SUBCHAPTER D. DISPUTE OF MEDICAL BILLS
28 TAC §§133.305, 133.307, and 133.308

1. INTRODUCTION. The Commissioner of Workers' Compensation (Commissioner), Texas Department of Insurance (Department), Division of Workers' Compensation (Division), adopts amendments to §§133.305, 133.307, and 133.308, concerning medical dispute resolution (MDR). The amendments are adopted with changes to the proposed text published in the December 14, 2007 issue of the *Texas Register* (32 TexReg 9257).

In addition to the publication of the proposal on December 14, 2007, a correction of error notice was published in the December 28, 2007 issue of the *Texas Register* (32 TexReg 10110) to correct a typographical error in the preamble of the proposed rule; the correction of error did not pertain to any proposed amendments to the rule text.

2. REASONED JUSTIFICATION. The amendments are necessary to implement statutory provisions of House Bill (HB) 724, HB 1003, and HB 2004 enacted by the 80th Legislature, Regular Session, effective September 1, 2007; and to clarify provisions of and ensure compliance with fee payment to independent review organizations (IROs). The amendments incorporate administrative-level hearings into the Division's MDR process as a step between MDR or IRO review and judicial review in resolution of medical fee and medical necessity disputes. The amendments also address licensing and professional specialty requirements for doctors performing reviews for IROs.

Changes to the Labor Code by HB 724 introduce the State Office of Administrative Hearings (SOAH) and the Division's contested case hearing process into the MDR process as a level of appeal that occurs after MDR or IRO review and prior to judicial review. Changes to the Labor Code by HB 1003 require IROs that use doctors to perform reviews of health care services provided under the Texas Workers' Compensation Act to only use doctors licensed to practice in Texas to perform the reviews. Changes to the Labor Code by HB 2004 require a doctor performing an independent review of a health care service provided to an injured employee, including a retrospective review, who reviews a specific workers' compensation case, to hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving.

Prior to September 1, 2005, the Division's MDR process allowed a party to appeal a decision to SOAH prior to judicial review. In order to shorten the appeal process, HB 7, enacted by the 79th Legislature, Regular Session, amended Labor Code §413.031 to remove appeals to SOAH from the MDR process. In compliance with the revision to the code, the Division revised its rules to reflect the change. On November 1, 2006, a Travis County District Court determined in *HCA Healthcare Corp. v. Texas Dept. Insurance and Division of Workers' Compensation,* Cause No. D-1-GN-06-000176, that the MDR process as revised by HB 7 did not provide due process to parties and found subsection (k) of Labor Code §413.031 to be facially unconstitutional. The District Court judgment remains pending upon appeal to the Third Court of Appeals

in Austin under Docket No. 03-07-0007-CV. During the 80th Legislative Session, the Texas Legislature enacted HB 724, which amended Labor Code §413.031(k) and added Labor Code §§413.031(k-1) – (k-2) and 413.0311.

Labor Code §413.031(k), (k-1), and (k-2) is applicable to a party to a medical dispute that is not subject to Labor Code §413.0311 or party to a dispute regarding spinal surgery subject to Labor Code §413.031(l). Under Labor Code §413.031(k), (k-1) and (k-2), a party is entitled to a hearing before SOAH for any dispute that remains unresolved after MDR or IRO review. A party aggrieved by a final decision of SOAH may seek judicial review conducted in the manner provided for judicial review of a contested case under Subchapter G, Chapter 2001 of the Texas Government Code.

Labor Code §413.0311 is applicable to a party to a medical fee dispute in which the amount sought in reimbursement does not exceed $2,000, a party appealing an IRO decision regarding determination of the retrospective medical necessity for a health care service for which the amount billed does not exceed $3,000, and a party appealing an IRO decision regarding determination of the concurrent or prospective medical necessity for a health care service. Under Labor Code §413.0311, a party is entitled to a contested case hearing for any dispute that remains unresolved after medical fee or medical necessity review. Hearings under Labor Code §413.0311 are to be conducted by a hearings officer in the manner provided for contested case hearings under Subchapter D, Chapter 410 of the Labor Code; however, a benefit review conference is not a prerequisite for a contested case hearing under Labor Code §413.0311.

HB 1003 amends Labor Code §413.031 by adding subsection (e-2), which provides that an IRO that uses doctors to perform reviews of health care services provided under this title may only use doctors licensed to practice in this state.

HB 2004 adds Labor Code §§408.0043 - 408.0045 to the Labor Code. Labor Code §408.0043 provides that a doctor, other than a dentist or chiropractor, who reviews a specific workers' compensation case regarding a health care service provided to an injured employee must hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving. Labor Code §408.0044 provides that a dentist who reviews a dental service provided in conjunction with a specific workers' compensation case must be licensed to practice dentistry. Labor Code §408.0045 provides that a chiropractor who reviews a chiropractic service provided in conjunction with a specific workers' compensation case must be licensed to engage in the practice of chiropractic.

Non-substantive changes based on comments were made to the proposed rule text at §133.307(a), (c)(2)(A), (c)(3)(C), (d)(2)(A)(i), (d)(2)(A)(ii), (d)(3)(A), (e)(3)(J), (f)(2)(A), (f)(2)(C), and (f)(2)(D); and §133.308(a), (d), (g)(1), (i), (l)(2), (l)(3), (t), (t)(1)(B)(i), (t)(1)(B)(ii), and (t)(1)(B)(v) – (vii).

In regard to proposed §133.307(a) and §133.308(a) (both subsections relating to Applicability), some commenters expressed concern that the proposed sections would be inappropriately made applicable to situations not covered by the controlling statutes on which the rules are based. The Division agrees in part and disagrees in part with the

comments. In response to the comments, the Division has clarified that the purpose of the proposed applicability provisions was to make the proposed sections applicable only to disputes expressly addressed in the applicability provisions of HB 724. The Division recognizes that not all the amendments in the proposed sections were based on HB 724; some proposed amendments were based on provisions of Labor Code §413.031 that were not amended by HB 724, and some proposed amendments were based on HB 1003 or HB 2004. In response to the concerns voiced in comments, the Division adopts language in §133.307(a) that makes the section generally applicable to requests for medical fee dispute resolution for non-network or certain authorized out-of-network health care not subject to a contract, that is remanded to the Division or filed on or after May 25, 2008, and the Division adopts language in §133.308(a) that makes the section generally applicable to the independent review of network and non-network preauthorization, concurrent, or retrospective medical necessity disputes that is remanded to the Division or filed on or after May 25, 2008. However, Labor Code §413.031 as amended by HB 724 and Labor Code §413.0311 as added by HB 724 address situations in which there was no controlling law prior to HB 724, because the previous controlling statutory provision, Labor Code §413.031(k), was struck down as unconstitutional. HB 724, Section 9, contains explicit provisions concerning applicability of Labor Code §413.031 and Labor Code §413.0311, and the Division adopts in §133.307(a)(2) and §133.308(a)(2) those applicability provisions. In regard to applicability of §133.307(f) and §133.308(t)(1), the provisions in the rule that are based

on Labor Code §413.031 as amended by HB 724 and Labor Code §413.0311 as added by HB 724.

In regard to proposed §133.307(c)(2)(A), a commenter expressed support for the provision, but recommended that the provision specify that electronic billing data be submitted in a format prescribed by the Division to avoid the data being filed using multiple formats. The Division agrees with this suggestion, and in response to the comment adopts language in §133.307(c)(2)(A) that states a request for medical fee dispute resolution shall include, "a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format…."

In regard to proposed §133.307(c)(3)(C), some commenters objected to the amendment that would change the word "proof" to "documentation," and asked that this proposed amendment not be adopted. The commenters expressed concern that this amendment would reduce the burden of proof for a injured employee who requests dispute resolution. Additionally, some commenters suggested that additional items be added to the list in the parentheses at the end of the subparagraph, and one commenter suggested that the phrase "like documents" be changed to "similar documents." In response to the concern regarding the proposed change of "proof" to "documentation," the Division clarifies that §133.307(c)(3)(C) does not establish the burden of proof an injured employee must meet, but only lists the types of evidence an injured employee should provide to the Division in support of his or her claim. As such, changing the word "proof" to "documentation" would not weaken an injured employee's burden.

However, in response to the comments, the Division agrees. In regard to the suggested additional items, the Division clarifies that the list in §133.307(c)(3)(C) is not intended to be exhaustive, and explains that the suggested items might be relevant to a fee dispute proceeding. However, rather than adopting an extensive list, in response to the comment the Division has added the word "including" to the start of the list to clarify that the list is not exhaustive and that additional items might be provided to the Division as proof of injured employee payment. The Division agrees to adopt the phrase "similar documents" in lieu of the proposed phrase "like documents," to clarify that the list is not exhaustive.

In regard to proposed §133.307(d)(2)(A)(i) and (ii), a commenter requested clarification regarding the requirement for the carrier to provide copies of EOBs and medical bills "in a paper format;" the commenter asked whether the provision would allow a carrier to submit e-billing and payment data in a paper format of its choice. In response to the comment, the Division clarifies that paper formats used should be in a Division approved paper billing format. The Division also specifies in §133.307(d)(2)(A)(i) that initial and reconsideration EOBs should be submitted "in a paper explanation of benefits format using an appropriate DWC approved paper billing format," and similarly specifies in §133.307(d)(2)(A)(ii) that specifies that copies of medical bills should be submitted "in a paper billing format using an appropriate DWC approved paper billing format."

In regard to proposed §133.307(d)(3)(A), a commenter noted that the proposed provision would require a health care provider responding to a request for medical fee dispute resolution to include with its response copies of relevant medical bills in a paper billing format. The commenter suggested that the provision additionally specify that the paper billing format used be a format prescribed by the Division, in order to avoid confusion that could arise if the format were not specified. The Division agrees with the suggestion, and specifies in §133.307(d)(3)(A) that medical bills submitted under the paragraph should be submitted "in a paper billing format using an appropriate DWC approved billing format."

In regard to proposed §133.307(e)(3)(J), commenters expressed concern that the rule does not provide the Division authority to dismiss a request for medical fee dispute resolution upon finding that the disputed health care treatment is not related to the compensable injury or finding that there is no compensable workers' compensation claim. The Division agrees that fee dispute resolution would not be appropriate when service has been found not to be related to a compensable injury. However, the Division has amended §133.307(e)(3)(J) to clarify that a dismissal may occur if "the Division determines that good cause exists to dismiss the request; including a party's failure to comply with the provisions of this section," but, the Division disagrees that the rule does not provide authority to dismiss because "good cause" could address these situations. If issues of medical necessity or compensability have already been raised and conclusively adjudicated, no medical necessity exists, or, the service is not related

to a compensable claim, then good cause would exist to dismiss the request for fee dispute resolution.

In regard to proposed §133.307(f)(2)(A), a commenter expressed concern that a party may not be able to meet the time frames proposed in the subparagraph when a medical review decision has been decided prior to the effective date of these adopted sections. The Division agrees that questions might exist in regard to the time frame for a party to file a request for an appeal to a Division contested case hearing when a medical dispute decision was issued between September 1, 2007, and the effective date of the rule, and that this concern is applicable to appeals to Division contested case hearings under both §133.307(f)(2)(A) and §133.308(t)(1)(B)(i). In response to the comment, the Division has adopted §133.307(f)(2)(A) with a minor change indicating that a written request for a contested case hearing must be filed "no later than the later of the 20th day after the effective date of this section or the 20th day after the date on which the decision is received by the appealing party," and the Division has adopted §133.308(t)(1)(B)(i) with a minor change indicating that a written request for a contested case hearing must be filed "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."

A commenter recommended grammatical revisions to proposed §133.307(f)(2)(C). The Division agreed that the suggested edits provided clarity and revised §133.307(f)(2)(C) to state "Prior to a Division contested case hearing, either

party may request a correction of a clerical error in a decision" and that "A request for a correction of a clerical error does not alter the deadlines for appeal."

In regard to §133.307(f)(2)(D) and §133.308(t)(1)(B)(v) (both provisions relating to the admission of evidence and witness testimony in Division contested case hearings), several commenters expressed concern that limiting admissible evidence to information presented during the MDR or IRO process goes against public policy in that it prevents parties from presenting complete claims and defenses. The commenters also indicated a concern that due process issues may arise if parties have insufficient time to investigate and respond to allegations which arise during a supplemental evidence exchange. The Division agrees that in order to eliminate due process challenges to the Division hearing process, the proposed sections should be revised and the first sentence of §133.307(f)(2)(D) and the entirety of §133.308(t)(1)(B)(v) as proposed were removed. In addition, limitations on documentary evidence admissible at a contested case hearing or limitations on witnesses who had not been disclosed during the MDR or IRO processes were not included in the adopted sections. As a result of not adopting proposed §133.308(t)(1)(B)(v), proposed §133.308(t)(1)(B)(vi) and (vii) have been renumbered in the adopted text as §133.308(t)(1)(B)(v) and (vi).

A commenter suggested that an IRO should be required to appear and testify at an appeal of the IRO's decision at no cost to the parties. In response, the Division explains that pursuant to Insurance Code §4202.009 "Information that reveals the identity of a physician or other individual health care provider who makes a review

determination for an independent review organization is confidential." To further clarify this in the rule text, the provision "The IRO is not required to participate in the SOAH hearing or any appeal" has been incorporated into and adopted in §133.308(t)(1)(A).

Several commenters made various suggestions regarding the language in §133.308(d). One commenter asked that the subsection be revised to provide additional clarification to parties. Two commenters suggested changing the word "all" to "the," because it is not necessary that a reviewer have the qualifications to provide all the care that might be required by an injury, only the qualifications related to the specific service being reviewed. Two commenters suggested adding the sentence, "Nothing in this subsection shall be construed to limit the clear statutory obligation to continually provide care that is necessary to cure or relieve the condition," to the end of the subsection, as a reference back to the governing statues which could help to eliminate potential disagreements related to the interpretation of the phrase "material recovery from or lasting improvement," and would better ensure that an injured worker receives necessary care by having an appropriate initial review rather. Additionally, one commenter requested that the medical specialty of spinal surgery be expressly addressed in subsection (d), and another commenter requested that the medical specialty of orthopedic surgery be expressly addressed in subsection (d). The Division does not believe these specialties need to be addressed because no distinction is made regarding them in HB 2004. However, the Legislature did make distinctions regarding dentistry and the practice of chiropractic in HB 2004 and the Division does believe it is

appropriate to address these fields of practice in subsection (d). In response to these comments, the Division has revised the language that was proposed in §133.308(d), and adopted the following text: "Professional specialty requirements. Notwithstanding Insurance Code Chapter 4202, an IRO doctor, other than a dentist or a chiropractor, performing a review under this section shall be a doctor who would typically manage the medical or dental condition, procedure, or treatment under consideration for review, and who is qualified by education, training and experience to provide the health care reasonably required by the nature of the injury to treat the condition until further material recovery from or lasting improvement to the injury can no longer reasonably be anticipated. A dentist meeting the requirements of subsection (c) of this section may perform a review of a dental service under this section, and a chiropractor meeting the requirements of subsection (c) of this section may perform a review of a chiropractic service under this section. Nothing in this subsection can be construed to limit an injured employee's ability to receive health care in accordance with the Labor Code and Division rules or to limit a review of health care to only health care provided or requested prior to the date of maximum medical improvement."

In regard to §133.308(g)(1)(A) and (B), a commenter cited use of the word "providers" in each subparagraph and asked that the words "health care" be placed in front of the word "providers" each time it is used. However, rather than inserting the words "health care" in front of each use of the word "providers," the Division has instead modified §133.308(g)(1)(A) to say "health care providers (providers)." This change

clarifies that the word "providers" is used in the section as a shortened form of "health care providers," and it is thus unnecessary to insert the words "health care" in the other places in the section where the word "providers" is used.

In regard to proposed §133.308(i), some commenters requested that the proposed language requiring a carrier to notify the Department of a request for an independent review on the day the request is received be modified to allow the carrier more time to notify the Department of the request. The commenters expressed concern that the proposed provisions would not allow sufficient time for the carrier to notify the Department. In response to these comments, the Division adopts language in §133.308(i) which requires a carrier to notify the Department of a request for an independent review "within one working day from the date" the request is received by the carrier or its URA.

In regard to proposed §133.308(l)(2) and (l)(3), a commenter said that due to the economics of the situation, parties often use clerical staff to determine what to submit to an IRO for use in an IRO review, and that a balancing act must be conducted, because IROs would prefer to just get documents that are relevant to the dispute, and not a mountain of records of which have nothing to do with the dispute. The commenter said that parties often send what they think is necessary, only to later learn that they may have needed to send more documentation. In response to the comment, the Division modified the language of §133.308(l)(2) and (3) to provide parties and their clerical staff additional guidance in determining what should be submitted to an IRO. As adopted,

§133.308(l)(2) clarifies that the IRO should be provided "all medical records of the employee in the possession of the carrier or the URA that are relevant to the review, including any medical records used by the carrier or the URA in making the determinations to be reviewed by the IRO," and as adopted §133.308(l)(3) says "that the IRO should be provided "all documents, guidelines, policies, protocols and criteria used by the carrier or the URA in making the decision."

In regard to proposed §133.308(t), some commenters voiced concerns regarding the weight given to an IRO decision by the proposed subsection. The commenters suggested that an IRO decision should not carry presumptive weight. In response to the comments, the Division notes that the purpose of the proposed provision was to address a party's burden in regard to appealing an IRO decision, and the Division makes a text change to clarify this intent. The proposed version of §133.308(t) contained the sentence: "In a Contested Case Hearing (CCH), the decision issued by an IRO carries presumptive weight that may only be overcome by a preponderance of evidence-based medical evidence to the contrary." In the adopted text, this sentence has been changed to say: "In a 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."

In regard to proposed §133.308(t)(1)(B)(ii), a commenter asked that the word "deliver" be changed to "send." The Division agrees to make this change, and the adopted version of §133.308(t)(1)(B)(ii) contains the word "send."

3. HOW THE SECTIONS WILL FUNCTION. Amended §133.305(a) adds definitions for "requestor" and "respondent." Additional amendments renumber the paragraphs in the subsection accordingly. Additionally, an amendment to subsection (a)(6) expands the definition of "non-network health care" as used in Texas Administrative Code, Title 28, Subchapter D to include health care delivered pursuant to Labor Code §413.011(d-1) and §413.0115. This amendment clarifies that health care provided through a voluntary or informal network is non-network health care.

New §133.307(a)(1) specifies that the section is applicable to a request for medical fee dispute resolution for non-network or certain out-of-network health care not subject to a contract, that is remanded to the Division or filed on or after May 25, 2008. New subsection (a)(2) specifies that except as provided in paragraph (2) of the subsection, dispute resolution requests filed prior to May 25, 2008, shall be resolved in accordance with the statutes and rules in effect at the time the request was filed. New subsection (a)(2) specifies that subsection (f) of the section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care not subject to a contract, that is pending for adjudication by the Division on September 1, 2007; remanded to the Division on or after September 1,2007; or filed on or after September 1, 2007. New subsection (a)(3) says that in resolving non-network 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 of Workers' Compensation (Division) is to adjudicate the payment, given the relevant statutory provisions and Division rules.

Amendments to §133.307(c)(2)(A) and (B) and to §133.307(d)(2)(A) and (3)(A) clarify that medical bills and explanation of benefits must be in a paper format rather than the format used for electronic submission of these documents. Amended §133.307(c)(3)(C) clarifies that documentation of employment payment may include provider billing statements or like documents in addition to copies of receipts.

Amended §133.307(d) adds language to specify that the response to a request for MDR must be submitted to the Division and to the requestor.

Amendments to §133.307(d)(2)(A)(i) and (ii) specify that the carrier's response to a request for MDR shall also include all initial and reconsideration EOBs in a paper explanation of benefits format and a copy of all medical bills in a paper billing format using an appropriate DWC approved paper billing format.

The amendment to §133.307(d)(3)(A) clarifies that any documentation, including medical bills, shall be in a paper billing format using an appropriate DWC approved billing format.

Amendments to subsection §133.307(e)(1) specify that when additional information is requested by the Division, the party providing the additional information must also send a copy of the information to all other parties at the time it is submitted to the Division.

Amended §133.307(e)(3)(J) adds that the Division may determine that good cause exists to dismiss a request for a parties' failure to comply with the provisions of that section.

New §133.307(f) introduces another level of administrative hearings into the MDR process that allow a hearing either before SOAH or through the Division's contested case hearing process. Language changes are adopted to reflect the new appeal process, to update statutory citations, and to be consistent with language in §133.308.

Under new §133.307(f)(1), parties to fee disputes in which the amount of reimbursement sought by the requestor in its request is greater than $2,000 may request a hearing before SOAH. New §133.307(f)(1)(A) says that to request a contested case hearing before SOAH, a party shall file a written request for a SOAH hearing with the Division's Chief Clerk of Proceedings in accordance with 28 TAC §148.3. New §133.307(f)(1)(B) requires the party seeking review of the MDR decision to 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.

Under new §133.307(f)(2), parties to fee disputes in which the amount of reimbursement sought by the requestor in its request is less than or equal to $2,000 may appeal the MDR decision by requesting a contested case hearing held by the Division. New §133.307(f)(2)(A) says that to request a Division contested case hearing, a written request for a Division contested case hearing must be filed with the Division's

Chief Clerk no later than the later of the 20th day after the effective date of this section or the 20th day after the date on which the decision is received by the appealing party; that the request must be filed in compliance with Division rules; and that the party appealing the 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 a hearing is filed with the Division. New §133.307(f)(2)(B) notes that requests that are timely submitted to a Division location other than the Division's Chief Clerk, such as a local field office of the Division, will be considered timely filed and forwarded to the Chief Clerk for processing; however, this may result in a delay in the processing of the request; and that any decision that is not timely appealed becomes final. To avoid overlap with 28 TAC Chapter 148, the previous §133.307(h) has been moved to subsection §133.307(f)(2)(C) and is made applicable only to Division contested case hearings. New §133.307(f)(2)(C) changes the words "clerical correction" to "correction of a clerical" and the words "clerical correction" to "correction of a clerical error." New §133.307(f)(2)(D) says that at a Division contested case hearing under this paragraph, parties may not raise issues regarding liability, compensability, or medical necessity at a contested case hearing for a medical fee dispute. New §133.307(f)(2)(E) says that except as otherwise provided in the section, a Division contested case hearing shall be conducted in accordance with Chapters 140 and 142 of Title 28. Amendments to renumbered §133.307(f)(2)(F) reflect the new appeal process. Amendments to renumbered §133.307(f)(2)(G) clarify that the costs of preparing a certified record of

hearing shall be the responsibility of the party seeking judicial review, and that 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.

New §133.308(a)(1) specifies that the section is applicable to independent review of network and non-network preauthorization, concurrent, or retrospective medical necessity disputes that are remanded to the Division or filed on or after May 25, 2008. Subsection (a)(1) further provides that except as provided in paragraph (2) of the subsection, dispute resolution requests filed prior to May 25, 2008, shall be resolved in accordance with the statutes and rules in effect at the time the request was filed.

New §133.308(a)(2) specifies that paragraph (1) of subsection (t) of the section applies to the independent review of network and non-network preauthorization, concurrent, or retrospective medical necessity disputes for a dispute resolution request that is pending for adjudication by the Division on September 1, 2007; remanded to the Division on or after September 1, 2007; or filed on or after September 1, 2007.

New §133.308(a)(3) says that when applicable, retrospective medical necessity disputes shall be governed by the provisions of Labor Code §413.031(n) and related rules.

New §133.308(a)(4) says 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.

An amendment to §133.308 creates a new subsection (c), which establishes that an IRO that uses doctors to perform reviews of health care services provided under §133.308 may only use doctors licensed to practice in Texas.

An amendment to §133.308 creates a new subsection (d), which specifies that an IRO doctor, other than a dentist or a chiropractor, performing a review under §133.308 shall be a doctor who would typically manage the medical or dental condition, procedure, or treatment under consideration for review, and who is qualified by education, training and experience to provide the health care reasonably required by the nature of the injury to treat the condition until further material recovery from or lasting improvement to the injury can no longer reasonably be anticipated. A dentist meeting the requirements of subsection (c) of this section may perform a review of a dental service under this section, and a chiropractor meeting the requirements of subsection (c) of this section may perform a review of a chiropractic serviced under this section. Further, nothing in the subsection can be construed to limit an injured employee's ability to receive health care in accordance with the Labor Code and Division rules or to limit a review of health care to only health care provided or requested prior to the date of maximum medical improvement. Amendments renumber the sections which follow accordingly.

Amendments to renumbered §133.308(i) clarify that a requestor shall file a request for independent review with the insurance carrier that actually issued the adverse determination or the carrier's utilization review agent that actually issued the adverse determination no later than the 45th calendar day after receipt of the denial of reconsideration, and clarify that a carrier shall notify the Department of a request for independent review within one working day from the date the request is received by the carrier or its URA.

Amendments to §133.308 in renumbered subsections (k) and (p)(1)(F) remove references to Insurance Code Articles 21.58C and 21.58A, which have been recodified as TIC Chapters 4202 and 4201.

An amendment to renumbered §133.308(h)(2) corrects a punctuation error.

An amendment to renumbered §133.308(j)(2) changes the phrase "individual or entity requesting medical necessity dispute resolution" to "requestor," and an amendment to paragraph (5) in renumbered subsection (j) reflects the fact that subsection (g) is renumbered as subsection (i).

An amendment to renumbered §133.308(l)(2) and (3) adds that the documentation submitted by the carrier or carrier's URA shall include all medical records of the employee in the possession of the carrier or the URA that are relevant to the review, including any medical records used by the carrier or the URA in making the determinations to be reviewed by the IRO and all documents, guidelines, policies, protocols and criteria used by the carrier or the URA in making the decision.

In regard to non-network retrospective medical necessity dispute resolution when reimbursement was denied for health care paid by the employee, an amendment in renumbered §133.308(r) clarifies that IRO fees are to be remitted to the assigned IRO by the carrier. An amendment in renumbered subsection (r)(9) states that §133.308 shall not be deemed to require an employee to pay for any part of a review, and that if application of a provision of the section would require an employee to pay for part of the cost of a review, that the cost shall instead be paid by the carrier.

An amendment to renumbered §133.308(t) specifies that in a contested case hearing, 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. Amendments to renumbered §133.308(t)(1)(A) and (B), introduce another level of administrative hearings into the MDR process that allow a hearing either before SOAH or through the Division's contested case hearing process.

Under the amendments, parties to retrospective medical necessity disputes in which the amount billed is greater than $3,000 may request a hearing before the SOAH by filing a written request for a SOAH hearing in accordance with 28 TAC §148.3 (relating to Requesting a Hearing); and parties to retrospective medical necessity disputes in which the amount billed is less than or equal to $3,000 dollars or who are appealing an IRO decision regarding determination of the concurrent or prospective medical necessity for a health service may appeal the IRO decision by requesting a Division contested case hearing.

Amended (t)(1)(A) specifies that a party to a retrospective medical necessity dispute in which the amount billed is greater than $3,000 may request a hearing before the State Office of Administrative Hearings (SOAH) by filing a written request for a SOAH hearing with the Division's Chief Clerk of Proceedings in accordance with §148.3 of this title (relating to Requesting a Hearing), the party appealing the IRO decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, and the IRO is not required to participate in the SOAH hearing or any appeal.

Amended 133.308(t)(1)(B) specifies that a party to a retrospective medical necessity dispute in which the amount billed is less than or equal to $3,000 or an appeal of an IRO decision regarding determination of the concurrent or prospective medical necessity for a health care service may appeal the IRO decision by requesting a Division contested case hearing conducted by a hearing officer at the Division, and that a benefit review conference is not a prerequisite to a Division contested case hearing under the subparagraph. Amended subsection (t)(1)(B)(i) states that a party is required to file an appeal with the Division's Chief Clerk 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; the appeal must be filed in compliance with Division rules; and requests that are timely submitted to a Division location other than the Division's Chief Clerk, such as a local field office of the Division, will be considered timely filed and forwarded to the Chief Clerk for processing; however, this may result in a delay in the processing of the request.

