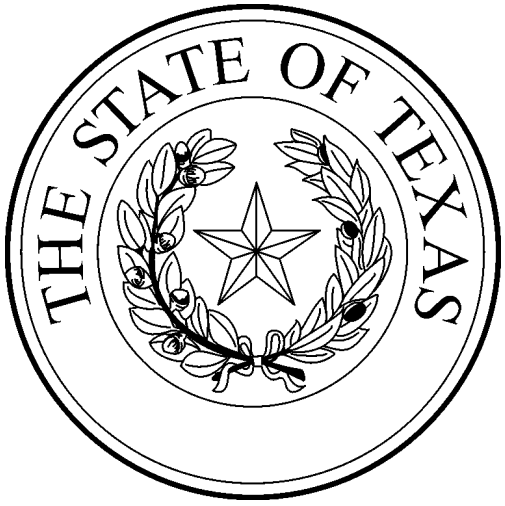
Self-Evaluation Report



Texas Workers' Compensation Commission

August 2003

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Texas Workers' Compensation Commission
Self-Evaluation Report

I. Key Functions, Powers, and Duties

A. Provide an overview of the agency's mission, key functions, powers, and duties. Specify which duties are statutory.

The Commission's primary responsibilities in the workers' compensation system are prioritized as follows:

- ensuring appropriate and timely delivery of benefits;
- overseeing and regulating system participants to ensure compliance with the statutes and rules; and
- providing training and informational services to our customers so they can better understand and operate within the system.

In order to ensure appropriate and timely delivery of benefits, the Commission collects and maintains claim and insurance coverage information; provides services to resolve benefit and medical disputes as quickly as possible; and responds to customer inquiries and requests for assistance.

The second responsibility is performed through the Commission's compliance and monitoring functions. These functions include performing compliance audits; reviews of referrals for suspected violations; fraud investigations; oversight of medical utilization patterns by health care providers; medical policy and guideline development; and certifications of employers to self-insure.

And third, our training and informational efforts are primarily addressed through the provision of: general workers' compensation information in seminars and publications; health and safety education services for employers and their employees; training for health care providers practicing in the workers' compensation system; tools to assist employers with developing return to work programs; and data compilation and analysis of workers' compensation injuries.

Although more specifically defined by rule, all noted Commission responsibilities are required by statute.

B. Does the agency's enabling law correctly reflect the agency's mission, key functions, powers, and duties?

Yes.

C. Please explain why these functions are needed. Are any of these functions required by federal law?

Due to competing interests of the major system participants, the Commission provides dispute resolution processes to ensure timely and appropriate delivery of benefits, promotes and ensures compliance with the applicable statutes and rules, and provides training and information both to system participants and other members of the public.

Federal law does not require the Commission to provide any of its functions. However, federal law does provide substantial funding for several Commission functions especially in the areas of injury data collection and workers' injury prevention and safety.

D. In general, how do other states carry out similar functions?

Workers' compensation programs vary greatly among the fifty states. In Texas, workers' compensation insurance is not mandatory except for governmental entities. While most states exclude small employers, Texas is the only state that does not require Texas private employers to provide workers' compensation coverage for their employees.

The structure, administration and role of the governing body differ in workers' compensation agencies. In some states, the governing body actually rules on individual cases similar to the structure of the old Texas Industrial Accident Board. In other states, the governing body is only a policymaking body with no direct involvement in the claims process.

In many states the workers' compensation agency is an independent organization, but sometimes the agency is a division of a larger department (i.e. Alabama Department of Industrial Relations, Florida Department of Labor and Employment Security).

Some states, like Ohio, have a state fund that insures all employers and acts as both the insurance carrier and arbitrator of disputes. In other states workers' compensation coverage is provided by commercial carriers who compete for the employer's business.

E. Describe any major agency functions that are outsourced.

West Texas Disaster Recovery and Operations Center (WTDROC). The Commission began hosting all of its mainframe computer operations at the West Texas Disaster Recovery and Operations Center (WTDROC) in 1997, which complied with legislative intent. By contract, the Commission pays Northrop Grumman, the State's contracted operator of WTDROC, $2.2 million per year for these services. The Commission's principal enterprise system, COMPASS, operates on the mainframe.

Through the Commission's Business Process Improvement (BPI) initiative, COMPASS is being replaced by TXCOMP over a multi-year development period. TXCOMP operates on a mid-range computer platform, using open standards, and widely accepted database, application server and development software.

Desktop Seat Management Contract. The Commission currently has a contract with Northrop Grumman for Desktop Seat Management services. The vendor provides computers, LAN (Local Area Network) support, SAN (Storage Area Network) support and maintenance and repair on the equipment (computers, file servers and SAN). Additionally, Northrop Grumman provides 1000 hours of project work to the Commission annually. The contract was initiated in March 2001 and terminates in August 2005.

Health and Human Services Consolidated Network (HHSCN) Interagency Agreement. The HHSCN interagency agreement provides the Commission with wide area network (WAN) support. All network communication equipment support is provided by HHSCN for the Commission. This includes support of data circuits and repair or replacement of routers and switches. This interagency agreement was initiated in September 2000.

F. Discuss anticipated changes in federal law and outstanding court cases as they impact the agency's key functions.

The **Energy Employees Occupational Illness Compensation Program Act of 2000** established a federal program to provide compensation to employees of the Department of Energy (DOE), its contractors and subcontractors, and companies that provided beryllium to the DOE and have contracted certain diseases due to exposure. There are six covered facilities in Texas. Covered employees are eligible for a lump sum payment of $150,000 for disability, and payment of future medical expenses associated with that disease. The DOE's Office of Worker Advocacy will assist workers with other occupational illnesses in filing state workers' compensation claims once agreements to do so have been entered into between the DOE and states. At this time, the DOE and Texas have not entered into agreements regarding the compensation of benefits through the Texas workers' compensation system. The impact to the Texas workers' compensation system is not known at this time.

The federal **HIPAA Privacy Rule** does not apply to entities that are workers' compensation insurers, workers' compensation administrative agencies or employers when disclosing health information as required by state law for workers' compensation system purposes. While health care information in the workers' compensation system is submitted by health care providers who may otherwise be covered by the rule, the Privacy Rule recognizes the legitimate need for insurers and other entities involved in the workers' compensation system to have access to an injured worker's PHI as authorized by state or other law. 45 C.F.R. §§164.512(a) and 164.502(b). Federal statutory or rule provisions may impact workers' compensation in the future, either substantively, or because of procedural requirements for health care providers who are subject to the Privacy Rule.

House Bill 2600, adopted during the 2001 Texas Legislative Session, amended Labor Code §413.011 to add new requirements for Commission reimbursement policies and guidelines: the Commission must

- use health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems with minimal modifications to those reimbursement methodologies as necessary to meet occupational injury requirements; and
- adopt the most current reimbursement methodologies, models, and values or weights used by the federal Health Care Financing Administration (HCFA) to achieve standardization, including applicable payment policies relating to coding, billing, and reporting.

The 2002 Medical Fee Guideline adopted by the Commission and effective August 1, 2003, requires use of the most recent payment policies adopted by the Medicare program. This will allow the workers'

compensation system to continuously synchronize with Medicare and will achieve the standardization goals established in HB-2600. The Commission and system participants must keep current on Medicare payment policies.

Outstanding Court Cases. The following addresses only the major cases affecting the Commission's operations. The listing does not include many pending cases that are brought by system participants after decisions by the State Office of Administrative Hearings (SOAH) and/or after the final administrative dispute decision by a Commission Appeals Panel or contested case hearing officer in a case not decided by the Appeals Panel.

1. The highest risk area in pending litigation cases is the challenges to the Commission's fee guidelines providing limitations on amounts paid for medical services and to rules relating to the Commission's medical policies. The most important pending cases is this area are summarized below:

    a. The Texas Supreme Court has currently scheduled oral argument for September 11, 2003 in a case challenging: (1) the Commission's 1996 Medical Fee Guideline, (2) a rule setting a one-year maximum period (from the date of a medical service) for participants to file medical disputes over the amount paid and/or the medical necessity of the particular medical service identified, and (3) the Commission's "audit and dispute" rules governing how insurance carriers and other payers of medical services will process, audit, and pay medical bills. Depending on the decision in this case, the Commission's ability to establish and maintain these rules and policies could receive substantial support or could be weakened. [*Texas Workers' Compensation Commission v. Patient Advocates of Texas and Allen J. Meril, M.D.*, Texas Supreme Court Cause No. 02-0804].
    b. A Travis County District court and the 3rd Court of Appeals denied motions requesting a stay of the August 1st effective date of the Commission's 2002 Medical Fee Guideline. The trial court recently upheld the new Guideline. The subsequent decisions of the trial court and any appellate court(s) could determine whether the Commission can sustain fee guidelines that include "Medicare" payment policies as directed by the Texas Legislature in 2001. [*Texas AFL-CIO and Texas Medical Association*, 126th Judicial District Court of Travis County, Texas, Cause No. GN 202203].
    c. The Texas Court of Appeals, Third District, in Austin this year issued two decisions concerning the validity and/or applicability of Commission rules affecting how medical payment disputes would be handled after the 3rd Court of Appeals' 1995 invalidation of the Commission 1992 Acute Care, Inpatient Hospital Fee Guideline. The two decisions upheld: (1) the use of the Commission's rule limiting the time period to one year (from the date of the medical service) to file requests with the Commission for medical dispute resolution and (2) the applicability of the Commission's rule [applying the "fair and reasonable" statutory standards in Texas Labor Code section 413.011(d)] to medical fee disputes when no specific Commission fee guideline was applicable. The Commission understands that the Texas Supreme Court will be asked to review both decisions which affect over 15,000 pending medical dispute cases and a potential maximum of $400 million in additional reimbursement requests (over the maximum amounts paid under the former 1992 hospital fee guideline). [*All Saints Health System, et. al. v. Texas Workers' Compensation Commission,* 3rd Court of Appeals Docket no. 03-02-00803-CV and *Hospitals & Hospital Systems v. Continental Casualty Co.*, 3rd Court of Appeals Docket No. 03-02-00429-CV].
    d. The Commission has been advised that an appeal probably will be taken from a Travis County district decision upholding the Commission's authority to request records relating to

treatment of injured employees by a medical doctor and to audit those records. The case is important because the Texas Workers' Compensation Act does not specifically authorize audits of such doctors and such audits are important to monitor and address any issues of quality of care, utilization of care, and compliance with the Commission's medical policies. [*Schade v. Texas Workers' Compensation Commission et. al*, 261st Judicial District Court of Travis County, Texas, Cause No. GN100093].

e. Two different lawsuits in Travis County District courts challenge the validity, applicability, and/or constitutionality of Commission rule(s) implementing the "fair and reasonable" statutory standards and/or requiring insurance carriers to develop and consistently apply a methodology to determine "fair and reasonable reimbursement amounts" for medical payments as applicable to ambulatory surgical care centers. The final decision of the appellate courts in subsection (c) above could impact these cases. [*East Side Surgical Center et. al. v. Texas Workers' Compensation Commission*, 98th Judicial District Court of Travis County, Texas, Cause No. GN202229 and *RGOI ASC, Ltd. V. Texas Workers' Compensation Commission et. al.*, 261st Judicial District Court of Travis County, Texas, Cause No. 204109].
f. A Travis County District court case is considering whether several large pharmacy "chains" and third-party billers for large pharmacy outlets have intentionally overcharged an insurance carrier for pharmacy prescriptions and whether those entities have been involved in "negligent misrepresentation" in those bills under Texas law for several years prior to the November 2001 initiation of that litigation. The case involves the validity of the alleged practice of the pharmacy "chains" and other third-party pharmacy billers in establishing a three-tier "usual and customary charge" pricing standard where the "walk-in" paying customer receives the lowest charge, third-party billers (except workers' compensation cases) receive a mid-level charge and workers' compensation cases are charged the highest rate. The decision in this case will affect the Commission's rule that requires payment of pharmacy prescription services to be the lower of the pharmacy's "usual and customary charge for the same or similar service" or a formula involving the "average wholesale price" plus a dispensing fee. [*Texas Mutual Insurance Co. v. Eckerd Corporation et. al.*, 261st Judicial District Court of Travis County, Texas, Cause No. GN 103641].
g. A Travis County District Court invalidated the removal of a doctor from the Commission's Approved Doctor List" by the Commission's Executive Director under authority granted by the Texas Legislature in 2001. The removal was made based upon the prior action of the Texas State Board of Medical Examiners to suspend the doctor's medical license and to place that suspension in a probation status. The Commission will appeal that decision. [*Brown v. Texas Workers' Compensation Commission et. al.*, 98th Judicial District Court of Travis County, Texas, Cause No. GN300344]. In a different case, the Austin 3rd Court of Appeals issued a decision on March 20, 2003 upholding the denial of a requested temporary injunction against a separate doctor based upon very similar facts and with a finding that the separate doctor did not have a right to a contested case hearing at the State Office of Administrative Hearings. [*Bell v. Texas Workers' Compensation Commission*, Court of Appeals for the Third Strict of Texas, Cause No. 03-02-00510-CV]. The two decisions have conflicting legal conclusions.
h. Numerous cases have been filed by the University of Texas System challenging the Commission's rules that the non-prevailing party in a medical fee dispute has the burden of proof to support a change in the prior decision. The medical fee dispute process involves the decision of the Commission's Medical Dispute Resolution Officer (MDRO) concerning the original payment decision made by the insurance carrier and then a full contested case hearing at the State Office of Administrative Hearings, if requested, after the MDRO's decision. [e.g. *The University of Texas System v. Texas Workers' Compensation Commission*

et. al., 200th Judicial District Court of Travis County, Texas, Cause No. GN201505].

i. Several pending cases involve whether medical providers can bypass the Commission's medical dispute resolution process and sue the insurance carriers in Justice of the Peace courts, county courts, and state district courts around the state for payment of their "usual and customary charges" (including when they are greater than the maximum payment amounts allowed by Commission rules). A Travis County district court has recently enjoined a medical provider from filing or pursuing court cases prior to going through the Commission's medical dispute process. [*Howell et. al. v. Texas Workers' Compensation Commission,* 201st Judicial District Court of Travis County, Texas, Cause No. GN200967] That decision has been appealed. [*Howell et. al. v. Texas Workers' Compensation Commission*, 3rd Court of Appeals at Austin, Cause No. 03-02-00502-CV].

j. Several pending cases address questions concerning the interpretation of Commission rules and policies concerning requirements upon insurance carriers to pay interest when paying a medical bill beyond the time limits set by the statute and Commission rules. [e.g. *Texas Mutual Insurance Co. v. Texas Workers' Compensation Commission*, 126th Judicial District Court of Travis County, Texas, Cause No. GN 201282].

2. Several employers have alleged that a federal law preemption provision (specified in the Occupational Safety and Health Act, 29 USC section 651), that effectively invalidates certain types of state laws, does not allow the Commission to even identify private employers as "hazardous employers" under the revised "Hazardous Employer Program" in Texas Labor Code Chapter 411, Subchapter D and as implemented by the Commission's revised rules in 28 TAC Chapter 164. Several SOAH decisions have contained conflicting decisions on this issue. One case is currently pending in Travis County district curt on this issue. [Skilled Craftsmen of Texas, Inc. v. Texas Workers' Compensation Commission, 53rd Judicial District Court of Travis County, Texas, Cause No. GN-300,684].

3. Several pending cases challenge the Commission's rule process for selecting a designated doctor. [e.g. *ProviderLaw et. al. v. Texas Workers' Compensation Commission*, 98th Judicial District Court of Travis County, Texas, Cause No. GN 200341] Another case involves allegations that injured workers have the right to request and receive additional designated doctor examinations if those workers are not satisfied with the impairment ratings or dates of maximum medical improvement decided by the original designated doctors rather than disputing those decisions through the Commission's dispute resolution process. [*Konesheck el. al. v. Texas Workers' Compensation Commission*, 345th Judicial District Court of Travis County, Texas, Cause No. GN 200608].

4. An insurance carrier has requested that a court invalidate the Commission's rule (28 TAC section 129.6) concerning "Bona Fide Offers of Employment" on the basis that the requirements in that rule allegedly exceed statutory authority. [*American Manufacturers Mutual Insurance. Co. v. Terrie Banks et. al*., 250th Judicial District Court of Travis County, Texas, Cause No. GN201717].

5. Several pending cases have requested that the courts find that the Commission has no discretion in deciding whether to grant a change of treating doctor or a benefit review conference as requested by an injured employee. [e.g. *Walker et. al. v. Messer et. al*., 170th Judicial District Court of McLennan County, Texas, Cause No. 2002-4044-4].

G. Please fill in the following chart, listing citations for all state and federal statutes that grant authority to or otherwise significantly impact the agency. Do not include general state statutes that apply to all agencies, such as the Public Information (Open Records) Act, the Open Meetings Act, or the Administrative Procedure and Texas Register Act. Provide the same information for Attorney General opinions from FY 1999 - 2003, or earlier significant Attorney General opinions, that affect the agency's operations.

Texas Workers' Compensation Commission
Exhibit 1: Statutes/Attorney General Opinions

Statutes

Citation/Title	Authority/Impact on Agency
Texas Workers' Compensation Commission, Texas Labor Code, Title 5, Subtitle A	Provides the framework for the Texas workers' compensation system and the legal authority and general duties of the Commission in that system.
Texas Mutual Insurance Company, Texas Insurance Code, Article 5.76-3	Legislation passed by the 77th Texas Legislature converted the Texas Workers' Compensation Insurance Fund to a domestic mutual insurance company, the Texas Mutual Insurance Co., with assets owned by the policyholders. Authority of the company to write workers' compensation insurance is issued by the Texas Department of Insurance. The company is the largest workers' compensation insurer and the insurer of last resort and exercises all rights, privileges, powers, and authority of any other mutual corporation organized to transact workers' compensation insurance business in Texas. The Commission and the Mutual are statutorily required to work together in a couple of areas. The Commission provides safety consultations and follow-up inspections of accident prevention plans for Mutual policyholders meeting specified criteria, and the Mutual works with the Commission to identify fraudulent activity in the workers' compensation system. Additionally, the Mutual has granted funds to the Commission for the development of mechanisms to control and lower medical costs as authorized by statute.
Property and Casualty Insurance Guaranty Act, Texas Insurance Code, Article 21.28-C	Financial difficulties experienced by workers' compensation carriers often have direct impact on voluntary compliance with our Act. The Commission coordinates with the Texas Property and Casualty Guaranty Association to ensure continuation of coverage for injured employees.

Various provisions, Texas Insurance Code	The Insurance Code contains other statutory provisions directly impacting insurers, insureds and the Commission. Examples include anti-fraud provisions related to coverage (§5.65C) and compensation rate and taxation provisions (§§5.55 et. seq., especially §5.68 for maintenance tax collection).
Health Care Utilization Review Agents, Texas Insurance Code, Article 21.58A, §14(c)	Article 21.58A applies to utilization review of health care services provided to persons eligible for workers' compensation medical benefits; in the event of a conflict between this article and Title 5, Labor Code, Title 5, Labor Code prevails.
Standards for Independent Review Organizations, Texas Insurance Code, Article 21.58C	Labor Code, §413.031 requires that prospective and retrospective reviews of the medical necessity of a health care service must be conducted by an independent review organization (IRO) under Article 21.58C, Insurance Code, in the same manner as review of utilization review decisions by health maintenance organizations.
Right to Select Practitioner Under Health and Accident Policies, Texas Insurance Code, Article 21.52, §3(c)	Labor Code §413.011(c) – This section may not be interpreted in a manner that would discriminate in the amount or method of payment or reimbursement for services in a manner prohibited by Section 3(d), Article 21.52, Insurance Code.
Offenses against property, Texas Penal Code, §§32.51 and 32.54	Anti-fraud penal provisions relating to obtaining or denying compensation benefits (§32.51) or obtaining coverage (§32.54) directly impact the Commission's compliance efforts (as well as insurers, the Fund or the Facility who may be entitled to restitution under §32.54).
Occupational Safety and Health Act of 1970, Public Law 91-596	Information is collected on occupational injury and illness data through the Annual Survey of Occupational Injuries and Illnesses and the Census of Fatal Occupational Injuries programs. This is a cooperative effort with the United States Department of Labor. Consultations are provided to employers to assist them in complying with federal occupational safety requirements.
Various provisions, Texas Health and Safety Code	Provisions affecting health issues for the people of the state also affect the workers' compensation system. In particular, provisions addressing the requirements for workers' compensation coverage for infectious diseases.

Attorney General Opinions	
Attorney General Opinion No.	**Impact on Agency**
DM-180	Political subdivisions of the state are required to provide workers' compensation coverage for their employees.
DM-189	A state agency has the responsibility for paying the cost of Commission-ordered physical examinations of injured employees.
Open Records Decision 619	Texas Labor Code §402.083(a) makes confidential only information in or derived from a claim file that explicitly or implicitly discloses the identity of the employee filing the workers' compensation claim. Whether information explicitly or implicitly discloses the identity of an employee must be determined on a case-by-case basis.
JC-0188	State agencies lack authority to require employees to exhaust compensatory leave accrued under state law or the federal Fair Labor Standards Act before receiving weekly income benefits under the workers' compensation law.

H. Please fill in the following chart:

Texas Workers' Compensation Commission Exhibit 2: Agency Contacts				
	Name	**Address**	**Telephone & Fax Numbers**	**E-mail Address**
Agency Head	Richard F. Reynolds Executive Director	4000 IH-35 South Austin, TX 78704	804-4400 Fax: 804-4431	Richard.Reynolds@twcc.state.tx.us
Agency's Sunset Liaison	Bob Shipe Dir., Govt Relations	4000 IH-35 South Austin, TX 78704	804-4250 Fax: 804-4251	Bob.Shipe@twcc.state.tx.us

II. History and Major Events

Provide a time line discussion of the agency's history, briefly describing the key events in the development of the agency, including:

- the date the agency was established;
- the original purpose and responsibilities of the agency;
- major changes in responsibilities or statutory authority;
- agency/policymaking body name and composition changes;
- the impact of state/federal legislation, mandates, and funding;
- the impact of significant state/federal litigation that specifically affects the agency's operations; and
- key organizational events, and areas of change and impact on the agency's organization (e.g., a major reorganization of the agency's divisions or program areas).

1913 - Texas enacted its first workers' compensation law.

1917 - The U.S. Supreme Court ruled that states could legally require employers to provide compensation to injured workers. Texas revised its workers' compensation law in 1917, but chose to retain voluntary employer participation in the system. Today, Texas is the only state that allows private employers to choose whether or not to provide workers' compensation insurance. Public employers in Texas must provide workers' compensation insurance.

1947 - the Legislature created the Second Injury Fund and classified certain occupational diseases as compensable.

1957 - the Legislature extended medical benefits to the injured workers' lifetime; established a maintenance tax paid by insurance carriers to fund the Industrial Accident Board (IAB); and extended the IAB's jurisdiction in medical disputes to after the date of a judgment or award.

1959 - the Legislature prohibited attorney fees in fatal cases in which the insurance carrier accepted liability.

1969 - the Legislature established a pre-hearing process to resolve disputes.

1973 - the Legislature allowed injured workers unrestricted choice of health care providers.

1975 - employees of certain public entities in Texas were brought into the system.

1987 - the Legislature authorized the IAB to establish guidelines for medical treatments and charges and appointed a Joint Select Committee on Workers' Compensation Insurance to study the state's workers' compensation system and to make recommendations for change.

1989 - The Joint Select Committee (the Committee) conducted a comprehensive, two-year study of the system that led to the adoption of the new Texas Workers' Compensation Act on December 13, 1989. The "New Law" included provisions that:

- created the Commission and eliminated the IAB;
- consolidated and enlarged state-administered workplace health and safety programs and created health and safety assistance and incentive programs;
- established a new benefit system and raised benefit levels;
- set tight deadlines for employers and insurance carriers to improve benefits delivery;
- established a more extensive administrative system to resolve disputes;
- established a program to allow disputes to be resolved informally and to assist unrepresented injured workers and other participants;
- broadened insurance alternatives available to employers and allowed large private employers to self-insure with Commission approval;
- mandated that the Commission assess administrative penalties against participants who violate the Act or Commission rules;
- granted the Commission authority to investigate fraud and changed Texas law to make some workers' compensation fraud a felony (until September 1, 1994);
- broadened the Commission's authority to develop and enforce medical fee and treatment guidelines and established other measures to control medical costs;
- limited attorney fees to time and actual expenses, up to a maximum of 25 percent of a workers' total recovery;
- established the Workers Compensation Research Center to conduct independent studies on the performance of the system; and
- established the Legislative Oversight Committee on Workers' Compensation to monitor the Commission and system and to recommend changes in the Act to the Legislature.

1990 – On April 1st, provisions of the Act establishing the Texas Workers' Compensation Commission became effective.

1991 - Benefit and administrative provisions of the Act went into effect and provisions authorizing the Commission to enforce the Act and Commission rules by assessing administrative penalties became effective on June 1st.

1992 - Provisions allowing arbitration as an alternate means of dispute resolution became effective.

1993

- Provisions allowing large, private employers to self-insure with Commission approval became effective.
- The Commission implemented the electronic data interchange (EDI) initiative and insurance carriers began electronic reporting initial claims payment transactions to the Commission.

1994 - Provisions making most non-covered employers subject to health and safety requirements became effective.

1995 - The Commission expanded the electronic data interchange (EDI) initiative to require insurance carriers to report subsequent claims payment transactions electronically.

The Legislature:

- extended the Commission sunset date to September 1, 2007;
- consolidated the Workers' Compensation Research Center and the Legislative Oversight Committee for Workers' Compensation and created the Research and Oversight Council on Workers' Compensation;
- required the Commission to establish qualifications and training for designated doctors.
- restricted communications with designated doctors to avoid influence.
- strengthened sanctions and administrative penalties against health care providers and designated doctors.
- required insurance carriers to file the employer's first report of injury electronically with the Commission.
- set qualifications and training requirements for Commission ombudsman.
- provided that the 401 weeks of income benefits for an occupational disease begins with the accrual of benefits.
- extended workers' compensation insurance benefits to volunteer emergency service personnel.
- transferred responsibility for hearings related to the Administrative Procedures Act (APA) held under the Texas Labor Code from the Commission to the State Office of Administrative Hearings (SOAH).

1997 - The Commission began hosting all of its mainframe computer operations at the West Texas Disaster Recovery and Operations Center (WTDROC).

The Legislature:

- created the State Office of Risk Management (SORM) to administer the state government employees workers' compensation insurance and the state risk management programs and abolished the Commission's Division of Risk Management;
- added new provisions to the Texas Workers' Compensation Act regarding judicial review, court judgments, and the Commission's right to notice and opportunity to intervene prior to issuance of a judgment or settlement;
- granted the Commission authority to adopt rules that require an employee to submit to not more than three required medical examinations in a 180-period and made it an administrative violation for a carrier to unreasonably request a medical examination; and
- authorized the Commission to extend the 104-week period for temporary income benefits if the employee had or was scheduled to have spinal surgery within 12 weeks before the expiration of the 104 weeks.

1999 – The Legislature:

- appropriated $2.5M for the Commission to evaluate and redesign our business processes and plan for the development of new automated systems.
- required carriers to offer payment of benefits by electronic funds transfer;
- prohibited carriers from requiring an employee to submit to medical examinations more frequently than annually if the employee's medical condition had not improved to allow the employee's return to work in the past year and two years had elapsed since the Commission's initial award of supplemental income benefits;

- authorized state employees to use all or part of their accrued annual leave after they have exhausted their sick leave rather than receiving income benefits;
- authorized the Commission to accept a grant from the Texas Workers' Compensation Insurance Fund to control medical costs and ensure the delivery of quality medical care;
- provided a mechanism for an insurance carrier to suspend TIBs based on an RME examination or for failure to attend an RME examination;
- authorized monthly payment of income and death benefits as provided by Commission rules;
- authorized the Commission to change to the fourth edition of the AMA Guides by rule;
- authorized payment of lifetime income and death benefits by annuity as provided by Commission rule;
- increased the maximum burial benefit to $6000;
- authorized the Commission to permit or require electronic transmission of information among workers' compensation system participants;
- broadened the criteria for coverage filing requirements to include political subdivisions and certified self-insurers;
- authorized benefit review officers and hearing officers to issue an interlocutory order for payment of part or all medical and income benefits;
- authorized the executive director to issue interlocutory orders for payment of medical benefits;
- authorized the Commission to require certain credentials for private rehabilitation providers by rule;
- changed lost-time guidelines to guidelines for expected and average return-to-work times;
- required the Commission to encourage modified duty and early return-to-work through an outreach program for employers and doctors;
- authorized the Commission to require the treating doctor or another doctor to perform a functional capacity examination on request of the employer, insurance carrier, or on the Commission's own motion;
- renamed the extra-hazardous employer program and revised the program's applicability to be consistent with court rulings;
- allowed for reinspection of accident prevention services determined to be inadequate and required reimbursement for the reinspection;
- provided that persons performing volunteer service under the direction of an officer/employee of the state or a political subdivision in a declared disaster area are covered by workers' compensation insurance for medical benefits if an injury is sustained;
- addressed salary continuation and supplementation with regard to the accrual and payment of temporary income benefits and clarified that payments do not affect the exclusive remedy provisions;
- directed the ROC to conduct interim studies on worker safety, return-to-work, quality and cost-effectiveness of health care delivery systems, medical provider treatment and insurance carrier utilization review practices.

2001 – The Legislature:

- appropriated $3.56M for the Commission's Business Process Improvement (BPI) program to continue redesign of business processes and develop new automated systems.
- passed and the Governor signed HB 2600, the most sweeping change to the Texas workers' compensation system since the reforms of 1989. The bill contained 17 articles designed to:

- improve the Commission's ability to regulate and sanction doctors in the workers' compensation system;
- require doctors treating workers' compensation patients to register with and be approved by the Commission;
- require the Commission to establish training, monitoring and disclosure requirements for registered doctors;
- formalize the role of the Medical Advisor and create a Medical Quality Review Panel (MQRP);
- allow the Commission to impose sanctions on insurance carriers for health care issues;
- require a feasibility study on the creation of regional workers' compensation medical networks, and if determined feasible:
    - require the Commission to contract with regional networks;
    - provide an option for injured workers and insurance carriers to participate in regional medical networks;
    - establish an advisory committee to set standards for quality, satisfaction and evaluation;
- require employers to report to the worker, treating doctor and insurance carrier whether they offer modified duty opportunities for injured workers;
- require insurance carriers to offer return-to-work coordination services;
- eliminate the current second opinion process for spinal surgery and include those services in the pre-authorization services;
- establish a minimum list of medical services requiring preauthorization and/or concurrent review;
- allow insurance carriers and health care providers to voluntarily offer and use certification programs for health care providers;
- allow the Commission to adopt rules requiring insurance carriers to pay for pharmaceutical services for the first seven days after an injury if the health care provider receives verification of coverage and confirmation of injury;
- modify the required medical examination process to bring the Commission designated doctors into the process more quickly to resolve questions on impairment and maximum medical improvement;
- modify qualification requirements for designated doctors;
- require the Commission to adopt a pharmaceutical formulary including generic and over-the-counter medication;
- modify statutory requirements for fee and treatment guidelines;
- require the use of independent review organizations for resolving preauthorization and medical necessity disputes;
- move the Commission sunset date from 9/1/07 to 9/1/05;
- establish that the insurance carrier must pay a claimant's attorney fees when the carrier requests judicial review and the claimant prevails in that review;
- provide that employees with third-degree burns covering over 40 percent of the body and requiring grafting, or with third-degree burns covering the majority of both hands or one hand and the face are eligible for lifetime income benefits;
- allow injured workers to count all IRS-reportable wages, including multiple jobs, for calculating their average weekly wage;
- expand the Subsequent Injury Fund (SIF) responsibility for reimbursements to a carrier to include initial pharmaceuticals when the injury is determined not to be compensable and payment of additional benefits paid to multiple job holders;

- provide for the SIF to make partial payment of insurance carrier claims;
- provide for a maintenance tax increase, if necessary, to fund the SIF;
- require insurance carriers at contested case hearings to file and deliver to the claimant a single document stating the true corporate name of the insurance carrier and the name and address of the insurance carrier's registered agent for service of process.

2001 – The Legislature also:

- Permitted TXDOT employees to use sick and annual leave prior to receiving workers' compensation benefits.

Litigation History – Major Cases Subsequent to Previous Sunset Legislation in 1995

1995

- Texas Workers' Compensation Commission v. Garcia, 893 S.W.2d 504 (Tex. Sup Ct.) – Texas Workers' Compensation Act was constitutionally valid against the "facial" constitutional challenges presented.

- Esis, Inc., Servicing Contractor v. Johnson, 908 S.W. 2d 554 (2nd App. Dist.) – "course and scope of employment" is not limited to the exact moment the employee reports for work, the moment when the employee's labors are completed, nor to the place where work is done. If the injury is the result of an activity that originates from the employment, and is received while the employee is actually engaged in furthering the employer's business, the injury is deemed to have been sustained within the course and scope of employment.

- Texas Hosp. Ass'n. v. Texas Workers' Compensation Commission, 911 S.W.2d 884 (3rd App. Dist.) - former inpatient, acute care hospital fee guideline of the Commission was declared void due to failure to comply with Administrative Procedure Act rule requirements for a reasoned justification and a restatement of the facts in the adoption preamble to the rule.

1996

- Ben Robinson Co. v. Texas Workers' Compensation Commission, 934 S.W.2d 149 (Third App. Dist.) – the federal Occupational Safety and Health Act (29 USC Section 651) preempted the Commission's former "Extra-Hazardous Employer Program" as applied to private employers under Texas Labor Code section 411.041 before it was amended.

- Chavis v. Director, State Workers' Compensation Division, 924 S.W. 2d 439 (9th App.) - Interpreted "occupational disease" definition as compensable if it: (1) arises from gradual and slow onset, not traceable to definite time, place and cause; or (2) arises from repeated physical exposure or repeated physical traumas.

- Saenz v. Fidelity & Guaranty Ins. Underwriters, 925 S.W.2d 607 (Tex. Sup. Ct.) – sole remedy for the wrongful inducement of an injured worker to settle a workers' compensation claim is rescission of the agreement.

1997

- Franks v. Sematech, Inc., 936 S.W.2d 959 (Tex. Sup. Ct.) – workers' compensation insurance carrier may assert a subrogation claim against a third party who caused the injured employee's injuries but that claim is still derivative of the injured employee's claim.
- Larchmont Farms, Inc. v. Parra, 941 S.W.2d 93 (Tex. Sup. Ct.) – New Jersey's workers' compensation law's exclusive remedy provision applied to an out-of-state Texas employee who was hired by a New Jersey corporation and who was injured on-the-job in New Jersey

1998

- In re Luby's Cafeterias, Inc., 979 S.W.2d 813 (14th App.) – Trial court must abate a litigation case by an injured employee against an employer until the Workers' Compensation Commission had made its final decision on whether the injury was compensable.

- Continental Casualty Co. v. Williamson, 971 S.W.2d 108 (12th App.) – Employer's failure to contest compensability of an alleged injury, when the employee did not suffer an injury, could not create a compensable injury.

- Lumbermen's Mutual Casualty Co. v. Manasco, 971 S.W. 2d 60 (Tex. Sup. Ct.) – an injured employee may not use Texas Labor Code section 410.307 (that provides in part that evidence of the extent of impairment is not limited to that presented to the commission if a court, after a hearing, finds there is a substantial change of condition) to reopen an impairment rating after his time for appeal has lapsed.

- Cardenas v. Continental Insurance Co., 960 S.W. 2d 401 (13th App/ Dist.) – court upheld jury ruling that injured employee did not have good cause to fail to report her injury to her employer within the required 30-day period of the injury and, therefore, the employer was released from liability from the workers' compensation claim.

- Anderson v. Hood County, 958 S.W. 2d 448 (2nd App. Dist.) – injured employee did not have good cause to fail to report her injury to her employer within the required 30-day period and, therefore, the court did not have to decide the issue of whether the injured employee also failed to file a claim for workers' compensation within the required one-year period.

- Texas General Indemnity Co. v. Eisler, 981 S.W.2d 744 (1st App. Dist.) – Texas Labor Code section 408.082 must be read in conjunction with section 408.121 so that an injured worker who reaches maximum medical improvement is entitled to impairment income benefits whether or not the injured worker was disabled for at least seven days.

- The Subsequent Injury Fund, State of Texas v. Service Lloyds Insurance Co., 961 S.W.2d 673 (1st App. Dist.) – an earlier judgment obtained by the insurance carrier against the Subsequent Injury Fund (SIF) was void and unenforceable because the insurance carrier never made the SIF a party to that lawsuit.

1999

- Albertson's, Inc. v. Sinclair, 984 S.W.2d 958 (Tex. Sup. Ct.) - Texas Labor Code section

410.253 (requiring a party appealing a decision of an Appeals Panel to file a copy of its petition for judicial review with the Commission on the same day that it files its petition in the trial court) is subject to the "mailbox rule" in the Texas Rule of Civil Procedure No. 5 and that the filing with the Commission is mandatory but not jurisdictional. The Court stated: "…we liberally construe workers' compensation legislation to carry out its evident purpose of compensating injured workers and their dependents." The issue was subsequently addressed in HB145 of the 78th Legislature.

