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News for Employers

HB 2600, passed by the 77th Legislature in 2001, brought a number of changes to the Texas workers' compensation system, two of which have a direct impact on employers.

First, Article 3 of HB 2600 requires employers—if asked in writing by a worker, health care provider, insurance carrier, or the Texas Workers' Compensation Commission (TWCC) — to notify the worker, the worker's treating doctor, and the insurance carrier about whether the employer offers modified duty or other return-to-work programs. If such services are offered, the employer must identify a contact person and provide additional information about the services. Article 3 also stipulates that insurance carriers are required to provide certain return-to-work coordination services if requested by an employer. The effective date of these requirements was June 17, 2001. However, TWCC cannot adopt related rules until January 1, 2004, so there are no standard formats for how this information must be communicated.

Additionally, Article 16 of HB 2600 prohibits the use of pre-injury liability waivers by nonsubscribing employers. More information about these HB 2600 provisions can be found on the ROC website (www.roc.state.tx.us).

Mid-Biennium Status of ROC's 2000 Biennial Report Policy Options and Recommendations

by Jon Schnautz

The last 15 months have been an extremely active time for the Texas workers' compensation system. In this period the Texas Legislature passed, and Governor Rick Perry signed, House Bill 2600, the most significant package of statutory changes to the system in more than a decade. Included in this legislation were items related to the cost and quality of medical care provided to injured employees, income benefits, and a variety of other legal and procedural matters.

In addition to their eventual impact on the operation of the workers' compensation system as a whole, these changes have led to a refocusing and reorganization of priorities among the agencies and entities involved in the administration and regulation of the workers' compensation system. These agencies include the Texas Workers' Compensation Commission (TWCC), the Research and Oversight Council on Workers' Compensation (ROC), the State Office of Risk Management (SORM), and, in its workers' compensation activities, the Texas Department of Insurance (TDI).

Many of the changes made by HB 2600, particularly those related to medical management, grew out of research conducted by the ROC in response to a previous legislative charge calling for more information on the relative cost and quality of care provided to injured employees in Texas. The findings from this study and related policy options were published in February 2001 in a report entitled *Striking the Balance: An Analysis of the Cost and Quality of Medical Care in the Texas Workers' Compensation System*. In general, the findings indicated that Texas spent significantly more than other states on medical care in the workers' compensation system, but that injured employees in Texas did not realize better return-to-work outcomes, health outcomes, or satisfaction with care. Previously, in December 2000, the ROC also produced its *2000 Biennial Report*, which contained related policy recommendations and

recommendations on a variety of other system issues, as well.

This article reviews the recommendations and policy options offered in both reports, and examines what if any related legislative or regulatory activity has occurred. Of the 27 recommendations and sub-recommendations included, 15 have seen direct legislative or regulatory action; five have been the subject of some action, either legislative, regulatory, judicial or otherwise; and seven have seen no direct action. Recommendations (and subsequent actions) will be organized by subject matter, with discussion of *Striking the Balance* policy options first, followed by recommendations from the *2000 Biennial Report*.

Striking the Balance Policy Options

1. Monitoring and regulation of health care providers and utilization review agents (URAs). The *Striking the Balance* report included several policy options related to this broad category of improved system oversight on health care providers, carriers and utilization review agents (URAs). It presented the following:

Policy Option a): *Health care providers – including doctors who treat injured employees and those who provide reviews for insurance carriers – should be subject to required training on workers' compensation system features and desired outcomes.* The report also suggested that TWCC establish systematic monitoring programs to identify for further scrutiny and/or disciplinary action providers or URAs who, based on comparisons to established standards or the practices of their peers, practice or review care outside the norms of quality, cost-effective care.

Action: Article 1 of HB 2600 included a provision calling for TWCC to establish by rule reasonable requirements for training, impairment rating testing, and disclosure of financial interests by health care providers in the system, as well as monitoring of health care providers and insurance carriers (as it pertains to their role in medical benefit delivery). Doctors are also required to apply for and be certified by TWCC to provide services in the workers' compensation system, with certain exceptions.[1]

In response to these mandates, TWCC in February 2002 adopted a number of new rules relating to training and registration requirements for doctors and monitoring of doctors and carriers.[2]

Some progress has also been made in development of a monitoring program. An effective monitoring effort will require the use of medical expertise by TWCC (see related discussion later in this article), both through TWCC's Medical Advisor and through a Medical Quality Review Panel (MQRP). As of this time, TWCC has hired a Medical Advisor and is reviewing applications, but has yet to appoint members to the MQRP. However, TWCC has called upon an ad hoc Medical Advisor's workgroup to provide input on monitoring program design and other issues. In addition, ROC staff has attempted to assist TWCC by designing and validating a data-based monitoring program focused on areas identified as particular utilization problems in the pre-HB 2600 studies, including physical medicine, injections, surgery, and diagnostic testing.[3] It is envisioned that this monitoring program would help identify potential "outlier" health care providers and insurance carriers that could then be subject to closer scrutiny through case-level clinical reviews, utilizing the medical expertise available through the Medical Advisor and MQRP.

ROC staff is also currently working with TWCC on development of a monitoring program to study the impairment ratings given by Designated Doctors and identify potential "outliers".

Policy Option b): *Improve regulation of health care providers and the Approved Doctors List (ADL).* TWCC's ADL lists those doctors who are allowed to treat injured employees in the workers' compensation system. Historically, this list has included almost all doctors licensed to practice medicine in Texas.[4] Particularly in light of the medical cost and quality concerns highlighted in the *Striking the Balance* report, better management and regulation of the ADL has been an issue of interest in the system for some time.

The *Striking the Balance* re-

port offered several policy options, including requiring re-enrollment to be included on the ADL and removal of doctors whose practices do not meet standards for quality care; stricter enforcement of statutory provisions on an injured employee's ability to change treating doctors[5]; possible limitations on an injured employee's initial choice of treating doctor to a specified period post-injury; creation of a pilot program to set up a Managed Care Organization (MCO) or Preferred Provider Organization (PPO) for workers' compensation coverage for state employees; and/or allowing Texas employers to create MCOs/PPOs according to state-set standards.

Actions: A number of these policy options, or variations thereof, were implemented through HB 2600. As discussed previously, Article 1 of HB 2600 and adopted TWCC rules require re-enrollment to the ADL and compliance with new training requirements by September 1, 2003.

