to an Editorial Advisory Board. Commenter provides examples and documentation to support this position.

Agency Response: The Division disagrees that ACOEM guidelines are the only guidelines that meet the statutory standards. The ODG treatment guidelines meet the statutory requirement for adoption in the State of Texas. Labor Code §413.011(e) requires the Commissioner to adopt treatment guidelines that are evidence-based, scientifically valid, and outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care.

The ODG guidelines are evidence-based. Labor Code §401.011 (18-a) defines “evidence-based medicine” to mean “the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts, and treatment and practice guidelines in making decisions about the care of individual patients.” The RAND Institute defined *evidence-based* and *peer-reviewed* to mean, at a minimum, a systematic review of literature published in medical journals included in the National Library of Medicine's MEDLINE, (RAND, *Evaluating Medical Treatment Guideline Sets for Injured Workers in California*). Finding that systematic reviews of the literature are standard and essential features of an evidence-based guideline development process, RAND determined that ODG was evidence-based and peer-reviewed, a criteria for inclusion in the RAND study of treatment guidelines.

The ODG guidelines are scientifically valid. ODG follows the steps integral to the process of creating evidence-based treatment guidelines. WLDI describes its methodology for formulating the ODG treatment guidelines in the *ODG Methodology Outline* at www.odg-disability.com/methodology_outline.pdf. *ODG Treatment* also includes a detailed document entitled *Appendix A, Methodology Description Using the AGREE Instrument*. This Appendix provides an extensive explanation of how *ODG Treatment* meets each of the 23 criteria established by the *AGREE Instrument*, including the rigorous means of developing the guidelines as described by the criteria for selecting the evidence

and the methods used for formulating the recommendations. The RAND Institute determined that ODG, and the other four guidelines studied, scored high in the rigor of development domain by clearly describing the methods used to search for evidence and formulate recommendations (RAND, *Evaluating Medical Treatment Guideline Sets for Injured Workers in California*, p. 32).. .

The ODG guidelines are outcome-focused. The information in ODG is a compilation of the current medical evidence that reflects the outcomes of new studies and clinical trials. This data is integrated into the guidelines to reflect advances in medical technology, drug therapies, or alternative medicine techniques. Application of this information in a clinical setting has a positive impact in shaping injured employee return to work outcomes. The *ODG Foreword* notes that studies included in the ODG are focused on one outcome: doing what is best for the injured employee. Additionally, the *ODG Foreword* reports the results of a study conducted in Ohio by CompManagement, Inc. The pilot study found that “following adoption of ODG statewide, results at CompManagement demonstrate savings in medical costs of 64 percent, in lost days of 69 percent, and minimized treatment delays.”

Further, the ODG guidelines are designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care by providing clear data on optimum frequency and duration of treatments. The ODG treatment guidelines explain that claims should ideally be managed based on the details of the case using the “Procedure Summary.” The ODG Procedure Summary

includes possible therapies and diagnostic methods, and provides a summary and reference to the most recent medical evidence with an indication of whether the procedure is recommended, not recommended, or under study. Within a Procedure Summary, ODG provides guidelines for instruction that include specific utilization review criteria often presented in an algorithmic format. Quality and timely care in workers' compensation cases have become synonymous with overall cost containment. The level of cost containment is directly proportional to the degree of over-utilization of medical treatment currently experienced within the system. Therefore, ODG satisfies the statutory requirement for adoption of treatment guidelines in the State of Texas.

The Division disagrees that ODG does not describe its process for rating the evidence for the treatment recommendation. The process used to rate the evidence for the ODG treatment guidelines is provided in the *ODG Explanation of Medical Literature Ratings*, the *Methodology Outline*, and *Appendix A, Methodology Description using the AGREE Instrument*. The Division disagrees that ODG does not describe its expert review process. *ODG Treatment* includes a detailed document entitled *Appendix A, Methodology Description using the AGREE Instrument*. This Appendix includes information about the involvement of stakeholders and further describes the review process by the ODG Editorial Advisory Board in the rigor development portion.

§137.100: Commenter states that the abstracts of studies are mostly the work of others and few are original to ODG. Depending on journal policy, abstracts may be created for a variety of purposes, and cannot be presumed to represent “evidence” of a degree suitable for guideline development. Abstracts cannot be presumed to represent evidence of a degree suitable for guideline development.

Agency Response: The Division clarifies that actual studies, not abstracts, are used to formulate the conclusions for the guidelines and abstracts are provided as an accommodation to the subscribers. The RAND Institute determined that ODG, and the other four guidelines studied, scored high in the rigor of development domain by clearly describing the methods used to search for evidence and formulate recommendations (RAND, *Evaluating Medical Treatment Guideline Sets for Injured Workers in California* p. 32).

§137.100: Commenters state that although ODG cites numerous abstracts and guidelines to support its conclusions, misclassification of the evidence, the use of a simplistic method to assess study quality, failure to identify the means through which low quality evidence was used for recommendations, and not providing a description of how the advisory panel functions do not meet the criteria for evidence-based guidelines as set forth in the Agree Criteria and similar documents in the peer-reviewed literature.

Agency Response: The Division disagrees that ODG does not follow all of the steps integral to the process of creating evidence-based medical treatment

guidelines. *ODG Treatment* includes a detailed document entitled *Appendix A, Methodology Description using the AGREE Instrument*. This Appendix provides an extensive explanation of how *ODG Treatment* meets each of the 23 criteria established by *AGREE*, including the rigorous means of developing the guidelines as described by the criteria for selecting the evidence and the methods used for formulating the recommendations. The Appendix describes stakeholder involvement with a reference to the *ODG Treatment in Workers' Comp. Editorial Advisory Board*. The *ODG Treatment Methodology Outline* describes the review by the ODG Editorial Advisory Board. The outline provides that "prior to publication, members of the ODG Editorial Advisory Board, as well as select organizations and individuals making up a cross-section of medical specialties and typical end-users externally review *ODG Treatment in Workers' Comp*. This same review process is continued on an annual basis." According to the *AGREE Instrument Training Manual 12 (2003)*, there is no standard by which the guideline advisory group should function, other than meeting the *AGREE Instrument* recommendation to have a representation of all the professional groups that are likely to use the guidelines, information about the composition of the guideline development group, which should include the affiliation and discipline of the group members. The RAND Institute determined that ODG, and the other four guidelines studied, scored high in the rigor of development domain by clearly describing the methods used to search for evidence and formulate recommendations. Further, the RAND study found that ODG, and the other

guidelines studied, included most of the relevant groups in the guideline development process. (RAND, *Evaluating Medical Treatment Guideline Sets for Injured Workers in California* p.32).

§137.100: Commenter questions whether the guidelines are editorially independent from the funding body since the ODG methodology outline acknowledges that contributors may be compensated. Commenter states that litigation is pending against the WLDI in federal court in the case of *Ranavaya v. WLDI*, U.S. District Court for the S.D. of West Virginia, Case No. 2:05-CV-109. Commenter provides documentation of the complaint and states that the plaintiff alleges breach of contract in connection with a royalty agreement, breach of a confidentiality agreement, and conversion of confidential business information. Commenter notes the pending litigation reveals that compensation to editors and contributors can include commissions on sales of products. Commenter takes no position on the merits of the case. Commenter further states that item 22 of the *Methodology Description Using the AGREE Instrument* provides that “The guideline is editorially independent from the funding body.” Commenter provides that ODG revised item 22 of the *AGREE Instrument* to state “The guideline is editorially independent from the functioning body.”

Agency Response: The Division disagrees that ODG is not editorially independent from the funding body. WLDI discloses in *ODG* that “the funding body is WLDI, an independent database development company focused on workplace health and productivity, founded in 1995, to create, maintain and

market information databases to implement standards for managing workforce productivity based on strict principals of evidence-based methodology, with ongoing focus on health care cost containment. There are no conflicts of interest among the guideline development members.” The RAND Institute used the *AGREE Instrument* to evaluate the editorial independence of ODG. (RAND, *Evaluating Medical Treatment Guideline Sets for Injured Workers in California p. xx and. 33*). To demonstrate editorial independence, it is necessary to demonstrate that a guideline is editorially independent from the funding body, and that conflicts of interest of guideline development members are recorded. *Id.* at 30. Applying the *AGREE Instrument*, the RAND Institute, determined that *ODG* demonstrated the editorial independence of its development group. *Id.* at p. xx and 33.

