TITLE 28. INSURANCE

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

CHAPTER 133 – GENERAL MEDICAL PROVISIONS

SUBCHAPTER D. DISPUTE OF MEDICAL BILLS
28 TAC §133.307 and §133.308

ADOPTION

1. INTRODUCTION.

The Commissioner of Workers' Compensation (Commissioner), Texas Department of Insurance (Department), Division of Workers' Compensation (Division) adopts amendments to §133.307 and §133.308 (relating to MDR of Fee Disputes and MDR of Medical Necessity Disputes, respectively). The amendments to §133.307 and §133.308 are adopted with changes to the proposed text as published in the March 23, 2012, issue of the *Texas Register* (37 TexReg 1980). These changes are more fully discussed below. These changes do not materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

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 preamble contains a summary of the factual basis of the rules, a summary of comments received from interested parties, the names of entities who commented and whether they were in support of or in opposition to the adoption of the rule, and the reasons why the Division agrees or disagrees with the comments and recommendations.

The Division published an informal draft of the proposed amendments on the Division's website for informal comment on December 6, 2011. There were five informal comments received. Following formal proposal of the amendments, the Division conducted a

public hearing on April 13, 2012. The public comment period closed on April 23, 2012. The Division received nine formal public comments.

The Division also published the following drafts of TDI-DWC forms for informal comment simultaneously with the rules proposed for formal comments. These informal draft forms pertain to medical dispute resolution and arbitration: *Medical Fee Dispute Resolution Request*, DWC Form—060; *Election to Engage in Arbitration*, DWC Form—044; *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference for Appeal of a Medical Fee Dispute Decision (BRC-MFD)*, DWC—Form 45M; and *Request to Schedule Medical Contested Case Hearing (MCCH)*, DWC Form—49.

2. REASONED JUSTIFICATION.

These adopted amendments implement statutory changes in House Bill 2605 and Senate Bill 809, enacted by the 82nd Legislature, Regular Session, effective September 1, 2011 (HB 2605 and SB 809) that concern the appeals process for medical fee disputes and medical necessity disputes, as well as the expedited provision of medical benefits for certain injuries sustained by first responders. These adopted rules also clarify and update Division rules in accordance with the provisions of other Division rules and Labor Code, Title 5 when performing medical dispute resolution activities under the Act.

HB 2605 made several legislative amendments that impact the resolution of medical fee dispute cases adjudicated by the Division. This bill enacted Labor Code §413.0312, which alters the appeals process applicable to medical fee disputes after the Division's review under Labor Code §413.031. Newly added Labor Code §413.0312 provides one appeal process for medical fee disputes regardless of the amount of reimbursement sought. Prior to the enactment of HB 2605, appeals of medical fee disputes were handled by a Division contested case hearing (CCH) if the amount of reimbursement sought by the

requestor in an individual fee dispute was $2,000 or less or a contested case hearing conducted by the State Office of Administrative Hearings (SOAH) if the amount of reimbursement sought exceeded $2,000. Parties who had exhausted all administrative remedies and who were aggrieved by the final decision of SOAH could seek judicial review of the decision in the manner provided for judicial review of a contested case under Chapter 2001, Subchapter G Government Code.

Pursuant to Labor Code §413.0312, the appealing party is now required to mediate the medical fee dispute at a benefit review conference (BRC) under Labor Code Chapter 410, Subchapter B. If the dispute remains unresolved after a BRC, the parties may elect to engage in binding arbitration as provided by Labor Code §413.0312(d) and under Chapter 410, Subchapter C. However, if arbitration is not elected, the party is entitled to a contested case hearing at SOAH to resolve the dispute in the manner provided for a contested case under Chapter 2001, Government Code. A party who has exhausted all administrative remedies and who is aggrieved by a final decision of SOAH may seek judicial review of the decision in the manner provided for judicial review of a contested case under Chapter 2001, Subchapter G Government Code and Labor Code §413.031(k-1)**.**

In addition to altering the appellate process applicable to medical fee disputes, Labor Code §413.0312 also requires reimbursement to the Division for the costs for services provided by SOAH in a contested case hearing involving a medical fee dispute. Except in cases where the injured employee is the nonprevailing party, Labor Code §413.0312(g) requires the nonprevailing party in the contested case hearing to reimburse the Division for the costs of a SOAH proceeding. If an injured employee is a nonprevailing party, Labor Code §413.0312(g) requires the insurance carrier to reimburse the Division for the SOAH costs unless otherwise agreed by the parties. Reimbursement must be remitted to the Division not

later than the 30th day after the date of receiving a bill or statement from the Division. Labor Code §413.0312(k) requires the Commissioner of Workers' Compensation to adopt rules that establish a procedure that will enable the Division to charge a party to a medical fee dispute, other than an injured employee, for the costs of services provided by SOAH in medical fee dispute cases.

In accordance with §44 of HB 2605, the above described legislative amendments affecting medical fee disputes apply only to the appeal of a medical fee dispute that is based on a review conducted by the Division on or after June 1, 2012. An appeal of a medical fee dispute that is based on a review conducted by the Division before that date is governed by the prior law.

HB 2605 also enacted legislative changes that affect the manner in which a person appeals a decision by an independent review organization (IRO). Specifically, this bill (1) amended Insurance Code §1305.355 and added §1305.356 which concerns the appeal of an IRO decision involving health care in a certified workers' compensation network; (2) amended Labor Code §413.031(k) and (k-1) which concerns the appeal of an IRO decision involving health care provided outside of a certified network; and (3) enacted Labor Code §504.054 which concerns the appeal of an IRO decision involving health care provided by a political subdivision in accordance with Labor Code §504.053(b)(2). These statutory amendments provide that a party to a medical necessity dispute that remains unresolved after review by an IRO is entitled to a contested case hearing conducted by a Division hearing officer in accordance with Labor Code §413.0311. Additionally, the new provisions require that in cases involving health care in a certified network, the hearing officer conducting the hearing shall consider evidence-based treatment guidelines adopted by the certified network. In a similar manner, the new statutory provisions in the Labor Code require that in cases involving

health care provided by a political subdivision under Labor Code §504.053(b)(2), the hearing officer conducting the hearing shall consider any treatment guidelines adopted by the political subdivision or pool if those guidelines meet the standards provided by Labor Code §413.011(e). A party who has exhausted all administrative remedies and who is aggrieved by a final decision of the Division's hearing officer may seek judicial review of the decision in the manner provided for judicial review of a contested case under Chapter 2001, Subchapter G Government Code**.**

As stated above, this adoption is also designed to implement provisions in SB 809 which concern a party's right to seek judicial review after exhausting the applicable administrative remedies in the medical fee dispute or review of the IRO decision as described above. HB 2605 provides for judicial review for network appeals. SB 809 amended Labor Code §413.031(k-1) and specifies the time frames for a party seeking judicial review. In a medical fee dispute, SB 809 provides in Labor Code §413.031(k-1) that the party seeking judicial review of a SOAH decision must file suit not later than the 45th day after the date on which SOAH mailed the party the notification of the decision. For purposes of Labor Code §413.031(k-1), the mailing date is considered to be the fifth day after the date the decision was issued by SOAH. In an appeal of an IRO decision, SB 809 provides in Labor Code §413.0311(d) that a party seeking judicial review of a decision of a Division hearing officer must file suit not later than the 45th day after the date on which the Division mailed the party the decision of the hearings officer. The mailing date is considered to be the fifth day after the date the decision of the hearings officer was filed with the Division.

Finally, this adoption implements provisions in HB 2605 that concern a first responder's claim for medical benefits. HB 2605 enacted Labor Code §504.055 and §504.056 which apply to a first responder as defined in Labor Code §504.055 who sustains a

serious bodily injury in the course and scope of employment. These statutes require the political subdivision, Division, and insurance carrier to accelerate and give priority to a first responder's claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury. These statutes further require the Division to accelerate, under rules adopted by the Commissioner, a contested case hearing requested by or an appeal submitted by a first responder regarding the denial of a claim for medical benefits. A first responder is required to provide notice to the Division and IRO that the contested case or appeal involves a first responder.

These adopted amendments are necessary in order to implement and incorporate the above described amendments and new provisions into existing Division rules that govern medical dispute resolution. The adopted amendments conform §133.307 to the appeal process provisions in HB 2605 for medical fee disputes, including provisions that require reimbursement to the Division for the costs of SOAH in a medical fee dispute. The adopted amendments to §133.308 conform that rule to legislative changes in HB 2605 that govern the appeal of an IRO decision in a medical necessity dispute. These adopted amendments also incorporate into §133.307 and §133.308 provisions that will provide for the accelerated review of a covered first responder's claim for medical benefits in medical fee and medical necessity disputes.

These adopted amendments also include changes that are intended to provide system participants with a clearer understanding of the appeals process for the appeal of Medical Fee Dispute Resolution (MFDR) Section decisions and IRO decisions. These changes will also provide the Division with greater flexibility in performing the appeals processes. Finally, to conform to current nomenclature this adoption also makes non-substantive changes in terminology throughout §133.307 and §133.308 such as adding the language "in the form

and manner required by the division" to text and changing the terms "Department" to "department", "Department's" to "department's", "Division of Workers' Compensation" or "Division" to "division", "Division's" to "division's", and adding the words "health care" to "provider", "injured" to "employee", and "insurance" to "carrier." The terms "provider" and "MDR" have been deleted from these adopted rules and replaced with the terms "health care provider" and "medical fee dispute resolution", respectively. In some instances, the acronym "MDR" has been deleted and changed to "MFDR." The term "MDR" has meant medical dispute resolution. The proposed term "MFDR" means medical fee dispute resolution and the process for the resolution of medical fee disputes is the focus of adopted §133.307.

The Division has changed some of the proposed language in the text of the rule as adopted in response to public comments received. The Division received a comment recommending that the Division clarify the information that subclaimant requestors are required to submit to the Division when seeking MFDR. In response to this comment, the Division removed the word "subclaimant" from §133.307(c)(2) and adopted new §133.307(c)(3) which contains requirements for subclaimant dispute requests. Adopted §133.307(c)(3) provides that the requestor shall provide the appropriate information with the request that is consistent with the provisions of 28 TAC §140.6 or §140.8 of this title (relating to Subclaimant Status: Establishment, Rights, and Procedures and Procedures for Health Care Insurers to Pursue Reimbursement of Medical Benefits under Labor Code §409.0091). A request made by a subclaimant under Labor Code §409.009 shall comply with 28 TAC §140.6. A request made by a subclaimant under Labor Code §409.0091 shall comply with the document requirements of 28 TAC §140.8.

The Division received comments that disagreed with language in proposed §133.307(g). The commenters believed the proposed text could be misconstrued to prohibit

the parties from raising at a BRC or at SOAH defenses relating to disputes over compensability, extent of injury, liability, or medical necessity that have not yet been finally adjudicated, and that the proposed text would prohibit parties from abating the case until the issues are resolved. Since the Division's proposed language was intended to prevent litigation of the issues affecting the injured employee without their presence, in response to suggested language the Division changed §133.307(g) to state that "if a party provides the benefit review officer or administrative law judge with documentation listed in subsection (d)(2)(H) or (I) of this section that shows unresolved issues regarding compensability, extent of injury, liability, or medical necessity for the same service subject to the fee dispute, then the benefit review officer or administrative law judge shall abate the proceedings until those issues have been resolved." This adopted rule is necessary to prevent the injured employee who may not be a party to the fee dispute from being bound by the ruling. Furthermore, it prevents a carrier from being ordered to pay for a bill in which it has no underlying legal obligation. Finally, it prevents conflicting or duplicative decisions. The requirement to present evidence is so the benefit review officer or administrative law judge can verify the existence of a dispute before abating the proceedings.

The Division received a comment that requested text in §133.307(g) that would allow a party to a medical fee dispute to appear at a benefit review conference via telephone. In response, the Division adopted text in §133.307(g)(1) that provides that a party may appear at a benefit review conference via telephone.

The Division received comments that disagreed with proposed text that would require an insurance carrier or the insurance carrier's utilization review agent to provide to the IRO a list of the health care providers known by the insurance carrier to have provided care to the

injured employee who have medical records relevant to the review. In response to this comment, the Division did not adopt this requirement.

