SUBCHAPTER A. Dispute Resolution – General Provisions
28 TAC §§140.6, 140.7, and 140.8

1. INTRODUCTION. The Commissioner of Workers' Compensation (Commissioner), Texas Department of Insurance (Department), Division of Workers' Compensation (Division) adopts new §140.6 concerning Subclaimant Status: Establishment, Rights, and Procedures, new §140.7 concerning Health Care Insurer Reimbursement Under Texas Labor Code §409.0091, and new §140.8 concerning Procedures for Health Care Insurers to Pursue Reimbursement of Medical Benefits. The new sections are adopted with changes to the proposed text as published in the April 25, 2008 issue of the *Texas Register* (33 *TexReg* 3377).

2. **REASONED JUSTIFICATION**. The adopted sections are necessary to implement the statutory provisions of House Bill (HB) 724 enacted by the 80th Legislature, Regular Session, 2007. HB 724 created new Labor Code §409.0091, which authorizes "health care insurers" to seek reimbursement from a workers' compensation insurance carrier for health care paid by the health care insurer for work related, compensable injuries.

Labor Code §409.009 is a general provision establishing the basic requirements for subclaim status and applies to all subclaimants. The Labor Code and court cases establish and clarify the obligation and authority of the Division to provide dispute resolution to subclaimants. Labor Code §408.021 entitles an injured employee who sustains a compensable injury to all health care reasonably required by the nature of the injury. Labor Code §413.015 requires insurance carriers to pay charges for medical services. Labor Code §413.031 provides certain procedures for certain requestors of

medical dispute resolution. Labor Code Chapter 410 governs proceedings to determine the liability of an insurance carrier for compensation for an injury under the Workers' Compensation Act. Section 402.061 authorizes the Commissioner of Workers' Compensation to adopt rules as necessary to implement and enforce the Workers' Compensation Act. Section 402.0111 authorizes the Commissioner of Workers' Compensation to exercise all executive authority, including rulemaking authority, under the Labor Code and laws of this State. The courts have established that subclaimants may not file suit until they have exhausted their administrative remedies. *In re Texas Mutual Insurance Company, 157 S.W. 3d 75.*

Prior to 2007, there were no distinctions among subclaimants or classes of subclaimants. House Bill 724, in 2007, enacted §409.0091, which established specific rules and procedures for one class of subclaimants: health care insurers who have claims based on data matches with the Division.

Section 409.0091 specifies some procedures but requires the Commissioner of Insurance and the Commissioner of Workers' Compensation to adopt or modify rules as necessary to: (1) allow a "health care insurer" access as a subclaimant to the appropriate dispute resolution process; (2) recognize the status of a subclaimant as a party to a dispute; (3) ensure that a workers' compensation insurance carrier is not penalized for denying payment in order to get additional information; (4) specify the process by which an employee who has paid for health care services may seek

reimbursement; and (5) clarify the processes required by, that fulfill the purpose of, and assist the parties in the proper adjudication of subclaims under §409.0091.

In response to written comments received from interested parties and further staff review of the proposal, the Division has changed some of the proposed language in the text of the rule as adopted. The changes, however, do not materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

Throughout the rule text, the term "workers' compensation carrier" has been changed to "workers' compensation insurance carrier" to be consistent with statutory terminology. Also, throughout the rule text, the term "employee" is changed to "injured employee" to more accurately identify employees in the system.

Section 140.6(b) was deleted because the definition of health care insurer was not needed in §140.6.

Section 140.6(c) was renumbered §140.6(b) and the phrase "as described in §409.009" was added to clarify the term "subclaimant".

In §140.6(c)(2)(D) a requirement was added that a subclaimant must provide the injured employee with written notice of the intent to pursue a claim for reimbursement of a benefit. This is in response to comments that raised concerns about a subclaimant proceeding to a hearing without the participation of the injured employee.

In §140.6(c), the heading was amended to read "Rights in Relation to the Injured Employee" to more accurately describe the subsection.

In §140.6(d), language was added to clarify that subclaimants other than those described in §409.0091 must use the procedures in that subsection.

New §140.6(d)(2) was added to provide that a health care insurer subclaimant must submit a reimbursement request in the form/format and manner prescribed by the Division. The purpose of this change is to provide guidance on the procedure to be used in this category of claims.

New §140.6(d)(3) was added to provide that workers' compensation insurance carriers must process reimbursement requests under this section pursuant to Chapters 133 & 134 of this title (relating to General Medical Provisions and Benefits – Guidelines for Medical Services, Charges, and Payments). The purpose of this change is to provide guidance on the procedure to be used in this category of claims.

Proposed §140.6(e)(2) was deleted because it was inaccurate because of the applicability provisions in §140.8(a).

Section 140.7(b) was renumbered §140.7(a) and a heading "Applicability" was inserted. This is consistent with the structure of §140.6 and §140.8.

Section 140.7(a) was renumbered §140.7(b) and the definition of "Health care insurer" was reworded to use the precise statutory language in §409.0091. This was in response to comments that we had deviated from the statutory language in §409.0091(a) and questions about the significance of that change.

Section 140.8(a) as adopted states that this section applies only to subclaims by a health care insurer based on information received under Labor Code §402.084(c-3).

It was inserted to be consistent with the structure of §140.6 and §140.7 and to respond to comments that §140.8 should only apply to subclaimants recognized in §409.0091.

Proposed §140.8(a) was renumbered to §140.8(b) and subsequent subsections were renumbered accordingly. In adopted §140.8(b) the language of the definition of "Health care insurer" was reworded to use the precise statutory language in §409.0091. This was in response to comments that we had deviated from the statutory language in §409.0091(a) and questions about the significance of that change.

§140.8(c) is renumbered to §140.8(d). In §140.8(d)(2) the following sentence is deleted because of comments that the requirement was unworkable: "A request for medical information must be for information that is contained in or in the process of being incorporated into the employee's medical billing record maintained by the health care insurer.

In adopted §140.8(d)(2), the term "agent" was replaced with "authorized representatives" in response to comments that "authorized representatives" more accurately identifies persons involved in this process.

In adopted §140.8(d)(2), the sentence "A workers' compensation carrier shall not be held responsible or otherwise penalized for the costs of obtaining additional information if the workers' compensation carrier denies payment in order to move to dispute resolution to obtain additional information to process the request" was replaced with "A workers' compensation insurance carrier shall not be penalized, including not being held responsible for the costs of obtaining additional information if the workers'

compensation insurance carrier denies payment in order to move to dispute resolution to obtain additional information to process the request." The sentence was reworded to use the precise statutory language in §409.0091. This was in response to comments that we had deviated from the statutory language in §409.0091(l) and questions about the significance of that change.

Section 140.8(e)(1)(E) clarifies that "If the claim is compensable" then, the notice shall include an explanation that the claim is compensable and that the health care provider must reimburse the injured employee for any amounts paid to the health care provider by the injured employee.

Section 140.8(e)(2) clarifies that the explanation of benefits must provide sufficient explanation regarding the basis for a denial of the reimbursement request.

Section 140.8(h)(1)(B) clarifies that a health care insurer may pursue dispute resolution to obtain an order from a hearings officer regarding compensability or eligibility for benefits in accordance with Labor Code Chapter 410 and applicable Division rules. The new language more accurately reflects the language in §409.0091(m).

3. HOW THE SECTIONS WILL FUNCTION. Adopted §140.6 establishes the procedures that apply to all subclaimants, including health care insurers. Subsection (a) specifies that §140.6 applies to a subclaim under Labor Code §409.009. Subsection (b) specifies that a subclaimant is a party to a claim concerning workers' compensation

benefits. Subsection (c) specifies a subclaimant's rights in relation to the injured employee and the circumstances in which a subclaimant may pursue a claim for reimbursement of a benefit without the participation of the injured employee. Subsection (d) provides that subclaimants who are not described in §409.0091 must pursue a claim for reimbursement of medical benefits and medical dispute resolution under Chapters 133 and 134 of this title (relating to General Medical Provisions and Benefits—Guidelines for Medical Services, Charges, and Payments). A health care insurer must submit a request in the form and manner prescribed by the Division. Workers' compensation insurance carriers must process requests from subclaimants pursuant to Chapters 133 and 134 of this title. Subsection (e) provides for a subclaimant to pursue a contested case hearing under Chapters 140-143 of this title (relating to Dispute Resolution).

Adopted §140.7 applies to health care insurers under Labor Code §409.0091. Subsection (a) specifies that this section only applies to subclaims by a health care insurer based on information received under Labor Code §402.084(c-3). Subsection (b) defines the term "health care insurer" as an insurance carrier and an authorized representative of an insurance carrier, as described by Labor Code §402.084(c-1). Subsection (c) provides for the reimbursement of health care insurers for medical benefits provided to or paid on behalf of an injured employee with a compensable workers' compensation claim in accordance with §409.0091 and §140.7 and §140.8 of this title. Subsection (d) specifies that it is not a defense to a subclaim by a health care

insurer under §409.0091 that: (1) the health care insurer has not sought reimbursement from a health care provider or the health care insurer's insured; (2) the health care insurer or the health care provider did not request preauthorization under §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) or Labor Code §413.014; or, (3) the health care provider did not bill the workers' compensation insurance carrier, as provided by §408.027, before the 95th day after the date the health care for which the health care insurer paid was provided.

Adopted §140.8 establishes the process for health care insurers seeking reimbursement from a workers' compensation insurance carrier when pursuing a claim for reimbursement of medical benefits under §409.0091. Subsection (a) states that this section only applies to subclaims by a health care insurer based on information received under Labor Code §402.084(c-3). Subsection (b) defines the term "health care insurer." Subsection (c) provides that a health care insurer seeking reimbursement must first file a reimbursement request with the workers' compensation insurance carrier. Subsection (c)(1) sets forth the procedure for filing a reimbursement request with the workers' compensation insurance carrier. The form used for the reimbursement request must be the form prescribed by the Division and must contain all the required elements listed on the form. Subsection (c)(2) also requires the health care insurer to provide a notice of the reimbursement request to the injured employee and the health care provider that performed the services that are the subject of the reimbursement request. Subsection (d) sets forth the deadlines for responding to the request for reimbursement and

establishes criteria for the workers' compensation insurance carrier when requesting additional information from the health care insurer for processing the reimbursement request. Any request by the workers' compensation insurance carrier for additional information shall be in writing and be relevant and necessary for the resolution of the request. A workers' compensation insurance carrier shall not be held responsible or otherwise penalized for the costs of obtaining additional information if the workers' compensation insurance carrier denies payment in order to move to dispute resolution to obtain additional information to process the request. Subsection (d) also establishes that it is the health care insurer's obligation to furnish its authorized representatives with any information necessary for the resolution of a reimbursement request. The Division considers any medical billing information or documentation possessed by the health care insurer or one of its authorized representatives to be simultaneously possessed by the health care insurer and all of its authorized representatives. If the workers' compensation insurance carrier has requested information from the health care insurer, the carrier must respond to the request for reimbursement within 120 days after the date the request was first received.

Section 140.8(e) provides that a workers' compensation insurance carrier must either pay, reduce, or deny a reimbursement request and provides the procedures to follow with each response. Subsection (f) requires a health care provider to refund to the injured employee all payments received from the injured employee for care relating to the claim within 45 days of receipt of the notice that the claim is compensable.

Subsection (g) sets forth the procedures for filing notice of subclaimant status if the reimbursement request is not accepted in its entirety. Subsection (h) sets forth the procedures for filing a request for dispute resolution, based on the reasons for the denial of the reimbursement request. Subsection (i) sets forth the procedures when multiple entities seek reimbursement for the same services.

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

Proposed §140.6

Comment: Commenter states that allowing a subclaimant to pursue a non-compensable claim without the involvement or agreement of the injured employee is not contemplated by the statute and could be prejudicial to the injured employee. The commenter further states that there is no provision for the concept of "reasonable diligence" in circumventing the statute or creating new entitlements through administrative rulemaking and the rule, as written, permits a subclaimant to pursue a workers' compensation claim rather than a subclaim. The statute does not allow the conversion of a subclaim to an independent claim in the manner contemplated by the adopted rule. The commenter also states that these aspects of the rule are beyond the provisions of the statute and would be outside the authority of the Division to implement.

Agency Response: The Division disagrees. Section 409.009 allows persons who provide compensation (directly or indirectly) to file a claim if they have sought and been refused reimbursement from a workers' compensation insurance carrier. In any dispute the injured employee is required to be given notice at that injured employee's last

known address of record. If the injured employee has an objection to the timing of the hearing, the injured employee may request a continuance. Newly adopted §140.6 affords safeguards for the injured employee that did not previously exist by rule.

Comment: Commenter states that the rules are deficient because they do not provide a method for a subclaimant to declare whether they are seeking reimbursement under §409.0091 or §409.009 and that they do not ensure that only compensable injuries within the allowed time frames are submitted for dispute resolution under §409.0091.

Agency Response: The Division disagrees that the rules are deficient because no such exclusive remedy language is contained in either §409.009 or §409.0091. Furthermore, §140.7 and §140.8 specifically implement the provisions, including time frames, of §409.0091. The Division disagrees that §409.0091 is the exclusive remedy for a §402.084(c-1) health care insurer and §409.009 was not amended to exclude §402.084(c-1) health care insurers.

Comment: Commenter states that the rule allows for inclusion of a health care insurer's authorized agent. This grants a right to subclaimants not provided for under §409.0091, and also to an individual that does not have the rights of a subclaimant. The commenter further states that the rule as proposed disregards the applicability of §409.0091 to a defined set of claims in time and grants dispute resolution rights to subclaimants and individuals who are not granted those rights in statute. The

commenter also states that §409.009 applies to all qualifying subclaims as of September 1, 1993; and, that §409.0091 is limited to compensable injuries occurring after September 1, 2007, or are the result of a data match under §402.084(c-3) between September 1, 2005 and January 1, 2007, as long as it was filed with the Division by March 1, 2008.

Agency Response: The Division agrees in part and has deleted proposed subsection (b) for clarification purposes. If an authorized representative meets the definition of subclaimant under §409.009, they necessarily have all rights a §409.009 subclaimant. If they do not meet the definition of a §409.009 subclaimant, the authorized representative is limited to pursuing only that which is allowed under §409.0091.

The Division disagrees that §409.0091 is the exclusive remedy for a §402.084(c-1) health care insurer. No such exclusive remedy language is contained in §409.0091. Additionally, §409.009 was not amended to exclude §402.084(c-1) health care insurers. Section 409.0091 allows a health care insurer to bring a claim which resulted from a data match, and limits the defenses available to a workers' compensation insurance carrier. Section 409.009 allows any person who has provided compensation, directly or indirectly, to or for an employee or beneficiary, and has sought and been refused reimbursement, to pursue dispute resolution.

Comment: Commenter states the proposed rule ignores the separate and distinct nature of a dispute under §409.009 as opposed to §409.0091, including applicability to

different parties, the different standards for filing a claim, different time periods for the claims, and different defenses available. The commenter states that while §409.009 does recognize a health care insurer, it does not recognize the right of their authorized representative, as does §409.0091. The commenter further states that when the authorized representative is merely a debt collector who has not provided any benefits, that representative would have no standing under §409.009. The commenter asserts that the rule allows a health care insurer under §402.084(c-1) and an authorized representative to pursue a claim under §409.009 and that there is no statutory authority to apply §402.084(c-1) to §409.009, nor to grant subclaim status to an authorized representative. The commenter states that to allow an authorized representative subclaim status is in direct conflict with §409.009 and that the rule ignores the differences as to who may be a subclaimant under §409.009 versus §409.0091.

Agency Response: The Division disagrees the rule ignores any provisions of §409.009 or §409.0091. No exclusive remedy language is contained in §409.0091. Additionally, §409.009 was not amended to exclude §402.084(c-1) health care insurers. Section 409.0091 allows a health care insurer to bring a claim which resulted from a data match, and limits the defenses available to a workers' compensation insurance carrier. Section 409.009 allows any person who has provided compensation, directly or indirectly, to or for an employee or beneficiary, and has sought and been refused reimbursement, to pursue dispute resolution.

If the authorized representative meets the definition of subclaimant under §409.009, they necessarily have all rights which a §409.009 subclaimant has, which includes pursuing a claim for compensability. If they do not meet the definition of a §409.009 subclaimant, the authorized representative is limited to pursuing only that which is allowed under §409.0091.

Comment: Commenter states that health care insurers have a direct legal interest in proceedings related to compensability, extent of injury, and liability of the workers' compensation claim if they have paid for health care. Such an insurer becomes the pro tanto owner of the claim to the extent of its subrogation interest. The commenter states that a subclaimant may request a benefit review conference pursuant to §141.1 of this title regardless of action or inaction by the injured employee. An injured employee's position that an injury is not compensable is not binding on the health care insurer. The commenter also states that subclaimant rights are created by statute, the health insurance policy itself, and by common law. Further, the rule as proposed fails to recognize that health care insurers have subrogation rights that are allowed under policy forms approved by the Texas Department of Insurance, Division of Life, Health and Licensing. TDI has approved health care insurer policy language granting insurers the right to pursue third party reimbursement through coordination of benefits and subrogation actions with or without the express permission of the health plan member. Once a health care insurer pays health insurance benefits on an insured member, it is

entitled to all the rights of the injured employee and cannot be bound by an agreement it wasn't a party to, a decision by the injured employee not to pursue benefits, or any decision by the Division it was not a party to.

Commenter states that proposed §140.6 establishes new barriers to health care insurers seeking dispute resolution which may unfairly effect the rights of a health care insurer to dispute a denial of compensability or issues on extent of injury. The commenter further asserts that the proposal to subject these subclaimants to prior agreements made by the injured employee, or to require the subclaimant to establish the level of participation of the injured employee in dispute resolution, are contrary to existing law and to superimpose a requirement (that an injured employee is not pursuing with reasonable diligence) to redress these contract rights is to rewrite the contract between the health care insurer and employer or individual.

Agency Response: The Division disagrees with the comment and declines to make a change. The Division agrees that some health care insurers may have a direct legal interest in a workers' compensation claim, but disagrees with commenters' assertion that a subclaimant health care insurer is entitled to dispute resolution regardless of action or inaction by the injured employee.

