SUBCHAPTER A. GENERAL RULES FOR ENFORCEMENT
28 TAC §180.2

INTRODUCTION. The Texas Department of Insurance, Division of Workers' Compensation (DWC) adopts amendments to 28 TAC §180.2, concerning filing a complaint. The amendments are adopted without changes to the proposed text published in the March 22, 2024, issue of the *Texas Register* (49 TexReg 1872). The rule will not be republished.

REASONED JUSTIFICATION. The amendments prevent health care providers or their agents from trying to use DWC's complaint process to collect fees instead of submitting their medical fee disputes properly through the medical fee dispute resolution (MFDR) process established by Texas Labor Code §413.031. Under the MFDR process, health care providers have one year after the date of service to bring a fee dispute, unless an exception applies. However, some health care providers and their agents have tried to use DWC's complaint process to collect disputed fees when they fail to file a fee dispute before the MFDR deadline. To address this problem, the amendments clarify that a health care provider cannot submit a complaint about a medical billing issue if the date of service for the medical billing issue was more than 12 months before the date of the complaint, unless an MFDR deadline exception applies. The restriction does not apply to a health care provider submitting a complaint under Insurance Code Chapter 1305.

The amendments also include nonsubstantive editorial and formatting changes that make updates for plain language and agency style to improve the rule's clarity.

Amending §180.2 is necessary to ensure that no health care provider or agent can use the complaint process to circumvent the MFDR filing deadline in 28 TAC §133.307(c), concerning medical fee dispute resolution. Labor Code §402.023 requires the commissioner to adopt rules about filing complaints, including how to file a complaint and what constitutes a frivolous complaint. Labor Code §413.031 requires the commissioner to adjudicate disputes over the amount of payment due for services determined to be medically necessary and appropriate for treatment of a compensable injury. DWC's MFDR rules, including §133.307, contain requirements for adjudicating those disputes. Amending §180.2 as proposed will prevent health care providers and their agents from using DWC's complaint process to avoid the MFDR rules that the commissioner adopted to comply with Labor Code §§402.023 and 413.031.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: DWC received three written comments on the proposal by the April 22, 2024, deadline, and no oral comments at the April 16, 2024, public hearing. Commenters in support of the proposal were: the American Property Casualty Insurance Association (APCIA) and the Insurance Council of Texas (ICT). An anonymous person or organization commented against the proposal.

Comments on §180.2. Two commenters stated that the proposed amendment will help prevent inappropriate and untimely requests for payments, promote fairness, and help ensure a level playing field, where all health care providers follow the same rules for

resolving fee disputes, resulting in a more efficient and effective workers' compensation system in Texas.

Agency Response to Comments on §180.2. DWC appreciates the comments and agrees.

Comment on §180.2. A commenter suggested that the proposed rule be further amended to include a requirement that a health care provider can only submit a complaint about a medical billing issue if the health care provider has not been paid per the fee guidelines or rules, and can show that the health care provider has done the following on time: billed for the services, submitted a request for reconsideration, and filed for medical fee dispute resolution.

Agency Response to Comment on §180.2. DWC appreciates the comment but declines to make the suggested change. DWC believes that the suggested change would be unduly limiting for health care providers, and would create a system in which even health care providers that were paid late, as long as they were paid, would be unable to file a complaint.

Comment on §180.2. A commenter stated that the rule does not allow a complaint about a cumulative issue with an insurance carrier consistently committing a violation. The commenter stated that some insurance carriers indicate that they never received a bill even when presented with proof of receipt, consistently deny or reduce bills even though they are aware that the bills warrant payment, or deny bills for reasons they know to be incorrect. The commenter stated that health care providers and agents make complaints to get DWC to enforce its rules for insurance carriers or their bill review agents, and that

health care providers and agents are having to hire additional staff to try to collect on bills from insurance carriers that have ignored, denied, or improperly reduced the bills. The commenter stated that, while the proposed rule will eliminate system burden for DWC and insurance carriers, it provides no relief for health care providers in their complaints.

Agency Response to Comment on §180.2. DWC appreciates the comment but disagrees that the amendments prevent a health care provider from submitting a complaint about a cumulative issue with an insurance company's payment practices. The MFDR process and the complaint process address different kinds of issues and provide different kinds of relief, although there can be some overlap in the information considered in each process. The MFDR process provides relief for a health care provider when the health care provider is owed money from a bill and the insurance carrier has improperly denied or reduced payment. The complaint process is to ensure compliance with the applicable statutes and DWC rules. DWC considers repeated violations and patterns of misconduct when assessing penalties in enforcement cases. The amended rule does not prevent filing a complaint for issues that would not be appropriate for MFDR--it only restricts the timeframe for a health care provider that has missed the MFDR filing deadline and now wants to use the complaint process to get around the missed deadline and collect on a medical bill.

