# CHAPTER 133. GENERAL MEDICAL PROVISIONS

## SUBCHAPTER A. GENERAL RULES FOR REQUIRED REPORTS

### §133.1. Applicability of Medical Billing and Processing.

(a) This chapter applies to medical billing and processing for health care services provided to injured employees subject to a workers' compensation health care network established under Insurance Code Chapter 1305, and to injured employees not subject to such networks, with the following exceptions pertaining only to health care services provided to an injured employee subject to a workers' compensation health care network established under Chapter 1305:

(1) Subchapter D of this chapter (relating to Dispute of Medical Bills);

(2) §133.210(f) of this chapter (relating to Medical Documentation); and

(3) §133.240(b) and (i) of this chapter (relating to Medical Payments and Denials).

(b) This chapter applies to all health care provided on or after May 2, 2006. For health care provided prior to May 2, 2006, medical billing and processing shall be in accordance with the rules in effect at the time the health care was provided.

*The provisions of this §133.1 adopted to be effective May 2, 2006, 31 TexReg 3544.*

### §133.2. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

(1) Bill review -- Review of any aspect of a medical bill, including retrospective review, in accordance with the Labor Code, the Insurance Code, Division or Department rules, and the appropriate fee and treatment guidelines.

(2) Complete medical bill -- A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter (relating to Required Billing Forms/Formats), or as specified for electronic medical bills in §133.500 of this chapter (relating to Electronic Formats for Electronic Medical Bill Processing).

(3) Emergency -- Either a medical or mental health emergency as follows:

(A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

(i) placing the patient's health or bodily functions in serious jeopardy, or

(ii) serious dysfunction of any body organ or part;

(B) a mental health emergency is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

(4) Final action on a medical bill –

(A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or

(B) denying a charge on the medical bill.

(5) Health care provider agent -- A person or entity that the health care provider contracts with or utilizes for the purpose of fulfilling the health care provider's obligations for medical bill processing under the Labor Code or Division rules.

(6) Insurance carrier agent -- A person or entity that the insurance carrier contracts with or utilizes for the purpose of providing claims services, including fulfilling the insurance carrier's obligations for medical bill processing under the Labor Code, the Insurance Code, Division or Department rules.

(7) Pharmacy processing agent -- A person or entity that contracts with a pharmacy in accordance with Labor Code §413.0111, establishing an agent or assignee relationship, to process claims and act on behalf of the pharmacy under the terms and conditions of a contract related to services being billed. Such contracts may permit the agent or assignee to submit billings, request reconsideration, receive reimbursement, and seek medical dispute resolution for the pharmacy services billed.

(8) Retrospective review -- The process of reviewing the medical necessity and reasonableness of health care that has been provided to an injured employee.

(9) In this chapter, the following terms have the meanings assigned by Labor Code §413.0115:

(A) Voluntary networks; and

(B) Informal networks.

*The provisions of this §133.2 adopted to be effective May 2,2006, 31 TexReg 3544; amended to be effective July 27, 2008, 33 TexReg 5701.*

**§133.3. Communication Between Health Care Providers and Insurance Carriers**.

(a) Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as "insurance carrier improperly reduced the bill" or "health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section.

(b) Communication between the health care provider and insurance carrier related to medical bill processing shall be made by telephone or electronic transmission unless the information cannot be sent by those media, in which case the sender shall send the information by mail or personal delivery.

(c) Health care providers and insurance carriers shall maintain, in a reproducible format, documentation of communications related to medical bill processing.

*The provisions of this §133.3 adopted to be effective May 2,2006, 31 TexReg 3544.*

**§133.4. Written Notification to Health Care Providers of Contractual Agreements for Informal and Voluntary Networks.**

(a) Applicability. This section applies to health care services that are rendered between August 1, 2008, and December 31, 2010, pursuant to an informal network or voluntary network fee agreement with a health care provider in accordance with Labor Code §413.011 and §413.0115.

(b) Person. Under this section "person" is defined as an individual, partnership, corporation, hospital district, insurance carrier, organization, business trust, estate trust, association, limited liability company, limited liability partnership or other entity to whom an informal network or voluntary network's fee arrangement with a health care provider is sold, leased, transferred, or conveyed on behalf of an insurance carrier. This term does not include an injured employee.

(c) Required Notice. Each informal network or voluntary network, or the insurance carrier, or the insurance carrier's authorized agent, as appropriate, shall notify each affected health care provider of any person that is given access to the informal or voluntary network's fee arrangement with that health care provider within the time and manner provided by this section.

(d) Notice. Notice to each contracted health care provider:

(1) must include the contact information for the informal or voluntary network, including, but not limited to, the name, physical address, and a toll-free telephone number accessible to all contracted health care providers;

(2) must include the following information in the body of the notice:

(A) name, physical address, and telephone number of any person that is given access to the informal or voluntary network's fee arrangement with a health care provider; and

(B) the start date and any end date during which any person has been given access to the health care provider's contracted fee arrangement.

(3) may be provided in an electronic format provided a paper version is available upon request by the Texas Department of Insurance, Division of Workers' Compensation (Division); and

(4) may be provided through a website link only if the website:

(A) contains the information stated in paragraphs (1), (2)(A) and (2)(B) of this subsection; and

(B) is updated at least monthly with current and correct information.

(e) Documentation. The informal or voluntary network, insurance carrier, or the insurance carrier's authorized agent, as appropriate, shall document the information provided in the notice as required by subsection (d) of this section, the method of delivery, to whom the notice was delivered, and the date of delivery. For the purpose of this section, a notice is determined to be delivered in accordance with §102.4(p) of this title (relating to General Rules for Non-Commission Communications). Failure to provide documentation upon the request of the Division or failure to provide notice that complies with the requirements of Labor Code §413.011 and this section creates a rebuttable presumption in a Division enforcement action and in a medical fee dispute that the health care provider did not receive the notification.

(f) Time of notification. Under this section:

(1) for contracts with health care providers in effect on August 1, 2008, initial notification must be made no later than November 1, 2008, and subsequent notices provided to health care providers in accordance with this section thereafter on a quarterly basis; and

(2) for contracts with health care providers entered into after August 1, 2008, initial notification must be made no later than the 30th day after the effective date of the contract and subsequent notices provided to health care providers in accordance with this section thereafter on a quarterly basis.

(g) Noncompliance. The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if:

(1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or

(2) there are no required contracts in accordance with Labor Code §413.011 (d-1) and §413.0115.

(h) Application of Division Fee Guideline. If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply pursuant to §134.1(e)(1) of this title (relating to Medical Reimbursement), or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable reimbursement pursuant to §134.1(e)(3) of this title.

(i) Administrative Violations. If notice to the health care provider does not meet the requirements of this section, the insurance carrier may be held liable for administrative violations in accordance with Labor Code provisions and Division rules.

(j) Severability Clause. If a court of competent jurisdiction holds that any provision of this section is inconsistent with any statutes of this state, are unconstitutional, or are invalid for any reason, the remaining provisions of this section shall remain in full effect.

(k) Expiration. In accordance with §413.011(d-6), the provisions of this rule shall expire on January 1, 2011. This section will continue to apply to health care services that were rendered between August 1, 2008, and December 31, 2010, pursuant to an informal network or voluntary network fee agreement with a health care provider.