- Texas Workers' Compensation Insurance Fund v. Serrano, 962 S.W.2d 536 (Tex. Sup. Ct.) - an insurance carrier, requesting reimbursement from the injured employee from the proceeds awarded to that employee (in a third party action against the person who caused the injuries to that employee), does not have to prove that the amount of benefits paid was reasonable and necessary because it is entitled to reimbursement.

- Koch Refining Co. v. Chapa, 11 S.W.3d 153 (Tex Sup. Ct.) – Generally, a premises owner does not have a duty to ensure that an independent contractor safely performs his work. However, when the premises owner retains some control over the independent contractor's work, it must exercise that control with reasonable care.

- Insurance Co. of State of Penn. V. Stelhik, 995 S.W.2d 939 (2nd App. Dist.) - court gave weight to memorandum interpretation by Commission's Executive Director, because he was charged with enforcement of the Act, even when the Appeals Panel decision in the case was contrary to the memorandum.

- Rodriguez v. Service Lloyds Insurance Co., 997 S.W.2d 248 (Tex. Sup. Ct.) – former Commission rule 130.5(e) that provided a 90 day period to contest an impairment rating (with no exceptions) could not be amended through a contested case hearing or appeals panel decision and Texas Labor Code section 410.307 does not create an independent, substantive right to reopen the impairment issue after an injured worker had failed to timely appeal. Also, if the workers' compensation dispute concerns an issue other than compensability or eligibility for income or death benefits, a party must appeal the final decision, if it is appealable, to a district court in Travis County under the substantial evidence rule of the Administrative Procedure Act. The 90-day issue was subsequently addressed by HB2198, HB3168, and SB820 in the 78th Legislature.

2000

- Kerrville State Hospital v. Fernandez, 28 S.W.3d 1 (Tex. Sup. Ct.) – the Texas Legislature waived the immunity of state agencies "completely" from claims under the "Anti-Retaliation Law" in Texas Labor Code section 451.001 that prevents a person from discharging or discriminating against an employee for filing a workers' compensation claim in good faith or hiring legal representation in such a claim. Note; The Texas Supreme Court in City of LaPorte v. Barfield, 898 S.W.2d 288, in 1995 held that earlier versions of the "Political Subdivisions Law" waived the immunity of political subdivisions only to the extent of providing reinstatement and back wages as remedies.

- National Liability and Fire Insurance Co. v. Allen, 15 S.W.3d 525 (Tex. Sup. Ct.) – reaffirmed ruling in Albertson's, Inc. case above and held that the Commission's record of a proceeding in a contested case hearing and in an Appeals Panel case is not admissible in a

judicial review proceeding unless it is offered in compliance with the Texas Rules of Evidence (e.g. need to demonstrate a witness's unavailability to testify at the trial court even if the witness testified in the administrative proceeding at the Commission).

- Lopez v. Texas Workers' Compensation Insurance Fund, 11 S.W.3d 490 (3rd App. Dist.) – the decision of an Appeals Panel of the Commission concerning payment of benefits remain effective until a final judicial decision rules otherwise.

- Continental Casualty Insurance Co. v. Functional Restoration Associates, 19 S.W.3d 393 (Tex. Sup. Ct.) – Texas Workers' Compensation Act did not grant an insurance carrier a statutory right to judicial review after an administrative decision on a medical dispute. This issue was subsequently addressed by HB2600 in the 77th Legislature.

- The Kroger Co. v. Keng, 23 S.W.3d 347 (Tex. Sup. Ct.) – nonsubscriber employer to workers' compensation insurance is not entitled to jury question regarding its employee's alleged comparative responsibility for his or her injuries. "To discourage employers from making that choice [nonsubscriber status], the Legislature included within the Act, a penalty provision, similar to section 406.033, that precluded nonsubscribing employers from relying on the traditional common-law defenses – contributory negligence, assumption of the risk and fellow servant – in defending against their employees' personal-injury actions."

- Payne v. Galen Hospital Corporation, 28 S.W.3d 15 (Tex. Sup. Ct.) – if an additional injury occurs in the probable sequence of events and arises from the actual compensable injury, it is deemed to have occurred in the course and scope of employment for workers' compensation purposes and the "dual-capacity doctrine" did not apply to allow a hospital employee to avoid application of the Texas Workers' Compensation Act's "exclusive remedy" provision barring her litigation case against the hospital for alleged negligence in filling a drug prescription to which she had a severe reaction.

- Texas Workers' Comp. Commission v. City of Eagle Pass/Texas Municipal League Workers' Joint Ins. Fund, 14 S.W.3d 801 (3rd App.) – self-insuring municipalities are "persons" subject to administrative penalties for making late benefit payments.

2001

- Argonaut Southwest Ins. Co. v. Walker, 64 S.W.3d 654 (6th App. Dist.) – the "savings clause" in Texas Civil Practice & Remedies Code section 16.064 (allowing a 60-day period to refile a case in a proper court when an earlier court dismisses because of lack of jurisdiction) does not apply to the 40-day period for a party to appeal a decision of the Commission's Appeals Panel.

- American Motorist Insurance Co. v. Fodge, 63 S.W.2d 801 (Tex. Sup. Ct.) – an injured employee cannot prosecute a lawsuit against a carrier to recover benefits and damages resulting from a denial of benefits by the carrier without a prior determination by the Texas Workers' Compensation Commission that such benefits are due to the injured employee.

- Fulton v. Associated Indemnity Corp., 46 S.W.3d 364 (Third App. Dist.) – invalidated the Commission's former rule at 28 TAC section 130.5(e) that provided: "The first impairment rating assigned to an employee is considered final if the rating is not disputed within 90 days

after the rating is assigned." This issue was subsequently addressed by HB2198, HB3168 and SB820 in the 78th Legislature.

2002

- Argonaut Insurance Co. v. Baker, 87 S.W.3d 526 (Tex. Sup. Ct.) – allowing a carrier to be reimbursed in a third-party action (against a person who caused the injuries of the injured employee) for benefits paid from the deductible amount in the workers' compensation insurance policy does not violate Texas Insurance Code article 5.55C section (f) that provides that an employee "may not be required to pay any of the deductible amount."

- Continental Casualty Co. v. Downs, 81 S.W.3d 803 (Tex. Sup. Ct.) – an insurance carrier cannot contest compensability after it fails to begin benefit payments or send a notice of refusal to pay within seven days after receiving written notice of an injury. This issue was subsequently addressed by HB2199 and SB1282 in the 78th Legislature.

- Texas Municipal League Intergovernmental Risk Pool v. Texas Workers' Comp. Commission, 74 S.W.3d 377 (Tex. Sup. Ct.) – Texas Workers' Compensation Act provision requiring payment of unclaimed death benefits into the Commission's Subsequent Injury Fund is constitutional.

III. Policymaking Structure

A. Please complete the following chart:

Texas Workers' Compensation Commission Exhibit 3: Policymaking Body					
Member Name	**Term/ Appointment Dates/ Appointed by ___** (e.g., Governor, Lt. Governor, Speaker)	**Qualification** (e.g., public member, industry representative)	**Address**	**Telephone & Fax Numbers**	**E-mail Address**
Richard A. Smith	Governor appointed for 6 year term – April 2002	Employer member	4000 IH-35 South Southfield Building Austin, TX 78704	804-4432 Fax: 804-4431	Commissioners@twcc.state.tx.us
Lonnie Watson	Governor appointed for 6 year term – March 1999	Employer member	4000 IH-35 South Southfield Building Austin, TX 78704	804-4432 Fax: 804-4431	Commissioners@twcc.state.tx.us
Mike Hachtman	Governor appointed for 6 year term – March 2003	Employer member	4000 IH-35 South Southfield Building Austin, TX 78704	804-4432 Fax: 804-4431	Commissioners@twcc.state.tx.us
Eddie Wilkerson	Governor appointed for 6 year term – June 2002	Wage Earner member	4000 IH-35 South Southfield Building Austin, TX 78704	804-4432 Fax: 804-4431	Commissioners@twcc.state.tx.us
Carolyn J. Walls	Governor appointed for 6 year term – May 2003	Wage Earner member	4000 IH-35 South Southfield Building Austin, TX 78704	804-4432 Fax: 804-4431	Commissioners@twcc.state.tx.us
Edward J. Sanchez	Governor appointed for 6 year term – May 2003	Wage Earner member	4000 IH-35 South Southfield Building Austin, TX 78704	804-4432 Fax: 804-4431	Commissioners@twcc.state.tx.us

Note: SB287, 78th Legislature, sets staggered, two-year terms for TWCC Commissioners; current member terms expire 2/1/05; the Governor is to appoint one member representing employers and two members representing wage earners to terms expiring February 1, 2006; and one member representing wage earners and two members representing employers to terms expiring February 1, 2007.

B. How is the chair of the policymaking body appointed?

Texas Labor Code Section 402.008 states "The governor shall designate a member of the Commission as the chairman of the Commission to serve in that capacity for a two-year term expiring February 1, of each odd-numbered year. The governor shall alternate the chairmanship between the members who are employers and the members who are wage earners."

C. Describe the primary role and responsibilities of the policymaking body.

Texas Labor Code Section 402.061 - Section 402.073 outlines the responsibilities of the Commissioners. According to the statutory language, the Commissioners:

- adopt rules;
- may accept gifts, grant or donations on behalf of the agency;
- appoint the Executive Director and the Director of Internal Audit;
- set reasonable fees for services provided by the Commission;
- may employ counsel to represent the Commission;
- consider and recommend legislative changes;
- may appoint advisory committees;
- prepare an annual financial report;
- establish qualifications for a representative before the Commission; and
- may impose sanctions that deprive a person of the right to practice before the Commission for more than 30 days.

D. List any special circumstances or unique features about the policymaking body or its responsibilities.

Commissioners of the Texas Workers' Compensation Commission are part-time Commissioners. Three Commissioners must represent wage earners and three Commissioners must represent employers. The Commissioners receive per diem and can receive up to $100 lost wage replacement per meeting, not to exceed $5,000 per year. Decisions regarding the employment of an executive director require the affirmative vote of at least two commissioners representing employers and two commissioners representing wage earners.

E. In general, how often does the policymaking body meet? How many times did it meet in FY 2002? in FY 2003?

In December the Commissioners approved a tentative monthly public meeting schedule for the coming year. Public hearings are held as needed for rule proposals.

In FY 2002 the Commissioners held seven public meetings and staff held six public hearings. In FY 2003 the Commissioners held seven public meetings and staff held one public hearing.

F. What type of training do the agency's policymaking body members receive?

When a new Commissioner is appointed, staff schedules a day of training that is based on the Commissioner's Handbook. The Handbook contains the following areas:

- agency background and history, and enabling legislation;
- organizational structure and programs;
- claims and dispute resolution process;
- Commission rules;
- state personnel requirements;
- Commissioner roles and responsibilities;
- process for contracts and purchasing;
- rule making;
- ethics;

- results of the most recent formal audit of the Commission;
- Texas open meetings requirements;
- Texas open records requirements;
- strategic planning and budgeting; and
- additional general information.

G. Does the agency have policies that describe the respective roles of the policymaking body and agency staff in running the agency? If so, please describe these policies.

The Texas Labor Code clearly defines the role of Commissioners and staff. However, in the mid-90s the Commissioners adopted Commissioner Role and Responsibilities which includes four sections as follows: Statement of Ethical Principles and Values; Statutory Provisions (non-inclusive); In Keeping with the Separation of Responsibilities Established by the Texas Workers' Compensation Act, and to Guide our Actions with Reference to Commission Activities; and the Commission Code of Ethics.

H. If the policymaking body uses subcommittees or advisory committees to carry out its duties, please fill in the following chart.

The Commissioners have committee and board appointments to carry out their duties. The Chairman makes these assignments and membership includes one wage earner member and one employer member. The memberships are as follows:

Texas Workers' Compensation Commission
Exhibit 4: Subcommittees and Advisory Committees

Name of Subcommittee or Advisory Committee	Size/Composition/How are members appointed?	Purpose/Duties	Legal Basis for Committee
Internal/Financial Operations Committee	Chairman Smith, Commissioners Hachtman and Sanchez	Preliminary liaisons with the internal auditor on issues involving budget, finance, internal operations and audits	
Texas Certified Self-Insurer Guaranty Association (TCSIGA) Board	Commissioners Watson and Walls	Serve as members of the TCSIGA Board of Directors; to review and make recommendations on approval, renewal or removal of certificate of authority to self-insure.	Labor Code, §407.122
Research and Oversight Council (ROC) Board	Chairman Smith and Commissioner Wilkerson	Serve as members of the ROC Board of Directors; review and approve research agenda and legislative recommendations for statutory changes.	Labor Code, §404.004

Texas Group Self-Insurance Guaranty Association	Not yet appointed		HB 2095 (78th Reg. Session)

Note: Medical Advisory Committee (MAC) members are appointed by the Commissioners, but MAC members advise the Medical Review Division.

I. How does the policymaking body obtain input from the public regarding issues under the jurisdiction of the agency? How is this input incorporated into the operations of the agency?

Commissioners receive public input through:

- public comments on proposed rules;
- personal contacts;
- correspondence addressed to the Commissioners;
- workers' compensation publications; and
- attendance at issue-related seminars and association meetings.

IV. Funding

A. Describe the agency's process for determining budgetary needs and priorities.

The Texas Workers' Compensation Act establishes a self-balancing maintenance tax that is collected on workers' compensation insurance premiums. The maintenance tax is paid by workers' compensation insurance carriers for the administration of the Commission and may not exceed two percent of gross workers' compensation insurance premiums. The tax is set annually (by October 31st) at a rate sufficient to cover the funding appropriated to the agency and all other costs paid by the state for the Commission's operations (e.g., employee benefits). The statute requires that any over-collections or spending reductions in the Commission's budget be accounted for in the setting of the maintenance tax for the following year.

The maintenance tax is collected by the Comptroller and deposited in general revenue. The amount collected and the effect of additional funding on the maintenance tax are always a consideration when making budget decisions.

The agency's cyclical process for determining budgetary needs and priorities begins with a review of the most immediately past Legislative Appropriations Request (LAR). The review begins with an examination and re-definition (if applicable) of the Commission's mission, goals, and strategies and their relative priorities during the strategic planning process.

Agency divisions submit requests for projected budget needs, including any new needs that have not been included in previous budgets. Requests for additional funding may be the result of new statutory or rule responsibilities, increased workload, etc. A budget document consolidating all division budget requests and justifications for additional funding is developed by Finance for review and consideration by executive management. The LAR, as approved by executive management, is presented to the Commissioners for their approval.

Operating budgets are developed consistent with the General Appropriations Act and regularly monitored. Executive management and all program areas are briefed monthly on the budget status. As new funding needs arise, executive management makes determinations on how to reallocate funds if necessary.

PLEASE FILL IN EACH OF THE CHARTS BELOW, USING EXACT DOLLAR AMOUNTS.

B. Show the agency's sources of revenue. Please include all local, state, and federal appropriations, all professional and operating fees, and all other sources of revenue collected by the agency.

Texas Workers' Compensation Commission
Exhibit 5: Sources of Revenue — Fiscal Year 2002 (Actual)

Source	Amount
General Revenue	$46,443,478
Federal	2,513,091
Earned Federal	224,406
Appropriated Receipts	1,379,073
Interagency Contracts	5,104
TOTAL	**$50,565,152**

C. If you receive funds from multiple federal programs, show the types of federal funding sources.

Texas Workers' Compensation Commission
Exhibit 6: Federal Funds — Fiscal Year 2002 (Actual)

Type of Fund	State/Federal Match Ratio	State Share	Federal Share	Total Funding
CFDA 17.005.000 ROSH/CFOI	50/50	$183,781	$183,781	$367,563
CFDA 17.504.002 OSHCON	10/90	204,850	1,843,646	2,048,496
CFDA 17.504 Data Collection	0/100	0	88,602	88,602
CFDA 17.600 MSHA	20/80	78,597	314,390	392,987
CFDA 93.283.009 FACE	0/100	0	82,671	82,671
TOTAL		**$467,228**	**$2,513,091**	**$2,980,319**

D. If applicable, please provide detailed information on fees collected by the agency.

Texas Workers' Compensation Commission
Exhibit 7: Fee Revenue and Statutory Fee Levels — Fiscal Year 2002

Description/ Program/ Statutory Citation	Current Fee/ Statutory maximum	Number of persons or entities paying fee	Fee Revenue	Where Fee Revenue is Deposited (e.g., General Revenue Fund)
Maintenance Tax/TLC §403.003	2002 – 1.67% 2003 – 1.51% Statutory maximum: 2.00%	2002 Taxable premiums $4,224,958,013 and 2003 taxable premiums estimated at $3,000,000,000	$69,972,904 Maintenance taxes paid by insurance companies in 2002	General Revenue Fund
Appropriated Receipts/GAA VIII-86, (2), Appropriation of Certain Fees	2002 LAR estimate - $1,324,737 2003 LAR estimate - $1,324,738	Undetermined	2002 Actual – $100,000 Admin penalties 581,984 Fee filings 330,577 Seminars 957 Furniture sales 47,268 Publication sales 2,733 Other sales 315,554 3rd party **$1,379,073 Total**	General Revenue Fund
GAA VIII-86, (3), Administrative Penalties	Commission appropriated maximum is $100,000	Approximately 325 persons/entities	$100,000 appropriated $1,418,423 unappropriated	General Revenue Fund
Self-Insurance Regulatory Fee/TLC, §407.102	Based on self-insurers indemnity costs	Two application fees and approximately 104 regulatory fee entities	2002: $2,000 Application fees 838,804 Regulatory fees	General Revenue Fund
Self-Insurer Maintenance Tax/Effect on General Maintenance Tax/TLC, §407.103	See maintenance tax above) Statutory maximum is 2%	Approximately 50 entities	2002 - $2,544,644 in maintenance taxes paid by self-insurers	General Revenue Fund

E. Show the agency's expenditures by strategy.

Texas Workers' Compensation Commission
Exhibit 8: Expenditures by Strategy — Fiscal Year 2002 (Actual)

Goal/Strategy	Amount
1-1-1 Health & Safety Services	$5,248,682
2-1-1 Medical Cost Containment	1,681,998
2-2-1 Investigations/Compliance	3,075,373
2-3-1 Develop and Implement Processes	9,504,482
2-4-1 Regulate Self-Insurance	717,390
3-1-1 Informal Dispute Resolution	8,501,293
3-1-2 Formal Dispute Resolution	6,588,400
4-1-1 Central Administration	4,388,119
4-1-2 Information Resources	8,722,533
4-1-3 Other Support Services	1,336,190
4-1-4 Regional Administration	800,692
GRAND TOTAL:	**$50,565,152**

F. Show the agency's expenditures and FTEs by program.

Texas Workers' Compensation Commission Exhibit 9: Expenditures and FTEs by Program — Fiscal Year 2002 (Actual)					
Program	**Budgeted FTEs, FY 2002**	**Actual FTEs as of August 31, 2002**	**Federal Funds Expended**	**State Funds Expended**	**Total Actual Expenditures**
Workers' Health and Safety	118.0	110.5	$2,513,091	$2,735,591	$5,248,682
Medical Cost Containment	45.3	33.8	0	1,681,998	1,681,998
Compliance and Enforcement	59.8	58.9	0	3,075,373	3,075,373
Records Management	313.8	291.0	0	9,504,482	9,504,482
Self-Insurance Regulation	14.0	14.0	0	717,390	717,390
Income Benefit Dispute Resolution	325.8	299.5	0	14,704,068	1,4704,068
Medical Benefit Dispute Resolution	34.3	31.7	0	1,186,317	1,186,317
Central Administration	90.0	79.5	0	4,388,119	4,388,119
Information Resources	68.7	62	0	7,882,948	7,882,948
Business Process Improvement	3.3	3	0	839,585	839,585
Support Services	33.8	31.3	0	1,336,190	1,336,190
TOTAL	**1,106.5**	**1015.2**	**$2,513,091**	**$48,052,060**	**$50,565,152**

G. Show the agency's objects of expense for each category of expense listed for your agency in

the General Appropriations Act FY 2004-2005.

Texas Workers' Compensation Commission Exhibit 10: Objects of Expense by Program or Function -- Fiscal Year 2004			
Object-of-Expense Informational Listing	**Workers' Health and Safety**	**Medical Cost Containment**	**Compliance and Enforcement**
Salaries	$3,588,586	$1,699,228	$1,992,434
Other Personnel	213,560	65,756	103,560
Professional Fees and Services	20,000	28,632	0
Consumables	76,124	14,509	6,900
Utilities	32,591	16,631	14,697
Travel	322,179	47,833	44,650
Rent - Building	412,935	194,800	145,984
Rent - Machine	13,190	21,098	13,680
Other Operating	280,619	443,051	92,697
Capital	0	0	0
Total, FY 2004 Object-of-Expense Informational Listing	**$4,959,784**	**$2,531,538**	**$2,414,602**

Texas Workers' Compensation Commission Exhibit 10, cont'd: Objects of Expense by Program or Function -- Fiscal Year 2004			
Object-of-Expense Informational Listing	**Records Management**	**Self-Insurance Regulation**	**Benefit Dispute Resolution**
Salaries	$4,991,784	$581,780	$14,311,650
Other Personnel	413,212	22,433	635,280
Professional Fees and Services	0	0	0
Consumables	66,800	3,175	65,769
Utilities	76,618	4,186	153,358
Travel	1,725	10,675	330,009
Rent - Building	0*	45,304	1,317,207
Rent - Machine	24,067	0	128,839
Other Operating	501,966	48,840	632,293
Capital	0	0	0
Total, FY 2004 Object-of-Expense Informational Listing	**$6,076,172**	**$716,393**	**$17,574,405**

*The full amount of savings realized under the new central office lease (effective 10/1/03) was reflected in the Commission's "Process Claim Files/Records Management" strategy in the General Appropriations Act.

Texas Workers' Compensation Commission Exhibit 10, cont'd: Objects of Expense by Program or Function -- Fiscal Year 2004			
Object-of-Expense Informational Listing	**Medical Dispute Resolution**	**Central Administration**	**Information Resources**
Salaries	$1,241,347	$3,771,505	$2,323,555
Other Personnel	50,700	159,845	109,280
Professional Fees and Services	0	27,000	2,182,896
Consumables	23,233	28,291	100,000
Utilities	8,266	30,171	747,931
Travel	17,334	49,327	32,000
Rent - Building	89,766	294,475	220,047
Rent - Machine	5,267	38,486	268,594
Other Operating	31,548	193,471	1,631,847
Capital	0	0	31,512
Total, FY 2004 Object-of-Expense Informational Listing	**$1,467,461**	**$4,592,571**	**$7,647,662**

Texas Workers' Compensation Commission Exhibit 10, cont'd: Objects of Expense by Program or Function -- Fiscal Year 2004		
Object-of-Expense Informational Listing	**Business Process Improvement**	**Support Services**
Salaries	$271,944	$843,728
Other Personnel	1,780	57,750
Professional Fees and Services	1,183,665	3,500
Consumables	8,000	60,080
Utilities	0	12,641
Travel	0	13,020
Rent - Building	0	106,788
Rent - Machine	0	7,368
Other Operating	1,711	298,818
Capital	1,678,335	0
Total, FY 2004 Object-of-Expense Informational Listing	**$3,145,435**	**$1,403,693**

Objects of Expense by Program or Function -- Fiscal Year 2005			
Object-of-Expense Informational Listing	**Workers' Health and Safety**	**Medical Cost Containment**	**Compliance and Enforcement**
Salaries	$3,588,586	$1,699,228	$1,992,434
Other Personnel	221,537	67,490	107,963
Professional Fees and Services	20,000	27,252	0
Consumables	69,449	14,509	6,900
Utilities	34,196	17,440	15,344
Travel	322,179	47,833	44,650
Rent - Building	412,935	194,800	145,984
Rent – Machine	14,159	22,345	14,787
Other Operating	287,674	397,253	88,789
Capital	0	0	0
Total, FY 2005 Object-of-Expense Informational Listing	**$4,970,715**	**$2,488,150**	**$2,416,851**

Objects of Expense by Program or Function -- Fiscal Year 2005			
Object-of-Expense Informational Listing	**Records Management**	**Self-Insurance Regulation**	**Benefit Dispute Resolution**
Salaries	$4,991,784	$581,780	$14,311,650
Other Personnel	433,260	23,773	655,199
Professional Fees and Services	0	0	0
Consumables	67,541	3,175	65,743
Utilities	79,819	4,397	143,101
Travel	1,725	9,330	320,848
Rent - Building	0	45,304	1,301,612
Rent – Machine	25,764	0	147,810
Other Operating	281,519	49,660	645,790
Capital	0	0	0
Total, FY 2005 Object-of-Expense Informational Listing	**$5,881,412**	**$717,419**	**$17,591,753**

Objects of Expense by Program or Function -- Fiscal Year 2005			
Object-of-Expense Informational Listing	**Medical Dispute Resolution**	**Central Administration**	**Information Resources**
Salaries	$1,241,346	$3,771,509	$2,323,555
Other Personnel	51,505	166,082	114,080
Professional Fees and Services	0	54,500	2,182,896
Consumables	23,233	28,051	10,300
Utilities	7,049	31,560	748,932
Travel	17,334	49,067	32,000
Rent - Building	90,262	294,475	220,047
Rent – Machine	6,178	42,031	6,647
Other Operating	35,467	212,346	2,100,857
Capital	0	0	113,012
Total, FY 2005 Object-of-Expense Informational Listing	**$1,472,374**	**$4,649,621**	**$7,845,026**

Objects of Expense by Program or Function -- Fiscal Year 2005		
Object-of-Expense Informational Listing	**Business Process Improvement**	**Support Services**
Salaries	$271,944	$843,728
Other Personnel	2,280	60,763
Professional Fees and Services	385,500	3,500
Consumables	5,000	50,924
Utilities	0	13,071
Travel	0	8,290
Rent - Building	0	106,788
Rent – Machine	0	6,498
Other Operating	1,211	298,818
Capital	300,000	0
Total, FY 2005 Object-of-Expense Informational Listing	**$965,935**	**$1,392,380**

H. Please fill in the following chart.

FISCAL YEAR 2000				
Category	**Total $ Spent**	**Total HUB $ Spent**	**Percent**	**Statewide Goal**
Heavy Construction	0	0	0	11.9%
Building Construction	0	0	0	26.1%
Special Trade	96,445	0	0	57.2%
Professional Services	30,000	0	0	20.0%
Other Services	4,390,360	166,920	3.80%	33.0%
Commodities	2,961,324	575,375	19.40%	12.6%
TOTAL	**7,478,129**	**742,295**	**23.20%**	
FISCAL YEAR 2001				
Category	**Total $ Spent**	**Total HUB $ Spent**	**Percent**	**Statewide Goal**
Heavy Construction	0	0	0	11.9%
Building Construction	0	0	0	26.1%
Special Trade	49,419	0	0	57.2%
Professional Services	29,800	23,800	79.80%	20.0%
Other Services	3,955,907	188,084	4.75%	33.0%
Commodities	1,800,626	426,764	23.70%	12.6%
TOTAL	**5,835,752**	**638,648**	**108.25%**	
FISCAL YEAR 2002				
Category	**Total $ Spent**	**Total HUB $ Spent**	**Percent**	**Statewide Goal**
Heavy Construction	0	0	0	11.9%
Building Construction	0	0	0	26.1%
Special Trade	10,215	0	0	57.2%
Professional Services	10,942	0	0	20.0%
Other Services	4,804,889	379,508	7.89%	33.0%
Commodities	2,753,918	789,987	28.60%	12.6%
TOTAL	**7,579,964**	**1,169,495**	**36.49%**	

I. Does the agency have a HUB policy? How does the agency address performance shortfalls related to the policy?

Commission procedure 16-01 contains the agency's HUB policy. To address performance shortfalls, the agency has implemented the following purchasing procedure: 1) for procurements $2,000 to $10,000, five HUB vendors must be contacted, 2) for procurements $10,000 to $15,000, ten HUB vendors must be contacted.

Many of the agency's purchases representing a significant share of the agency's budget are made using existing contracts, (i.e., Texas Building and Procurement Commission term contract, Department of Information Resources) and are for items areas such as conference space, registration for employee training, and books/ reference materials including subscriptions, periodicals, and information services. These categories are not reportable as HUB expenditures.

J. For agency with contracts valued at $100,000 or more:

	Response / Agency Contact
Does your agency follow a HUB subcontracting plan to solicit bids, proposals, offers, or other applicable expressions of interest for subcontracting opportunities available under contracts of $100,000 or more? (Tex. Government Code, Sec. 2161.252; TAC 111.14)	For contracts, $100,000 or more, the agency does follow a HUB subcontracting plan. Agency contacts: James Werchan or Sharlana Dillard

K. For agencies with biennial appropriations exceeding $10 million:

	Response / Agency Contact
Do you have a HUB coordinator? (Tex. Government Code, Sec. 2161.062; TAC 111.126)	Yes. The agency's HUB Coordinator is not a full time position. This individual has other responsibilities and spends approximately 30% time on HUB related functions.
Has your agency designed a program of HUB forums in which businesses are invited to deliver presentations that demonstrate their capability to do business with your agency? (Tex. Government Code, Sec. 2161.066; TAC 111.127)	The agency has not designed a program of HUB forums. However, the agency frequently participates in other state agencies' forums.
Has you agency developed a mentor-protégé program to foster long-term relationships between prime contractors and HUBs and to increase the ability of HUBs to contract with the state or to receive subcontracts under a state contract? (Tex. Government Code, Sec. 2161.065; TAC 111.128)	The Commission does not engage in the kind of purchasing activity that lends itself to the HUB mentor-protégé program.

V. Organization

A. Please fill in the chart below. If applicable, list field or regional offices.

Texas Workers' Compensation Commission
Exhibit 12: FTEs by Location — Fiscal Year 2002

Headquarters, Region, or Field Office	Location	Number of Budgeted FTEs, FY 2002	Number of Actual FTEs as of August 31, 2002
Central Office	Austin	557.5	499.3
Records Archiving Center	Austin	40.5	37.5
Region I			
Dallas Field Office	Dallas	58.0	53.2
Denton Field Office	Denton	15.0	12.4
Fort Worth Field Office	Fort Worth	51.0	44.9
Tyler Field Office	Tyler	24.0	22.3
Waco Field Office	Waco	24.5	22.5
Region II			
Beaumont Field Office	Beaumont	13.0	12.0
Bryan Field Office	Bryan	8.0	6.9
Houston East Field Office	Houston	45.0	39.4
Houston West Field Office	Houston	41.5	42.0
Lufkin Field Office	Lufkin	7.5	7.5
Missouri City Field Office	Missouri City	21.0	21.6
Region III			
Austin Field Office	Austin	18.0	16.8
Corpus Christi Field Office	Corpus Christi	14.0	14.0
Laredo Field Office	Laredo	8.5	8.2
San Antonio Field Office	San Antonio	43.5	40.7
Victoria Field Office	Victoria	10.0	9.5
Weslaco Field Office	Weslaco	19.0	20.1
Region IV			
Abilene Field Office	Abilene	11.0	11.0
Amarillo Field Office	Amarillo	10.0	10.0
El Paso Field Office	El Paso	29.0	28.4
Lubbock Field Office	Lubbock	10.0	10.0
Midland Field Office	Midland	12.0	12.0
San Angelo Field Office	San Angelo	6.0	5.0
Wichita Falls Field Office	Wichita Falls	9.0	8.0
	TOTAL	**1106.5**	**1015.2**

Note: The Commission did not budget the full 1,128 FTEs included in the General Appropriations Act for several reasons. In accordance with a contingency rider (HB 2600) in Article IX, the Commission's FTE cap was reduced by 3.6 in FY 2002 and 15.6 in FY 2003. For budget purposes, the Commission decided to account for the biennial reduction in the first year, with a slight modification to reduce an FTE by one-half rather than six-tenths. Additionally, six FTEs were not budgeted as a result of outsourcing the agency's desktop seat management services

for personal computers. Thus, the number of positions that the Commission was able to budget was 1,128 – 15.5 – 6 = 1,106.5.

B. What was the agency's FTE cap for fiscal years 2002 - 2005?

The Commission's FTE cap during the FY 2002-2003 biennium was 1,124.4 in FY 2002 and 1,112.4 in FY 2003. For the FY 2004-2005 biennium, the cap established for the agency in the General Appropriations Act is 1,042. The Commission's bill pattern shows an FTE cap of 1,050, but an Article IX provision reduces the Commission's cap in order to meet the legislatively adopted human resource staff-to-staff ratio. Additionally, the cap may actually be lower if reductions must be made to comply with the management-to-staff ratios adopted by the 78th Legislature.

Despite the established FTE cap, the Commission is not able to fill all of its authorized positions because of funding limitations for salaries. Current salary funding is not sufficient to compensate the authorized positions at the levels commensurate with the necessary skill sets.

C. How many temporary or contract employees did the agency have as of August 31, 2002?

As of August 30, 2002 (the last working day of the quarter), seventeen temporary and contract employees were performing services for the Commission.

D. Please fill in the chart below.

Texas Workers' Compensation Commission
Exhibit 13: Equal Employment Opportunity Statistics

FISCAL YEAR 2000

Job Category	Total Positions	Minority Workforce Percentages					
		Black		Hispanic		Female	
		Agency	Civilian Labor Force %	Agency	Civilian Labor Force %	Agency	Civilian Labor Force %
Officials/Administration	33	6.1%	3.7%	15.2%	10.0%	45.5%	30%
Professional	519	11.8%	8.7%	25.6%	9.3%	61.1%	46.3%
Technical	64	10.9%	13.2%	31.3%	16.4%	46.9%	39.7%
Protective Services	0	0.0%	16.8%	0.0%	19.4%	0.0%	19.4%
Para-Professionals	109	19.3%	22.7%	43.1%	28.5%	92.7%	55.6%
Administrative Support	341	21.1%	19.2%	45.5%	21.6%	89.2%	81.3%
Skilled Craft	0	0.0%	10%	0.0%	24.3%	0.0%	16.7%
Service/Maintenance	3	0.0%	28.9%	100.0%	36.3%	0.0%	20.5%

FISCAL YEAR 2001							
Job Category	Total Positions	Minority Workforce Percentages					
		Black		Hispanic		Female	
		Agency	Civilian Labor Force %	Agency	Civilian Labor Force %	Agency	Civilian Labor Force %
Officials/Administration	21	9.5%	7.0%	14.3%	11.0%	57.1%	31.0%
Professional	542	10.7%	9.0%	26.6%	10.0%	61.1%	47.0%
Technical	50	8.0%	14.0%	32.0%	18.0%	38.0%	39.0%
Protective Services	0	0.0%	18.0%	0.0%	21.0%	0.0%	21.0%
Para-Professionals	112	19.6%	18.0%	44.6%	31.0%	94.6%	56.0%
Administrative Support	341	21.7%	19.0%	42.8%	27.0%	90.0%	80.0%
Skilled Craft	0	0.0%	10.0%	0.0%	28.0%	0.0%	10.0%
Service/Maintenance	3	0.0%	18.0%	100.0%	44.0%	0.0%	26.0%

FISCAL YEAR 2002							
Job Category	Total Positions	Minority Workforce Percentages					
		Black		Hispanic		Female	
		Agency	Civilian Labor Force %	Agency	Civilian Labor Force %	Agency	Civilian Labor Force %
Officials/Administration	25	4.0%	7.0%	12.0%	11.0%	40.0%	31.0%
Professional	533	9.8%	9.0%	25.1%	10.0%	61.4%	47.0%
Technical	43	9.3%	14.0%	30.2%	18.0%	34.9%	39.0%
Protective Services	0	0.0%	18.0%	0.0%	21.0%	0.0%	21.0%
Para-Professionals	108	18.5%	18.0%	46.3%	31.0%	95.4%	56.0%
Administrative Support	304	21.4%	19.0%	46.4%	27.0%	90.1%	80.0%
Skilled Craft	0	0.0%	10.0%	0.0%	28.0%	0.0%	10.0%
Service/Maintenance	3	0.0%	18.0%	100.0%	44.0%	0.0%	26.0%

E. Does the agency have an equal employment opportunity policy? How does the agency address performance shortfalls related to the policy?

The Commission does have an equal employment opportunity policy that is included in the agency's Human Resources Manual. As stated in the policy, complaints regarding possible discrimination or harassment are encouraged to be reported to supervisors, management, and the Employee Relations Office within the Human Resources division. Complaints are investigated by Human Resources and, if violations of an agency policy are found, appropriate remedial action is taken.

VI. Guide to Agency Programs

A. Please complete the following chart.

Texas Workers' Compensation Commission Workers' Health and Safety Program Exhibit 14A: Program or Function Information — Fiscal Year 2002	
Name of Program or Function	Workers' Health and Safety
Location/Division	Austin Central Office
Contact Name	Bill DeCabooter, Director of Workers' Health and Safety Division
Number of Budgeted FTEs, FY 2002	118
Number of Actual FTEs as of August 31, 2002	110.5

B. What are the key services of this function or program? Describe the major activities involved in providing all services.

