Weslaco Independent School District
504 Network
Provider Handbook

HELPFUL CONTACT INFORMATION

Preauthorization of Medical Care

Vendor: TRISTAR
Tristar Managed Care
Fax: 361-857-0123

Access to Provider Listing

Phone: 956-969-6530

Website: https://www/wisd.us/departments/risk-management

Submit Medical Bills

Vendor TRISTAR
Tristar Managed Care
Fax: 361-857-0123

Workers' Compensation Adjuster:

Adjuster: Vicky Norton
Claims Examiner III
TRISTAR Risk Management
Office: 361-857-0115 ext. 2909
Fax: 361-857-0123
Vicky.Norton@tristargroup.net

Billing Inquiries:

Vendor TRISTAR
Tristar Risk Management
P.O. Box 2805
Clinton, IA 52733-2805

Phone (361)857-0115
Fax: (361)857-0123

Weslaco ISD Representative:

Name	Dr. Raul Cantu 319 W 4th Street Weslaco, TX 78596
Phone	956-969-6530
Fax:	956-973-2500
Email:	racantu@wisd.us

Complaint Handling for the Network

Name	Jina Torres
Phone	956-969-6529
Fax:	956-973-2500
Email:	jaatorres@wisd.us

Return to Work Program

Name	Dr. Raul Cantu 319 W 4th Street Weslaco, TX 78596
Phone	956-969-6530
Fax:	956-969-6581
Email:	racantu@wisd.us

ABOUT THE PROGRAM

General information about the program including when it started and who participates

PROVIDING MEDICAL CARE TO WESLACO INDEPENDENT SCHOOL DISTIRCT EMPLOYEES

Provider Roles

The treating doctor, except in the case of emergency treatment, is the initial treating doctor seen by an injured employee from Weslaco ISD's 504 network. The treating doctor is the doctor who is primarily responsible for managing the injured employee's health care. The treating doctor provides and oversees initial and ongoing care to an injured employee until he/she reaches maximum medical improvement, returns to work with or without restrictions and/or is discharged from care. This includes determining whether the injured employee needs to be referred to other medical providers and/or medical care facilities for evaluation and/or treatment. If the injured employee requires care that the treating doctor cannot provide, a referral will be made to a specialty

provider within Weslaco ISD's 504 Network list of contracted providers who can render appropriate care for the injury. If care is needed from a specialty provider not covered by the Weslaco ISD's 504 Network, the treating doctor must contact Tristar at 361-857-0115 to request an out of network referral. A treating doctor shall be a doctor of medicine, osteopathic medicine, optometry, dentistry, podiatry or chiropractic who is licensed and authorized to practice.

Accessing the Network

How to access the providers and specialists

Preauthorization of Medical Care

All preauthorization review services are provided by TRISTAR. The requestor or injured employee shall request and obtain preauthorization from TRISTAR prior to providing or receiving the following non-emergency health care:

(1) Inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;
(2) Outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;
(3) Spinal surgery;
(4) All work hardening or work conditioning services requested by non-exempted work hardening or work conditioning programs or division exempted programs if the proposed services exceed or are not addressed by the Texas Division of Workers' Compensation (DWC) treatment guidelines
(5) Physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
(i) Modalities, both supervised and constant attendance;
(ii) Therapeutic procedures, excluding work hardening and work conditioning;
(iii) Orthotics/Prosthetics Management;
(iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and

(B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;
(C) Except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:

(i) the date of injury; or
(ii) a surgical intervention previously preauthorized by the insurance carrier;

(6) 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;
(7) All psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program;
(8) Unless otherwise specified, a repeat individual diagnostic study with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline or without a reimbursement rate established in the current Medical Fee Guideline;
(9) All durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);
(10) Chronic pain management/interdisciplinary pain rehabilitation;
(11) Drugs not included in the applicable DWC formulary;
(12) Treatments and services that exceed or are not addressed by DWCs adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §134.506, 134.530 or 134.540 of the Texas Workers' Compensation Rules (relating to Pharmaceutical Benefits);
(13) Required treatment plans; and
(14) Any treatment for an injury or diagnosis that is not accepted by the insurance carrier

Network providers may submit an entire treatment plan for approval. This would be treated as a preauthorization request and no further preauthorization will be required for treatment identified in the plan.

***Emergency care does not require preauthorization.**

Concurrent Utilization Review of Medical Care

All concurrent utilization review services are provided by TRISTAR. Approval must be requested and obtained prior to providing an extension of health care. The health care requiring concurrent utilization review for an extension for previously approved services includes:
(1) Inpatient length of stay;
(2) All work hardening or work conditioning services requested by non-exempted work hardening or work conditioning programs or DWC exempted programs if the proposed services exceed or are not addressed by DWC's treatment guidelines;

(3) Physical and occupational therapy services
(4) Investigational or experimental services or use of devices;
(5) Chronic pain management/interdisciplinary pain rehabilitation; and
(6) Required treatment plans

Timelines for Notification of UR Decisions

The notification of the UR decision occurs within three (3) working days of receipt of the request for preauthorization or request for concurrent utilization review, except for inpatient hospital admissions, which is due within one working day of the receipt of the request. In urgent concurrent cases, the parties involved are notified within 24 hours of the request.