§137.100: Commenter provides that procedural summaries should indicate whether linked articles are rated as high quality evidence or low quality evidence. Commenter believes that listing low quality articles in the high quality article section mischaracterizes and bolsters the low quality article. Commenter states there is no indication that the links meet the statutory requirements of being evidence based and scientifically valid. Commenters provide examples to support this position.

Agency Response: The Division disagrees. Each article cited in ODG receives a rating, indicating the level of quality. These quality ratings are contained with the article summary, and they are available to users when they click on the links to each article. See, *ODG Explanation of Medical Literature Ratings*. Within the Procedure Summaries, there are no high quality article sections or low quality article sections. Each treatment guideline summary and subsequent recommendation in ODG is hyper-linked into the studies on which it is based, in abstract form, which have been ranked, highlighted and indexed. See ODG Methodology Outline at www.odg-disability.com/methodology_outline.pdf. These references allow users to evaluate the strength of medical evidence behind guideline recommendations. If they disagree with the ODG rating of a study, the ODG interpretation of a study, or if they think ODG has overlooked a specific study, they are encouraged to provide their feedback to the ODG authors. The classification of the article as a high priority reference or a low priority reference appears after the procedure summary and in the summaries of the medical studies. The summaries of the medical studies include a rating to evaluate the quality of the study.

§137.100(a): Commenter recommends return to work and treatment guidelines be the same for both in network and non-network claims as it would be less confusing.

Agency Response: The Division is unable to make this change because workers' compensation networks are governed by the Insurance Code. Workers' compensation health care networks certified in accordance with Insurance Code §1305 may choose a treatment guideline or guidelines to suit their individual business requirements and health care models. It is not feasible for the Division to adopt multiple guidelines and maintain a consistency with all certified networks. The position of the Division is that this would create greater confusion and would not lead to any kind of consistency.

§137.100(a): Commenter states ODG guidelines were formulated by occupational medicine doctors, and not orthopedic surgeons or neurosurgeons, even though orthopedic surgeons or neurosurgeons will manage 80-85% of the serious workers' compensation injuries.

Agency Response: The Division disagrees. According to the *ODG Treatment in Workers' Comp*, 26 (2006); *ODG Treatment in Workers' Comp, Editorial Advisory Board*, 5-8 (2006); and *ODG Treatment in Worker's Comp, Methodology Description Using the AGREE Instrument*, 1573-1574 (2006), ODG is independent of any medical specialty group and multidisciplinary in scope. These references further support that ODG represents various medical specialties, including occupational medicine doctors, orthopedic surgeons, chiropractors, and physical therapists.

§137.100(a): Commenter recommends the ODG treatment materials should efface any return to work content. Commenter supports this recommendation with a statement that the effectiveness of MDA return to work guidelines may be jeopardized by the format and structure of the ODG's intermingling of return to work guidelines throughout their treatment recommendations. This intermingling will expose non-network claims users to the risk of applying the incorrect ODG return to work information on Texas employees.

Agency Response: The Division agrees and §137.100 is revised to indicate that the adoption of ODG Treatment in Workers Comp does not include the ODG return to work pathways.

§137.100(a): Commenters support ODG. A commenter states the ODG offers strong evidence-based support for the use of behavioral interventions among injured employees and for those with chronic conditions. Another commenter states the adoption of ODG will best serve the purpose intended by the Texas Legislature to serve as a treatment guideline required for use in non-network claims. Commenters state ODG incorporates an integrated approach, which includes a section promoting patient education and involvement in their own care. Commenter also states ODG is used successfully in 13 other states and provinces, decreases costs, and is totally independent, not related to any medical organization. Commenter states they have adopted and utilize ODG treatment guidelines as an educational tool for member physicians, especially for non-

occupational medicine doctors. Commenter also states that for physicians who have purchased ODG the cost has not been an issue.

Agency Response: The Division appreciates the supportive comments regarding the use of ODG.

§137.100(a): Commenter opines that sections of the ODG do not have a specific evidentiary basis, and provides the example of intervals between medical visits and number of physical therapy visits outlined. Commenter states there may be incongruence between the health care provider's treatment plan and what is in the guidelines.

Agency Response: The Division agrees that although in certain circumstances incongruence between the guidelines and the health care provider's treatment plan may occur, both health care providers and insurance carriers must apply the disability management concepts in a manner that supports the goal of improved return to work outcomes.

§137.100(a): Commenter recommends deletion of a bifurcated system approach (e.g., network vs. non-network) with the following language substitution: "Health care providers shall provide treatment in accordance with treatment guidelines that are being used by workers' compensation health care networks."

Agency Response: The Division disagrees. Such an approach leads to uncertainty as to which guideline is being used. Network choices are based on

individual business practices and health care models adopted by the network and are not necessarily consistent between networks. Consequently, it is not feasible for the Division to adopt the same guidelines as certified health care networks and maintain a consistency with all certified networks.

137.100(a): Commenter recommends the use of ACOEM as a treatment guideline. Commenters, in the alternative, suggest use of two guidelines when the primary guideline does not address the condition or procedure. Commenter recommends the use of ACOEM and ODG while the Division reevaluates both in more depth. Commenter suggests using ACOEM as the primary guideline and ODG as the secondary guideline for treatment not covered by ACOEM. Commenter further recommends the use of other guidelines or evidence when a condition or procedure is not sufficiently addressed by ODG or ACOEM. Another commenter states the proposed rule will create significant confusion among Texas employees, network health care providers and third parties because the Division has selected a single treatment guideline that would apply only in non-network care. Commenter asserts that the validity of ODG evidence-based guidelines being linked to the evidence in the studies and references relevant to specific treatment is questionable. ODG guidelines are based on selected studies, many of which do not meet reasonable, scientific criteria. Commenter believes ODG does not include a comprehensive and critical review of relevant literature in support of many of the guidelines, especially those related to the

management of pain. Commenter additionally disagrees that ODG meets the criteria for recognition by AHRQ, as official acknowledgment of privately sponsored guidelines does not exist.

Agency Response: The Division declines to adopt ACOEM instead of ODG, or to adopt ACOEM in addition to ODG, at this time. The adopted ODG meets the requirement of the Labor Code, is consistent with the goals of the Division and at this time best meets the objectives of HB 7. However, the Division agrees that documentation may be submitted to support a diagnosis or treatment not addressed by ODG. Such documentation could include other guidelines, such as ACOEM, when certain treatments or services are not included or addressed by ODG. The Division disagrees that confusion will occur among Texas employees, network health care providers and third parties because the Division has selected a single treatment guideline that would apply only in non-network care. The Division disagrees that ODG does not include a comprehensive review of the literature in support of the treatment guideline. Actual studies, not abstracts, are reviewed to formulate the guideline recommendations. *The ODG Methodology Outline* provides sufficient detail about the development of ODG. The recommendations are based on the available studies that have been conducted and released, noting that studies are sometimes not available for publication. With regard to the management of pain, *ODG* includes a treatment guideline devoted specifically to pain. *ODG* indicates that its higher priority references for the management of pain address behavioral interventions, complementary

alternative medicine, injections, low back pain, medical treatment guidelines, medications, assessment and management, chronic pain, miscellaneous, psychological evaluation and treatment, reflex sympathetic complex regional pain syndrome, therapeutic intervention, and spinal cord stimulation. *ODG* at 1258-1272. *ODG* indicates that its low priority references for the management of pain address complimentary alternative medicine, injections, low back pain, medical treatment guidelines, medications, assessment and management, chronic pain, miscellaneous, psychological evaluation and treatment, and therapeutic intervention. *ODG* 1273-1276. The Division acknowledges that inclusion of a guideline in the National Guideline Clearinghouse does not constitute an endorsement or recognition by AHRQ or any of its contractors of the guideline.

§137.100(a): Commenter recommends adoption of at least one set of treatment guidelines that have been developed by the medical profession, such as ACOEM. Commenter states this would ensure that practicing orthopedists have the flexibility to treat injured employees in the most clinically appropriate way and to ensure consistency with care that may be provided in network settings.

