Legislative Report

For the Year 2008

Submitted to:
The Governor's Office
Lieutenant Governor
Speaker of The House of Representatives
and
Legislative Offices

By:

The Office of Injured Employee Counsel

November 7, 2008

Signed: 

Norman Darwin, Public Counsel

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I. Introduction

The Office of Injured Employee Counsel (OIEC) was formally established on March 1, 2006 as a result of the adoption of House Bill (HB) 7, 79th Texas Legislature, Regular Session, 2005. HB 7 abolished the Texas Workers' Compensation Commission (TWCC) and established the Division of Workers' Compensation (DWC) as a division within the Texas Department of Insurance (TDI). HB 7 also transferred TWCC's Ombudsman Program to OIEC. The Public Counsel of OIEC was appointed by Governor Rick Perry on December 8, 2005, and reappointed on March 9, 2007.

OIEC was established to represent the interests and provide services to all unrepresented injured employees who request assistance. OIEC's main functions include:

1) Assisting injured employees in the workers' compensation system by providing free ombudsman services in TDI's administrative dispute resolution system;

2) Educating injured employees about their rights and responsibilities and improving their ability to effectively navigate through the workers' compensation system; and

3) Advocating on behalf of injured employees as a class in order to protect their rights and to achieve a balanced workers' compensation system.

OIEC also refers injured employees to the Department of Assistive and Rehabilitative Services, the Texas Workforce Commission, TDI, and other social or regulatory services, such as the Health and Human Services Commission or licensing boards to assist injured employees with:

1) finding employment,
2) training opportunities,
3) returning to work,
4) filing complaints with appropriate licensing boards or other regulatory agencies,
5) obtaining financial assistance, and
6) reporting alleged administrative violations.

Additionally, OIEC provides outreach presentations, workshops, seminars, speaking engagements, or other forums to workers' compensation system stakeholders regarding the agency, its role, and its services.

The Public Counsel and OIEC staff are proud to serve as the voice of the injured employees in the Texas workers' compensation system.

Workers' compensation coverage is not mandatory in Texas; therefore, OIEC's primary service population is injured employees who work for employers that participate in the Texas workers' compensation system. Also included in OIEC's primary service population are beneficiaries of injured employees fatally injured on the job whose employers participate in the Texas workers' compensation system.

Based on a 2008 study conducted by TDI's Workers' Compensation Research and Evaluation Group, approximately 67 percent of Texas employers carry workers' compensation insurance while 75 percent of all employees in the State are covered by workers' compensation.[1]

Legislative Report:

In accordance with Texas Labor Code §404.106, OIEC is required to submit a report to the Governor, Lieutenant Governor, Speaker of the House of Representatives, and the Chairs of legislative committees with appropriate jurisdiction not later than December 1st of even numbered years. This legislative report must include:

- A description of the activities of OIEC;
- Identification of any problems in the workers' compensation system from the perspective of injured employees as a class, as considered by the public counsel, with recommendations for regulatory and legislative action; and
- An analysis of the ability of the workers' compensation system to provide adequate, equitable, and timely benefits to injured employees at a reasonable cost to employers. TEX. LAB. CODE §404.106.

In preparing this report, OIEC has coordinated with TDI to obtain needed information and data. OIEC is administratively attached to TDI and appreciates the research and data support provided by TDI. OIEC has made every effort to obtain current information to make this report a meaningful analysis of the Texas workers' compensation system.

[1]Source: Employer Participation in the Texas Workers' Compensation System: 2008 Estimates conducted by the Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, September 2008.

II. OIEC's Mission, Philosophy, and Description of Agency's Activities

A. Mission

OIEC's mission is to assist, educate, and advocate on behalf of the injured employees of Texas.

B. Philosophy

OIEC is committed to protecting the rights of the injured employees of Texas in the workers' compensation system. OIEC provides the highest level of professional, efficient, and effective customer service; and maintains a work environment that values a diverse workforce, ethical management practices, teamwork, respect, and dignity.

C. Agency Organization

For the FY 2008-2009 biennium, OIEC was appropriated additional funds of approximately $1.9 million and 25 FTEs for the purpose of enhancing the Ombudsman Program. The 25 FTEs were transferred from TDI in September, 2007. The additional Ombudsmen allowed OIEC to become involved earlier in the dispute resolution process and to advocate the injured employee's position to the opposing party at that time.

Additionally, for the FY 2008-2009 biennium, OIEC was appropriated approximately $2.3 million, which represents 33 injured employee customer service representatives and three supervising employees to answer OIEC's toll-free injured employee assistance number and to provide customer service to all injured employees in support of OIEC becoming a "one-stop-shop" for injured employees. The concept of a "one-stop-shop" agency allows injured employees to contact a single agency, which reduces confusion by all system participants in a complex workers' compensation system.

As a result of the additional staff, the agency recently reorganized to reflect the agency's changing face and to increase efficiencies in fulfilling OIEC's mandate. The agency added a seventh RSA position to support the seven Ombudsman teams. The RSA addition allows one RSA to support each Ombudsman team. Each Ombudsman team consists of approximately 15 Ombudsmen. A legal assistant position was also created to provide additional legal research support for the agency.

A Reporting Analyst position was created to ensure the agency keeps abreast of the many reporting requirements and produces meaningful, quality reports for the Legislature, the Governor's Office, the Legislative Budget Board, the State Auditor's Office, and other agencies.

The General Counsel and Employee Relations positions were eliminated to free up funds from the Central Office and provide more resources in the field with TDI's creation of an additional field office (Austin South) in FY 2008. The General Counsel functions were combined with the Deputy Public Counsel position while the employee relations functions were absorbed by the Director of Legal Services. These changes permit OIEC to direct additional resources to its efforts to assist, educate, and advocate on behalf of the injured employees of Texas. There are four major programs within OIEC supporting its mission. These programs are:

- **Ombudsman Program** provides free assistance to unrepresented injured employees. Ombudsmen conduct meetings with injured employees to prepare them for informal and formal administrative dispute resolution proceedings, and assist the injured employee during the proceedings.

  The Ombudsman Program is comprised of 65 Ombudsmen, 30 Ombudsman Assistants, and 10 Ombudsman Associates working in the 25 field offices in Texas. The Program is managed by a Director, four Associate Directors, and seven Ombudsman Supervisors. The Supervisors provide oversight, direction, and management in the field offices across the State. At least one Ombudsman and Ombudsman Assistant is located in every field office.

  Assisting Injured Employees Through the Ombudsman Program. An Ombudsman Assistant contacts the injured employee, explains the workers' compensation process, and schedules an appointment with the injured employee to meet with an Ombudsman and prepare for the Benefit Review Conference (BRC). The injured employee is informed that Ombudsman assistance is free of charge, and that the injured employee has the right at any time to obtain an attorney and decline the assistance of an Ombudsman. A majority of injured employees who do not retain an attorney accept the assistance of an Ombudsman. In fact, more then 15,000 letters are sent annually to confirm that an injured employee has accepted assistance and is set for a preparation

appointment, yet less than 100 letters are sent annually confirming that an injured employee has declined Ombudsman assistance.

