SUBCHAPTER C. MEDICAL BILL PROCESSING/AUDIT BY INSURANCE CARRIER.
28 TAC §§133.240 AND 133.250.

SUBCHAPTER D. DISPUTE OF MEDICAL BILLS.
28 TAC §§133.305 AND 133.308.

INTRODUCTION. The Texas Department of Insurance, Division of Workers' Compensation (DWC) adopts amended 28 TAC §§133.240, 133.250, 133.305, and 133.308, concerning medical disputes for workers' compensation claims. The amendments implement House Bill (HB) 1306, 89th Legislature, Regular Session (2025).

The amendments to §§133.240, 133.250, 133.305, and 133.308 are adopted without changes to the proposed text published in the October 24, 2025, issue of the *Texas Register* (50 TexReg 6982). Sections §§133.240, 133.250, 133.305, and 133.308 will not be republished.

REASONED JUSTIFICATION. HB 1306 added Texas Labor Code §504.057, which requires expedited medical benefits and accelerated medical dispute resolution for claims for medical benefits by a death investigation professional who sustains a serious bodily injury in the course and scope of employment, and requires that the death investigation professional inform DWC and the independent review organization that a contested case hearing or appeal involves a death investigation professional. The amendments are necessary to implement the changes in HB 1306. They specify that the insurance carrier must expedite and give priority to a claim for medical benefits by a death investigation professional who sustains a serious bodily injury in the course and scope of employment, including all health care required to cure or relieve the effects naturally resulting from a compensable injury. They also specify that DWC will accelerate and give priority to an appeal from a denial of a claim for medical benefits, and that the death investigation

professional must provide notice to DWC and the independent review organization that a contested case or appeal involves a death investigation professional.

Section 133.240. The amendments to §133.240 add the requirement from HB 1306 that an insurance carrier must accelerate and give priority to a qualifying claim for medical benefits by a death investigation professional, including all required health care for the claim. Amending §133.240 is necessary to ensure that the rule is consistent with HB 1306.

Section 133.250. The amendments to §133.250 add the requirement from HB 1306 that an insurance carrier must accelerate and give priority to a qualifying claim for medical benefits by a death investigation professional, including all required health care for the claim. Amending §133.250 is necessary to ensure that the rule is consistent with HB 1306.

Section 133.305. The amendment to §133.305 adds a definition of "death investigation professional" to tie it to the definition in Labor Code §504.057 from HB 1306. Amending §133.305 is necessary to ensure that the rule is consistent with HB 1306.

Section 133.308. The amendments to §133.308 add the requirement from HB 1306 that DWC will accelerate and give priority to an appeal from a denial of a qualifying claim for medical benefits made by a death investigation professional, as well as to actions involving all health care required to cure or relieve the effects naturally resulting from a compensable injury. The amendments add the requirement from HB 1306 that the death investigation professional must notify DWC and the independent review organization that

the contested case hearing or appeal involves a death investigation professional. Amending §133.308 is necessary to ensure that the rule is consistent with HB 1306.

SUMMARY OF COMMENTS AND INFORMATION SUBMITTED, AND AGENCY RESPONSE.

Commenters: DWC received one written comment, and no oral comments. No commenters included information, data, research, or analysis about the cost, benefit, or effect of the proposal. The commenter, which was in support of the proposal, was the Office of Injured Employee Counsel (OIEC).

Comment on §§133.240, 133.250, 133.305, and 133.308. OIEC stated that they support the amendments as they benefit the injured employees of Texas to ensure conformity with HB 1306.

Agency Response to Comment on §§133.240, 133.250, 133.305, and 133.308. DWC appreciates the comment.

SUBCHAPTER C. MEDICAL BILL PROCESSING/AUDIT BY INSURANCE CARRIER.

28 TAC §§133.240 AND 133.250.

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts amended §§133.240 and 133.250 under Labor Code §§504.057, 402.00111, 402.00116, and 402.061.