*The provisions of this §133.4 adopted to be effective July 27, 2008, 33 TexReg 5701.*

**§133.5. Informal Network and Voluntary Network Reporting Requirements to the Division.**

(a) Reporting Requirement. Each informal network and voluntary network must provide the following information to the Texas Department of Insurance, Division of Workers' Compensation (Division):

(1) the informal network or voluntary network's name and federal employer identification number (FEIN);

(2) an executive contact for official correspondence for the informal network or voluntary network;

(3) a toll-free telephone number by which a health care provider may contact the informal network or voluntary network;

(4) a list of each insurance carrier with whom the informal network or voluntary network contracts, including the insurance carrier's FEIN; and

(5) a list of each entity or insurance carrier agent associated with the informal or voluntary network working on behalf of the insurance carrier, including contact information for each entity.

(b) Reporting Format. Reports, including changes, must be submitted through the Division's on-line reporting system accessible through the Division's website at www.tdi.state.tx.us.

(c) Reporting Timeframe. Each informal network and voluntary network that has a contract with an insurance carrier or an insurance carrier's authorized agent in effect on September 1, 2007, must report to the Division in accordance with this section no later than August 1, 2008. Except as otherwise provided in this subsection, informal and voluntary networks must report to the Division no later than the 30th day after the effective date of a contract signed with an insurance carrier or an insurance carrier's authorized agent.

(d) Reporting Changes. Each informal and voluntary network shall report any changes to the information provided under subsection (a) of this section to the Division not later than the 30th day after the effective date of the change in accordance with Labor Code §413.0115 and this section.

(e) Administrative Violations. If the informal and voluntary network report does not meet the requirements of Labor Code §413.0115 and this section, the informal or voluntary network may be held liable for any administrative violations.

(f) Expiration. The provisions of this rule shall expire on January 1, 2011.

*The provisions of this §133.5 adopted to be effective July 27, 2008, 33 TexReg 5701.*

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## SUBCHAPTER B. HEALTH CARE PROVIDER BILLING PROCEDURES

### §133.10. Required Billing Forms/Formats.

(a) Health care providers shall submit medical bills for payment:

(1) on standard forms used by the Centers for Medicare and Medicaid Services (CMS);

(2) on applicable forms prescribed for pharmacists and dentists specified in subsections (b) and (c) of this section; or

(3) in electronic format in accordance with Subchapter G of this chapter (relating to Electronic Medical Billing, Reimbursement, and Documentation).

(b) Pharmacists and pharmacy processing agents shall submit bills using the Division form DWC-66. A pharmacist or pharmacy processing agent may submit bills using an alternate billing form if:

(1) the insurance carrier has approved the alternate billing form prior to submission by the pharmacist or pharmacy processing agent; and

(2) the alternate billing form provides all information required on the Division form DWC-66.

(c) Dentists shall submit bills for dental services using the current American Dental Association claim form.

(d) All information submitted on required billing forms must be legible and completed in accordance with Division instructions.

*The provisions of this §133.10 adopted to be effective May 2 ,2006, 31 TexReg 3544; amended to be effective December 24, 2006, 31 TexReg 10098; amended to be effective May 1, 2008.*

### §133.20. Medical Bill Submission by Health Care Provider.

(a) The health care provider shall submit all medical bills to the insurance carrier except when billing the employer in accordance with subsection (j) of this section.

(b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied. The medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A)-(H) of this title (relating to MDR of Fee Disputes), which establishes the generally acceptable standards for documentation.

(c) A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills.

(d) The health care provider that provided the health care shall submit its own bill, unless:

(1) the health care was provided as part of a return to work rehabilitation program in accordance with the Division fee guidelines in effect for the dates of service;

(2) the health care was provided by an unlicensed individual under the direct supervision of a licensed health care provider, in which case the supervising health care provider shall submit the bill;

(3)the health care provider contracts with an agent for purposes of medical bill processing, in which case the health care provider agent may submit the bill; or

(4) the health care provider is a pharmacy that has contracted with a pharmacy processing agent for purposes of medical bill processing, in which case the pharmacy processing agent may submit the bill.

(e) A medical bill must be submitted:

(1) for an amount that does not exceed the health care provider's usual and customary charge for the health care provided in accordance with Labor Code §§413.011 and 415.005; and

(2) in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care.

(f) Health care providers shall not resubmit medical bills to insurance carriers after the insurance carrier has taken final action on a complete medical bill and provided an explanation of benefits except in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills).

(g) Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier.

(h) Not later than the 15th day after receipt of a request for additional medical documentation, a health care provider shall submit to the insurance carrier:

(1) any requested additional medical documentation related to the charges for health care rendered; or

(2) a notice the health care provider does not possess requested medical documentation.

(i) The health care provider shall indicate on the medical bill if documentation is submitted related to the medical bill.

(j) The health care provider may elect to bill the injured employee's employer if the employer has indicated a willingness to pay the medical bill(s). Such billing is subject to the following:

(1) A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to:

(A) prompt payment, as provided by Labor Code §408.027;

(B) interest for delayed payment as provided by Labor Code §413.019; and

(C) medical dispute resolution as provided by Labor Code §413.031.

(2) When a health care provider bills the employer, the health care provider shall submit an information copy of the bill to the insurance carrier, which clearly indicates that the information copy is not a request for payment from the insurance carrier.

(3) When a health care provider bills the employer, the health care provider must bill in accordance with the Division's fee guidelines and §133.10 of this chapter (relating to Required Billing Forms/Formats).

(4) A health care provider shall not submit a medical bill to an employer for charges an insurance carrier has reduced, denied or disputed.

(k) A health care provider shall not submit a medical bill to an injured employee for all or part of the charge for any of the health care provided, except as an informational copy clearly indicated on the bill, or in accordance with subsection (l) of this section. The information copy shall not request payment.

(l) The health care provider may only submit a bill for payment to the injured employee in accordance with:

(1) Labor Code §413.042;

(2) Insurance Code §1305.451; or

(3) §134.504 of this title (relating to Pharmaceutical Expenses Incurred by the Injured Employee).

*The provisions of this §133.20 adopted to be effective May 2, 2006, 31 TexReg 3544; amended to be effective January 29, 2009, 34 TexReg 430.*

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

### §133.200. Insurance Carrier Receipt of Medical Bills from Health Care Providers.

(a) Upon receipt of medical bills submitted in accordance with §133.10(a)(1) and (2) of this chapter (relating to Required Medical Forms/Formats), an insurance carrier shall evaluate each medical bill for completeness as defined in §133.2 of this chapter (relating to Definitions).

(1) Insurance carriers shall not return medical bills that are complete, unless the bill is a duplicate bill.

(2) Within 30 days after the day it receives a medical bill that is not complete as defined in §133.2 of this chapter, an insurance carrier shall:

(A) complete the bill by adding missing information already known to the insurance carrier, except for the following:

(i) dates of service;

(ii) procedure/modifier codes;

(iii) number of units; and

(iv) charges; or

(B) return the bill to the sender, in accordance with subsection (c) of this section.