At the preparation appointment, the Ombudsman becomes familiar with the disputed issues in the injured employee's claim and educates the injured employee regarding documentation needed to support the injured employee's position. The Ombudsman explains the expectations at a BRC. If legal issues arise in a case and the Ombudsman needs additional research or legal assistance, the Ombudsman contacts the assigned staff attorney for assistance. At the BRC, the Ombudsman assists the injured employee in presenting the case to the Benefit Review Officer. At the conclusion of the BRC, the case is either resolved or is scheduled for a Contested Case Hearing (CCH).

Subsequent preparation appointments occur between the BRC and the CCH so that the Ombudsman can prepare the injured employee for the CCH and ensure all documents are properly obtained and exchanged. The Ombudsman may enlist additional research or legal assistance from the staff attorney to help prepare opening and closing arguments, cross-examination of witnesses, organization and presentation of evidence, and discuss legal strategy. After the conclusion of the CCH and depending on the outcome of the decision, either party can appeal the decision to DWC's Appeals Panel, a three judge panel and the final arbitrator in the administrative dispute resolution process. The Ombudsman also assists an injured employee with preparing an appeal or a response to an appeal and getting the documents filed timely.

All administrative remedies are exhausted after the outcome of the appeal is entered by DWC. As such, either party may file in district court to have the disputed issues further evaluated. OIEC has no statutory authority to assist an injured employee in court. Consequently, an injured employee must either retain legal counsel or pursue the claim pro se at district court. Based on telephone calls received and issues raised to OIEC staff, it appears that there are only a few attorneys who will represent injured employees in workers' compensation cases in district court. OIEC makes referrals to the State Bar of Texas' Attorney Referral Service to attempt to help injured employees find a lawyer to represent them in court. It is important to note that an injured employee without representation can win every issue throughout the administrative workers' compensation process only to lose on a default judgment in district court solely due to a lack of representation.

- **Customer Services** was created to provide a "one-stop-shop" to all

unrepresented injured employees at any point in their claim when assistance is requested.

One of OIEC's Customer Service Standards is to acknowledge written inquiries, complaints, or correspondence as soon as possible, but in most cases within 2 business days (16 business hours) after receipt. The standards are included in OIEC's Compact With Texans, which can be found on OIEC's website.

OIEC's Customer Service Program is comprised of 27 customer service representatives (CSRs), two Supervisors and a Director. The Supervisors provide oversight, direction, and management to the CSRs and are located in the Dallas and San Antonio field offices. There is at least one CSR in nearly all of the field offices.

A call center is maintained in the Fort Worth field office, managed by the Director, and is assigned to answer OIEC's toll-free line and provides back-up support to TDI staff for answering local calls in field offices as necessary.

Educating Injured Employees through Customer Service. OIEC CSRs provide advocacy assistance by educating and assisting injured employees in person or by telephone. They answer questions about the workers' compensation process or provide assistance in other ways; such as assistance in identifying and completing various claim forms and identifying and rectifying problems or disagreements.

CSRs also begin the early intervention process of identifying and attempting to resolve disputes. After five days, if the dispute is not resolved, the CSR explains the dispute resolution process to the injured employee, provides information as to what is needed to overcome a denial or dispute of benefits, and forwards the injured employee to the Ombudsman Program for assistance during the dispute resolution process.

DWC will continue to be available to provide regulatory customer service to other workers' compensation stakeholders, such as health care providers, insurance adjusters and attorneys, through its customer service assistants.

Excellence in customer service requires that the injured employees be treated respectfully and courteously while working within OIEC's "one-stop-shop" model. The OIEC CSRs provide daily assistance to injured employees by phone or in person at which time they also gather relevant claim information by completing an information sheet and making appropriate Dispute Resolution Information System (DRIS) entries. Injured employees are asked to verify the basic claim information contained within the computer system. All requested changes are submitted to DWC, the regulatory agency, for computer entry. Injured employees ask questions, explain their problems, and identify their reason for contacting OIEC. CSRs will assist by providing general and specific claims processing

information, directions for the use and completion of forms, and answers to questions. They will also attempt to resolve misunderstandings or identify disputes and take appropriate action. Third parties, such as insurance carrier adjusters or healthcare providers, may be contacted for additional information.

If it is determined that there is an unresolvable dispute, the CSR will forward the injured employee's dispute, along with an information sheet and copies of all documents relevant to the dispute, to the Ombudsman Program to begin preparation for the formal dispute resolution process. The information sheet contains sufficient data about the claim and dispute for the assigned Ombudsman to be able to understand the unresolved issues. The transfer from Customer Service to the Ombudsman Program will be accomplished by use of a Referral Box, which is a specifically formatted e-mail template tailored to relay vital information regarding the customer's workers' compensation claim.

Beginning in September of 2008, CSRs began entering the relevant claim and dispute information, including a list of forwarded documents, onto a computerized index coversheet that is used by the Ombudsman during the formal proceedings. The index coversheet and documentation is given to the Ombudsman assigned to handle the formal dispute resolution. Entries are made in DWC's DRIS to record the transfer of the dispute from Customer Service to the Ombudsman Program.

- **Legal Services** provides Regional Staff Attorneys (RSAs) as a resource for the Ombudsmen as they fulfill their mandate to assist, educate, and advocate for injured employees. RSAs supervise the work of the Ombudsman Program and advise Ombudsmen in providing assistance to injured employees in preparation for informal and formal hearings. Legal Services is comprised of a Director, a legal assistant, and seven RSAs. One RSA is assigned to each regional team throughout the State. The RSA is available to serve as a legal resource for all team members.

Legal Services analyzes and provides comments on rules proposed by TDI and suggests legislative recommendations that will protect the interests of injured employees. The department also determines whether there are issues pending before either the Texas appellate courts or the Supreme Court where OIEC needs to intervene to serve as a voice for the injured employees of Texas.

Serving as an Advocate for Injured Employees. OIEC represents injured employees as a class through the following mechanisms:

- Rulemaking Initiatives. OIEC participates in rules proposed by TDI and DWC that impact injured employees, and OIEC proposes and adopts its own rules on behalf of injured employees.

- Amicus Curiae Briefs. OIEC files amicus curiae (friend of the court) briefs when a case is pending before court and the decision may impact a large number of injured employees.

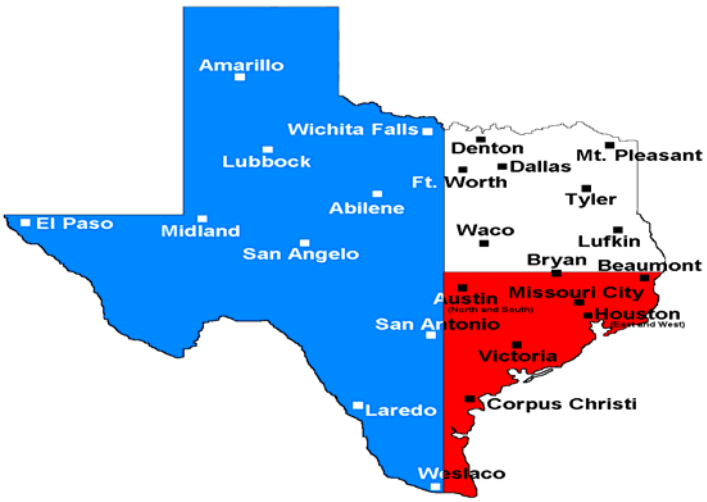
A description of rulemaking initiatives and amicus curiae briefs can be found on pages 22 through 32 of this report.

