

**SUBCHAPTER D. Dispute of Medical Bills**  
**28 TAC §§133.305, 133.307, and 133.308**

**1. INTRODUCTION.** The Commissioner of the Division of Workers' Compensation, Texas Department of Insurance, adopts new §§133.305, 133.307, and 133.308, concerning medical dispute resolution (MDR). The sections are adopted with changes to the proposed text published in the June 23, 2006 issue of the *Texas Register* (31 TexReg 5044).

**2. REASONED JUSTIFICATION.** These sections are necessary to: implement statutory provisions of House Bill (HB) 7, enacted by the 79th Legislature, Regular Session, effective September 1, 2005; address the merger of two agencies with similar purposes and processes; and improve efficiencies within the MDR process.

Sections 133.305, 133.307, and 133.308 are necessary to implement HB 7 amendments to Labor Code §413.031 and new Labor Code §413.032 to conform the MDR process for medical disputes arising from non-network care or from certain authorized out-of-network care with the overall stated system aims of HB 7 as provided in Labor Code §402.021 (b)(3) – (9). HB 7 amended Labor Code §408.027 relating to payment of health care providers and added Labor Code §408.0271 relating to reimbursement by health care provider. The sections are necessary to implement and clarify the changes to the Labor Code regarding payment and reimbursement that affect the dispute resolution process. HB 7 also added §413.0111 to the Labor Code relating

to processing agents. The sections are necessary to implement the provisions of Labor Code §413.0111 and establish requirements and procedures for pharmacies to use pharmacy processing agents or assignees to process claims under the terms and conditions agreed on by the pharmacies. Additionally, the sections implement HB 7 amendments to Labor Code §413.031 regarding independent review organization (IROs) and implement new Labor Code §413.032 regarding IRO decisions and appeals. The sections establish the binding effect of IRO decisions, specify elements of the IRO decision, and institute quality monitoring of IROs. HB 7 further provides direct judicial review for an appeal from an IRO or from the Division, thus removing the State Office of Administrative Hearings (SOAH) layer from the MDR process. These HB 7 changes to the MDR process are implemented in the sections. The Commissioner also adopts the simultaneous repeal of existing §§133.305, 133.307, and 133.308, published elsewhere in this issue of the *Texas Register*.

The Division posted an informal draft of the new sections relating to MDR on February 13, 2006 and invited public input, which included a stakeholder meeting on March 9, 2006. Following publication of the proposed new sections in the *Texas Register* on June 23, 2006, the Division held a public hearing on July 26, 2006, and received comments suggesting changes to the proposed sections. In response to comments made at the hearing and written comments from interested parties, the Commissioner is adopting these sections with some changes to the proposal as published. Throughout the adopted rule, the Division has made editorial and

grammatical changes to the rule, as proposed, for clarity. The Division also updated references to the Insurance Code throughout the rule as the result of the enactment of the nonsubstantive revision of the Insurance Code by the 79th Legislature, Regular Session, HB 2017, which are effective April 1, 2007. The adopted sections should be read in conjunction with Labor Code §§413.031 and 413.032, and other statutes and rules as applicable.

**§133.305.** In subsection (a)(1), as adopted, the Division has added a definition of *adverse determination* for clarification that MDR intake requires a sufficient method, which meets the definition of *adverse determination*, to determine that an issue of medical necessity exists and dismiss the request for resolution of fee disputes. In response to a comment that a definition of *life-threatening condition* should be added to the definitions, the Division has added a definition of *life-threatening* in subsection (a)(2), as adopted, that mirrors the definition in Insurance Code Article 21.58A, §2(12). In response to a comment that Labor Code §413.0111 does not confer health care provider status on pharmacy processing agents and concern that §133.308(e)(1) unintentionally assigned such status, the Division has revised the references to pharmacy processing agents in §§133.305(a)(2)(A) ((a)(4)(A) as adopted), 133.307(b)(1), and 133.308(e)(1) by adding the words *or a* after the word *provider* and deleting the words *which includes* or *including* before the term *pharmacy processing agent(s)*. In subsection (a)(2)(B) ((a)(4)(B) as adopted), in response to a comment to clarify when an employee may request MDR, the words *a carrier* have been deleted to

clarify that an injured employee may request MDR when a carrier or a health care provider denies the injured employee's refund request. In subsection (a)(2)(C) ((a)(4)(C) as adopted) and §133.307(b)(2), in response to comments, the words *or carrier* were added after the words *a Division* and before the word *audit* to clarify that an insurance carrier, in addition to the Division, may request a health care provider refund after a carrier audit or review pursuant to Labor Code §408.0271. In response to a comment that the definition of *network health care* conflicts with 28 TAC §§10.102(i), 10.103(a)(4)(B)(iv), and 10.104(a)(2), the Division has revised subsection (a)(3) and (4), ((a)(5) and (6) as adopted) by adding the words *or arranged* to clarify that such networks may contract to provide health care. Subsection (a)(3) ((a)(5) as adopted) has also been revised by adding the words *including authorized out-of-network care* before the words *health care network* and *as defined* to clarify that *network health care* includes authorized out-of-network health care. In response to a comment regarding the processing of medical necessity and compensability related disputes prior to resolution of fee disputes, the Division has rewritten the language in subsection (b) to clarify that dispute resolution for compensability, extent of injury, liability, and/or medical necessity must be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021. In subsection (c)(4), in response to comments asserting that the Division has no jurisdiction to adjudicate contract disputes between parties, regardless of whether hidden discounts exist, the Division has deleted the phrase *indicating a contracted discount rate with the*

*provider and has provided* and added the words *based on* between the words *denied payment* and *a contract*. In the same subsection, the phrase *in accordance with Insurance Code Chapter 1305* has been added after the words *workers' compensation health care network* to clarify that workers' compensation networks must be certified under Insurance Code Chapter 1305. In response to comments that the language in subsection (d) was too broad and would require the redaction of contact information for persons who may have relevant information relating to the dispute, the Division has revised the language by deleting the word *confidential* between the word *contains* and the word *information*, deleting the phrase *or a party in the dispute*, and substituting the word *patient* for the word *person* and the words *that patient* for the words *the person* to appropriately narrow the scope of the subsection. In response to several comments that question the constitutionality of the removal by HB 7 of the SOAH from the MDR appeal process, the Division has added a severability clause in new subsection (e), which provides that if a court of competent jurisdiction holds that any provision of §§133.305, 133.307, and 133.308 is inconsistent with any of the statutes of the state, are declared unconstitutional, or are invalid for any reason, the remaining sections would still be effective. The constitutionality of Labor Code §413.031(k), from which the statutory basis of these rules is derived, is currently being litigated. If a court of competent jurisdiction were to declare Labor Code §413.031(k) and provisions of these rules that implement §413.031(k) unconstitutional, then the provisions unaffected by a court's decision would be valid.

**§133.307.** In proposed subsection (a), the Division has revised the effective date from September 1, 2006 to January 15, 2007, to give both the Division and stakeholders adequate time to prepare for the changes in procedure to the MDR rules and process. In response to comments that subsection (c)(1) was confusing and a comment that the timeframe to request a refund notice of 20 days, as proposed, was not long enough, the Division has revised the timeframe for filing a refund notice from 20 days, as proposed, to 60 days and has revised the subsection for further clarification. In subsection (c)(2)(D), in response to a comment that if a carrier denies payment on the basis of compensability, then other threshold issues may not be addressed and it may be necessary for the carrier to enter additional reasons into the record as part of the MDR process, the Division has added the word *liability* after the words *extent of injury* and before the words *and/or medical necessity*. In subsection (c)(2)(E), the Division agreed to clarify and added the word *applicable* before the words *medical records* in response to a comment requesting that the Division explain that only those medical records in possession of the health care provider are required. In response to a comment to clarify when an employee may need to request MDR, subsection (c)(3) has been changed to clarify that an injured employee may request MDR when a carrier or a health care provider denies the injured employee's refund or reimbursement request. In subsection (c)(4), in response to a comment that along with the request, the Division will provide a copy of all documentation submitted in support of the request, the Division has added the phrase *and the documentation submitted in accordance with paragraphs*

(2) and (3) of this subsection after the words *the request* and before the words *to the respondent*. In subsection (d), the words *to request* have been changed to *to a request for*, for clarification and readability. In subsection (d)(1), the word *calendar* has been added in two instances to clarify that *14 days* means *14 calendar days* in response to comments requesting clarification of the time frame. In subsection (d)(2)(A)(iii), the Division has added the words *not already provided by the requestor* after the words *the fee dispute*, in response to comments that the subsection be modified to require that the responding party only include medical records or documents provided by the requestor in the original request because there is no reason to make both parties file identical records and documentation. The Division revised subsection (d)(2)(B) by deleting the sentence that states "[r]esponses shall not address new or additional denial reasons or defenses after the filing of a request," and adding the sentence that states "[i]f the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MDR will be dismissed in accordance with subsection (e)(3)(G) and (H) of this section." These changes will allow a carrier to submit a subsequent response when a final decision is rendered regarding threshold issues such as compensability, extent of injury, liability, and medical necessity, in response to several comments that the language be changed to allow a carrier to provide additional evidence to support the reason for reduction or denial of payment. In subsection (d)(2)(C), a commenter requested that the language be revised to require the carrier to submit a written statement that the carrier did not receive information relevant to the

dispute prior to the MDR request and to clarify whether an affidavit or written statement is required. In response to this comment, the Division has revised subparagraph (C) by deleting the words *so certify when the carrier files the request form with* and substituting the words *include that information in a written statement in the response the carrier submits to* to allow the carrier to submit a written statement indicating the carrier has not received the information prior to the MDR request. In subsection (d)(2)(D), the Division added the words *medical fee* before *dispute* and the words *or liability* have been added after the words *extent of injury* and the words *has not been resolved and 11 (PLN 11)* have been deleted for clarification. Also, the Division has added subsection (d)(2)(E), which states "[i]f the medical fee dispute involves medical necessity issues, the carrier shall attach a copy of documentation that supports an adverse determination in accordance with §19.2005...." This change clarifies that MDR intake requires sufficient documentation, which meets the definition of *adverse determination*, to determine that an issue of medical necessity exists and dismiss the request for resolution of medical fee dispute. In subsection (e)(1), the Division has added the sentence that states "[t]he Division shall forward any additional information received by the parties," for clarification. The Division has deleted subsection (e)(2) and moved rule language to adopted subsection (e)(3)(H) based upon a comment that requested the dismissal of medical fee disputes involving compensability, extent of injury, or liability, instead of providing for the abatement of medical fee disputes, to avoid a pending status and allow the opportunity to refile and start the fee dispute process. This is also

consistent with the dismissals of medical fee disputes involving medical necessity issues. The Division renumbered subsection (e)(3) ((e)(2) as adopted), (e)(4) ((e)(3) as adopted), (e)(5) ((e)(4) as adopted), and (e)(6) ((e)(5) as adopted), accordingly. In subsection (e)(4)(F) ((e)(3)(F) as adopted) the language *pursuant to a private contractual fee arrangement* has been substituted for the words *to an employee by a network provider subject to Insurance Code Chapter 1305*; or for consistency with the change to §133.305(c)(4) made in response to a comment that the Division has no jurisdiction to adjudicate contract disputes between private parties. In subsection (e)(3)(G), the word *if* has been deleted as unnecessary and for consistency with the other subparagraphs and the words *adverse determination of* have been added before the words *medical necessity* for clarification. In subsection (e)(3)(H), the Division has deleted proposed language that indicated the Division may dismiss a request for MDR involving contract rates not pertaining to networks certified under Insurance Code Chapter 1305 because the provision would be duplicative of adopted subsection (e)(3)(F). Adopted subsection (e)(3)(H) incorporates the provision of deleted proposed subsection (e)(2) and provides for the dismissal of medical fee disputes involving related disputes pertaining to compensability, extent of injury, or liability for the claim, which have not been resolved. In subsection (e)(5) ((e)(4) as adopted), the words *and to representatives of record for the parties* have been added in response to a few commenters who requested that the Division send the fee dispute decision to the parties' representatives, as well as to the parties to the dispute. In subsection (f), the

Division has added the sentence that states "[t]he Division and the Department are not considered to be parties to the medical dispute pursuant to Labor Code §413.031(k)," in response to comments that the proposed rule does not provide for an evidentiary hearing and to clarify the statutory provision.

**§133.308.** In proposed subsection (a), the Division has revised the effective date from September 1, 2006 to January 15, 2007, to give both the Division and stakeholders adequate time to prepare for the changes in procedure to the MDR rules and process. Also in subsection (a), in response to a few comments that §133.309 is subject to pending litigation and may be rendered invalid, the Division revised the reference from §133.309 to Labor Code §413.031(n) and related rules. The Division has rewritten subsection (e) for clarification and for consistency with other sections that distinguish network versus non-network disputes, as well as in response to a commenter who questioned why the proposed subsection, (e)(3) specifically, excluded non-network employees from medical necessity disputes. The revised subsection states who may be considered requestors in network disputes in (e)(1): in (A), providers, or qualified pharmacy processing agents acting on behalf of a pharmacy, for preauthorization, concurrent, and retrospective medical necessity dispute resolution; and in (B), employees for preauthorization, concurrent, and retrospective medical necessity dispute resolution. The revised subsection states who may be considered requestors in non-network disputes in (e)(2): in (A), providers, or qualified pharmacy processing agents acting on behalf of a pharmacy, for preauthorization, concurrent, and retrospective

medical necessity dispute resolution; and in (B), employees for preauthorization and concurrent medical necessity dispute resolution; and for retrospective medical necessity dispute resolution when reimbursement was denied for health care paid by the employee. In response to a comment regarding the 45-day timeframe, the Division has revised the text of subsection (g) by inserting the word *calendar* after *45th* and before *day* and inserting the words *receipt of* after the words *day after* and before the words *the denial of reconsideration* to address the commenter's concern. Also in subsection (g), the Division has deleted the reference to *Insurance Code Article 21.58A*, and has inserted the phrase *§133.305 of this subchapter*, to reference the definition of *life-threatening* that the Division added in §133.305(a)(2). In response to a comment that subsection (h)(3) be revised to state that a requestor does not have to seek reconsideration of a determination on a life-threatening condition prior to seeking an IRO determination, the Division has revised the paragraph by adding the words *involving a life-threatening condition* between the words *dispute* and *has not been submitted*. In subsection (k)(1), in response to a comment that the paragraph be revised to indicate what constitutes a provider as a party to the dispute, the Division has added the words *or providers with relevant records* between the words *the party* and *shall deliver*. In subsection (n), the words *and to representatives of record for the parties* were added between the words *the parties* and *and transmitted* for clarification of to whom the IRO decision will be mailed or transmitted. In subsection (n), the Division has also revised the language by deleting the words *by facsimile to* and adding

the words *in the form and manner prescribed by* between the words *transmitted* and *the Department* to provide the Department with the flexibility to adapt new technology, such as, for example, email transmission of decisions, in order to improve the efficiency of the IRO process. In response to several comments requesting that subsection (o) be revised to allow a carrier to use a peer review report for subsequent denials of the same claim, the Division has added the words *health care services subsequently reviewed for that compensable injury* after the words *denials of the same* and deleted the word *claim* to provide clarification and appropriately narrow the scope of the subsection. Also in response to the same comments, the Division has revised the catchline of the subsection by adding the words *Peer Review Report after an*, between the words *Carrier Use of* and *IRO Decision*, to reflect the changes made to the text. In subsection (p)(8), the title (*relating to MDR - General*) was deleted and the words *of this subchapter* were inserted to conform to *Texas Register* format. In subsection (r)(2), the Division inserted the word *including* after the words *making the decision*, in response to a comment that the appellate record should include all documents submitted to the IRO by either party and all documents reviewed by the IRO during the dispute to clarify that subparagraphs (r)(2)(A) - (r)(2)(J) do not enumerate all the items that could be included in the record. In subsection (t), the language (*relating to MDR - General and MDR of Fee Disputes*) was deleted and the words (*relating to MDR of Fee Disputes*) were inserted to correct the reference.