Article 2 of HB 2600 also called for a feasibility study for regional workers' compensation health care networks created based on the PPO model. The bill created a Governor-appointed Health Care Network Advisory Committee (HNAC) to set standards and establish a report card for these networks, initiate the feasibility study, and evaluate network feasibility based on the results. TWCC, under the HNAC's direction, is also charged with entering into one or more consultant contracts to execute the feasibility study and, if deemed feasible, contract with one or more regional networks by December 31, 2002. At its most recent meeting in mid-February 2002, the HNAC approved a Request for Proposals (RFP) asking for consulting services for the feasibility study. Proposals from consultants interested in conducting the feasibility study were due April 8, 2002.

If created, the regional networks under Article 2 of HB 2600 would be voluntary for insurance carriers and employees.[6] Insurance carriers could participate or not participate, and could, for the first several years of operation, participate on either a regional basis or for particular covered employers.[7] Employees who opt to participate would be bound to receive care in the network for a particular compensable injury if they do not leave the network prior to 14 days after first receiving treatment for that injury, but would be allowed to change doctors within the network.[8] Participation in the network is encouraged through income benefit incentives for workers, including a decrease in the retroactive period for an injured worker to receive temporary income benefits (TIBs) for the first week of lost time and a 50 percent increase in the statutory cap on TIBs. Other aspects of these networks would include publication of a "report card" grading network performance in a variety of areas, a design for which the ROC is statutorily charged with creating in conjunction with the feasibility consultant and the HNAC.

In the area of change of treating doctor requests, TWCC determined through an internal review and based on an August 2000 ROC report that inconsistencies and regional field office variations existed in the approval of requests.[9] In January 2001, TWCC issued an advisory restating the statutory provisions pertaining to change of treating doctor requests, and what constitutes a legitimate request for a change.[10] ROC will continue to track the change of treating doctor issue, with particular focus on potential "doctor shopping" (i.e., a practice of seeking a change to secure a more favorable medical evaluation, new impairment rating, etc.) and any potential need for related legislative or regulatory changes.

2. Medical pricing reforms. ROC suggested in the *Striking the Balance* report that TWCC revise its fee guidelines to correspond to other commonly-used medical fee standards and adopt other changes in regard to prescription drug benefits. Specific policy options included:

Policy Option a): *Update the fee guidelines to do the following: convert to a system that uses the most current Current Medical Procedural Terminology (CPT) codes for medical services; tie workers' compensation fees to a national standard such as Medicare's Resource-Based Relative Value System (RBRVS) or a market-based standard; establish a fee guideline or individual reimburse-*

Table 1:
Mid-Biennium Status of ROC Recommendations

RECOMMENDATION	ACTIVITY/STATUS
1. Monitoring and Enforcement a) Health care providers should be subject to required training on workers' compensation system features and desired outcomes. b) Improve regulation of health care providers and the Approved Doctors List (ADL).	1.a) and b) Article 1 of HB 2600 called for TWCC to establish registration, training, and financial disclosure requirements for health care providers in the system. It also called for monitoring of health care providers and insurance carriers in their performance of medical management functions. TWCC has adopted rules for registration, training and financial disclosure by health care providers (Rules 180.1, 180.2, 180.20-180.27, and 180.7). Compliance is required by 9/1/03. TWCC and ROC are also in the early stages of developing a monitoring program for health care providers and insurance carriers.
2. Medical Pricing Reforms a) Update the fee guidelines to convert to current CPT codes; tie workers' compensation fees to a Medicare or market standard; establish a guideline or reimbursement amount for ambulatory and outpatient surgery; and implement "case rates". b) Require generic drug equivalents and development of a formulary.	2.a) Article 6 of HB 2600 calls for use of the Medicare ground rules and payment policies in workers' compensation, with minimum necessary modifications. TWCC is currently considering a new fee guideline proposal that would adopt Medicare ground rules and payment policies as well as update CPT codes and set new Medicare-based reimbursement levels. Early work is also under way on a hospital and ambulatory surgery fee guideline. 2.b) Article 6 of HB 2600 requires generic drugs to be used unless otherwise ordered by the prescribing doctor and requires TWCC to establish a formulary. In December 2001, TWCC adopted new pharmaceutical rules (Rules 134.500, 134.502-134.504, and 134.506) to address these requirements. The formulary as adopted is very broad and includes all drugs approved by the FDA.
3. Communication and Utilization Improvements a) Replace the current treatment guidelines with an evidence-based model. b) Implement an input-based mechanism for new treatments or drugs. c) Emphasize the use of treatment plans.	3.a) Article 6 of HB 2600 abolished the TWCC treatment guidelines and requires that any new guideline be "nationally recognized, scientifically valid and outcome-based." TWCC proposed a combination treatment and lost time guideline in October 2001 but withdrew this proposal after public comment. Adoption of a treatment guideline is now optional by TWCC per HB 2600. The lost time guideline is required by pre-HB 2600 statutory mandate. 3.b) No direct action. 3.c) No direct action.
4. Medical Dispute Resolution Require TWCC to use Texas-licensed doctors to make decisions on medical necessity disputes, pre-authorization disputes, and change of treating doctor requests; and use this medical expertise in monitoring and regulation of system participants.	Article 6 of HB 2600 requires TWCC to use an Independent Review Organization (IRO) model for medical necessity and pre-authorization disputes. TWCC Rules 133.305, 133.307, and 133.308 were or amended in December 2001 to implement changes. This incorporates review by a doctor in these cases. There has been no specific action to use medical expertise in change of treating doctor requests; however, Article 1of HB 2600 creates a Medical Quality Review Panel to provide expertise to TWCC for monitoring efforts, guideline development, and other purposes as needed, under the direction of the TWCC Medical Advisor.