- **Administration and Operations** provides technical and administrative support to the agency. Functions within this department include strategic planning and reporting, performance measure monitoring and reporting, communications and outreach initiatives including website maintenance, and training efforts. OIEC is administratively attached to TDI, and Administration and Operations staff serve as liaisons to services provided by TDI, such as human resources, budget and purchasing, facilities, computer technology, and office supply needs.

OIEC's Central Office is located at 7551 Metro Center Drive in Austin, Texas, and there are 25 field offices strategically located around the State. OIEC staff is housed within the Central Office and each field office. Field office locations are generally determined by DWC based upon claim activity and demand for services in a specific geographic area.

Figure 1

Field Office Locations



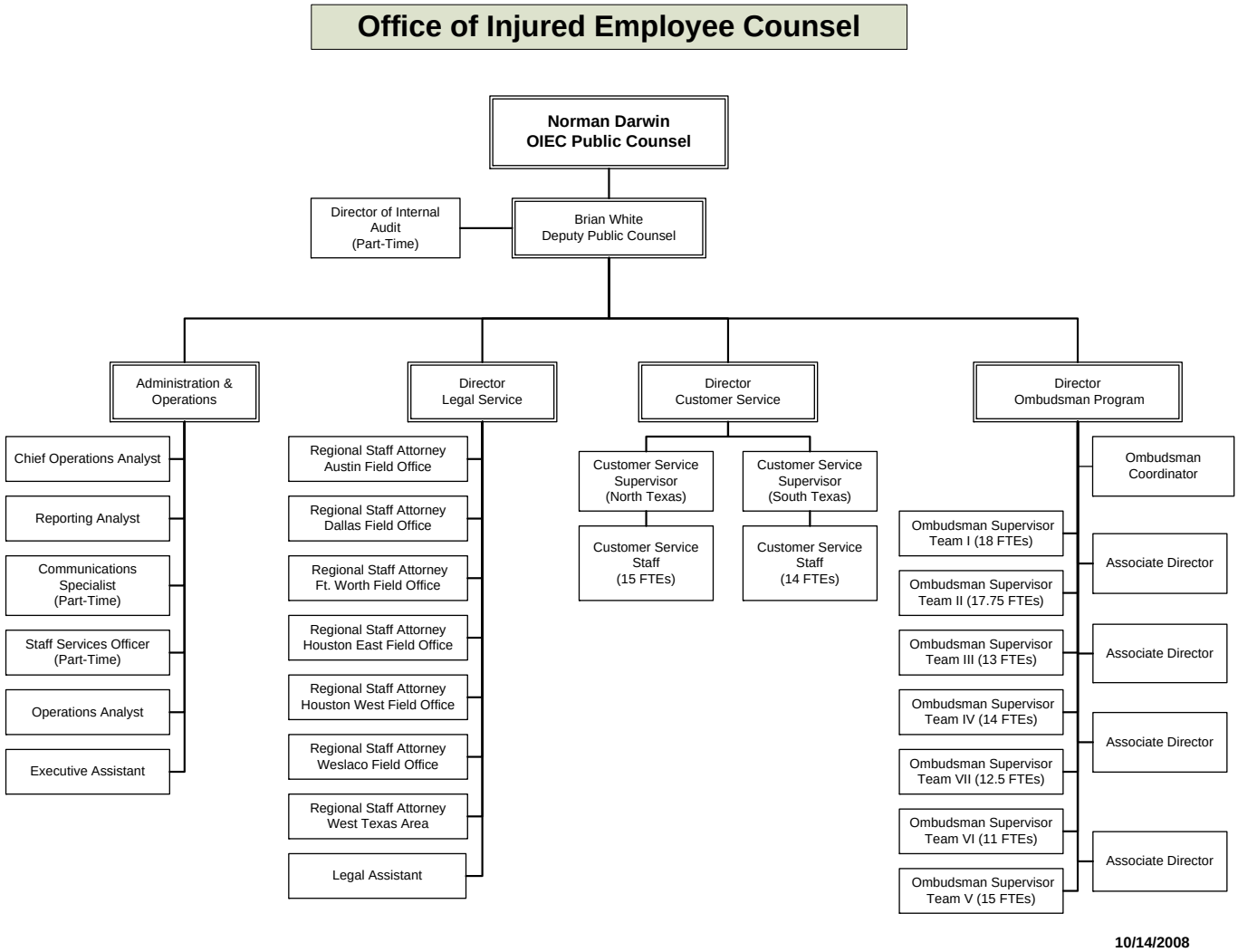
Some field offices are staffed with additional OIEC personnel based upon the number of proceedings that are docketed for unrepresented injured employees.

Field offices are located in the following areas: Abilene, Amarillo, Austin North, Austin South, Beaumont, Bryan/College Station, Corpus Christi, Dallas, Denton, El Paso, Fort Worth, Houston East, Houston West, Laredo, Lubbock, Lufkin, Midland/Odessa, Missouri City, San Angelo, San Antonio, Tyler, Victoria, Waco, Weslaco, and Wichita Falls.

In addition to field offices, Ombudsmen may also travel to designated proceeding locations, such as Mount Pleasant and Uvalde to ensure injured employees do not have to travel in excess of 75 miles to attend a dispute resolution proceeding as required by Texas Labor Code §410.005.

Figure 2

Current Organizational Chart



D. Facts About OIEC

- The average age of an OIEC employee is 45. One-fourth of the employees are under the age of 30, while 43 percent are between the ages of 40 and 49. More than 30 percent are 50 or older.

- The average State tenure for an OIEC employee is 10.83 years. Almost 10 percent of OIEC employees have at least 20 years of experience while almost 50 percent have between 10 and 20 years of experience.

- The average turnover rate in FY 2007 was 15.31 percent. The average turnover for the agency in FY 2008 was 12.1 percent.

- According to the agency's 2008 Survey of Organizational Excellence, 92 percent of OIEC employees see themselves working for this agency in two years.

- Approximately 24 percent of OIEC's workforce will be eligible to retire through FY 2013.

- OIEC's percentage of minority employees is well above the Statewide Civilian Workforce Composition with 16 percent Black and 46 percent Hispanic. The Statewide Composition is 11 percent Black and 28 percent Hispanic.

- Approximately 90 percent of OIEC's workforce is female.

E. Organizational Training and Employee Development

Training Committee. An agency Training Committee has been developed and consists of employees from all walks of OIEC with various skill sets. It is a multi-program committee created to design an agency training program. This Committee will also develop a more comprehensive career path for Ombudsman Assistants and Customer Service Representatives. Additionally, the Committee will coordinate Legal Services' RSA training, including but not limited to Practical Skills Training. The Training Committee is based out of San Antonio, which has been selected due to the growing number of work-related injuries in the area.