It is accurate to state that a health care insurer has an interest in proceedings related to claims for which they have paid health care, and that a health care insurer's rights are created by statute, the terms of the policy, and common law. Subrogation is a remedy in courts of equity by which the court places one party, to whom a legal right

does not belong, into the shoes of another party for the purpose of doing justice. However, the Division's appeals process is not a court of equity, and the Division has not been given the opportunity to create rules based solely on equitable principals. Instead, the Division's rules must be based on statutes, and §§140.6 – 140.8 implement §409.009 and §409.0091. In §§140.6 – 140.8, the Division has not attempted to interpret or promulgate rules based on the language in health care insurer policies or the common law.

Labor Code §410.030(b) provides that a signed agreement: "…is binding on the claimant, if represented by an attorney, to the same extent as on the insurance carrier. If the claimant is not represented by an attorney, the agreement is binding on the claimant through the conclusion of all matters relating to the claim while the claim is pending before the division, unless the commissioner for good cause relieves the claimant of the effect of the agreement." A health care insurer may obtain the rights of the injured employee once it provides health care to an injured employee; however, pursuant to Labor Code §410.030(b), once an injured employee has signed an agreement, he or she is bound by the agreement and does not have the right to ignore that agreement, so there is no longer a right to pass on to the health care insurer. Pursuant to Labor Code §410.205, "a decision of the appeals panel regarding benefits is final in the absence of a timely appeal for judicial review." Once an injured employee receives a final decision from the appeals panel he or she is bound by the decision and

does not have the right to ignore that decision, so there is no longer a right to pass on to the health care insurer.

The Division notes that §§140.6 – 140.8 do not attempt to restrict or limit the rights a health care insurer has under other statutes, the terms of an insurance policy, or common law. If a health care insurer chooses to pursue the remedies available under §409.009 and §409.0091, it must comply with Title 5 of the Labor Code and Division rules. However, the health care insurer is not precluded from pursuing other remedies available under other statutes, the terms of an insurance policy, or common law instead.

Proposed §140.6(a)

Comment: Several commenters state that HB 724 created new §409.0091, which addressed certain health care insurer subclaimants, as defined in §402.084(c-1), and that §409.009, which was not amended by HB 724, no longer applies to this type of health care insurer subclaimant. The commenters also state the proposed rule creates a conflict by giving all health care insurers the same rights and remedies that §409.0091 grants to only those health care insurers that meet the definition found in §409.0091. The commenters state that there are different filing requirements, different remedies available and different defenses to the subclaim under the two different statutes. The commenters also state that there is no statutory authority for conflating the special statutory features of certain health care insurer subclaimants and their authorized

representatives with those of other types of subclaimants. The commenters state HB 724 did not amend §409.009(e) and although that section contains the term "health care insurer," it does not include or reference "an authorized representative" of an insurance carrier in the way that the definition in §409.0091(a) does. The commenters state that based on the Texas Government Code §311.026(b), §409.0091 is more specific in its definition and includes specific rights and remedies for "health care insurers;" therefore, it must prevail over the general §409.009.

Commenter states that HB 724 also amended Labor Code §408.027(d) to specifically state that there are two paths – §409.009 and §409.0091 – for other types of "accident or health insurance carriers" to take where a claim has not been disputed for compensability. Commenter asserts that the Texas Legislature intended significant distinction between the term "…health insurance carrier" as stated in §408.027(d) and the HB 724 addition of new Labor Code provision §409.0091(a) which defines a "health care insurer." Therefore, a "health care insurer" may not recover reimbursement from the workers' compensation insurance carrier in the manner described by §409.009 or §409.0091 because its process is set forth only in §409.0091.

One commenter states that, in addition, "authorized representatives" of §402.084(c-1) health care insurers do not qualify to be a subclaimant under §409.009 since they did not "provide compensation" as required by statute and that health care insurers and their authorized representatives lack standing to litigate a compensability dispute pursuant to Section 11 of HB 724 which limits their subclaims to "an injury that

has not been denied for compensability or that has been determined by the division to be compensable." Several commenters recommend the following applicability language for §140.6:

"(a) Applicability. This section is applicable to a subclaim pursued under §409.009, including a subclaim pursued by a health care insurer, except for a health care insurer defined by §409.0091(a) as an insurance carrier and an authorized representative of an insurance carrier as described by §402.084(c-1)."

Agency Response: The Division disagrees that §409.0091 is the exclusive remedy for a §402.084(c-1) health care insurer. No such exclusive remedy language is contained in §409.0091. Additionally, §409.009 was not amended to exclude §402.084(c-1) health care insurers. Section 409.0091 allows a health care insurer to bring a claim which resulted from a data match, and limits the defenses available to a workers' compensation insurance carrier. Section 409.009 allows any person who has provided compensation, directly or indirectly, to or for an employee or beneficiary, and has sought and been refused reimbursement, to pursue dispute resolution.

If the authorized representative meets the definition of subclaimant under §409.009, they necessarily have all rights which a §409.009 subclaimant has, which includes pursuing a claim for compensability. If they do not meet the definition of a §409.009 subclaimant, the authorized representative is limited to pursuing only that which is allowed under §409.0091. However, in order to avoid confusion, the §402.084(c-1) definition is removed from §140.6.

Comment: Commenter asserts that the proposed rule is inconsistent with the plain language of the statute and §409.009 grants no more than a right to file a claim and not a right to dispute resolution. Commenter recommends that if the adopted rule is adopted, §140.6 should specifically state that it is not applicable to network claims in which the health care provider was not part of the insurance carrier's workers' compensation health care network. Commenter states that an insurance carrier in a workers' compensation health care network has no liability for medical care or treatment rendered outside the network. Section 409.009 does not grant any right contrary to the network provisions and Insurance Code §1305.003(b) specifically indicates that in the event of a conflict between the Insurance Code and the Labor Code, the Insurance Code controls.

Commenter states that no subclaimant should be allowed to raise issues of "waiver" by the workers' compensation insurance carrier. A claim that is compensable solely as a result of "waiver" is not a claim for which a health care insurance carrier should be relieved of its own contractual obligation to pay.

Agency Response: The Division disagrees with the comment and declines to make a change. It is accurate to state that a health care insurer has an interest in proceedings related to claims for which they have paid health care, and that a health care insurer's rights are created by statute, the terms of the policy, and common law. Subrogation is a remedy in courts of equity by which the court places one party, to whom a legal right

does not belong, into the shoes of another party for the purpose of doing justice. However, the Division's appeals process is not a court of equity, and the Division has not been given the opportunity to create rules base solely on equitable principals. Instead, the Division's rules must be based on statutes. Sections 140.6 – 140.8 implement §409.009 and §409.0091. In §§140.6 – 140.8, the Division has not attempted to interpret or promulgate rules based on the language in health care insurer policies or the common law.

Labor Code §410.030(b) provides that a signed agreement: "…is binding on the claimant, if represented by an attorney, to the same extent as on the insurance carrier. If the claimant is not represented by an attorney, the agreement is binding on the claimant through the conclusion of all matters relating to the claim while the claim is pending before the division, unless the commissioner for good cause relieves the claimant of the effect of the agreement." A health care insurer may obtain the rights of the injured employee once it provides health care to an injured employee; however, pursuant to Labor Code §410.030(b), once an injured employee has signed an agreement he or she is bound by the agreement and does not have the right to ignore that agreement, so there is no longer a right to pass on to the health care insurer. Pursuant to Labor Code §410.205, "a decision of the appeals panel regarding benefits is final in the absence of a timely appeal for judicial review." Once an injured employee receives a final decision from the appeals panel he or she is bound by the decision and

does not have the right to ignore that decision, so there is no longer a right to pass on to the health care insurer.

The Division notes that §§140.6 – 140.8 do not attempt to restrict or limit the rights a health care insurer has under other statutes, the terms of an insurance policy, or common law. If a health care insurer chooses to pursue the remedies available under §409.009 and §409.0091, it must comply with Title 5 of the Labor Code and Division rules. However, the health care insurer is not precluded from pursuing other remedies available under other statutes, the terms of an insurance policy, or common law instead.

The Division disagrees that §409.009 only grants a right to file a written claim without the right to take any kind of action regarding that claim. The Labor Code and court cases establish and clarify the authority and obligation of the Division to provide administrative relief in the form of dispute resolution to resolve disputed claims.

Section 409.009 places no limitations or restrictions on arguments, defenses, or legal theories which a subclaimant may bring. Likewise, a subclaimant is subject to any defenses which the workers' compensation carrier may have against the injured employee. Section 409.0091 specifically limits defenses available to the workers' compensation carrier, but does not limit arguments or legal theories available to the health care insurer.

Proposed §140.6(b)

Comment: A commenter asserts that §140.6(b) is an attempt to engraft concepts contained in §409.0091 onto §409.009 and that the legislature would have done so explicitly had that been their intention. The commenter states a comparison should be made to §410.006, which explicitly provides that either a carrier or a claimant may be "represented" by another individual; however, that representative does not become a party to the dispute.

Commenter states the rule of statutory construction, *expressio unius est exclusio alterius*, "provides that the inclusion of a specific limitation excludes all others." *Continental Cas. Ins. Co. v. Functional Restoration Associates*, 19 S.W.3d 393 (Tex. 2000). That case noted that where the Workers' Compensation Act provided a right to appeal to judicial review in one context (i.e., indemnity and compensability issues), and did not in another (specifically appeals of medical review issues), the courts could not read into the statute such a right. It was only after a subsequent legislative amendment that the parties were granted the right to appeal medical review issues to the courthouse. Further, the commenter states, §409.0091 provides that "health care insurer" includes "an authorized representative of an insurance carrier" and because §409.009 does not, *expressio unius est exclusio alterius*, precludes such a construction.

The commenter states §409.0091 is the legislature's circumvention of the prohibition against assignment of benefits as provided by §408.202. Commenter states medical benefits under §401.011(5) may not be assigned to another party and that §409.0091 provides a very specific exception, while §409.009 does not.

The commenter states that any attempt to expand the definition of "health care insurer" under §409.009 is clearly in excess of the grant of authority given to the Division by the legislature. *Fulton v. Associated Indemnity Corp.*, 46 S.W.3d 364 (Tex. App.- Austin 2001, pet. denied). The commenter also states that §402.084(c-1) is *explicit* that "insurance company" is defined as noted "for purposes of this section only." It is only by the explicit incorporation of this section by §409.0091 that the limitations of §402.084(c-1) are ignored. No such incorporation is included in §409.009.

Agency Response: The Division disagrees that the adopted rule is an attempt to engraft concepts contained in §409.0091 onto §409.009. If an authorized representative meets the definition of subclaimant under §409.009, they necessarily have all rights of a §409.009 subclaimant. If they do not meet the definition of a §409.009 subclaimant, the authorized representative is limited to pursuing only that which is allowed under §409.0091. However, as previously stated, in order to avoid confusion the Division removed the §402.084(c-1) definition from §140.6.

Proposed §140.6(c)

Comment: The commenters state the issue of party status under §409.009 has not been definitively established and the uncertain status of the subclaimant was specifically addressed by the Legislature with §409.0091 but not in §409.009. Additionally, this subsection makes a potential subclaimant a party to the entire claim

even though the person has not yet asked for reimbursement from the insurance carrier. The commenters recommend deleting §140.6(c) and moving the language to §140.7.

Another commenter proposes the following language for this subsection:

"(b) Subclaimant status. A person who has provided compensation to or for an employee or legal beneficiary may become a subclaimant if the person has sought and been denied reimbursement by the workers' compensation."

Agency Response: The Division disagrees in part that the issue of party status has not been established but adopted §140.6(b) has been amended in order to clarify and avoid confusion.

Comment: Commenter states that §409.009 is found in Chapter 409 and *not* Chapter 410, which deals with adjudication of disputes. The only other section that specifically allows a contested case hearing is §413.0311 and this section *explicitly* incorporates the *manner* provided for Chapter 410 proceedings. It does not incorporate any substantive rights. Section 409.0091 arguably also allows for a contested case hearing; however, it is only by virtue of subsection (l) that a subclaimant is granted "party" status under §409.0091. Section 409.009 contains no similar provision extending to the subclaimant "party" status. If §409.0091 grants "party" status and §409.009 does not, the Division is *precluded* from doing so as this is to be considered a clear expression of legislative intent.

Agency Response: The authority of the Division to provide dispute resolution to subclaimants is fully discussed in the Reasoned Justification portion of this preamble. Section 409.0091(l) provides, in part, that "The commissioner of insurance and the commissioner of workers' compensation shall modify rules under this subtitle as necessary to allow the health care insurer access as a subclaimant to the appropriate dispute resolution process." "This subtitle" is the entire Texas Workers' Compensation Act.

If a health care insurer meets the definition of subclaimant under §409.009, they necessarily have all rights which a §409.009 subclaimant has, which includes pursuing a claim for compensability. If they do not meet the definition of a §409.009 subclaimant, the health care insurer is limited to pursuing only that which is allowed under §409.0091. This is consistent with Division Appeals Panel decisions.

Comment: Commenters state that §140.6(c) conflicts with §409.009 and Division Appeals Panel decisions, which have established that a person that has paid compensation may become a subclaimant only if the person has filed a request for reimbursement with the insurance carrier and has been denied reimbursement. Commenters also state a person that has paid compensation is not automatically a party to the claim just by virtue of the fact that the person has paid or provided benefits. This rule will be disruptive to the dispute resolution process because it automatically gives subclaimant status and due process requires all parties be given notice and the

opportunity to be heard and present evidence. Commenter states that it is not discretionary for a person to seek reimbursement before becoming a subclaimant, it is mandatory under §409.009. Commenter recommends §140.6(c) should be amended to read: "(c) Subclaimant Status. A person who has provided compensation under §409.009 may become a subclaimant if the person has sought and been refused reimbursement from the insurance carrier."

Agency Response: The Division disagrees in part with this comment. Subsection 140.6(c) is not intended, nor should it be read, to state that anyone can establish subclaimant status without meeting the requirements of §409.009. Section 140.6(c) simply recognizes the status of a subclaimant as a party. It does not define subclaimant.

Proposed §140.6(d)

Comment: Commenter states that since the rule allows a subclaimant to pursue a claim without an injured employee's participation, the injured employee has the risk of loss of lifetime entitlement to both medical and indemnity benefits.

Agency Response: In any dispute, the injured employee is required to be given notice at that injured employee's last known address of record. If the injured employee has an objection to the timing of the hearing, the injured employee may request a continuance. New §140.6 affords safeguards for the injured employee that did not previously exist and adopted §140.6(c)(2)(D) and (c)(3)(A) are added to the rule to require a subclaimant to provide the injured employee with written notice of the intent to pursue a

claim for reimbursement of a benefit and to show the subclaimant has met this requirement at a contested case hearing.

Comment: Commenters recommend a one year timeline to pursue a written request for reimbursement with the insurance carrier even though this requirement is not included in §409.009. Other commenters recommend a time limit be imposed on how long a person can have subclaimant status. The commenters state the Division has authority to adopt such a deadline as confirmed by the Texas appellate courts in *Hospitals and Hospital Systems v. Continental Casualty Company and Patient Advocates of Texas v. TWCC.* A commenter recommends the Division adopt a 90 day time limit for the insurance carrier to respond to a request for reimbursement, and a 120 day deadline for the subclaimant to request dispute resolution after the response or failure to respond. The commenters recommend the following language:

"(1) A person who has provided compensation under §409.009 shall file and pursue a written request for reimbursement with the insurance carrier within one year of the date that the compensation was paid or otherwise provided by the person."

Agency Response: The Division disagrees with these comments. Although there are statutory limitations in §409.0091 on time limits for filing a claim for reimbursement and bringing a case to dispute resolution which are reflected in §140.7 and §140.8, there are no statutory deadlines for filing under §409.009.

Comment: Commenters state that §409.009 does not limit a subclaimant to pursue reimbursement for only medical benefits and recommends §140.6(d) should be amended to read, "*A subclaimant may pursue a claim for reimbursement of a compensation benefit…"*

Agency Response: The Division agrees. Adopted §140.6(c)(1) and (2) have been revised and the term "compensation" has been deleted. The text now states "reimbursement of a benefit" as the term "benefit" is defined in Labor Code §401.011(5).

Comment: Commenter states health plans are concerned with a health plan's ability to recoup payments for care that should have been covered through workers' compensation. The commenter states that health plans should be able to pursue dispute resolution regardless of the actions taken by an injured employee. Additionally, the commenter states the rule creates a barrier to establishing the legitimacy of a claim by making their actions contingent on the actions of the injured employee. The commenter also states that the obligation to protect enrollees extends to enrollees covered by a health plan and recommends that the Division either:

(a) eliminate sections of the proposed rule that would limit the ability of plans to independently pursue dispute resolution; or,

(b) make clear that not pursuing with "reasonable diligence," the proposed standard of the draft rule, may be established by the subclaimant.

Agency Response: The Division disagrees that the rules create a barrier for subclaimants. In any dispute the injured employee is required to be given notice at that injured employee's last known address of record. If the injured employee has an objection to the timing of the hearing, the injured employee may request a continuance. New §140.6 affords safeguards for the injured employee that did not exist by rule before; however, the Division does not believe that these safeguards constitute barriers to a subclaimant's pursuit of recovery.

Proposed §140.6(d)(1)

Comment: Commenters state the rule ignores the statutory requirement that the person who provided compensation must first file a request for reimbursement and have been denied by the workers' compensation insurance carrier before becoming a subclaimant. Commenter states that paying for or providing a benefit does not automatically confer subclaimant status under §409.009. Commenter recommends the following language: "(b)(1) A subclaimant may file and pursue a subclaim for reimbursement of compensation that has been provided to an injured employee only after first requesting reimbursement from and being denied that reimbursement by the appropriate workers' compensation insurance carrier, and is entitled to appropriate dispute resolution in accordance with the Texas Workers' Compensation Act (Act) and Division of Workers' Compensation (Division) rules."

Agency Response: The Division disagrees with commenters' interpretation of §140.6. Section 140.6 does not relieve a potential subclaimant from the requirements of §409.009 prior to pursuing dispute resolution.

Comment: Commenter states the rule should include the provision that "a subclaimant may not pursue the claim and participate in any dispute resolution process contrary to positions taken by the injured employee and is subject to the direction and control of the injured employee." Further, the commenter states that a subclaimant does not have a right to judicial review, since the statutory sections concerned do not provide for judicial review separate from other provisions in the Act providing for dispute resolution.

