Summary of House Bill 7 (79th Legislature)

Prepared by the Texas Workers' Compensation Commission

Creation of the Division of Workers' Compensation at the Texas Department of Insurance (TDI) (Chapter 402, Labor Code)

- Effective September 1, 2005, The Texas Workers' Compensation Commission (TWCC) is abolished and its functions transferred to the Division of Workers' Compensation (Division) within the Texas Department of Insurance (TDI).
- The Division will be administered by a single Commissioner of Workers' Compensation, appointed by the Governor for a two-year term. HB 7 gives the Commissioner of Workers' Compensation all executive authority over the functions of the Division, including rulemaking authority.
    - The Governor shall appoint the Commissioner of Workers' Compensation no later than October 1, 2005.
- The Commissioner of Insurance shall develop and implement policies that clearly separate the respective responsibilities of TDI and the Division. The Commissioner of Insurance may also provide advice, research and comment regarding the adoption of rules by the Commissioner of Workers' Compensation.
- TDI will provide the staff and facilities necessary to perform the administrative duties (i.e., budget planning, purchasing, human resources, and information systems) of the Division.
- HB 7 clarifies the mission of the Division and sets out basic goals for the workers' compensation system, which include:
    - Treating injured employees with dignity and respect;
    - Providing a fair and accessible dispute resolution process;
    - Providing access to prompt, high quality medical care within the statutory framework; and
    - Providing services to facilitate an injured employee's return to work as soon as it is considered safe and appropriate by the employee's health care provider.
- HB 7 removes the statutory designation of specific divisions within the Division, allowing the Commissioner of Workers' Compensation the flexibility to modify the Division's organizational structure as necessary to meet performance goals. The Division will continue to provide current customer service and dispute resolution services through regional offices.
- To the extent determined feasible, the Division shall establish a single point of contact for injured employees receiving services from the Division.
- HB 7 requires the Division to provide incentives for overall compliance and to link regulatory outcomes with performance-based oversight.
    - At least biennially, the Division will assess the performance of insurance carriers and health care providers against regulatory goals established by the Commissioner of Workers' Compensation.
    - Based on this assessment, insurance carriers and health care providers will be placed into regulatory tiers based on performance – poor performers, average performers, and consistently high performers. The Division will then focus its regulatory oversight on poor performers.

- The Commissioner of Workers' Compensation will also develop regulatory incentives designed to promote greater overall compliance and performance, including modified penalties, self-audits, or flexibility.

Creation of the Office of Injured Employee Counsel (Chapter 404, Labor Code)

- HB 7 also creates a new state agency, the Office of Injured Employee Counsel (OIEC), whose primary mission is to represent the interests of injured employees in the workers' compensation system.
  - The OIEC will be administered by a Public Counsel, appointed by the Governor no later than October 1, 2005.
  - The OIEC is administratively attached to TDI and TDI will provide the staff and facilities necessary to perform the administrative duties (i.e., budget planning, purchasing, human resources, and information systems) of the OIEC.
- Duties of the OIEC include:
  - Advocating on behalf of injured employees as a class during rulemaking related to workers' compensation;
  - Providing ombudsman assistance to injured employees during Division administrative dispute proceedings;
  - Referring injured employees to local, state, and federal financial assistance, rehabilitation and work placement programs, and other social services;
  - Identifying problems with the workers' compensation system from the perspective of injured employees and issuing a biennial report to the Governor, Lieutenant Governor, Speaker of the House of Representatives and the legislature that includes proposed legislative and regulatory recommendations to address these problems; and
  - Submitting a notice of injured employee rights and responsibilities to TDI and the Division for adoption by both the Commissioner of Insurance and the Commissioner of Workers' Compensation.
- TWCC's ombudsman program shall be transferred to the OIEC by March 1, 2006.
- The Public Counsel shall adopt initial rules for the OIEC by March 1, 2006.

Workers' Compensation Research (Chapter 405, Labor Code)

- HB 7 keeps the research function at TDI under the direction of the Commissioner of Insurance and renames it the "Workers' Compensation Research and Evaluation Group."
- HB 7 also requires the Commissioner of Insurance to adopt an annual research agenda for the Group. Under HB 7, the Group must also produce a biennial report on the impact of networks on the cost and quality of medical care and an annual report card comparing workers' compensation health care delivery networks certified by TDI.