The Commission's Workers' Health and Safety program provides Texas employers and employees with health and safety resources and services to prevent occupational injuries and illnesses. This includes development and provision of health and safety services such as needs analysis, education, consultations, and inspections. The program is administered with the following functions: Regulatory, Voluntary, Research and Analysis, and Agency Risk Management.

1. Regulatory

The agency's Workers' Health and Safety programs that are regulatory in nature include the Accident Prevention Services, Hazardous Employer, Rejected Risk, and Drug-Free Workplace programs.

a. The **Accident Prevention Services (APS) Program** inspects insurance companies to ensure that they are providing the required accident prevention services to their policyholders. As part of an insurance carrier inspection, APS also conducts policyholder inspections to verify the accident prevention services provided by the insurance carrier. The Program also monitors each new insurance carrier writing workers' compensation policies in Texas by evaluating and approving their accident prevention service plan, and by performing an initial inspection between six months and a year of their first policy effective date. In addition, APS administers the Field Safety Representative program. Individuals who provide accident prevention services for an insurance company writing workers' compensation must meet the Field Safety Representative qualifications. APS reviews the qualifications and maintains the Field Safety Representative database.

b. The **Hazardous Employer (HE) Program** identifies Texas employers that have injury rates substantially above the averages for their industries. The HE program reinforces

identified employers' accident prevention plans through inspections to create safer workplaces, and provides safety and health consultative services as requested by hazardous employers.

c. The **Rejected Risk (RR) Program** works with companies needing safety and health assistance as identified by the Texas Mutual Insurance Company. Inspections of these employers are conducted to confirm implementation of their accident prevention plans.

d. The **Approved Professional Source (APS) Program** monitors the requirement that individuals must be designated as an APS in order to provide safety consultations under the HE program, RR Program, or for application to the agency's Self-Insurance Program. The Approved Professional Source program includes initial and update training of the Commission rules regarding these programs.

e. The **Drug-Free Workplace Program** administers the statutory provision that requires all companies that employ 15 or more workers and carry workers' compensation insurance to institute a written drug policy. Random audits of employers' drug policies are conducted to ensure compliance.

2. Voluntary Programs

Workers' Health and Safety administers several programs that provide voluntary, proactive safety and health services to Texas employers to help them prevent injuries. These include the Safety Education and Training program, Safety Violations Hotline, and Occupational Safety and Health Consultation programs.

a. The **Safety Education and Training (SET) Program** educates employees and employers across the state through on-site company training and regional seminars, safety and health videos and publications, and other forms of outreach. Over 30 training courses are available, including Accident Prevention Planning, OSHA Record keeping, Blood borne Pathogen Exposure Control, Lockout/Tagout, Ergonomics, Workplace Violence Prevention, and Construction/General Industry Programs. SET also plans and conducts an annual statewide safety and health conference.

Thousands of Texas employers use the Resource Center Library to access free safety and health training video loans and free safety and health publications. Over 2,500 video titles are available, and over 170 safety and health publications can be downloaded from the Commission web site. Many of these videos and publications include Spanish translation. The Resource Center Library is part of the Texas Library System, and provides inter-agency loan and research services to internal and external customers.

b. The **Safety Violations Hotline** is a tool for Texans to report violations of occupational safety and health laws. This 24-hour, toll-free hotline (800-452-9595) can be used by anyone wishing to report suspected violations. The allegations are sent to employers and workers' compensation insurance carriers for investigation and results are reported back to the Commission. All private and public Texas employers (except Federal) must post a notice in both English and Spanish explaining the Safety Violations Hotline and providing the phone number to employees. Hazards may be reported via calls to the

hotline that are taken in both English and Spanish or by email from the Commission's web site. A person reporting a hazard may choose to remain anonymous.

c. Free safety and health consultations are provided to Texas employers by the **Occupational Safety and Health Consultation (OSHCON) Program**. The focus of the program is on smaller employers (250 or fewer employees on site and no more than 500 nationwide) in high-hazard industries, although limited assistance is available to larger employers. The program is largely funded by a grant by the Occupational Safety and Health Administration (OSHA), but is non-regulatory in nature. No fines or citations are issued if hazards are found. Instead, Oscan's safety and health professionals help employers understand OSHA safety regulations, identify and correct workplace hazards, and establish required written programs. When agreeing to an OSHCON consultation, an employer must commit to eliminating any serious hazards identified during the visit. OSHCON also recognizes employers with exemplary safety and health programs through its Safety and Health Achievement Recognition Program (SHARP). Eligible employers may be exempt from programmed OSHA inspections for up to two years when they participate in SHARP.

3. Research and Analysis

The **Safety Information Systems (SIS) Program** of Workers' Health and Safety collects, analyzes, and distributes occupational injury, illness, and fatality information for the state of Texas. Data collection programs include the Bureau of Labor Statistics (BLS) Annual Survey of Occupational Injuries and Illnesses, the BLS Census of Fatal Occupational Injuries, and the annual OSHA survey. These programs are either partially or entirely funded by the U.S. Department of Labor through grants. In addition, SIS conducts analysis of Commission claims data, maintains a fatality database for Texas, and conducts research of health and safety topics and issues. Services provided to customers include injury and illness publications, online database and tables, and data analysis services to businesses and agencies.

4. Agency Risk Management

The Risk Management function is responsible for managing agency risk management programs, agency claims management process, and the employee health and safety program.

C. When and for what purpose was the program or function created? Describe any statutory or other requirements for this program or function.

The Workers' Health and Safety Program was created to administer state and federal health and safety programs to reduce injuries and illnesses in Texas workplaces. It is designed to provide effective health and safety resources to employers, employees and other entities that support the Texas workforce to eliminate the occurrence of injuries, illnesses, fatalities and hazardous exposures.

The provisions for the Workers' Health and Safety programs and functions are described in Chapter 411 of the Texas Workers' Compensation Act, Texas Labor Code, Title 5, Subtitle A. Chapters 160 – 169 of the Texas Workers' Compensation Commission Rules cover the Workers' Health and Safety programs.

D. Describe any important history not included in the general agency history section, including a discussion of how the services or functions have changed from the original intent. Will there be a time when the mission will be accomplished and the program or function will no longer be needed?

The Extra Hazardous Employer Program has changed since its inception when the Commission was created. In the mid-nineties, a private employer brought a lawsuit against the Commission after being identified as extra hazardous. The courts decided that the program was preempted by OSHA. As a result of the lawsuit, the program now treats private employers differently than public employers. Private employers continue to be identified, but other than remaining on the list, these employers have no required action. The Legislature revised the statute to reflect this ruling and to change the program name to the Hazardous Employer Program.

Up until August 2002, the Texas Workers' Compensation Commission administered a grant from the Mine Safety and Health Administration (MSHA), which funded safety training to the mining industry in Texas. This training was provided by the University of Texas – Austin. Administration of the grant was transferred directly to the University of Texas beginning in FY 2003.

The Program also administered the Fatality Assessment Control and Evaluation (FACE) program through a National Institute of Occupational Safety and Health (NIOSH) grant from FY 1997 through FY 2002. The FACE program conducted voluntary investigations of workplace fatalities in Texas to determine the causes, and then provided educational information about these incidents to Texas employers in an effort to prevent similar occurrences in the future.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

Generally speaking, groups affected by Workers' Health and Safety include employers, employees, governmental entities, insurance carriers, associations, and educational institutions.

Qualifications exist for the following programs:

1. **Hazardous Employer Program**: All employers having five or more employees are subject to being identified as Hazardous Employers if their injury rates exceed the established thresholds for their industries.

2. **Rejected Risk Program**: Texas Mutual Insurance Company identifies employers for the Rejected Risk Program in accordance with the Texas Insurance Code Article 5.76. These are generally small employers, those who haven't been in business very long, and those with poor safety records.

3. **Field Safety Representative Program**: A field safety representative providing accident prevention services on behalf of an insurance company writing workers' compensation insurance in Texas must meet the qualification requirements stipulated in Commission Rule 166.8. Qualifications vary depending on schooling, experience, and certifications. In FY 2002 (the last

full year for which data is available), 170 individuals were approved as Field Safety Representatives.

4. **Approved Professional Source Program**: An individual providing safety consultations under the Hazardous Employer, Rejected Risk or Self-Insurance Programs must meet the qualifications provided in Commission Rule 164.9. Qualifications vary depending on schooling, experience, and certifications. There are currently 528 individuals qualified as Approved Professional Sources.

5. **OSHCON Program**: The OSHCON program is a free service available to private Texas employers. The focus is on employers with 250 or fewer employees on-site and less than 500 nationwide in high hazard industries. Limited assistance is available to larger employers. The Safety and Health Achievement Recognition Program (SHARP), which is an OSHA inspection exemption program, is available only to employers that have worked with OSHCON for at least one year; have had a comprehensive OSHCON consultation; are in an industry that is identified as high hazard and/or that has a high average days away restricted time (DART); have corrected all identified serious hazards; have instituted all elements of an exemplary safety and health program; and have DART and total recordable case rate (TRCR) below the national rates for their industry.

6. **Drug-Free Workplace Program**: Drug policies of Texas employers that carry workers' compensation insurance and employ 15 or more people are audited randomly for compliance.

7. **Bureau of Labor Statistics (BLS) Annual Survey of Occupational Injuries and Illnesses:** Participants in this survey are chosen by stratified sample by BLS.

8. **OSHA Survey**: Participants in this survey are chosen by stratified sample by OSHA.

F. Describe how the program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. List any field or regional services.

Strategic planning is conducted each year and an Operational Plan for the Workers' Health and Safety program is developed. The Operational Plan includes program descriptions, timelines, milestones, projects and quick hits. Project management software (Microsoft Project) is used to track progress and milestones, and the operational plan is reviewed on a monthly basis.

In addition to staff located at Agency headquarters in Austin, the Workers' Health and Safety program employs 32 safety and health professionals with the OSHCON program who work in 18 of the Commission's field offices across the state.

G. If the program or function works with local units of government, (e.g., Councils of Governments, Soil and Water Conservation Districts), please include a brief, general description of these entities and their relationship to the agency.

The program works with a variety of local units of government in the following ways:

1. inspections are conducted for those that are identified as Hazardous Employers (see explanation of Hazardous Employer Program in Section M);
2. investigations are conducted for those which have safety violations reported against them (see explanation of Safety Violations Hotline in Section B);
3. safety and health training is provided regularly to government entities upon request;
4. research and injury/illness data analysis are provided regularly to government entities upon request; and
5. safety consultations are available upon request.

H. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

The following chart reflects the funding sources for the Workers' Health and Safety program for FY 2002. This is the only Commission program that currently receives federal funds.

General Revenue		$2,227,076.19
Federal Funds		
RSOH CFOI Grant	183,781.31	
OSHCON Grant	1,843,646.49	
OSHA Data Collection Grant	88,602.18	
MSHA Grant (not renewed after FY 02)	314,389.79	
FACE Grant (not renewed after FY 02)	82,671.25	
Total Federal Funds		$2,513,091.02
Appropriated Receipts		$ 284,109.28
Earned Federal Funds		$ 224,406.00
Total		**$5,248,682.49**

The OSHA Data Collection Grant is figured by the Department of Labor by allotting $23 per survey unit.

Funding increases to the OSHCON grant base are determined by the Department of Labor as a percentage or share of funding received based on performance in the following areas:

- Percent of consultation visits conducted in high-hazard establishments (goal is 90%)
- Percent of initial visits to small businesses (goal is 90%)
- Percent of serious hazards verified as corrected no later than ninety (90) days after the correction due date (goal is 95%)
- Total number of visits (initial, training and assistance, follow-up) planned vs. actual (goal is 80% of planned)

The more standards met, the greater percentage of funds to be received.

I. Are current and future funding resources appropriate to achieve program mission, goals, objectives, and performance targets? Explain.

Yes. As it currently exists, the program can meet all goals and expectations with the current funding.

J. Identify any programs internal or external to the agency that provide identical or similar services or functions. Describe the similarities and differences.

Safety and Health Training:

Several entities outside of the Commission provide training and publications to employers, to include: workers' compensation insurance carriers; the Texas Department of Health; State Office of Risk Management (SORM); the Occupational Safety and Health Administration (OSHA); the National Safety Council; the National Institute of Occupational Safety and Health (NIOSH); the Centers for Disease Control (CDC); and other trade and labor associations. Some of these entities, however, have limited jurisdiction. Private companies that offer safety and health training make a profit from their services, while Workers' Health and Safety provides training on a cost-recovery basis. The Program has access to many areas of expertise and data sources within the organization, which enable it to provide a broad knowledge base to its customers.

Consultations: Workers' compensation insurance carriers may provide consultative services to their policyholders as a part of the required accident prevention services. There is typically no charge by the insurance carrier for periodic assistance of this nature. Private safety and health professionals and companies also provide safety and health consultations, but they charge their customers for this service.

Data Analysis and Research: Some workers' compensation insurance carriers and trade associations do produce studies of workplace injury and illness data.

Identification of Employers with High Injury Rates: OSHA analyzes the results of its Annual Survey, which is conducted by the Workers' Health and Safety program in Texas, to identify trends by industry and type of occupational injury or illness. The Annual Survey enables OSHA to identify employers with high injury rates, which it uses to target programmed inspections. However, the Survey uses only a sample of Texas employers and compiles data from the OSHA 300 logs.

Hotline for Reporting Safety Violations: The Occupational Safety and Health Administration (OSHA) also provides a free hotline (800-321-OSHA) for reporting workplace safety or health emergencies. The service provides a 24-hour point of contact so that those who want to notify OSHA as soon as possible of imminent dangers on the job can do so. OSHA's jurisdiction is limited and does not include public employers (except Federal).

K. Discuss how the program or function is coordinating its activities to avoid duplication or conflict

with the other programs listed in Question J and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

The Division works closely with Region VI of OSHA with partnerships and initiatives to compliment federal injury prevention efforts. The OSHCON program supports OSHA's strategic goals and initiatives as part of the grant requirements.

L. Please provide any additional information needed to gain a preliminary understanding of the program or function.

The following tables highlight performance in the various health and safety programs administered by the Commission.

HAZARDOUS EMPLOYER PROGRAM	Year								
	1995	1996	1997	1998	1999	2000	2001	2002	01/01 - 06/30 2003
Total employers identified	671	449	140	92	637	737	1,013	850	432
Private employers	N/A	N/A	N/A	N/A	553	649	913	750	401
Public employers	N/A	N/A	N/A	N/A	84	88	100	100	31
Workers employed	140,965	60,896	26,212	35,415	147,296	136,669	125,769	206,025	83,726
Percent reduction in injury rates	52%	51%	66%	22%	28%	72%	73%	49%	N/A

REJECTED RISK EMPLOYER PROGRAM	Year								
	1995	1996	1997	1998	1999	2000	2001	2002	01/01 - 06/30 2003
Employers identified	330	349	308	157	162	215	346	299	108
Workers employed	9,589	18,539	11,959	4,101	4,449	5,910	13,960	12,274	6,754
Percent reduction in injury rates	24%	45%	51%	59%	34%	37%	35%	46%	N/A

OCCUPATIONAL SAFETY AND	Year

HEALTH CONSULTATION (OSHCON)	1995	1996	1997	1998	1999	2000	2001	2002	01/01 - 06/30 2003
Employer consultations	1,710	2,586	2,561	2,725	2,887	2,880	3,074	3,011	1,659
Number of consultations	2,745	2,919	2,862	2,907	2,955	3,023	3,235	3,190	1,692
Workers employed	94,190	124,813	124,197	130,633	132,620	134,364	138,107	141,622	76,243
Percent reduction in injury rates	10%	16%	14%	15%	12%	18%	34%	52%	N/A

ACCIDENT PREVENTION SERVICES	Year								
	1995	1996	1997	1998	1999	2000	2001	2002	01/01 - 06/30 2003
Policyholders inspected	337	368	343	404	241	404	395	379	189
Percent reduction in injury rates	N/A	N/A	N/A	N/A	N/A	16%	24%	43%	38%

SAFETY VIOLATIONS HOTLINE	Year								
	1995	1996	1997	1998	1999	2000	2001	2002	01/01 - 06/30 2003
Health and safety complaints	759	594	616	638	700	654	528	560	206
Employers with safety hazards identified	211	162	165	181	117	251	247	215	192
Safety hazards corrected	330	198	190	219	162	352	477	301	115

SAFETY TRAINING PROGRAMS	Year								
	1995	1996	1997	1998	1999	2000	2001	2002	01/01 - 06/30 2003
Employers receiving training	2,368	1,635	855	2,688	1,817	2,210	1,746	1,442	464
Workers receiving training	6,167	5,422	3,084	7,321	3,950	4,108	4,313	2,969	1,589
SAFETY MATERIALS DISTRIBUTED	**Year**								
	1995	1996	1997	1998	1999	2000	2001	2002	01/01 - 06/30 2003
Drug-free workplace guides distributed	2,818	3,344	2,288	2,935	1,455	1,409	4,704	10,239	8,697
Safety publications distributed	59,553	102,815	83,364	92,280	80,168	102,431	229,152	505,917	347,028
Safety videos loaned	7,332	7,037	6,825	7,072	6,529	6,818	6,271	6,370	3,450

M. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. If this is a regulatory program, please describe:

- why the regulation is needed;
- the scope of, and procedures for, inspections or audits of regulated entities;
- follow-up activities conducted when non-compliance is identified;
- sanctions available to the agency to ensure compliance; and
- procedures for handling consumer/public complaints against regulated entities.

1. Accident Prevention Services

Why the regulation is needed: This program is needed to ensure that insurance carriers that write workers' compensation insurance in Texas provide accident prevention services to their policyholders as required by Section 411.061 of the Texas Workers' Compensation Act. The required accident prevention services are intended to safeguard Texas workers from occupational injuries and illnesses.

The scope of, and procedures for, inspections or audits of regulated entities: All insurance carriers that write workers' compensation insurance in Texas are regulated by this program. Companies are inspected on a cyclical basis every other year, along with select policyholders to verify that accident prevention services have been provided as indicated by the carriers. Policyholders are chosen for inspection using various criteria, including premium amount; number of injuries, illnesses, and fatalities; number of hazard reports to the Safety Violations Hotline, and status as a Hazardous Employer.

Follow-up activities conducted when non-compliance is identified: If an insurance carrier does not pass inspection, a re-inspection is conducted within 180 – 270 days, and the carrier is required to reimburse the Commission for the cost of the re-inspection.

Sanctions available to the agency to ensure compliance: All violations found during any insurance carrier inspection are referred to the Commission's Compliance and Practices Division, which then issues administrative penalties.

Procedures for handling consumer/public complaints against regulated entities: If a policyholder makes a complaint against their insurance carrier, then that policyholder's file is reviewed during that carrier's programmed inspection. Depending on the nature of the complaint, the inspection of the carrier in question may be accelerated to address serious issues.

2. Hazardous Employer Program

Why the regulation is needed: Section 411.041 of the Texas Workers' Compensation Act requires the Workers' Health & Safety Division to identify employers who are hazardous. The law defines a hazardous employer as one whose injury rate is greater than the rate to be expected for their industry (in their SIC code). The intent of the program is to make these employers aware of how their occupational injury/illness histories compare to the industry norms, and to encourage them to institute accident prevention programs to prevent future incidents.

The scope of, and procedures for, inspections or audits of regulated entities: Employers subject to scrutiny by the Hazardous Employer program are those with workers' compensation insurance and those without workers' compensation coverage who have at least five employees. Employers are defined by the combination of their Federal Employer Identification Number (FEIN) and their Standard Industrial Classification (SIC) code. Employment figures used are the highest employment in any one month during the 12-month audit period under consideration. Injuries used to compute the employer's injury rate are fatalities, occupational diseases regardless of lost time and injuries resulting in at least seven calendar days of lost time. The expected injury rate is the rate for the employer's SIC code contained in the Bureau of Labor Statistics Survey of Occupational Injuries.

Employers are given the opportunity to verify the information used to determine their status as hazardous. Quarterly cycles are used, during which each employer not already on the program has its injury rate computed and compared to the expected injury rate. Each quarter claims are reviewed, duplicate claims are eliminated, and missing data is completed. The employer is asked then to verify their FEIN, SIC, employment and injury information. Once the data is verified, it is reevaluated and the injury rate recomputed, which either drops the employer from consideration or identifies the company as hazardous.

Small employers, with less than 20 employees in all their SIC codes combined, can avoid being placed on the hazardous employer list by requesting an OSHCON consultation within 30 days of receiving notification of tentative identification. They must complete the consultation within 90 days of notification.

Once identified, a private employer remains on the hazardous employer list for 12 months.

Identified public employers must obtain the services of an Approved Professional Source. They can obtain the Approved Professional Source from their insurance carrier or from the Commission Approved Professional Source list. The Approved Professional Source must audit the employer's current safety program and develop an accident prevention plan. The employer must implement the accident prevention plan and pass an inspection by the Commission.

Follow-up activities conducted when non-compliance is identified: If a public sector employer passes the hazardous employer inspection and their injury rate at the time of the inspection is at or below the BLS rate, they are off the program. If the employer passes the inspection, but their injury rate is above the BLS rate, the employer is no longer considered hazardous, but they are put in monitoring status for six months. At the end of those six months, the employer is removed from monitoring status. If, however, the employer's injury rate is still significantly above the BLS rate, they will be kept on monitoring status for an additional six months.

If a public employer fails the inspection, they are kept as hazardous for an additional six months. During that period, they must make written progress reports every 60 days. After six months, a different inspector will conduct a second inspection.

Sanctions available to the agency to ensure compliance: If an employer does not pass the second inspection, they may be referred to Compliance and Practices for possible administrative penalties.

Procedures for handling consumer/public complaints against regulated entities: N/A

3. Rejected Risk Program

Why the regulation is needed: Texas Mutual Insurance Company is the insurer of last resort for workers' compensation in Texas. Texas Mutual identifies employers for the Rejected Risk Program in accordance with the Texas Insurance Code Article 5.76. The law requires Workers' Health and Safety to inspect the accident prevention plans of these employers.

The scope of, and procedures for, inspections or audits of regulated entities: Employers subject to the Rejected Risk Program are generally small employers, those who haven't been in business very long, and those with poor safety records. Texas Mutual will also provide the Approved Professional Source to conduct a consultation to help the employer develop an accident prevention plan. Once the plan has been developed, the employer is given six to nine months to implement it. During that 6-9 month period, a Commission inspector will perform a compliance inspection to see that the employer has implemented the accident prevention plan.

Follow-up activities conducted when non-compliance is identified: Texas Mutual Insurance Company decides how long an employer stays on the program, which is usually two to four years. If one of the components is not effectively implemented, the employer fails the inspection. The employer may then cancel their coverage within 30 days. If they do not cancel, Texas Mutual may elect to cancel the employer's coverage.

Sanctions available to the agency to ensure compliance: If, after failing an inspection, the employer does not cancel their coverage and Texas Mutual does not elect to cancel the employer's coverage, the employer is referred to the Compliance and Practices Division of the Commission for possible administrative penalties.

Procedures for handling consumer/public complaints against regulated entities: N/A

4. Drug-Free Workplace Program

Why the regulation is needed: Section 411.091 of the Texas Workers' Compensation Act requires employers to adopt a policy designed to eliminate drug abuse and its effects in the workplace.

The scope of, and procedures for, inspections or audits of regulated entities: All Texas employers with 15 or more employees and workers' compensation insurance coverage are subject to this statute. Random audits of employers' drug policies are conducted (approximately 10 a month). In addition, qualified employers are automatically audited if they have had an accident resulting in a fatality; have failed to provide a copy of their Drug Abuse Policy to the Commission during a consultation, random audit, training, and/or inspection; have a deficiency noted on a Commission inspector's Compliance Review Checklist; and/or have been newly identified as a Hazardous or Rejected Risk employer.

Follow-up activities conducted when non-compliance is identified: Employers with Drug Abuse Policies that are not in compliance receive a notice that includes a list of the changes necessary to bring the policy into compliance; instructions for submitting an amended policy; and resources for further information and/or instructions.

Sanctions available to the agency to ensure compliance: Employers that do not respond or comply with the audit findings are referred to the Commission's Compliance and Practices Division and may be subject to administrative penalties.

Procedures for handling consumer/public complaints against regulated entities: N/A

N. Please fill in the following chart for each regulatory program. The chart headings may be changed if needed to better reflect the agency's practices.

Other than some appeals by employers designated as hazardous, the Commission does not receive complaints from the entities regulated by the health and safety program.

Texas Workers' Compensation Commission Exhibit 14B: Program or Function Information — Fiscal Year 2002	
Name of Program or Function	Medical Cost Containment
Location/Division	Austin Central Office
Contact Name	Judy Bruce, Director of Medical Review Division Bill Nemeth, M.D., Medical Advisor
Number of Budgeted FTEs, FY 2002	45.3*
Number of Actual FTEs as of August 31, 2002	33.8*

*For the FY 2002-2003 biennium a portion of the program FTEs and funding for the Medical Cost Containment program are reflected in the Compliance and Enforcement program. The reason for that allocation is that funding appropriated for the implementation of HB2600 was placed in the enforcement/compliance strategy. Funding and staff for the FY 2004-2005 biennium are allocated consistent with functions performed.

The medical cost containment functions are performed primarily by the Medical Review Division and the Office of the Medical Advisor.

B. What are the key services for this function or program? Describe the major activities involved in providing all services.

The Medical Cost Containment function works to ensure that injured employees receive quality health care delivered in a cost-effective manner. There are several sections performing major activities in providing the services of this function:

1. **Medical Rules and Guideline Development** is responsible for the research and analysis of economic factors and treatment protocols that form the basis for development of the medical rules, and fee, treatment and/or return to work guidelines. This section's primary purpose, through rule and guideline development, is to help ensure quality health care, injury-specific treatments and appropriateness of care while achieving effective medical cost containment. In developing or revising these rules and guidelines, the section may seek input from the Medical Advisory Committee and other pertinent work groups comprised of participants in the workers' compensation system.

2. **Reimbursement Administration** provides specialized work in the implementation of fee guideline policy. The functions include policy interpretation, training for external/internal system participants, and subsequent rule review and revision due to reimbursement guidelines.

3. **Medical Compliance Team** monitors the conduct of health care providers and insurance carriers involved in providing medical benefits for injured workers. The team conducts audits of health care providers to determine their compliance with the Texas Labor Code. Also, the team reviews medical complaint referrals to determine insurance carriers and health care providers compliance with the Texas Labor Code.

4. **Medical Quality Review** monitors health care providers for violations of statutes and rules and for the appropriateness of conduct relating to the delivery, evaluation, or remuneration of health care in the workers' compensation system. The Medical Advisor and the Medical Quality Review Panel provide medical expertise and recommendations. The major activities involve the identification of providers that fail to appropriately deliver health care, the collection and review of documentation relating to the delivery of the health care including review by the members of the Medical Quality Review Panel.

5. **List Management Group** is primarily responsible for the inclusion, removal and reinstatement of health care providers (MD, DO, DC, DDS, OD, DPM) to and from the Commission's Approved Doctor List (ADL) and the Designated Doctor List (DDL).

6. **Medical Benefits Services (MBS*)*** educates health care providers, insurance carriers, and other system participants about requirements under the Texas Workers' Compensation Act and Commission rules that primarily pertain to the delivery of medical benefits to injured employees.

   MBS conducts education programs in three different areas: Medical Review General Education Seminar, Impairment Rating Training Seminars for Designated Doctors and other Impairment Evaluating Doctors, and seminars concerning the implementation of effective return to work programs to limit the impact of on the job illness or injury on the injured employee and the employer. To further these educational programs, MBS has developed on-line and hard copy training programs for doctors applying to be on the Approved Doctor List and for persons developing a return to work program.

7. **Healthcare Network Advisory Committee** is statutorily charged with determining the feasibility of establishing regional workers' compensation health care delivery networks that encompass effective cost-control and monitoring mechanisms while ensuring quality medical outcomes.

C. When and for what purpose was the program or function created? Describe any statutory or other requirements for this program or function.

The Medical Cost Containment function, with the creation of the Medical Review division, was enacted in 1989 with the passage of what is now Chapter 413 of the Texas Labor Code. The division is responsible for monitoring health care providers, insurance carriers, and workers' compensation claimants who receive medical services to ensure the compliance of those persons with rules adopted by the Commission related to health care, including medical polices and fee guidelines. Additionally, the division is responsible for regulating health care providers who serve as designated doctors under chapter 408 of the Act.

Passage of House Bill 2600 during the 77th Legislative Session resulted in the addition of several new functions within the medical cost containment function. The Reimbursement Administration section was created to focus on the development and implementation of new guidelines using HCFA (now Centers for Medicare and Medicaid Services - CMS) policies and any other HB-2600 related projects. The legislation also created a Healthcare Network Advisory Committee to determine the feasibility of using networks in the workers' compensation system to contain medical costs.

The responsibilities of the Medical Advisor position were specifically identified to include controlling the

excessive utilization of health care services in the workers' compensation system and promoting higher quality and more efficient health care. Additionally, the legislation mandated the appointment of a Medical Quality Review Panel to assist the Medical Advisor in performing the duties required under Section 413.0511. House Bill 2600 also expanded the responsibilities of the list management function in processing all ADL and DDL applications for health care providers wanting to participate in the workers' compensation system.

D. Describe any important history not included in the general agency history section, including a discussion of how the services or functions have changed from the original intent. Will there be a time when the mission will be accomplished and the program or function will no longer be needed?

Guideline Development. Upon the passage of House Bill 2600 (77th Legislature), the requirements of §413.011 changed the Commission-developed treatment guidelines and authorizing the adoption of nationally recognized, scientifically valid and outcome-based treatment guidelines, to include return to work guidelines. Prior to the statutory change, the Commission had adopted and conducted revisions of four Commission treatment guidelines.

Medical Compliance. The Medical Compliance Team was originally established as the Regulation & Analysis Section in 1991 and its primary functions were to review medical complaint referrals for compliance with the Texas Workers' Compensation Act and to conduct medical audits of health care providers and insurance carriers to determine their compliance with the Texas Workers' Compensation Act Since that time, the team and its functions have changed quite a few times.

- The team's responsibilities expanded in 1994 to include the Spinal Surgery Second Opinion Process, which became its own section in 1995.
- Between 1996 and 1998, the team conducted health care provider audits, reviewed requests for admission to the Approved Doctor List, and reviewed designated doctor applications for admission to the Designated Doctor List.
- In 1999, the team was combined with other audit teams to conduct insurance carrier audits, health care provider audits, and reviews of medical complaint referrals.
- In 2002, the team was separated and since that time has been conducting health care provider audits and reviews of medical complaint referrals.

Spinal Surgery Second Opinion Process. A Spinal Surgery Second Opinion Section processed statutorily required second opinions on requests for spinal surgery. Upon the passage of House Bill 2600, the requirements of §413.014 folded spinal surgery cases into a mandated list of items requiring preauthorization. Consequently, Rule 133.206, which governed the spinal surgery second opinion process, was repealed and the activities of this section were phased out accordingly.

Healthcare Network Advisory Committee (HNAC). The Commission entered into a contract, on behalf of the HNAC, with Med Fx, Mill Valley, California, to conduct a feasibility study to determine whether fee-for-service regional workers' compensation health care delivery networks are feasible.

There will always be a need to provide educational services regarding, rulemaking on, and regulation of medical care in the workers' compensation system because the delivery of medical benefits to injured employees is a dynamic function. Other resources that may provide educational or regulatory functions do not commonly have system-wide perspective.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

The workers' compensation system participants most commonly affected by the Medical Cost Containment activities are healthcare providers, insurance carriers, employers and injured workers.

Qualifications for most of the functions performed by this program relate to the entity's licensure or certification. For instance, all insurance carriers licensed by the Texas Department of Insurance to write workers' compensation insurance and all public entities are impacted by the rules and regulations of the program. In FY 2002, two hundred fifty-one insurance companies wrote workers' compensation insurance coverage.

Effective September 1, 2003, if doctors wish to be approved for inclusion to the Approved Doctors List (ADL), they must have a clear status with their respective licensing board and be in good standing with the Commission. Prior to that time the statute allowed all doctors licensed in Texas to provide care to workers' compensation patients. If a doctor has been removed or sanctioned by the Commission and wishes to be reinstated to the ADL, the doctor must have an unrestricted license to practice at the time of reinstatement, overcome the conditions that resulted in the doctor's deletion and be in good standing with the Commission. Although the Commission is currently in the process of receiving and reviewing doctors' applications for ADL-certification, based on past billing data, approximately 30,000 doctors have billed for at least one workers' compensation patient per year.

F. Describe how the program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. List any field or regional services.

The rulemaking and education functions are primarily guided by statutory changes and Commission or management direction.

Medical Compliance Audit Program. The Medical Compliance Team identifies possible auditable issues, applies a risk-based selection criteria to the possible auditable issues and develops an audit plan that identifies the auditable issues, selection criteria, audit type, providers identified for audit, and the auditor assigned to conduct the audit. Management approves the audit plan before it is implemented.

An audit program that details each step of the audit and who is responsible for completing that step is developed for each type of audit. A letter of engagement is submitted to the health care provider requesting submission of medical records to the Commission for review. Upon receipt of the medical records, an auditor reviews the documentation for compliance with the Texas Labor Code. A preliminary report is submitted to the health care provider notifying the provider of the audit findings and requesting that the provider submit a written response to any findings with which the provider disagrees. Upon receipt of the provider's response, the response is incorporated into the audit report. The Commission reviews the response and provides the Commission's position modifying or maintaining the original finding. The final audit report is submitted to the health care provider. If the provider received payments in excess of the fee guidelines, then a refund order may accompany the final audit report. If the provider exceeded a fee guideline, then the Commission may bill the provider for the audit. If the health care

provider violated the Texas Labor Code, then referrals may be made to the Compliance & Practices Division to initiate the administrative violation process.

Medical Complaint Referrals. Medical complaint referrals from insurance carriers, health care providers and injured workers are submitted to the intake section of the Compliance & Practices Division. The Compliance & Practices Division records the referral into the violation records support system database, requests documentation needed to review the referral, and submits the referral to the Medical Review Division's Medical Compliance Team for review.

The Medical Compliance Team reviews the referral for compliance with the Texas Labor Code. Medical referrals that are in violation of the Texas Labor Code are referred back to the Compliance & Practices Division to initiate the administrative violation process. The medical referrals that are in compliance with the Texas Labor Code are referred back to the Compliance & Practices Division for closure.

Medical Quality Review. A flow chart is included in Subsection L that reflects the administration of the Medical Quality Review process.

Approved Doctor List (ADL) Management. Doctors on or applying to be on the ADL may be approved for inclusion, removed by Executive Director or Commissioner action, or reinstated (if previously removed).

Inclusion. Applications are received, reviewed and licenses are verified with the appropriate licensing authority. If the doctor has any disciplinary actions with the licensing board, a file is compiled with all the appropriate documentation and a Summary of Facts and Recommendation (SOF) document outlining the doctor's overall history. The recommendation is forwarded to the Medical Advisor for his approval and, subsequently, submission to Quality Medical Evaluation Team (QMET) for final recommendation and action. Once QMET has voted on the recommendation, the doctor will be notified of the Commission's approval or denial of the doctor's application to the ADL which includes the reasons for the action. Within 14 days after receiving the notice, the doctor may file a response that addresses the reasons given for the denial or an admission with restriction(s). If a response is not received by the 15th day after the doctor receives the notice, the action shall be final and no further notice shall be sent. If a response disagreeing with the action is timely received, the Commission shall review the response and shall notify the doctor of the Commission's final decision. If the final decision is to approve with restrictions or deny, the Commission's final notice shall explain the reason why the doctor's response did not convince the Commission to grant the doctor an unrestricted admission to the ADL.

Removal. There are two types of removals: Executive Director and Commissioner Approved Removals, pursuant to Commission Rule 180.26.

Executive Director Removal. If the doctor's license to practice in this state is revoked, suspended, or not renewed by the appropriate licensing authority or if the suspension or revocation is stayed, deferred, probated, or voluntarily surrendered, then the Executive Director has the authority to remove the doctor from the ADL. Notification procedures and a doctor's opportunity to respond are the same as those listed above.

Commissioner-Approved Removal. Health care providers on the ADL who are

sanctioned by their respective licensing authority, referred to the Commission by internal and external individuals or entities, or convicted of a crime related to health care or public welfare, etc. are presented to the Commissioners for action. Before being presented to the Commissioners, files are compiled with all the appropriate documentation and a Summary of Facts and Recommendation (SOF) outlining the doctor's overall status history. The staff recommendation is forwarded to the Medical Advisor for his approval and, subsequently, submitted to QMET. Once QMET has voted on the recommendation, notice is sent to the doctor of the Commission's intent to take action. Not later than 20 days after receiving the notice, a doctor may request a hearing at the State Office of Administrative Hearings by filing such a request with the Chief Clerk of Proceedings at the Commission. If no request for hearing is filed within the time allowed, the recommendation for sanction will be reviewed by the commissioners at a public meeting and a decision made. If a hearing was held, the commissioners shall review the decision of the administrative law judge after the hearing is held. The case is presented to the Commissioners by the Medical Advisor and Director of Medical Review. Final Orders containing the Commissioners' decision are mailed to the doctor.