Commenter states that if there was ever a right for a subclaimant to pursue dispute resolution regarding issues of compensability, that right was abrogated by the legislature in 2007 with the adoption of §409.0091.

Commenter requests a 60 day automatic stay in favor of the injured employee. This stay would guarantee that injured employees who wish to participate in dispute resolution are not rushed and provide a disincentive for subclaimants to pursue a dispute at a pace that leaves an injured employee unprepared. The commenter recommends the following language be added to §140.6(d)(4)(A): "The Division shall continue a hearing once, if the Division receives a request for a continuance from the employee no later than five calendar days before the date of the scheduled contested case hearing. The Division shall reschedule the hearing to a date no sooner than sixty

days (60) after the scheduled hearing date, unless the parties otherwise agree. The Division shall immediately notify the subclaimant and the carrier of a continuance that was granted or denied under this subsection." The commenter also recommends the following language be added to §140.6(d)(4)(B): "The exchange deadlines, set out in Chapter 142, shall be extended in cases stayed under § 140.6(d)(4)(A). Any evidence obtained by the injured employee during the stay is admissible at the contested case hearing, without a showing of good cause, where the injured employee exchanges that evidence no later than 5 business days following taking possession of the evidence."

Agency Response: The Division disagrees that a subclaimant is subject to the position and control of an injured employee in every circumstance. However, §140.6 provides sufficient safeguards for the injured employee that did not exist previously by rule. Finally, the Division disagrees that the recommended language is necessary. In any dispute, the injured employee is required to be given notice at that injured employee's last known address of record. If the injured employee has an objection to the timing of the hearing, the injured employee may request a continuance.

Proposed §140.6(d)(2)

Comment: Commenters recommend the term "with reasonable diligence" as used in proposed §140.6(d)(2)(C) be either deleted or defined. Another commenter states that there is no "reasonable diligence" requirement in the statute and such a requirement cannot be created for the rule, absent statutory authority. The commenter asserts that

such a requirement would impose impermissible burdens on a party. Commenter states that there is a difference between a subclaimant's dissatisfaction with the pace at which an injured employee is pursuing a claim, and an injured employee not pursuing the claim at all.

Commenter recommends that the phrases "not pursuing the dispute with reasonable diligence" and "unable to contact the employee through the exercise of reasonable diligence" should be defined. The commenter states this is needed to avoid disparity among hearing officers concerning what must be shown to establish reasonable diligence in both the pursuit of the claim and in efforts to contact the injured employee.

Commenters state a subclaimant should be required to have made "continuous and persistent efforts" to locate the injured employee. The commenters also state the subclaimant should be required to document and demonstrate the efforts made.

Agency Response: The Division disagrees that the terms need to be defined. Reasonable diligence is a term of art and must be determined on a case by case basis. It can only be determined by examining all of the facts and circumstances in an individual case, in some cases, including a review of whether the subclaimant's efforts were continuous, persistent, and reasonable.

Comment: The commenter expresses concern that this section places no obligation on the subclaimant to notify an injured employee prior to pursuing a claim for

reimbursement, and recommends that prior to attempting to pursue a dispute with the Division, without the participation of the injured employee, the subclaimant should be required to certify that it contacted the injured employee "in writing, by verifiable means." Commenter recommends that the notice should advise the injured employee of the consequences of a dispute decision and that free assistance is available through the Office of the Injured Employee Counsel (OIEC). The commenter also recommends that the notice should be at the beginning of the dispute resolution process or at a stage prior to the contested hearing to reduce the potential for unfair surprise and maximize opportunities for the injured employee to participate at the earliest stages of dispute resolution.

Agency Response: The Division agrees that notice to the injured employee is necessary and amends §140.6 to clarify: In any dispute the injured employee is required to be given notice at that injured employee's last known address of record, and if the injured employee has an objection to the timing of the hearing, the injured employee may request a continuance. New §140.6 affords safeguards for the injured employee that did not previously exist.

Comment: Commenters recommend that proposed §140.6(d)(2) be limited to health care insurers, other than a health care insurer as defined in §409.0091(a).

Agency Response: The Division disagrees with the suggested change. The comment suggests that §409.0091 is the exclusive remedy for a §402.084(c-1) health care

insurer. No such exclusive remedy language is contained in §409.0091. Additionally, §409.009 was not amended to exclude §402.084(c-1) health care insurers. Section 409.0091 allows a health care insurer to bring a claim which resulted from a data match, and limits the defenses available to a workers' compensation insurance carrier. Section 409.009 allows any person who has provided compensation, directly or indirectly, to or for an employee or beneficiary, and has sought and been refused reimbursement, to pursue dispute resolution.

Comment: Commenter recommends the term "prior agreement" be defined to mean an agreement that is reached prior to the filing of a request for reimbursement by a health care insurer. The commenter states this would prevent abuses by workers' compensation insurance carriers who may solicit agreements from injured employees only as a tactic for preventing a health care insurer the ability to pursue a compensability dispute.

Commenter states that a claimant should not be unfairly surprised or prejudiced by a health care insurer subclaimant efforts in dispute resolution. The commenter recommends these concerns be addressed without infringing on a health care insurer's contractual right to reimbursement or subrogation by notice to the claimant and the free granting of continuances. The commenter also recommends that the rule include the following provision: "The subclaimant may establish that an injured worker is not pursuing the dispute with reasonable diligence by any means which a BRO or CCH

officer, through their sole discretion accepts as probative of the intention of the injured worker to pursue or not pursue his or her rights to invoke the dispute process."

Agency Response: The Division disagrees the recommended changes are necessary. In any dispute, the injured employee is required to be given notice at that injured employee's last known address of record. The injured employee's agreement or testimony before a benefit review conference or contested case hearing that the injury is not compensable is evidence which the benefit review officer or hearing officer must consider and weigh when making a determination on a claim. However, reasonable diligence is a term of art and must be determined on a case by case basis. It can only be determined by examining all of the facts and circumstances in an individual case.

Proposed §140.6(d)(2)(C)

Comment: A commenter states this subsection implies that even in cases where injured employees may be participating, the subclaimant is permitted to press forward without the injured employee's permission. The commenter recommends adding §140.6(d)(2)(D) to read: "An injured employee is presumed to be pursuing a dispute with reasonable diligence, unless the subclaimant provides clear and convincing evidence to the contrary."

Agency Response: The Division disagrees with the suggested language. Reasonable diligence is a term of art and must be determined on a case by case basis. It can only be determined by examining all of the facts and circumstances in an individual case.

Proposed §140.6(d)(3)

Comment: Commenter states this new language is not contained in the statute and since it could be against the interests of the injured employee, the subclaimant should be absolutely certain that the injured employee is not intending to pursue the claim. The commenter recommends §140.6(d)(3)(A) be amended to read "it has contacted the injured employee and the injured employee states in writing that the injured employee will not pursue the dispute."

Agency Response: The Division disagrees with the suggested language. Reasonable diligence is a term of art and must be determined on a case by case basis. It can only be determined by examining all of the facts and circumstances in an individual case. The burden of proof in an administrative hearing under the Labor Code is preponderance of the evidence.

Comment: Commenter states the law does not provide that an injured employee must pursue a claim or recovery with "reasonable diligence". The Division is creating a new "reasonable diligence" standard not contained in the statute.

Commenter states that allowing a subclaimant to proceed in the absence of an injured employee does not take into account the various reasons that a subclaimant cannot locate an injured employee and allowing the subclaimant to proceed without the injured employee may result in irrevocable injury (financially) to an injured employee

who may end up being liable for the payment of what may have been a compensable injury.

Agency Response: The Division disagrees with commenters assertions. In any dispute the injured employee is required to be given notice at that injured employee's last known address of record. If the injured employee has an objection to the timing of the hearing, the injured employee may request a continuance. New §140.6 affords safeguards for the injured employee that did not previously exist including reasonable diligence --- intended as safeguard for the injured employee rights.

Proposed §140.6(d)(3)(A)

Comment: Commenter states that there are significant legal consequences for injured employees in workers' compensation disputes. Injured employees have a right to due process, right to notice, and right to be heard. Therefore, the commenter recommends that the contact requirement be strengthened to require that contact with the injured employee be in writing, by verifiable means or in writing, via certified mail, return receipt requested. Commenter further recommends that the written notice contain a conspicuous warning that the decision will be binding against the injured employee even if the injured employee does not participate in the hearing and text informing the injured employee that free assistance in the dispute resolution process is available to the injured employee through the Office of the Injured Employee Counsel.

Agency Response: The Division agrees that injured employees have the rights to due process, to notice, and to be heard. Although notices sent to injured employees are in writing and sent to the last known address on record for the employee, the Division agrees that a warning regarding a possible decision and contact information for the Office of Injured Employee Counsel is reasonable and the rule is amended accordingly.

Comment: Commenter expresses concern that the proposed rule appears to indicate an intention by the Division to abandon the 10-day letter requirement in the situation of a subclaimant action. The commenter states that it is essential that the Division, as the regulatory body, continue to send a warning letter to injured employees, which states that if they do not participate in the hearing, the issue may be resolved against them and a decision will be binding against them even though they did not participate in the hearing.

Agency Response: The practice of sending a "10-day letter" to a party who fails to attend a contested case hearing is not mandated by statute or rule. It is a practice performed by Hearings Officers to insure due process. The Division has no intention of discontinuing the 10-day letter practice at this time. If the injured employee requires additional time for the hearing, the injured employee may request a continuance.

Proposed §140.6(e)(2)

Comment: Commenter recommends proposed §140.6(e)(2) be deleted. Commenter states §409.009 was not amended to provide a specific dispute resolution process for health care insurers. Commenters recommend that §140.6(e)(2) be limited to health care insurers, other than a health care insurer as defined in §409.0091(a). The commenters also recommend that if the subsection is not deleted, a phrase should be added in §140.6(e)(1) that the subclaimant should pursue medical dispute resolution in the same manner as an injured employee or as a health care provider as appropriate.

Agency Response: The Division disagrees that §409.0091 is the exclusive remedy for a §402.084(c-1) health care insurer. No such exclusive remedy language is contained in §409.0091. Additionally, §409.009 was not amended to exclude §402.084(c-1) health care insurers. Section 409.0091 allows a health care insurer to bring a claim which resulted from a data match, and limits the defenses available to a workers' compensation insurance carrier. Section 409.009 allows any person who has provided compensation, directly or indirectly, to or for an employee or beneficiary, and has sought and been refused reimbursement, to pursue dispute resolution.

Proposed §140.7(a)

Comment: Several commenters recommended language changes to proposed §140.7(a) to read as follows:

"(a) Health Care Insurer. In this section, health care insurer means an insurance carrier and an authorized representative of an insurance carrier, as described in §402.084(c-1)."

The commenters state that this suggested definition slightly changes the definition used in the statute and recommends the statutory definition in order to avoid any unexpected impact.

Agency Response: The Division agrees with the general substance of the recommended change, which is consistent with the statutory definition, and has revised §140.7 accordingly.

Proposed §140.7(a) and (b)

Comment: A commenter recommends that subsection (b) be amended to indicate §140.7 gives the justification and statutory authority for "claims."

Agency Response: The Division disagrees that the change is necessary but has revised §140.7 as a result of other comments received.

Proposed §140.7(b)

Comment: Commenter recommends modifying this subsection to remove the language stating §140.7 applies to a health care insurer identified based on information received under §402.084(c-3), which is a Division data match. The commenter states that the subclaim may not "be based on" the information received under §402.084(c-1),

and §409.0091 is not limited by the information, rather it is limited by the definition of a health care insurer in §409.0091.

Agency Response: Section 409.0091(n) states that "Except as provided by subsection (s), 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 §402.084(c-3)."

Section 409.0091(s) states, "On or after September 1, 2007, from information provided to a health care insurer before January 1, 2007, under §402.084(c-3), the health care insurer may file not later than March 1, 2008:

(1) a subclaim with the division under subsection (l) if a request for reimbursement has been presented and denied by a workers' compensation insurance carrier; or

(2) a request for reimbursement under subsection (f) if a request for reimbursement has not previously been presented and denied by the workers' compensation insurance carrier."

All of the filing deadlines in §409.0091 are tied to the date of a data match. Without a data match, there would be no basis upon which to establish a filing deadline. Therefore, §409.0091 only applies to cases where there is a data match under §402.084(c-3).

Comment: Commenters recommend that §140.7 should clearly indicate that it does not apply to network claims where the provider was not a part of the carrier's workers' compensation health care network. Commenter states a carrier in a network has no liability for medical treatment rendered outside of that network. Therefore, a provider or health care insurer would have no standing as a subclaimant. Commenter further states §409.0091 does not grant any right contrary to the network provisions and the Insurance Code specifically indicates that in the event of a conflict between the Insurance Code and the Labor Code, the Insurance Code controls.

Agency Response: The Division clarifies that adopted §§140.6 – 140.8 does not prevent a person from seeking reimbursement or dispute resolution for medical services paid by the person when the individual to whom the medical service was provided was subject to treatment through a workers' compensation health care network. However, adopted §§140.6 – 140.8 also do not attempt to supplant the provisions in Chapter 1305 of the Insurance Code. Insurance Code §1305.003(b) provides in part: "In the event of a conflict between Title 5, Labor Code, and this chapter as to… the resolution of disputes regarding medical benefits provided through those networks, this chapter prevails." This provision is also contained in Labor Code §408.031(b). Therefore, if a provision of the Labor Code Title 5 were to conflict with a provision of Insurance Code Chapter 1305, the Insurance Code Chapter 1305 would prevail. Based on this reasoning, the Division does not have statutory authority to adopt a rule under Labor Code Title 5 which is contrary to the Insurance Code Chapter 1305.

The Insurance Code §1305.006 provides: "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee: (1) emergency care; (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103." If a health care insurer believes it has a valid subclaim under the §409.0091, it may request reimbursement and pursue dispute resolution. However, if the injured employee for whom the care was provided is subject to certified network requirements, the workers' compensation insurance carrier may not be liable for the health care unless the health care was provided by an in-network provider selected or assigned pursuant to Insurance Code Chapter 1305 or unless the health care meets one of the three out-of-network exceptions listed in Insurance Code §1305.006.

Comment: Commenter states that §140.7 implies that there is only one type of health care insurer, whereas there are two types of health care insurers that may pursue reimbursement claims against the workers' compensation insurance carriers. There are health care insurers as defined by §402.084(c-1) and there are all other health care insurers (i.e., unlicensed health care insurers and licensed health care insurers without qualified Chapter 504 fraud programs). Commenter states that health care insurers as

defined in §402.084(c-1) must seek rights and remedies under the provisions of §409.0091, and these health care insurers do not have the option of deciding whether to pursue reimbursement under §409.0091 "*based on information received under §402.084(c-3)"* or instead pursue reimbursement under §409.009 independent of their status as a §402.084(c-1) health care insurer. Commenter states this would conflict with proper statutory construction as mandated by Texas Government Code §311.026(b). Commenters recommend that subsection 140.7(b) be rewritten as follows: "(b) This section applies to claims by a health care insurer as defined in §402.084(c-1)."

Agency Response: The Division has made the recommended change to §140.7(b). However, the Division disagrees that §409.0091 is the exclusive remedy for a §402.084(c-1) health care insurer. No such exclusive remedy language is contained in §409.0091. Additionally, §409.009 was not amended to exclude §402.084(c-1) health care insurers. Section 409.0091 allows a health care insurer to bring a claim which resulted from a data match, and limits the defenses available to a workers' compensation insurance carrier. Section 409.009 allows any person who has provided compensation, directly or indirectly, to or for an employee or beneficiary, and has sought and been refused reimbursement, to pursue dispute resolution.

Comment: Commenters assert that there is no statutory authority for §140.7 to apply only to subclaimants who have obtained data matches under the authority of

§402.084(c-3). Commenter further states that health care insurers may identify potential subclaims outside of the matching process provided by §402.084(c-3); and, in accordance with §408.027(d), may request reimbursement for these claims. Another commenter states §409.0091 creates a process applicable to a health care insurer regardless of whether the claim is identified through a data match under §402.084 or some other method. The commenters recommend the deletion of §140.7(b) as proposed.

Agency Response: The Division disagrees. Section 409.0091(n) states that: "Except as provided by subsection (s), 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 §402.084(c-3)."

Section 409.0091(s) states, "On or after September 1, 2007, from information provided to a health care insurer before January 1, 2007, under §402.084(c-3), the health care insurer may file not later than March 1, 2008:

(1) a subclaim with the division under subsection (l) if a request for reimbursement has been presented and denied by a workers' compensation insurance carrier; or

(2) a request for reimbursement under subsection (f) if a request for reimbursement has not previously been presented and denied by the workers' compensation insurance carrier."

All of the filing deadlines in §409.0091 are tied to the date of a data match. Without a data match, there would be no basis upon which to establish a filing deadline. Therefore, the Division has determined that §409.0091 only applies to cases where there is a data match under §402.084(c-3).

Proposed §140.7(c)

Comment: Commenters state that §140.7 should be limited to health care insurers as defined in §409.0091(a). The commenters recommend the rule specify that health care insurers are not entitled to reimbursement on the basis of waiver. The commenters also recommend adding the following language: "Notwithstanding §409.009, §409.0091 sets forth the exclusive rights and remedies for health care insurers and their authorized representatives, as described by §402.084(c-1)."

Agency Response: The Division disagrees with the suggested change. The Division disagrees that §409.0091 is the exclusive remedy for a §402.084(c-1) health care insurer. No such exclusive remedy language is contained in §409.0091. Additionally, §409.009 was not amended to exclude §402.084(c-1) health care insurers. §409.0091 allows a health care insurer to bring a claim which resulted from a data match, and limits the defenses available to a workers' compensation insurance carrier. Section 409.009 allows any person who has provided compensation, directly or indirectly, to or for an employee or beneficiary, and has sought and been refused reimbursement, to pursue dispute resolution.

Section 409.009 places no limitations or restrictions on arguments, defenses, or legal theories which a subclaimant may bring. Likewise, a subclaimant is subject to any defenses which the workers' compensation carrier may have against the injured employee. Section 409.0091 specifically limits defenses available to the workers' compensation insurance carrier, but does not limit arguments or legal theories available to the health care insurer.

