TITLE 28. INSURANCE

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

CHAPTER 133: GENERAL MEDICAL PROVISIONS

**SUBCHAPTER A: GENERAL RULES FOR MEDICAL BILLING AND PROCESSING
AMEND: §133.2**

**SUBCHAPTER C: MEDICAL BILL PROCESSING/AUDIT BY INSURANCE CARRIER
AMEND: §133.240 AND §133.250**

**SUBCHAPTER D: DISPUTE OF MEDICAL BILLS
AMEND: §133.305**

1. INTRODUCTION.

The Texas Department of Insurance (Department), Division of Workers' Compensation (Division) adopts amendments to §133.2, concerning Definitions, §133.240, concerning Medical Payments and Denials, §133.250, concerning Reconsideration for Payment of Medical Bills, and §133.305, concerning MDR (medical dispute resolution) - General. These sections are adopted without changes to the proposed text published in the November 1, 2013 issue of the *Texas Register* (38 TexReg 7601). A correction of error was published in the November 8, 2013, issue of the *Texas Register* (38 TexReg 8012) to correct errors in the proposal published November 1, 2013. There was not a request for a public hearing submitted to the Division.

In conjunction with this adoption order, the Division is adopting amendments to 28 TAC §134.110, concerning Reimbursement of Injured Employee for Travel Expenses Incurred; §134.502, concerning Pharmaceutical Services; and §134.600, concerning Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care. The adoption of amendments to §§134.110, 134.502, and 134.600 are also published in this issue of the *Texas Register*.

The Division adopts non-substantive changes throughout the text of §§133.2, 133.250, and 133.305. These non-substantive changes include renumbering subsections for clarity and changing the capitalization of the words "Division" and "Department" to conform to current agency style.

2. REASONED JUSTIFICATION.

These amendments are necessary to implement Senate Bill 1322 and House Bill 3152, 83rd Legislature, Regular Session, effective September 1, 2013. These amendments are also necessary to implement House Bill 4290, 81st Legislature, Regular Session, effective September 1, 2009, which revises the definitions of "adverse determination" and "utilization review" in Insurance Code Chapter 4201 to include retrospective reviews and determinations regarding the experimental or investigational nature of a service.

These amendments are also necessary for the Division to comply with the requirement of Labor Code §402.00114 to regulate and administer the business of workers' compensation in Texas and ensure that Labor Code Title 5 and other laws regarding workers' compensation are executed. Under Labor Code §402.00116, the Division is required to administer and enforce Labor Code Title 5, other workers' compensation laws of this state, and other laws applicable to the Division.

In accordance with Government Code §2001.033(a)(1), the Division's reasoned justification for these rules is set out in this order, which includes the preamble. The entire adoption order is part of the reasoned justification for the new sections. The following paragraphs include a detailed, section-by-section description and reasoned justification of all of the amendments necessary to harmonize the amendments with 28 TAC §19.2001 and §19.2017 (Subchapter U), concerning Utilization Reviews for Health Care Provided Under Workers' Compensation Coverage published in the February 15, 2013, issue of the *Texas Register* (38 TexReg 892). Harmonization of these

adopted sections with Subchapter U is beneficial because consistency benefits both system participants and injured employees. The adopted amendments to §§133.2, 133.240, and 133.250 are also important for reasons set out in the adoption order of Subchapter U.

The Division adopts these amendments to clarify that: (1) retrospective review of the medical necessity and appropriateness of a health care service is utilization review; (2) the insurance carrier must provide the requesting health care provider a reasonable opportunity to discuss the pending adverse determination, both before the insurance carrier issues the adverse determination on the health care service after retrospective utilization review of the health care service and after a request for reconsideration (appeal) of the adverse determination; and (3) all utilization review under Chapter 133 must be performed by a utilization review agent (URA) certified by or an insurance carrier registered with the Department to perform utilization review in accordance with Insurance Code Chapter 4201 and Subchapter U.

The Division made no changes to the proposed text in response to public comments. No changes to the proposed text materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

Section 133.2 addresses **Definitions**. New §133.2(1) defines "adverse determination" which corresponds with the definition of the term in 28 TAC §19.2003(b)(1) concerning Definitions. The definition of "adverse determination" clarifies that an adverse determination does not include a determination that health care services are experimental or investigational. Although this clarification is inconsistent with the statutory definition of "adverse determination" in Insurance Code §4201.002(1), it is consistent with Labor Code §408.021 and §413.014. Insurance Code §4201.054, provides that, in the event of a conflict between Insurance Code Chapter 4201 and the Labor Code Title 5, Labor Code Title 5 prevails. Although injured employees under non-network coverage are

entitled to experimental or investigational health care, those services must be preauthorized under Labor Code §413.014.

New §133.2(8) defines "reasonable opportunity" which corresponds with the definition of the term in 28 TAC §19.2003(b)(28), that implements the required peer-to-peer discussion requirements under Insurance Code §4201.206.

Amended §133.2(9) defines "retrospective utilization review" which corresponds with the definition of the term in 28 TAC §19.2003(b)(31). A correction of error notice published in the November 8, 2013 issue of the *Texas Register* (38 TexReg 8012) corrected the formatting of §133.2(9) published in the November 1, 2013, issue of the *Texas Register*.

Existing §133.2(a)(8) is deleted because its provisions have expired. Labor Code §413.0115 provides a definition for "informal network" that became obsolete with the expiration of Labor Code §413.011(d-1). Labor Code §413.0115(b) states that "not later than January 1, 2011 each informal network or voluntary network must be certified as a workers' compensation health care network under Chapter 1305, Insurance Code." Labor Code §413.0115 also contains a definition for "voluntary network" which pertains to voluntary workers' compensation health care delivery networks established by insurance carriers under former Labor Code §408.0233, as that section existed before its repeal by Chapter 265, Acts of the 79th Legislature, Regular Session. Labor Code §408.0281 also provides a definition for "informal network" and "voluntary network" which pertains to the provision of pharmaceutical services, enacted by HB 528, 82nd Legislature, Regular Session, effective June 17, 2011.

Existing §133.2(b) is deleted because its effective date is no longer necessary.

