# *Political Subdivision Workers' Compensation Alliance*

## Contract Provider Manual

**October 22, 2026 Release**

# Political Subdivision Workers' Compensation Alliance Contract Provider Manual

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# I. Introduction

Pursuant to Texas Labor Code, Chapter 504.053, Texas political subdivisions have established the Political Subdivision Workers' Compensation Alliance (the Alliance) to directly contract with health care providers for treatment of public employees injured on the job. The Alliance direct contracting program is designed to be a cooperative relationship, and we encourage dialogue on issues that arise in the medical treatment of public employees injured on the job.

The contract (Agreement) between a political subdivision or an intergovernmental risk pool and a provider defines many of the administrative and medical management aspects of treatment of injured workers within the broader framework of the Labor Code provisions and adopted rules that apply to workers' compensation generally, and those that apply to political subdivisions specifically.

This Provider Manual contains specific responsibilities under the contract, including preauthorization and utilization review, treatment plans, disability management, processing of medical bills, and dispute resolution.

# II. What is the Alliance?

The Political Subdivision Workers' Compensation Alliance (the Alliance) is formed through an Interlocal agreement among a group of five Texas intergovernmental risk pools (Pools) that have joined together to exercise the option to directly contract with health care providers for the provision of workers' compensation medical benefits to the injured employees of the member Political Subdivisions of each Pool. The Alliance is comprised of the following Pools: **Texas Association of Counties Risk Management Pool; Texas Association of School Boards Risk Management Fund; Texas Municipal League Intergovernmental Risk Pool; Texas Council Risk Management Fund and Texas Water Association Risk Management Fund.**

The Alliance performs the provider recruiting, contracting and credentialing functions for the Pools that use the services of Alliance contracted health care providers. The Alliance's governing body, the Board of Directors, may conduct internal reviews of certain controversies that might arise under the Agreement.

**EACH PARTICIPATING POOL IS RESPONSIBLE FOR CLAIM DECISIONS AND PAYMENT FOR CONTRACTED SERVICES RELATED TO CLAIMS OF ITS MEMBER EMPLOYERS AS OUTLINED IN THIS PROVIDER MANUAL.**

The Alliance anticipates that a number of long-term benefits are available to participating providers and to taxpayer-funded political subdivisions through participation in this initiative. As instrumentalities of local government, the Pools participating in the Alliance are not motivated by profit; rather the Pools' goal is to provide quality medical care to injured public employees without spending unnecessary public dollars, and to do so under terms agreeable to the quality providers sought by the Alliance.

The Alliance anticipates that directly contracting with quality providers will produce more integrated, cost-effective care delivered to injured employees of the members of participating Pools. The Alliance strives to cooperatively resolve treatment and reimbursement issues that can delay or complicate the delivery of appropriate care to patients, creating unnecessary disputes.

# III. Contact Information for Participating Intergovernmental Risk Pools

***For preauthorization information, see pages 15 - 16 of this Provider Manual.***

**Texas Association of School Boards Risk Management Fund**
P.O. Box 2010
Austin, TX 78768-2010
Phone: 800-482-7276 • Fax: 800-580-6720
www.tasbrmf.org
www.tasbrmf.org/about/contact-us.aspx for Contact List

**Texas Municipal League Intergovernmental Risk Pool**
P.O. Box 149194
Austin, TX 78714-9194
Phone: 800-537-6655
Fax: 512-491-2481
www.tmlirp.org
www.tmlirp.org/contact for Contact List

**Texas Association of Counties Risk Management Pool**
Claims Administrator - Sedgwick
P.O. Box 160120
Austin, TX 78716
Phone: 800-752-6301 • Fax: 512-346-9321
www.county.org/Risk-Management
www.county.org/About-TAC/Contact-Us-Member-Feedback for Contact List

**Texas Water Association Risk Management Fund**
Claims Administrator - Sedgwick
P.O. Box 26655
Austin, TX 78755-0655
Phone: 800-752-6301 • Fax: 512-346-9321
www.twcarmf.org
www.twcarmf.org/contact/ for Contact List

**Texas Council Risk Management Fund**
Claims Administrator - Sedgwick
P.O. Box 26655
Austin, TX 78755-0655
Phone: 800-752-6301 • Fax: 512-346-9321
www.tcrmf.org
www.tcrmf.org/contact/ for Contact List

# IV. Alliance Provider Direct Contracting Program

The Alliance's Directory of Contract Providers and Provider Lookup Search Engine is available on the PSWCA website www.pswca.org. This directory can be used to identify Alliance Contract Providers available for referral. Additionally, providers may call the adjustor at the appropriate Pool that is handling the claim to obtain additional assistance with referrals.

# V. The Alliance Provider Relations Staff

You may reach the Alliance Provider Relations staff at 1-866-99PSWCA (1-866-997-7922).

The Provider Relations staff is here to assist you with issues related to your direct contract Agreement with the Alliance. We will help you with applications, credentialing, provider status, changes to the list of providers covered under your Agreement, and the resolution of other issues directly related to your Agreement with the Alliance.

We will also help direct you to the Responsible Pool that is handling a claim in which you may be interested. ***It is important to note that the Alliance has no authority or control over specific claim decisions made by the participating Pools.*** However, we will make every attempt to help you make the appropriate contact with the Responsible Pool to resolve your issue. The Alliance tracks recurrent issues and brings them to the attention of the participating Pools to try to identify solutions to administrative problems.

Additionally, the Alliance Provider Relations staff can direct you to the proper web page to download forms, purchase or obtain treatment guidelines, and access other useful information.

It is helpful to know that most, but not all, cities, counties, school districts, community MHMR centers, water districts, and river authorities in Texas are members of the intergovernmental risk pools that participate in the Alliance. Because it is sometimes difficult to determine who has the coverage for a new workers' compensation patient, contact information for the claims staff with each Pool is provided in section III (Contact Information for Participating Intergovernmental Risk Pools). You may contact a Pool to determine whether a political subdivision employer in your area is covered by an Alliance participating Pool.

# VI. Standard Terms, Conditions and Procedures

The following terms, conditions and procedures reference rules and forms promulgated by the Texas Department of Insurance, Division of Workers' Compensation. Any rules or forms cited may be found at http://www.tdi.texas.gov/wc/

## A. Definitions

All applicable definitions included in the Alliance Agreement, section 2, are reprinted here for ease of reference. This section also contains terms and definitions that are only relevant to the provisions of this Provider Manual. Refer to the Agreement and the provisions of the Provider Manual to review all pertinent provisions of your Agreement with the Alliance.

Act: Title 5, Texas Labor Code.

Agreement: The Direct Contract Agreement executed by the Alliance and the Contract Provider.

Bill Review: Review of any aspect of a medical bill, including retrospective review, in accordance with the Act, rules, the Agreement, and the adopted fee and treatment guidelines.

Commissioner of Insurance: The appointed Commissioner of the Texas Department of

Insurance. Commissioner of Workers' Compensation: The appointed Commissioner of the Texas Department of Insurance Division of Workers' Compensation.