(3) The insurance carrier may contact the sender to obtain the information necessary to make the bill complete, including the information specified in paragraph (2)(A)(i) - (iv) of this subsection. If the insurance carrier obtains the missing information and completes the bill, the insurance carrier shall document the name and telephone number of the person who supplied the information.

(b) An insurance carrier shall not return a medical bill except as provided in subsection (a) of this section. When returning a medical bill, the insurance carrier shall include a document identifying the reason(s) for returning the bill. The reason(s) related to the procedure or modifier code(s) shall identify the reason(s) by line item.

(c) The proper return of an incomplete medical bill in accordance with this section fulfills the insurance carrier's obligations with regard to the incomplete bill.

(d) An insurance carrier shall not combine bills submitted in separate envelopes as a single bill or separate single bills spanning several pages submitted in a single envelope.

*The provisions of this §133.200 adopted to be effective May 2, 2006, 31 TexReg 3544.*

### §133.210. Medical Documentation.

(a) Medical documentation includes all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results.

(b) When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents.

(c) In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation:

(1) the two highest Evaluation and Management office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes;

(2) surgical services rendered on the same date for which the total of the fees established in the current Division fee guideline exceeds $500: a copy of the operative report;

(3) return to work rehabilitation programs as defined in §134.202 of this title (relating to Medical Fee Guideline): a copy of progress notes and/or SOAP (subjective/objective assessment plan/procedure) notes, which substantiate the care given, and indicate progress, improvement, the date of the next treatment(s) and/or service(s), complications, and expected release dates;

(4) any supporting documentation for procedures which do not have an established Division maximum allowable reimbursement (MAR), to include an exact description of the health care provided; and

(5) for hospital services: an itemized statement of charges.

(d) Any request by the insurance carrier for additional documentation to process a medical bill shall:

(1) be in writing;

(2) be specific to the bill or the bill's related episode of care;

(3) describe with specificity the clinical and other information to be included in the response;

(4) be relevant and necessary for the resolution of the bill;

(5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;

(6) indicate the specific reason for which the insurance carrier is requesting the information; and

(7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.

(e) It is the insurance carrier's obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. The Division considers any medical billing information or documentation possessed by one entity to be simultaneously possessed by the other.

(f) Workers' compensation health care networks established under Insurance Code Chapter 1305 may decrease the documentation requirements of this section.

*The provisions of this §133.210 adopted to be effective May 2, 2006, 31 TexReg 3544.*

**§133.230. Insurance Carrier Audit of a Medical Bill.**

(a) An insurance carrier may perform an audit of a medical bill that has been submitted by a health care provider to the insurance carrier for reimbursement. The insurance carrier may not audit a medical bill upon which it has taken final action.

(b) If an insurance carrier decides to conduct an audit of a medical bill, the insurance carrier shall:

(1) provide notice to the health care provider no later than the 45th day after the date the insurance carrier received the complete medical bill. For onsite audits, provide notice in accordance with subsection (c) of this section;

(2) pay to the health care provider no later than the 45th day after receipt of the health care provider's medical bill, for the health care being audited:

(A) for a workers' compensation health care network established under Insurance Code Chapter 1305, 85 percent of the applicable contracted amount; or

(B) for services not provided under Insurance Code Chapter 1305, 85 percent of:

(i) the maximum allowable reimbursement amounts established under the applicable Division fee guidelines;

(ii) the contracted amount for services not addressed by Division fee guidelines; or

(iii) the fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) for services not addressed by clause (i) or (ii) of this subparagraph;

(3) make a determination regarding the relationship of the health care services provided for the compensable injury, the extent of the injury, and the medical necessity of the services provided; and

(4) complete the audit and pay, reduce, or deny in accordance with §133.240 of this chapter (relating to Medical Payments and Denials) no later than the 160th day after receipt of the complete medical bill.

(c) If the insurance carrier intends to perform an onsite audit, the notice shall include the following information for each medical bill that is subject to audit:

(1) employee's full name, address, and Social Security number;

(2) date of injury;

(3) date(s) of service for which the audit is being performed;

(4) insurance carrier's name and address;

(5) a proposed date and time for the audit, subject to mutual agreement; and

(6) name and telephone number of the person who will perform the onsite audit, has the authority to act on behalf of the insurance carrier, and shall personally appear for the onsite audit at the scheduled date and time.

(d) During the insurance carrier's onsite audit, the health care provider shall:

(1) make available to the insurance carrier: all notes, reports, test results, narratives, and other documentation the health care provider has relating to the billing(s) subject to audit; and

(2) designate one person with authority to: negotiate a resolution, serve as the liaison between the health care provider and the insurance carrier, and be available to the insurance carrier's representative.

(e) On the last day of the onsite audit, the health care provider's liaison and the insurance carrier's representative shall meet for an exit interview. The insurance carrier's representative shall present to the health care provider's liaison a list of unresolved issues related to the health care provided and the billed charges. The health care provider's liaison and the insurance carrier's representative shall discuss and attempt to resolve the issues.

*The provisions of this §133.230 adopted to be effective May 2, 2006, 31 TexReg 3544.*

**§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)

(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 chapter (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 the form and manner prescribed by the Division and indicate any interest amount paid, and the number of days on which interest was calculated. 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 the health care was:

(A) determined to be unreasonable and/or unnecessary;

(B) provided by a health care provider other than

(i) the treating doctor selected in accordance with §408.022 of the Texas Labor Code,

(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 Procedure for Requesting Required Medical Examinations) and §126.6 of this title (relating to Order for Required Medical Examination), or

(iv) a doctor performing a designated doctor examination in accordance with §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings); or

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

(f) 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 (relating to Medical Reimbursement).

(g) 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.

(h) 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 chapter (relating to Reconsideration for Payment of Medical Bills).

(i) If dissatisfied with the reconsideration outcome, the health care provider may request medical dispute resolution in accordance with §133.305 of this chapter (relating to Medical Dispute Resolution - General).

(j) 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 provided an explanation of benefits except as provided in §133.250 and §133.305 of this chapter.

(k) 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 (relating to Interest for Late Payment on Medical Bills and Refunds), without any action taken by the Division. The interest payment shall be paid at the same time as the medical bill payment.

(l) 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.

(m) When an insurance carrier remits payment to a pharmacy processing agent, the pharmacy's reimbursement shall be made in accordance with the terms of its contract with the pharmacy processing agent.

(n) 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.

*The provisions of this §133.240 adopted to be effective May 2, 2006, 31 TexReg 3544.*

**§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.

(b) The health care provider shall submit the request for reconsideration no later than eleven 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) The 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 chapter (relating to Communication Between Health Care Providers and Insurance Carriers) that provides a rational basis to modify the previous denial or payment.

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

(f) The insurance carrier shall take final action on a reconsideration request within 21 days of receiving the request for reconsideration. The insurance carrier shall provide an explanation of benefits for all items included in a reconsideration request in the form and format prescribed by the Division.

(g) A health care provider shall not resubmit a request for reconsideration earlier than 26 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.

(h) 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 §133.305 of this chapter (relating to Medical Dispute Resolution - General).