Amended subsection (t)(1)(B)(ii) requires the appealing party to send a copy of its written request for a hearing to all other parties in the dispute, and says that the IRO is not required to participate in the Division contested case hearing or any appeal. Amended subsection (t)(1)(B)(iii) says that except as otherwise provided in the section, the hearing will be conducted in accordance with Chapter 140 and 142 of Title 28 of the Texas Administrative Code. Amended (t)(1)(B)(iv) provides that Prior to a Division contested case hearing, a party may submit a request for a letter of clarification by the IRO to the Division's Chief Clerk; that 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 but, the request may not ask the IRO to reconsider its decision or issue a new decision. Amended (t)(1)(B)(iv)(I) specifies that 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, and that 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. Amended (t)(1)(B)(iv)(II) specifies that the Department will forward a party's request for a letter of clarification by the IRO to the IRO that conducted the independent review. Amended (t)(1)(B)(iv)(III) specifies that 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, and that 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. Amended (t)(1)(B)(iv)(IV) specifies that a request for a letter of clarification does not alter the deadlines for appeal. Amended subsection (t)(1)(B)(v) specifies that a party to a medical necessity dispute who has exhausted all administrative remedies may seek judicial review of the Division's decision and judicial review shall be conducted in the manner provided for judicial review of contested cases under Chapter 2001, Subchapter G Government Code. Amended subsection (t)(1)(B)(v) further provides that 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; and, 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).

Amended subsection (t)(1)(B)(vi) provides that upon receipt of a court petition seeking judicial review of a contested case hearing, the Division shall prepare and submit to the District Court a certified record of the contested case hearing. Amended subsection (t)(1)(B)(vi)(I)(-a-) – (-e-) lists what must be included in the notice to the Division concerning an appeal for judicial review. Amended subsection (t)(1)(B)(vi)(II)(-a-) – (-f-) lists what is included in a certified record. Amended subsection (t)(1)(B)(vi)(III) provides that the Division shall assess the party seeking judicial review the expense incurred by the Division in preparing and copying the record, including transcription

costs, in accordance with the Government, §2001.177; and that 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.

Amended §133.308(u) states that a written appeal for non-network spinal surgery must be filed no later than 20 days after the date the IRO decision is sent to the appealing party, and that the appeal must be filed in compliance with Division rules.

Amended §133.308(v) changes the words "health care provider" to "requestor."

4. SUMMARY OF COMMENTS AND AGENCY RESPONSES.

General

Comment: In regard to the proposed sections, a commenter asks "What about pharmaceutical coverage, co-pay, tier ranking, and medical necessity disputes?"

Agency Response: The Department clarifies that the proposed sections address dispute resolution for fee and medical necessity disputes arising in relation to workers' compensation benefits. Patient copayments are not permitted under Texas workers' compensation law, so the proposed sections do not contemplate or address copayments. Additionally, the proposed sections do not address tier ranking.

Comment: A commenter asks whether the proposed sections are only related to workers' compensation.

Agency Response: The Division clarifies that the proposed sections only relate to workers' compensation. Specifically, the proposal is related to resolution of fee disputes arising under Title 5 of the Labor Code (the Workers' Compensation Act); and the proposal is related to resolution of medical necessity disputes arising under both the Workers' Compensation Act and Insurance Code Chapter 1305 (the Workers' Compensation Healthcare Network Act).

Comment: A commenter suggests that designated doctors should be allowed to charge a "no show" fee for missed appointments because there is approximately a 50% no-show rate. The commenter says that a doctor must still perform functions when there is a missed appointment, but is not compensated – and loses money. The commenter notes that attorneys can charge for missed appointments and urges the Division to address the disparity by bringing back the missed appointment fee that doctors could previously charge.

Agency Response: The Division clarifies that the proposed sections concern dispute resolution of fee and medical necessity disputes and not the amendment of fee guidelines. The Division notes that the amendment of fee guidelines were addressed in the rule proposal for §§134.1, 134.2, 134.203, and 134. 204, published in the Texas Register on October 5, 2007, (32 TexReg 6966). The public comment period for that proposal lasted from October 5 through November 5, 2007, and the Division received and responded to a similar formal comment.

Comment: A commenter thanks the Division for the opportunity to comment on the proposed rules. The commenter expresses belief that the proposed rules follow the enacted legislation, but suggests concern that parties will not be permitted to develop a full evidentiary record at the contested case hearing. The commenter asserts that this is necessary for due process rights in contested case hearings. The commenter further asserts that a full evidentiary record is necessary to ensure that decisions are fair, just and reasonable. The commenter also expresses concern about the possibility of health care providers "unbundling" services in an attempt to obtain an Division CCH rather than a SOAH hearing. The commenter recommends requiring parties to bring all related disputes in one claim between a health care provider and an employee or carrier.

Agency Response: The Division agrees to not adopt proposed §133.307(f)(2)(B) and §133.308(t)(1)(B)(v), which relate to the admission of evidence. The subparagraphs in §133.307(f)(2) and the clauses in §133.308(t)(1)(B) have been renumbered as appropriate.

The Division declines to make a change regarding "bundling" of claims. The Legislate could have chosen to require a party to bring all disputes that may be related to a claim at one time, but it did not choose to do so. The Division believes that to create such a requirement by rule would impose burdens and delays not intended by the Legislature, because a party would have to wait before it could request dispute

resolution, and might miss the required deadlines for earlier disputes. Additionally, a requirement that all related disputes be brought at one time might create a conflict with the dispute sequence requirements of §133.305(b), which requires that disputes regarding compensability, extent of injury, liability, or medical necessity be resolved prior to the submission of medical fee disputes.

Comment: A commenter says that the Division contested case hearing/SOAH appeal sections of proposed §133.307 and §133.308 address only traditional medical fee and IRO disputes and fail to address appeal of carrier refund disputes, even though 28 TAC §133.260 specifically makes refund disputes subject to 28 TAC §§133.305, 133.307, and 133.308. Specifically, the commenter notes that §133.305(a)(4)(C) defines a medical fee dispute as including "a provider dispute regarding the results of a Division *or carrier audit or review* which requires the provider to refund an amount for health care services previously paid by the carrier," and says that these involve carrier refund requests arising under Labor Code §408.0271 and 28 TAC §133.260. The commenter suggests that HB 724 requires all carrier refund disputes to be appealed to SOAH pursuant to Labor Code §413.031 because Labor Code §413.0311 is not applicable as it applies only to reviews under Labor Code §413.031(b)-(i) which do not involve carrier refund disputes. As further support for this statement, the carrier notes that carrier refund request disputes do not involve reimbursements sought by a requestor, but that Labor Code §413.0311 is only applicable to a medical fee dispute "in which the amount

of *reimbursement sought by the requestor* in its request for medical dispute resolution does not exceed $2,000." The commenter recommends that the adopted rules specifically address appeals of carrier refund disputes, and that all such disputes be referred to SOAH.

Agency Response: The Division disagrees with the comment, and declines to make a change because no change is necessary. Under Labor Code §408.0271, a health care provider is required to refund a payment for a service found by the carrier to be inappropriate and failure to reimburse a payment constitutes an administrative violation. Since the health care provider is required to refund the payment pursuant to Labor Code §408.0271, it is the health care provider that would file a request for dispute resolution because the provider would seek reimbursement for the services provided in the amount that had been refunded. The provider's request should be filed pursuant to the processes set out in §133.307 and §133.307. Since the provider would be a requestor seeking reimbursement and the dispute would be the amount of payment due for services, Labor Code §413.031 would be applicable - and Labor Code §410.0311 would be applicable if the amount of reimbursement sought by the provider in its request for medical dispute resolution does not exceed $2,000.

Comment: A commenter expresses concern regarding disparities in the system and the qualifications for doctors.

Agency Response: In preparing these rules, the Division has attempted to balance the rights and obligations of all parties in a way that satisfies the requirements of the Labor Code and best ensures a fair opportunity for medical dispute resolution, and the Division has attempted to address the professional certification qualifications of IRO review doctors in a way that is consistent with the Labor Code.

Comment: A commenter discusses injured worker pay and temporary income benefits. The commenter notes that an insurance company pays based on income before taxes and payroll deductions. The commenter submits that temporary income benefits should be calculated based on the cash to the injured worker not on the payment prior to insurance taxes and payroll. As an example, the commenter says that if an injured worker is to receive $576 as temporary income benefits, then the injured worker should receive no less cash than would occur if the injured worker accepts light duty because an injured worker is very financially stressed.

Agency Response: The Division clarifies that provisions concerning temporary income benefits are beyond the scope of this rule.

Comment: A commenter notes that while it is not in this rule, the commenter would like to address changing of treating doctors. The commenter suggests that an injured employee should get a "mulligan" concerning treating doctors, and should be able to

change treating physicians with no questions asked, no forms, and no denial by the insurance company, at any time with in the first 60 days.

Agency Response: The Division appreciates the comment; however, the subject of changing treating doctors is beyond the scope of this rule.

Comment: A commenter says that it has experienced problems regarding past medical records and their impact on treatment decisions for current workers' compensation claims. The commenter says that it is difficult to get older medical records without a special subpoena, and that with some claims it is not possible to make all the records available to an IRO within the time limits.

The commenter says that there is a need to balance efficiency with quality, and that the solution rests with the contested case hearing process; the majority of fee and medical necessity disputes are small, but the important ones end up in contested case hearings. The commenter says that the system only works at the contested case hearing level, where, if something should not be performed, the best incentive to not have it performed is for the doctor to not be paid for it.

The commenter says that complex coding issues are difficult, and that it is not cost effective to develop a case for Medical Fee Dispute Resolution, so parties wait until an appeal to develop their case. The commenter says that allowing a hearing officer to determine good cause for the admission of evidence may sound reasonable, but would be arbitrary and invite additional litigation. The commenter says that allowing a hearing

officer to determine good cause for the admission of evidence would conflict with the hearing officer's duty to fully develop the record under 28 TAC Chapter 142. The commenter says that it would give a hearing officer too much discretion. The commenter says that it would like to avoid bad decisions, because with good decisions there is no wiggle room, and the number of disputes will go down.

The commenter says that the number of disputes began to drop when the Medical Fee Guideline was linked to Medicare payment policies and when the Division began policing doctors and removing them from the ADL. The commenter says that this shows it is more sensible to address the root problem, rather than sacrificing quality for efficiency or an expedited process.

Agency Response: Based on the numerous comments received regarding limitations on evidence, the Division did not adopt proposed §133.307(f)(2)(D) and §133.308(t)(1)(B)(v). The subparagraphs in §133.307(f)(2) and the clauses in §133.308(t)(1)(B) have been renumbered as appropriate.

Comment: A commenter says that it is important to note that most, if not all stakeholders object to the provisions in §133.307(f)(1)(D) and §133.308(t)(1)(B)(v), and that this shows they do not believe the rule provisions to be appropriate.

The commenter notes says that stakeholders hoped the rule would allow addition evidence to be introduced, rather than create limitations based on what was submitted during the medical dispute process.

The commenter surmises that the Division could have concerns that parties would hide behind the law and ambush one another at hearing. In response to such concerns, the commenter suggests requiring an exchange of evidence and witness lists a set number of days prior to a hearing.

The commenter also expresses certainty that the Division is concerned about hearing officers making what would be tantamount to a medical decision. To address this, the commenter recommends adding a provision that would require a hearing officer to forward new documentation to an IRO and have the IRO doctor prepare an indemnity report and send it back to the parties for further proceedings. The commenter would recommend that an additional fee be included in the provision, to reimburse IROs for their costs associated with the indemnity report.

Agency Response: Based on the numerous comments received regarding limitations on evidence, the Division did not adopt proposed §133.307(f)(2)(D) and §133.308(t)(1)(B)(v). The subparagraphs in §133.307(f)(2) and the clauses in §133.308(t)(1)(B) have been renumbered as appropriate.

The Division declines to insert a rule outlining a time frame for exchange of evidence and witness lists in this section. That would, more appropriately, belong in 28 TAC Chapter 142 relating to (Dispute Resolution – Benefit Contested Case Hearing).

The Division declines to require the hearing officer to forward new documentation to the IRO for the purpose of preparing an indemnity report. The Division also declines to charge additional fees to reimburse IROs for their costs associated with the indemnity

report. The hearing officer currently has the option to entertain requests from the parties for a letter of clarification from the IRO. Labor Code §413.031 and §413.0311 do not provide for a second review by an IRO. Additionally, to require the hearing officer to forward documents to the IRO would be to usurp the authority of the hearing officer as outlined in 28 TAC Chapter 142 (relating to Dispute Resolution – Benefit Contested Case Hearing).

§133.305:

Comment: Two commenters say that the treatment guidelines and Medicare payment policies are key factors that provide for the control of medical costs in the Texas workers' compensation system and insure that only high quality, medically necessary health care treatment and services are provided to injured employees.

The commenters express belief that it is critical for Division hearing officers, independent review doctors, and Division medical fee dispute resolution staff to acknowledge and apply applicable provisions of the treatment guidelines and Medical payment policies during the course of the medical dispute resolution and associated contested case hearing processes. To this end, the commenters recommend adding a new subsection to §133.305(f) that says: "Applicability of Treatment Guidelines Adopted by the Commissioner of Workers' Compensation and Medicare Payment Policies. (1) The treatment guidelines adopted by the Commissioner of Workers' Compensation and Medicare payment policies are applicable to all medical disputes

that arise in the Texas workers' compensation system. (2) The treatment guidelines and Medicare payment policies shall be considered during the medical fee payment dispute resolution review process. Applicable provisions of the guidelines and payment policies shall be referenced in all decisions issued at the conclusion of the medical fee payment dispute resolution review process. (3) The treatment guidelines and Medicare payment policies shall be considered during the medical dispute resolution by independent review organization process. Applicable provisions of the guidelines and payment policies shall be referenced in the independent review report issued at the conclusion of the medical dispute resolution by informal review organization process. (4) The treatment guidelines and Medicare payment policies shall be considered by a Division hearing officer during the course of a contested case hearing. Applicable provisions of the guidelines and payment policies shall be referenced in the contested case hearing decision issued at the conclusion of a medical dispute contested case process. (5) The decision of the Division or independent review report shall include an explanation and justification for any deviation from the applicable treatment guidelines and Medicare payment policies."

Agency Response: The Division agrees in part and disagrees in part with the commenters and declines to make a change because no change is necessary.

The Division agrees that use of treatment guidelines is important; however, §133.308 already requires an IRO reviewer to consider the Division's treatment guidelines and to explain any divergences from the treatment guidelines in a decision.

IROs do not make fee determinations, so, it is unnecessary to require IRO reviewers to consider Medicare payment policies in determining medical necessity. Additionally, the purpose of these sections is not to direct the Division to act in a specific way, so, it is unnecessary for the rules to mandate that the Division or the Division staff apply Medicare payment policies or Division treatment guidelines in a particular way.

Comment: A commenter says that it is not clear whether a subclaimant has a remedy under fee or medical necessity disputes.

Agency Response: The Division clarifies that the proposed rule did not address subclaims. The Division notes that an early, informal draft of this rule did contain provisions specific to subclaimants. However, the overwhelming number of comments received in response to the informal draft indicated that subclaims should be addressed on their own, rather than as a part of this rule, so that the Division can thoroughly and effectively address all the issues associated with subclaims.

Rules developed by the subclaim rule team will determine the remedies that are available for subclaimants.

§§133.305(a) and (c); 133.307(a) - (c), (c)(1), (d), and (f); and 133.308(a), (e), (g), (i), (j), (m) - (p), (r)(2), (r)(2)(B), (s), and (t):

Comment: A commenter notes that informal rules are being considered by the Division to address subclaimant reimbursement and dispute resolution issues and expresses

belief that the best course of action would be to create within the new subclaimant rules being considered a separate dispute resolution rule applicable only to subclaimants and workers' compensation insurance carriers. However, the commenter notes a compulsion to submit comments addressing the role of subclaimants in these proposed rules regarding the dispute process.

The commenter suggests the following specific changes to rule text:

-- In §133.305(a), the addition of the definition "medical benefit dispute--A dispute that involves an insurance carrier denying reimbursement to a subclaimant for a health care service paid in behalf of the injured employee where there is no dispute as to the compensability of the injury or illness. The insurance carrier denies the paid health care services as medical benefits under the Act. The dispute is reviewed by an independent review organization (IRO) pursuant to the Insurance Code, the Labor Code and related rules, including §133.308 of this subchapter (relating to MDR by Independent Review Organizations)" and "subclaim--A claim for reimbursement pursuant to Labor Code §409.009 or §409.0091 where the subclaimant has made benefit payments in behalf of the injured employee and been denied reimbursement by the carrier or employer" and adding a subparagraph to the definition for "medical dispute resolution" that says it includes "a medical benefit dispute resulting from a request for reimbursement under Labor Code §409.009 and §409.0091."

-- In §133.305(c), the addition of "(other than subclaims)" after the words "when resolving disputes."

-- In §133.307(a), the addition of a paragraph (2) to the applicability subsection which says, "This section applies to a request for medical fee dispute resolution that arises pursuant to a subclaim brought by a health care insurer under §409.009 and §409.0091."

-- In §133.307(b), the addition of a paragraph (5) that says, "a health care insurer that qualifies as a subclaimant as provided by Labor Code §§409.009 or 409.0091 and has a dispute over the amount of reimbursement due in its subclaim."

-- In §133.307(c), the addition of a new paragraph (4) that says, "Health Care Insurer Request. The health care insurer shall complete the required section of the request in the form and manner prescribed by the Division. The health care insurer shall file the request with the MDR section by any mail service or personal delivery. The request shall include: (A) the form DWC-60 table listing the specific disputed health care services, and the information required by §409.00911(f) relating to its subclaim; (B) a copy of any insurance carrier explanation of benefits statement (EOB) received by the subclaimant and relevant to the dispute; (C) if no EOB was received, documentation of the health care insurer's submission of the original request for reimbursement, including date of submission;(D) a statement of the subclaim, that shall include: (i) a description of the health care services under dispute; (ii) the subclaimant's reasoning for why the disputed fees should be reimbursed; (iii) how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues including, if necessary, a discussion of fair and reasonable reimbursement if the dispute involves health care for which the Division

has not established a maximum allowable reimbursement; (E) if the requestor is an authorized representative of the health care insurer, an affidavit certifying that the requestor is the authorized representative of the health care insurer."

-- In §133.307(c)(1), the addition of a subparagraph (C) that says, "A health care insurer subclaimant shall file a request for medical fee dispute resolution no later than the 120th calendar day after the workers' compensation carrier fails to respond to a request for reimbursement or after receipt of the workers' compensation insurance carrier's notice of denial or reduction of reimbursement."

-- In §133.307(d), the addition of the words "or the health care insurer's request for reimbursement" to subparagraph (C) following the words "the employee's reimbursement request."

-- In §133.307(f), that language be incorporated into the rule which sets venue for subclaimant Division contested case hearings and SOAH hearings in Austin.

-- In §133.308(a), addition of a new paragraph (2) that says, "This section applies to the independent review of medical benefit disputes that arise pursuant to a subclaim brought under Labor Code §409.009 or §409.0091."

-- In §133.308(e), addition of the words "a health care insurer subclaimant" following the words "any of the treating providers."

-- In §133.308(g), addition of a paragraph (3) that says, "In disputes arising as part of a subclaim, health care insurers pursuing a subclaim pursuant to Labor Code §409.009 or §409.0091."

-- In §133.308(i), breaking down of the subsection into paragraphs, and the insertion of a paragraph (2) that says, "A subclaimant requestor shall file a request for independent review with the carrier or the carrier's URA no later than the 120th calendar day after: (A) receipt of a denial of reimbursement based upon the health care service not being a valid medical benefit; or, (B) the failure of the insurance carrier to respond to a request for reimbursement."

-- In §133.308(j), breaking down of the subsection into paragraphs, and the insertion of a paragraph (2) that says, "The Department may dismiss a request for medical benefit dispute resolution if: (A) the requestor informs the Department, or the Department otherwise determines, that the dispute no longer exists; (B) the requestor is not a proper party to the dispute pursuant to subsection (g); (C) the request for dispute resolution is untimely pursuant to subsection (i) of this section; (D) the request for medical benefit dispute resolution was not submitted in compliance with the provisions of this subchapter; (E) the request for reimbursement was not submitted in compliance with §409.009 or §409.0091; or (F) the Department determines that good cause otherwise exists to dismiss the request."

-- In §133.308(m), the addition of a paragraph (4) that says, "Notwithstanding paragraph (1) of this subsection, in resolution of a subclaim, a subclaimant shall reimburse copy expenses for additional records requested by an IRO. Reimbursement shall be made pursuant to §134.120 of this title."

-- In §133.308(n), addition at the end of the subsection a sentence that says, "This subsection does not apply to medical benefit disputes."

-- In §133.308(o), addition of a paragraph (5) that says, "for subclaim medical benefit disputes, no later than the 30th day after the IRO receipt of the IRO fee."

-- In §133.308(p), insertion of a new paragraph (2) that says, "The IRO decision in a review of medical benefits under a health care insurer subclaim must include: (A) a list of all documents reviewed by the IRO, including the dates of those documents; (B) a statement that clearly determines for each disputed health care service whether that service is reimbursable as a medical benefit; (C) an analysis of, and explanation for each medical benefit determination; (D) a certification by the IRO that the reviewing provider has no known conflicts of interest pursuant to the Insurance Code Chapter 4201, Labor Code §413.032, and §12.203 of this title."

-- In §133.308(r)(2), addition of the words "and medical benefit" following the words "In non-network disputes."

-- In §133.308(r)(2)(B), addition of the words "or a medical benefit dispute arising from a subclaim" following the words "in a retrospective medical necessity dispute."

-- In §133.308(r)(2)(B)(ii), addition of the words "and any costs incurred under subsection (m)(4)" following the words "the IRO fee."

-- In §133.308(s), breaking down of the subsection into paragraphs, and the insertion of a paragraph (2) that says "Upon receipt of an IRO decision in a subclaim medical benefit dispute that determines the paid health care to constitute medical benefits, the

carrier must process the reimbursement request, make payment (including fees and costs per subsection (r)), and issue a new explanation of benefits (EOB) to reflect the payment within 21 days."

-- In §133.308(t), that language be incorporated into the rule which sets venue for subclaimant Division contested case hearings in Austin.

Agency Response: The Division declines to make these change, because the rule proposal did not address subclaimants and it would constitute a substantive change if the adopted sections were to include provisions addressing subclaimants. The Division notes that an early, informal draft of this rule did contain provisions specific to subclaimants. However, the overwhelming number of comments received in response to the informal draft indicated that subclaims should be addressed on their own, rather than as a part of this rule, so that the Division can thoroughly and effectively address all the issues associated with subclaims. Rules developed by the subclaim rule team will determine the remedies that are available for subclaimants.

§133.305(a):

Comment: In order to provide consistency, clarity and due process in the medical dispute resolution process, a commenter recommends addition of a new definition to §133.305 which says, "Amount in dispute - the amount in dispute is determined either by the nature of the service or the amount of the service disputed by the insurance carrier. For example, but not by way of limitation: (A) an inpatient admission service is

the determined from the first day of admission to the hospital until the day of discharge from the hospital; or (B) a physical therapy service is the determined from the commencement of initial treatment or the proposed initial treatment to the conclusion of the treatment or proposed treatment if less than six weeks of treatment or proposed treatment; or (C) the amount of the diagnostic study." Additionally, the commenter recommends addition of a new definition to §133.305 which says, "Dispute - a medical fee dispute and/or prospective medical dispute and/or retrospective medical dispute." The commenter explains that this definition should be applied in such a way that: 1) if the dispute concerns inpatient admission, then the amount in dispute includes the entire inpatient admission; 2) if the dispute concerns outpatient ambulatory service center treatment, then the amount in dispute is based on the procedures or services provided on that particular date of service; and 3) if the dispute concerns physical therapy, then the amount in dispute is based on what was requested – for instance, if it is six weeks (two visits each week), then the entire six weeks should be taken into consideration in determining the amount in dispute; or, the amount in dispute could be the entire amount that the carrier is billed.

Agency Response: The Division disagrees and declines to make a change because the proposed definitions are unnecessary and too narrow. The Division notes that the term "amount in dispute" is not used in the sections, so, it is not necessary to provide a definition for the term. The Division also notes that the rule already contains definitions for individual types of disputes, so, it is unnecessary to create a broad definition for the

term "dispute." Additionally, the recommended definition for "dispute" would exclude disputes requiring concurrent IRO review as a type of dispute and is, thus, too narrow.

§133.305(a)(8):

Comment: In regard to §133.305(a)(8), a commenter suggests that the definition of "requestor" as any "party" is ambiguous and may lead to confusion. The commenter says that absent rare situations where an injured worker actually pays for medical services the only parties who should be able to request medical dispute resolution should be providers, employers, or carriers.

The commenter suggests that the proposed section should specify that a claimant may not file for medical fee dispute resolution in a dispute between a provider and a carrier or employer.

The commenter also suggests that for consistency with proposed §133.307(b)(3) and (b)(4), the definition should clarify that a claimant may only file a request for medical dispute resolution when the claimant is in a dispute with a carrier for reimbursement of medical expenses paid by the claimant or the claimant is in a dispute with the medical provider because the claimant paid the provider in excess of the applicable fee guidelines.

Agency Response: The Division disagrees with the commenter's suggestion, and declines to make the recommended change because such a change would place unnecessary and improper limitations on an injured employee's ability to pursue medical

dispute resolution. The Division notes that safeguards are already in place within §133.307 and §133.308 to specify who may request dispute resolution and limit the filing of inappropriate disputes. Section 133.307(b)(3) and (4) states which parties may be requestors in medical fee disputes and §133.308(g)(1) and (2) states which parties may be requestors in medical necessity disputes.

Comment: A commenter suggests that the definition for "requestor" in §133.305(a)(8) is too expansive. The commenter says that the definition, as proposed, could be read to include any injured employee submitting a request for dispute resolution even between medical providers and insurers. The commenter says that if this is permitted, it could shift the cost of the IRO fee in retrospective disputes from the provider to the insurer. The commenter says that an injured employee is not a proper participant in a dispute that arises between an insurer and a health care provider over reimbursement of medical bills and this provision could lead to an injured employee being held more responsible for the costs of treatment beyond what the insurer is willing to pay. The commenter says that its purpose is to leave the employee out of any responsibility for the cost of treatment completely and not have the injured employee drawn into a dispute indirectly.

Agency Response: The Division disagrees with the comment and declines to make a change because a change is unnecessary. The definition for "requestor" in §133.305 is intended to be general and is intended to include an injured employee because injured

employees are allowed to pursue medical dispute resolution. However, it is unnecessary to address the possibility of injured employees becoming inappropriately involved in disputes in §133.305 because safeguards are in place in §133.307 and §133.308. Section 133.307(c)(3) addresses the situations in which an injured employee may request medical fee dispute resolution and §133.308(g)(1)(B) and §133.308(g)(2)(B) address the situations in which an injured employee may request medical necessity review.

Comment: A commenter addresses §133.305(a)(8). The commenter asserts that the definition is contradictory because the party seeking relief is not always the party who filed a request for medical dispute resolution. The commenter says that in later stages the definition does not make sense and that the definition has been interpreted to shift the burden of proof in later proceedings. The commenter recommends dropping the words "the party seeking relief in medical dispute resolution," and suggests changing the definition of "respondent" to reflect that the respondent is the person responding to a request for dispute resolution.

Agency Response: The Division disagrees and declines to make a change because no change is necessary. As noted in §133.305(a), the definitions in §133.305 apply when the terms are used in Subchapter D of 28 TAC Chapter 133 and a requestor is a party who has timely filed a request for medical dispute resolution pursuant to §133.307 or §133.308 because the party is seeking relief under that section.

Because the applicability of the definition is expressly limited to Subchapter D, the definition is not applicable in later stages of the dispute resolution process, unless the section controlling the later proceeding references §133.305 (such as with 28 TAC §148.3(c), which says that a petition must "be signed by a requestor or respondent as defined by §133.305").

The Division notes that 28 TAC Chapter 148, which is relevant to appeals that proceed to SOAH, establishes its own definitions for the parties involved in disputes under Chapter 148. Specifically, a "petitioner" is "the person who has filed a written request for a hearing in accordance with these procedures [the procedures in Chapter 148]," and "respondent" is "the person responding to the petitioner's request for a hearing."

Further, the Department notes that the burden of proof in a Division contested case hearing rests on the party that requests the contested case hearing.

