TITLE 28. INSURANCE

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

CHAPTER 140: DISPUTE RESOLUTION – GENERAL PROVISIONS

Title 28 Texas Administrative Code (TAC) §§140.1, 140.8, and new 140.9

1. INTRODUCTION. The commissioner of workers' compensation (commissioner), Texas Department of Insurance, Division of Workers' Compensation (DWC) adopts amendments to 28 TAC §140.1 and §140.8. The commissioner also adopts new §140.9. The changes replace "hearing officer" and "hearings officer" with "administrative law judge," replace "commission" with "division," replace "appeals panel members" with "appeals panel judges," and delete the definition for director of the hearings division. The changes also include one style and usage change by deleting the word "the" from within the parentheses in §140.1(1). New §140.9 requires that all requests to presiding officers from carriers, carrier representatives, claimants represented by an attorney, or claimants assisted by the Office of Injured Employee Counsel (OIEC) must include a statement that the requesting party made reasonable efforts to confer with other parties about the request. New §140.9 also creates timeframes for parties to respond to such requests. Carriers and carrier representatives are required to send copies of requests and responses to OIEC as well as the injured employee when a claimant is assisted by OIEC.

The amendments to §140.1 and §140.9 are adopted without changes to the proposed text as published in the November 2, 2018, issue of the *Texas Register* (43 TexReg 7315). Section 140.8 is adopted with changes to correct a citation, and this rule will 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" and "hearings officer" in the Texas Workers' Compensation Act with "administrative law judge." These amendments make conforming changes to the division's rules. In addition, DWC is replacing outdated references and removing an unused definition.

New §140.9 requires that parties represented by an attorney or assisted by OIEC must include with any requests a signed statement that the requesting party made reasonable efforts to confer with other parties about the request. Further, new §140.9 sets a deadline for responses to requests. Responses to requests for continuance must be filed within three days of receipt of the request and any responses to other requests must be filed within five days of receipt. The new rule provides presiding officers with discretion to consider a request or response that is not timely filed or that otherwise fails to comply with requirements of the new section. Claimants who are neither represented by an attorney nor assisted by OIEC may request to continue a proceeding by contacting the division in any manner.

Requiring parties to confer and report their attempts to reach agreement facilitates the contested case process as it encourages parties to resolve disputes on

their own and at the earliest point possible. It also informs the presiding officer of dates the parties are available for rescheduled proceedings, which will reduce continuances. This requirement also informs the presiding officer when a request is unopposed so that it can be ruled on immediately.

Creation of a timeframe for filing responses informs parties how long they have to file responses and assures them that no action will be taken on a contested request until the response time has elapsed.

Authorizing presiding officers to consider untimely or otherwise noncompliant requests and responses in the interest of justice provides appropriate discretion to the presiding officer to reach a just result based on case-specific circumstances presented. Authorizing claimants who are neither represented by an attorney nor assisted by OIEC to request a continuance by contacting the division in any manner is consistent with current practice and keeps the dispute resolution process accessible to claimants who are navigating it on their own.

3. SUMMARY OF COMMENTS AND AGENCY RESPONSE

General: Commenter expressed support for the proposal. Commenter supports the addition of §140.9(b) that requires requests be sent to both the claimant and OIEC (if claimant is being assisted by OIEC). Commenter explained that OIEC assists injured employees through the administrative process and that forwarding copies of requests to OIEC will increase efficiencies in the system and allow enough time for OIEC to help injured employees respond to requests and meet deadlines.

DWC Response: DWC appreciates the supportive comment.

4. NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL

For: Office of Injured Employee Counsel

For, with changes: None

Against: None

Neither for nor against: None

5. STATUTORY AUTHORITY. The amendments and new §140.9 are adopted under the authority of Labor Code §§402.00111, 402.00116, 402.00128, 402.061, 410.027, and 410.157.

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.

Labor Code §410.027 states that the commissioner shall adopt rules for conducting benefit review conferences.

Labor Code §410.157 states that the commissioner shall adopt rules governing procedures under which contested case hearings are conducted.

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

6. TEXT.

§140.1. Definitions. The following words and terms, when used in this part, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Benefit dispute--A disputed issue arising under the Texas Workers' Compensation Act (Act) in a workers' compensation claim regarding compensability or eligibility for, or the amount of, income or death benefits.