*The provisions of this §133.250 adopted to be effective May 2, 2006, 31 TexReg 3544.*

**§133.260. Refunds.**

(a) An insurance carrier shall request a refund within 240 days from the date of service or 30 days from completion of an audit performed in accordance with §133.230 (relating to Insurance Carrier Audit of a Medical Bill), whichever is later, when it determines that inappropriate health care was previously reimbursed, or when an overpayment was made for health care provided.

(b) The insurance carrier shall submit the refund request to the health care provider in an explanation of benefits in the form and manner prescribed by the Division.

(c) A health care provider shall respond to a request for a refund from an insurance carrier by the 45th day after receipt of the request by:

(1) paying the requested amount; or

(2) submitting an appeal to the insurance carrier with a specific explanation of the reason the health care provider has failed to remit payment.

(d) The insurance carrier shall act on a health care provider's appeal within 45 days after the date on which the health care provider filed the appeal. The insurance carrier shall provide the health care provider with notice of its determination, either agreeing that no refund is due, or denying the appeal.

(e) If the insurance carrier denies the appeal, the health provider:

(1) shall remit the refund with any applicable interest within 45 days of receipt of notice of denied appeal; and

(2) may request medical dispute resolution in accordance with §133.305 of this chapter (relating to Medical Dispute Resolution - General).

(f) The health care provider shall submit a refund to the insurance carrier when the health care provider identifies an overpayment even though the insurance carrier has not submitted a refund request.

(g) When making a refund payment, the health care provider shall include: a copy of the insurance carrier's original request for refund, if any; a copy of the original explanation of benefits containing the overpayment, if available; and a detailed explanation itemizing the refund. The explanation shall:

(1) identify the billing and rendering health care provider;

(2) identify the injured employee;

(3) identify the insurance carrier;

(4) specify the total dollar amount being refunded;

(5) itemize the refund by dollar amount, line item and date of service; and

(6) specify the amount of interest paid, if any, and the number of days on which interest was calculated.

(h) All refunds requested by the insurance carrier and paid by a health care provider on or after the 60th day after the date the health care provider received the request for the refund shall include interest calculated in accordance with §134.130 of this title (relating to Interest for Late Payment on Medical Bills and Refunds).

*The provisions of this §133.260 adopted to be effective May 2, 2006, 31 TexReg 3544.*

**§133.270. Injured Employee Reimbursement for Health Care Paid.**

(a) An injured employee may request reimbursement from the insurance carrier when the injured employee has paid for health care provided for a compensable injury, unless the injured employee is liable for payment as specified in:

(1) Insurance Code §1305.451, or

(2) §134.504 of this title (relating to Pharmaceutical Expenses Incurred by the Injured Employee).

(b) The injured employee's request for reimbursement shall be legible and shall include documentation or evidence (such as itemized receipts) of the amount the injured employee paid the health care provider.

(c) The insurance carrier shall pay or deny the request for reimbursement within 45 days of the request. Reimbursement shall be made in accordance with §134.1 (relating to Medical Reimbursement).

(d) The injured employee may seek reimbursement for any payment made above the Division fee guideline or contract amount from the health care provider who received the overpayment.

(e) Within 45 days of a request, the health care provider shall reimburse the injured employee the amount paid above the applicable Division fee guideline or contract amount.

(f) The injured employee may request, but is not required to request, reconsideration prior to requesting medical dispute resolution in accordance with §133.305 of this chapter (relating to Medical Dispute Resolution - General).

(g) The insurance carrier shall submit injured employee medical billing and payment data to the Division in accordance with §134.802 of this title (relating to Insurance Carrier Medical Electronic Data Interchange to the Division).

*The provisions of this §133.270 adopted to be effective May 2, 2006, 31 TexReg 3544.*

**§133.280. Employer Reimbursement for Health Care Paid.**

(a) An employer may request reimbursement from the insurance carrier when the employer has paid for health care provided for a compensable injury, and provided notice of injury in compliance with Labor Code §409.005.

(b) The employer shall be reimbursed in accordance with §134.1.

(c) The employer may seek reimbursement for any payment made above the Division fee guideline or contract amount from the health care provider who received the overpayment.

(d) The employer's request for reimbursement shall be legible and shall include:

(1) a copy of the health care provider's required billing form;

(2) any supporting documentation submitted by the health care provider as required in §133.210 of this chapter (relating to Medical Documentation); and

(3) documentation of the payment to the health care provider.

(e) The insurance carrier shall submit employer medical bill and payment data to the Division in accordance with §134.802 of this title (relating to Insurance Carrier Medical Electronic Data Interchange to the Division).

*The provisions of this §133.280 adopted to be effective May 2, 2006, 31 TexReg 3544.*

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## SUBCHAPTER D - DISPUTE OF MEDICAL BILLS

### §133.305. MDR - General.

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

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

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

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

(A) a medical fee dispute; or

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

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

(ii) a retrospective medical necessity dispute.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*The provisions of this §133.305 adopted to be effective December 31, 2006, 31 TexReg 10339; amended to be effective May 25, 2008, 33 TexReg 3954.*

**§133.306. Interlocutory Orders for Medical Benefits.**

(a) The executive director may delegate the authority to issue interlocutory orders for accrued and/or future medical benefits to Division staff, in accordance with §402.042 of the Texas Labor Code.

(b) The Division may enter an interlocutory order for accrued or future medical benefits when:

(1) the Division determines that an insurance carrier has disputed medical benefits as the result of a liability, compensability, or extent of injury dispute that an insurance carrier has raised in accordance

with §124.2 of this title (relating to Carrier Reporting and Notification Requirements), and the Division determines that those medical benefits are or were medically necessary and constitute essential medical treatment(s) and/or service(s) and are not subject to the medical dispute resolution process; or

(2) At the conclusion of the medical dispute resolution process or an informal resolution conference, as set forth in §133.305 of this title (relating to Medical Dispute Resolution)

(A) the Division determines that an insurance carrier has disputed medical benefits as the result of a liability, compensability, or extent of injury dispute that an insurance carrier has raised in accordance with §124.2 of this title, and the Division deems that the disputed medical benefits are or were medically necessary and constitute essential medical treatment(s) and/or service(s); or

(B) the Division determines that future medical benefits for which preauthorization is required are medically necessary and constitute essential medical treatment(s) and/or service(s).

(c) The Commission shall enter an interlocutory order only when, absent the interlocutory order, the injured employee would not receive essential medical treatment.

(d) A party shall comply with an interlocutory order entered in accordance with this section on the earlier of the seventh day after receipt of the order or the date the Commission establishes in the body of the order.

(e) The insurance carrier may dispute an interlocutory order entered under this title by filing a written request for a hearing in accordance with §413.055 of the Texas Labor Code (relating to Interlocutory Orders; Reimbursement) and §133.305 and §148.3 of this title (relating to Requesting a Hearing).

(f) An insurance carrier that makes an overpayment pursuant to an interlocutory order may be eligible for reimbursement from the subsequent injury fund. An insurance carrier must make a request for reimbursement in accordance with §116.11 of this title (relating to Request for Reimbursement or Payment from the Subsequent Injury Fund).

(g) This rule shall apply for all requests submitted on or after July 15, 2000.