Labor Code §504.057 requires that insurance carriers expedite claims for medical benefits by death investigation professionals who sustain a serious bodily injury in the course and scope of employment, that DWC accelerate disputes about those claims, and

that the death investigation professionals inform DWC and the independent review organization that a contested case hearing or appeal involves a death investigation professional.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code.

Labor Code §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to DWC or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

TEXT.

§133.240. Medical Payments and Denials.

(a) An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

(b) For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance Code Chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of this title (relating to Benefits-

-Guidelines for Medical Services, Charges, and Payments). For pharmaceutical services provided to any injured employee, the insurance carrier shall not deny reimbursement based on medical necessity for pharmaceutical services preauthorized or agreed to under Chapter 134, Subchapter F of this title (relating to Pharmaceutical Benefits).

(c) The insurance carrier shall not change a billing code on a medical bill or reimburse health care at another billing code's value.

(d) The insurance carrier may request additional documentation, in accordance with §133.210 of this title (relating to Medical Documentation), not later than the 45th day after receipt of the medical bill to clarify the health care provider's charges.

(e) The insurance carrier shall send the explanation of benefits in accordance with the elements required by §133.500 and §133.501 of this title (relating to Electronic Formats for Electronic Medical Bill Processing and Electronic Medical Bill Processing, respectively) if the insurance carrier submits the explanation of benefits in the form of an electronic remittance. The insurance carrier shall send an explanation of benefits in accordance with subsection (f) of this section if the insurance carrier submits the explanation of benefits in paper form. The explanation of benefits shall be sent to:

(1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and

(2) the injured employee when payment is denied because:

(A) of an adverse determination;

(B) the health care was provided by a health care provider other than:

(i) the treating doctor selected in accordance with Labor Code §408.022;

(ii) a health care provider that the treating doctor has chosen as a consulting or referral health care provider;

(iii) a doctor performing a required medical examination in accordance with §126.5 of this title (relating to Entitlement and Procedure for Requesting Required Medical Examinations) and §126.6 of this title (relating to Required Medical Examination);

(iv) a doctor performing a designated doctor examination in accordance with Labor Code §408.0041; or

(C) the health care was unrelated to the compensable injury, in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements).

(3) the prescribing doctor, if different from the health care provider identified in paragraph (1) of this subsection, when payment is denied for pharmaceutical services because of any reason relating to the compensability of, liability for, extent of, or relatedness to the compensable injury, or for reasons relating to the reasonableness or medical necessity of the pharmaceutical services.

(f) The paper form of an explanation of benefits under subsection (e) of this section, §133.250 of this title (relating to Reconsideration for Payment of Medical Bills), or §133.260 of this title (relating to Refunds) shall include the following elements:

(1) division claim number, if known;

(2) insurance carrier claim number;

(3) injured employee's name;

(4) last four digits of injured employee's social security number;

(5) date of injury;

(6) health care provider's name and address;

(7) health care provider's federal tax ID or national provider identifier if the health care provider's federal tax ID is the same as the health care provider's social security number;

(8) patient control number if included on the submitted medical bill;

(9) insurance carrier's name and address;

(10) insurance carrier control number;

(11) date of bill review/refund request;

(12) diagnosis code(s);

(13) name and address of company performing bill review;

(14) name and telephone number of bill review contact;

(15) workers' compensation health care network name (if applicable);

(16) pharmacy, durable medical equipment, or home health care services informal or voluntary network name (if applicable) pursuant to Labor Code §408.0281 and §408.0284;

(17) health care service information for each billed health care service, to include:

(A) date of service;

(B) the CPT, HCPCS, NDC, or other applicable product or service code;

(C) CPT, HCPCS, NDC, or other applicable product or service code description;

(D) amount charged;

(E) unit(s) of service;

(F) amount paid;

(G) adjustment reason code that conforms to the standards described in §133.500 and §133.501 of this title if total amount paid does not equal total amount charged;

(H) explanation of the reason for reduction/denial if the adjustment reason code was included under subparagraph (G) of this paragraph and if applicable;

(18) a statement that contains the following text: "Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of the liability under Labor Code §408.024. However, pursuant to §133.250 of this title, the health care provider may file an appeal with the insurance carrier if the health care provider disagrees with the insurance carrier's determination";

(19) if the insurance carrier is requesting a refund, the refund amount being requested and an explanation of why the refund is being requested; and

(20) if the insurance carrier is paying interest in accordance with §134.130 of this title (relating to Interest for Late Payment on Medical Bills and Refunds), the interest amount paid through use of an unspecified product or service code and the number of days on which interest was calculated by using a unit per day.