5. Return to work Provide incentives to employers to offer accident prevention and disability management programs that include modified duty options for injured workers.	No direct action. Article 3 of HB 2600 addressed communication issues involving return to work between employers, health care providers and employees, and required insurance carriers to provide certain return-to-work services.
6. Expand Temporary Income Benefit compensation rate for employees with multiple employment.	Article 10 of HB 2600 allows injured employees to claim wages from multiple employment. Insurance carriers are eligible for reimbursement for benefits paid based on multiple employment. TWCC has proposed rules 120.4, 122.5, 128.1, 128.2 and 128.7 to implement this and related provisions.
7. Identification of injured workers whose medical condition substantially changes after MMI/impairment rating becomes final, and who may be adversely affected by TWCC Rule 130.5 (e), which establishes finality for MMI-impairment rating determinations.	Historically, injured workers have been required to dispute an MMI determination or impairment rating within 90 days or have it become final. Court action last year invalidated TWCC Rule 130.5 (e), which was the basis for this time limit. TWCC repealed the 90-day provision in the rule effective 1/2/02 and issued Advisory 2002-04 on 3/4/2002 to explain that the 90-day rule cannot be utilized as a basis for MMI certification or impairment rating finality. Although no legislative action was taken on this issue, this court action has significantly altered debate surrounding any limit of MMI or impairment rating reassessment before the statutory 104-week limit.
8. Medical interlocutory orders; TWCC should establish a procedure to identify cases where such orders may be appropriate.	TWCC has not established a procedure for identifying such cases and indicates they will be handled on a case-by-case basis. To date, no medical interlocutory orders have been issued.
9. Medical cost containment program for state employees (a program to encourage use of workers' compensation medical care networks by state employees).	No action taken specific to this recommendation. However, a feasibility study for a much broader network option was initiated by Article 2 of HB 2600.
10. Fraud monitoring, enforcement and reporting (ROC suggested a comprehensive approach considering aspects of the Model Insurance Fraud Act developed by he National Association of Insurance Commissioners).	HB 1562 was the most significant fraud related bill approved by the 77th legislative session. It calls for more fraud reporting, expands immunity provisions for reporting fraud, and requires the development of antifraud plans.
11. Regulatory enforcement efforts (ROC recommended a thorough review of enforcement and compliance efforts at TWCC).	Several provisions of HB 2600 relate to this recommendation; TWCC was budgeted $1.48 million for the 2002-03 biennium for HB 2600 implementation activities with an emphasis on enforcement.
12. Authorize a cost allocation program for payment of state agency workers' compensation claims.	Article 14 of HB 2600 and HB 2976 both created a "risk-reward" program that makes state agencies more responsible for their workers' compensation costs. SORM adopted rules to implement this program and has calculated and distributed workers' compensation reallocation amounts for FY 2002 for covered agencies.
13. Adequacy of representation (ROC recommended evaluation of adequacy of assistance available to injured workers, particularly in complex cases).	Article 8 of HB 2600 requires an insurance carrier to pay an injured employee's attorney's fees in cases in which the carrier appeals to district court and loses. This provision expires 9/1/05.
14. Waivers by non-subscribers to the workers' compensation system (ROC recommended that uncertainty about the legality of such waivers be clarified by court or legislative action).	In April 2001, the Texas Supreme Court ruled that such waivers were not prohibited by the Labor Code. Through Article 16 of HB 2600, pre-injury waivers of the common law right to sue by employees of non-subscribers were prohibited.

Source: Research and Oversight Council on Workers' Compensation, 2002.

ment amounts for outpatient surgery and ambulatory surgery services, which are currently reimbursed at "fair and reasonable" amounts; and implement "case rates" (set reimbursement amounts for particular injury types, rather than reimbursement at the individual treatment level).

Actions: Article 6 of HB 2600 included a provision calling for TWCC's fee guidelines to "reflect the standardized reimbursement structures found in other health care delivery systems," allowing the commission to make "minimal modifications" to meet special circumstances that may apply to occupational injuries. In essence, this mandate requires TWCC to adopt the payment policies of the Medicare system, which control how services may be billed and how they should be coded and are ultimately paid. This change also adopts the most recent CPT codes and RBRVS structure.

HB 2600 did not speak to the actual reimbursement levels for various professional services in the new guideline, but did indicate that TWCC must use the Medicare methodology as a base. HB 2600 also required TWCC to establish workers' compensation conversion factors that must be applied to reflect economic indicators in health care and other statutory factors.[11]

In June 2001, TWCC proposed a new professional services fee guideline that did not apply the Medicare payment policies. After public comment, this proposal was withdrawn in October 2001, and replaced in December with a proposal that incorporated the Medicare policies by reference, with any changes or modifications to be made by TWCC as the need arises. Both the first and second guideline proposals also involved a good deal of debate and controversy surrounding the reimbursement levels for the various categories of professional services. TWCC is tentatively scheduled to consider and perhaps adopt the new professional services fee guideline in late April 2002.

TWCC is also in the early stages of developing a hospital and outpatient surgery and ambulatory surgical center fee guideline that would set pricing and apply the relevant Medicare payment policies. Suggestions as to the creation of this fee guideline have been taken from a workers' compensation stakeholders' group that participated in the creation of HB 2600 in order to help TWCC develop and prioritize aspects of these fee guidelines.

The only policy option offered in the medical pricing area of the ROC's *Striking the Balance* report that has not received any direct legislative or regulatory attention is the option that case rates could be used for particular injuries rather than per-service reimbursements. The network model that is the subject of the HB 2600 Article 2 feasibility study could incorporate certain managed care concepts, but would do so in a "fee for service" model similar to that in the workers' compensation system in general.

Policy Option b): *Require generic drug equivalents and development of a formulary.* In the *Striking the Balance* report the ROC offered an option that generic prescription drugs be used in cases where generic equivalents are available, and that over-the-counter drugs be reimbursable if specifically requested by a doctor. In addition, the report included a policy option that TWCC establish a prescription drug formulary for workers' compensation to clarify pharmaceutical issues and reduce disputes.[12]

Actions: Article 6 of HB 2600 included mandates for each facet of this policy option. In December 2001, TWCC adopted an open formulary requiring generics unless otherwise specified by the prescribing doctor, and allowing over-the-counter drugs to be prescribed at the doctor's discretion. The formulary adopted is very general, in that it includes all drugs approved by the federal Food and Drug Administration (FDA) and does not speak to the appropriateness of particular drugs for particular medical conditions. The adoption of a more descriptive formulary may still be necessary to achieve the intended goals of clarifying appropriate pharmaceutical benefits and minimizing disputes.

3. Communication and utilization improvements. The ROC identified in the *Striking the Balance* report three policy options in this area. They were:

Policy Option a): *Replace the current treatment guidelines with an evidence-based model.*

Actions: Article 6 of HB 2600 abolished the TWCC treatment guidelines in place as of the

bill's passage, effective January 1, 2002. In addition, a previous mandate to adopt a treatment guideline was removed; however, if treatment guidelines are adopted, they must be "nationally recognized, scientifically valid, and outcome-based."[13]

The former treatment guidelines, which combined negotiated and evidence-based models, were abolished January 1, 2002. In October 2001, TWCC proposed a combination treatment and return-to-work/lost time guideline based on a proprietary guideline produced by Intracorp. This proposal was withdrawn in February 2002 after public comment. Particular concern in the comment involved a lack of clarity about the intended or required use of the guideline, the cost of the guideline based on its proprietary nature, and specific criticisms of its treatment and lost time duration provisions. TWCC has not yet proposed a replacement lost-time or treatment guideline.