Agency Response: The Division declines to make the recommended change. The adopted *ODG* meets the requirement of the Labor Code, is consistent with the goals of the Division, and best meets the objectives of HB 7. The Division anticipates health care providers' ability to use these tools, and the treatment guidelines as a framework to develop treatment for injured employees. The

health care provider must consider care above or below the guidelines consistent with the unique factors associated with an injury. The rules anticipate certain care outside or inconsistent with the treatment guidelines be managed through treatment planning and coordinated with the preauthorization process. Injured employees continue to be entitled to necessary medical care in accordance with Labor Code §408.021. The Division will monitor the use of the disability management tools by all system participants to assure compliance with the intent of HB 7.

§137.100(a): Commenter is encouraged that the chosen guidelines meet the National Guidelines Clearinghouse's inclusion criteria. Commenter recommends that the Division consider development of a continuous monitoring of treatment guidelines implementation with practicing physician input. Commenter states the Division should understand that no single set of guidelines will address all medical situations and that adopted guidelines will be imperfect and need constant review and editing.

Agency Response: The Division position is that meeting the criteria for inclusion in the National Guidelines Clearinghouse registry supports the selection of ODG as Division treatment guidelines. The Division also agrees that the studies and research supporting evidence-based medicine are dynamic. ODG's web version includes ongoing review and updates as new research and studies become available.

§137.100(a): Commenter recommends clarification to state that treatment in conformance with the adopted guidelines are binding unless a particular patient has a diagnosis or needs a therapy regimen, surgery or treatment not covered by the ODG treatment guidelines. Commenter states that ODG is not a default treatment guideline to a preferred one selected by the insurance carrier.

Agency Response: The Division disagrees that additional clarification is necessary. Care within the guidelines is presumed reasonable and reasonably required as stated in §137.100(c). Such care may be retrospectively reviewed by the insurance carrier to confirm medical necessity. Care not addressed by the guidelines or that exceeds the guidelines requires preauthorization, in some cases the preauthorization request may be through a treatment plan. The Division agrees that ODG is the adopted Division treatment guidelines.

§137.100(a): Commenter recommends the adoption of one treatment guideline for the workers' compensation system, as this would facilitate recruitment of physicians.

Agency Response: The Division agrees that treatment and return to work guidelines help establish benchmarks for treatment and return to work for the workers' compensation system. Standards tend to clarify the expectations of system participants and should, when fully integrated into the system, decrease

administrative hassles. In the long term this approach should improve injured employees' access to care.

§137.100(c): Commenters have concerns with provisions in the rule proposals that would allow health care providers to submit treatment plan for services that are provided in accordance with the Division treatment guidelines. Submission of a treatment plan to an insurance carrier for preauthorization for services that are presumed to be “reasonable” and “reasonably required” to the insurance carrier would unnecessarily add requirements and costs to stakeholders.

Agency Response: The Division agrees that this provision when applied with proposed §137.100(d) could be burdensome to insurance carriers. Subsection (d), as proposed, is deleted and clarifying language regarding care within the guidelines and treatment plans has been added to §137.300.

§137.100(c): Commenter recommends the rule require IROs to consider the treatment guidelines adopted and explain any deviation.

Agency Response: The Division disagrees that additional language regarding IROs is necessary or appropriate within this section. The position of the Division is that IRO decisions should be fully explained and documented in accordance with applicable IRO rules.

§137.100(c): Commenter recommends deleting the §401.011(22-a) Labor Code reference from the rule, so that the subsection would read, "Health care provided in accordance with the Division treatment guidelines is presumed reasonable as specified in Labor Code §413.017."

Agency Response: The Division disagrees with commenter's recommendation because inclusion of both statutory definitions is necessary to properly convey the Division's policy which includes both reasonable and reasonably required health care.

§137.100(c): Commenter recommends clarification that presumption of reasonableness of care will only be applied when the underlying diagnosis of the care is undisputed, or upon final resolution of the diagnosis in dispute.

Agency Response: The Division disagrees with commenter's recommendation because issues of compensability, extent of injury and liability and how those issues are resolved are outside the scope of this rule. These new sections relate to disability management and any issues of compensability, extent of injury and liability will still need to be addressed by the appropriate statutes and rules.

§137.100(c): Commenters recommend adding the following language to subsection (c): "Health care services should not be denied or approved simply because they are included or excluded from the Division treatment guidelines." Not all services listed in the guidelines will be medically necessary for every

patient, just as some patients may need services in excess of those listed in accordance with the treatment guidelines. The basis of evidence-based guidelines is that the clinical presentation of the patient allows the physician to prescribe the most appropriate and effective treatment.

Agency Response: The Division declines to make the recommended changes. Adopted subsection (e) allows insurance carriers to retrospectively review treatment within the guidelines for medical necessity. This is consistent with the concept that not all care is necessary in every instance.

§137.100(c): Commenter believes the intent of HB 7 and these rules is that treatments contemplated in the guidelines are presumed appropriate and necessary only where the health care provider's diagnosis is based on objective, documented, evidence-based medical findings (e.g., not subjective complaints alone) be clearly stated in the rule. Commenter states this concept helps to clarify what health care providers must do before enjoying the presumption of medical necessity.

Agency Response: The disability management concept and corresponding guidelines are intended as a tool to assist system participants not to limit necessary health care services. If an insurance carrier disputes a diagnosis they may seek a treating doctor examination to define the compensable injury or a designated doctor examination. The Division clarifies that issues related to compensability, extent of injury and liability are outside the scope of this rule.

§137.100(c): Commenter is concerned that this subsection is too rigid and does not take into account claims in which the treatment required to “cure or relieve” the compensable injury will exceed the adopted treatment guidelines.

Agency Response: The Division acknowledges the commenter’s concerns and notes that the adoption of treatment guidelines does not diminish the provisions of §408.021 of the Labor Code. The adopted disability management rules are intended to facilitate the efficient delivery of health care and promote early and appropriate return to work.

§137.100(d) and §137.300(b): Commenter recommends reduction of the “hassle factor” in order to get more medical providers back into the workers’ compensation system. Commenter recommends that if treatment guidelines are adopted, then a doctor treating within the guidelines should be automatically preauthorized and automatic preauthorization means that they will be paid unless it is found non-compensable.

Agency Response: The Division agrees that reducing hassle factors in the workers’ compensation system is an important concept in developing a health care provider-friendly environment and intends for the treatment guidelines to provide a framework of benchmarks for system participants. These benchmarks help define expectations and health care providers benefit from clear expectations. The Division disagrees that care within the guidelines be deemed

preauthorized. Although care within the guidelines is presumed reasonable and reasonably required, it is unlikely that all care within the guidelines will be medically necessary or required in each specific case. The treatment guideline rule allows the insurance carrier, when appropriate, to deny payment for care that is not medically necessary even though the care was included in the guideline. That denial of payment must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017.

§137.100(d): Commenter supports the inclusion of the term “health care provider” as opposed to doctor throughout the rule as it keeps the proposed rule consistent with the Division preauthorization rule.

Agency Response: The Division agrees that the reference was not clear and subsection (d) is deleted. Reference to this process is more appropriately addressed in the §137.300 and is clarified in that section.

§137.100(d): Commenter states that to require preauthorization of a treatment plan negates voluntary certification as allowed by §413.013(f). Another commenter also suggests that education efforts are needed to promote the more appropriate use of voluntary certification for participants, as commenter advocates for the deletion of the proposed preauthorization of care for treatments and services within the adopted guideline. Commenters also state that this

provision is in conflict with Labor Code 413.014(f), which provides that an insurance carrier and health care provider may voluntarily discuss health care treatment and treatment plans, and, the insurance carrier may certify or agree to pay for health care consistent with these agreements.

Agency Response: The Division disagrees the treatment guidelines conflict with the Labor Code. Insurance carriers and health care providers may continue to discuss and voluntarily certify care not subject to the preauthorization and concurrent review requirements of Division §134.600. The Division disagrees that additional education efforts are necessary to facilitate voluntary certification. After four years of Division data collection efforts regarding preauthorization and voluntary certification, it is noted that voluntary certification is used infrequently. Anecdotally, health care providers have reported to the Division the unwillingness of insurance carriers to significantly participate in the voluntary certification process.

