TITLE 28. INSURANCE

PART 2. TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

CHAPTER 133: GENERAL MEDICAL PROVISIONS

Title 28 Texas Administrative Code (TAC) §133.308

1. INTRODUCTION. The commissioner of workers' compensation (commissioner), Texas Department of Insurance, Division of Workers' Compensation (DWC) adopts amendments to 28 TAC §133.308. The change replaces "hearing officer" with "administrative law judge." The amendments are adopted without changes to the proposed text published in the November 2, 2018, issue of the *Texas Register* (43 TexReg 7314). This rule will not be republished. The public comment period ended on December 3, 2018. No public hearing was requested.

2. BACKGROUND AND PURPOSE. House Bill (HB) 2111, enacted by the 85th Texas Legislature, Regular Session, replaced all references to "hearing officer" in the Texas Workers' Compensation Act with "administrative law judge." The purpose of this amendment is to make conforming changes to DWC's rules.

3. SUMMARY OF COMMENTS AND AGENCY RESPONSE

General: Commenter expressed support for the proposal.

DWC Response: DWC appreciates the supportive comment.

4. NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL

For: Office of Injured Employee Counsel

5. STATUTORY AUTHORITY. The amendment is adopted under the authority of Labor Code §§402.00111, 402.00116, 402.00128, and 402.061.

Labor Code §402.00111 states that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority, under the Texas Workers' Compensation Act.

Labor Code §402.00116 states that the commissioner of workers' compensation is the division's chief executive and administrative officer and shall administer and enforce the Texas Workers' Compensation Act, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to the division or the commissioner of workers' compensation.

Labor Code §402.00128 states that the commissioner of workers' compensation shall conduct the daily operations of the division and otherwise implement division policy and, among other functions, may delegate; assess and enforce penalties; and enter appropriate orders.

Labor Code §402.061 states that the commissioner shall adopt rules as necessary for the implementation and enforcement of the Texas Workers' Compensation Act.

The adopted amendments affect the Texas Workers' Compensation Act, Texas Labor Code, Title 5, Subtitle A.

6. TEXT.

§133.308. MDR of Medical Necessity Disputes

(a) Applicability. The applicability of this section is as follows.

(1) This section applies to the independent review of medical necessity disputes that are filed on or after June 1, 2012. Dispute resolution requests filed prior to June 1, 2012 shall be resolved in accordance with the statutes and rules in effect at the time the request was filed.

(2) When applicable, retrospective medical necessity disputes shall be governed by the provisions of Labor Code §413.031(n) and related rules.

(3) All independent review organizations (IROs) performing reviews of health care under the Labor Code and Insurance Code, regardless of where the independent review activities are located, shall comply with this section. The Insurance Code, the Labor Code and related rules govern the independent review process.

(b) IRO Certification. Each IRO performing independent review of health care provided in the workers' compensation system shall be certified pursuant to Insurance Code Chapter 4202 and Chapter 12 of this title (relating to Independent Review Organizations).

(c) Professional licensing requirements. Notwithstanding Insurance Code Chapter 4202, an IRO that uses doctors to perform reviews of health care services provided under this section may only use doctors licensed to practice in Texas that hold the appropriate credentials under Chapter 180 of this title (relating to Monitoring and Enforcement). Personnel employed by or under contract with the IRO to perform independent review shall also comply with the personnel and credentialing requirements under Chapter 12 of this title.

(d) Conflicts. Conflicts of interest will be reviewed by the department consistent with the provisions of the Insurance Code §4202.008, Labor Code §413.032(b), §§12.203, 12.204, and 12.206 of this title (relating to Conflicts of Interest Prohibited, Prohibitions of Certain Activities and Relationships of Independent Review Organizations and Individuals or Entities Associated with Independent Review Organizations, and Notice of Determinations Made by Independent Review Organizations, respectively), and any other related rules. Notification of each IRO decision must include a certification by the IRO that the reviewing health care provider has certified that no known conflicts of interest exist between that health care provider and the injured employee, the injured employee's employer, the insurance carrier, the utilization review agent, any of the treating health care providers, or any of the health care providers utilized by the insurance carrier to review the case for determination prior to referral to the IRO.

(e) Monitoring. The division will monitor IROs under Labor Code §§413.002, 413.0511, and 413.0512. The division shall report the results of the monitoring of IROs to the department on at least a quarterly basis. The division will make inquiries, conduct audits, receive and investigate complaints, and take all actions permitted by the Labor Code and other applicable law against an IRO or personnel employed by or under contract with an IRO to perform independent review to determine compliance with applicable law, this section, and other applicable division rules.