Policy Option b): *Implement an input-based mechanism for new treatments or drugs.* ROC's *Striking the Balance* report suggested that system participants be allowed to petition TWCC for the inclusion of new medical treatments or drugs into the workers' compensation system. TWCC would then make a decision as to whether or not the proposed treatment or drug should be reimbursed in the system.

Actions: No direct statutory or regulatory action has been taken on this policy option as of this writing, but several aspects of HB 2600 and its implementation lend themselves directly or indirectly to this input-based model. In the area of the fee guideline, for example, the current proposal calls for use of the Medicare payment policies. TWCC received public comment on the proposal asking that the commission consider creating a process to allow stakeholder petition and input on modifications to the policies.

Also, in general, the passage of HB 2600 involved the participation and input of a variety of workers' compensation system stakeholders, and the bill's authors have asked TWCC to continue consulting with this group during the implementation phase. Through Article 1 of HB 2600 and the creation of the Medical Quality Review Panel and clarification of the duties of the Medical Advisor, TWCC also has new resources and expertise to make decisions after stakeholder input. The ROC will continue to follow TWCC's progress involving stakeholder input following models such as these.

Policy Option c): *Emphasize the use of treatment plans.* ROC offered an option that TWCC consider, in the case of more serious injuries, requiring doctors to submit treatment plans to the insurance carrier and the injured employee. ROC further suggested these treatment plans be subject to voluntary pre-authorization (also known as pre-certification).

Actions: No specific action has been taken on this policy option. In an attempt to encourage communication between system participants about medical issues, Article 6 of HB 2600 did clarify that TWCC cannot prohibit doctors and insurance carriers from reaching voluntary pre-certification agreements; however, neither party is required to participate in such an agreement.[14] The TWCC rule adopted to implement changes to pre-authorization requirements included allowing these voluntary certification agreements.[15]

Discussion by TWCC during the treatment/lost time guideline proposal (discussed in the previous section) also involved requiring pre-authorized treatment plans for claims that exceed a certain lost-time standard for an injury, but this provision was not added to the rule, and the rule itself was withdrawn.

4. Medical dispute resolution. ROC offered a policy option in the *Striking the Balance* report that TWCC be required to use Texas-licensed doctors (either as contracted peer reviewers or as medical panelists) to make decisions on medical necessity disputes, pre-authorization disputes, and change of treating doctor decisions. ROC further recommended that TWCC utilize this expertise in the monitoring and regulation of outlier system participants.

Actions: Article 6 of HB 2600 mandated the use of Independent Review Organizations (IROs) to resolve medical necessity and pre-authorization disputes in the workers' compensation system. IROs are private entities that employ or contract with doctors to perform medical necessity reviews, and have pro-

vided reviews of decisions made by Health Maintenance Organizations (HMOs) in the group health setting for several years. The experience in the HMO process indicated that IROs could provide quicker, higher quality medical necessity decisions than TWCC's internal medical dispute resolution process. The IRO fee for conducting a review is either $460 or $650, depending on the medical specialty of the doctor performing the review. The fee dispute aspect of medical dispute resolution could either be conducted in-house by TWCC Medical Review staff, as it was pre-HB 2600, or contracted out to an outside agency.

In December 2001, TWCC adopted new medical dispute resolution rules to reflect the HB 2600 changes. Since the medical dispute resolution rule is an extremely important and complex part of the system, TWCC executive staff indicated at the time of adoption that it would revisit the adopted rule after 90 days of experience with the new process to determine whether any modifications or changes should be made. Concerns from system stakeholders early on have included the workload and workflow associated with submissions of requests for medical dispute resolution to the IROs, as well as the cost of the reviews in cases in which the medical services in dispute are less than the cost of the IRO review.

HB 2600 also mandated new medical expertise for TWCC in other areas not specifically related to dispute resolution, such as in the creation of the Medical Quality Review Panel, which is envisioned to play an important role in any monitoring and enforcement efforts related to outlier providers and carriers. Also, in an effort to both ensure more medical expertise in the utilization review process and improve accountability for medical decisions, utilization review activities must be conducted under the direction of a Texas-licensed doctor.[16]

5. Return to work. ROC offered an option in the *Striking the Balance* report that legislative changes be considered to provide incentives to employers to offer accident prevention and disability management programs that include modified duty options for injured workers.

Actions: No direct action was taken on this option. Article 3 of HB 2600 did address communication issues involving return-to-work, requiring that employers provide notice about modified or light duty options offered, and also requires insurance carriers to provide certain return-to-work coordination services (see sidebar article on page 1).[17]

Biennial Report Recommendations

In addition to the policy options contained in the *Striking the Balance* report, ROC also offered a number of recommendations in the *2000 Biennial Report*. These follow, divided into five general categories – income benefit issues; medical care and medical dispute issues; enforcement issues; system administration issues; and legal issues.

Income Benefit Issues

6. Recommendation: *Expand Temporary Income Benefits (TIBs) compensation rate for injured workers with multiple employment* *(page 71, 2000 Biennial Report).* Since the 1989 reform, an injured employee's compensation rate has been based only on the wages earned from the job where the injury occurred. Texas workers' compensation law has not allowed income from other jobs to be considered in establishing the average weekly wage used to calculate income benefits. Injured employees who have relied on income from more than one job, therefore, may not be adequately compensated. Fourteen other states include multiple employment provisions in their workers' compensation statutes.[18]

Actions: Article 10 of HB 2600 included a provision related to multiple employment. Specifically, *Labor Code* Section 408.042 was amended to allow injured employees to claim wages from more than one job toward the calculation of their average weekly wage, which is used to calculate the amount of income benefits due an injured employee. Carriers would pay all income benefits based on this total average weekly wage, and also be allowed to seek reimbursement from the Subsequent Injury Fund (SIF) for the portion of those income benefits paid based on multiple employment. The same statutory caps on income ben-

efits would apply regardless of whether multiple employment is present or not (see discussion in the item on the Maximum Compensation Rate).