§137.100(d): Commenter states that the insurance carrier is allowed to deny any recommendation beyond the guidelines as being unreasonable or not medically necessary, while the rule as a whole seems to state all medical treatment is limited to that provided in the guidelines, or subject to a preauthorized treatment plan when the proposed treatment exceeds the guidelines.

Agency Response: The Division clarifies that injured employees are entitled to medical services as specified in the Labor Code. Adoption of treatment

guidelines and treatment planning provide benchmarks for system participants to develop treatment for injured employees. The Division anticipates certain care may be outside or inconsistent with the treatment guidelines and in order to efficiently manage those situations the rules implement treatment plans so that injured employees may continue to receive necessary medical care in accordance with the Labor Code.

§137.100(d): Commenter recommends if the proposed requirements for treatment plans are adopted, then commenter recommends deletion of subsection (d). Commenter states the rules as proposed could be an unnecessary administrative burden on system participants.

Agency Response: The Division clarifies that subsection (d) as proposed is deleted. Requirements related to treatment planning are included in §137.300.

§137.100 (d) and (f): Commenter states that the implementation of these rules will be a learning curve and behavior change for all system participants, and further states no one should believe that medical necessity denials for inappropriate care will cease with adopted treatment guidelines.

Agency Response: The Division believes that the framework of treatment guidelines and treatment planning should lead to a better understanding of overall system benchmarks. Appropriate consistent use and application of these

tools should decrease inappropriate treatments and inappropriate denials of medical necessity.

§137.100 (d) and (f): Commenter recommends the deletion of subsections (d) and (f) so that all health care rendered within the treatment guidelines is considered reasonable and appropriate. Commenter believes the provisions of subsections (d) and (f) are contrary to legislative intent as the rationale behind HB 7's requirement in §413.011 of the Labor Code is to adopt treatment guidelines that provide the workers' compensation system with a communication tool whereby both health care providers and insurance carriers would have a mutual understanding that health care provided within the guidelines is considered appropriate and medically necessary. Commenter states the proposed rules increase the administrative burden of the health care provider. This burden is exacerbated by the ability of the insurance carrier to deny on relatedness and the inability of these rules to address compensability issues. This will result in more health care providers leaving the workers' compensation system.

Agency Response: The Division disagrees that subsections (d) and (f) are contrary to legislative intent. However, proposed subsection (d) is deleted from this rule and clarifying language is added to §137.300 to specify the requirements of treatment planning. As a result of that deletion, subsection (f) is now subsection (e). Although care provided within the guidelines is presumed to be

reasonable, renumbered subsection (e) identifies that this is a rebuttable presumption based on the specific facts of the claim. Not all injures will need all care identified in the guidelines and some claims may need treatments or services not identified or in excess of the guidelines. The Division notes that the disability management rules have not been developed to deal with compensability or extent issues that are addressed in other Division rules. The Division believes adoption and implementation of the disability management concept and associated rules will increase communication opportunities for system participants, bring structure and certainty to the process, and ultimately decrease administrative burdens for system participants.

§137.100(d): Commenters recommend deleting subsection (d), including the deletion of the reference to subsection (d) in subsection (f). As the proposed rules already presume that all treatment according to the treatment guidelines are reasonable and necessary, commenters state that there is no reason to permit the medical provider to submit a request for preauthorization of a treatment plan within treatment guidelines. Commenters believe that submission of a treatment plan for services presumed to be “reasonable” and “reasonably required” is duplicative and adds unnecessary costs and time to stakeholders for the preauthorization process, retrospective audit for preauthorization validation, increased use of the reconsideration process, and increased medical dispute resolution costs, including IRO fees. Sections 137.100(g) and 137.300(a) include

provisions that address when treatment plans are required for submission to the insurance carrier for a medical necessity determination. Commenters further opine that health care providers are afforded resolution of conflicts under Division rules 133.305, 133.307, 133.308, 134.650, and 134.600(r). A commenter suggests this rule provision will increase the number of medical disputes and undermine the treatment guideline by providing for a back-door through which a health care provider can obtain a prospective guarantee of payment of medical bills.

Agency Response: The Division disagrees that proposed subsections (d) and (f) are duplicative of other rule provisions. However, proposed subsection (d) is deleted from this rule and clarifying language is added to §137.300 to specify the requirements of treatment planning. Although care provided within the guidelines is presumed to be reasonable, subsection (e) identifies that this is a rebuttable presumption based on the specific facts of the claim. Not all injuries will need all care identified in the guidelines and some claims may need treatments or services not identified or in excess of the guidelines. Although proposed subsection (d) is deleted and additional language is added to §137.300, the Division disagrees that this provision would be duplicative. This approach prevents unnecessary care and overutilization and insulates health care providers from the cost of providing services that the insurance carriers deem not medically necessary. The Division notes that language has been added to

§137.300 to clarify when treatment within the guidelines should be included in a treatment plan.

§137.100(e): Commenter recommends that if treatment is provided in excess or beyond the scope of the adopted treatment guidelines, then the health care provider should be afforded a peer-to-peer interview with the insurance carrier's doctor within 24 hours.

Agency Response: The Division disagrees that additional direction is required regarding the preauthorization process. Peer-to-peer reviews are accounted for in §134.600. In addition, the time frames established in §134.600 are consistent with Insurance Code, Article 21.58A.

§137.100(e): Commenter expresses concern that the rule as proposed does not explicitly clarify how it dovetails with the preauthorization rule 134.600. Unless clarified, confusion is going to arise about when the treatment guideline rule or the preauthorization rule takes precedence.

Agency Response: The Division notes the commenter's concern and clarifies that details related to treatment planning in proposed §137.100 are deleted, and additional language regarding the relationship between preauthorization, treatment guidelines and treatment planning is added to §137.300.

§137.100(e)(2): Commenter requests clarification as to whether the term “treatment plan” is actually the intended term, or if the subsection refers to any and all services preauthorized in accordance with §134.600.

Agency Response: The Division notes that subsections (d) and (e) are changed to clarify which services an insurance carrier is liable for in excess of the Division treatment guidelines.

§137.100(e): Commenter recommends a new subsection (e) be added, with subsequent subsection re-numbering, to read, “The insurance carrier may not deny payment for health care services delivered in accord with treatment guidelines defined in subsection (a) of this section or an approved treatment plan as defined in section 137.300, relating to Treatment Planning.”

Agency Response: The Division declines to make the change. Although care within the guidelines is presumed reasonable and reasonably required, it is unlikely that all care within the guidelines will be medically necessary or required in each specific case. The treatment guideline rule allows the insurance carrier, when appropriate, to deny payment for care that is not medically necessary even though the care was included in the guideline. That denial of payment must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017. The Division notes that preauthorized care, including preauthorized treatment plans, are not subject to retrospective review of medical necessity. However, other

factors, such as compensability or compliance with other billing requirements, could result in denial of reimbursement.

§137.100(f): Commenter states the rules only require the denying party to reference the source of their denial by simply stating their denial is based on ODG guidelines without being required to identify the specific component of the guidelines alluded to. Commenter states the main problem anticipated is that whatever guidelines are adopted, they will be used in the context of denying treatment.

Agency Response: The Division notes that division rules related to medical billing and reimbursement identify the specific requirements for denial of medical bills. The adopted guidelines establish an initial framework for reasonably required medical care. Although use of guidelines may result in denial of some services, and subsequently, some related medical necessity disputes, the adopted treatment guidelines provide a consistent benchmark for system participants. Overall, adoption of the disability management rules facilitates communication between system participants resulting in improved return to work outcomes.

§137.100(f): Commenter recommends the rules clearly define the responsibility of any reviewing physician to ensure all appropriate medical records are obtained, and states the rules are not sufficiently strong enough when addressing

this issue. Commenter recommends the entity denying the recommendations of the orthopedic surgeon should be required to be a licensed practicing orthopedic surgeon in Texas, who is an active fellow of AAOS. This concept should apply at all levels of any appeals process.

Agency Response: The Division declines. Standards related to the review of proposed medical care and retrospective review of medical care are already defined in the Insurance Code and Division rules, therefore, no additional clarification is needed. Insurance Code 21.58A includes specific requirements for peer-to-peer reviews.