(f) Requestors. The following parties may be requestors in medical necessity disputes:

(1) In network disputes:

(A) health care 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;

(B) injured employees or a person acting on behalf of an injured employee for preauthorization, concurrent, and retrospective medical necessity dispute resolution; and

(C) subclaimants in accordance with §§140.6, 140.7, or 140.8 of this title, as applicable.

(2) In non-network disputes:

(A) health care 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;

(B) injured employees or injured employee's representative for preauthorization and concurrent medical necessity dispute resolution; and, for retrospective medical necessity dispute resolution when reimbursement was denied for health care paid by the injured employee; and

(C) subclaimants in accordance with §140.6 of this title (relating to Subclaimant Status: Establishment, Rights, and Procedures), §140.7 of this title (relating to Health Care Insurer Reimbursement under Labor Code §409.0091), or §140.8 of this title (relating to Procedures for Health Care Insurers to Pursue Reimbursement of Medical Benefits under Labor Code §409.0091), as applicable.

(g) Requests. A request for independent review must be filed in the form and manner prescribed by the department. The department's IRO request form may be obtained from:

(1) the department's website at http://www.tdi.texas.gov/; or

(2) the Managed Care Quality Assurance Office, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

(h) Timeliness. A requestor shall file a request for independent review with the insurance carrier that actually issued the adverse determination or the insurance carrier's utilization review agent (URA) that actually issued the adverse determination no later than the 45th calendar day after receipt of the insurance carrier's denial of an appeal. The insurance carrier shall notify the department of a request for an independent review within one working day from the date the request is received by the insurance carrier or its URA. In a preauthorization or concurrent review dispute request, an injured 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 an appeal to the insurance carrier.

(i) Dismissal. The department may dismiss a request for medical necessity dispute resolution if:

(1) the requestor informs the department, or the department otherwise determines, that the dispute no longer exists;

(2) the requestor is not a proper party to the dispute pursuant to subsection (f) of this section;

(3) the department determines that the dispute involving a non-life-threatening condition has not been submitted to the insurance carrier for an appeal;

(4) the department has previously resolved the dispute for the date(s) of health care in question;

(5) the request for dispute resolution is untimely pursuant to subsection (h) of this section;

(6) the request for medical necessity dispute resolution was not submitted in compliance with the provisions of this subchapter; or

(7) the department determines that good cause otherwise exists to dismiss the request.

(j) IRO Assignment and Notification. The department shall review the request for IRO review, assign an IRO, and notify the parties about the IRO assignment consistent with the provisions of Insurance Code §4202.002(a)(1), §1305.355(a), Chapter 12, Subchapter F of this title (relating to Random Assignment of Independent Review Organizations), any other related rules, and this subchapter.

(k) Insurance Carrier Document Submission. The insurance carrier or the insurance carrier's URA shall submit the documentation required in paragraphs (1) - (6) of this subsection to the IRO not later than the third working day after the date the insurance carrier or URA receives the notice of IRO assignment. The documentation shall include:

(1) the forms prescribed by the department for requesting IRO review;

(2) all medical records of the injured employee in the possession of the insurance carrier or the URA that are relevant to the review, including any medical records used by the insurance carrier or the URA in making the determinations to be reviewed by the IRO;

(3) all documents, guidelines, policies, protocols and criteria used by the insurance carrier or the URA in making the decision;

(4) all documentation and written information submitted to the insurance carrier in support of the appeal;

(5) the written notification of the initial adverse determination and the written adverse determination of the appeal to the insurance carrier or the insurance carrier's URA; and

(6) any other information required by the department related to a request from an insurance carrier for the assignment of an IRO.

(l) Additional Information. The IRO shall request additional necessary information from either party or from other health care providers whose records are relevant to the review.

(1) The party or health care providers with relevant records shall deliver the requested information to the IRO as directed by the IRO. If the health care provider requested to submit records is not a party to the dispute, the insurance carrier shall reimburse copy expenses for the requested records pursuant to §134.120 of this title (relating to Reimbursement for Medical Documentation). Parties to the dispute may not be reimbursed for copies of records sent to the IRO.

(2) If the required documentation has not been received as requested by the IRO, the IRO shall notify the department and the department shall request the necessary documentation.

(3) Failure to provide the requested documentation as directed by the IRO or department may result in enforcement action as authorized by statutes and rules.