**3. HOW THE SECTIONS WILL FUNCTION.** Section 133.305 outlines the general requirements of the MDR process. The section defines terms relevant to MDR, including *network health care* and *non-network health care*. The section uses *preauthorization or concurrent* for consistency with the use of those terms in Insurance Code Article 21.58A and related rules. The section sets forth the dispute sequence for resolving medical dispute issues, and requires all issues of compensability, extent of injury, liability and medical necessity to be resolved before a medical fee dispute can be processed. The section also establishes circumstances in which the Division may assess administrative fees, sets out requirements for redacting confidential information, and provides for the severability of any clauses a court may strike down so that the remaining provisions are still effective.

Section 133.307 establishes the new MDR process for resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury. This section applies to certain authorized out-of-network care not subject to a fee contract, as well as to non-network health care. The section specifies who can be a requestor, the manner in which requests must be made, and the time requirements that govern requests. The request for medical fee dispute resolution shall be filed not later than one year after the date of service in dispute, unless issues of compensability, extent of injury, liability and medical necessity exist. Section 133.307 allows a requestor access to MDR to resolve a fee dispute for which issues of compensability, extent of injury, liability and/or medical

necessity have been finally determined through dispute resolution regardless of the date of service, if the submission of the request for MDR is within 60 days of the final determination.

Section 133.307 outlines the following three steps for resolving fee disputes. First, the requestor is required to present all information necessary to resolve the dispute upon the initial request for dispute resolution. The Division will notify the respondent of the dispute by providing a copy of all the information submitted by the requestor. Second, in response to the dispute, the section requires the respondent, most often the carrier, to provide all information required by this section, including any missing explanation of benefits that may identify outstanding compensability, extent of injury, liability, medical necessity, or fee issues. If compensability, extent of injury, liability and/or medical necessity issues are identified, the fee dispute request will be dismissed until the issue is resolved. Third, the section provides that the Division may request additional information from the disputing parties and may raise new issues in the MDR process. The section also sets forth the reasons that justify dismissing a request for dispute resolution.

The section provides that aggrieved parties who disagree with the decision may seek judicial review of the decision by filing a petition in a Travis County district court. The section outlines the appropriate appeals process for parties to MDR seeking judicial review, the process for preparing a record for appeal of an MDR decision, and the

contents of the record. The section also explains the Division's assessment of expenses for preparing the record.

Section 133.308 provides the process for the review of network and non-network preauthorization, concurrent or retrospective medical necessity disputes. The section specifies who can be a requestor, the manner in which requests must be made, and the time requirements that govern requests. The section also states the process for IRO assignment and carrier document submission. The section establishes IRO fees and corresponding time limits for payment along with the consequences of case dismissal in the event of non-compliance with the section. Further, the section addresses the process for an IRO to request a designated doctor exam. The time frames for IRO decisions are set forth, as well as the required contents of the IRO decision. The section provides that the IRO is responsible for determining the prevailing party and compiling the appellate record in the case of judicial review. The process of appealing IRO decisions is outlined in the section. IRO decisions are not agency decisions, and the Department and the Division are not parties to any such appeals. Both network and non-network appeals processes are detailed, as well as those for appeals of non-network spinal surgery. The section also addresses who will pay the costs for the appeal.

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

**General:** A commenter approves of the proposed rules, appreciates the opportunity to provide feedback regarding medical billing disputes, and thanks the Division for soliciting input from stakeholders prior to proposing the rules.

**Agency Response:** The Division appreciates the commenter's support.

**General:** A commenter states that the Texas Legislature passed HB 2600 and HB 7, in large part, because the size and the diversity of the state make access to pharmacy care a serious concern, particularly in rural areas of the state.

**Agency Response:** The Division understands the commenter's concerns about access to pharmacy care and has incorporated references to pharmacy processing agents in the sections.

**General:** A commenter does not recognize any language in the proposed rules that addresses the merger of the IRO processes of the Department and the Division. The commenter asks several related questions including: (1) whether IRO requests of the Department will be processed as pre-HB 7 reviews; (2) whether the Health and Workers' Compensation Network and Quality Assurance Division will include the Department's request for the IRO; and (3) whether IROs now come under the Division of Workers' Compensation.

**Agency Response:** The effective date for the transition of Division IRO processes to the Department is anticipated to be January 15, 2007, which is specified in §§133.307(a) and 133.308(a). IRO assignments previously handled by the Division will

transfer to the Health and Workers' Compensation Health Care Network and Quality Assurance Division at that time. The Division provides clarification by adding a definition for the term *adverse determination* to §133.305(a), which is consistent with the Department's utilization review agent rules and also provides consistency within the MDR process.

**General:** A commenter states that to facilitate a quality IRO review, the requesting forms need to be completely and accurately completed because failure to do so may result in a high level of incomplete and inaccurate data, which could have a deleterious effect on the quality of the resultant review.

**Agency Response:** The Division expects that parties requesting independent review will make a good faith effort to complete all of the necessary information. Additionally, the online submission form is programmed with required fields that must be completed in order to be submitted.

**General:** A commenter respectfully requests that the rule be amended to provide for one of two options: (1) an administrative hearing presided over by State Office of Administrative Hearings (SOAH) administrative law judges who specialize in hearings held to resolve medical necessity and payment disputes; or (2) an administrative hearing presided over by Division hearing officers who specialize in hearings held to resolve all medical disputes (medical necessity and payment disputes). The

commenter is concerned that the MDR process lacks an administrative hearing and an opportunity for the disputing parties to build a record that includes the presentation of evidence and witnesses, as well as the cross-examination of witnesses presented by health care providers and injured employees. Members of the commenter's association are concerned about the lack of an agency record for appeals of IRO and Division medical fee dispute decisions to district court. Another commenter requests that dispute resolution be conducted under the provisions of the Administrative Procedure Act so that the decisions of the Division will not be based solely on unverified documents filed by parties to the dispute. According to the commenter, failure of the agency to conduct the review and hearing of the request in the manner described in these provisions would result in a violation of the division's statutory duty and a denial of fundamental due process guaranteed to the commenter by the Texas Constitution and the U.S. Constitution. Another commenter states that the opportunity for a hearing before a SOAH administrative law judge has been lost now for almost a year and thinks that everybody that participates in the system has now recognized that this is not good for the system.

**Agency Response:** The Division disagrees with the commenter that it has the statutory authority to make the requested change. HB 7, §8.013(b) states that "[e]ffective September 1, 2005, the State Office of Administrative hearings may not accept for hearing a medical dispute that remains unresolved pursuant to Section 413.031, Labor Code. A medical dispute that is not pending for a hearing by the State

Office of Administrative Hearings on or before August 31, 2005, is subject to subsection (k), Section 413.031, Labor Code, as amended by this Act, and is not subject to a hearing before the State Office of Administrative Hearings." Labor Code §413.031(k) does not provide the Division with the authority to create a system for administrative appeals of medical disputes prior to judicial review. Labor Code §401.021 and §408.027(e) do not require hearings for medical fee disputes. Labor Code §401.021 provides that only certain specified provisions of the Texas Administrative Procedures Act are applicable to "a proceeding" under the Texas Workers' Compensation Act due to the language of the statute "except as otherwise provided by . . . [that Act]" and HB 7 specifically removed the language in §413.031 both for an entitlement to a hearing and for a contested case hearing at the SOAH for medical fee and necessity disputes. Labor Code §408.027(e) does not apply because a hearing should not be implied in §413.031 when the entitlement to a hearing has been specifically deleted and because the more recent and specific provisions of HB 7 are properly regarded as an exception to the earlier and more general language. The Division disagrees that the MDR process lacks an opportunity for disputing parties to build a record because §133.307(f) and §133.308(r) provide each party to a dispute with a meaningful opportunity to be heard in an informal adjudication or informal decision making process, prior to any court's review of the dispute. A party may provide documentation and explanation to support its position and to dispute or reject the position and information provided by another party to the dispute. Each decision contains a listing of the information

submitted by each party and the rationale and basis for the decision. The Division and its predecessor agency have utilized informal adjudications to finally resolve numerous medical disputes for many years. Finally, the rule provides that a certified copy of the record of the dispute, all relevant documentation submitted for MDR, and the decision will be made available for any judicial review. Texas courts have affirmed that certain informal adjudications satisfy constitutional due process requirements. See, for example, *Bell v. Tex. Workers' Comp. Comm'n*, 102 S.W.3d 29, 303-306 (Tex. App. – Austin, 2003, no pet). Recent federal appellate court decisions have expanded the constitutional use of informal adjudications involving largely policy decisions and legislative facts. They have upheld the use of substantial evidence review for informal adjudications and have set strict requirements before additional due process, such as a formal evidentiary hearing, is required. See, for example, *Continental Air Lines, Inc. v. Dole*, 784 F.2d 1245 (5th Cir. 1986); *National tower, LLC v. Plainville Zoning Bd. Of Appeals*, 297 F.3d 14, 20-21 (1st Cir. 2002); and *Cascade Natural Gas. Corp. v. Fed. Energy Reg. Comm'n*, 955 F.2d 1412, 1425-26 (10th Cir. 1992). Judicial review is available after the informal adjudication occurs and, also, provides constitutional due process. *Lujan v. G&G Fire Sprinklers, Inc.*, 532 U.S. 189, 197 (2001). In this manner, the procedural processes provided in these rules conform to the constitutional due process requirements.

**General:** A commenter recommends the Division require, within the rules, a written

explanation of any denials or reductions in payment for each line item on the explanation of benefits (EOB) because physicians will not understand the exception codes which are not mentioned in this rule and which have increased in number and all the different meanings associated with these codes may cause unnecessary disputes.

**Agency Response:** The Division disagrees with the commenter that it is necessary to amend the rules. Labor Code §408.027(e) requires that an insurance carrier send to the Division, the health care provider, and the injured employee a report that sufficiently explains the reasons for the reduction or denial of payment for health care services provided to the employee.

**General:** A commenter recommends a time limit be placed on a carrier to request a refund based upon the rationale that carriers have in years past requested refunds from physicians years after the services were provided.

**Agency Response:** The Division disagrees that these rules need to establish a timeframe to request refunds as §133.260 establishes the process and timeframes for carriers to request refunds. Labor Code §408.0271(a) provides that if the health care services provided to an injured employee are determined by the carrier to be inappropriate, then the carrier shall: (1) notify the health care provider in writing of the carrier's decision; and (2) demand a refund by the provider of the portion of payment on the claim that was received by the health care provider for the inappropriate services.

**§133.305(a):** A commenter states that instead of referencing the definition of *life-threatening condition* listed in Insurance Code Article 21.58A, a definition for the term should be included in the definitions section of the adopted rule because many providers do not have copies of the Insurance Code available to reference.

**Agency Response:** The Division agrees with the commenter and has added a definition of *life-threatening* in subsection (a)(2), as adopted, consistent with the definition contained in Insurance Code Article 21.58A. In conjunction with this change, the Division has also corrected the reference in §133.308(g) by deleting the words *Insurance Code Article 21.58A* and adding the words *§133.305 of this subchapter*.

**§133.305(a)(2)(A):** A commenter supports specific references to Labor Code §413.0111, which authorizes pharmacies to use agents to process claims, under proposed §133.305 and §133.307 as legitimate requestors and parties to disputes involving reimbursement of pharmacy related medical bills. Another commenter further states this provision is not sufficient in assisting injured employees in obtaining their medications or in assisting pharmacy agents' ability to collect reimbursement.

**Agency Response:** Labor Code §413.0111 allows pharmacy processing agents who demonstrate that they are authorized by a pharmacy to act on its behalf, to participate in the MDR process. This expands access to the MDR process to pharmacy processing agents granting participation that was not previously available to them. The definition of *medical fee dispute* in proposed (a)(2)(A) ((a)(4)(A) as adopted) includes a qualified

pharmacy processing agent's dispute of a carrier's reduction or denial of a bill as a type of dispute, as intended by Labor Code §402.021(a)(2) and allowed by Labor Code §413.031. However, subsection (a)(2)(A) ((a)(4)(A) as adopted) has been changed to clarify that a pharmacy processing agent is not considered to be a health care provider.

**§133.305(a)(2)(A):** A commenter requests clarification on what entities are considered to be *qualified pharmacy agents*.

**Agency Response:** The Division clarifies that in subsection (a)(2)(A) ((a)(4)(A) as adopted) a qualified pharmacy agent is an agent or assignee of a pharmacy authorized to process claims and act on behalf of the pharmacy under terms and conditions agreed on by the pharmacy. Section 133.307, as adopted, requires documentation to be provided to MDR demonstrating the relationship between the pharmacy and the pharmacy processing agent, the dates of service covered by the contract, and a clear assignment by the pharmacy of the right to participate in the MDR process.

**§133.305(a)(2)(A):** A commenter states that Labor Code §413.0111 does not confer health care provider status on pharmacy processing agents. Rather, that section authorizes pharmacies to use agents or assignees to process claims and act on behalf of pharmacies only under the terms and conditions agreed upon by the pharmacies. The commenter suggested that subsection (a)(2)(A) may unintentionally create the

opportunity for abuse and confusion and exceeds the Division's authority by improperly granting independent rights and status to processing agents.