§137.100(f): Commenter opines that a doctor who performs as a patient advocate in initiating medical necessity appeals should not be penalized by having to pay the IRO fee. Commenter further objects to allowing an insurance carrier's critique of the patient's case and subsequently identifying new issues of contention. Labor Code §413.031 relating to Medical Dispute Resolution establishes which party in a medical necessity dispute is responsible for the IRO fee.

Agency Response: The Division recognizes the commenter's concern but notes that these issues are outside the scope of this rule making initiative.

§137.100(f): Commenter recommends a revision to add (e) after the reference to (d) otherwise, insurance carriers may retroactively deny services even if they have been preauthorized or rendered in an emergency.

Agency Response: The Division declines to make the recommended change. However, proposed subsection (d) is deleted from this rule. Further, the Division clarifies that services preauthorized in accordance with §134.600 are not subject to retrospective review of medical necessity as noted in Labor Code §413.014.

§137.100(f): Commenter recommends adding the words “in excess of treatment guidelines and ...” Commenter additionally recommends the deletion of the rest of the sentence referencing subsection (d).

Agency Response: The Division declines to make the recommended change, however proposed subsection (d) is deleted. Additionally, the Division clarifies that proposed subsection (f) (adopted subsection (e)) establishes that the insurance carrier may retrospectively review health care provided within the treatment guidelines unless it has been preauthorized or voluntarily certified. Health care that exceeds the treatment guidelines is required to be preauthorized in accordance with §134.600.

§137.100(f): Commenters recommend deleting the following language from subsection (f): “...not preauthorized under subsection (d) of this section” and “...that outweighs the presumption of reasonableness established by Labor Code

413.017,” in order to provide consistency with the recommendation to delete subsection (d).

Agency Response: The Division declines to make the recommended changes. Subsection (d) as proposed is deleted and new subsection (d) pertains to the insurance carriers' liability for certain health care. The Labor Code §413.017 establishes the presumption of reasonableness. Deletion of the language “...that outweighs the presumption of reasonableness established by Labor Code §413.017,” would effectively negate the presumption of reasonableness established by the Labor Code.

§137.100(f): Commenters recommend the following phrase addition to the last sentence, “...or that demonstrates that the claimant has not benefited from the same or similar type of treatment in the past.”

Agency Response: The Division declines to make the recommended change. Medical necessity is established on a case-by-case basis consistent with the principles of evidence-based medicine. A specific blanket statement as indicated is potentially contrary to the concept of evidence-based medicine as applied to an individual case.

§137.100(f): Commenters suggest the proposed rule may be so restrictive that insurance carriers may not have the tools to combat medical billing, over-utilization, fraud and abuse as the proposal potentially prohibits the insurance

carrier from denying payment in claims when the claimant may have fully recovered from the compensable injury prior to the rendition of care within the guidelines.

Agency Response: The Division disagrees. Adopting the disability management concept leaves all the tools previously available to insurance carriers in place. Further, these disability management rules provide for an improved communication process for health care providers and insurance carriers to discuss an injured employees' health care and offer insurance carriers excellent tools to evaluate the utilization of health care. In addition, subsection (e) allows an insurance carrier to retrospectively review health care provided within the treatment guidelines. The Division is committed to removing fraud and abuse from the workers' compensation system but is equally committed to safeguarding necessary medical care for injured employees.

§137.100(h): Commenter recommends changes to subsection (h) to read, "the insurance carrier shall not deny treatment 'or payment' solely because the diagnosis or treatment is not specifically addressed by the Division treatment guidelines or the Division treatment protocols."

Agency Response: The Division declines to make this recommendation. The recommended language is unnecessary and potentially confusing. Addition of the suggested language could lead to confusion distinguishing between medical and fee disputes. Although treatment denied in accordance with a treatment

guideline leads to denial of payment, the dispute should be processed as a medical necessity dispute and proceed according to §133.308.

§137.100(i): Commenters support the effective date of January 1, 2007, provided at least 45 days to implement the new treatment paradigm is available for system and process changes to occur that are necessary for compliance.

Agency Response: The Division agrees. The implementation date for treatment guidelines has been changed to May 1, 2007.

§137.300: Commenters recommend added language to specify the information that should be included on a treatment plan submitted by the treating doctor and a requirement for a standard format with the inclusion of all diagnoses and associated treatments. A commenter recommends the treatment plan should identify co-morbid conditions that affect the treatment being requested for the injury. Commenter makes an additional recommendation to add language to §137.300 to specify the information that should be included on a treatment plan in a standardized format with all diagnoses and associated treatments.

Agency Response: The Division declines to make the recommended changes. Treatment plans submitted as a result of this section are required to comply with the requirements of §134.600, which establishes the components of a complete preauthorization request. The request shall include information to substantiate

the medical necessity of the health care requested. Additionally, a specific Division form is unnecessary as long as the requirements of §134.600(f) are met.

§137.300: Commenter understands and agrees that there should be a global treatment plan created and overseen by the treating physician.

Agency Response: The Division agrees and clarifies that only required treatment plans as identified in subsection (a) must be coordinated by the treating doctor.

§137.300: Commenter states in the initial phase, health care providers with a proven track record of achieving desired outcomes should be allowed to pursue treatment plans that have proven to be effective, particularly for patients identified as at risk for delayed recovery. Commenter explains such necessity may modestly exceed the guidelines.

Agency Response: The Division disagrees. Health care outside the guidelines requires preauthorization and in specified circumstances treatment planning through the preauthorization process. This increases the opportunity for communication between health care providers and insurance carriers, minimizes over utilization of services and adds to surety of payment for health care providers.

§137.300(a): Commenters recommend a health care provider submit a treatment plan only upon the request of the insurance carrier or the insurance carrier's utilization review program. A commenter recommends the timeline be established at 20 days for the treatment plan submission. Another commenter recommends a treatment plan be required once a claim becomes at risk for excessive lost time and poor return to work and recovery outcomes. The process should be used prudently on those claims at greatest risk for poor outcomes since processing treatment plans is burdensome to the system participants.

Agency Response: The Division disagrees. The intent of the disability management rules is to provide tools for the efficient utilization of health care. In order for these tools to be used consistently, criteria for the use of treatment planning is established in these rules. Treatment planning, when conducted only at the request of the insurance carrier, would allow for vastly different standards between insurance carriers and potentially lead to additional administrative costs and confusion for health care providers. This would defeat the purpose of establishing benchmarks for consistent use throughout the system and hinder efforts to compare and identify high performers in the system.

§137.300(a): Commenters recommend a limit to the specified period of time that can be covered by a treatment plan. A commenter recommends rule clarity as to the length of time the treatment plan is to cover with caution and consideration

given to the expense of processing preauthorization requests. Another commenter recommends that both this section and §134.600 should state that durations for treatment plans be no more than 30 days, as commenter believes a treatment plan should be limited to a specified time frame. Commenter notes that §134.600(g) provides for a sixty-day time frame to request health care for treating an injury or diagnosis that is not accepted by the insurance carrier in accordance with Labor Code §408.0042.

Agency Response: The Division agrees that treatment plans should cover a specified time period and the language has been changed to indicate that treatment plans shall cover health care treatments and services to be provided to the injured employee for a minimum of 30 days. Insurance carriers and health care providers may negotiate a longer time frame that is appropriate to the specific case as part of the treatment plan through the preauthorization process. For example, a treatment plan covering an extended period of time may be appropriate for a catastrophic injury. Communication between insurance carriers, health care providers and injured employees should lead to an effective treatment planning process minimizing inappropriate requests and/or denials. The Division disagrees that the time period for treatment plans should mirror §134.600(g). The treatment plans addressed by §134.600(g) serve a specific purpose related to compensability issues and the dispute resolution time frames.

§137.300(a)(1): Commenter recommends the use of a lost time parameter as criteria for requiring treatment planning for at risk claims. Additionally, commenter states the other criteria for requiring treatment planning are reasonable.

Agency Response: The Division agrees that the disability management and the treatment planning process would benefit from the inclusion of a time parameter as a trigger for treatment planning. The rule is changed to establish a treatment planning link to the optimum days listed in adopted §137.10 or 60 days from the date of injury, whichever is greater.