Comment: In regard to §133.305(a)(8), a commenter suggests that the definition of "requestor" is overly broad and suggests revising the definition to say "Requestor – The party that files a request for medical dispute resolution with the Medical Fee Dispute Resolution Section of the Division of Workers' Compensation in a medical fee dispute or files a request for independent review with the insurance carrier; the party seeking relief in medical dispute resolution." The commenter also recommends adding two subparagraphs to the definition that say "(A) An injured employee may not file a request

for medical dispute resolution in a medical fee payment dispute or retrospective medical necessity dispute that arises between a health care provider and carrier, and "(B) An injured employee may only file a request for medical dispute resolution in the manner provided for by §133.307(b)(3) and (b)(4) of this title (relating to MDR Fee Disputes) and §133.308(g)(1)(B) and (g)(2)(B)."

Agency Response: The Division agrees in part, and disagrees in part. The Division agrees to make the suggested change to the definition for "requestor." However, §133.308 already establishes limitations on when an injured employee can request an independent review and §133.307 already establishes limitations on when an injured employee can request fee dispute resolution, so, it is unnecessary to place such limitations in the definition for "requestor." For this reason, the Division disagrees with the suggestion to add new subparagraphs (A) and (B) to the definition and declines to make this recommended change.

§133.305(c):

Comment: A commenter notes that §133.305(c) allows the Division to assess fees against providers. The commenter says that the provision fails to recognize that good faith disagreements can occur. The commenter says that fees should not be assessed in the absence of bad faith and requests that the subsection either be deleted or modified to include a lack of good faith in the action of the carrier or provider as triggering the imposition of division administrative fees.

Agency Response: The Division disagrees with the comment and declines to make a change because no change is necessary. Assessment of an administrative fee is discretionary on the part of the Department and is based upon the specific facts of each medical dispute.

§133.307:

Comment: In regards to §133.307, a commenter suggests that if medical providers believe a Division contested case hearing would offer an advantage to them over a SOAH review, they might "unbundle" services to qualify for review through a Division contested case hearing. The commenter says that it is critical that the section contain a prohibition on medical providers or other requestors from unbundling services that are related to treatment involving the same injury.

The commenter also suggests that the proposed rule should contain an affirmative requirement that all services related to the same injury shall be consolidated in a single claim and that consolidated claims over the applicable maximum dollar amounts be transferred to SOAH.

Agency Response: The Division declines to make a change regarding "bundling" of claims. The Legislature could have chosen to require a party to bring all disputes that may be related to a claim at one time, but, it did not choose to do so. The Division believes that to create such a requirement by rule would impose burdens and delays not intended by the Legislature because a party would have to wait before it could request

dispute resolution and might miss the required deadlines for earlier disputes. Additionally, a requirement that all related disputes be brought at one time could create a conflict with the dispute sequence requirements of §133.305(b), which requires that disputes regarding compensability, extent of injury, liability, or medical necessity be resolved prior to the submission of medical fee disputes.

The Division clarifies that nothing prevents a health care provider from combining medical bills for the same patient and the same claim (with multiple dates of service) into one medical fee dispute. If appealed, after a medical dispute decision is issued, such a dispute would be considered one medical fee dispute for proceedings in a contested case hearing.

§§133.307(a), 133.308(a); 133.307(f)(2)(D) and 133.308(B)(v):

Comment: Commenters cite the applicability provisions in §133.307(a) and §133.308(a). The commenters say that they disagree with the intent to apply all of §133.307 and §133.308 to medical fee disputes that have already been filed and in which documentary exchanges have already been made. One commenter states that although the Legislature made the statute providing the right to a hearing effective as stated there is no requirement that aspects of these proposed rules dealing with evidentiary issues at hearings must be effective on the listed dates. A commenter asserts that the proposed sections impermissibly apply evidentiary provisions retroactively. A second commenter says that the section cannot be made applicable

retroactively to a time when another statutory provision existed. The commenter says that disputes filed prior to September 1, 2007 must be handled under the statute and rule in effect at the time the dispute was filed.

The first commenter recommends that the effective date of §133.307(f)(2)(D) and §133.308(B)(v) be the date the rules are adopted and that the provisions be applied to disputes filed after that date. The second commenter recommends that the proposed language making the section applicable to health care pending on September 1, 2007 be deleted.

Agency Response: The Division agrees in part and disagrees in part. A primary purpose of these rules is to implement HB 724, which provides a process for the appeal of administrative disputes arising under Labor Code §413.031. The Labor Code provision that had provided the process for appealing administrative decisions (Labor Code §413.031(k) as revised by HB 7, 79th Regular Legislative Session) was found to be unconstitutional, so prior to HB 724, there was no statutory provision in place to provide a process for appealing administrative decisions under Labor Code §413.031. To resolve the lack of statutory provisions, the enacting clause in Section 9 of HB 724 makes the bill applicable to "workers' compensation medical disputes described by Section 413.031, Labor Code, as amended by this Act and Section 413.0311, Labor Code, as added by this Act… that are pending for adjudication by the division of workers' compensation of the Texas Department of Insurance on or after the effective date of this Act [September 1, 2007]…."

In regard to the appeal of a dispute described by Labor Code §413.031 or §413.0311, the Division disagrees that it is attempting to make these processes retroactive to a time when another statutory provision existed, because there was not a valid statutory provision in place prior to HB 724, only the unconstitutional statutory provision found in Labor Code §413.031(k) as it existed prior to HB 724. In regard to the appeal of a dispute described by Labor Code §413.031 or §413.0311, the Division is using the specific terms of applicability listed in Section 9 of HB 724.

However, not all the amendments in §133.307, and §133.308 are based on HB 724, so the effective dates in Section 9 of HB 724 would not be applicable to them.

For this reason, the Division agrees in part with the commenter and disagrees in part with the commenter. In response to the comment the Division has changed the applicability provisions in §133.307(a) and §133.308(a) to specify that §133.307 and §133.308 are applicable to disputes filed May 25, 2008; however, the Division has also adopted language §133.307(a) and §133.308(a) that keeps the proposed dates of applicability in regard to §133.307(f) and §133.308(t)(1), the subsection in §133.307 and the paragraph in §133.308(t) that implement HB 724. Because these provisions implement HB 724 in order to cover the statutory gap addressed by HB 724, these provisions adopt the specific terms of applicability listed in Section 9 of HB 724.

§133.307(b):

Comment: In regard to §133.307(b), a commenter asks why carriers and third party administrators have been removed from the list of parties that may request a fee dispute. The commenter says that not allowing carriers to file fee disputes necessitates the filing of a complaint when a party refuses to refund an overpayment following subsequent denial after reconsideration. The commenter says that it takes a significant period of time for TDI to investigate a complaint and take enforcement action. Further, it is confusing to providers that they must refund a disputed amount following denial of reconsideration and also a fee dispute if they disagree with the carrier's findings.

Agency Response: The Division clarifies that in proposed §133.307(b) it did not remove carriers or third party administrators from the list of parties that may request fee dispute resolution. No changes were proposed for §133.307(b), and parties who may request a fee dispute are the same under the proposal as under current rules.

The process for refund of a payment by a provider to a carrier is regulated by Labor Code §408.0271 (relating to Reimbursement by Health Care Provider) and 28 TAC §133.260 (relating to Refunds). Labor Code §408.0271 provides a refund process in which the carrier must notify a provider of its decision that the care that was reimbursed for has been found to be inappropriate and demand reimbursement from the provider. Under Labor Code §408.0271, a health care provider is required to refund a payment for a service found by the carrier to be inappropriate and failure to reimburse a payment constitutes and administrative violation. Additionally, under Labor Code

§408.0271, it is the health care provider that has the option of filing an appeal based on a carrier demand for reimbursement.

Rule provisions that provide a refund process in conflict with the requirements of Labor Code §408.0271 would not be valid.

§133.307 (c)(1)(A); (c)(2)(A), (B) and (E); and (e)(3); and §133.308(j)(4):

Comment: A commenter states that if health care insurer subclaimants are to proceed to dispute resolution in the same manner as injured employees or health care providers, then the rule should be amended to provide exceptions when requirements for injured employees and/or health care providers would not be applicable to health insurer subclaimants.

Specifically, the commenter says that §133.307(c)(1)(A) requires that requests for medical fee dispute resolution be filed within one year after a date of service, but, many subclaims filed under Labor Code §409.009 relate to dates of service older than one year. The Commenter notes that health care insurer subclaimants may obtain data on claims going back to September 1, 2002, and HB 724 provides that a health care insurer must file a request for reimbursement with the workers' compensation insurance carrier not later than six months after the date on which the health care insurer received information under Labor Code 402.084(c-3) and not later than 18 months after the health care insurer paid for the health care service. The commenter also notes that HB 724 provides that for subclaims based on data matched prior to January 1, 2007, a

subclaimant may file a subclaim or request for reimbursement by March 1, 2008. The commenter says that the Division could have made the time limits for providers and claimants applicable to subclaimants, but did not. The commenter recommends that subclaimants be made exempt from the one year filing requirement under §133.307(c)(1)(A) since it conflicts with specific statutory provisions relating to subclaimants.

Additionally, the commenter says that subclaimants filing medical fee disputes should be exempt from document submission requirements in §133.307(c)(2)(A), (B) and (E), because a health care insurer would not possess these documents. The commenter says that a subclaimant should only be required to provide documentation that forms the basis for a reimbursement request or medical records exchanged pursuant to Labor Code §409.0091 because a requirement for additional medical records would place the Division's fee dispute in the position of deciding issues that go beyond the request for reimbursement.

In addition, the commenter notes that §133.307(e)(3) provides reasons for dismissal of a medical fee dispute. The commenter says that subparagraphs (D) and (F) should not apply to subclaimants. The commenter notes that subparagraph (D) allows dismissal when the health care in question has previously been adjudicated by the Division and the commenter says that an exception is necessary to prevent the Division from dismissing a medical fee dispute that did not involve the HCI subclaimant as a party. The commenter notes that subparagraph (F) allows dismissal of a request

for dispute resolution if the Division determines that the medical fee dispute is for health care services "provided pursuant to a private contractual fee arrangement." The commenter says the clear intent of the provision is for it to be applicable when a contract exists between a workers' compensation carrier and a health care provider. The commenter says that a large number of subclaims will be based on health care services paid by a health care insurer under a contract with a health care provider and subclaimants should be exempt from the provision.

Additionally, the commenter notes that §133.308(j)(4) allows the Department to dismiss a request for independent review if the Department has previously resolved the dispute for the dates of health care in question. The commenter notes that while a request for IRO review may involve health care that has already been the subject of an IRO review, the parties to the dispute may not be the same if a subclaimant is involved. The commenter says that a subclaimant should not have a request dismissed based on an IRO review filed by another party.

Finally, the commenter notes that the DWC-60 form does not have a box for a HCI subclaimant to check as a requester or respondent.

Agency Response: The Division declines to make a change, because the rule proposal did not address subclaimants and it would constitute a substantive change if the adopted sections were to include provisions addressing subclaimants. The Division notes that an early, informal draft of this rule did contain provisions specific to subclaimants. However, the overwhelming number of comments received in response

to the informal draft indicated that subclaims should be addressed on their own, rather than as a part of this rule, so that the Division can thoroughly and effectively address all the issues associated with subclaims. Rules developed by the subclaim rule team will determine the remedies that are available for subclaimants.

§133.307(c)(2):

Comment: Three commenters suggest adding an additional requirement to §133.307(c)(2) to require a requestor to identify all other fee disputes between requestor and carrier involving the same patient with the same date of injury and for which the requestor has or will seek additional reimbursement. One commenter says that such a requirement would assist in avoiding multiple contested case hearings between the parties. Another commenter says such a change would expedite the resolution of all issues involving that employee and save transactional costs for all.

Agency Response: The Division disagrees with the suggested language establishing a requirement for the requestor to identify other medical fee disputes for which it may seek additional reimbursement and declines to make a change. Not all medical fee disputes will be appealed to a contested case hearing, thus, identifying all other medical fee disputes whether closed or active would serve no purpose.

The Division does clarify that a requestor may combine medical bills for the same injured worker and date of injury, if, upon initial request, the dates of service are within one year or meet the exceptions as outlined in §133.307(c)(1)(B). Such a request,

although consisting of several medical bills, would be considered one medical fee dispute. This dispute may be appealed to the next administrative level together as it related to the statutory language of §413.0111(a)(1) "a medical fee dispute."

§133.307(c)(2)(A):

Comment: A commenter expresses support for the provision in §133.307(c)(2)(A) that calls for a requestor to file a paper copy of disputed medical bills, but recommends that the requirement be for electronic billing data to be submitted in a format prescribed by the Division to avoid the data being filed using multiple formats. The commenter says that such a requirement would avoid confusion that could arise if the format for submitting a bill is not specified.

Agency Response: The Division agrees with the comment and has made the recommended change.

§133.307(c)(3):

Comment: A commenter suggests making changes to §133.307(c)(3) to require an injured employee to show verifiable or confirmable proof of payment for treatment received, such as copies of receipts, cancelled checks, or credit card receipts or payments, as part of the request for hearing. The commenter suggests that this requirement would prevent situations where "the doctor tells the employee, 'Look, I am

not going to go ahead and bill you now. But in order for me to get paid, go ahead and submit this request and act like you have already been charged for this treatment.'"

Agency Response: The Division disagrees because the rule already places limitations on when an injured employee can request fee dispute resolution, thus, the recommended changes are unnecessary. Additionally, the recommended changes would create the requirement that an injured employee prove standing before the Division would consider the underlying issues of the dispute, this would place an unnecessarily burden on injured employees' access to the dispute resolution system. The Division notes that the hypothetical situation described by the commenter would constitute fraud and would be prohibited under the current rule.

§133.307(c)(3)(C):

Comment: Several commenters made suggestions in regard to the proposed text change in §133.307(c)(3)(C).

One commenter suggests adding the words "EOB statements" in front of the words "provider billing statements, and changing the word "like" to "similar."

Another commenter asserts that the proposed text would change a requirement for "proof" to be only "documentation" and that the proposed text says that provider billing statements are a type of evidence sufficient to demonstrate payment by an employee. The commenter says that the rule was sufficient and that no compelling reason exits to dilute the current requirement that proof of payment be filed by the

employee. The commenter asserts that an employee should only be permitted to bring a dispute if he or she can offer proof of actual payment and an employee certainly cannot win the case without "proof" of payment. The commenter says that weakening the requirement to mere "documentation" is merely an invitation to commit fraud and the potential use of forged documents. The commenter also says that listing "provider billing statements or like documents" as sufficient evidence of payment of the bill by the employee is extremely problematic because receipt of a bill is not proof of payment of a bill. The commenter says that it would be fraudulent to offer a bill into the record as proof of payment and that the proposed rule text would create unnecessary disputes and invite fraud.

Three other commenters also say that "provider billing statements or like documents" would not substantiate that an injured employee actually paid for medical care and ask that the text be amended to state that the injured employee must submit proof of actual payment. Two of the commenters specifically ask that the text be changed to say "proof of employee payment, such as receipts that document payment by the injured employee, and cancelled checks." One of the commenters asserts that a provider billing statement by itself does not adequately prove that an injured employee has made payment. Another commenter asserts that this recommended change would: "(1) ensure that the parties submit all relevant materials to the dispute; (2) deter fraud; (3) deter gamesmanship on the part of some injured workers' and some health care providers; and (4) comply with the Texas Constitution among other reasons."

Agency Response: The Division agrees in part and disagrees in part, and the Division agrees to make a revision to the rule text.

In regard to the first commenter, the Division agrees that a provider EOB statement might be a relevant piece of evidence in determining whether an injured employee had paid for medical services and what amount the injured employee has paid. However, the intent is not to provide an exhaustive list of potential evidence in §133.307(c)(3)(C). Instead, the items listed in the subparagraph are intended to be examples of what might be offered as evidence. Rather than adding to the list of possible evidence, the Division has added the word "including" in front of the words "copies of receipts" as an indication that the list is not exhaustive. The Division agrees to change the word "like" to "similar."

In regard to the commenters who express concern over the proposed change of the word "proof" to "documentation," the Division clarifies that §133.307(c)(3)(C) does not establish the burden of proof an injured employee must meet, but only lists the types of evidence an injured employee should provide to the Division in support of its claim. As such, changing the word "proof" to documentation" does not weaken an injured employee's burden. However, the Division agrees to change the word "documentation" back to "proof" in the adopted rule text.

The Division disagrees with the comment that suggests including provider billing statements as a type of evidence is an invitation to fraud. The Division notes that the section does not state that a provider billing statement "is sufficient evidence of payment

of the bill by the employee." A billing statement, in and of itself, is not sufficient to prove that a party paid a bill. However, a billing statement could support such a finding if it is offered in conjunction with other evidence, such as a canceled check in the amount of the bill that is made out to the provider named on the billing statement. Additionally, the Division clarifies that the term "like documents" is not solely a reference to provider billing statements, but is a reference to all the types of documents listed in the subparagraph. Finally, the Division does not agree that the recommendation would ensure that parties submit all relevant materials to the dispute, deter fraud or gamesmanship, or is required by the Texas Constitution. For these reasons, the Division declines to delete the words "provider billing statements." As noted above, the Division has changed the words "like documents" to "similar documents."

§133.307(d)(1):

Comment: A commenter notes that §133.307(d)(1) says a response is deemed timely if received by the Division within 14 calendar days after the date the respondent received the requestor's dispute.

The commenter says that determining timelines based on when documents are received may become a disputed issue.

The commenter suggests changing all time frames to set a time frame that DWC can actually verify should a dispute over timeline arise, e.g., base the time frame on when documents are filed and not when received by the respondent.

Agency Response: The Division disagrees with the suggestion and declines to make a change, because no change is necessary. As outlined in §133.307(c)(4), the Division forwards the dispute request to the respondent, and the respondent is deemed to have received the request on the acknowledgement date as defined in 28 TAC §102.5 (relating to General Rules for Written Communications to and from the Commission). 28 TAC §102.5(d) states, "For purposes of determining the date of receipt for those written communications sent by the Commission which require the recipient to perform an action by a specific date after receipt, unless the great weight of evidence indicates otherwise, the Commission shall deem the received date to be the earliest of: five days after the date mailed via United States Postal Service regular mail; the first working day after the date the written communication was placed in a carrier's Austin representative box; or the date faxed or electronically transmitted." Given the provisions in §133.307(c)(4) and §102.5(d), it is possible to calculate the date of receipt, which means it is possible to calculate the date on which the response is due.

In addition, when the Division places documents in a carrier representative box, a "carrier sign sheet" requesting a signature acknowledging receipt of documents is attached. This document is maintained in the dispute file.

§133.307(d)(2)(A)(i) and (A)(ii):

Comment: In regard to §133.307(d)(2)(A)(i) and (A)(ii), a commenter requests clarification regarding the requirement for the carrier to provide "in a paper format."

The commenter expresses an assumption that the provision allows a carrier to submit e-billing and payment data in a paper format of its choice.

Agency Response: The Division clarifies that paper formats used should be in a Division approved billing format. To further clarify that paper formats used should be in a Division approved billing format, the Division has made a change to the proposed rule text that specifies this.

§133.307(d)(2)(B):

Comment: Two commenters address §133.307(d)(2)(B).

One commenter says that during the medical dispute resolution process the provider is allowed to present all reasons to support additional reimbursement and is not limited to only those reasons given to the carrier prior to filing the request for MDR.

The commenter says that a carrier should be allowed to present all reasons to support denial, and not be limited to the reasons presented to the provider prior to filing of the request for medical fee dispute resolution.

The commenter says that this denies the carrier of the right to a meaningful audit and helps promote billing fraud.

The commenter says that Labor Code §408.027 requires the carrier to pay or dispute a medical bill within 45 days of receipt of it, and that the statute allows the carrier to audit the bill and is required to complete the audit within 160 days of receipt of the bill. The commenter says that if the provider requests medical fee dispute resolution

prior to completion of the audit, the carrier is deprived from using any new reasons for denial discovered during the audit.

A second commenter says that the provision is directed at carriers, and that it is a "one-way street." The commenter notes that parties are allowed to make amendments to their pleadings or arguments at virtually every level of a dispute process, but that this is the only dispute process that essentially establishes a statute of limitations that doesn't exist in the statute. Additionally, the commenter says that the point when new issues are cut off is established by the opposing party. The commenter says that this prevents a full airing of issues.

The commenter notes that it previously commented on this provision when the rule was last revised, and that the apparent response of the Division was to add subsection (e)(2) which allows the Division *sua sponte* to add its own issues. However, says the commenter, in its experience the Division does not use subsection (e)(2).

Agency Response: The Division disagrees with the comments, and declines to make a change.

The Division clarifies that pursuant to 28 TAC §133.230(a), an insurance carrier may perform an audit on a medical bill that has been submitted by a health care provider to the insurance carrier for reimbursement. However, the insurance carrier may not audit a medical bill upon which it has taken final action. In addition, §133.230 provides that if an insurance carrier decides to conduct an audit, the insurance carrier shall provide notice to the health care provider no later than the 45th day after the date

the insurance carrier received the completed medical bill. This would mean that that no explanation of benefits with reasons for denial for final action would have been received at the point the insurance carrier notified the health care provider of the audit. Therefore, when the insurance carrier completes the audit, there will be no "new" reasons; there will be the "original" reasons for payment, reduction or denial on the first explanation of benefits for final action after the audit. The carrier has the opportunity to include all reasons for denial in the explanation of benefits sent after the audit.

The health care provider, if unsatisfied with the carrier's final action, may request reconsideration as a prerequisite to requesting medical dispute resolution. A carrier has two opportunities to bring up reasons for payment reduction or denial prior to medical dispute resolution.

The Division notes that carriers are not singled out, and that limitations do exist on the issues that a provider can raise in a medical fee dispute resolution proceeding. Specifically, pursuant to §133.307(e)(3)(G), the Division will dismiss a request for fee dispute resolution if it contains issues concerning unresolved adverse determinations of medical necessity. This provision is also related to subsection (e)(2), commented on by the second commenter. Under (e)(2), the Division may raise issues of medical necessity when it determines that they exist, but were not voiced in the request or response for medical fee dispute resolution. Once raised, this would result in a dismissal pursuant to §133.307(e)(3)(G).

Comment: A commenter expresses support for the concept of prohibiting new issues and defenses from being raised subsequent to a filing of a response to a dispute, and recommends the adoption of this paragraph without changes.

Agency Response: The Division appreciates the support, but clarifies that §133.307 (d)(2)(b) says the response shall address only those denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed with the Division and the other party, not subsequent to filing a response. The limitation is based on the date the request for medical dispute resolution is filed.

§133.307(d)(3)(A):

Comment: A commenter notes that §133.307(d)(3)(A) requires a health care provider responding to a request for medical fee dispute resolution to include with its response copies of relevant medical bills in a paper billing format. The commenter suggests that the provision additionally specify that the paper billing format be a format prescribed by the Division, in order to avoid confusion that could arise if the format is not specified. The commenter suggests that the provision require the provider to submit its electronic billing data using the appropriate DWC approved billing form.

Agency Response: The Division agrees with the comment, and has changed the text in §133.307(d)(3)(A) to specify "in a paper billing format using an appropriate DWC approved billing format."

§133.307(e),(f)(1) and (2):

Comment: In regard to §133.307(e),(f)(1) and (2), a commenter suggests changing the phrase "in which the amount of reimbursement sought" to "in which the amount in dispute sought."

The commenter says that this change will: "(1) ensure that the parties submit all relevant materials to the dispute; (2) deter fraud; (3) deter gamesmanship on the part of some injured workers' and some health care providers; and (4) comply with the Texas Constitution among other reasons."

Agency Response: The Division disagrees with this comment and declines to make a change, because the suggested change would be contrary to Labor Code §413.0311. The Legislature specifically uses the term "amount of reimbursement sought" in Labor Code §413.0311. For this reason, the term has been incorporated into the rule. The Division believes that use of the term in the statute shows Legislative intent that the determining factor for whether a dispute should proceed to SOAH or to a Division CCH is to be the amount of reimbursement sought, and the Division does not believe that it has authority to adopt a different factor on which to make such a determination.

§133.307(e),(f)(1)(B), and (f)(2)(A):

Comment: In regard to §133.307(e), (f)(1)(E)B), and (f)(2)(A), two commenters suggest adding the words "by verifiable means" to the end of each provision. One of the commenter says that this suggestion will: "(1) ensure that the parties submit all

relevant materials to the dispute; (2) deter fraud; (3) deter gamesmanship on the part of some injured workers' and some health care providers; and (4) comply with the Texas Constitution among other reasons."

A third commenter offers a similar suggestion, asking that a party's request for an appeal not be considered "timely" unless the copy of the request sent to the opposing party is provided via certified mail. In support of this suggestion, the commenter notes that insurers all too often never receive a copy of a request to appeal an MDR decision, and that establishing such a requirement as this would encourage compliance.

Agency Response: The Division disagrees with the comments and declines to make a change. These referenced provisions already require a party to send copies of the noted documents to opposing parties, so if the opposing party does not receive the document, it can raise an argument or base an objection on the fact that it did not receive the document. If such an argument is made, the party responsible for sending the documents will already need to show that the documents were sent. Addition of the words "by verifiable means" would not enhance a party's ability to object to documents; it would just create a new issue to be determined, and actually lead to additional "gamesmanship," because a party might have received the documents, but could still argue that it did not receive the document by verifiable means. Additionally, the Division does not see which provision of the Texas Constitution would require such a change.

§307(e)(1):

Comment: A commenter cites §133.307(e)(1), which requires a party to submit additional information to the Division upon a request for such information. The commenter recommends inserting the following sentence into the provision, immediately following the requirement that a party submit the requested additional information no later than 14 days after it is requested: "If the information requested by the Division is not in the possession of the party, the party shall notify the Division within the 14 day time limit."

Agency Response: The Division disagrees with the comment and declines to make a change, because the recommended change is unnecessary and would just add costs for system participants. If a party does not supply additional information to the Division within 14 days of a request for additional information, the Division makes a determination using the information it has. Received notice from a party indicating that the party has no additional information would not change the Division's actions. However, the requirement would create a cost for the party required to send the notice.

Comment: In regard to §133.307(e)(1), a commenter suggests that the Division clarify whether the Division must receive additional information within 14 business days or 14 calendar days.

Agency Response: The Division draws the commenter's attention to 28 TAC §102.3(b). Section 102.3 (b) states, "A working day is any day, Monday - Friday, other than a national holiday as defined by Texas Government Code, §662.003(a) and the

Friday after Thanksgiving Day, December 24th and December 26th. Use in this title of the term 'day,' rather than "working day" shall mean a calendar day." The Division clarifies that, pursuant to §102.3(b), use of the term "day" means "calendar day."

§133.307(e)(3):

Comment: Two commenters note that §133.307(e)(3) allows the Division to dismiss a request for medical fee dispute resolution, and that §133.307(f) provides that a party to a medical dispute may seek review of the medical dispute resolution decision or dismissal. However, commenters say the provision fails to state what the basis of the appeal would be in the event a request for medical fee dispute resolution is dismissed. The commenters ask that the section be changed to limit the issues in an appeal of a dismissal to only the reason for dismissal. Additionally, the commenters say that the rule does not provide the Division authority to dismiss a request for medical fee dispute resolution upon finding that the disputed health care treatment is not related to the compensable injury or finding that there is no compensable workers' compensation claim.

In regard to these points, one commenter suggests: 1) adding a new basis for dismissal that says the Division may dismiss a request for medical fee dispute resolution if "the Division determines that the dispute health care was provided for an injury that is not compensable," and 2) adding a new subparagraph to the provision that

says "An appeal of a Division dismissal shall be limited to the reason the Division has dismissed the dispute."

Agency Response: The Division agrees in part and disagrees in part. The Division has modified §133.307(e)(3)(J) to say that a request for fee dispute resolution may be dismissed if "the Division determines that good cause exists to dismiss the request; including a party's failure to comply with the provisions of this section." The Division agrees that all disputing parties, if known, should receive a copy of a dismissal with the specific reasons for dismissal and it is the Division's procedure to provide copies to all disputing parties. However, the Division does not agree that the appeal of dismissals needs to be addressed in the rule text in §133.307. Instead, issues in a Division contested case hearing are established pursuant to 28 TAC §142.7 of this title (relating to Statement of Disputes), and issues in SOAH hearings are established pursuant to SOAH rules.