Proposed §140.8

Comment: Commenter recommends that §140.8 be limited to health care insurers as defined in §409.0091(a). The procedures for health care insurer subclaimants are distinct by statute. Section 409.0091(a) health care insurers have different rights and remedies than §409.009 subclaimants that do not meet the §409.0091(a) definition. The commenter recommends amending the heading of §140.8 to read as follows: "§140.8 Procedures for Health Care Insurers to Pursue Reimbursement of Medical Benefits Under §409.0091."

Agency Response: The Division agrees that §409.0091 provides distinct provisions available to certain health care insurers defined in §409.0091 and the rule is amended accordingly.

Comment: Commenter states that §140.8 attempts to address the process for dispute resolution at the Division but does not specify submission and processing procedures

for a request for reimbursement under §409.0091(f)-(j). The commenter also states that the rules do not provide guidance to workers' compensation insurance carriers on how to handle requests for reimbursement received from multiple authorized agents of a health care insurer; or, how to ensure the validity of the agent's authorization to collect this debt on behalf of the health care insurer or how to close out a claim if payment has been processed to one authorized agent, but an additional authorized agent seeks additional payments for the same claim.

Additionally, the commenter states that there is no direction to health care insurers about the appropriate way to authorize an agent to collect a debt which may be owed by a carrier; or, whether health care insurers may contract with more than one authorized agent and how such a situation will be handled. The commenter asserts §140.8(h)(2) as proposed recognizes that multiple authorized agents may cause confusion and sets forth a first-come right to dispute resolution for multiple authorized agents, yet the rule provides no guidance for the parties before the dispute process begins. The commenter also asserts that §409.0091(r) specifically grants rule making authority to both the Commissioner of Insurance and the Commissioner of the Division of Workers' Compensation "to clarify the processes required by, fulfill the purpose of, or assist the parties in the proper adjudication of subclaims under this subtitle" as this statute has implications on the business processes for both health care insurers and workers' compensation insurers.

Agency Response: The Division disagrees with commenter's assertions. The processes and procedures to be followed for the submission of a medical fee dispute and dispute resolution which are within the jurisdiction of the Division, are contained in §133.307 of this title, relating to MDR of Fee Disputes. Section133.307 also contains the requirements for a workers' compensation insurance carrier to process and respond to a request for reimbursement. In accordance with Labor Code §413.031 the role of the Division is to adjudicate the payment given. However, the Labor Code does not provide authority for the Division to govern debt collection. The adopted rules are intended to primarily address the dispute resolution aspects for subclaimants and are placed in Chapter 140 of this title. Other processing aspects for subclaimants may be proposed, adopted, and placed in appropriate chapters of the rules as necessary to reduce disputes.

Comment: Commenter states proposed §140.8 does not provide an efficient system by which group health care providers and injured employees may be notified of and must process reimbursements of any owed copays, deductibles and coinsurance collected from an injured employee for a compensable injury. Commenter also states these provisions do not provide adequate guidance to these parties and may actually lead to increased disputes, although the rules do not provide for guidance on how one of these parties is to proceed in a dispute. Commenter supports that a health care provider would owe any copays, deductibles and coinsurance collected from an

injured employee for health care provided by a health care insurance carrier for a compensable injury, the commenter has concerns over the timing of the notice to the health care provider and the injured employee of the possible need for reimbursement. Commenter further states that the issue is exacerbated by the fact that proposed §140.8 requires the health care provider to submit reimbursement for all copays, deductibles and coinsurance collected from an injured employee within 45 days of receipt of the notice that the claim is compensable. Commenter questions whether either of these notices would be considered receipt that the claim is compensable.

Commenter asserts proposed §140.8 does not provide guidance as to which party is responsible for documenting the amount paid by the injured employee. The commenter questions whether the injured employee or the health care provider is to provide the documentation; or, if this information is supposed to be in the Explanation of Benefits required by the workers' compensation insurance carrier under adopted §140.8(d)(1)(E) and if so, how is the workers' compensation insurance carrier supposed to discover that information? The commenter also questions what happens when there is conflicting documentation or just a straight refusal by the health care provider to reimburse?

Commenter states that there is no definitive notice that a claim has been determined to be compensable and monies are actually owed.

Commenter noted that a notice to the group health care provider and the injured employee is required twice in the Division's proposed rule. However, the

commenter said they see no notice requirement after a dispute resolution at the Division of Workers' Compensation. Commenter states that neither of the required notices is a guarantee that money is owed to an injured employee, rather than *may* be owed.

Agency Response: The Division agrees in part and disagrees in part. When there is a medical fee dispute filed, all parties are required to be given notice. Parties include the health care provider, the health care insurer, the injured worker, and the workers' compensation insurer. A party wishing to participate in dispute resolution has the burden to establish that they are entitled to the relief they seek. This includes establishing that health care was provided and that it was provided for a compensable injury. The final result of dispute resolution is sent to all parties. Furthermore, subrogation of claims between insurance carriers is a remedy in equity which is a complex and challenging process within the civil legal system and is equally complex and challenging in the Division's informal administrative system. However, the Division is committed to adjudicating disputes between insurance carriers in the same manner as disputes between injured employees, employers, health care providers, and workers' compensation insurance carriers.

Comment: Commenter states that the proposed rule fails to require the subclaimant to provide evidence of the date of the injury or that the data match was conducted before January 1, 2007, and that it was filed with the Division before March 1, 2008.

Commenter states that the proposed rule should be clarified to ensure that any claim prior to the effective date of the bill which was not filed by the March 1, 2008 deadline must utilize the §409.009 process and has no opportunity to utilize the §409.0091 process. Commenter states that by combining the dispute processes for both statutory sections into one the adopted rule makes it impossible to ensure compliance with the statute.

Commenter states that under §408.027(d) a subclaimant seeking reimbursement for health care related to a compensable injury must choose to seek reimbursement under either §409.009 or §409.0091, but not both. Commenter states this is further evidenced by the last two words in §408.027(d) — "may recover reimbursement…§409.009 or §409.0091, as applicable." Per the commenter, this section alone highlights that the statutory construction intends two separate and mutually exclusive dispute processes rather than the combined dispute process adopted in the Division's rule.

Agency Response: The Division disagrees. The Division believes that the plain language of the statute does not need to be repeated in the rule. The Division disagrees that §409.0091 is the exclusive remedy for a §402.084(c-1) health care insurer. No such exclusive remedy language is contained in §409.0091. Additionally, §409.009 was not amended to exclude §402.084(c-1) health care insurers. Section 409.0091 allows a health care insurer to bring a claim which resulted from a data match, and limits the defenses available to a workers' compensation insurance carrier.

Section 409.009 allows any person who has provided compensation, directly or indirectly, to or for an employee or beneficiary, and has sought and been refused reimbursement , to pursue dispute resolution.

Section 409.009 places no limitations or restrictions on arguments, defenses, or legal theories which a subclaimant may bring. Likewise, a subclaimant is subject to any defenses which the workers' compensation insurance carrier may have against the injured employee. Section 409.0091 specifically limits defenses available to the workers' compensation insurance carrier, but does not limit arguments or legal theories available to the health care insurer.

Comment: Commenter states that there should be a good faith standard on the part of the health care insurer before it submits a bill, and that the health care insurer at least have a good faith belief that this is a compensable claim or part of a compensable claim.

Agency Response: The Division disagrees with this comment and declines to make a change. It is true that a party requesting reimbursement under the Labor Code should act in good faith; however, the Division does not believe that it has authority to set out a specific standard of good faith within this rule.

Furthermore, good faith is already sufficiently addressed by Labor Code §415.008, relating to Fraudulently Obtaining or Denying Benefits; Administrative

Violation, and Labor Code §415.009, relating to Frivolous Actions; Administrative Violation.

Comment: Commenter states that the adopted rule should clarify that appeals of medical necessity and medical fee disputes are subject to the recently adopted §133.307 and §133.308.

Agency Response: The Division clarifies that appeals of medical necessity and medical fee disputes are subject to the current version of §133.307 and §133.308, with any modifications addressed in §140.8.

Comment: Commenter recommends a new section be added to deter an opposing party from forcing each reimbursement request to a dispute resolution process and delay payment of a compensable medical benefit paid by a health care insurer. This concept is also consistent with the concept of a prevailing party having its expenses reimbursed. The commenter recommends the following:

"(i) Not withstanding the provisions of §§133.307 and 133.308, any dispute resolution fees paid by a health insurer to bring a subclaim to resolution shall be reimbursed to the subclaimant by the carrier if the subclaim prevails, in whole or in part, in the dispute resolution outcome."

Agency Response: The Division disagrees with the comment and declines to make the requested change, because the requested change would violate §409.0091(l).

Section 409.0091(l) provides in part, "Rules modified or adopted under this section should ensure that the workers' compensation insurance carrier is not penalized, including not being held responsible for costs of obtaining the additional information, if the workers' compensation insurance carrier denies payment in order to move to dispute resolution to obtain additional information to process the request." Section 409.0091(l) does not make a distinction regarding the outcome of dispute resolution, therefore a rule provision contrary to §409.0091(l) would be invalid, even if it only applied in situations where a subclaimant ultimately prevails in dispute resolution.

Proposed §140.8(a)

Comment: Commenter recommends that the definition of the term "health care insurer" in §140.8(a) be conformed to the definition found in §409.0091(a). The commenter asserts that the Division and the Commissioner of Workers' Compensation do not have the authority to amend or modify a definition set forth by a statutory provision.

Agency Response: The Division agrees. Section 140.8(a) has been revised accordingly.

Proposed §140.8(b)

Comment: Commenter states that the proposed rule omits a limitation found in §409.0091(n) on the health care insurer's ability to file reimbursement requests, in that health care insurers must file for reimbursement no later than six months after the date

the health care insurer received information and not later than 18 months after the health care insurer paid for the health care service. Further, this limitation only applies to subclaims based on established compensable claims occurring on or after September 1, 2007.

Agency Response: The Division disagrees with the proposed change. These valid limitations in §409.0091(n) do not need to be repeated in this rule.

Comment: Commenter asserts that the early notices before a final adjudication of the recovery of payments in §140.8(b)(2) and possibly §140.8(d)(1)(E) as proposed, could lead to confusion and ill-will between the injured employee and their primary treating doctor or other provider in group health, who are likely to be ignorant of workers' compensation regulations.

Agency Response: The Division disagrees. The Division believes that timely notices increase understanding and good will.

Comment: The commenter states that the exception under §409.0091(s) is only available for certain health care insurers that received information on those potential subclaims from the Division under §402.084(c)(3) of the Labor Code before January 1, 2007 and those requests had to be filed by March 1, 2008. The commenter also states that the health care insurer's limitation of not later than six months after the date on which the health care insurer received information under §402.084(c-3) and not later

than 18 months after the health care insurer paid for the health care service applies to potential subclaims on all established compensable claims occurring on or after September 1, 2007.

Agency Response: If the authorized representative meets the definition of subclaimant under §409.009, they necessarily have all rights which a §409.009 subclaimant has, which includes pursuing a claim for compensability. If they do not meet the definition of a §409.009 subclaimant, the authorized representative is limited to pursuing only that which is allowed under §409.0091.

The Division disagrees that §409.0091 is the exclusive remedy for a §402.084(c-1) health care insurer. No such exclusive remedy language is contained in §409.0091. Additionally, §409.009 was not amended to exclude §402.084(c-1) health care insurers. Section 409.0091 allows a health care insurer to bring a claim which resulted from a data match, and limits the defenses available to a workers' compensation insurance carrier. Section 409.009 allows any person who has provided compensation, directly or indirectly, to or for an employee or beneficiary, and has sought and been refused reimbursement, to pursue dispute resolution.

Proposed §140.8(b)(1)

Comment: Commenter recommends the following language for §140.8(b)(1):

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

required elements on the form. A request is not complete or deemed to be filed with the workers' compensation insurance carrier until all statutorily required information, including the date the information was provided, is received by the workers' compensation insurance carrier."

Commenter states that statutorily required information is often, but not always, somewhere in the attachments to the form. This requires the workers' compensation insurance carrier to manually wade through the attachments, which can be voluminous, to pull out the required information. This makes these requests much harder to review and process. Additionally, the date of match is a required element to determine timeliness.

Agency Response: The Division disagrees. Section 409.0091(f) requires submission of specific information in an health care insurer's request for reimbursement; however, §409.0091(f), does not specify that time frames are to be stayed if all the information is not submitted, and §409.0091(i) and (j) permit a workers' compensation insurance carrier to request additional information, establishing an additional amount of time for such a request. The Division believes that introducing a delay based on arguments concerning the "completeness" of a request for reimbursement would unnecessarily delay the reimbursement process, considering that the rule contains provisions allowing a workers' compensation insurance carrier to request additional information. The Division declines to make the suggested language changes.

Comment: Commenters recommend that the adopted rule clarify that health care insurers must submit a completed form DWC-26 with all required information and that merely putting "see attached" on the form and then submitting pages of screen prints is not acceptable. Commenters also recommend adding the word "complete" before "reimbursement request" in §140.8(b), §140.8(c), and §140.8(d). Commenter states that this will ensure that the timelines only begin when the request is complete.

Agency Response: The Division agrees in part, but also disagrees in part and declines to make a change. The Division clarifies that a health care insurer seeking reimbursement must submit a form DWC-26, as adopted §140.8(b)(1) requires a request to be in the form/format and manner prescribed by the Division and requires the request to contain all the required elements listed on the form. However, the Division declines to insert the word "complete" before the words "reimbursement request" in §140.8(b), §140.8(c), and §140.8(d), because the Division does not want to create additional disputes based on arguments that a request is not "complete" which would unnecessarily delay the reimbursement determination process. For this same reason, the Division declines to create a definition for "complete reimbursement request." If a workers' compensation insurance carrier believes it has not obtained all the information necessary to make a determination, it should request additional information as permitted by the statute.

Proposed §§140.8(b)(1), (f)(1), (f)(5), (g)(1), (g)(2), and (g)(3)

Comment: Commenter states that adopted §140.8 imposes new requirements that did not exist at the time that many requests for reimbursement and or subclaims were filed. The commenter states that adopted §140.8 needs to make some accommodation for these requests for reimbursement and subclaims that are already "in the pipeline". The commenter states that many requests for reimbursement were presented prior to the adoption of DWC-26 by the Division, to require elements of a form not then in existence. The commenter states that it is not appropriate to impose a requirement retrospectively that did not exist at the time of the original request for reimbursement. The commenter recommends that the DWC-26 form requirement should apply only to §409.009 requests for reimbursement made after the effective date of the rule.

Commenter states that health care insurers have been filing requests for reimbursement under §409.009 absent any deadline for filing a notice of subclaimant status. To impose a deadline on these requests for reimbursement could prevent a health care insurer from filing a subclaim if 120 days have already expired from the date the carrier fails to respond to a request for reimbursement or reduces or denies the requested reimbursement amount. Commenter also states that no deadline for filing a subclaim exists in statute or rule for §409.009 and this provision should not apply to requests for reimbursement that were made prior to the effective date of the rule.

Commenter recommends that the following subsections should not apply to notices of subclaimant status that have already been filed with the Division: §§140.8(f)(5), 140.8(g)(1), 140.8(g)(2), and 140.8(g)(3).

Agency Response: The Division disagrees with the comment. The statute did not "grandfather" claims already in process. An administrative agency may make changes applicable to future steps in pending cases. No one has a vested right in a procedural remedy. Texas Dept. of Health v. Long, 659 S.W. 2d 158. These are procedural rules. The rules will apply to all procedures and processes occurring on or after the effective date of these rules. They will not apply to procedures and processes that have occurred prior to the effective date of these rules.

Proposed §140.8(c)

Comment: Commenter questions whether a carrier that cannot request information that is not in the files of the health insurer or in the process of being incorporated into the file will be allowed to deny a claim because the carrier needs that information. The commenter states that this limitation in the rule is not found in the statute.

Agency Response: The Division notes that provision referenced by the commenter has been removed in response to another comment; as such the commenter's concerns have been addressed.

Comment: Commenter states that timely filing is a threshold question in evaluating a claim. It depends on when the health care insurer under §409.0091 received the claim information, when they actually paid the bill, and when they received the data match information. The commenter asks, if the information isn't provided, can it be requested,

or is it outside the scope of allowable information to be requested?

Agency Response: The Division agrees that the date of the data match is a threshold requirement for reimbursement eligibility. As such, health care insurers seeking reimbursement should provide the workers' compensation insurance carriers with information detailing the date of the data match.

Proposed §140.8(c)(1)

Comment: Commenter states that §140.8(c)(1) is silent on the effect of a failure to respond to a subclaim. The commenter recommends that §140.8 include a provision that failure of the insurance carrier to respond will result in the workers' compensation insurance carrier in effect waiving its right to dispute the request and that the Division will order immediate payment of the request for reimbursement.

Agency Response: The Division agrees with the comment, but declines to make the requested change, because the requested change would violate §409.0091(q). Section 409.0091(q) does not authorize the waiver of a carrier's right to dispute a request upon failing to respond to a subclaim request. Furthermore, §409.0091(q) provides: "An action or failure to act by a workers' compensation insurance carrier under this section may not serve as the basis for an examination or administrative action by the department or the division, or for any cause of action by any person, except for judicial review under this subtitle." If the Division were to order immediate payment of the request for reimbursement because a workers compensation insurance carrier failed to

respond to a request for reimbursement, it would constitute an administrative action in violation of §409.0091(q).

Proposed §140.8(c)(1), (c)(2), & (c)(3)

Comment: Commenter recommends that proposed §140.8(c)(2) be amended to add this sentence ""Additional information" does not include any of the statutorily required information discussed in subsection (b)." Commenter states this is necessary because a stakeholder believes that the request to provide the required elements in §409.0091 is "additional information." The commenter states the clear language of the statute is that "additional information" is that information needed beyond the elements outlined in the statute.

Agency Response: The Division disagrees with the comment and declines to make the change requested. The statute does not contain language stating that "additional information" is solely information needed beyond the elements outlined in the statute, and the Division does not believe that creating such a provision would aid in the resolution of claims. Instances might occur when a workers' compensation insurance carrier needs to request additional information, even if such information had previously been provided pursuant to the statute, such as if the information could not be read or was accidentally left incomplete. Preventing the workers' compensation insurance carrier from requesting the information as part of the initial request and response period would only increase the likelihood of such a claim leading to a dispute resolution.