**Agency Response:** The Division disagrees that subsection (a)(2)(A) ((a)(4)(A) as adopted) improperly grants rights or status to pharmacy processing agents. Labor Code §413.0111, allows for *pharmacies to use agents or assignees to process claims and act on the behalf of the pharmacies under terms and conditions agreed on by the pharmacies*. Subsection (a)(2)(A) ((a)(4)(A) as adopted) specifically includes a *qualified pharmacy processing agent* as one who can bring a dispute of an insurance carrier reduction or denial of a medical bill. To be qualified, the agent must clearly demonstrate that the pharmacy has assigned its right to participate in the MDR process on its behalf. This rule does not expand or grant rights or status to the pharmacy processing agent. Subsection (a)(2)(A) ((a)(4)(A) as adopted) has been changed to clarify that a pharmacy processing agent is not considered a health care provider.

**§133.305(a)(5):** A commenter requests clarification regarding preauthorization disputes. The commenter states that the proposed rules seem to require preauthorization of pharmacy services in contradiction to Labor Code §413.0141, relating to the seven-day initial pharmacy coverage and carrier eligibility for reimbursement.

**Agency Response:** The Division disagrees that subsection (a)(5) ((a)(7) as adopted) changes the requirements for the preauthorization of pharmacy services. This

subsection merely defines preauthorization and concurrent medical necessity disputes as a type of dispute that can be brought to MDR. Treatments and services that require preauthorization are listed in Labor Code §413.014 and 28 TAC §134.600 relating to Preauthorization, Concurrent Review, and Certification of Health Care. In accordance with Labor Code §413.0141 and 28 TAC §134.501, pharmaceutical services provided within the initial seven days following the date of injury do not require preauthorization and if payment is denied by the carrier on such services, MDR may be requested by the provider under subsection (a).

**§133.305(a)(2)(C):** Several commenters state that the wording of subsection (a)(2)(C) ((a)(4)(C) as adopted) could be interpreted to allow medical disputes seeking refund orders only after a Division audit or a Division review. These commenters recommend that this subsection be amended to clarify that an insurance carrier may also request a health care provider refund after a carrier audit or review pursuant to Labor Code §408.0271. One commenter suggested adding the phrase *retrospective review of a paid bill by the carrier in which a refund is requested* to the types of disputes that can be brought as a medical fee dispute.

**Agency Response:** The Division agrees that this subsection should be clarified and has revised subsection (a)(2)(C) ((a)(4)(C) as adopted) to include a dispute resulting from a carrier audit or review by adding the words *or carrier* after the word *Division* and before the word *audit*.

**§133.305(a)(3):** Commenter states the definition of *network care* conflicts with 28 TAC §§10.102(i), 10.103(a)(4)(B)(iv), and 10.104(a)(2) and confuses the distinction between network and out-of-network care.

**Agency Response:** The Division disagrees that the definition of *network care* conflicts with TDI rules. Insurance Code §1305.006 and 28 TAC §10.61 provide that an insurance carrier that establishes a network or contracts with a network is liable for out-of-network care in certain circumstances. 28 TAC §10.2 (a)(18) defines *network* as an organization that provides or arranges to provide health care services to injured employees. Out-of-network health care is different from non-network health care. For clarification, subsections (a)(3) and (4) ((a)(5) and (6) as adopted) have been revised by adding the words *or arranged* between the words *delivered* and *by a certified workers' compensation network*. In addition, the Division revised subsection (a)(5) to clarify that network care includes authorized out-of-network care.

**§133.305(b):** A commenter requested clarification of §133.307 regarding the processing of medical necessity and compensability related disputes prior to resolution of fee disputes.

**Agency Response:** The Division revised subsection (b) for consistency with various changes to §133.307.

**§133.305(c):** A commenter expressed concern that the language of subsection (c) does not recognize that good faith disagreements and disputes can and will occur and recommends the section be deleted. If not deleted, the commenter suggests including language that a lack of good faith in the action of the carrier or provider be present before imposing administrative fees.

**Agency Response:** The Division disagrees with the recommendation. Labor Code §413.020 requires the Division to establish, by rule, procedures to charge insurance carriers a reasonable fee for access to or evaluation of health care treatment fees or charges. In addition, this statute requires procedures to charge insurance carriers who unreasonably dispute charges that are consistent with Division rules. The dispute resolution process is costly to the system and therefore the Division has included provisions to discourage actions that result in unnecessary or avoidable disputes. The language in this rule makes the assessment of the fee discretionary and the Division may consider the facts presented by the parties related to the dispute.

**§133.305(c)(3) and (4):** A commenter asked how health care providers can obtain a copy of a contract from the carrier to determine if a workers' compensation discount is warranted. The commenter states that there are situations where third parties processing claims for carriers have contracts for discounted rates that they inappropriately apply to workers' compensation claims and the health care provider has no knowledge of the contract.

**Agency Response:** The Division is not authorized to adjudicate a medical fee dispute pertaining to a contractual, private fee arrangement. If a carrier contends that contractual terms apply to a medical service rather than Division rules, the carrier will be required to produce a copy of the agreement. If a contract is produced, it can be provided to the health care provider. However, if a fee contract cannot be verified by either party, the Division may issue a MDR decision based on Division rules.

**§133.305(c)(4):** The commenters recommend that proposed subsection (c)(4) be deleted. The commenters state the subsection is in conflict with Texas Labor Code §413.011(d), §413.016(b), and §415.005(a). Section 1305.153 of the Insurance Code only applies to reimbursement of network providers and does not prohibit the application of PPO discounts or processes in non-network contracts. Insurers and providers may contract for negotiated fees that are below Division fee guidelines regardless of whether the medical care is rendered through a certified health care network or not. The commenters state that there is no requirement in the law that such discount fee arrangements be negotiated or brokered by a certified health care network. Another commenter questions whether this provision indicates that negotiated discounts are only allowed through networks.

**Agency Response:** The Division disagrees with the recommendation to delete subsection (c)(4). Labor Code §413.011(d) allows an insurance carrier to pay fees to a health care provider that are inconsistent with Division fee guidelines if the insurance

carrier has a contract with the health care provider and the contract includes a specific fee schedule. Such contracts are not limited to certified networks. Subsection (c)(4) describes the situation where the contract provided to MDR as the basis of a reduction or denial of payment indicates that the arrangement between the insurance carrier and the health care provider is one that requires network certification. In this situation, the Division may assess a fee for MDR. Subsection (c)(4) has been changed to provide additional clarity.

**§133.305(c):** A commenter expressed concern that the language of subsection (c) does not recognize that good faith disagreements and disputes can and will occur and recommends the section be deleted. If not deleted, commenter suggests including language that a lack of good faith in the action of the carrier or provider be present before imposing administrative fees.

**Agency Response:** The Division disagrees with the recommendation. Labor Code §413.020 requires the Division to by rule establish procedures to charge insurance carriers a reasonable fee for access to or evaluation of health care treatment fees or charges. In addition, this statute requires procedures to charge insurance carriers who unreasonably dispute charges that are consistent with Division rules. The dispute resolution process is costly to the system and therefore the Division has included provisions to discourage actions that result in unnecessary or avoidable disputes. The

language in this rule makes the assessment of the fee discretionary and the Division may consider the facts presented by the parties related to the dispute.

**§133.305(d):** A few commenters express concern that the language in this subsection is too broad and requires the redaction of contact information for persons who may have relevant information relating to the dispute. One commenter states that the subsection as proposed would require, for example, the redaction of all information identifying employers, other health care providers and other persons involved in the dispute or the injured worker's claim when many of these persons could have relevant information relating to the dispute and should be identified. Another commenter objects to the language *any information that identifies the person* and requests that the words *the name and other personally identifiable information of any other claimant* be substituted to avoid the redaction of contact information for parties to the dispute well beyond a reasonable scope.

**Agency Response:** The Division agrees that the language should be clarified but disagrees that redaction should be limited to claimants in the workers' compensation system. Many times information is submitted in MDR that does not relate to a workers' compensation claim, but contains medical information on a named patient. The intent of this provision is to require the party offering such confidential health information to redact all identifying information from the documents before they are submitted to MDR. Subsection (d) has been revised to clarify that documentation containing health

information related to a person other than the claimant involved in the dispute must be redacted to remove any information that could identify the person by deleting the word *confidential* between the word *contains* and the word *information*, deleting the phrase *or a party in the dispute*, and substituting the word *patient* for the word *person* in two places.

**§133.307(a)(3):** A commenter recommends the phrase *authorized out-of-network healthcare* be defined in §133.305 as this term is used in §133.307.

**Agency Response:** The Division agrees and has revised §133.305 (a)(3) ((a)(5) as adopted) to clarify that *authorized out-of-network care* is a component of network health care. Subsection (a)(3) ((a)(5) as adopted), references Insurance Code Chapter 1305, which establishes workers' compensation networks, including authorized out-of-network care as provided in 1305.006, relating to Insurance Carrier Liability for Out-of-Network Health Care.

**§133.307(b):** A commenter questions why carriers are not allowed to request MDR for fees in this section when, under §133.260, health care providers are allowed to request MDR if a carrier seeks a refund from a health care provider. The commenter states that the rules do not provide a method for the carrier to pursue overpayment. The commenter questions why a health care provider is required to provide responses in §133.307(d) and (d)(3), if the carrier cannot request MDR and believes it would not be

an onerous burden to add *carrier* to §133.307(b).

**Agency Response:** The Division declines to revise §133.307(b) because §133.260 establishes a process for the carrier to request and receive a refund for overpayment. The health care provider is required to send the carrier the refund and submit an MDR request if the health care provider disagrees with the refund request. This process eliminates the need for the carrier to pursue MDR for a refund request. Labor Code §408.0271, (regarding Reimbursement by Health Care Provider) states that the health care provider commits an administrative violation if the provider does not submit the refund to the carrier. If a provider fails to provide the requested refund, then the provider may be fined by the Division's Legal and Compliance area.

**§133.307(b)(1):** A commenter supports specific references to pharmacy processing agents in accordance with §413.0111 under proposed §133.305 and §133.307. The commenter supports references in the rule to Labor Code §413.0111 because this statute authorizes pharmacies to use pharmacy processing agents and other assignees in reimbursements claim processing.

**Agency Response:** The Division appreciates commenter's support and acknowledges the legislative intent of §413.0111 and HB 7. Accordingly, the rules provide specific references to pharmacy processing agents.

**§133.307(b)(1):** A commenter states that Labor Code §413.0111 does not provide

health care provider status to pharmacy processing agents and feels that §133.307(b)(1) creates confusion. The commenter believes this proposed rule language exceeds the Division authority and creates improper rights and status to pharmacy processing agents, which may not exist in the pharmacy and pharmacy processing agent contract.

**Agency Response:** The Division agrees to clarify this subsection to avoid unnecessary confusion and revised §133.307(b)(1) to allow health care providers or qualified pharmacy processing agents to request MDR for fee disputes. Labor Code §413.0111 is clear; the Commissioner must authorize pharmacies to use agents or assignees to process claims, and act on the behalf of pharmacies under terms and conditions agreed on by pharmacies. Thus, if a pharmacy chooses to utilize a pharmacy processing agent, the pharmacy processing agent may request MDR.

**§133.307(b)(2):** A commenter seeks clarification of (b)(2) in order to know what is meant by *review*. The commenter wants to know whether a *review* pursuant to paragraph (b)(2) includes carrier audits, which result in a refund request. Another commenter seeks clarification concerning whether paragraph (b)(2) includes carrier audits and wants to know if the carrier, after paying a health care provider, can later claim that the carrier overpaid. A commenter recommends paragraph (b)(2) be amended to clarify that an insurance carrier may also request a health care provider refund after a carrier audit pursuant to Labor Code §408.0271.

**Agency Response:** The Division clarifies that (b) allows disputes regarding refunds requested by the carrier to be processed through MDR. However, to provide greater rule clarification subsection (b)(2) has been changed by adding the words *or carrier* between the words *the results of a Division* and *audit or review*. The commenter is further advised that a carrier may seek a refund of overpayment in accordance with 28 TAC §133.260. The language of §133.305(a)(4)(C) has also been changed and the phrase *or carrier* is added to provide consistency in the rules. A carrier may seek a refund of overpayment in accordance with §133.260.

**§133.307(c)(1):** A commenter states that requiring a pharmacy or pharmacy processing agent to go through the different workers' compensation systems (such as those for medical necessity, compensability, extent of injury, liability) with different timeframes just to get a \$10 or \$12 prescription paid is a mechanism that does not work for delivery of pharmacy if this system is about the injured workers. The commenter believes it is more expensive to go through the MDR process than a \$10 or \$12 prescription.

**Agency Response:** The Division believes that HB 7 made progress towards some of these issues as pharmacy processing agents are now provided access to MDR in accordance with Labor Code §413.031. The Division understands the comment but disputes regarding fees cannot be adequately addressed or resolved until threshold issues such as compensability, extent of injury, liability, or medical necessity are

determined.

**§133.307(c)(1)(A) and (B):** A commenter seeks clarification of the subsection (c)(1) *timelines* for filing disputes. The commenter believes that providers will be confused by this rule because most health care providers do not have rule books and merely file a bill and then are angry when the bill is not paid. The rule is also confusing to employees and should be laid out in plain language terms for employees who do not have attorneys to explain the rule to them. The commenter interprets the rule to mean that requestors have one year to request MDR, but if there is a medical necessity or other issue and a final determination is reached prior to the one year deadline, it is possible that a party would have less than one year to request MDR. A commenter recommends the subsection be amended to clarify that the exceptions to the MDR timeline listed may be filed after the one year deadline. Another commenter questions whether the 60-day timeline applies when a medical necessity dispute or compensability/extent of injury dispute is resolved before one year from the date of service.

**Agency Response:** The Division agrees that subsection (c)(1) should be revised for clarification. A requestor has one year from the date of service in dispute to request MDR. However, if issues of medical necessity, compensability, extent of injury, or liability are pending, a decision must be reached on these issues before MDR can properly address fee disputes in accordance with §413.031(c). Therefore, an individual seeking MDR, that also has pending threshold issues, will have either one year, or 60

days after a final decision is received on the threshold issues, whichever affords the individual the most time to request MDR.

**§133.307(c)(1)(A):** A commenter recommends clarification in §133.307(c)(1)(A) by adding the term *Division* before decision, which would be consistent with subsection (e)(2).