(g) When the insurance carrier pays a health care provider for health care for which the division has not established a maximum allowable reimbursement, the insurance carrier shall explain and document the method it used to calculate the payment in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline).

(h) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and §124.3 of this title (relating to

Investigation of an Injury and Notice of Denial/Dispute) if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:

(1) the injury is not compensable;

(2) the insurance carrier is not liable for the injury due to lack of insurance coverage; or

(3) the condition for which the health care was provided was not related to the compensable injury.

(i) If dissatisfied with the insurance carrier's final action, the health care provider may request reconsideration of the bill in accordance with §133.250 of this title.

(j) If the health care provider is requesting reconsideration of an adverse determination, the request for reconsideration constitutes an appeal for the purposes of §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determinations). If dissatisfied with the reconsideration outcome, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).

(k) Health care providers, injured employees, employers, attorneys, and other participants in the system shall not resubmit medical bills to insurance carriers after the insurance carrier has taken final action on a complete medical bill and provide an explanation of benefits except as provided in §133.250 and Chapter 133, Subchapter D of this title.

(l) All payments of medical bills that an insurance carrier makes on or after the 60th day after the date the insurance carrier originally received the complete medical bill shall include interest calculated in accordance with §134.130 of this title without any action

taken by the division. The interest payment shall be paid at the same time as the medical bill payment.

(m) Except as provided by Insurance Code §1305.153, when an insurance carrier remits payment to a health care provider agent, the agent shall remit to the health care provider the full amount that the insurance carrier reimburses. If the insurance carrier remits payment under Insurance Code §1305.153, then the payment must be made in accordance with that section.

(n) When an insurance carrier remits payment to a pharmacy processing agent, the pharmacy processing agent's reimbursement from the insurance carrier shall be made in accordance with §134.503 of this title. The pharmacy's reimbursement shall be made in accordance with the terms of its contract with the pharmacy processing agent.

(o) An insurance carrier commits an administrative violation if the insurance carrier fails to pay, reduce, deny, or notify the health care provider of the intent to audit a medical bill in accordance with Labor Code §408.027 and division rules.

(p) For the purposes of this section, all utilization review must be performed by an insurance carrier that is registered with or a utilization review agent that is certified by the Texas Department of Insurance to perform utilization review in accordance with Insurance Code Chapter 4201 and Chapter 19 of this title.

(1) All utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Insurance Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in the course and scope of employment.

(2) An insurance carrier must accelerate and give priority to a claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury, under the following conditions:

(A) In accordance with Labor Code §501.028(b), the claim is by a member of the Texas military forces who, while on state active duty, sustains a serious bodily injury, as defined by Penal Code §1.07.

(B) In accordance with Labor Code §504.057(c), the claim is by a death investigation professional who sustains a serious bodily injury, as defined by Penal Code §1.07, in the course and scope of employment.

(q) When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title (relating to Notice of Determinations Made in Utilization Review). Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 if this title (relating to Requirements Prior to Issuing Adverse Determination), including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively.

§133.250. Reconsideration for Payment of Medical Bills.

(a) If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill, the health care provider may request that the insurance carrier reconsider its action. If the health care provider is requesting reconsideration of a bill denied based on an adverse determination, the request for reconsideration constitutes an

appeal for the purposes of §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determinations) and may be submitted orally or in writing.

(b) The health care provider shall submit the request for reconsideration no later than 10 months from the date of service.

(c) A health care provider shall not submit a request for reconsideration until:

(1) the insurance carrier has taken final action on a medical bill; or

(2) the health care provider has not received an explanation of benefits within 50 days from submitting the medical bill to the insurance carrier.