(m) Designated Doctor Exam. In performing a review of medical necessity, an IRO may request that the division require an examination by a designated doctor and direct the injured employee to attend the examination pursuant to Labor Code §413.031(g) and §408.0041. The IRO request to the division must be made no later than 10 days after the IRO receives notification of assignment of the IRO. The treating doctor and insurance carrier shall forward a copy of all medical records, diagnostic reports, films, and other medical documents to the designated doctor appointed by the division, to arrive no later than three working days prior to the scheduled examination. Communication with the designated doctor is prohibited regarding issues not related to the medical necessity dispute. The designated doctor shall complete a report and file it with the IRO, in the form and manner prescribed by the division no later than seven working days after completing the examination. The designated doctor report shall address all issues as directed by the division.

(n) Time Frame for IRO Decision. The IRO will render a decision as follows:

(1) for life-threatening conditions, no later than eight days after the IRO receipt of the dispute;

(2) for preauthorization and concurrent medical necessity disputes, no later than the 20th day after the IRO receipt of the dispute;

(3) for retrospective medical necessity disputes, no later than the 30th day after the IRO receipt of the IRO fee; and

(4) if a designated doctor examination has been requested by the IRO, the above time frames begin on the date of the IRO receipt of the designated doctor report.

(o) IRO Decision. The decision shall be mailed or otherwise transmitted to the parties and to representatives of record for the parties and transmitted in the form and manner prescribed by the department within the time frames specified in this section.

(1) The IRO decision must include:

(A) a list of all medical records and other documents reviewed by the IRO, including the dates of those documents;

(B) a description and the source of the screening criteria or clinical basis used in making the decision;

(C) an analysis of, and explanation for, the decision, including the findings and conclusions used to support the decision;

(D) a description of the qualifications of each physician or other health care provider who reviewed the decision;

(E) a statement that clearly states whether or not medical necessity exists for each of the health care services in dispute;

(F) a certification by the IRO that the reviewing health care provider has no known conflicts of interest pursuant to the Insurance Code Chapter 4202, Labor Code §413.032, and §12.203 of this title; and

(G) if the IRO's decision is contrary to the division's policies or guidelines adopted under Labor Code §413.011, the IRO must indicate in the decision the specific basis for its divergence in the review of medical necessity of non-network health care.

(2) The notification to the department shall also include certification of the date and means by which the decision was sent to the parties.

(p) Insurance Carrier Use of Peer Review Report after an IRO Decision. If an IRO decision determines that medical necessity exists for health care that the insurance carrier denied and the insurance carrier utilized a peer review report on which to base its denial, the peer review report shall not be used for subsequent medical necessity denials of the same health care services subsequently reviewed for that compensable injury.

(q) IRO Fees. IRO fees will be paid in the same amounts as the IRO fees set by department rules. In addition to the specialty classifications established as tier two fees in department rules, independent review by a doctor of chiropractic shall be paid the tier two fee. IRO fees shall be paid as follows:

(1) In network disputes, a preauthorization, concurrent, or retrospective medical necessity dispute for health care provided by a network, the insurance carrier

must remit payment to the assigned IRO within 15 days after receipt of an invoice from the IRO;

(2) In non-network disputes, IRO fees for disputes regarding non-network health care must be paid as follows:

(A) in a preauthorization or concurrent review medical necessity dispute or retrospective medical necessity dispute resolution when reimbursement was denied for health care paid by the injured employee, the insurance carrier shall remit payment to the assigned IRO within 15 days after receipt of an invoice from the IRO.

(B) in a retrospective medical necessity dispute, the requestor must remit payment to the assigned IRO within 15 days after receipt of an invoice from the IRO.

(i) If the IRO fee has not been received within 15 days of the requestor's receipt of the invoice, the IRO shall notify the department and the department shall dismiss the dispute with prejudice.

(ii) After an IRO decision is rendered, the IRO fee must be paid or refunded by the nonprevailing party as determined by the IRO in its decision.

(3) Designated doctor examinations requested by an IRO shall be paid by the insurance carrier in accordance with the medical fee guidelines under the Labor Code and related rules.

(4) Failure to pay or refund the IRO fee may result in enforcement action as authorized by statute and rules.

(5) For health care not provided by a network, the non-prevailing party to a retrospective medical necessity dispute must pay or refund the IRO fee to the prevailing party upon receipt of the IRO decision, but not later than 15 days regardless of whether an appeal of the IRO decision has been or will be filed.