**Agency Response:** The Division disagrees with the commenter's recommendation to add the term *Division* because a medical fee dispute cannot be sufficiently resolved until any threshold issues of compensability, extent of injury, liability, or medical necessity are determined. In accordance with Labor Code §410.251 a party that has exhausted its remedies under the Texas Workers' Compensation Act and is aggrieved by a final decision of the Division appeals panel may seek judicial review. Therefore, medical fee disputes cannot be resolved and will be dismissed until a final decision is reached on those threshold issues. A party is given 60 days after a final decision is reached on these threshold issues to request MDR for fees. The Division has deleted (e)(2) in response to other comments. Furthermore, Labor Code §413.031(c) provides guidance for resolving fee disputes for services determined to be medically necessary and appropriate for treatment of a compensable injury.

**§133.307(c)(1)(A) and (B):** A commenter questions whether all health care providers treating an injured employee will receive notice of disputes of compensability/extent of

injury or medical necessity. The commenter states that health care providers currently do not receive such notices.

**Agency Response:** The Division appreciates that notice to a health care provider of disputed threshold issues, such as compensability, extent of injury, liability, and medical necessity, is necessary for a less burdensome system. Under Labor Code §408.027 a carrier must send to the Division, the health care provider, and the employee a report explaining reasons for reduction or denial of payment. 28 TAC §133.240(e) requires carriers to provide reasons for denial of payment in an explanation of benefits. 28 TAC §124.2 (regarding Carrier Reporting and Notification Requirements) does not require carriers to send notification regarding compensability/extent of injury disputes to all health care providers treating an injured employee. However, the Division is reviewing the issue regarding notice of compensability and extent of injury and is considering future revisions to 28 TAC §124.2 and other relevant rules.

**§133.307(c)(1)(C):** A commenter recommends subsection (c)(1)(C) be amended to clarify that an insurance carrier may also request a health care provider refund after an audit pursuant to Labor Code §408.0271.

**Agency Response:** The Division declines to make this change. Subsection (c)(1)(C) ((c)(1)(B)(iii) as adopted) pertains to provider refunds due to a Division audit or review. Carriers may request refunds from health care providers in accordance with 28 TAC §133.260.

**§133.307(c)(1)(C):** A commenter states the 20 day timeline to file a dispute after receipt of a refund notice is not sufficient for health care providers to conduct the necessary research related to a refund request. Instead, the commenter recommends a limited timeframe for the carrier to request a refund.

**Agency Response:** The Division agrees with the recommendation to extend the timeline to 60 days to file a dispute after receipt of a refund notice and revised subsection (c)(1)(C) ((c)(1)(B)(iii) as proposed) for consistency. The Division disagrees with the recommendation to add a timeframe limit for a carrier to request a refund; this is outside the scope of this rule because carrier refund requests are addressed by the Division in §133.260 and Labor Code §408.0271.

**§133.307(c)(2)(E):** A commenter recommends subsection (c)(2)(E) be amended to require copies of medical records only when applicable as pharmacy disputes do not typically involve medical records and pharmacists do not routinely have access to medical records for an injured worker. This provision could impose unnecessary time, copy, mail, and processing costs to the system.

**Agency Response:** The Division agrees with the clarification and revised subsection (c)(2)(E) to add the word *applicable* before the words *medical records*. The Division further clarifies that only those medical records in possession of the health care provider are applicable and required. For disputes relating to pharmaceutical services, the

doctor's prescription would be required and may be the only medical record necessary.

**§133.307(c)(1)(A) and (B):** A commenter requests clarification of language in subsection (c)(1)(A) and (B) and recommends the language be amended to the more specific *medical fee dispute* rather than the general *dispute*.

**Agency Response:** The Division agrees with this recommendation and revised the rule to provide clarification by adding the word *fee* between the words *medical* and *dispute*. The Division has also similarly revised subsection (d)(2)(D) for language clarification and consistency with this change.

**§133.307(c)(2)(G):** A commenter states that HB 7 amended Labor Code §413.031(b) to allow a health care provider to submit a charge in excess of a fee guideline and is entitle the health care provider to review of medical service if reasonable medical justification exists for the deviation. A commenter is concerned that §133.307(c)(2)(G) prevents a health care provider from being reimbursed for more than the maximum allowable reimbursement (MAR), despite the fact that the higher amount is sometimes justified.

**Agency Response:** The Division disagrees that the subsection prevents a health care provider from being reimbursed for more than the justified maximum allowable reimbursement because this subsection pertains to treatment and services in which the Division has not established a maximum allowable reimbursement rate. The Division

clarifies that maximum allowable reimbursement rates are governed by Labor Code §413.011, and related rules (generally 28 TAC §§134.202 through 134.506).

**§133.307(c)(2)(H):** A commenter supports the Division's recognition of proprietary contractual information between the pharmacy and its agents but has concerns about the routine disclosure of the assignment of rights for every MDR request. The commenter states this requirement is unwarranted, and results in unnecessary administrative costs, and converts private arrangements to public record. The commenter believes the proof of assignment should only be required only when both the provider and processing agent are asserting the right to reimbursement for the same pharmacy claim and the provider and the processing agent have been unable to resolve the assignment under the terms of their contract.

**Agency Response:** The Division appreciates commenter's support. However, the Division disagrees with the recommendation. Labor Code §413.0111 establishes that a pharmacy may use a pharmacy processing agent to process claims or act on behalf of the pharmacy. Documentation must be provided to demonstrate the relationship between the pharmacy and the pharmacy processing agent and establish that there is a clear assignment of the right to participate in the MDR process. The right to participate in the MDR process cannot be assumed because Labor Code §413.031 sets forth specific provisions for health care providers seeking review of medical services provided or for authorization of payment. The rule does not require disclosure of confidential

contractual terms, only an agreement to verify the assignment of rights. A signed and dated copy of an agreement would meet the requirements of the rule.

**§133.307(c)(3):** A commenter questions whether an injured worker should look to the carrier for reimbursement when the injured worker paid a provider for health care services. The commenter states the carrier, not the injured employee, should be required to ask the provider for a refund or go to MDR if necessary.

**Agency Response:** The Division declines to make this change in the rule because the process an injured employee must follow to request refunds is addressed by 28 TAC §133.270. Section 133.270 establishes that an injured employee may request reimbursement from the insurance carrier when the injured employee has paid for health care provided for a compensable injury. The carrier is required to reimburse the injured employee the Division fee guideline or contract amount. The injured employee may then seek reimbursement for any payment made above the Division fee guideline or contract amount from the health care provider who received the overpayment. In both these circumstances the injured employee may request MDR if the carrier or provider denies reimbursement. However, the Division revised §133.307(c)(3) and §133.305(a)(4)(B) to clarify that an employee may request dispute resolution of a reduction or denial of a refund request whether the reduction or denial is received from a carrier or a health care provider.

**§133.307(c)(4):** Two commenters recommend that the Division, or alternatively the requesting party, forward to the respondent a copy of the request and all documentation supporting the request which was submitted to the Division. In order to provide a complete response, the respondent should receive a copy of all information supporting the request not only a copy of the request.

**Agency Response:** The Division agrees that the respondent should receive a complete request and changed (c)(4) for clarification of such. A complete request meets the criteria outlined in subsection (c)(2) and (3), which includes items beyond the request form such as medical bills and medical documentation.

**§133.307(d):** A commenter requests typographical corrections to this subsection.

**Agency Response:** The Division agrees with the recommendation and subsection (d) has been revised to reflect these typographical changes.

**§133.307(d):** A commenter questions why a health care provider would be a respondent in an MDR dispute if a carrier is not allowed to be a requestor.

**Agency Response:** The Division clarifies that a health care provider may be a respondent when an injured employee submits an MDR request for a refund from a health care provider.

**§133.307(d)(1):** A commenter recommends that subsection (d)(1) be amended to

provide respondents at least 20 days to allow for extenuating circumstances and other reasons such as a health care providers office staff being out on vacation. Another commenter recommends that when a copy of a request for MDR is placed in the Division's carrier boxes the timeframe should begin when a carrier's representative signs a form acknowledging receipt of a request for MDR. Triggering the timeframe by placing the request for MDR in the carrier's agency mailbox does not comply with the legislative goals set forth in Labor Code §402.021.

**Agency Response:** The Division disagrees with the recommendation to extend the timeline to respond to 20 calendar days. The Division believes that 14 calendar days is sufficient time to respond to a dispute as it is the intent of the MDR rules to expedite resolution between the disputing parties as set forth in Labor Code §402.021. The Division clarifies that the recommendation for the carrier's signature to begin the 14 calendar day timeframe is outside the scope of this rule and is established by 28 TAC §102.5. However, the Division has revised subsection (d)(1) by inserting the word *calendar* between the words *14* and *days* in both sentences.

**§133.307(d)(2)(A)(iii):** Two commenters recommend the subsection be modified to require the responding party to only include medical records or documents not provided by the requestor in the original request. A commenter states there is no reason to make both parties file identical records and documentation. The proposed subsection would result in a large volume of duplicate information being submitted as part of the dispute

resolution process.

**Agency Response:** The Division clarifies that subsection (d)(2) requires the respondent to only provide relevant information not submitted by the requestor. The Division revised subsection (d)(2)(A)(iii) to further clarify that only additional information not submitted by the requestor is required.

**§133.307(d)(2)(A)(v):** A commenter opposes this subsection, believing that it shifts the burden of proving fair and reasonable reimbursement from the health care provider to the carrier. The commenter states that case law and prior rules have supported the placement of the burden on the provider to prove that what is charged is a reasonable and necessary fee. The commenter feels providers should have the burden to show that what they charge is reasonable. Such as an exemption that allows providers to go outside of a fee guideline if the charge can be justified. The commenter believes statutory support exists for placing the burden on provider.

**Agency Response:** The Division disagrees this provision places the burden of proving fair and reasonable reimbursement on the carrier only. Section 133.307 requires the provider and carrier to submit documentation that discusses, demonstrates, and justifies that the payment amount being sought by the provider and reimbursed by the carrier is a fair and reasonable rate. Further, the requirement that carriers provide documentation supporting a fair and reasonable reimbursement is consistent with the requirements of 28 TAC §134.1 and Labor Code §413.011.

**§133.307(d)(2)(B):** Several commenters recommend either deleting subsection (d)(2)(B) in its entirety or modifying it to allow carriers to provide additional evidence to support the reason for reduction or denial of payment. The commenters state that the subsection is applied unfairly because there is no similar restriction placed on health care providers. One commenter states that if a carrier denies payment on the basis of compensability, other threshold issues may not be addressed and it may be necessary for the carrier to enter these additional reasons into the record as part of the MDR process. It would be inefficient for the system to require the carrier to audit for both compensability and medical necessity for services that the carrier determines to be noncompensable. Further, compensability may be disputed after a request is filed but before a response is provided. In this situation, it would be appropriate to add this information. The commenter believes the carrier's ability to enter additional information is limited, but that the provider's ability to enter additional information is not limited. Several commenters believe subsection (d)(2)(B) is in fact a waiver provision for carriers; carriers waive any defenses not listed on DWC-62 even though there is no statutory basis for waiver in Labor Code §413.031. A commenter believed subsection (d)(2)(B) was an inoperable pleading requirement, which prevents the Division from addressing problems that often end up in litigation instead of being resolved in mediation. The commenter feels that by not addressing issues in the mediation process the Division perpetuates an unresolved issue. The commenter is unaware of any other

adjudicative process that limits a party to the defenses they raised during the mediation process. One commenter states that in a Travis County district case, *Texas Mutual Insurance Company v. Texas Workers' Compensation Commission*, Cause No. GN501779, the Division entered into an agreement that lack of specificity on an EOB is not a basis for ordering the carrier to pay. Subsection (d)(2)(B) is also in conflict with Texas Labor Code §408.027, which allows carriers to audit medical bills within 160 days after receipt of the medical bill and after making the initial payment within 45 days. Additionally, several commenters believe that subsection (d)(2)(B) also creates a due process conflict with proposed §133.307(e)(3), which allows the Division to raise issues in the MDR process if appropriate to administer the medical dispute process consistent with the Act. Commenter estimates that this subsection would have resulted in a \$43 million dollar overpayment in medical bills in 2003.

**Agency Response:** The Division disagrees that this subsection should be deleted or that the subsection creates a due process conflict with §133.307(e)(3). Labor Code §402.061 provides the commissioner of workers' compensation with the authority to adopt rules as necessary to implement and enforce the Workers' Compensation Act. These rules provide the process for accomplishing resolution of disputes in a timely and fair manner by allowing health care providers the opportunity to timely address all the reasons for denial or reduction of its bill. In order to timely resolve medical fee disputes, the health care provider must have and is entitled to notice of all the reasons for denial or reduction of its bill. However, the Division has revised subsection (d)(2)(B) to allow a

carrier to submit a subsequent response when a final decision is rendered regarding threshold issues such as compensability, extent of injury, liability, or medical necessity. Medical necessity reviews require an adverse determination in accordance with 28 TAC §19.2005 and subsection (d)(2)(E) has been added to allow carriers to bring up the issue of medical necessity by providing documentation that supports an adverse determination in accordance with §19.2005. Additionally, the language in §133.305(b) has been revised to clarify the appropriate sequence with the resolution of medical fee disputes. The Division disagrees with commenter's characterization regarding the agreed orders entered in the Travis County district court case because the case involved a different rule and the agreed orders were specific to the facts of that case. The Division further disagrees that the rule is in conflict with Labor Code §408.027 because the rule does not alter those timeframes. Finally, the Division disagrees that §133.307 (e)(3) ((e)(2) as adopted) presents a due process conflict because the Division will forward any additional information requested by the Division to the parties and will accept responses to additional issues raised by the Division in accordance with §133.307 (e)(1). In order to clarify subsection (e)(1), the Division has added the sentence that states "[t]he Division shall forward any additional information received by the parties."

**§133.307(d)(2)(C):** A commenter recommends this subsection be amended to require the carrier to submit a written statement that the carrier did not receive information

relevant to the dispute prior to the MDR request. The commenter states the subsection does not clarify whether an affidavit or written statement is required. Further, the commenter suggests a written statement would be the lowest overall cost to the system.

**Agency Response:** The Division agrees with this recommendation and subsection (d)(2)(C) has been changed by inserting the phrase *include that information in a written statement in the response the carrier submits to* to replace the language *so certify when the carrier files the request form with* to allow a carrier to submit a written statement indicating the carrier has not received the information prior to the MDR request.

**§133.307(e)(2):** A commenter questions the distinction between medical necessity disputes being dismissed before fee dispute resolution versus disputes involving compensability or extent of injury being abated before fee dispute resolution. The commenter recommends consistency and suggests dismissal for both processes to avoid a pending status and allow the opportunity to re-file and start the fee dispute process.