Complete Medical Bill: A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in Title 28 of the Texas Administrative Code, Section 133.10 (relating to Required Billing Forms/Formats), or as specified for electronic medical bills in 28 Tex. Admin. Code, Chapter 135 (relating to Electronic Medical Billing, Reimbursement and Documentation).

Contract Provider: An individual or group that provides Health Care Services to Injured Employees pursuant to written Agreement with the Alliance.

Designated Claims Administrator: The entity responsible for administering workers' compensation Claims for a Pool.

Division: The Texas Department of Insurance, Division of Workers' Compensation.

Doctor: A doctor of medicine, osteopathic medicine, optometry, dentistry, podiatry, or chiropractic, who is licensed and authorized to practice.

Emergency: Either a medical or mental health emergency as follows:

1. A medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain that the absence of immediate medical attention could reasonably be expected to result in:

    a. Placing the patient's health or bodily functions in serious jeopardy, or

    b. Serious dysfunction of any body organ or part;

2. A mental health emergency is a condition that could reasonably be expected topresent danger to the person experiencing the mental health condition or another person.

Employee: A person in the service of a political subdivision who has been employed by law or a person for whom optional coverage is provided under Section 504.012 or 504.013 of the Act.

Fee Dispute: A dispute over the amount of payment for health care rendered to an injured employee and determined to be medically necessary and appropriate for treatment of that employee's compensable injury. The dispute is for reasons other than the medical necessity of the care (*e.g.*, based upon the requirements of the Agreement and the adopted fee and treatment guidelines).

Final Action on a Complete Medical Bill:

1. Sending a payment that makes total reimbursement for a bill in accordance with the current contract between the provider and the Alliance.

2. In the absence of an applicable fee guideline or negotiated contracted amount, sending a payment that makes the total reimbursement for that bill a fair and reasonable

reimbursement in accordance with 28 Tex. Admin. Code §134.1 (f) (relating to Medical Reimbursement); and/or

3. Denying a charge on the medical bill.

Health Care Practitioner: An individual who is licensed to provide or render and who provides or renders health care or a non-licensed individual who provides or renders health care under the direction or supervision of a Doctor.

Health Care Provider: A Health Care Practitioner or health care facility.

Health Care Provider Agent: A person or entity that the Health Care Provider contracts with or utilizes for the purpose of fulfilling the Health Care Provider's obligations for medical bill processing under the Act or Division rules.

Health Care Services: Health care that is rendered or provided to an Injured Employee for the treatment of a compensable injury. The term includes all reasonable and necessary medical aid, medical examinations, medical treatments, medical diagnoses, medical evaluations, medical services, and other services and supplies, listed under § 401.011(19), Texas Labor Code.

Injured Employee: An employee of a member Political Subdivision of one of the Pools that comprise the Alliance who sustains a workplace injury or occupational disease.

Independent Review: A review of a dispute between an Injured Employee or a Contract Provider and a Pool regarding the necessity or appropriateness of health care on a specific claim. The independent review is conducted by a TDI assigned independent qualified medical reviewer.

Internal Dispute Resolution-Internal Review: A review conducted by or at the direction of the Alliance Governing Board of a complaint regarding an unresolved dispute as specified in the Agreement and this Provider Manual. The dispute may be associated with the Alliance direct contracting program, or from disputes between a provider and a Pool regarding health care payments or approvals as further outlined in the Agreement and this Provider Manual.

Life-Threatening: A disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Political Subdivision: A county, municipality, special district, school district, junior college district, housing authority, community center for mental health and mental retardation services established under Subchapter A, Chapter 534, Health and Safety Code, or any other legally constituted political subdivision of the state.

Pool: Two or more Political Subdivisions collectively self-insuring under an interlocal agreement pursuant to Chapter 791, Government Code as named in Article I of the Agreement. The term also includes a Pool's Designated Claims Administrator.

Preauthorization: The process required to request approval from a Pool to provide a specific treatment or service before the treatment or service is provided.

Provider Manual: This manual of procedures that is incorporated by reference and made apart of the Agreement between the Health Care Practitioner and the Alliance.

Responsible Pool:

1. The Pool of which the Injured Employee's employer is a member, and

2. The Pool that is responsible for handling the workers' compensation claim.

Retrospective Review: The process of reviewing the medical necessity and reasonableness of health care that has been provided to an Injured Employee.

Treating Doctor: A Contract Provider:

1. Whose specialty has been designated by the Alliance as a specialty that may serve as a Treating Doctor;

2. Who has entered into a Direct Contract Agreement to provide treating doctor functions; and

3. Who has been designated as the Treating Doctor for the Injured Employee.

Utilization Review: Prospective or concurrent review of the medical necessity and appropriateness of health care services being provided or proposed to be provided to an Injured Employee.

Working Day: A working day is any day, Monday - Friday, other than a national holiday as defined by Texas Government Code § 662.003 (a) and the Friday after Thanksgiving Day, December 24th and December 26th. Unless otherwise indicated, "day" refers to calendar day.

## B. Limited Authorization to Use PSWC Alliance Name, Symbol and Service Mark; Not an Endorsement

During the term of the Agreement, Contract Providers, the Alliance, and Participating Pools shall have the right to use each other's name solely to make reference, without further elaboration, to Contract Provider as a participating provider in the Alliance direct-contracting program. Contract Providers, the Alliance, and Pools shall not otherwise use each other's name, symbol or service mark without prior written approval. The Contract Provider may not in any way, publicly or privately, portray such participation in the Alliance direct-contracting program as an endorsement by the Alliance or a participating Pool of the Contract Provider's services.

## C. Applicability of the Act and the Workers' Compensation Health Care Network Act

Pursuant to section 504.053 of the Act, and except as expressly provided otherwise in the Provider Manual or the Agreement, the following statutory provisions and the rules adopted there under, do not apply to a Pool which elects to provide Medical Benefits to its Injured Employees by directly contracting with Health Care Providers:

Sections 408.004 and 408.0041 of the Texas Labor Code (unless use of an RME or DD is

necessary to resolve an issue relating to the entitlement to or amount of income benefits under the Workers' Compensation Act).

1. Sections 408.022 - 408.032 of the Texas Labor Code.

2. Chapter 413 of the Texas Labor Code, except for section 413.042 (private claims; administrative violation).

3. Chapter 1305, Insurance Code (The Workers' Compensation Health Care Network Act), except for sections 1305.501 (evaluation of networks), 1305.502 (consumer report cards), and 1305.503 (confidentiality requirements).

## D. Duties of Health Care Practitioners

1. Guideline and Protocol Compliance; Cooperation. Contract Provider agrees to follow treatment guidelines, return-to-work guidelines, and individual treatment protocols adopted by the Alliance, as applicable to an Injured Employee's injury, as provided in Article VI of the Agreement and as detailed in this Provider Manual. Contract Provider shall be cooperative with Alliance Staff and the Alliance Medical Advisor on quality-of-care concerns, questions, or discussions related to care plans and return-to-work guidelines, attending claims analytics meetings, concerns related to timely filing of all DWC forms and general timely response to any questions or concerns the Alliance Staff, Medical Advisor, or Alliance Risk Pools' representatives may have.