Section 133.240 addresses **Medical Payments and Denials**. Amendments to §133.240 implement Insurance Code §1305.153(f)-(j), harmonize the rule with Subchapter U requirements

concerning adverse determinations, and update the definitions for "informal network" and "voluntary network."

Amended §133.240(e) clarifies that the insurance carrier shall send the explanation of benefits to the injured employee when payment is denied because of an adverse determination. The phrase "determined to be unreasonable and/or unnecessary" is deleted and replaced with the term "adverse determination" to correspond with Insurance Code §4201.002(1), 28 TAC §19.2003(b)(1), and new §133.2(1).

Amended §133.240(f)(16) adds the requirement to include the name of the durable medical equipment or home health care services informal or voluntary network. Existing §133.240(f)(16) requires the name of a pharmacy informal or voluntary network to be included on the bill, if applicable. The amendments also add citations to Labor Code §408.0281 and §408.0284. Labor Code §408.0281 provides a definition for "informal network" and "voluntary network" which pertains to the provision of pharmaceutical services and was enacted by HB 528, 82nd Legislature, Regular Session, effective June 17, 2011. Labor Code §408.0284 provides a definition for "informal network" and "voluntary network" which pertains to the provision of durable medical equipment and home health care services and was enacted by SB 1322, 83rd Legislature, Regular Session, effective September 1, 2013.

Amended §133.240(j) clarifies that if a request for reconsideration of an adverse determination is made, the request for reconsideration constitutes an appeal for the purposes of 28 TAC §19.2011.

Amended §133.240 corresponds with the requirements of Insurance Code §1305.153(f)-(j), enacted by HB 3152, 83rd Legislature, Regular Session, effective September 1, 2013. New §133.240(q) requires the insurance carrier to comply with 28 TAC §19.2009, concerning Notice of

Determinations Made in Utilization Review, and 28 TAC §19.2010, concerning Requirements Prior to Issuing an Adverse Determination, when denying payment due to an adverse determination. The Division clarifies that for the notice for retrospective review adverse determination required by 28 TAC §19.2009 may be satisfied by including the elements required in the notice in the explanation of benefits required by §133.240(f).

These amendments are also necessary to harmonize this section with the requirements in 28 TAC §19.2010 that require insurance carriers to provide health care providers a reasonable opportunity to discuss the plan of treatment for the injured employee and the pending adverse determination before issuing the adverse determination. Because §133.240(q) pertains to retrospective utilization review, the words "billed health care" have been added to conform to the requirement that health care providers be given a reasonable opportunity to discuss the services under review with the insurance carriers since the services have already been provided.

Existing §133.240(q) is deleted because its effective date is no longer necessary.

Section 133.250 addresses **Reconsideration for Payment of Medical Bills**. Amended §133.250 harmonizes with Subchapter U requirements concerning requests for reconsideration following an adverse determination and the allowance of a reasonable opportunity for health care providers to discuss the billed health care. The amendments to §133.250 also clarify the requirements for oral and written requests for reconsideration.

Amended §133.250(a) is necessary to correspond with Insurance Code §4201.354, which requires that the procedures for appealing an adverse determination provide that the adverse determination may be appealed orally or in writing. Amended §133.250(a) clarifies that if the health care provider is requesting reconsideration of a bill denied based on an adverse determination, the request for reconsideration constitutes an appeal for the purposes of 28 TAC §19.2011 and may be

submitted orally or in writing. Amended §133.250(a) is also necessary to harmonize with 28 TAC §19.2011.

Amended §133.250(d) adds the word "written" to clarify the requirements that apply to written requests for reconsideration and is necessary to distinguish this subsection from new §133.250 (e) concerning "oral" requests for reconsideration.

New §133.250(e) is necessary to correspond with Insurance Code §4201.354 and §1305.354 which require procedures for oral appeals of adverse determinations. Section 133.250(e) provides minimum guidelines for oral requests for reconsideration following the denial of health care services based on an adverse determination. New §133.250(e) also corresponds with Insurance Code §4201.054, that requires the Commissioner of Workers' Compensation to regulate a person who performs utilization review of a medical benefit provided under Labor Code Title 5. New §133.250(e) corresponds with Labor Code §402.021(b) that provides that the workers' compensation system must minimize the likelihood of disputes and resolve them promptly and fairly when identified. New §133.250(e) is also necessary to align with 28 TAC §19.2011(a)(3) which provides that an injured employee, the injured employee's representative, or the provider of record may appeal the adverse determination orally or in writing. New §133.250(e) is also consistent with 28 TAC §10.103 concerning workers' compensation network requests for reconsideration. New §133.250(e) additionally provides for a delayed effective date to allow time for insurance carriers to update their procedures.

Amended §133.250(f) adds the word "written" to clarify the requirements that apply when an insurance carrier receives written requests for reconsideration and to distinguish this subsection from new §133.250(e) concerning "oral" requests for reconsideration.

New §133.250(k) is necessary to conform to the requirements of Insurance Code §1305.354(a)(3). New §133.250(k) requires that in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of 28 TAC §19.2010 and §19.2011. New §133.250(k) is also necessary to clarify that the reasonable opportunity to discuss a pending adverse determination required under 28 TAC §19.2011 applies to the issuance of adverse determinations on requests for reconsideration. Because new §133.250(k) pertains to retrospective utilization review, the words "billed health care" have been added to conform to the requirement that the health care providers have a reasonable opportunity to discuss the services under review with the insurance carriers since the services have already been provided. These conforming changes will enable the monitoring of whether a reasonable opportunity for discussion was offered and the collecting of information on peer-to-peer discussion results to ensure compliance with Subchapter U.

Existing §133.250(j) is deleted because its effective date is no longer necessary. With the exception of new §133.250(e), §133.250 will become effective 20 days after the date it is filed in the Office of the Secretary of State in accordance with Government Code §2001.036. New §133.250(e) will apply to oral requests made on or after six months from the effective date of §133.250.

Section 133.305 addresses **MDR--General**. The definition of the term "adverse determination" in §133.305(a)(1) is deleted because it is redundant to the definition in new §133.2(1).