The Division agrees that fee dispute resolution would not be appropriate when health care services are found to not be related to a compensable injury. The Division has amended §133.307(e)(3)(J) to say that a request for fee dispute resolution may be dismissed if "the Division determines that good cause exists to dismiss the request; including a party's failure to comply with the provisions of this section." If issues of medical necessity or compensability have already been raised and conclusively adjudicated, no medical necessity exists, or the service is not related to a compensable claim then good cause would exist to dismiss the request for fee dispute resolution.

§133.307(e)(3)(C):

Comment: In regard to §133.307(e)(3)(C), a commenter suggests that the provision creates a conflict with §133.307(f), which does not require an injured employee to seek reconsideration for reimbursement for health care services paid by the injured employee. The commenter says that an injured employee is not required to seek reconsideration for health care services paid, and that dismissal of a request for medical fee dispute resolution based on the injured employee's failure to submit the dispute to the carrier for reconsideration would be inappropriate.

Agency Response: The Division clarifies that §133.307(e)(3) says that the Division "may" dismiss a request for Medical Fee Dispute Resolution for failure to request reconsideration for medical bills submitted. The action of dismissal is discretionary on the part of the Division, and an injured employee is not expected or required to seek request for reconsideration for health care services paid for out of pocket. The requirement for reconsideration is established by 28 TAC §133.250, and is applicable to health care providers, not injured employees.

§133.307(f):

Comment: A commenter cites §133.307(f)(1) and (2), and suggests that the paragraphs be rewritten to clarify that the dollar amount threshold is defined by the amount stated in the initial request for dispute resolution.

Agency Response: The Division disagrees with the comment and declines to make a change, because a change is unnecessary. As proposed, the rule text provides that the determination is based on the amount sought by the requestor in its requests for MDR. A party only files one request for MDR, so it is unnecessary to include the adjective "initial."

Comment: A commenter references §133.307(f)(1)(A) and (2)(A), noting that it provides that a written request for a contested hearing before SOAH or the Division must be filed more than 20 days after the date on which the medical review decision is received before the Division. The commenter also notes that §133.307(f)(2)(B) and §148.3(d) provide that a medical review decision becomes final if not timely appealed. The commenter suggests that party may not be able to meet these time frames in regard to a medical review decision that has been decided prior to the effective date of the adopted rule or a medical review decision that has been remanded. The commenter suggests adding a new paragraph to §133.307(f) which says "A request for a contested case hearing of a MDR decision or dismissal relating to a medical fee dispute that is pending on (effective date of the adopted rule changes) or that is remanded to the Division from a district court without prior review by SOAH shall be considered timely filed if the request is filed with the Division's Chief Clerk by (90 days from the effective date of the adopted rule changes) or no later than the 90th day after the date on which the medical fee dispute is remanded to the Division."

Agency Response: The Division agrees in part, and disagrees in part. The Division agrees that questions might exist in regard to the time frame for a party to file a request for an appeal to a Division contested case hearing when a medical dispute decision was issued between September 1, 2007, and the effective date of the rule. The Division recognizes that this concern is applicable to appeals to Division contested case hearings under both §133.307(f)(2)(B) and §133.308(t)(1)(B)(i). However, the Division does not agree that such a question exists regarding appeals to SOAH contested case hearings, because 28 TAC §148.3 was in effect on September 1, 2007, and it provides the time frame for filing an appeal to SOAH.

The Division does not agree that 90 days is a reasonable amount of time to allow a party with such a decision to file an appeal. The Division has modified §133.307(f)(2)(A) to say, "To request a Division contested case hearing, a written request for a Division contested case hearing must be filed with the Division's Chief Clerk no later than the later of the 20th day after the effective date of this section or the 20th day after the date on which the decision is received by the appealing party…," and the Division has modified §133.308(t)(1)(B)(i) to say "The written appeal must be filed with the Division's Chief Clerk 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…."

The Division disagrees that a time frame needs to be established for a party to request setting for a remanded dispute, because such a time frame is unnecessary. If

the Division receives a court order ordering that a hearing be set for a remanded dispute, the Division will comply with the court order. The Division does not have authority to deny a hearing for a dispute when the dispute has been remanded by a higher court.

§133.307(f)(2):

Comment: Regarding §133.307(f)(2), a commenter suggests that the Division should amend the provision to provide a more efficient dispute resolution process which would avoid multiple contested case hearings on the same claim. To this end, the commenter suggests adding a new subsection that says, "If at the time of the contested case hearing there are additional medical fee disputes between the parties involving the same patient and same date of injury then either party may file a motion or the hearing officer may issue an order to consolidate the additional fee disputes into the medical fee dispute set for contested case hearing." A second commenter also suggests adding this text, along with a provision that says "Failure of the parties to join additional medical fee disputes involving the same patient and same date of injury that could have been made a part of the contested case hearing proceeding will result in a waiver by the party requesting MDR to pursue that disputed issue further." The second commenter asserts that such a change would make the medical dispute resolution system more efficient and would prevent requestors from gaming the system by breaking down large dollar medical dispute into several smaller disputes that would each require a hearing.

Agency Response: The Division disagrees with the comments and declines to make a change. The current dispute resolution process was devised by the Legislature and incorporated into Labor Code §§413.031, 413.0311, and 413.032, and the Division lacks authority to substitute that process with a different dispute resolution process.

Requiring a health care provider to consolidate all medical bills where additional reimbursement is sought before filing with medical dispute resolution would be administratively burdensome, and requiring a coordination of initial bill submissions and requests for reconsideration for different dates of service, just to consolidate a medical dispute, might cause the health care provider to miss a filing deadline.

However, the Division clarifies that nothing prevents a health care provider from combining medical bills for same patient and same claim, with multiple dates of service into one medical fee dispute. If appealed after a medical dispute decision is issued, it would be considered one medical fee dispute for proceedings in a contested case hearing.

§133.307(f)(2)(B):

Comment: In regard to §133.307(f)(2)(B), a commenter says that the section creates two different rules for determination of timely filing without rationale. The commenter says that for appeals to SOAH under 28 TAC §148.3(b), filing in the Central Office, not a field office, is required.

The commenter says that the section also contradicts proposed §133.308(t)(1)(B)(i), relating to IRO appeals to a contested case hearing.

Agency Response: The Division disagrees with the commenter and declines to make a change. The Division notes that two different rules for determination of timely filing are not established, as §133.307(f)(2)(B) is only applicable to contested case hearings before the Division, and 28 TAC §148.3(b) is only applicable to contested case hearings before SOAH.

The Division notes that §133.307(f)(2)(B) does not contradict §133.308(t)(1)(B)(i), as the two sections deal with different types of disputes. However, in response to another comment, the Division has adopted a revised version of §133.308(t)(1)(B)(i) that more closely resembles §133.307(f)(2)(B).

§133.307(f)(2)(B) and §133.308(t)(1)(B)(ii):

Comment: A commenter notes that §133.307(f)(2)(B) allows appeals to be submitted at DWC field offices, but that §133.308(t)(1)(B)(i) requires appeals for medical necessity disputes to be sent to the DWC Chief Clerk. The commenter suggests that for consistency in the place and manner in which one files a dispute, parties be allowed to file disputes in local fields offices, which would then be forwarded to DWC's Chief Clerk for processing.

Agency Response: The Division agrees with the commenter that there should be consistency in how appeals are filed, and the Division agrees to adopt a revised version

of §133.308(t)(1)(B)(i) which provides for a party to be able to file a written request for a Division contested case hearing at a local field office of the Division.

§133.307(f)(2)(C):

Comment: A commenter recommends that the provision concerning letters of clerical correction be moved from §133.307(f)(2)(C) and made the sole provision in subsection (f), and that the remaining provisions in proposed subsection (f) be renumbered as subsection (g).

Agency Response: The Division disagrees with this comment and declines to make a change. The Division observes that current placement of the provision regarding letters of clerical correction means that it is only applicable to Division contested case hearings, and notes that the commenter's suggestion would result in the provision being applicable to both SOAH hearings and Division contested case hearings. However, it is unnecessary to make the provision regarding letters of clerical correction applicable to SOAH hearings, because 28 TAC §148.3(e) already provides a provision regarding letters of clerical correction that is applicable to SOAH hearings. For this reason, the recommended change would be redundant, and would possibly result in a conflict between §§133.307 and 148.3.

Comment: In regard to §133.307(f)(2)(C), a commenter recommends that the sentence, "Prior to a Division contested case hearing, either party may request a clerical

correction of an error in a decision," be rewritten as, "Prior to a Division contested case hearing, either party may request a correction of a clerical error in a decision."

The Commenter also recommends that the sentence, "Only the Division can determine if a clerical correction is required," be rewritten as, "The Division shall determine if a clerical correction is required."

Finally, the commenter recommends that the sentence, "A request for clerical correction does not alter the deadlines for appeal" be rewritten as, "A request for a correction of a clerical error does not alter the deadlines for appeal."

The commenter asserts that the recommended changes will "(1) ensure that the parties submit all relevant materials to the dispute; (2) deter fraud; (3) deter gamesmanship on the part of some injured workers' and some health care providers; and (4) comply with the Texas Constitution among other reasons."

Agency Response: The Division agrees in part and disagrees in part. The Division does not see how the recommended changes address submission of relevant materials or how they would deter fraud or gamesmanship, and the Division does not understand which provision of the Texas Constitution would require such changes. However, the Division does agree to make the first and third recommended text changes.

The Division declines to make the second recommended change, because it would change the meaning of the text. As proposed, the text indicates that allowing a party to request correction of a clerical error does not confer onto the party the ability to determine that a clerical error is required. However with the commenter's suggested

change, the text would no longer impart that information; instead, the text would state that the Division has a duty to make a determination regarding the need for a correction of clerical error.

§133.307(f)(2)(D):

Comment: A commenter quotes proposed §133.307(f)(2)(D) and asserts that the provision conflicts with the Texas Constitution; the case of *Hartford Cas. Ins. Co. v. State*, 159 S.W.3d 212, 216 (Tex. App.-Austin 2005, pet filed); Labor Code §413.031; and the Administrative Procedure Act. The commenter also says that the Honorable Travis County District Judge Stephen Yelenosky has ruled that parties are entitled to full contested case hearings under the Texas Constitution.

The commenter says that the Texas Constitution and both statutes require a contested case hearing be held as a *de novo* proceeding in which the Division conducts a formal hearing, takes witness testimony, and rules on objections to evidence. The commenter says that because of this, it is appropriate to allow a party to have an opportunity to offer evidence in a formal contested case process that allows for discovery, witness testimony, and cross-examination.

The commenter notes that a party is required to present a request for review at a level below the Division contested case hearing. The commenter says that withholding information is inconceivable, because trying a contested case is a waste of time and resources if the dispute could be resolved at the more informal agency.

The commenter concludes by asking that the Division withdraw the proposal and comply with the laws of the state.

Agency Response: Based on the numerous comments received regarding limitations on evidence, the Division did not adopt proposed §133.307(f)(2)(D). The subparagraphs in §133.307(f)(2) have been renumbered as appropriate.

Comment: A commenter expresses belief that limiting the evidence that may be presented at a contested case hearing is a violation of the due process provisions in the state and federal Constitutions, and says that that the Division should make all efforts to ensure a complete, full, and fair hearing at the contested case level. The commenter says that the proposed evidentiary limitations are arbitrary and capricious.

The commenter also says that evidentiary limitations are problematic because on the independent review level, parties do not exchange what is sent to the IRO, so do not know what evidence the contested case hearing may be limited to and will not be able to make timely, valid objections to exhibits at a contested case hearing.

As a third point, the commenter says that constitutional issues may be raised concerning cases filed before the adoption of the rule, because the parties in those cases would not have been put on notice that their filings will limit what evidence can be presented at a contested case hearing. The commenter says that proposed evidentiary limitations specifically apply retroactively without fair notice being provided to the parties.

The commenter concludes by saying that by generally prohibiting new evidence at a contested case hearing and by allowing hearing officers to determine good cause, there will be less certainty in the system because one hearing officer's determination of good cause may be different from another hearing officer's opinion. The commenter suggests that for this reason, all evidence offered and the testimony of all identified witnesses should be allowed into evidence at a contested case hearing.

Agency Response: Based on the numerous comments received regarding limitations on evidence, the Division did not adopt proposed §133.307(f)(2)(D). The subparagraphs in §133.307(f)(2) have been renumbered as appropriate.

Comment: A commenter quotes proposed §133.307(f)(2)(D) and asserts that the proposed rule goes against public policy because it restricts parties from presenting claims and defenses, and presenting information that may arise in the supplemental exchange that the opposing party may not have had sufficient opportunity to address through additional documentation. Further, the commenter believes that there is a due process problem if a party has insufficient opportunity to investigate and respond to the allegations which may arise in the supplemental exchange, and by having rules different from SOAH, encourages parties to "game the system" to obtain MDR through the agency with the most beneficial rules. The commenter suggests that DWC adopt SOAH's dispute resolution rules for consistency and continuity.

Agency Response: The Division agrees to not adopt proposed §133.307(f)(2)(D). The subparagraphs in §133.307(f)(2) have been renumbered as appropriate.

Comment: A commenter states that proposed §133.307(f)(2)(D) fails to provide parties with adequate due process because it does not provide for a full evidentiary hearing, with the right to present witnesses, to cross-examine witnesses, and issue subpoenas to compel attendance. The commenter also states that the proposed rules offer determinations based solely on unverified documents. Commenter asserts that to allow the parties to develop a full record and fairly present their case as well as ensure that determinations in contested case hearings are accurate and of high quality, it is essential that parties be able to call all witnesses with relevant information on the dispute and not be limited to witnesses identified in unverified documents, and parties must also have the right to subpoena witnesses and documents.

The commenter asserts Labor Code §401.021 provides that a proceeding, hearing, judicial review, or enforcement of a commissioner order, decision or rule is governed by Subchapter D of the APA. The commenter notes that Subchapter D includes application of rules of evidence, the right to cross examine, testimony of witnesses taken under oath, issuance of subpoenas, discovery and other due process requirements. The commenter states that medical disputes must be resolved according to the provisions of the APA made applicable to the division and failure to conduct

proper hearings on medical disputes violates the parties' due process rights and the division's statutory duties.

The commenter recommends that proposed §133.307(f)(2)(D) be deleted and in its place should be inserted a new section granting the parties the right to a full evidentiary hearing, with the right to present witnesses, cross-examine witnesses, and issue subpoenas to compel attendance.

As an alternative to completely deleting and replacing the paragraph, the commenter suggests deleting from the paragraph the words "disclosed in said documentary evidence during the medical fee dispute under this subchapter except upon a showing of good cause. Parties may not raise issues regarding liability, compensability, or medical necessity at a contested case hearing for a medical fee dispute."

Agency Response: The Division disagrees with the comment, and declines to make the recommended change to insert new a section regarding an evidentiary hearing with the right to present witnesses, cross-examine witnesses, and issue subpoenas to compel attendance.

The commenter bases its recommendations on the provisions of Labor Code §401.021, stating that this section makes the APA applicable to contested case hearings, and that therefore the rules of evidence are applicable in contested case hearings. However, the commenter disregards the limiting statement "Except as otherwise provided by this subtitle," which is in Labor Code §401.021. It is actually

Labor Code §410.003 (relating to Application of Administrative Procedure Act) and §410.153 (also relating to Application of Administrative Procedure Act) that say how the APA applies to Division Contested Case hearings. These sections leave applicability of the APA to the Commissioner's discretion, and pursuant to the Commissioner's rule at 28 TAC §142.1 (relating to Application of the Administrative Procedure Act), only Government Code §2001.201 (relating to Enforcement of Subpoenas) is applicable to Division contested case hearings.

The Division agrees to not adopt proposed §133.307(f)(2)(D); however, the Division declines to insert a new section granting the parties a right to a full evidentiary hearing, with the right to present witnesses and issue subpoenas to compel attendance. Twenty-eight TAC Chapter 142 rules address benefit contested case hearings and the specific issues of concern to the commenter. As such, no additional rules are required.

Comment: A commenter recommends removing the provisions which limit the documentary evidence and witnesses to those disclosed in the MFD except upon a showing of good cause. The commenter believes that limiting the evidence in this way will keep employees from submitting evidence in addition to that submitted by the carrier. The commenter further believes that this limitation would raise due process issues and be contrary to *HCA Healthcare Corp. v. Texas Dept. of Ins. and Division of Workers' Compensation* (Cause No. D-1-GN-06-000176). Further, the commenter

asserts this would be contrary to the intent of HB 724 and the focus should be on making the best decisions with all of the relevant evidence.

Agency Response: Based on the numerous comments received regarding limitations on evidence, the Division did not adopt proposed §133.307(f)(2)(D).

Comment: A commenter states that proposed §133.307(f)(2)(D) limits the evidence that may be considered during the course of a DWC contested case hearing and is contrary to the intent of HB 724 and the district court decision that found §413.031 of the Labor Code (as amended by HB 7) unconstitutional.

The commenter asserts that the development of a record of review includes the filing of documentary evidence and presentation of witnesses – while the medical dispute fee resolution and the medical necessity informal review processes are part of a very informal process that both merely involve paper reviews of disputed issues presented to the agency for review and resolution and do not afford a hearing officer who considers the evidence introduced and witnesses presented by the disputing parties.

The commenter states the proposed rule defeats the purpose of disputing parties having a right to a hearing where they can develop their record of review as was contemplated by the Texas Legislature when HB 724 was passed.

The commenter states HB 7 attempted to streamline the medical dispute resolution process by eliminating the State Office of Administrative Hearings (SOAH)

appeal process that was set out in §413.031 of the Labor Code. Further, an Austin district court judge subsequently invalidated §413.031(k) of the Labor Code as amended by HB 7 and the court's decision declared §413.031(k) was facially unconstitutional because it failed to afford parties to a medical dispute brought under §413.031 of the Labor Code and pending before the DWC with an opportunity for a hearing in which witnesses are sworn and the parties can rebut adverse evidence and cross-examine adverse witnesses before a final order is issued. Commenter states the judge ruled that parties are entitled to full contested case hearing under the Texas Constitution.

The commenter asserts the Texas Legislature passed HB 724 to provide disputing parties with the right to a hearing and the filing of HB 724 was in response to the district court ruling and system stakeholder requests for this issue to be rectified.

The commenter asserts that limiting the evidence and witnesses that may be presented by disputing parties at a DWC contested case hearing would create the same constitutional issue that resulted in the invalidation of §413.031 of the Labor Code as it was amended by HB 7 and would constitute a disregard of the will of system stakeholders who sought a legislative fix to the invalidation of §413.031 of the Labor Code and the right to an administrative law hearing where they may present all of the evidence and witnesses they wish to have considered by the hearing officer.

The commenter states that this proposed rule provision is in conflict with the Texas Constitution, *Hartford Cas. Ins. Co. v. State*, 159 S.W.3d 212, 216 (Tex. App.-

Austin 2005, pet filed), the agency's organic statute, §410.163, §413.031, other sections of the Labor Code, and the Administrative Procedure Act. The commenter asserts that under the Constitution and both statutes, the contested case hearing is a *de novo* proceeding; the Division shall conduct a formal hearing, take witness testimony, and rule on objections to exhibits; thus, it is appropriate to allow a party to have an opportunity to offer evidence in a formal contested case process that allows for discovery, witness testimony, and cross-examination.

The commenter states that the parties, which are required to present their requests for review to the Division before obtaining a hearing at the Division, will continue to present pertinent information at that stage; trying a contested case would be a waste of time and resources if the dispute could be resolved at the more informal agency level. Further, while it is conceivable that a party may withhold information at the first level of review, it is not clear what would be gained by doing so.

The commenter believes other factors, such as the informality of the Division process, the delay in a final decision created if a party appeals a decision, and the expense of a formal contested case hearing, all encourage a party to use the Division process and contribute to the low appeal rate. The commenter asserts that §410.163(b) of the Labor Code provides that a hearing officer shall ensure the preservation of the rights of the parties and the full development of facts required for the determinations to be made.

The commenter requests that DWC amend the rule to provide the disputing parties with the right to submit evidence and witnesses for consideration by the contested case hearing officer. Further, the rule should also require the disputing parties to exchange their documentary evidence and list of witnesses within a specific time frame prior to the contested case hearing.

The commenter requests that the rule provide the contested case hearing officer with the authority to direct the independent review doctor to review any new evidence and issue an addendum report to his original report and the rule should provide that the IRO shall be paid $150 by the party that was responsible for the original IRO fee.

The commenter requests that §133.307(f)(2)(D) be revised to say:

"At a Division contested case hearing under this paragraph, the parties shall be limited to documentary evidence exchanged and to witnesses reasonably disclosed in the manner provided by this subtitle. Parties may not raise issues regarding liability, compensability, or medical necessity at a contested case hearing for a medical fee dispute.

"(1) The parties to a Division contested case hearing shall exchange their documentary, other relevant evidence, and list of witnesses 14 days before the contested hearing.

"(2) A party who sends a document relating to a benefit contested case hearing to the Commission shall also deliver copies of the document to all other parties, or their representatives or attorneys. Delivery shall be accomplished by presenting in person,

mailing by first class mail, facsimile or electronic transmission. The document sent to the Commission shall contain a statement certifying delivery. The following statement of certification shall be used:

"'I hereby certify that I have on this _____ day of _____, _____, delivered a copy of the attached document(s) to (state the names of all parties to whom a copy was delivered) by (state the manner of delivery).'

"(3) The contested case hearing officer shall issue an order and direct the informal review organization to review any new medical evidence and issue an addendum report to the original IRO report. The party that was responsible for paying the initial IRO fee shall be ordered by the contested case hearing officer to pay an additional fee.

"(A) The party responsible for paying the initial IRO fee shall pay the IRO an addendum IRO report fee of:

"(i) $150 for review of up to 50 pages of additional medical evidence; or

"(ii) $200 for review of more than 50 pages of additional medical evidence.

"(B) The hearing officer shall abate the contested case hearing until such time the IRO completes the review of the new medical evidence.

"(C) The IRO shall complete the review of the additional medical evidence no later than 7 business days after receipt of the medical evidence and hearing officer order.

"(i) The review of the additional medical evidence shall be used to clarify and/or correct the initial IRO report.

"(ii) The IRO shall forward the addendum report to the representatives of the disputing parties and the contested case hearing officer.

"(iii) The contested case hearing officer shall reset the hearing upon receipt of the IRO's addendum report.

"(4) The Division may take enforcement action against a party who is deemed to have a pattern of practice of withholding evidence and offering the withheld evidence at a contested case hearing."

Agency Response: Based on the numerous comments received regarding limitations on evidence, the Division did not adopt proposed §133.307(f)(2)(D).

The Division disagrees with the commenter's recommended text additions, and declines to make the recommended changes because the areas covered by the recommended changes are addressed by 28 TAC Chapters 140 and 142.

Comment: A commenter recommends modifying §133.307(f)(2)(D) to say: "At a Division contested case hearing under this paragraph, the parties shall be limited to documentary evidence exchanged and to witnesses reasonably disclosed during the

medical fee dispute under this subchapter including the prehearing and hearing process except upon a showing of good cause. Good cause is shown if an ordinarily prudent person would not have exchanged the documentary evidence or listed the witness under the same or similar circumstances." The commenter says these recommendations would (1) ensure that the parties submit all relevant materials to the dispute; (2) deter fraud; (3) deter gamesmanship on the part of some injured workers' and some health care providers; and (4) comply with the Texas Constitution among other reasons.

Agency Response: Based on the numerous comments received regarding limitations on evidence, the Division did not adopt proposed §133.307(f)(2)(D). The Division declines to accept the commenter's definition of "good cause," as well as additional language for this section, since the Division has chosen to delete this section from the rule.

§133.307(f)(2)(D) and §133.308(t)(1)(B)(v):

Comment: In regard to submitting evidence at the MDR level, a commenter says it is not unusual for the parties to submit whatever information they have readily available, but that they do not submit testimony from doctors and get separate reports from them at that stage. The commenter states the reason for this is because 99 percent of the time, the problem will be resolved without going through that expense, time, and effort. The commenter states the parties will resolve those things, or the Division will make a

determination and resolve them. The commenter states a full hearing cannot be had at the MDR level and the parties have a right to a full hearing.

The commenter states that oral testimony and cross-examination are not available at the initial MDR stage.

The commenter asserts the information in the treating doctor's records may or may not be correct and until a party is able to cross examine the doctor and the patient in the presence of a Hearing Officer, those issues rarely come out. The commenter asserts the contested case hearing is an opportunity to air those discrepancies.

Agency Response: Based on the numerous comments received regarding limitations on evidence, the Division did not adopt proposed §133.307(f)(2)(D) and §133.308(t)(1)(B)(v). The clauses in §133.308(t)(1)(B) have been renumbered as appropriate.

Comment: A commenter expresses opposition to subsection (f)(2)(D) of §133.307 and subsection (f)(1)(B)(v) of §133.308 which would limit the evidence in a contested case hearing to the documentation that was filed during the medical dispute resolution process.

The commenter states that the stakeholders view the entire process of medical dispute resolution as a very informal process because there is no opportunity to present evidence in front of a Hearing Officer, perform discovery, or present witnesses. The commenter states HB 7 amended §413.031(k) of the Labor Code in an attempt to

streamline the medical dispute process; however, a Travis County District Court Judge ruled the statute was facially unconstitutional because the provision did not provide the parties with opportunity for an administrative law hearing in which they could develop their record by presenting all their evidence, present witnesses, and conduct cross examination and discovery.

The commenter states that Representative Burt Solomons filed HB 724 to try to rectify this problem.

The commenter asserts that there can be no doubt that the parties should be able to present their full case at a contested case hearing since the medical dispute process is not the type of process in which you can devote their record.

The commenter thinks providers will begin to take their entire medical record and throw it at the IRO and dump it into the mix for the medical fee dispute process which adds unnecessary paper flow in the system.

The commenter suggests that evidence should not be limited because new medical evidence could occur that may be relevant to the dispute, which if not allowed to be introduced could result in health care being denied.

The commenter states the opposite is true as well, if that evidence the carrier may develop in the interim is not allowed to be introduced, health care may be delivered that could injure an employee or even cripple an injured employee if not costing their life. The commenter asserts that is what happened in a lot of the spinal surgery cases back in the '90s.

The commenter states most medical bills (75 to 80 percent) are actually paid, or, do not file a dispute and only a small percentage go to dispute resolution. The commenter states even a smaller number would proceed to a contested case hearing. The commenter states that is why the commenter is perplexed as to why the Division is even considering a provision to limit evidence when it would set up a situation very similar to the reality that was faced when HB 7 had §413.031(k) struck down as being facially unconstitutional because it deprived the parties of the right to have that hearing to develop their full record. The commenter asserts the proposed rule provisions would have the same effect.

Agency Response: Based on the numerous comments received regarding limitations on evidence, the Division did not adopt proposed §133.307(f)(2)(D) and §133.308(t)(1)(B)(v). The clauses in §133.308(t)(1)(B) have been renumbered as appropriate.

Comment: A commenter is opposed to subsection (f)(2)(D) of §133.307 and subsection (f)(1)(B)(v) of §133.308, which would limit the evidence in a CCH to the documentation that was filed during the medical dispute resolution process.

The commenter states that DWC does not appear willing to apply or follow the traditional rules of evidence for Texas in contested case hearings. The commenter states that the medical dispute fee resolution and medical necessity informal review processes are part of a very informal process and are merely paper reviews of disputed

issues. The commenter states that in the medical dispute resolution process, there is no hearing officer who considers the evidence introduced and witnesses presented by the disputing parties. The commenter states the proposed rule provision would defeat the purpose of disputing parties having a right to hearing where they can develop their record of review as was contemplated by the Texas Legislature when HB 724 was passed and the development of a record of review includes the filing of documentary evidence and presentation of witnesses.

The commenter states the State Office of Administrative Hearings (SOAH) applies and follows the rules of evidence when conducting an MDR hearing and DWC's failure to apply the rules of evidence in a medical contested case hearing will create two different standards of review for the same types of medical disputes and same or similar issues. Commenter asserts that this is confusing to system stakeholders, and will result in inconsistent decisions being issued and will allow inappropriate evidence to be considered during the medical contested case hearing.

