CLIENT NEWSLETTER

THE LAW OFFICE OF RICKY D. GREEN, PLLC

JUNE 21, 2012

Good day readers, we hope you stay cool this summer. Yesterday, June 20, 2012, was the first day of summer, called the summer solstice. Please have a happy and safe summer time.

As the Division issues new rules, our law firm will bring this new information to you. The Division has adopted new amendments regarding dispute resolution for medical fee disputes. These adopted amendments affect medical fee and medical necessity disputes that are filed with the Texas Division of Workers' Compensation on or after June 1, 2012.

Medical Fee Disputes Process

The new amendment provides one appeal process for medical fee disputes, regardless of the amount of reimbursement requested. The appealing party must request a benefit review conference (BRC) now under DWC Rule 133.307(g). After the BRC is held, the parties can proceed to a contested case hearing (CCH) before the State Office of Administrative Hearings (SORM).

The example of the process is this: a doctor provides treatment and bills $1,200.00 for the service. The carrier audits the bill and pays $400. The doctor wants the remaining $800 and files for Medical Fee Dispute Resolution (MFDR). Let's say that the Division's MFDR agrees with the carrier and orders that the carrier only pay $400. The doctor can appeal the MFDR decision by requesting a BRC with the Division within 20 days after receiving the MFDR decision. If the doctor and carrier cannot resolve the dispute at the BRC, then the parties can either agree to binding arbitration (highly unlikely) or the doctor can request a CCH with the State Office of Administrative Hearings (SORM). So, a medical fee CCH is with SORM and not the Division. If the doctor is still unhappy with the SORM Administrative Law Judge's decision, then the doctor can request judicial review.

Medical Necessity Dispute Process

Regarding medical necessity disputes, all disputes, including spinal surgery and certified workers' compensation health care network claims, are handled at a CCH before the Division after review by an independent review organization (IRO).

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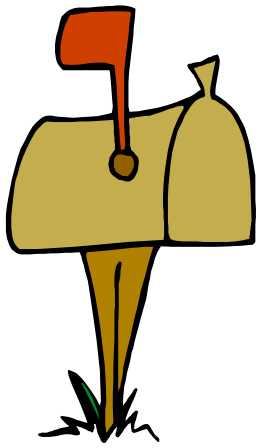
New Forms

The DWC has also revised existing DWC forms related to medical fee dispute resolution and arbitration and created new forms that are to be used by workers' compensation system participants due to the new amendments. The DWC has revised DWC Form-060, "Medical Fee Dispute Resolution Request," and DWC Form-044, "Election to Engage In Arbitration." The DWC has created new DWC Form-045M, "Request to Schedule, Reschedule, or Cancel Benefit Review Conference for Medical Fee Dispute," and new DWC Form-049, "Request to Schedule Medical Contested Case Hearing." The DWC Form-045A is replaced by the newly adopted DWC Form-049, effective June 1, 2012. A copy of the new forms are attached to the end of this newsletter.

Workers' compensation system participants should use the revised and new forms for disputes filed on or after June 1, 2012.



QUESTIONS? COMMENTS? Have questions or comments about any of the stories in the newsletter or general questions about a workers' compensation matter? Drop us a line at questions@rickydgreen.com, or give us a call at (512) 280-0055. We look forward to handling all of your workers' compensation needs.

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Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution
7551 Metro Center Drive, Suite100 • MS-48
Austin, TX 78744-1645
(512) 804-4812 phone

Complete, if known:

DWC Claim #

Carrier Claim #

Medical Fee Dispute Resolution Request

I. REQUESTER INFORMATION

1. Type of Requester (check the appropriate box)

☐ Injured Employee ☐ Health Care Provider ☐ Pharmacy Processing Agent ☐ Subclaimant

2. If Injured Employee is checked in Box 1, provide the following information:

Is the injured employee a first responder, as defined in Texas Labor Code §504.055, who sustained a serious bodily injury*? ☐ Yes ☐ No If yes, the medical fee dispute resolution process will be expedited.