**Agency Response:** The Division agrees with this recommendation and proposed subsection (e)(2), regarding abatement of disputes, has been deleted. A provision regarding disputes containing compensability, extent of injury, and/or liability issues has been added in subsection (e)(3)(H), pertaining to Division dismissals. This provides MDR processing consistency for fee disputes containing medical necessity or compensability, extent of injury, or liability issues.

**§133.307(e)(3):** A commenter recommends that the subsection either be deleted or more specific or detailed language added regarding when the Division may raise issues in the process. System participants will benefit from a detailed clarification of the intent of this provision and examples of this provision, as well as a response mechanism afforded to all parties.

**Agency Response:** Labor Code §413.031 states that the role of the division, in resolving fee disputes for services determined to be medically necessary and appropriate for treatment of a compensable injury, is to adjudicate the payment, in accordance with the statutory provisions and commissioner rules. Labor Code §413.008 requires carriers (upon request) to submit to Division any information relating to treatment, services, fees and charges. HB 7 enacted Labor Code §402.021 (b)(3) and (5) states that the goal of the Division is to provide appropriate benefits in a timely and cost-effective manner and minimize the likelihood of disputes and resolve quickly when identified. In order to adequately administer the intent of HB 7, and comply with statutory provisions, the Division must be able to obtain relevant and necessary information in order to determine fundamental issues regarding fee disputes. The Division must also administer the MDR process consistent with the provisions of the Labor Code and Division rules. It is not feasible for a list of examples and response mechanisms to be included in the rule as such a list may limit the scope of the Division's duties and different issues may require different response processes. Therefore, the

division declines to either delete or revise subsection (e)(3) ((e)(2) as adopted).

**§133.307(e)(4):** Commenters recommend that dismissals of a dispute be mandatory for each of the enumerated situations listed in the subsection by using the words *shall* or *must* instead of *may*.

**Agency Response:** The Division declines to make this change. Subsection (e)(4) ((e)(3) as adopted) relates to actions taken by the Division and, as such, regulatory language is not required. The Division will consistently apply the criteria in this subsection for dismissals but will maintain its independent duty to provide for exceptions as needed in order to accomplish the intent of HB 7 and other statutory provisions.

**§133.307(e)(4):** A commenter requests clarification regarding dismissals and recommends incorporating in the rule a procedure to address cases where an injured employee disagrees with the Division as to whether the MDR request is untimely. Such clarification would prevent injured employees from getting lost in the system. A dismissal is not a final decision, and once a dispute has been dismissed there is no process in the rule by which an injured employee may dispute the dismissal. The commenter questions whether a dismissal is an exhaustion of administrative remedies.

**Agency Response:** The Division disagrees that subsection (e)(4) ((e)(3) as adopted) requires clarification or a procedure specific to injured employees. A party may request MDR within the time frames provided by subsection (c)(1) and if a party's request is

dismissed there is no provision in the rule to prohibit a party from resubmitting a request for MDR as long as they comply with subsection (c)(1). A dismissal of a request for MDR may be a final decision and a party to a medical dispute is entitled to judicial review in accordance with Labor Code §413.031(k), which states that a party to medical dispute that remains unresolved is entitled to judicial review.

**§133.307(e)(4)(H):** A few commenters request clarification of subsection (e)(4)(H) ((e)(3)(H) as adopted) and question why a request would be dismissed when a non-certified network provider contract does not comply with the cited provisions and is the basis of the disputed reimbursement. One commenter states that MDR should resolve a dispute over reimbursement based on a provider contract that does not comply with the Labor Code. A different commenter questions whether the Division will dismiss medical fee disputes that involve contract rates per Labor Code §413.016(b). A commenter questions where unwarranted discounts taken by the carrier fit in MDR and provides the example of a carrier that uses a billing service and a health care provider that signs a discount contract. In this scenario, the carrier does not have a workers' compensation discount agreement with the health care provider but the network takes a discount, and the commenter asks whether a health care provider access MDR for this scenario.

**Agency Response:** The Division agrees that some clarification is necessary. Subsection (e)(4)(F) ((e)(3)(F) as adopted) has been revised to provide that the Division

will dismiss medical fee disputes regarding contract rates. The Division has no jurisdiction to adjudicate contract disputes between parties regardless of whether hidden discounts exist. Any disputes over the terms of a valid contract between carrier and provider cannot be properly decided by MDR because the Division does not have the authority to negotiate contract terms between carriers and health care providers. In the scenario described by the commenter, the carrier would be unable to produce a valid workers' compensation contract with health care provider therefore the health care provider would be allowed access to MDR. In the absence of such a contract, the Division will apply fee guidelines.

**§133.307(e)(5):** A commenter recommends the subsection be amended to require the Division to send the MDR decision to the injured employee, as well as to the disputing parties. A few other commenters recommend the MDR decision be sent to a party's representative if the party was represented during the MDR process.

**Agency Response:** The Division clarifies that the intent of subsection (e)(5) ((e)(4) as adopted) is to notify the identified disputing parties. However, the Division agrees that a representative of record for a party, such as an attorney, should receive notice of the decision and has revised (e)(5) ((e)(4) as adopted) to reflect this change.

**§133.307(f):** Several commenters state that the proposed rule does not provide for an evidentiary hearing and only offers determinations based on unverified documents.

These commenters recommend that medical disputes be resolved according to the provisions of the Administrative Procedures Act (APA) which allows, for example, the right to cross examine and take testimony of witnesses under oath. Failure to conduct proper hearings on medical disputes violates the parties' due process rights and the division's statutory duties. These commenters recommend the rule be amended to provide for an administrative hearing for all medical disputes presided over by either State Office of Administrative Hearings (SOAH) administrative law judges or Division hearing officers. Commenters state an adjudicative process for these disputes should be in place. These commenters also state the legislature and the agency must comply with the Texas Constitution, Labor Code §413.031(k), and Government Code §2001.171.

**Agency Response:** There are no statutory provisions for the Division to provide administrative hearings for medical fee disputes. Labor Code §413.031(k) does not provide the Division with the authority to create a system for administrative appeals of medical disputes prior to judicial review. Labor Code §401.021 and §408.027(e) do not require hearings for medical fee disputes. Furthermore, HB 7 amended §413.031 (k) to specifically delete statutory language that entitled a party with an unresolved medical fee dispute, to a State Office of Administrative Office hearing. The rule's provisions for an informal adjudication were made after the agency made the following constitutional due process analysis of (1) whether any party to a dispute has a constitutional protected property or liberty interest at stake and, if so, (2) what process is due to sufficiently

protect that interest. *Bd. Of Regents v. Roth*, 408 U.S. 564, 569-71 (1972). A legitimate claim of entitlement is required for a constitutional property interest. *Nat'l Collegiate Athletic Ass'n v. Yeo*, 171 S.W.3d 863, 870 n. 19 (Tex.2005) and *Bd. Of Regents v. Roth*, 408 U.S. at 577. A health care provider's expectation of additional reimbursement does not rise to a constitutional entitlement. *ElderCareProps., Inc. v. Tex. Dep't of Human Servs.*, 63 S.W.3d 551, 556 (Tex.App. – Austin2001, pet. denied). Similarly, an injured employee's request for medical care (or reimbursement for medical care) is not, in itself, a constitutional entitlement. *American Manufacturers Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 60 (1999). Finally, a workers' compensation insurer cannot show that it has a legitimate claim of entitlement to not utilize its required reserves to pay proper medical claims. Each insurer voluntarily agrees to assume obligations to pay claims for health care as required by the Texas Workers' Compensation Act when they voluntarily enter into any insurance contract with an employer. Each insurer must comply with statutory requirements to maintain adequate monetary reserves to pay such claims. Texas Insurance Code Article 5.61. Similarly, no constitutionally protected property interest was found in escrow money that employers were required to pay because they were legislative preconditions for the privilege of engaging in future cigarette sales. *Grand River Enters. Six Nations Ltd. V. Pryor*, 425 F.3d 158, 174 (2nd Cir. 2005, writ of cert. denied in *King v. Grand River Enters. Six Nations Ltd.*, 2006 U.S. LEXIS 7501).

**§133.307(f):** A commenter is concerned that the 30 day deadline for filing a petition for

judicial review is not an adequate amount of time for health care providers to assimilate what is required to file and recommends 90 days.

**Agency Response:** The Division understands the commenter's concern; however, the 30 day deadline is a provision of Government Code, Subchapter G, §2001.176(a).

**§133.308(a):** A few commenters note that §133.308(a) references §133.309, the validity of which is currently being litigated. One commenter asks what effect an invalidation of §133.309 would have on the §133.308, and another suggests changing the statutory reference to Labor Code §413.031.

**Agency Response:** The Division is aware of the issue of the commenter's concern, and has changed this subsection to reference Labor Code §413.031(n) rather than §133.309.

**§133.308(e)(1):** A commenter asserts that Labor Code §413.0111 does not confer health care provider status on pharmacy processing agents, and voices concern that the wording of §133.308(e)(1) unintentionally assigns this status, in excess of Division authority.

**Agency Response:** The Division notes that the section does not define a pharmacy processing agent as a type of provider, but will make a change to the proposed text in order to address the commenter's concerns by adding the word *or* after the word *provider* and deleting the word *including* before the term *pharmacy processing agents*.

**§133.308(e)(3):** A commenter requests to know why the proposed subsection excludes non-network employees from medical necessity disputes.

**Agency Response:** Employees who do not fall under the network requirements are listed as possible parties to a medical dispute, except for certain retrospective medical necessity disputes because once the services have been rendered to the employee the employee would not incur any out of pocket expenses and would not need to access MDR. The language of §133.308(e)(2)(B), as adopted, clarifies this.

**§133.308(f):** A commenter states that there is a conflict between this subsection and 28 TAC §10.103(a)(4)(B)(iv), because the proposed subsection provides that a request for independent review must be filed in the form and manner prescribed by the Department and the Department's IRO request form may be obtained from either the Department's website or physical address, while §10.103(a)(4)(B)(iv) provides that notice of the requesting party's right to seek review of the denial by an IRO and the procedures for obtaining that review in the form of notice referenced in §10.102(i) of this subchapter. The commenter also notes that §133.308(g) conflicts with 28 TAC §10.104(a)(2) and §133.308(j) conflicts with 28 TAC §10.103(a)(4)(B).

**Agency Response:** The Division does not agree that a conflict between this subsection and 28 TAC §10.103 (a)(4)(B)(iv) exists when both direct a party to the same Internet website and mailing address. Neither does the Division see a conflict

between §133.308(g) and 28 TAC §10.104(a)(2); and §133.308(j) and 28 TAC §10.103(a)(4)(B).

**§133.308(f):** A commenter commends the Division on creating an MDR process that allows injured employees to be a party in the process and thanks the Division for the opportunity to comment on the adopted rules. The commenter recommends that forms for the adopted rules be written for an 8th grade reading level and be available in both Spanish and English, and also recommends that this subsection include a telephone number that injured employees can use to request IRO request forms because many injured employees may not have access to the internet and requesting forms via the phone can save time over mailing in a request and waiting for the forms to be sent through the mail.

**Agency Response:** The Division appreciates the comment. The Division agrees with the suggestion regarding the readability of the form and is currently developing such a form. Additionally, while an injured employee may not have internet access at home, Internet access and assistance with forms is available at Division field offices in addition to other locations.

**§133.308(g):** In regard to adopted §133.308(g), a commenter wonders what happens to an injured employee if the provider misses the 45th day. The commenter also asks what happens if there is a change in condition after the 45th day or if the carrier and

provider agree to a treatment plan that does not include the requested service, but after the 45th day the provider decides the requested service is necessary.

**Agency Response:** If a request for independent review is not filed before the 45th day, the Department may dismiss the request for medical necessity dispute resolution as untimely pursuant to §133.308(h)(5). If an injured employee has a change of condition after the 45th day that causes the provider to believe the denied treatment has become medically necessary, a new preauthorization process would commence based on the change of condition.

**§133.308(g):** A commenter notes that adopted §133.308(g) states: “[a] requestor shall file a request for independent review with the insurance carrier (carrier) or the carrier's utilization review agent (URA) no later than the 45th day after the denial of reconsideration” and asks if the rule means 45 calendar days, from what point the count of 45 days begins, and if the 45th day would be different if the person is notified by mail or notified by fax.

**Agency Response:** The Division has changed the text of the subsection to clarify that the count of 45 days begins upon receipt of the denial of reconsideration and that the 45 days are calendar days by inserting the word *calendar* after *45th* and before *day* and inserting the words *receipt of* after the words *day after* and before the words *the denial of reconsideration*. The Division also inserted in §133.307(d)(1) the word *calendar* between the words *within 14* and *days after* for language consistency.

**§133.308(g):** Concerning this subsection, a commenter states that requiring a carrier or URA to forward the request for IRO to the Division puts an onerous burden on the carrier or URA. The commenter asserts that this is an unnecessary step, as the Division is ultimately the entity to appoint the IRO.

**Agency Response:** The Division declines to make the requested change because Insurance Code Article 21.58A, §6A requires the carrier or URA to forward the request to the Department.

**§133.308(h):** Commenters recommend that the proposed section be changed by deleting the word *may* and inserting the word *shall* or *must* before the phrase *dismiss a request for medical necessity dispute resolution if* in proposed §133.308(h). Dismissal of the dispute should be mandatory for each of the enumerated situations because the Division has consistently determined that the listed items are valid reasons to deny access to the MDR process.

**Agency Response:** The Division disagrees with the recommendation because each case will be slightly different, and the Division believes that the best approach is to allow discretion for a determination on a case-by-case basis.

**§133.308(h)(3):** A commenter requests that this section be revised to state that a requestor does not have to seek reconsideration of a determination on a life-

threatening condition prior to seeking an IRO determination, and recommends that the section be changed to state “the Department determines that the dispute involving a non-life-threatening condition has not been submitted to the carrier for reconsideration.”

**Agency Response:** The Division notes that §133.308(g) already provides that an employee with a life-threatening case is entitled to an immediate review by an IRO and does not need to go through reconsideration. However, for clarification, the Division has made the requested change to subsection (h)(3).

**§133.308(j):** Commenters assert that three working days is an unreasonable amount of time for a party to provide all the pertinent information required in a medical necessity dispute. One commenter asserts that three days is unreasonable because the carrier is being asked to provide all the documentation even when it is the medical provider who requested the dispute resolution. A second commenter asserts that it is unlikely the IRO will have a file set up to receive documents within such a short time period. The commenters suggest that the subsection be changed to allow a carrier seven days or 10 working days to provide required documentation.