In November 2001, TWCC proposed new rules to implement the multiple employment provisions and other related items.[19] These proposed rules relate to the calculation of the average weekly wage for employees with multiple employment; creation of a multiple employment wage statement for use in claiming these wages; and the calculation of the average weekly wage for public school district employees.[20] These rules are currently being revised based on public comment and may be adopted in late April. The new multiple employment provision takes effect July 1, 2002.

7. Recommendation: *Identification of workers whose medical condition substantially changes after the maximum medical improvement (MMI)/impairment rating becomes final* *(page 71, 2000 Biennial Report).* The issue of substantial change of condition has been discussed and debated in the workers' compensation system for some time. According to TWCC Rule 130.5(e), in effect for more than a decade, the first certification of MMI and impairment rating given to an injured employee was final unless the employee disputed it within 90 days. This provision was intended to provide some finality to the MMI and impairment rating process absent a timely appeal.

Problems can arise, however, if an injured employee does not dispute the MMI assessment or impairment rating but later experiences a deterioration in his or her medical condition necessitating lost work time, since the employee may no longer be eligible for income benefits.

In March 2000, TWCC amended Rule 130.5 (e) to soften the finality of impairment ratings if, even after the 90 day period, medical evidence could show an error in the rating's calculation or serious problem with diagnosis or treatment.[21]

Actions/Events: The substantial change of condition issue was also discussed to no resolution during the 2001 Legislative Session. A committee substitute to House Bill 2449, which did not pass, would have allowed a reopening of an MMI assessment and impairment rating based on certain substantial changes in condition (namely, when a spinal surgery had occurred), but would have placed the 90-day timeframe to dispute in the statute, anticipating that a court could reject the rule entirely since the *Labor Code* sets no such timeframe.

In April 2001, in its review of the case *Fulton v. Associated Indemnity*, the 3rd Court of Appeals in Austin did just that, declaring the 90-day timeframe in Rule 130.5(e) invalid because it had no statutory basis.[22] In response, TWCC repealed the rule in January 2002, and in February issued Advisory 2002-04, stating that any injured employee whose impairment rating was closed by the application of the 90-day rule is no longer limited by this timeframe.

The *Fulton* decision has substantially changed the debate about the 90-day rule, since under the current arrangement no injured worker – regardless of whether he or she experiences a substantial change of condition – will be limited by a time-certain deadline in appealing an MMI determination or impairment rating, outside of the statutory requirement for an MMI assessment within 104 weeks of the date income benefits begin to accrue.[23] ROC will continue to evaluate this issue in preparation for a possible follow-up recommendation in the *2002 Biennial Report.*

8. Recommendation: *Maximum compensation rate* *(page 76, 2000 Biennial Report).* Due to concern that the statutory cap on Temporary Income Benefits (TIBs)[24] may not be adequate for high-wage earners, and that little public information about the maximum compensation rate is available in TWCC-required employer work-site postings and brochures, the ROC suggested additional research on the issue and monitoring of efforts to publicize this feature of the system.

Actions: Article 2 of HB 2600 addressed the maximum on TIBs in the potential regional networks that may be created after a feasibility study. As an incentive for employees to participate in the regional networks, the statutory weekly cap on TIBs would be increased by 50 percent.[25]

In August 2001, the ROC

published a *Texas Monitor* article on the maximum compensation rate issue.[26] It examined maximum rates for TIB-equivalent benefits in other states and how they compared to that in Texas; Texas was found to rank 27th among the 50 states and the District of Columbia in the actual maximum weekly benefit amount for TIBs.[27]

The article concluded that, given the uncertain effects of increasing the cap, the ROC should take the opportunity (presented by the features of Article 2 of HB 2600) to study the issue and determine its impact on benefit adequacy, return-to-work patterns, and system costs.

Medical Care and Disputes

9. Recommendation: *Two-track dispute resolution process* *(page 74, 2000 Biennial Report).* ROC recommended in the *Biennial Report* that TWCC examine a redesign of its current medical dispute resolution system and improve medical expertise in its medical necessity decisions.

Actions: As noted previously, Article 6 of HB 2600 included a comprehensive redesign of the TWCC medical dispute resolution process. All medical necessity and pre-authorization disputes are now to be decided by Independent Review Organizations (IROs), as described earlier in this article. The statute still retains two distinctly different dispute tracks for income and medical benefit issues.

10. Recommendation: *Medical interlocutory orders* *(page 75, 2000 Biennial Report).* ROC staff recommended that TWCC develop a procedure to identify cases where interlocutory orders – which may be used to ensure that injured employees receive necessary medical care in a timely manner in cases involving disputes, with the outcome of the dispute eventually determining liability for payment – may be appropriate.

Actions: TWCC has yet to develop a procedure to evaluate potential medical interlocutory orders, and has indicated that it intends to evaluate requests for these orders on a case-by-case basis. To date, TWCC has not issued any medical interlocutory orders.

11. Recommendation: *Medical cost containment program for state employees* *(page 77, 2000 Biennial Report).* In the *2000 Biennial Report*, the State Office of Risk Management (SORM) recommended that any state agency that sustains combined workers' compensation loses of $300,000 or more during any three-year period be required to participate in a "Gateway Physician Program," under which the agency's injured employees would be encouraged to receive treatment from a network of doctors and facilities. ROC supported this recommendation with the stipulation that employees in the program be allowed to change doctors for legitimate reasons.

Actions: House Bill 1192, introduced in the 2001 Legislative Session, would have established this program. This bill did not pass; however, a feasibility study for a much broader network program was included in Article 2 of HB 2600, and if regional networks are found to be feasible, state agencies will be required to offer the network option to their employees.

12. Recommendation: *Removal of doctors from the Approved Doctor List based upon license revocation, suspension or cancellation* *(page 80, 2000 Biennial Report).* TWCC suggested additional clarifying authority to remove doctors from the Approved Doctor List (ADL) for actions taken by licensing boards or certain court actions. ROC agreed in the *2000 Biennial Report* and further suggested that TWCC be authorized to mandate a variety of training, certification, monitoring and practice restrictions for a doctor who engages in inappropriate treatment or utilization review practices.

Actions: Article 1 of HB 2600 included provisions greatly expanding TWCC's authority to train, certify, monitor and sanction outlier doctors and insurance carriers.

13. Recommendation: *Clarification of TWCC authority to contract for medical review functions* *(page 85, 2000 Biennial Report).* TWCC recommended adding authority to allow it to contract for various uses of medical expertise. ROC supported this recommendation.