Reinstatement. Requests for reinstatement are received from doctors. Licensure history is verified with the appropriate licensing authority, and additional documentation is compiled to create a Summary of Facts and Recommendation outlining the doctor's license, disciplinary and billing history with the Commission. The recommendation is forwarded to the Medical Advisor for approval and, subsequently, submitted to QMET for final recommendation. If, in the Medical Advisor's opinion, the doctor has not met the requirements for reinstatement, the Commission shall notify the doctor of the Commission's intent to recommend to the Commissioners that the doctor be denied reinstatement to the ADL. Within 14 days after receiving the notice, a doctor may file a response that addresses the reasons given for the denial of request. The Medical Advisor shall review the response and make a recommendation that is considered by QMET. The Medical Advisor and Director of Medical Review, with QMET's final recommendation, present the reinstatement case to the Commissioners for final action. Final Orders on the Commissioner's decision are mailed to the doctor.

A flow chart of the ADL management process is included in Subsection L.

Healthcare Network Advisory Committee. The Medical Advisor is the chairman of the HNAC, and the Commission provides administrative and procurement services as directed by statute.

G. If the program or function works with local units of government, (e.g., Councils of Governments, Soil and Water Conservation Districts), please include a brief, general description of these entities and their relationship to the agency.

The program works with local units of government in their role as "insurance carriers" for political subdivisions in the same manner as the program works with all insurance carriers.

H. Identify all funding sources and amounts for the program or function, including federal grants and

pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

The program is primarily funded through General Revenue. Two of the program's functions generate appropriated receipts -- Medical Benefits Services and Medical Compliance Audits.

Funding Source	FY 2002 Expenditures
General Revenue	$1,412,667
Appropriated Receipts	269,331
Total	**$1,681,998**

In addition, with statutory authority for both entities, the Commission requested and the Texas Mutual Insurance Company has provided a $2.2 million grant in FY2003 for the purposes of controlling and lowering medical costs in the Commission system and ensuring the delivery of quality medical care.

The feasibility study and initial creation of a network by the Healthcare Network Advisory Committee is being funded by the Commission's Subsequent Injury Fund. The cost of those activities is statutorily limited to a total of $1.5 million.

I. Are current and future funding resources appropriate to achieve program mission, goals, objectives, and performance targets? Explain.

Funding is appropriate to provide current services. However, one method for improving quality services would be to perform more on-site compliance audits. Additional funds would be needed to change from the current desk-audit practices.

J. Identify any programs internal or external to the agency that provide identical or similar services or functions. Describe the similarities and differences.

There are other program areas within the Commission that provide education and training services. However, Medical Benefit Services is the only program area that provides education and training specifically concerning the medical benefits.

Healthcare Provider Regulation. Within the program, there are two types of healthcare provider reviews being conducted. The Medical Quality Review Team conducts quality review audits of health care providers and insurance carriers, focusing on the appropriateness of medical treatment provided with medical policies and recognized treatment guidelines. The Medical Compliance Team's focus is conducting medical compliance audits of health care providers with regards to the appropriateness of payment in accordance with the Texas Labor Code, Commission's Rules and the fee guidelines.

Other licensing boards provide reviews of healthcare, i.e., Board of Medical Examiners, Board of Chiropractic Examiners. The main difference between the licensing boards and the Commission's review and regulation functions is that the licensing boards regulate all health care providers, whereas the Commission only regulates those in the workers' compensation system.

K. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question J and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

A training alliance comprised of all Commission programs providing training has been formed to provide a forum for discussing common training issues and coordinating the use of resources and expertise.

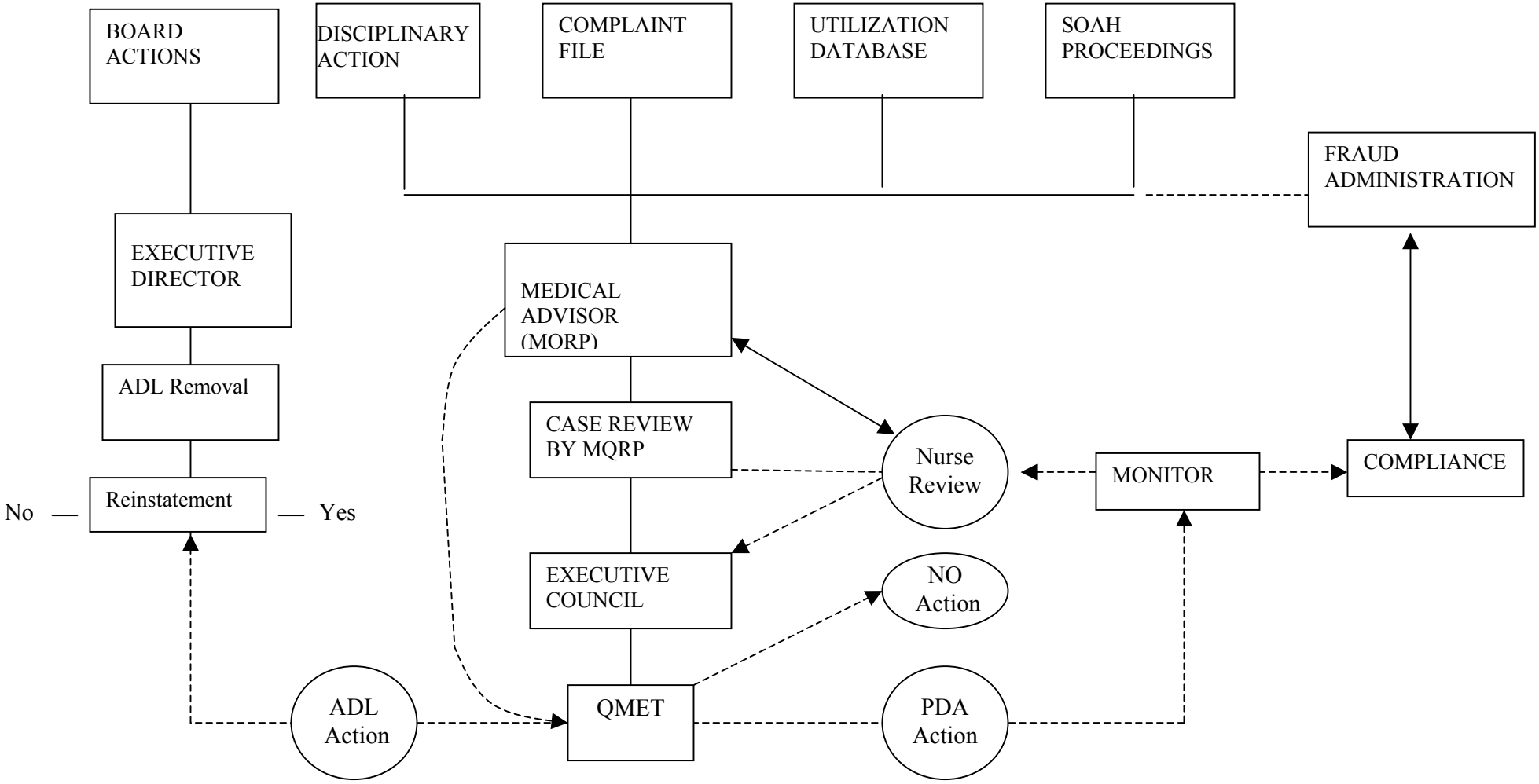
The quality and compliance reviews of healthcare providers are coordinated through the division. Quality related issues are submitted to the Medical Advisor to determine if the Medical Quality Team or the Medical Compliance Team should conduct the review.

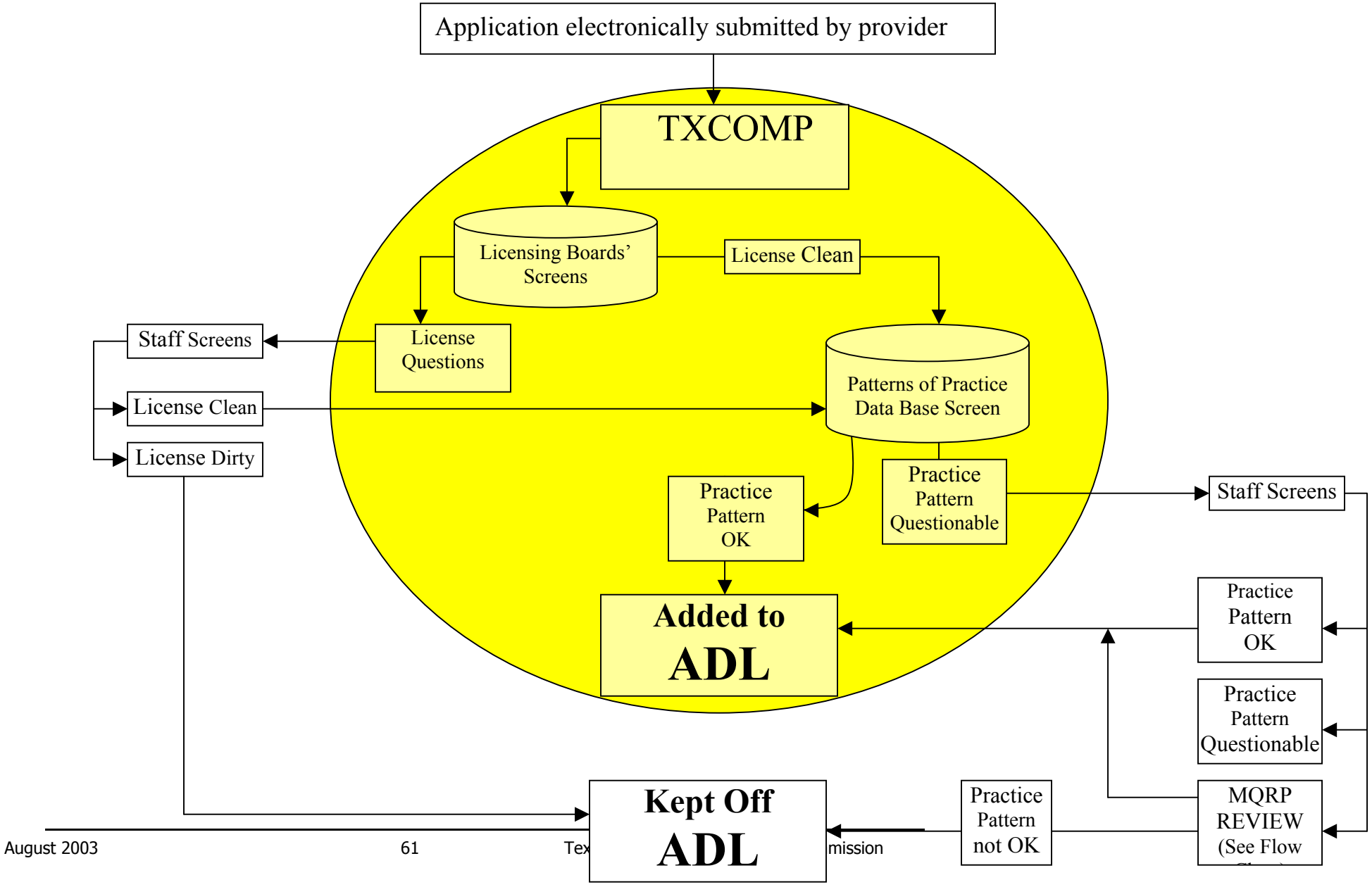
The Medical Advisor works directly with the Executive Directors of the listed licensing boards to coordinate the Commission's efforts and those of the boards.

L. Please provide any additional information needed to gain a preliminary understanding of the program or function.

Flow charts for the Medical Quality Review Panel process and the ADL Management process are included on the following pages.

Medical Quality Review Process




Application electronically submitted by provider
TXCOMP
Licensing Boards' Screens
License Clean
Staff Screens
License Questions
Patterns of Practice Data Base Screen
License Clean
License Dirty
Practice Pattern OK
Practice Pattern Questionable
Staff Screens
Added to ADL
Practice Pattern OK
Practice Pattern Questionable
Kept Off ADL
Practice Pattern not OK
MQRP REVIEW (See Flow

M. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. If this is a regulatory program, please describe:

- why the regulation is needed;
- the scope of, and procedures for, inspections or audits of regulated entities;
- follow-up activities conducted when non-compliance is identified;
- sanctions available to the agency to ensure compliance; and
- procedures for handling consumer/public complaints against regulated entities.

1. Medical Compliance Audit Program

Why the regulation is needed: Regulation is required to ensure compliance with the Texas Labor Code, medical policies and fee guidelines. The main purpose is to regulate the medical cost of the workers' compensation system. Medical cost is one of the contributing factors in the high cost of the Texas workers' compensation system. By conducting audits and complaint referrals, the Commission is taking action to control medical cost. Also, both the audits and complaint reviews send signals to the system participants that the Commission is taking action to ensure compliance and thereby entice participants to remain in compliance.

The scope of, and procedures for, inspections or audits of regulated entities: The scope of the medical compliance audits is all medical billing and medical forms reporting of the health care provider. The audits are conducted in accordance with Rule 134.900 of the Texas Workers' Compensation Commission and the Generally Accepted Government Audit Standards. Section 413.020 of the Texas Labor Code enables the Commission to charge for the audit. Section 413.016 directs the Commission to order a refund if charges are paid to the health care provider in excess of the medical policies or fee guidelines.

Follow-up activities conducted when non-compliance is identified: Section 413.013 (4) requires the Commission to increase the intensity of the review for compliance with the medical policies or fee guidelines if the health care provider has established a practice or pattern in charges and treatments inconsistent with the medical policies and fee guidelines.

Sanctions available to the agency to ensure compliance: Section 413.016 directs the Commission to order a refund if charges are paid to the health care provider in excess of the medical policies or fee guidelines. The section also directs the Medical Review Division to refer the health care provider alleged to have violated the Texas Labor Code to the Compliance and Practices Division. Section 414.007 of the Texas Labor Code states the Compliance and Practices Division shall review information and referrals received from the Medical Review Division and may initiate violation proceedings.

Procedures for handling consumer/public complaints against regulated entities: Consumer complaints may be considered in the audit selection process to determine if a health care provider should be audited. Consumer complaint referrals may also be reviewed by the Medical Compliance Team to initiate the administrative violation process.

2. Medical Quality Review

Why the regulation is needed: Review of healthcare provided in the workers' compensation system is needed to ensure quality care in the system and to decrease the expenses of health care costs may be reviewed.

The scope of, and procedures for, inspections or audits of regulated entities: All doctors and carriers providing services in the workers' compensation system.

Follow-up activities conducted when non-compliance is identified: Sanctions may be imposed, reviews may be expanded and re-reviewed and monitored to ensure compliance with the sanctions.

Sanctions available to the agency to ensure compliance: Sanctions include: Progressive Disciplinary Agreements that are expected to improve medical quality and cost containment, suspension or deletion of a doctor from the Approved Doctor List or Designated Doctor List, reduction of allowable reimbursement, mandatory preauthorization, supervision or peer review monitoring, restrictions on appointment and mandatory participation in training classes.

Procedures for handling consumer/public complaints against regulated entities: The Medical Quality Team works with C&P intake to screen and respond to consumer/public complaints.

N. Please fill in the following chart for each regulatory program. The chart headings may be changed if needed to better reflect the agency's practices.

See performance data provided in subsection L of the Compliance and Enforcement program description.

A. Please complete the following chart.

Texas Workers' Compensation Commission Exhibit 14C: Program or Function Information — Fiscal Year 2002	
Name of Program or Function	Compliance and Enforcement
Location/Division	Austin Central Office
Contact Name	Stephen Quick, Director of Compliance and Practices Division
Number of Budgeted FTEs, FY 2002	59.8*
Number of Actual FTEs as of August 31, 2002	58.9*

* For the FY 2002-2003 biennium a portion of the program FTEs and funding for the Medical Cost Containment program are reflected in the Compliance and Enforcement program. The reason for that allocation is that funding appropriated for the implementation of HB2600 was placed in the enforcement/compliance strategy. Funding and staff for the FY 2004-2005 biennium are allocated consistent with functions performed.

B. What are the key services of this function or program? Describe the major activities involved in providing all services.

The Compliance & Practices Division is responsible for this function and is organized into three primary sections: 1) The Office of Investigations; 2) Audits & Enforcement; and 3) Violation Processing (aka Intake).

1. The **Office of Investigations** is charged with investigating allegations of workers' compensation fraud. Investigations may lead to prosecution and recovery of money gained through fraudulent schemes.

2. **Audits and Enforcement (A and E)** conducts performance reviews of insurance carriers as mandated by TLC 414.004. These audits are performed on-site either at the carriers' Austin representatives' offices or at the carriers' offices. Audits of governmental entities are performed as desk audits at the Commission. A&E monitors carriers, employers, and attorneys for compliance with the Texas Workers' Compensation Act and Rules through review of violation referrals submitted to the Division from external sources and intra-agency sources. A&E enforces compliance by issuing penalties, warnings, and educational letters to violators.

3. **Violation Processing** reviews information and referrals concerning alleged violations of the Act and Rules. After conducting an initial review, referrals may be made to other agencies or divisions within Commission or initiation of administrative violation proceedings may be initiated.

C. When and for what purpose was the program or function created? Describe any statutory or other requirements for this program or function.

The Office of Investigations was established under §414.005 of the Labor Code to investigate allegations of workers' compensation fraud. The statutory provision was included in the Act as it was reformed in 1989. That statute states that the Compliance and Practices division shall maintain an investigation unit to conduct

investigations relating to alleged violations of the Workers' Compensation Act or Commission rules, with particular emphasis on violations of Chapters 415 and 416 of the Labor Code.

The Audits and Enforcement program was created to fulfill the monitoring duties and the carrier performance review requirements of Chapter 414 of the Texas Workers' Compensation Act.

D. Describe any important history not included in the general agency history section, including a discussion of how the services or functions have changed from the original intent. Will there be a time when the mission will be accomplished and the program or function will no longer be needed?

Since the statute designates Compliance and Practices as the division responsible for imposing penalties and sanctions against violators, there is no foreseeable time when the functions performed by Audits & Enforcement will no longer be necessary to meet the statutorily mandated compliance objectives.

The referral and intake functions have not changed significantly; however, with the development and implementation of up-to-date electronic database systems, the efficiency and effectiveness of the referral processing system has been greatly enhanced.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

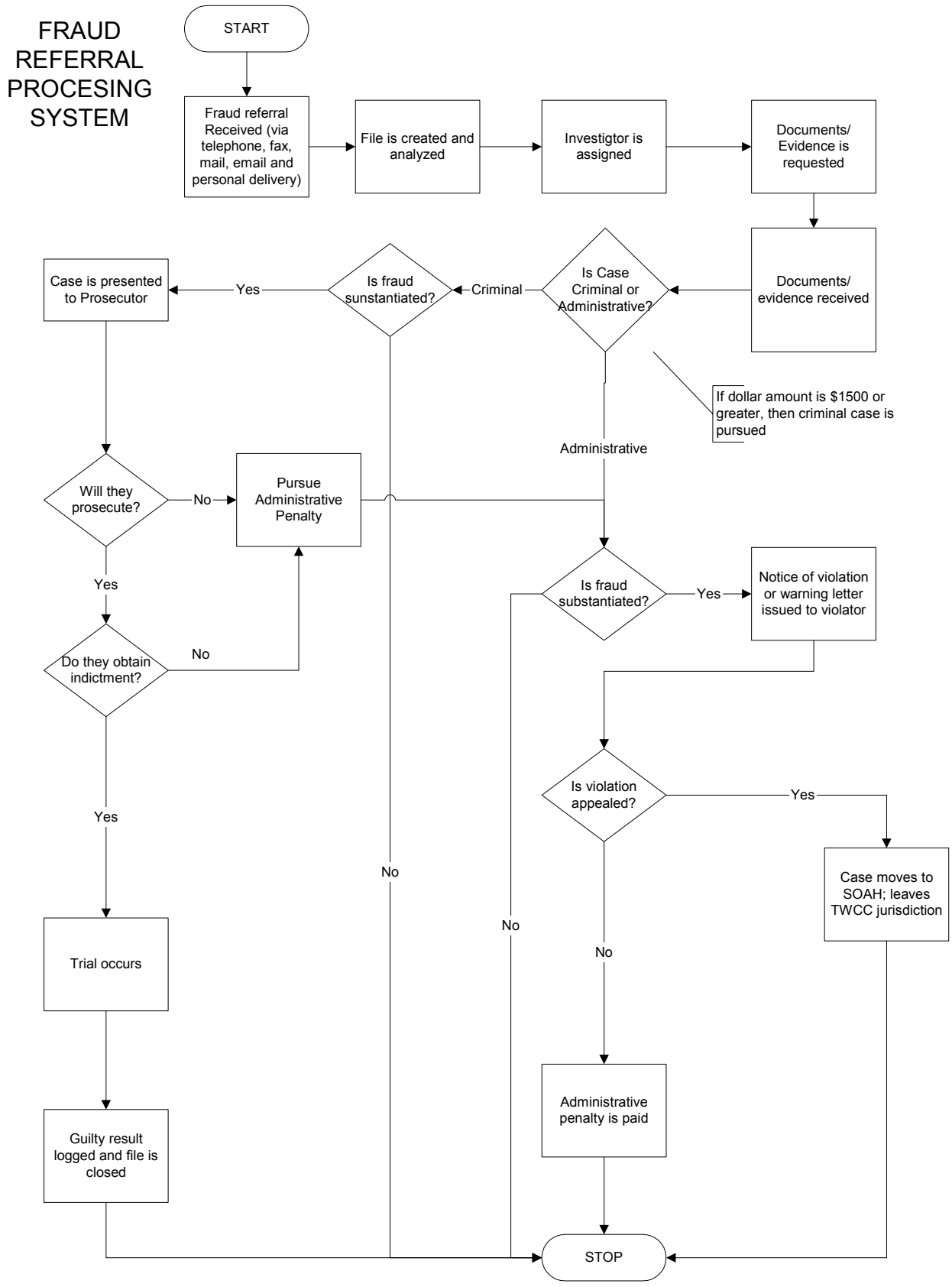
The functions of the Office of Investigation affect all system participants. Approximately 75% of fraud allegations are against injured workers. Approximately 15% of the fraud allegations are against health care providers. The other 10% of fraud allegations involve attorneys, carriers and employers. Employers, employees, insurance carriers, and Texas consumers pay the cost of fraud in lost jobs and profit, lower wages and benefits, and higher costs for services and premiums.

Audits and violation referral reviews affect insurance carriers by bringing about improved compliance through carrier acknowledgement of violations and through carrier action plans to improve compliance. Injured workers and health care providers are affected by improvements in benefit delivery that result from enforcement action.

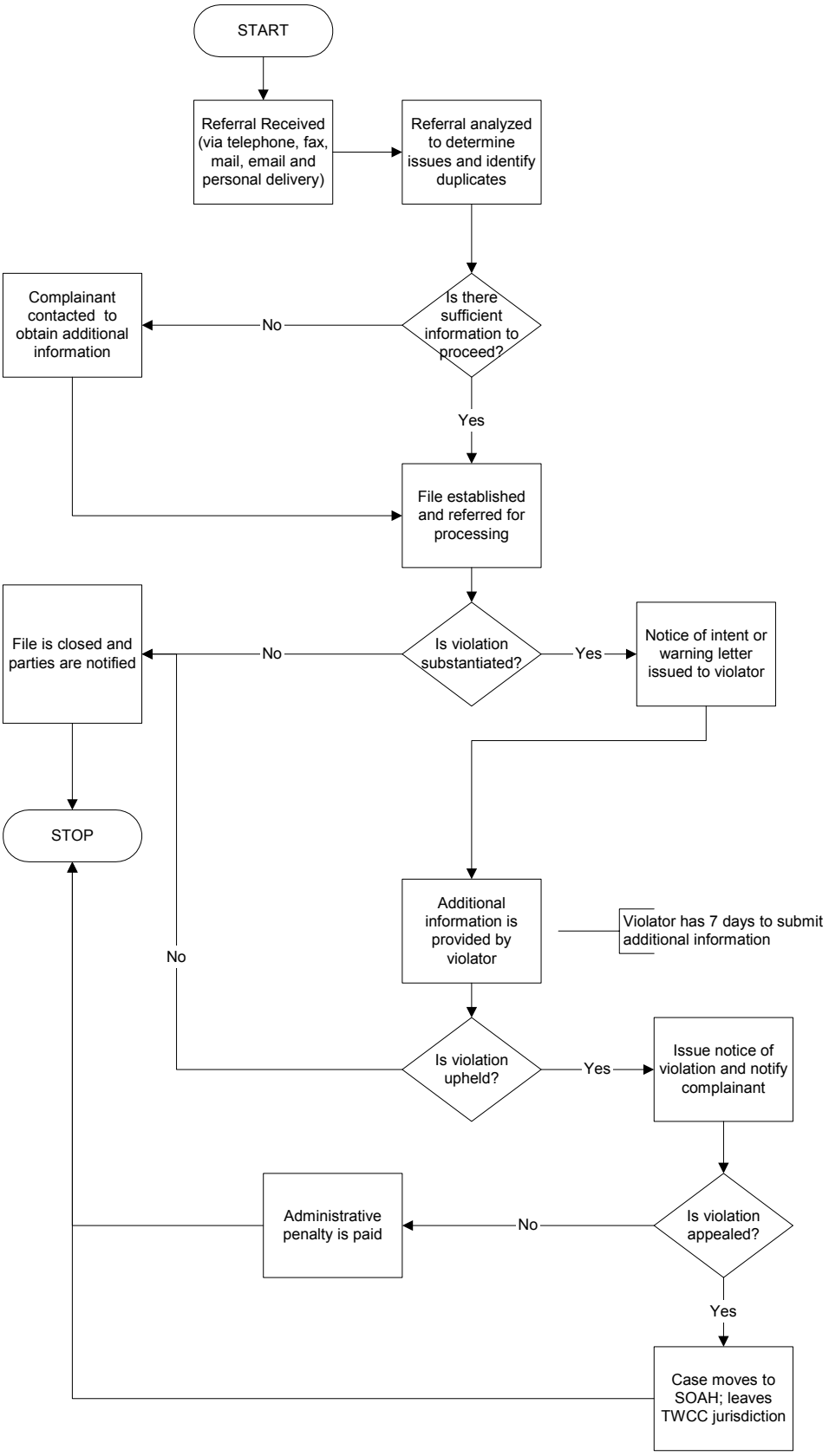
F. Describe how the program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. List any field or regional services.

The Office of Investigations has 17 investigators -- 9 located in the central office; three in the Fort Worth Field Office; one each in Houston East and West Field Offices; one in the El Paso Field Office, and two in the San Antonio Field Office. Referrals of alleged fraud are received in all locations; however, the central office serves as the primary location for intake referrals. After assigning a case number to a referral, the case is assigned to an investigator. There are no statutory timeframes for completing an investigation in the Labor Code; however, other statutory timeframes such as those in the Penal Code may apply.

The following flow charts reflect how fraud and allegations of administrative violations are handled.


FRAUD REFERRAL PROCESING SYSTEM
START
Fraud referral Received (via telephone, fax, mail, email and personal delivery)
File is created and analyzed
Investigtor is assigned
Documents/ Evidence is requested
Documents/ evidence received
Is Case Criminal or Administrative?
Criminal
Is fraud sunstantiated?
Yes
Case is presented to Prosecutor
If dollar amount is $1500 or greater, then criminal case is pursued
Administrative
Will they prosecute?
No
Pursue Administrative Penalty
Yes
Do they obtain indictment?
No
Yes
Trial occurs
Guilty result logged and file is closed
No
Is fraud substantiated?
Yes
Notice of violation or warning letter issued to violator
Is violation appealed?
Yes
Case moves to SOAH; leaves TWCC jurisdiction
No
Administrative penalty is paid
No
STOP

VIOLATION REFERRAL PROCESING SYSTEM



G. If the program or function works with local units of government, (e.g., Councils of Governments, Soil and Water Conservation Districts), please include a brief, general description of these entities and their relationship to the agency.

The Office of Investigations works with the Texas Department of Insurance, the Texas Workforce Commission, the Texas Department of Public Safety, the State Office of Risk Management, the Texas Mental Health and Mental Retardation and numerous other state agencies. The Office of Investigation also works with numerous federal law enforcement agencies such as the FBI and the Postal Service. The Office of Investigations works as a collaborative effort with these state and federal agencies to identify fraudulent schemes, prevent fraud and present cases for prosecution.

Additionally, the Office of Investigations works with local authorities, such as district attorneys, to prosecute cases. Investigations that are ripe for criminal prosecution are presented to local authorities. If the prosecuting authority accepts the case, the Commission remains involved in providing documentation and expertise needed for prosecution of the case.

Since local units of government are required by statute to maintain workers' compensation insurance, they are a party that must also be monitored for compliance with the Texas Workers' Compensation Act and rules. Non-compliance may result in monetary penalties for these local units of government.

H. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Funding Source	FY 2002 Expenditures
General Revenue	$2,888,578
Appropriated Receipts	186,795
Total	**$3,075,373**

The Compliance and Enforcement program generates appropriated receipts through the collection of administrative penalties. By Appropriations Act rider, the amount appropriated to the agency from penalty collections is limited to $100,000 per year.

I. Are current and future funding resources appropriate to achieve program mission, goals, objectives, and performance targets? Explain.

The current funding resources are appropriate to achieve program mission, goals, objectives and performance targets.

J. Identify any programs internal or external to the agency that provide identical or similar services or functions. Describe the similarities and differences.

The State Office of Risk Management, the Texas Department of Mental Health and Mental Retardation, the Texas Youth Commission, the Texas Department of Criminal Justice and the Department of Human

Services, and other various state agencies all have investigative units to identify "wrong doings" by their employees which may include workers' compensation fraud. Many large insurance carriers have Special Investigation Units that identify possible fraudulent activity that affects their company or policy- holders. The Texas Mutual Insurance Company has a specialized program established to identify, prevent, and prosecute workers' compensation fraud.

There are no other programs that provide similar functions to that of Audits & Enforcement.

K. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question J and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

If a fraud investigation involves a state employee, the Office of Investigation has interagency agreements with the affected agency and the State Office of Risk Management (which serves as the state's insurance carrier) to obtain and share information for the proper enforcement of laws. The unit also works with other insurance carriers to share information and obtain evidence for the proper enforcement of applicable laws, including working with the Texas Mutual Insurance Company as required by statute. The Office of Investigation also participates in federal Joint Task Forces meetings to share information regarding fraudulent schemes. The Office of Investigation also works with the National Insurance Crime Bureau.

L. Please provide any additional information needed to gain a preliminary understanding of the program or function.

The following tables provide detailed performance data relating to the work done by the Compliance and Enforcement program.

ADMINISTRATIVE REFERRALS

RECEIVED ADMINISTRATIVE REFERRALS BY VIOLATOR TYPE		
Violator Type	**FY01**	**FY02**
Carrier	5654	6944
Claimant	198	167
Employer	376	301
HCP	779	1586
Attorney	26	27
Other	276	126
TOTAL	**7309**	**9151**

COMPLETED ADMINISTRATIVE REFERRALS BY VIOLATOR TYPE		
Violator Type	**FY01**	**FY02**
Carrier	4036	6817
Claimant	29	192
Employer	337	325
HCP	671	1339
Attorney	5	25
Other	192	188
TOTAL	**5270**	**8886***

*Reported performance is based on change of violation types made in FY2003. Therefore, figure is not the same as reported for FY2002 performance measure.

REFERRALS FOUND WITH NO MERIT BY VIOLATOR TYPE		
Violator Type	**FY01**	**FY02**
Carrier	0	0
Claimant	0	1
Employer	0	0
HCP	0	3
Attorney	0	0
Other	0	0
TOTAL	**0**	**4**

PENALTIES BY VIOLATOR TYPE		
Violator Type	**FY01**	**FY02**
Carrier	1585	1666
Claimant	0	0
Employer	32	19
HCP	78	101
Attorney	2	2
Other	5	-1(withdrawal)
TOTAL	**1702**	**1787**

PENDING REFERRALS BY VIOLATOR TYPE		
Violator Type	**FY01**	**FY02**
Carrier	3409	2631
Claimant	265	20
Employer	132	84
HCP	436	548
Attorney	28	14
Other	200	48
TOTAL	**4470**	**3345**

AVERAGE DAYS TO COMPLETE ADMINISTRATIVE REFERRALS BY VIOLATOR TYPE		
Violator Type	**FY01**	**FY02**
Carrier	139.13	145.48
Claimant	59.41	138.98
Employer	106.40	104.48
HCP	217.57	109.90
Attorney	149.40	186.44
Other	211.69	176.06
TOTAL	**149.24**	**139.24**

AVERAGE DAYS TO COMPLETE ADMINISTRATIVE AND FRAUD REFERRALS COMBINED

AVERAGE DAYS TO COMPLETE ADMINISTRATIVE/FRAUD REFERRALS BY VIOLATOR TYPE		
Violator Type	**FY01**	**FY02**
Carrier	140.55	145.12
Claimant	137.14	91.99
Employer	123.74	103.45
HCP	263.41	115.61
Attorney	350.35	189.97
Other	226.98	180.49
TOTAL	**159.84**	**136.47**

AUDITS PERFORMED BY C&P
(Includes Performance Audits and Medical Audits)*

COMPLETED AUDITS BY TYPE		
Violator Type	**FY01**	**FY02**
Carrier Group	72	38
Independent Carrier	14	4
Self Ins. Gov't Entity	34	26
Self Ins. Gov't Pool	2	1
Cert. Self Ins.	14	6
MD	33	46
DO	2	4
DC	9	5
TOTAL	**180**	**130**

*Medical compliance audits of healthcare providers were conducted in the Compliance & Practices division before that function was moved to Medical Review.

FRAUD REFERRALS

RECEIVED FRAUD REFERRALS BY VIOLATOR TYPE		
Violator Type	**FY01**	**FY02**
Carrier	15	55
Claimant	639	1396
Employer	15	52
HCP	88	163
Attorney	6	17
Other	32	38
TOTAL	**795**	**1721**
COMPLETED FRAUD REFERRALS BY VIOLATOR TYPE		
Violator Type	**FY01**	**FY02**
Carrier	19	20
Claimant	415	473
Employer	13	7
HCP	127	49
Attorney	12	6
Other	34	11
TOTAL	**620**	**566***

*Reported performance is based on change of violation types made in FY2003. Therefore, figure is not the same as reported for FY2002 performance measure.

PENALTIES BY VIOLATOR TYPE		
Violator Type	FY01	FY02
Carrier	0	0
Claimant	19	34
Employer	0	0
HCP	1	0
Attorney	0	0
Other	1	0
TOTAL	**21**	**34**

PENDING REFERRALS BY VIOLATOR TYPE		
Violator Type	FY01	FY02
Carrier	7	7
Claimant	146	201
Employer	10	13
HCP	88	127
Attorney	9	10
Other	20	31
TOTAL	**280**	**389**

CASES REFERRED TO PROSECUTING AUTHORITIES BY VIOLATOR TYPE		
Violator Type	FY01	FY02
Carrier	0	0
Claimant	8	13
Employer	0	0
HCP	8	7
Attorney	0	0
Other	6	1
TOTAL	**22**	**21**

CONVICTIONS BY VIOLATOR TYPE		
Violator Type	FY01	FY02
Carrier	0	0
Claimant	0	7
Employer	0	0
HCP	6	2
Attorney	0	0
Other	3	2
TOTAL	**9**	**11**

AVERAGE DAYS TO COMPLETE FRAUD REFERRALS BY VIOLATOR TYPE		
Violator Type	FY01	FY02
Carrier	442.632	22.150
Claimant	142.571	72.791
Employer	573.308	55.857
HCP	507.787	271.714
Attorney	434.083	204.667
Other	296.188	290.11
Total	**250.62**	**92.93**

M. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. If this is a regulatory program, please describe:

- why the regulation is needed;
- the scope of, and procedures for, inspections or audits of regulated entities;
- follow-up activities conducted when non-compliance is identified;
- sanctions available to the agency to ensure compliance; and
- procedures for handling consumer/public complaints against regulated entities.

Why the regulation is needed: To ensure that parties to the workers' compensation system comply with the requirements as included in the TWCC Act and Rules.

The scope of, and procedures: The violation referral database is used to monitor the activities of system participants and to identify topics and participants for audit.

Follow-up activities: Part of the enforcement process of violation referrals requires that the violator come into compliance on the current referral being reviewed. The enforcement process also reviews for historical compliance issues of the same type as the referral being reviewed. Historical information affects the severity of the enforcement process.

Sanctions available: C&P has various enforcement techniques available. The audits and enforcement (A & E) section in the Compliance and Practices division can pursue violations of the Act and commission rules by issuing administrative penalties, warning letters or education letters. However, the Office of Investigations (OI) can pursue prosecution of fraudulent activities either criminally or administratively as described below:

- **Criminal.** If an investigation establishes criminal fraud, a prosecuting authority may begin criminal prosecution. Workers' compensation fraud involving amounts of $1,500 or more, in benefits or premiums, is a felony punishable by fines, orders for restitution, and imprisonment.
- **Administrative.** The Commission may prosecute fraud through the administrative violation process by assessing fines up to $10,000 and restitution as authorized by the Texas Workers' Compensation Act and the Texas Insurance Code.

Additionally, the Commission may adopt rules providing for:

- A reduction or denial of fees;
- Public or private reprimand by the Commission;
- Suspension from practice before the Commission; or
- Restriction, suspension, or revocation of the right to receive reimbursement under the Act.