**Agency Response:** The Division disagrees with the commenter that there is statutory authority to extend the time frame beyond three days, because Insurance Code Article §21.58A, §6A(2) and Insurance Code §1305.355(a)(2) require documents to be provided within three days. The Division notes that the carrier or its URA is only required to submit documentation that was used to make the initial adverse

determination and for the reconsideration, and is therefore already in the possession of the carrier or the URA. However, in §133.305(a)(2), the Division has added a definition of *adverse determination* for clarification of the meaning of that word in these rules.

**§133.308(j):** In regard to §133.308(j), a commenter notes that in practice it is typically a URA that is making a utilization review decision and that as the system is designed carriers are usually just doing bill review. The commenter suggests that the language of the rule be changed to reflect actual practice of carriers. The commenter notes that the time frames have been set by the legislature.

**Agency Response:** The Division has taken the practices of carriers into consideration in writing the adopted rules, and would point out that adopted §133.308(j) states “[t]he carrier or the carrier’s URA shall submit the documentation required....” Some carriers do perform utilization review and do send in IRO requests. Carriers are required under Insurance Code Article 21.58A to adhere to the IRO law.

**§133.308(k):** A commenter states that adopted rule §133.308(k) conflicts with 28 TAC §10.104(a)(2) because it adds a requirement not found in §10.104(a)(2). The commenter also asserts that the subsection adds a requirement not actually seen in the Texas Department of Insurance rules. The commenter believes that if an IRO can request additional information, then all parties should be notified of the request, allowed to review the information when it is provided, and allowed to respond to the information.

The commenter says that the confidentiality requirements of the IRO process are a problem because the parties do not know who the IRO is or what the IRO is reviewing.

**Agency Response:** The Division does not agree that a conflict between proposed §133.308(k) and 28 TAC §10.104(a)(2). Section §10.104(a)(2) lists specific items that are to be provided by a carrier, and §133.308(k) allows an IRO to request any additional relevant information from parties or other providers. The Division anticipates that parties will follow all the rules promulgated by the Texas Department of Insurance, including §10.104 and §133.308. At the outset of the IRO review parties are allowed to provide any documents they feel are relevant to the review. The purpose of the IRO review is to review documents and determine medical necessity. The confidentiality of who does a review for an IRO is a legislative mandate contained in Insurance Code Article 21.58C, §2(h).

**§133.308(k):** A commenter requests that the date of receipt of the dispute be defined as the date of receipt of all necessary documents and states that the Division has variously designated receipt of the request form or payment as the start of the dispute process and asserts that neither the data contained on the form nor the data on the payment check comprise information that has a direct bearing on quality of the review, which is to determine medical necessity. The commenter explains that this subsection does not provide any time allowance for the IRO to receive the necessary records to conduct a quality review and explains that the time element of the process is a major

determinant of the quality of the IRO review.

**Agency Response:** The Division disagrees with the suggested change because it is unnecessary. Insurance Code Article 21.58C already requires the IRO to render its decision not later than the earlier of either (a) 15 days after receipt of information necessary to make the determination or (b) 20 days after the date the IRO receives the request that the determination be made.

**§133.308(k)(1):** A commenter asks that this subsection be changed to clarify the identification of who is considered a party to the dispute. The commenter refers specifically to the language that states "if the provider requested to submit records is not a party to the dispute, then copy expenses for the requested records shall be reimbursed by the carrier." The commenter asserts that the subsection does not indicate what constitutes a provider as a party of the dispute and therefore is gray.

**Agency Response:** The Division disagrees with the commenter's requested change to this subsection because further identification of the parties is not necessary. The commenter is advised that §133.308(e) already specifies who can be a requestor in preauthorization, concurrent, and retrospective medical necessity dispute resolution. A *party* may be either an entity who files a request for independent review or an entity that is called upon to respond to a request for independent review. There may be other providers whose records are relevant to the review that are called upon to submit records, but who are not parties to the review. However, the Division agrees to add the

additional phrase *or providers with relevant records* after the words *the party* and before the words *shall deliver* in the first sentence of this subsection for clarification.

**§133.308(k)(3):** A commenter states that allowing the Division to bring an enforcement action against a carrier if the carrier fails to provide the requested information as directed by the IRO or the Division is too harsh, considering that only three days are allowed to provide the document. The commenter suggests that either §133.308(k)(3) be deleted or that an enforcement action only be allowed if the failure to provide the documents is made in bad faith.

**Agency Response:** The Division disagrees that the suggested changes are necessary. Insurance Code Article 21.58A, §9 gives the Department and the Division the authority to enforce the law. This section does not impose such a limitation as requested.

**§133.308(l):** A commenter states that failure to appear at a designated doctor examination increases costs, delays resolution of the dispute and shows a disregard for the process. Another commenter notes that scheduling multiple examinations would lead to a lengthier, costlier dispute resolution process. The commenters suggest that this subsection be modified to provide that a dispute is dismissed with prejudice if a claimant fails to attend a scheduled designated doctor examination without a good faith reason.

**Agency Response:** The Division agrees in part, but does not believe that dismissal must be mandatory and declines to change this subsection because the language in subsection (h)(7) already addresses the commenter's concerns.

**§133.308(l):** A commenter notes that the nature of designated doctor exams makes them appropriate only to address future or ongoing issues, not to address the medical necessity of services that have been delivered in the past. The commenter suggests limiting IRO requests for a referral to a designated doctor to preauthorization or concurrent review.

**Agency Response:** The Division disagrees that this language change is necessary. Labor Code §408.0041 does not appear to contain any language to authorize limiting IRO requests for a referral to a designated doctor to solely preauthorization or concurrent review.

**§133.308(m):** In regard to the time-frame for IRO decisions set out in §133.308(m), a commenter notes that the commenter would not want to wait over a week for a decision in the case of a life-threatening situation.

**Agency Response:** The Division notes that Insurance Code Article 21.58C, §2 (c)(2)(B) specifically sets forth the eight day time-frame for life-threatening situations.

**§133.308(m):** A commenter requests that the timeframes in this subsection be revised

so that they are consistent, stating that this subsection creates the basis for three separate levels of quality because it sets forth different time frames and initiation measures depending upon whether the case is an emergency, or requires preauthorization or concurrent, or retrospective review; thus creating three separate tracks for IRO reviews that will entail three separate quality measurement procedures. The commenter believes that for consistent quality an IRO review must consist of the same tasks and time allowed for each task regardless of the class of the request; and medical necessity is not related to the class of request. Further, the commenter asserts that: it should be mandatory that any quality monitoring process be consistent, understood, and have uniform measures; all types of cases should have a sufficient time for a quality review after the IRO receives adequate medical information.

**Agency Response:** The timeframes to which the commenter is referring are consistent with those set forth Insurance Code Article 21.58A and Insurance Code Chapter 1305. Preauthorization is not required for emergency services.

**§133.308(n):** A commenter requests that this subsection state the time frame allowed for judicial review so that the injured employee may take appropriate action to obtain an attorney and file a petition in district court within 30 days, which will help insure that an injured employee's case is not discarded on a technicality. The commenter further notes that making injured employees aware of the 30-day filing period would help injured employees assert their appellate rights and reduce complaints from injured

employees dissatisfied with the results at the administrative level.

**Agency Response:** The Division declines to make the commenter's requested change because subsection (r)(1) already sets forth the appeal timeframe and subsection (n) incorporates this section by reference.

**§133.308(n):** A commenter recommends that injured employees receive all notices and responses of a request of an IRO review, regardless of whether the injured employee is considered a party in the process. The commenter says it is imperative to keep the injured employee informed of disputes based on health care that he or she received, and notes that increased communication is one of the goals of HB 7. Commenter asserts that keeping the injured employee informed at the various stages of the MDR process aids in communication for all workers' compensation system participants and provides injured employees with necessary information about their individual claim and appellate rights, and recommends that the words *and the injured employee* be added after the words *to the parties* and before the words *transmitted to* in this subsection.

**Agency Response:** The Division declines to make the suggested change because IROs are already required under 28 TAC §12.206 to send the determination to the injured employee or his representative in all cases. However, in subsection (n), the Division has added the words *and to representatives of record for the parties* between the words *the parties* and *and transmitted* for clarification of to whom the IRO decision

must be mailed or transmitted.

**§133.308(n):** A commenter states that the IRO should be required to send the injured employee notice of the injured employee's right to appeal the IRO decision, regardless of whether the injured employee is the requestor or is considered to be a party. The commenter asserts that notice of the injured employee's right to appeal should be required by rule, should be attached to the body of the IRO decision, and should include the timeframe in which the IRO decision can be appealed.

**Agency Response:** An injured employee always has the right to file an appeal when the employee is a party. Labor Code §413.031(k) only allows *a party to a medical dispute* to seek judicial review of an IRO decision. If an injured employee is not a party in the IRO, he or she does not have a right to appeal the IRO decision and the Division does not have the authority to create such a right by rule. In addition, because Labor Code §413.032 specifies the elements that are to be included in the IRO decision, and the timelines for appeal filing are not one of those elements, the Division declines to make the suggested change. However, the Division anticipates that IROs may offer timeline information or refer injured employees to the Division field offices for further assistance with an appeal as a good customer service practice.

**§133.308(n):** A commenter suggests that an appropriate customer assistance telephone number should be required as a part of the required notice (within the body

of the IRO decision) to field questions regarding the dispute process, particularly for spinal surgery cases. The commenter suggests, at a minimum, requiring IRO decisions to publish either the Texas Department of Insurance or the Office of Employee Counsel's contact information in order to assist injured employees through this complex process.

**Agency Response:** The Division declines to make the suggested change because Labor Code §413.032 specifies the elements that are to be included in the IRO decision, and agency telephone numbers are not one of those elements. However, the Division anticipates that IROs may offer the Department's telephone number or refer injured employees to Division field offices for further assistance with an appeal as a good customer service practice.

**§133.308(n)(1)(B) and §133.308(r)(2)(H):** A commenter objects to screening criteria in general and specifically objects to the inclusion of a laundry list of screening criteria in the proposed rules and related forms because inclusion of such specific information would eventually become obsolete and outdated and necessitate rule changes; a prudent and effective document control procedure for screening criteria is required so that revisions to such are acknowledged, tracked, and updated.

**Agency Response:** Labor Code §413.031(e-1) specifies that guidelines must be considered. The Division is unable to identify a laundry list of screening criteria or guidelines in the proposed rule language that requires the suggested change.

**§133.308(n)(1)(G):** The commenter requests that this subsection be revised to state that if a requestor specifies that guidelines be reviewed then that specification be included in the request submission because the practice of IROs independently citing guidelines or screening criteria creates opportunities for ambiguity and results in a broadening of issues for appeal.

**Agency Response:** The Division declines to make the suggested change because it is unnecessary. Guidelines must be considered by the IRO pursuant to Labor Code §413.031(e)(1). Under that subsection, the IRO must explain if there is a divergence from the guidelines. Additionally, Insurance Code Article 21.58A, §6A(2)(B) requires the URA to provide any documents used by the plan in making the adverse determination to the IRO.

**§133.308(o):** A commenter requests that the language in this subsection be revised, because as currently drafted it prohibits the carrier from using a peer review report for any subsequent denials of the same claim if the IRO determines that medical necessity exists for a disputed health care service and no reason exists to prohibit the use of the peer report for health care services that were not reviewed within the scope of the IRO determination. Another commenter recommends amending this subsection by changing the title to *Carrier use of peer review* and adding the additional words *for the same dates of health care services* at the end of the provision to narrow the scope of the

subsection, which the commenter believes is overly broad when it proscribes the use of a peer review for services that an IRO decision may not even address. The commenter further states that because IRO decisions only address the medical necessity of *claims* for services rendered on certain dates, an IRO decision that conflicts with a peer review should not also preclude use of that same peer review rendered on future dates. A commenter states that this proposed subsection must be revised because, if the medical dispute goes up on the necessity of only one aspect of what a peer has opined, then the restriction should only apply to that one aspect. The commenter provides this example: if a peer review addresses medications, work hardening, and durable medical equipment. If the requestor only pursues the work hardening and prevails, then the carrier should still be able to use the peer review on the issues of medications and durable medical equipment. Another commenter requests that this subsection should be deleted or amended because while the peer review report may address a number of medical services or other non-medical benefits issues, the IRO decision may only address one or a few of the medical services addressed by the peer review report and believes that it would be unfair to prohibit the insurer from utilizing the peer review report for subsequent medical necessity denials for services not addressed by the IRO in the same *claim* when the IRO agreed with the peer review report in part and disagreed with the peer review in part. Another commenter requests that this subsection be deleted or amended because while the peer review report may address a number of medical services, the IRO decision may only address one or a few of the

medical services addressed by the peer review report and it would not be fair to prohibit the carrier from utilizing the peer review report for subsequent medical necessity denials for services not addressed by the IRO in the same *claim*. Likewise, it would not be fair to prohibit the carrier from utilizing the peer review report for subsequent medical necessity denials when the IRO agreed with the peer review report in part and disagreed with the peer review in part.

**Agency Response:** The Division agrees and has clarified the language in this subsection to say that the peer review report that has been overturned by the IRO shall not be used for subsequent medical necessity denials of the same health care services subsequently reviewed for the compensable injury. The Division agrees with the commenter to make a similar language change to the title of this subsection by revising the title to *Carrier Use of Peer review after an IRO Decision* and has added the phrase *health care services subsequently reviewed for that compensable injury* and deleting the words *the same claim* at the end of the provision to clarify and appropriately narrow the scope of the subsection.

**§133.308(o):** A commenter notes that the term *claim* in the proposed rule appears to refer to the claim for the *specific health care* denied by the carrier, as interpreted in the former version of §133.308(p)(6). The Commenter asserts that the removal of the phrase *disputed health care* from the proposed rule, in conjunction with the customary understanding of a *claim* as a claim for compensation in its entirety, will lead to

confusion. The commenter notes that peer review reports may not restrict their opinions to the medical necessity of the specific medical condition, illness or injury subject to the instant IRO review and a literal application of the proposed rule would render the entirety of each peer review reviewed during an IRO process valueless, even with respect to matters not subject to the instant IRO review.

**Agency Response:** The Division agrees that clarification is necessary and has added language to state that the peer review report that was overturned by the IRO may not be used for subsequent medical necessity denials of the same health care services subsequently reviewed for the compensable injury. In addition, the Division agrees to revise the title of the section by adding the words *peer review report after an* after the words *use of* and *IRO Decision*.