New Employee Training. All new employees are required to participate in new employee training. Training courses are available on the Intranet and may include a course description page with prerequisite reading, the course itself, and helpful links. The training courses consist of slideshows, videos, or videos with a handout. Some courses include audio. All employees are also required to read the employee manual and take core training offered by OIEC and TDI, such as Ethics, Confidentiality, Preventing Sexual Harassment, and Workplace Conduct.

Ethics Training and Committee. To underscore the value that OIEC places on ethics and to ensure that all employees understand and practice the highest ethical standards, OIEC provides ethical training to all employees. Furthermore, OIEC created a "values statement" that defines the culture and values that define our organization which is available on the agency's website. OIEC has established an Ethics Committee that provides a forum for the discussion of ethical dilemmas and their resolution and helps to disseminate information on ethical topics across the agency.

Ombudsman Training Program. Ombudsman Associates participate in a year-long training program at the end of which they earn their Type 03 workers' compensation adjuster's license and are reclassified as Ombudsman I. The training program for an Associate consists of training divided into two parts. In Part I (26 weeks) the Associates complete new employee orientation courses, classroom studies, customer services, and observation of activities. After completing Part I, the Associates enter Part II of the program. In Part II (also 26 weeks) the Associates begin conducting meetings with injured employees in preparation for dispute resolution hearings and assisting in proceedings, while being observed and evaluated by an Associate Director of the Ombudsman Program (Senior Ombudsman). During Part II, the Associates are required to obtain their Type 03 workers' compensation adjuster's license. Upon successful completion of the training program, Associates are eligible for a career ladder promotion to an Ombudsman I.

The Ombudsman I must have at least one year of workers' compensation experience as required by the Labor Code §404.152. They participate in proceedings, assist injured employees to obtain supporting documentation and to appropriately and timely exchange evidence, maintain an index folder, and work closely with the Ombudsman Assistants to effectively assist injured employees. If an Ombudsman I was not previously an Associate, then the Ombudsman I must

complete a 20-week training program during which time a Type 03 workers' compensation adjuster's license must be obtained.

The Ombudsman II must have at least two years of workers' compensation experience. The Ombudsman II must maintain all of the requirements of an Ombudsman I and may be required to assist Ombudsman Supervisors and Associate Directors in the training and mentoring of new OIEC staff.

All Ombudsmen assist with early intervention when injured employees request assistance. The goal of early intervention is for OIEC to contact injured employees as soon as possible and to assist them in resolving issues before the need to enter formal dispute resolution arises.

Ombudsmen must remain current on continuing education requirements in order to maintain their Type 03 workers' compensation adjuster's licenses. These credits are offered through Practical Skills Training conducted by the RSAs and the annual conferences. Additional training is provided through monthly teleconferences and individual training based upon management recommendation.

Practical Skills Training Program. The Practical Skills Training Program is designed to help the Ombudsmen refine their skills in assisting injured employees in proceedings before TDI. At least three different practical skills training courses are offered by the RSAs each year. The training is delivered in six regional locations across the State, and the Ombudsmen receive continuing education credits for participating in the training which helps them fulfill the requirements for maintaining their Type 03 workers' compensation adjuster's licenses.

The courses are designed to give practical information to the Ombudsmen, which they can immediately implement into the performance of their job duties. There is a lecture and discussion component at each training session. In addition, written material is prepared to provide more detailed resource material than can be presented in a lecture. The written materials from each practical skills training are posted on OIEC's intranet for future reference. Finally, each practical skills training includes some practical application of the material to test the participants' knowledge of the subject matter covered in the training. Those exercises provide an excellent opportunity to provide feedback from the trainer and the participants and a chance to have a little fun, which plays a significant role in team building.

Customer Service Representative (CSR) Training. A comprehensive training program is provided to each CSR as they are hired so that they will have the information necessary to respond accurately and promptly to the issues that injured employees bring to them.

Training manuals with copies of the Workers' Compensation Act and Rules are provided to each CSR with the requirement that they be conversant with the information contained therein. Requirements include completing workers'

compensation training modules and reviewing the agency website links to provide for ongoing educational and procedural presentations, including instructions on the use of Compass and TXComp (workers' compensation automation systems). A monthly review of Appeals Panel's decisions is also required, as they provide interpretations of the Act and Rules and procedural clarifications.

Before being assigned to providing customer service to injured employees, CSRs are required to observe interactions between injured employees and Ombudsmen. In addition, new CSRs are assigned a senior CSR, Ombudsman Associate, or Ombudsman Assistant as a mentor for guidance and advice. They are also required to observe hearing preparation sessions, BRCs and CCHs. Training exercises are designed to help employees determine the questions to ask injured employees and the information needed should the injured employee's dispute proceed through DWC's administrative dispute resolution process. This extensive training is designed to produce employees who are well-equipped to provide exceptional customer service.

Monthly Teleconferences. Monthly teleconferences are held to ensure OIEC staff stays abreast of information necessary to continue to effectively serve the injured employees of Texas. Teleconferences may be held for specific functions, such as Ombudsman or CSR, or for the agency as a whole. RSAs may make presentations on legal issues or on new legislation, policies, and procedures. The agency's training committee has the opportunity to request particular topics be included in the teleconferences and serves as the coordinator on agency education and training initiatives.

Annual OIEC Conference. OIEC's conference is held each year in July for all OIEC staff to come together in one place. The conference generally lasts 2½ days. Since OIEC staff is located throughout Texas, the conference provides an opportunity to get to know each other–providing a face with a name, building OIEC's network, and increasing agency relations to overcome geographical barriers among OIEC's 25 locations.

Training sessions are held that promote teamwork and ethics as well as provide information about other aspects of the agency with which staff may not be familiar. Breakout sessions developed and targeted to the employee's job duties are held on a variety of topics including current legislative activities, changes in workers' compensation laws and rules, and new agency policies and procedures. Information presented at the conference is designed to enhance the skills of staff and increase

communication within the agency in order to provide excellent service to the injured employees of Texas. OIEC believes that effective teamwork yields business efficiencies, which are required from State agencies supported by public funds.

In 2008, the conference was held in Austin. In 2009, it will be held in San Antonio, which serves as the hub for OIEC's Training Committee.

Conference on Leadership. OIEC conducted a Conference on Leadership in October 2008. All OIEC Supervisors and Directors attended the conference. Speakers included selected OIEC and TDI staff from around the State. Presentations were made and information was shared regarding different aspects of leadership. Information was also shared regarding ideas for business process improvements.

F. Description of Agency Activities – FY 2007 and FY 2008

Access Plan and Servicing Non-English Speaking Customers. In recognizing both Texas' diverse and increasing non-English speaking populations and OIEC's statutory responsibility to assist all unrepresented injured employees of Texas, OIEC places its communication efforts as a top priority. As such, OIEC has developed an access plan to the agency's programs and facilities as required by Labor Code §404.005(a). This plan assures that non-English speaking injured employees have access to services offered by OIEC.

OIEC provides outreach and information materials for injured employees and employers. All literature and materials are available in English and Spanish and other languages upon request.

Other resources are also available to members of the non-English speaking public. OIEC's toll free number (1-866-EZE-OIEC • 1-866-393-6432) provides assistance to callers in both English and Spanish. Also, OIEC's website (www.oiec.state.tx.us) is available in both English and Spanish and may be used as a helpful resource.