§137.300(a): Commenter states the rule lacks details pertaining to amended or modified treatment plans.

Agency Response: The Division disagrees that additional explanation is necessary because changes or extensions of care in a preauthorized treatment plan are addressed through the concurrent review provisions of §134.600 (q)(6).

§137.300(a): Commenter recommends minimal duration times for specific treatment plans based on aging of claims, but allowing flexibility between treating doctor and payor to ease negotiations.

Agency Response: The Division agrees. The language has changed to require a treatment plan for a minimum of 30 days. Insurance carriers and health care

providers may negotiate a longer duration for a treatment plan as part of the preauthorization process.

§137.300(a): Commenter recommends the development of an accompanying treatment planning form, which could be a modification of the DWC Form-73, to include specific treatment recommendations, CPT codes, and appropriate time frames. Commenter states this would allow for a standardized information set and format to simplify and ease the process.

Agency Response: The Division declines to develop an additional Division form for the submission of treatment plans. Treatment plans submitted as a result of this section are required to comply with the requirements of §134.600 and the new sections.

§137.300(a): Commenters recommend that in addition to specifying who is responsible, the rule specify deadlines for the submission of the treatment plan, and if the treatment plan is not timely submitted, then allow the insurance carrier to request a designated doctor exam for purposes of addressing a treatment plan.

Agency Response: The Division declines because additional language would be duplicative of the provisions of §134.600, which establishes the required elements and time frames for submission of a preauthorization request. Treatment plans are submitted as preauthorization requests. Other Division

rules allow the insurance carrier the option of requesting designated doctor evaluations of medical care and do not require a specified time frame.

§137.300(a): Commenters recommend the following language, "...the treating doctor is required to submit written treatment plans to the insurance carrier within ten (10) working days of receipt of a written request from the insurance carrier when..." Commenters suggest this approach would require the treating doctor to submit a treatment plan as specified in subsection (a)(1-3) only if the insurance carrier has requested a treatment plan in writing. Commenters state a treatment plan is not necessary in all claims in which a diagnosis is not included in the treatment or return to work guidelines, especially if there is not sufficient injury severity to support the time and expense of developing a treatment plan.

Agency Response: The Division declines to make the recommendation to require the treating doctor to submit a treatment plan only if the insurance carrier requests a treatment plan in writing. The change would require the initiation of the treatment planning process only on the request of an insurance carrier. Currently, the Division rejects this concept because treatment planning, when conducted only at the request of the insurance carrier, would allow for vastly different standards between insurance carriers and potentially lead to additional administrative costs and confusion for health care providers. This would defeat the purpose of establishing benchmarks for consistent use throughout the system and hinder efforts to compare and identify high performers in the system. The

Division agrees that a treatment plan may not be required in all instances. With the adoption of treatment guidelines a majority of injuries and treatment for injuries that resolve quickly are likely addressed within the treatment guidelines and would not require a treatment plan. Additionally, language has been changed to require treatment plans in only certain circumstances.

§137.300(a): A commenter recommends the deletion of the reference to diagnosis not addressed by the return to work guidelines in subsection (a)(2). The commenter states a lack of diagnosis being included in the Division's return to work guidelines is irrelevant when addressing the appropriateness and medical necessity of health care in the Texas Workers' compensation system.

Agency Response: The Division agrees and the reference to diagnosis not included in the return to work guidelines is deleted from subsection (a).

§137.300(a): Commenter recommends adding in subsection (a) an additional requirement stating, "treatment plans are required when treatment is outside the optimum return to work guidelines are exceeded."

Agency Response: The Division agrees that criteria for required treatment plans should include a lost time reference and subsection (a) is changed to link to the adopted return to work guidelines.

§137.300(a): Commenter recommends substitutions of “reasonably” for “all” to subsection (a) to read, “A treatment plan shall include the identification of ‘reasonably’ anticipated health care and treatment and services to be provided to the injured employee for a specified period of time.”

Agency Response: The Division agrees in concept and the language has been changed to incorporate the language *all reasonably anticipated* into subsection (a).

§137.300(a): Commenter recommends amended language to also state that treatment planning rules have been adopted to improve the quality of treatment provided to injured employees and improve return to work outcomes in the Texas workers' compensation system, and to confirm that the rules do not apply to claims subject to workers' compensation health care networks under Chapter 1305 of the Insurance Code.

Agency Response: The Division declines to make the recommended change, as similar language is already included in §137.1. The Division declines to make the modifications to the rule that reiterates the provisions of the Labor and Insurance Codes. Labor Code, §413.011(g) provides that rules adopted relating to disability management do not apply to claims subject to workers' compensation networks. Workers compensation networks are required to adopt their own treatment guidelines, return-to work guidelines, and individual treatment protocols, pursuant to Insurance Code §1305.304. Based on the

specificity of the Labor Code and Insurance Code provisions, the Division believes it is unnecessary to restate such provisions in the adopted rules.

§137.300(b): Commenters recommend the deletion of subsection (b) and any references to it in the remaining, re-numbered subsections. Subsection (b) as proposed would be an administrative burden for system participants. Voluntary certification, preauthorization, and concurrent review issues would be intermingled in a single treatment plan, because this treatment is already outside the treatment guidelines. Commenters state the recommended deletion of subsection (b) would be consistent with other recommended section and subsection deletions that pertain to treatments and services or treatment plans that are presumed to be reasonable. Submission of a treatment plan for services that are presumed to be “reasonable” and “reasonably required” adds unnecessary requirements and costs to stakeholders. A commenter opines that §137.100(g) and §137.300(a) include provisions that address when treatment plans are required for submission to the insurance carrier for a medical necessity determination.

Agency Response: The Division agrees to change subsection (b) and the permissive language regarding treatment planning for treatments and services within the Division’s treatment guideline is deleted.

§137.300(c): Commenter states that when an orthopedic surgeon is not defined as the treating doctor, then communication of any denials and subsequent appeals bypass the orthopedic surgeon. By rule, the commenter notes, the insurance carrier only needs to communicate with the treating doctor. Commenter additionally opines that the control and management of a patient post-operatively should be clearly defined as the responsibility of the surgeon and not abrogated to the treating doctor.

Agency Response: The Division disagrees that communication of any denials and subsequent appeals will bypass the health care provider if that health care provider is not also the treating doctor that submits the treatment plan to the insurance carrier. However, the adopted rule added language in subsection (e) to facilitate communication between the necessary parties and provides that the treatment plan include the contact information of the health care providers involved in the delivery of care proposed within the treatment plan and requires the treating doctor to inform the health care provider(s) of the approval or denial of the treatment plan. In addition, prior to an adverse determination by a utilization review agent and subject to notice requirements, the health care provider who orders the service submitted by the treating doctor in the treatment plan, is afforded a reasonable opportunity to discuss the plan of treatment for the injured employee with the appropriate doctor or health care provider performing the review in accordance with Insurance Code Article 21.58 A §4(k), recodified as §4201.206.

§137.300(c): Commenters recommend changing the rule from treating doctor to requesting doctor. Commenters state that treating doctors may not be able to adequately support and defend preauthorization requests for specialty treatment, thereby, delaying necessary treatment to injured employees. Commenters state this approach was previously required in the Texas workers' compensation system and it created extreme periods of delayed recovery, inefficiencies, and disputes. A commenter states this provision is another administrative burden upon the treating doctor and, therefore, recommends striking the language requiring a treating doctor to submit the treatment plan. Another commenter notes the proposed rule appears to conflict with multiple utilization review regulations within the Division and TDI requiring review of service by same licensed type and/or specialty as the requestor.

Agency Response: The Division declines to make the recommended revision. The treating doctor is responsible for efficient and cost-effective utilization of health care as outlined in the Labor Code §§408.021(c), 408.023(l), and 408.025(c). In order to fulfill this responsibility, treating doctors must be proactively involved in the development and support of services and treatments recommended for the early and appropriate return to work of injured employees. The Division disagrees that there is a conflict as to §21.58A of the Insurance Code. Insurance Code Article 21.58A §4(i), recodified as Section 4201.153(d), provides that denials of treatment must be referred to an appropriate physician,

dentist, or other health care provider to determine medical necessity. Therefore, the statute requires review of service by an appropriate health care provider, not necessarily review by a health care provider with the same type of license and/or specialty practice. In addition, prior to an adverse determination by a utilization review agent and subject to notice requirements, the health care provider who ordered the service submitted by the treating doctor in the treatment plan, is afforded a reasonable opportunity to discuss the plan of treatment for the injured employee with the appropriate doctor or health care provider performing the review in accordance with Insurance Code Article 21.58 A §4(k), recodified as §4201.206.