**§133.308(p):** A commenter states that the proposed subsection is not acceptable as it is written and urges the harmonization of payment terms in this subsection. The commenter believes changes to the proposal are necessary to prevent IROs from performing tasks and accruing expenses without being assured payment. Additionally, the commenter is surprised that the Division and the Department failed to consider the agreement reached in January 2002 between the Texas Workers' Compensation Commission (TWCC) and various groups, including the commenter, relating to payment of IRO fees. At that time, asserts the commenter, it asked for and received the blessing from TWCC that it would receive payment up front.

**Agency Response:** The Division disagrees that the proposed rule creates a high risk that an IRO will perform tasks and not receive payment. Section 133.308(p)(4) requires payment by the specified party to be made within 15 days of receipt of the invoice and provides for enforcement action where payment is not made. If the IRO is not paid, the Division has the authority to take enforcement action as specified in subsection (u).

**§133.308(p)(2)(A):** A commenter requests that the proposed subsection be revised to avoid requiring the carrier to pay the IRO fee for all concurrent review medical necessity disputes, because there is no reason to make the carrier responsible for the fee in those IRO concurrent reviews where the carrier is the prevailing party. According to the commenter, the non-prevailing party should always be responsible for the costs of the IRO dispute; though the statute requires the carrier to pay the costs in the preauthorization contest, there is no such statutory requirement for concurrent review disputes. The commenter further states that the proposed rule encourages the filing of baseless IRO disputes on concurrent reviews, adds costs, and delays to the system. Another commenter requests that this subsection be amended by adding a provision to require that the health care provider pay the IRO fee for disputes related to concurrent review based upon the rationale that the proposed process, which allows for unlimited concurrent review disputes with no cost to the requestor, adds burden and cost to the system with no tangible benefit. According to the commenter, Labor Code §413.031(h) does not require carriers to pay the initial cost for disputes related to concurrent review,

only to pay for those related to preauthorization.

**Agency Response:** The Division disagrees that the requested change is necessary. Under 28 TAC §134.600, concurrent review is a continuation of preauthorization and therefore the payment requirement applies.

**§133.308(p)(3):** A commenter notes that the former version of §133.308 assigned the cost of a designated doctor exam to the party liable for the IRO fee, rather than specifying that the carrier was liable for the expense as is set out in the proposed version. The commenter says that the shift of liability in the proposed rule is unclear, because a carrier is only required to pay for the costs of IRO reviews of medical necessity, as per Labor Code §413.031(h), in regard to preauthorization/concurrent review issues arising under Labor Code §413.011(g) or treatment plans relating to disability management under Labor Code §413.011(g). The commenter states that designated doctor exams requested by IROs should be taxed as IRO review costs to the non-prevailing party in retrospective reviews where permitted.

**Agency Response:** The Division disagrees, because Labor Code §413.031(g) states that an IRO may request that the commissioner order a designated doctor exam under Labor Code Chapter 408, and Labor Code §408.0041(h) states that the carrier is liable for expenses of the examinations listed in that subsection.

**§133.308(p)(5):** A commenter asks about the language *but not later than 15 days* and

asks whether this refers to 15 days from receipt of the IRO notice. A commenter requests that the Division lengthen the time-frame listed in this subsection from 15 working days to 20 because time-frames are often hard to comply with in a physician's office where the health care provider may be out of the office for two weeks at a time. Additionally, the commenter notices that in this process there is nothing addressed in change of condition or if the carrier and the health care provider make some arrangement to try some other avenue of patient care. The commenter would like to see that if there is a major change in a patient's condition that they can just communicate with the carrier and are not caught up in having to go to MDR.

**Agency Response:** The Division declines to change the language to lengthen the timeframe because the Division expects the parties to make arrangements as necessary in order to comply with the law. In addition, if there is a change in condition a new preauthorization process would start that would not necessarily lead to MDR, but could.

**§133.308(p)(7):** A commenter states that there should be a time-line for withdrawal of an IRO request which allows the request to be cancelled with no fee. The commenter suggests allowing seven or five days for such a cancellation.

**Agency Response:** The Division disagrees that this change is necessary because the rationale of the IRO withdrawal fee is to reimburse the IRO for the various expenses it incurs.

**§133.308(p)(7):** A commenter is gratified to see the new provision for the IRO withdrawal fee.

**Agency Response:** The Division appreciates the comment.

**§133.308(q):** A commenter states that since this subsection states the carrier has defense to a medical necessity dispute if it timely complies with the IRO decision then there should be a provision here requiring payment of interest to the health care provider for failure to pay within a timely manner. The commenter also asks whether the payment of the medical bill must be made regardless of appeal.

**Agency Response:** The Division declines to make a change because Labor Code §408.027 requires carriers to pay bills in a timely manner and subsection (u) provides that the Division may pursue enforcement action if carriers fail to make timely payments. Yes, payment of a medical bill must be made regardless of appeal, based upon Labor Code §413.031(m), which provides that IRO decisions are binding during the pendency of a dispute.

**§133.308(q):** In regard to §133.308(q), a commenter notes that allowing an IRO decision to be received, then processed by the provider is a good sequence, but adds that the section should be conditioned upon final resolution of the medical necessity dispute.

**Agency Response:** The Division disagrees with commenter's suggestion. Pursuant to Labor Code §413.031(m), the decision of an IRO in regard to a medical necessity dispute is binding during the pendency of a dispute.

**§133.308(r):** A commenter is concerned about the IRO decision and whether it is enforceable, given that the Division and the Department are specifically excluded from being parties to the IRO decision; and asks whether there will be a vehicle for judicial review contained in the rules, because under the Government Code there must be a review of an agency decision to invoke the substantial evidence rule.

**Agency Response:** Labor Code §413.031(k) provides that, except in spinal surgery cases, a party to a medical dispute that remains unresolved after a review of the medical service may seek judicial review of the decision, which shall be conducted *in the manner* provided for judicial review of contested cases under Subchapter G, Chapter 2001, Government Code.

**§133.308(r):** A commenter requests that language be added to this subsection to specify who must pay for the cost of copying, noting that the IRO fee does not include the cost of copying.

**Agency Response:** The Division disagrees that a change to this section is necessary. Subsection (r)(1) already states that "[t]he party requesting the record shall pay the IRO copying costs for the record."

**§133.308(r):** A commenter requests that this subsection specify that the Division will be the actual custodian of record and will prepare and certify the record because, as proposed, the rule requires the IRO to be custodian of record. The commenter asserts that this places an undue burden on the IRO because the IRO is not equipped to prepare a record, will not get reimbursed for the record, and lacks the authority to actually certify a record that is to go before a district court.

**Agency Response:** The Division declines to make the commenter's requested change because Labor Code §413.031(k) specifically provides that the Division and the Department are not to be parties to the medical dispute though judicial review is to be conducted *in the manner* provided under Government Code Chapter 2001, Subchapter G.

**§133.308(r):** A commenter strongly urges that a provision be inserted in this subsection prohibiting an IRO from being a party or a testifying or consulting witness in any appellate proceedings.

**Agency Response:** The Division does not have the statutory authority to make the requested change. It is not in the Division's authority to determine who can be party to a case.

**§133.308(r)(1):** A commenter requests that the language in this subsection be revised to state that if an appealing party prevails, then the IRO should refund all copying costs to the appealing party, based upon the rationale that if the appealing party prevails, then one can assume that the IRO made a mistake from which it would be improper for one to profit. The commenter notes that in such a situation the appealing party would have had to spend money on legal representation to overturn the IRO's mistake.

**Agency Response:** The Division declines to make the requested change because there is no statutory authority upon which to base this suggested change.

**§133.308(r)(1):** A commenter requests that this provision be revised to state that an appeal is final on the date the appeal is signed, instead of when the decision is received. Citing Government Code §2001.176(a), which allots 30 days on which to appeal a final and appealable decision, the commenter believes a distinction needs to be made between final, and final and non-appealable decisions when the judgments are final upon their signing instead of upon receipt by a party, noting the importance of such distinction when the 30 days allowed for appeal runs from the date an appeal is final.

**Agency Response:** The Division declines to make the commenter's requested change in this section because in order to appeal an IRO decision, a party must have received a copy of it and thus subsection (n) provides for this.

**§133.308(r)(2):** A commenter requests the additional words *all documents submitted to*

*the IRO by either party and be added between the phrase the record shall include and the phrase the following documents that are in the possession of the IRO and which were reviewed by the IRO in making the decision* because the appellate record should include all documents submitted to the IRO by either party and all documents reviewed by the IRO during the dispute.

**Agency Response:** The Division agrees to make a similar, but different change to the subsection by inserting the word *including* after the words *making the decision* and the colon. The word *including* means *not necessarily limited to*, which will help clarify that the record could include items not enumerated in subsection (r)(2)(A)-(J), but nevertheless reviewed by the IRO in making its decision.

**§133.308(r)(2):** A commenter requests that the language in this subsection be revised to provide that the Division compile the record for appeal of the IRO decision and the Division determine the prevailing party because (1) IROs may not want to or may not be qualified to determine the prevailing party (e.g. especially in a split decision); (2) this subsection is in conflict with the Government Code, which requires the Division to create the record; and (3) the determination of the prevailing party is very important because the burden of proof essentially shifts.

**Agency Response:** The Division disagrees that the requested change is necessary because Labor Code §413.031(k) specifically provides that the Division and the Department are not considered to be parties to the medical dispute for purposes of

judicial review of the decision.

**§133.308(r)(2)(H):** A commenter recommends deleting §133.308(r)(2)(H), based upon the rationale that any pertinent medical literature or documentation relied on by the IRO as part of the IRO's decision should be included with the decision and not tacked on as additional documentation in the record after the decision.

**Agency Response:** The Division declines to make the commenter's requested change because subsection (r)(2)(H) does not imply that the IRO decision should not include the elements listed in subsection (r)(2)(H). The Division agrees that the IRO decision should list or describe (though not necessarily *contain*) *any pertinent literature or documentation relied on by the IRO as part of the IRO's decision* because Labor Code §413.032(a)(1) specifies that the IRO decision shall include all medical records, as well as *other documents reviewed by the organization*. Paragraph (2) merely describes what information should be included with the record for non-network appeals.

**§133.308(s):** A commenter states that the language in this subsection should provide that the written appeal should also be sent to the injured employee's treating doctor, in addition to both parties to the proceeding (the carrier and injured employee) and the Division's Chief Clerk as required by 28 TAC §142.5(c), because providing the written appeal to the health care provider and treating doctor increases communication within the workers' compensation system, which will likely prevent injured employees from

being barred from the dispute resolution system based on a technicality.

**Agency Response:** 28 TAC §142.5(c)(1)(E) requires the request for a benefit contested case hearing to be delivered to all the other parties as provided by §142.4 of this chapter. Section 142.4 states that a party who sends a document relating to a benefit contested case hearing to the Division shall also deliver copies of the document to all other parties. If the treating doctor is a party to the dispute he will be copied.

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

**For with changes:** American Insurance Association; Barnes, Anderson, Jury & Brenner; Concentra, Inc.; Downs Stanford, P.C.; Envoy Medical Systems. L.L.C.; Fair Isaac Corporation; Flahive, Ogden & Latson; Hassle-Free Pharmacy Services; Insurance Council of Texas; Law Offices of John D. Pringle; MedPro Clinics; North Texas Pain Recovery Center; Office of Injured Employee Counsel; State Office of Risk Management; Texas Mutual Insurance Company; The Boeing Company; The RSL Group, Inc.; Workers' Compensation Pharmacy Alliance; and Zenith Insurance Company.

**Against:** None.

**6. STATUTORY AUTHORITY.** The sections are adopted pursuant to Labor Code §§401.024, 402.083, 408.0041(a), 408.027(g), 408.0271, 408.031(a), 413.002(d), 413.0111, 413.020, 413.031, 413.031(b), (c), (e), and (g), 413.032(a), 413.0511(b)(8),

413.0512(c), 402.00111, 402.061, Insurance Code Article 21.58A §14(c) and Government Code §2001.177(a). Labor Code Section 401.024 authorizes the commissioner to require by rule the use of facsimile or other electronic means to transmit information. Section 402.083 provides that information derived from a claim file regarding an employee is confidential. Section 408.0041(a) provides that at the request of a carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about the impairment caused by the compensable injury. Section 408.027(g) provides that §§408.027 and 408.0271 apply to health care provided through a workers' compensation health care network established under Chapter 1305 and that the commissioner of workers' compensation shall adopt rules as necessary to implement the provisions of §§408.027 and 408.0271. Section 408.0271 states that if health care services provided to an employee are determined by the carrier to be inappropriate, the carrier shall notify the provider in writing of the carrier's decision and demand a refund of the portion of payment on the claim received by the provider for the inappropriate services and the provider may appeal such a carrier's determination no later than the 45th day after the date of the carrier's request for the refund. Section 408.031(a) allows injured employees to receive benefits under a workers' compensation health care network established under Insurance Code Chapter 1305. Section 413.002(d) provides that if the commissioner determines that an IRO is in violation of Labor Code Chapter 413, rules adopted by the commissioner under Chapter 413, applicable provisions of Labor Code Title 5, the

commissioner or a delegated representative shall notify the IRO of the alleged violation and may compel the production of any documents or other information as necessary to determine whether the violation occurred. Section 413.0111 provides that the rules adopted by the commissioner for the reimbursement of prescription medications and services must authorize pharmacies to use agents or assignees to process claims and act on behalf of the pharmacies under terms and conditions agreed upon by the pharmacies. Section 413.020 provides the authority to adopt rules which enable the Division to charge a carrier a reasonable fee for or access to evaluation of health care treatment, fees, or charges. The section also provides that the Division may charge a provider who exceeds a fee or utilization guideline or a carrier who unreasonably disputes charges that are consistent with a fee or utilization guideline a reasonable fee for review of health care treatment, fees, or charges. Section 413.031 specifies the processes for an IRO decision and appeal and states that the commissioner by rule shall specify the appropriate dispute resolution process for fee disputes in which a claimant has paid for medical services and seeks reimbursement. Section 413.031(b) provides that: a provider who submits a charge in excess of the fee guidelines or treatment policies is entitled to a review of the medical service to determine if reasonable medical justification exists for the deviation; a claimant is entitled to a review of a medical service for which preauthorization is sought by the provider and denied by the carrier; and the commissioner shall adopt rules to notify claimants of their rights under this subsection. Section 413.031(c) provides that in resolving disputes over the

amount of payment due for services determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the Division is to adjudicate the payment given the relevant statutory provisions and commissioner rules. Section 413.031(e) provides that except as provided by subsections (d), (f), and (m), a review of the medical necessity of a health care service provided under this chapter or Chapter 408 shall be conducted by an independent review organization under Insurance Code Article 21.58C in the same manner as reviews of utilization review decisions by health maintenance organizations. Section 413.031(g) provides that in performing a review of medical necessity under Subsection (d) or (e), an independent review organization may request that the commissioner order an examination by a designated doctor under Chapter 408. Section 413.032(a) provides that an IRO that conducts a review under Chapter 413 shall specify the minimum elements on which the IRO decision is based. Section 413.0511(b)(8) authorizes the Division's medical advisor to monitor the quality and timeliness of decisions made by designated doctors and independent review organizations, and the imposition of sanctions regarding those decisions. Section 413.0512(c) authorizes the Division's medical quality review panel to recommend to the medical advisor appropriate action regarding utilization review agents, and independent review organizations, and the addition and deletion of doctors from the list of approved doctors under §408.023 or the list of designated doctors established under §408.1225. Insurance Code Article 21.58A, §13 grants the commissioner of workers' compensation the authority to adopt rules as necessary to

implement Article 21.58A, as this section applies to utilization review of health care services provided to persons eligible for workers' compensation medical benefits under Labor Code Title 5. Government Code §2001.177(a) provides that a state agency by rule may require a party who appeals a final decision in a contested case to pay all or a part of the cost of preparation of the original or a certified copy of the record of the agency proceeding that is required to be sent to the reviewing court. 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. Section 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.