Actions: Article 1 of HB 2600 amended Section 413.051 of the *Labor Code* to allow TWCC to contract with a health care provider, health care pro-

vider professional review organization, or other entity for a variety of medical management purposes.

14. Recommendation: *Judicial review of medical disputes* *(page 88, 2000 Biennial Report).* ROC recommended that the legislature clarify that medical dispute proceedings are reviewable in district court pursuant to Section 2001 of the Government Code.

Actions: Article 6 of HB 2600 added language to the statute clarifying the ability of a party to seek judicial review if aggrieved after a decision of the State Office of Administrative Hearings (SOAH) on a medical issue in dispute.[28]

Enforcement Issues

15. Recommendation: *Fraud monitoring, enforcement, and reporting* *(page 74, 2000 Biennial Report).* ROC suggested that the legislature consider a comprehensive approach to insurance fraud in general, considering aspects of the Model Insurance Fraud Act developed by the National Association of Insurance Commissioners (NAIC).

Actions: HB 1562 was the most prominent bill approved in the 2001 session related to the detection and prevention of insurance fraud. It requires an annual report from the Insurance Fraud Unit created under the *Texas Insurance Code*; expands good faith immunity provisions for reporting fraud; requires insurers that collect direct, written premiums to adopt antifraud plans; and, specific to workers' compensation, allows certain subclaimants on workers' compensation claims to access the claims records of TWCC, including access, under a confidentiality agreement, to all records to determine whether subclaims may exist.[29]

16. Recommendation: *Regulatory enforcement efforts (general)* *(page 75, 2000 Biennial Report).* ROC recommended a thorough review of enforcement and compliance efforts, focusing on areas such as funding for enforcement activities, creation of incentives to encourage compliance rather than simply punish noncompliance, and other issues.

Actions: Several provisions of HB 2600 dealt with enforcement and compliance issues. Aside from those already mentioned, a provision in Article 6 amended Chapter 415 of the *Labor Code* to require TWCC to adopt by rule a schedule of specific monetary penalties for specific administrative violations, and added penalties for subsequent violations and violations committed willfully or intentionally.[30]

System Administration Issues

17. Recommendation: *Late claims by injured workers filed against insolvent insurance carriers* *(page 73, 2000 Biennial Report).* When an insurance carrier becomes insolvent and enters bankruptcy proceedings, filing deadlines are imposed to bring claims against the company. Such deadlines could bar an injured employee from pursuing a claim. The Texas Department of Insurance (TDI) currently utilizes agreed orders, entered in each pending receivership involving workers' compensation claims, that ensure injured employees will not be barred by such a deadline. TDI indicated it could adopt a rule for future receiverships to ensure that employees would be covered. ROC recommended that, rather than utilizing an ad hoc procedure to ensure that injured employees are not barred from recovering benefits, TDI, the Texas Property and Casualty Insurance Guaranty Association (TPCIGA), and TWCC should develop a more formal resolution to this issue through statutory amendment, development of a TDI rule, or a Memorandum of Understanding (MOU). Such a formalized procedure would help ensure that injured employees are informed of their ability to file claims on latent conditions after the filing deadline.

Actions: No legislative or regulatory action was taken on this item. The ROC will consider this issue for possible inclusion in the *2002 Biennial Report*.

18. Recommendation: *Require election of workers' compensation coverage injury notices be provided to guardians of legally incompetent employees* *(page 75, 2000 Biennial Report).* Under Section 406.093 of the *Labor Code*, the guardians of legally incompetent employees "may exercise … rights on behalf of the employee … as granted under the Act." ROC recommended additional

research to understand the scope of this issue and to ensure that the guardians of legally incompetent employees have a mechanism whereby they can meaningfully elect coverage or decline it,[31] and make medical decisions on behalf of a legally incompetent injured employee.

Actions: No legislative or regulatory action was taken on this item. The ROC has continued to monitor guardianship issues and will examine related topics for possible inclusion in the *2002 Biennial Report*.

19. Recommendation: *Authorize a cost-allocation program for payment of state agency workers' compensation claims* *(page 77, 2000 Biennial Report).* Historically, to provide an incentive to improve safety and reduce injury costs, state agencies have been required to fund 25 percent of their workers' compensation claim costs. A cost allocation program that would place more responsibility on individual state agencies to reduce injuries and control costs has also been contemplated, and was included in the State Office of Risk Management's (SORM's) enabling legislation. Statutory design problems with this program led to its removal during the 1999 Legislative Session. SORM recommended amending Section 412.012 of the *Labor Code* to grant authority for the cost-allocation program, known informally as a "risk-reward" program. ROC agreed in concept with this recommendation in the *2000 Biennial Report*, asking that special care be paid to potential appropriation issues and catastrophic losses.

Actions: The 2001 Legislature passed HB 2976, which created the "risk-reward" program for state agency workers' compensation costs.[32] Under the program, SORM is required to establish formulas for allocating the state's workers' compensation costs among covered agencies based on the agencies' claims experience, workforce size, payroll, and other factors. SORM has passed rules to implement these provisions and as of this writing is in the process of entering into interagency contracts with affected state agencies to implement the new structure.

20. Recommendation: *Consolidation of insurance purchasing for state agencies* *(page 78, 2000 Biennial Report).* SORM recommended that it provide full-service risk and insurance management services for state agencies, including enabling consolidated purchasing of insurance by SORM for all lines of insurance other than health and life. ROC included this recommendation in the *2000 Biennial Report*.

Actions: HB 1203, approved in the 2001 Legislature, consolidated state insurance purchasing for all lines but health and life insurance with SORM, and gave SORM oversight on the purchase of most commercial insurance coverage for state agencies other than universities. This bill is effective September 1, 2002.

21. Recommendation: *Vacation/sick leave use by employees of the Texas Department of Transportation (TxDOT)* *(page 86, 2000 Biennial Report).* TxDOT recommended a statutory change to allow its employees injured on the job to use sick or annual leave in lieu of workers' compensation income benefits. TxDOT further suggested that, if the employee elects to take sick leave, all sick leave must be exhausted before income benefits are received; if annual leave is taken, the employee could elect to take all or part of that leave and be eligible for income benefits only after the elected portion of leave is used. ROC supported this recommendation.