The Division has also made changes to some of the proposed text that are not in response to comment that are non-substantive and necessary to clarify and correct as proposed. First, the Division throughout §133.307 and §133.308 has replaced the term "reconsideration" with "appeal." This nonsubstantive change is being made due to ongoing standardization of this terminology across the health care industry and in Division and Department rules. This change occurs in §133.307(c)(2)(J), (d)(2)(B), (f)(3)(A); and §133.308(h), (i)(3), (k)(5) and (s)(2)(D). The Division clarifies that the usage of the term "appeal" in §133.307(c)(2)(J), (d)(2)(B), and (f)(3)(A) refers to appeals submitted to the insurance carrier in accordance with §133.250 of this title regarding medical bill processing/audit by insurance carrier. The Division also clarifies that the usage of the term "appeal" in §133.308(h), (i)(3), (k)(5) and (s)(2)(D) refers to appeals submitted to the insurance carrier or the insurance carrier's utilization review agent in accordance with §133.250 of this title or §134.600 of this title regarding prospective and concurrent review of health care, as applicable. Second, the Division in §133.308(g)(2) has corrected the name of the area within the Department from which a person may obtain an IRO request form. The Division has corrected this name to read the "Managed Care Quality Assurance Office".

Description of adopted amendments to §133.307

Section 133.307 governs non-certified network medical fee dispute resolution. The adopted amendments to subsection (a) make this rule applicable to a request for MFDR as authorized by the Act that is filed on or after June 1, 2012. Fee disputes filed with the Division prior to June 1, 2012 will be governed by the statutes and rules in effect immediately before the effective date of HB 2605. The Division has adopted the date of June 1, 2012 in

§133.307 to be consistent with §44 of HB 2605. This adopted amendment is necessary because under §44 of HB 2605, the new appellate process applies only to the appeal of a medical fee dispute that is based on a review conducted by the Division on or after June 1, 2012. Additionally, since HB 2605 now places the financial liability of SOAH costs on the non-prevailing party in a medical fee dispute, this adopted applicability date is necessary because it will ensure that parties requesting appeals of medical fee disputes at SOAH will have clear notification of their potential liability in the cases.

Adopted §133.307(a)(3) requires that a request for medical fee dispute resolution that involves a first responder's request for reimbursement of medical expenses paid by the first responder be accelerated by the Division and given priority in accordance with the provisions of Labor Code §504.055. This adopted amendment is necessary in order to implement Labor Code §504.055(e) which requires the Division to accelerate, under rules adopted by the Commissioner, an appeal submitted by a first responder regarding the denial of a claim for medical benefits.

The adopted amendments to §133.307(b) update the persons who may be requestors under the rule by adding subclaimants to the list of persons who may be requestors. Subclaimants are added in accordance with §§140.6, 140.7, and 140.8 of this title relating to Subclaimant Status: Establishment, Rights, and Procedures; Health Care Insurer Reimbursement under Labor Code §409.0091; and Procedures for Health Care Insurers to Pursue Reimbursement of Medical Benefits under Labor Code §409.0091, respectively, which provide rules allowing subclaimants to participate in medical fee dispute resolution before the Division. This adopted amendment is necessary to conform §133.307 with those Chapter 140 rules.

The adopted amendments to §133.307(c)(1) state that a decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to adopted subsection (g) of this rule. This adopted amendment is necessary because there may be a dispute over the timeliness which parties should be permitted the opportunity to appeal.

Section 133.307(c)(2) will govern requests for MFDR by health care providers and pharmacy processing agents. The adopted amendments to §133.307(c)(2) remove reference to the DWC-60 table and describes the information that must be included in requests for MFDR by health care providers and pharmacy processing agents (PPAs). These adopted amendments are necessary in order to provide clarity in Division rules on the information required to be included in a request for MFDR from a health care provider and pharmacy processing agent. The adopted amendments are also necessary in order to allow other relevant records related to the date of service in dispute to be sent with the request and not to unduly limit the records that may be sent since other relevant records related to the service in dispute may be available to support a party's position. To this end, the Division has provided in adopted amendments to §133.307(c)(2)(M) that a request for MFDR is to include a copy of all applicable medical records "related" to the dates of service in dispute as opposed to "specific" to the dates of service in dispute. Additionally, adopted §133.307(c)(2)(Q) will allow a requestor to submit any other documentation that the requestor deems applicable to the medical fee dispute.

Also included in the adopted amendments to §133.307(c)(2) are changes to §133.307(c)(2)(J) and (K). The adopted amendments to §133.307(c)(2)(J) state that the requestor must provide a paper copy of all medical bills related to the dispute as originally submitted to the insurance carrier in accordance with Chapter 133 of this title and a paper

copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter. The adopted amendments to §133.307(c)(2)(K) require the requestor to provide a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with Chapter 133 of this title. These adopted amendments require the submission of paper copies of the medical bills, appeal requests, and EOBs. If medical bills, appeal requests, or explanation of benefits (remittance advice) were processed electronically in accordance with Chapter 133, Subchapter G, the parties may submit the documentation using the paper forms and formats described in Chapter 133, or they may choose to provide other documentation that contains all the same information found in the paper equivalent. These adopted amendments are necessary because currently there are technological barriers that prevent the Division from safely accepting and distributing the information in electronic formats as a matter of standard process. However, the Division is working on addressing these issues so that the Division may consider accepting these documents electronically in the future.

Finally, the adopted amendments to §133.307(c)(2)(O) incorporate into this rule provisions that will also allow a requestor to submit documentation that supports the requestor's position that the payment amount being sought for pharmaceutical services where the Division has not established a reimbursement rate is a fair and reasonable reimbursement in accordance with the Division's pharmacy fee guideline. These adopted amendments are necessary to reflect recent adopted amendments to the Division's pharmacy fee guideline in 28 TAC §134.503 which included the removal of maximum allowable reimbursement (MAR) terminology from that rule and provided for "reimbursement rates that are fair and reasonable" in certain specified instances.

Section 133.307(c)(3) will govern requests for MFDR from subclaimants. The adopted amendments clarify the information that must be submitted to the Division for a request for medical fee dispute by a subclaimant. These adopted amendments are necessary in order to conform this rule to existing Division rules applicable to requests for MFDR submitted by subclaimants, specifically §140.6 and §140.8. Section 140.6 governs subclaims pursued under Labor Code §409.009 and §140.8 provides procedures for health care insurers to pursue reimbursement of medical benefits under Labor Code §409.0091. Both sections include rules that govern how each respective subclaimant participates in medical fee dispute resolution. Thus, the adopted rule provides that the subclaimant requesting medical fee dispute resolution shall provide the appropriate information with the request that is consistent with 28 TAC §140.6 or §140.8. The adopted amendments provide that a request made by a subclaimant under Labor Code §409.009 shall comply with 28 TAC §140.6 and submit the documents to the Division required thereunder, and a request made by a subclaimant under Labor Code §409.0091 shall comply with the document requirements of 28 TAC §140.8 and submit the documents to the Division required thereunder.

Section 133.307(c)(4) will govern requests for MFDR by injured employees. The adopted amendments to these provisions remove reference to the DWC-60 table and describes the information that must be included in requests for MFDR injured employees. These adopted amendments are necessary in order to provide clarity in Division rules on the information required to be included in a request for MFDR from an injured employee and to ensure the Division has the necessary information to resolve the disputes.

The adopted amendments to §133.307(d) which governs a respondent's response to a request for MFDR specifies the information and records that are required to be submitted by the respondent to the Division. These adopted amendments are necessary to provide clarity

in Division rules as to the information and records that must be included in a response and to ensure the Division has the necessary information to resolve the disputes.

Additionally, consistent with the amendments to subsection (c) of this section, the adopted amendments to subsection (d)(2)(B) and (C) of this section delete the requirement of "using an appropriate DWC approved paper billing format" and provides for the submission of a paper copy of all initial and appeal EOBs related to the dispute not submitted by the requestor, and a paper copy of all medical bills related to the dispute if different from that originally submitted to the insurance carrier. As with the adopted amendments to §133.307(c)(2)(J) and (K), these amendments only require the respondent to provide documentation using the paper forms and formats described in Chapter 133, or they may choose to provide other documentation that contains all the same information found in the paper equivalent. These adopted amendments are necessary because as stated the Division currently cannot safely receive and distribute this documentation electronically as a matter of standard process.

Also consistent with adopted amendments to subsection (c), adopted amendments to §133.307(d)(2)(E)(v) incorporate into this rule provisions that will also allow a respondent to submit documentation that supports the respondent's position that the amount paid for pharmaceutical services where the Division has not established a reimbursement rate is a fair and reasonable reimbursement in accordance with the Division's pharmacy fee guideline. These adopted amendments are necessary to reflect recent adopted amendments to the Division's pharmacy fee guideline in 28 TAC §134.503 which included the removal of MAR terminology from that rule and provided for "reimbursement rates that are fair and reasonable" in certain specified instances.

Adopted §133.307(e) states that a requestor may withdraw its request for MFDR by notifying the Division prior to a decision. This provision is necessary in order to provide clarity in Division rules that a requestor of MFDR may choose to withdraw its dispute from the medical fee dispute resolution process.

The adopted amendments to §133.307(f)(3) concern the authority of the Division to dismiss a request for MFDR. The adopted amendments clarify that the dismissal of a request for MFDR is not a final decision by the Division, and that a request for MFDR dismissed by the Division may be submitted for review as a new dispute that is subject to the requirements of §133.307. These adopted amendments are intended to clarify that the appropriate procedure for a party that is requesting MFDR after a dismissal is not an appeal of the dismissal, but instead to correct and submit the corrected request as a new request that would also be subject to the requirements of this section. These adopted amendments are necessary to provide clarity to the parties that a requestor does have the opportunity to correct and re-file the new request for MFDR and the new request will be subject to the provisions in §133.307.

The adopted amendments also delete from this subsection several grounds that previously served as a basis for a dismissal. The ground in former subsection (f)(3)(A) which allowed the Division to dismiss a request when the requestor informed the Division, or the Division otherwise determined, that the dispute no longer exists is deleted because that basis equates to withdrawing of the request now addressed in adopted §133.307(e). In addition, the Division's determination that a dispute no longer exists is good cause for dismissal. Good cause dismissals are provided for by subsection (f)(3)(E). The grounds previously listed in subsection (f)(3)(B), (D), and (E) are deleted because a Division determination that the requestor is not a proper party, the dispute was previously adjudicated, or a request was

untimely are decisions better characterized as final decisions that may be appealed by the requestor. The ground allowing dismissal when the dispute is for health care services provided pursuant to a private contractual fee arrangement is deleted because under the Act the Division has original jurisdiction to ensure that these contracts comply with applicable statutory requirements and that the pharmacy informal or voluntary network complies with the health care provider notice requirements under Labor Code §408.0281.

Finally, the adopted amendments clarify and delete unnecessary language in provisions that allow the Division to dismiss a medical fee dispute when the request contains unresolved issues of medical necessity, compensability, extent of injury, or liability.

Section 133.307(g) governs the appeal of a Division decision in a fee dispute and these adopted amendments are necessary to implement the changes made by HB 2605 to Labor Code §413.031 and the addition of Labor Code §413.0312. The amendments also delete provisions that are no longer required and clarify the procedures for the appeal of an MFDR decision in accordance with changes made by HB 2605.

As previously stated, HB 2605 provides one appeal process for appealing a Division decision in a medical fee dispute. Consistent with HB 2605, the appealing party is now required to first mediate the dispute at a BRC at the Division. The adopted amendments §133.307(g) provide that the Division's decision in a medical fee dispute is final if a request for a BRC is not requested. The adopted amendments to §133.307(g)(1) provide that an appealing party must request a BRC within 20 days from the date of the party's receipt of the decision. These amendments are necessary in order to provide for the timely resolution of medical fee disputes.

The adopted amendments to §133.307(g) also provide that if a party provides the benefit review officer or administrative law judge with documentation listed in

§133.307(d)(2)(H) or (I) that shows unresolved issues regarding compensability, extent of injury, liability, or medical necessity for the same service subject to the fee dispute, then the benefit review officer or administrative law judge shall abate the proceedings until those issues have been resolved. This adopted rule is necessary to prevent the injured employee who may not be a party to the fee dispute from being bound by the ruling. Furthermore, it prevents a carrier from being ordered to pay for a bill in which it has no underlying legal obligation. Finally, it prevents conflicting or duplicative decisions. The requirement to present evidence is so the benefit review officer or administrative law judge can verify the existence of a dispute before abating the proceedings.

The adopted amendments to §133.307(g)(1)(B) prohibit the parties at a BRC from resolving the dispute by negotiating fees that are inconsistent with any applicable fee guidelines adopted by the Commissioner of Workers' Compensation. These adopted amendments are consistent with statutory provisions in Labor Code §413.0312(c) and are necessary in order to ensure that reimbursements for health care services are not in violation of the applicable fee guidelines adopted by the Commissioner.