Comment: Some commenters recommend deletion of the sentence limiting the request for information to that which is in or in process of being incorporated into the health insurer's files. Commenter states this limitation is not found in the statute and is an impermissible limitation on the workers' compensation insurance carrier's right and responsibility to get all information necessary to properly audit and pay the claim. Another commenter states that this limitation is outside the rule making authority of the Division. Commenter states that this provision would artificially and unnecessarily restrict the information a workers' compensation insurance carrier may request in considering a heath care insurer's claim to reimbursement. Commenter states that this provision regarding medical documentation is often not in the health insurers files or even asked for, although the health insurer can get that information from the provider with whom it has a contract. The commenters state that workers' compensation insurance carriers have no way of knowing what documents and information is contained in or in the process of being incorporated into the employee's medical billing record maintained by the health care insurer. A commenter states that an insurer, to properly review a reimbursement request by a health care insurer must be in a position to review the entire relevant medical record and medical reports.

Commenter states that an example of information that the workers' compensation insurance carrier may need from the §402.084(c-1) health care insurer that would be outside of this limitation would include the documentation of when the health care insurer received the §402.084(c-3) information from the Division. The

commenters state that this information is critical to determine if there is a timely request for reimbursement and timely filing of the subclaim. Additionally, the workers' compensation insurance carrier may need medical reports in order to determine whether or not the treatment arose out of the compensable injury; and, that this limitation creates compliance issues for the workers' compensation insurance carrier.

Commenter states that there is no process under the rule for workers' compensation insurance carriers to obtain those documents and information when they are not provided per request under the above rule language. The commenter recommends an additional sentence to §140.8(c)(2) that requires health care insurers to provide the same medical documentation that a health care provider is required to submit for reimbursement. The commenters recommend the following language be added: "The health care insurer and its authorized agent shall produce all relevant requested information that is in their possession, custody, control or to which they have access as may be necessary to substantiate the claim."

Commenter states this limitation directly conflicts with proposed §140.8(g)(3)(C) which requires the subclaimant to file "sufficient information to substantiate the claim" with the request for medical dispute resolution. It stands to reason that the subclaimant should be required to produce "sufficient information to substantiate the claim" to the workers' compensation insurance carrier as part of the reimbursement request so that the workers' compensation carrier does not have to wait for the dispute resolution process in order to get this information.

Commenter states that proposed §140.8(c)(2) already contains the restriction that the workers' compensation insurer may seek only information that is "relevant and necessary for the resolution of the dispute." The commenter states that this restriction is necessary and appropriate, but not the restriction that limits the information that can be obtained. The commenter states that it is difficult to understand why the Division is proposing to prohibit the workers' compensation insurer from obtaining information that is admittedly "relevant and necessary for the resolution of the dispute" merely because it is not in the health care insurer's billing record.

Agency Response: The Division generally agrees with this comment, declines to add the suggested sentence, but agrees to delete the proposed sentence that reads: "A request for medical information must be for information that is contained in or in the process of being incorporated into the employee's medical billing record maintained by the health care insurer."

Comment: Commenter recommends deletion of language in §140.8(c)(2) that limits the kind of penalty a workers' compensation carrier should not be subjected to in order to obtain necessary information. The commenter states this limitation narrows the statute, which contains no limitation on what penalties the workers' compensation insurance carrier should not be subjected to.

Commenter states that it is not clear whether the insurance carrier can deny the claim due to a lack of information if the insurance carrier does not request the information.

Agency Response: The Division disagrees with the comment and declines to make the suggested change. The sentence referenced by the commenter is necessary to implement §409.0091(l). Section 409.0091(l) provides in part: "Rules modified or adopted under this section should ensure that the workers' compensation insurance carrier is not penalized, including not being held responsible for costs of obtaining the additional information, if the workers' compensation insurance carrier denies payment in order to move to dispute resolution to obtain additional information to process the request." In addition, §409.0091(j) does not authorize the waiver of a workers' compensation insurance carrier's right to deny a health care insurer reimbursement request submitted with insufficient information to substantiate the request.

Proposed §140.8(c)(2)

Comment: Commenter references proposed §140.8(c)(2), and asserts that workers' compensation insurance carriers have no way of knowing what documents and information are contained in or in the process of being incorporated into the employee's medical billing record maintained by the health care insurer. The commenter says that there is no process under the rule for workers' compensation insurance carriers to

obtain those documents and information when they are not provided per request under the above rule language.

Commenter says that proposed rules place no penalties, presumptions or burdens on health care insurers for failure to include all information in their requests for reimbursement necessary to comply with the provisions of §409.0091, and none for a group health care insurer's failure to comply with workers' compensation insurance carrier requests for additional information, but that instead the proposed rule places any burden resulting from a health care insurer's failure to comply on the workers' compensation insurance carrier. The commenter notes that the 90 and 120 day deadlines under §409.0091 and the proposed rule begins to run as soon as a request for reimbursement is received, regardless of whether or not a health care insurer has complied with §409.0091(f) or a carrier's information request, that the rule appears to have no penalties or incentives for a failure to use the form required in §140.8(b), and that it appears that carriers must simply request additional information when the form is not used.

Agency Response: The Division disagrees with the comment, and declines to make a change. The Division notes that the language in §140.8(c)(2) placing a limitation on what may be requested has been removed in the adopted text. As such, the commenters' concerns in relation to that language are resolved.

The Division notes that adopted §140.8(b)(1) provides that "The request must be in the form/format and manner prescribed by the Division of Workers' Compensation

(Division) and must contain all the required elements listed on the form." Upon receipt of a request for reimbursement, if a workers' compensation insurance carrier believes that this rule has been violated it can file a complaint with the Division pursuant to 28 TAC §180.2, relating to Referrals.

It is correct that the time frames in §140.8 begin upon receipt of a request for reimbursement – this is necessary for accord with the time frames established by §409.0091(i) and (j). If a workers' compensation insurance carrier does not receive sufficient information to process a request when the request is first received, the workers' compensation carrier should request additional information as permitted by §409.0091(j).

Comment: Some commenters recommend that proposed §140.8(c)(2) be amended to include language that conforms to the statute, to provide that a workers' compensation insurance carrier should not be "penalized, including not being held responsible for the costs of obtaining the additional information, if the workers' compensation insurance carrier denies payment in order to move to dispute resolution to obtain additional information to process the request."

Agency Response: The Division declines to make a change in response to this comment, as it is already addressed in adopted §140.8(d)(2).

Comment: Some commenters recommend deleting the word "agent" from proposed §140.8(c)(2) and replacing it with "authorized representative", since "agent" can have multiple meanings and the authority differs.

Agency Response: The division agrees with this comment and has changed the terms accordingly.

Comment: Commenter recommends changing the words "[S]ubstantiate the claim" to "establish the workers' compensation insurance carrier's liability for the claim."

Commenters recommend that, following the requirement that the health care insurer has the obligation to provide its agents with information necessary for the resolution of the reimbursement request, an additional requirement be added that provides for the agent to furnish this information to the workers' compensation insurance carrier.

Agency Response: The Division disagrees with the comment and recommendations. A claim involves other issues than liability. The rules already allow a workers' compensation insurance carrier to request information necessary to adjust a claim.

Comment: Commenter recommends adding the following language to §140.8(c)(2) to read as follows: "It is the health care insurer's obligation to furnish its agents with any information within its possession that is necessary for the resolution of a reimbursement request"

Commenter states that the health care insurer and its agents have no problem providing additional information to a workers' compensation insurance carrier if that information is within the possession of either entity. The commenter also states that this was a good faith agreement between the parties in the legislative negotiations to cooperate when additional information was needed by the workers' compensation insurance carrier and provide that additional information within 30 days if possible. The commenter states, however, there was always an issue related to materials in possession of third parties that neither the workers' compensation carrier nor the health care insurer could compel production. The commenter states that it was recognized that certain information, such as medical records, were not in the possession of either the health care insurer or its agents, and the workers' compensation insurance carrier may need that information, the solution was to allow the parties to enter dispute resolution to enable either the agency or an independent review organization to request information in the possession of third parties or that could not be obtained by other means.

Agency Response: The Division agrees with the comment in part and agrees to change the wording as follows: "It is the health care insurer's obligation to furnish its authorized representatives with any information within its possession or control that is necessary for the resolution of a reimbursement request." Also, hearing officers have been delegated authority to approve subpoena requests to enable parties to properly prepare and possibly reach an agreement before requesting dispute resolution.

Proposed §140.8(d)(1)(A)

Comment: Commenters recommend the following language for §140.8(d)(1)(A): "For each medical benefit paid that is determined to be a correct payment and not subject to an appropriate defense, the workers' compensation insurance carrier shall pay the health care insurer the lesser of…"

Commenters state that this adds the qualifying language that is in the statute giving the workers' compensation insurance carrier certain defenses including determining whether it is a "medical benefit" and "a correct payment" and does not have a defense allowed under the workers' compensation law and §409.0091.

Agency Response: The Division disagrees with the comment and the suggested added language. The suggested language is unnecessary and may be interpreted to remove other reasons for which a carrier might elect to pay a claim.

Comment: Commenters state that proposed §140.8(d)(1)(A) implies that the workers' compensation insurance carrier must pay the applicable fee amount, regardless of other defenses. The commenters state that under §409.0091(h) the workers' compensation insurance carrier would be within its rights to apply a defense to some of the payment, or determine that some of the payments were not medical benefits, or were not "correct payments." The commenters recommend the rule be clarified to provide that after the workers' compensation insurance carrier determines that the heath care paid was for a

medical benefit and was a correct payment, and that no other defenses apply, then the workers' compensation insurance carrier "shall" pay the health care insurer the lesser of the amount payable under the applicable fee guideline as of the date of service or the actual amount paid by the health care insurer.

Agency Response: The Division disagrees. The suggested language is unnecessary. Section 140.8(d)(2) accommodates the rights of the carrier to deny or reduce payment. Subsection (d)(1) does not imply that the "carrier must pay the applicable fee amount, regardless of other defenses" when read in conjunction with the totality of §140.8(d)(1).

Proposed §140.8(d)(1)(E)

Comment: Commenters recommend deleting proposed §140.8(d)(1)(E). The commenter states that this provision is unnecessary because subsection (3) requires the workers' compensation insurance carrier to provide an explanation of benefits and Section 11 of H.B. 724 specifically provides that subclaims under §409.0091 must be on a compensable claim and not on a claim that has been denied based on compensability. Commenters state that there is no statutory authority in §409.0091(i) or (j) to allow the Division to impose this duty on the workers' compensation carrier. In addition, this requirement potentially requires the workers' compensation insurance carrier to waive an unresolved compensability dispute or a compensability dispute that has already been resolved in favor of the carrier.

Commenter states that the workers' compensation carrier response to a §409.0091 request for reimbursement may be to deny reimbursement based on a compensability issue. In such a situation, it would be clearly outside the authority of the Division to require the workers' compensation insurance carrier to send a notice to the health care provider and employee that includes "*an* explanation that the claim is compensable."

If this provision remains in the adopted rule, then commenter recommends the rule be clarified to provide that a workers' compensation insurance carrier provide the injured employee and health care provider with an explanation whether the claim is compensable and, if not, the basis for the workers' compensation insurance carrier's determination that the claim is not compensable. Such a provision should further state that the workers' compensation insurance carrier is relieved of their regulatory duty to provide the injured employee with a plain language notice of the workers' compensation insurance carrier's decision to not accept the claim as being compensable.

Agency Response: The Division disagrees with the comment. However, adopted §140.8(e)(1)(E) is amended to clarify that "If the claim is compensable" then "the notice shall include an explanation that the claim is compensable and that the health care provider must reimburse the injured employee for any amounts paid to the health care provider by the injured employee." The Division also clarifies that this notice may be included in the explanation of benefits required by adopted subsection (e)(2). In addition, the adopted rule is designed to accomplish the statutory requirements on the

Commissioner of Workers' Compensation and the Commissioner of Insurance to implement rules consistent with the specified mandates in §409.0091(l), (o), and (r).

Comment: Those commenting state that it should not be the responsibility of the workers' compensation insurance carrier to notify the employee and health care provider. Commenter states this obligation is invoked when the workers' compensation insurance carrier *pays* the claim. Commenter further states that if the provider and the claimant had initially done what was necessary, then the workers' compensation insurance carrier would not be required to issue such a notice. The commenters recommend this notice obligation fall to the health insurance carrier.

Agency Response: The Division disagrees. The notice requirement in §140.8(d)(1)(E) requires the carrier to give its response to the reimbursement request to the injured employee and health care provider. In the same notice, it requires an explanation that, if the claim is compensable, the health care provider must reimburse the injured employee for any amounts paid to the health care provider by the injured employee. It is appropriate that the carrier explain its own position on the reimbursement request. It is economical and efficient to include the notice on reimbursement in the same communication.

Proposed §140.8(d)(1)(E) & (e)

Comment: Commenter states that reimbursement of medical payments made by the injured employee ought to be made by the workers' compensation insurance carrier rather than the health care provider. The commenter states that there is no meaningful process for dispute resolution when the health care provider and injured employee do not agree on the amount of money paid by the injured employee for health care. The commenter recommends the language in §140.8(d)(1)(E) be amended to require the workers' compensation insurance carrier to reimburse the injured employee for any amounts paid to the health care provider by the employee.

Commenter recommends the language in §140.8(e) be amended to require the workers' compensation insurance carrier to reimburse the injured employee any payments made by the injured employee to the health care provider, including but not limited to, copays and deductibles.

Agency Response: The Division disagrees. A health care provider directly received the additional funds from the injured employee and is in the best position to determine the amount of refund that is due to the injured employee.

Proposed §140.8(d)(1)(E) and (g)(3)(C)

Comment: Commenter recommends that the form DWC-026 be revised to require the mailing address of the provider be included. This creates problems for the carrier as to where to send a copy of the carrier's response under §140.8(d)(1)(E) and where to send

the explanation of benefits as required under §140.8(g)(3)(C) or where the carrier may request documents from the provider.

Commenter recommends that the form DWC-026 be revised to include the dates under §409.0091(n) or (s), as applicable. The commenter states that carriers are forced with every reimbursement request to ask for these dates as "additional information" in order to determine compliance with §409.0091(n) time limits, made applicable through §409.0091(f). The commenter states that the Division has made no mention of how, or if, it intends to enforce the §409.0091(n) deadlines.

Agency Response: The Division duly notes the recommendations. However, the recommendations do not constitute comment on the proposed rules, but rather comment regarding a Division form. The Division will apply the deadlines, if the issue is raised, in dispute resolution.

Proposed §140.8(d)(1)(F)

Comment: Commenters recommend the last sentence of adopted §140.8(d)(1)(F) be amended as follows: "The workers' compensation insurance carrier is liable for payment in accordance with Division fee guidelines and §409.0091(g) and (h)."

Commenters state that this language change is necessary to clarify that there are some statutory deductions and to ensure that the workers' compensation insurance carrier never pays more than it would have paid had the bill been properly submitted to the workers' compensation carrier. The commenters state the term "full payment" could

be interpreted to require the workers' compensation insurance carrier to pay the full amount under workers' compensation even though the provider did receive some compensation from the group health insurer and the workers' compensation insurance carrier has already paid the group health insurer.

Agency Response: The Division disagrees. The totality of §140.8(d)(1) accommodates the concerns of the comment. The referenced sentence adequately incorporates the payment guidance in the Rule, which covers the statutory deductions. Please see §140.8(d)(1)(A) and 140.8(d)(1)(D).

Comment: Those commenting state that the rule creates additional liabilities not contemplated by the statute and adoption of this rule as proposed would be *ultra vires*. The commenters state that §409.0091(b) only applies to health care insurers and does not apply to health care providers. The amount of all payments that are due to the health care providers are the amount of those payments that are paid to the health care insurers under §409.0091 as evidenced by §409.0091(g). Otherwise subsection (g) would provide for an offset on the part of the workers' compensation insurance carrier per the fee guidelines.

Agency Response: The Division agrees that §409.0091(b) states that the section applies "only to a request for reimbursement by a health care insurer." However, the statutory section is not limited to application to health care insurers. There are multiple facets to reimbursement requests from health care insurers, and the Division is tasked

with providing rules to implement the entire statutory section while continuing to enforce other provisions of the Labor Code. Labor Code §408.027 provides for reimbursement of health care providers and §413.011 provides for Division medical fee reimbursement guidelines. Workers' compensation insurance carriers are liable for the reimbursement of health care provided to injured employees and this reimbursement is based on the Division's medical fee reimbursement guidelines. Section 409.0091(g) states that: "The workers' compensation insurance carrier shall reduce the amount of the reimbursable subclaim by any payments the workers' compensation insurance carrier previously made to the same health care provider..." This provision of §409.0091 does not conflict with the requirement of adopted §140.8(e)(1)(E) because subsection (e)(1)(E) pertains to the health care provider ultimately receiving the fee guideline reimbursement amount established by a Division medical fee reimbursement guideline for the services that health care provider provided to the injured employee. In addition, §409.0091(o) requires that Division rules be amended or adopted to provide for reimbursement to the injured employee who has paid for health care services.

Comment: Commenter states that the health care provider has created the problem if it incorrectly files with the health care insurer for payment for medical services rendered; therefore, the health care provider should be the deemed to have made its election of a remedy by the way it sought payment for services and should not be entitled to

additional reimbursement since the health care provider did not have to pay back the money it incorrectly received.

Agency Response: The Division disagrees with this comment and declines to make a change. The fact that the wrong carrier was billed does not necessarily mean that the health care provider made an "election of remedy" with its initial care and payment. The commissioners have the obligation under the statute to "adopt additional rules to clarify the processes required by, fulfill the purpose of, or assist the parties in the proper adjudication of subclaims" under §409.0091.

Proposed §140.8(d)(2)

Comment: Commenters recommend deleting §140.8(d)(2). Commenter states that §140.8(d)(2) is vague and does not add anything to the requirement in §140.8(d)(3) that the workers' compensation insurance carrier provide an explanation of benefits.

Commenter recommends that if §140.8(d)(2) is not deleted, then a clear definition of what is considered "a sufficient explanation" should be added, including a statement that standard denial codes in workers' comp are sufficient explanation of denial and will protect the workers' compensation insurance carrier from other payments sought by the health care insurer. Commenter recommends that the Division include a provision that failure to provide a sufficient explanation does not entitle the health care insurer to any payment other than the correct payment provided for by the Labor Code and applicable Division rules.