## **7. TEXT.**

### **§133.305. MDR - General.**

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

(1) Adverse determination--A determination by a utilization review agent that the health care services furnished or proposed to be furnished to a patient are not medically necessary, as defined in Insurance Code Article 21.58A (§4201.002 effective April 1, 2007).

(2) Life-threatening--A disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted, as defined in Insurance Code Article 21.58A, §2(12) (§4201.002 effective April 1, 2007).

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

(A) a medical fee dispute; or

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

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

(ii) a retrospective medical necessity dispute.

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

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

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

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

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

(6) Non-network health care--Health care not delivered or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules.

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

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

(b) Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee

dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §§413.031 and 408.021.

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

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

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

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

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

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

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

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

**§133.307. MDR of Fee Disputes.**

(a) Applicability. This section applies to a request for medical fee dispute resolution for non-network or certain authorized out-of-network health care not subject to a contract, which was filed on or after January 15, 2007. Dispute resolution requests filed prior to January 15, 2007 shall be resolved in accordance with the rules in effect at the time the request was filed. In resolving non-network disputes which are over the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the Division of Workers' Compensation (Division) is to adjudicate the payment, given the relevant statutory provisions and Division rules.

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

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

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

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

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

(c) Requests. Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. Requestors shall file two legible copies of the request with the Division.

(1) Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request.

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

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

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

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

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

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

(A) a copy of all medical bill(s) as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in

accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) proof of employee payment (copies of receipts);

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

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

(d) Responses. Carrier or provider responses to a request for MDR shall be legible and submitted in the form and manner prescribed by the Division.

(1) Timeliness. The response will be deemed timely if received by the Division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information.

(2) Carrier Response. Upon receipt of the request, the carrier shall complete the required sections of the request form and provide any missing information not provided by the requestor and known to the carrier.

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

(i) all initial and reconsideration EOBs related to the health care in dispute not submitted by the requestor or a statement certifying that the carrier did not receive the provider's disputed billing prior to the dispute request;

(ii) a copy of all medical bill(s) relevant to the dispute, if different from that originally submitted to the carrier for reimbursement;

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

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

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

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

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

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

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

(B) The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the

Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MDR will be dismissed in accordance with subsection (e)(3)(G) or (H) of this section.

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

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

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

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

(A) any documentation, including medical bills and employee payment receipts, supporting the reasons why the refund request was denied;

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

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

(e) MDR Action. The Division will review the completed request and response to determine appropriate MDR action.

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

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

(3) Dismissal. The Division may dismiss a request for medical fee dispute resolution if:

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

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

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

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

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

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

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

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

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

(J) the Division determines that good cause exists to dismiss the request.

(4) Decision. The Division shall send a decision to the disputing parties and to representatives of record for the parties and post the decision on the Department Internet website.

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

(f) Appeal. A party to a medical fee dispute may seek judicial review of the decision by filing a petition in a Travis County district court not later than the 30th day after the date on which the decision is received by the appealing party. The parties will be deemed to have received the decision on the acknowledgement date as defined in §102.5 of this title. Any decision that is not timely appealed becomes final. If a party to a medical fee dispute files a petition for judicial review of the MDR Section decision, the party shall, at the time the petition is filed with the district court, send a copy of the petition for judicial review to the Division. The Division and the Department are not considered to be parties to the medical dispute pursuant to Labor Code §413.031(k). The following information must be included in the petition or provided by cover letter:

- (1) the MDR Section tracking number for the dispute being appealed;
- (2) the names of the parties;
- (3) the cause number;
- (4) the identity of the court; and

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

(g) Record for Appeal. The Division shall upon receipt of the court petition prepare a record of the MDR Section review and submit a copy of the record to the district court. The Division shall assess the party seeking judicial review expenses incurred by the Division in preparing and copying the record. The record shall contain:

(1) the MDR Section decision;

(2) the request for MDR;

(3) all documentation and written information submitted by the requestor;

(4) all documentation and written information submitted by the respondent;

(5) other documents contained in the MDR Section files (e.g. correspondence, orders for production);

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

(7) if not specified in the decision, citations to the particular provisions in statutes, rules, and other authorities that are utilized to support the decision; and

(8) signed and certified custodian of records affidavit;

(h) Letter of Clerical Correction. Upon receipt of a Division decision, either party may request a clerical correction of an error in a decision. Clerical errors are non-

substantive and include but are not limited to typographical or mathematical calculation errors. Only the Division can determine if a clerical correction is required. A request for clerical correction does not alter the deadlines for appeal.

**§133.308. MDR by Independent Review Organizations.**

(a) Applicability. This section applies to the independent review of network and non-network preauthorization, concurrent or retrospective medical necessity disputes for a dispute resolution request filed on or after January 15, 2007. Dispute resolution requests filed prior to January 15, 2007 shall be resolved in accordance with the rules in effect at the time the request was filed. When applicable, retrospective medical necessity disputes shall be governed by the provisions of Labor Code §413.031(n) and related rules. All independent review organizations (IROs) performing reviews of health care under the Labor Code and Insurance Code, regardless of where the independent review activities are located, shall comply with this section. The Insurance Code, the Labor Code and related rules govern the independent review process.

(b) IRO Certification. Each IRO performing independent review of health care provided in the workers' compensation system shall be certified pursuant to Insurance Code Article 21.58C (Chapter 4202 effective April 1, 2007).

(c) Conflicts. Conflicts of interest will be reviewed by the Department consistent with the provisions of the Insurance Code Article 21.58C, §2(f) (Chapter 4202.008 effective April 1, 2007), Labor Code §413.032(b), §12.203 of this title (relating to

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

(d) Monitoring. The Division will monitor IROs under Labor Code §§413.002, 413.0511, and 413.0512. The Division shall report the results of the monitoring of IROs to the Department on at least a quarterly basis.

(e) Requestors. The following parties are considered requestors

(1) In network disputes:

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

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

(2) In non-network disputes:

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

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

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

(1) the Department's Internet website at [www.tdi.state.tx.us](http://www.tdi.state.tx.us); or

(2) the Health and Worker's Compensation Network Certification and Quality Assurance Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

(g) Timeliness. A requestor shall file a request for independent review with the insurance carrier (carrier) or the carrier's utilization review agent (URA) no later than the 45th calendar day after receipt of the denial of reconsideration. The carrier shall immediately notify the Department upon receipt of the request for an independent review. In a preauthorization or concurrent review dispute request, an employee with a life-threatening condition, as defined in §133.305 of this subchapter (relating to Medical Dispute Resolution – General), is entitled to an immediate review by an IRO and is not required to comply with the procedures for a reconsideration.

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

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

(2) the individual or entity requesting medical necessity dispute resolution is not a proper party to the dispute;

(3) the Department determines that the dispute involving a non-life-threatening condition has not been submitted to the carrier for reconsideration;

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

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

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

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

(i) IRO Assignment and Notification. The Department shall review the request for IRO review, assign an IRO, and notify the parties about the IRO assignment consistent with the provisions of Insurance Code Article 21.58C, §2(a)(1)(A) (Chapter 4202.002(a)(1) effective April 1, 2007), §1305.355(a), Chapter 12, Subchapter F of this title (related to Random Assignment of Independent Review Organizations), any other related rules, and this subchapter.

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

- (1) the forms prescribed by the Department for requesting IRO review;
- (2) all medical records of the employee in the possession of the carrier that are relevant to the review;
- (3) all documents, guidelines, policies, protocols and criteria used by the carrier in making the decision;
- (4) all documentation and written information submitted to the carrier in support of the appeal;
- (5) the written notification of the initial adverse determination and the written adverse determination of the reconsideration; and
- (6) any other information required by the Department related to a request from a carrier for the assignment of an IRO.

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

(1) The party or providers with relevant records shall deliver the requested information to the IRO as directed by the IRO. If the provider requested to submit records is not a party to the dispute, the carrier shall reimburse copy expenses

for the requested records pursuant to §134.120 of this title (relating to Reimbursement for Medical Documentation). Parties to the dispute may not be reimbursed for copies of records sent to the IRO.

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

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

(l) Designated Doctor Exam. In performing a review of medical necessity, an IRO may request that the Division require an examination by a designated doctor and direct the employee to attend the examination pursuant to Labor Code §§413.031(g) and 408.0041. The IRO request to the Division must be made no later than 10 days after the IRO receives notification of assignment of the IRO. The treating doctor and carrier shall forward a copy of all medical records, diagnostic reports, films, and other medical documents to the designated doctor appointed by the Division, to arrive no later than three working days prior to the scheduled examination. Communication with the designated doctor is prohibited regarding issues not related to the medical necessity dispute. The designated doctor shall complete a report and file it with the IRO, on the form and in the manner prescribed by the Division no later than seven working days after completing the examination. The designated doctor report shall address all issues as directed by the Division.

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

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

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

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

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

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

(1) The IRO decision must include:

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

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

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

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

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

(F) a certification by the IRO that the reviewing provider has no known conflicts of interest pursuant to the Insurance Code Article 21.58A (Chapter 4201 effective April 1, 2007), Labor Code §413.032, and §12.203 of this title; and

(G) if the IRO's decision is contrary to:

(i) the Division's policies or guidelines adopted under Labor Code §413.011, the IRO must indicate in the decision the specific basis for its divergence in the review of medical necessity of non-network health care; or

(ii) the network's treatment guidelines, the IRO must indicate in the decision the specific basis for its divergence in the review of medical necessity of network health care.

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

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

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

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

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

(A) in a preauthorization or concurrent review medical necessity dispute or an employee reimbursement dispute, the carrier shall remit payment to the assigned IRO within 15 days after receipt of an invoice from the IRO.

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

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

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

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

(4) Failure to pay or refund the IRO fee may result in enforcement action as authorized by statute and rules and removal from the Division's Approved Doctor List.

(5) For health care not provided by a network, the non-prevailing party to a retrospective medical necessity dispute must pay or refund the IRO fee to the prevailing party upon receipt of the IRO decision, but not later than 15 days regardless of whether an appeal of the IRO decision has been or will be filed.

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

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

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

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

(r) Appeal. A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division are considered parties to an appeal. Appeals of IRO decisions will be as follows:

(1) Non-Network Appeal Procedures. A carrier shall comply with the IRO decision in accordance with Labor Code §413.031(m). A party to a medical necessity dispute may seek judicial review of the IRO decision by filing a petition in a Travis County district court not later than the 30th day after the date on which the decision is received by the appealing party. The parties will be deemed to have received the decision on the acknowledgement date as defined in §102.5 of this title (relating to General Rules for Written Communications to and from the Commission). Any decision that is not timely appealed becomes final. A party to a medical necessity dispute who

appeals the decision shall, at the time the petition is filed, send a copy of the petition for judicial review to the IRO that issued the decision being appealed, and request that the IRO provide a record for the appeal. The party requesting the record shall pay the IRO copying costs for the records.

(2) Record for Non-Network Appeal. If a party to a medical necessity dispute files a petition for judicial review of the IRO decision, the IRO, upon request, shall provide a record of the review and submit it to the requestor within 15 days of the request. The record shall include the following documents that are in the possession of the IRO and which were reviewed by the IRO in making the decision including:

- (A) medical records;
- (B) all documents used by the carrier in making the decision that resulted in the adverse determination under review by the IRO;
- (C) all documentation and written information submitted by the carrier to the IRO in support of the review;
- (D) the written notification of the adverse determination and the written determination of the reconsideration;
- (E) a list containing the name, address and phone number of each provider who provided medical records to the IRO relevant to the review;
- (F) a list of all medical records or other documents reviewed by the IRO, including the dates of those documents;
- (G) a copy of the decision that was sent to all parties;

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

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

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

(3) Network Appeal Procedures. A party to a medical necessity dispute may seek judicial review of the decision as provided in Insurance Code §1305.355.

(s) Non-Network Spinal Surgery Appeal. A party to a preauthorization or concurrent medical necessity dispute regarding spinal surgery may appeal the IRO decision in accordance with Labor Code §413.031(I) by requesting a Contested Case Hearing (CCH).

(1) The written appeal must be filed with the Division Chief Clerk no later than 10 days after receipt of the IRO decision and must be filed in compliance with §142.5(c) of this title (relating to Sequence of Proceedings to Resolve Benefit Disputes).

(2) The CCH must be scheduled and held not later than 20 days after Division receipt of the request for a CCH.

(3) The hearing and further appeals shall be conducted in accordance with Chapters 140, 142, and 143 of this title (relating to Dispute Resolution/General Provisions, Benefit Contested Case Hearing, and Review by the Appeals Panel).

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

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

(u) Enforcement. If the Department believes that any person is in violation of the Labor Code, Insurance Code and related rules, the Department may initiate an enforcement action. Nothing in this section modifies or limits the authority of the Department or the Division.

**CERTIFICATION.** This agency 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 \_\_\_\_\_, 2006.

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Norma Garcia  
General Counsel  
Division of Workers' Compensation  
Texas Department of Insurance

IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that new §§133.305, 133.307, and 133.308, concerning Medical Dispute Resolution (MDR), are adopted.

AND IT IS SO ORDERED.

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ALBERT BETTS  
COMMISSIONER OF WORKERS' COMPENSATION  
TEXAS DEPARTMENT OF INSURANCE

ATTEST:

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Norma Garcia  
General Counsel

COMMISSIONER'S ORDER NO. DWC-06-0052