The adopted amendments to §133.307(g)(1)(C) incorporate the first responder provisions in HB 2605 by providing that a first responder's request for a benefit review conference must be accelerated by the division and given priority in accordance with Labor Code §504.055, and the first responder must provide notice to the division that the case involves a first responder.

The adopted amendments to §133.307(g)(1)(C) also clarify that a request for a BRC shall include a copy of the MFDR decision which will satisfy the documentation requirements under the Division rules governing BRCs, specifically §141.1(a) of this title (relating to Requesting and Setting a Benefit Review Conference). This adopted amendment is

necessary in order to provide guidance to the parties as to what documents will satisfy the documentation requirements under the Division's BRC rules.

Consistent with HB 2605, the adopted amendments in to §133.307(g)(2) provide that if the medical fee dispute remains unresolved after a Division BRC, the parties may elect to engage in arbitration as provided by Labor Code Chapter 410, Subchapter C, and Chapter 144 of this title (relating to Dispute Resolution). However, if arbitration is not elected then the parties are entitled to request a contested case hearing at SOAH to resolve the dispute in the manner provided for a contested case under Chapter 2001, Government Code. The adopted amendments to §133.307(g)(2)(A) specify that a written request for a contested case hearing at State Office of Administrative Hearings must be filed not later than 20 days after conclusion of the BRC. This 20 day filing deadline is consistent with filing deadlines for requesting a SOAH hearing currently in §148.3. Finally, the adopted amendments §133.307(g)(2) implement the first responder amendments in HB 2605 by providing that the Division will accelerate a first responder's request for arbitration by the Division or a request for a contested case hearing before the State Office of Administrative Hearings, and the first responder must provide notice to the Division that the contested case involves a first responder.

The adopted amendments in §133.307(g)(3) provide that a party to a medical fee dispute who has exhausted all administrative remedies may seek judicial review of the decision of the Administrative Law Judge at SOAH. The Division and the Department are not considered to be parties to the medical dispute pursuant to Labor Code §413.031(k-2) and §413.0312(f). These adopted amendments are necessary in order to implement the provisions in HB 2605 that govern judicial review in medical fee dispute cases. Additionally, the adopted amendments in §133.307(g)(3) incorporate the legislative amendments in SB

809 that require a party seeking judicial review of a decision of SOAH to file suit not later than the 45th day after the date on which SOAH mailed the party the notification of the decision. SB 809 and these adopted amendments deem the mailing date the fifth day after the date the decision was issued by SOAH. Finally, the adopted amendments clarify that a party seeking judicial review of the decision of the administrative law judge shall at the time the petition for judicial review is filed with the district court file a copy of the petition with the division's chief clerk of proceedings. These provisions are adopted in accordance with Government Code §2001.176(b) which requires a copy of the petition to be filed with the agency. This amendment is also necessary because it will provide the Division with the information necessary to prepare the record of proceedings for the district court.

The adopted amendments in §133.307(h)require the non-prevailing party at SOAH to reimburse the Division for the costs for services provided by the SOAH, including any interest required by law, not later than the 30th day after the date of receiving a bill or statement from the division. If the injured employee is the non-prevailing party, these adopted amendments require the insurance carrier to reimburse the Division for the costs for services provided by SOAH. The adopted amendments also provide that in the event of a dismissal, the party requesting the hearing, other than the injured employee, shall reimburse the Division for the costs for services provided by SOAH unless otherwise agreed by the parties. These adopted amendments are necessary to implement Labor Code §413.0312(k) which requires that the Commissioner by rule to establish procedures to enable the Division to charge a party to a medical fee dispute, other than an injured employee, for the costs of services provided by SOAH.

Description of adopted amendments to §133.308

The adopted amendments amend the title of this section to "MDR of Medical Necessity Disputes" in order to provide more clarity as to the contents of this section.

The adopted amendments to §133.308(a) provide that the section is applicable to the independent review of medical necessity disputes filed with the Division on or after June 1, 2012. The adopted appeal procedure applies to any decision appealed following an IRO in accordance with the provisions of HB 2605. Accordingly, the adopted amendments provide that dispute resolution requests filed prior to June 1, 2012 shall be resolved in accordance with the statutes and rules in effect at the time the request was filed. These amendments are necessary to make the rule more current and to comply with the provisions of HB 2605 and SB 809.

The adopted amendments to §133.308(b) update and clarify that rule by adding that IROs are also required be certified pursuant to Chapter 12 of this title (relating to Independent Review Organizations). These amendments are necessary to conform this rule to current Department rules that govern the certification of IROs.

The adopted amendments §133.308(c) clarify that IRO doctors that perform reviews of health care services provided under this section must also hold the appropriate credentials under Chapter 180 of this title (relating to Monitoring and Enforcement). The adopted amendments further clarify that personnel employed by or under contract with the IRO to perform independent review shall also comply with the personnel and credentialing requirements under Chapter 12 of this title. The amendments to adopted subsection (c) are necessary to update and clarify the rule so that it is consistent with other Division and Department rules.

The adopted amendments delete specialty requirements in previous subsection (d) as those requirements are included in the applicable credentialing requirements incorporated in the adopted amendments to subsection (c).

The adopted amendments to §133.308(d) relate to conflicts of interest. These amendments update and clarify this rule by adding §12.204 and §12.206 of this title (relating to Prohibitions of Certain Activities and Relationships with Independent Review Organizations, and Notice of Determinations Made by Independent Review Organizations) to the list of existing provisions that the Department may review to determine if a conflict of interest exists in accordance with existing Division rules. The adopted amendments also update this rule in accordance with the provisions of Labor Code §413.032(b) which requires notification of each IRO decision to include in its certification by the IRO that the reviewing health care provider has certified that no known conflicts of interest exist between the health care provider and the "injured employee's employer, the insurance carrier, the utilization review agent, any of the treating health care providers, or any of the health care providers utilized by the insurance carrier to review the case for determination prior to referral to the IRO."

The adopted amendments to §133.308(e) clarify the Division's monitoring and investigative duties under the Act by stating in this rule that the Division will make inquiries, conduct audits, receive and investigate complaints, and take all actions permitted by the Labor Code and other applicable law against an IRO or personnel employed by or under contract with an IRO to perform independent review to determine compliance with applicable law, this section, and other applicable division rules.

Section 133.308(f)(1) lists who may request an IRO in network disputes. The adopted amendments allow a person acting on behalf of an injured employee to be a requestor in

medical necessity disputes. This amendment is necessary to conform this rule with Insurance Code §1305.355(a)(1) which pertains to certified networks and independent review, and requires the URA agent to permit the employee or person acting on behalf of the employee to seek review of an adverse determination by an IRO. The adopted amendments to subsection (f)(1) also clarify that subclaimants in accordance with §140.6 of this title (relating to Subclaimant Status: Establishment, Rights, and Procedures), §140.7 of this title (relating to Health Care Insurer Reimbursement under Labor Code §409.0091), or §140.8 of this title (relating to Procedures for Health Care Insurers to Pursue Reimbursement of Medical Benefits under Labor Code §409.0091), as applicable, may be a requestor in a medical necessity dispute. This amendment is necessary to conform this rule to existing Division rules governing subclaimants and medical necessity disputes.

Section 133.308(f)(2) lists the persons who may request an IRO in non-network disputes. The adopted amendment clarifies that an injured employee's representative may request a review by an IRO. The adopted amendments to subsection (f)(2) also clarify that subclaimants in accordance with §140.6 of this title (relating to Subclaimant Status: Establishment, Rights, and Procedures), §140.7 of this title (relating to Health Care Insurer Reimbursement under Labor Code §409.0091), or §140.8 of this title (relating to Procedures for Health Care Insurers to Pursue Reimbursement of Medical Benefits under Labor Code §409.0091), as applicable, may be a requestor in a medical necessity dispute. This amendment is necessary to conform this rule to existing Division rules governing subclaimants and medical necessity disputes.

The adopted amendments to §133.308(g) updated the Department's website address to the most current address. The adopted amendments also delete and replace the name

"Health and Workers' Compensation Network Certification and Quality Assurance Division" with the current name which is "Managed Care Quality Assurance Office."

The adopted amendments to §133.308(o) delete from that rule provisions that require an IRO in a network dispute whose decision is contrary to the network's treatment guidelines to indicate in the decision the specific basis for its divergence in the review of medical necessity of network health care. The amendment is necessary in order to better align this rule with statutes governing reviews by independent review organizations. Additionally, a certified network's treatment guidelines are not presumed reasonable by statute in the same way the treatment guidelines adopted by the Division are under Labor Code §413.017, which is why Labor Code §413.031 requires an IRO to explain any divergence from the Division's adopted treatment guidelines in non-network disputes. No similar statute requires an IRO to explain any divergence from treatment guidelines adopted by a certified network.

The adopted amendments to §133.308(o) also correct a typographical error in subsection (o)(1)(F) by replacing Chapter "4201" with Chapter "4202."

The adopted amendments to §133.308(q) removes a reference to the Division's Approved Doctor List because that list no longer exists and the language is no longer necessary.

The adopted amendments to §133.308(r) for clarity incorporates into this rule the statutory provision in Labor Code §413.031(m) that provides that the decision of an IRO under Labor Code §413.031(d) is binding during the pendency of a dispute. This adopted amendment restates statutory requirements.

Section 133.308(s) governs the appeal of an IRO decision, and the adopted amendments to these provisions are necessary to implement the requirements of HB 2605 that prescribe the manner in which a party may appeal a decision of an IRO. As stated, HB

2605 provides one appeal process following the decision by an IRO, and this appeals process will apply to an IRO review of a medical service provided in a certified network, outside of a certified network, and by a political subdivision pursuant to Labor Code §504.053(b)(2). Specifically, consistent with HB 2605 the adopted amendments provide that a party may appeal an IRO decision by requesting a Division contested case hearing conducted by a Division hearing officer. A BRC is not a prerequisite to a Division CCH. Under the adopted amendments the appeal must be filed with the Division's Chief Clerk of Proceeds no later than 20 days after the date the IRO decision is sent to the appealing party. The language proposed for deletion in §133.308(s) is proposed for the purpose of conforming the rule to the provisions of HB 2605.

The adopted amendments to §133.308(s) specifies the respective treatment guidelines that the hearing officer at a Division CCH must consider when reviewing the decision by an IRO. These adopted amendments are necessary to implement provisions in Insurance Code §1305.356 enacted by HB 2605 which require the hearing officer in a certified network dispute to consider evidence-based treatment guidelines adopted by the network. The amendments are also necessary to implement Labor Code §504.054 enacted by HB 2605. This statute requires the hearing officer in a dispute involving a political subdivision that provides medical benefits under Labor Code §504.053(b)(2) to consider any treatment guidelines adopted by the political subdivision or pool if those guidelines meet the standards provided by Labor Code §413.011(e). Finally, these adopted amendments are necessary to provide clarity to the hearing officer and parties to the medical dispute as to what treatment guidelines must be considered by the hearing officer during the dispute.

The adopted amendments to subsection (s) also include amendments to the letter of clarification process. These adopted amendments clarify that the Department may at its

discretion forward the party's request for a letter of clarification to the IRO that conducted the independent review. It also states that the Department will not forward to the IRO a request for a letter of clarification that asks the IRO to reconsider its decision or issue a new decision. The purpose of this adopted amendment is to prevent unnecessary referrals of a request for a LOC to the IRO.

Finally, the adopted amendments in subsection (s) are necessary to implement legislative amendments in SB 809 concern judicial review in medical necessity disputes. The adopted amendments state a party seeking judicial review under this section must file suit not later than the 45th day after the date on which the division mailed the party the decision of the hearing officer. The mailing date is considered to be the fifth day after the date the decision of the hearing officer was filed with the division. The adopted amendments also provide that the judicial review will be governed by the substantial evidence rule. This adopted amendment is necessary to clarify the applicable standard of review in a judicial review of a medical necessity dispute.

Adopted new §133.308(u) states that in accordance with Labor Code §504.055(d), an appeal regarding the denial of a claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury involving a first responder will be accelerated by the division and given priority. The party seeking to expedite the contested case hearing or appeal shall provide notice to the division and independent review organization that the contested case hearing or appeal involves a first responder. These adopted amendments are necessary to implement provisions in HB 2605 which require the Division to accelerate a contested case hearing requested by or submitted by a first responder regarding the denial of a claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury.