2. Referrals. Referrals must be made to Contract Providers unless there are no Contract Provider options available. If there are no Contract Providers available, referrals to non-Contract Providers must be approved by the Responsible Pool prior to the referral being made to a non-Contract Provider. The Responsible Pool shall approve or deny a referral to a non-Contract Provider not later than the seventh day after the date on which the referral is requested. The Alliance's Directory of Contract Providers and Provider Lookup Search Engine will also be available on the PSWCA website at www.pswca.org to identify Alliance Contract Providers for referrals. Additionally, customers may call the adjustor at the appropriate Pool that is handling the claim to obtain additional assistance with referrals.

3. Reporting and Records Compliance. Notwithstanding section 504.053 of the Act, a Contract Provider shall comply with the requirements for reports and records established by the Texas Department of Insurance rule under section 408.025 of the Labor Code.

4. Disclosure of Financial Interest. Notwithstanding section 504.053 of the Act, a Contract Provider shall comply with section 413.041 of the Labor Code regarding the disclosure of financial interests and rules adopted by the Texas Department of Insurance. To learn how to comply with this requirement, see the last chapter of this Provider Manual, **X. Links to Useful Information,** under Information for Providers.

5. Statutory/Regulatory Compliance. Contract Provider must comply with all applicable statutory and regulatory requirements under federal and state law, except as otherwise provided by the Agreement and this Provider Manual. Contract Provider must provide written notification to the Alliance within 10 calendar days of the date the Contract Provider learns that the Contract Provider is or is likely to be out of compliance with any federal or state regulation or with the requirements of the Agreement.

6. Notice Requirements. Contract Provider shall give the Alliance not less than sixty (60) days advance written notice of any change in address, telephone number, or Tax Identification Numbers, and will provide written notice to the Alliance within (60) days of any change in the list of providers subject to the Agreement if the Agreement is signed by a representative of an associated group of providers.

7. Impairment Ratings/MMI Determinations. Notwithstanding section 504.053 of the Act, a Contract Provider who intends to provide certifications of maximum medical improvement or assign impairment ratings, shall comply with the impairment rating training and testing requirements established by Texas Department of Insurance rule under Subsection 408.023(n) of the Labor Code.

8. Brand and Generic Drugs. Contract Provider shall prescribe generic prescription drugs when available and clinically appropriate. If in the medical judgment of Contract Provider a brand-name drug is necessary, Contract Provider must specify on the prescription that brand-name drugs be dispensed in accordance with applicable state and federal law, and must maintain documentation justifying the use of the brand-name drug in the patient's medical record. If an Injured Employee chooses to receive a brand-name drug rather than a generic drug that is prescribed by Contract Provider, the Injured Employee shall pay the difference in cost between the generic drug and brand-name drug. This is required by Rule 134.502 (c) per the Texas Labor Code.

   Pharmacy Closed Formulary. As required by Texas Labor Code §408.028(b). Contract Provider shall prescribe drugs within the pharmacy closed formulary.

9. "N" Drugs. All drugs listed as "N" are excluded in the pharmacy closed formulary. Contract Provider shall request preauthorization for all drugs listed as "N" with the exception of claims with dates of injury prior to January 1, 1991. The Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) has posted a listing of status "N" drugs published in Official Disability Guidelines – Treatment in Workers' Comp (ODG) Appendix A, ODG Workers' Compensation Drug Formulary. The "N" drugs can be found at http://www.tdi.texas.gov/wc/pharmacy/. Preauthorization is required for all "N" prescriptions that are excluded from the pharmacy closed formulary unless there is a documented agreement between the Pool and prescribing doctor. Contract Provider shall provide supporting documentation to the Pool when prescribing "N" drugs. When considering "N" drug prescriptions, Contract Provider shall consider "Y" status drugs as an alternative as "Y" drugs are available for the majority of the drug classifications.

10. Quality Health Care Delivery and Return to Work Monitoring. The Alliance's Physician Advisory Panel will monitor and provide feedback to Contract Providers and to the Pools regarding health care delivery and return to work under continuous process and quality improvement initiatives. Contract Providers are expected to work collaboratively with the Alliance to systematically measure for health care quality (evidence-based practice protocols) and return to work outcomes.

11. Disability Management. Contract Provider agrees to follow the treatment protocols, treatment planning, case management, and return-to-work planning requirements adopted by the Alliance. The Alliance will provide an online link where providers may purchase the adopted protocols and requirements.

12. Return-to-Work Guidelines. The Alliance adopts by reference the current edition of *The Medical Disability Advisor, Workplace Guidelines for Disability Duration, (*MD Guidelines) excluding all sections and tables relating to rehabilitation, as guidelines for the evaluation of expected or average return-to-work time frames. Rehabilitation shall be

addressed by the treatment guidelines in subsection 6.2 of the Agreement (*Official Disability Guidelines*). The Alliance will provide an online link where providers may purchase the adopted guidelines.

13. Treatment Guidelines. The Alliance adopts by reference the *Official Disability Guidelines (ODG), Treatment in Workers' Comp.,* current edition, published by the Work Loss Data Institute. Copies of the treatment guidelines or online access to the guidelines may be obtained at the ODG website at https://www.mcg.com/odg/

    If ODG does not address a treatment, the Alliance will then use the *Occupational Medicine Practice Guidelines*, current edition, published by the American College of Occupational and Environmental Medicine (ACOEM) as the guideline resource. You may obtain the ACOEM Practice Guidelines by visiting ACOEM's website at: http://www.acoem.org

    If neither guideline addresses a specific condition or treatment, the Alliance may reference other evidence-based, scientifically valid, outcome focused treatment guidelines.

    A Pool may not deny treatment solely on the basis that a treatment for a compensable injury is not specifically addressed by the treatment guidelines adopted by the Alliance.

14. Treatment Protocols. The Alliance may, at the suggestion of its Physician Advisory Committee, implement specific treatment protocols in keeping with sound evidence-based medical practice.

15. Treatment Planning Required for Certain Cases. Treatment planning is a process to stimulate comprehensive, quality, and time-certain health care planning for injured employees who have complex problems and are not regaining function and recovering from their injuries in a timely fashion.

    Upon request of the Responsible Pool, the Treating Doctor shall develop and submit a Treatment Plan to the appropriate Pool for preauthorization on any case in which:

    a. The proposed health care or treatment is outside the parameters of evidence-based treatment, as recommended by the *Official Disability Guidelines (ODG) Treatment in Workers' Comp.*, or the American College of Occupational and Environmental Medicine (ACOEM), or

    b. The actual or anticipated lost time from work will exceed the optimum lost time per given ICDM diagnostic code provided in the *MDGuidelines*, excluding all sections and tables relating to rehabilitation.