*The provisions of this §133.306 adopted to be effective July 15, 2000, 25 TexReg 2115.*

**§133.307. MDR of Fee Disputes.**

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

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

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

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

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

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

(3) In resolving non-network disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the Division

of Workers' Compensation (Division) is to adjudicate the payment, given the relevant statutory provisions and Division rules.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(J) the Division determines that good cause exists to dismiss the request, including a party's failure to comply with the provisions of this section.

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

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

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

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

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

(B) The party seeking review of the MDR decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute at the same time the request for hearing is filed with the Division.

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

(A) To request a Division contested case hearing, a written request for a Division contested case hearing must be filed with the Division's Chief Clerk no later than the later of the 20th day after the effective date of this section or the 20th day after the date on which the decision is received by the appealing party. The request must be filed in compliance with Division rules. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute at the same time the request for a hearing is filed with the Division.

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

(C) Prior to a Division contested case hearing, either party may request a correction of a clerical error in a decision. Clerical errors are non-substantive and include, but are not limited to, typographical or mathematical calculation errors. Only the Division can determine if a clerical correction is required. A request for a correction of a clerical error does not alter the deadlines for appeal.

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

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

(F) A party to a medical fee dispute who has exhausted all administrative remedies may seek judicial review of the Division's decision. Judicial review under this paragraph shall be conducted in the manner provided for judicial review of contested cases under Chapter 2001, Subchapter G Government Code. The parties will be deemed to have received the decision as provided in §102.5 of this title. A decision becomes final and appealable when issued by a Division hearing officer. If a party to a medical fee dispute files a petition for judicial review of the Division's decision, the party shall, at the time the petition is filed with the district court, send a copy of the petition for judicial review to the Division's Chief Clerk. The Division and the Department are not considered to be parties to the medical dispute pursuant to Labor Code §§413.031(k-2) and 413.0311(e). The following information must be included in the petition or provided by cover letter:

(i) the DWC number(s) for the dispute being appealed;

(ii) the names of the parties;

(iii) the cause number;

(iv) the identity of the court; and

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

(G) The Division shall, upon receipt of the court petition, prepare a record of the Division contested case hearing and submit a copy of the record to the district court. The Division shall assess the party seeking judicial review expenses incurred by the Division in preparing the certified copy of the record, including transcription costs, in accordance with Government Code §2001.177 (relating to Costs of Preparing Agency Record). Upon request, the Division shall consider the financial ability of the party to pay the costs, or any other factor that is relevant to a just and reasonable assessment of costs.

*The provisions of this §133.307 adopted to be effective December 31, 2006, 31 TexReg 10339; amended to be effective May 25, 2008, 33 TexReg 3954.*

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

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

(1) This section applies to the independent review of network and non-network preauthorization, concurrent, or retrospective medical necessity disputes that is remanded to the Division or filed on or after May 25, 2008. Except as provided in paragraph (2) of this subsection, dispute resolution requests filed prior to May 25, 2008, shall be resolved in accordance with the statutes and rules in effect at the time the request was filed.

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

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

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

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

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

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

(b) IRO Certification. Each IRO performing independent review of health care provided in the workers' compensation system shall be certified pursuant to Insurance Code Chapter 4202.

(c) Professional licensing requirements. Notwithstanding Insurance Code Chapter 4202, an IRO that uses doctors to perform reviews of health care services provided under this section may only use doctors licensed to practice in Texas.

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

(e) Conflicts. Conflicts of interest will be reviewed by the Department consistent with the provisions of the Insurance Code §4202.008, Labor Code §413.032(b), §12.203 of this title (relating to Conflicts of Interest Prohibited), and any other related rules. Notification of each IRO decision must include a certification by the IRO that the reviewing provider has certified that no known conflicts of interest exist between that provider, the employee, any of the treating providers, or any of the providers who reviewed the case for determination prior to referral to the IRO.

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

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

(1) In network disputes:

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

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

(2) In non-network disputes:

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

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

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

(1) the Department's Internet website at www.tdi.state.tx.us; or

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

(i) Timeliness. A requestor shall file a request for independent review with the insurance carrier (carrier) that actually issued the adverse determination or the carrier's utilization review agent (URA) that actually issued the adverse determination no later than the 45th calendar day after receipt of the denial of reconsideration. The carrier shall notify the Department of a request for an independent review within one working day from the date the request is received by the carrier or its URA. In a preauthorization or concurrent review dispute request, an employee with a life-threatening condition, as defined in §133.305 of this subchapter (relating to MDR -- General), is entitled to an immediate review by an IRO and is not required to comply with the procedures for a reconsideration.

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

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

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

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

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

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

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

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

(k) IRO Assignment and Notification. The Department shall review the request for IRO review, assign an IRO, and notify the parties about the IRO assignment consistent with the provisions of Insurance Code

§4202.002(a)(1), §1305.355(a), Chapter 12, Subchapter F of this title (related to Random Assignment of Independent Review Organizations), any other related rules, and this subchapter.

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

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

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

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

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

(5) the written notification of the initial adverse determination and the written adverse determination of the reconsideration; and

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

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

(1) The party or providers with relevant records shall deliver the requested information to the IRO as directed by the IRO. If the provider requested to submit records is not a party to the dispute, the carrier shall reimburse copy expenses for the requested records pursuant to §134.120 of this title (relating to Reimbursement for Medical Documentation). Parties to the dispute may not be reimbursed for copies of records sent to the IRO.

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

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

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

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

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

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

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

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

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

(1) The IRO decision must include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(s) Defense. A carrier may claim a defense to a medical necessity dispute if the carrier timely complies with the IRO decision with respect to the medical necessity or appropriateness of health care for an employee. Upon receipt of an IRO decision for a retrospective medical necessity dispute that finds that medical necessity exists, the carrier must review, audit, and process the bill. In addition, the carrier shall tender

payment consistent with the IRO decision, and issue a new explanation of benefits (EOB) to reflect the payment within 21 days upon receipt of the IRO decision.

(t) Appeal. A decision issued by an IRO is not considered an agency decision and neither the Department nor the Division are considered parties to an appeal. In a Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence-based medical evidence. Appeals of IRO decisions will be as follows:

(1) Non-Network Appeal Procedures. A party to a medical necessity dispute may seek review of a dismissal or decision as follows:

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

(B) A party to a retrospective medical necessity dispute in which the amount billed is less than or equal to $3,000 or an appeal of an IRO decision regarding determination of the concurrent or prospective medical necessity for a health care service may appeal the IRO decision by requesting a Division CCH conducted by a Division hearing officer. A benefit review conference is not a prerequisite to a Division CCH under this subparagraph.

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

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

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

(iv) Prior to a Division CCH, a party may submit a request for a letter of clarification by the IRO to the Division's Chief Clerk. A copy of the request for a letter of clarification must be provided to all parties involved in the dispute at the time it is submitted to the Division. A request for a letter of clarification may not ask the IRO to reconsider its decision or issue a new decision.

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

(II) The Department will forward the party's request for a letter of clarification by the IRO to the IRO that conducted the independent review.