Workers' Compensation Health Care Networks (Chapter 1305, Insurance Code)

- Workers' compensation insurance carriers, certified self-insurers, groups of self-insurers and governmental entities that self-insure may elect to contract with or

establish health care networks certified by TDI in accordance with Chapter 1305, Insurance Code.

  - The Commissioner of Insurance shall adopt rules regarding the certification of workers' compensation health care networks by December 1, 2005.
  - TDI will accept applications from networks seeking certification beginning January 1, 2006.
  - An insurance carrier may begin to offer medical benefits through a network upon certification of the network by the Commissioner of Insurance.

- If an employer contracts with an insurance carrier that establishes or contracts with a certified network, the employer's employees will be required to obtain medical care for their work-related injuries through the network if the employees live within the network service area. However, the insurance carrier will be liable for approved out-of-network referred care, emergency care, and health care for an employee who does not live in the network service area.
- An injured employee, who lives in the network service area, may choose a treating doctor from the list of doctors maintained by the network. If an injured employee does not make an initial choice within 14 days, the network will assign a treating doctor to the injured employee. An injured employee who does not live within the network's service area would continue to choose a treating doctor from the Division's Approved Doctor's List (ADL). However, an injured employee may be liable for medical care that is related to the compensable injury if that employee is required to seek care within a network and that employee sees a non-network provider without network approval.
- If an injured employee is dissatisfied with his or her initial choice of treating doctor, the injured employee is entitled to select another treating doctor from the network's list of doctors. A network cannot deny an injured employee's initial request to change treating doctors. However, any subsequent requests by an injured employee to change treating doctors are subject to network approval.
- An injured employee may request that his or her primary care provider under a group health HMO plan also serve as his treating doctor if the primary care provider agrees to abide by the network requirements.
- HB 7 also requires TDI to review and make recommendations to the 80th Legislature on the possibility of allowing injured employees to receive treatment from an employee's primary care provider under a Preferred Provider Organization (PPOs) plan.
- Under HB 7, a network may operate under its own treatment guidelines and preauthorization requirements, although treatment guidelines used by a network must meet minimum statutory criteria. Treatment may not be denied solely because it is not specifically addressed by the treatment guidelines used by the insurance carrier or network.
- The network must ensure that its list of health care providers includes an adequate number of treating doctors and specialists, who are available and accessible to employees 24 hours a day, seven days a week, within the network's service area. There must be sufficient numbers and types of health care providers to ensure choice, access, and quality of care to injured employees.
- Pharmacy services are specifically excluded from workers' compensation networks. These services will continue to be provided and paid in accordance

with the closed formulary and pharmacy fee guideline adopted by the Commissioner of Workers' Compensation.

- An HMO or a PPO may be certified as a workers' compensation health care network if they meet all the requirements.
- HB 7 also requires the Research Group at TDI to publish an annual report card comparing workers' compensation networks on a variety of measures, including access to care, health-related outcomes, return-to-work outcomes, employee satisfaction of care, and health care costs and utilization of care.

Approved Doctor List (ADL) (§408.023, Labor Code)

- Retains the ADL and the associated requirements for non-network doctors until 9/1/2007 (or an earlier date, if determined by the Commissioner of Workers' Compensation). Network doctors are not required to be on the ADL.
- However, HB 7 requires doctors, including network doctors, to comply with the Division's financial disclosure and impairment rating training and testing requirements.

Health Care Definitions (§401.001, Labor Code)

- "Health care reasonably required" is defined as care that is clinically appropriate and considered effective for the employee's injury in accordance with evidence-based medicine or practice standards recognized in the medical community.
- "Evidenced-based medicine" is defined as the use of current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and treatment and practice guidelines.