The adopted amendments to §133.308(v) state that the department or the division may initiate appropriate proceedings under Chapter 12 of this title (relating to Independent Review Organizations) or Labor Code, Title 5 and division rules against an independent review organization or a person conducting independent reviews. This amendment is necessary to clarify the enforcement authority of the Department or the Division against IROs or persons conducting independent reviews.

3. HOW THE SECTION(S) WILL FUNCTION.

Adopted §133.307 contains the requirements and process for: (1) the request for medical fee dispute resolution by the Division, including the acceleration of first responder requests; (2) a party to respond to a request for medical fee dispute resolution; (3) a party to appeal the decision of the MFDR Section; (4) a party to seek judicial review; and (5) the billing of a non-prevailing party, other than an injured employee, for the costs of services provided by SOAH.

Adopted §133.308 contains requirements for: (1) the Division's monitoring activities of IROs; (2) the certification and professional licensing of independent review organizations (IROs); (3) who may request a decision by an IRO; (4) the information that must be included with the request; (5) the timeframe for the IRO decisions and the information that must be included in the IRO decisions; and (6) IRO fees. Additionally, this rule also sets forth the process and requirements necessary to: (1) appeal a medical necessity (IRO) dispute through the Division; (2) seek judicial review; and (3) accelerate and give priority to a request by a first responder's request for an appeal regarding the denial of a claim for medical benefits. Last, this rule provides that the Department or the Division may initiate appropriate enforcement proceedings under 28 TAC Chapter 12 or Labor Code, Title 5 and Division rules against an IRO or a person conducing independent reviews.

4. SUMMARY OF COMMENTS AND AGENCY'S RESPONSE TO COMMENTS.

§133.307(a)(1): A commenter does not agree with substituting "as authorized by the Texas Workers' Compensation Act" for the phrase "non-network or certain authorized out-of-network health care not subject to a contract." The commenter states that the proposed amendment is not sufficiently clear that network fee disputes are not subject to resolution under this provision.

Agency Response: The Division disagrees that this adopted amendment makes §133.307 unclear. The authority of the MFDR Section to adjudicate medical fee disputes comes from Labor Code Chapter 413, Insurance Code Chapter 1305, and related Department and Division rules.

§133.307(a)(3), (g)(1)(C), and (g)(2): One commenter suggests the following language "first responder or a person acting on behalf of the first responder" and states that the purpose of the legislation seems better served by letting more than just the first responder make the request to expedite. Commenters recommend that the rules be modified to allow the "requestor" to provide notice that the dispute involves a first responder because in most fee disputes it is the health care provider submitting the dispute. The commenter hopes the Division allows the doctor or other health care provider who is seeking dispute resolution to provide the notice that the dispute involves a first responder because there is a concern that the first responder may have to additionally submit a notice to the Division. Several commenters are concerned that the proposed language will limit or exclude who may make a request under this section with respect to "first responders" and ask that the language be changed to ensure that there are no limitations on who may make a request on behalf of or

assist a "first responder." Another commenter disagrees with any text that would allow a health care provider to request dispute resolution on behalf of an injured employee under Labor Code §504.055.

Agency Response: The Division disagrees that the recommended modifications are necessary because allowing a health care provider to identify the injured employee as a first responder in a request for medical fee dispute resolution will not expedite "medical benefits" under Labor Code §504.055 for the first responder as the health care has already been rendered. The Division notes that nothing in the Act or Division rules prevent a first responder from obtaining assistance in completing the forms to request expedited medical fee dispute resolution in situations where the first responder is the requestor. Additionally, pursuant to 28 TAC §150.3, a representative or lay representative may submit the request on behalf of the first responder when there is a dispute involving an injured employee's request for reimbursement from an insurance carrier for expenses paid by the injured employee.

§133.307(a)(3) and §133.308(u): A commenter also requested clarification as to how a "first responder" satisfies notification that the claim relates to a "first responder" and if the notification applies in all applicable situations. The commenter asks if the Division provided form for requesting medical fee dispute resolution in and of itself provide the notice the case involves a first responder or does there have to be a separate notification from the first responder.

Agency Response: The Division clarifies that a first responder who indicates on the Division's revised form for requesting medical fee dispute resolution that the dispute involves a first responder will be deemed by the Division to have provided the notice required by the

rule. The first responder would not be required to file with the Division a separate notification in order to have the dispute expedited by the Division.

§133.307(a)(3) and §133.308(u): A commenter suggested that there may need to be more specific rule language to ensure that subsection (c) of Labor Code §504.055 is addressed and to ensure that insurance carriers and political subdivisions are required to accelerate claims for "first responders" in all applicable situations.

Agency Response: The Division disagrees. The Division notes that language requiring insurance carriers and utilization review agents who perform utilization review to comply with the provisions in Labor Code §504.055 is already contained in 28 TAC §§133.240, 133.250 and 134.600. Additionally, the Department has posted for informal comment rules in 28 TAC Chapter 19 relating to agent's licensing and utilization review that will require the acceleration of claims of first responders by insurance carriers, utilization review agents, and health care providers. Provisions in these rules requiring insurance carriers and political subdivisions to accelerate claims for "first responders" are outside the scope of these rules and better addressed in other Division and Department rules.

§133.307(a)(3) and §133.308(u): A commenter states that the use of the term "first responder" lends itself to the misinterpretation that all first responders, regardless of where they might be employed, when appealing a denied claim are entitled to the procedures set out in Labor Code §504.055(d). The commenter suggests clarification that §137.308(u) only applies to first responders either employed by or volunteering for a political subdivision as restricted under Labor Code §504.055(a).

Agency Response: The Division disagrees that the term "first responder" lends itself to misinterpretation. Labor Code §504.055 defines the term and states to what first responders the section applies. Additionally, the Division has recently adopted amendments to 28 TAC §133.305 effective July 1, 2012 which defines "first responder" and "serious bodily injury" for purposes of 28 TAC Chapter 133, Subchapter D. This definition tracks the statutory definitions of "first responder" and "serious bodily injury."

§133.307(b)(2): Commenter requests that a carrier be added as an eligible requestor for medical fee dispute resolution. The commenter states that currently, if an overpayment is made and a refund is requested from the healthcare provider; the only recourse a carrier has is to file a formal complaint. The commenter states it would be helpful if the carrier could go to medical fee dispute resolution instead when a refund is not received within the required timeframes.

Agency Response: The Division disagrees with adding insurance carriers to the list of persons who have standing to request MFDR under §133.307. The request is outside the scope of this rule and would need to be addressed as a separate rulemaking project.

§133.307(b)(3) and (4): A commenter recommends these rules be revised to read "the injured employee or person acting on behalf of an injured employee." The commenter notes that this language is included in §133.308(f)(1)(B) and the definition of requestor should be the same in all types of medical disputes.

Agency Response: The Division disagrees with adding the commenter's suggested language to adopted subsection (b) of this rule. This suggested text is unnecessary because existing Division rules in 28 TAC Chapter 150 allow attorneys and authorized representatives

to provide services to injured employees in accordance with those rules. The Division notes that the language "the injured employee or person acting on behalf of an injured employee" is adopted in §133.308(f)(1)(B) because the language mirrors language in Texas Insurance Code §1305.355(a), which relates to the independent review of adverse determinations in certified network cases.

§133.307(b)(5): The commenters state that granting requestor status to subclaimants for dispute resolution under Chapter 133 of this title appears to be inappropriate. The commenter states that "rule 140.6(d) requires carriers to process reimbursement requests under Chapters 133 and 134 but requires dispute resolution to be processed under Chapters 140 – 143." The commenter further states "similarly, rule 140.8(h)(1)(C) requires that 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." The commenter recommends the following clarifying language be included in this rule: "However, disputes regarding liability, extent of injury, or medical necessity must be resolved prior to pursuing a medical fee dispute."

Agency Response: The Division disagrees that it is inappropriate to grant requestor status to subclaimants in medical fee disputes. Current Division rules in 28 TAC Chapter 140 provide that §133.307 will govern a medical fee dispute between a subclaimant and an insurance carrier. The Division also disagrees with adopting commenter's recommended rule language because that language is unnecessary in this rule. This adopted amendment conforms §133.307 with these Chapter 140 rules and clarify that a subclaimant may be a requestor of medical fee dispute resolution in accordance with those rules.

§133.307(c)(2): The commenter states that under 28 TAC §140.6, subclaimants must pursue a claim for reimbursement of medical benefits and participate in medical dispute resolution in the same manner as an injured employee or health care provider. The commenter opines that the Division has failed to recognize the application of rules concerning health care insurers and MFDR. The commenter states health care insurers often do not have the documentation necessary for health insurance claims and that because of the limits on the documentation that health care insurers have, the Legislature set out requirements for health care insurers in Labor Code §409.0091(f). Commenter asserts that the Division exceeds this authority by asking for more than the statute. The commenter states that under 28 TAC §140.8 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 explanation of benefits (EOB) relevant to the fee dispute received from the workers' compensation insurance carrier, and sufficient information to substantiate the claim. The commenter states that the requirement of the proposed rule extend beyond those of §140.8 and contradict that section.

Agency Response: The Division agrees that this rule needs to be clarified with regard to the information a subclaimant must submit in a request for MFDR so that it is consistent with existing Division rules in 28 TAC Chapter 140. Therefore, the Division has adopted §133.307(c)(3) which specifically applies to subclaimant dispute requests. Under this adopted rule, subclaimants described by Labor Code §409.009 shall provide the required information that is consistent with 28 TAC §140.6 and subclaimants described by Labor Code §409.0091 shall provide the required information that is consistent with 28 TAC §140.8.

§133.307(c)(1): The commenter supports proposed §133.307(c)(1).

Agency Response: The Division appreciates the supportive comment.

§133.307(c): A commenter states that it assumes that a request for MFDR would be imaged by the Division and therefore one copy of the request would suffice. Alternatively, the commenter questions whether accepting an electronic filing would also suffice and if so, would not a form be a better vehicle for such a filing.

Agency Response: The Division disagrees with the requestor because there are technological barriers that prevent the Division from safely accepting and distributing the information in the suggested electronic methods. Therefore, the Division must receive two legible paper copies of the request so that the Division will have a copy to forward to the respondent. The Division will continue to explore ways to allow parties to electronically transmit information for medical fee disputes to the Division; however, the Division does not currently have the means to securely accept and transmit these requests.

§133.307(c)(2)(J) and (K); and (c)(3): A commenter states that permitting parties to provide "documentation that contains all the same information found in the paper equivalent" instead of providing either an electronic form or promulgated electronic format that is capable of being printed on paper where such form or format was originally used could lead to unnecessary confusion and prolong the time needed for review of the submitted documents to find the necessary information. The commenter states that if there is an electronic form or promulgated electronic format that is capable of being printed on paper, that electronic document should be printed and submitted in place of having to cull through documentation that contains all the same information. A commenter also recommends replacing the word

"facsimile" in this rule with "electronic transmission" in order to make this provision consistent with other filing provisions in Division rules.

Agency Response: The Division disagrees with allowing the submission of the information required by this rule in the suggested electronic formats. Currently, there are technological barriers that prevent the Division from safely accepting and distributing the information in the suggested electronic methods. The Division is working on addressing these issues so that the Division may consider accepting these transmissions in the future. The Division notes that under this adopted rule any paper format would suffice as long as the submission contains all of the information contained on the medical bill and explanation of benefits.

§133.307(c)(2)(C) and (3)(A): A commenter states that the proposed rules require form and manner prescription but deletes references to the DWC-60. The commenter states that the DWC-60 is a better alternative than submitting the same information in various documents accompanying a MFDR request as the DWC-60 provides check boxes and fields that seek to elicit or reference the MFDR-required information for determination of filing requirement compliance, and provides expedited recognition through standardized presentation of organized information. The commenter inquires whether the Division proposes to discontinue the DWC-60 and/or accept MFDR requests that are not on a promulgated alternative form.

Agency Response: The Division clarifies that the DWC Form-60 is still required to be used and has been amended to conform to changes in these adopted rules. Adopted §133.307(c) requires the request to be submitted "in the form and manner prescribed by the division." The "form and manner" continues to be the DWC Form-60.