*bodily injury that creates a substantial risk of death or that causes death, serious permanent disfigurement, or protracted loss or impairment of the function of any bodily member or organ

3. Requester's Name (Last, First, Middle)	**4. Requester's Address** (Street or PO Box, City, State, Zip Code)	
5. Requester's Phone Number	**6. Requester's Fax Number**	**7. Requester's E-mail Address**

II. CLAIM INFORMATION

8. Injured Employee's Name	**9. Date of Injury** (mm/dd/yyyy)

III. TABLE OF DISPUTED SERVICES

(Not required if Injured Employee is checked in Section I, Box 1. Injured Employees must provide documentation as listed in the *Frequently Asked Questions* on page 3 of this form.)

10. Provide the requested information in the table below.

Dates of Service in Dispute	Treatment or Service Codes in Dispute	Amount Billed	Amount Paid	Amount in Dispute	Place of Service (Code or Description)
TOTAL					

For TDI-DWC Use Only

III. TABLE OF DISPUTED SERVICES (Continued) (Not required if Injured Employee is checked in Section I, Box 1. Injured Employees must provide documentation as listed in the *Frequently Asked Questions* on page 3 of this form.)

Dates of Service in Dispute	Treatment or Service Codes in Dispute	Amount Billed	Amount Paid	Amount in Dispute	Place of Service (Code or Description)
	TOTAL from Page 1				
	GRAND TOTAL				

Requester's Name:

DWC Claim Number:

For TDI-DWC Use Only

Frequently Asked Questions
Medical Fee Dispute Resolution Request (DWC Form-060)

What documentation is required when filing the DWC Form-060?
The required documentation of disputed services that must accompany the request for medical fee dispute resolution varies depending on the type of entity requesting medical fee dispute resolution as set forth in 28 Texas Administrative Code (TAC), §133.307. See the chart below for guidance for specific types of requesters. In addition, all requesters except injured employees must complete the *Table of Disputed Services*.

Health Care Provider or Pharmacy Processing Agent

- A paper copy of all medical bills related to the dispute
- A paper copy of all medical bills submitted to the insurance carrier for reconsideration
- A paper copy of each explanation of benefits (EOB) related to the dispute (or convincing evidence that the insurance carrier received the request for EOB)
- A copy of the final decision regarding compensability, extent of injury, liability and/or medical necessity for the health care related to the dispute, if applicable
- A copy of all applicable medical records related to the dates of service in dispute
- A position statement of the disputed issues in accordance with 28 TAC §133.307(c)(2)(N)
- If the dispute involves health care for which the TDI-DWC has not established a maximum allowable reimbursement or reimbursement rate, documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate in accordance with 28 TAC §134.1 or §134.503, as applicable
- A signed and dated copy of the agreement between the agent and the pharmacy (applies only to pharmacy processing agent)
- Other documentation the requester believes is applicable to the medical fee dispute

Subclaimant

Subclaimants must provide the appropriate information and/or documentation with the request that is consistent with the provisions of 28 TAC §140.6 or §140.8 as follows:

- A request made by a subclaimant under Labor Code §409.009 must comply with 28 TAC §140.6.
- A request made by a subclaimant under Labor Code §409.0091 must comply with 28 TAC §140.8.

Injured Employee

- A description of the service(s) in dispute, including the date(s) of service, the amount you paid for each disputed service, and the amount of the medical fee in dispute
- An explanation of why the disputed amount should be refunded or reimbursed, and how the submitted documentation supports the explanation for each disputed amount
- Proof of injured employee payment (copies of receipts, health care provider billing statements, or similar documents)
- A copy of the insurance carrier's or health care provider's denial of reimbursement or refund relevant to the dispute (or convincing evidence of the injured employee's attempt to obtain reimbursement or refund)

Where do I file the DWC Form-060?
If you are requesting medical fee dispute resolution and you are not the injured employee, you must mail or personally deliver **two (2) copies** of the completed DWC Form-060 and required documentation to the TDI-DWC at the following address:

Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution Section
7551 Metro Center Drive, Suite 100 • MS-48
Austin, TX 78744-1645

If you are the injured employee, you may file by mail or in person as shown above or you may fax the completed DWC Form-060 and required documentation to TDI-DWC at (512) 804-4811.

Is there a deadline for filing the DWC Form-060?
Generally, the request must be filed no later than one year after the date(s) of the service in dispute. Exceptions to the one-year filing deadline can be found in TDI-DWC rule, 28 TAC §133.307(c)(1). The request is deemed filed when it is received in the Medical Fee Dispute Resolution Section at the TDI-DWC.