OIEC has 25 field offices throughout the State to service the needs of injured employees. A majority of these offices, specifically, 88 percent of the field offices, have OIEC staff that is able to provide personal assistance in Spanish. Almost half of the Ombudsmen speak Spanish and are available for non-English speaking injured employees.

OIEC provides interpreter services for non-English speakers through a State employee or a private provider. Interpreter services are also available for injured employees in various stages of the workers' compensation dispute resolution process.

OIEC is in compliance with Labor Code §404.005(a) and is committed to making information and services available to Texans who speak languages other than English. Further, OIEC is committed to continuing its efforts to improve and expand its offerings to non-English speakers in the State.

New Employees on Board in FY 2008. The 80th Texas Legislature, 2007, transferred 25 employees (effective September 1, 2007) from TDI to OIEC to augment the Ombudsman Program.

The 25 transferees from TDI entered service with OIEC as Ombudsman Associates and began a year-long training program. At the end of the training they had earned their Type 03 workers' compensation adjuster's licenses, and were reclassified as Ombudsman I.

An additional 36 Customer Service Representative (CSR) positions were appropriated to OIEC on September 1, 2007 so that OIEC would be able to provide "one-stop-shop" convenience to injured employees who had little understanding of the intricacies of the workers' compensation claim process.

Agency Reorganization Resulting from Program Evaluation. After careful evaluation, OIEC was reorganized to better align itself with its mission. More information on this reorganization can be found on page 3 of this report. A current agency organizational chart is located on page 9.

Sunset Review Evaluation and Preparation Plan. OIEC's Sunset date was originally set for FY 2009 but was moved to FY 2011 as a result of the 80th Texas Legislature, 2007.

OIEC informally began preparing for Sunset Review in June 2008. OIEC reviewed and analyzed other Sunset Advisory Reports in order to develop a practice model Self-Evaluation Report. Other State's Workers' Compensation systems and Ombudsman Programs were researched to develop best practices in the industry. OIEC also developed a business plan to serve as a communication tool in preparing for Sunset Review and monitoring the agency's achievements.

OIEC will begin the Sunset Review process in 2009 by developing and submitting a Self-Evaluation Report (SER) to the Sunset Advisory Commission.

Business Plan Created. A business plan was created in FY 2008 to provide an operational road map for achieving agency goals, consistent with its enabling statute, mission, strategic planning goals, and strategies.

The plan describes in specific terms who is responsible, what actions will be taken, within what time frame, and how the agency will know when it has accomplished the items in its plan. The plan is an accountability and coordination tool to keep all employees focused on the most important activities in order to fulfill the organization's mission effectively and efficiently.

Rights and Responsibilities Publication Revised. OIEC revised its educational publication entitled "Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System" (Rights and Responsibilities). OIEC's Rights and Responsibilities publication is designed to provide injured employees with necessary information after sustaining a work-related injury. OIEC considers the Rights and Responsibilities a key tool in its efforts to fulfill the agency's mission to assist, educate, and advocate on behalf of injured employees. The publication was sent to approximately 200,000 injured employees during the FY 2007.

OIEC revised the publication to keep injured employees abreast of the recent workers' compensation laws passed during the 80th Legislative Session. Changes to the publication include more information about choosing a treating doctor in a workers' compensation health care network, obtaining medical treatment if the employer is a political subdivision, and the removal of the Approved Doctor List.

Internal Audit Results. OIEC contracted with Garza/Gonzalez & Associates regarding Agency Contract 08-448-01 for internal auditing services in accordance with the Texas Internal Audit Act, Chapter 2102, Texas Government Code. An internal audit was conducted on the Payroll and Human Resources Areas of OIEC, its compliance with applicable State requirements, and established policies and procedures for the year ended August 31, 2008.

Since OIEC is administratively attached to TDI, the audit was focused on TDI's and OIEC's policies and procedures. The results of the audit disclosed that such controls were adequate and no instances of noncompliance were noted. However, certain matters were noted that are opportunities for strengthening internal controls and operating efficiency and complying with OIEC's established policies and procedures. OIEC works with TDI staff to ensure full compliance with State and federal laws and to create business efficiencies where appropriate.

Benchmarking Efforts. OIEC is a member of the International Association of Industrial Accident Boards and Commissions (IAIABC). The IAIABC is an association of government agencies that administer and regulate their jurisdiction's workers' compensation acts. Along with these government entities, various private organizations involved in the delivery of workers' compensation coverage and benefits participate in the IAIABC. Since its inception in 1914, the IAIABC has

worked to improve and clarify laws, identify model laws and procedures, develop and implement standards, and provide education and information sharing. OIEC shares best practices with the IAIABC and incorporates other states' best practices that would enhance the services provided to the injured employees of Texas.

Best Practices. During the month of August 2008, Customer Service management began a project of contacting other states' workers' compensation agencies to review their websites and determine the type of customer service programs they have, their best customer service practices, and how they train their staff. Best ideas will be reviewed and submitted to the leadership staff for possible use by OIEC.

Calls were made to 30 agencies but personal contact was only made with representatives from 25. All but two of those states contacted had some type of customer assistance program, although some only offered a very limited amount of regulatory assistance. Only California had customer service easily available for walk-ins because, like Texas, they have a large number of field offices placed throughout the state. Although all states that offered customer service took walk-ins as well as telephone calls, most states only had two or three offices located within the state so it was highly unlikely that they handled a very large volume of walk-in customers.

In obtaining the referenced information, it was noted that OIEC CSRs provide assistance and services equal to or exceeding services provided by customer assistants and Ombudsmen in many of the other states agencies. Several states, including Alabama, Florida, Georgia, Maine, Missouri, New Hampshire, and Wisconsin, will contact an adjuster to attempt to resolve regulatory issues. However, most indicated that they do not provide advocacy assistance. Their primary function is to answer questions. In most states, if there is a dispute the injured employee is told that they can either hire an attorney or represent themselves without assistance from an agency employee. Customer service in these agencies rarely had any outreach programs, although they usually had some type of written materials that could be mailed.

Customer service training varied greatly from zero to six months of study. Most agencies simply placed a new customer assistant with an experienced customer assistant for 3-4 weeks to learn by observation.

Some best practices obtained from the various agencies' websites being considered are the use of claim processing flow charts, currently posted by both Pennsylvania and California in their agency websites, a claims checklist, posted in the New Mexico agency website, and a down-loadable customer handbook in Illinois. Pennsylvania, in addition to the usual toll-free line, provides answers to questions submitted through an e-mail hotline. California holds monthly injured employee informational workshops in its field offices.

Customer Service On-line Survey. In an effort to measure and continually improve the service that OIEC provides to its customers, OIEC has posted the "2008 Customer Service Survey" online. This survey is available to all customers who have contact with OIEC and will measure the quantity and quality of service it provides.

Policy Development Program. OIEC's Policy Development Program was initiated in an effort to better communicate and receive ideas from all employees. Recognizing the value and ideas of each employee, this program was designed to serve as a channel of communication for "great ideas."