Medical Guidelines (§§ 408.052 and 413.011, Labor Code)

- HB 7 allows insurance carriers to pay above or below the Division's fee guidelines, if the insurance carrier has a contract with the provider and the contract contains a fee schedule.
- Under HB 7, the Commissioner of Workers' Compensation is required to adopt a pharmacy fee guideline as well as treatment and return to work guidelines; however any treatment guidelines adopted must be "evidence-based, scientifically valid and outcome-focused."
- Medical treatment may not be denied solely because it is not specifically addressed by the Division's treatment guideline.
- The Commissioner of Workers' Compensation may also adopt disability management rules, including the use of treatment plans, for non-network claims.
- The Division must study access to surgically implanted, inserted, or otherwise applied devices and the reimbursement rates. The Division is required to recommend any statutory changes necessary to ensure appropriate access to these medical needs.
- HB 7 also gives the Commissioner of Workers' Compensation the authority to identify areas of this state in which access to health care providers is less available and to adopt appropriate standards, guidelines, and rules regarding the delivery of health care in those areas.

Preauthorization (§§408.0042 and 413.014, Labor Code)

- HB 7 adds physical and occupational therapy to the list of medical services requiring preauthorization by statute.
- Upon request by an insurance carrier, an injured employee must submit to a medical examination by the treating doctor to define the compensable injury. Treatment for an injury or diagnosis that is not accepted by the insurance carrier after the examination must be preauthorized before treatment is rendered.
- HB 7 also clarifies that preauthorized treatments and services are not subject to retrospective review of medical necessity.
- Workers' compensation networks certified by TDI, however, are not required to abide by the list of services required to be preauthorized in the Labor Code or Division rules.

Pharmacy-Related Provisions (§§408.028 and 413.0111)

- HB 7 requires the Commissioner of Workers' Compensation to adopt a closed formulary for prescription medications by rule. The formulary must include an appeal process for treating doctors to use if a determination is made and documented that a drug not on the formulary is medically necessary.
- HB 7 also requires the Commissioner of Workers' Compensation to adopt a fee schedule for pharmaceutical services. The rules adopted must authorize pharmacies to use agents or assignees to process claims and act on behalf of pharmacies.
- Since pharmacy services are specifically excluded from WC networks under HB 7, the closed formulary and pharmacy fee guideline adopted by the Commissioner of Workers' Compensation would also apply to network claims.

Pain Management (§408.032, Labor Code)

- HB 7 requires the Division to study the issue of requiring accreditation of interdisciplinary pain rehabilitation programs and facilities and report the findings to the legislature.

Peer Review Doctors (§408.0231, Labor Code)

- The Commissioner of Workers' Compensation shall adopt rules establishing quality standards and sanctions for peer review doctors.
- HB 7 also requires peer review doctors to be Texas-licensed.

Payment for Health Care (§408.027, Labor Code)

- Payments by an insurance carrier must be in accordance with the Division's established fee guidelines if the treatment is not provided through a health care network and or at some other contracted rate.
- A health care provider waives any right to payment unless a medical bill is submitted to the insurance carrier on or before the 95th day after the date of service.
- The insurance carrier must pay, reduce, deny or determine to audit the health care provider's claim not later than the 45th day after receipt.

- If there is to be an audit, the insurance carrier must within 45 days of receipt, pay 85 percent of the fee guideline amount or the contracted rate. The audit and any remaining payment must be completed within 160 days of receipt. An insurance carrier's failure to meet these deadlines is an administrative violation. These provisions are applicable to health care networks.
- If an injury is found to not be compensable, a workers' compensation insurance carrier may recover medical costs paid from an accident or health benefit plan or other responsible person. Likewise, if an injury is found to be compensable, an accident or health benefit plan or other responsible person may recoup the amount paid for health care services from the workers' compensation carrier.

Electronic Medical Billing (§ 408.0251, Labor Code)

- The Commissioner of Workers' Compensation shall adopt rules requiring insurance carriers to accept medical bills from providers electronically by January 1, 2006.
- On or after January 1, 2008, the Commissioner of Workers' Compensation may adopt rules requiring insurance carriers to pay medical bills to providers electronically.