(III) The IRO shall send a response to the request for a letter of clarification to the Department and to all parties that received a copy of the IRO's decision within 5 days of

receipt of the party's request for a letter of clarification. The IRO's response is limited to clarifying statements in its original decision; the IRO shall not reconsider its decision and shall not issue a new decision in response to a request for a letter of clarification.

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

(v) A party to a medical necessity dispute who has exhausted all administrative remedies may seek judicial review of the Division's decision. Judicial review under this paragraph shall be conducted in the manner provided for judicial review of contested cases under Chapter 2001, Subchapter G Government Code. A decision becomes final and appealable when issued by a Division hearing officer. If a party to a medical necessity dispute files a petition for judicial review of the Division's decision, the party shall, at the time the petition is filed with the district court, send a copy of the petition for judicial review to the Division's Chief Clerk. The Division and the Department are not considered to be parties to the medical necessity dispute pursuant to Labor Code §§413.031(k-2) and 413.0311(e).

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

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

(-a-) Any applicable Division docket number for the dispute being appealed;

(-b-) the names of the parties;

(-c-) the cause number;

(-d-) the identity of the court; and

(-e-) the date the petition was filed with the court.

(II) The record of the hearing includes:

(-a-) all pleadings, motions, and intermediate rulings;

(-b-) evidence received or considered;

(-c-) a statement of matters officially noticed;

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

(-e-) any decision, opinion, report, or proposal for decision by the officer presiding at the hearing and any decision by the Division; and

(-f-) a transcription of the audio record of the Division CCH.

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

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

(i) medical records;

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

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

(iv) the written notification of the adverse determination and the written determination of the reconsideration;

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

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

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

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

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

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

(2) Network Appeal Procedures. A party to a medical necessity dispute may seek judicial review of a dismissal or the decision as provided in Insurance Code §1305.355 and Chapter 10 of this title (relating to Workers' Compensation Healthcare Networks).

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

(1) The written appeal must be filed with the Division Chief Clerk no later than 20 days after the date the IRO decision is sent to the appealing party and must be filed in compliance with Division rules.

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

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

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

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

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

*The provisions of this §133.308 adopted to be effective December 31, 2006, 31 TexReg 10339; amended to be effective May 25, 2008, 33 TexReg 3954.*

**§133.309. Alternate Medical Necessity Dispute Resolution by Case Review Doctor.**

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

(1) case review doctor--a commission selected doctor from the commission's Approved Doctor List assigned to conduct retrospective review of health care for medical necessity under this subsection.

(2) claim-specific--pertaining to one injured employee, a single workers' compensation claim filed by that injured employee, and a single insurance carrier (carrier), as defined in §133.1(a)(10) of this title, (relating to Definitions for Chapter 133 – Benefits—Medical Benefits) that has accepted liability for the claim.

(3) retrospective medical necessity dispute--a dispute regarding health care provided to an injured employee by a health care provider (HCP), as defined in §133.1(a)(9) of this title, for which reimbursement has been denied to an injured employee or HCP by the carrier based upon the carrier's determination that the health care is not medically necessary.

(b) Applicability.

(1) Alternate Medical Necessity Dispute Resolution by Case Review Doctor (AMDR) is the exclusive process to resolve claim-specific retrospective medical necessity disputes, wherein:

(A) the sum of disputed billed charges on a single bill is less than the tier one fee as established for the review of health care by an Independent Review Organization (IRO) (pursuant to Article 21.58C of the Texas Insurance Code); or

(B) the sum of disputed billed charges on multiple bills is less than the tier one fee as established for the review of health care by an IRO. Multiple billings may not include bills from more than one HCP.

(2) This rule applies to AMDR requests filed with the commission on or after October 1, 2004.

(3) The AMDR process is expressly limited to the resolution of retrospective medical necessity disputes as defined in paragraph (b)(1)(A) and (B) of this subsection.

(4) This process shall not be utilized for the purpose of reviewing or appealing an IRO decision or a State Office of Administrative Hearings (SOAH) decision, nor pending decisions before those bodies, regarding retrospective medical necessity disputes.

(5) For medical services in which the sum of disputed billed charges, as determined in accordance with paragraph (b)(1) of this subsection, is greater than or equal to the tier one fee for an IRO review or for

requests received prior to October 1, 2004, the requesting party must file a separate request that adheres to the medical dispute process outlined in §133.308 of this title (relating to Medical Dispute Resolution By Independent Review Organizations).

(6) All disputes involving issues other than medical necessity shall be filed separately and processed under §133.307 of this title (relating to Medical Dispute Resolution of a Medical Fee Dispute) and/or §141.1 of this title (relating to Requesting and Setting a Benefit Review Conference).

(7) Where any terms or parts of this section or its application to any person or circumstance are determined by a court of competent jurisdiction to be invalid, the invalidity does not affect other provisions or applications of this section that can be given affect without the invalidated provision or application.

(c) Effect of Other Disputes.

(1) If, by the fifteenth day after the carrier receives the first written notice of the injury, the carrier has not disputed liability or compensability of the claimed injury, the carrier is liable for all medically necessary care that is provided for the claimed injury until the carrier timely disputes liability or compensability of that injury. A request for AMDR regarding the medical necessity of health care that was provided to treat the claimed injury prior to the carrier's dispute shall proceed to an AMDR final decision and order.

(2) If, by the sixtieth day after the carrier receives the first written notice of the injury, or a later day if there is a finding of evidence that could not reasonably have been discovered earlier, the carrier still has not disputed liability or compensability of the claimed injury, the carrier is liable for all medically necessary care that is provided for the claimed injury. A request for AMDR regarding the medical necessity of health care provided to treat the claimed injury shall proceed to an AMDR final decision and order.

(3) If the carrier timely disputes liability for the subject claim, denies compensability of the injury, or denies compensability of the body parts or conditions for which the health care in dispute was provided, AMDR will not proceed until after final adjudication by the commission finds liability and compensability for the injury.

(4) A request for AMDR regarding the medical necessity of health care provided for body parts or conditions already accepted by the carrier as to liability or compensability, or already adjudicated as to liability or compensability, shall proceed to a final decision and order.

(d) Parties. The following individuals shall be parties to an AMDR:

(1) the HCP who has been denied reimbursement for health care rendered;

(2) the prescribing/referring doctor, if that doctor is not the HCP who provided the care in dispute;

(3) the injured employee, if denied reimbursement for health care paid by the injured employee; and

(4) the carrier. The carrier participates in this process as a responding party and shall not be considered a requesting party.

(e) Timeliness. A request shall be filed with and received by the commission no later than one year from the disputed health care's date of service.

(1) A request by a HCP may be submitted only after exhaustion of the reconsideration process as established in §133.304 of this title (relating to Medical Payments and Denials).

(2) A request by an injured employee shall be initiated by contacting the commission in any manner for assistance with the AMDR requirements. The injured employee's initial contact establishes the date used to determine timeliness. The injured employee is not required to request reconsideration under §133.304 of this title prior to requesting AMDR.

(3) A party who fails to timely file a request waives the right to AMDR.

(f) Request by HCPs.

(1) Two copies of the request for AMDR shall be submitted to the commission in the form and manner prescribed by the commission.