§133.307(c)(2)(M), (d)(2)(B) and (C): A commenter states that expanding the scope to require all relevant documents related to the date of service in dispute, as opposed to only requiring specific documents, is unnecessary, creates unnecessary expenses, vague, overbroad and overly burdensome. The commenter states that documents should be limited to those that are specific yet relevant to the contested issues and not those that are simply relevant to the date of service. A commenter also states that requiring an insurance carrier to provide a paper copy of all EOBs and medical bills (if different from that originally submitted to the insurance carrier for reimbursement) related to the dispute is unnecessarily burdensome, particularly as it is incumbent upon the provider to construct and support their own case in chief for additional reimbursement and provide adequate evidence to legally justify any order doing so. The commenter recommends narrowing the scope from "related to" to "relevant to the issue(s) in dispute."

Agency Response: The Division disagrees and declines to make the recommended change. The Division's use of the word "related" is clearly not intended to include non-relevant documents.

§133.307(c)(2)(P): A commenter asks the Division to clarify in the preamble that pharmacy processing agents may not seek reimbursement greater than that their assignor pharmacies would be entitled to receive had the pharmacy billed the carrier directly without the use of a processing agent.

Agency Response: This comment addresses pharmaceutical reimbursement which was discussed more fully in the adoption of §134.503 and is outside the scope of these rules.

§133.307(d)(2): A commenter inquires what if the request is missing required information, and will incomplete requests be handled or rejected by the division? It is commenter's opinion that requests that are missing required information should be rejected by the Division until they are complete. Another commenter opines that rules which require a carrier "provide any missing information not provided by the requestor and known to the respondent" threatens to improperly shift the burden to a respondent if there is no prima facie dispute.

Agency Response: The Division disagrees that all incomplete requests for medical fee dispute resolution should be dismissed at the outset. There may be cases where the requestor for medical fee dispute resolution does not have access to required information. Additionally, the Division disagrees that requiring the respondent to provide any missing information not provided by the requestor and known to the respondent improperly shifts the burden of proof upon the respondent. This provision is similar to a discovery process and allows for the Division to obtain all the information it needs to adjudicate the fee dispute given the relevant statutory provisions and relevant rules.

§133.307(d)(2)(E)(v): A commenter requests that the Division clarify what the term "reimbursement rate" refers to in the context of fair and reasonable reimbursement and suggests the following language: "documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable reimbursement in accordance with Labor Code §413.011 and §134.1 or §134.503 of this title if the dispute involves health care for which the division has not established a MAR or pharmaceutical reimbursement rate, as applicable."

Agency Response: The Division disagrees that clarification is necessary because the adopted amendments are sufficiently clear when read together with §134.503. The Division

notes that these adopted amendments reflect recent adopted amendments to the Division's pharmacy fee guideline in 28 TAC §134.503 which included the removal of MAR terminology from that rule and provided for "reimbursement rates that are fair and reasonable" in certain specified instances.

§133.307(e): A commenter supports permitting a requestor to withdraw its request for medical fee dispute resolution (MFDR) by notifying the Division but suggests it may be beneficial to have a form the requestor may use to notify all parties of its withdrawal. Another commenter recommends the following language be added at the end of proposed §133.307(e): "If all parties to a dispute agree to withdraw the requestor's request, any party may withdraw the request for MFDR by notifying the division in writing of dispute resolution with sufficient documentation in support of resolution agreement."

Agency Response: The Division disagrees with prescribing a specific form because the Division's MFDR Section's internal process is to notify the respondent via the carrier representative boxes of the requestor's withdrawal from medical fee dispute resolution. The Division also disagrees with the recommended language that would allow any party to notify the Division of the withdrawal of a request for MFDR and declines to add the suggested language. Allowing the respondent to withdraw the dispute may lead to disagreements as to whether the requestor truly intended to withdraw a dispute. Requiring the requestor to communicate the withdrawal to the Division will prevent such disputes from arising.

§133.307(f)(3): A commenter states that the Division should clarify that the applicable medical fee dispute resolution deadlines are not tolled by a filing that is dismissed. The

commenter suggests adding to this subsection "Deadlines. All filings must comply with the requirements of §133.307(c)(1) related to timeliness."

Agency Response: The Division disagrees and declines to add the suggested language because adopted §133.307(c)(1) already states that a requestor shall timely file the request with the Division's MFDR Section or waive the right to MFDR. The instances where a deadline is tolled are set forth in 28 TAC §133.307(c)(1)(B). Also, 28 TAC §140.8 provides that a subclaimant under that section is not subject to the one year filing deadline.

§133.307(f)(3)(B) and (D): A commenter believes the two subparagraphs should not be deleted from subsection (f)(3) as it is appropriate for the DWC to dismiss a request for medical fee dispute resolution when the requestor is not a proper party to the dispute or the fee disputes for the date(s) health care in question have been previously adjudicated by the DWC.

Agency Response: The Division disagrees and believes they should not be grounds for dismissal. Adopted §133.307(f)(3) clarifies that the dismissal of a request for MFDR is not a final decision by the Division, and that a request for MFDR dismissed by the Division may be submitted for review as a new dispute, which will also be subject to the requirements of this section. These adopted amendments are intended to clarify that the appropriate procedure for a party that is requesting MFDR after a dismissal is not an appeal of the dismissal, but instead to correct and submit the corrected request as a new request. The deletion of these grounds for dismissal are not intended to allow an improper party into a medical fee dispute or allow for the re-adjudication of a dispute previously adjudicated. Rather, a Division determination that the requestor is not a proper party or the dispute was previously

adjudicated is a decision better characterized as a final decision that may be appealed but not resubmitted.

§133.307(f)(3)(D): A commenter suggests that this rule should require that all legal grounds for and facts supporting the good cause determination be explicitly set out in detail in the order of dismissal.

Agency Response: The Division disagrees that the requested provisions are necessary for this rule. The Division's practice when dismissing a request is to provide a written dismissal that includes the reasons for the dismissal.

§133.307(f)(4): The commenter suggests adding a timeframe for the Division to render a decision on medical fee disputes just as there is a deadline for medical necessity disputes as well as specific timeframes for all other parties in a medical fee dispute. The commenter opines that depending upon the amount ordered the lengthy delay in the Division's medical fee dispute process could result in a higher interest payment than the additional amount owed in the finding. The commenter states that it would be helpful to all parties of a medical fee dispute if the Division were held to a specific timeframe to render a decision.

Agency Response: The division disagrees with adding language regarding a timeframe within which the Division must render a decision on medical fee disputes. Medical fee disputes are adjudicated on a case-by-case basis. The Division's goal is to give each fee dispute its due diligence in order to ensure appropriateness and consistency. Factors such as new issues raised (not previously addressed by the Division), legal challenges impacting the dispute, and whether the Division requires additional information to adjudicate the dispute are all considered and may affect the Division's ability to process a fee dispute.

928

929 **§133.307(g):** Several commenters disagree with the proposed text because they say the text
930 may be construed to prohibit a party at a BRC or at SOAH from raising unresolved issues
931 regarding liability, extent of injury, compensability, or medical necessity. Commenters think
932 that this draft proposal is inconsistent with proposed §133.307(f)(3) because that subsection
933 allows the Division to dismiss a request for medical fee dispute resolution if there are
934 unresolved issues of medical necessity, compensability, extent of injury, or liability. The
935 commenters are concerned that if there is an award while a dispute involving compensability,
936 extent of injury, liability, or medical necessity is outstanding, a party may be forced to pay a
937 medical fee for a claim later determined to be non-compensable or a medical service later
938 determined to be unrelated to the compensable injury. The commenters state the rule should
939 be clarified to state, "Should a party raise unresolved issues regarding liability, extent of
940 injury, compensability, or medical necessity at a benefit review conference or contested case
941 hearing at the State Office of Administrative Hearings for a medical fee dispute then the
942 proceeding shall be abated until the issues relevant to the medical fee dispute are resolved.
943 Another commenter states that the proposed rule should be clarified that while one may not
944 raise the issue at the hearing, one can use such evidence.
945 **Agency Response:** The Division agrees that clarification of the proposed language is
946 necessary to prevent parties from misconstruing the language of the proposed rule to create
947 a process that prohibits abatement. Although the Division does not adopt the text suggested
948 by the commenters, the Division has adopted similar text stating that if a party provides the
949 benefit review officer or administrative law judge with documentation listed in
950 §133.307(d)(2)(H) or (I) that shows unresolved issues regarding compensability, extent of
951 injury, liability, or medical necessity for the same service subject to the fee dispute, then the

benefit review officer or administrative law judge shall abate the proceedings until those issues have been resolved. This adopted rule is necessary to prevent the injured employee who may not be a party to the fee dispute from being bound by the ruling. Furthermore, it prevents a carrier from being ordered to pay for a bill in which it has no underlying legal obligation. Finally, it prevents conflicting or duplicative decisions. The requirement to present evidence is so the benefit review officer or administrative law judge can verify the existence of a dispute before abating the proceedings.

§133.307(g)(1): A commenter suggests that the rule provide for parties to appear telephonically for medical fee dispute benefit review conferences. The commenter states that the Division has allowed telephonic appearances for parties in the past at medical fee dispute prehearings, and formal language in the rule would secure this courtesy. The commenter suggests adding the language "A party may appear at a benefit review conference via telephone" to this rule.

Agency Response: The division agrees. Adopted §133.307(g)(1) establishes the BRC be conducted in the manner required by Labor Code Chapter 410, Subchapter B and 28 TAC Chapter 141. Nothing in Labor Code Chapter 410, Subchapter B or 28 TAC Chapter 141 prohibits a party from appearing at a BRC for a medical fee dispute telephonically. Therefore, for clarity, the Division has added the text recommended by the commenter to subsection (g)(1).

§133.307(g)(1)(B): A commenter does not support this section of the proposed rule. Commenter questions the reason for this addition and does not understand why if the parties agree to a different amount it would not be allowed. There has already been additional costs

incurred by all parties to go through the administrative process and negotiation of amounts at this level can be effective for both parties to resolve the matter.

Agency Response: The Division disagrees. The Division clarifies that the reason parties may not resolve the dispute by negotiating fees that are inconsistent with any applicable fee guidelines adopted by the Commissioner at a BRC is because this provision is required by statute. Specifically, Labor Code §413.0312(c) provides that "at a benefit review conference conducted under this section, the parties to the dispute may not resolve the dispute by negotiating fees that are inconsistent with any applicable fee guidelines adopted by the commissioner." Additionally, this adopted rule is consistent with longstanding principles in workers' compensation law that disallow settlements outside of the statutes and Commissioner rules. The Division also notes that Labor Code §413.031(c) states that in resolving disputes over the amount of payment due for services determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment given the relevant statutory provisions and commissioner rules.

§133.307(h): A commenter states that it is aware that this provision providing for the billing of the non-prevailing party is necessary because it is required by HB 2605. The commenter provides various reasons why it disagrees with this law.

Agency Response: The Division agrees that HB 2605 requires a non-prevailing party in a medical fee dispute to pay the SOAH costs and these adopted rules are adopted in accordance with the requirements of HB 2605.

§133.308(c): A commenter states that this section makes references to the licensing qualifications of the individuals who may perform certain reviews under the aegis of an

Independent Review Organization. Commenter suggests that the language in subsection (d) of this rule not be struck and remain in whole or in part so that it is clear, without having to seek out the other references, which licensed health care professional may perform a review on another similarly licensed health care professional. Commenter further opines that, in particular, the rule should clearly state that a reviewer for an IRO should be in the same or similar specialty and, if a surgical intervention is the subject of a review, a surgeon of the same or similar specialty should be the licensed health care professional performing the review.

Agency Response: The Division disagrees because adopted subsection (c) of this section merely repeats existing specialty requirements in 28 TAC §12.202(f). 28 TAC §12.202(f) states that "an [IRO] that performs independent review of a health care service provided under the Labor Code Title 5 or the Insurance Code Chapter 1305 shall comply with the licensing and professional specialty requirements for personnel performing independent review as provided by the Labor Code §§408.0043 - 408.0045 and 413.031; the Insurance Code §1305.355; and Chapters 133 and 180 of this title (relating to General Medical Provisions and Monitoring and Enforcement)."

§133.308(f): A commenter opposes these amendments because it requires a health care insurer subclaimant to engage in medical necessity disputes. The commenter further argues that all medical necessity disputes will be resolved prior to the subclaimant obtaining the claim since the health care insurer has already made a determination of whether the health care that is the subject of the subclaim is medically necessary.

Agency Response: The Division disagrees. These rules do not require a health care insurer to pursue a medical necessity denial in every case but allow them to engage in

dispute resolution when appropriate. If the denial is based on medical necessity, 28 TAC §133.308 provides the process to resolve the dispute. The Division notes that Labor Code §409.0091(l) provides that "any dispute that arises from a failure to respond to or a reduction or denial of a request for reimbursement of services that form the basis of the subclaim must go through the appropriate dispute resolution process under the Act and Division rules."