The commenter suggests that limiting the evidence and witnesses that may be presented by disputing parties at a DWC contested case hearing would create the same constitutional issue that resulted in the invalidation of §413.031 of the Labor Code as it was amended by HB 7. Commenter states that such an act would also constitute a disregard of the will of system stakeholders who sought a legislative fix to the invalidation of §413.031 of the Labor Code and the right to an administrative law hearing at which they may present all of the evidence and witnesses they wish to have

considered by the hearing officer. The commenter states the Texas workers compensation system needs some long term continuity in this regard.

Agency Response: The Division has not adopted proposed §133.307(f)(2)(D) and §133.308(t)(1)(B)(v). The clauses in §133.308(t)(1)(B) have been renumbered as appropriate.

The Division disagrees with the commenter in regard to applicability of the Administrative Procedure Act (APA) to Division contested case hearings, and declines to make a change to make the APA applicable to Division Contested case hearings. Additionally, the Division declines to make SOAH's rules applicable to Division contested case hearings; when the Legislature chose to establish a bifurcated system for appealing fee dispute and IRO decisions, it was aware that SOAH and the Division are regulated by different statutes and have different rules. However, the Legislature expressly stated that certain appeals are to be "conducted by a hearings officer in the manner provided for contested case hearings under [Labor Code] Subchapter D, Chapter 410," and the Division is not going to attempt to circumvent through rule the Legislature's intentions.

Labor Code §410.003 (relating to Application of Administrative Procedure Act) and §410.153 (also relating to Application of Administrative Procedure Act) says how the APA applies to Division Contested Case hearings. These sections leave applicability of the APA to the Commissioner's discretion, and pursuant to the Commissioner's rule at 28 TAC §142.1 (relating to Application of the Administrative

Procedure Act), only Government Code §2001.201 (relating to Enforcement of Subpoenas) is applicable to Division contested case hearings.

Comment: A commenter is opposed to §133.307(f)(2)(D) and §133.308(t)(1)(B)(v) and states that the rules' limitation on evidence except for good cause denies the parties the due process that HB 724 was meant to address.

The commenter asserts that the MDR/IRO process is entirely a "paper" review where neither party appears before the agency to present anything and witnesses play no role in the process. The commenter asserts there is no reason for a party to identify witnesses at the dispute level and there is no reason a party would do so. The commenter states that most witnesses will be expert witnesses which are different from fact witnesses and are identified at a later time for the purpose of offering testimony. The commenter asserts that expert witnesses will not be known or designated at the time of the MDR/IRO filings, no discovery will have been (or can be) conducted and all relevant documents will not be known. The commenter states that it is the purpose of the hearing to develop and present the relevant evidence and the proposed restrictions on evidence are a denial of state and federal due process.

The commenter states that in the bill analysis to HB 724 the Legislature made clear that the purpose of re-introducing the right to an administrative hearing was in part because "there was no administrative record to review if and when such disputes were appealed to court." The commenter believes that the Legislature did not believe the

limited record produced in the medical dispute was adequate. The commenter suggests that limiting the evidence to the MDR/IRO filings will produce an inadequate administrative record.

The commenter asserts that a similar predecessor Commission rule (§148.18(a)) lead to needless, time-consuming litigation over what constituted "good cause", rarely resulted in more efficient hearings and, in fact, caused lengthier hearings and was abandoned by SOAH.

The commenter notes that the evidence listed in clause (v)(I)-(VIII), does not include documents submitted by the provider to the IRO.

Agency Response: Based on the numerous comments received regarding limitations on evidence, the Division did not adopt proposed §133.307(f)(2)(D) and §133.308(t)(1)(B)(v). The clauses in §133.308(t)(1)(B) have been renumbered as appropriate.

Comment: A commenter is opposed to §133.307(f)(2)(D) and §133.308(t)(1)(B)(v). Commenter asserts a similar rule was proposed by SOAH, but was rejected by SOAH because it denied a fair hearing.

The commenter states every hearing officer, individually, determines what "good cause" is and refers to his written comment that contains his suggested definition for "good cause." The commenter is opposed to the proposed rules because he would not be able to offer any learned treatises on medical procedures or treatment.

The commenter states that under the proposed rules, discograms would not be admissible at the hearing because they were not used at the medical dispute resolution process.

The commenter states that often a party's attorney would not get the file until after it was sent to SOAH, so, the reality is that the attorney may not have been involved or hired before medical dispute began. The commenter states that, effectively, there has been no assistance of counsel on the carrier or provider's side and may not realize they have left something out or they should have tried to discover other items before they could get started in the contested case.

The commenter suggests that all discovery be allowed, including requests for admission, requests for production, requests for disclosure, interrogatories, and depositions.

The commenter expresses concern that he may not be allowed to call or cross-examine an expert witness who was not disclosed at the MDR. The commenter also expresses concern that there will be two different procedures to handle the same sort of dispute; SOAH could offer a *de novo* hearing while the Division does not. The commenter believes that what will occur at the Division is a contested case hearing officer will only do a substantial evidence review and upon further appeal only another substantial evidence review will occur without a full contested hearing. The commenter states he is in agreement with Ron Beal's comments.

The commenter asserts that if the Division is going to allow discovery, there should be sanctions if the other side does not respond to discovery and there should be a process, if necessary, to allow extensions of time for people to conduct discovery.

The commenter states that when evidence is allowed in at a *de novo* hearing the same rules should apply to any party who wants to put on evidence.

Agency Response: Based on the numerous comments received regarding limitations on evidence, the Division did not adopt proposed §133.307(f)(2)(D) and §133.308(t)(1)(B)(v). The clauses in §133.308(t)(1)(B) have been renumbered as appropriate. The Division notes that discovery is allowed pursuant to the provisions in 28 TAC Chapter 142, and declines to establish duplicate provisions in these sections.

Comment: A commenter agrees with other comments concerning admissibility of documentary evidence submitted at contested case hearings and believes that everyone wants a complete record. The commenter believes the proposed rules give too much discretion to the hearing officer regarding admission of evidence.

Agency Response: Based on the numerous comments received regarding limitations on evidence, the Division did not adopt proposed §133.307(f)(2)(D) and §133.308(t)(1)(B)(v). The clauses in §133.308(t)(1)(B) have been renumbered as appropriate.

§133.307(f)(2)(D) and §133.308(t)(1)(B)(v)(i)-(vii):

Comment: A commenter indicates that, by limiting the admissibility of evidence to that which was considered during the MDR determination, the proposed rules undermine the hearing officer's role as the sole judge of the relevance and materiality of evidence, as well as jeopardizing the hearing officer's ability to fully develop the record.

The commenter further notes that the proposed sections are in conflict with the controlling statutes in Labor Code Chapter 410. In particular, the rules fail to include specific requirements for the parties to disclose "the identity and location of any witness known to the parties to have knowledge of relevant facts or to submit any witness statements or to provide photographs." The commenter says that a party has a statutory right to be provided with this information under Section §410.160. The commenter is concerned that parties submitting information in the MDR process may avoid the statutory duty set forth in §410.160.

The commenter also urges that the reason that the Legislature provided for parties to obtain information through interrogatories and depositions is to allow for parties to learn of and call additional witnesses at the hearing or to discover and submit additional documents at the hearing. These are things that would not be available at the time of the MDR determination process.

The commenter takes issue with the concept of "good cause" for admitting additional documents or allowing additional witnesses. The commenter states that it is ambiguous as to what constitutes "good cause." The commenter believes that the test

for admitting evidence should be if it was discovered during the discovery process and is relevant to the determination of the case.

The commenter further argues that legislative intent to provide an informal, low-cost method of resolving medical fee disputes is undermined by the proposed rules. For example, since evidence admitted and witnesses disclosed is limited to that which was considered during the MDR determination, the commenter argues that the carrier may be required to retain an expert witness for every MDR dispute in the event that the case goes to contested case hearing.

Two other commenters express agreement with the comments made by this commenter.

Agency Response: The Division agrees in part and disagrees in part. The Division disagrees that the controlling statute is located in Insurance Code Chapter 410. Rather, the controlling statute is Labor Code §413.0311, which provides for hearings "conducted by a hearings officer in the manner provided for contested case hearings under Subchapter D, Chapter 410" of the Labor Code.

Based on the numerous comments received regarding limitations on evidence, the Division did not adopt proposed §133.307(f)(2)(D) and §133.308(t)(1)(B)(v)(i) – (vii). The clauses in §133.308(t)(1)(B) have been renumbered as appropriate.

§133.307(f)(2)(E):

Comment: A commenter recommends adding the following text to the end of §133.307(f)(2)(E) as follows:

"Additional exceptions are:

"(i) Requests for Admission, Requests for Disclosure and Requests for Production may be used to establish facts, obtain information and obtain documents. Requests for Admission, Requests for Disclosure and Requests for Production shall be served no later than 30 days before the contested case hearing, unless otherwise agreed. Responses shall be exchanged no later than ten days after receipt of the propounded Requests;

"(ii) A party who sends a document relating to a contested case hearing to the Division or to another party, or its representatives or attorney shall do so by verifiable means. Any document sent to the Division relating to a contested case hearing shall contain a statement certifying delivery. The following statement of certification shall be used: 'I hereby certify that I have on this day of _____,_____ delivered a copy of the attached document to (state the names of all parties to whom a copy was delivered) by (state the manner of delivery);' and

"(iii) The failure to timely respond to Interrogatories, Requests for Admission, Requests for Disclosure or Requests for Production shall result in the preclusion of evidence by the party required to respond."

Agency Response: The Division declines to accept the commenter's additions to §133.307(f)(2)(E), because the issues the commenter addresses are covered in 28 TAC Chapter 142.

§133.307(f)(2)(F):

Comment: In regard to §133.307(f)(2(F), a commenter recommends offering both the time frame and venue for appeal within the text of the section. The commenter says that providing the 30 day time frame and identifying venue in Travis County within the text of the rule would provide for a clear manner and would properly inform injured employees of their right to appeal.

Agency Response: The Division disagrees with the comment and declines to make a change, because such a change is not necessary and would not be in keeping with the way other Division rules address appeal under the Government Code; for instance, 28 TAC §148.15(f) provides that appeal of a SOAH contested case hearing that follows an IRO review is conducted "in accordance with the APA, §§2001.171, 2001.174, and 2001,176." The Division notes that access to the Government Code is available via the internet through the State of Texas website, and the Office of Injured Employee Counsel is available to provide assistance and guidance to injured employees who do not understand the processes under these sections.

Comment: A commenter says that §133.307(f)(2)(F) sets out the information that must be included in a petition for judicial review. The commenter says that the petition for judicial review should include more specific information that will assist the Division and other parties with matching a petition for judicial review to the underlying claim and medical dispute resolution decision, and recommends that in addition to requiring Division tracking numbers for the filed dispute, there also be a requirement for a specific insurer number which would be placed on all documents.

Two commenters offer similar suggestions, suggesting that a clause be added to the list for "the carrier claim number" or "the insurance carrier claim number." These two commenters also suggest that the words "The DWC number(s) for the dispute being appealed" be replaced with the words " DWC claim number" or "the DWC MDR tracking number(s) for the dispute being appealed," and one of these commenters suggests that the petition number only be required "if known." The other commenter asserts that the recommended changes will "to: (1) ensure that the parties submit all relevant materials to the dispute; (2) deter fraud; (3) deter gamesmanship on the part of some injured workers' and some health care providers; and (4) comply with the Texas Constitution among other reasons."

Agency Response: The Division disagrees with the comments and declines to make the recommended changes. The Division clarifies that the listed information is not necessarily required to be in a petition, but must be provided in a cover letter if not in

the petition. The Division notes that it is the rules of civil procedure and local court rules that dictate what must be in a petition for judicial review.

The purpose of this provision is simply to ensure that the Division has sufficient information concerning an appeal to be able to assemble the correct administrative record for use by the District Court. The recommended changes would not further this goal; for instance, the Division does not need a carrier's internal claim number. Additionally, if a party does not know the petition cause number for a case it has filed, it should contact the district clerk's office and get the number before serving a copy of the petition on the Division.

The Division does not see how making the recommended change would ensure that the parties submit all relevant materials to the dispute, deter fraud, or deter gamesmanship. Additionally, the Division does not see which provision of the Texas Constitution would require such a change.

The Division's staff has determined that the list of information in §133.307(f)(2)(F) as proposed is sufficient for the Division to be able to assemble an administrative record.

Comment: In regard to §133.307(f)(2)(F), a commenter recommends that the sentence, "The parties will be deemed to have received the decision as provided in §102.5 of this title," be deleted.

The commenter also recommends that in the sentence which reads, "A decision becomes final and appealable when issued by a Division hearing officer," the words "hearing officer" be replaced with the words "and received by the party."

The commenter asserts that the recommended changes will "to: (1) ensure that the parties submit all relevant materials to the dispute; (2) deter fraud; (3) deter gamesmanship on the part of some injured workers' and some health care providers; and (4) comply with the Texas Constitution among other reasons."

A second commenter also recommends deleting the words "hearing officer" in stating that Division hearing officers are employed by the Division of Workers' Compensation, therefore the decisions issued by hearing officers are decisions of the Division.

Agency Response: The Division disagrees with the comments and declines to make a change. The purpose of this provision is to provide a calculable time at which a decision of a hearing officer becomes final and appealable, so that parties can determine when the time frames in Subchapter G of Chapter 2001 of the Government Code become applicable. The recommended changes would insert uncertainty into this process, and possibly lead to further dispute regarding the time frame for a party to appeal to district court. Additionally, the Division does not see how the recommended changes address submission of relevant materials or how they would deter fraud or gamesmanship, and the Division does not understand which provision of the Texas Constitution would require such changes.

The Division agrees that a Division hearing officer is a Division employee, and thus a decision made by a Division hearing officer is a decision of the Division. However, the Division disagrees with the second commenter's suggestion and declines to make the recommended change. While the decision may be a Division decision, the hearing officer is the person who actually examines evidence and makes a decision on behalf of the Division, and the hearing officer is the person who actually issues the decision on behalf of the Division. The specific point when the hearing officer actually issues the decision has been selected as the point when a decision becomes final and appealable, but use of the amorphous phrase "when issued by the Division" would not convey this intent.

§133.308:

Comment: A commenter says that it is critical that an IRO reviewer do the following with each report:

1) Attach a resume to the report, including the date of last clinical practice and ratio of current clinical practice compared to peer or IRO reviews and independent medical examination (IME) opinions.

2) Sign with the reviewer's own name and contact information.

3) If care is denied to an injured employee, be available to provide cross examination and testimony at all hearings at no cost to the injured employee, because

the reviewer is paid a high fee for the review, and the fee should carry with it the responsibility to explain and defend it.

The commenter says that there is no substitute for the IRO, and that the reviewer should do his own exams, rather than using a designated doctor for exam by proxy. The commenter notes that an IRO reviewer has a huge responsibility, since his opinion has weight over other qualified doctors.

In addition, the commenter says that the same rules and qualifications as newly stated for IROs should also apply to IME, required medical examination (RME), and peer review doctors.

Agency Response: The Division disagrees with this comment. The Division clarifies that pursuant to Insurance Code §4202.009 "Information that reveals the identity of a physician or other individual health care provider who makes a review determination for an independent review organization is confidential." As such, the Division does not have the authority to require an IRO reviewer to attach identifying information to a decision or to be available to provide testimony in a hearing. Because of this, proposed §133.308(t)(1)(B)(ii) expressly provides that "The IRO is not required to participate in the Division CCH or any appeal," and proposed §133.308(u)(4) expressly provides that "The IRO is not required to participate in the CCH or any appeal." The Division adopts these provisions as proposed. Additionally, to further clarify that an IRO is not required to participate in an hearing or any appeal, the provision "The IRO is not required to

participate in the SOAH hearing or any appeal" has been incorporated into and adopted in §133.308(t)(1)(A).

In response to commenter's comment concerning exams, the Division notes that Insurance Code §4202.009 would prevent it from requiring an IRO reviewer to personally perform exams – meeting with an injured employee in person to conduct an exam would likely reveal the identity of the health care provider making the review determination for the IRO.

Finally, the Division notes that this rule is not applicable to IME, RME, or peer review doctors. As such, the Division declines to make any changes that would be applicable to them. Such changes would expand applicability of these sections beyond the intent of the Division, and would constitute a substantial change, as it would affect individuals who would not have been impacted by the rule as proposed.

Comment: In regard to §133.308, a commenter suggests that the provisions should require that care be rendered immediately, and that disputes be processed afterward; that spinal surgeons be required to be board certified by the American Board of Spine Surgeons; and that injured workers be able to sign Health Insurance Portability and Accountability Act (HIPAA) forms at all examining doctor visits and receive a copy of the complete file on the spot, so as to avoid undue influence by carriers. The commenter says that requiring immediate care would reduce costs to both injured workers and carriers.

Agency Response: The Division disagrees with the comment and declines to make any changes.

The Division declines to make the first recommended change, because it lacks statutory authority to do so. The Division notes that Labor Code §413.014 requires preauthorization in certain instances; therefore, the Division does not have statutory authority to develop a process beyond what the statute requires.

In regard to the second recommended change, the Division notes that subsection (d) addresses professional specialty requirements. However, The Division declines to make the second recommended change, because it would not be advisable to reference specific specialties in this rule. There are numerous fields of medicine that may be relevant to an injured employee, and it would be difficult, to address each one on an individual basis in this section. If the Division attempted to make such a list in this section, but left a field off, there would be questions as to the applicability of professional specialty requirements for that field.

In regard to the third recommended change, the Division notes that the rule proposal did not addressed in-person examinations. As such, it would be a substantial change if provisions were added to address the process for receiving records during an in-person examination.

Comment: In regard to §133.308, a commenter says that there should be a difference between the IRO process for group health and worker's compensation, and that it is not

appropriate to match the two up. The commenter says that the fist reason they should not be matched up is that group health is not workers' compensation. The commenter notes that workers' compensation has income benefits, maximum medical improvement, and impairment ratings. The commenter also says that court told us there is a different process when it ruled Labor Code §413.031(k) unconstitutional, and that the Legislature obviously agreed with the analysis of the court by introducing and actually passing HB 724. The commenter says that it would be nice if one could match up the health and workers' compensation process, but obviously one cannot.

The commenter suggests that the standards for group health could be challenged in court, and says that it is important to note that the Legislature intended to fix the workers' compensation process by providing for a hearing which is governed by the Administrative Procedure Act, and that under the Administrative Procedure Act parties are entitled to present their cases in full, subject to objections by other parties and relaxed rules of evidence.

Agency Response: The Division disagrees with the comment and declines to establish a process for workers' compensation IRO reviews that is different from IRO reviews conducted under the Insurance Code, because it does not have statutory authority to do so. Labor Code §413.031(d) expressly provides "A review of the medical necessity of a health care service requiring preauthorization under §413.014 or commissioner rules under that section or §413.011(g) shall be conducted by an

independent review organization under Chapter 4202, Insurance Code, in the same manner as reviews of utilization review decisions by health maintenance organizations."

The Division agrees in part and disagrees in part with the comment that the Legislature intended to provide for a hearing conducted under the Administrative Procedure Act, and declines to make a change in regard to this statement. It is correct that hearings that proceed to SOAH will be conducted under the Administrative Procedure Act, because Labor Code §413.031(k) says that a hearing conducted by SOAH "shall be conducted in the manner provided for a contested case under Chapter 2001, Government Code." However, pursuant to Labor Code §410.153 (relating to Application of Administrative Procedure Act), "Chapter 2001, Government Code, applies to a contested case hearing to the extent that the commissioner finds appropriate…," and pursuant to 28 TAC §142.1 (relating to Application of Administrative Procedure Act), only "§2001.201, relating to enforcement of subpoenas" applies to contested case hearings under Labor Code Chapter 410.

§133.308(a):

Comment: A commenter says that §133.308(a)(1)(A) makes the section applicable to disputes filed prior to September 1, 2007. However, the commenter says, disputes filed prior to September 1, 2007, must be handled under the statute and rule in effect at the time the dispute was filed, and an agency cannot make its rule or processes retroactive

to a time when another statutory provision existed. As such, the commenter recommends deleting subparagraph (A), and renumbering the provision appropriately.

A second commenter also recommends deletion of the last sentence of §133.308(a)(1)(A). The commenter says this change is to: "(1) limit the number of disputes; (2) clarify who must file the medical dispute; and (3) provide due process among other reasons."

Agency Response: The Division agrees in part and disagrees in part. A primary purpose of these rules is to implement HB 724, which provides a process for the appeal of administrative disputes arising under Labor Code §413.031. The Labor Code provision that had provided the process for appealing administrative decisions (Labor Code §413.031(k) as revised by HB 7, 79th Regular Legislative Session) was found to be unconstitutional, so prior to HB 724, there was no statutory provision in place to provide a process for appealing administrative decisions under Labor Code §413.031. To resolve the lack of statutory provisions, the enacting clause in Section 9 of HB 724 makes the bill applicable to "workers' compensation medical disputes described by Section 413.031, Labor Code, as amended by this Act and Section 413.0311, Labor Code, as added by this Act… that are pending for adjudication by the division of workers' compensation of the Texas Department of Insurance on or after the effective date of this Act [September 1, 2007]…."

In regard to the appeal of a dispute described by Labor Code §413.031 or §413.0311, the Division disagrees that it is attempting to make these processes

retroactive to a time when another statutory provision existed, because there was not a valid statutory provision in place prior to HB 724, only the unconstitutional statutory provision found in Labor Code §413.031(k) as it existed prior to HB 724. In regard to the appeal of a dispute described by Labor Code §413.031 or §413.0311, the Division is using the specific terms of applicability listed in Section 9 of HB 724.

However, not all the amendments in §133.307 and §133.308 are based on HB 724, so the effective dates in Section 9 of HB 724 would not be applicable to them. For this reason, the Division agrees in part with the commenter and disagrees in part with the commenter. In response to the comment the Division has changed the applicability provisions in §133.307(a) and §133.308(a) to specify that §133.307 and §133.308 are applicable to disputes filed May 25, 2008; however, the Division has also adopted language §133.307(a) and §133.308(a) that keeps the proposed dates of applicability in regard to §133.307(f) and §133.308(t)(1), the subsection in §133.307 and the paragraph in §133.308(t) that implement HB 724. Because these provisions implement HB 724 in order to cover the statutory gap addressed by HB 724, these provisions adopt the specific terms of applicability listed in Section 9 of HB 724.

§133.308(a)(3):

Comment: In regard to §133.308(a)(3), a commenter recommends inserting the word "Department" between the words "related" and "rules" in the sentence "The Insurance Code, the Labor Code and related rules govern the independent review process."

A second commenter recommends a similar change, suggestion that the words "Texas Department of Insurance" between inserted between the words "related" and "rules." The second commenter says this change is to: "(1) limit the number of disputes; (2) clarify who must file the medical dispute; and (3) provide due process among other reasons."

Agency Response: The Division disagrees with the comments and declines to make the recommended change, because inserting the word "Department" would imply that Division rules are not applicable to IRO reviews conducted under the Labor Code. Such a change would be inaccurate, as Division rules (such as §133.305 and §133.308) play a part in governing the IRO process along with the Department's rules.

In regard to the second commenter's reason for making the change, the Division does not see how making the recommended change would limit the number of disputes, clarify who must file the medical dispute, or provide due process.

§133.308(c):

Comment: In regard to §133.308(e), a commenter recommends adding the term "medicine" after "practice".

Agency Response: The Division disagrees with the comment and declines to make the suggested change because it would be too limiting and would not be in compliance with HB 2004. To add "medicine" would mean that only physicians (doctors of medicine

and osteopathy) could do independent reviews. The definition of "doctor" in the Labor Code includes more medical professions than just doctors of medicine and osteopathy.

§133.308(d):

Comment: Several commenters addressed §133.308, concerning professional specialty requirements. One commenter specifically recommends that this subsection be amended to provide additional clarification for the parties.

Four commenters suggest adding to the provision a requirement that a reviewer be qualified by "licensure in this state and the same, or similar." One of the commenters says that the basis for its recommendation is its belief that the Legislature intended to limit reviews of health care services to those health care providers with the same specialty, and as an alternative to its suggested language, the commenter suggests that the section should provide a definition of the phrase "hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving." The commenter says that as drafted, the provision merely parrots the language of the statute, and does not provide sufficient guidance on what specialty a doctor is required to hold in any given case. This commenter also recommends deleting the phrase "until further material recovery from or lasting improvement to the injury can no longer reasonably be anticipated." The commenter recommends this, because it believes that a phrase concerning maximum medical improvement is not necessary or related to professional specialty requirements. The commenter says that limiting the

requirement of the reviewer to only review health care provided before maximum medical improvement is contrary to the statute.

Two commenters recommend that the provision require that the reviewer be able to "provide or prescribe" the service that is the subject of review. As a basis for this suggestion, one of the commenters asserts that a medical doctor would be an appropriate IRO reviewer, even if the medical doctor cannot provide the service, because the medical doctor could "prescribe" a service to be "provided" by a different doctor. The commenter says that any other interpretation of the statute would result in no doctor being able to serve as an IRO reviewer in workers' compensation.

In regard to the phrase "training and experience to provide all health care reasonably required," two commenters recommend changing the word "all" to "the." These commenters also recommend deleting the phrase "until further material from or lasting improvement to the injury can no longer reasonably be anticipated." One commenter says that use of the word "all" is overly broad, and goes beyond the statute, and says that the phrase recommended for deletion is unnecessary. The other commenter also recommends putting the word "compensable" in front of the word "injury" and "condition," and says that its suggested changes would: "(1) limit the number of disputes; (2) clarify who must file the medical dispute; and (3) provide due process among other reasons."

One commenter asks that spinal surgeons be required to be board certified by the American Board of Spine Surgeons, and another commenter says that denials of

payment or services that were requested or performed by an orthopedic surgeon should only be denied by a similarly qualified orthopedic surgeon.

Two commenters recommend an addition to follow the words "reasonably required by the nature of the injury." The commenters suggest that adding "including to both generally treat the condition and to provide expertise on the specific procedure and treatment being requested." The commenters say this would ensure that a physician reviewer is knowledgeable and trained in the specific procedure and treatment under consideration, and help provide clear direction so that the physician reviewer and IRO are confident that the review is assigned to a physician that has the experience and training to make sound determination in a case under review. These commenters also suggest adding the sentence "Nothing in this subsection shall be construed to limit the clear statutory obligation to continually provide care that is necessary to cure or relieve the condition" to the end of the provision. The commenters say that this would be an important reference back to governing statute which will help to eliminate any potential disagreements and litigation related to otherwise what "material recovery from or lasting improvement" might be interpreted to mean, and would better ensure that an injured worker receives necessary care by having an appropriate initial review rather than delaying care if an appeal is necessary.

These two commenters also ask the following questions:

1. How will DWC ensure prospectively that doctors do have the appropriate education, training and experience, both in terms of generally treating the condition, as well as providing and reviewing the treatment in question?

2. What process will be used to review cases retrospectively to ensure appropriate compliance?

3. What enforcement action will be taken against carriers, URAs, and IROs that do not comply with the law? Should specific administrative penalties be imposed for violations and should the rule include harsher penalties for violators that show a "pattern of practice" of noncompliance?

4. What type of complaint or dispute process will be available to providers who want to challenge the appropriateness of the doctor reviewing a case?

Agency Response: The Division agrees in part with the commenters, and disagrees in part. Due to the number of comments, it is apparent that the subsection needs to be revised to provide additional clarification of the requirements.

In regard to the comments concerning adding to the provision a requirement that a reviewer be qualified by "licensure in this state and the same, or similar," the Division disagrees and declines to make the suggested change because it is not necessary. The Division notes that §133.308(c) specifically addresses professional licensing requirements; therefore it would be redundant to address them a second time in subsection (d).

In regard to the comment that the phrase "until further material recovery from or lasting improvement to the injury can no longer reasonably be anticipated" would limit a reviewer to reviewing only care provided before maximum medical improvement and should be removed, the Division disagrees and declines to make a change. The Division notes that this phrase is not the complete definition of maximum medical improvement, thus does not create a limitation based on maximum medical improvement. The intent of the Division is to ensure that a reviewer can completely provide the service being reviewed, and the Division believes that use of this phrase captures that intent.