(2) Each copy of the request shall be legible and shall include:

(A) a designation that the request is for AMDR;

(B) a copy of all medical bill(s) as originally submitted for reconsideration in accordance with §133.304 of this title;

(C) copies of written notices of adverse determinations from a carrier (both initial and on reconsideration) such as an explanation of benefits indicating that reimbursement is denied due to the health care not being medically necessary, or, if the carrier failed to respond to the request (either initial or on reconsideration), verifiable evidence or documentation of the carrier's receipt of the request; and

(D) a maximum of five single-sided documents, which may include a summary, supporting the medical necessity of disputed care, clearly identified as the documentation to be reviewed by the case review doctor. The prescribing/referring doctor shall provide the required documentation to the requesting HCP.

(g) Request by Injured Employee. Requests by the injured employee shall be legible and shall include:

(1) a designation that the request is for AMDR;

(2) documentation or evidence (such as itemized receipts) of the amount the injured employee paid the HCP;

(3) a copy of any written notice, if in the possession of the requestor, of adverse determinations from a carrier such as an explanation of benefits indicating that reimbursement is denied due to the health care not being medically necessary, or, if the carrier failed to respond to the request for reimbursement, verifiable evidence or documentation of the carrier's receipt of the request; and

(4) a maximum of five single-sided documents, which may include a summary, supporting the medical necessity of disputed care, clearly identified as the documentation to be reviewed by the case review doctor. The prescribing/referring doctor shall provide the required documentation to the injured employee.

(h) Assignment. The commission, within 10 days of receipt of a complete request for AMDR, shall assign a case review doctor to review and resolve the disputed medical necessity. The case review doctor will be selected, at the commission's discretion, from among commission-approved doctors having appropriate qualifications. The case review doctor shall be considered a doctor performing medical case review for

purposes of §413.054 of the Act. The doctors utilized by the commission for this process will be of sufficient number to service the volume of AMDR requests. The case review doctor shall:

(1) be of the same or similar licensure as the prescribing/referring or performing doctor;

(2) have no known conflicts of interest with any of the providers known by the case review doctor to have examined, treated or reviewed records for the injured employee's injury claim;

(3) not have previously treated or examined the injured employee within the past 12 months, nor have examined or treated the injured employee with regard to a medical condition being evaluated in the AMDR request; and

(4) preserve the confidentiality of individual medical records as required by law. Written consent from the injured employee is not required for the case review doctor to obtain medical records relevant to the review.

(i) Notification Order.

(1) The commission, also within 10 days of receipt of a complete request for AMDR, shall issue written notification to the parties which:

(A) indicates the case reviewer's name, license number, practice address, telephone number and fax number;

(B) explains the purpose of the case review;

(C) orders the requestor to pay the case review fee to the case review doctor no later than 14 days from the date of the order, unless the requestor is an injured employee, in which case the carrier is ordered to pay the case review fee; and

(D) advises the carrier to forward a written response to the case review doctor.

(2) The commission's notice to the carrier shall also include a copy of the AMDR request. The notice shall be forwarded to the carrier through its Austin representative. The carrier is deemed to have received the notification order and request for AMDR in accordance with §102.5(d) of this title (regarding General Rules for Written Communication to and from the Commission).

(3) Once the notification order has been issued, withdrawals by any party are not permitted.

(j) Case Review Fee. The AMDR case review fee is $100.00.

(1) An injured employee is never liable for the AMDR case review fee.

(2) The case review fee shall be initially paid by the requestor, unless the requestor is an injured employee, in which case the carrier pays the case review fee. Untimely payment of the case review fee will result in either:

(A) a dismissal of the requestor's AMDR request; or

(B) the issuance of an order to the carrier requiring payment of the case review fee when the requestor is an injured employee.

(3) Final liability for the AMDR case review fee shall be determined as provided in subsection (n) of this section.

(k) Carrier Response. No later than 14 days from the date of the notification order, the carrier shall submit directly to the case review doctor:

(1) the $100.00 case review fee with an annotation identifying the case review number, when required; and

(2) a written response by facsimile or electronic transmission, either explaining why the disputed health care is not medically necessary, or indicating that no documentation will be submitted for review. The response shall be limited to a maximum of five single-sided documents, which may include a summary, supporting the carrier's position. The carrier may elect to provide this written response. If the carrier elects to not provide a written response, the AMDR process will proceed to a final decision and order.

(l) Case Review. The case review doctor shall review up to five single-sided documents provided by each party.

(1) If a party's documentation exceeds the limit of a maximum of five single-sided documents, the case review doctor shall not review any of the offending party's documentation and the case review doctor shall indicate this in the report.

(2) If the case review doctor does not receive a timely response from the carrier, the case review doctor shall proceed with the review and issue the report required by subsection (m) of this section.

(3) To avoid undue influence on the case review doctor, any communication regarding the AMDR dispute between a party and the case review doctor, before, during, or after the review, is prohibited.

(4) Upon completion of the case review, the case review doctor shall maintain a copy of the report, all documentation submitted by the parties, the date the documentation was received and from whom, and the date and time the report was issued to, and received by, all parties. The case review doctor shall forward to the commission, upon request, copies of the retained information.

(m) Report. No later than five days after the date the carrier's response was due, the case review doctor shall issue a report addressing the medical necessity of the disputed health care.

(1) The report must include:

(A) the specific reasons for the case review doctor's determination, including the clinical basis for the decision;

(B) a description of, and the source of, the screening criteria that were utilized;

(C) a description of the qualifications of the case review doctor; and

(D) a certification by the case review doctor that no known conflicts of interest exist with any of the providers known by the case review doctor to have examined, treated or reviewed records for the injured employee's injury claim. The certification must also include a statement that the case review doctor has not previously treated or examined the injured employee within the past 12 months, nor has the case review doctor examined or treated the injured employee with regard to a medical condition being evaluated in the AMDR request.

(2) The case review doctor shall forward the completed report and a copy of the reviewed carrier's response to all parties and the commission.

(A) This information shall be forwarded to all parties and the commission by facsimile or electronic transmission.

(B) If the party is an injured employee and a facsimile number has not been provided, this information shall be provided by other verifiable means.

(3) Requests for clarification from the parties will not be accepted by the commission or the case review doctor. The commission, at its discretion, may seek clarification from the case review doctor and may require the case review doctor to issue an amended report within three days of the commission's request.

(n) Final Decision and Order. The case review doctor's report is deemed to be a commission decision and order, and is effective the date signed by the case review doctor.

(1) The decision and order is final and is not subject to further review.

(2) If the decision and order indicates that none of the disputed care was medically necessary, the decision and order will direct the prescribing/referring doctor to reimburse the requestor the case review fee only if the requestor is a pharmacy or durable medical equipment provider. No other parties shall reimburse, or be entitled to reimbursement of, the case review fee.

(3) If the decision and order indicates that any of the disputed care was medically necessary it will include an order that the carrier pay, in accordance with the commission's fee guidelines, for the care that was determined by the case review doctor to be medically necessary. The carrier will also be ordered to reimburse the requestor the case review fee.

(4) A party shall comply with the decision and order within 20 days of receipt.

(5) This final decision and order shall not be used by a carrier to prospectively deny future medical care.