§133.308(f)(1)(C) and (2)(C): A commenter states that granting requestor status to subclaimants for dispute resolution under Chapter 133 of this title appears to be inappropriate. The commenter states that "rule 140.6(d) requires carriers to process reimbursement requests under Chapters 133 and 134 but requires dispute resolution to be processed under Chapters 140 – 143." The commenter further states "similarly, rule 140.8(h)(1)(C) requires that 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." The commenter recommends the following clarifying language be included in this rule: "However, disputes regarding liability, extent of injury, or medical necessity must be resolved prior to pursuing a medical fee dispute."

Agency Response: The Division disagrees that it is inappropriate to grant requestor status to subclaimants in appeals of medical necessity disputes. Subclaimants are already permitted to be requestors pursuant to statute and other division rules. These adopted amendments merely conform §133.308 with Labor Code §409.009 and §409.0091 and Division rules in Chapter 140. The Division also disagrees with adopting commenter's recommended rule language. This rule governs appeals of an IRO decision. The commenters recommended text pertains to medical fee disputes.

§133.308(f)(2)(B): A commenter suggests that this section be revised to read "injured employees or a person acting on behalf of an injured employee" rather than "injured employees or injured employee's representative." Commenter states that this language is included in proposed §133.308(f)(1)(B) which deals with who may be a requestor in network medical necessity disputes and commenter does not believe that a difference in the definition of requestor is required or warranted for non-network medical disputes.

Agency Response: The Division disagrees with adding the commenter's suggested language to adopted subsection (f)(2)(B) because that subsection applies in non-network disputes and the adopted terminology in the rule regarding representatives is consistent with existing Division rules in Chapter 150 which govern representation of parties before the agency and qualifications of the representatives. Additionally, the Division has also adopted this representative terminology in subsection (f)(2)(B) in order to distinguish that provision from the adopted provisions regarding "a person acting on behalf" in subsection (f)(1)(B) which apply to network dispute and is modeled after statutory language in Insurance Code §1305.355(a).

§133.308(h): Several commenters state that the provision in this rule that provides for immediate review by an IRO in cases involving an injured employee with a "life-threatening condition" is inappropriate for the workers' compensation rules. The commenters states that "Labor Code §413.014 and Insurance Code §1305.351 expressly exempt emergency treatment and services from preauthorization" and "DWC Rule §134.600 exempts emergency medical treatment and services from prospective and concurrent utilization review requirements." Commenter states that interjecting that term into the workers compensation rules could mislead stakeholders into believing that the expedited utilization review and

appeal provisions for life-threatening conditions covered by health insurance and health benefit plans also applies to workers compensation.

Agency Response: The Division disagrees that the terms as used in this rule are inappropriate. The terms "life threatening condition" and "emergency treatment" are not the same. "Life threatening" is an existing term that is defined in Insurance Code §4201.002 and 28 TAC §12.5 and §133.305. "Emergency care" and "emergency" are defined in Insurance Code §4201.002 and 28 TAC §133.2, respectively. These terms have been used without any noted disruption or confusion reported to the Division by system participants.

§133.308(k)(6): Several commenters state that the proposed requirement in this subsection that a list of the health care providers known by the insurance carrier to have provided care to the injured employee who have medical records relevant to the review be submitted to the IRO by the insurance carrier or insurance carrier's URA is unreasonably burdensome and should be deleted. The commenters give the example of legacy workers' compensation claims involving whether or not opiate narcotic medication should be continued five years after the date of injury. The commenters state it is absurd to require the insurance carrier to identify all the health care providers who performed services in the emergency room on the date of the accident and all physical therapists who rendered medical care five years prior to the date that the prescription for narcotics was issued. Further, some commenters state that under subsection (k)(2) the insurance carrier is already required to submit all medical records in the possession of the insurance carrier or utilization review agent (URA) that are relevant to the review. Consequently, the list is not needed to identify health care providers who provided relevant care since that information is readily available to the independent review

organization (IRO) by reviewing the submitted records and the proposed list serves no legitimate purpose.

Agency Response: The Division agrees that the list is not necessary at this time and has made the suggested change.

§133.308(n)(1): A commenter states it understands that an IRO cannot make an immediate determination in a case involving a life-threatening condition; however, it would seem that when a life-threatening condition is involved, the IRO should be able to make a determination in no more than three days after receipt of the dispute as opposed to the eight days permitted by the current rule.

Agency Response: The Division disagrees because Insurance Code §4202.003(1)(B) provides that "the eighth day after the date the organization receives the request that the determination be made" is appropriate for a life-threatening condition as defined by Insurance Code §4201.002.

§133.308(o): Several commenters believe that the proposed deletion of subsection (o)(1)(G)(ii) is improper. Commenters make several statutory construction, policy, and general rulemaking authority arguments in support of retaining this provision.

Agency Response: The Division disagrees that the proposed deletion of subsection (o)(1)(G)(ii) is improper. For non-network cases, Labor Code §413.031(e-1) states that in performing a review of medical necessity under Labor Code §413.031(d) or (e), the IRO shall consider the Division's healthcare reimbursement policies and guidelines adopted under Labor Code §413.011. Further, if the IRO's decision is contrary to the Division's policies or guidelines adopted under Labor Code §413.011, the IRO must indicate in the decision the

specific basis for its divergence in the review of medical necessity. However, there is no comparable statute that requires an IRO in a certified network case whose decision is contrary to the network's adopted guidelines to indicate in the decision the specific basis for its divergence from the network's guidelines. Since non-network treatment guidelines have a presumption of reasonableness under Labor Code §413.017, it is important that the reason for any divergence by an IRO is explained in the IRO decision. There is no such statutory presumption for treatment guidelines adopted by a certified network, therefore it is less important for an IRO to explain a divergence from a network's treatment guidelines. However, it should be noted that IROs are still required to describe the source of the screening criteria or clinical basis used in making their decisions as well as provide an analysis and explanation for their decisions, including findings and conclusions used to support the decision. Thus, in light of the statutory requirement on IROs in non-network cases and the lack of such statutory requirement for network cases, it is appropriate to delete this requirement from the rule. Additionally, it is not the intent of the Division in deleting this requirement from the rule to allow an IRO to ignore a certified network's treatment guidelines, nor will the deletion prevent the Division from adequately monitoring decisions issued by IROs.

§133.308(r): A commenter seeks clarification of what is meant by "An insurance carrier may claim a defense to a medical necessity dispute if the insurance carrier timely complies with the IRO decision with respect to the medical necessity or appropriateness of health care for an injured employee." The commenter states that if the purpose of the provision is to say that the carrier should comply with the IRO decision and provide care to the injured employee consistent with that decision, the rule should state that purpose explicitly.

Agency Response: The Division clarifies that this provision provides that an insurance carrier does not waive a medical necessity defense during an appeal of an IRO decision because the carrier timely complied with the IRO decision.

§133.308(r): A commenter requests clarification on the rule that provides "the decision of an IRO under Labor Code §413.031(m) is binding during the pendency of a dispute." The commenter seeks clarification as to whether during the time a carrier appeals the IRO decision to a CCH and the IRO decision is reversed, can the carrier go to the subsequent injury fund (SIF) for reimbursement of the money that has been paid to the health care provider?

Agency Response: The Division disagrees that clarification in this rule is necessary. As stated in the adoption of amendments to §116.11 of this title (relating to Request for Reimbursement from the Subsequent Injury Fund) in 2009, an IRO decision is not an order or decision of the Commissioner. Thus, an insurance carrier would not qualify for SIF reimbursement in cases where an IRO decision is overturned.

§133.308(s): A commenter supports the addition of the added language, "A party to a medical dispute that remains unresolved after review under Labor Code §504.053(d)(3) or Insurance Code §1305.355 is entitled to a contested care hearing in the same manner as a hearing conducted under Labor Code §413.0311."

Agency Response: The Division appreciates the supportive comment.

§133.308(s): A commenter recommends revising proposed amendments to §133.308(s) to address prehearing procedures regarding the exchange of documents. The commenter recommends that the rule address procedures at the prehearings that have been conducted

at the field offices on medical necessity disputes. The commenter states that the Division sends out prehearing orders for medical necessity disputes many of which in accordance with 28 TAC §142.13(g) require all documentary evidence not previously exchanged to be exchanged not later than 3 days prior to the date of the scheduled prehearing. The commenter states that 28 TAC §142.13(g) allows the Division to include time limits for discovery in a notice setting an expedited hearing or a hearing held without a prior BRC. The commenter states that strictly speaking a prehearing order is not a notice of hearing. The commenter recommends revising this rule to include the following language: "Before the division CCH, the division will convene a telephonic prehearing. Parties may exchange pertinent information at any time before the telephonic prehearing."

Agency Response: The Division disagrees with the suggested language and declines to make the change at this time because the comment is outside the scope of these rules and pertain to rule in 28 TAC Chapter 142.

§133.308(s): A commenter states that the standards for the CCH decision should be similar to the standards for IRO decisions found in draft §133.308(o) and recommends the following language: "CCH Decision. The division CCH decision must include: (A) a list of all medical records and other documents reviewed by the hearing officer including the dates of those documents; (B) an analysis of, and explanation for, the decision including the findings of fact and conclusions of law used to support the decision; (C) a statement that clearly states whether or not medical necessity exists for each of the health care services in dispute; (D) if the hearing officer's decision is contrary to the IRO decision then the decision must specify the basis for not following the IRO decision; (E) if the hearing officer's decision is contrary to

the applicable treatment guideline identified in this section then the decision must specify the basis for the divergence from the treatment guideline."

Agency Response: The Division declines to add the commenter's language because these provisions are not necessary since the contents of a hearing officer's decision is governed by the applicable provisions of 28 TAC Chapter 142. Those rules already provide that decisions will be in writing, include findings of fact and conclusions of law, and be signed by the hearing officer.

§133.308(s)(1)(D): A commenter seeks clarification and asks what happens if the treatment guidelines adopted by the political subdivision or pool do not meet the standards provided by Labor Code §413.011(e)? The commenter asks if this section means that when the guidelines do not meet those standards the hearing officer should proceed as if the guidelines do not exist, then this section should state that explicitly.

Agency Response: The Division disagrees that any clarification to this rule is necessary. This adopted rule mirrors statutory language in Labor Code §504.054(b) and already clearly provides that the hearing officer shall consider any treatment guidelines adopted by the political subdivision or pool that provides medical benefits under §504.053(b)(2) if those guidelines meet the standards provided by §413.011(e).

§133.308(s)(1)(E)(ii): A commenter disagrees with including language that a letter of clarification cannot "ask the IRO to reconsider its decision or to issue a new decision." The commenter states that in those instances where the clarification calls into question the accuracy of the IRO decision, it seems of little value to preclude the IRO from having the opportunity to make necessary corrections.

Agency Response: Adopted §133.308(s)(1)(E)(ii) states that the Department may at its discretion forward the party's request for a letter of clarification to the IRO that conducted the independent review and that the Department will not forward to the IRO a request for a letter of clarification that asks the IRO to reconsider its decision or issue a new decision. The purpose of this adopted amendment is to prevent unnecessary referrals of a request for a letter of clarification to the IRO. The Division clarifies that the purpose of a letter of clarification in this instance is for the requestor to be able to ask the IRO to clarify or explain its decision. The purpose is not for the requestor to have an opportunity to ask the IRO to reconsider its decision or to issue a new decision.

§133.308(s)(1)(D): A Commenter urges the Division to place language requiring the hearing officer to consider "evidence based" treatment guidelines in these rules. The commenter opines that when treatment guidelines are used, they should always be based on evidence derived from sound scientific methods. Such evidence should demonstrate which treatment guidelines are appropriate and beneficial, with the benefits outweighing the side effects or risks of that treatment.

Agency Response: The Division declines to add the words "evidence-based" because the statutes cited within this adopted rule already require treatment guidelines to be evidence-based.

§133.308(u): The commenters recommend that the rules be clarified to allow the "requestor" to provide notice that the dispute involves a first responder. One commenter suggests the following language "first responder or a person acting on behalf of the first responder" and states that the purpose of the legislation seems better served by letting more than just the

first responder make the request to expedite. Several commenters are concerned that the proposed language will limit or exclude who may make a request under this section in respect to "first responders" and ask that the language be changed to ensure that there are no limitations on who may make a request on behalf of or assist a "first responder." Another commenter disagrees with any text that would allow a health care provider to request dispute resolution on behalf of an injured employee under Labor Code §504.055.