Questions?
You can get more information about the medical fee dispute resolution process by calling the TDI-DWC Medical Fee Dispute Resolution Section at (512) 804-4812 or e-mailing mdrinquiry.atlas.tdi@tdi.state.tx.us. You can also access the medical fee dispute resolution rules on the TDI website at http://www.tdi.texas.gov/wc/mfdr/.

NOTE: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004).

Texas Department of Insurance
Division of Workers' Compensation
Hearings / Dispute Resolution Services
7551 Metro Center Drive, Suite 100 • MS-35
Austin, TX 78744-1645
(512) 804-4010 phone • (512) 804-4011 fax

Complete, if known:

DWC Claim #:

Carrier Claim #:

Election to Engage in Arbitration

Type (or print in black ink) each item on this form

I. CLAIM DISPUTE INFORMATION

1. DWC Claim Number	**2. Medical Fee Dispute Decision Number** (if applicable)
3. Claimant's Name	**4. Insurance Carrier's Name**
5. Field Office	
6. Date Benefit Review Conference Ended, if applicable (mm/dd/yyyy)	

7. Check ONLY one box to indicate the type of dispute for which arbitration is elected:

☐ Medical fee dispute
☐ Indemnity dispute Specify benefit issues remaining in dispute:

NOTE: Arbitration may be elected only for disputes that remain unresolved after a Benefit Review Conference.

8. Is the injured employee a first responder, as defined in Texas Labor Code §504.055, who sustained a serious bodily injury*? ☐ Yes ☐ No

*bodily injury that creates a substantial risk of death or that causes death, serious permanent disfigurement, or protracted loss or impairment of the function of any bodily member or organ

II. ELECTION OF ARBITRATION

By signing below, the parties to the above referenced claim pending before the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC), elect, pursuant to Texas Labor Code, Chapters 410 and 413, to engage in arbitration concerning the issues identified in Box 7.

The parties understand that this arbitration election requires the consent of the parties affected by the dispute, and that once the arbitration election is filed with the TDI-DWC, the parties are no longer entitled to a TDI-DWC Contested Case Hearing, or review by the TDI-DWC Appeals Panel or the State Office of Administrative Hearings (SOAH) and that judicial review is strictly limited. Further, the parties understand that the election for arbitration is binding and irrevocable on the parties signing below for the resolution of the above referenced disputes. The decision of the arbitrator is final unless vacated by a court of competent jurisdiction, based on the provisions of §410.121 of the Texas Labor Code. The parties also acknowledge that that they are familiar with the arbitration provisions of the Texas Labor Code §410.024 and §§410.101-410.121, and the TDI-DWC Arbitration Rules in 28 Texas Administrative Code §§144.1-144.16, and agree to abide by them.

Insurance Carrier

9. Insurance Carrier's Name	**10. Phone Number**
11. Insurance Carrier Representative's Printed Name	**12. Alternate Phone Number**
13. Insurance Carrier Representative's Signature	**14. Date of Signature** (mm/dd/yyyy)

For TDI-DWC Use Only

Check the appropriate box: ☐Injured Employee ☐Health Care Provider ☐Subclaimant ☐Pharmacy Processing Agent		
15. If injured employee is checked above, is the employee assisted by the Office of Injured Employee Counsel (OIEC)? ☐ Yes ☐ No		
16. Requester's Printed Name	**17. Phone Number**	**18. Alternate Phone Number**
19. Requester's Signature		**20. Date of Signature** (mm/dd/yyyy)
21. Representative's Printed Name (if applicable)		
22. Phone Number		**23. Alternate Phone Number**
24. Representative's Signature		**25. Date of Signature** (mm/dd/yyyy)

Frequently Asked Questions

What is the purpose of electing arbitration?
Arbitration may be used only to resolve disputed benefit issues. It is an alternative to a Contested Case Hearing and requires mutual agreement of the parties. Arbitration may be elected, in accordance with 28 TAC, Chapter 144, for any disputes arising out of claim(s) that are under the jurisdiction of the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC).