(6) The IRO fees may include an amended notification of decision if the department determines the notification to be incomplete. The amended notification of decision shall be filed with the department no later than five working days from the IRO's receipt of such notice from the department. The amended notification of decision does not alter the deadlines for appeal.

(7) If a requestor withdraws the request for an IRO decision after the IRO has been assigned by the department but before the IRO sends the case to an IRO reviewer, the requestor shall pay the IRO a withdrawal fee of $150 within 30 days of the withdrawal. If a requestor withdraws the request for an IRO decision after the case is sent to a reviewer, the requestor shall pay the IRO the full IRO review fee within 30 days of the withdrawal.

(8) In addition to department enforcement action, the division may assess an administrative fee in accordance with Labor Code §413.020 and §133.305 of this subchapter.

(9) This section shall not be deemed to require an employee to pay for any part of a review. If application of a provision of this section would require an employee to pay for part of the cost of a review, that cost shall instead be paid by the insurance carrier.

(r) Defense. An insurance carrier may claim a defense to a medical necessity dispute if the insurance carrier timely complies with the IRO decision with respect to the medical necessity or appropriateness of health care for an injured employee. Upon receipt of an IRO decision for a retrospective medical necessity dispute that finds that medical necessity exists, the insurance carrier must review, audit, and process the bill. In addition, the insurance carrier shall tender payment consistent with the IRO decision, and issue a new explanation of benefits (EOB) to reflect the payment within 21 days upon receipt of the IRO decision. The decision of an IRO under Labor Code §413.031(m) is binding during the pendency of a dispute.

(s) Appeal of IRO decision. A decision issued by an IRO is not considered an agency decision and neither the department nor the division is considered a party to an appeal. In a division Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence based medical evidence. A party to a medical dispute that remains unresolved after a review under Labor Code §504.053(d)(3) or Insurance Code §1305.355 is entitled to a contested case hearing in the same manner as a hearing conducted under Labor Code §413.0311. A party to a medical necessity dispute may seek review of a dismissal or decision at a division CCH as follows:

(1) A party to a medical necessity dispute may appeal the IRO decision by requesting a division CCH conducted by a division administrative law judge. A benefit review conference is not a prerequisite to a division CCH under this subsection.

(A) The written appeal must be filed with the division's Chief Clerk of Proceedings no later than the later of the 20th day after the effective date of this section or 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the division. Requests that are timely submitted to a division location other than the division's Chief Clerk of Proceedings, such as a local field office of the division, will be considered timely filed and forwarded to the Chief Clerk of Proceedings for processing; however, this may result in a delay in the processing of the request.

(B) The party appealing the IRO decision shall send a copy of its written request for a hearing to all other parties involved in the dispute. The IRO is not required to participate in the division CCH or any appeal.

(C) Except as otherwise provided in this section, a division CCH shall be conducted in accordance with Chapters 140 and 142 of this title (relating to Dispute Resolution--General Provisions and Dispute Resolution--Benefit Contested Case Hearing).

(D) At a division CCH, the administrative law judge shall consider the treatment guidelines:

(i) adopted by the network under Insurance Code §1305.304, for a network dispute;

(ii) adopted by the division under Labor Code §413.011(e) for a non-network dispute; or

(iii) adopted, if any, by the political subdivision or pool that provides medical benefits under Labor Code §504.053(b)(2) if those treatment guidelines meet the standards provided by Labor Code §413.011(e).

(E) Prior to a division CCH, a party may submit a request for a letter of clarification by the IRO to the division's Chief Clerk of Proceedings. A copy of the request for a letter of clarification must be provided to all parties involved in the dispute at the time it is submitted to the division.

(i) A party's request for a letter of clarification must be submitted to the division no later than 10 days before the date set for hearing. The request must include a cover letter that contains the names of the parties and all identification numbers assigned to the hearing or the independent review by the division, the department, or the IRO.

(ii) The department may at its discretion forward the party's request for a letter of clarification to the IRO that conducted the independent review. The department will not forward to the IRO a request for a letter of clarification that asks the IRO to reconsider its decision or issue a new decision.

(iii) The IRO shall send a response to the request for a letter of clarification to the department and to all parties that received a copy of the IRO's decision within 5 days of receipt of the party's request for a letter of clarification. The IRO's response is limited to clarifying statements in its original decision; the IRO shall not reconsider its decision and shall not issue a new decision in response to a request for a letter of clarification.

(iv) A request for a letter of clarification does not alter the deadlines for appeal.