Agency Response: The Division agrees with the commenters that request clarification and has changed the rule text to read: "In accordance with Labor Code §504.055(d), an appeal regarding the denial of a claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury involving a first responder will be accelerated by the division and given priority. The party seeking to expedite the contested case hearing or appeal shall provide notice to the division and independent review organization that the contested case hearing or appeal involves a first responder." The Division declines to include the text "first responder or a person acting on behalf of the first responder", but has made changes because a request to expedite a medical necessity dispute proceeding may expedite medical benefits for the first responder pursuant to Labor Code §504.055. These changes clarify that a request for an expedited appeal regarding the denial of a claim for medical benefits, including all health care required curing or relieving the effects naturally resulting from a compensable injury involving a first responder will be accelerated by the division and given priority. The changes also state that the party seeking to expedite the contested case hearing or appeal shall provide notice to the division and independent review organization that the contested case hearing or appeal involves a first responder.

§133.308(u): A commenter supports the removal of the separate appeal requirements regarding spinal surgeries. The commenter believes all medical necessity disputes should be treated the same and appreciates the division's changes regarding this matter.

Agency Response: The Division appreciates the supportive comment.

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

For, with changes: Property Casualty Insurers Association of America; State Office of Risk Management; Burck, Lapidus, Jackson & Chase, P.C.; Texas Medical Association; Insurance Council of Texas; The Law Office of Pamela R. Beachley; Texas Association of School Boards Risk Management Fund; Office of Injured Employee Counsel; Texas Mutual Insurance Company; and the Combined Law Enforcement Association of Texas

Against: None

6. STATUTORY AUTHORITY.

SUBCHAPTER D. DISPUTE OF MEDICAL BILLS

The amendments are adopted under Labor Code §§401.011(31); 402.00111; 402.00116(a) and (b); 402.061; 413.031(e-1), (k), (k-1), and (m); 413.0311(a); 413.0312; 413.032(b); 504.054; 504.055; Insurance Code §§1305.355, 1305.356, 4201.002(7), and 4202.003(1)(A) and (B); and Government Code §2001.176(b).

Labor Code §401.011(31) defines "medical benefit" as payment for health care reasonably required by the nature of a compensable injury and intended to cure or relieve the effects naturally resulting from the compensable injury, including reasonable expenses incurred by the employee for necessary treatment to cure and relieve the employee from the effects of an occupational disease before and after the employee knew or should have known the nature of the disability and its relationship to the employment; promote recovery; or enhance the ability of the employee to return to or retain employment.

Labor Code §402.00111 provides that except as otherwise provided by Labor Code, Title 5, the Commissioner of Workers' Compensation (Commissioner) shall exercise all executive authority, including rulemaking authority, under Labor Code, Title 5.

Labor Code §402.00116(a) provides that the Commissioner is the Division's chief executive and administrative officer and shall administer and enforce Labor Code, Title 5, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to the Division or the Commissioner.

Labor Code §402.00116(b) provides that the Commissioner has the powers and duties vested in the Division by Labor Code, Title 5 and other workers' compensation laws of this state.

Labor Code §402.061 provides that the Commissioner shall adopt rules as necessary for the implementation and enforcement of the Act.

Labor Code §413.031(e-1) states that in performing a review of medical necessity under Labor Code §413.031(d) or (e), the IRO shall consider the Division's healthcare reimbursement policies and guidelines adopted under Labor Code §413.011. Further, if the IRO's decision is contrary to the Division's policies or guidelines adopted under Labor Code §413.011, the IRO must indicate in the decision the specific basis for its divergence in the review of medical necessity.

Labor Code §413.031(k) and (k-1) provide that a party to a medical dispute that remains unresolved after a review of the medical service under this statute is entitled to a hearing under Labor Code §413.0311 or §413.0312, as applicable. Further, Labor Code §413.031(k-1) provides that a party who has exhausted all administrative remedies described by subsection (k) of this statute and who is aggrieved by a final decision of the division or the State Office of Administrative Hearings may seek judicial review of the decision. Judicial

review under subsection (k-1) of this statute shall be conducted in the manner provided for judicial review of a contested case under Chapter 2001, Subchapter G Government Code, except that in the case of a medical fee dispute the party seeking judicial review under this statute must file suit not later than the 45th day after the date on which the State Office of Administrative Hearings mailed the party the notification of the decision. Further, subsection (k-1) of this statute, the mailing date is considered to be the fifth day after the date the decision was issued by the State Office of Administrative Hearings.

Labor Code §413.031(m) provides that the decision of an independent review organization under Labor Code §413.031(d) is binding during the pendency of a dispute.

Labor Code §413.0311(a) applies to the appeal of an independent review organization decision regarding determination of the medical necessity for a health care service.

Labor Code §413.0312 applies to medical fee disputes that remain unresolved after any applicable review under Labor Code §413.031(b) - (i). This statute requires that, at a benefit review conference conducted under this section, the parties to the dispute may not resolve the dispute by negotiating fees that are inconsistent with any applicable fee guidelines adopted by the Commissioner. This statute provides that parties may elect arbitration as provided in Labor Code §410.104 after the benefit review conference. If arbitration is not elected as described by subsection (d) of this statute, a party to a medical fee dispute described by subsection (a) of this statute is entitled to a contested case hearing at the State Office of Administrative Hearings. This statute requires that all medical fee dispute cases go to a contested case hearing at the State Office of Administrative Hearings on appeal from the benefit review conference if arbitration is not elected and those hearings shall be conducted in the manner provided for a contested case hearing under Chapter 2001, Government Code. This statute also specifies that the Commissioner or the Division may

participate in a contested case hearing at the State Office of Administrative Hearings under subsection (e) of this statute if the hearing involves the interpretation of fee guidelines adopted by the Commissioner. The Division and the Department are not considered to be parties to the medical fee dispute for purposes of this statute. Further, under this statute, the cost of the contested case hearing shall be paid by the non-prevailing party. This statute additionally provides that on appeal, judicial review follows the contested case hearing held at the State Office of Administrative for the medical fee dispute and the suit must be filed within 45 days of the date that the State Office of Administrative Hearings mailed the party the decision (and the mailing date is the 5th day after the date the decision was filed with the Division).

Labor Code §413.032(b) provides that the IRO shall certify that each physician or other health care provider who reviews the decision certifies that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the IRO.

Labor Code §504.054 provides that a party to a medical dispute that remains unresolved after the review described by Labor Code §504.053(d)(3) is entitled to a contested case hearing which is to be conducted by the Division in the same manner as a hearing conducted under Labor Code §413.0311. This statute further provides that the hearing officer shall consider any treatment guidelines adopted by the political subdivision or pool that provides medical benefits under Labor Code §504.053(b)(2) if those guidelines meet the standards provided by Labor Code §413.011(e); furthermore, a party that has exhausted all administrative remedies and is aggrieved by a final decision of the Division may

seek judicial review in the manner provided for a contested case under Chapter 2001, Subchapter G Government Code and the review is governed by the substantial evidence rule.

Labor Code §504.055 provides for the expedited provision of medical benefits for certain injuries sustained by first responders in the course and scope of employment. This statute defines "first responder" and in Labor Code §504.055(b) specifies that this statute applies only to a first responder who sustains a serious bodily injury, as defined by Penal Code §1.07, in the course and scope of employment and includes a first responder providing services on a volunteer basis. Labor Code §504.055(c) provides that the political subdivision, Division, and insurance carrier shall accelerate and give priority to an injured first responder's claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury described by Labor Code §504.055(b). Labor Code §504.055(d) requires the Division to accelerate a contested case hearing requested by or an appeal submitted by a first responder regarding the denial of a claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury described by Labor Code §504.055(b). This statute further requires first responders to provide notice to the Division and independent review organization that the contested case or appeal involves a first responder.

Insurance Code §1305.355 pertains to the independent review of adverse determinations and contains numerous provisions, including that a party to a medical dispute that remains unresolved after a review under that section is entitled to a hearing and judicial review of the decision in accordance with Insurance Code §1305.355; a determination of an independent review organization related to a request for preauthorization or concurrent review is binding during the pendency of a dispute and the insurance carrier and network

shall comply with the determination; and the utilization review agent shall provide to the IRO, not later than the third business day after the date the utilization review agent receives notification of the assignment of the request to an IRO a list of the providers who provided care to the employee and who may have medical records relevant to the review.

Insurance Code §1305.356 provides that a party to a medical dispute that remains unresolved after review under Insurance Code §1305.355 is entitled to a Division contested case hearing in the same manner as a hearing conducted under Labor Code §413.0311. Further, at a Division contested case hearing for the resolution of a medical dispute involving a network the hearing officer shall consider evidence based treatment guidelines adopted by the network under Insurance Code §1305.304. A party that has exhausted all administrative remedies under Insurance Code §1305.356(a) and is aggrieved by a final decision of the Division may seek judicial review of the decision and this review shall be conducted in the manner provided for judicial review of a contested case under Chapter 2001, Subchapter G Government Code, and is governed by the substantial evidence rule.

Insurance Code §4201.002(7) defines "life-threatening" to mean a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Insurance Code §4202.003(1)(A) and (B) provides that the standards adopted under Insurance Code §4202.002 must require each IRO to make the organization's determination for a life-threatening condition as defined by Insurance Code §4201.002, not later than the earlier of the fifth day after the date the organization receives the information necessary to make the determination; or the eighth day after the date the organization receives the request that the determination be made.

Government Code §2001.051 provides that in a contested case, each party is entitled to an opportunity for hearing after reasonable notice of not less than 10 days and to respond and to present evidence and argument on each issue involved in the case. Government Code §2001.176(b)(2) requires a person who initiates judicial review in a contested case to serve upon the state agency a copy of petition for judicial review.

7. TEXT.

§133.307. *MDR of Fee Disputes*.

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

(1) This section applies to a request to the division for medical fee dispute resolution (MFDR) as authorized by the Texas Workers' Compensation Act that is filed on or after June 1, 2012. Dispute resolution requests filed prior to June 1, 2012, shall be resolved in accordance with the statutes and rules in effect at the time the request was filed.

(2) In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

(3) In accordance with Labor Code §504.055 a request for medical fee dispute resolution that involves a first responder's request for reimbursement of medical expenses paid by the first responder will be accelerated by the division and given priority. The first responder shall provide notice to the division that the request involves a first responder.

(b) Requestors. The following parties may be requestors in medical fee disputes:

(1) the health care provider, or a qualified pharmacy processing agent, as described in Labor Code §413.0111, in a dispute over the reimbursement of a medical bill(s);

(2) the health care provider in a dispute about 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;

(3) the injured employee in a dispute involving an injured employee's request for reimbursement from the insurance carrier of medical expenses paid by the injured employee;

(4) the injured employee when requesting a refund of the amount the injured employee paid to the health care provider in excess of a division fee guideline; or

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

(c) Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division.

(1) Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

(A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

(B) A request may be filed later than one year after the date(s) of service if:

(i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;

(ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the insurance carrier previously denied payment based on medical necessity; or

(iii) the dispute relates to a refund notice issued pursuant to a division audit or review, the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice.

(2) Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include:

(A) the name, address, and contact information of the requestor;

(B) the name of the injured employee;

(C) the date of the injury;

(D) the date(s) of the service(s) in dispute;

(E) the place of service;

(F) the treatment or service code(s) in dispute;

(G) the amount billed by the health care provider for the treatment(s) or service(s) in dispute;

(H) the amount paid by the workers' compensation insurance carrier for the treatment(s) or service(s) in dispute;

(I) the disputed amount for each treatment or service in dispute;

(J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions);

(K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB;

(L) when applicable, a copy of the final decision regarding compensability, extent of injury, liability and/or medical necessity for the health care related to the dispute;

(M) a copy of all applicable medical records related to the dates of service in dispute;

(N) a position statement of the disputed issue(s) that shall include:

(i) the requestor's reasoning for why the disputed fees should be paid or refunded,

(ii) how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and

(iii) how the submitted documentation supports the requestor's position for each disputed fee issue;

(O) documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable;

(P) if the requestor is a pharmacy processing agent, a signed and dated copy of an agreement between the processing agent and the pharmacy clearly demonstrating the dates of service covered by the contract and a clear assignment of the pharmacy's right to participate in the MFDR process. The pharmacy processing agent may redact any proprietary information contained within the agreement; and

(Q) any other documentation that the requestor deems applicable to the medical fee dispute.