Can I change my mind after electing to engage in arbitration?
No, an election to engage in arbitration is binding and irrevocable on all parties.

Can I appeal the arbitrator's decision?
There is no right to appeal except as provided in the Texas Labor Code, Section 410.121. The final award rendered by the arbitrator cannot be appealed to the TDI-DWC's Contested Case Hearing, TDI-DWC's Appeals Panel, or to the State Office of Administrative Hearings (SOAH).

What is the deadline for filing the DWC Form-044?
This form must be signed by all parties and filed with the TDI-DWC not later than the 20th day after the conclusion of the Benefit Review Conference as shown in Box 6 on the form.

Where do I file the DWC Form-044?
Submit the completed form to the TDI-DWC by mailing it to the address shown at the top of the form or by faxing the form to (512) 804-4011.

What happens after I file the DWC Form-044?
The TDI-DWC will assign an arbitrator not later than 30 days after the date on which the election is filed and will notify the parties. Each party is entitled to one rejection of an assigned arbitrator. The arbitrator will schedule an arbitration proceeding to be held within 30 days of being assigned the case and shall notify the parties, the employer, and the TDI-DWC of the date and time.

NOTE: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004).

Claimant's Name: DWC Claim Number:		For TDI-DWC Use Only

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite100 • MS-94
Austin, TX 78744-1645
(800) 252-7031 phone • (512) 804-4378 fax

Complete if known:

DWC Claim #

Carrier Claim #

Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)

Type (or print in black ink) each item on this form

I. REQUEST SPECIFICATIONS

1. Check ONLY one box to indicate the purpose of your request:

☐ Schedule a BRC-MFD ☐ Reschedule a BRC-MFD ☐ Cancel a BRC-MFD

2. Check the appropriate box(es) for services you are requesting, if any:

☐ Expedited BRC-MFD (specify reason*)

_____

*Does not include claim involving a first responder. See Section III, Box 11 regarding expedited first responder claims.

☐ Special Accommodations (specify)

_____

☐ Telephonic BRC-MFD

II. INJURED EMPLOYEE CLAIM INFORMATION

3. Employee's Name (Last, First, Middle)	**4. Employee's SSN***
5. Employee's Physical Address (Street, City, State, Zip Code)	
6. Insurance Carrier's Name	**7. Date of Injury** (mm/dd/yyyy)
8. Employer's Business Name (at the time of the injury)	
9. Employer's Business Address (Street or PO Box, City, State, Zip Code)	

*Title 28 Texas Administrative Code §141.1(d) requires that in order to schedule a benefit review conference, a request must be submitted in the form and manner required by TDI-DWC. Provision of the social security number is not mandatory, but failure to provide that number may result in delay of the request. The social security number may be used to identify the injured employee.

III. PARTY REQUESTING TO SCHEDULE, RESCHEDULE, OR CANCEL A BRC-MFD

10. Check the appropriate box: ☐ Injured Employee ☐ Insurance Carrier ☐ Health Care Provider ☐ Sub-claimant ☐ Pharmacy Processing Agent

11. If Injured Employee is checked in Box 10, provide the following information:
Is the injured employee a first responder, as defined in Texas Labor Code §504.055, who sustained a serious bodily injury*? ☐Yes ☐ No If Yes, the BRC-MFD will be expedited.
*bodily injury that creates a substantial risk of death or that causes death, serious permanent disfigurement, or protracted loss or impairment of the function of any bodily member or organ

12. Is the injured employee assisted by the Office of Injured Employee Counsel (OIEC)? ☐ Yes ☐ No

13. Requester's Printed Name

14. Requester's Mailing Address (Street or PO Box, City, State, Zip Code)		For TDI-DWC Use Only
15. Business/Firm Name (if applicable)		
16. Phone Number	**17. Alternate Phone Number**	

Request to SCHEDULE a BRC-MFD (Complete Section IV)

IV. DOCUMENTATION OF YOUR EFFORTS TO RESOLVE THE MEDICAL FEE DISPUTE

18. To document your efforts to resolve the medical fee dispute, you must attach a copy of the TDI-DWC Medical Fee Dispute Resolution decision to this request.

I certify I will provide a copy of this request to the opposing party or parties. I further certify that any pertinent information in my possession that was not previously exchanged during the Medical Fee Dispute Resolution process has been provided to the opposing party or parties.