Amended §133.305(a)(6) adds a citation to Labor Code §408.0281 that provides a definition for "informal network" and "voluntary network" which pertains to the provision of pharmaceutical services and was enacted by HB 528, 82nd Legislature, Regular Session, effective June 17, 2011. Amended §133.305(a)(6) adds a citation to Labor Code §408.0284 because it provides a definition for "informal network" and "voluntary network" which pertains to the provision of durable medical

equipment and home health care services and was enacted by SB 1322, 83rd Legislature, Regular Session, effective September 1, 2013.

Amended §133.305(a)(7) adds the word "utilization" for clarity and updates the citation to §133.308 to reflect its current title.

3. HOW THESE SECTIONS WILL FUNCTION.

Section 133.2 specifies the meanings of the words and terms when used in Chapter 133, unless the context clearly indicates otherwise. Section 133.240 provides requirements applicable to medical payments and denials. Section 133.250 specifies requirements for reconsideration for payments of medical bills. Section 133.305 provides requirements for medical dispute resolution.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSES.

General

Comment: Commenters greatly appreciate and support the amendments because they offer enhanced clarity. Commenters believe the amendments harmonize the rules to Subchapter U, promote the delivery of quality health care in a cost-effective manner, require URAs to adhere to reasonable standards for conducting utilization review, and improve communication and cooperation between a provider and URA.

One commenter supports the amendments because they clarify that utilization review includes a retrospective review of the medical necessity and appropriateness of a health care service. The commenter also supports the amendments because they require an insurance carrier to provide the physician a reasonable opportunity to discuss the pending adverse determination both before issuing the adverse determination and after an appeal of the adverse determination.

Agency Response: The Division appreciates the supportive comments.

Comment: One commenter states that the rules make utilization review more burdensome and expensive from an administrative standpoint, which is not the most effective way to satisfy the mandate to control medical costs in the workers' compensation system. The commenter thinks the rules should have been written to follow existing Division rule language and conform to the Labor Code.

Agency Response: The Division asserts that these rules are necessary to implement HB 4290; Insurance Code Chapter 4201, to the extent not in conflict with Labor Code Title 5 or Insurance Code Chapter 1305; and in order to consistently apply utilization review of health care services. Additionally, these rules promote efficient regulation of URAs through the alignment of health and workers' compensation URA certification and registration requirements, utilization review timeframes, and utilization review standards. These rules also align differences in utilization review timeframes and standards within workers' compensation for network and non-network claims.

Comment: One commenter suggests that the best way to conform the current proposed rule changes with Subchapter U is to incorporate the commenter's suggested changes to these proposed rules into Subchapter U.

The commenter objects to the references to other codes and rules and the cross-referencing to other sections of this title because they make it difficult to understand what these sections mean without consulting other material. The commenter recommends that the references be revised to specifically explain what the code or rule referred to actually means. The commenter states the proposed rules are lengthy and complex and they should be self-contained rather than reference other rule sections because this change would ensure that system participants can more readily determine their responsibilities under the rules.

Agency Response: The Division declines to make the suggested changes. Amendments to Title 28 Chapter 19, Subchapter U are outside the scope of the amendments to Chapter 133 included in this adoption. The Division declines to delete the references to other codes and rules because an entity that performs utilization review is required to comply with the cited rules and statutes, and inclusion of the entire text of other rules and statutes would be repetitive. The Division has determined that the rules are more streamlined and easier to understand by including cross-references, and also provides notice of the requirements in other rules and statutes.

§133.2

Comment: A commenter suggests that the amendments to §133.2 be effective no sooner than 45 days after adoption.

Agency Response: The Division declines to make the suggested change to the effective date. The Division has determined that giving stakeholders 20 days to comply from the date the adoption order is filed with the Secretary of State is sufficient. The sections are necessary to implement HB 4290, 81st Legislature, Regular Session, effective September 1, 2009, and to conform with Subchapter U rules adopted effective February 20, 2013.

Comment: Several commenters assert the definition of "adverse determination" in §133.2(1) conflicts with Insurance Code §4201.002(1) and the standards for health care coverage in the Workers Compensation Act. The commenters assert that Insurance Code §4201.054(c) mandates that Title 5 of the Labor Code prevail over Insurance Code Chapter 4201 when there is a conflict. The commenters assert Labor Code §408.021 states that the injured worker is entitled to "…all health care reasonably required by the nature of the injury as and when needed," and that the term "health care reasonably required" is defined in Labor Code §401.011(22-a). The commenters assert the proposed language suggests that the standard for entitlement to workers' compensation medical treatment is "medically necessary or appropriate" which is not defined in the Workers' Compensation

Act and is subject to an interpretation that could differ from the statutory standard of "health care reasonably required." The commenters suggest deleting the words "medically necessary or appropriate" in the definition and inserting the words "reasonably required" in their place.

Agency Response: The Division declines to make the suggested changes. The phrase "medically necessary or appropriate" is consistent with the definition of "adverse determination" under Insurance Code §4201.002, which defines "adverse determination" as a determination by a URA that health care services provided or proposed to be provided to a patient are not medically necessary or are experimental or investigational. Also, the phrase "medically necessary or appropriate" is used in 28 TAC §12.5(1), which defines "adverse determination" for purposes of independent review. Introducing the phrase "health care reasonably required" would result in inconsistent definitions of "adverse determination" in the context of utilization review and independent review. Furthermore, nothing may be construed to limit health care reasonably required under Labor Code §408.021. The Division's position is that, based on Labor Code §408.021, an injured employee under both network and non-network coverage is entitled to health care reasonably required by nature of the injury as and when needed.

Comment: A commenter supports §133.2(8)(A) which defines "reasonable opportunity."

Agency Response: The Division appreciates the supportive comment.

Comment: A commenter requests that one working day be further defined in §133.2(8)(A) as at least a 24-hour period in order to give the provider sufficient time to respond to an inquiry from the URA because this change would help ensure that the conversation between the URA and the provider actually takes place.

Agency Response: The Division declines to make the suggested change to the definition of the term "working day." "Working day" is consistent with Insurance Code §4201.002(16) which

defines "working day" as "a weekday that is not a legal holiday" and is also consistent with 28 TAC §102.3, concerning Computation of Time, which states that "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." A 24-hour period would conflict with the statutory definition as one 24-hour period could cover more than one weekday that is not a holiday.