(o) Dismissal. The commission may dismiss a request for AMDR if the commission determines that good cause exists.

*The provisions of this §133.309 adopted to be effective September 12, 2004, 29 TexReg 8567.*

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## CHAPTER 133. GENERAL MEDICAL PROVISIONS

## SUBCHAPTER G - ELECTRONIC MEDICAL BILLING, REIMBURSEMENT, AND DOCUMENTATION

### §133.500. Electronic Formats for Electronic Medical Bill Processing.

(a) The Division prescribes standard electronic formats by adopting the following implementation guides for the medical billing transactions:

(1) Billing:

(A) Professional Billing – ANSI x12 837(P) Version 4010.

(B) Institutional/Hospital Billing – ANSI x12 837(I) Version 4010.

(C) Dental Billing – ANSI x12 837(D) Version 4010.

(D) Pharmacy Billing – NCPDP Telecommunications Standard Version 5.1.

(2) Acknowledgment:

(A) Functional Acknowledgment – ANSI x12 997 Version 4010.

(B) Detail Acknowledgment – ANSI x12 824 Version 4010.

(3) Remittance – ANSI x12 835 Version 4010.

(4) Reporting – IAIABC 837 Version 4010.

(5) Documentation – ANSI x12 275 Version 4050.

(b) An implementation guide is a:

(1) specification document for national standard electronic formats as defined in subsection (a) of this section and published by a national standard setting organization that defines data requirements, data transaction sets, and data mapping; or

(2) published specification document that defines specific data requirements, data set transactions, data mapping, or data edits and is intended to accompany national standard implementation guides.

(c) Medical billing transactions must:

(1) contain all fields required in the applicable format implementation guide as set forth in subsection (a) of this section and associated Division implementation guides; and

(2) be populated with current and correct values defined in the applicable implementation guide as set forth in subsection (a) of this section and associated Division implementation guides.

(d) Insurance carriers and health care providers may exchange electronic data in a non-prescribed format by mutual agreement. All data elements required in the Division prescribed formats must be present in a mutually agreed upon format.

*The provisions of this §133.500 adopted to be effective August 10, 2006, 31 TexReg 6230.*

**§133.501. Electronic Medical Bill Processing.**

(a) Applicability.

(1) Electronic medical bill processing is the exclusive process to exchange medical bill data in accordance with §133.500 of this chapter (relating to Electronic Formats for Electronic Medical Bill Processing) for professional, institutional/hospital, pharmacy, and dental services.

(2) Insurance carriers must be able to exchange electronic data by January 1, 2008 unless the insurance carrier is excepted from the process in accordance with paragraph (6) of this subsection.

(3) Health care providers must be able to exchange electronic data by January 1, 2008 unless the health care provider is excepted from the process in accordance with paragraph (5) of this subsection.

(4) Health care providers and insurance carriers may contract with other entities for electronic medical bill processing. Insurance carriers and health care providers are responsible for the acts or omissions of its agents executed in the performance of services for the insurance carrier or health care provider.

(A) Health care provider agent is a person or entity that the health care provider contracts with or utilizes for the purpose of fulfilling the health care provider's obligations for electronic medical bill processing under the Texas Labor Code or Division rules.

(B) Insurance carrier agent is a person or entity that the insurance carrier contracts with or utilizes for the purpose of providing claims service or fulfilling the insurance carrier's obligations for electronic medical bill processing under the Texas Labor Code or Division rules.

(5) A health care provider is waived from the requirement to submit medical bills electronically to an insurance carrier if:

(A) the health care provider employs 10 or fewer full time employees~~,~~ and workers' compensation constitutes less than 10% of their practice; or

(B) the health care provider requests and the Division approves a waiver. The Division will approve a request on a case-by-case basis and will base the decision on whether or not electronic billing causes an unreasonable financial burden on the health care provider.

(6) An insurance carrier is waived from the requirement to receive medical bills electronically from health care providers on approval from the Division. The Division may grant an exception on a case-by-case basis if an insurance carrier establishes that electronic billing will result in an unreasonable financial burden.

(b) Electronic medical bill.

(1) An electronic medical bill is a medical bill submitted electronically by a health care provider or an agent of the health care provider.

(2) A complete electronic medical bill is an electronic medical bill that:

(A) is submitted in accordance with this chapter, and

(B) identifies the:

(i) injured employee;

(ii) employer;

(iii) insurance carrier;

(iv) health care provider; and

(v) service, supply, or medication.

(3) The received date of an electronic medical bill is the date the bill is electronically transmitted in accordance with §102.4(p) of this title (relating to General Rules for Non-Division Communication). An electronic medical bill is considered received if it meets the criteria of a complete electronic medical bill.

(c) Acknowledgment.

(1) A Functional Acknowledgment is an electronic notification to the sender of an electronic file that the file has been received and:

(A) accepted as a complete, correct file, or

(B) rejected with a valid rejection code.

(2) A Detail Acknowledgment is an electronic notification to the sender of an electronic transaction within an electronic file that the transaction has been received and:

(A) accepted as a complete, correct submission, or

(B) rejected with a valid rejection code.

(3) An insurance carrier must acknowledge receipt of an electronic medical bill by returning a Detail Acknowledgment within one business day of receipt of the electronic submission.

(A) Notification of a rejection is transmitted in a Detail Acknowledgment when an electronic medical bill does not meet the definition of a complete electronic medical bill or does not meet the edits defined in the applicable implementation guide or guides.

(B) A health care provider may not submit a duplicate electronic medical bill earlier than 45 days from the date submitted if an insurance carrier has acknowledged acceptance of the original complete electronic medical bill. A health care provider may submit a corrected medical bill electronically to the insurance carrier after receiving notification of a rejection. The corrected medical bill is submitted as a new, original bill.

(4) Acceptance of a complete medical bill is not an admission of liability by the insurance carrier. An insurance carrier may subsequently reject an accepted electronic medical bill if it is determined that the employer listed on the medical bill is not a policyholder of the insurance carrier.

(A) The subsequent rejection must occur no later than 7 days from the date of receipt of the complete electronic medical bill.

(B) The rejection transaction must clearly indicate the reason for the rejection is due to denial of liability.

(d) Electronic remittance notification.

(1) An electronic remittance notification is an explanation of benefits (EOB), submitted electronically regarding payment or denial of a medical bill, recoupment request, or receipt of a refund.

(2) An insurance carrier must provide an electronic remittance notification no later than 45 days after receipt of a complete electronic medical bill or within 5 days of generating a payment.

(e) Electronic documentation.

(1) Electronic documentation consists of medical reports and/or records submitted electronically that are related to an electronic medical bill.

(2) Complete electronic documentation related to an electronic medical bill:

(A) is submitted by fax, electronic mail, or in an electronic format and

(B) identifies the:

(i) injured employee,

(ii) insurance carrier,

(iii) health care provider;

(iv) related medical bill(s), and

(v) date(s) of service.

(3) When a health care provider submits electronic documentation related to an electronic medical bill, the documentation must be submitted within 7 days of submission of the electronic medical bill.

*The provisions of this §133.500 adopted to be effective August 10, 2006, 31 TexReg 6230.*