Signature of Requester_____ **Date**_____

Request to RESCHEDULE or CANCEL a BRC-MFD (Complete Section V)

V. DOCUMENTATION OF GOOD CAUSE FOR RESCHEDULING OR CANCELING A BRC-MFD

19. Check ONE box below to indicate the description applicable to your request:

☐ Reschedule or cancel PRIOR to BRC-MFD (Complete 20 and 22)
☐ Reschedule AFTER failing to attend BRC-MFD (Complete 21 and 22)

20. If you are requesting to reschedule or cancel a BRC-MFD and the date you are submitting this form is more than 10 days after the date* you received the notice of setting, but before the BRC-MFD is scheduled to be held, attach the indicated information and any supporting documentation to this form:

a) a description of objective facts beyond your control, which reasonably:

- prevent you from attending the BRC-MFD; or
- prevent the BRC-MFD from accomplishing its purpose (may include a description of your need for a reasonable amount of additional time to secure necessary evidence for the dispute); OR

b) a description of objective facts which make the BRC-MFD unnecessary.

*The date the notice of setting is received is deemed to be the 5th day after the date of the notice.

NOTE: *If this information is not provided, the BRC-MFD may not be rescheduled or canceled. Canceling a BRC-MFD without simultaneously rescheduling is considered a withdrawal of the dispute on the issue and must comply with TDI-DWC rules, 28 Texas Administrative Code §130.12, if applicable.*

If you did not submit the initial request for the BRC-MFD that you are requesting to reschedule or cancel, have you obtained the agreement of the opposing party to the rescheduling or cancelation of the BRC-MFD?
☐ Yes ☐ No

Employee's Name:

DWC Claim Number:

For TDI-DWC Use Only

21. If you are requesting to reschedule after failing to attend a BRC-MFD, you must attach a description of objective facts beyond your control, which reasonably prevented you from attending the BRC-MFD and from notifying the TDI-DWC to cancel or reschedule in advance of the BRC-MFD.

If you do not submit the request by close of business on the third business day after the BRC-MFD was held, you must also attach a description of objective facts beyond your control, which reasonably prevented you from doing so and which justify the subsequent delay in filing the request.

Attach any supporting documentation.

NOTE: *If this information is not provided, the BRC-MFD may not be rescheduled.*

22. I certify that I will provide a copy of this request to the opposing party or parties.

Signature of Requester_____ **Date**_____

NOTE: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004).

Frequently Asked Questions

Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)

NOTE: *This form may only be used to request the scheduling, rescheduling, or cancelation of a Benefit Review Conference for the appeal of a Medical Fee Dispute decision (BRC-MFD). Do not submit this form to schedule a BRC-MFD unless you are prepared to proceed. This form should not be used to request other actions by the Texas Department of Insurance, Division of Workers' Compensation* (TDI-DWC)*, such as a letter of clarification, a contested case hearing, or a BRC on matters other than appeal of a TDI-DWC medical fee dispute decision.*

Where will the BRC-MFD be held?
The TDI-DWC will schedule the BRC-MFD at a location not more than 75 miles from the injured employee's residence at the time of the injury or the address on this form, unless good cause exists for the selection of a different location. You may request another location, but must provide an acceptable reason to relocate the proceeding. The TDI-DWC will determine whether a change in location is appropriate.

What type of special accommodations will the TDI-DWC provide?
The TDI-DWC will provide accommodations to parties who qualify under the Americans with Disabilities Act (ADA), and other reasonable accommodations at the discretion of the benefit review officer.

Employee's Name:

DWC Claim Number:

For TDI-DWC Use Only

Who determines whether a BRC-MFD is expedited?
If an expedited BRC-MFD is requested in Section I, Box 2, the TDI-DWC will determine whether scheduling the BRC-MFD more quickly is appropriate.

If the injured employee is the requester and Yes is checked in Section III, Box 11 to indicate that the injured employee is a first responder, the TDI-DWC will expedite the BRC-MFD.