Medical Dispute Resolution (§413.031, Labor Code)

- A party to a medical dispute wanting to appeal a review by an independent review organization (IRO) or by the Division must seek judicial review directly rather than appeal the IRO decision to the State Office of Administrative Hearings (SOAH).
  - Effective September 1, 2005, SOAH may not accept a medical dispute that remains unresolved for a hearing. A medical dispute that is not pending for a hearing by SOAH on or before August 31, 2005, is not subject to a SOAH hearing but may be appealed to court for judicial review.
- An IRO decision must meet minimum standards established by the Commissioner of Workers' Compensation.
- The IRO decision is binding during the pendency of a dispute.
- Insurance carriers will be required to pay for all IRO reviews relating to preauthorization and retrospective medical necessity disputes within a network. For medical disputes relating to care provided outside of a network, the insurance carrier will continue to pay for the IRO review in the case of a preauthorization dispute and the non-prevailing party will continue to pay for the IRO review in the case of retrospective medical necessity disputes.
- The Division has authority to monitor IROs and report the results of monitoring activities to TDI quarterly.
- For in-network medical care, fee disputes will be handled by the network's internal complaint process, while fee disputes for out-of-network medical care will continue to be resolved by the Division. Any appeal of a Division fee dispute decision must be made directly to district court rather than to SOAH.

Medical Advisory Committee

- HB 7 abolishes the Medical Advisory Committee (MAC) effective September 1, 2005.

Return-to-Work Information and Assistance (§§413.023 – 413.025, Labor Code)

- The Division will provide information to employers and employees about the benefits of early return to work and methods for enhancing the ability to return to work.
- The Division will assist injured employees receiving income benefits to return to work, including referring injured employees to other employment assistance programs and initiating post-referral contacts with injured employees.
- The Division will ensure return-to-work outcome data is tracked by using data from the Division, the Texas Workforce Commission (TWC), the Department of Assistive and Rehabilitative Services (DARS), and insurance carriers.

Return-to-Work Pilot Program (§413.022, Labor Code)

- HB 7 creates a pilot return-to-work program for small employers with workers' compensation insurance, which provides grants for up to $2,500 per employer to pay for workplace modification initiatives that facilitate early return to work. This pilot, which begins January 1, 2006 and expires September 1, 2009, is funded by administrative penalties (up to $100,000 a year) collected by the Division.

Case Management (§413.021, Labor Code)

- The insurance carrier must evaluate every compensable injury that could result in lost time as early as practical to determine if skilled case management is necessary to address return to work issues. Case managers who are appropriately licensed to practice in this State must be used to perform these evaluations. A claims adjuster may not be used as a case manager.

Vocational Rehabilitation (§409.012, Labor Code)

- HB 7 requires the Division and the Department of Assistive and Rehabilitative Services (DARS) to report to the legislature by 8/1/2006 on cooperative actions taken to improve access to and effectiveness of vocational rehabilitation programs.

Determination of Compensable Injury (§408.0042, Labor Code)

- Upon request by an insurance carrier, the Division shall require an injured employee to submit to a single examination with the treating doctor to define the scope of the compensable injury. The report will define the compensable injury after which the insurance carrier will either accept the injuries and diagnoses listed in the treating doctor's report or dispute the specific injuries and diagnoses. Treatment for an accepted diagnosis/injury may not be reviewed later for compensability, but may be reviewed for medical necessity. Treatment for an injury or diagnosis that is not accepted by the insurance carrier must be preauthorized before treatment is rendered.
- For in-network medical care, HB 7 also requires insurance carriers to notify a health care provider in writing if the carrier decides to dispute the compensability

of a claim. An insurance carrier is prohibited from denying a medical bill on the basis of compensability for services that were provided prior to the carrier's written notification to the provider. However, if the carrier successfully contests the compensability of the claim, the carrier is liable for a maximum of $7,000 in medical services.

Maximum Medical Improvement (MMI) and Impairment Ratings (§§408.123-124, Labor Code)

- Once a treating doctor certifies MMI and assigns an impairment rating, an injured employee shall receive written notice about the employee's entitlement to dispute the report.
- The Commissioner of Workers' Compensation may adopt subsequent editions of the **AMA *Guidelines*** by rule (currently the statute requires the use of the fourth edition of the *AMA Guidelines*).