While participation in this program is optional, all OIEC employees are encouraged to submit their ideas on how to improve OIEC, OIEC's policies or procedures, or work environment. OIEC's executive management team reviews the ideas or recommendations submitted monthly. Confidentiality of the employee who submitted the policy recommendations is being provided to encourage all OIEC employees to participate in providing suggestions to improve our agency.

Outreach Efforts. OIEC's outreach efforts are a key element in serving the injured employees in Texas. Since the agency is relatively new, it has been a continuing effort to inform the public about the services offered to injured employees and other parties in the Texas workers' compensation system.

OIEC participated in 36 presentations, workshops, seminars, speaking engagements, and other forums in FY 2008 where OIEC staff speak to workers' compensation system stakeholders regarding OIEC, its role, and its services.

OIEC is currently maximizing outreach efforts to ensure Texans are aware of the public service OIEC provides. OIEC's increased outreach initiatives include:

1) comprehensive education and resource materials for injured employees, employers, and health care providers;

2) a public service announcement, both in English and Spanish, that increases the public's awareness about OIEC and its efforts to help injured employees return to work;

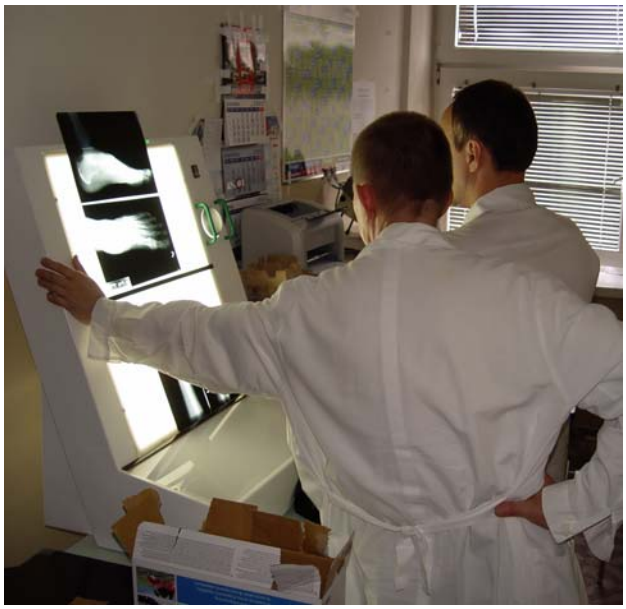
3) a dynamic and user-friendly website relaying the latest workers' compensation developments that impact injured employees, which is also available for OIEC's Spanish-speaking customers; and

4) an aggressive Customer Service initiative whereby injured employees upon reporting a work-related injury are contacted by OIEC in order to educate the customer about their rights and responsibilities in the workers' compensation system and OIEC's services. In addition, families of employees who sustain work-related fatalities are contacted to inform them of death and burial benefits to which they may be entitled. The local legislative representative is also contacted to advise the representative of a potentially work-related fatality in the community.

Over the next biennium, OIEC will increase its outreach efforts through quarterly educational presentations for injured employees in our field offices, enhanced brochures and marketing materials, which will be made available to both injured employees and health care providers, and a streamlined website. The endeavors ensure that information is available to injured employees about the claim process and services that OIEC offers.

Medical Dispute Resolution. HB 724 (Texas Legislature, Regular Session, 2007) changed the process to provide parties in a medical necessity or medical fee dispute an opportunity to administratively appeal a medical dispute resolution decision to either a CCH at TDI or the State Office of Administrative Hearings (SOAH) based on the amount in controversy.

An appeal to a CCH at TDI is allowed for retrospective medical necessity disputes where the amount billed does not exceed $3,000, medical fee disputes in which the amount of reimbursement sought does not exceed $2,000, and prospective and concurrent medical necessity disputes. An appeal to SOAH is provided for disputes where the dollar amounts in dispute exceed those allowed for a CCH at TDI. This statutory change became effective September 1, 2007, and injured employees are requesting Ombudsman assistance in these cases. The Ombudsmen have received extensive training on these new processes and are ready and able to assist.



OIEC has been actively working with TDI to simplify the complex administrative dispute resolution process in the workers' compensation

system. OIEC believes that a streamlined process will be more efficient for all stakeholders, particularly injured employees. OIEC also believes a simplified process will provide more participation and comprehension for all injured employees of Texas. OIEC has proposed legislative recommendations in Part IV of this report to streamline DWC's dispute resolution process.

Commitment to Open Government. In an effort to promote better communication internally and externally, OIEC has made the following information available on its website:

1) OIEC Business Plan – to provide an operational road map for achieving agency goals, consistent with its enabling statute, mission, strategic planning goals, and strategies to internal and external customers. The plan describes in specific terms who is responsible, what actions will be taken, within what time frame, and how the agency will know when it has accomplished the items in its plan. The plan is an accountability and coordination tool to keep all employees focused on the most important activities in order to fulfill the organization's mission effectively and efficiently.

2) OIEC Organizational Chart – to provide internal and external customers a view of the organization of agency staff. OIEC's Organization Chart can also be found on page 9.

3) OIEC Budget – to provide internal and external customers a view of the agency's budget and how taxpayer's money is spent.

Providing a "One-Stop-Shop." As mentioned earlier in this report, 36 CSR positions were appropriated to OIEC on September 1, 2007 so that OIEC would be able to provide "one-stop-shop" customer service. The concept of a "one-stop-shop" agency provides for injured employees to contact a single agency, which reduces confusion by all system participants in a complex workers' compensation system. In an effort to provide this convenience to injured employees, OIEC has been coordinating with TDI to separate the duties of OIEC CSR staff and TDI's customer assistance staff in order to provide this "one-stop-shop" convenience. OIEC CSR staff provides advocacy, assistance, and education about the workers' compensation system while TDI staff process official and regulatory actions.

Referral Services Assistance. OIEC refers injured employees to the Department of Assistive and Rehabilitative Services (DARS), the Texas Workforce Commission (TWC), TDI or other social or regulatory services, such as the Health and Human Services Commission (HHSC) or licensing boards, to assist injured employees with:

1) finding employment,

2) training opportunities,

3) returning to work,

4) filing complaints with appropriate licensing boards or other regulatory agencies,

5) obtaining financial assistance, and

6) reporting alleged administrative violations.

DARS and TWC attend OIEC's Education Conference to ensure efficiencies in the referral process. There is also a Memorandum of Agreement (MOA) between OIEC, TDI, and DARS to ensure the most effective referral process.

OIEC also makes referrals to the State Bar for assistance in finding legal representation for an injured employee, in district court cases, where an attorney is critical and the Ombudsmen are not permitted to provide assistance.

In FY 2008, OIEC assisted almost 2,000 injured employees with referrals to other agencies, social, and regulatory services.

Survey of Organizational Excellence. At the beginning of calendar year 2008, OIEC employees were asked to participate in the Survey of Organizational Excellence. The survey provides information about the employees' perceptions of the effectiveness of the agency, and the employees' satisfaction with the agency. The survey is provided by the Organizational Excellence Group, University of Texas School of Social Work.

Over 82 percent of OIEC employees responded to the survey, which is considered a high response rate.

Since the 2008 survey is the first survey in which OIEC has participated, it represents the benchmark against which future surveys will be based.