§133.240(q) and §133.250(k)

Comment: Several commenters assert that the phrase "where the insurance carrier is questioning" in §133.240(q) and §133.250(k) is too vague. Commenters state that the Division should replace the phrase "in any instance where the insurance carrier is questioning" with the phrase "prior to the issuance of an adverse determination relating to." Commenters believe when an insurance carrier engages in utilization review, it is questioning the necessity or appropriateness of the health care services. Commenters believe §133.240 should state that prior to issuing an adverse decision, an insurance carrier shall give the health care provider a reasonable opportunity to discuss the services.

Several commenters believe the requirements of Insurance Code §4201.206 only apply to a utilization review agent before issuing an adverse determination and not when the insurance carrier is questioning the medical necessity or appropriateness of health care services. One commenter suggests modifying the language in §133.240(q) because the "reasonable opportunity" requirements of Insurance Code §4201.206 and §4201.456 do not apply to "any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services."

Several commenters assert the Division does not have rulemaking authority to expand the reasonable opportunity requirements of the statute to "insurance carriers" or to "any instance" where there is a question of medical necessity.

A commenter suggests modifying §133.240(q) and §133.250(k) by replacing the term "insurance carrier" with "utilization review agent" and changing the language "When denying payment due to an adverse determination" to "When issuing an adverse determination."

Agency Response: The Division declines to make the suggested change. New §133.240(q) and §133.250(k) are consistent with Insurance Code §4201.026 which uses the phrase "who questions the medical necessity or appropriateness." They are also consistent with Subchapter U. The term "insurance carrier" is used in new §133.240(q) and §133.250(k) because an entity that conducts utilization review in the workers' compensation system is required to comply with the applicable statutes and regulations to conduct utilization review. The Division recognizes that the party directly responding to a request for retrospective utilization review may be the insurance carrier if the insurance carrier is a certified utilization review agent or the insurance carrier's utilization review agent. Under the definition of "agent" in §133.2, the system participant who utilizes or contracts with an agent may also be responsible for the administrative violations of that agent.

§133.250

Comment: A commenter thinks §133.250(a) should require all requests for reconsideration be in writing because there needs to be an official record of a request for reconsideration. The commenter believes that permitting oral requests, with no real standards of what is required in the oral request, is an invitation to additional confusion, misunderstandings, delays, and disputes. The commenter suggests §133.250(a) be modified to require that only written requests for reconsideration constitute an appeal for the purposes of §19.2011.

Agency Response: The Division disagrees that §133.250(a) should be modified to only allow written requests for reconsideration. Amended §133.250(a) corresponds with Insurance Code §4201.354 that provides that an adverse determination may be appealed orally or in writing.

Amended §133.250(a) is also consistent with the requirements of Insurance Code §1305.354 for workers' compensation network coverage, and is necessary to harmonize with 28 TAC §19.2011.

Comment: A commenter believes that §133.250(a) and (b) are inconsistent because §19.2011 refers to Insurance Code §1305.354 and §134.600 which provide that parties may request an appeal or reconsideration within 30 days from the issuance or receipt of an adverse determination. The commenter thinks the 30-day requirement is inconsistent with §133.250(b) which allows parties up to 10 months from the date of service to submit a request for appeal or reconsideration. The commenter suggests §133.250(b) should exclude utilization review from the 10 month window.

Agency Response: The Division declines to make the suggested change because a request for reconsideration following the issuance of an adverse determination in a network is governed by other rules, including 28 TAC §19.2011(b)(1) and §10.103. Amended §133.250 pertains to retrospective utilization review, while amended §134.600 pertains to prospective and concurrent utilization review. Title 28 TAC §19.2011(b)(1) pertains to network appeals of retrospective review adverse determinations and requires compliance with the 30 day requirement of Insurance Code §1305.354 . Title 28 TAC §19.2011(b)(2) pertains to non-network appeals of retrospective review adverse determinations and requires compliance with 28 TAC §133.250.

Comment: Several commenters believe that the requirements of §133.250(e) which permits oral requests without requiring that the requests be reduced to writing will cause confusion, misunderstandings, delays, and disputes. Commenters suggest requiring that all oral requests for reconsideration be reduced to writing for proper documentation including the date the request was made, identification of the health care services subject to the request, and the documents that provide a rational basis to modify the previous denial or payment.

A commenter believes that §133.250(e) misleads health care providers into believing that the oral requests for reconsideration should go to the insurance carrier and not to the URA that issued the adverse determination. The commenter thinks that §133.250(e) fosters miscommunication between the URA and the health care provider by requiring the insurance carrier to send an acknowledgement letter and list of documents to be submitted. The commenter asserts it is the health care provider, not the URA or insurance carrier, who has superior knowledge of the scope of the request for reconsideration and the documents that provide a rational basis to modify the adverse determination.

A commenter suggests §133.250(e) should be deleted; however, if the Division believes it is necessary to allow oral requests for reconsideration, the burden should not be on the insurance carrier to file written documentation within five working days of the oral request by the medical provider. The commenter believes that placing the burden on the insurer is inappropriate and unfair because it is the medical provider, not the insurer, who is making the request for reconsideration. The commenter states that placing the burden on the carrier does not lessen the potential confusion, delays and disputes that may be generated by permitting oral requests.

A commenter questions what evidence the Division will require for a party to prove its case based on an oral request. The commenter thinks the proposed rule is burdensome as it requires carriers to send each health care provider requestor a letter acknowledging the oral request for reconsideration and when the request was received.

Agency Response: The Division declines to make the suggested changes. Amended §133.250(e) corresponds with Insurance Code §4201.355 which requires that within five working days from the date an appeal is received, a letter acknowledging the date of receipt must be sent to the appealing party with a list of the documents the appealing party must submit for review. The

insurance carrier may add language specifying where and to whom the documents should be submitted to avoid miscommunication. Amended §133.250(e) also corresponds with Insurance Code §1305.354 which pertains to the reconsideration of adverse determinations by workers' compensation health care networks. Further, Insurance Code §4201.354 requires that the procedures for appealing an adverse determination must provide that the adverse determination may be appealed orally or in writing and is consistent with the requirements of Insurance Code §1305.354 for workers' compensation network coverage. Amended §133.250(e) is necessary to align with 28 TAC §19.2011(a)(3) which provides that an injured employee, the injured employee's representative, or the provider of record may appeal the adverse determination orally or in writing. Amended §133.250(e) is also consistent with 28 TAC §10.103 concerning workers' compensation network requests for reconsideration.