(F) A party to a medical necessity dispute who has exhausted all administrative remedies may seek judicial review of the division's decision. Judicial review under this paragraph shall be conducted in the manner provided for judicial review of contested cases under Chapter 2001, Subchapter G Government Code, and is governed by the substantial evidence rule. The party seeking judicial review under this section must file suit not later than the 45th day after the date on which the division mailed the party the decision of the administrative law judge. The mailing date is considered to be the fifth day after the date the decision of the administrative law judge was filed with the division. A decision becomes final and appealable when issued by a division administrative law judge. If a party to a medical necessity dispute files a petition for judicial review of the division's decision, the party shall, at the time the petition is filed with the district court, send a copy of the petition for judicial review to the division's Chief Clerk of Proceedings. The division and the department are not considered to be parties to the medical necessity dispute pursuant to Labor Code §413.031(k-2) and §413.0311(e).

(G) Upon receipt of a court petition seeking judicial review of a division CCH held under this subparagraph, the division shall prepare and submit to the district court a certified copy of the entire record of the division CCH under review.

(i) The following information must be included in the petition or provided to the division by cover letter:

(I) any applicable division docket number for the dispute being appealed;

(II) the names of the parties;

(III) the cause number;

(IV) the identity of the court; and

(V) the date the petition was filed with the court.

(ii) The record of the hearing includes:

(I) all pleadings, motions, and intermediate rulings;

(II) evidence received or considered;

(III) a statement of matters officially noticed;

(IV) questions and offers of proof, objections, and rulings on them;

(V) any decision, opinion, report, or proposal for decision by the officer presiding at the hearing and any decision by the division; and

(VI) a transcription of the audio record of the division CCH.

(iii) The division shall assess to the party seeking judicial review expenses incurred by the division in preparing the certified copy of the record, including transcription costs, in accordance with the Government Code §2001.177 (relating to Costs of Preparing Agency Record). Upon request, the division shall

consider the financial ability of the party to pay the costs, or any other factor that is relevant to a just and reasonable assessment of costs.

(2) If a party to a medical necessity dispute properly requests review of an IRO decision, the IRO, upon request, shall provide a record of the review and submit it to the requestor within 15 days of the request. The party requesting the record shall pay the IRO copying costs for the records. The record shall include the following documents that are in the possession of the IRO and which were reviewed by the IRO in making the decision including:

(A) medical records;

(B) all documents used by the insurance carrier in making the decision that resulted in the adverse determination under review by the IRO;

(C) all documentation and written information submitted by the insurance carrier to the IRO in support of the review;

(D) the written notification of the adverse determination and the written determination of the appeal to the insurance carrier or the insurance carrier's URA;

(E) a list containing the name, address, and phone number of each health care provider who provided medical records to the IRO relevant to the review;

(F) a list of all medical records or other documents reviewed by the IRO, including the dates of those documents;

(G) a copy of the decision that was sent to all parties;

(H) copies of any pertinent medical literature or other documentation (such as any treatment guideline or screening criteria) utilized to support the decision or, where such documentation is subject to copyright protection or is voluminous, then a listing of such documentation referencing the portion(s) of each document utilized;

(I) a signed and certified custodian of records affidavit; and

(J) other information that was required by the department related to a request from an insurance carrier or the insurance carrier's URA for the assignment of the IRO.

(t) Medical Fee Dispute Request. If the requestor has an unresolved non-network fee dispute related to health care that was found medically necessary, after the final decision of the medical necessity dispute, the requestor may file a medical fee dispute in accordance with §133.305 and §133.307 of this subchapter (relating to MDR-General and MDR of Fee Disputes, respectively).

(u) In accordance with Labor Code §504.055(d), an appeal regarding the denial of a claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury involving a first responder will be accelerated by the division and given priority. The party seeking to expedite the contested case hearing or appeal shall provide notice to the division and independent review organization that the contested case hearing or appeal involves a first responder.

(v) Enforcement. The department or the division may initiate appropriate proceedings under Chapter 12 of this title or Labor Code, Title 5 and division rules

against an independent review organization or a person conducting independent reviews.

7. CERTIFICATION. The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Issued at Austin, Texas, on December 17, 2018.

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Nicholas Canaday III
General Counsel
Texas Department of Insurance,
Division of Workers' Compensation

The commissioner adopts amendments to §133.308.

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Cassie Brown
Commissioner of Workers' Compensation

COMMISSIONER'S ORDER NO. _____

ATTEST:

Nicholas Canaday III

General Counsel

Texas Department of Insurance, Division of Workers' Compensation

COMMISSIONER'S ORDER NO. _____