Comment on §180.2. A commenter stated that DWC rules do not require a health care provider to collect their workers' compensation bills or to file requests for reconsideration or medical dispute resolution at all, but that the rules do require an insurance company to take final action on a medical bill within 45 days of receiving the claim; and that an

insurance carrier commits an administrative violation if they fail to pay, reduce, or deny and notify the health care provider of their intent to audit the bill. The commenter also stated that an insurance carrier violates §134.201(b) when continued noncompliance on multiple bills over long periods of time shows willfulness and intentional violation. The commenter stated that if a health care provider can prove that the insurance carrier received a bill on time, and the insurance carrier cannot prove that they took final action on the medical bill within 45 days of receiving it, then that would be a violation. The commenter stated that the complaint process and the request for reconsideration and medical dispute resolution processes are independent of each other and should remain that way. The commenter stated that, while health care providers and their agents understand that the request for reconsideration and medical dispute resolution processes are necessary for the proper collection of a medical bill, a complaint can and should be filed separately and independently on an insurance carrier or their agents for violations of the rules.

Agency Response to Comment on §180.2. DWC rules do not require a health care provider to request reconsideration or medical dispute resolution because not every bill needs this action. But if a health care provider wants to dispute how an insurance carrier has handled a particular bill or a set of bills, the MFDR process that DWC adopted under Labor Code §413.031 is the way to adjudicate those disputes. The amended rule does not prevent filing a complaint for issues that would not be appropriate for MFDR--it only restricts the timeframe for a health care provider that has missed the MFDR filing deadline and now wants to use the complaint process to get around the missed deadline and collect on a medical bill.

Comment on §180.2. A commenter stated that if the rule is going to have a time limit for filing complaints on the insurance carrier, this should also apply to filing complaints on health care providers. The commenter stated that health care providers are responding to complaints that are years after the date of service.

Agency Response to Comment on §180.2. DWC appreciates the comment but declines to make the change because it is beyond the scope of this project. DWC proposed the amendments to ensure that medical fee disputes are properly brought under the established MFDR process, and that health care providers cannot use the complaint process as a back door to dispute a medical billing issue if they miss the MFDR deadlines. That said, on the topic of complaint timing, DWC has made improvements in the last few years, and is now resolving about 97% of enforcement cases within 365 days.

Comment on §180.2. A commenter suggested that insurance carriers and their bill review agents should be required to attend training seminars. The commenter stated that health care providers in the system are required to attend continued training and testing and compliance with system rules and adherence to the Labor Code. The commenter stated that insurance companies should also be required to be in compliance with DWC rules and the Labor Code. The commenter stated that DWC should address timely and correct payment to health care providers immediately, especially MD and DO providers, who have the highest number of complaints due to the financial and additional time requirements just to get paid for their services, to ensure that providers remain in the DWC system. The commenter stated that the system is currently struggling with the lack of MD and DO

providers, as well as specialty providers, and cannot afford to lose those providers due to issues of insurance carriers consistently violating 28 TAC §§133.240(a) and (o), and 134.201, and Labor Code §§415.002 and 415.021.

Agency Response to Comment on §180.2. DWC appreciates the comment but declines to make the change because it is beyond the scope of this project. Insurance carriers are already required to comply with applicable statutes and rules. The complaints DWC receives from health care providers are fairly evenly split among MDs, DOs, and DCs. DWC proposed the amendments to ensure that medical fee disputes are properly brought under the established MFDR process, and that health care providers cannot use the complaint process as a back door to dispute a medical billing issue if they miss the MFDR deadlines.

Comment on §180.2. A commenter stated that the proposed rule does not sufficiently address changes to 28 TAC §§133.240(a) and (o), and 134.201, and Labor Code §§415.002(a)(11) and (20), and 415.021. The commenter stated that the proposed rule actually contradicts those sections.

Agency Response to Comment on §180.2. DWC appreciates the comment but disagrees that the proposed text omits changes to or contradicts the cited sections. This is a solution that is narrowly tailored to continue to allow health care providers to bring their medical billing disputes properly under the MFDR process while preventing abuse of the complaint system when the health care provider has failed to meet the MFDR filing deadlines. The amendments do not affect the cited sections, which deal with requirements for insurance carriers to take action on medical bills, and with administrative violations for

noncompliance with those, as well as medical fee guideline requirements. Additional amendments to the cited sections would not accomplish their goal of stopping attempts to circumvent the MFDR process for adjudicating medical billing disputes.

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28 TAC §180.2.

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts the amendments to 28 TAC §180.2 under Labor Code §§402.023, 408.027, 413.031, 415.003, 402.00111, 402.00116, and 402.061.