Actions: This change was implemented by the 2001 Legislature both through SB 453 and Article 14 of HB 2600.[33]

Legal Issues

22. Recommendation: *Adequacy of representation* *(page 73, 2000 Biennial Report).* Injured workers have often raised concerns about the adequacy of representation in the workers' compensation system. Since 1991, workers have been largely limited in their assistance within the system to TWCC ombudsmen, with relatively limited attorney access. Concerns exist particularly with the adequacy of assistance available to injured workers in matters including the complete denial of a claim, complex medical disputes, and appeals to the State Office of Administrative Hearings (SOAH) or of TWCC Appeals Panel decisions to district court.[34] ROC recom-

mended research to evaluate the adequacy of assistance and the system's fairness to injured workers, while considering ways to maintain low frictional costs associated with attorney involvement.

Actions: Article 8 of HB 2600 requires an insurance carrier to pay an injured employee's attorney's fees in cases where a carrier appeals a TWCC decision to district court and loses. This provision could help injured employees retain counsel if they prevail in the TWCC administrative review process. The provision also has a "sunset" aspect, as it expires on September 1, 2005, forcing an examination before that time of the effects of the change.[35] ROC has continued to examine the issue of representation adequacy, particularly in cases appealed to district court, and will consider this issue for inclusion in a future research agenda.

23. Recommendation: *Waivers by non-subscribers to the workers' compensation system* *(page 76, 2000 Biennial Report).* ROC noted uncertainty surrounding the issue of whether an employer who does not carry workers' compensation coverage may use a waiver (often in conjunction with an alternative occupational injury benefits plan) to avoid liability in the event its employees are injured on the job. ROC recommended such uncertainty be clarified by the courts or by legislative action.

Actions: In April 2001, the Texas Supreme Court ruled that such waivers were not prohibited under the *Labor Code*. At the same time, the Legislature was considering several statutory proposals related to the legality of such waivers. Article 16 of HB 2600 stipulated that pre-injury waivers by employees of non-subscribers are void and unenforceable.

In February 2002, the ROC published a report examining subscription trends in the workers' compensation system and a number of related issues. One finding specific to the waiver issue indicated that if pre-injury waivers were allowed, 24 percent of employers currently subscribing to the workers' compensation system said they would be likely to drop their coverage. Approximately 18 percent reported that they would likely drop coverage if they could have their employees sign post-injury waivers, the legality of which was not directly affected by the HB 2600 change.[36]

Conclusion

Looking back to 1998. As the previous review indicated, many of the issues raised in the ROC's *2000 Biennial Report* and related reports have been the subject of recent legislative or regulatory attention. HB 2600 was the vehicle for most of these issues.

In addition, many issues discussed in the ROC's *1998 Biennial Report* and not previously acted upon have received attention in the last 15 months. ROC recommended through the 1998 report a pilot project under which Required Medical Examination (RME) doctors – which are typically chosen by insurance carriers to address medical evaluation issues – instead be selected by TWCC from the Designated Doctor List. This recommendation was offered as a way to assess injured employee contentions that RME evaluations are often biased in favor of insurance carriers.

Although this pilot program was never initiated, Article 5 of HB 2600 requires that for issues involving assessments of MMI or impairment rating, insurance carrier requests for examinations would be conducted by doctors from TWCC's Designated Doctor List, rather than by the carrier.[37] Carriers would still be allowed to request an RME once the designated doctor, whose opinion carries presumptive weight in disputes on these issues, has made his or her determination. ROC is also required to study and report on the effects of this change and has included a corresponding project in its FY 2002/03 research agendas, with a report to the 78th Legislature in 2003 also planned.

Other recommendations from the 1998 report included the development by TWCC of a monitoring and sanction program for doctors and insurance carriers; improving access to medical expertise for TWCC through use of a Medical Advisor and/or network of physicians; and clarifying TWCC's ability to impose greater medical practice controls or pre-authorization controls on providers who frequently violate provisions of the *Labor Code*. All these recommendations were embodied in Article 1 of HB

2600. As noted, these are now being implemented through monitoring programs for doctors and carriers, creation of the Medical Advisor and Medical Quality Review Panel, and other efforts.

Looking Ahead. In other cases, actions and events since the 2000 *Biennial Report* have significantly changed the complexion of system issues. Examples include the substantial change of condition and waiver issues mentioned previously, where court action altered the previous debate. In other cases, the provisions of HB 2600 themselves have done the same.

For example, Article 4 of HB 2600 added certain services to TWCC's mandatory pre-authorization list, requiring that those services be prospectively reviewed by the carrier for medical necessity.[38] The bill did not explicitly address whether other, additional services should be added. When TWCC proposed changes to its pre-authorization rule in June 2001 (in part to implement the statutory changes), a number of other medical services were proposed for addition to the list. This led to a debate among system participants about the appropriateness of requiring additional administrative burdens of all health care providers at the same time the system was attempting, through Article 1, to focus attention on outliers.

When the new pre-authorization rule was adopted in November 2001, the additional proposed non-statutory services were removed, as were several other services previously on the list but not required to be by statute. Part of the rationale for this action was that under the new medical dispute resolution model of Article 6 of HB 2600, the carrier is responsible for the IRO review cost of a dispute arising over a service on the pre-authorization list, whereas for retrospective medical necessity disputes, the cost is borne by the losing party to the dispute.[39]

This liability for the cost of IRO reviews, the general HB 2600 focus on provider-specific rather than across-the-board sanctions, and the greater guarantee of payment involved with pre-authorization has significantly changed the debate on this system issue. The ROC will continue to examine this and other issues that have been re-framed by the policy changes made under HB 2600.

In general, there are several other lessons that can be gleaned from the experiences during the period since the *2000 Biennial Report*, particularly those involving HB 2600. For one, the effective dates of the various new rule provisions required by the bill, while logical for each section of the bill in isolation, when combined into one proposal, were very ambitious. A comprehensive implementation plan, taking into consideration the interrelationships of the various articles and sections, would have helped ensure that appropriate resources were allocated to priority issues. Given the scope of the bill, resource allocation within TWCC will probably continue to be a challenge. While the implementation process would have benefitted from these changes, it should also be noted that TWCC has made significant progress in moving forward on the various important pieces of HB 2600, including medical monitoring, medical dispute resolution, network feasibility, and guideline development.

ROC looks forward to continuing to play an active role in implementation, as well. Just as TWCC has been required to reassess pre-HB 2600 priorities and allocations, the ROC has also been required to dedicate the majority of its research and oversight resources to HB 2600-related items. ROC will update these efforts and spotlight ongoing challenges in the *2002 Biennial Report*.