(2) Benefit proceeding--A proceeding pursuant to the Act, Chapter 410, conducted by a presiding officer to resolve one or more benefit disputes. Benefit proceedings include benefit review conferences, benefit contested case hearings, appeals, and, after January 1, 1992, arbitration.

(3) Party to a proceeding--A person entitled to take part in a proceeding because of a direct legal interest in the outcome.

(4) Presiding officer--The division employee, or independent arbitrator, assigned to conduct a proceeding. Presiding officers include benefit review officers, administrative law judges, appeals panel judges, and arbitrators.

(5) Special accommodations--Individuals and equipment necessary to allow an individual who does not speak English or who has a physical, mental, or developmental handicap to participate in a proceeding. The term includes spoken language translators and sign language translators.

(6) Stipulation--A voluntary accord between parties to a benefit contested case hearing regarding any matter relating to the hearing that does not constitute an agreement, as defined by the Act, §401.011(3), or a settlement, as defined by the Act, §401.011(40).

§140.8 Procedures for Health Care Insurers to Pursue Reimbursement of Medical Benefits under Labor Code §409.0091.

(a) Applicability. This section applies only to subclaims by a health care insurer based on information received under Labor Code §402.084(c-3).

(b) Health care insurer. "Health care insurer" means an insurance carrier and an authorized representative of an insurance carrier, as described by Labor Code §402.084(c-1).

(c) Request to Workers' Compensation Insurance Carrier. A health care insurer seeking reimbursement must first file a reimbursement request with the workers' compensation insurance carrier.

(1) Form. The request must be in the form/format and manner prescribed by the Division of Workers' Compensation (Division) and must contain all the required elements listed on the form.

(2) Notice. The health care insurer must give notice of the request to the injured employee and the health care provider that performed the services that are the subject of the reimbursement request. The notice shall include a copy of the reimbursement request and an explanation that the health care insurer is seeking reimbursement for medical care costs.

(d) Deadlines for Response to Reimbursement Request to the Workers' Compensation Insurance Carrier.

(1) 90 Day Response Deadline. The workers' compensation insurance carrier must respond to a reimbursement request under this section by either paying, reducing, or denying payment in writing not later than the 90th day after the date the reimbursement request was first received, unless additional information is requested, pursuant to paragraph (2) of this subsection.

(2) Request for Additional Information. The workers' compensation insurance carrier may request additional information from the health care insurer if there is not sufficient information to substantiate the claim. The health care insurer has 30 days after receiving the request for more information to provide the information requested to the workers' compensation insurance carrier. Any request for additional information shall be in writing, be relevant and necessary for the resolution of the request. A workers' compensation insurance carrier shall not be penalized, including not being held responsible for costs of obtaining the additional information, if the workers' compensation insurance carrier denies payment in order to move to dispute resolution to obtain additional information to process the request. It is the health care insurer's

obligation to furnish its authorized representatives with any information necessary for the resolution of a reimbursement request. The Division considers any medical billing information or documentation possessed by the health care insurer or one of its authorized representatives to be simultaneously possessed by the health care insurer and all of its authorized representatives.

(3) 120 Day Response Deadline. If the workers' compensation insurance carrier has requested additional information from the health care insurer pursuant to paragraph (2) of this subsection, the workers' compensation insurance carrier must respond in writing to the health care insurer's reimbursement request not later than the 120th day after the date the reimbursement request was first received, unless otherwise provided by mutual agreement.

(e) Response to a Reimbursement Request. The workers' compensation insurance carrier must respond to a reimbursement request by either paying, reducing or denying payment.

(1) Paying or Reducing Payment.

(A) The workers' compensation insurance carrier shall pay the health care insurer the lesser of:

(i) the amount payable under the applicable Division fee guideline as of the date of service; or

(ii) the actual amount paid by the health care insurer.

(B) If No Fee Guideline. In the absence of a Division fee guideline for a specific service paid, the amount per service paid by the health care insurer shall

be considered in determining a fair and reasonable payment pursuant to §134.1 of this title (relating to Medical Reimbursement).

(C) Interest. The health care insurer may not recover interest as a part of the payable amount.

(D) Previous Payments. The workers' compensation insurance carrier shall reduce any reimbursable amount by any payments the workers' compensation insurance carrier previously made to the same health care provider for the provision of the same health care on the same dates of service. In making such a reduction in reimbursement, the workers' compensation insurance carrier shall provide evidence of the previous payments made to the health care provider.