(d) A written request for reconsideration shall:

(1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill;

(2) include a copy of the original explanation of benefits, if received, or documentation that a request for an explanation of benefits was submitted to the insurance carrier;

(3) include any necessary and related documentation not submitted with the original medical bill to support the health care provider's position; and

(4) include a bill-specific, substantive explanation in accordance with §133.3 of this title (relating to Communication Between Health Care Providers and Insurance Carriers) that provides a rational basis to modify the previous denial or payment.

(e) An oral request for reconsideration must clearly identify the health care services(s) denied based on an adverse determination and include a substantive explanation in accordance with §133.3 of this title that provides a rational basis to modify the previous denial or payment. Not later than the fifth working day after the date of receipt of the request for reconsideration, the insurance carrier must send to the requesting party a letter acknowledging the date of the receipt of the oral request that

includes a reasonable list of documents the requesting party is required to submit. This subsection applies to reconsideration requests made on or after six months from the effective date of this rule.

(f) An insurance carrier shall review all written reconsideration requests for completeness in accordance with subsection (d) of this section and may return an incomplete written reconsideration request no later than seven days from the date of receipt. A health care provider may complete and resubmit its written request to the insurance carrier.

(g) The insurance carrier shall take final action on a reconsideration request within 30 days of receiving the request for reconsideration. The insurance carrier shall provide an explanation of benefits:

(1) in accordance with §133.240(e) - (f) of this title (relating to Medical Payments and Denial) for all items included in a reconsideration request in the form and format prescribed by the division when there is a change in the original, final action; or

(2) in accordance with §133.240(e)(1) and §133.240(f) of this title when there is no change in the original, final action.

(h) A health care provider shall not resubmit a request for reconsideration earlier than 35 days from the date the insurance carrier received the original request for reconsideration or after the insurance carrier has taken final action on the reconsideration request.

(i) If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).

(j) For the purposes of this section, all utilization review must be performed by an insurance carrier that is registered with, or a utilization review agent that is certified by, the Texas Department of Insurance to perform utilization review in accordance with Insurance Code Chapter 4201 and Chapter 19 of this title.

(1) All utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Insurance Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in the course and scope of employment.

(2) An insurance carrier must accelerate and give priority to a claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury, under the following conditions:

(A) In accordance with Labor Code §501.028(b), the claim is by a member of the Texas military forces who, while on state active duty, sustains a serious bodily injury, as defined by Penal Code §1.07.

(B) In accordance with Labor Code §504.057(c), the claim is by a death investigation professional who sustains a serious bodily injury, as defined by Penal Code §1.07, in the course and scope of employment.

(k) In any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title (relating to Requirements Prior to Adverse Determination) and §19.2011 of this title, including the requirement that prior to issuance of an adverse determination on the request for reconsideration the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care

with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively.

SUBCHAPTER D. DISPUTE OF MEDICAL BILLS.

28 TAC §§133.305 AND 133.308.

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts amended §§133.305 and 133.308 under Labor Code §§504.057, 402.00111, 402.00116, and 402.061.

Labor Code §504.057 requires that insurance carriers expedite claims for medical benefits by death investigation professionals who sustain a serious bodily injury in the course and scope of employment, that DWC accelerate disputes about those claims, and that the death investigation professionals inform DWC and the independent review organization that a contested case hearing or appeal involves a death investigation professional.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code.

Labor Code §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to DWC or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

TEXT.

§133.305. MDR--General.

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

(1) First responder--As defined in Labor Code §504.055(a). (2) Life-threatening--A disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted, as defined in Insurance Code §4201.002.

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

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

(A) a medical fee dispute; or

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

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

(ii) a retrospective medical necessity dispute.

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

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

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

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

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

(6) Non-network health care--Health care not delivered or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules. "Non-network health care" includes health care delivered pursuant to Labor Code §408.0281 and §408.0284.