        Treatment planning is subject to Preauthorization. The treatment planning process requires the TreatingDoctor to complete and submit an Alliance Preauthorization - Treatment Planning Form to request Preauthorization for the proposed plan of treatment. Important elements of this Request for Approval of Treatment Plan Form include demographic information; brief history of present illness and important clinical findings (including relevant diagnoses and codes); requested services and CPT codes including frequencies and timeframe(s) for requested services (not to

exceed one month for sub-acute and early chronic cases less than one year old); and a mandatory evidence-based rationale for proposed services. This process will allow for the resubmission of an amended treatment plan based on medical necessity considerations.

A provider may access and download Preauthorization or Treatment Planning Forms by visiting the Alliance website at www.pswca.org.

16. Case Management. The Alliance may adopt rules relating to the application of case management services to specific claims exceeding the lost time parameters adopted to demarcate claims "at risk" for undesirable clinical and return-to-work outcomes. Contracted Providers are required to cooperate with case managers assigned to aclaim.

17. Patient Compliance with Treatment Recommendations. Achieving timely recovery and return to work requires a coordinated effort from all participating parties including the injured worker, Contracted Provider(s), the employer, and the participating Pool. If a Contract Provider identifies patient non-compliance with reasonable treatment recommendations or directions, the Contract Provider should contact the adjustor at the Pool responsible for handling the claim to identify the non-compliance issue and seek the Pool's assistance in obtaining compliance. For adjustor contact information, see section III of the Provider Manual or visit the Alliance website at www.pswca.org.

18. Return to Work Planning. Treating Doctors and referral/consulting Contract Providers may be requested to participate in education and training regarding appropriate return-to-work planning and coordination in order to ensure that an Injured Employee is timely and safely returned to duty. Alliance participating Pools and their members may offer education and training to inform you of return-to work programs offered by specific employers.

19. Preauthorization Requirements. The Health Care Services that require Preauthorization are identified on the Alliance Preauthorization List, found at Appendix A. A Request for Preauthorization shall be submitted to the Responsible Pool using the applicable Pool's Preauthorization Request form. You maydownload the Request for Preauthorization and Treatment Planning forms by visiting the Alliance website at www.pswca.org.

Post-stabilization treatment and treatments and services for an Emergency or a Life-Threatening condition do not require Preauthorization. Preauthorization may be requested from the Responsible Pool that covers the claim.

## PREAUTHORIZATION CONTACT INFORMATION FOR EACH POOL

**Texas Association of School Boards Risk Management Fund**
www.tasbrmf.org
**Preauthorization:**
Preauthorization Phone Number: 800-482-7276
Preauthorization Fax Number: 888-777-8272

**Texas Municipal League Intergovernmental Risk Pool**
http://tmlirp.org/coverages/workers-compensation
**Preauthorization**
Preauthorization Phone Number: 800-407-0704
Preauthorization Fax Number: 855-287-4028
Preauthorization Email: urreferrals@genexservices.com

**Texas Association of Counties Risk Management Pool**
www.county.org
Claims Administrator: Sedgwick
**Preauthorization:**
Preauthorization Phone Number: 800-580-2273
Preauthorization Fax Number: 800-580-3123
Preauthorization Email: UR@WellComp.com

**Texas Water Association Risk Management Fund** http://
www.twcarmf.org
Claims Administrator: Sedgwick
**Preauthorization Only:**
Preauthorization Phone Number: 800-580-2273
Preauthorization Fax Number: 800-580-3123
Preauthorization Email: UR@WellComp.com

**Texas Council Risk Management Fund**
http://www.tcrmf.org
Claims Administrator: Sedgwick
**Preauthorization Only**
Preauthorization Phone Number: 800-580-2273
Preauthorization Fax Number: 800-580-3123
Preauthorization Email: UR@WellComp.com

20. Medical Billing and Processing. Required Billing Forms/Formats. All information submitted on required billing forms must be legible and completed in accordancewith applicable instructions. Contract Providers shall submit medical bills forpayment:

a. On standard forms used by the Centers for Medicare and Medicaid Services (CMS); TDI-DWC 67 Instructions for Completing the CMS- 1500 (Rev.02/12).

b. In electronic format in accordance with Rule 133.501, of the Texas Labor Code Rules (relating to Electronic Medical Billing).

**MEDICAL BILL E-BILLING VENDOR CONTACT INFORMATION FOR EACH POOL:**

**Texas Association of School Boards Risk Management Fund**
WorkCompEDI
Toll Free: 800-297-6909
Website: https://txdwcedi.info/
Payer ID: WR902

**Texas Municipal League Intergovernmental Risk Pool**
Jopari Solutions Inc. eBill
Website: https://www.jopari.com/ebill-enrollment/
Phone: 800-630-3060
Payer ID: A0245

**Texas Association of Counties Risk Management Pool**
WorkCompEDI
Toll Free: 800-297-6909
Website: https://txdwcedi.info/
Payer ID: WZ633

**Texas Water Association Risk Management Fund**
WorkCompEDI (Payer ID is via Careworks)
Toll Free: 800-297-6909
Website: https://txdwcedi.info/
Payer ID: CB888

**Texas Council Risk Management Fund**
WorkCompEDI (Payer ID is via Careworks)
Toll Free: 800-297-6909
Website: https://txdwcedi.info/
Payer ID: CB888

21. Medical Bill Submission by Contract Provider.

a. Contract Provider shall submit all medical bills to the Responsible Pool. All bills are required to be electronically submitted per Rule 133.501 (3) unless the health care provider is exempt per Rule 133.500 (b) (1).

b. Contract Provider shall submit a medical bill no later than the 95th calendar day after the date the services are provided.

c. Contract Provider shall include correct billing codes from the applicable year's AMA CPT reference or Division fee guidelines in effect on the date(s) of service when submitting medical bills.

d. A medical bill must be submitted:

i. For an amount that does not exceed Contract Provider's usual and customary charge for the health care provided in accordance with Labor Code §§ 413.011 and 415.005.
ii. In the name of the licensed Health Care Provider that provided the Health Care Services or that provided direct supervision of an unlicensed individual who provided the Health Care Services.

e. Contract Provider shall not resubmit medical bills to a Pool after the Final Action on a Medical Bill and provided an explanation of benefits except in accordance with the section relating to Reconsideration for Payment of Medical Bills of this Provider Manual.

f. Contract Provider may correct and resubmit as a new bill an incomplete bill that has been returned by a Pool.

g. Not later than the 15th day after receipt of a request for additional medical documentation, a Contract Provider shall submit to a Pool:

i. Any requested additional medical documentation related to the charges for Health Care Services rendered; or

ii. A notice the Contract Provider does not possess requested medical documentation.

h. Contract Provider shall indicate on the medical bill if documentation is submitted related to the medical bill.

i. A Contract Provider shall not submit a medical bill to an Injured Employee for all or part of the charge for any of the health care provided, except as aninformational copy clearly indicated on the bill, or in accordance with subsection (k) of this section. The information copy shall not request payment.