Strengths. According to the survey, OIEC employees perceive the agency:

- is able to relate its mission and goals to environmental changes and demands;
- delivers quality service to its clients;
- is strong in its use of tools and processes for external communication;
- has a relatively low level of perceived "burnout" which can negatively influence an organization's performance; and
- permits employees to have some control over their jobs and the outcome of their efforts.

Weaknesses. Some areas the agency will strive to improve based on survey results which suggest a need for improvement include:

- Fair Pay;
- Physical Environment; and
- Benefits.

Compared to employees in organizations of similar size or mission OIEC has more favorable results.

Ombudsman Program - Customer Satisfaction Survey. OIEC contracted with the University of North Texas Survey Research Center (SRC) to conduct a customer satisfaction survey pursuant to Government Code §2114. The survey was designed to measure the satisfaction of injured employees who have had a dispute with their workers' compensation claims or were assisted by an Ombudsman. The objectives of the survey were to measure injured employees' opinions of:

- The fairness of the workers' compensation dispute process;
- Assistance they may have received from an Ombudsman; and
- Assistance they may have received from an attorney during the dispute process.

The survey serves as a comparison against a previous survey conducted in 1997 by the Research and Oversight Council on Workers' Compensation (ROC), which is now a part of TDI's Workers' Compensation Research and Evaluation Group.

The report includes OIEC's Compact with Texans, applicable customer-related performance measures, methodology, findings, and a 1997 and 2008 comparison. Highlights of the survey findings can be found on pages 57 through 64 of this report. The full report can be found on OIEC's website at http://www.oiec.state.tx.us.

Rulemaking Initiatives. OIEC has been actively involved in developing agency rules in accordance with Chapter 2001 of the Government Code. Labor Code §404.006 gives the Public Counsel rulemaking authority. OIEC worked with the *Texas Register* at the Secretary of State's Office to provide for the new agency's rulemaking activities. Chapters 275 through 300, Part VI, Title 28 of the Texas Administrative Code have been reserved for OIEC rulemaking initiatives.

In accordance with the authority granted to OIEC in Labor Code §404.104, OIEC has been active in the rule development process at DWC. OIEC has attended all stakeholder meetings concerning workers' compensation rules and will continue to do so. In addition, OIEC has commented on both informal, pre-proposal draft rules and formal, proposed rules. OIEC's role in providing comments to pre-proposal drafts and proposed rules is critical to ensuring that the interests of injured employees are protected in the

workers' compensation system. As a result, OIEC's efforts in this regard will be ongoing.

OIEC has actively participated in the following TDI and DWC workers' compensation rules, which were adopted in FY 2007 and FY 2008:

- **Health Care Provider Billing Procedures, §133.10.** Subsection (b) is amended to change the implementation date for use of the National Council for Prescription Drug Programs (NCPDP) Universal Claim Form (UCF) from January 1, 2007 to January 1, 2008. The use of DWC form DWC-66 is extended through December 31, 2007. Until that time, the DWC-66 is required to be used for paper billings.

  The amendment extends the date on which pharmacists and pharmacy processing agents are required to begin using the UCF in order to make it consistent with the implementation date of the electronic medical billing requirements recently adopted by DWC. This will allow a longer period of transition for health care providers and insurance carriers to integrate these forms into their processes.

- **Office of Injured Employee Counsel, §§276.1, 276.2.** OIEC adopted new §276.1 concerning chapter definitions and §276.2 concerning OIEC's mission to create a clear understanding of OIEC's statutory mission to assist, educate, and advocate on behalf of the injured employees of Texas.

- **Electronic Formats for Electronic Claim Data Request and Report, §102.11.** The 77th Texas Legislature, Regular Session, 2001, enacted HB 1562, amending Labor Code §402.084 to authorize the Texas Workers' Compensation Commission, now DWC, to establish by rule a reasonable fee for information requested in an electronic data form by subclaimants or their representatives to control insurance fraud. The 79th Texas Legislature, Regular Session, 2005, enacted HB 251, amending Labor Code §402.084 to require DWC to release to an insurance carrier certain data, on request, that will allow the carrier to identify potential subclaims and pursue recovery allowed under Labor Code §409.009.

  HB 251 authorizes DWC to establish by rule a reasonable fee not to exceed five cents for each claimant listed in an information request.

The section is necessary to implement a system that uses a computer program developed by DWC, which compares information submitted from potential subclaimants, or their representatives, to information contained in workers' compensation claim data. The system will provide information in a secure manner to insurance carriers that will assist them in determining if they provided health insurance coverage for claims that have related workers' compensation claims.

- **Medical Billing and Processing, §§133.305, 133.307, 133.308.** These sections are necessary to: implement statutory provisions of HB 7, enacted by the 79th Legislature, Regular Session, effective September 1, 2005; address the merger of two agencies with similar purposes and processes; and improve efficiencies within the medical dispute resolution process.

  Sections 133.305, 133.307, and 133.308 are necessary to implement HB 7 amendments to Labor Code §413.031 and new Labor Code §413.032 to conform the medical dispute resolution process for medical disputes arising from non-network care or from certain authorized out-of-network care with the overall stated system aims of HB 7 as provided in Labor Code §402.021 (b)(3) – (9). HB 7 amended Labor Code §408.027 relating to payment of health care providers and added Labor Code §408.0271 relating to reimbursement by health care providers. The sections are necessary to implement and clarify the changes to the Labor Code regarding payment and reimbursement that affect the dispute resolution process. HB 7 also added §413.0111 to the Labor Code relating to processing agents. The sections are necessary to implement the provisions of Labor Code §413.0111 and establish requirements and procedures for pharmacies to use pharmacy processing agents or assignees to process claims under the terms and conditions agreed on by the pharmacies. Additionally, the sections implement HB 7 amendments to Labor Code §413.031 regarding independent review organization (IROs) and implement new Labor Code §413.032 regarding IRO decisions and appeals. The sections establish the binding effect of IRO decisions, specify elements of the IRO decision, and institute quality monitoring of IROs. HB 7 further provides direct judicial review for an appeal from an IRO or from DWC, thus removing the State Office of Administrative Hearings (SOAH) layer from the MDR process.

- **Disability Management, §§137.10, 137.100, 137.300.** The new sections are necessary to implement changes as a result of HB 7, enacted by the 79th Legislature, Regular Session. Sections 137.1, 137.10, 137.100, and 137.300, are necessary to implement HB 7 amendments to Labor Code §413.011 that require the Commissioner of Workers' Compensation (Commissioner) to adopt by rule treatment guidelines that are evidence-based, scientifically valid, outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. The purpose of the treatment guidelines is to ensure the quality of medical care and to achieve effective medical cost control. HB 7 also amended Labor Code §413.011 to require the

Commissioner to adopt by rule return to work guidelines for the purpose of enhancing timely and appropriate return to work. HB 7 further amended Labor Code §413.018 to require the Commissioner by rule to provide for the periodic review of medical care provided in claims in which guidelines for expected or average return to work time frames are exceeded. The Commissioner also adopts the new titles of Chapter 137 and Subchapter B.