Agency Response: The Division does not agree with the recommended alternative language. Adopted §140.8(e) has been revised to clarify that the explanation of benefits shall provide sufficient explanation of the denial of the reimbursement request. Regarding failure to provide a sufficient explanation, there are no circumstances under which a health care insurer could be entitled to anything other than correct payment under the Labor Code and Division rules.

Comment: Commenter recommends amending proposed §140.8(d)(2) by adding this sentence: "If the denial is due to the fact that compensability has not been determined, agreed, or settled in a pre-existing contested case, the workers' compensation insurance carrier shall deny the request as pending determination of compensability and allow the health care insurer to file an abated subclaim under subsection (f)(6)."

Commenter states that in order to maintain efficiency in the workers' compensation system, it is not good public policy to require additional parties seeking reimbursement or subclaimant status to pursue a contested case to determine compensability when a pre-existing contested case is pending. Public policy dictates an abatement of the subclaimant's dispute resolution rights pending resolution of the existing contested case

Agency Response: The Division cannot agree with the comment or the recommended addition. The statutory language obviously contemplates the ability of a subclaimant to independently raise its remedies and proceed; therefore, the Division does not have the

authority to create the recommended "abatement" of the subclaim. The injured employee is required to be noticed of the action and therefore has the ability to intervene, if appropriate or seek other action deemed necessary.

Proposed §140.8(d)(3)

Comment: Commenter recommends a defined time within which the workers' compensation carrier must provide the concerned parties the Explanation of Benefits be included.

Agency Response: The Division disagrees. Time limits are set for a workers' compensation insurance carrier to respond to a health care insurer's request for reimbursement. The workers' compensation carrier's response must include an explanation of benefits as required by §140.8(d)(1)(E), (2) & (3). Therefore, the time limit for providing an explanation of benefits is the same as the time limit for the response to the request for reimbursement.

Comment: Commenter states that any notice requirement should be the responsibility of the health care insurer who initiated the subclaim process, rather than the responsibility of the workers' compensation insurance carrier. Commenter states that there is no statutory requirement in §409.0091 for the workers' compensation insurance carrier to provide an Explanation of Benefits to the employee and to all health care

providers merely because a health care insurer has filed a request for subclaim reimbursement.

Agency Response: The Division disagrees. The notice requirement in §140.8(d)(1)(E) and 140.8(d)(3) require the carrier to give a response to the reimbursement request to the injured employee and health care provider. The same notice requires an explanation that, if the claim is compensable, the health care provider must reimburse the injured employee for any amounts paid to the health care provider by the injured employee. It is appropriate that the carrier explain its own position on the reimbursement request. It is economical and efficient to include the notice on reimbursement in the same communication.

Proposed §140.8(e)

Comment: Commenter recommends that the rule provide that the Division should place a copy of the subclaimant's notice in the workers' compensation insurer's box at Division's Central office within two days of receipt.

Agency Response: The Division disagrees. Prior to filing for Notice of Subclaimant Status, the party must file a request for reimbursement with the workers' compensation insurer and have that request denied. Filing a Notice of Subclaimant Status merely allows the subclaimant to be notified of any further proceedings on the claim. The workers' compensation insurer is already aware of the existence and claim of the subclaimant, based on the Request for Reimbursement.

Comment: Commenter stated that §140.8(e) does not provide any direction as to how a dispute over health care provider reimbursement to the injured employee would be handled.

Agency Response: The Division disagrees. Such a dispute would be handled under §133.307 of this title.

Proposed §140.8(e)(2)

Comment: Commenters state §140.8(e)(2) permits subclaimants to file their notice of subclaimant status with any field office location or the Division's central office. Commenters recommend that subclaimants file their notice of subclaimant status only with the Division's central office. This requirement would greatly reduce the chance of the requests being misplaced by field office personnel and generally speed up processing time.

Agency Response: The Division disagrees. Any notice is deemed received by the Division when filed at any Division office.

Proposed §140.8(f)(2)

Comment: Commenter recommends worker's compensation insurance carriers be notified of the filing of a notice of subclaimant status; and, that §140.8(f)(2) should be amended to include this provision. Commenter recommends 140.8(f)(2) be amended to

provide that the notice may be filed with the Division Field Office responsible for managing the injured employee's claim; and, that the notice must also be filed with workers' compensation insurance carrier. Commenter states that this recommendation for filing the subclaimant notice will result in the notice being filed with either the appropriate Division field office or the Division's central office so that the notice can be matched up with the correct claim.

Agency Response: The Division disagrees. Prior to filing for Notice of Subclaimant Status, the party must file a request for reimbursement with the workers' compensation insurer and have that request denied. Filing a Notice of Subclaimant Status merely allows the subclaimant to be notified of any further proceedings on the claim. The workers' compensation insurer is already aware of the existence and claim of the subclaimant, based on the Request for Reimbursement. Within the Division, filings with a field office are the same as filing with the Central Office and matters are administratively forwarded. Central filing is not required nor necessary.

Proposed §140.8(f)(4)

Comment: Commenter recommends that §140.8(f)(4) include a requirement for a separate notice for each health care provider involved.

Agency Response: The Division agrees; however, the current provisions are adequate to satisfy the concern of the comment.

Proposed §140.8(f)(6)

Comment: Commenter recommends the addition of a new paragraph in §140.8(f) to read as follows:

"(6) Abatement of Subclaim. If reimbursement has been denied under subsection (d)(2) because of a pending contested case and subclaim filed, the subclaimant may not request dispute resolution until resolution of the pending contested case. If the contested case is determined compensable, settled, or agreed the carrier shall review the abated subclaim pursuant to the deadlines established under subsection (c) for reimbursement requests and reimburse the abated subclaim pursuant to subsection (d)(1) and issue an explanation of benefits pursuant to subsection (d)(3). If reimbursement of the abated subclaim is denied pursuant to subsection (d)(2), then the subclaimant may seek dispute resolution under subsection (g)."

Commenter states this provision would create a process to efficiently address pre-existing contested case determinations of compensability and then defines how workers' compensation insurance carriers and health care insurers can resolve a pending subclaim subsequent to the resolution of the pending contested case.

Agency Response: The Division cannot agree with the comment or the recommended addition. The statutory language obviously contemplates the ability of a subclaimant to independently raise its remedies and proceed; therefore, the Division does not have the authority to create the recommended "abatement" of the subclaim. The injured

employee is required to be noticed of the action and therefore has the ability to intervene, if appropriate or seek other action deemed necessary.

Proposed §140.8(g)

Comment: Commenter asserts that §140.8(g) attempts to refer disputes into resolution disputes already defined and operating under existing rules which is problematic. First, existing dispute resolution rules were not written to address the type and nature of disputes that will now be generated and addressed under the adopted rule. Second, the categorization of dispute types by reason for denial is not effective or logical in determining the form of dispute resolution that should apply, citing examples such as when the categories are not mutually exclusive – meaning the rule is unclear as to which dispute resolution applies in any given case. Third, the categories place a workers' compensation insurance carrier refusal or failure to respond within a legitimate dispute category creating an incentive for workers' compensation insurance carriers to ignore the requirements to respond timely.

Commenter recommends amendments to the proposed rule because the Division has incorrectly divided the disputes into three categories. Commenter states that the first category (Claim or Treatment Not Compensable) includes two very different types of denials that should not be placed within the same category and directed to BRC/CCH. Commenter further reasons that the second dispute category under adopted §140.8(g), Lack of Medical Necessity, focuses on a single form of carrier

objection which appears to be crafted to coincide with the existing MDR definitions of §133.308 rather than the actual nature of subclaimant disputes. Commenter also states that the third adopted dispute category (Reduction, Denial or Failure to Respond) combines a peculiar amalgam of underpayments, unspecified denials and failure to respond.

The commenter recommends four generic dispute types: compensability disputes, medical benefit disputes, medical fee disputes, and non-response. Specifically, the commenter recommends under §140.8(g) that the rules applicable to dispute resolution would vary according to the "underlying nature of the dispute between the carrier and subclaimant" and not according to the "reason for denial of reimbursement" as adopted by the Division. The commenter states that compensability disputes should be restricted to determining compensability of an injury or illness through the BRC/CCH process and therefore recommends deleting "or Treatment" from §140.8(g)(1). The commenter recommends deletion of "of the carrier's utilization review agent" from subsection (g)(2)(A) because, per the commenter, the health care insurer will have no knowledge of who the entity is because unlike a typical workers' compensation treatment situation, the denial for reimbursement would only come from the workers' compensation insurance carrier and not the utilization review agent. The commenter explains that the medical benefit dispute category is appropriate because the dispute involves a compensable injury or illness with disagreements as to whether

specific health care services paid by the health care insurer are medical services under the Act.

Agency Response: The Division disagrees with the comment and declines to make the changes. In response to the three points raised by the commenter, the Division notes:

First, the proposed sections take into consideration the fact that the dispute resolution procedures referred to are existing procedures. Such provisions are necessary for compliance with §409.0091(l) and (m). Section 409.0091(l) provides in part, "Any dispute that arises from a failure to respond to or a reduction or denial of a request for reimbursement of services that form the basis of the subclaim must go through the appropriate dispute resolution process under this subtitle and division rules." Section 409.0091(m) provides "In a dispute filed under Chapter 410 that arises from a subclaim under this section, a hearing officer may issue an order regarding compensability or eligibility for benefits and order the workers' compensation insurance carrier to reimburse health care services paid by the health care insurer as appropriate under this subtitle. Any dispute over the amount of medical benefits owed under this section, including medical necessity issues, shall be determined by medical dispute resolution under §413.031 and §413.032." Section 140.8(g)(1) concerns indemnity disputes that are based on lack of compensability. In this context the compensable disputes are whether the claimed injury is compensable and whether the requested medical fee is for medical care for an injurious condition that is part of the compensable

injury. Subclaimants who wish to file a request for dispute resolution for such a dispute are referred to §141.1 of this title (relating to Requesting and Setting a Benefit Review Conference), because it contains the Division rules promulgated pursuant to Labor Code Chapter 410. Section 140.8(g)(2) concerns disputes that are based on lack of medical necessity and §140.8(g)(3) concerns fee disputes. Subclaimants who wish to file a request for dispute resolution for such disputes are referred to §133.307 and §133.308 of this title, because these are the Division rules promulgated pursuant to Labor Code §413.031 and §413.032. Subclaimant disputes are already handled in "Exceptions" and are specifically listed in §140.8(g)(2) and (3) to address differences that are necessary to address subclaimant disputes. Division proceedings under Labor Code Chapter 410 currently include subclaimants, so no exceptions for subclaimants need to be included in §140.8(g)(1).

The Division declines to make the suggested changes to §140.8(g)(2), because the framework for referring evaluation of "medical benefits" to independent review organizations as suggested by the commenter would not be in compliance with the Labor Code or Texas Department of Insurance rules adopted under the Insurance Code. Specifically, Labor Code §413.031(d) provides that independent review organizations are to review "the medical necessity of a health care service," and §12.5 defines "independent review organization" as "An entity that is certified by the commissioner to conduct independent review under the authority of the Act…." and "independent review" as "A system for final administrative review of the medical

necessity and appropriateness of health care services being provided or proposed to be provided to an individual…" As described by the commenter, review of a "medical benefit" to determine whether it was "(i) reasonably required for the diagnosis, evaluation, or treatment of the compensable injury or illness; and (ii) intended to cure or relieve the effects of the injury or illness; or (iii) intended to promote the injured employee's recovery; or (iv) intended to enhance the employee's ability to return to work or retain employment," would not be a review of medical necessity, but rather a review of compensability. As such, it would not be appropriate for an independent review organization to perform such a review.

The Division disagrees with the comment and declines to make the requested changes regarding a workers compensation insurance carrier's failure to respond to a request for reimbursement, because the requested change would violate §409.0091(q). Section 409.0091(q) provides: "An action or failure to act by a workers' compensation insurance carrier under this section may not serve as the basis for an examination or administrative action by the department or the division, or for any cause of action by any person, except for judicial review under this subtitle." If the Division were to order immediate payment of the request for reimbursement because a workers' compensation insurance carrier failed to respond to a request for reimbursement, it would constitute an administrative action in violation of §409.0091(q).

Proposed §140.8(g)(1)

Comment: Some commenters recommend that one of the categories of disputes that can be requested for dispute resolution should be changed from "Claim or Treatment Not Compensable" to "Treatment Not Related to the Compensable Injury" because no compensability disputes may be brought under §409.0091. Commenter explained that subclaimants under §409.0091 may not file a subclaim on a workers' compensation claim that the comp carrier has denied and the injured employee is not pursuing. Thus there will be no disputes over compensability as the stricken language exceeds the statutory authority provided by HB 724. Because compensability is beyond the scope of HB 724, the first commenter also recommends deleting "compensability" from subsection (g)(1)(A), deleting subsection (g)(1)(B) entirely and deleting "compensability" from subsection (g)(1)(C). Commenter supports that §140.8(g)(1) should be rewritten "Treatment Not Related to the Compensable Injury" because Section 11 of HB 724 clearly states that the law applies to subclaims based on an injury that has not been denied for compensability, or that has been determined by the Division to be compensable.

Agency Response: The Division disagrees that §409.0091 is the exclusive remedy for a §402.084(c-1) health care insurer. No such exclusive remedy language is contained in §409.0091. Additionally, §409.009 was not amended to exclude §402.084(c-1) health care insurers. Section 409.0091 allows a health care insurer to bring a claim which resulted from a data match, and limits the defenses available to a workers' compensation insurance carrier. Section 409.009 allows any person who has provided

compensation, directly or indirectly, to or for an employee or beneficiary, and has sought and been refused reimbursement , to pursue dispute resolution.

Comment: Commenter asserts that the subclaimant has no independent right to pursue compensability. The commenter states that §409.009 grants no more than the right to "file" a claim. Section 11 of HB 724 specifically provided that "[t]he changes made by this Act apply only to subclaims based on an injury that has not been denied for compensability or that has been determined by the division to be compensable." Thus, the commenter reasons that §409.009(m) must be read in this context. Further, subsection (m) explicitly references Chapter 410 of the Labor Code (Adjudication of Disputes). Chapter 410 discusses the parties to disputes under that chapter in Labor Code §410.006: the claimant and the insurance carrier. Subclaimants are not mentioned. Health care providers are not mentioned. While the Labor Code §413.0311 (relating to Review of Certain Medical Disputes; Contested Case Hearing) also references Chapter 410, it does so only as a matter of *procedure* as evidenced by the use of the word "manner". Thus, per commenter, subsection (m), particularly when read in light of Section 11 of HB 724, merely provides that if the subclaimant files a claim for reimbursement, and if the *claimant* then elects to pursue the claim, then the hearing officer may make a finding of compensability. The commenter concludes that to hold otherwise would be to render Section 11 meaningless and since subsection (m) and Section 11 may be read together, they must be.

Agency Response: The Division disagrees. The authority of the Division to provide dispute resolution to subclaimants is fully discussed in the reasoned justification portion of this preamble.

Comment: Commenter states that this entire subsection is outside the rulemaking authority of the Commissioner and conflicts with Section 11 of HB 724 which clearly states that the law (§409.0091) applies only to a subclaim based on a compensable injury occurring on or after September 1, 2007 *and* based on an injury that has not been denied for compensability, or has been determined by the Division to be compensable. The health care insurer and its authorized representative have standing to pursue a subclaim only if the workers' compensation insurance carrier has either accepted compensability, has accepted the medical condition, or if the Division has rendered a final decision that the injury is compensable or a final decision that determines the medical condition is part of the compensable injury. Commenter recommends deletion of the entire subsection and replacing it with the following: "(1) Claim or Treatment Not Compensable. The health care insurer or its authorized representative may file a reimbursement request under subsection (b) of this rule with the workers' compensation insurance carrier within 18 months of payment for the services if the workers' compensation has accepted the liability for the claim or treatment within the period of time or if the Division has determined that the claim is compensable or that the treatment is part of the compensable injury within the period of time."

Agency Response: The Division disagrees. If the requester meets the requirements for subclaimant status under §409.009, they may request a benefit review conference to pursue a compensability dispute under that section. The authority of the Division to provide dispute resolution to subclaimants is fully discussed in the reasoned justification portion of this preamble.

Comment: Some commenters recommend deleting the subsection because the specific provisions of §409.0091, are effective September 1, 2007, there is no statutory authority in HB 724 (notably Section 11) allowing a subclaimant health care insurer or authorized representative to pursue compensability determinations, and §409.009 does not apply to certain health care insurers, as defined in §409. 0091(a). In the alternative, both commenters recommend the following language as a substitute: "(B) The health care insurer, other than a health care insurer as defined by §409.0091(a), may pursue dispute resolution to establish that the injury claim is compensable under §409.009 and §140.6 of this title (relating to Subclaimant Status: Establishment, Rights, and Procedures)."

Agency Response: The Division declines to make the suggested changes. The authority of the Division to provide dispute resolution to subclaimants is fully discussed in the reasoned justification portion of this preamble.

Proposed §140.8(g)(2)(B)

Comment: Commenter recommends revision of the subsection by adding the following at the end of the sentence "… except that appeal of an IRO decision will be made to the State Office of Administrative Hearings as provided in Labor Code §413.031 and not under §133.308(t) of this title." The commenter maintains that §409.0091 specifically says that dispute resolution shall be under §413.031 and §413.032 and specifically excludes reference to §413.0311 passed in the same legislation as the new §409.0091. Thus, the commenter contends that any omission in legislation must be assumed to have been done for a reason so the statute should not be construed to include a section that is not explicitly included.

Agency Response: The Division disagrees with the comment and declines to make a change. Resolution of disputes is addressed in §409.0091(l) and (m). Section 409.0091(l) provides, in part, "Any dispute that arises from a failure to respond to or a reduction or denial of a request for reimbursement of services that form the basis of the subclaim must go through the appropriate dispute resolution process under this subtitle and division rules." Section 409.0091(m) provides, in part, "Any dispute over the amount of medical benefits owed under this section, including medical necessity issues, shall be determined by medical dispute resolution under §413.031 and §413.032."

Pursuant to these provisions, a fee dispute or a medical necessity dispute resulting from a request for reimbursement under §409.0091 should be resolved under the Division's medical dispute resolution process and §413.031 and §413.032. These sections

provide the initial level of dispute resolution for fee disputes and medical necessity disputes.