Required Medical Examinations (RMEs) (§408.004-.0041, Labor Code)

- Insurance carriers may only request an RME prior to a designated doctor examination in order to examine the appropriateness of the health care received outside of a network. However, an insurance carrier may continue to request an RME to examine issues relating to the employee's impairment rating or date of maximum medical improvement (MMI) after a designated doctor's examination, regardless of whether the injured employee is receiving medical care in- or outside of a network.
- An injured employee may have a doctor of the employee's choice at an RME examination if the RME examination relates to the employee's impairment rating or MMI date. If the injured employee is subject to a workers' compensation health care network, the doctor who attends the RME examination with the employee must be the employee's treating doctor.

Designated Doctor (§408.0041, Labor Code)

- HB 7 expands the list of issues that a designated doctor may examine, including issues relating to the extent of the employee's injury, whether the employee's disability is a direct result of the compensable injury, the ability of the employee to return to work, and similar issues.
- The report of the designated doctor still has presumptive weight during Division benefit disputes and the Division will base its determination on the designated doctor's report unless the preponderance (as opposed to the "great weight") of other medical evidence is to the contrary.
- Additionally, HB 7 requires that the insurance carrier continue to pay benefits based on the designated doctor's opinion during the pendency of a dispute. However, the insurance carrier may still unilaterally suspend Temporary Income Benefits (TIBs) if the injured employee fails to attend a designated doctor exam without good cause.
- A network doctor may not serve as a designated doctor or perform an RME examination for an employee receiving medical care through a network with which the doctor contracts or is employed.

- Rules regarding the changes in the Designated Doctor and RME processes must be adopted on or before February 1, 2006.

State Average Weekly Wage (§408.047, Labor Code)

- The state average weekly wage (SAWW) from September 1, 2005 through September 30, 2006 is set at $540.
- On and after October 1, 2006 the state average wage will be 88% of the average weekly wage in covered employment as computed by the Texas Workforce Commission (TWC). By rule, the Commissioner of Workers' Compensation may increase this percentage up to 100%.
- As a result, the change in the SAWW will result in an increase in the maximum and minimum income benefit amounts paid to employees injured after October 1, 2006 by approximately 12 percent.

Income Benefit Retroactive Period (§408.082, Labor Code)

- HB 7 reduces the amount of time an injured employee must be off work before that employee may recoup income benefits for the initial waiting period (i.e., the first 7 days of disability) from four weeks to two weeks. The two-week period applies only to an injury that occurs on or after September 1, 2005.

Supplemental Income Benefits (§408.1415, Labor Code)

- HB 7 clarifies the eligibility requirements for Supplemental Income Benefits (SIBs) and requires the Commissioner of Workers' Compensation to adopt rules regarding the level of activity an injured employee must have with the Texas Workforce Commission (TWC) and the Department of Assistive and Rehabilitative Services (DARS), as well as the number of job applications that must be submitted by an injured employee each quarter to meet minimum work-search requirements.

Benefit Dispute Resolution (Chapter 410, Labor Code)

- HB 7 requires that information that the Division determines to be useful to parties in resolving disputes will be published by the Division and made available to the parties when a Benefit Review Conference (BRC) or Contested Case Hearing (CCH) is scheduled.
- The Division may also hold BRCs telephonically by agreement of the injured employee.
- HB 7 also requires any party requesting a BRC to demonstrate to the Division any previous efforts that party made to resolve the disputed issues before a BRC is scheduled by the Division.
- A Benefit Review Officer (BRO) must complete at least 40 hours of training in dispute resolution/mediation techniques.
- BRCs are limited to two per disputed issue, and the BRC will become more of a true mediation session, wherein the BRO will not make recommendations on the disputed issues nor issue interlocutory orders to pay benefits; however, an interlocutory order can be issued by other division staff.

- HB 7 also makes the Appeals Panel a single three-member tribunal that can either reverse or remand a CCH decision instead of several panels of administrative law judges. HB 7 also requires the Appeals Panel to issue and maintain a precedent manual composed of precedent-establishing benefit dispute decisions.
- The record of the CCH is admissible during judicial review in accordance with Texas Rules of Evidence, as decided in *National Liability v. Allen*, 15 S.W.3d 525.

<u>Intoxication Presumption (§401.013, Labor Code)</u>

- HB 7 sets up a rebuttable presumption that an employee is intoxicated if the employee tests positive for a controlled substance as defined by Section 481.002, Health and Safety Code, through a blood test or urinalysis.