In regard to inserting the words "or prescribe," the Division disagrees and declines to make this change because it would not be in line with the way the Division interprets the statute. The purpose of requiring professional specialty requirements is to ensure that the reviewer has the qualifications to understand and fully review the medical service that is the subject of review. However, allowing doctors that could only "prescribe" the service would not necessarily accomplish this.

In regard to the recommendation to change the word "all" to "the," the Division agrees to make this change. It is not necessary that a reviewer have the qualifications to provide all the care that might be required by an injury; the reviewer only needs to have qualifications related to the specific service being reviewed.

In regard to the suggestion to add the word "compensable" in two places, the Division disagrees and declines to make a change. Section 133.308 concerns medical

necessity, and issues of compensability have no relation to it. A particular service may or may not be compensable, but that would have no effect on whether the service is medically necessary. Additionally, the Division does not see how this change would limit the number of disputes, clarify who must file a medical dispute, or provide due process.

In regard to the comments asking that specific medical specialties of spinal surgery and orthopedic surgery be addressed, the Division disagrees and declines to make a change, because doctors that practice these specialties must meet the same requirements as doctors in other medical specialties, and it is unnecessary to attempt to list every potential medical specialty in this rule. There are numerous fields of medicine that may be relevant to an injured employee, and it would be difficult to address each one on an individual basis in this section. If the Division attempted to make such a list, but left a field off, there would be questions as to the applicability of professional specialty requirements for that field. However, because HB 2004, in Labor Code §408.0044 and §408.0045, does make distinctions regarding dentists and chiropractors, the Division believes it is necessary to make a distinction in §133.308(d) regarding these practice areas. For this reason, the Division has inserted the sentence "A dentist meeting the requirements of subsection (c) of this section may perform a review of a dental service under this section, and a chiropractor meeting the requirements of subsection (c) of this section may perform a review of a chiropractic service under this section," into §133.308(d).

In regard to the suggestions to add the phrase "including to both generally treat the condition and to provide expertise on the specific procedure and treatment being requested," the Division disagrees and declines to make a change, because the suggested change is unnecessary. The Division believes that the subsection as adopted is sufficient to address professional specialty requirements.

In regard to the suggestion to add the sentence "Nothing in this subsection shall be construed to limit the clear statutory obligation to continually provide care that is necessary to cure or relieve the condition" to the end of the provision, the Division agrees that addition of such a statement can help capture the intent of the law, and has added similar wording to the subsection.

In regard to the questions, the Division provides these responses:

1. The qualification of IRO review doctors are submitted as a part of the IRO certification process under Insurance Code §4202.002 and Department rules in 28 TAC Chapter 12. In addition, the IRO should select the appropriate reviewer.

2. If a party believes that the IRO did not select the appropriate provider, he or she may file a complaint with TDI.

3. The enforcement actions taken against a party that does not comply with the law depend on the specific facts of a case and the status of the party – administrative penalties, injunctive actions, certification suspensions, or other processes might be appropriate.

4. A party can challenge the appropriateness of a doctor reviewing a case by filing a complaint with DWC or the Health and Workers' Compensation Networks Division.

§133.308(e):

Comment: In regard to §133.308(e) a commenter recommends requiring the IRO to send a certified statement that the reviewing physician is licensed to practice medicine in Texas.

Agency Response: The Division disagrees with the comment and declines to make the suggested changes because the IRO is already required to include this information by utilizing the IRO decision template. Additionally, the inclusion of "practice of medicine" is too restrictive, as it would only allow for doctors of medicine and osteopathy to perform reviews.

§133.308(g)(2)(A):

Comment: A commenter recommends that §133.308(g) be modified by placing the words "health care" in front of the word "providers" and placing the word "only" behind it. The commenter says this change is to: "(1) limit the number of disputes; (2) clarify who must file the medical dispute; and (3) provide due process among other reasons."

Agency Response: The Division disagrees with the comment, and declines to make a change. It is unnecessary to insert the words "health care" in front of providers, due to a

text change made in response to a comment regarding §133.308(g)(1). It would not be accurate to insert the word "only" as recommended, because health care providers are not the only parties who may make a request for non-network preauthorization, concurrent, or retrospective medical necessity dispute resolution. Qualified pharmacy processing agents acting on behalf of a pharmacy, as described in Labor Code §413.0111, are also permitted to make such requests. Additionally, the Division does not agree that making the recommended change would limit the number of disputes or provide due process.

§133.308(g)(1):

Comment: In regard to §133.308(g)(1), a commenter expressed concern that that the party identification for network claims may be too broad. The commenter says that subparagraph (B) in this paragraph would allow injured employees to be a party to retrospective medical necessity disputes. The commenter recommends two changes: In subparagraph (A), the commenter recommends adding the words "health care" in front of the word "providers." In subparagraph (B) the commenter recommends adding the words "for health care that the injured employee has paid for" to the end of the sentence.

Agency Response: The Division agrees in part and disagrees in part with the comment. The term "provider" is generally understood to mean "health care provider;" however, the Division has made a change in the adopted rule to clarify that "provider" is

a shortened form of "health care" provider. This change is in line with text in §133.307(b)(1). The Division declines to insert the words "health care" everywhere "provider" appears, because the change made makes that unnecessary.

The Division disagrees with the comment and declines to make the suggested change to limit "employees for preauthorization, concurrent, and retrospective medical necessity dispute resolution for health care that the injured employee has paid for." The injured employee is a claimant and has the right to request preauthorization, concurrent, and retrospective review, regardless of whether the health care has been paid for. To make this change would eliminate these employee rights.

§133.308(g)(2):

Comment: In regard to §133.308(g)(1), a commenter recommends adding the words "health care" in front of the word "providers" for purposes of clarity.

Agency Response: The Division agrees with the comment. However, the Division declines to make the suggested change because the change is unnecessary based on a change made to §133.308(g)(1).

§ 133.308(i):

Comment: In regard to §133.308(i), a commenter suggests that the subsection be reworded to require a requestor to file a request for independent review with the carrier or its designated URA. The commenter says that this suggestion is based on the fact

that a utilization review decision may be rendered when a carrier is in the process of transitioning from one URA to another; as preparation for an independent review takes a considerable amount of time and effort, the previous URA may have little incentive to do more than the minimum, and it would be in the carrier's interest to have the current agent respond.

Agency Response: The Division disagrees with the suggestion. The Labor Code and the Insurance Code set a short time frame for initiation of a an IRO review, so it is important that the entity that actually issued an adverse decision receive notice of a request for independent review so that it may prepare and promptly send required documentation to the assigned IRO. Additionally, if a carrier changes its URA after the URA has issued an adverse decision, the party impacted may not be aware of the change or have contact information for the new URA – a requirement that the request for independent review be sent to a different URA could effectively result in the party missing appeal deadlines.

The Division notes that if a URA fails to perform functions required by the Labor Code and the Insurance Code, including functions related to appeal for an adverse decision, such failure could form the basis for an enforcement action.

Comment: A commenter says that requiring notification to the Department of a request for IRO review on the same day that the request is received by the carrier or its URA is unreasonable, arbitrary, and unduly burdensome. The commenter says that there will

be days when a request is received late in the day, and that the proposed requirements creates potential for an unfortunate game of "gotcha." The commenter requests that the time frame be expanded to three days to notify the Department of a request for IRO review.

Agency Response: The Division disagrees with the comment and declines to make the recommended change because allowing a carrier or URA three days to submit a request for IRO review would not allow the Department sufficient time to assign an IRO and notify parties of the assignment. The requirement is not unreasonable or arbitrary, because Insurance Code anticipates the IRO receiving documents from the carrier and beginning its review at the three-day point. For a carrier to be able to submit documents to a carrier by the third day after an IRO review request, the Department must have received notice of the request for IRO review, assigned the IRO, and notified the parties of the assignment of IRO before the third day. To meet the statutory requirements, the Department needs notice of the IRO request on the day the carrier or URA receives it. The Division notes that this requirement is not unduly burdensome, and actually provides a carrier or URA more time to notify the Department than was allowed in the rule in effect at the time of proposal, which required notice of an IRO review request to the Department "immediately."

Comment: Commenters address the time frame to notify the Division of a request for IRO. Three commenters say that the proposal includes an unreasonably restrictive time

frame for insurers to notify the DWC of and request an independent review. The commenters say that requiring notification to the Department of a request on the same day as receipt of a request for an IRO review is unrealistically short and would place an unreasonable burden on insurers. One commenter alleges that the Department never turns anything around in one day, and the other commenter asserts that no other stakeholder, nor the Department, faces such a stringent requirement. The commenters recommend that the words "on the same day" be changed to "within three working days from the date."

A third commenter notes that IRO requests may be sent to a URA, and because the URA does not know what to do with the request, the request just sits for a day or two, then is forwarded to the carrier. For this reason, the commenter suggests that the section allow a carrier three days to notify the Department of an IRO request, and expand that time to five days when the request is received by a URA. In addition, the commenter recommends rewording the first sentence in the subsection to say: "A requestor shall file a request for independent review with the insurance carrier (carrier) on the claim or the carrier on the claim's utilization review agent (URA) that actually issued the adverse determination no later than the 45th calendar day after receipt of the denial of reconsideration." According to the commenter, these changes would "(1) limit the number of disputes; (2) clarify who must file the medical dispute; and (3) provide due process."

One of the commenters also asserts that changing "immediately" to "on the same day" is a reduction in time, because it has been told that "immediately" means "one business day." The commenter says that a request for IRO review can sometimes be forwarded to the Department in one day, but that it routinely cannot. The commenter recommends allowing two to three days for a carrier to notify the Department of an IRO request, because it typically takes a day to a day and a half to do so. The commenter says that problems are not simply with forwarding information to the Department, but in how the carrier receives the request for IRO. The commenter notes that the request form could be forwarded to the carrier in different ways, and that it requires a minimum of four people to deal with the form, and the commenter says that 100 percent of the request forms it received in the past year had missing, incorrect, or misleading information. Additionally, the commenter says that as designed, the request form does not collect all the information a carrier needs when notifying the Department of an IRO request, so the carrier has to obtain that information. The commenter says that it is unreasonable to get it done on the same day a request is received, and that the way the section is written sets up every utilization review agent and carrier for failure.

Agency Response: The Division disagrees with the comments and declines to make the recommended change because allowing a carrier or URA three or five days to submit a request for IRO review would not allow the Department sufficient time to assign an IRO and notify parties of the assignment in a way that is consistent with the requirements of the Insurance Code. The Insurance Code anticipates the IRO receiving

documents from the carrier and beginning its review at the three-day point, so prior to that time the Department must receive notice of the request for IRO review, assign the IRO, and notify the parties of the assignment of IRO. To meet the statutory requirements, the Department needs prompt notice of the IRO request when the carrier or URA receives it. The Division notes that the current time frame requires a carrier to "immediately" notify the Department of a request for IRO review, and that the proposal expanded this "immediate" time frame.

The Division notes that the Department does generally complete an IRO assignment within one day. Delayed IRO assignments are typically the result of a party's failure to submit the required information to the Department.

The Division also notes that allowing a carrier five days to notify the Department of a request for IROs would make it impossible for the carrier to comply with the Insurance Code's requirement that the carrier send documentation to the IRO the third day after the request for IRO review. Section 133.308 requires a party to send an IRO request to the URA that issues an adverse determination, and carriers should ensure that URAs know what to do when a request is received. The Division does not see how making the third commenter's recommended changes would limit the number of disputes, clarify who must file the medical dispute, or provide due process; and declines to make the changes.

In regard to the commenter's concerns about the IRO review request form, the Department will review the form to ensure that it captures all the necessary information.

Comment: A commenter recommends that language be added to §133.308(i) to correct an issue of carriers or URAs not forwarding IRO requests to the Department because they do not believe the requests to be timely. The commenter states that the issue of timeliness should be decided by the Department, and not by a party to the dispute. The commenter recommends the words "regardless of whether the carrier or URA believes the request to be timely" be added to the end of the sentence that says "The carrier shall notify the Department of a request for an independent review on the same day the request is received by the carrier or its URA."

Agency Response: The Division disagrees with the comment and declines to make the suggested change because it is unnecessary. The rule as proposed is sufficient to establish the requirement that carriers file all timely requests for IRO review. Failure to make a timely referral of an IRO request is an enforcement issue and a party that believes a valid request for IRO review was not forwarded to the Department should file a complaint with the Department.

Comment: In regard to §133.308(i), a commenter notes that many requests for independent review are incomplete, and requests that the provision be changed to require that a request for IRO review be filed "within one business day and upon receipt of a complete request."

Agency Response: The Division agrees in part, and disagrees in part. The Insurance Code anticipates the IRO receiving documents from the carrier and beginning its review at the three-day point, so prior to that time the Department must receive notice of the request for IRO review, assign the IRO, and notify the parties of the assignment of IRO. To meet the statutory requirements, the Department needs prompt notice of the request for IRO review when the carrier or URA receives it. Allowing a carrier one business day to notify the Department of a request for IRO review will permit the Department time to assign an IRO and notify the parties of the assignments, so the Division agrees to make a text change. However, rather than using the term "business day," the Division uses the term "working day," as this is a term defined in 28 TAC §102.3 to be used in the calculation of time.

The Division declines to add the words "and upon receipt of a complete request" to the provision, as this would give a carrier the ability to determine whether a request for IRO should be filed. Parties are expected to provide complete information to carriers when an IRO is requested. However, carriers should act to file IRO requests with the information that is available. If a carrier is not able to file an IRO request, the Department should be notified.

§133.308(j)(5) and (6):

Comment: In regard to §133.308(j)(5) and §133.308(j)(6), a commenter makes recommendations for purposes of clarity concerning authority to dismiss IRO requests.

The commenter suggests adding the words "the department determines" before the words "the request" in each paragraph.

Agency Response: The Division disagrees with the comment and declines to make the suggested change, because it is unnecessary. The language in subsection (j) is sufficiently clear to indicate that authority to dismiss a request for IRO review rests with the Department.

§133.308(l):

Comment: A commenter strongly recommends a process whereby the carrier submits to an injured employee a list containing a detailed description of the medical records that the carrier submitted to the IRO for review. The commenter says that by providing injured employees with a detailed listing of information being filed with an IRO, carriers would be less likely to incur copy costs from health care providers when the injured employee requests medical records for a contested case hearing (CCH) on medical issues.

The commenter also strongly recommends allowing an injured employee or health care provider to supplement the carrier's submission, and the commenter suggests that an injured employee be notified and allowed to supplement when the Department notifies parties of an IRO assignment. The commenter says that such a notice should give the injured employees a set time frame to supplement the information for IRO review. The commenter suggests that for the IRO review to be a meaningful

administrative review; both parties, and not just the carrier, must be able to submit information to the IRO for a decision, because the carrier and injured employee are adverse parties. The commenter says that information the carrier believes is relevant to the dispute is often different than the information the injured employee believes is relevant to the dispute, so the injured employees should be given the opportunity to supplement the carrier's submission to ensure a meaningful administrative review by the IRO.

Agency Response: The Division disagrees with the comment, and declines to make the recommended changes for the following noted reasons. The injured employee is not always party to an MDR proceeding, so it would be inappropriate and possibly confusing for all injured employees to receive documents lists and deadline notices concerning IRO reviews. Additionally, most of the deadlines incorporated in this section are set by statute to ensure that necessary medical care is timely delivered – the Division cannot extend statutory deadlines to allow parties to argue over documents. Finally, the purpose of an IRO review is not to be a forum where parties can argue about the relevance or importance of documents or records. The purpose of the IRO review is to review the documents considered by the URA and render a decision based on those documents.

The Division notes that the current rule provisions do not prohibit parties (including an injured employee that is party to the dispute) from submitting documents to an IRO. However, the Division does not believe that creating a formal process with

time frames for submission of rebuttal documents would be in compliance with statutory provisions, and the Department thinks that creation of such a process would delay the IRO review. If parties have arguments to present concerning the weight of evidence, the arguments should be presented in a contested case hearing.

Comment: In regard to §133.308(l), a commenter suggests that there are reasons that parties do not submit all documentation to an IRO. The commenter says that providers may not have sufficient professional staff, so they make the best effort to gather records they think support their case and present those to the IRO, and that some carriers are in a similar situation. The commenter says this results in evidence being left out.

The commenter further says that carriers make their best effort to submit records, but that there are some things they do not have. The commenter says that IROs would prefer to just get documents that are relevant to the dispute, and not a mountain of records which have nothing to do with the dispute. For this reason, there is a balancing act that needs to be made.

The commenter says that clerical staff makes the determination regarding what should go to an IRO, because of the economics of the situation, in that carriers and providers have many other duties to perform. The commenter says that they see the IRO process as an informal process where they shouldn't have to jump through a lot of hoops. The commenter says that some parties make their best effort to send what they think makes their case, only to find out later that they may have needed to do more.

Agency Response: The Division agrees that records or documents with no relation to a medical necessity dispute should not be sent to an IRO, but clarifies that it is important for an IRO to receive all the relevant material, including any records or documentation reviewed by a carrier or URA in making an adverse determination. An IRO should not only be receiving the documentation that supports a particular party's position.

To provide guidance to the clerical staff that is determining what should be sent to the IRO, the Division makes the following clarifying changes to the text in §133.308:

The words "or the URA" are added following the word "carrier in §133.308(l)(2) and (3), and the words "including any medical records used by the carrier or the URA in making the determinations to be reviewed by the IRO" are added to the end of §133.308(l)(2).

§133.308(l) and (m):

Comment: A commenter says that denials need to be based on current medical records, and that it is the responsibility of the reviewing physician to make sure that he has been provided with such information when he performs the review.

Agency Response: The Division agrees in part and disagrees in part. The Division declines to make a change. The Division agrees that reviews need to be based on current medical records, but does not believe that changes to the rule are necessary to accomplish this. Section 133.308(m) provides that an IRO shall request additional

medical information from either party or other providers whose records are relevant to review, and provides that the parties or providers shall deliver those requested records to the IRO. The subsection also provides that failure to provide the requested documentation to the IRO may result in enforcement action as authorized by statutes and rules.

§133.308(o):

Comment: A commenter says that delay of care is a very critical element, and that time limits are part of standard of care. The commenter says that when there are times when there is a critical window in which to provide care, and that an injured employee cannot wait a few days, a week, or a month. The commenter says that the first interest should be to care for the injured worker, and after that one should worry about money the care should be provided first, and parties can fight about it later.

The commenter says that in most cases proceeding in this way would render a dispute obsolete. The commenter concluded by saying that no injured worker should be required to give up a part of their body or their function because of the bottom line of some insurance company.

Agency Response: The Division agrees that delay of care can be a critical issue in regard to an injured worker's improvement; however, the Division declines to make a change concerning the process of medical necessity review, because it does not have the statutory authority to make the changes requested by the commenter. Labor Code

§413.014 requires that a provider seek preauthorization or concurrent review for specified medical services, and Labor Code §413.031(d) requires that reviews of medical necessity issues be conducted by an independent review organization under Chapter 4202 of the Insurance Code in the same manner as reviews of utilization review decisions by health maintenance organizations. The Division notes that Insurance Code and §133.308 do take the special requirements of life-threatening conditions into consideration. Pursuant to Insurance Code §4201.360, review of life-threatening situations proceeds directly to independent review, and pursuant to Insurance Code §4202.003, the IRO decision must be issued no later than the eighth day after the date the IRO receives the request that the determination be made. These provisions are incorporated into §133.308 at subsections (i) and (o)(1).

§133.308(p):

Comment: A commenter notes that §133.307(d)(2)(B) prohibits any new denial reasons or defenses from being raised once a requestor files a dispute, and suggests that a similar provision be included in §133.308(p). The commenter expresses belief that all parties should be required to assert issues for dispute early in the claim to achieve an earlier resolution of the dispute, and that failing to limit carrier issues after dispute resolution has been requested causes confusion in the dispute resolution process, unnecessarily requires additional use of state resources, and may provide a tactic to delay medical care to an injured employee.

Agency Response: The Division disagrees with the comment and declines to make the suggested changes, because it would not be in line with the dispute sequence as established in §133.305(b). Section 133.307(d)(2)(B) places limitations on issues that can be raised in an appeal of a fee dispute, because issues of medical necessity or compensability should already have been resolved prior to resolution of fee disputes. However, in regard to §133.308, it is possible that fee dispute issues may arise or exist even after medical necessity issues are resolved.

Comment: A commenter says that information concerning denials should be sent to all physicians involved, because it is not efficient to only send this notice to the treating doctor.

Agency Response: The Division disagrees with the comment and declines to make a change, because the rule already provides for sufficient notice of the IRO decision by requiring that it be sent to all parties and their representatives of record. The Division notes that an IRO may not have contact information for all doctors involved in an injured employee's care, and that not all doctors involved in an injured employee's care will have an interest in the outcome of an IRO review.

§133.308(p)(1):

Comment: A commenter suggests that the basis of a denial should specify the precise reason for the denial, and that penalties should be directed toward insurance

companies and their designates when reference is only made globally to their internal criteria or to the official disability guidelines.

Agency Response: The Division disagrees and declines to make a change, because insurance companies do not control what is in an IRO decision. The Division notes that an IRO decision is required to include an analysis of and an explanation for a decision, including the findings and conclusions used to support the decision.

Comment: A commenter opines that there is no transparency between the carrier, the injured employee, and the doctors engaged to render opinions. The commenter says that lawyers write letters to doctors that are designed to discredit the injured employee and tell doctors they believe there is nothing wrong. Because of this, the commenter says that there should be no written communication submitted by a carrier to a provider unless it is also simultaneously submitted to the Division and the injured employee or the injured employee's representative. The commenter says that there should be complete transparency of all records and communications submitted to doctors.

Agency Response: The Division disagrees with this comment and declines to make a change, because it would be unfeasible to require a carrier to copy the Division and the injured employee on every communication made to a doctor. In most instances carriers exchange communications with doctors as a regular course of business, and the exchanges have no bearing on disputes. There is no reason for such documents to be simultaneously submitted to the Division and the injured employee, and submission of

such documents would greatly increase expenses to carriers and to the Division, but provide no benefit to the injured employee.

The Division notes that Department procedures related to IRO reviews include notification to the claimant when an IRO review is requested. The notice includes: the date of the IRO assignment, name and contact information for the IRO, the name of the referring carrier, a contact number for the Department, and a description of the type of information that the carrier or utilization provider is required to submit to the carrier. Using the contact information, a claimant can submit documents that the claimant feels are relevant to the IRO. Additionally, the IRO decision contains a list of all the medical records and other documents reviewed by the IRO in making the decision; therefore an injured employee is able to receive notice of what documents an IRO reviewer used to make its decision. Taken as a whole, the Department believes that this information provides transparency into the documentation used by an IRO reviewing doctor to reach a decision.

§133.308(p)(1)(D):

Comment: In regard to §133.308(p)(1)(D), a commenter recommends requiring the IRO decision to include an affirmative statement that the reviewing physician holds a license to practice medicine in Texas.

Agency Response: The Division disagrees with the comment and declines to make the suggested change, because it is unnecessary. An IRO is already required to

include information concerning reviewer licensure as a part of the IRO decision template, so it is unnecessary to duplicate the requirement in §133.308(p)(1)(D).

§133.308(p)(1)(G)(ii):

Comment: A commenter recommends requiring an IRO reviewer to affirmatively state the name of the treatment guideline within a network, because each network may have a different treatment guideline than the one adopted by the Division. The commenter says that this would provide an injured employee with necessary information should one choose to appeal the IRO decision.

Agency Response: The Division disagrees with the comment and declines to make a change, because the suggested change would constitute a substantive change from the proposed rule. The recommended change would place more stringent requirements on IRO reviewers when they prepare an IRO decision. Because the rule proposal included no changes to the requirements of an IRO decision, interested parties were not put on notice that changes might be made to the requirements in the adoption of the rules and were not afforded an opportunity to comment on such changes.

§133.308(r):

Comment: In regard to §133.308(r), a commenter suggest adding a requirement that an IRO also forward a copy of its invoice to an agent acting on behalf of a carrier,

because self-insured entities using third party administrators might not be familiar with IROs or deadlines for payments.

Agency Response: The Division disagrees with the comment and declines to make the suggested change because: (1) the carrier does not necessarily provide its agent's contact information to the IRO; (2) the suggested change would unnecessarily increase the costs to the IRO; (3) the carrier is in a better position to forward the information to its agent; and (4) the carrier is the party ultimately responsible for the payment of the IRO fee.

§133.308(r)(6):

Comment: In regard to §133,308(r)(6), a commenter says that this section appears to require a carrier to pay an additional fee when the Department requires an IRO to include an amended notification of decision. The commenter asks that this point be clarified.

Agency Response: The Division clarifies that §133.308(r) requires a party to pay IRO fees in the same amount as required by Department rules (located at 28 TAC §12.403, relating to Fee Amounts). Section 133.308(r)(6) says that those required fees are to an amended notification, when one is required by the Department, thus a carrier would not be required to pay an additional fee. The Division notes that there were no proposed changes to §133.308(r)(6), and that its provisions are a part of the current IRO procedure under §133.308.

§133.308(s):

Comment: A commenter says that §133.308(s) makes retrospective IRO decisions enforceable pending appeal. The commenter says that this requires a carrier to prepare an explanation of benefits and make payment within 21 days, but that there is no statutory provision to support this. The commenter says that in support of this section, the Division has previously cited Labor Code §413.031(m), but that that section indicates that IRO decisions under §413.031(d) are binding pending appeal. The commenter asserts that §413.031(d) only refers to prospective IRO reviews, and dose not refer to retrospective reviews.

Agency Response: The Division clarifies that the Labor Code does not provide a process for how an IRO is to conduct retrospective review; therefore the Commissioner has the obligation of establishing the process through rule. So far as a retrospective review is related to medical services paid for by a claimant, the Commissioner has specific rulemaking authority to adopt §133.308(s) under §413.031(f). Additionally, the Commissioner has rulemaking authority to adopt a process for retrospective reviews under Labor Code §402.00111 and §402.061.

This provision is related to Labor Code §413.031(m) in that the Commissioner has adopted a process similar to the process for prospective and concurrent IRO reviews – during the pendency of an IRO dispute concerning a retrospective IRO

review, the decision is binding and the parties should proceed in compliance with the decision.

§133.308(t):

Comment: A commenter says that when an IRO rules in favor of an injured worker, the decision needs to be protected because, while it is not intentional, injured workers do not have equal protection of the law in the system. The commenter says that its comments about IROs apply equally to other doctors and relates an incident involving a utilization review agent (URA) who claimed to be a specialist. Upon cross examination, it was shown that the majority of the URA's income came from reviews conducted between patient visits. The commenter asserts that no good doctor has time to render effective opinions between patient visits.

Agency Response: The Division agrees that an IRO decision needs to have relevance in later proceedings. However, the Division does not believe that it has authority to give an IRO decision more weight, depending on which party the decision favors. The Division clarifies that the adopted rules do not relate to specialization of URAs.

Comment: In regard to §133.308(t), a commenter asserts that the Division has no statutory authority to state that an IRO decision carries presumptive weight or that such presumptive weight must be overcome by a preponderance of evidence-based medical evidence to the contrary. The commenter expresses belief that an IRO decision should

be treated like any other evidence that is submitted at a contested case hearing, and that once a party challenging the IRO decision presents evidence contrary to that decision, the hearing officer has to consider all the evidence and decide where the preponderance of evidence lies. The commenter says that it believes it may prove extremely difficult to find evidence-based medicine to establish that a particular injured employee is an outlier from the treatment guidelines, which are evidence-based. The commenter recommends the removal of the term "evidence-based" from this subsection because there is no statutory authority for its inclusion, and it establishes a standard of proof that is nearly impossible to meet.

A second commenter says that it does not support the assignment of presumptive weight to an IRO decision, because the Labor Code and Insurance Code do not assign presumptive weight to an IRO decision. The commenter says that the Commissioner does not have the statutory authority to assign presumptive weight to IRO decisions, and recommends that the sentence "An opinion issued by an IRO shall be given great weight that may be overcome by a preponderance of evidence-based medical evidence to the contrary" be used in lieu of the proposed sentence: "In a Contested Case Hearing (CCH), decision issued by an IRO carries presumptive weight that may only be overcome by a preponderance of evidence-based medical evidence to the contrary."