Procedures for handling complaints against regulated entities: C&P is responsible for the processing of violation referrals against parties to the workers' compensation system, complaints against these entities are the responsibility of the TWCC Customer Service Team.

N. Please fill in the following chart for each regulatory program. The chart headings may be changed if needed to better reflect the agency's practices.

INTAKE REFERRALS Exhibit 15: Complaints Against Regulated Entities or Persons – Fiscal Years 2001 and 2002		
	FY 2001	**FY 2002**
Number of complaints received	7309	9151
Number of complaints completed	5270	8886
Number of complaints dropped/found to be without merit	0	4
Number of penalties assessed	1702	1787
Number of complaints pending from prior years	4470	3345
Average time period for completion of a complaint	149.24 days	139.24 days
Number of entities inspected or audited by the agency	180	130
Total number of entities or persons regulated by the agency		
***Private Employers:**	302,557	295,744
Injured Workers:	209,320	183,019
Doctors:	86,594	90,179
Attorneys:	882	892
Insurance Carriers:	268	251

*Does not include all public entities.

FRAUD INTAKE REFERRALS Exhibit 15: Complaints Against Regulated Entities or Persons – Fiscal Years 2001 and 2002		
	FY 2001	**FY 2002**
Number of complaints received	795	1721
Number of complaints completed	620	566
Number of complaints dropped/found to be without merit	0	0
Number of penalties assessed	21	34
Number of complaints pending from prior years	280	389
Average time period for completion of a complaint	250.616	92.671
Number of entities inspected or audited by the agency	N/A	N/A
Total number of entities or persons regulated by the agency		
Private Employers:	302.557	295,744
Injured Workers:	209,320	183,019
Doctors:	86,594	90,179
Attorneys:	882	892
Insurance Carriers:	268	251

A. Please complete the following chart.

Texas Workers' Compensation Commission Exhibit 14D: Program or Function Information — Fiscal Year 2002	
Name of Program or Function	Records Management
Location/Division	Central Austin Office and All Field Offices
Contact Name	Brent Hatch, Director of Customer Services Frank Roddey, Director of Support Services (Records Archiving Center)
Number of Budgeted FTEs, FY 2002	313.8
Number of Actual FTEs as of August 31, 2002	291

B. What are the key services of this function or program? Describe the major activities involved in providing all services.

The Records Management function is performed by the Customer Services Division, all field offices and the Records Archiving Center within the Support Services Division. The function is composed of three activities: collecting and maintaining injury claim information; collecting and maintaining insurance coverage information; and archiving inactive claim information.

1. **Claim Information**. The role of collecting and maintaining claim data is shared between the field offices and the central office. Clerical personnel in both the field offices and central office enter claim data in the Commission's mainframe computer system. The key service of this function is to provide an electronic historical record of the injury reported by an injured worker, insurance carrier, employer, or health care provider. This historical record is used for claim administration and dispute resolution purposes as well as various statistical purposes and performance measurements.

2. **Insurance Coverage Information.** The role of collecting and maintaining information related to workers' compensation insurance coverage by employers is crucial to the administration of the claim and for communication with the injured worker, employer, insurance carrier, and health care provider regarding claim administration issues. A coverage database of all employers who report to the Commission on the workers' compensation insurance coverage is maintained on-line, the hard copy documents greater than two years old from the date of receipt are stored at the Archiving Center. The history of the employer's workers compensation insurance coverage is tracked and allows for specific claims to be linked to the proper insurance carrier.

3. **Records Archiving and Services**. The Records Archiving and Services Center (Records Center) is responsible for maintaining and microfilming workers' compensation claim file and insurance coverage records according to the agency's retention schedule and for

providing copies of these records to eligible requestors.

C. When and for what purpose was the program or function created? Describe any statutory or other requirements for this program or function.

The purpose of this program is to facilitate the administration of claims by having the most accurate, up-to-date claim information available. Statutory authority for the data collection and maintenance function is in Chapters 402, 408, 409, and 406 of the Labor Code. The most recent coverage information is now available to the general public through Texas OnLine.

The archiving function is performed to comply with Section 402.081 of the Labor Code, which requires the Commission to maintain claim files for 50 years from the date of a worker's injury, or longer if benefits are still being paid on the 50th anniversary of the injury. A paper copy of the file is kept for 10 years. After 10 years, the file is microfilmed, the paper copy is destroyed, and the filmed copy is kept for 40 years. The Act also provides that most information in a claim file is confidential and may not be released except to certain persons specifically listed in the Act. This program copies and releases claim records to the persons authorized by the Act to receive that information.

D. Describe any important history not included in the general agency history section, including a discussion of how the services or functions have changed from the original intent. Will there be a time when the mission will be accomplished and the program or function will no longer be needed?

Ten years ago, the collection and maintenance of claim data was very labor intensive. With the advent of electronic data interchange (EDI), where insurance companies submit documents directly into the Commission's computer mainframe, work has been reduced allowing for the consolidation and evolution of some positions. Some staff that performed data entry functions can now augment customer service activities.

Except when the function was performed by the Texas Department of Insurance (1991 – August, 1993), the Commission has always been responsible for collecting and maintaining insurance coverage information. In April, 2002, the Commission entered into an agreement for the collection and reporting of proof of coverage information with the National Council on Compensation Insurance, Inc. (NCCI) and Insurance Services Offices, Inc (ISO). Insurance carriers now report directly to one of the vendors their "proof of coverage" information, and the two vendors electronically send the information to the Commission daily. Until mechanisms are built through the Business Process Improvement project to load the electronic input directly into the Commission's automated systems, the collection and maintenance of coverage data will continue to be labor intensive.

As TXCOMP, the Commission's new automated system being developed through the Business Process Improvement project, comes on-line, some staff positions will evolve further into the customer service arena. However, the need for records maintenance will continue, if perhaps in a less labor-intensive form.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

This program affects injured workers, beneficiaries, insurance carriers, healthcare providers, employers, and other system participants who require current information for effective claim management. The program's functions also directly support internal Commission staff performing other claims-related functions.

In FY 2002, 196,038 claims were created, 63,265 were created from hard copy documents and 132,773 were created from electronic data interchange information with minimal human intervention. Additionally, in FY 2002, the agency received 367,499 proof of coverage documents from non-subscribing and subscribing employers. A Research and Oversight Council study showed that approximately 65% of Texas employers, employing approximately 84% of the workforce, had workers' compensation insurance coverage in 2001.

F. Describe how the program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. List any field or regional services.

The records management functions are administered via procedural direction and performance measure guidelines that both the field operations and central operations follow. For instance, the performance measure goal is to create all claims in two days or less.

For injuries reported to the Commission, staff searches the database for an existing injury, and if one does not exist, they create a new claim record based on the criteria of the claim. The claim can be created as a:

- reportable claim which indicates that the injured worker had at least one day of lost time but less than eight days of lost time and has no impairment; or

- income indemnity claim which indicates that the injured worker: has greater than eight days of lost time; has received an impairment rating greater than 1%; has died; or is receiving income benefits.

Claim data is collected both in hard copy and electronic data interchange format. The electronic data interchange format is reported by insurance carriers and is only collected in the central office. In addition, hard copy documentation is collected which provides medical information, dates of maximum medical improvement, impairment ratings, releases to return to work, denial text information and the initiation, suspension, and resumption of income benefits when the insurance carrier is not able to send the data electronically. Staff file supporting hard copy documentation and retire or retrieve files from the Archive Center as appropriate. They link coverage to the correct employer and insurance carrier based on the supporting documentation. They also protect the confidentiality of records.

Staff in the central office is responsible for maintaining the insurance coverage database.

Files in field offices are sent to the Records Center for storage when there has been no activity in the file for 120 days. Files are typically most active during the first five years after creation. If a retired file becomes active again, it is shipped out to the field office handling the claim. Requests for claim files or a

document out of a claim file are normally completed within 24 hours. After microfilming a claim file, the film is duplicated with the original being kept at the Texas State Library and the duplicate being kept in the Records Center Fire-Proof vault.

The Records Center is responsible for reviewing and making decisions regarding the release of confidential claim file information to eligible requestors for a fee. Confidential claim file information is released in accordance with Title 5 Subtitle A, Texas Workers' Compensation Act, Sections 402-064, 402.083 through 402.087 and 402.091 and Advisory 95-01 and Advisory 99-01. Eligible parties, as defined by the statute, request claim file information by completing Commission-approved forms and submitting applicable fees. Response time to provide requested information varies from three days to two weeks, depending on the location of the file and the priority listed by the requestor. The copies of requested documents are not released until payment is received.

G. If the program or function works with local units of government, (e.g., Councils of Governments, Soil and Water Conservation Districts), please include a brief, general description of these entities and their relationship to the agency.

Not applicable

H. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Funding Source	FY 2002 Expenditures
General Revenue	$9,106,584
Appropriated Receipts	397,898
Total	**$9,504,482**

I. Are current and future funding resources appropriate to achieve program mission, goals, objectives, and performance targets? Explain.

Current and future funding resources appear to be appropriate to achieve the programs mission and goals.

J. Identify any programs internal or external to the agency that provide identical or similar services or functions. Describe the similarities and differences.

Externally, there are two vendors maintaining proof of insurance coverage information -- NCCI and ISO. The vendors do not maintain non-subscriber information, and they do not require or maintain a specific level of data quality. Additionally, the public does not have access to proof of coverage information maintained by the vendors.

The Texas State Library has a microfilming operation similar to the one at the Records Center. The Library also has a records storage facility but does very little "open shelf" records storage. The majority of their storage is "box" storage. The Commission's current Records Center has over 260,000 linear feet of open shelving space, and the claim files cannot be boxed due to the large volume of update mail that

must be interfiled.

K. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question J and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

The Texas State Library supports the microfilming needs of other state agencies, but does not microfilm Commission claims due to the high volume.

L. Please provide any additional information needed to gain a preliminary understanding of the program or function.

The following table provides some performance measurement data for the records management program.

Performance Measures	Fiscal Year 2001	Fiscal Year 2002
Number of Injury Records Created	213,852	196,038
Number of Injury Records Created for Income/Indemnity Injuries	108,453	99,253
Percentage of Injury Records Created in Three Days or Less	92.8%	97.85%
Average Number of Days to Create Injury Records	2.17	1.7

M. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. If this is a regulatory program, please describe:

- why the regulation is needed;
- the scope of, and procedures for, inspections or audits of regulated entities;
- follow-up activities conducted when non-compliance is identified;
- sanctions available to the agency to ensure compliance; and
- procedures for handling consumer/public complaints against regulated entities.

This is not a regulatory program.

N. Please fill in the following chart for each regulatory program. The chart headings may be changed if needed to better reflect the agency's practices.

Not applicable

A. Please complete the following chart.

Texas Workers' Compensation Commission Exhibit 14E: Program or Function Information — Fiscal Year 2002	
Name of Program or Function	Self-Insurance Regulation
Location/Division	Austin Central Office
Contact Name	Ed Buchanan, Director of Self-Insurance Regulation
Number of Budgeted FTEs, FY 2002	14
Number of Actual FTEs as of August 31, 2002	14

B. What are the key services of this function or program? Describe the major activities involved in providing all services.

The key service of the Self-Insurance program is to offer large private employers that qualify, the option to self-insure their workers' compensation liabilities. Approval to act as a "Certified Self-Insurer" constitutes employer coverage under the Texas Workers' Compensation Act and allows the employer to act in the capacity of its own insurance carrier.

Self-Insurance Regulation accepts applications from large private employers that wish to become "Certified Self-Insurers." Applicants are evaluated for the Self-Insurance program regarding their financial stability, safety program plans and the ability to provide a benefit delivery system. Upon completion of this evaluation, the Director of Self-Insurance Regulation presents a report and a recommendation regarding the applicant to the Board of the Texas Certified Self-Insurer Guaranty Association (Guaranty Association) and the Texas Workers' Compensation Commission (TWCC) Commissioners in their respective public meetings. Upon approval, the applicant company is issued a Certificate of Authority to Self-Insure for a one-year period.

The program has ongoing regulatory responsibility to monitor the financial condition of each Certified Self-Insurer and the adequacy of each company's security deposit, to review the adequacy of safety program plans, and conduct claims liability audits as needed.

C. When and for what purpose was the program or function created? Describe any statutory or other requirements for this program or function.

The statutory authority for the Self-Insurance program was passed by the Legislature in 1989, to become effective starting in 1993. The purpose of the Self-Insurance program is to offer the option of self-insuring workers' compensation liabilities to larger companies that qualify for the program.

Section 407 of the Texas Labor Code outlines the statutory requirements for the program, the Division of Self-Insurance Regulation and the Texas Certified Self-Insurer Guaranty Association. The Division is

authorized to accept applications, review qualifications, set security deposits, review safety program plans, audit claims reserves, call security deposits and bill related fees for the program.

D. Describe any important history not included in the general agency history section, including a discussion of how the services or functions have changed from the original intent. Will there be a time when the mission will be accomplished and the program or function will no longer be needed?

Administration of the Self-Insurance program has remained unchanged from its original intent.

The mission of the oversight and regulation of Certified Self-Insurers will remain as long as the program has companies that are actively self-insured or companies that have unpaid liabilities. The duty to monitor and regulate the long payout on worker's compensation claims could last fifty years or more after the last claim occurrence.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

The Self-Insurance program allows qualified, large employers to become Certified Self-Insurers in order to pay their own workers' compensation liabilities. In order to apply for the Self-Insurance program in Texas, a company must have a total unmodified workers' compensation insurance premium of $500,000 in Texas, or $10 million nationally. Additional qualifications include the following:

- Qualifying Credit/Debt Rating (one of the following)
    - Dun & Bradstreet rating of 3A1 or better
    - Standard & Poor's rating of BBB or better
    - Moody's rating of Baa or better
    - Minimum tangible net worth of $5 million with a ratio of tangible net worth to long-term debt of 1.5 to one or greater
- Audited Financial Statements
- Security Deposit of the greater of $300,000 or 125% of outstanding liabilities
- Excess Insurance with a minimum of $5 million per occurrence
- A plan for claims administration that designates a qualified claims servicing contractor
- An effective safety program plan

The program of private self-insurance in Texas covers a diverse group of companies that span the manufacturing, transportation, retail, services, and construction industries. The following table provides additional statistical information concerning these industries:

Self-Insurance Program Statistical Information Regarding Regulated Entities As of August 31, 2001 and 2002		
	FY 2001	**FY 2002**
Active Number of Certificates Issued -	56	55
Entities Represented -	244	275
Number of Employees Covered -	238,169	246,131
Distribution by Number of Companies –		
Manufacturing	50 %	44 %
Transportation	8 %	9 %
Retail	13 %	15 %
Services	16 %	21 %
Construction	13 %	11 %
Distribution by Manual Premium –		
Manufacturing	39 %	38 %
Transportation	20 %	21 %
Retail	29 %	29 %
Services	10 %	9 %
Construction	2 %	3 %
Distribution by Number of Employees Covered –		
Manufacturing	26 %	24 %
Transportation	20 %	18 %
Retail	39 %	42 %
Services	13 %	14 %
Construction	2 %	2 %

F. Describe how the program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. List any field or regional services.

Responsibility for the administration of the Self-Insurance program is shared by the Commissioners, the Self-Insurance Regulation division, and the Texas Certified Self-Insurer Guaranty Association.

It is the responsibility of the division to accept and process applications for the program, as well as monitor active and withdrawn companies. Financial qualifications are reviewed and analyzed; security deposits are calculated and accepted; excess insurance is reviewed; safety program plan inspections are conducted; on-site claims liability audits are conducted as needed; and the Self-Insurance Regulatory Fee and the Commission and Research and Oversight Council Maintenance Taxes are billed and collected.

Based upon the work outlined above, the division director recommends qualifying applicants for approval to the Texas Certified Self-Insurer Guaranty Association and the Commissioners in each of their respective public meetings. The Texas Certified Self-Insurer Guaranty Association votes on the acceptance of each applicant as a member of the Guaranty Association and the Commissioners vote to approve or deny issuance of a Certificate of Authority to Self-Insure for a one-year period. Companies reapply every year to renew

their Certificate in the program. Due to the size of the program and the fact that most company contact personnel for larger companies are out of state, the program does not have staff in any field or regional offices.

G. If the program or function works with local units of government, (e.g., Councils of Governments, Soil and Water Conservation Districts), please include a brief, general description of these entities and their relationship to the agency.

Not applicable for this program.

H. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Self-Insurance Regulation is funded through the Self-Insurance Regulatory Fee that is assessed to Certified Self-Insurers (Texas Labor Code 407.102). All costs associated with the program, including matching payroll and benefit costs, as well as allocated indirect costs, are billed to the users of this program in the Self-Insurance Regulatory Fee. Like the Commission's maintenance tax, the fees are deposited in the General Revenue account. The result is that the users of this program pay for 100% of its costs.

Funding Source	FY 2002 Expenditures
General Revenue	$717,390
Total	**$717,390**

I. Are current and future funding resources appropriate to achieve program mission, goals, objectives, and performance targets? Explain.

Yes.

J. Identify any programs internal or external to the agency that provide identical or similar services or functions. Describe the similarities and differences.

With the passage of HB 2095 (78th Legislature), the Texas Department of Insurance (TDI) will now be performing similar functions for companies that apply for certification as group self-insurers.

K. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question J and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

Certification of groups for self-insurance is a brand new responsibility for TDI that has not been fully developed at this time.

L. Please provide any additional information needed to gain a preliminary understanding of the program or function.

No additional information submitted.

M. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. If this is a regulatory program, please describe:

- why the regulation is needed;
- the scope of, and procedures for, inspections or audits of regulated entities;
- follow-up activities conducted when non-compliance is identified;
- sanctions available to the agency to ensure compliance; and
- procedures for handling consumer/public complaints against regulated entities.

Why the regulation is needed: Regulation is needed to ensure that only qualified companies are allowed into the program and that financial qualifications, safety program plans and effective claims administration are maintained, so that proper payments for workers' compensation claims are made. Ensuring that companies have the required level of Security Deposit on file serves to protect other members of the Texas Certified Self-Insurer Guaranty Association from assessments due to the possible impairment of one of the other Certified Self-Insurers.

The scope of, and procedures for, inspections or audits of regulated entities: In addition to requiring investment grade financial standards to be approved for the program, companies must provide a security deposit equal to $300,000 or 125% of their outstanding liabilities, whichever is greater. A safety plan inspection is conducted upon initial application, upon the first renewal and every three years thereafter in order to ensure that the applicant has an effective safety program plan in place. On-site claims examination audits are conducted as needed to verify the proper reporting of claims liability amounts.

Follow-up activities conducted when non-compliance is identified: Follow-up activities for significant non-compliance could result in the revocation of a company's Certificate of Authority, the calling of the company's security deposit, or the director's refusal to recommend an applicant for approval of an initial or renewal application by the Guaranty Association and the Commissioners. More information on these sanctions is provided in the next item of this section.

Sanctions available to the agency to ensure compliance: There are three primary types of sanctions that are available to ensure compliance with the program requirements. The first type is the revocation of the company's Certificate of Authority. This sanction would seek to revoke the company's current certificate through a hearing at the State Office of Administrative Hearings. It has not been necessary to utilize this sanction since the program's inception.

The second type of sanction is the calling of the security deposit once a Certified Self-Insurer has been declared impaired. Since the program's inception, two security deposits were called due to the companies' failure to continue the payment of their claims obligations. These companies were in bankruptcy at the time.

The third type of sanction is failure to renew the certification. The lack of a recommendation by the director, if the company does not meet the necessary minimum standard, would most likely result in a voluntarily withdrawal from the program. Companies generally would rather withdraw than risk rejection by either the Guaranty Association or the Commissioners.

Certified self-insurers are subject to the same sanctions and penalties as other employers and carriers.

Procedures for handling consumer/public complaints against regulated entities: Typically, any complaints from the public tend to be claim specific situations, and as such, they are handled by Customer Services. Self-Insurance Regulation handles matters regarding the application and approval of companies that wish to self-insure. Complaints against Certified Self-Insurers concerning their Certificate of Authority have been nonexistent.

N. Please fill in the following chart for each regulatory program. The chart headings may be changed if needed to better reflect the agency's practices.

Texas Workers' Compensation Commission
Self-Insurance Regulation
Exhibit 15: Complaints Against Regulated Entities or Persons – Fiscal Years 2001 and 2002

	FY 2001	FY 2002
Number of complaints received	0	0
Number of complaints resolved	0	0
Number of complaints dropped/found to be without merit	0	0
Number of sanctions:		
Certificates Revoked –	0	0
Security Deposits Called –	0	0
Companies not Recommended by Director -	0	0
Number of complaints pending from prior years	0	0
Average time period for resolution of a complaint	N/A	N/A
Number of entities inspected or audited by the agency:		
Safety Program Plan Inspections -	19	19
Examination Audits -	9	5
Total number of entities or persons regulated by the agency as of August 31 of each year:		
Number of Companies Regulated[1] -	81	82
Entities Represented -	332	365
Number of Employees -	314,785	323,820
Active Number of Certificates Issued -	56	55
Entities Represented -	244	275
Number of Employees Covered -	238,169	246,131
Percentage of Written Workers' Compensation Premiums -	14 %	12 %

1 Certificates of Authority are issued at the parent level of the corporation to include all requested subsidiaries.

A. Please complete the following chart.

Texas Workers' Compensation Commission Exhibit 14F: Program or Function Information — Fiscal Year 2002	
Name of Program or Function	Income Benefit Dispute Resolution
Location/Division	Central Austin Office and Field Offices
Contact Name	Brent Hatch, Director of Customer Services Heidi Jackson, Director of Hearings Scott Huston, Manager of Workers' Compensation Training and Education
Number of Budgeted FTEs, FY 2002	325.8 (estimated)
Number of Actual FTEs as of August 31, 2002	299.5

B. What are the key services of this function or program? Describe the major activities involved in providing all services.

The Commission's Customer Services, Hearings and Workers Compensation Training and Education divisions share responsibility for the income benefit dispute resolution program. The benefit dispute resolution program is responsible for responding to inquiries from system participants on claim matters and administering the benefit dispute resolution processes delineated in the statute. The benefit dispute resolution program correlates with the portions of the Commission's informal and formal dispute resolution strategies that are not related to medical benefit dispute resolution.

Informal income benefit dispute resolution includes the efforts made by Commission staff to answer questions and informally mediate issues before attending a benefit review conference (BRC). Conducting a BRC is also considered informal income benefit dispute resolution. The formal income benefit dispute resolution functions include contested case hearings, appeals panel review, and appeals to district court.

Income benefit dispute resolution is performed through the following activities: customer services; ombudsman assistance; customer relations; designated doctor selection; workers' compensation education and training; quality services; and hearings.

1. **Customer Services** provides general information to system participants regarding the workers' compensation system. Staff help injured employees with claim specific questions; explain the law and rules in simple language; maintain a line of communication with insurance carriers to resolve disputes at the earliest time possible; and respond to health care providers and employers' requests for information. Additionally, staff develops policy, process and procedures for routine customer services and claim administration services provided by the Commission's field offices.

2. **The Ombudsman Program** is designed primarily to assist injured workers prepare for income benefit dispute resolution proceedings and present the injured worker's side of the dispute at those proceedings if requested to do so by the injured worker. This service is provided at no

expense to the injured worker. The ombudsman may not give legal advice or assist any injured worker who has hired an attorney or who has other representation. All unrepresented injured workers are offered ombudsman assistance and no request for that assistance is denied.

3. **Customer Relations** monitors the level of customer service provided to the agency's public and, as necessary, provides suggestions for improvement. The level of service is monitored through the administration of a customer satisfaction survey and other ad hoc surveys, publication of the survey results, and responding to and tracking claims-related issues. To aid in the assessment of customer relations, the Commission developed a workgroup composed of representatives from other state agencies to discuss and resolve common customer service issues facing state government.

4. **Workers' Compensation Training & Education** provides technical workers' compensation training to internal and external customers. The program also coordinates, monitors, and manages continuing education accreditation for agency staff, including Ombudsman staff.

5. **Program Quality Services (PQS)** conducts quality reviews of functions performed in the Commission's field offices to assure compliance with rules, policies, and procedures and provides technical consultations with field office staff. The reviews serve as a feedback loop to validate training that is provided and to identify areas for future educational efforts.

6. **Hearings** provides dispute resolution services for income benefit and compensability disputes. The dispute resolution services include:

    a. informal dispute resolution conferences (Benefit Review Conferences – BRCs), in which agency mediators utilize mediation techniques in the agency's field offices to help the parties reach a mutually satisfactory resolution to their disputed issues at an informal level;
    b. evidentiary hearings (Benefit Contested Case Hearings – BCCHs), in which hearing officers who are agency attorneys functioning in the role of administrative law judges in the agency's field offices receive testimony and evidence from the parties and issue decisions and orders adjudicating the disputed issues;
    c. appeal level review (Appeals Panel), in which agency attorneys located in the central office review requests for appeals of BCCH decisions and orders and make decisions in panels of three judges to affirm, reverse and remand, or reverse and render the decision from the BCCH;
    d. arbitration services (Arbitration), in which an arbitrator assigned by the agency would conduct arbitration proceedings and enter a final award regarding income benefits and compensability disputes (this provision of the law has not been utilized to any meaningful extent since its inception, and not at all in the last five years); and
    e. old law claims, for continued processing of old law awards for injuries that occurred prior to January 1, 1991. Agency benefit review officers, who are properly trained in old law processes, conduct prehearing conferences and hearings. Other division staff process awards including awards of medical benefits.

C. When and for what purpose was the program or function created? Describe any statutory or other requirements for this program or function.

The benefit dispute resolution program (consisting of all three levels of dispute resolution: mediation, hearing, and appeal review, as well as the arbitration) was created with the passage of the workers' compensation reform legislation enacted in 1989. The purpose was to provide timely and fair dispute resolution for system participants regarding issues of compensability and amount/duration/liability for income benefits. The statutory requirements for this function are located in Chapter 410 of the Labor Code. The Commission's rules regarding the procedural aspects of the hearings division are Chapters 140-144 and 147.

The other functions that support performance of the benefit dispute resolution efforts have evolved since 1989. In 1993, the Customer Service program (known as Employer Employees Field Services then) was designed to address the rights of injured workers and employers in the workers' compensation system. Additional statutory requirements supporting the need for this program are under Chapters 408, 409, and 410.

Section 409.041 of the Texas Labor Code, which became effective Sept. 1, 1993, and was subsequently amended in 1995, and 1997, created the functions of the Ombudsman Program as it is known today. The purpose is to assist injured workers at Commission dispute proceedings and at the State Office of Administrative Hearings for appeals of decisions on medical disputes. Sections 409.042 – 409.044 address the training requirements for ombudsmen and the requirements to notify injured employees of the Ombudsman program.

The Program Quality Services (PQS) function was created in 1995 to ensure consistent application of the Commission's policies and processes across the state. The Customer Relations function was created in February 2000 to monitor, improve, and report on the level of customer service provided to the agency's external customers. The assessment of customer service satisfaction is supported by Chapter 2114 of the Texas Government Code.

D. Describe any important history not included in the general agency history section, including a discussion of how the services or functions have changed from the original intent. Will there be a time when the mission will be accomplished and the program or function will no longer be needed?

The Ombudsman program was created by the Workers' Compensation Act of 1989. As originally implemented by the Commission, ombudsmen offered advice to injured workers and employers on general questions about the workers' compensation system. In 1993, the Ombudsman Program was expanded to provide free assistance to injured employees at proceedings as the need for assistance in administrative law dispute proceedings rapidly expanded in the early years of the "new law."

In 2000, the Workers' Compensation Training & Education (WC-T&E) and Program Quality Services (PQS) functions were combined. This provided further opportunities for:

- Identifying best practices,

- Identifying training needs,
- Delivering timely information necessary to expedite the claim file process,
- Validating claim data, and providing workers' compensation training to all system participants.

As created by the Texas Labor Code, the necessity of the benefit dispute resolution program and its functions will always be needed unless a major statutory change is enacted.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

The benefit dispute resolution program affects all workers' compensation system participants, especially injured workers, employers, and insurance carriers. Workers are eligible for medical and income benefits for workplace injuries if their employers are subscribers to workers compensation insurance, are participants in the certified self-insured system, or are governmental self-insured participants. Insurance carriers eligible to participate are those that are authorized by the Texas Department of Insurance to carry workers compensation insurance.

With the exception of ombudsman assistance, there are no qualifications or eligibility requirements for those persons or entities affected. In order to receive Ombudsman assistance, an injured employee must have an unresolved benefit dispute that has been scheduled for an administrative proceeding before the Commission and not be represented by counsel or other types of representation available under the Texas Labor Code.

F. Describe how the program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. List any field or regional services.

The dispute resolution program is administered through the combination of central office and regional field office direction. The Customer Services, Hearings, and Workers' Education and Training divisions in the central office assist with establishing, documenting, and training on policies and procedures. Four regional directors are responsible for managing the operations of the 24 current field offices throughout the state.

1. Customer calls and walk-in customers in the central office and field offices are routed to staff to answer questions, provide information, and initiate informal dispute resolution. A large portion of this function is informing system participants of their rights and responsibilities.

2. Disputes enter the program in the field offices after being received and initially worked by the field office customer assistants and dispute resolution officers. Approximately 68% of disputes are resolved before an official proceeding. Disputes that are not able to be resolved at that level but are ready for further mediation efforts are set for a BRC. Approximately 19,000 BRCs are conducted annually. Approximately 64% of the disputes resolve at the BRC-level and the remainder require a BCCH. Those disputes that proceed to BCCH result in approximately 7,200 BCCHs, which conclude with a final decision and order. Parties dissatisfied with that decision file an appeal with the Appeals Panel approximately 50% of the time. The AP considers approximately 3,300 requests for appeal, and issues a decision to affirm, reverse and render, or

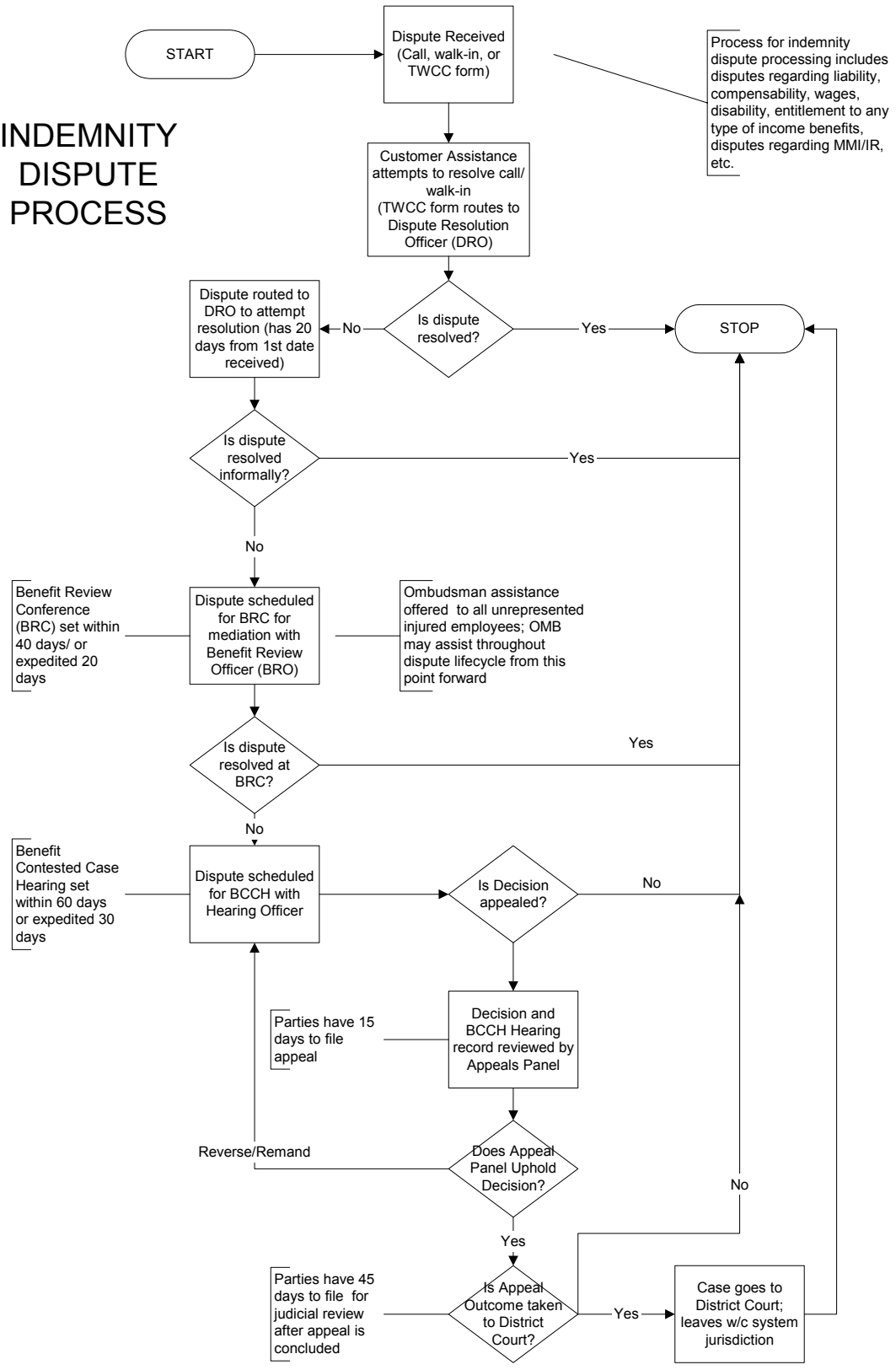
reverse and remand the decision. Infrequently (in less than 5% of the appeals) the Appeals Panel allows the hearing officer's decision to become their final decision pursuant to §410.204. The Appeals Panel affirms more than 90% of the hearing officers' BCCH decisions. Less than 20% of the Appeals Panel decisions are appealed to District Court (equating to less 1% of all disputes).

3. The hearings function is administered by central office direction through the hearings director, proceedings manager, appeals manager/judge, and the dispute processing supervisors. The proceedings teams in the field consist of regional teams with working-supervisor hearing officers and benefit review officers.

4. Five Senior Ombudsmen are located in the central office. The senior ombudsmen provide:

    a. training and mentoring for new field office ombudsmen; continuous monitoring to ensure ombudsmen maintain current adjusters' licenses; continuing education courses and on-going training for all ombudsmen;
    b. direction for the program through direct involvement in the hiring of ombudsmen and establishment of performance standards for all ombudsmen:
    c. guidance for the ombudsman program through the provision of technical advice to all ombudsman and to agency personnel, other than hearing officers or appeals panel members, on complex and complicated cases; and
    d. assistance at proceedings (benefits review conferences and benefit contested case hearings) conducted in the Commission's field offices and at the State Office of Administrative Hearings.

The flow chart on the following page is a simplified portrayal of the benefit dispute process.


INDEMNITY DISPUTE PROCESS
START
Dispute Received (Call, walk-in, or TWCC form)
Process for indemnity dispute processing includes disputes regarding liability, compensability, wages, disability, entitlement to any type of income benefits, disputes regarding MMI/IR, etc.
Customer Assistance attempts to resolve call/ walk-in (TWCC form routes to Dispute Resolution Officer (DRO)
Is dispute resolved?
No
Yes
STOP
Dispute routed to DRO to attempt resolution (has 20 days from 1st date received)
Is dispute resolved informally?
Yes
No
Benefit Review Conference (BRC) set within 40 days/ or expedited 20 days
Dispute scheduled for BRC for mediation with Benefit Review Officer (BRO)
Ombudsman assistance offered to all unrepresented injured employees; OMB may assist throughout dispute lifecycle from this point forward
Is dispute resolved at BRC?
Yes
No
Benefit Contested Case Hearing set within 60 days or expedited 30 days
Dispute scheduled for BCCH with Hearing Officer
Is Decision appealed?
No
Parties have 15 days to file appeal
Decision and BCCH Hearing record reviewed by Appeals Panel
Reverse/Remand
Does Appeal Panel Uphold Decision?
No
Yes
Parties have 45 days to file for judicial review after appeal is concluded
Is Appeal Outcome taken to District Court?
Yes
Case goes to District Court; leaves w/c system jurisdiction

The workers' compensation training and education function is administered by a training plan that is developed based on training needs assessments conducted through formal surveys and through continuous informal feedback and routine quality reviews. The central office Training & Education section serves as a centralized training resource location for the Commission's regional field office operations, providing timely guidance to internal and external customers about the claims rules and procedures. The Program Quality Services section continuously revises/develops field office quality assurance measures guided by a formal quality plan including:

- Legislative changes;
- Commission Act, Rules and Procedures;
- Executive management guidance;
- State Auditors Office findings/recommendations; and
- Feedback from interview, meetings, and agency staff concerns.

The customer relations function is performed through internal ad hoc surveys, focus groups, and general outreach. Additionally, every two years, the Commission seeks assistance from the Survey and Research Center of the University of North Texas to administer an overall analysis of customer satisfaction level of Commission services. A customer service report based on the results of this survey is reported to the Legislative Budget Board and the Governor's Office in even-numbered years.