Labor Code §402.023 requires the commissioner to adopt rules about the filing of a complaint under Title 5, Subtitle A of the Labor Code. The rules must, at a minimum, ensure that DWC clearly defines the method for filing a complaint and define what constitutes a frivolous complaint under Subtitle A.

Labor Code §408.027 addresses payment of health care providers in accordance with the fee guidelines or contracted network rates, and requires the commissioner to adopt rules necessary to implement the provisions of §§408.027 and 408.0271.

Labor Code §413.031 addresses medical dispute resolution. It entitles a party, including a health care provider, to a review of a medical service provided or for which authorization of payment is sought if a health care provider is denied payment or paid a reduced amount for the medical service rendered; denied authorization for the payment for the service requested or performed if authorization is required or allowed by Subtitle A or commissioner rules; ordered by the commissioner to refund a payment received; or ordered to make a payment that was refused or reduced for a medical service rendered.

It also entitles a health care provider who submits a charge in excess of the fee guidelines or treatment policies to a review of the medical service to determine if reasonable medical justification exists for the deviation. It requires the commissioner to adopt rules to notify claimants of their rights for that process, and states that DWC's role is to adjudicate the payment given the relevant statutory provisions and commissioner rules. It also requires the commissioner to specify by rule the appropriate dispute resolution process for disputes in which a claimant has paid for medical services and seeks reimbursement. It allows the commissioner to prescribe by rule an alternative dispute resolution process to resolve disputes about medical services costing less than the cost of a review of the medical necessity of a health care service by an independent review organization.

Labor Code §415.003 states that a health care provider commits an administrative violation if the person: (1) submits a charge for health care that was not furnished; (2) administers improper, unreasonable, or medically unnecessary treatment or services; (3) makes an unnecessary referral; (4) violates DWC's fee and treatment guidelines; (5) violates a commissioner rule; or (6) fails to comply with a provision of Subtitle A.

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.

§180.2. Filing a Complaint.

(a) Any person may submit a complaint to the division for alleged administrative violations, except as provided in subsection (b) of this section.

(b) A health care provider cannot submit a complaint about a medical billing issue if the date of service for the medical billing issue was more than 12 months before the date of the complaint, unless the issue qualifies for an exception to the filing deadline under §133.307(c)(1)(B) of this title, concerning medical fee dispute resolution. If the issue qualifies for an exception to the medical fee dispute resolution filing deadline under §133.307(c)(1)(B), then a health care provider cannot submit a complaint about that issue if the medical fee dispute resolution filing deadline in §133.307(c)(1)(B) has passed. This subsection does not apply to a health care provider submitting a complaint under Insurance Code Chapter 1305.

(c) A person may submit a complaint to the division:

(1) through the division's website;

(2) by email;

(3) through written correspondence;

(4) by fax; or

(5) in person. The division will help a person submitting an in-person complaint reduce the complaint to writing.

(d) A complaint submitted on the form provided by the division or in any other written format must contain the following information as applicable:

(1) complainant's name and contact information;

(2) name and contact information of the subject or parties of the complaint, if known;

(3) name and contact information of witnesses, if known;

(4) claim file information, including, but not limited to, the name, address, and date of injury of the injured employee, if known;

(5) the statement of the facts about the alleged violation, including the dates or time period the alleged violation occurred;

(6) the nature of the alleged violation, including the specific sections of the Act and division rules alleged to have been violated, if known;

(7) supporting documentation relevant to the allegation that may include, but is not limited to, medical bills, Explanation of Benefits statements, copies of payment invoices or checks, and medical reports, as applicable;

(8) supporting documentation for alleged fraud that may include photographs, video, audio, and surveillance recordings, and reports; and

(9) other sources of pertinent information, if known.

(e) Contact information may include, but is not limited to, name, address, telephone number, fax number, email address, business name, business address, business telephone number, and websites.

(f) A complaint must contain sufficient information for the division to investigate the complaint.

(g) On receipt of a complaint, the division will review, monitor, and may investigate the allegation against a person or entity who may have violated the Act or division rules.

(h) The division will assign priorities to complaints being investigated based on a risk-based complaint investigation system that considers:

(1) the severity of the alleged violation;

(2) whether the noncompliance or alleged violation is ongoing;

(3) whether a commissioner order has been violated; or

(4) other risk-based criteria the division determines necessary.

(i) A person commits an administrative violation if the person submits a complaint to the division that is:

(1) frivolous, as defined in §180.1 of this title (relating to Definitions);

(2) groundless or made in bad faith; or

(3) done specifically for competitive or economic advantage.

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 May 7, 2024.

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The commissioner adopts the amendments to 28 TAC §180.2.

Jeff Nelson
Commissioner
TDI, Division of Workers' Compensation

Commissioner's Order No. 2024-8645