§137.300(c): Commenters recommend revising the paragraph and offer suggested language so that the treating doctor is still required to express concurrence with the plan in writing, but once obtained, the health care provider actually rendering the service may submit their own plan directly to the insurance carrier and be the health care provider conferring with a peer if necessary to discuss the treatment plan. One commenter offered the following recommended revision, “When a health care provider develops a treatment plan pursuant to subsection (a) or (b) of this section, it shall be submitted to the treating doctor who will indicate approval of the plan in writing. The treating doctor or his representative shall then submit the approved plan to the insurance carrier to be processed as a preauthorization request pursuant to §134.600 of this title

(relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care).” Another commenter’s recommendation is to seek the treating doctor’s sign-off on the proposed treatment plan that the physical therapist/occupational therapist establishes, and then that treatment plan is submitted to the insurance carrier for approval.

Agency Response: The Division declines to make the recommended changes. §§401.011, 408.021, 408.023, and 408.025 of the Labor Code detail the responsibilities of a treating doctor. These responsibilities include the efficient management of medical care, the efficient utilization of health care, and except in an emergency, the responsibility to approve or recommend all health care. The Labor Code clearly intends the treating doctor to be the focal point for health care provided to an injured employee. The treatment planning process is the tool that facilitates the ability of the treating doctor to meet his or her obligations under the Labor Code. Distributing these responsibilities to other system participants undermines the intent of the Labor Code.

§137.300(c): Commenter recommends deleting the reference to subsections (a) and (b) as this would be consistent with other recommended section and subsection changes/deletions. Commenter asserts it is appropriate for the treating doctor to be the point of contact for treatment plans with the insurance carriers as this is consistent with their gatekeeper role in the workers’ compensation system.

Agency Response: The Division acknowledges the recommendation and notes that the recommendation is addressed through the revision of the section. The section is changed and renumbered to clarify the instances requiring treatment planning and the services required for inclusion in a treatment plan.

§137.300(c): Commenter recommends increasing the preauthorization response time to five days for treatment planning, instead of the current three-day response time in §134.600. Commenter recommends the development of different preauthorization time frame standards for evaluating a comprehensive treatment plan. The Division should seek additional appropriate stakeholder input on the time frames because the time frames in the preauthorization rule are not sufficient for the complexities of a treatment plan.

Agency Response: The Division notes that a revision to the time frames included in §134.600 are outside the scope of this rule. Addition of time frames to this rule would create a bifurcated preauthorization process and likely lead to additional administrative burdens for system participants. Any changes to the time frames included in §134.600 will be addressed through a separate rule making activity which would include stakeholder input.

§137.300(c): Commenter recommends a revision to allow the health care provider to submit a physician approved treatment plan or physician authorization directly to the insurance carrier; or require the insurance carrier to supply

preauthorization to the physician and the involved health care providers individually. Commenter states §137.300(c) as proposed creates an undue burden on the treating doctor and causes delays in receiving timely care.

Agency Response: The Division declines to make the recommended changes. Labor Code §§401.011, 408.021, 408.023, and 408.025 detail the responsibilities of a treating doctor. These responsibilities include the efficient management of medical care, the efficient utilization of health care, and except in an emergency, the responsibility to approve or recommend all health care. The Labor Code clearly intends the treating doctor to be the focal point for health care provided to an injured employee. The treatment planning process is the tool that facilitates the ability of the treating doctor to meet these obligations under the Labor Code. Distributing these responsibilities to other system participants undermines the Labor Code. The Division also disagrees that development of a treatment plan will delay timely care. Treatment planning should lead to the systematic delivery of care, more efficient utilization of services and improved return to work outcomes for injured employees.

§137.300(c): Commenter seeks clarification as to whether the treatment plans must be approved in their entirety as submitted by the treating doctor.

Agency Response: The Division notes that a required treatment plan is on the list of items requiring preauthorization. Criteria for submitting and processing preauthorization requests is established in §134.600.

§137.300(c): Commenter recommends the treating doctor be designated as a gatekeeper or coordinator of care and be reimbursed for those services. Commenter states that if there is an issue of the treating doctor wanting control and continuity of a patient, a copy of the treatment plan submitted to the insurance carrier could be required to be submitted to the treating physician simultaneously.

Agency Response: The Division agrees that the treating doctor has special responsibilities as required by the Labor Code and believes that the disability management concept and associated rules facilitate the treating doctor's ability to successfully comply with those responsibilities. Issues related to reimbursement are not directly addressed in this rule making activity but are included in §134.202 (relating to Medical Fee Guideline).

§137.300(d): Commenter supports the effective date provided there is at least 45 days to implement the new treatment paradigm for system and process changes to occur that are necessary for compliance.

Agency Response: The Division agrees and §§ 137.10, 137.100 and 137.300 are changed to reflect an implementation date of May 1, 2007.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.

For: Work Loss Data Institute.

For, with changes: Individuals, a Legislator, American College of Occupational and Environmental Medicine, Positive Health Management, Healthcare Consulting Associates, State Office of Risk Management, American Airlines, Texas Mutual Insurance Company, Zenith Insurance Company, American Academy of Orthopaedic Surgeons, Somi Healthlink, Reed Group, Ltd., Healthsouth Corporation, Texas Association of School Boards, Insurance Council of Texas, Concentra, Inc., American Insurance Association, Flahive, Ogden & Latson, Law Offices of W.J. Bill Morris, WORK REHAB, Texas Medical Association, BIOMET, Texas Association of Business, Texas Physical Therapy Association, Office of Injured Employee Council, Physicians Cooperative of Texas, and Texas Orthopaedic Association.

Against: Individuals, Texas Association of Neurological Surgeons, and the Texas Spine Society.

Neither For or Against: Fair Isaac Corporation and WorkSTEPS.

6. STATUTORY AUTHORITY. The new sections are adopted under Labor Code §§413.011 (e), 413.011 (g), 401.011, 413.021, 409.005, 408.023, 408.025, 413.017, 413.018, 413.013, 408.021, 402.00111, and 402.061. Section 413.011(e) provides that the Commissioner by rule shall adopt treatment guidelines and return-to-work guidelines and may adopt individual treatment protocols with specific criteria for such adoption. Section 413.011 (g) provides that the Commissioner may adopt rules relating to disability management that are

designed to promote appropriate health care at the earliest opportunity after the injury to maximize injury healing and improve stay-at-work and return-to-work outcomes through appropriate management of work-related injuries or conditions. Section 401.011 contains definitions used in the Texas workers' compensation system (in particular, 401.011(18-a), the definition of "evidence-based medicine," 401.011(22-a), the definition of "health care reasonably required" and 401.011(42), the definition of "treating doctor"). Section 413.021 requires an insurance carrier to provide the employer with return-to-work coordination services as necessary to facilitate an employee's return to employment. Section 409.005 provides the procedure for filing a report of injury, the format to be used, authorizes the adoption of rules regarding the information that must be included in the report, and requires the employer to notify the employee, the treating doctor, and the insurance carrier of the existence or absence of opportunities for modified duty or a modified duty return-to-work program available through the employer. Section 408.023 requires the Division to develop a list of doctors licensed in Texas who are approved to provide health care services under the Workers' Compensation Act and authorizes the Commissioner to adopt rules to define the role of the treating doctor and to specify outcome information to be collected for a treating doctor. Section 408.025 authorizes the Commissioner by rule to adopt requirements for reports and records, and provides that the treating doctor is responsible for maintaining efficient utilization of health care. Section 413.017 provides that certain medical

services are presumed reasonable. Section 413.018 provides that the commissioner by rule shall provide for the periodic review of medical care provided in claims in which guidelines for expected or average return to work time frames are exceeded and the Division shall review the medical treatment provided in a claim that exceeds the guidelines and may take appropriate action to ensure that necessary and reasonable care is provided.