Comment: One commenter supports amended §133.250(e), which provides that an oral request for reconsideration of an adverse determination must include a substantive explanation in accordance with §133.3 and provide a rational basis to modify the previous denial or payment. The commenter states that this change is appropriate because it aligns the oral request for reconsideration requirements with the written request requirements.

Agency response: The Division appreciates supportive the comment.

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

For: CID Management, Texas Medical Association, and Texas Mutual Insurance Company
For, with changes: Office of Injured Employee Counsel, Property Casualty Insurers Association of America, American Insurance Association, Insurance Council of Texas, and State Office of Risk Management

6. STATUTORY AUTHORITY.

Amendments to §133.2 are adopted under the Labor Code §§401.011(42-a), 402.00111, 402.00114, 402.00116, 402.00128, 402.061, 408.021, 408.027, 413.011, 413.0115, 413.014; Insurance Code §§4201.002, 4201.206, 4201.054; and Government Code §2001.036.

Labor Code §401.011(42-a) provides that "utilization review" has the meaning assigned by Chapter 4201, Insurance Code. Section 402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code. Labor Code §402.00114 requires the Division to regulate and administer the business of workers' compensation in this state and ensure that Labor Code Title 5 and other laws regarding workers' compensation are executed. Labor Code §402.00116 requires the Commissioner of Workers' Compensation to administer and enforce Labor Code Title 5, other workers' compensation laws of this state, and other laws applicable to the Division. Section 402.00128 vests general operational powers in the commissioner of workers' compensation to conduct daily operations of TDI-DWC and implement policy, including the authority to delegate, assess, and enforce penalties and enter appropriate orders as authorized by Labor Code Title 5. . Section 402.061 provides that the Commissioner of Workers' Compensation shall adopt rules as necessary for the implementation and enforcement of Title 5, Labor Code. Section 408.021, in part, entitles an employee who sustains a compensable injury to all health care reasonably required by the nature of the injury as and when needed and specifically entitles the employee to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. Section 408.027 provides requirements for payment of health care providers by insurance carriers and requires the commissioner to adopt rules as necessary to implement the provisions of §408.027 and §408.0271. Section 413.0115 defines "informal network" to mean a health care provider network described by Section 413.011(d-1).

Section 413.0115 also provides that "voluntary network" means a voluntary workers' compensation health care delivery network established by an insurance carrier under former Labor Code §408.0223, as that section existed before repeal by Chapter 265, Acts of the 79th Legislature, Regular Session, 2005. Section 413.014 provides, in part, that division rules adopted under this section must provide that preauthorization and concurrent review are required at a minimum for any investigational or experimental services or devices.

Insurance Code §4201.002 provides definitions related to utilization review agents, including the definition of "adverse determination", "utilization review", and "utilization review agent." Section 4201.206 provides that subject to the notice requirements of Chapter 4201, Subchapter G, before an adverse determination is issued by a utilization review agent who questions the medical necessity or appropriateness, or the experimental or investigational nature, of a health care service, the agent shall provide the health care provider who ordered the service a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the agent's determination. Section 4201.054 provides that Title 5, Labor Code, prevails in the event of a conflict between Chapter 4201 and Title 5, Labor Code.

Government Code §2001.036 provides, in part, that a rule takes effect 20 days after the date on which it is filed in the office of the secretary of state.

Amendments to §133.240 and §133.250 are adopted under the Labor Code §§402.00111, 402.00114, 402.00116, 402.00128, 402.061, 408.0043, 408.0044, 408.0045, 408.027, 408.0281 and 408.0284; Insurance Code §§1305.153, 1305.354, 4201.354, 4201.355; and Government Code §2001.036.

Labor Code §402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code. Labor Code

§402.00114 requires the Division to regulate and administer the business of workers' compensation in this state and ensure that Labor Code Title 5 and other laws regarding workers' compensation are executed. Labor Code §402.00116 requires the Commissioner of Workers' Compensation to administer and enforce Labor Code Title 5, other workers' compensation laws of this state, and other laws applicable to the Division. Section 402.00128 vests general operational powers in the commissioner of workers' compensation to conduct daily operations of TDI-DWC and implement policy, including the authority to delegate, assess, and enforce penalties and enter appropriate orders as authorized by Labor Code Title 5. Section 402.061 provides that the Commissioner of Workers' Compensation shall adopt rules as necessary for the implementation and enforcement of Title 5, Labor Code. Section 408.0043 provides in part that a person, other than a chiropractor or a dentist, who performs health care services as a doctor performing a utilization review of a health care service provided to an injured employee who reviews a specific workers' compensation case must hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving. Section 408.0044 provides, in part, that a dentist performing a utilization review of a dental service provided to an injured employee in conjunction with a specific workers' compensation case must be licensed to practice dentistry. Section 408.0045 provides, in part, that a chiropractor performing a utilization review of a chiropractic service provided to an injured employee in conjunction with a specific workers' compensation case must be licensed to engage in the practice of chiropractic. Section 408.027 provides requirements for payment of health care providers by insurance carriers and requires the commissioner to adopt rules as necessary to implement the provisions of §408.027 and §408.0271. Section 408.0281 defines "informal network" and "voluntary network" for the provision of pharmaceutical services. Section 408.0284 defines

"informal network" and "voluntary network" for the provision of durable medical equipment or home health care services.

Insurance Code §1305.153 concerns provider reimbursement in workers' compensation health care networks and provides requirements for contracts and contractual disclosures when a person is serving as both a management contractor or a third party to which the certified network delegates a function and as an agent of the health care provider. Section 1305.354 concerns reconsideration of adverse determinations by workers' compensation health care networks and provides, in part, requirements for the written reconsideration procedures that utilization review agents shall maintain and make available. Section 4201.002 provides definitions related to utilization review agents, including the definition of "adverse determination" and "utilization review agent." Section 4201.354 provides, in part, that adverse determinations may be appealed orally or in writing by an enrollee, a person acting on the enrollee's behalf, or the enrollee's physician or other health care provider. Section 4201.355 provides, in part, that the procedures for appealing an adverse determination must provide that, within five working days from the date the utilization review agent receives the appeal, the agent shall send to the appealing party a letter acknowledging the date of receipt and the letter must also include a list of the documents that the appealing party must submit for review.