Notice of adverse determinations are sent in writing to the provider of record within one (1) day of the verbal or faxed notification, requesting the provider contact TRISTAR Managed Care within one business day to schedule a peer to peer conversation between the requesting physician and the reviewing physician.

No authorization for services is required if there is a documented medical emergency.

Reconsideration Process.

If the initial response is an adverse determination of preauthorization or concurrent utilization review, the requestor or injured employee may request reconsideration orally or in writing within 30 days of receipt.

A response to the request for reconsideration is submitted as soon as practicable but not later than the 30th day after receiving the request or within three (3) working days for concurrent utilization review or within one (1) day for inpatient length of stay. The period during which the reconsideration is to be completed shall be based on the medical or clinical immediacy of the condition, procedure, or treatment.

In any instance where medical necessity or appropriateness of the health care services is in question, prior to the issuance of an adverse determination on the request for reconsideration, a reasonable opportunity to discuss the proposed health care with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively, will be afforded to the requestor.

A written report is sent to the applicable parties advising of the reconsideration determination. If the determination is adverse, the requestor or injured employee are notified of their right to appeal by filing a request for review by an Independent Review Organization.

A request for preauthorization for the same health care shall only be resubmitted when the requestor provides objective clinical documentation to support a substantial change in the injured employee's medical condition or that 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.

Treatment Guidelines

The Official Disability Guidelines Treatment in Work Comp (ODG) and The Medical Disability Advisor (MDA), Workplace Guidelines for Disability Duration by Presley Reed, MD are the treatment and return to work guidelines. As a secondary source, we will utilize American College of Occupational and Environmental Medicine (ACOEM) when ODG does not address a specific treatment or service. No one source addresses all situations and IMO's utilization review service relies on multiple sources in determination of medical necessity of treatment. Additional sources may include:

- Milliman and Robertson Healthcare Management Guidelines, Vol. 7
- American Academy of Orthopaedic Surgeons
- Guidelines for Chiropractic Quality Assurance & Practice Parameters (Mercy Guidelines)
- AHCPR Clinical Practice Guideline: Acute Low Back Problems in Adults
- HCIA Length of Stay by Diagnosis and Operation/Western Region
- Appropriateness Evaluation Protocol
- National Guideline Clearinghouse
- Hayes Alert
- Cochrane Library
- Procedural/Utilization Facts
- Raj: Practical Management of Pain
- Current medical literature

Reporting Maximum Medical Improvement (MMI) and Permanent Impairment Rating (PIR)

The reporting of MMI and PIR information requires the physician to evaluate the condition of the injured employee, establish a date of MMI, assign a PIR

and determine anticipated future medical treatment. A Maximum Medical Improvement (MMI) date, projected or actual, should be made at each office visit. A PIR should be done when the injured employee reaches MMI and should be based on the statutory Permanent Impairment Guidelines in place by the Division of Workers' Compensation at that time.

Treatment Plans

We believe that documented treatment plans assist all parties in managing the work place injury and thereby expediting the injured employee's recovery. All medical providers are required to maintain and submit up-to-date treatment plans for injured employees after each visit. The plan should be submitted to the claims adjuster within two business days after each office visit.

Return to Work Coordination

Weslaco Independent School District has a very active return to work program and offers alternate duty positions to meet the injured employee's activity restrictions. Weslaco ISD's 504 Network medical providers are expected to work with the District's representative in an effort to bring injured employees back to work when it is medically appropriate. Continued progress toward full release is monitored closely.

SUBMISSION OF MEDICAL BILLS

All medical bills and supporting documentation should be submitted to:

TRISTAR Risk Management
PO Box 2805
Clinton, IA 52733-2805

Should a Weslaco ISD 504 Network provider have an issue with his/her reimbursement for services rendered to an injured employee, the provider should contact TRISTAR immediately to resolve the issue.

PROVIDER GRIEVANCE PROCEDURE

Inquiries and/or complaints

Situations occur when providers may have questions and/or are dissatisfied with services. All providers are encouraged to resolve inquiries and complaints by contacting:

TRISTAR Risk Management
Phone: 361-857-0115
Fax: 361-857-0123

Grievance/Appeal

Issues regarding medical payments and/or bills are **not** processed as a grievance/appeal. A grievance/appeal is a written statement of concern for a medical issue, which should include the following:

- provider name, address, phone number and Tax ID#
- a summary of the issue(s) grieved/appealed
- any previous contact with Weslaco ISD's 504 Network representatives
- the provider's proposed resolution
- the provider's signature and the date signed

Grievances/appeals should be directed to:

TRISTAR Risk Management
Phone: 361-857-0115
Fax: 361-857-0123