CHAPTER 140. DISPUTE RESOLUTION--GENERAL PROVISIONS

§140.1. Definitions

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

(1) Benefit dispute--A disputed issue arising under the Texas Workers' Compensation Act (the Act) in a workers' compensation claim regarding compensability or eligibility for, or the amount of, income or death benefits.

(2) Benefit proceeding--A proceeding pursuant to the Act, Chapter 410, conducted by a presiding officer to resolve one or more benefit disputes. Benefit proceedings include benefit review conferences, benefit contested case hearings, appeals, and, after January 1, 1992, arbitration.

(3) Director of the hearings division--The director of the Division of Hearings and Review, or his delegatee.

(4) Party to a proceeding--A person entitled to take part in a proceeding because of a direct legal interest in the outcome.

(5) Presiding officer--The commission employee, or independent arbitrator, assigned to conduct a proceeding. Presiding officers include benefit review officers, hearing officers, and appeals panel members, and, after January 1, 1992, arbitrators.

(6) Special accommodations--Individuals and equipment necessary to allow an individual who does not speak English or who has a physical, mental, or developmental handicap to participate in a proceeding. The term includes spoken language translators and sign language translators.

(7) Stipulation--A voluntary accord between parties to a benefit contested case hearing regarding any matter relating to the hearing that does not constitute an agreement, as defined by the Act, §401.011(3), or a settlement, as defined by the Act, §401.011(40).

The provisions of this §140.1 adopted to be effective May 24, 1991, 16 TexReg 2607; amended to be effective June 9, 2005, 30 TexReg 3236.

§140.2. Special Accommodations.

(a) The commission, on its own motion or upon request, will provide special accommodations to an individual who intends to participate in a proceeding and who does not speak English, or who has a physical, mental, or developmental handicap.

(b) A request for special accommodations may be made by the individual desiring them, the carrier, or anyone knowing of the need.

(c) The request:

(1) may be made in any manner;

(2) should describe the special accommodations needed; and

(3) should be sent to the commission no later than 10 days before the date of the proceeding.

The provisions of this §140.2 adopted to be effective May 24, 1991, 16 TexReg 2607.

§140.3. Expedited Proceedings

In addition to expedited proceedings provided by any other commission rule, the commission may provide expedited benefit review conferences and benefit contested case hearings for resolution of disputes involving compensability, liability for essential medical treatment, or any type of issue as defined by commission policy for which the executive director or delegate determines an expedited proceeding will serve the best interests of the workers' compensation system or its participants.

The provisions of this §140.3 adopted to be effective May 24, 1991, 16 TexReg 2607; amended to be effective September 1, 1993, 18 TexReg 5214.

§140.4 Conduct and Decorum

(a) The presiding officer may at the beginning of any proceeding and during the course of that proceeding establish rules of decorum to be followed during the proceeding. The presiding officer may also establish times for beginning the proceeding, for recesses, and for ending the proceeding.

(b) Parties and participants in a proceeding shall conduct themselves with dignity, shall show courtesy and respect for one another and for the presiding officer, shall follow the decorum prescribed by the presiding officer at the proceeding, and shall adhere to the beginning times of the proceeding, and to the times established for each recess and for ending the proceeding.

(c) To maintain and enforce proper conduct and decorum at a proceeding, and to enforce promptness at a proceeding, the presiding officer may take appropriate action, including, but not limited to:
    (1) issuing a warning;
    (2) excluding any person from the proceeding;
    (3) recessing the proceeding; and
    (4) referring an action for possible enforcement as an administrative violation.

The provisions of this §140.4 adopted to be effective May 24, 1991, 16 TexReg 260; amended to be effective June 9, 2005, 30 TexReg 3236.

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§140.5. Correction of Clerical Error.

(a) The executive director or the executive director's designee may at any time revise an order or decision to correct clerical error:

    (1) at the joint written request of the parties;

    (2) at the request of a party affected by the order or decision; or

    (3) on his or her own motion.

(b) When a party requests correction of clerical error, the request must:

    (1) include a copy of the order or decision marked to indicate the alleged error;

    (2) state the requested correction, and the reasons for making it;

    (3) be filed with the hearings division; and

    (4) be sent to all other parties affected by the order or decision.

(c) A party affected by the order or decision may file a response to the request no later than 10 days after receipt of the request.

(d) No later than 30 days after the request was filed, the hearings division shall either:

(1) issue and deliver to the parties a corrected order or decision; or

(2) advise the parties in writing that the order or decision was correct as originally entered.

(e) When clerical error is corrected on the motion of the executive director or designee, a copy of the corrected order or decision will be delivered to all affected parties.

The provisions of this §140.5 adopted to be effective May 24, 1991, 16 TexReg 2607; amended to be effective May 1, 1996, 21 TexReg 3436.

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

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

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

(c) Rights in Relation to the Injured Employee.

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Claims for Reimbursement of Medical Benefits.

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

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

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

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

The provision of this §140.6 adopted to be effective September 23, 2008, 33 TexReg 8002.

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

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

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

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

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

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

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

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

The provision of this §140.7 adopted to be effective September 23, 2008, 33 TexReg 8002.

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

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

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

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

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

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

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

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

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

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

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

(1) Paying or Reducing Payment.

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

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

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

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

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

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

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

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

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

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

(g) Filing Notice of Subclaimant Status.

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

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

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

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

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

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

(1) Claim or Treatment Not Compensable.

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

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

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

(2) Lack of Medical Necessity.

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

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

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

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

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

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

(3) Reduction, Denial or Failure to Respond.

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

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

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

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

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

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

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

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

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

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

The provision of this §140.8 adopted to be effective September 23, 2008, 33 TexReg 8002.