j. The Contract Provider may only submit a bill for payment to the Injured Employee in accordance with:

i. Labor Code §413.042 which provides in relevant part that a health care provider may not pursue a private claim against a workers' compensation claimant for all or part of the cost of a health care service provided to the claimant by the provider unless the injury is finally adjudicated not compensable under the Workers' Compensation Act; or

ii. 28 Tex. Admin. Code §134.504 (relating to Pharmaceutical Expenses Incurred by the Injured Employee

22. Pool Receipt of Medical Bills from Contract Providers.

a. Upon receipt of medical bills submitted in accordance with section 4.1 of the Agreement and this Provider Manual (relating to Required Medical Forms/Formats), a Pool shall evaluate each medical bill for completeness as defined in the Definition section of this Provider Manual (see "Complete MedicalBill").

i. A Pool shall not return a Complete Medical Bill to the provider, unless the bill is a duplicate bill.

ii. Within 30 days after the day a Pool receives a bill that is not a Complete Medical Bill the Pool shall correct or add information already known or return the bill consistent with subsection (c) below. The Pool will make reasonable efforts not to exceed the time standard established above.

iii. A Pool may contact the sender to obtain the information necessary to make the bill complete.

b. A Pool shall not return a medical bill except as provided in subsection (a) of this section. When returning a medical bill, a Pool shall include a document identifying the reason(s) for returning the bill. The reason(s) related to the procedure or modifier code(s) shall identify the reason(s) by line item.

c. The proper return of an incomplete medical bill in accordance with this section fulfills a Pool's obligations with regard to the incomplete bill.

d. A Pool shall not combine bills submitted in separate envelopes as a single bill or separate single bills spanning several pages submitted in a single envelope.

23. Medical Documentation.

a. A Contract Provider is required to adhere to the statutory time frames for submitting DWC 60 and DWC 73 documents. The Division monitors providers timeliness of submissions and providers are subject to Texas Department of Insurance fines for failure to timely submit.

b. Medical documentation includes all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results.

c. When submitting a medical bill for reimbursement, the Contract Provider shall provide required documentation in legible form.

d. In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation:

i. The two highest Evaluation and Management office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes;

ii. Surgical services rendered on the same date for which the total of the fees established in the current TDI Division of Workers' Compensation fee guideline exceeds $500: a copy of the operative report;

iii. Return-to-work rehabilitation programs as defined in 28 Tex. Admin. Code §134.202 (relating to Medical Fee Guideline): a copy of progress notes and/or SOAP (subjective/objective assessment plan/procedure) notes, which substantiate the care given, and indicate progress, improvement, the date of the next treatment(s) and/or service(s), complications, and expected release dates;

iv. Any supporting documentation for procedures that do not have an established Division maximum allowable reimbursement (MAR), to include an exact description of the health care provided; and

v. For hospital services: an itemized statement of charges.

24. Pool Audit of a Medical Bill.

a. The Responsible Pool may perform an audit of a medical bill that has been

submitted by a Contract Provider to the Pool for reimbursement.

b. If the Responsible Pool decides to conduct an audit of a medical bill, the Pool shall:

i. Make a determination regarding the relationship of the Health Care Services provided for the compensable injury, the extent of the injury, and the medical necessity of the services provided;

ii. Complete the audit and pay, reduce, or deny in accordance with the following section of this Manual (relating to Medical Payments and Denials) no later than the 160th day after receipt of the Complete Medical Bill.

25. Pool Medical Payments and Denials.

a. The Responsible Pool shall take final action after conducting bill review on a Complete Medical Bill or determine to audit the medical bill in accordance with the preceding section of the Provider Manual (relating to Pool Audit of a Medical Bill), not later than the 45th day after the date the Responsible Pool received a Complete Medical Bill. The Responsible Pool's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

b. The Responsible Pool shall not change a billing code on a medical bill or reimburse health care at another billing code's value without the consent of the provider.

c. The Responsible Pool may request additional documentation, in accordance with the section of this Provider Manual relating to Medical Documentation, not later than the 45th day after receipt of the medical bill to clarify Contract Provider's charges.

d. The Responsible Pool shall send the explanation of benefits to:

i. Contract Provider when the Pool makes payment or denies payment on a medical bill; and

ii. The Injured Employee when payment is denied because the health care was:

a) Determined to be unreasonable and/or unnecessary:

b) Provided by a Health Care Provider other than

i) The Treating Doctor,

ii) A Contract Provider that the Treating Doctor has chosen as a consulting or referral Health Care Provider,

iii) A Doctor performing a Required Medical Examination in accordance with 28 Tex. Admin. Code §126.5 (relating to Procedure for Requesting Required Medical Examinations) and 28 Tex. Admin. Code §126.6 (relating to Order for Required Medical Examination), or

iv) A Doctor performing a Designated Doctor Examination in accordance with 28 Tex. Admin. Code §130.6 (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings); or

c) Unrelated to the compensable injury, in accordance with 28 Tex. Admin. Code §124.2 (relating to Carrier Reporting and Notification Requirements).

e. When the Responsible Pool pays Contract Provider for Health Care Services for which there is not a contracted rate, and the Centers for Medicare and Medicaid Services ("CMS") or the Division does not establish a relative value unit and/or a payment amount, the Pool shall explain and document the method it used to calculate the payment in accordance with 28 Tex. Admin. Code §134.1 (relating to Medical Reimbursement).

f. The Responsible Pool shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and 28 Tex. Admin. Code §§ 124.2 and 124.3 (relating to Investigation of an Injury and Notice of Denial/Dispute) if the Pool reduces or denies payment for health care provided based solely on the Pool's belief that:

i. The injury is not compensable;

ii. The Pool is not liable for the injury because the injured worker's employer is not a member of a Pool or the injured worker does not meet the definition of an employee; or

iii. The condition for which the health care was provided was not related to the compensable injury.

g. If dissatisfied with the Responsible Pool's Final Action on a Complete Medical Bill, Contract Provider may request reconsideration of the bill in accordance with the next section of the Provider Manual (relating to Reconsideration for Payment of Medical Bills) unless the Pool's final action is the result of a determination made in a Retrospective Review, in which case the request for reconsideration is governed by section VII (relating to Preauthorization, Utilization and Retrospective Review-Reconsideration of Adverse Determination) of this Provider Manual.

h. All payments of medical bills that a Pool makes on or after the 60th day after the date the Responsible Pool originally received the Complete Medical Bill shall include interest calculated in accordance with 28 Tex. Admin. Code §134.130 (relating to Interest for Late Payment on Medical Bills and Refunds). The interest payment shall be paid at the same time as the medical bill payment.

i. When the Responsible Pool remits payment to a Health Care Provider Agent, it is the agent's responsibility to remit to Contract Provider the full amount that the Pool reimburses.