Section 413.013 authorizes the Commissioner by rule to establish programs for prospective, concurrent, and retrospective review and resolution of disputes regarding health care treatments and services, for the systematic monitoring of the necessity of treatments administered and fees charged and paid for medical treatments to ensure that the medical policies or guidelines are not exceeded, to detect practices and patterns by insurance carriers, and to increase the intensity of review for compliance with the medical policies or fee guidelines. Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed (specifically health care that enhances the ability of the employee to return to or retain employment) and provides that, except in an emergency, all health care must be approved or recommended by the employee's treating doctor. Section 402.00111 provides that the Commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Section 402.061 provides that the Commissioner of workers' compensation has

the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

7. TEXT.

CHAPTER 137. DISABILITY MANAGEMENT

SUBCHAPTER A. GENERAL PROVISIONS

§137.1. Disability Management Concept.

(a) Disability management is a process designed to optimize health care and return to work outcomes for injured employees to avoid delayed recovery in the Texas Workers' Compensation System.

(b) This chapter is designed to provide disability management tools, such as treatment and return to work guidelines, treatment protocols, treatment planning, and case management to benchmark, manage, and achieve improved outcomes. The Division may use these tools for the following purposes, including, but not limited to:

- (1) resolving income benefit disputes;
- (2) resolving medical benefit disputes;
- (3) establishing performance-based tiers;
- (4) defining performance-based incentives;
- (5) determining sanctions or penalties;
- (6) performing medical quality reviews; or

(7) assessing other matters deemed appropriate by the Commissioner of Workers' Compensation.

(c) The Division will utilize this chapter to implement and interpret specific provisions contained in Labor Code §413.011(a) and (e), and this chapter takes precedence over any conflicting payment policy provisions adopted or utilized by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program.

(d) Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to Medical Dispute Resolution by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over adopted treatment guidelines, treatment protocols, treatment planning and Medicare payment policies.

SUBCHAPTER B. RETURN TO WORK

§137.10. Return to Work Guidelines.

(a) Insurance carriers, health care providers, and employers shall use the disability duration values in the current edition of *The Medical Disability Advisor, Workplace Guidelines for Disability Duration*, excluding all sections and tables relating to rehabilitation, (MDA), published by the Reed Group, Ltd. (Division return to work guidelines), as guidelines for the evaluation of expected or average return to work time frames.

(b) Information on how to obtain or inspect copies of the Division return to work guidelines may be found on the Division's website: www.tdi.state.tx.us.

(c) The Division return to work guidelines provide disability duration expectancies. The Division return to work guidelines shall be presumed to be a reasonable length of disability duration and shall be used by:

(1) health care providers to establish return to work goals or a return to work plan for safely returning injured employees to medically appropriate work environments;

(2) insurance carriers as a basis for requesting a designated doctor examination to resolve an issue regarding an injured employee's ability to return to work as well as a basis to initiate case management and to refer an injured employee to vocational rehabilitation providers; and

(3) employers, insurance carriers, health care providers, and injured employees to facilitate and improve communications among the parties regarding the return to work goals or plans established by health care providers.

(d) The health care provider, insurance carrier, employer, and Division may consider co-morbid conditions, medical complications, or other factors that may influence medical recoveries and disability durations as mitigating circumstances when setting return to work goals or revising expected return to work durations and goals.

(e) Disability duration values in the guidelines are not absolute values and do not represent specific lengths or periods of time at which an injured employee

must return to work; the values represent points in time at which additional evaluation may take place if full medical recovery and return to work have not occurred. System participants may, however, determine additional evaluation is appropriate at any time during a claim. The disability duration values depict a continuum from the minimum time to the maximum time for most individuals to return to work following a particular injury. An insurance carrier may request additional return to work information from a health care provider at any time. An insurance carrier may not use the Division return to work guidelines as the sole justification or the only reasonable grounds for reducing, denying, suspending or terminating income benefits to an injured employee.

(f) For all diagnoses or injuries that are not addressed by the Division return to work guidelines, system participants shall establish disability duration parameters and return to work goals in accordance with the principles of evidence-based medicine as defined by Labor Code §401.011(18-a).

(g) This section is effective on or after May 1, 2007.

CHAPTER 137. DISABILITY MANAGEMENT

SUBCHAPTER C. TREATMENT GUIDELINES

§137.100. Treatment Guidelines.

(a) Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines – Treatment in Workers' Comp*,

excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) or §137.300 of this title (relating to Required Treatment Planning).

(b) Information on how to obtain or inspect copies of the Division treatment guidelines may be found on the Division's website: www.tdi.state.tx.us.

(c) Health care provided in accordance with the Division treatment guidelines is presumed reasonable as specified in Labor Code §413.017, and is also presumed to be health care reasonably required as defined by Labor Code §401.011 (22-a).

(d) The insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines unless:

(1) the treatment(s) or service(s) were provided in a medical emergency; or

(2) the treatment(s) or service(s) were preauthorized in accordance with §134.600 or §137.300.

(e) An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided

within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017.

(f) A health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600, or may be required to submit a treatment plan in accordance with §137.300.

(g) The insurance carrier shall not deny treatment solely because the diagnosis or treatment is not specifically addressed by the Division treatment guidelines or Division treatment protocols.

(h) This section applies to health care provided on or after May 1, 2007.

SUBCHAPTER D. TREATMENT PLANNING

§137.300 Required Treatment Planning.

(a) A treatment plan shall include the identification of all reasonably anticipated health care treatment and services to be provided to the injured employee for a minimum of 30 days. Treatment plans shall be consistent with the principles of evidence-based medicine and health care reasonably required as defined in Labor Code 401.011(18-a) and (22-a) and shall be submitted for preauthorization by the treating doctor. Treatment plans are required when:

(1) treatment or service is anticipated to exceed or is not included in Division treatment guidelines or Division treatment protocols in accordance with §137.100 of this title (relating to Treatment Guidelines); and the treatment or service will be provided after the greater of:

(A) 60 days from the date of injury; or

(B) the optimum days listed in §137.10 of this title (related to Return to Work Guidelines);

(2) a diagnosis is not included in Division treatment guidelines or Division treatment protocols; or

(3) deemed necessary by the Commissioner as a result of sanctions imposed in accordance with Labor Code §408.0231(e) and (f) and other relevant sections of this title.

(b) A treatment plan is not required for treatments and services within the Division treatment guidelines or Division treatment protocols unless the treatments or services are submitted as part of a required treatment plan in accordance with subsection (a) of this section.

(c) When a health care provider identifies treatments and services that require preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care), the treatment or service may be submitted for preauthorization by a health care provider unless the health care is submitted as part of a treatment plan in accordance with subsection (a) of this section.

(d) When a health care provider develops a treatment plan pursuant to subsection (a) or (b) of this section, it shall be submitted by the treating doctor to the insurance carrier and processed as a preauthorization request pursuant to §134.600. If the health care provider is not the treating doctor and identifies services that require a treatment plan pursuant to subsection (a) of this section, the health care provider shall confer with the treating doctor to develop the required treatment plan in accordance with subsection (a) of this section.

(e) The treating doctor shall confer with the health care providers, insurance carriers, employers, or injured employees as necessary to develop the treatment plan. The treatment plan shall include the identity and contact information of the health care providers involved in the delivery of care proposed within the treatment plan.

(f) The treating doctor shall inform the parties identified in subsection (e) of this section of the approval or denial of the treatment plan.

(g) This section applies to health care provided on or after May 1, 2007.

CERTIFICATION. This agency certifies that the adopted sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on _____, 2006.

Norma Garcia
General Counsel
Division of Workers' Compensation
Texas Department of Insurance

IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that new §§137.1, 137.10, 137.100, and 137.300, concerning Disability Management, are adopted.

AND IT IS SO ORDERED.

ALBERT BETTS
COMMISSIONER OF WORKERS' COMPENSATION

ATTEST:

DWC-06-0057
TITLE 28. INSURANCE
Part 2. Texas Department of Insurance,
Division of Workers' Compensation
Chapter 137. Disability Management

Adopted Sections
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Norma Garcia
General Counsel

COMMISSIONER'S ORDER NO. _____