G. If the program or function works with local units of government, (e.g., Councils of Governments, Soil and Water Conservation Districts), please include a brief, general description of these entities and their relationship to the agency.

The Commission refers injured workers to the Texas Rehabilitation Commission for vocational rehabilitation services, if appropriate. The two agencies are currently working on methods for sharing data that will allow tracking the outcome of Commission referrals.

Local units of government are not involved in the program, except to the extent that they are governmental self-insured employers who are involved in the workers compensation system as a participant or are requesting training and education services provided by the Commission.

H. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Funding Source	FY 2002 Expenditures
General Revenue	$14,512,459
Appropriated Receipts	191,609
Total	**$14,704,068**

I. Are current and future funding resources appropriate to achieve program mission, goals, objectives, and performance targets? Explain.

In general, the current funding for this program is sufficient to provide the required services. However,

further improvements could be made in the timely resolution of disputes, one of the program's main goals, with additional resources.

Limited resources may cause income benefit disputes to not receive the pre-BRC dispute resolution attention that enhances the likelihood of a dispute being resolved at that level. The more disputes that are resolved as early as possible in the process, fewer are forwarded to the more formal dispute resolution processes. At the BRC level, due to limited resources in certain high volume areas (primarily hearing room space, Benefit Review Officers and Ombudsmen), BRCs are not always scheduled within the 40-day period that is directed by rule (BRC set date within 40 days of receipt of request for BRC). Some of the steps that have been taken to address this include video or teleconferencing BRC proceedings. We also schedule up to eight BRCs per day, which limits the amount of time that staff are able to devote to the parties in the mediation session to approximately 45 minutes. Longer sessions would mean fewer sessions per day, which would result in even more sessions being scheduled outside the required timeframe. Likewise, similar shortages of hearing officers, ombudsmen and hearing room space limit the agency's ability to timely schedule and hold BCCHs within a 60-day period (BCCH set date within 60 days of the BRC). Regarding appeals, the statute requires the Appeals Panel to issue a decision within 30 days of the date the appeal response is filed. If a decision is not issued, the hearing officer's decision becomes the final decision of the Appeals Panel as a matter of law. Some decisions that are appealed, which are determined through review would be affirmed by the Appeals Panel, are allowed to become the final decision of the Appeals Panel so limited resources can be focused on appeals of decisions that raise new or complex issues, or decisions that would necessitate reversal. Any additional proceedings of significant number, such as adding or shifting medical disputes to the field offices, or new disputes that emerge as a result of new legislation, would definitely require more staff resources.

J. Identify any programs internal or external to the agency that provide identical or similar services or functions. Describe the similarities and differences.

Workers' Assistance Centers provide assistance to injured workers in some Texas cities. Additionally, injured employees also have the right to obtain legal counsel to represent them in dispute resolution proceedings; however, those services are not free and are paid out of the injured workers' income-replacement benefits (up to 25% of income benefits).

There are no other internal or external programs that provide dispute resolution functions (mediation, contested case hearings, and administrative appeals) for benefit disputes.

Training is provided by other programs in the Commission, but the subject matter and target audiences are different from the training on workers' compensation policies and procedures provided by this program on workers' compensation policies and procedures.

K. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question J and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

Injured workers are entitled, by statute, to their choice of assistance in handling their claim. They may have an ombudsman, an attorney, someone other than an attorney; or they may choose to represent themselves. The services provided by workers' assistance centers vary by location. Furthermore, such centers are not available in all cities with Commission field offices.

Due to the statutory delineation of the types of disputes that are subject to resolution in the Hearings Division and the Medical Review Division, there is no duplication of the dispute resolution functions. However there are instances where there is conflict as to whether the disputed issue is one of *compensability* or one of *reasonable and necessary medical care* for the treatment of a compensable injury. This issue is currently the subject of an internal, agency study to review the nature of these disputes and propose rules to enhance the dispute resolution efforts regarding medical necessity.

The Commission has formed a training alliance team to maximize use of subject matter experts, technical personnel, and equipment to coordinate both external and internal (employee) training delivery. The team meets as needed and is comprised of a representative from each of other agency sections responsible for training. In addition, these sections rely on a web-based agency training calendar to ensure efficient training delivery for all participants.

L. Please provide any additional information needed to gain a preliminary understanding of the program or function.

The following table provides some performance measurement data for the benefit dispute resolution program.

Performance Measures	Fiscal Year	
	2001	2002
Percentage of Benefit Dispute Cases Resolved by the Commission's Informal Dispute Resolution System	91%	89.34%
Number of Benefit Dispute Cases Resolved Prior to Benefit Review Conference	54,686	48,522
Number of Compensation Benefit Dispute Cases Concluded in Benefit Review Conference (BRC)	18,440	19,219
Percentage of Compensation Benefit Dispute Cases for BRC in which Unrepresented Parties Received Ombudsman Services	54.09%	54.83%
Percentage of Benefit Dispute Cases Resolved by the Commission's Formal Dispute Resolution System (Beginning with Contested Case Proceedings)	8.22%	9.99%
Number of Compensation Benefit Dispute Cases Concluded in Contested Case Hearing (CCH)	6,584	7,222
Number of Appeals Panel Decisions Filed for Judicial Review	478	475
Percentage of Benefit Dispute Cases for CCH in which Unrepresented Parties Received Ombudsman Services	43.76%	43.42%

M. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. If this is a regulatory program, please describe:

- why the regulation is needed;
- the scope of, and procedures for, inspections or audits of regulated entities;
- follow-up activities conducted when non-compliance is identified;
- sanctions available to the agency to ensure compliance; and
- procedures for handling consumer/public complaints against regulated entities.

This is not a regulatory program.

N. Please fill in the following chart for each regulatory program. The chart headings may be changed if needed to better reflect the agency's practices.

Not applicable.

A. Please complete the following chart.

Texas Workers' Compensation Commission Exhibit 14G: Program or Function Information — Fiscal Year 2002	
Name of Program or Function	Medical Dispute Resolution
Location/Division	Central Austin Office
Contact Name	Judy Bruce, Director of Medical Review
Number of Budgeted FTEs, FY 2002	34.2 (estimated)
Number of Actual FTEs as of August 31, 2002	31.7

B. What are the key services of this function or program? Describe the major activities involved in providing all services.

The Medical Dispute Resolution program handles the following types of medical disputes: prospective medical necessity disputes (or preauthorization disputes); retrospective medical necessity disputes; medical fee disputes; and carrier requests for refund disputes. For prospective and retrospective medical necessity disputes, the Commission uses independent review organizations (IROs) to make decisions as required by statute.

The program also performs informal resolution conferences to resolve disputes after a decision has been made by an IRO, but before they proceed to a hearing conducted by the State Office of Administrative Hearings (SOAH) and participates in SOAH hearings on appeals of some medical dispute decisions.

C. When and for what purpose was the program or function created? Describe any statutory or other requirements for this program or function.

Section 413.031 of the Labor Code as adopted in 1989 includes provisions for medical dispute resolution processes, separate from the income benefit dispute resolution processes. The medical dispute resolution program handles disputes predominantly between health care providers and insurance carriers over payment for health care that has been provided or has been recommended. However, injured workers may also file disputes.

The Commission has adopted Rules 133.305 – 133.308 and 134.600 to specify the type of issues that may be handled through the medical dispute resolution process and the procedures for doing so.

D. Describe any important history not included in the general agency history section, including a discussion of how the services or functions have changed from the original intent. Will there be a time when the mission will be accomplished and the program or function will no longer be needed?

As a result of statutory changes enacted by the 77th Legislature, Independent Review Organizations (IROs) have been used since January 1, 2002 to resolve disputes over prospective and retrospective medical necessity of health care services provided to injured workers. There are currently seven IROs certified by the Texas Department of Insurance and utilized by the Commission to review disputes over prospective and retrospective medical necessity.

It is anticipated that implementation of a new Medical Fee Guideline (MFG) on August 1, 2003 will result in an increase in disputes due to a learning curve for system participants. In the long term, implementing a new fee guideline may reduce the number of "fee-related" disputes. In addition, disputes over medical necessity may decrease because of adoption of Medicare payment polices.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

The medical dispute resolution program primarily affects health care providers, insurance carriers, and injured workers. A health care provider may seek relief for unpaid medical bills or for preauthorization requests for services listed in Commission Rule 134.600 that have been denied. Insurance carriers are typically the respondents in disputes over payment of health care services provided or recommended. An injured worker may file a medical dispute over a preauthorization denial or for reimbursement of out-of-pocket expenses paid by the injured worker that are being denied based on either medical necessity or fee amount.

F. Describe how the program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. List any field or regional services.

The medical dispute resolution program is administered through the use of three main functions.

1. The **Intake or Operations Support Section** is responsible for receiving mail; screening and setting up of the dispute file; receiving and responding to telephonic requests via the Medical Dispute Information Line; file maintenance; and mail-out of medical dispute resolution Findings and Decisions.

2. The **Medical Dispute Resolution Officer (MDRO) Section** is responsible for monitoring and reviewing dispute files for response timeframes; making IRO assignments for prospective and retrospective medical necessity disputes; issuing Findings and Decisions in retrospective medical necessity disputes and fee disputes; case managing IRO assignments; and closing cases in the automated system.

3. **APA Proceedings** is responsible for conducting reviews of Findings and Decisions issued on disputes that are appealed to the State Office of Administrative Hearings (SOAH) for the

identification of possible errors and conducting informal resolution conferences (IRCs) between the disputing parties to seek an informal resolution prior to the formal hearing taking place at SOAH. Commission staff also represents the agency in formal SOAH hearings in some cases. This function is shared organizationally between the Medical Dispute Resolution and Administrative Procedures Act sections of Medical Review and Legal Services, respectively.

G. If the program or function works with local units of government, (e.g., Councils of Governments, Soil and Water Conservation Districts), please include a brief, general description of these entities and their relationship to the agency.

The program does not work with local units of government except to the extent that they are governmental self-insured employers who are involved in the workers compensation system as a participant.

H. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Funding Source	FY 2002 Expenditures
General Revenue	$1,172,174
Appropriated Receipts	14,143
Total	**$1,186,317**

The program is funded with General Revenue. The Commission does not pay the cost of disputes reviewed by Independent Review Organizations (IROs). The insurance carrier pays the IRO fee for preauthorization disputes, and the "losing party" pays the fee for retrospective medical necessity disputes.

The Commission must pay the costs of dispute resolution services provided by the State Office of Administrative Hearings (SOAH) above the hours allocated to the agency. This includes appeals in which the Commission is not a party before SOAH. Most of the Commission's disputes appealed to SOAH are medical disputes, and as the volume of disputes handled by the agency has increased, the number of appeals to SOAH have also increased. As a result, the amount the Commission has paid to SOAH for dispute resolution services has become significant -- $211,000 in FY 2002 and $368,000 as projected for FY 2003.

I. Are current and future funding resources appropriate to achieve program mission, goals, objectives, and performance targets? Explain.

House Bill 3168, passed during the 78th Legislature, allows the Commission to prescribe, by rule, an alternate dispute resolution process to resolve disputes regarding medical services costing less than the cost of an IRO review. The new alternative process has the potential of dramatically increasing the number of medical disputes received if participants have not been filing disputes because they find the cost of an IRO review prohibitive. Although the Commission reported a fiscal impact for the funding of additional FTEs, no additional funding was appropriated to implement the new provisions.

J. Identify any programs internal or external to the agency that provide identical or similar services or functions. Describe the similarities and differences.

Dispute resolution services are provided through the Commission's field offices for disputes regarding entitlement to income benefits through Benefit Review Conferences, Contested Case Hearings and the Appeals Panel. The medical dispute resolution program is similar in that there is an appeal process however; the appeals are conducted externally at the State Office of Administrative Hearings. The statute establishes different processes for handling income benefit and medical disputes, and any appeals of those decisions.

The Commission assigns Independent Review Organizations (IROs) to resolve prospective and retrospective medical necessity disputes. In addition to licensing and regulating the IROs, the Texas Department of Insurance (TDI) also assigns IROs to resolve prospective medical necessity disputes in HMO cases. The volume of disputes being assigned to IROs and the level of involvement in processing disputes going to IROs is much higher at the Commission than at TDI.

K. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question J and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

The medical dispute resolution program determines if there are any income benefit disputes pending. These income benefit dispute issues include but are not limited to compensability of a claim, relatedness of an injury, or extent of injury in a claim. An income benefit dispute has to be fully adjudicated before being considered by the medical dispute resolution program.

The Commission has entered into an MOU with the Texas Department of Insurance (TDI) regarding regulation of utilization review (UR) agents and of IROs. The MOU delineates the expectations of each of the two agencies.

L. Please provide any additional information needed to gain a preliminary understanding of the program or function.

The table below shows the number of medical disputes received and worked in FY 2001 and 2002.

Medical Review Division –Medical Dispute Resolution		
	FY 2001	**FY 2002**
Number of disputes received	16,298	16,852
Number of disputes competed	16,091	15,715
Number of preauthorization, medical necessity, and medical fee disputes completed	8,292	8,434
Number of disputes processed as "no jurisdiction" or incomplete (M9)	3,726	4,184
Percent of disputes resolved in the informal medical dispute resolution system	91.5%	91.9%
Number of disputes pending from prior years	1,985	3,655
Average time period for resolution of a dispute		
Preauthorization:	29	63
Medical Fee:	182	87
Medical Necessity:	231	155

M. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. If this is a regulatory program, please describe:

- why the regulation is needed;
- the scope of, and procedures for, inspections or audits of regulated entities;
- follow-up activities conducted when non-compliance is identified;
- sanctions available to the agency to ensure compliance; and
- procedures for handling consumer/public complaints against regulated entities.

This is not a regulatory program.

N. Please fill in the following chart for each regulatory program. The chart headings may be changed if needed to better reflect the agency's practices.

Not applicable.

A. Please complete the following chart.

Texas Workers' Compensation Commission Exhibit 14H: Program or Function Information — Fiscal Year 2002	
Name of Program or Function	Central Administration
Location/Division	Austin Central Office
Contact Name	Richard F. Reynolds, Executive Director Virginia May, Deputy Executive Director of Operations Craig Smith, Deputy Executive Director of Legal and Compliance Linda McKee, Director of Executive Communication and Public Information Floyd Bermea, Director of Human Resources Bob Shipe, Director of Governmental Relations Laurie Crumpton, Director of Strategic Planning and Programs Paula Urban, Chief Financial Officer Janet Marshall, Budget Manager Kaylene Ray, Manager of Legal Services Susan Cory, General Counsel Carole Fox, Internal Auditor
Number of Budgeted FTEs, FY 2002	90
Number of Actual FTEs as of August 31, 2002	79.5

B. What are the key services of this function or program? Describe the major activities involved in providing all services.

The Central Administration program is comprised of the following essential business elements: Deputy Executive Directors; Executive Communication and Public Information; Human Resources; Governmental Relations; Strategic Planning and Programs; Finance; Budget; Legal Services; General Counsel; and Internal Audit.

1. The **Executive Director** serves as the executive officer and administrative head of the Commission and conducts and directs the day-to-day operations of the Commission.

2. **Deputy Executive Directors (DEDs)** are responsible for the operations of particular functional areas of the agency. One DED manages all field operations, human resources, and workers' health and safety. The other DED manages the agency's regulatory programs and legal issues.

3. **Communication and Public Information** tracks all executive management correspondence; handles requests for documents under the Public Information Act; manages all public meetings

and public hearings; produces agency brochures, news releases, and other public information documents; and serves as the point of contact for communications with the commissioners.

4. **Human Resources** is responsible for employment services; benefits; payroll; and employee relations.

5. **Governmental Relations** serves as the agency liaison to the Legislature and legislative staff.

6. **Strategic Planning and Programs** coordinates the agency's strategic and operational planning functions, including statistical analysis and performance measurement. Development of the agency's websites is also managed under this function.

7. **Finance** performs the agency's accounting functions and prepares the Commission's annual financial statement.

8. **Budget** prepares and monitors the Commission's legislative appropriations request, external operating budget, and the internal division operating budgets.

9. **Legal Services** protects and preserves the legal rights of the Commission on issues such as contracts, personnel, ethics, etc. and administers the Subsequent Injury Fund. The division also provides legal advice and works with the Office of the Attorney General in representing the Commission in lawsuits.

10. **General Counsel** provides legal advice to the Commissioners and the Executive Director and coordinates the rulemaking functions of the agency.

11. **Internal Audit** examines and evaluates the adequacy and effectiveness of the agency's control processes and the quality of operations and services performed in carrying out assigned responsibilities.

C. When and for what purpose was the program or function created? Describe any statutory or other requirements for this program or function.

All functions within the central administration program are necessary for managing an agency.

Chapter 2102 of the Government Code defines criteria requiring the establishment of an internal audit function at state agencies. Other Government Code provisions require other functions to be performed by state agencies, even though the provisions do not specify the placement of the function within the organization.

D. Describe any important history not included in the general agency history section, including a discussion of how the services or functions have changed from the original intent. Will there be a time when the mission will be accomplished and the program or function will no longer be needed?

The Commission received gubernatorial approval for the creation of deputy executive director positions in 1998. The creation of those positions allows the executive director to focus on key policy issues.

While the activities/projects performed under the central administration program vary from year-to-year, the basic purpose of the functions have not changed and will continue to be necessary in the future.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

Central administration primarily affects Commission employees in the provision of tools necessary to perform the functions required of the agency. The public information and correspondence functions have a direct impact on all workers' compensation system participants.

F. Describe how the program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. List any field or regional services.

The central administration program includes the agency's executive management functions – performed by the executive director and the deputy executive directors. All other functions in the central administration program are administered by a division director or manager who reports directly to either the Executive Director or a Deputy Executive Director.

Section 2102.005 requires that Internal Audit perform an annual risk assessment to identify issues/conditions that present a significant risk for the agency. The risk assessment process includes soliciting input from agency management, the Commissioners, and external oversight agencies, such as the State Auditor's Office. The results of the risk assessment are used to develop a fiscal year audit plan, which is presented to the Commissioners for review and approval. Once approved, audits commence. If operating conditions change, or if significant issues arise, approval is requested from the Commissioners to deviate from the audit plan. Upon the completion of an audit, a written report is prepared and distributed to agency management, the Commissioners, the State Auditor's Office, the Legislative Budget Board, and the Governor's Office.

G. If the program or function works with local units of government, (e.g., Councils of Governments, Soil and Water Conservation Districts), please include a brief, general description of these entities and their relationship to the agency.

Central administration personnel work regularly with several state agencies such as the State Auditor's Office, the Texas Workforce Commission, and the Comptroller of Public Accounts.

H. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

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Funding Source	FY 2002 Expenditures
General Revenue	$4,384,209
Appropriated Receipts	250
Interagency Contract	3,660
Total	**$4,388,119**

I. Are current and future funding resources appropriate to achieve program mission, goals, objectives, and performance targets? Explain.

Current and future funding is appropriate for the accomplishment of mission, goals, and performance targets. However, like other Commission programs and other state agencies, retention and recruiting are a significant concern due to budget limitations.

J. Identify any programs internal or external to the agency that provide identical or similar services or functions. Describe the similarities and differences.

Other state agencies perform the same or similar functions in support of their organization as those in the central administration program. However, the subject matter and nature of the work performed by other agencies generally differs from the Commission's.

K. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question J and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

Internal Audit coordinates its annual audit plan with the State Auditor's Office to identify any possible duplication. Since the Comptroller's audits generally focus on expenditures and compliance with state expenditure laws, the Commission typically does not perform that type of review, unless the annual risk assessment process indicates a significant risk in that area.

L. Please provide any additional information needed to gain a preliminary understanding of the program or function.

Not applicable

M. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. If this is a regulatory program, please describe:

- why the regulation is needed;
- the scope of, and procedures for, inspections or audits of regulated entities;
- follow-up activities conducted when non-compliance is identified;
- sanctions available to the agency to ensure compliance; and
- procedures for handling consumer/public complaints against regulated entities.

Central administration functions are not considered regulatory, as defined.

N. Please fill in the following chart for each regulatory program. The chart headings may be changed if needed to better reflect the agency's practices.

Not applicable.

A. Please complete the following chart.

Texas Workers' Compensation Commission Exhibit 14I: Program or Function Information — Fiscal Year 2002	
Name of Program or Function	Information Systems
Location/Division	Austin Central Office
Contact Name	Lynda Hailey, Director of Information Systems
Number of Budgeted FTEs, FY 2002	68.7 (estimated)
Number of Actual FTEs as of August 31, 2002	62

B. What are the key services of this function or program? Describe the major activities involved in providing all services.

Information Systems provides the following services:

- telephone services including system maintenance, movement of phones and technical troubleshooting;
- computer support including movement of computers, installation, troubleshooting, assisting in use of software and hardware, supporting the network and hardware which provides the ability for all sites to communicate;
- printer technical troubleshooting and assistance;
- legacy system (COMPASS) modifications to meet business needs;
- project management, system development in support of the BPI project;
- automation training and help desk services;
- video streaming and video conferencing support;
- internet and intranet hardware system support;
- e-mail services;
- protection of agency data with appropriate hardware, virus protection and access control;
- mainframe services through contract with Northrup Grumman;
- printing of notices and letters to provide information to system participants;
- printing of mainframe reports to provide information to agency staff; and
- managing the receipt of electronic data interchange (EDI) and electronic claim submission (ESC) transmissions to the agency.

C. When and for what purpose was the program or function created? Describe any statutory or other requirements for this program or function.

Prior to the creation of the Texas Workers' Compensation Commission (TWCC) on April 1, 1990, the predecessor agency captured information based on the existing statutory requirements and used a mainframe shared with the Higher Education Coordinating Board. The legacy mainframe system

(COMPASS) was purchased from the state of Washington to gather data, primarily claim and coverage information, to meet new statutory requirements when the Commission was formed. The Information System function continues to support the mainframe activity for both the pre-1991 workers' compensation law and the law currently in existence.

D. Describe any important history not included in the general agency history section, including a discussion of how the services or functions have changed from the original intent. Will there be a time when the mission will be accomplished and the program or function will no longer be needed?

As legislation has been created and the need to capture additional information was needed, the COMPASS legacy system was modified to add functionality. Until 1997 when the mainframe operations were moved to the West Texas Disaster Recovery and Operations Center (WTDROC), the mainframe was housed at the central office and the Information Systems program provided technical support. In 1998, the Commission added file servers at each location across the state and the network capability to allow for the use of personal computers to provide email, mainframe access, and a suite of business software (word processing, spreadsheet, presentation, etc.).

An automation initiative, Business Process Improvement (BPI), is identifying new and revised processes to simplify or eliminate while still meeting the business needs of the agency. The Commission is in the process of designing and developing a new automated system, TXCOMP, to replace the COMPASS database.

The mission of the Information Systems program is to provide technical support to maximize the Commission's effectiveness and productivity, and there will always be a need for the function as technology continues to evolve.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

Currently, the division mainly supports agency staff. As the TXCOMP system is implemented and public access grows, the division will also provide direct support through the Help Desk function and indirect support through the technical functions such as systems development and network operations to external system participants.

F. Describe how the program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. List any field or regional services.

Most Information Systems functions are performed from the Austin Central Office and are performed based on established guidelines and policies. Services are provided through four functional areas: Systems Development, Network, End User Support, and Telecommunications. In addition, the Security Officer and IS Contract Manager report directly to the Director.

Several Information Systems functions have been outsourced during the past several years. Information Systems relies upon a Desktop Seat Management contract to provide physical computer support at the

field offices. Also by contract, the Commission's mainframe operations are supported at the West Texas Disaster Recovery Center.

G. If the program or function works with local units of government, (e.g., Councils of Governments, Soil and Water Conservation Districts), please include a brief, general description of these entities and their relationship to the agency.

The Information Systems program does not routinely work with local units of government.

H. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Funding Source	FY 2002 Expenditures
General Revenue	$7,881,504
Interagency Contract	1,444
Total	**$7,882,948**

I. Are current and future funding resources appropriate to achieve program mission, goals, objectives, and performance targets? Explain.

Current funding is appropriate to meet the program's needs.

J. Identify any programs internal or external to the agency that provide identical or similar services or functions. Describe the similarities and differences.

There are staff in other Commission programs that perform statistical and other ad hoc reporting functions.

K. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question J and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

Information Systems works closely with the statistical reporting staff to ensure the most appropriate area provides the services requested. Now, and during the development of TXCOMP, the IS Division will work closely with these staff to prevent duplication of services.

There is a MOU with the Health and Human Services Commission Network to provide WAN functionality for the Commission. The MOU has been in place for three years, and the HHSCN has provided excellent service to Commission and remains cost beneficial.

L. Please provide any additional information needed to gain a preliminary understanding of the program or function.

Information Systems staff will continue to support the legacy system environment while learning new technology to support the TXCOMP implementation until the complete replacement of the mainframe programs.

M. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. If this is a regulatory program, please describe:

- why the regulation is needed;
- the scope of, and procedures for, inspections or audits of regulated entities;
- follow-up activities conducted when non-compliance is identified;
- sanctions available to the agency to ensure compliance; and
- procedures for handling consumer/public complaints against regulated entities.

Not applicable

N. Please fill in the following chart for each regulatory program. The chart headings may be changed if needed to better reflect the agency's practices.

Not applicable.

A. Please complete the following chart.

Texas Workers' Compensation Commission Exhibit 14J: Program or Function Information — Fiscal Year 2002	
Name of Program or Function	Business Process Improvement
Location/Division	Austin Central Office
Contact Name	Stacey Jefferson, Director of Business Process Improvement
Number of Budgeted FTEs, FY 2002	3.3 (Estimated)
Number of Actual FTEs as of August 31, 2002	3

B. What are the key services of this function or program? Describe the major activities involved in providing all services.

The purpose of the Business Process Improvement (BPI) program is to support the agency's BPI Project initiative. The BPI staff develops plans for the agency's migration from its mainframe system to an open, online system capable of providing external parties with workers' compensation information and services. This team has developed a plan through FY2007 that will support a more efficient and effective workers' compensation system for all of Texas' participants. The team works with the program areas to develop business requirements and design documentation for re-engineered processes and works with Information Systems (IS) and contractors to communicate requirements and ensure system applications meet business needs. The team also develops test scenarios and scripts and performs quality assurance functions to certify that developed applications meet the requested specifications.

C. When and for what purpose was the program or function created? Describe any statutory or other requirements for this program or function.

The BPI program was created in FY1999 after BPI Project funding was appropriated to the agency to perform a consultative business process re-engineering study and develop a technology plan. The goals were to move the agency off of its closed legacy application to a system that would allow the Commission to provide improved services and support processes that were less paper intensive. The passage of HB2511 (76th Legislature), which required the Commission to reduce paper filing requirements within the Texas workers' compensation system, served as an additional motivation for the agency to focus more attention on improved processes. Fulfilling this mandate through the BPI initiative is another important responsibility for the BPI Division. Subsequently, HB2600 mandated additional data collection responsibilities for the agency and the BPI Division is incorporating these requirements into the overall BPI project plan.

D. Describe any important history not included in the general agency history section, including a discussion of how the services or functions have changed from the original intent. Will there be a time when the mission will be accomplished and the program or function will no longer be needed?

There may not be a need to retain the existing structure and associated staff once the full migration from the legacy COMPASS system to the future TXCOMP system is complete. However, there will still be a need for the agency to continuously improve its systems and services and to perform functions such as establishing business requirements, project plans, and designing and testing applications.

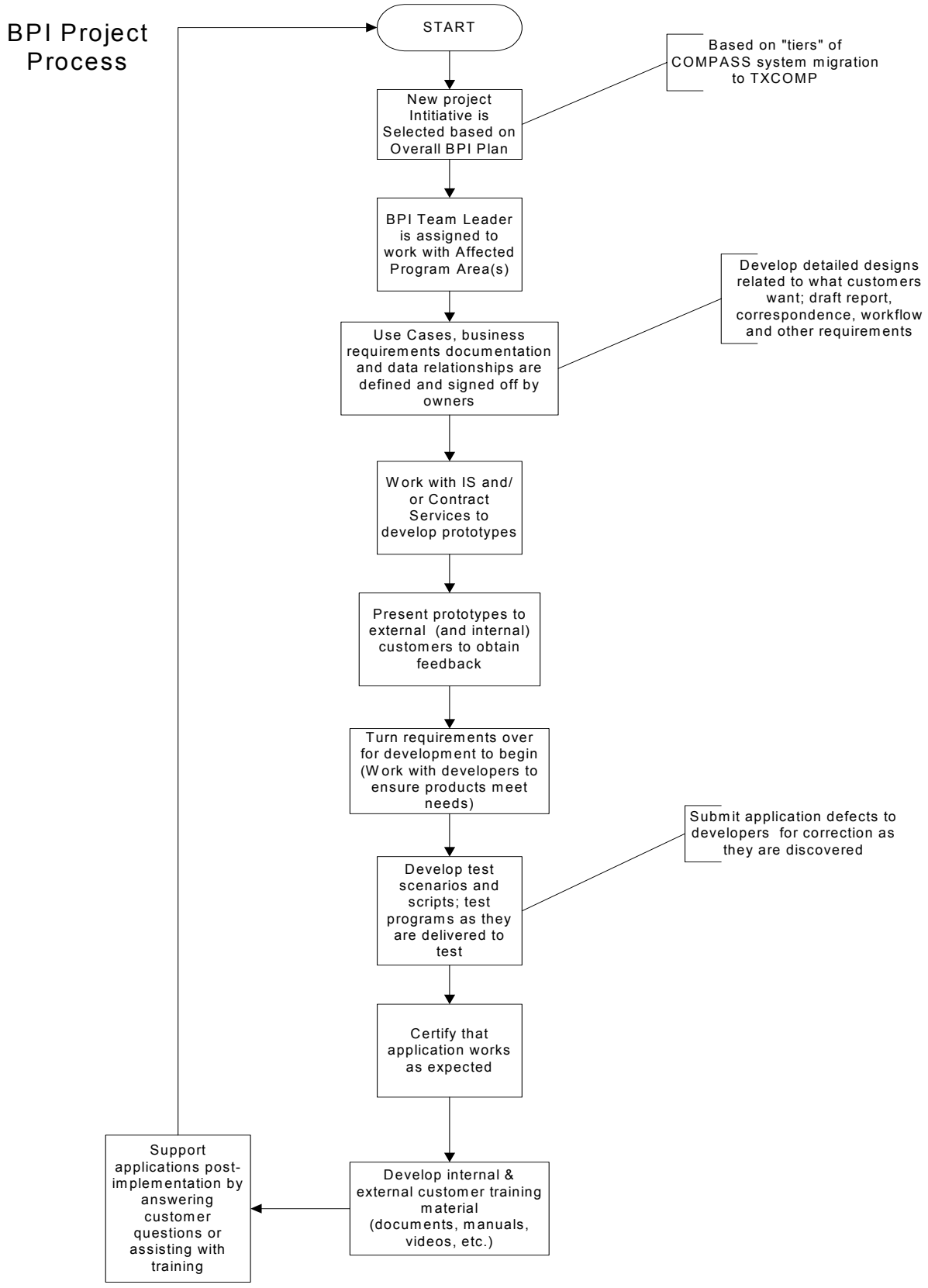
E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

The work of the BPI program affects all external and internal customers as each new TXCOMP application is released. Currently, medical providers and insurance carriers' Austin representatives are two of the external groups the program is working closely with to ensure the first two TXCOMP applications meet their needs. Additionally, the program works with all of the agency's internal users to ensure delivered applications satisfy their requirements.

F. Describe how the program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. List any field or regional services.

The flowchart on the following page depicts the manner in which the BPI work is conducted.

BPI Project Process



G. If the program or function works with local units of government, (e.g., Councils of Governments, Soil and Water Conservation Districts), please include a brief, general description of these entities and their relationship to the agency.

Not applicable.

H. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Funding Source	FY 2002 Expenditures
General Revenue	$839,585
Total	**$839,585**

Specifically, the BPI project itself (consulting dollars, hardware/ software acquisition, etc) was originally funded as an exceptional item capital project that is requested in addition to the agency's baseline budget. Since the FY 2000-2001 biennium, most of the initiative's funding has been included in the Commission's baseline appropriations. The Project was appropriated $2.5 million for the FY00-01 biennium to accomplish a re-engineering study, a technology assessment, and to implement a few quick-win initiatives. The amount appropriated for the FY 2002-2003 biennium was $3.56 million, and these funds were used to acquire the new technology platform, hardware and software, and to implement the first several TXCOMP applications that would support the agency's goal of migrating off of its legacy COMPASS mainframe application. The Project has been appropriated $3.56 million for the FY04-05 biennium to continue its progress.

I. Are current and future funding resources appropriate to achieve program mission, goals, objectives, and performance targets? Explain.

With another approximately $3.56 million for the FY 2006-2007 biennium, the Commission plans to complete the COMPASS replacement. After FY 2007, the Commission plans to no longer include the BPI project in its baseline funding request.

J. Identify any programs internal or external to the agency that provide identical or similar services or functions. Describe the similarities and differences.

There are no functions within the Commission that provide identical or similar services or functions. Externally, most agencies have some form of either business or systems analysts that identify requirements for systems work. A significant difference between what the Commission's program does and what is done in other organizations is that not only are the requirements gathered and documented, but the same team that best understands them is responsible for testing them and determining that the developed applications meet the documented requirements. Another difference is the amount of internal and external customer feedback related to proposed processes and prototyped systems solicited by this area.

K. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question J and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

The BPI Project impacts all areas of the Commission, therefore, the BPI Division must work closely with each area to ensure that business owners are aware of what projects are being worked and which ones are scheduled to be worked in the near future. The rules development process, agency forms development and publication, and external training seminars are all examples of areas the BPI program must work closely with to ensure that business requirements are aligned and proposed processes are as efficient and effective as possible.

The BPI program has worked closely with the Texas State Board of Medical Examiners and the Texas Chiropractic Examiners Board to develop appropriate systematic intake of provider licensure information to assist in automating the Commission's Approved Doctor List application processes. Additionally, the Commission is working with Texas Workforce Commission to establish some additional data exchanges related to Texas employer data and with Texas Rehabilitation Commission regarding return to work data. All of this data will be important intake processes for the new TXCOMP applications.

L. Please provide any additional information needed to gain a preliminary understanding of the program or function.

Not necessary.

M. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. If this is a regulatory program, please describe:

- why the regulation is needed;
- the scope of, and procedures for, inspections or audits of regulated entities;
- follow-up activities conducted when non-compliance is identified;
- sanctions available to the agency to ensure compliance; and
- procedures for handling consumer/public complaints against regulated entities.

The BPI program is not a regulatory program, but the Project is responsible for ensuring the applications developed will support this agency's ability to regulate the Texas workers' compensation system.

N. Please fill in the following chart for each regulatory program. The chart headings may be changed if needed to better reflect the agency's practices.

Not applicable.

A. Please complete the following chart.

Texas Workers' Compensation Commission Exhibit 14K: Program or Function Information — Fiscal Year 2002	
Name of Program or Function	Support Services
Location/Division	Austin Central Office
Contact Name	Frank Roddey, Director of Support Services
Number of Budgeted FTEs, FY 2002	33.8
Number of Actual FTEs as of August 31, 2002	31.3

B. What are the key services of this function or program? Describe the major activities involved in providing all services.

The Support Services Division is responsible for providing a variety of centralized support for the agency. These services include: procurement and contracting, facility and leasing management, forms/publications management and distribution, mail operations, copy center services, switchboard services for the central office, security for agency facilities, physical asset management, fleet vehicle management, and agency supply store.

Administrative Services operates the Commission Document Handling Section, which receives, sorts and distributes all incoming mail to the central office, Records Center and field offices; operates a distribution center for carrier representatives; manages mail services and postage accounts for the agency; manages contracts for pre-sort services, express and parcel delivery services; operates the agency copy center; operates the central office switchboard; manages the agency publications section that provides agency publications for sale to the public; manages agency forms; operates the agency courier service; and staffs the lobby receptionist desk at central office.

Purchasing and Contracts Section procures goods and services to support the agency. Includes the purchase of office supplies and materials, durable goods and capital equipment; term contracts for office equipment and services; contracts for professional and consulting services; and interagency contracts. The Purchasing Section also manages the agency Procurement Card program and operates the Supply Store for office supplies at central office.

Leasing and Property Management manages all leases for the central office, Records Archiving Center and field offices; develops specifications for new and replacement leases in coordination with affected division and field office; performs space planning functions for the agency; coordinates office moves; manages and maintains the modular furniture for the agency; manages the capital asset program for the agency, including coordination of the annual capital assets inventory; is responsible for facility safety and security, including the emergency evacuation plan for the central office; and coordinates the agency fleet management program.

C. When and for what purpose was the program or function created? Describe any statutory or other requirements for this program or function.

The Division was created in 1991. Statutory requirements for this Division include the Texas Government Code; Texas Administrative Code, and Texas Building and Procurement Commission rule, regulations and guidelines.

D. Describe any important history not included in the general agency history section, including a discussion of how the services or functions have changed from the original intent. Will there be a time when the mission will be accomplished and the program or function will no longer be needed?

Services provided by the Support Services Division will be required as long as the agency is in existence.

E. Describe who or what this program or function affects. List any qualifications or eligibility requirements for persons or entities affected. Provide a statistical breakdown of persons or entities affected.