Agency Response: The Division disagrees with the comments concerning the relevance of an IRO decision; however, it agrees to make a change to the text to clarify

the provision. There is clear evidence in the Labor Code that the Legislature intended an IRO decision to be more than just evidence in a contested case hearing. First, is the fact that the Legislature requires an IRO review if there is a question concerning medical necessity. The IRO process was added in 2002 as a way of ensuring that people who are medically trained are the ones making decisions about medical necessity, rather than having administrative staff make such decisions. In addition, because the Legislature felt that use of a medical opinion was so important, it chose to make the IRO decisions binding pending appeal. In 2005, the Legislature further showed its position that IRO reviews are important by removing the contested case process from medical necessity review, and requiring that appeals proceed directly to district court. Issues concerning due process and a party's ability to develop a record sufficient to proceed to appeal lead the Legislature to revise Labor Code 413.031 again in 2007 and reinsert the contested case hearing process. However, the Legislature still did not choose to downgrade the IRO process. Pursuant to Labor Code §413.0311, the purpose of a contested case hearing is for "an appeal of an independent review organization decision." The IRO decision is not a piece of evidence to be sued in an appeal under the Labor Code, the IRO decision is the subject of the appeal. For that reason, a party challenging an IRO decision is the one who must appeal and the one who must overcome the IRO decision.

The Division declines to degrade the value of the IRO decision, as this would be contrary to the value ascribed to an IRO decision by the Legislature and would be

contrary to the Labor Code's requirement that the contested case hearing be an appeal of the IRO decision. However, in regard to the comments addressing the weight of an IRO decision, the Division agrees to make a text change to clarify a party's burden in regard to an IRO decision. The proposed version of §133.308(t) contained the sentence: "In a Contested Case Hearing (CCH), the decision issued by an IRO carries presumptive weight that may only be overcome by a preponderance of evidence-based medical evidence." This sentence has been changed to say: "In a 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."

In regard to the first commenter's comment concerning a requirement for "evidence-based medical evidence" the Division disagrees with the comment and declines to make a change. In §413.011(e), the Labor Code requires treatment guidelines to be "evidence-based." Additionally, Labor Code §401.011(18-a) defines "Health care reasonably required" as being "health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with: (A) evidence-based medicine; or (B) if that evidence is not available, generally accepted standards of medical practice recognized in the medical community." (Emphasis added.) The purpose of the IRO is to determine if health care is medically necessary, and the IRO uses the Division's guidelines to make that determination. It is only reasonable that a party wanting to overcome the IRO decision use evidence that is based on the same standards used to develop the

treatment guidelines used by the IRO and the same standards used to determine what is "Health care reasonably required."

Comment: A commenter says that while it does not object to the rule including language that indicates that neither TDI nor the DWC are parties to an appeal of an IRO decision, the rule provision that provides that a decision by an IRO is not an agency decision is problematic given the fact that TDI and the DWC may not delegate their statutory decision-making duties to a non-government entity or person. The commenter asserts that the authority to render decisions in all disputes that are presented to the Division for adjudication rests solely with the agency itself.

The commenter recommends that the word "decision" be changed to "opinion," and that the rule text be changed to say that the "opinion is considered to be an agency decision," but that "Not withstanding the fact that an IRO opinion is deemed to be a decision of the agency, neither the Department nor the Division are considered parties to an appeal."

Agency Response: The Division disagrees with the comment and declines to make a change. The Division notes that it is the Legislature that has given an IRO authority to make a decision regarding medical necessity. Prior to HB 2600, passed by the 77th Legislature, regular session, Texas Workers' Compensation Commission staff made determinations in both fee disputes and medical necessity disputes. However, amendments to Labor Code §413.031 divided these functions. Division staff still makes

determinations in fee disputes, but IROs make decisions regarding medical necessity. Specifically, Labor Code §413.031 says, "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", but that "A review of the medical necessity of a health care service requiring preauthorization under Section 413.014 or commissioner rules under that section or Section 413.011(g) shall be conducted by an independent review organization…."

The Division declines to change the word "decision" to "opinion," because "decision" is the term used in the Labor Code to describe the result of an IRO review." Labor Code §413.031 states "It is a defense for the insurance carrier if the carrier timely complies with the decision of the independent review organization." Labor Code §413.0311 references "an appeal of an independent review organization decision" in two places. Labor Code §413.032 concerns "Independent Review Organization Decision; Appeal", and contains a minimum list of elements that must be included in an IRO "decision." (emphasis added.)

Comment: A commenter suggests that a serious defect exists in the current law, because no peer review doctor or IRO reviewer is impartial or fair in any review. The commenter notes that an IRO decision may overturn multiple credible doctors, despite the reviewer having never examined the patient. The commenter says that it is insanity

and it is dangerous to injured workers to ever give "presumptive weight" to any doctor who has not personally seen and examined the injured worker and conferred with the doctor requesting the care. Conversely, the commenter says that an IRO opinion should be protected when the reviewer rules in favor of the injured worker.

Agency Response: The Division disagrees with the comment; however the Division agrees to make a clarifying text change. Pursuant to Labor Code §413.0311(a) (2) and (3), it is the IRO decision that is being appealed. The Division interprets these provisions to mean that a party appealing an IRO decision has the burden of overcoming it. The purpose of the language in §133.308(t) is to specify that the party appealing an IRO decision has the burden of overcoming the decision, and the adopted language has been revised to state "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" in order to more directly express this.

§133.308(t)(1)(A):

Comment: A commenter recommends that §133.308(t)(1)(A) state the 20-day time frame to appeal an IRO decision, because injured employees will not always have access to 28 TAC §148.3. The commenter says that this change would properly informs injured employees of their ability to appeal a decision, and would reduce system participant confusion.

Agency Response: The Division disagrees with the comment and declines to make the suggested change, because the process for filing an appeal to SOAH, including the time frame to file an appeal, is already set in 28 TAC Chapter 148. An attempt to provide the same regulations in this rule would be redundant and could create the opportunity for arguments concerning conflicting rule provisions.

§133.308(t)(1)(B):

Comment: In regard to §133.308(t)(1)(B), a commenter recommends adding a provision that says "If at the time of the contested case hearing there are additional medical necessity disputes between the parties involving the same patient and same date of injury, then either party may file a motion to consolidate the additional medical necessity disputes into the medical necessity dispute set for contested case hearing. Failure of the parties to join additional medical necessity disputes involving the same patient and same date of injury that could have been made a part of the contested case hearing proceeding will result in a waiver by the party requesting MDR to pursue that disputed issue further." The commenter says that this change would make the medical dispute resolution system more efficient by avoiding multiple contested case hearings on the same claim, and would prevent a requestor from gaming the system by breaking down a large dollar medical dispute into several smaller disputes that would each require a hearing.

Agency Response: The Division disagrees with the comment and declines to make a change, because there is no statutory authority to require a party to consolidate all medical necessity disputes into one dispute, and because the recommended language would conflict with Labor Code §413.0311 and §413.031.

Labor Code §413.0311 addresses two types of appeals related to medical necessity: "an appeal of an independent review organization decision regarding determination of the retrospective medical necessity for a health care service for which the amount billed does not exceed $3,000;" and "an appeal of an independent review organization decision regarding determination of the concurrent or prospective medical necessity for a health care service." In each instance the section references "an appeal" of "[a] decision." However, with the recommended text, the appeal would be of multiple decisions, which would be in direct conflict with the statute.

Additionally, Labor Code §413.031(l) establishes a specific process for review of a medical dispute regarding spinal surgery. The provisions of Labor Code §413.031 would potentially be violated if disputes regarding spinal were required to be consolidated with all other medical necessity disputes involving the same patient and same date of injury.

Comment: A commenter references §133.308(t)(1)(B), and expresses belief that the Division should amend the provision to provide a more efficient dispute resolution process which would avoid multiple contested case hearings on the same claim and

prevent requestors from gaming the system by breaking down large dollar medical disputes into several smaller disputes that would each require a hearing. To this end, the commenter suggests adding a new subparagraph that says, "If at the time of the contested case hearing there are additional medical fee disputes between the parties involving the same patient and same date of injury then either party may file a motion or the hearing officer may issue an order to consolidate the additional fee disputes into the medical fee dispute set for contested case hearing."

Agency Response: The Division disagrees with the comment and declines to make a change. The current dispute resolution process was devised by the Legislature and incorporated into Labor Code §§413.031, 413.0311, and 413.032, and the Division lacks authority to substitute that process with a different dispute resolution process.

The Division notes that the commenter's suggestion would require the consolidation of multiple disputes, even if they had not proceeded through all the steps of dispute resolution. For instance, when both a medical necessity issue and a fee dispute issue exist, the medical necessity issue must be resolved prior to review of the fee dispute issue. However, under the commenter's proposed change, if the medical necessity dispute is appealed to a contested case hearing, the fee dispute would become consolidated with it, possibly without having proceeded through the reconsideration process outlined in 28 TAC §133.250 or the medical fee dispute resolution process outlined in §133.307.

§133.308(t)(1)(B)(i) and (ii):

Comment: In regard to §133.308(t)(1)(B)(i), a commenter recommends replacing the words "sent to" with "received." Additionally In regard to §133.308(t)(1)(B)(ii), the commenter recommends replacing the word "deliver" with "send."

The commenter says these changes are to: "(1) limit the number of disputes; (2) clarify who must file the medical dispute; and (3) provide due process among other reasons."

Agency Response: The Division disagrees in part and agrees in part. The Division declines to replace the words "sent to" with "received," because such a change would make it more difficult to affirmatively prove when the 20 day appeal period begins. An IRO is not part of the Division, so 28 TAC §102.5 (relating to General Rules for Written Communications to and from the Commission), which provides a means for determining the date a communication is received, is not applicable. Instead, 28 TAC §102.4 (relating to General Rules for Non-Commission Communications) is applicable. Section 102.4(h) provides a means for determining the date a communication is sent.

The Division does not see how making the recommended change would limit the number of disputes, clarify who must file a medical dispute, or provide due process. However, as used in this sentence, "send" would be a synonym to "deliver," and the Division agrees to make this change.

§133.308(t)(1)(B)(i) and (u)(1):

Comment: In regard to §133.308(t)(1)(B)(i) and §133.308(u)(1), a commenter says that these provisions conflict with the appeal procedures for appeal of retrospective medical necessity disputes to SOAH found in §133.308(t)(1)(A), appeals procedures for appeal of medical fee disputes to SOAH found in §133.307(f)(1)(A), and appeals procedures for appeal of medical fee disputes to medical CCH found in §133.307(f)(2)(A).

The commenter recommends that §133.308(t)(1)(B)(i) and §133.308(u)(1) be rewritten to state that a written appeal must be filed with the Division's Chief Clerk no later than 20 days after the date the decision is received.

Agency Response: The Division disagrees with the comment and declines to make a change. The Division notes that no conflict exists, because the sections cited by the commenter are applicable to different types of appeals, either appeals to SOAH or appeals of fee dispute decisions.

The Division notes that a difference exists between fee dispute resolution decisions and IRO decisions in that fee dispute resolution decisions are communications from the Division and IRO Decisions are communications from a non-division entity.

The Division's rule at 28 TAC §102.5 (relating to General Rules for Written Communications to and from the Commission) provides a means for determining the date a communication is *received* from the Division, so it is appropriate that a time frame concerning such a communication be calculated from the date the communication is *received*. However, §102.5 is not applicable to an IRO, because IROs are not part of

the Division. Instead, 28 TAC §102.4 (relating to General Rules for Non-Commission Communications) is applicable to IROs. Section 102.4(h) provides a means for determining the date a communication is *sent*. Therefore, it is appropriate that a time frame based on a communication from a non-division entity be calculated from the date the communication is *sent*.

The time frame for appeals to SOAH is established by the Division's current rule in 28 TAC §148.3. The Division has not proposed any amendments to that section at this time.

§133.308(t)(1)(B)(i) and (vi):

Comment: A commenter says that an adequate period of time should be allowed for an appeal to be made, and recommends allowing 60 to 90 days for such a process.

Agency Response: The Division agrees in part and disagrees in part and declines to make a change. The Division agrees that parties should be allowed adequate time to appeal an IRO decision, but believes that 20 days is an adequate amount of time in which to file an appeal. The Division notes that this is the amount of time allowed by earlier versions of this rule, and that this was a sufficient amount of time in the past. The Division notes that the amount of time to file an appeal to District court is mandated by the Government Code, and the Division cannot expand that time through rule.

§133.308(t)(1)(B)(ii):

Comment: A commenter recommends that the MDR rules assert a time frame in which to exchange information, in order to insure that the exchange of information is made systematically and appeals are made in a timely fashion.

Agency Response: The Division agrees that information should be exchanged in a timely manner, but disagrees that a provisions needs to be added to the MDR rules to address this and declines to make a change because no change in necessary. As proposed, the rules already provide for time frames for the exchange of information. Specifically, proposed §133.307(f)(2)(E) and §133.308(t)(2)((B)(iii) say that Division contested case hearings shall be conducted in accordance with 28 TAC Chapters 140 and 142. Section 142.13(g) provides for the hearing officer to set a time frame for exchange of discovery when a hearing is held without a prior benefit review conference. In addition, the Division notes that parties may be granted additional time to conduct discovery pursuant to 28 TAC §142.13(f).

§133.308(t)(1)(B)(iv):

Comment: A commenter notes that proposed §133.308(t)(1)(B)(iv) provides that prior to the issuance of a CCH decision, a party may submit a request for a letter of clarification by the IRO to the DWC's chief clerk, but that the last sentence of the provision says that that a request for a letter of clarification may not ask the IRO to reconsider its decision or issue a new decision. The commenter suggests that this language could cause an IRO to believe that he or she may not review the underlying

decision and reverse their decision if appropriate. The commenter says that the proposed language could result in unnecessary and inappropriate services being approved by the IRO process. The commenter recommends deleting the last sentence of the clause.

A second commenter also recommends deletion of the last sentence of §133.308(t)(1)(B)(iv), and additionally recommends deletion of §133.308(t)(1)(B)(iv)(IV). The commenter says these changes are to: "(1) limit the number of disputes; (2) clarify who must file the medical dispute; and (3) provide due process among other reasons."

Agency Response: The Division disagrees with the comments and declines to make the suggested change because a letter of clarification is not intended to be a request for a new review but to clarify the original decision due to ambiguity, lack of documentation provided by any party to the IRO for the review, and conflicts of information within the decision. The letter of clarification is not an alternative form of review in which the IRO conducts a new independent review, but rather an opportunity to assist in the next level of proceeding by allowing the Division to know if all information that should have been made available to the IRO was in fact made available for the review. In the event that all pertinent information was not made available by the concerned parties, enforcement action is available to the Division for failure to comply with the IRO request requirements.

The Division does not see how deletion of §133.308(t)(1)(B)(iv) or §133.308(t)(1)(B)(iv)(IV) would limit the number of disputes, clarify who must file the

medical dispute, or provide due process, and thus declines to make the recommended change.

§133.308(t)(1)(B)(v):

Comment: A commenter disagrees with the proposed §133.308(t)(1)(B)(v), because the opposing party may provide inaccurate or incomplete medical information and the IRO may be making its decision based on this information. The commenter believes the rules should allow the presentation of additional documentary evidence if the claimant's medical condition so dictates. The commenter believes that DWC should consider the most recent medical evidence in making decisions.

The commenter opposes DWC adopting procedural rules that are different from SOAH, since it is confusing to stakeholders and encourages requestors to game the system to obtain the most favorable rules.

Agency Response: The Division has not adopted proposed §133.308(t)(1)(B)(v). The clauses in §133.308(t)(1)(B) have been renumbered as appropriate.

The Division disagrees with the commenter and declines to make a change in regard to the comments concerning the Division adopting rules for its contested case hearings that differ from SOAH's rules. When the Legislature chose to establish a bifurcated system for appealing fee dispute and IRO decisions, it was aware that SOAH and the Division are regulated by different statutes and have different rules. However, the Legislature expressly stated that certain appeals are to be "conducted by a hearings

officer in the manner provided for contested case hearings under [Labor Code] Subchapter D, Chapter 410," and the Division is not going to attempt to circumvent through rule the Legislature's intentions.

Comment: With regard to proposed §133.308(t)(1)(B)(v), a commenter expresses belief that the section unfairly eliminates the parties' due process rights by limiting the documentary evidence and witnesses to those disclosed early in the MDR process. The commenter contends that this conflicts with Labor Code section 401.021.

The commenter recommends that this section be eliminated and a new section proposed that ensures parties the right to a full evidentiary hearing.

The commenter thanks the Division for consideration of these issues.

Agency Response: The Division has not adopted proposed §133.308(t)(1)(B)(v), and the clauses in §133.308(t)(1)(B) have been renumbered as appropriate. The Division disagrees with the commenter with regard to Labor Code §401.021.

The commenter bases its recommendations on the provisions of Labor Code §401.021, stating that this section makes the APA applicable to contested case hearings, therefore the rules of evidence are applicable in contested case hearings. However, commenter disregards the limiting statement "Except as otherwise provided by this subtitle," which is in Labor Code §401.021. It is actually Labor Code §410.003 (relating to Application of Administrative Procedure Act) and §410.153 (also relating to Application of Administrative Procedure Act) that says how the APA applies to Division

Contested Case hearings. These sections leave applicability of the APA to the Commissioner's discretion, and pursuant to the Commissioner's rule at 28 TAC §142.1 (relating to Application of the Administrative Procedure Act), only Government Code §2001.201 (relating to Enforcement of Subpoenas) is applicable to Division contested case hearings.

Comment: A commenter recommends removing the provisions which limit the documentary evidence and witnesses to those disclosed to the IRO, except upon a showing of good cause. The commenter believes that limiting the evidence in this way will keep employees from submitting evidence in addition to that submitted by the carrier. The commenter further believes that this limitation would raise due process issues and be contrary to *HCA Healthcare Corp v. Texas Dept. of Ins. and Division of Workers' Compensation* (Cause No. D-1-GN-06-000176). Further, the commenter asserts this would be contrary to the intent of HB 724. The commenter believes that the focus should be on making the best decision, regarding medical necessity, with all of the relevant evidence, rather than whether the IRO's decision is supported by a preponderance of the evidence.

Agency Response: The Division has not adopted proposed §133.308(t)(1)(B)(v). The clauses in §133.308(t)(1)(B) have been renumbered as appropriate.

Comment: A commenter is opposed to §133.308 which would limit the evidence in a CCH to the documentation that was filed during the medical dispute resolution process.

The commenter states that the stakeholders view the entire process of medical dispute resolution as a very informal process because there is no opportunity to present evidence in front of a Hearing Officer, perform discovery, or present witnesses. The commenter states HB 7 amended §413.031(k) of the Labor Code in an attempt to streamline the medical dispute process; however, a Travis County District Court Judge ruled the statute was facially unconstitutional because the provision did not provide the parties with opportunity for an administrative law hearing in which they could develop their record by presenting all their evidence, present witnesses, and conduct cross examination and discovery.

The commenter states that Representative Burt Solomons filed HB 724 to try to rectify this problem.

The commenter asserts that there can be no doubt that the parties should be able to present their full case at a contested case hearing, since the medical dispute process is not the type of process in which one can develop a record.

The commenter thinks the proposed sections would result in providers taking their entire medical record and throwing it at the IRO, dumping it into the mix for the medical fee dispute process – something that would add unnecessary paper flow in the system.

The commenter suggests that evidence should not be limited because new medical evidence could occur that may be relevant to the dispute that, if not allowed to be introduced, could result in health care being denied.

The commenter states the opposite is true as well, if evidence the carrier develops in the interim is not allowed to be introduced, health care may be delivered that could further injure an injured employee or end the injured employee's life. The commenter asserts that this often happened with spinal surgery cases in the 1990s.

The commenter states most medical bills (75 to 80 percent) are actually paid and only a small percentage go to dispute resolution. The commenter states even a smaller number would proceed to a contested case hearing. The commenter states that is why it is perplexed that the Division is even considering a provision to limit evidence when the commenter believes it would set up a situation very similar to the reality that was faced when HB 7 had §413.031(k) struck down as being facially unconstitutional because it deprived the parties of the right to have that hearing to develop their full record. The commenter asserts the proposed rule provisions would have the same effect.

The commenter requests that §133.308(t)(1)(B)(v) be revised to say: "At a Division contested case hearing under this paragraph, the parties shall be limited to documentary evidence exchanged and to witnesses reasonably disclosed in the manner provided by this subtitle. Parties may not raise issues regarding liability,

compensability, or medical necessity at a contested case hearing for a medical fee dispute.

"(1) The parties to a Division contested case hearing shall exchange their documentary, other relevant evidence, and list of witnesses 14 days before the contested hearing.

"(2) A party who sends a document relating to a benefit contested case hearing to the Commission shall also deliver copies of the document to all other parties, or their representatives or attorneys. Delivery shall be accomplished by presenting in person, mailing by first class mail, facsimile or electronic transmission. The document sent to the Commission shall contain a statement certifying delivery. The following statement of certification shall be used: 'I hereby certify that I have on this _____ day of _____, _____, delivered a copy of the attached document(s) to (state the names of all parties to whom a copy was delivered) by (state the manner of delivery).'

"(3) The contested case hearing officer shall issue an order and direct the informal review organization to review any new medical evidence and issue an addendum report to the original IRO report. The party that was responsible for paying the initial IRO fee shall be ordered by the contested case hearing officer to pay an additional fee of $150.

"(4) The Division may take enforcement action against a party who is deemed to have a pattern of practice of withholding evidence and offering the withheld evidence at a contested case hearing."

Agency Response: The Division has not adopted proposed §133.308(t)(1)(B)(v). The clauses in §133.308(t)(1)(B) have been renumbered as appropriate.

The Division declines to insert a provision outlining a time frame for exchange of evidence and witness lists in this section, as those provisions are addressed in 28 TAC Chapter 142 (relating to Dispute Resolution – Benefit Contested Case Hearing).

The Division declines to require the hearing officer to forward new documentation to the IRO for the purpose of preparing an indemnity report. The Division also declines to charge additional fees to reimburse IROs for their costs associated with the indemnity report. The hearing officer currently has the option to entertain requests from the parties for a letter of clarification from the IRO. To require the hearing officer to forward documents to the IRO would be to usurp the authority of the hearing officer as outlined in 28 TAC Chapter 142 (relating to Dispute Resolution – Benefit Contested Case Hearing).

Comment: A commenter recommends language revisions to the subclauses in proposed §133.308(t)(1)(B)(v) which states "documentary evidence exchanged and to witnesses reasonably disclosed during the medical fee dispute under this subchapter including the prehearing and hearing process except upon a showing of good cause. Good cause is shown if an ordinarily prudent person would not have exchanged the documentary evidence or listed the witness under the same or similar circumstances."

Agency Response: The Division has not adopted proposed §133.308(t)(1)(B)(v). The clauses in §133.308(t)(1)(B) have been renumbered as appropriate.

The Division declines to accept the commenter's definition of "good cause," as well as additional language for this section, since the Division has chosen to delete this section from the rule.

§133.308(t)(1)(B)(v):

Comment: A commenter says that the IRO reviewer should be available for cross-examination; should examine an injured employee, when necessary; and should not be anonymous, but rather should provide information concerning qualifications, amount of practice, and how much active practice is pursued in the filed of service being reviewed.

Agency Response: The Division disagrees with the comment and declines to make a change, because the recommended changes would not be consistent with provisions in the Insurance Code. Insurance Code §4202.009 provides that "information that reveals the identity of a physician or other individual health care provider who makes a review determination for an independent review organization is confidential," and the Division cannot adopt a rule provision that would violate this section.

§133.308(t)(1)(B)(vi):

Comment: In regard to proposed 133.308(t)(1)(B)(vi), a commenter recommends offering both the time frame and venue for appeal within the text of the section. The

commenter says that providing the 30 day time frame and identifying venue in Travis County within the text of the rule would provide for a clear manner and would properly inform injured employees of their right to appeal.

Agency Response: The Division disagrees with the comment and declines to make a change, because such a change is not necessary and would not be in keeping with the way other Division rules address appeal under the Government Code; for instance, 28 TAC §148.15(f) provides that appeal of a SOAH contested case hearing that follows an IRO review is conducted "in accordance with the APA, §§2001.171, 2001.174, and 2001,176." The Division notes that access to the Government Code is available via the internet through the State of Texas website, and the Office of Injured Employee Counsel is available to provide assistance and guidance to injured employees who do not understand the processes under these sections.

Comment: In regard to proposed §133.308(t)(1)(B)(vi), a commenter recommends that the words "hearing officer" be deleted. The commenter bases his suggestion on the fact that a division hearing officer is employed by the Division, thus making a decision issued by a hearing officer a decision of the Division.

Agency Response: The Division agrees that a Division hearing officer is a Division employee, and thus a decision made by a Division hearing officer is a decision of the Division. However, the Division disagrees with the suggestion and declines to make the recommended change. While the decision may be a Division decision, the hearing

officer is the person who actually examines evidence and makes a decision on behalf of the Division, and the hearing officer is the person who actually issues decisions on behalf of the Division. The specific point when the hearing officer actually issues the decision has been selected as the point when a decision becomes final and appealable, but use of the amorphous phrase "when issued by the Division" would not convey this intent.

Comment: A commenter recommends that §133.308(t)(1)(B)(vi) be redrafted to say: "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. A decision becomes final and appealable when issued by the Division and received by the party. 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. 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)."

The commenter says this change would: "(1) limit the number of disputes; (2) clarify who must file the medical dispute; and (3) provide due process among other reasons."

Agency Response: The Division agrees in part and disagrees in part, and agrees to make some, but not all of the recommended changes.

The Division does not see how making the recommended change would limit the number of disputes, clarify who must file a medical dispute, or provide due process. However, the Division recognizes that most of the proposed change is identical to language concerning judicial appeal that was proposed in §133.307. The Division believes that use of similar language would assist parties in interpreting and applying both sections, and agrees to the suggested change so far as it is a reflection of language in §133.307.

However, the commenter also suggests that a decision should be determined to be final and appealable when "issued by the Division and received by the party," rather than when "issued by the hearing officer." The purpose of this provision is to establish the point when a decision becomes final and appealable, but use of the phrase "when issued by the Division and received by the party" would not convey this intent. Therefore the Division declines to make this change.

§133.308(t)(1)(B)(vii)(I):

Comment: A commenter says that §133.308(t)(1)(B)(vii)(I) sets out the information that must be included in a petition for judicial review. The commenter says that the petition for judicial review should include more specific information that will assist the Division and other parties with matching a petition for judicial review to the underlying claim and

medical dispute resolution decision, and recommends deleting the list of items included in the proposed section, and replacing them with the following items in the following order: the medical dispute resolution tracking number(s) for the dispute being appealed; the carrier claim number; DWC claim number; the names of the parties; the petition cause number, if known; the identity of the court; and the date the petition was filed with the court.

A second commenter offers a similar suggestion, asking that the proposed list of items be replaced with the following items in the following order: the DWC MDR Tracking number(s) for the dispute being appealed; the names of the parties; the insurance carrier claim number; the petition cause number; the identity of the court; and the date the petition was filed with the court. The commenter says this change would: "(1) limit the number of disputes; (2) clarify who must file the medical dispute; and (3) provide due process among other reasons."

Agency Response: The Division disagrees with the comments and declines to make the recommended changes. The Division clarifies that the listed information is not necessarily required to be in a petition, but must be provided in a cover letter if not in the petition. The Division notes that it is the Rules Of Civil Procedure and local court rules that dictate what must be in a petition for judicial review.

The Division does not see how making the recommended change would limit the number of disputes, clarify who must file a medical dispute, or provide due process.

The purpose of this provision is simply to ensure that the Division has sufficient information concerning an appeal to be able to assemble the correct administrative record for use by the District Court. The recommended changes would not further this goal; for instance, the Division does not need a carrier's internal claim number. Additionally, if a party does not know the petition cause number for a case it has filed, it should contact the district clerk's office and get the number before forwarding a copy of the petition to the Division.

The Division's staff has determined that the list of information in §133.308(t)(1)(B)(vii)(I) as proposed is sufficient for the Division to be able to assemble an administrative record.