(7) Preauthorization or concurrent medical necessity dispute--A dispute that involves a review of adverse determination of network or non-network health care requiring preauthorization or concurrent utilization 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 title (relating to MDR of Medical Necessity Disputes).

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

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

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

(11) Serious bodily injury--As defined by §1.07, Penal Code.

(12) State active duty--As defined by §437.001, Government Code.

(13) State training and other duty--As defined by §437.001, Government Code.

(14) Texas military forces--As defined by §437.001, Government Code.

(15) Death investigation professional--As defined by §504.057, Labor Code.

(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 title if the decision indicates the following:

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

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

(3) the insurance carrier has reduced the payment based on a contracted discount rate with the health care provider but has not made the contract or the health

care provider notice required under Labor Code §408.0281 available upon the division's request;

(4) the insurance carrier has reduced or denied payment based on a contract that indicates the direction or management of health care through a health care provider arrangement that has not been certified as a workers' compensation network, in accordance with Insurance Code Chapter 1305 or through a health care provider arrangement authorized under Labor Code §504.053(b)(2); or

(5) the insurance carrier or healthcare 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 injured 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, or 133.308 of this title is inconsistent with any statutes of this state, unconstitutional, or invalid for any reason, the remaining provisions of these sections remain in full effect.

(f) Texas Military Forces. For a claim under Labor Code §501.028, the travel of a member of the Texas military forces to or from the member's duty location is considered to be in the course and scope of the member's employment if the member is:

(1) serving on state active duty and engaged in authorized duty under written orders; or

(2) on state training and other duty.

§133.308. MDR of Medical Necessity Disputes.

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

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

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

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

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

(c) Professional licensing requirements. Notwithstanding Insurance Code Chapter 4202, an IRO that uses doctors to perform reviews of health care services provided under this section may only use doctors licensed to practice in Texas that hold the appropriate credentials under Chapter 180 of this title (relating to Monitoring and Enforcement). Personnel employed by or under contract with the IRO to perform independent review shall also comply with the personnel and credentialing requirements under Chapter 12 of this title.

(d) Conflicts. Conflicts of interest will be reviewed by the department consistent with the provisions of the Insurance Code §4202.008, Labor Code §413.032(b), §§12.203, 12.204, and 12.206 of this title (relating to Conflicts of Interest Prohibited, Prohibitions of

Certain Activities and Relationships of Independent Review Organizations and Individuals or Entities Associated with Independent Review Organizations, and Notice of Determinations Made by Independent Review Organizations, respectively), and any other related rules. Notification of each IRO decision must include a certification by the IRO that the reviewing health care provider has certified that no known conflicts of interest exist between that health care provider and the injured employee, the injured employee's employer, the insurance carrier, the utilization review agent, any of the treating health care providers, or any of the health care providers utilized by the insurance carrier to review the case for determination prior to referral to the IRO.

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

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

(1) In network disputes:

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

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

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

(2) In non-network disputes:

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

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

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

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

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

(2) the Managed Care Quality Assurance Office, Mail Code LH-MCQA, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

(h) Timeliness. A requestor shall file a request for independent review with the insurance carrier that actually issued the adverse determination or the insurance carrier's utilization review agent (URA) that actually issued the adverse determination no later than the 45th calendar day after receipt of the insurance carrier's denial of an appeal. The

insurance carrier shall notify the department of a request for an independent review within one working day from the date the request is received by the insurance carrier or its URA. In a preauthorization or concurrent review dispute request, an injured employee with a life-threatening condition, as defined in §133.305 of this subchapter (relating to MDR--General), is entitled to an immediate review by an IRO and is not required to comply with the procedures for an appeal to the insurance carrier.

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

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

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

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

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

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

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

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

(j) IRO Assignment and Notification. The department shall review the request for IRO review, assign an IRO, and notify the parties about the IRO assignment consistent with the provisions of Insurance Code §4202.002(a)(1), §1305.355(a), Chapter 12,

Subchapter F of this title (relating to Random Assignment of Independent Review Organizations), any other related rules, and this subchapter.