<u>Carrier Single Point of Contact (§409.021, Labor Code)</u>

- Each insurance carrier is required to establish a single point of contact in the carrier's office for an injured employee.

<u>Exclusive Remedy (§408.001, Labor Code)</u>

- A determination that an injury is not compensable under Sections 406.032, 409.002, or 409.004 of the Labor Code (for reasons such as the employee's: intoxication or willful attempt to injure himself; untimely notice to employer; or untimely filing of a claim, etc.) does not adversely affect the exclusive remedy requirements in the Labor Code.

<u>Use of Post-Injury Liability Waivers by Nonsubscribing Employers (§406.033, Labor Code)</u>

- HB 7 places certain statutory limitations on the validity of post-injury waivers signed by employees of nonsubscribers, including prohibiting the signing of a waiver before the 10th business day after the employee was injured; ensuring that an employee has received a medical evaluation from a nonemergency doctor; and ensuring that the waiver is voluntary and is clearly identifiable in any written agreement.

<u>Enforcement (Chapter 415, Labor Code)</u>

- HB 7 removes the requirement that the state show that a party committed a violation of the Act or rules "willfully or intentionally" in order to assess administrative penalties. HB 7 also removes the current classification system for administrative penalties in the Act and aligns the enforcement structure of the Division with the current enforcement structure of TDI by authorizing the Commissioner of Workers' Compensation to assess administrative penalties up to $25,000 per day per occurrence.
- HB 7 also makes it clear that an insurance carrier commits an administrative violation if that carrier makes a statement denying all future medical care for a compensable injury.

- Finally, HB 7 establishes civil and administrative penalties for the deceptive use of words and symbols resembling the Division's, TDI's, or a state agency's name.

Fraud (§409.092, Labor Code)

- Allows the Division to share investigative material that relates to a felony regarding workers' compensation or involves restitution with insurance carriers.

Health and Safety (Chapter 411, Labor Code)

- Inspection of insurance carriers for the adequacy of accident prevention services is discretionary rather than being required every two years.
- The hazardous employer and drug-free workplace programs are eliminated, as is the requirement for carriers and the agency to use "qualified" field safety representatives in providing accident prevention services.
- The Division is to provide educational materials for employees and employers relating to safe working conditions and prohibited retaliation and on best practices for return-to-work programs and workplace safety.

The University of Texas System (UT), Texas A&M University System (A&M), and Political Subdivisions (Chapters 501-505, Labor Code)

- HB 7 aligns the sick and annual leave provisions for UT and A&M employees with similar provisions for other state employees by clarifying that a employee in each of these programs may use their accrued sick or annual leave in lieu of receiving Temporary Income Benefits (TIBs). If an employee chooses to use sick leave, that employee must first exhaust this leave before receiving TIBs. Once an employee's sick leave has been exhausted, that employee may then choose to use one or more weeks of annual leave in lieu of receiving TIBs.
- HB 7 also requires political subdivisions to evaluate whether it is feasible to establish or contract with a WC network that is certified by TDI and, if feasible, to do so. If not feasible, political subdivisions can exercise other options laid out in Chapter 504, Labor Code, including direct contracting with health care providers. However, political subdivisions will still be subject to the same data reporting and report card requirements as other workers' compensation health care delivery networks certified by TDI.

Insurance Rates and Premiums (Articles 5.55-5.60A, Insurance Code)

- The Commissioner of Insurance shall report (not later than December 1, 2006) to the Governor, Lieutenant Governor, Speaker of the House of Representatives and members of the legislature each even-numbered year regarding the effect HB 7 has had on the affordability and availability of workers' compensation insurance for employers.
- Insurance carriers are required to file their underwriting guidelines with TDI.
- The Commissioner of Insurance will conduct a public hearing biennially (beginning not later than December 1, 2008) to review workers' compensation insurance rates. The Commissioner of Insurance by rule may mandate rate or premium changes if a determination is made that rates or premiums charged do not meet established rating standards.

Sunset Dates

- HB 7 includes a 2009 sunset date for TDI, the Division and the new OIEC.

Effective Date

- Except as otherwise provided, this Act takes effect September 1, 2005.