§133.308(t)(1)(B)(vii)(II):

Comment: In regard to §133.308(t)(1)(B)(vii)(II), a commenter recommends deleting the list of items included in the record of the hearing as was proposed, and suggests replacing it with the following items in the following order: each pleading, motion, and intermediate ruling; evidence received or considered; a statement of matters officially noticed; questions and offers of proof, objections, and rulings on them; proposed findings and exceptions; each decision, opinion, or report by the officer presiding at the hearing; and all staff memoranda or data submitted to or considered by the contested case hearing officer or members of the agency who are involved in making the decision.

The commenter says this change would: "(1) limit the number of disputes; (2) clarify who must file the medical dispute; and (3) provide due process among other reasons."

Agency Response: The Division disagrees and declines to make the recommended changes, because they are unnecessary, inappropriate, and would result in a denial of due process to parties seeking to appeal a Division hearing officer's decision. Additionally, the Division does not see how making the recommended change would limit the number of disputes, clarify who must file a medical dispute, or provide due process.

In response to the commenters suggestion to replace the word "all" in the first item and the word "any" in the fifth item with the word "each," The Division notes that this change in wording would have no effect, and the Division declines to do it because it is unnecessary.

In response to the commenters suggestion to add an item for "proposed findings and exceptions," the Division notes the following factors: If proposed findings or exceptions are offered as a motion or pleading, they are already covered by the first item in the list. If proposed findings or exceptions are offered as an oral motion during the course of the hearing, they will be included in the transcript of the hearing. For this reason, it is unnecessary to include a separate item for proposed findings and exceptions, and the Division declines to make the suggested change.

In response to the commenters suggestion to add an item for "all staff memoranda or data submitted to or considered by the contested case hearing officer or members of the agency who are involved in making the decision," the Division notes that this language would be overly-inclusive – such items might include internal memoranda that are not relevant to the appeal or draft opinions that are not intended to be issued. It would be inappropriate to include such items in the agency record of a contested case hearing.

Finally, in response to the commenter's suggestion to delete the item "a transcription of the audio record of the Division CCH" from the list of items included in the agency record, the Division notes this: the purpose of having a contested case hearing is to allow parties to examine and cross-examine witnesses and offer legal arguments. If an appellate court is to be able to review testimony or know what arguments were presented to the hearing officer, a transcript of the hearing is essential. The commenter's suggestion to not include a transcript of the hearing in the agency record would prevent an appellate court from being able to review what occurred at the contested case hearing, and deny parties their due process rights.

§133.308(t)(1)(B)(vii)(III):

Comment: In regard to §133.308(t)(1)(B)(vii)(III), a commenter expresses support for the provision, but recommends adding the sentence "If DWC determines that a party is

unable to pay such costs, DWC may waive the cost to produce the certified record in part or whole."

Agency Response: The Division appreciates the commenter's support, but disagrees with the recommendation and declines to make the change requested by the commenter, because no change is necessary. The Division has authority to waive the cost of the cost to produce the certified record in part or whole without a need to incorporate an express provision to that effect in this rule.

§133.308(t)(1)(C):

Comment: In regard to §133.308(t)(1)(C), a commenter recommends adding the words "as set forth in the State Fee Schedule 28 TAC §108.1" to the end of the sentence that says "The party requesting the record shall pay the IRO copying costs for the records." The commenter says this change is to: "(1) limit the number of disputes; (2) clarify who must file the medical dispute; and (3) provide due process among other reasons."

Agency Response: The Division disagrees with this comment and declines to make a change, because 28 TAC §108.1 (related to Charges for Copies of Public Information) is not related to a request made to an IRO pursuant to §133.308(t)(1)(C), because 28 TAC §108.1 concerns requests for information made to the Division pursuant to the Public Information Act. An IRO is a private entity, and not a part of the Division or the Department; therefore, a request made to the IRO is not a request made to the Department or the Division. Additionally, in some instances the information used by an

IRO in making its decision would be specifically exempt from disclosure. However, if a party is appealing a decision of the IRO, the party is able to access the information pursuant to §133.308(t)(1)(C in order to pursue the appeal.

Finally, the Division does not see how making the recommended change will would limit the number of disputes, clarify who must file the medical dispute, or provide due process.

§133.308(t)(1)(C)(viii):

Comment: In regard to section §133.308(t)(1)(C)(viii), a commenter recommends adding a comma followed by the words "learned treatise" behind the words "any pertinent medical literature." The commenter says this change is to: "(1) limit the number of disputes; (2) clarify who must file the medical dispute; and (3) provide due process among other reasons."

Agency Response: The Division disagrees and declines to make a change, because no change is necessary. A "learned treatise" is a form of "medical literature" and, therefore, does not need to be listed separately from "medical literature." The Division does not see how making the recommended change would limit the number of disputes, clarify who must file the medical dispute, or provide due process.

§133.308(u)(2):

Comment: In regard to §133.308(u)(2), a commenter says that 20 days is not adequate notice to prepare for a hearing. The commenter says that, at times, it takes the Division 3 - 7 days to set a hearing and notify the parties. This means, asserts the commenter, that the time to prepare is dropped to two weeks or less. The commenter says that this makes it impossible for a carrier to identify and obtain an expert witness to testify and adequately prepare for a hearing. The commenter says that the time frame is arbitrary, without medical basis, and unrealistic.

The commenter points out that a spinal surgical event is invasive and impacts the rest of the injured worker's life, and says that it is important to note that by the time the dispute is appealed at CCH, three medical doctors will have determined that the procedure is not medically necessary. To support this statement regarding three doctors, the commenter lists the initial preauthorization denial, the reconsideration denial and the IRO denial.

The commenter recommends that the time frame be expanded to 60 days, asserting that this would ensure that both parties have time to prepare and stating that this would be consistent with 28 TAC §142.6(b) as it regards the time frame allowed for setting a CCH without a prior BRC.

Agency Response: The Division disagrees and declines to make a change, because §133.308(u)(2) was not a proposed provision, but rather was part of the current rule.

The purpose of this provision is to provide an expedited contested case hearing review process, as the issue involves the medical necessity of spinal surgery. Labor

Code §410.025 gives the Commissioner authority to prescribe the time within which a benefit review conference must be scheduled. Section 142.6(b), cited by the commenter, does not concern expedited hearing settings.

The Division disagrees that in all cases three doctors will have determined that the procedure is not medically necessary by the time it reaches the IRO. The injured employee would have determined that the procedure was medically necessary, the carrier's URA would have twice determine that the procedure was not medically necessary, and the IRO may have either upheld or overturned the URA's determination.

The Division notes that a party has 20 days in which to examine an IRO decision and determine whether an appeal is appropriate. Additionally, the Division notes that a party is not required to wait until the contested case hearing is set on the docket to begin preparing its case, but can begin preparing for an appeal the moment the IRO decision is received.

§133.308(w):

Comment: A commenter says that §133.308(w) is entirely unnecessary. The commenter questions the purpose of including the language in the proposal, and asserts that the inclusion of this language in a rule is a major departure from the Division's normal mode of operation. The commenter asks that the subsection be deleted.

A second commenter recommends deleting the words "Enforcement. If the Department believes that any person is in violation of the Labor Code, Insurance Code, or related rules, the Department may initiate an enforcement action." The commenter says that this change would: "(1) limit the number of disputes; (2) clarify who must file the medical dispute; and (3) provide due process among other reasons."

Agency Response: The Division disagrees with the comments and declines to make the suggested change because the agency has authority to pursue enforcement actions when the insurance Code, Labor Code, and agency rules are violated. Stating that the Department may initiate enforcement actions is not a divergence from Division or Department procedures, as this authority is often addressed in agency rules. In response to the question, the Division notes that the language was included in the proposal because the subsection had been renumbered, as indicated by the fact that "(w)" was underlined in the proposal. The Division notes that the language was not a proposed provision in the rule, but was a part of the current rule.

The Division does not see how making the recommended change would limit the number of disputes, clarify who must file the medical dispute, or provide due process.

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

For with Changes: Texas Medical Association; Pringle & Gallagher, L.L.P.; Sedgwick CMS; Zenith Insurance Company; Medtronic, Inc.; Gardere Wynne Sewell, LLP; American Insurance Association; Texas Pain Society; Property Casualty Insurers

of America; Office of Injured Employee Counsel; Insurance Council of Texas; Texas Mutual Insurance; Texas Lobby Solutions, Inc.; Insurance Council of Texas; Flahive, Ogden & Latson; Texas Hospital Association; Two individuals.

Against: An individual; Stone, Loughlin & Swanson.

Neither for nor against: Four individuals.

6. STATUTORY AUTHORITY. The amendments are adopted pursuant to Labor Code §§408.0271, 413.002, 413.0111, 413.020, 413.031, 413.0311, 413.032, 408.0043, 408.0044, 408.0045, 401.024, 402.00111, 402.083 and 402.061; Insurance Code §4201.054 and Government Code §2001.177. Labor Code §408.0271 states that if health care services provided to an employee are determined by the carrier to be inappropriate, the carrier shall notify the provider in writing of the carrier's decision and demand a refund of the portion of payment on the claim received by the provider for the inappropriate services and the provider may appeal such a carrier's determination no later than the 45th day after the date of the carrier's request for the refund. Labor Code §413.002(d) provides that if the commissioner determines that an IRO is in violation of Labor Code Chapter 413, rules adopted by the commissioner under Chapter 413, applicable provisions of Labor Code Title 5, the commissioner or a delegated representative shall notify the IRO of the alleged violation and may compel the production of any documents or other information as necessary to determine whether the violation occurred. Labor Code §413.0111 provides that the rules adopted by the

commissioner for the reimbursement of prescription medications and services must authorize pharmacies to use agents or assignees to process claims and act on behalf of the pharmacies under terms and conditions agreed upon by the pharmacies. Labor Code §413.020 provides the authority to adopt rules which enable the Division to charge a carrier a reasonable fee for access to or evaluation of health care treatment, fees, or charges. The section also provides that the Division may charge a provider who exceeds a fee or utilization guideline or a carrier who unreasonably disputes charges that are consistent with a fee or utilization guideline a reasonable fee for review of health care treatment, fees, or charges. Labor Code §413.031 specifies the processes for the decision and appeal for medical fee and medical necessity disputes not subject to Labor Code §413.0311, states that the commissioner by rule shall specify the appropriate dispute resolution process for fee disputes in which a claimant has paid for medical services and seeks reimbursement, and provides that an IRO that uses doctors to perform reviews of health care services provided under this title may only use doctors licensed to practice in this state. Labor Code §413.0311 specifies the processes for the decision and appeal for medical fee and medical necessity disputes which involve a party to a medical fee dispute in which the amount sought in reimbursement does not exceed $2,000, a party appealing an IRO decision regarding determination of the retrospective medical necessity for a health care service for which the amount billed does not exceed $3,000, and a party appealing an IRO decision regarding determination of the concurrent or prospective medical necessity for a health

care service. Labor Code §413.032(a) provides that an IRO that conducts a review under Chapter 413 shall specify the minimum elements on which the IRO decision is based. Labor Code §408.0043 provides that a doctor, other than a chiropractor or a dentist, performing an independent review of a health care service provided to an injured employee, including a retrospective review, who reviews a specific workers' compensation case to hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving. Labor Code §408.0044 provides that a dentist performing an independent review of a dental service provided to an injured employee, including a retrospective review, who reviews a specific workers' compensation case must be licensed to practice dentistry. Labor Code §408.0045 provides that a chiropractor performing an independent review of a chiropractic service provided to an injured employee, including a retrospective review, who reviews a specific workers' compensation case must be licensed to engage in the practice of chiropractic. Labor Code §401.024 authorizes the commissioner to require by rule the use of facsimile or other electronic means to transmit information. Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Labor Code §402.083 provides that information in or derived from a claim file regarding an employee is confidential. Labor Code §402.061 provides that the commissioner of workers' compensation has the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

Insurance Code §4201.054 grants the commissioner of workers' compensation the authority to adopt rules as necessary to implement Chapter 4201, as that Article applies to utilization review of health care services provided to persons eligible for workers' compensation medical benefits under Labor Code Title 5. Government Code §2001.177(a) provides that a state agency by rule may require a party who appeals a final decision in a contested case to pay all or a part of the cost of preparation of the original or a certified copy of the record of the agency proceeding that is required to be sent to the reviewing court.

7. TEXT.

§133.305. MDR - General.

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

(1) Adverse determination--A determination by a utilization review agent that the health care services furnished or proposed to be furnished to a patient are not medically necessary, as defined in Insurance Code §4201.002.

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

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

(A) a medical fee dispute; or

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

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

(ii) a retrospective medical necessity dispute.

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

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

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

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

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

(6) Non-network health care--Health care not delivered or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules. "Non-network health care" includes health care delivered pursuant to Labor Code §§ 413.011(d-1) and 413.0115.

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

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

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

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

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

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

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

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

(3) the carrier has reduced the payment based on a contracted discount rate with the provider but has not made the contract available upon the Division's request;

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

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

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

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

§133.307. MDR of Fee Disputes.

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

(1) This section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care not subject to a contract, that is remanded to the Division or filed on or after May 25, 2008. Except as provided in paragraph (2) of this subsection, dispute resolution requests filed prior to May 25, 2008, shall be resolved in accordance with the statutes and rules in effect at the time the request was filed.

(2) Subsection (f) of this section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care not subject to a contract, that is:

(A) pending for adjudication by the Division on September 1, 2007;

(B) remanded to the Division on or after September 1,2007; or

(C) filed on or after September 1, 2007.

(3) In resolving non-network 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 of Workers' Compensation (Division) is to adjudicate the payment, given the relevant statutory provisions and Division rules.

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

(1) the health care provider (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 provider in a dispute about the results of a Division or carrier audit or review which requires the provider to refund an amount for health care services previously paid by the insurance carrier;

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

(4) the employee when requesting a refund of the amount the employee paid to the provider in excess of a Division fee guideline.

(c) Requests. Requests for medical dispute resolution (MDR) 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 with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request.

(A) A request for medical fee dispute resolution 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 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) Provider Request. The provider shall complete the required sections of the request in the form and manner prescribed by the Division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include:

(A) a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills);

(B) a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB;

(C) the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division;

(D) 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;

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

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

(i) a description of the health care for which payment is in dispute,

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

(iii) how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues, and

(iv) how the submitted documentation supports the requestor position for each disputed fee issue;

(G) 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) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable; and

(H) 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 MDR process. The pharmacy processing agent may redact any proprietary information contained within the agreement.

(3) Employee Dispute Request. An employee who has paid for health care may request medical fee dispute resolution of a refund or reimbursement request that has been denied. The employee's dispute request shall be sent to the MDR Section by mail service, personal delivery or facsimile and shall include:

(A) the form DWC-60 table listing the specific disputed health care in the form and manner prescribed by the Division;

(B) an explanation of the disputed amount that includes a description of the health care, why the disputed amount should be refunded or reimbursed, and how the submitted documentation supports the explanation for each disputed amount;

(C) Proof of employee payment (including copies of receipts, provider billing statements, or similar documents);

(D) a copy of the 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 employee's attempt to obtain reimbursement or refund from the carrier or health care provider;

(4) Division Response to Request. The Division will forward a copy of the request and the documentation submitted in accordance with paragraph (2) or (3) 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 MDR 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) Carrier Response. Upon receipt of the request, the carrier shall complete the required sections of the request form and provide any missing information not provided by the requestor and known to the carrier.

(A) The response to the request shall include the completed request form and:

(i) all initial and reconsideration EOBs, in a paper explanation of benefits format using an appropriate DWC approved paper billing format, related to the health care in dispute not submitted by the requestor or a statement certifying that the carrier did not receive the provider's disputed billing prior to the dispute request;

(ii) a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, relevant to the dispute, if different from that originally submitted to the carrier for reimbursement;

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

(iv) 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; and

(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 of this title if the dispute involves health care for which the Division has not established a MAR, as applicable.

(B) The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR 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 MDR will be dismissed in accordance with subsection (e)(3)(G) or (H) of this section.

(C) If the carrier did not receive the provider's disputed billing or the employee's reimbursement request relevant to the dispute prior to the request, the carrier shall include that information in a written statement in the response the carrier submits to the Division.

(D) If the medical fee dispute involves compensability, extent of injury, or liability, the 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).

(E) If the medical fee dispute involves medical necessity issues, the 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).

(3) Provider Response. Upon receipt of the request, the provider shall complete the required sections of the request form and provide any missing information not provided by the requestor and known to the provider. The response shall include:

(A) any documentation, including medical bills, in a paper billing format using an appropriate DWC approved billing format, and employee payment receipts, supporting the reasons why the refund request was denied;

(B) a statement of the disputed fee issue(s), which includes a discussion regarding how the submitted documentation supports the provider's position for each disputed fee issue; and

(C) a copy of the provider's refund payment, if applicable.

(e) MDR Action. The Division will review the completed request and response to determine appropriate MDR 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 MDR 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. The Division may dismiss a request for medical fee dispute resolution if:

(A) the requestor informs the Division, or the Division otherwise determines, that the dispute no longer exists;

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

(C) the Division determines that the medical bills in the dispute have not been submitted to the carrier for reconsideration;

(D) the fee disputes for the date(s) of health care in question have been previously adjudicated by the Division;

(E) the request for medical fee dispute resolution is untimely;

(F) the Division determines the medical fee dispute is for health care services provided pursuant to a private contractual fee arrangement;

(G) the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR - General);

(H) the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to §124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals;

(I) the request for medical fee dispute resolution was not submitted in compliance with the provisions of the Labor Code and this chapter; or

(J) 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 and to representatives of record for the parties and post the decision on the Department Internet website.

(5) Division Fee. The Division may assess a fee in accordance with §133.305 of this subchapter.

(f) Appeal to Contested Case Hearing. A party to a medical fee dispute may seek review of the MDR decision or dismissal as provided in this subsection. Parties are deemed to have received the MDR decision as provided in §102.5 of this title.

(1) A party to a medical fee dispute in which the amount of reimbursement sought by the requestor in its request for MDR is greater than $2000.00, may request a contested case hearing before the State Office of Administrative Hearings (SOAH).

(A) To request a contested case hearing before SOAH, a party shall file a written request for a SOAH hearing with the Division's Chief Clerk of Proceedings in accordance with §148.3 of this title (relating to Requesting a Hearing).

(B) The party seeking review of the MDR 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.

(2) A party to a medical fee dispute in which the amount of reimbursement sought by the requestor in its request for MDR is equal to or less than $2000.00 may request a Division contested case hearing conducted by a Division hearing officer. A benefit review conference is not a prerequisite to a Division contested case hearing under this paragraph.

(A) To request a Division contested case hearing, a written request for a Division contested case hearing must be filed with the Division's Chief Clerk no later than the later of the 20th day after the effective date of this section or the 20th day after the date on which the decision is received by the appealing party. The request must be filed in compliance with Division rules. The party appealing the 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 a hearing is filed with the Division.

(B) Requests that are timely submitted to a Division location other than the Division's Chief Clerk, such as a local field office of the Division, will be considered timely filed and forwarded to the Chief Clerk for processing; however this may result in a delay in the processing of the request. Any decision that is not timely appealed becomes final.

(C) Prior to a Division contested case hearing, either party may request a correction of a clerical error in a decision. Clerical errors are non-substantive and include, but are not limited to, typographical or mathematical calculation errors.

Only the Division can determine if a clerical correction is required. A request for a correction of a clerical error does not alter the deadlines for appeal.

(D) At a Division contested case hearing under this paragraph, parties may not raise issues regarding liability, compensability, or medical necessity at a contested case hearing for a medical fee dispute.

(E) Except as otherwise provided in this section, a Division contested case hearing shall be conducted in accordance with Chapters 140 and 142 of this title (relating to Dispute Resolution/General Provisions and Benefit Contested Case Hearing).

(F) A party to a medical fee 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. The parties will be deemed to have received the decision as provided in §102.5 of this title. A decision becomes final and appealable when issued by a Division hearing officer. If a party to a medical fee 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. The Division and the Department are not considered to be parties to the medical dispute pursuant to Labor Code §§413.031(k-2) and 413.0311(e). The following information must be included in the petition or provided by cover letter:

(i) the DWC number(s) 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.

(G) The Division shall, upon receipt of the court petition, prepare a record of the Division contested case hearing and submit a copy of the record to the district court. The Division shall assess the party seeking judicial review expenses incurred by the Division in preparing the certified copy of the record, including transcription costs, in accordance with 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.

§133.308. MDR by Independent Review Organizations.

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

(1) This section applies to the independent review of network and non-network preauthorization, concurrent, or retrospective medical necessity disputes that is remanded to the Division or filed on or after May 25, 2008. Except as provided in paragraph (2) of this subsection, dispute resolution requests filed prior to May 25, 2008,

shall be resolved in accordance with the statutes and rules in effect at the time the request was filed.

(2) Paragraph (1) of subsection (t) of this section applies to the independent review of network and non-network preauthorization, concurrent, or retrospective medical necessity disputes for a dispute resolution request that is:

(A) pending for adjudication by the Division on September 1, 2007;

(B) remanded to the Division on or after September 1, 2007; or

(C) filed on or after September 1, 2007.

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

(4) 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.

(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.

(d) Professional specialty requirements. Notwithstanding Insurance Code Chapter 4202, an IRO doctor, other than a dentist or a chiropractor, performing a review under this section shall be a doctor who would typically manage the medical or dental condition, procedure, or treatment under consideration for review, and who is qualified by education, training and experience to provide the health care reasonably required by the nature of the injury to treat the condition until further material recovery from or lasting improvement to the injury can no longer reasonably be anticipated. A dentist meeting the requirements subsection (c) of this section may perform a review of a dental service under this section, and a chiropractor meeting the requirements of subsection (c) of this section may perform a review of a chiropractic service under this section. Nothing in this subsection can be construed to limit an injured employee's ability to receive health care in accordance with the Labor Code and Division rules or to limit a review of health care to only health care provided or requested prior to the date of maximum medical improvement.

(e) 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 of this title (relating to Conflicts of Interest Prohibited), and any other related rules. Notification of each IRO decision must include a certification by the IRO that the reviewing provider has certified that no known conflicts of interest exist between that provider, the employee, any of the treating providers, or any of the providers who reviewed the case for determination prior to referral to the IRO.

(f) 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.

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

(1) In network disputes:

(A) health care providers (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; and

(B) employees for preauthorization, concurrent, and retrospective medical necessity dispute resolution.

(2) In non-network disputes:

(A) 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; and

(B) employees 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 employee.

(h) 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 Internet website at www.tdi.state.tx.us; or

(2) the Health and Workers' Compensation Network Certification and Quality Assurance Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

(i) Timeliness. A requestor shall file a request for independent review with the insurance carrier (carrier) that actually issued the adverse determination or the carrier's utilization review agent (URA) that actually issued the adverse determination no later than the 45th calendar day after receipt of the denial of reconsideration. The 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 carrier or its URA. In a preauthorization or concurrent review dispute request, an 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 a reconsideration.

(j) 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 (g) of this section;

(3) the Department determines that the dispute involving a non-life-threatening condition has not been submitted to the carrier for reconsideration;

(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 (i) 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.

(k) 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 (related to Random Assignment of Independent Review Organizations), any other related rules, and this subchapter.

(l) Carrier Document Submission. The carrier or the 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 carrier 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 employee in the possession of the carrier or the URA that are relevant to the review, including any medical records used by the 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 carrier or the URA in making the decision;

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

(5) the written notification of the initial adverse determination and the written adverse determination of the reconsideration; and

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

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

(1) The party or providers with relevant records shall deliver the requested information to the IRO as directed by the IRO. If the provider requested to submit records is not a party to the dispute, the 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.

(n) 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 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 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, on the form and in the 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.

(o) 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.

(p) 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 provider has no known conflicts of interest pursuant to the Insurance Code Chapter 4201, Labor Code §413.032, and §12.203 of this title; and

(G) if the IRO's decision is contrary to:

(i) 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; or

(ii) the network's treatment guidelines, the IRO must indicate in the decision the specific basis for its divergence in the review of medical necessity of 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.

(q) Carrier Use of Peer Review Report after an IRO Decision. If an IRO decision determines that medical necessity exists for health care that the carrier denied and the 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.

(r) 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 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 employee, the 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 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 and removal from the Division's Approved Doctor List.

(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 carrier.

(s) Defense. A carrier may claim a defense to a medical necessity dispute if the carrier timely complies with the IRO decision with respect to the medical necessity or appropriateness of health care for an employee. Upon receipt of an IRO decision for a retrospective medical necessity dispute that finds that medical necessity exists, the carrier must review, audit, and process the bill. In addition, the 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.

(t) Appeal. A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division are considered parties to an appeal. In a 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. Appeals of IRO decisions will be as follows:

(1) Non-Network Appeal Procedures. A party to a medical necessity dispute may seek review of a dismissal or decision as follows:

(A) A party to a retrospective medical necessity dispute in which the amount billed is greater than $3,000 may request a hearing before the State Office of Administrative Hearings (SOAH) by filing a written request for a SOAH hearing with

the Division's Chief Clerk of Proceedings in accordance with §148.3 of this title (relating to Requesting a Hearing). The party appealing the IRO decision shall deliver 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 SOAH hearing or any appeal.

(B) A party to a retrospective medical necessity dispute in which the amount billed is less than or equal to $3,000 or an appeal of an IRO decision regarding determination of the concurrent or prospective medical necessity for a health care service 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 subparagraph.

(i) The written appeal must be filed with the Division's Chief Clerk 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 compliance with Division rules. Requests that are timely submitted to a Division location other than the Division's Chief Clerk, such as a local field office of the Division, will be considered timely filed and forwarded to the Chief Clerk for processing; however, this may result in a delay in the processing of the request.

(ii) 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.

(iii) 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 Benefit Contested Case Hearing).

(iv) 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. 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. A request for a letter of clarification may not ask the IRO to reconsider its decision or issue a new decision.

(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 will forward the party's request for a letter of clarification by the IRO to the IRO that conducted the independent review.

(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.

(v) 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. 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. 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).

(vi) 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:

(-a-) Any applicable Division docket number for the dispute being appealed;

(-b-) the names of the parties;

(-c-) the cause number;

(-d-) the identity of the court; and

(-e-) the date the petition was filed with the court.

(II) The record of the hearing includes:

(-a-) all pleadings, motions, and intermediate rulings;

(-b-) evidence received or considered;

(-c-) a statement of matters officially noticed;

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

(-e-) any decision, opinion, report, or proposal for decision by the officer presiding at the hearing and any decision by the Division; and

(-f-) 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.

(C) If a party to a medical necessity dispute properly requests review of an IRO decision by SOAH or through a Division CCH, 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:

(i) medical records;

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

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

(iv) the written notification of the adverse determination and the written determination of the reconsideration;

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

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

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

(viii) 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;

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

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

(2) Network Appeal Procedures. A party to a medical necessity dispute may seek judicial review of a dismissal or the decision as provided in Insurance Code §1305.355 and Chapter 10 of this title (relating to Workers' Compensation Healthcare Networks).

(u) Non-Network Spinal Surgery Appeal. A party to a preauthorization or concurrent medical necessity dispute regarding spinal surgery may appeal the IRO decision in accordance with Labor Code §413.031(l) by requesting a Contested Case Hearing (CCH).

(1) The written appeal must be filed with the Division Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in compliance with Division rules.

(2) The CCH must be scheduled and held not later than 20 days after Division receipt of the request for a CCH.

(3) The hearing and further appeals shall be conducted in accordance with Chapters 140, 142, and 143 of this title (relating to Dispute Resolution/General Provisions, Benefit Contested Case Hearing, and Review by the Appeals Panel).

(4) The party appealing the IRO decision shall deliver 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 CCH or any appeal.

(v) Medical Fee Dispute Request. If the requestor has an unresolved 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 of Fee Disputes).

(w) Enforcement. If the Department believes that any person is in violation of the Labor Code, Insurance Code, or related rules, the Department may initiate an enforcement action. Nothing in this section modifies or limits the authority of the Department or the Division.

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

Issued at Austin, Texas, on _____, 2008.

_____
Norma Garcia

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

IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that amendments to §§133.305, 133.307, and 133.308 specified herein, concerning MDR, are adopted.

AND IT IS SO ORDERED.

_____
ALBERT BETTS
COMMISSIONER OF WORKERS' COMPENSATION
TEXAS DEPARTMENT OF INSURANCE

ATTEST:

_____
NORMA GARCIA
General Counsel

COMMISSIONER'S ORDER NO._____