What is pertinent information documentation?
It is documentation that is related to the disputed issue and will be used at the BRC-MFD to help resolve the dispute. Pertinent information includes all documentation exchanged during the Medical Fee Dispute Resolution process and any additional documentation identified as relevant since the issuance of the Medical Fee Dispute Resolution decision. You are required to provide pertinent information to the opposing party before requesting a BRC-MFD. You are also required to provide pertinent information to the TDI-DWC not later than 14 days before the scheduled BRC-MFD, but you should **not** attach this information to this request. You are not required to provide information to the opposing party or to the TDI-DWC if that information was previously provided during the Medical Fee Dispute Resolution process.

Who determines whether to reschedule or cancel a BRC-MFD?
The determination of whether there is good cause to reschedule or cancel a BRC-MFD is made at the discretion of the TDI-DWC benefit review officer on a case-by-case basis. Even if good cause exists, the benefit review officer may deny the request based on other considerations.

Where do I send the form?
You can fax or mail the completed form using the contact information listed at the top of the form. You can also fax, mail or personally deliver the completed form to the field office handling the claim. For field office addresses and fax numbers, visit the TDI website at **www.tdi.texas.gov/wc/dwccontacts.html#offices** or call the TDI-DWC at 1-800-252-7031. You are also required to send a copy of the form to the opposing party or parties.

Is any of the requested information optional?
No, provide all information requested in the sections of the form that apply to your request. Sections I, II, and III apply to all requests. Section IV applies to a request to schedule a BRC-MFD. Section V applies to a request to reschedule or cancel a BRC-MFD. A BRC-MFD will only be scheduled, rescheduled, or canceled if the form is complete. An incomplete form may delay resolution of your dispute.

Am I required to attend the BRC-MFD?
If you do not attend, the BRC-MFD may be held without you. Failure to attend a BRC-MFD could result in a recommendation of a penalty or fine unless you can show good cause for your absence. An injured employee should attend any proceeding related to a dispute about his or her claim, even if the injured employee did not request the proceeding.

Who do I contact if I have questions about requesting, rescheduling, or canceling a BRC-MFD?
Contact the TDI-DWC by calling 1-800-252-7031. An injured employee who is not represented by an attorney may also receive assistance by contacting the Office of Injured Employee Counsel (OIEC) at 1-866-393-6432.

What happens after the TDI-DWC receives my DWC Form-045M?
If your request to schedule, reschedule, or cancel a BRC-MFD is approved, you and the opposing party or parties will be notified, including the time, date and location of the BRC-MFD, if applicable. If you are notified your request regarding a BRC-MFD is denied, you may resubmit the request with additional information or request an expedited contested case hearing to determine if your request should be approved.

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • MS-35
Austin, TX 78744-1645
(512) 804-4010 phone • (512) 804-4011 fax

Complete if known:

DWC Claim #

Carrier Claim #

Request to Schedule a Medical Contested Case Hearing (MCCH)

Type (or print in black ink) each item on this form

I. REQUEST SPECIFICATIONS

1. Check the appropriate box to indicate the type of medical contested case hearing you are requesting:

☐ Appeal of an Independent Review Organization (IRO) Medical Necessity Decision to the TDI-DWC.
Attach a copy of the IRO decision.

☐ Appeal of Medical Fee Dispute Decision to State Office of Administrative Hearings (SOAH).
Enter the date the Benefit Review Conference ended (mm/dd/yyyy)

IMPORTANT NOTE: In an appeal to SOAH, the non-prevailing (losing) party is required to reimburse the TDI-DWC for the costs of the services provided at SOAH. In the event of a dismissal, the party who requested the SOAH hearing is required to reimburse the TDI-DWC. These requirements do not apply to the injured employee.

2. Check the appropriate box(es) for services you are requesting, if any:

☐ Expedited MCCH (specify reason*) _____

☐ Special Accommodations (specify) _____

*Does not include claim involving a first responder. See Section III, Box 11 regarding expedited first responder claims.

II. INJURED EMPLOYEE CLAIM INFORMATION

3. Employee's Name (Last, First, Middle)

4. Employee's Physical Address (Street, City, State, Zip Code)

5. Employee's Social Security Number*	**6. Date of Injury** (mm/dd/yyyy)

7. Insurance Carrier's Name

8. Employer's Business Name (at the time of the injury)

9. Employer's Business Address (Street or PO Box, City, State, Zip Code)

*Title 28 Texas Administrative Code §133.307 and §133.308 require that in order to process a request for medical dispute resolution, a request must be filed in the form and manner required by TDI-DWC. Provision of the social security number is not mandatory, but failure to provide that number may result in delay of the request. The social security number may be used to identify the injured employee.