(3) Subclaimant Dispute Request. The requestor shall provide the appropriate information with the request that is consistent with the provisions of §140.6 or §140.8 of this title. A request made by a subclaimant under Labor Code §409.009 shall comply with §140.6 of this title and submit the documents to the Division required thereunder. A request made by a subclaimant under Labor Code §409.0091 shall comply with the document requirements of §140.8 of this title and submit the documents to the Division required thereunder.

(4) Injured Employee Dispute Request. An injured employee who has paid for health care may request MFDR of a refund or reimbursement request that has been denied. The injured employee's dispute request shall be sent to the MFDR Section in the form and manner prescribed by the division by mail service, personal delivery or facsimile and shall include:

(A) the name, address, and contact information of the injured employee;

(B) the date of the injury;

(C) the date(s) of the service(s) in dispute;

(D) a description of the services paid;

(E) the amount paid by the injured employee;

(F) the amount of the medical fee in dispute;

(G) an explanation of why the disputed amount should be refunded or reimbursed, and how the submitted documentation supports the explanation for each disputed amount;

(H) proof of employee payment (including copies of receipts, health care provider billing statements, or similar documents); and

(I) a copy of the insurance carrier's or health care provider's denial of reimbursement or refund relevant to the dispute, or, if no denial was received, convincing evidence of the injured employee's attempt to obtain reimbursement or refund from the insurance carrier or health care provider.

(5) Division Response to Request. The division will forward a copy of the request and the documentation submitted in accordance with paragraph (2), (3), or (4) of this subsection to the respondent. The respondent shall be deemed to have received the request on the acknowledgment date as defined in §102.5 of this title (relating to General Rules for Written Communications to and from the Commission).

(d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.

(1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the

respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

(2) Response. Upon receipt of the request, the respondent shall provide any missing information not provided by the requestor and known to the respondent. The respondent shall also provide the following information and records:

(A) the name, address, and contact information of the respondent;

(B) a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider in accordance with this chapter, related to the health care in dispute not submitted by the requestor or a statement certifying that the respondent did not receive the health care provider's disputed billing prior to the dispute request;

(C) a paper copy of all medical bill(s) related to the dispute, submitted in accordance with this chapter if different from that originally submitted to the insurance carrier for reimbursement;

(D) a copy of any pertinent medical records or other documents relevant to the fee dispute not already provided by the requestor;

(E) a statement of the disputed fee issue(s), which includes:

(i) a description of the health care in dispute;

(ii) a position statement of reasons why the disputed medical fees should not be paid;

(iii) a discussion of how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues;

(iv) a discussion regarding how the submitted documentation supports the respondent's position for each disputed fee issue; and

(v) documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable reimbursement in accordance with Labor Code §413.011 and §134.1 or §134.503 of this title if the dispute involves health care for which the division has not established a MAR or reimbursement rate, as applicable.

(F) The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section.

(G) If the respondent did not receive the health care provider's disputed billing or the employee's reimbursement request relevant to the dispute prior to the request, the respondent shall include that information in a written statement.

(H) If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier shall attach a copy of any related Plain Language Notice in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements).

(I) If the medical fee dispute involves medical necessity issues, the insurance carrier shall attach a copy of documentation that supports an adverse determination in accordance with §19.2005 of this title (relating to General Standards of Utilization Review).

(e) Withdrawal. The requestor may withdraw its request for MFDR by notifying the division prior to a decision.

(f) MFDR Action. The division will review the completed request and response to determine appropriate MFDR action.

(1) Request for Additional Information. The division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the division no later than 14 days after receipt of this request. If the division does not receive the requested additional information within 14 days after receipt of the request, then the division may base its decision on the information available. The party providing the additional information shall forward a copy of the additional information to all other parties at the time it is submitted to the division.

(2) Issues Raised by the Division. The division may raise issues in the MFDR process when it determines such an action to be appropriate to administer the dispute process consistent with the provisions of the Labor Code and division rules.

(3) Dismissal. A dismissal is not a final decision by the division. The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of this section. The division may dismiss a request for MFDR if:

(A) the division determines that the medical bills in the dispute have not been submitted to the insurance carrier for an appeal, when required;

(B) the request contains an unresolved adverse determination of medical necessity;

(C) the request contains an unresolved compensability, extent of injury, or liability dispute for the claim; or

(D) the division determines that good cause exists to dismiss the request, including a party's failure to comply with the provisions of this section.

(4) Decision. The division shall send a decision to the disputing parties or to representatives of record for the parties, if any, and post the decision on the department's website.

(5) Division Fee. The division may assess a fee in accordance with §133.305 of this subchapter (relating to MDR--General).

(g) Appeal of MFDR Decision. A party to a medical fee dispute may seek review of the decision. Parties are deemed to have received the MFDR decision as provided in §102.5 of this title. The MFDR decision is final if the request for the benefit review conference is not timely made. If a party provides the benefit review officer or administrative law judge with documentation listed in subsection (d)(2)(H) or (I) of this section that shows unresolved issues regarding compensability, extent of injury, liability, or medical necessity for the same service subject to the fee dispute, then the benefit review officer or administrative law judge shall abate the proceedings until those issues have been resolved.

(1) A party seeking review of an MFDR decision must request a benefit review conference no later than 20 days from the date the MFDR decision is received by the party. The party that requests a review of the MFDR decision must mediate the dispute in the manner required by Labor Code, Chapter 410, Subchapter B and request a benefit review conference under Chapter 141 of this title (relating to Dispute Resolution--Benefit Review Conference). A party may appear at a benefit review conference via telephone. The benefit review conference will be conducted in accordance with Chapter 141 of this title.

(A) Notwithstanding §141.1(b) of this title (relating to Requesting and Setting a Benefit Review Conference), a seeking review of an MFDR decision may request a benefit review conference.

(B) At a benefit review conference, the parties to the dispute may not resolve the dispute by negotiating fees that are inconsistent with any applicable fee guidelines adopted by the commissioner.

(C) A party must file the request for a benefit review conference in accordance with Chapter 141 of this title and must include in the request a copy of the MFDR decision. Providing a copy of the MFDR decision satisfies the documentation requirements in §141.1(d) of this title. A first responder's request for a benefit review conference must be accelerated by the division and given priority in accordance with Labor Code §504.055. The first responder must provide notice to the division that the contested case involves a first responder.

(2) If the medical fee dispute remains unresolved after a benefit review conference, the parties may request arbitration as provided in Labor Code, Chapter 410, Subchapter C and Chapter 144 of this title (relating to Dispute Resolution). If arbitration is not elected, the party may appeal the MFDR decision by requesting a contested case hearing before the State Office of Administrative Hearings. A first responder's request for arbitration by the division or a contested case hearing before the State Office of Administrative Hearings must be accelerated by the division and given priority in accordance with Labor Code §504.055. The first responder must provide notice to the division that the contested case involves a first responder.

(A) To request a contested case hearing before State Office of Administrative Hearings, a party shall file a written request for a State Office of Administrative

Hearings hearing with the Division's Chief Clerk of Proceedings not later than 20 days after conclusion of the benefit review conference in accordance with §148.3 of this title (relating to Requesting a Hearing).

(B) The party seeking review of the MFDR decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute at the same time the request for hearing is filed with the division.

(3) A party to a medical fee dispute who has exhausted all administrative remedies may seek judicial review of the decision of the Administrative Law Judge at the State Office of Administrative Hearings. The division and the department are not considered to be parties to the medical dispute pursuant to Labor Code §413.031(k-2) and §413.0312(f). Judicial review under this paragraph shall be conducted in the manner provided for judicial review of contested cases under Chapter 2001, Subchapter G Government Code, except that in the case of a medical fee dispute the party seeking judicial review must file suit not later than the 45th day after the date on which the State Office of Administrative Hearings mailed the party the notification of the decision. The mailing date is considered to be the fifth day after the date the decision was issued by the State Office of Administrative Hearings. A party seeking judicial review of the decision of the administrative law judge shall at the time the petition for judicial review is filed with the district court file a copy of the petition with the division's chief clerk of proceedings.

(h) Billing of the non-prevailing party. Except as otherwise provided by Labor Code §413.0312, the non-prevailing party shall reimburse the division for the costs for services provided by the State Office of Administrative Hearings and any interest required by law.

(1) The non-prevailing party shall remit payment to the division not later than the 30th day after the date of receiving a bill or statement from the division.

(2) In the event of a dismissal, the party requesting the hearing, other than the injured employee, shall reimburse the division for the costs for services provided by the State Office of Administrative Hearings unless otherwise agreed by the parties.

(3) If the injured employee is the non-prevailing party, the insurance carrier shall reimburse the division for the costs for services provided by the State Office of Administrative Hearings.

§133.308. *MDR of Medical Necessity Disputes*.

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

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

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

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

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

(c) Professional licensing requirements. Notwithstanding Insurance Code Chapter 4202, an IRO that uses doctors to perform reviews of health care services provided under this section may only use doctors licensed to practice in Texas that hold the appropriate

credentials under Chapter 180 of this title (relating to Monitoring and Enforcement). Personnel employed by or under contract with the IRO to perform independent review shall also comply with the personnel and credentialing requirements under Chapter 12 of this title.

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

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

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

(1) In network disputes:

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

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

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

(2) In non-network disputes:

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

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

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

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

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

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

(h) Timeliness. A requestor shall file a request for independent review with the insurance carrier that actually issued the adverse determination or the insurance carrier's utilization review agent (URA) that actually issued the adverse determination no later than the 45th calendar day after receipt of the insurance carrier's denial of an appeal. The insurance carrier shall notify the department of a request for an independent review within one working day from the date the request is received by the insurance carrier or its URA. In a preauthorization or concurrent review dispute request, an injured employee with a life-threatening condition, as defined in §133.305 of this subchapter (relating to MDR--General), is entitled to an immediate review by an IRO and is not required to comply with the procedures for an appeal to the insurance carrier.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(m) Designated Doctor Exam. In performing a review of medical necessity, an IRO may request that the division require an examination by a designated doctor and direct the injured employee to attend the examination pursuant to Labor Code §413.031(g) and §408.0041. The IRO request to the division must be made no later than 10 days after the IRO receives notification of assignment of the IRO. The treating doctor and insurance carrier shall forward a copy of all medical records, diagnostic reports, films, and other medical

documents to the designated doctor appointed by the division, to arrive no later than three working days prior to the scheduled examination. Communication with the designated doctor is prohibited regarding issues not related to the medical necessity dispute. The designated doctor shall complete a report and file it with the IRO, in the form and manner prescribed by the division no later than seven working days after completing the examination. The designated doctor report shall address all issues as directed by the division.

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

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

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

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

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

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

(1) The IRO decision must include:

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

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

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

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

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

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

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

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

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

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

(1) In network disputes, a preauthorization, concurrent, or retrospective medical necessity dispute for health care provided by a network, the insurance carrier must remit payment to the assigned IRO within 15 days after receipt of an invoice from the IRO;

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

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

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

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

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

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

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

(5) For health care not provided by a network, the non-prevailing party to a retrospective medical necessity dispute must pay or refund the IRO fee to the prevailing party

upon receipt of the IRO decision, but not later than 15 days regardless of whether an appeal of the IRO decision has been or will be filed.

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

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

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

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

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

decision of an IRO under Labor Code §413.031(m) is binding during the pendency of a dispute.

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

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

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

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

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

(D) At a division CCH, the hearing officer shall consider the treatment guidelines:

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

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

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

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

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

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

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

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

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

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

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

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

(II) the names of the parties;

(III) the cause number;

(IV) the identity of the court; and

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

(ii) The record of the hearing includes:

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

(II) evidence received or considered;

(III) a statement of matters officially noticed;

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

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

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

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

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

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

(A) medical records;

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

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

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

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

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

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

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

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

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

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

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

(v) Enforcement. The department or the division may initiate appropriate proceedings under Chapter 12 of this title or Labor Code, Title 5 and division rules against an independent review organization or a person conducting independent reviews.

8. CERTIFICATION.

This agency hereby certifies that the adopted amendments rules have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas on May 11, 2012.

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 §133.307 and §133.308 of this title (relating to MDR of Fee Disputes and MDR of Medical Necessity Disputes, respectively) are adopted.

AND IT IS SO ORDERED.

X

ROD BORDELON
COMMISSIONER OF WORKERS'
COMPENSATION

ATTEST:

X

Dirk Johnson
General Counsel

COMMISSIONER ORDER NO.