26. Reconsideration for Payment of Medical Bills (Fee Disputes).

a. If Contract Provider is dissatisfied with a Pool's Final Action on a Medical Bill, Contract Provider may request that the Responsible Pool reconsider its action in accordance with this section unless the Pool's final action is the result of a determination made in a Retrospective Review, in which case the request for reconsideration is governed by the Section VII (relating to Preauthorization, Utilization and Retrospective Review-Reconsideration of Adverse Determination) of this Provider Manual.

b. Contract Provider shall submit the request for reconsideration no later than eleven months from the date of service.

c. Contract Provider shall not submit a request for reconsideration until:

i. The Responsible Pool has taken Final Action on a Medical Bill; or

ii. Contract Provider has not received an explanation of benefits within 50 days from submitting the Complete Medical Bill to the Responsible Pool.

d. The request for reconsideration shall:

i. Reference the original bill or send a copy of the original explanation of benefits and include the same billing codes, date(s) of service, and dollar amounts as the original bill.

ii. Include any necessary and related documentation not submitted with the original medical bill to support Contract Provider's position; and

iii. Include a bill-specific, substantive explanation in accordance with 28 Tex. Admin. Code §133.3 (relating to Communication between Health Care Providers and Insurance Carriers) that provides a rational basis to modify the previous denial or payment.

e. The Responsible Pool shall review all reconsideration requests for completeness in accordance with subsection (d) of this section and may return an incomplete reconsideration request, no later than seven days from the date of receipt. Contract Provider may complete and resubmit its request to the Pool.

f. The Responsible Pool shall take final action on a reconsideration request within 21 days of receiving the request for reconsideration. The Responsible Pool shall provide an explanation of benefits for all items included in a reconsideration request.

g. Contract Provider shall not resubmit a request for reconsideration earlier than 26 days from the date the Responsible Pool received the original request for reconsideration or after the Pool has taken final action on the reconsideration request.

h. Fee Disputes. All Fee Disputes not resolved to Contract Provider's satisfaction after requesting reconsideration in accordance with this Provider Manual may be reviewed as provided by section VIII of the Agreement (relating to Dispute Resolution) if the Contract Provider files a written request for review no later than one (1) year after the date(s) of service in dispute.

27. Refunds.

a. The Responsible Pool shall request a refund within 240 days from the date of service or 30 days from completion of a Pool Audit of a Medical Bill whichever is later, when it determines that inappropriate health care was previously reimbursed, or when an overpayment was made for Health Care Services provided. The Responsible Pool shall submit the refund request to Contract Provider in an explanation of benefits

b. Contract Provider shall respond to a request for a refund from the Responsible Pool by the 45th day after receipt of the request by:

i. Paying the requested amount; or

ii. Submitting an appeal to the Responsible Pool with a specific explanation of the reason Contract Provider has failed to remit payment.

c. The Responsible Pool shall act on Contract Provider's appeal within 45 days after the date on which Contract Provider filed the appeal. The Responsible Pool shall provide Contract Provider with notice of its determination, either agreeing that no refund is due, or denying the appeal.

d. If the Responsible Pool denies the appeal, Contract Provider:

i. Shall remit the refund with any applicable interest within 45 days of receipt of notice of denied appeal; and

ii. May request an internal review of the Responsible Pool's denial of appeal as provided in section VIII (Relating to Dispute Resolution) of this Provider Manual.

e. Contract Provider shall submit a refund to the Responsible Pool when Contract Provider identifies an overpayment even though Contract Provider has not received a refund request.

f. When making a refund payment, Contract Provider shall include a copy of the Responsible Pool's original request for refund, if any, and a copy of the original explanation of benefits containing the overpayment, if available. The explanation shall:

i. Identify the billing and rendering Contract Provider;

ii. Identify the Injured Employee;

iii. Identify the Responsible Pool;

iv. Specify the total dollar amount being refunded;

v. Itemize the refund by dollar amount, line item and date of service; and

vi. Specify the amount of interest paid, if any, and the number of days on which interest was calculated.

g. All refunds requested by the Responsible Pool and paid by Contract Provider on or after the 60th day after the date Contract Provider received the request for the refund shall include interest calculated in accordance with 28 Tex. Admin. Code§134.130 (relating to Interest for Late Payment on Medical Bills and Refunds).

## E. Duties of Alliance Treating Doctors

A Treating Doctor is a Contract Provider practicing medicine in a specialty physician category that the Alliance has designated to serve as a Treating Doctor. An Alliance Treating Doctor agrees to abide by the requirements in the preceding section D. (Regarding Duties of Health Care Practitioners) of this Provider Manual, and in addition agrees to abide by the following specific duties relating to the role of Treating Doctor.

1. Contract Provider agrees to serve as a Treating Doctor and to accept the responsibility to coordinate all of the Injured Employee's health care needs for the Injured Employee's compensable injury. Notwithstanding section 504.053 of the Labor Code, a Treating Doctor is responsible for the efficient management of medical care as required by section 408.025(c), Texas Labor Code (whether care is furnished directly by the Treating Doctor or by a Health Care Practitioner upon the referral of the Treating Doctor).

2. A Treating Doctor shall provide health care to the Injured Employee for the Injured Employee's compensable injury and shall make referrals to other Contract Providers or request a referral to non-Contract Providers if medically necessary services are not available from a Contract Provider. The Alliance's Directory of Contract Providers and Provider Lookup Search Engine is available on the PSWCA website, www.pswca.org to identify Alliance Contract Providers for referrals. The Alliance can provide electronic file (.pdf format) versions of the Directory to Contract Providers upon request. Additionally, a Treating Doctor may call the adjustor at the Responsible Pool to obtain additional assistance with referrals.

3. Referrals to non-Contract Providers must be approved by the Responsible Pool. The Responsible Pool shall approve or deny a referral to a non-Contract Provider not later than the seventh day after the date on which the referral is requested, or sooner if circumstances and the condition of the Injured Employee require expedited consideration.

4. A Treating Doctor shall cooperate in the medical case management process as required by the Alliance, including participation in return-to-work planning as described in the subsection D above.

5. Notwithstanding Section 504.053 of the Labor Code, a treating doctor shall comply with the requirements established by the Commissioner of Workers' Compensation rule under Subsections 408.023(l) and (m) (relating to duties of treating doctors) including 28 Tex. Admin.

6. Code Section 180.22 (relating to Health Care Provider Roles and Responsibilities). You may access rules by using the links found in section X. (Relating to Other Useful Information Resources and Web Links) of this Provider Manual.

# VII. Preauthorization, Utilization Review, and Retrospective Review by Pools; Independent Review

## A. General Provisions

1. The Responsible Pool shall notify the Injured Employee or the Injured Employee's representative, if any, and Contract Provider of a determination made in a Utilization Review or Retrospective Review. Notification of an adverse determination shallinclude:

    a. The principal reasons for the adverse determination;

    b. The clinical basis for the adverse determination;

    c. A description of or the source of the screening criteria that were used as guidelines in making the determination;

    d. For any provider consulted, the professional specialty;

    e. A description of the procedure for the reconsideration process; and

    f. Notification of the availability of independent review in the form prescribed by the Texas Department of Insurance.