Fee disputes fall under §413.031(c); pursuant to this section the Division has the role of resolving disputes over the amount of payment due. Medical necessity disputes fall under §413.031(d) and (e); pursuant to these subsections, medical necessity disputes are resolved through use of an Independent Review Organization (IRO), and §413.032 establishes the minimum elements that must be included in an IRO decision. Additionally, §413.031(f) provides, "The commissioner by rule shall specify the appropriate dispute resolution process for disputes in which a claimant has paid for medical services and seeks reimbursement."

After the initial level of dispute resolution under §413.031(c), (d), (e), or (f), parties with an unresolved dispute are entitled to an administrative hearing. Section 413.0311 applies to disputes that have been through the initial process as set out in §413.031(b) through (i) and that involve 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 or an appeal of an IRO regarding determination of the retrospective medical necessity for a health care service for which the amount billed does not exceed $3,000. It provides for a hearing by a Division hearing officer under Labor Code Chapter 410, Subchapter D. Section 413.031(l) applies to a medical dispute regarding spinal surgery that remains unresolved after a review by an independent review organization as provided by subsections (d) and (e), and provides

for dispute resolution as provided by Chapter 410. Section 413.031(k) applies to any dispute that does not fall under §413.0310 or §413.031(l), and provides for a SOAH hearing.

Comment: Some commenters state that this subsection should be limited to health care insurers as defined in §409.0091(a) meaning " an insurance carrier and an authorized representative of an insurance carrier, as described by §402.084(c-1)." Commenters also state that since §409.0091(m) provides that any dispute over the amount of medical benefits owed under this section, including medical necessity issues, shall be determined by medical dispute resolution under §§413.031 and 413.032, and does not reference §413.0311, §413.0311 applies only to listed medical disputes that remain unresolved after applicable review under §413.031(b) through (i). Further, commenters point out that health care insurer disputes are not listed in §413.031(b) through (i). Thus, commenters recommend that the subsection conform to the statute so that all health care insurer subclaimant appeals regarding medical necessity go to the State Office of Administrative Hearings.

Agency Response: Adopted §140.8 is limited to health care insurers as defined in §409.0091(a). In some instances disputes arising from subclaimant claims should proceed to SOAH. Resolution of disputes is addressed in §409.0091(l) and (m). Section 409.0091(l) provides, in part, "Any dispute that arises from a failure to respond to or a reduction or denial of a request for reimbursement of services that form the basis

of the subclaim must go through the appropriate dispute resolution process under this subtitle and division rules." Section 409.0091(m) provides, in part, "Any dispute over the amount of medical benefits owed under this section, including medical necessity issues, shall be determined by medical dispute resolution under §413.031 and §413.032."

Pursuant to these provisions, a fee dispute or a medical necessity dispute resulting from a request for reimbursement under §409.0091 should be resolved under the Division's MDR process and §413.031 and §413.032. These sections provide the initial level of dispute resolution for fee disputes and medical necessity disputes.

Fee disputes fall under §413.031(c); pursuant to this section the Division has the role of resolving disputes over the amount of payment due. Medical necessity disputes fall under §413.031(d) and (e); pursuant to these subsections, medical necessity disputes are resolved through use of an Independent Review Organization (IRO), and §413.032 establishes the minimum elements that must be included in an IRO decision. Additionally, §413.031(f) provides, "The commissioner by rule shall specify the appropriate dispute resolution process for disputes in which a claimant has paid for medical services and seeks reimbursement."

After the initial level of dispute resolution under §413.031(c), (d), (e), or (f), parties with an unresolved dispute are entitled to an administrative hearing. Section 413.0311 applies to disputes that have been through the initial process as set out in §413.031(b) through (i) and that involve 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 or an appeal of an IRO regarding determination of the retrospective medical necessity for a health care service for which the amount billed does not exceed $3,000. It provides for a hearing by a Division hearing officer under Labor Code Chapter 410. Section 413.031(l) applies to a medical dispute regarding spinal surgery that remains unresolved after a review by an independent review organization as provided by Subsections (d) and (e), and provides for dispute resolution as provided by Chapter 410. Section 413.031(k) applies to any dispute that does not fall under §413.0310 or §413.031(l), and provides for a SOAH hearing.

Proposed §140.8(g)(2)(C) & (g)(3)(B)

Comment: Commenter recommends clarification regarding §140.8(g)(2)(C) and how it works with certain provisions of §133.308 (relating to MDR by Independent Review Organizations). The commenter states the adopted rule requires that a subclaimant shall follow the independent review process allowed for a non-network health care provider seeking retrospective review under §133.308 and provides certain exceptions from that rule for health care insurer subclaimants. Section 133.308 (j) provides for reasons that the Department may dismiss a request for medical necessity dispute resolution including that "the Department has previously resolved the dispute for the date(s) of health care in question." The commenter maintains that an health care insurer subclaimant may be filing a dispute for dates of service that were the subject of a

dispute between a health care provider and a workers' compensation insurance carrier. Thus, the rule should clarify that §133.308(j)(4) does not apply to medical necessity dispute filed by an health care insurer subclaimant unless the dispute that was previously resolved was based on a filing by the subclaimant for the dates of health care in question.

Commenter also recommends clarification regarding §140.8(g)(3)(B) related to the reasons for dismissal in the medical fee dispute resolution process allowed for a health care provider under §133.307 (relating to MDR of Fee Disputes). Under §133.307(e)(3), the Department may dismiss a request for medical fee dispute among others, if the fee disputes for the dates of health care in question have been previously adjudicated by the Division; and the Division determines that the medical fee dispute is for health care services provided pursuant to a private contractual fee arrangement. The commenter states that an health care insurer subclaimant may be filing a dispute for dates of service that were the subject of a dispute between a health care provider and a workers' compensation insurance carrier.

Commenter recommends that the Division should clarify that §133.307(e)(3)(D) does not apply to a medical fee dispute filed by an health care insurer subclaimant unless the dispute that was previously resolved was based on a filing by the subclaimant for the dates of the health care in question. Many disputes filed by health care insurer subclaimants involve health care services provided by health care providers participating as contracted providers with health insurers .

While §133.307(e)(3)(F) was intended to apply to a contractual fee arrangement between a workers' compensation insurance carrier or network, the commenter recommends that the Division clarifies that §133.307(e)(3)(F) does not apply to a contractual fee arrangement between a health care insurer and health care provider. The commenter recommends that the Division can make the clarification regarding both subsections either in the rule preamble or by amendments to the text.

Agency Response: The Division disagrees with the recommended clarification of §140.8(g)(2)(C). The recommended change is contrary to the statutory language in §409.0091(d).

The Division disagrees with the recommended clarification of §140.8(g)(3)(B). §133.307(e)(3)(F) does apply to a contractual fee agreement between a health care insurer and health care provider. Further, §409.0091(h) provides that "For each medical benefit paid, the workers' compensation insurance carrier shall pay to the health care insurer the lesser of the amount payable under the applicable fee guideline as of the date of service or the actual amount paid by the health care insurer."

Proposed §140.8(g)(3)(A)

Comment: Commenters recommend deletion of §140.8(g)(3(A). Commenter states that the Division has no statutory authority for an extension of the timelines contained in §409.0091. Additionally, the commenter asserts no compensability disputes may be brought under §409.0091 because Section 11 of HB 724 clearly says that subclaimants

under §409.0091 may not file a subclaim for an injury that is not compensable. Thus, commenter recommends deleting the subsection in its entirety. Commenter justifies the deletion since §409.009 (n) does not provide for another 60 days to be allotted for filing a medical dispute resolution with the Division after the date the requestor receives the final decision on compensability or extent of injury issues. Commenter states that §402.084(c-1) health care insurers and their authorized agents do not have standing to raise compensability and extent of injury issues as a result of HB 724 Section 11. Commenter also refers to §409.0091(n) and adds that it does not have any exceptions other than the exceptions found in subsection (s) and what is adopted is not a subsection (s) exception. The commenter maintains that because the legislature has specifically addressed the limitation periods, the Division is without rulemaking authority to alter those limitation periods in any way. Commenter states that there is no statutory provision under §409.0091(n) or elsewhere that gives the Commissioner the authority to extend the time to file for medical dispute resolution by allowing 60 additional days after the requestor receives the final decision on compensability or extent of injury issues. Aside from requesting the subsection to be deleted, the commenter also recommends that the Division limits the definition of subclaimants to health care insurers as defined in §409.0091(a).

Agency Response: The Division disagrees. Section 409.0091(n) only applies to requests for reimbursement and not when dispute resolution must begin. The Division is authorized to establish timelines for other procedures by §409.0091(r).

The Division disagrees with the recommendation that the Division limit the definition of subclaimants to health care insurers as defined in §409.0091(a). The Division disagrees that §409.0091 is the exclusive remedy for a §402.084(c-1) health care insurer. No such exclusive remedy language is contained in §409.0091. Additionally, §409.009 was not amended to exclude §402.084(c-1) health care insurers. Section 409.0091 allows a health care insurer to bring a claim which resulted from a data match, and limits the defenses available to a workers' compensation insurance carrier. Section 409.009 allows any person who has provided compensation, directly or indirectly, to or for an employee or beneficiary, and has sought and been refused reimbursement, to pursue dispute resolution.

Proposed §140.8(g)(3)(B)

Comment: Some commenters recommend that §140.8(g)(3)(B) be limited to health care insurers as defined in §409.0091(a). Those commenting state that any disputes over the amount of medical benefits owed under this section, including medical necessity issues would be determined under Labor Code §413.031 (relating to Medical Dispute Resolution) and §413.032 (relating to Independent Review Organization; Appeal). The comments also state that §409.0091(m) does not reference §413.0311 that creates a review for certain medical disputes and contested case hearings. Commenters further state that §413.0311 applies only to enumerated medical disputes that remain unresolved after any applicable review under §413.031(b) through (i) and

health care insurer disputes are not listed in §413.031(b) through (i). Thus, commenters recommend that the Division amend this subsection and conform to the statute so that all health care insurer subclaimant appeals regarding medical fee issues go to the State Office of Administrative Hearings.

Agency Response: Section 140.8 is limited to health care insurers as defined in §409.0091(a). In some instances disputes arising from subclaimant claims should proceed to SOAH. Resolution of disputes is addressed in §409.0091(l) and (m). Section 409.0091(l) provides, in part, "Any dispute that arises from a failure to respond to or a reduction or denial of a request for reimbursement of services that form the basis of the subclaim must go through the appropriate dispute resolution process under this subtitle and division rules." Section 409.0091(m) provides, in part, "Any dispute over the amount of medical benefits owed under this section, including medical necessity issues, shall be determined by medical dispute resolution under §413.031 and §413.032."

Pursuant to these provisions, a fee dispute or a medical necessity dispute resulting from a request for reimbursement under §409.0091 should be resolved under the Division's medical dispute resolution process and §413.031 and §413.032. These sections provide the initial level of dispute resolution for fee disputes and medical necessity disputes.

Fee disputes fall under §413.031(c); pursuant to this section the Division has the role of resolving disputes over the amount of payment due. Medical necessity disputes

fall under §413.031(d) and (e); pursuant to these subsections, medical necessity disputes are resolved through use of an Independent Review Organization (IRO), and §413.032 establishes the minimum elements that must be included in an IRO decision. Additionally, §413.031(f) provides, "The commissioner by rule shall specify the appropriate dispute resolution process for disputes in which a claimant has paid for medical services and seeks reimbursement."

After the initial level of dispute resolution under §413.031(c), (d), (e), or (f), parties with an unresolved dispute are entitled to an administrative hearing. Section 413.0311 applies to disputes that have been through the initial process as set out in §413.031(b) through (i) and that involve 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 or an appeal of an IRO regarding determination of the retrospective medical necessity for a health care service for which the amount billed does not exceed $3,000. It provides for a hearing by a Division hearing officer under Labor Code Chapter 410, Subchapter D. Section 413.031(l) applies to a medical dispute regarding spinal surgery that remains unresolved after a review by an independent review organization as provided by subsections (d) and (e), and provides for dispute resolution as provided by Chapter 410. Section 413.031(k) applies to any dispute that does not fall under §413.0310 or §413.031(l), and provides for a SOAH hearing.

Proposed §140.8(h)

Comment: Commenter opines that the adopted language may actually cause more problems than it solves. For example, it may not be possible to get a release for all services in which case the proposed language could require the carrier to pay both parties. The commenter further states that the statute provides for a defense for payment and there are no requirements or limitations on that defense. The commenter recommends adding language that protects the workers' compensation carrier from paying more than the maximum payment allowed under §409.0091, and language that tracks the normal legal rule that the first in time has the rights.

Commenter recommends that §140.8(h) be limited to health care insurers as defined in §409.0091(a), a continuation of its premise that the rule should not confer on all subclaimants the party status that is only statutorily authorized for certain "health care insurer" subclaimants, as that term is defined in §409.0091(a) and recommends that §140.6(c) be moved to §140.7. The commenter specifically recommends that the Division rewrite §140.8(h) to add language that in no event may a workers' compensation insurance carrier be required to make payment above the maximum allowable reimbursement as set forth in the Texas Workers' Compensation Act and Division rules.

Agency Response: The Division does not agree with these comments. The Division sees a need to provide rules to meet these contingencies and does so within the authority of §409.0091(r). Payment of a bill is an absolute defense to a claim.

140.8(h)(1) & (h)(2)

Comment: Commenters assert that this subsection is outside the rulemaking authority of the Division because, under §409.0091(e), the defense that the carrier has already paid for the services has not been taken away by the Legislature. Further, the comments state that it is clear under §409.0091(g) and (h) that the workers' compensation insurance carrier will never have to pay for the services more than one time and that the maximum amount that the carrier will ever have to pay is "the lesser of the amount payable under the applicable fee guideline as of the date of service or the actual amount paid by the health care insurer." For those reasons, commenter recommends that §140.8(h)(1) should be amended to read, "In no event will the worker's compensation insurance carrier be required to make payment for the medical services individually or in the aggregate in an amount in excess of the maximum payment allowed under §409.0091(g) and (h)." Commenter recommends amending §140.8(h)(1) to read, "In no event will the worker's compensation insurance carrier be required to make payment for the medical services individually or in the aggregate in an amount in excess of the maximum payment allowed under §409.0091(g) and(h). Commenters recommend amending §140.8(h)(2) to read, "The first subclaimant in time

to file a dispute with the Division is the only subclaimant that has a right to dispute resolution and reimbursement for those specific services rendered."

Agency Response: The Division disagrees. The rule does not preclude the statutory defense of a prior payment for the medical care that is the subject of the reimbursement request. This subsection merely sets out a non-exclusive process to help those involved to decide which of the multiple entities attempting to collect payment for the same medical service should be paid.

General Comments

Comment: Commenter requests that the fiscal impact be revisited by getting specific information from the State Office of Risk Management, workers' compensation carriers, and other affected parties.

Commenter states that the rules as adopted will negatively impact injured employees because injured employees will lose control over their own claim and lose their due process rights when their claim can be adjudicated in their absence.

Commenter states the Division and workers' compensation insurance carriers will be negatively impacted by increased disputes where compensability has not been disputed by the injured employee or where the reimbursement request could have been paid if the workers' compensation insurance carrier had all the information to properly review the request. Workers' compensation insurance carriers will experience increased costs due to their inability to clarify whether the treatment was truly for the injury. In addition,

the commenter maintains that the rules allow subclaimant disputes to take unnecessary time and resources away from the workers' compensation's system's primary goal of getting the injured employee health care and income benefits.

Commenter states that the impact statement of the adopted rule indicates that subclaimant reimbursement requests will not take any more time to process than a medical bill. Commenter states workers' compensation insurance carriers have already experienced the processing of these requests, and they take much longer than a normal medical bill. The information provided is not in one place and in one format and is not on the standard form required for medical bills, which requires manual processing. Commenter states grandfathered claims involve archiving and labor to pull the files. Additionally, since some of the information required for many bill review systems is not required of these subclaimants, manual default codes must be inserted to allow the automated process in the bill review to move forward. Commenter asserts that the rule will result in additional costs and that the rule presupposes that it is not doing anything more than is required under the legislation and thus, if there is a cost, it is due to the legislation not to the rule.

Agency Response: The comment is directed more at the statutory requirements, rather than the rules. The rules are mere implementation of the mandate of the statute. The Division has no authority to study, alter, or delete statutory provisions without a statutory mandate. The Division sees no reason or basis to review the processing times and costs involved.

Comment: Commenter recommends, with no explanation, rewriting all of the adopted rules.

Agency Response: The Division declines to accept the revisions. Without an explanation of the reason and basis for the recommended changes to the rule language, the submission does not constitute a comment and the Division has nothing to which to respond.

Comment: Commenter states that the rules as proposed would allow a subclaimant to independently pursue issues of compensability, and this is potentially prejudicial to the interests of an injured employee. Commenter states that the proposed rules do not contain the appropriate safeguards to prevent such prejudice. Commenter asserts that the cited case of *Texas Mutual Ins. Co. v. Sonic Systems Int'l* rejected the subclaimant's position that §409.009 allows a party to seek reimbursement as a subclaimant and that a subclaimant's right to pursue recovery is wholly derivative of the injured employee's right. Commenter states that the proposed adopted rules do not in any way guarantee that an injured employee has, *in fact*, received notice of the hearing.

Agency Response: The Division disagrees. In any dispute the injured employee is required to be given notice at that injured employee's last known address of record. If the injured employee has an objection to the timing of the hearing, the injured employee may request a continuance. Historically, subclaimants have been allowed to file these

disputes without the participation under §409.009. New §140.6 affords safeguards for the injured employee that did not exist by rule before. The notice requirement in §140.8(d)(1)(E) requires the carrier to give its response to the reimbursement request to the injured employee and health care provider.

Comment: A comment requests that the Division withdraw the proposed rules, and re-propose language that is more closely aligned with the statutory language and legislative intent.

Agency Response: The Division is of the opinion that the rules as adopted, are aligned with the statutory language. The Division considers the rules to be necessary and appropriate implementation language for the statutory provisions. The Division does not agree there is a need to withdraw the proposed rules, nor does it think that public interest would be served in doing so.