For TDI-DWC Use Only

III. REQUESTER INFORMATION

10. Check the appropriate box:

☐ Injured Employee ☐ Health Care Provider ☐ Subclaimant ☐ Pharmacy Processing Agent

☐ Insurance Carrier ☐ Attorney for_____

11. Provide the following information:

Is the injured employee a first responder, as defined in Texas Labor Code §504.055, who sustained a serious bodily injury*? ☐ Yes ☐ No

If yes, TDI-DWC will expedite an MCCH as follows:

- Medical Fee Dispute: MCCH will be expedited only if the requester is the injured employee.
- Medical Necessity Dispute: MCCH will be expedited regardless of requester type.

*bodily injury that creates a substantial risk of death or that causes death, serious permanent disfigurement, or protracted loss or impairment of the function of any bodily member or organ

12. If injured employee is checked in Box 10, is the employee assisted by the Office of Injured Employee Counsel (OIEC)? ☐ Yes ☐ No

13. Requester's Mailing Address (Street or PO Box, City, State, Zip Code)

14. Requester's Printed Name/Title	**15. Phone Number**
16. Requester's Signature	**17. Date of Signature** (mm/dd/yyyy)

NOTE: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004).

Employee's Name:

DWC Claim Number:

For TDI-DWC Use Only

Frequently Asked Questions
Request to Schedule Medical Contested Case Hearing (MCCH)

Where will the MCCH be held?

- **Medical Fee Dispute:** The State Office of Administrative Hearings (SOAH) will schedule the hearing at the SOAH offices in Travis County.
- **Medical Necessity Dispute:** The Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) will schedule the MCCH at a location not more than 75 miles from the injured employee's residence at the time of the injury or the address on this form, unless good cause exists for the selection of a different location. You may request another location, but must provide an acceptable reason to relocate the proceeding. The TDI-DWC will determine whether a change in location is appropriate. In addition, injured employees may request the MCCH be held through a telephone conference.

What type of special accommodations will be provided?

The TDI-DWC or SOAH will provide accommodations to parties who qualify under the Americans with Disabilities Act (ADA), and other reasonable accommodations at the discretion of the hearing officer.

Who determines whether an MCCH is expedited?

If an expedited MCCH is requested in Section I, Box 2, the TDI-DWC will determine whether scheduling the MCCH more quickly is appropriate.

If Yes is checked in Section III, Box 11 to indicate that the injured employee is a first responder, the TDI-DWC will expedite an MCCH as follows:

- **Medical Fee Dispute:** MCCH will be expedited only if the requester is the injured employee.
- **Medical Necessity Dispute:** MCCH will be expedited regardless of requester type.

What is the deadline for filing the DWC Form-049?

- **Medical Fee Dispute:** You must submit the form to the TDI-DWC no later than the 20th day after the conclusion of the Benefit Review Conference.
- **Medical Necessity Dispute:** You must submit the form to the TDI-DWC no later than the 20th day after the date the Independent Review Organization (IRO) decision is sent to the appealing party.

Where do I send the DWC Form-049?

The completed form, including a copy of the IRO decision (if applicable), must be faxed to (512) 804-4011 or mailed to the address shown below.

Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • MS-35
Austin, TX 78744-1645

Is any of the requested information optional?

No, provide all requested information. An MCCH will only be scheduled if the form is complete. An incomplete form may delay resolution of your dispute.

Am I required to attend the MCCH?

If you do not attend, the MCCH may be held without you. Failure to attend an MCCH could result in a recommendation of a penalty or fine unless you can show good cause for your absence. An injured employee should attend any proceeding related to a dispute about his or her claim, even if the injured employee did not request the proceeding.

Who do I contact if I have questions about requesting an MCCH?

Contact the TDI-DWC by calling (512) 804-4010 or 1-800-252-7031. An injured employee who is not represented by an attorney may also receive assistance by calling the Office of Injured Employee Counsel (OIEC) at 1-866-393-6432.