2. For adverse determinations made pursuant to Retrospective Review, the adverse determination must be issued in response to a claim for payment consistent with the timelines established in section VI (D) (relating to Medical Billing and Processing) of this Provider Manual, an adverse determination issued under this subsection shall comply with all applicable requirements related to adverse determinations in this section.

## B. Preauthorization Responses.

1. On receipt of a Preauthorization request from a Contract Provider for proposed services that require Preauthorization, the Responsible Pool shall issue and transmit a determination indicating whether the proposed Health Care Services are preauthorized and respond to requests for Preauthorization within the periods prescribed by this section.

2. For all other requests for Preauthorization, the Responsible Pool shall issue and transmit the preauthorization determination not later than the third Working Day after the date the request is received.

## C. Utilization Review and Retrospective Review Standards

1. Screening criteria used for Utilization Review and Retrospective Review shall be consistent with the Alliance's treatment guidelines, return-to-work guidelines, and individual treatment protocols. A Pool's Utilization Review program and Retrospective Review program shall include a process for a Treating Doctor, a specialist, or the Alliance to request approval from the Responsible Pool for deviation from the treatment guidelines, return-to-work guidelines, and individual treatment protocols where required by the particular circumstances of an employee's injury.

2. The Responsible Pool may not deny treatment solely on the basis that a treatment for a compensable injury is not specifically addressed by the treatment guidelines adopted by the Alliance.

## D. Reconsideration of Adverse Determination (Regarding Medical Necessity of Care)

1. An Injured Employee, a person acting on behalf of the Injured Employee, or the Injured Employee's requesting provider may, not later than the 30th day after the date of issuance of written notification of an adverse determination, request reconsideration of the adverse determination in writing.

2. Not later than the 5th calendar day after the date of receipt of the request for reconsideration, the Responsible Pool shall send to the requesting party a letter acknowledging the date of the receipt of the request that includes a reasonable list of documents the requesting party is required to submit.

   A request for preauthorization for the same Health Care Services may only be submitted for reconsideration when the requestor provides:

   a. Additional clinical documentation, information or data that was not provided inthe original request; or

   b. Objective clinical documentation to support a substantial change in the Injured Employee's medical condition or demonstrates that the Injured Employee has met clinical prerequisites for the requested health care that had not been previously met before submission of the previous request.

3. After completion of the review of the request for reconsideration of the adverse determination, the Responsible Pool shall issue a response letter to the Injured Employee or person acting on behalf of the Injured Employee, and the Injured Employee's requesting provider, that explains the resolution of the reconsideration; and includes:

   a. A statement of the specific medical or clinical reasons for theresolution;

   b. The medical or clinical basis for the decision

   c. For any provider consulted, the professional specialty and state(s ) in which the provider is licensed; and

   d. Notice of the requesting party's right to seek review of the denial by an Independent Review Organization (IRO).

4. Written notification to the requesting party of the determination of the request for reconsideration shall be provided as soon as practicable, but no later than the 30th day after the date the Responsible Pool received the request.

5. The Responsible Pool shall provide expedited reconsideration for denials of continued stays for hospitalized Injured Employees. The period duringwhich the reconsideration is to be completed shall be based on the medical or clinical immediacy of the condition, procedure, or treatment, but shall not exceed one Working Day from the date of receipt of all information necessary to complete the reconsideration for continued hospital stays.

6. The request for reconsideration shall be reviewed by a provider who has not previously reviewed the case and who is of the same or a similar specialty as a provider who typically manages the condition, procedure, or treatment under review.

**E. Independent Review (IRO) of Adverse Determination (Regarding Medical Necessity of Care).**

1. With the exception of subsections 6 and 7 below, this section reflects Texas Department of Insurance rules regarding IRO. In the event of a conflict, the current Texas Department of Insurance rules prevail.

2. IRO requests will be accepted from

   a. Health care providers (Providers), or qualified pharmacy processing agents acting on behalf of a pharmacy, as described in Labor Code §413.0111, for preauthorization, concurrent, and retrospective medical necessity dispute resolution;and

   b. Employees for preauthorization, concurrent, and retrospective medical necessity dispute resolution.

3. IRO requests must be filed on the Texas Department of Insurance request form. This can be obtained from:

   a. The Department's Internet website at http://www.tdi.texas.gov/forms/form20numeric.html

   b. The Health and Workers' Compensation Network Certification and Quality Assurance Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104

4. A requestor shall file a request for independent review with the Responsible Pool that actually issued the adverse determination or the Responsible Pool's utilization review agent (URA) that actually issued the adverse determination not later than the 45th calendar day after receipt of the denial of reconsideration. The Responsible Pool shall notify the Texas Department of Insurance of a request for an independent review within one working day from the date the request is received by the Responsible Pool or its URA. Within one working day of receipt of a complete request for independent review, TDI will randomly assign an IRO to conduct the independent review and notify the URA, the payer, the IRO, the injured employee or the injured employee's representative, injured employee's provider of record, and any other providers listed by the URA as having records relevant to the review of the assignment. In a preauthorization or concurrent review dispute request, an employee with a life-threatening condition, as defined in §133.305 of this subchapter (relating to MDR--General), is entitled to an immediate review by an IRO and is not required to comply with the procedures for a reconsideration. (Rule 133.308(h))

5. The Responsible Pool shall pay for the independent review provided under this section.

6. After an independent review organization's (IRO) review and decision under this section, the requestor may request a Medical Contested Case Hearing from the Division of Workers' Compensation no later than 20 days after the date the IRO decision is sent to the appealing party.

7. An appeal to the governing body of the Pool shall be submitted to the address of the Responsible Pool as defined in section III of this Provider Manual

## VIII. Dispute Resolution

**A. Disputes Regarding Fees or Other Contract Issues Under The Agreement**

A dispute regarding fees or other contract issues under the Agreement are governed by section 8.1 of the Agreement.

**B. Alternative Dispute Resolution of Disputes Unresolved After Internal Review**

A dispute under the Agreement that is not resolved to Contract Provider's satisfaction after Internal Review is governed by section 8.2 of the Agreement.

**C. Disputes Regarding Medical Necessity (denial of Preauthorization or denial of payment for services after Retrospective Review and Reconsideration)**

A dispute involving an issue regarding medical necessity is between the Responsible Pool and the Contract Provider and shall be resolved in accordance with Division rules, including an Independent Review (IRO) and Division medical contested case hearing, laid out in section VII of this Provider Manual.

The Responsible Pool will follow the statutory process for dispute resolution for issues relating to the manner of providing medical benefits. The provider may appeal denial of medical necessity to the governing body of the Responsible Pool, but the provider is responsible to meet statutory deadlines for appeal of a denial of medical necessity to an IRO or medical contested case hearing.