Comment: A comment recommends the Division withdraw the adopted rules and re-propose rules with specific separate process for §409.009 and §409.0091 classes of subclaimants. The first rule should establish the rights and procedures as well as expectations of the different disputing parties who are parties to subclaimant disputes, whether they are under §409.009 or §409.0091 without mingling the rights of the parties that are separate and distinct and under separate sections of the statute. The second rule should focus on the process for subclaims that arise out of §409.009. The third rule

should focus on the process of §409.0091 claims. Further, disputes that remain after the IRO process and after the fee dispute process, should go to SOAH.

Agency Response: Section 140.8 of the adopted rule applies to §409.009 subclaimants. Section 140.7 and §140.8 apply to §409.0091 subclaimants. The Division disagrees that §409.0091 is the exclusive remedy for a §402.084(c-1) health care insurer. No such exclusive remedy language is contained in §409.0091. Additionally, §409.009 was not amended to exclude §402.084(c-1) health care insurers. Section 409.0091 allows a health care insurer to bring a claim which resulted from a data match, and limits the defenses available to a workers' compensation insurance carrier. Section 409.009 allows any person who has provided compensation, directly or indirectly, to or for an employee or beneficiary, and has sought and been refused reimbursement, to pursue dispute resolution.

The Division is of the opinion that the rules as adopted, are aligned with the statutory language. The Division considers the rules as necessary and appropriate implementation language for the statutory provisions. The Division does not agree there is a need to withdraw the proposed rules, nor does it think that public interest would be served in doing so.

In some instances, disputes arising from subclaimant claims will proceed to SOAH. Resolution of disputes is addressed in §409.0091(l) and (m). Section 409.0091(l) provides, in part, "Any dispute that arises from a failure to respond to or a reduction or denial of a request for reimbursement of services that form the basis of the

subclaim must go through the appropriate dispute resolution process under this subtitle and division rules." Section 409.0091(m) provides, in part, "Any dispute over the amount of medical benefits owed under this section, including medical necessity issues, shall be determined by medical dispute resolution under Labor Code §413.031 and §413.032."

Pursuant to these provisions, a fee dispute or a medical necessity dispute resulting from a request for reimbursement under §409.0091 should be resolved under the Division's medical dispute resolution process and §413.031 and §413.032. These sections provide the initial level of dispute resolution for fee disputes and medical necessity disputes.

Fee disputes fall under §413.031(c); pursuant to this section the Division has the role of resolving disputes over the amount of payment due. Medical necessity disputes fall under §413.031(d) and (e); pursuant to these subsections, medical necessity disputes are resolved through use of an Independent Review Organization (IRO), and §413.032 establishes the minimum elements that must be included in an IRO decision. Additionally, §413.031(f) provides, "The commissioner by rule shall specify the appropriate dispute resolution process for disputes in which a claimant has paid for medical services and seeks reimbursement."

After the initial level of dispute resolution under §413.031(c), (d), (e), or (f), parties with an unresolved dispute are entitled to an administrative hearing. Section 413.0311 applies to disputes that have been through the initial process as set out in

§413.031(b) through (i) and that involve 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 or an appeal of an IRO regarding determination of the retrospective medical necessity for a health care service for which the amount billed does not exceed $3,000. It provides for a hearing by a Division hearing officer under Labor Code Chapter 410, Subchapter D. Section 413.031(l) applies to a medical dispute regarding spinal surgery that remains unresolved after a review by an independent review organization as provided by subsections (d) and (e), and provides for dispute resolution as provided by Chapter 410. Section 413.031(k) applies to any dispute that does not fall under §413.0310 or §413.031(l), and provides for a SOAH hearing.

Comment: Commenter states subclaimants under §409.0091 should not be allowed to pursue compensability issues because §409.003 gives only a claimant the right to file a claim for benefits.

Agency Response: The Division disagrees. Section 409.009 gives the right to a subclaimant to file a claim. Without the right to enforce payment of its claim through the DWC statutory and rules provisions, the status of subclaimant under §409.009 would be meaningless. The authority of the Division to provide dispute resolution to subclaimants is fully discussed in the Reasoned Justification portion of this preamble.

Comment: Commenter states the proposal preamble did not address the statutory amendments to §408.027(d) which were enacted with the passage of HB 724. Commenter recommends the preamble include language to reference §408.027(d) because this statutory language is important in establishing the rights of subclaimants to reimbursement and dispute resolution.

Agency Response: The Division disagrees. The amendments to §408.027(d) reference a right to recovery under §§409.009 and 409.0091. No separate rules or preamble language is needed for §408.027(d).

Comment: Commenters assert that the proposal preamble states that the rules as proposed do not address the reimbursement provisions of certified Workers' Compensation Health Care Networks because those provisions are addressed in Chapter 1305 of the Texas Insurance Code.

Commenter states there is no statutory authority for this statement. Commenter asserts the language of §408.027(d) does not discriminate among claims served by networks and claims not served within networks. Commenters state that this statement may imply that adopted §§140.6 – 140.8 prevent a person from seeking reimbursement or dispute resolution for medical services paid by a person if that medical service should have been treated in a workers' compensation health care network had the medical service been originally identified as a workers' compensation benefit. Commenter recommends this statement be clarified because health care insurers should clearly

have the ability to seek recovery for health care services related to compensable injuries whether or not the services were provided within a network.

Agency Response: The Division clarifies that adopted §§140.6 – 140.8 does not prevent a person from seeking reimbursement or dispute resolution for medical services paid by the person when the individual to whom the medical service was provided was subject to treatment through a workers' compensation health care network. However, adopted §§140.6 – 140.8 also do not attempt to supplant the Insurance Code provisions in The Insurance Code Chapter 1305. Insurance Code §1305.003(b) provides in part: "In the event of a conflict between Title 5, Labor Code, and this chapter as to… the resolution of disputes regarding medical benefits provided through those networks, this chapter prevails." This provision is also contained in Labor Code section 408.031(b). Therefore, if a provision of the Labor Code Title 5 were to conflict with a provision of Insurance Code Chapter 1305, the Insurance Code Chapter 1305 would prevail. Based on this reasoning, the Division does not have statutory authority to adopt a rule under Title 5 of the Labor Code which is contrary to the Insurance Code Chapter 1305.

The Insurance Code §1305.006 provides: "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee: (1) emergency care; (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and (3) health care provided by an out-of-network provider pursuant to a referral from the

injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103." If a health care insurer believes it has a valid subclaim under the Labor Code §409.0091, it may request reimbursement and pursue dispute resolution. However, if the injured employee for whom the care was provided is subject to certified network requirements, the workers' compensation insurance carrier may not be liable for the health care unless the health care was provided by an in-network provider selected or assigned pursuant to the Insurance Code Chapter 1305 or unless the health care meets one of the three out-of-network exceptions listed in the Insurance Code §1305.006.

Comment: Commenter asserts that there is no statutory authority to limit §409.0091 to subclaimants "who have claims based on data matches with the Division." The commenter states §409.0091 applies to ALL "health care insurers" as that term is defined under specific Labor Code sections. The commenter also states §409.0091(b) states the section applies only to a request for reimbursement by a health care insurer and that there is no limitation stating that the section is ONLY applicable to a health care insurer who have claims based on data matches with the Division. Further, Section 11 of HB 724 states, "The changes made by this Act applies only to subclaims based on an injury that has not been denied for compensability or that has been determined by the division to be compensable". The commenter asserts §409.0091

creates a process applicable to a health care insurer regardless of whether the claim is identified through a data match under §402.084 or some other method.

Agency Response: Section 409.0091(n) states that "Except as provided by subsection (s), 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 §402.084(c-3)."

Section 409.0091(s) states that "On or after September 1, 2007, from information provided to a health care insurer before January 1, 2007, under §402.084(c-3), the health care insurer may file not later than March 1, 2008:

(1) a subclaim with the division under subsection (l) if a request for reimbursement has been presented and denied by a workers' compensation insurance carrier; or

(2) a request for reimbursement under subsection (f) if a request for reimbursement has not previously been presented and denied by the workers' compensation insurance carrier.

All of the filing deadlines in §409.0091 are tied to the date of a data match. Without a data match, there would be no basis to establish a filing deadline. Therefore, the Division has determined that §409.0091 only applies to cases where there is a data match under §402.084(c-3).

Comment: Commenter questions whether or not the Division will take enforcement action against the representatives of group health insurance companies who exhibit a pattern of practice of not complying with the statute and/or Division rules, e.g. repeatedly failing to appear at benefit review conferences and/or contested case hearings, filing frivolous subclaims, and routinely filing subclaims beyond filing deadlines. The commenter recommends the Division include language in the rule adoption preamble and adopted rules that gives notice of the fact that the agency will initiate enforcement action when it is determined that a pattern of practice exists.

Agency Response: All persons who violate the Texas Workers' Compensation Act or Commissioner rules are subject to enforcement action, as provided in the Act and the Rules. Parties that act in bad faith or that fraudulently make requests for reimbursement should be appropriately penalized, as permitted by the Labor Code; however, the Division disagrees that any modifications to this rule are required to provide for that. Existing statutes in Labor Code and current Division rules in Chapter 180 of this title, relating to Monitoring and Enforcement, already provide penalties for parties that act fraudulently or in bad faith.

Labor Code §415.002(a) provides that an insurance carrier or its representative commits an administrative violation if that person violates a commissioner rule or fails to comply with a provision of this the Workers' Compensation Act. Additionally, Labor Code §415.008 contains provisions making it a class B administrative violation to make a false or misleading statement; misrepresent or conceals material facts; fabricate, alter,

conceal, or destroy a document; or conspire to do one of these things; and Labor Code §415.008 makes it a class B administrative to bring, prosecute, or defend an action for benefits under the Workers' Compensation Act, or request initiation of an administrative violation proceeding that does not have a basis in fact or is not warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law.

Finally, §180.2 of this title (relating to Referrals) provides that, "Any person may make a referral to the commission: for fraudulent acts or omissions by any system participant; for failure of a health care provider to provide reasonable and necessary health care; for failure of an insurance carrier to ensure that all and only reasonable and necessary health care is approved and reimbursed in accordance with the Statute and Rules; or for other violations of the Statute or Rules by any system participant."

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

For, with changes: Medrecovery Management, The 4600 Texas Group, Texas Association of Health Plans.

Against: State Representative Burt Solomons, Insurance Council of Texas.

Neither For Nor Against, with changes: Zenith Insurance Company, American Insurance Association, Service Group Insurance Co., Flahive, Ogden & Latson, Pam Beachly, Office of Injured Employee Counsel, State Office of Risk Management, Texas Mutual Insurance Co.

6. STATUTORY AUTHORITY. The new sections are adopted under Labor Code §409.0091(l), which requires the commissioner of insurance and the commissioner of

workers' compensation to modify rules under this subtitle as necessary to allow the health care insurer access as a subclaimant to the appropriate dispute resolution process, recognize in the rules the status of a subclaimant as a party to the dispute, and to ensure that the workers' compensation insurance carrier is not penalized, including not being held responsible for costs of obtaining the additional information, if the workers' compensation insurance carrier denies payment in order to move to dispute resolution to obtain additional information to process the request; Labor Code §409.0091(o), which requires the commissioner of insurance and the commissioner of workers' compensation to amend or adopt rules to specify the process by which an employee who has paid for health care services described by Labor Code §408.027(d) may seek reimbursement; Labor Code §409.0091(r), which provides that the commissioner of insurance and the commissioner of workers' compensation may adopt additional rules to clarify the processes required by, fulfill the purpose of, or assist the parties in the proper adjudication of subclaims under this section; Labor Code §413.031 provides for procedures for medical dispute resolution; 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 §402.061 provides that the Commissioner of Workers' Compensation has the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act; Labor Code §408.021 entitles an injured employee who sustains a compensable injury to all health care reasonably required by the nature of

the injury as and when needed; Labor Code §413.013 requires the Division by rule to establish programs related to health care treatments and services for dispute resolution, monitoring, and review; Labor Code §413.015 requires insurance carriers to pay charges for medical services as provided in the statute and requires that the Division ensure compliance with the medical policies and fee guidelines through audit and review; Labor Code §413.016 provides for refund of payments made in violation of the medical policies and fee guidelines.

7. TEXT.

§140.6. Subclaimant Status: Establishment, Rights, and Procedures.

(a) Applicability. This section is applicable to a subclaim pursued under Labor Code §409.009, including a subclaim pursued by a health care insurer.

(b) Party status. A subclaimant as described in §409.009 is a party to a claim concerning workers' compensation benefits.

(c) Rights in Relation to the Injured Employee.

(1) A subclaimant may file and pursue a claim for reimbursement of a benefit that has been provided to an injured employee, and is entitled to appropriate dispute resolution in accordance with the Texas Workers' Compensation Act (Act) and Division of Workers' Compensation (Division) rules.

(2) A subclaimant may pursue a claim for reimbursement of a benefit that has been provided to an injured employee and participate in the dispute resolution process without the participation of the injured employee if:

(A) there is no prior written agreement between the injured employee and the workers' compensation insurance carrier or no final decision by the Division on the issue in dispute;

(B) the workers' compensation insurance carrier has denied the entitlement to benefits under the Act and Division rules;

(C) the injured employee is not pursuing dispute resolution to establish the injured employee's entitlement to benefits with reasonable diligence; and

(D) the subclaimant has provided the injured employee with written notice of:

(i) subclaimant's intent to pursue a claim for reimbursement of a benefit;

(ii) warning that a decision rendered may be binding against the injured employee; and

(iii) contact information for the Office of the Injured Employee Counsel.

(3) At a contested case hearing without the participation of the injured employee, the subclaimant must show, in addition to other facts:

(A) subclaimant provided written notice to the injured employee as specified in paragraph (2)(D) of this subsection;

(B) it has contacted the injured employee and the injured employee is not pursuing the dispute with reasonable diligence; or

(C) it has been unable to contact the injured employee through the exercise of reasonable diligence.

(d) Claims for Reimbursement of Medical Benefits.

(1) Subclaimants, other than subclaimants described in §409.0091, must pursue a claim for reimbursement of medical benefits and participate in medical dispute resolution in the same manner as an injured employee or in the same manner as a health care provider, as appropriate, under Chapters 133 and 134 of this title (relating to General Medical Provisions and Benefits-Guidelines for Medical Services, Charges and Payments).

(2) A health care insurer subclaimant must submit a reimbursement request in the form/format and manner prescribed by the Division and must contain all the required elements listed on the form.

(3) Workers' compensation insurance carriers must process reimbursement requests from subclaimants pursuant to Chapters 133 and 134 of this title.

(e) Contested Case Hearing. A subclaimant may pursue a contested case hearing under the provisions of Chapters 140 - 143 of this title (relating to Dispute Resolution).

§140.7. Health Care Insurer Reimbursement under Labor Code §409.0091.

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

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

(c) Reimbursement of Health Care Insurers. A health care insurer may be reimbursed for medical benefits provided to or paid on behalf of an injured employee with a compensable workers' compensation claim in accordance with Labor Code §409.0091, the procedures of §140.8 of this title (relating to Procedures for Health Care Insurers to Pursue Reimbursement of Medical Benefits under Labor Code §409.0091), and this section.

(d) Certain Defenses Not Allowed. A workers' compensation insurance carrier shall not deny a reimbursement request under Labor Code §409.0091 from a health care insurer because:

(1) the health care insurer has not sought reimbursement from the health care provider or the health care insurer's insured;

(2) the health care insurer or the health care provider did not request preauthorization under §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) or Labor Code §413.014; or

(3) the health care provider did not bill the workers' compensation insurance carrier, as provided by Labor Code §408.027, before the 95th day after the date the health care for which the health care insurer paid was provided.

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

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

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

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

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

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

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

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

(2) Request for Additional Information. The workers' compensation insurance carrier may request additional information from the health care insurer if there is not sufficient information to substantiate the claim. The health care insurer has 30 days after receiving the request for more information to provide the information requested to the workers' compensation insurance carrier. Any request for additional information shall be in writing, be relevant and necessary for the resolution of the request. A workers' compensation insurance carrier shall not be penalized, including not being held responsible for costs of obtaining the additional information, if the workers' compensation insurance carrier denies payment in order to move to dispute resolution to obtain additional information to process the request. It is the health care insurer's obligation to furnish its authorized representatives with any information necessary for the resolution of a reimbursement request. The Division considers any medical billing information or documentation possessed by the health care insurer or one of its authorized representatives to be simultaneously possessed by the health care insurer and all of its authorized representatives.

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

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

(1) Paying or Reducing Payment.

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

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

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

(B) If No Fee Guideline. In the absence of a Division fee guideline for a specific service paid, the amount per service paid by the health care insurer shall be considered in determining a fair and reasonable payment pursuant to §134.1 of this title (relating to Medical Reimbursement).

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

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

reduction in reimbursement, the workers' compensation insurance carrier shall provide evidence of the previous payments made to the health care provider.

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

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

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

The EOB must provide sufficient explanation regarding the basis for a denial of the reimbursement request.

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

(g) Filing Notice of Subclaimant Status.

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

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

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

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

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

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

(1) Claim or Treatment Not Compensable.

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

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

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

(2) Lack of Medical Necessity.

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

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

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

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

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

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

(3) Reduction, Denial or Failure to Respond.

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

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

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

(B) A medical dispute based on the workers' compensation insurance carrier's failure to respond to a health care insurer's reimbursement request or the result of a reduction or denial of the requested reimbursement amount for reasons other than those listed in paragraph (1) or (2) of this subsection is subject to medical dispute resolution pursuant to §133.307 of this title, notwithstanding the definition of medical fee dispute in §133.305 of this title (relating to MDR - General), and the health care insurer must follow the medical fee dispute resolution process allowed for a health care provider under that section, with any modifications specified by this subsection.

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

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

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

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

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

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

8. CERTIFICATION

This agency certifies that the adopted sections 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.

_____
Stan Strickland, Deputy Commissioner
Legal Services
Texas Department of Insurance
Division of Workers' Compensation

IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that new §140.6 concerning Subclaimant Status: Establishment, Rights, and Procedures, new §140.7 concerning Health Care Insurer Reimbursement Under Texas Labor Code §409.0091, and new §140.8 concerning Procedures for Health Care Insurers to Pursue Reimbursement of Medical Benefits.

AND IT IS SO ORDERED.

_____
ALBERT BETTS
COMMISSIONER OF WORKERS' COMPENSATION

ATTEST:

_____
Stan Strickland, Deputy Commissioner
Texas Department of Insurance
Division of Workers' Compensation
Legal Services

COMMISSIONER'S ORDER NO._____