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

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

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

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

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

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

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

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

(1) The party or health care providers with relevant records shall deliver the requested information to the IRO as directed by the IRO. If the health care provider

requested to submit records is not a party to the dispute, the insurance carrier shall reimburse copy expenses for the requested records pursuant to §134.120 of this title (relating to Reimbursement for Medical Documentation). Parties to the dispute may not be reimbursed for copies of records sent to the IRO.

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

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

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

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

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

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

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

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

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

(1) The IRO decision must include:

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

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

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

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

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

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

(G) if the IRO's decision is contrary to the division's policies or guidelines adopted under Labor Code §413.011, the IRO must indicate in the decision the

specific basis for its divergence in the review of medical necessity of nonnetwork health care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(r) Defense. An insurance carrier may claim a defense to a medical necessity dispute if the insurance carrier timely complies with the IRO decision with respect to the medical necessity or appropriateness of health care for an injured employee. Upon receipt of an IRO decision for a retrospective medical necessity dispute that finds that medical necessity exists, the insurance carrier must review, audit, and process the bill. In addition, the insurance carrier shall tender payment consistent with the IRO decision, and issue a new explanation of benefits (EOB) to reflect the payment within 21 days upon receipt of the IRO decision. The decision of an IRO under Labor Code §413.031(m) is binding during the pendency of a dispute.

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

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

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

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

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

(D) At a division CCH, the administrative law judge shall consider the treatment guidelines:

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

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

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

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

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

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

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

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

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

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

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

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

(II) the names of the parties;

(III) the cause number;

(IV) the identity of the court; and

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

(ii) The record of the hearing includes:

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

(II) evidence received or considered;

(III) a statement of matters officially noticed;

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

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

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

(iii) The division shall assess to the party seeking judicial review expenses incurred by the division in preparing the certified copy of the record, including transcription costs, in accordance with the Government Code §2001.177 (relating to Costs of Preparing Agency Record). Upon request, the division shall consider the financial ability of the party to pay the costs, or any other factor that is relevant to a just and reasonable assessment of costs.

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

(A) medical records;

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

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

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

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

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

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

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

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

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

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

(u) First Responders. In accordance with Labor Code §504.055(d), an appeal regarding the denial of a claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury involving a first

responder will be accelerated by the division and given priority. The party seeking to expedite the contested case hearing or appeal must provide notice to the division and independent review organization that the contested case hearing or appeal involves a first responder.

(v) Texas Military Forces. In accordance with Labor Code §501.028, the division will accelerate and give priority to an appeal from a denial of a claim for medical benefits.

(1) This subsection applies to a claim for medical benefits made by a member of the Texas military forces who, while on state active duty, sustains a serious bodily injury, as defined by Penal Code §1.07.

(2) The division will accelerate and give priority to actions involving all health care required to cure or relieve the effects naturally resulting from a compensable injury.

(3) The member must notify the division and IRO that the CCH or appeal involves a member of the Texas military forces.

(w) Death investigation professionals. In accordance with Labor Code §504.057, the division will accelerate and give priority to an appeal from a denial of a claim for medical benefits.

(1) This subsection applies to a claim for medical benefits made by a death investigation professional who sustains a serious bodily injury, as defined by Penal Code §1.07, in the course and scope of employment.

(2) The division will accelerate and give priority to actions involving all health care required to cure or relieve the effects naturally resulting from a compensable injury.

(3) The death investigation professional must notify the division and IRO that the CCH or appeal involves a death investigation professional.

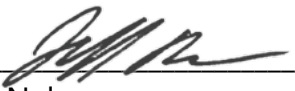
(x) Enforcement. The department or the division may initiate appropriate proceedings under Chapter 12 of this title or Labor Code, Title 5 and division rules against an independent review organization or a person conducting independent reviews.

CERTIFICATION. The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on January 8, 2026.

Kara Mace
General Counsel
TDI, Division of Workers' Compensation

The commissioner adopts amended 28 TAC §§133.240, 133.250, 133.305, and 133.308.



Jeff Nelson
Commissioner
TDI, Division of Workers' Compensation

Commissioner's Order No. 2026-9724