The Division serves both internal and external customers. The internal customers are staff and divisions of the agency. The external customers mainly include participants in the worker's compensation system (injured workers, insurance carriers, health care providers and employers and their representatives) and other entities that have an interest in the agency's business operations.

F. Describe how the program or function is administered. Include flowcharts, timelines, or other illustrations as necessary to describe agency policies and procedures. List any field or regional services.

The Support Services Division functions are provided from the central office. The division is administered in accordance with the following agency procedures that are on the agency's Intranet:

- Facilities & Property Management – Procedures 06-01, 06-02, 06-04, 06-05, 06-06, 06-07;
- Administrative Management – Procedures 03-30, 03-31, 03-46, 03-52, 03-53;
- Contracts & Purchasing – Procedures 16-01, 16-02, 16-03, 16-04, 16-05; and
- Records – Procedures 19-04, 19-13, 19-15.

G. If the program or function works with local units of government, (e.g., Councils of Governments, Soil and Water Conservation Districts), please include a brief, general description of these entities and their relationship to the agency.

The functions of the Division do not normally involve working with local governments.

H. Identify all funding sources and amounts for the program or function, including federal grants and pass-through monies. Describe any funding formulas or funding conventions. For state funding sources, please specify (e.g., general revenue, appropriations rider, budget strategy, fees/dues).

Funding Source	FY 2002 Expenditures
General Revenue	$1,332,500
Appropriated Receipts	3,690
Total	**$1,336,190**

I. Are current and future funding resources appropriate to achieve program mission, goals, objectives, and performance targets? Explain.

Yes.

J. Identify any programs internal or external to the agency that provide identical or similar services or functions. Describe the similarities and differences.

Most state agencies have an organizational element responsible for providing support services to their agency similar to those provided by the Commission Support Services Division, however, there are no programs internal or external to the agency, other than the TBPC Print Shop discussed below, that provide these or similar services or functions to the Commission facilities and employees.

The Administrative Services section operates a quick copy center to support agency copy needs of a moderate volume in accordance with the Council of Competitive Government approved guidelines for quick copy centers. Copy requests include items such as the agency public meeting agenda packet, information for distribution to system participants, speaker's bureau and in-house meetings documents and training material for Commission conducted training seminars. The Texas Building and Procurement Commission (TBPC) operates a Print Shop and a Quick Copy Center that provides support to state agencies for requirements that exceed their capabilities and for high volume copy services.

K. Discuss how the program or function is coordinating its activities to avoid duplication or conflict with the other programs listed in Question J and with the agency's customers. If applicable, briefly discuss any memorandums of understanding (MOUs), interagency agreements, or interagency contracts.

The Commission uses its own resources for low to moderate volume copy requirements and uses the Commission Print Shop/Quick Copy Center for high volume print/copy requirements.

L. Please provide any additional information needed to gain a preliminary understanding of the program or function.

Not applicable

M. Regulatory programs relate to the licensing, registration, certification, or permitting of a person, business, or other entity. If this is a regulatory program, please describe:

- why the regulation is needed;
- the scope of, and procedures for, inspections or audits of regulated entities;
- follow-up activities conducted when non-compliance is identified;
- sanctions available to the agency to ensure compliance; and
- procedures for handling consumer/public complaints against regulated entities.

The Support Services Division is not a regulatory program.

N. Please fill in the following chart for each regulatory program. The chart headings may be changed if needed to better reflect the agency's practices.

Not applicable.

VII. Agency Performance Evaluation

A. What are the agency's most significant accomplishments?

Low Dispute Rate

Even though there are many potential opportunities for dispute between the parties in a claim, the vast majority of workers' compensation claims proceed through the system with no disputes. Of injuries with at least one day of lost time, (i.e., claims that are required to be reported to the Commission), only about 18% of them have any income benefit dispute arise during the "life" of the claim. Since there are many workers' compensation claims in which there is medical care provided but no lost time (which means the claim is not reported to the Commission), the percent of all on-the-job injuries with disputed income benefit issues is even smaller than the 18%.

Multiple disputes may arise in the same claim throughout the course of the "claim life." For instance, there may be an initial dispute over whether an injury was work-related and a later dispute over the appropriate impairment rating. If a dispute arises, the Commission works toward resolving the issue(s) as quickly as possible.

Ombudsman Assistance at Dispute Proceedings

Sections 409.041-409.044 of the Labor Code require that the Commission maintain an ombudsman program to assist injured workers (or their beneficiaries) in obtaining benefits. The statute also specifies the eligibility and training requirements for ombudsmen. Currently, 64.5 ombudsmen assist unrepresented injured workers (and some employers) at dispute proceedings held by the Commission and at proceedings held by the State Office of Administrative Hearings on medical dispute appeals. Ombudsmen are located in the field offices, with the number of ombudsmen necessary for each field office being based on workload demand.

Ombudsman assistance is offered to every injured worker scheduled for a dispute proceeding if the worker has not reported having a representative. An ombudsman meets with the injured worker prior to a proceeding and will also attend the proceeding with the injured worker, if requested to do so. In FY 2002, ombudsmen assisted at 55% of benefit review conferences and at 43% of contested case hearings. Although assistance may be provided in preparing appeals to the Appeals Panel, mechanisms are inadequate to accurately track assistance information at that level of dispute resolution. An employer may also receive ombudsman assistance if the employer is disputing compensability of a claim that the insurance carrier has accepted. However, employers rarely request ombudsmen assistance.

The difference in proceeding outcomes when an injured worker is assisted by an ombudsman versus when assisted by an attorney is relatively small. For instance, CY 2002, the claimant prevailed in contested case hearings 48% of the time when assisted by ombudsmen and 53% of the time when assisted by attorneys. The difference partially may be the result of the fact that an attorney has the ability to review and select cases, whereas an ombudsman must assist anyone and everyone requesting that assistance.

Income Benefit Dispute Resolution

In keeping with the goal of resolving disputes at the lowest, most informal level, the Commission has consistently resolved approximately 68% of all income benefit disputes received without parties having to attend an official dispute resolution proceeding. There was some fluctuation in the number of disputes received and the percent resolved prior to a proceeding when a statutory change was implemented January 1, 2002.

Increased Designated Doctor Requests

Enactment of a 2001 statutory change to use designated doctors to address questions on maximum medical improvement and impairment ratings, rather than waiting to use their expertise later in the dispute resolution process, resulted in an increase of over 350% in the number of designated doctor requests in 2002. Commission staff handled the increased workload during a time when resources were decreasing as a result of budget reductions. The Designated Doctor Scheduling function for selected field offices currently is being moved to the central office to bring standardization to the process and to free-up field office staff for other customer service activities.

Medical Cost and Quality Control

The Commission is making strides to improve the quality of health care provided to workers injured on the job. Since the enactment of statutory changes made by the 77th Legislature, the Commission has developed and implemented a process for conducting quality reviews of medical care provided in the workers' compensation system. Implementation of the medical quality review process included: development of rules for the review of healthcare practices and the actions the Commission may take in response to reviews; creation of a Medical Quality Review Panel (MQRP) of health care providers to review medical files and provide medical opinions on care being provided; appointment of an executive committee of the MQRP; requesting statutory changes to provide MQRP members with immunity from lawsuits and to allow increased sharing of information between the Commission and the medical licensing boards; and development of utilization reports based on the medical data submitted to the Commission. The medical quality review process is being used to identify doctors who will not be certified for the Approved Doctor List (ADL). Doctors must be certified for the ADL or have received a temporary exception to the requirement to be on the ADL, in order to provide and be reimbursed for health care in the workers' compensation system after September 1, 2003.

The Commission adopted, and successfully defended in district court, a new Medical Fee Guideline for health care provided in the workers' compensation system that became effective August 1, 2003. The new guideline should greatly contribute to containing medical costs in the system.

Enforcement

The Commission enforces the workers' compensation system's statutes and rules through fraud detection and administrative violations identified during audits and complaint investigations. In the last couple of years, accomplishments have been realized in these enforcement areas. Working with federal agencies, criminal indictments have been secured against several health care providers with large practices that were primarily comprised of treating injured workers. Through audit efforts, the Commission identified a problem with the manner in which insurance carriers were reporting benefit payments. The statistics on the average days to initiate benefits have steadily declined with the continued audit enforcement efforts and correction of the reporting error. Additionally, agency enforcement efforts have resulted in improved compliance by health care providers in timely filing reports of maximum medical improvement/impairment rating.

Workforce Training

The Commission has successfully leveraged technology to provide staff with much of the subject matter training required to perform job functions. With staff dispersed in offices throughout the state, the ability to provide training without requiring travel expenditures is critical. The agency's New Employee Orientation and the required introductory training requirements are provided online via the agency's intranet. Teleconferences and videoconferences are held routinely to disseminate information and to provide guidance. Those sessions are also made available through the intranet to allow all Commission staff access to the information on an "as and when needed" basis.

Business Process Improvement Initiative

The Commission has begun replacing its antiquated mainframe-based automation system. The new automated systems will enable to the Commission to convert from a heavily paper-driven agency to one that allows participants in the workers' compensation system to use web-based tools to manage workers' compensation claims and access increased amounts of information. During FY 2003, the agency implemented automated applications, approval processing, and reporting functions for doctors applying to be on the Commission's Approved Doctor List and began accepting electronic filings of employers' workers' compensation insurance coverage information. During the next biennium, online systems will be developed to support injury claim reporting and maintenance.

In the course of moving to a more heavily automated system, continuing to comply with the confidentiality provisions regarding workers' compensation information is of utmost importance. The Commission has worked with the Department of Information Resources to successfully test the security mechanisms in place to deter people without proper authorization from accessing information through automated systems.

Improved Customer Service and Distribution of Data

The Commission continually strives to improve the ability to provide customers with the information and services they need to function in the workers' compensation system. Use of websites has dramatically expanded the agency's ability to serve customers.

The Commission identified the information that was most commonly requested and has worked toward making that material available on the agency's website if possible. Now, most all agency notices and publications are available on the site, and system participants routinely use the site to remain informed on Commission business and policy. During the last year, the Commission has developed an on-line curriculum for doctors wishing to be certified for participation in the system. Doctors have been complimentary of the both the curriculum itself and the convenience of being able to access and complete the training as their schedules allow.

Through the combined use of statistical reporting tools and deployment through websites, the Commission has improved the amount and types of workers' compensation data that is available to internal and external customers. A visitor to the agency's external website is now able to define specific injury information needed, such as location, costs, and industrial distribution, and receive the output without having to make a request through the Public Information process. Additionally, numerous workload reports have been developed and are distributed for management purposes through the agency's intranet system. The Commission also accepts email comments on proposed rules.

The Commission is currently working to present critical information in a Spanish format on its website. Until now, most of the information on the website has been available only in English, even though the Commission recognizes the importance of reaching Spanish-speaking system participants. Evidence of our efforts to be accessible to Spanish-speaking participants is seen in the availability of brochures and forms in Spanish, the ability to reach a Spanish-speaking person to answer questions or assist with a claim, and the provision of translators, if requested, in dispute proceedings.

A new addition to the Commission's customer service efforts is a hotline number that has been designated for reporting concerns about service that has been provided by Commission staff. Reports on calls received via the hotline are reported to executive management and the Commissioners.

Safer Workplaces in Texas

Based on an annual survey of employers nationwide, Texas' injury rate continues to remain at least 15% below the national rate. Although the Commission is not able to directly correlate the services it provides with the injury rate, there is evidence that after receiving education and consultation services from the Commission, many employers experience a reduction in injury rates. In FY 2001 (the last full year for which a claims comparison can be made), employers receiving inspection and consultation services from the Commission had a 35% reduction overall in injury rates.

B. Describe the internal process used to evaluate agency performance, including how often performance is formally evaluated and how the resulting information is used by the policymaking body, management, the public, and customers.

The Commission uses a number of mechanisms to track performance: performance measures, both those reported to the Legislative Budget Board (LBB) and Governor's Office of Budget and Planning (GOBP) and those that are used for internal management purposes; audits of agency functions; production of a System Data Report; customer service surveys through the strategic planning process; and participation in the Survey of Organizational Excellence. In the workers' compensation system, participants are often operating from adversarial positions. Thus, performance evaluation can be tricky because satisfaction or dissatisfaction does not always correlate to the agency's performance of its duties.

The agency's LBB/GOBP performance measures are reported monthly by each division. Division managers are required to review and sign off on the performance that is reported. Quarterly, at meetings of the directors and other agency management staff, performance for the agency's key measures is reviewed, and measures that are over-performing or under-performing relative to projections are discussed. Additionally, during the past couple of years, the Commission has been developing performance reports that are delivered via an intranet to provide Commission staff with access to current statistical information. The online information is being used in some areas for individual performance evaluations and in others for managing resources.

Through annual risk assessment and direction from the Commissioners throughout the year, critical agency operations are identified for review by Internal Audit staff. Implementation of recommended improvements made through the audit process are monitored and reported to management on a monthly basis.

The Commission publishes a statistical report on key information about the workers' compensation

system twice a year. The Commission and external parties use that information to identify trends and to assess how the system is performing.

In conjunction with the strategic planning process, the Commission conducts a customer satisfaction survey and participates in the Survey of Organizational Excellence. These two surveys allow the Commission to assess performance both from the perspective of our external customers and from that of the agency's own employees. Since the same customer satisfaction survey has been used twice, the Commission has been able to identify areas of improvement and areas needing improvement. Likewise, the survey of Commission employees allows for comparison across years.

C. What are the agency's biggest opportunities for improvement?

Improve Timeliness for Processing Medical Disputes

With the enactment of the statutory changes regarding medical dispute resolution made by the 77th Legislature through House Bill 2600, the number and timeframes for resolution of medical disputes received by the Commission have increased significantly. As a result, the Commission must explore methods for reducing the number of disputes being filed and the timeframes required to handle those disputes.

Also, the absence of a clear method for handling the denial of future medical care and the denial of pharmaceutical services is presenting problems in the delivery of medical care to injured workers. An internal study is being conducted on the future medical question and a statutorily directed study may be conducted by insurance carriers and pharmacies on the pharmacy question. The results of those studies will produce options for addressing those issues.

Implementing Medical Fee Guidelines Based on Medicare

As of August 1, 2003, the Commission is implementing a medical fee guideline that includes use of Medicare reimbursement methodologies and payment policies. The adoption and successful defense of a guideline that will reduce medical costs and is consistent with statutory intent is a significant accomplishment. Implementation of the new guideline, however, presents a number of potential challenges.

- Like other system participants, the Commission will be challenged during upcoming months and years to find effective ways to stay abreast of changing Medicare policies and procedures and to analyze and provide policy guidance on the application of those changes in the workers' compensation system.
- Implementation will require that the Commission monitor and assess the impact of the new guideline on the system, including affects on medical costs, access to health care, and efficacy of care that is being provided.
- The volume of medical fee disputes will likely increase in the short term even further as system participants seek policy guidance for the application of the Medicare payment policies through the dispute resolution processes.
- Although updates to Medicare reimbursements and policies are automatically incorporated in the guideline as developed, the Commission is still required by statute to update medical fee guidelines every two years. Compliance with that statutory provision will likely require the

continued expenditure of enormous time and resources for the development and defense of future guideline updates.

Staff Retention

Steps must be taken to ensure that the Commission's workforce has the skills and expertise necessary for the changing work environment. With a significant number of long-tenured employees expected to take advantage of the retirement incentive adopted by the 78th Legislature, implementation of a well-defined succession plan has increased in importance. Additionally, the changing nature of some of the agency's business functions will require either training existing staff or hiring new staff with skill sets that are different than those used in the past – skills such as medical expertise, familiarity with Medicare reimbursement methodologies, and technical skills associated with the new automation tools acquired through the Business Process Improvement Project.

Monitoring Claims Administration

A key Commission goal is regulating how workers' compensation claims are administered in terms of compliance with statutory and rule provisions, payment of appropriate benefits, etc. To better perform this regulatory responsibility, the Commission will be evaluating options for:

- adopting a disability management guideline to establish general standards for the handling of the various types of workers' compensation injuries;
- collecting useful information on injured workers' return to work status and establishing standards for appropriate return to work expectations by injury type; and
- developing "report cards" on health care providers participating in the workers' compensation system.

Enhanced Consistency of Application of Statute and Rules

An ongoing challenge for the Commission, with offices located throughout Texas, is ensuring that agency functions are performed consistently regardless of the location. Monitoring tools must be used and targeted training must continue to be used to ensure that actions taken in working claim issues and dispute resolution outcomes do not vary solely because of policy application in the various field offices.

Increased Number of Compliance Referrals

The number of referrals to the Commission of suspected violations of the statute and rules has increased dramatically during the last several years. Although it has been the agency's policy in the past to work all referrals rather than prioritizing the referrals to determine those that will be worked, changes in that policy have been and will continue to be required if the number of referrals do not moderate or decrease.

Identification and Elimination of Fraudulent Activity

Although many participants in the workers' compensation system will state that fraud is a significant problem in the system, at this time, an acceptable methodology does not exist to quantify the amount of fraud and/or its impact on the system. Thus, it is very difficult to assess the effectiveness of the Commission's efforts to combat fraud.

Reduction of Dispute Timeframes

Although the Commission is proud of its success in resolving most disputes as early in the dispute resolution process as possible, ensuring that all disputes are handled quickly continues to require the agency's attention.

Business Process Improvement Initiative

As stated in the accomplishments section, the Commission has made significant movement toward developing automated systems to make communications between all system participants and access to necessary information easier. However, developing the systems and educating Commission staff, as well as all external parties using the systems, will be a major undertaking for the next several years.

D. How does the agency ensure its functions do not duplicate those of other entities?

The Commission performs its functions as required by statute. Although commonality exists with some of the functions performed by the Commission and by other entities, coordination rather than duplication is our goal in fulfilling those common missions that we share with other entities.

For instance, in performing investigations of possible fraudulent activity in the workers' compensation system, the Commission regularly shares information and resources with other entities, such as insurance carriers and federal agencies, to build a case against a participant that all entities have identified for investigation. Additionally, through open communications, the Commission has attempted to implement increased health care provider monitoring and regulation functions in the workers' compensation system without conflicting with the functions performed by those agencies charged specifically with licensing and regulating all health care providers, regardless of the type of insurance. This coordination will be enhanced because of 2003 legislation regarding sharing confidential information between the Commission and licensing boards.

E. Are there any other entities that could perform any of the agency's functions?

Some of the functions performed by the Commission are similar to those performed by other state agencies. However, with two possible exceptions, in order to perform many of those functions, as mandated by the workers' compensation statutes, experience and expertise from other Commission program areas is required and/or process and staffing changes would be required by another entity to replicate those in place at the Commission.

The Texas Department of Insurance (TDI) performs two functions that are very similar to functions performed at the Commission. When independent review organizations were statutorily required for the Commission's medical dispute process, it was based on TDI's experience in resolving preauthorization disputes between healthcare providers and health management organizations (HMOs). The Commission also receives preauthorization disputes that could be handled in the same manner as the HMO disputes. However, the volume of preauthorization disputes in the workers' compensation system is significantly more than processed by TDI, and the Commission's statute allows for an appeal of the IRO's decision to SOAH that is not a part of the HMO dispute process.

TDI also, with the passage of HB 2095 during the 78th Legislature, will certify groups of employers in the same type of business to self-insure for workers' compensation coverage. The review and certification process may be very similar to processes currently used by the Commission to review and certify private

employers meeting certain statutory requirements to qualify as a Certified Self-Insurer.

F. What process does the agency use to determine customer satisfaction and how does the agency use this information?

As part of the strategic planning process, the Commission conducts a customer satisfaction survey every two years. For that survey, the Commission has contracted with a university to contact a sample from each of the participant groups receiving services from the Commission – injured employees; injured employees assisted by the Commission's ombudsmen; insurance carriers; health care providers; and employers receiving health and safety education and training services.

During the past year, the Commission has implemented a customer courtesy hotline for persons having interactions with the agency to report concerns about service provided by a Commission employee. The nature of the calls received through the hotline and the actions taken by the Commission, if action is appropriate, are reported directly to the Commissioners.

Additionally, feedback is always requested from system participants receiving education and training from the Commission through seminars, on-site consultations, web-based training.

The responses gathered through the survey, individual training evaluations, the hotline and other communication avenues are reviewed to identify areas for improvement.

G. Describe the agency's process for handling complaints against the agency, including the maintenance of complaint files and procedures for keeping parties informed about the process. If the agency has a division or office, such as an ombudsman, for tracking and resolving complaints from the public or other entities, please provide a description.

Complaints are received and handled in a variety of ways by the Commission. Some complaints are in writing; others are made via telephone, fax, or email. Because of the adversarial nature of the agency's business, the vast majority of complaints received are related to specific claims, and are, therefore, not tracked and processed under Section 402.023 of the Labor Code. However, tracking and communication mechanisms do exist for all complaints received by the Commission.

Most of the correspondence received by the executive director is general information, legislative inquiries into claims or requests for information, and claimants filing complaints or requesting assistance. An executive suspense database is maintained to track all requests/complaints received. In that system all correspondence is logged into the database, assigned to the appropriate division for resolution, and tracked to ensure a timely response is provided to the person initiating the communication. Most of the executive suspense correspondence is handled by the Commission's Customer Service and Hearings (dispute resolution) divisions, as those divisions have the most contact with injured workers and other system participants seeking to understand what to do in a claim or how to dispute a decision that has been made regarding a claim.

Other than human resource-type complaints, all complaints and allegations against Commission employees (i.e., ex-parte communication, release of confidential information, improper use of state property, theft, etc.) are forwarded to the agency's Complaint Team. The Complaint Team is a group comprised of the Deputy Executive Directors (DED) of Legal and Compliance and Operations, and the

Directors of Compliance & Practices, HR, Communication, and Internal Audit. In addition, a representative from Legal Services participates on the team. The team's purpose is to: provide a uniform understanding by management of the nature of various complaints received; ensure that complaints are disseminated to the appropriate division for investigation; ensure that duplication of effort does not occur; reduce the possibility of compromising an investigation currently underway by another division or external investigative authority (FBI, District Attorney's Office, etc.); and ensure that consistent remedial actions are taken, when necessary. Additionally, the structure allows the team to identify recurring complaints against employees or other issues that may need to be addressed at a broader level.

Other Commission functions also involve handling complaints. Suspected violations in the handling of or fraudulent activity in a claim are reported to the Commission's Compliance and Practices division. Those referrals and their disposition are logged into an automated violation tracking system. Additionally, the Commission is continuously involved in the rulemaking process – implementing statutory or policy changes, amending rules to respond to system participant suggestions, reviewing existing rules for necessity, etc. Therefore, system participants actively provide comments, suggestions, and complaints about the rules in place or rules that they feel should be adopted. If a participant files an official rule petition, it is handled by the Commissioners in accordance with Commission rules and Administrative Procedures Act provisions; otherwise, communications regarding rules are used to provide indications of rule areas that may need modification, and are not tracked as complaints.

As evidenced by the preceding discussion, much of the Commission's business is associated with responding to complaints about claims in the workers' compensation system. Centralizing all complaint handling, without regard to whether related to a claim, would be problematic given the volume of workers' compensation claims. The agency takes its responsibilities to be responsive very seriously and has systems in place to assist in evaluating complaint patterns and identifying problems needing attention.

Please fill in the following chart. The chart headings may be changed if needed to better reflect

the agency's practices.

Texas Workers' Compensation Commission Exhibit 16: Complaints Against the Agency – Fiscal Years 2001 and 2002		
	FY 2001	**FY 2002**
Number of complaints received	0	0
Number of complaints resolved	0	0
Number of complaints dropped/found to be without merit	0	0
Number of complaints pending from prior years	0	0
Average time period for resolution of a complaint	NA	NA

Note: As discussed in Subsection G, most complaints received by the Commission are related to a specific workers' compensation claim.

I. What process does the agency use to respond to requests under the Public Information (Open Records) Act?

This agency has responsibility for protecting the confidentiality of claim file information. All written requests submitted under the Public Information Act are directed to Communications and Public Information (CPI) staff. When a request is received, it is logged into the database and assigned to the appropriate division for collection of requested information. Once the information is received, it is reviewed in coordination with Legal Services staff to ensure the information can be released or to identify the need for an Attorney General opinion. Once approved for release, CPI staff prepares a cost letter and releases the information upon receipt of payment. CPI staff files monthly reports with the Texas Building and Procurement Commission.

In 2002 the agency received 982 requests and in 2003 the agency received 488 requests through July 28th.

J. Please fill in the following chart with updated information and be sure to include the most recent e-mail address if possible.

Texas Workers' Compensation Commission
Exhibit 17: Contacts

INTEREST GROUPS
(groups affected by agency actions or that represent others served by or affected by agency actions)

Group or Association Name/ Contact Person	Address	Telephone & Fax Numbers	E-mail Address
Joe Woods Assistant Vice President Southwest Regional Manager American Alliance of Insurers	1212 Guadalupe St. Suite 103 Austin, TX 78701	322-9224 Fax: 322-9277	jwoods@allianceai.org
Fred Bosse American Insurance Association	100 Congress Ave. Austin, TX 78701	322-3100	rcobb@sw.aiadc.org
Rick Gentry Insurance Council of Texas	2801 South IH-35 Austin, TX 78741	444-9611	snichols@insurancecouncil.org
Judy Roach Texas Certified Self-Insurance Assoc.	1115 San Jacinto Blvd Suite 275 Austin, TX 78701	322-0514 Fax: 480-8051	judyroach@austin.rr.com
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Texas Chiropractic Association	815 Brazos, Suite 802 Austin, TX 78701	477-9292 Fax: 477-9296	
Texas Association of School Boards	7703 N. Lamar Blvd. Austin, TX 78752	467-0222	
Jack Latson Flahive, Ogden & Latson	505 W. 12th Street P.O. Box 13367 Capitol Station Austin, TX 78711	477-4405 Fax: 867-1700	JWL@fol.com
Harris & Harris	5300 Bee Cave Road Building III Austin, TX	346-5533	
Patient Advocates of Texas	P.O. Box 850069 Mesquite, TX 75185	817-429-0011 Fax: 972-494-5224	
Injured Workers Assistance Center	6900 Anderson Blvd. Suite 201 Ft. Worth, TX 76120	817-451-8484 Fax: 817-451-4646	

INTERAGENCY, STATE, OR NATIONAL ASSOCIATIONS
(that serve as an information clearinghouse or regularly interact with the agency)

Group or Association Name/ Contact Person	Address	Telephone & Fax Numbers	E-mail Address
National Council on Compensation Insurance (NCCI)	901 Peninsula Corporate Circle Boca Raton, FL 33487	561-893-1000 Fax: 561-893-1191	
Bob Collyer Southern Association of Workers' Compensation Administrators (SAWCA)	P.O. Box 11697 Daytona Beach, FL 32120	386-304-1993 Fax: 386-304-8820	
Western Association of Workers' Compensation Boards (WAWCB)			
Gregory Krohm International Association of Industrial Accident Boards and Commissions (IAIABC)	5610 Medical Circle Suite 14 Madison, WI 53719	608-663-6355 Fax: 608-663-1546	gkrohm@iaiabc.org
Jeff Rucker Region VI Office of Safety and Health Administration (OSHA)	525 South Griffin St. Suite 602 Dallas, TX 75702	214-767-4736 X244 Fax: 214-767-4693	Rucker.Jeffrey@dol.gov

LIAISONS AT OTHER STATE AGENCIES (with which the agency maintains an ongoing relationship, e.g., the agency's assigned analyst at the Legislative Budget Board, or attorney at the Attorney General's office)			
Agency Name/Relationship/ Contact Person	**Address**	**Telephone & Fax Numbers**	**E-mail Address**
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Marvin Kelly Texas Property and Casualty Guaranty Association (TPCIGA)	9120 Burnet Road Austin, TX 78758	345-9335 Fax: 345-9341	
Don Walker/Nelly Herrera Office of the Attorney General	P.O. Box 12548 Austin, TX 78711	463-2100	
Texas Department of Information Resources	300 West 15th St. Suite 1300 Austin, TX 78711	475-4700 Fax: 475-4759	
Mike Brevell Texas Rehabilitation Commission		424-4062	
Texas Building and Procurement Commission	1711 San Jacinto Austin, TX 78701	463-6363	
Jed Rogers Texas State Library and Archives Commission	4400 Shoal Creek Blvd Austin, TX 78756	452-9242 X157	
Sandra Vice State Auditor's Office	P.O. Box 12067 Austin, TX 78701	936-9500 Fax: 936-9400	svice@sao.state.tx.us
Texas State Board of Medical Examiners	333 Guadalupe Street Tower III, Suite 610 Austin, TX 78701	305-7011 Fax: 305-7008	
Texas Board of Chiropractic Examiners	333 Guadalupe Street Tower III, Suite 825 Austin, TX 78701	305-6700 Fax: 305-6705	

VIII. 78th Legislative Session Chart

Fill in the chart below or attach information if it is already available in an agency-developed format. In addition to summarizing the key provisions, please provide the intent of the legislation. For example, if a bill establishes a new regulatory program, please explain why the new program is necessary (e.g., to address specific health and safety concerns, or to meet federal mandates). For bills that did not pass, please briefly explain the issues that resulted in failure of the bill to pass (e.g., opposition to a new fee, or high cost of implementation).

Texas Workers' Compensation Commission
Exhibit 18: 78th Legislative Session Chart

Legislation Enacted - 78th Legislative Session

Bill Number	Author	Summary of Key Provisions/Intent
HB 145	Solomons	Allows Commission to bring suit to enforce its decisions and orders; requires a party seeking judicial review to provide the Commission with written notice simultaneously with the filing of the court petition and makes that a jurisdictional issue.
HB 833	Hochberg	Allows an injured worker to select brand name drugs and pay for the difference in price; requires the Commission to change rules to help pharmacies bill and insurance carriers process and pay pharmacy bills; requires the Commission to consider rule making petition based on a study funded by carriers and pharmacists in developing fee guideline for prescription drugs; rules adopted must clearly define methodology for determining payment amounts and must take into account fees paid by other payers and the costs and expenses incurred by pharmacists. (See SCR 48)
HB 1878	Dutton	Requires a workers' compensation insurance carrier that receives an order or writ of withholding under Chapter 158 of the Family Code to withhold an amount not to exceed the maximum amount allowed regardless of whether the income benefits are paid as lump sum or as a periodic payment.
HB 2095	Cook, R.	Allows employers in the same type of business who belong to a trade association in Texas to join together to self-insure for workers' compensation.
HB 2116	Brown, F.	Provides that members of TEXAS TASK FORCE 1, a program of the Texas Engineering Extension Service that provides training and responds to assist in search, rescue and recovery efforts following natural or man-made disasters, are covered by workers' compensation insurance when the Task Force is activated or during any training session sponsored or sanctioned by the Task Force.
HB 2198	Solomons	Addresses the issues that have arisen as a result of the Fulton v. Associated Indemnity Corporation court decision. Specifically, it provides that the first certification of maximum medical improvement and assignment of an impairment rating becomes final if not disputed within 90 days after written notification is provided; includes statutory exemptions and allows the Commission to adopt rules to prescribe additional exceptions when "compelling circumstances" exist.
HB 2199	Solomons	Addresses the issues that have arisen as a result of the Continental Casualty Co. v. Downs court decision and addresses several self-insurance issues. Changes the "pay or dispute" period from seven days to 15 days; this does not affect the accrual due date of the requirement to begin payment of benefits within seven days of the 8th day of disability; clarifies that the insurance carrier does not waive the right to dispute compensability until after the 60th day and eliminates

		the need for "cert-21s" in order to preserve the right to dispute up until the 60th day if no income benefits are due; clarifies that carrier notification for certified self-insurers and political subdivisions that self-insure begins when the third party administrator or other claims administrator receives notice of injury.
HB 2323	McReynolds	Addresses the problems that occur when suit is filed in the wrong jurisdiction and allows the court to transfer the suit to the proper jurisdiction if the original suit was timely filed.
HB 3168	Giddings	Addresses the issues that have arisen as a result of the Fulton v. Associated Indemnity Corporation court decision (See HB 2198); gives the Commission authority to develop an alternate medical dispute resolution process for low-cost medical necessity disputes.
SB 287	Ellis	Sets staggered, two-year terms for Commissioners; current member terms expire 2/1/05; the Governor is to appoint one member representing employers and two members representing wage earners to terms expiring on 2/1/06; and one member representing wage earners and two members representing employers to terms expiring 2/1/07.
SB 478	Duncan	Excludes certain workers who provide services to a political subdivision from the definition of employee for workers' compensation insurance purposes (e.g., stock show, rodeo, carnival, circus, musical, vocal or theatrical performance, etc.)
SB 820	Fraser	Addresses the issues that have arisen as a result of the Fulton v. Associated Indemnity Corporation court decision (See HB 2198).
SB 1282	Fraser	Clarifies that carrier notification for certified self-insurers and political subdivisions that self-insure begins when the third party administrator or other claims administrator receives notice of injury.
SB 1572	Carona	Authorizes the Commission to adopt treatment protocols and guidelines that are scientifically valid and outcome-based even if not nationally recognized.
SB 1574	Carona	Provides immunity from suit and civil liability for medical quality review panel (MQRP) members; provides confidentiality to information collected by Medical Advisor or MQRP; permits the Board of Medical Examiners, the Board of Chiropractic Examiners and the Commission to share confidential information.
SB 1652	Shapiro	Extends workers' compensation insurance coverage to out-of-state employees of the Texas A&M University System; if employee pursues claim in state where injury occurred, employee is not entitled to Texas workers' comp benefits.
SB 1804	Harris	Provides that insurance carriers are liable for payment for treatment and pharmaceutical services that have been "voluntarily preauthorized;" requires independent review organizations to consider the Commission adopted payment policies and guidelines when resolving a medical necessity dispute if a party raises the issue.
SCR 48	Van de Putte	Requires the Commission to consider rule making petition based on a study funded by carriers and pharmacists in developing fee guideline for prescription drugs; rules adopted must clearly define methodology for determining payment amounts and must take into account fees paid by other payers and the costs and expenses incurred by pharmacists. (See HB 833)
Legislation Not Passed - 78th Legislative Session		
Bill Number	**Author**	**Summary of Key Provisions/Intent**
HB 322	Noriega	Allow state employees with workers' compensation injuries to use partial sick leave days to supplement workers' compensation income benefit payments.
HB 328	Chisum	Allow employers to ask job applicants questions about previous workers' compensation injuries.
HB 566	Berman	Allow health care providers to pursue a private claim against a workers' compensation claimant if claimant does not dispute the insurance carrier's

		denial.
HB 570	Brown, F.	Limit the liability of certain employers who do not provide workers' compensation insurance coverage.
HB 851	Brown, F.	Limit the liability of contractors who enter into a building or construction contract with a governmental entity.
HB 959	Allen	Resolve a determination of whether the survivor of certain public employees is entitled to payment of assistance in favor of the survivor if any reasonable doubt arises from the circumstances of the employee's death,
HB 1356	Thompson	Require the Commission to provide claims information to insurance carriers that are not a party to the claim.
HB 1375	Farabee	Exempt contractors who enter into a building or construction contract with a governmental entity for which the total dollar amount in a fiscal year is less than $9,000 from the requirement to provide workers' compensation insurance coverage for the contractor's employees.
HB 1896	King	Require injured employees of employers to receive treatment from a provider participating in the insurance carrier network.
HB 2057	Chisum	Exclude wages from multiple employers in the calculation of average weekly wage.
HB 2098	Oliveira	Clarify that carrier notification for political subdivisions that self-insure begins when the third party administrator or other claims administrator receives notice of injury. (Similar provision in HB 2199)
HB 2177	Elkins	clarifies that carrier notification for certified self-insurers and political subdivisions that self-insure begins when the third party administrator or other claims administrator receives notice of injury. (Similar provision in HB 2199)
HB 2307	Jones, Jesse	Require the Commission to consider the fact that an employee remains eligible for social security disability insurance benefits when resolving a dispute regarding the impairment or attainment of maximum medical improvement.
HB 2406	Stick	Increase the maximum hourly rate for legal fees in workers' compensation benefit matters.
HB 2427	Brown, F.	Allow Texas Tech University and Texas Tech University Health Sciences Center to self-ensure.
HB 2788	Eiland	Allow an employee or legal beneficiary to seek damages from the employer liable for a compensable injury or death and to pursue a claim for workers' compensation benefits.
HB 2808	Giddings	Extend the period for the Commission to accept a grant from the Texas Mutual Insurance Company to 9/1/05.
HB 2982	Nixon	Prohibit an employee of a subcontractor or independent contractor from seeking damages from a third party who is a premises owner or general contractor engaged in building or construction.
HB 3000	Capelo	Prohibit an insurance carrier from denying payment for services by a surgical assistant or surgical first assistant based solely on their title.
HB 3071	Wohlgemuth	Change Commissioner terms to two years. (See SB 287)
HB 3161	Capelo	Create presumption that firefighters and peace officers that contract hypertension or heart disease have contracted them in the line of duty.
HB 3162	Capelo	Create presumption that certain emergency first responders that suffer disability or death under certain circumstances are considered to be in the course and scope of employment.
HB 3220	Bohac	Prescribe timelines for requesting a letter of clarification from a designated doctor.
HB 3233	Smith, Todd	Transfer contested case hearings to the State Office of Administrative Hearings.
HB 3285	Martinez-Fischer	Establish conversion factors for medical fee guidelines.
HB 3445	Wohlgemuth	Change Commissioner terms to two years. (See SB 287)
HB 3533	Laubenberg	Prohibit specific words and terms in connection with advertisement, solicitation, business name, business activity, product or service.