(E) Notice to Injured Employee and Health Care Provider. The workers' compensation insurance carrier must give notice of its response to the reimbursement request to the injured employee and the health care provider that performed the services that are the subject of the reimbursement request. If the claim is compensable, the notice shall include an explanation that the claim is compensable and that the health care provider must reimburse the injured employee for any amounts paid to the health care provider by the injured employee.

(F) The health care provider may submit a reimbursement request to the workers' compensation insurance carrier for any money owed under Division fee guidelines for the medical services rendered on a compensable claim and is entitled to dispute resolution under §133.307 of this title (relating to MDR of Fee Disputes). The workers' compensation insurance carrier is liable for full payment in accordance with

Division fee guidelines and applicable rules for the medical services rendered on a compensable claim.

(2) Explanation of Benefits. The workers' compensation insurance carrier must provide the health care insurer, all health care providers, and the injured employee an explanation of benefits (EOB) in the form and manner prescribed by the Division. The EOB must provide sufficient explanation regarding the basis for a denial of the reimbursement request.

(f) Reimbursement of Injured Employee. If the injured employee's medical care costs are reimbursable under Title 5 of the Labor Code, a health care provider must refund to the injured employee any payments made by the injured employee to the health care provider, including but not limited to, copays and deductibles. Reimbursement must be made within 45 days of receipt of the notice that the claim is compensable.

(g) Filing Notice of Subclaimant Status.

(1) 120 Day Deadline. A health care insurer must file a written notice of subclaimant status with the Division not later than the 120th day after a workers' compensation insurance carrier fails to respond to a health care insurer's reimbursement request or reduces or denies the requested reimbursement amount.

(2) Location for Filing Notice. The notice may be filed with the Division of Workers' Compensation at any local Division field office or at the Division's central office in Austin, Texas.

(3) One Injured Employee Per Notice. A health care insurer must file separate notices for each individual injured employee in which the health care insurer seeks subclaimant status.

(4) One Notice Per Injured Employee Date of Injury. If an individual injured employee has multiple claims based on different dates of injury, the health care insurer must file a separate notice for each date of injury for which medical benefits were provided.

(5) Form. The notice of subclaimant status must be in the form and manner prescribed by the Division.

(h) Request for Dispute Resolution. The rules applicable to dispute resolution vary according to the reason for denial of reimbursement. Disputes regarding extent of injury, liability, or medical necessity must be resolved prior to pursuing a medical fee dispute. A request for medical dispute resolution may be filed in lieu of a request for subclaimant status, and shall be considered a request for subclaimant status for purposes of this section.

(1) Claim or Treatment Not Compensable.

(A) A health care insurer must file a request for a benefit review conference pursuant to §141.1 of this title (relating to Requesting and Setting a Benefit Review Conference) with the Division not later than the 120th day after a workers' compensation insurance carrier reduces or denies the requested reimbursement amount based on compensability or extent of injury issues.

(B) The health care insurer may pursue dispute resolution to obtain an order from an administrative law judge regarding compensability or eligibility for benefits in accordance with Labor Code Chapter 410 and applicable Division rules.

(C) A subclaim dispute based on a denial of reimbursement due to compensability or extent of injury is subject to dispute resolution pursuant to Chapters 140 - 143 of this title (relating to Dispute Resolution).

(2) Lack of Medical Necessity.

(A) A health care insurer must file a request for medical dispute resolution with the workers' compensation insurance carrier or the insurance carrier's utilization review agent not later than the 120th day after a workers' compensation insurance carrier reduces or denies the requested reimbursement amount due to lack of medical necessity.

(B) A medical dispute based on the workers' compensation insurance carrier's denial of a health care insurer's reimbursement request due to lack of medical necessity is subject to dispute resolution pursuant to §133.308 of this title (relating to MDR of Medical Necessity Disputes).

(C) A subclaimant shall follow the independent review process allowed for a non-network health care provider seeking retrospective review of a service under that section, with any modifications specified by this subsection.

(D) A request for reconsideration is not required prior to a request for independent review, notwithstanding the requirements for requesting independent review under §133.308 of this title.

(E) A request for independent review may be filed, notwithstanding the timeliness requirements for filing a request for independent review under §133.308 of this title.

(F) Notwithstanding the provisions of §133.308 of this title, regarding independent review organization requests for additional information, if a health care provider is requested to submit records, the health care insurer shall reimburse the health care provider copy expenses for the requested records.