Notes

[1] See *Texas Labor Code* Section 408.023(g), which allows TWCC to modify registration and training requirements for doctors who infrequently provide care, those who perform solely peer review or utilization review functions for carriers, or who participate in regional networks under 408.0222.

[2] See TWCC rules 180.1, 180.2, 180.20-180.27, and 180.7, available online at www.twcc.state.tx.us.

[3] See *Striking the Balance: An Analysis of the Cost and Quality of Medical Care in the Texas Workers' Compensation System.* Report to the 77th Legislature. Research and Oversight Council on Workers' Compensation and Med-FX, LLC, January 2001, Section II, pp. 29-35.

[4] In recent years, TWCC has taken more aggressive steps to remove doctors from the ADL for actions taken by other licensing boards (often because the provider is either deceased or has lost his or her license to practice), and, in a smaller number of cases, for substantive violations of the *Labor Code*.

[5] See *Labor Code* Section 408.022 (b)-(e).

[6] The networks would be voluntary for employees in all cases; state employers would be required to offer the network option to their employees (see *Labor Code* Section 408.0222 (a).)

[7] See *Labor Code* Section 408.0221 (b): "An insurance carrier may limit its election to participate in a regional network established under Section 408.0221 to a particular employer or a particular region of the state. This subsection expires January 1, 2006."

[8] See *Labor Code* Section 408.0222 (e), (s).

[9] See Lee, Amy, *Change of Treating Doctor Issues in the Texas Workers' Compensation System*, Research and Oversight Council on Workers' Compensation, August 2000.

[10] See TWCC Advisory 2001-01, January 2001, available online at www.twcc.state.tx.us.

[11] See *Labor Code* Section 413.011 (a)-(c).

[12] A formulary is a list of allowable drugs, reimbursement amounts, and dosage guidelines.

[13] See *Labor Code* Section 413.011 (e).

[14] See *Labor Code* Section 413.014 (e).

[15] See TWCC Rule 134.600 (j). The rule allows voluntary certification; if the carrier agrees to this certification, it is bound to the agreement in the same manner as a pre-authorization approval. Any dispute over a voluntary certification agreement would be handled as a retrospective dispute under the medical dispute resolution rule rather than as a pre-authorization dispute.

[16] See *Labor Code* Section 408.023 (h).

[17] See *Labor Code* Section 409.005 (j) and 413.021 (a).

[18] See *Multiple Employment in the Texas Workers' Compensation System: Features and Benefits*, available in full text on the ROC website, www.roc.state.tx.us.

[19] See proposed TWCC rules 120.4, 122.5, 128.1, 128.2 and 128.7.

[20] See *Labor Code* Section 408.0446.

[21] Rule 130.5(e) spoke to three circumstances in which the 90-day rule might not apply: 1) a significant error on the part of the certifying doctor in applying the appropriate American Medical Association (AMA) Guides and/or calculating the impairment rating; 2) a clear misdiagnosis or a previously undiagnosed medical condition; or 3) prior improper or inadequate treatment of the injury which would render the certification of MMI or impairment rating invalid.

[22] *Fulton v. Associated Indemnity*, 3rd Court of Appeals, Cause No. 03-00-00449CV. The Court said, "We declare Rule 130.5(e) invalid to the extent it prevents a reassessment of MMI certification because the impairment rating or MMI was not disputed within 90 days."

[23] Since the *Labor Code* (Section 401.011 (30) (B)) still provides for an assessment of MMI no later than 104 weeks after the date income benefits begin to accrue (a concept known as "statutory MMI"), many injured employees will still be limited by this factor in assessing a new MMI date, regardless of the repeal of Rule 130.5 (e).

[24] Currently $536 a week, based on 100% of the State Average Weekly Wage for manufacturing workers. See *Labor Code* Section 408.047 and 408.061 (a).

[25] See *Labor Code* Section 408.0222 (m)(2).

[26] See "Maximum Weekly Compensation Amount: A Multi-State Comparison." *Texas Monitor*, Vol. 6, No. 2, Summer 2001, pp. 5-8.

[27] In 1989, before the overhaul of the Texas workers' compensation system, Texas' maximum weekly benefit amount ranked 41st. Rankings among the states do not take into account cost-of-living differences. See Barth, Peter S., Richard Victor and Stacey Eccleston, *Workers' Compensation in Texas: Administrative Inventory*. Cambridge, Massachusetts, Workers' Compensation Institute, 1989.

[28] See *Labor Code* Section 413.031 (k).

[29] See *Labor Code* Section 402.084 (b). A subclaimant is defined for workers' compensation purposes as a person who has "provided compensation, including health care provided by a health care insurer, directly or indirectly, to or for an employee or legal beneficiary; and sought and been refused reimbursement from an insurance carrier (see Section 409.009)." In general, this could include a non-workers' compensation insurance plan that pays indemnity benefits or pays for medical care related to a workers' compensation claim, or other such entities under similar circumstances.

[30] Changes to *Labor Code* Section 415.0035 provide that an insurance carrier or health care provider commits an administrative violation if they violate a provision of the *Labor Code* or a TWCC decision or order. In addition, a penalty can be issued for any violation after notice had been provided, regardless of whether the violation is willful or intentional; and penalties can be issued without notice for willful or intentional violations.

[31] *Labor Code* Section 406.034 speaks to an employee's ability to waive workers' compensation coverage and retain common-law rights in the event of injury or death in the course and scope of employment.

[32] See *Labor Code* Section 412.0123. This provision was also included in Article 14 of HB 2600.

[33] See *Labor Code* Section 505.060.

[34] According to the December 2001 TWCC System Data Report (available online at www.twcc.state.tx.us), an estimated 0.6 percent of the 77,047 benefit disputes TWCC received in 2001 (or about 450) were appealed to district court.

[35] See *Labor Code* Section 408.221 (c).

[36] See Shields, Joseph, and D.C. Campbell, *A Study of Nonsubscription to the Texas Workers' Compensation System: 2001 Estimates*. Research and Oversight Council on Workers' Compensation, February 2002, p. 60.

[37] See *Labor Code* Sections 408.004 and 408.0041.

[38] See *Labor Code* Section 413.014 (c).

[39] See *Labor Code* Sections 413.031 (h)-(j).

The ROC website (www.roc.state.tx.us) now features a page devoted to HB 2600 implementation. It includes links to related ROC research findings and to full text of the final version of the bill.

Abstracts of all ROC research reports and back issues of the *Texas Monitor* are also available on the website.

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