HB 3589	Giddings	Establish a regional workers' compensation healthcare pilot project if the HB 2600 (77th Session) directed feasibility study found that regional networks may be feasible.
HB 3590	Giddings	Provide confidentiality to information collected by Medical Advisor or MQRP; permit the Board of Medical Examiners, the Board of Chiropractic Examiners and the Commission to share confidential information. (Similar provisions included in SB 1574)
SB 101	Van de Putte	Prohibit certain Commission employees from employment with a workers' compensation insurance carrier for up to a period of two years following employment with the Commission.
SB 477	Duncan	Exclude a professional athlete of the Central Hockey League from the definition of employee for workers' compensation insurance purposes.
SB 603	Ellis	Create specific criminal penalties for overcharging by health care providers under the workers' compensation system.
SB 675	Estes	Clarify that recovery of workers' compensation benefits is the exclusive remedy of an employee covered by workers' compensation insurance or a legal beneficiary for the death of, or work-related injury against a parent or subsidiary corporation of the employer.
SB 728	Staples	Include certain actions in the definition of "line of duty" and clarify that a death or disease resulting in death from those actions is considered an "occupational death."
SB 819	Fraser	Clarify that an insurance carrier who fails to begin payment of benefits or dispute compensability on or before the seventh day after the carrier is notified does not waive the right to contest the compensability of the injury. (Similar provision in SB 820)
SB 1134	Carona	Require an injured employee to receive medical treatment from a provider participating in an established insurance carrier network.
SB 1311	Van de Putte	Allow an injured worker to select brand name drugs and pay for the difference in price; require an insurance carrier to pay for pharmaceutical services provided prior to receipt of notice by the pharmacy of the insurance carrier's intent to deny the claim; require the Commission to adopt a pharmaceutical fee guideline that takes into consideration the methodology used by other states, a pharmacy's usual and customary retail charge for a product, and the additional risks and administrative expenses incurred for providing services to injured workers. (Similar provisions in HB 833 and SCR 48)
SB 1397	Ogden	Provide that members of TEXAS TASK FORCE 1, a program of the Texas Engineering Extension Service that provides training and responds to assist in search, rescue and recovery efforts following natural or man-made disasters, are covered by workers' compensation insurance when the Task Force is activated or during any training session sponsored or sanctioned by the Task Force. (Similar provisions in HB 2116)
SB 1414	Deuell	Provide that certain diseases or illnesses suffered by first responders are presumed to be in the course and scope of employment under certain conditions.
SB 1529	Brimer	Require the Governor to appoint the Subsequent Injury Fund administrator.
SB 1573	Carona	Require independent review organizations to consider the Commission adopted payment policies and guidelines when resolving a medical necessity dispute. (Similar provision included in SB 1574)
SB 1575	Carona	Provide immunity from suit and civil liability for medical quality review panel (MQRP) members. (Similar provision included in HB 1804)
SB 1576	Carona	Establish a regional workers' compensation healthcare pilot project if the HB 2600 (77th Session) directed feasibility study found that regional networks may be feasible.
SB 1767	Carona	Require the Commission Medical Advisor or a member of the Commission's

		Medical Quality Review Panel to conduct a review of an insurance carrier's denial of a preauthorization request.

IX. Policy Issues

A1. Brief Description of Issue

What is the appropriate manner in which to calculate the state's average weekly wage, which then serves the standard for setting the maximum and minimum rates for the various workers' compensation benefit types?

B1. Discussion

As enacted in 1989, §408.047 of the Texas Labor Code provided that the "state average weekly wage (SAWW) equals the annual average of the average weekly wage of **manufacturing production workers** in this state, as determined by the Texas Employment Commission."

The Workforce Commission advised the Commission that it would no longer be able to calculate a state average weekly wage based on **manufacturing production workers** in the way this has been done in the past because the Standard Industrial Classification (SIC) coding system has been replaced by the North American Industry Classification System (NAICS). The industries that make up the manufacturing sector under NAICS are different than the SIC model; 12 SIC codes that were previously listed in manufacturing have been moved to other sectors, and 21 SIC codes previously in other sectors are now in manufacturing under NAICS. The net result is about a $40 increase in the SAWW for workers' compensation cap purposes. The wage of manufacturing production workers is no longer a usable basis for the benefits cap, without an increase of about $40 a year in the cap. Long term, as ALL manufacturing workers are brought into this wage calculation (not just production), even larger increases in the SAWW are likely.

The Texas Workforce Commission was faced with a similar issue during the 77th Legislature because its statute tied the rate of benefits for unemployment compensation to a formula that included the annual average weekly wage of manufacturing production workers. During the 77th Legislature, HB 567 was enacted tying the calculation of the cap on unemployment benefits to 47.6 percent of the average weekly wage of all **covered employment in this state**. This meant that all sectors of employment were to be included rather than only manufacturing production workers.

The current SAWW and workers' compensation benefit cap, based on the current SIC model of manufacturing production workers, is $537.[2] Since the Texas Workforce Commission will no longer calculate this average based on the data it has been using and since further changes are forthcoming, the 78th Legislature enacted SAWW amounts by statute for FY 2004 and 2005. It was assumed a long-term solution would be determined through the Commission's Sunset review.

C1. Possible Solutions and Impact

Option : Retain the calculation based on manufacturing sectors as defined by NAICS. The impact would be that the SAWW used to establish caps for workers' compensation income benefits would increase significantly.

2 This is the weekly cap for TIBs, LIBs, and Death Benefits. IIBs and SIBs are capped at 70 percent of this amount per week.

Option : Find a new wage calculation to which to link the workers' compensation weekly benefit cap that is NAICS based and likely not to be discontinued or methodologically revised in the near future. This option was utilized by the Workforce Commission to resolve a similar issue. If this option is preferred, there are several possible NAICS wage calculations to which the workers' comp cap could be tied. The most stable methodology may be to tie the cap to a percentage of the average weekly wage for all covered employment in the state. The current workers' compensation weekly benefits cap of $537 is about 79 percent of the SAWW for all covered employment, and could be linked to this rate at some similar percentage.

Option: Based on historical data, the Legislature could set a dollar-certain amount in Section 408.047 for the weekly cap each biennium.

A2. Brief Description of Issue

Are there factors that make controlling medical costs in the workers' compensation system more difficult than in other health care delivery systems?

B2. Discussion

Medical costs in the workers' compensation system have escalated over the past several years. The Workers' Compensation Research Institute has found that the Texas workers' compensation medical costs are considerably higher than those costs in other states' workers compensation systems and cost in other health care delivery systems in Texas. System participants and policymakers have sought to understand what is driving the costs, and the Commission has been given additional authority to try and bring costs down. However, tools that appear to assist, to some extent, in controlling costs in other systems are not available in Texas workers' compensation system.

The Commission's statutory authority currently has to effect controls on medical costs is primarily on the "back end" of a claim rather than the "front end." Other than the authority to adopt guidelines for the fees that may be charged and paid for medical care in the workers' compensation system and preauthorization requirements, controlling doctors who are allowed to practice in the system and insurance carriers who review and pay bills that are submitted must occur after care has been given.

System participants continue to discuss whether implementing the use of various "managed care tools" would assist in bringing Texas' workers' compensation medical costs down. In this vein, House Bill 2600 created a Healthcare Network Advisory Committee (HNAC) to study the feasibility of creating regional workers' compensation health care networks and, if found feasible, to create pilot networks that would function within the parameters established by statute and the standards developed by HNAC. However, the ability to balance the divergent interests and work within the statutory utilization limitations has challenged the HNAC's movement forward. Other examples of the types of tools that have been and will continue to be debated for inclusion in the workers' compensation system are co-payments, deductibles, and limitations on doctor selection.

Also under consideration is the usefulness of preauthorization in controlling medical costs. While the Act provides flexibility for the Commission to designate health care services that will require express preauthorization or concurrent review by the insurance carrier, the Act expressly requires preauthorization for five categories of services [Texas Labor Code section 413.014(c)]. At times, the cost of processing and paying for internal and external peer reviews of such services may exceed the value of such services

and, thus, may lessen or defeat the utilization review benefits of the preauthorization process. In addition, consideration should be given to why other health care delivery systems no longer require preauthorization/precertification.

C2. Possible Solutions and Impact

Several possible options exist for affecting medical costs by controlling care before it is given. More than one of these options could be adopted at the same time.

Option: Require injured workers to pay a co-payment for specified types of care, such as office visits.

Option: Allow employers to have a role in the selection of an injured worker's treating doctor. For example, if the employer provides group health insurance and workers' compensation insurance, an injured worker should be required to select a treating doctor in the group health plan.

Option: Expand the role of workers' compensation health care networks.

Option: Contract with a single payer (Trailblazer, for example) so that each claim, regardless of carrier, is reviewed under the same standard. All medical bills would be sent to the same address and health care providers and insurance carriers would be able to piggyback on the e-billing systems already developed to support Medicare.

Option: Allow chiropractors to serve only as referral and consultant doctors

Option: Change "lifetime medical benefit" language to "medically necessary benefits" to counter the perception that injured workers are entitled to medical care for their lifetime without regard to necessity or relatedness to the injury.

Option: Delete list of services for which mandatory preauthorization is required, and possibly strengthen the authority of the Commission to implement alternative utilization control mechanisms such as disability management processes with required payment by the losing party of peer reviews to resolve conflicts.

A3. Brief Description of Issue

What is the best way to prohibit system participants from passing themselves off as the Commission or an agent of the Commission?

B3. Discussion

The Commission consistently receives complaints from agency staff and the public about organizations that are presenting themselves in such a way that someone would think they were the state agency. We see this through the use of names and/or logos that are very similar to the Commission's. These "imposters" are often using the guise of the Commission's appearance to attract injured workers as clients for health care or legal services.

C3. Possible Solutions and Impact

Continue to seek a legislative remedy. This was an agency initiative during the 77th and 78th Legislative Sessions. In 2001 it was sponsored by Representative Kenn George (HB3213) and was reported favorably from the House Committee on Business and Industry and recommended for the House Local and Consent calendar where it died. In 2003, a similar initiative was sponsored by Representative Jodie Laubenberg (HB3533) and assigned to the House Committee on Business and Industry where it was not scheduled for a hearing.

A4. Brief Description of Issue

Does "due process" for disputes by system participants in the workers' compensation system need to be streamlined to eliminate added costs to the system and prevent delay in resolution of disputes that include timely provision of medical care?

B4. Discussion

1. **Statute/SOAH Rule.** The Texas Workers' Compensation Act contains numerous provisions that allow system participants to have a State Office of Administrative Hearings (SOAH) contested case hearing (CCH) BEFORE a dispute can be concluded administratively. The Act, also, is silent on whether the Administrative Procedure Act's requirements for a CCH [Texas Government Code sections 2001.003(1) and Chapter 2001 Subchapters C through Z] are applicable to certain actions by the Commission related to system participants. In addition, the Act often allows a system participant to request a SOAH CCH to contest an action by the Commission or by another system participant without requiring that participant to pay the costs of the SOAH if the SOAH decision is adverse to that participant. Finally, SOAH, pursuant to statutory authority (i.e. Tex. Gov't Code section 2003.050) , issued SOAH procedural rules that declared in the original adoption preamble that SOAH would review the initial administrative decision on the dispute "de novo" and that SOAH would not adopt the Commission's rule [i.e. 28 TAC section 148.18(a)] that required a party to show "good cause" before it could introduce evidence at the SOAH hearing that had not been provided for the initial administrative decision in the dispute.

2. **SOAH Costs to the System and Paid by Commission**. The vast majority of SOAH hearing costs billed to the Commission have involved medical necessity and medical fee disputes between health care providers and insurance carriers. The Commission does not initiate the action that results in a hearing request for medical disputes but it's required to pay increasing costs to SOAH – over the "capped" amounts appropriated to SOAH – and the Commission has not been appropriated any additional amounts to pay for these costs. In fiscal year 2002, the Commission paid SOAH over $200,000 in such costs. In fiscal year 2003, the projected costs could almost double. The Commission is funded by a maintenance tax paid by workers' compensation insurance carriers.

3. **Due Process Participant Costs – Medical Dispute Cases.** The present system does not limit the incentives for filing such disputes. First, system participants can initiate a SOAH CCH and can increase the "due process" costs for adversaries (e.g. by filing many motions and discovery issues requiring responses from other parties) without having to pay the SOAH costs if the decision is

adverse to their positions. Second, due to the SOAH "de novo" rule requirement, parties can require other participants to call witnesses and obtain admissible evidence to defend against "new evidence" that the unsuccessful party did not submit prior to the initial dispute process. Third, several SOAH decisions have interpreted a Commission rule [i.e. 28 TAC section 133.308(w)] (that provides that the initial decision of the Independent Review Organization (IRO) in medical necessity disputes should be given presumptive weight) has no effect other than requiring the unsuccessful party to have the burden of proof [that was already required by Commission rule at 28 TAC section 148.21(h)]. Therefore, parties that received a favorable IRO decision must provide expert witnesses and admissible evidence – other than from the IRO - to sustain the position in the SOAH hearing initiated by the unsuccessful party. In addition, the SOAH decision will be made by an administrative law judge rather than a medical doctor. Fourth, the medical dispute cases taken to SOAH are the only cases at SOAH where an initial administrative dispute process has already occurred. Fifth, most participants in non-workers' compensation cases do not receive a right to a SOAH contested case hearing or other administrative hearing after a decision on a medical necessity issue by an Independent Review Organization.

4. The present medical fee dispute process encourages a lengthy and costly dispute process that is not common in other state agency regulatory processes. The Commission's initial decision-making process does not include an expensive hearing and discovery. However, under the present process, it often becomes a first stepping stone (that has little or no relevance to subsequent steps) to a costly and lengthy process beyond the Commission that does little to discourage unsuccessful participants. Appeals to SOAH and the courts mean that decisions provided by medical experts (IRO) are subject to review and reversal by non-medical persons.

5. **SOAH Hearings Requested When Act Is Silent.** System participants have requested and/or demanded SOAH hearings to review Commission actions even when the Texas Workers' Compensation Act does not provide for such hearings. The requests and demands for SOAH hearings have been made directly to the Commission or in lawsuits filed against the Commission on the basis that the Commission's action can not be effective until after a SOAH hearing and decision that sustains the action. The requests and demands have been based upon the broad language in the Administrative Procedure Act that contains the following definitions: "(1) `Contested case' means a proceeding, including a ratemaking or licensing proceeding, in which the legal rights, duties, or privileges of a party are to be determined by a state agency after an opportunity for adjudicative hearing [and] (2) `License" includes the whole or a part of state agency permit, certificate, approval, registration, or similar form of permission required by law." [Texas Government Code section 2001.003] While the APA excludes the Texas Workers' Compensation Commission from the definition of "state agency" [Texas Government Code section 2001.003], the Texas Workers' Compensation Act addresses the applicability of the APA. [Texas Labor Code section 401.021]. A recent appellate court decision did not find an implied right to a SOAH hearing after the Commission's action to remove a doctor from the Approved Doctor List (based upon a previous probated suspension by the doctor's licensing board). [Bell. v.. Texas Workers' Compensation Commission, 102 S.W.2d 299 (3rd App. – Austin, 2003)]. Another case in Travis County district court has reached an opposite conclusion. The Bell case decision noted that the Texas State Board of Medical Examiners "…afforded Dr. Bell the process he was due before his license was suspended." Therefore, the Commission expects, for example, that actions to deny doctors from admission to the new Approved Doctor List for reasons other than a licensing board's suspension of a license may result in new legal challenges based, in part, upon the Administrative Procedure Act.

C4. Possible Solutions and Impact

1. Due Process For Medical Disputes.

Alternative options to streamline the due process could include:

a. Eliminating SOAH hearings and make the initial administrative decision the final one before any court review.
b. Eliminating SOAH hearings in medical necessity cases and making the decision of the Independent Review Organization the final administrative decision (by a medical doctor as opposed to an administrative law judge).
c. Requiring "substantial evidence rule" review by SOAH (rather than "de novo" review) of the initial administrative decision and requiring the losing party to pay the SOAH costs. Note: "Substantial evidence rule" does not allow the administrative judge to substitute his/her judgment for the judgment of the state agency on the weight of the evidence on questions committed to agency discretion and allows reversal if the substantial rights of the appellant have been prejudiced. [Texas Government Code section 2001.174]
d. Requiring the losing party in the initial administrative decision to have the burden of proof at SOAH, SOAH to give presumptive weight to the initial administrative decision unless the great eight of the evidence is to the contrary, and requiring the losing party to pay the SOAH costs.
e. Requiring the losing party always to pay the costs of the initial administrative decision together with the costs of any SOAH review.

2. Due Process When Act Is Silent

Options include:

a. Amending the Act to clearly provide that the Act and the Administrative Procedure Act shall not require a SOAH hearing unless the Act specifically provides for one for the action challenged

b. Amending the Act to provide for immediate effectiveness of important actions pending the outcome of any required SOAH hearing and for strict standards before SOAH or any court can issue of stay of the Commission's actions, which have become effective. For example, a removal of a doctor from the Commission's Approved Doctor List due to the quality of care being substantially different from care that is considered to be fair and reasonable presently becomes effective only after a SOAH proposal for decision and the subsequent consideration of that proposal by the Commissioners. That decision could be made effective after the Commission's Medical Advisor and Medical Quality Review Panel doctors involved had considered and rejected any rebuttal of the initial findings sent to the doctor.

c. Amending the Act to remove areas where SOAH hearings should no longer be provided.

d. Require the losing party at SOAH to pay SOAH costs.

A5. Brief Description of Issue

How should the Commission handle denials of future medical care?

B5. Discussion

Resolving questions about proposed medical care (including methods for ensuring prescribed pharmaceuticals are timely dispensed) has been a major challenge for the Commission. A carrier frequently states that "no further medical care will be reimbursed for a claim." The statement often results in the termination of medical care because the health care provider recognizes the risk of providing care that ultimately is not paid for. Since there has been no denial of a medical bill, the issue is not ripe for medical dispute resolution and there is not another clear avenue for resolving the question.

The dispensation of prescriptions is particularly problematic for similar reasons to those stated above. The carrier may state that no further medications will be approved or may state that a pharmacy is not guaranteed payment until the bill is reviewed for medical necessity. These situations also often result in discontinued or untimely medical care for the injured worker. The Commission, in working with system participants, has not found an acceptable method for resolving those situations.

C5. Possible Solutions and Impact

Option: Statutorily require an insurance carrier to pay for pharmaceuticals prescribed by the doctor treating the injured worker (treating doctor, referral doctor, etc.). If the insurance carrier determines that a medication is not medically necessary, the prescribing health care provider must reimburse the insurance carrier for the amount paid for the medication.

Option: Establish a dispute resolution process for handling prospective denials of medical services not requiring preauthorization (including pharmacy services).

A6. Brief Description of Issue

What changes would improve the return to work outcomes for Texas workers injured on the job?

B6. Discussion

Texas workers, in comparison with other states, take longer to return to work after being injured on the job. Without an exact method for capturing information on whether an injured worker has returned to employment, return-to-work timeframes have been based on length of time income benefits are paid. Longer time to return-to-work equates to more income benefits being paid which increases costs in the workers' compensation system.

C6. Possible Solutions and Impact

Option: Make return-to-work programs mandatory.

Option: Create financial incentives for employers to establish return-to-work programs.

Option: Require review by a Commission-assigned doctor at a specified time for each injured worker still receiving benefits.

A7. Brief Description of Issue

Can the Commission exercise any regulatory/enforcement authority to ensure employer compliance with the employer's duty in Texas Labor Code section 411.103 to provide a safe workplace?

B7. Discussion

In 1996, the 3rd Court of Appeals in Austin found that the federal Occupational Safety and Health Act (29 USC section 651) preempted the Commission's former "Extra-Hazardous Employer Program" as it had been applied to private employers under Texas Labor Code section 411.041 prior to statutory amendments in 1999. Currently several employers are challenging even their identification as a "Hazardous Employer" under the Commission's amended "Hazardous Employer Program" for private employers by alleging that the same federal law preempts even the Commission's identification of such employers. The Commission has requested and received legal advice from the Texas Attorney General's office that other possible actions of the Commission, that were being considered to address an employer's failure to maintain a safe workplace, might be considered by a court to be preempted by that federal statute.

C7. Possible Solutions and Impact

Texas has not chosen to attempt to qualify under the federal Occupational Safety and Health Act to carry out employer safety functions that otherwise are preempted under that Act. To qualify is a very lengthy and costly endeavor and the federal government has not approved any new OSHA states since 1996. Additional legal input could be obtained to see if the provisions of Texas Labor Code section 411.103 could be addressed, in part, through the authority of other agencies, or through new or amended provisions in the Texas Workers' Compensation Act that would not be affected by the federal law's preemption provisions.

A8. Brief Description of Issue

What actions can be taken to ensure that workers' compensation insurers, rather than employers, are responsible for obtaining, monitoring, and complying with requirements for adjusting and payment of workers' compensation claims under a negotiated deductible workers' compensation policy?

B8. Discussion

The Commission's staff, working closely with the Texas Department of Insurance and the Texas Property & Casualty Insurance Guaranty Association (TPCIGA) (that assumes the adjusting and payment functions for workers' compensation claims of insurance carriers found insolvent by order of the Commissioner of

Insurance), has been advised that certain employers, under negotiated deductible insurance policies, had assumed the responsibility for some or all of the actions taken to adjust and pay claims within the deductible amounts of those policies. Examples include the hiring of third-party administrators to adjust and pay those claims, paying those administrators for the amounts needed to pay the claims, and otherwise supervising the actions of the third party administrators. During a period of time preceding an insolvency order, the Commission received claim-specific complaints that timely claims payments were not being made by some of the third-party administrators and many of those complaints were validated. After. an insolvency order had been entered, the Commissions staff received information from TPCIGA staff that TPCIGA was not able to promptly resume claims payments, in part, because the files of the insolvent insurance carrier did not contain records of which claims were being handled by which third-party administrator hired by an employer and because those administrators were reluctant or opposed to transferring the claims files to TPCIGA. Finally, the ability of such employers to control the administration of the claims processing under the negotiated deductible policies creates a type of self-insurance not authorized in the Texas Labor Code and without the protections and requirements for certified self-insurers in Texas Labor Code Chapter 407. Although Insurance Code, §5.55C required negotiated deductible polices, actual practices in negotiated deductible polices may have contributed to the lack of growth in the number of active certified self-insurers.

C8. Possible Solutions and Impact

Statutory changes could clarify the responsibilities of the employer and the insurance carrier for negotiated deductible policies and could provide for monitoring and enforcement if system participants engaged in practices that were not consistent with those responsibilities. The policyholder should not be involved in the claims process other than to reimburse the insurance company for the losses up to the deductible amount.

A9. Brief Description of Issue

With the creation of the Medical Advisor and the Medical Quality Review Panel, is there a role for the Medical Advisory Committee?

B9. Discussion

The Medical Advisory Committee (MAC) was established in Section 413.005 of the Labor Code at the time of the 1989 reforms to provide the Medical Review division with access to medical expertise for assistance with the development of medical policies and guidelines. The MAC's composition is specified in the Workers' Compensation Act. Confusion over the appropriate role for the committee and the sheer number of members makes developing effective working relationships between the division and the MAC cumbersome.

In 2001, the Legislature specified responsibilities of a Medical Advisor and a Medical Quality Review Panel (MQRP) in Section 413.0512. The MAC's responsibilities can appear to be duplicative of the responsibilities of the Medical Advisor and the MQRP.

C9. Possible Solutions and Impact

Option: Abolish the Medical Advisory Committee, retaining the Medical Review division's authority to create advisory committees as needed to work specific issues.

A10. Brief Description of Issue

Should the Commission be given statutory responsibility to provide for and enforce a process for insurance carrier adjustment of medical bills, and injured employee payment of those bills, when the injured employee has obtained reimbursement from a third party under Chapter 417 of the Labor Code?

B10. Discussion

The issue arises when an injured employee or their legal beneficiary receives a third party settlement and the workers' compensation carrier recovers what it has paid. The remainder of the recovery is treated as an advance against future benefits including medical benefits. This means that the carrier does not have to pay indemnity or medical benefits until the remainder of the recovery has been exhausted. This causes two difficulties. The first is that §417.002 makes the claimant responsible for the medical payments, but §413.042 prohibits the health care provider from billing the claimant directly. The health care provider is left with unpaid bills but no mechanism to collect payment from the claimant. We have a stand-off, the injured employee has been paid a sum of money to be used for future benefits, the carrier has been excused from liability, and the health care provider is providing services but can not bill the injured employee to collect for services rendered.

Another issue concerns the way the advance is exhausted. The net recovery is an advance against future benefits. However, when this advance is exhausted, the carrier is required to resume payment of benefits (both indemnity and medical). In order for an advance to be considered exhausted, the claimant must have paid his or her own benefits out of the advance. These "payments" have to be in accordance with the statute and rules. Any moneys expended in a manner that is not consistent with the statute and rules should not count towards exhausting the advance. That means that if the employee has a $100 advance due to a settlement and the employee pays a $100 medical bill that has an MAR of $75, the employee only gets $75 credit towards the advance even if he paid the full $100. Employees are often not aware of this and spend their recovery in ways that are not consistent with the statute and rules and thus end up having to pay more out of their own pocket than they thought they would.

The other problem is that carriers are not always aware of the existence of a third party settlement. This means that the carrier would continue to pay benefits even though they are entitled to subrogation. This increases costs to carriers and, through premiums, to employers.

We estimate that the Commission hears reports of such a problem approximately 10-12 times a year (though the problems are probably more widespread). Medical Review, Customer Services, Compliance and Practices, and possibly other divisions learn of this problem from system participants.

Claimants may be harmed also if the health care providers do bill them and the claimant pays the health care providers directly without the bills being audited by the insurance carrier. If they pay more in medical bills than is allowed under our rules (fee guidelines, pre-authorization, etc.), they may exhaust the

amount they recovered but be refused by the insurance carrier when they apply for the carrier to resume payment of medical benefits. If this happens, the claimant may be unable to receive required medical care.

C10. Possible Solutions and Impact

We recommend that Chapter 417 be amended to require the carrier to adjust the claim for the injured employee for compliance with commission rules and guidelines.

In addition, we recommend that §413.042 be amended to permit a health care provider to pursue a private claim against an injured employee who receives a third party settlement.

These changes would allow the Commission to write rules addressing billing for services provided to an injured employee who receives a settlement from a third party. A possible scenario would be for the health care provider to bill the injured employee with a copy to the carrier. The carrier would advise the injured employee the correct amount to pay the health care provider. This would have the health care provider paid the appropriate amount and create a "paper trail" of the amount paid from the third party settlement for the carrier to calculate when to begin pay benefits to the injured employee, if benefits are due.

An option might be to provide explicit statutory authority for courts to require that recovered damages be placed in a type of trust fund account with restrictions on disbursements above a reasonable estimate of past and future medical expenses.

A11. Brief Description of Issue

Should evidence admitted in the Commission's hearing process also be admitted in any subsequent court appeal, and should the court appeal be limited to review under the "substantial evidence rule"?

B11. Discussion

For compensability, extent of injury, income-benefit, and several other types of disputes, the statute provides for a 3-tiered administrative system. First, a "Benefit Review Conference" allows for mediation. Second, a full, contested case hearing (CCH) is held. Third, a Commission Appeals Panel may review the CCH record and make the final administrative decision. However, when the unsuccessful party appeals to court, the court review is "modified de novo", which requires both parties to present admissible testimony from fact and expert witnesses at the SOAH hearing and to present new arguments and evidence. This process is expensive for all parties and can be especially burdensome to an injured employee who is no longer receiving income benefits and cannot afford to pay for an attorney. Most reviews of administrative agency decisions in Texas are under the "substantial evidence rule" which does not allow the judge in the court to substitute his/her judgment for the judgment of the state agency on the weight of the evidence on questions committed to agency discretion, and allows reversals if the substantial rights (of the party appealing) have been prejudiced.

C11. Possible Solutions and Impact

Consideration should be given to reviewing the Texas Workers' Compensation Act to require admission of the evidence and record during the Commission's CCH and Appeal Panel process in court unless the court finds that a mistake was made in admitting all or any part of such evidence. In addition, consideration should be given to requiring court appeals to be under the "substantial evidence rule" or similar process

A12. Brief Description of Issue

Should the Labor Code be amended to provide clear authority to the Commission to acquire and use proprietary data from public and/or private sources (such as charge and payment and contract data) in rulemaking, especially in establishing fees for health care provided in the workers' compensation system?

B12. Discussion

Texas Labor Code, §413.011(b) provides that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. . . "

To find out what fees are charged and paid for similar treatment of injured individuals outside the workers' compensation system the Commission must seek data from outside sources. The data from the outside sources has been considered as proprietary and confidential, usually as trade secrets or as commercial or financial information that is confidential, and therefore cannot be divulged by the Commission to the public.

The Commission uses this data in meeting its statutory requirements under the Labor Code and rulemaking requirements under the Administrative Procedure Act such as statement of a reasoned justification.

C12. Possible Solutions and Impact

Option: Add provisions to the statute that:

1. make it clear that copyrighted and proprietary data and other trade secrets and computer software information obtained by the Commission pursuant to software license agreements, other contracts, or orders of the Commission, is exempt from the Texas Public Information Act without the necessity of obtaining an opinion of the Texas Attorney General under Gov't Code Chapter 552, subchapter G; and

2. authorize the Commission to use confidential or proprietary data, criteria, and information purchased or otherwise obtained from external entities, in rulemaking without revealing the confidential information and while maintaining the confidentiality of the data.

Option: Amend the statute to require the Employee Retirement System to provide the Commission with information and data about the ERS contracts and payments for medical care for state employees, and authorize Commission use as in Option 1 above.

Option: Amend the statute to set the fees paid for health care in the workers' compensation system at the amount paid by the ERS at the time the health care was provided.

Option: Amend the statute to require the Commission to adopt workers' compensation fees that are the same as those paid by the ERS.

Option: Amend the statute to require the Commission to adopt workers' compensation fees that are the same as those paid by the ERS with minimal modifications to account for co-pays and deductibles.

A13. Brief Description of Issue

Should the Commission be given explicit statutory authority to review and audit entities other than insurance carriers and be given authority to collect the costs of these audits as appropriate?

B13. Discussion

Presently, several health care providers and other related entities are challenging in court the authority of the Commission to audit and require review of records of such providers. While most audits are conducted by requesting copies of records be sent to the Commission for review, on-site audits are necessary to ascertain whether a health care provider is violating the Act, Commission rule, or other policy.

C13. Possible Solutions and Impact

Amend the Act to explicitly allow for Commission audits under specified requirements and for payment to the Commission for the reasonable costs of such audits.

A14. Brief Description of Issue

Should the Commission have sanction authority over health care providers other than doctors?

B14. Discussion

Presently, the provisions of Texas Labor Code section 408.0231 provide for sanctions of doctors and carriers while omitting other providers. While the treating doctor is responsible for ensuring efficient utilization of care, other types of providers have important roles and should be subject to appropriate sanctions.

C14. Possible Solutions and Impact

Consideration should be given to amending the Texas Workers' Compensation Act to provide for appropriate sanction authority over health care providers other than doctors.

A15. Brief Description of Issue

Should the Texas Workers' Compensation Act be amended to provide for the Executive Director or his designee to immediately suspend a provider whose conduct endangers the public or injured employees, followed by an expedited hearing? Also, should the statute be amended to affirm that any sanction imposed on a doctor by action of the Commission is binding during any appeals in court?

B15. Discussion

Presently a doctor can delay the effective date of any sanction by a lengthy SOAH hearing and lengthy court reviews. However, several licensing boards have immediate suspension authority, including the Board of Medical Examiners, the Pharmacy Board, the Chiropractic Board, the Dental Board, and the Physical Therapist Board. In addition, the Act does not explicitly provide that the decision of the Commissioners (even after a SOAH hearing) is binding during court appeals.

C15. Possible Solutions and Impact

Consideration should be given to amend the statute both to provide for an immediate suspension of a provider whose conduct endangers the public or injured employees, followed by an expedited hearing, and to provide explicitly that a sanction by the Commission is binding during court appeals.

A16. Brief Description of Issue

Should the Texas Workers' Compensation Act be amended to prohibit a party (when appealing a Commission decision in a contested case hearing or an Appeals Panel decision to court) from being able to obtain a reversal of the decision simply because the other party in the administrative process fails to timely respond to a request for admissions in the court proceeding?

B16. Discussion

Presently, some insurance carriers are obtaining court reversals of Commission administrative decisions in favor of injured employees simply on the basis that the injured worker has not timely responded to a "request for admissions" and, therefore, the proposed admissions (e.g. never was an injury, injury did not occur at work, etc.) will be considered as admitted facts. The injured worker may not have the financial ability to pay for an attorney, to participate at all in the court proceeding, and may not understand the harsh consequences (e.g. canceling ability to obtain future medical benefits) of failing to timely respond to a

request for admissions.

C16. Possible Solutions and Impact

Consideration should be given to amending the statute to prohibit such court reversals. Parties may still provide their own evidence to support a requested reversal of a Commission decision.

A17. Brief Description of Issue

Should changes to the Labor Code be made to facilitate paper reduction?

B17. Discussion

The suggestions in "C" below support the Commission's goal of reducing paper required in the system.

C17. Possible Solutions and Impact

Mailing "Rights and Responsibilities" to Employer: The existing statute, §409.011, requires that the Commission mail this statement to the individual employers annually. Amend the statute to require carriers to provide a *Statement of Employers' Rights & Responsibilities* to the employer when the policy is issued, and to state that the Commission will provide employers and the public at large with access to "rights and responsibilities" and place them online. This change supports our paper reduction goals by providing substantial paper and postage savings and encourages online public access to information.

TWCC-2, Employer's Request for Reimbursement: The existing statute, §408.003(c), requires an employer to file a copy of the employer's request for reimbursement, with the Commission. Amend the statute to state that this form does not have to be filed with the Commission unless requested by the Commission, but must continue to be filed with the carrier. TWCC has no need for this piece of paper and any impact that the employer's payments (full salary continuation) may have on indemnity benefits is reported to TWCC electronically. Eliminating the need for this filing will save TWCC staff time by discontinuing data entry of receipt and system generation of a letter that acknowledges receipt. Additional staff time will also be saved in TWCC central and regional mailrooms where these forms are received, sorted, date stamped, filed, and eventually microfilmed.

TWCC-5, Employer's Notice of No Coverage or Termination of Coverage: The existing statute, §§406.004 and 406.007, requires an employer to file a copy of this notice with the Commission. Amend the statute to state that this form does not have to be filed with the Commission unless requested by the Commission. The Commission receives quarterly data extracts from Texas Workforce Commission that identify Texas employers. The covered employer information received through the Proof of Coverage process allows the Commission to subtract the number of covered employers from the Workforce Commission employer data to determine employers that are not covered. TWCC receives benefits in staff time not receiving, sorting, stamping, data entering, filing, and microfilming these forms.

Independent Contractor Coverage Records (Joint Agreements): Amend §406.144 and §406.145 to omit the requirement for independent contractors and building and construction workers to file

contractual coverage agreements with the Commission. Currently, about 95,000 such contracts are filed with the Commission annually and fewer than 75 inquiries relating to these contracts are received**.** However, the Commission serves as the sole independent source of the documents in a premium dispute between the insurance carrier and the employer. This requires an inordinate amount of staff time to process and maintain. These contracts are also required to be filed with the insurance carrier and information needed by independent contractors or building and construction workers could be retrieved from the insurance carrier by TWCC or any party requiring the information. The Commission could, by rule, establish the retention requirements for parties within the workers' compensation system.

Notice of Benefit Review Conference: The existing statute, §410.025, requires that a Benefit Contested Case Hearing (CCH) be scheduled at the time the Benefit Review Conference (BRC) is scheduled, even though many BRCs never go forward to a CCH. By requiring this CCH date be provided to the parties when the BRC is set, a great deal of confusion is created for customers and many unnecessary phone calls result. Amend the statute to state that "upon conclusion of the BRC, a CCH will be scheduled to address any unresolved issues." This should save staff time and also support our paper reduction goals.

A18. Brief Description of Issue

For review and enforcement purposes, Commission authority to access records should include the records of all types of system participants. Currently, the statute makes explicit reference only to insurance carriers.

B18. Discussion

The Commission's sanctions authority extends beyond carriers, and access to participant's records is essential to the Commission's ability to review and audit for compliance and thus, enforcement of the law and rules.

Also, in many instances, a review of a system participant's compliance with the law and rules necessitates a review of another participant's records, e.g. in reviewing or auditing a carrier's timely payments of medical bills, it may be necessary to review the records of health care providers, rather than rely on the carrier's records alone.

C18. Possible Solutions and Impact

Consideration should be given to amending the statute to explicitly specify that all system participants are required to cooperate with the commission and provide access to records. Currently, the statute makes explicit reference only to insurance carriers.