(3) Reduction, Denial or Failure to Respond.

(A) A health care insurer must file a request for medical dispute resolution with the Division not later than:

(i) the 120th day after a workers' compensation insurance carrier fails to respond to a health care insurer's reimbursement request or reduces or denies the requested reimbursement amount for reasons other than lack of medical necessity; or

(ii) 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability or extent of injury issues raised in accordance with this subsection.

(B) A medical dispute based on the workers' compensation insurance carrier's failure to respond to a health care insurer's reimbursement request or the result of a reduction or denial of the requested reimbursement amount for reasons other than those listed in paragraph (1) or (2) of this subsection is subject to medical dispute resolution pursuant to §133.307 of this title, notwithstanding the

definition of medical fee dispute in §133.305 of this title (relating to MDR--General), and the health care insurer must follow the medical fee dispute resolution process allowed for a health care provider under that section, with any modifications specified by this subsection.

(C) Notwithstanding the requirements of §133.307(c)(2) of this title, a health care insurer shall only be required to include with a request for medical fee dispute resolution, a copy of the health care insurer reimbursement request as originally submitted to the workers' compensation insurance carrier, a copy of the EOB relevant to the fee dispute received from the workers' compensation insurance carrier, and sufficient information to substantiate the claim.

(D) A request for reconsideration is not required prior to a request for medical fee dispute resolution, notwithstanding the requirements for requesting medical fee dispute resolution under §133.307 of this title.

(E) A request for medical fee dispute resolution may be filed, notwithstanding the timeliness requirements for filing a request for medical fee dispute resolution under §133.307 of this title.

(i) Multiple Entities Seeking Reimbursement for Same Services. If there are multiple entities seeking reimbursement for the same services and dates of services for the same health care insurer for the same injured employee, the following apply:

(1) When the workers' compensation insurance carrier obtains a release from the health care insurer indicating that those specific services have been paid in full, no other entity may collect for those specific services.

(2) If a dispute remains over the fees to be paid for those specific services, the first in time to file a dispute with the Division is the only subclaimant that has a right to dispute resolution, and reimbursement, for that injured employee's claim and those specific services rendered unless that subclaimant abandons the dispute resolution process prior to a final adjudication of the issues.

§ 140.9 Requests by Parties.

(a) This subsection applies to carriers, carrier representatives, claimants represented by an attorney, and claimants assisted by the Office of Injured Employee Counsel (OIEC). The parties shall work collaboratively to reach any agreement reasonably necessary for the efficient disposition of a case. Unless presented during a proceeding, all requests to presiding officers, including rescheduling and continuance requests, discovery requests, and other requests, must be in writing and include a signed statement that the requester made reasonable efforts to confer with the other party or parties about the request. If the requester was unable to confer with the other party or parties, the statement must summarize the efforts made to confer. If the parties conferred, the statement must:

(1) include whether the other party or parties oppose the request; and

(2) for a request to reschedule or continue a proceeding, propose a date and time the parties are available for the rescheduled proceeding that has been coordinated with the division's docketing section.

(b) Requests must be sent to the division and to the opposing party or parties. For claimants represented by an attorney, requests must be sent to the claimant and

the claimant's representative. For claimants assisted by OIEC, requests must be sent to the claimant and to OIEC.

(c) Unless otherwise directed or allowed by a presiding officer, any responses to requests for rescheduling and continuance must be filed, in writing, with the division and delivered to all parties within three days of receipt of the request and any responses to other requests must be filed, in writing, with the division and delivered to all parties within five days of receipt.

(d) Unless precluded by other law, a presiding officer may, in the interest of justice, consider a request or response that is not timely filed or which otherwise fails to comply with the requirements of this section. The presiding officer may reconsider previous rulings made in the absence of this information.

(e) Requests to reschedule or cancel a benefit review conference must meet the requirements of §141.2 of this title (relating to Canceling or Rescheduling a Benefit Review Conference).

(f) Claimants who are neither represented by an attorney nor assisted by OIEC may request a continuance by contacting the division in any manner.

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.

X _____

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

The commissioner adopts amendments to §§140.1 and 140.8 and adopts new §140.9.

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Cassie Brown
Commissioner of Workers' Compensation

COMMISSIONER'S ORDER NO. _____

ATTEST:

X _____

Nicholas Canaday III

General Counsel

Texas Department of Insurance, Division of Workers' Compensation

COMMISSIONER'S ORDER NO. _____