Government Code §2001.036 provides, in part, that a rule takes effect 20 days after the date on which it is filed in the office of the secretary of state, except that if a later date is required by statute or specified in the rule, the later date is the effective date.

Amendments to §133.305 are adopted under the Labor Code §§402.00111, 402.00128, 402.061, 408.0281, 408.0284, 413.011, 413.0115; and Government Code §2001.036.

Labor Code §402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code. Section 402.00128 vests general operational powers in the commissioner of workers' compensation to conduct daily operations of TDI-DWC and implement policy, including the authority to delegate, assess, and enforce penalties and enter appropriate orders as authorized by Labor Code Title 5. Section 402.061 provides that the Commissioner of Workers' Compensation shall adopt rules as necessary for the implementation and enforcement of Title 5, Labor Code. Section 408.0281 concerns reimbursement for pharmaceutical services and, in part, defines "informal network" and "voluntary network" for the provision of pharmaceutical services. Section 408.0284 concerns reimbursement for durable medical equipment and home health care services and defines, in part, "informal network" and "voluntary network" for the provision of durable medical equipment or home health care services. Section 413.011 provides requirements for reimbursement policies and guidelines, treatment guidelines and protocols, subsections (d-1)-(d-3) of this section have expired. Section 413.0115 concerns requirements for certain voluntary or informal networks and provides, in part, that "informal network" means a health care provider network described by §413.011(d-1). Section 413.0115 also provides, in part that "voluntary network" means a voluntary workers' compensation health care delivery network established by an insurance carrier under former Labor Code §408.0223, as that section existed before repeal by Chapter 265, Acts of the 79th Legislature, Regular Session, 2005.

Government Code §2001.036 provides, in part, that a rule takes effect 20 days after the date on which it is filed in the office of the secretary of state.

7. TEXT.

CHAPTER 133: GENERAL MEDICAL PROVISIONS
SUBCHAPTER A: GENERAL RULES FOR MEDICAL BILLING AND PROCESSING

AMEND: §133.2

§133.2. *Definitions*.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

(1) Adverse determination--A determination by a utilization review agent made on behalf of a payor that the health care services provided or proposed to be provided to an injured employee are not medically necessary or appropriate. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. An adverse determination does not include a determination that health care services are experimental or investigational.

(2) Agent--A person whom a system participant utilizes or contracts with for the purpose of providing claims service or fulfilling medical bill processing obligations under Labor Code, Title 5 and rules. The system participant who utilizes or contracts with the agent may also be responsible for the administrative violations of that agent. This definition does not apply to "agent" as used in the term "pharmacy processing agent."

(3) Bill review--Review of any aspect of a medical bill, including retrospective review, in accordance with the Labor Code, the Insurance Code, division or department rules, and the appropriate fee and treatment guidelines.

(4) Complete medical bill--A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter (relating to Required Billing Forms/Formats), or as specified for electronic medical bills in §133.500 of this chapter (relating to Electronic Formats for Electronic Medical Bill Processing).

(5) Emergency--Either a medical or mental health emergency as follows:

(A) 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:

(i) placing the patient's health or bodily functions in serious jeopardy, or

(ii) serious dysfunction of any body organ or part;

(B) a mental health emergency is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

(6) Final action on a medical bill--

(A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or

(B) denying a charge on the medical bill.

(7) Pharmacy processing agent--A person or entity that contracts with a pharmacy in accordance with Labor Code §413.0111, establishing an agent or assignee relationship, to process claims and act on behalf of the pharmacy under the terms and conditions of a contract related to services being billed. Such contracts may permit the agent or assignee to submit billings, request reconsideration, receive reimbursement, and seek medical dispute resolution for the pharmacy services billed.

(8) Reasonable opportunity--At least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with the utilization review agent during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination:

(A) no less than one working day prior to issuing a prospective utilization review adverse determination;

(B) no less than five working days prior to issuing a retrospective utilization review adverse determination; or

(C) prior to issuing a concurrent or post-stabilization review adverse determination.

(9) Retrospective utilization review--A form of utilization review for health care services that have been provided to an injured employee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.

CHAPTER 133: GENERAL MEDICAL PROVISIONS
SUBCHAPTER C: MEDICAL BILL PROCESSING/AUDIT BY INSURANCE CARRIER
§133.240 AND §133.250

§133.240. *Medical Payments and Denials*.

(a) An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

(b) For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance Code Chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments). For pharmaceutical services provided to any injured employee, the insurance carrier

shall not deny reimbursement based on medical necessity for pharmaceutical services preauthorized or agreed to under Chapter 134, Subchapter F of this title (relating to Pharmaceutical Benefits).

(c) The insurance carrier shall not change a billing code on a medical bill or reimburse health care at another billing code's value.

(d) The insurance carrier may request additional documentation, in accordance with §133.210 of this title (relating to Medical Documentation), not later than the 45th day after receipt of the medical bill to clarify the health care provider's charges.

(e) The insurance carrier shall send the explanation of benefits in accordance with the elements required by §133.500 and §133.501 of this title (relating to Electronic Formats for Electronic Medical Bill Processing and Electronic Medical Bill Processing, respectively) if the insurance carrier submits the explanation of benefits in the form of an electronic remittance. The insurance carrier shall send an explanation of benefits in accordance with subsection (f) of this section if the insurance carrier submits the explanation of benefits in paper form. The explanation of benefits shall be sent to:

(1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and

(2) the injured employee when payment is denied because:

(A) of an adverse determination;

(B) the health care was provided by a health care provider other than:

(i) the treating doctor selected in accordance with Labor Code §408.022;

(ii) a health care 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 §126.5 of this title (relating to Entitlement and Procedure for Requesting Required Medical Examinations) and §126.6 of this title (relating to Required Medical Examination);

(iv) a doctor performing a designated doctor examination in accordance with Labor Code §408.0041; or

(C) the health care was unrelated to the compensable injury, in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements).