## IX. Notice to Pools, the Alliance, and Contract Providers

**A. Notice Will Be In Writing**

Notices required or permitted by the Agreement will be in writing and delivered by U.S. mail, email, certified mail, return receipt requested or commercial overnight carrier as outlined in this Provider Manual.

**B. Notice Regarding Reconsideration of A Medical Billing or Claim Related Action**

Notice to the Responsible Pool regarding reconsideration of a medical billing or claim related action shall be addressed to the Pool as required by section III (relating to Contact Information for Participating Intergovernmental Risk Pools) of this Provider Manual and this section.

**C. Notice Regarding A Dispute**

Notice to the Alliance regarding a dispute shall be delivered to the Alliance as outlined in section VIII of this Provider Manual and this section.

**D. Notice To Contract Provider**

Notice to Contract Provider shall be addressed as set forth on the signature page of the Agreement.

# X. Other Useful Information Resources and Web Links

## General Information

***Texas Department of Insurance, Division of Workers' Compensation***
***Commissioner of Workers' Compensation***
http://www.tdi.texas.gov/wc/index.html
***Texas Department of Insurance Home Page:***
www.tdi.texas.gov/wc/

## Forms

***TDI Workers' Compensation Forms Home Page:***
http://www.tdi.texas.gov/forms/form20.html
***Work Status Report (DWC Form-073):***
http://www.tdi.texas.gov/forms/dwc/dwc073wkstat.pdf

***Report of Medical Evaluation (DWC Form-069):***
http://www.tdi.texas.gov/forms/dwc/dwc069medrpt.pdf

***Texas Standardized Credentialing Application:***
http://www.tdi.texas.gov/forms/form9credential.html

## Stay at Work/Return to Work Program

***Stay at Work/Return to Work Program Information:***
http://www.tdi.texas.gov/wc/rtw/index.html

## Law and Rules Applicable to Workers' Compensation

***Act:*** https://www.tdi.texas.gov/wc/act/index.html

***Financial Disclosure:*** https://www.tdi.texas.gov/pubs/fastfacts/fffinancialdisc.pdf

***Rules:*** https://www.tdi.texas.gov/wc/rules/index.html

# APPENDIX A

# LIST OF HEALTH CARE SERVICES THAT REQUIRE PREAUTHORIZATION

July 1, 2018

***NOTE: THIS PREAUTHORIZATION LIST IS NOT THE SAME AS THE DIVISION OF WORKERS' COMPENSATION PREAUTHORIZATION LIST (ADMINISTRATIVE RULE 134.600)***

## I. General Information

The Alliance may modify this list from time to time. The Alliance will notify Contract Providers of changes to this list by posting changes on the Alliance website, or through other notifications.

## II. Emergency Treatments

**POST-STABILIZATION TREATMENT, AND TREATMENTS AND SERVICES FOR AN EMERGENCY OR A LIFE-THREATENING CONDITION DO NOT REQUIRE PREAUTHORIZATION.**

## III. Non-emergency health care that requires preauthorization includes:

A. Inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;

B. Outpatient surgical or ambulatory surgical services to the spine only including all injections to the spine;

C. Spinal surgery;

D. All work hardening or work conditioning programs;

E. Physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

1. Level I code range for Physical Medicine and Rehabilitation, but limited to:

(a) Modalities, both supervised and constant attendance;

(b) Therapeutic procedures, excluding work hardening and work conditioning;

(c) Orthotics/Prosthetics Management;

(d) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and

(e) Stimulator devices (including but not limited to TENS Units,

Interferential Units, Neuromuscular Stimulators, Dual Units,Spinal Cord Stimulator, Peripheral Nerve Stimulator, Brain Stimulator).

(f) Physical therapy treatment modalities and/or procedural units per visit in excess of CMS and ODG guidelines (typically 4 modalities and/or procedural units).

2. Level II temporary code(s) for physical and occupational therapy services provided in a home setting;

3. Except for the first six visits of occupational therapy following the evaluation when such treatment is rendered within the first 90 days immediately following:

(a) The date of injury, or

(b) A surgical intervention previously preauthorized by the Responsible Pool or their designated utilization review agent (URA);

4. Physical therapy exceeding six (6) regular sessions within the first 90 days of the date of injury and six (6) post-op sessions within the first 6 months post-surgery. Notwithstanding this provision, if a provider requests preauthorization during the initial 90 days or 6 months post-surgery, the preauthorization decision supersedes and will determine the number of sessions.

F. Any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care;

G. Psychotherapy exceeding six (6) visits or cognitive therapy exceeding six (6) visits, repeat psychotherapy interviews, and biofeedback, except when any service is part of a preauthorized or Division exempted return-to-work rehabilitation program;

H. Psychological testing exceeding 3 hours with no more than 4 tests (MMPI-2, BDI, BAI, P-3), all repeat psychological testing.

I. Unless otherwise specified in this subsection, a repeat individual diagnostic study:

1. With a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline, or

2. Without a reimbursement rate established in the current Medical Fee Guideline;

J. All durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);

K. Chronic pain management/interdisciplinary pain rehabilitation;

L. Drugs:

*1.* Identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp;*

2. Any drug created through compounding;

3. Any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating potential efficacy of the treatment, but which is not broadly accepted as the prevailing standard of care as defined in Labor Code 413.014 (a);

4. An intrathecal drug delivery system;

M. Treatments and services that exceed or are not addressed by the Alliance adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the Responsible Pool or their designated URA.

N. Any treatment for an injury or diagnosis that is not accepted by the Responsible Pool or their designated URA pursuant to Labor Code §408.0042 and §126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury).

O. The health care requiring concurrent review for an extension for previously approved services includes:

1. Inpatient length of stay;

2. All work hardening or work conditioning programs;

3. Physical and occupational therapy services as referenced in section E above;

4. Investigational or experimental services or use of devices;

5. Chronic pain management/interdisciplinary pain rehabilitation; and

6. Required treatment plans.

**---END OF REQUIRED PREAUTHORIZATION LIST---**

# APPENDIX B

## LIST OF PREAUTHORIZATION FORMS

Texas Association of School Boards Risk Management Fund
https://www.pswca.org/docs/TASB_Healthcare_Preauth_Form_2019.pdf
https://www.pswca.org/docs/TASB_Drug_Preauth_Form_2019.pdf

Texas Municipal League Intergovernmental Risk Pool
https://www.pswca.org/docs/TASB_Healthcare_Preauth_Form_2019.pdf
https://www.pswca.org/docs/TASB_Drug_Preauth_Form_2019.pdf

Texas Association of Counties Risk Management Pool
https://www.pswca.org/docs/WellComp%20Preauth%20Form.pdf

Texas Water Association Risk Management Fund https://
www.pswca.org/docs/WellComp%20Preauth%20Form.pdf

Texas Council Risk Management Fund
https://www.pswca.org/docs/WellComp%20Preauth%20Form.pdf

**End**

***Political Subdivision Workers' Compensation Alliance***

**Contract Provider Manual**