(3) the prescribing doctor, if different from the health care provider identified in paragraph (1) of this subsection, when payment is denied for pharmaceutical services because of any reason relating to the compensability of, liability for, extent of, or relatedness to the compensable injury, or for reasons relating to the reasonableness or medical necessity of the pharmaceutical services.

(f) The paper form of an explanation of benefits under subsection (e) of this section, §133.250 of this title (relating to Reconsideration for Payment of Medical Bills), or §133.260 of this title (relating to Refunds) shall include the following elements:

(1) division claim number, if known;

(2) insurance carrier claim number;

(3) injured employee's name;

(4) last four digits of injured employee's social security number;

(5) date of injury;

(6) health care provider's name and address;

(7) health care provider's federal tax ID or national provider identifier if the health care provider's federal tax ID is the same as the health care provider's social security number;

(8) patient control number if included on the submitted medical bill;

(9) insurance carrier's name and address;

(10) insurance carrier control number;

(11) date of bill review/refund request;

(12) diagnosis code(s);

(13) name and address of company performing bill review;

(14) name and telephone number of bill review contact;

(15) workers' compensation health care network name (if applicable);

(16) pharmacy, durable medical equipment, or home health care services informal or voluntary network name (if applicable) pursuant to Labor Code §408.0281 and §408.0284;

(17) health care service information for each billed health care service, to include:

(A) date of service;

(B) the CPT, HCPCS, NDC, or other applicable product or service code;

(C) CPT, HCPCS, NDC, or other applicable product or service code description;

(D) amount charged;

(E) unit(s) of service;

(F) amount paid;

(G) adjustment reason code that conforms to the standards described in §133.500 and §133.501 of this title if total amount paid does not equal total amount charged;

(H) explanation of the reason for reduction/denial if the adjustment reason code was included under subparagraph (G) of this paragraph and if applicable;

(18) a statement that contains the following text: "Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the

unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of the liability under Labor Code §408.024. However, pursuant to §133.250 of this title, the health care provider may file an appeal with the insurance carrier if the health care provider disagrees with the insurance carrier's determination";

(19) if the insurance carrier is requesting a refund, the refund amount being requested and an explanation of why the refund is being requested; and

(20) if the insurance carrier is paying interest in accordance with §134.130 of this title (relating to Interest for Late Payment on Medical Bills and Refunds), the interest amount paid through use of an unspecified product or service code and the number of days on which interest was calculated by using a unit per day.

(g) When the insurance carrier pays a health care provider for health care for which the division has not established a maximum allowable reimbursement, the insurance carrier shall explain and document the method it used to calculate the payment in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline).

(h) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and §124.3 of this title (relating to Investigation of an Injury and Notice of Denial/Dispute) if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:

(1) the injury is not compensable;

(2) the insurance carrier is not liable for the injury due to lack of insurance coverage; or

(3) the condition for which the health care was provided was not related to the compensable injury.

(i) If dissatisfied with the insurance carrier's final action, the health care provider may request reconsideration of the bill in accordance with §133.250 of this title.

(j) If the health care provider is requesting reconsideration of an adverse determination, the request for reconsideration constitutes an appeal for the purposes of §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determinations). If dissatisfied with the reconsideration outcome, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).

(k) Health care providers, injured employees, employers, attorneys, and other participants in the system shall not resubmit medical bills to insurance carriers after the insurance carrier has taken final action on a complete medical bill and provided an explanation of benefits except as provided in §133.250 and Chapter 133, Subchapter D of this title.

(l) All payments of medical bills that an insurance carrier makes on or after the 60th day after the date the insurance carrier originally received the complete medical bill shall include interest calculated in accordance with §134.130 of this title without any action taken by the division. The interest payment shall be paid at the same time as the medical bill payment.

(m) Except as provided by Insurance Code §1305.153, when an insurance carrier remits payment to a health care provider agent, the agent shall remit to the health care provider the full amount that the insurance carrier reimburses. If the insurance carrier remits payment under Insurance Code §1305.153, then the payment must be made in accordance with that section.

(n) When an insurance carrier remits payment to a pharmacy processing agent, the pharmacy processing agent's reimbursement from the insurance carrier shall be made in accordance with §134.503 of this title. The pharmacy's reimbursement shall be made in accordance with the terms of its contract with the pharmacy processing agent.

(o) An insurance carrier commits an administrative violation if the insurance carrier fails to pay, reduce, deny, or notify the health care provider of the intent to audit a medical bill in accordance with Labor Code §408.027 and division rules.

(p) For the purposes of this section, all utilization review must be performed by an insurance carrier that is registered with or a utilization review agent that is certified by the Texas Department of Insurance to perform utilization review in accordance with Insurance Code, Chapter 4201 and Chapter 19 of this title. Additionally, all utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in course and scope of employment.

(q) When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title (relating to Notice of Determinations Made in Utilization Review). Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title (relating to Requirements Prior to Issuing Adverse Determination), including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively.

§133.250. *Reconsideration for Payment of Medical Bills*.

(a) If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill, the health care provider may request that the insurance carrier reconsider its action. If the health care provider is requesting reconsideration of a bill denied based on an adverse determination, the request for reconsideration constitutes an appeal for the purposes of §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determinations) and may be submitted orally or in writing.

(b) The health care provider shall submit the request for reconsideration no later than 10 months from the date of service.

(c) A health care provider shall not submit a request for reconsideration until:

(1) the insurance carrier has taken final action on a medical bill; or

(2) the health care provider has not received an explanation of benefits within 50 days from submitting the medical bill to the insurance carrier.

(d) A written request for reconsideration shall:

(1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill;

(2) include a copy of the original explanation of benefits, if received, or documentation that a request for an explanation of benefits was submitted to the insurance carrier;

(3) include any necessary and related documentation not submitted with the original medical bill to support the health care provider's position; and

(4) include a bill-specific, substantive explanation in accordance with §133.3 of this title (relating to Communication Between Health Care Providers and Insurance Carriers) that provides a rational basis to modify the previous denial or payment.

(e) An oral request for reconsideration must clearly identify the health care service(s) denied based on an adverse determination and include a substantive explanation in accordance with §133.3 of this title that provides a rational basis to modify the previous denial or payment. Not later than the fifth working day after the date of receipt of the request for reconsideration, the insurance carrier must send to the requesting party a letter acknowledging the date of the receipt of the oral request that includes a reasonable list of documents the requesting party is required to submit. This subsection applies to reconsideration requests made on or after six months from the effective date of this rule.

(f) An insurance carrier shall review all written reconsideration requests for completeness in accordance with subsection (d) of this section and may return an incomplete written reconsideration request no later than seven days from the date of receipt. A health care provider may complete and resubmit its written request to the insurance carrier.

(g) The insurance carrier shall take final action on a reconsideration request within 30 days of receiving the request for reconsideration. The insurance carrier shall provide an explanation of benefits:

(1) in accordance with §133.240(e) - (f) of this title (relating to Medical Payments and Denials) for all items included in a reconsideration request in the form and format prescribed by the division when there is a change in the original, final action; or

(2) in accordance with §133.240(e)(1) and §133.240(f) of this title when there is no change in the original, final action.

(h) A health care provider shall not resubmit a request for reconsideration earlier than 35 days from the date the insurance carrier received the original request for reconsideration or after the insurance carrier has taken final action on the reconsideration request.

(i) If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).

(j) For the purposes of this section, all utilization review must be performed by an insurance carrier that is registered with, or a utilization review agent that is certified by, the Texas Department of Insurance to perform utilization review in accordance with Insurance Code, Chapter 4201 and Chapter 19 of this title. Additionally, all utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in course and scope of employment.

(k) In any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title (relating to Requirements Prior to Adverse Determination) and §19.2011 of this title, including the requirement that prior to issuance of an adverse determination on the request for reconsideration the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively.

CHAPTER 133: GENERAL MEDICAL PROVISIONS
SUBCHAPTER D: DISPUTE OF MEDICAL BILLS
§133.305

§133.305. *MDR--General*.

(a) Definitions. The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise.

(1) First responder--As defined in Labor Code §504.055(a).

(2) Life-threatening--A disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted, as defined in Insurance Code §4201.002.

(3) Medical dispute resolution (MDR)--A process for resolution of one or more of the following disputes:

(A) a medical fee dispute; or

(B) a medical necessity dispute, which may be:

(i) a preauthorization or concurrent medical necessity dispute; or

(ii) a retrospective medical necessity dispute.

(4) Medical fee dispute--A dispute that involves an amount of payment for non-network health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that injured employee's compensable injury. The dispute is resolved by the division pursuant to division rules, including §133.307 of this title (relating to MDR of Fee Disputes). The following types of disputes can be a medical fee dispute:

(A) a health care provider, or a qualified pharmacy processing agent as described in Labor Code §413.0111, dispute of an insurance carrier reduction or denial of a medical bill;

(B) an injured employee dispute of reduction or denial of a refund request for health care charges paid by the injured employee; and

(C) a health care provider dispute regarding the results of a division or insurance carrier audit or review which requires the health care provider to refund an amount for health care services previously paid by the insurance carrier.

(5) Network health care--Health care delivered or arranged by a certified workers' compensation health care network, including authorized out-of-network care, as defined in Insurance Code Chapter 1305 and related rules.

(6) Non-network health care--Health care not delivered or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules. "Non-network health care" includes health care delivered pursuant to Labor Code §408.0281 and §408.0284.

(7) Preauthorization or concurrent medical necessity dispute--A dispute that involves a review of adverse determination of network or non-network health care requiring preauthorization or concurrent utilization review. The dispute is reviewed by an independent review organization (IRO) pursuant to the Insurance Code, the Labor Code and related rules, including §133.308 of this title (relating to MDR of Medical Necessity Disputes).

(8) Requestor--The party that timely files a request for medical dispute resolution with the division; the party seeking relief in medical dispute resolution.

(9) Respondent--The party against whom relief is sought.

(10) Retrospective medical necessity dispute--A dispute that involves a review of the medical necessity of health care already provided. The dispute is reviewed by an IRO pursuant to the Insurance Code, Labor Code and related rules, including §133.308 of this title.

(11) Serious bodily injury--As defined by §1.07, Penal Code.

(b) Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.

(c) Division Administrative Fee. The division may assess a fee, as published on the division's website, in accordance with Labor Code §413.020 when resolving disputes pursuant to §133.307 and §133.308 of this title if the decision indicates the following:

(1) the health care provider billed an amount in conflict with division rules, including billing rules, fee guidelines or treatment guidelines;

(2) the insurance carrier denied or reduced payment in conflict with division rules, including reimbursement or audit rules, fee guidelines or treatment guidelines;

(3) the insurance carrier has reduced the payment based on a contracted discount rate with the health care provider but has not made the contract or the health care provider notice required under Labor Code §408.0281 available upon the division's request;

(4) the insurance carrier has reduced or denied payment based on a contract that indicates the direction or management of health care through a health care provider arrangement that has not been certified as a workers' compensation network, in accordance with Insurance Code Chapter 1305 or through a health care provider arrangement authorized under Labor Code §504.053(b)(2); or

(5) the insurance carrier or healthcare provider did not comply with a provision of the Insurance Code, Labor Code or related rules.

(d) Confidentiality. Any documentation exchanged by the parties during MDR that contains information regarding a patient other than the injured employee for that claim must be redacted by the party submitting the documentation to remove any information that identifies that patient.

(e) Severability. If a court of competent jurisdiction holds that any provision of §§133.305, 133.307, or 133.308 of this title is inconsistent with any statutes of this state, unconstitutional, or invalid for any reason, the remaining provisions of these sections remain in full effect.

8. CERTIFICATION.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on

X

Dirk Johnson
General Counsel
Texas Department of Insurance,
Division of Workers' Compensation

IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that the amendments to 28 TAC §133.2, concerning Definitions; §133.240, concerning Medical Payments and Denials; §133.250, concerning Reconsideration for Payment of Medical Bills; and §133.305, concerning MDR—General, are adopted.

AND IT IS SO ORDERED.

X

ROD BORDELON
COMMISSIONER OF WORKERS' COMPENSATION

ATTEST:

X

Dirk Johnson
General Counsel

COMMISSIONER ORDER NO.