- **Disability Management Emergency Rule, Treatment Planning, §137.300**. The Commissioner of DWC adopted on an emergency basis an amendment to §137.300, concerning Required Treatment Planning, to change the applicability date for required treatment planning from health care provided on or after May 1, 2007, to health care provided on or after September 1, 2007. Section 137.300 is part of rules adopted relating to disability management. The disability management rules include 28 Texas Administrative Code §§137.10, 137.100, 137.300, and were adopted and published in the January 12, 2007, issue of the *Texas Register* (32 Tex. Reg. 163). Section 137.300 (g) established an effective date for the implementation of the required treatment planning section of disability management rules.

- **Employer's First Report of Injury and Notice of Injured Employee Rights and Responsibilities, §120.2**. The adopted amendments to §120.2 are necessary to implement Labor Code §409.005 and to provide for the distribution of the Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System (Rights and Responsibilities) contemplated by Labor Code §404.109.

- **General Provisions, §276.3.** New §276.3 is necessary to implement state agency rulemaking procedures in accordance with the Administrative Procedure Act, Chapter 2001 of the Texas Government Code. The public benefit anticipated as a result of the adopted section shall be the implementation of HB 7, 79th Texas Legislature, Regular Session, 2005, which provided the Public Counsel rulemaking authority to enact Chapter 404 of the Texas Labor Code in accordance with the requirements provided in Chapter 2001 of the Government Code. The adoption of §276.3 provides the opportunity for workers' compensation stakeholders, the citizens of Texas, and any other person the ability to file a rule petition to the Public Counsel for review, consideration, and disposition.

- **Health Facility Fees, §134.402.** These amendments are necessary to maintain the stability of the ASC reimbursement rates during the period DWC develops a new ASC fee guideline in order to address new changes in Medicare's ASC reimbursement methodology. These amendments do not apply to political subdivisions with contractual relationships under Labor Code §504.053(b)(2).

  Labor Code §413.011 and §413.0511(b)(1), of the Texas Workers' Compensation Act (Act) require DWC to adopt health care reimbursement

policies and guidelines that are: (1) developed in consultation with DWC Medical Advisor; (2) the most current reimbursement methodologies, models, values or weights used by the Centers for Medicare and Medicaid Services (CMS) in order to achieve standardization; (3) fair and reasonable; and (4) designed to ensure the quality of medical care; and achieve effective medical cost control.

Beginning in January of 2008, Medicare's new ASC fee schedule will move toward standardizing the reimbursement methodologies of outpatient hospital and ASC facilities by changing the ASC methodology to be more like that of the outpatient hospital reimbursement methodology.

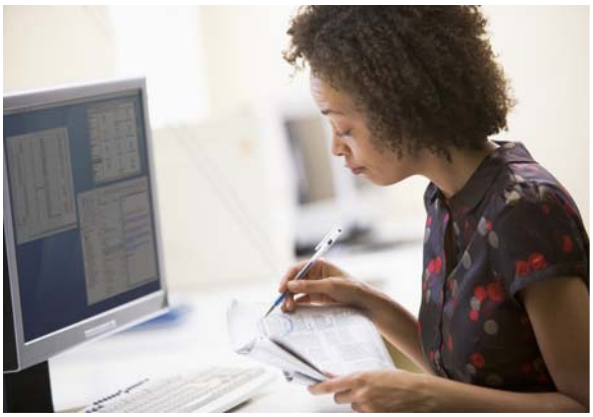
Medicare's new ASC fee schedule will incorporate relative payment weights for groups of procedures with similar resource and clinical characteristics, based on the Ambulatory Payment Classifications that are key elements of the Medicare Outpatient Prospective Payment System. The list of procedures eligible for payment under the Medicare ASC payment system will be greatly expanded. In the Medicare system, reimbursement for high cost devices and surgically implanted devices will be included in the procedure reimbursement amount. This is a significant change and the current PAF in §134.402 is not compatible with this new methodology.

The rule amendments will continue the use of reimbursement structures and amounts at the Medicare ASC 2007 rates for services provided on January 1, 2008 through August 31, 2008. This will maintain the stability of the ASC reimbursement rates during the period a new ASC fee guideline utilizing the new Medicare ASC methodology is being developed and assure system participants of a timeline for implementation of the new Medicare methodologies.

- **Inpatient and Outpatient Hospital Fee Guidelines, §§134.403 and 134.404.** In accordance with Labor Code §413.011, the Workers' Compensation Commissioner is required to promulgate health care reimbursement policies and guidelines that reflect standardized reimbursement structures found in other health care delivery systems with minimum modifications to meet occupational injury requirements. Furthermore, to achieve such standardization, DWC is required to adopt current reimbursement methodologies, models, and values or weights used by the Centers for Medicare and Medicaid Services and may deviate from Medicare policies where

appropriate. OIEC recommended the adoption of §§134.403 and 134.404 without changes.

- **Performance-Based Oversight, §180.19.** Rule 180.19 provides that DWC will assess and tier system participants once during a biennium with no option for reassessment. OIEC supports the concept of placing system participants in a tier once during a biennium without an opportunity for reassessment. OIEC believes an assessment once within a biennium encourages system participants to place importance on the PBO process and makes it easier for injured employees to draw conclusions about system participants' performance in the workers' compensation system.



- **Medical Reimbursement Policies, §§134.1 and 134.2 and Medical Fee Guidelines, §§134.203 and 134.204.** The Commissioner adopts amended §134.1 and new §§134.2, 134.203, and 134.204 to comply with Labor Code §413.012, which directs fee guidelines to be reviewed and revised to reflect fair and reasonable fees and to reflect medical treatment or ranges of treatment that are reasonable and necessary at the time the review and revision are conducted.

- **Return-to-Work, §§137.41 and 137.49.** HB 886 amends Labor Code §413.022 by requiring the Commissioner to establish by rule an optional preauthorization plan for eligible employers who participate in the pilot program. The optional preauthorization plan allows small employers to obtain Division approval of workplace modifications and changes prior to incurring the out-of-pocket expenses associated with implementing the modifications and changes. The adopted amendment and new section are necessary to implement amendments enacted under HB 886, by the 80th Legislature, Regular Session, to Labor Code §413.022 (relating to return-to-work pilot program for small employers; fund).

  The adopted amendment to §137.41 and new §137.49 establishes the optional preauthorization plan. The adopted amendment to §137.41 incorporates new §137.49 into the rules in Subchapter B that establish and set forth the terms, conditions, and requirements for the pilot program. New §137.49 establishes the procedures and requirements for the optional preauthorization plan whereby small employers may submit a proposal plan to DWC that describes the workplace modifications and other changes that the employer proposes to make to accommodate an injured employee's return to work. This new rule also provides that if DWC approves the employer's proposal, DWC will guarantee reimbursement of the expenses incurred by the employer in implementing the modifications and changes from the return-to-work account.

- **Health Care Provider Billing Procedures, §133.10.** The adopted amendment to §133.10(a)(3) is necessary to correct the inaccurate reference to Subchapter F as the subchapter that governs electronic billing ("eBilling"). Subchapter G contains the rules governing eBilling. The adopted amendment to §133.10(b) replacing the current National Council for Prescription Drug Programs ("NCPDP") Universal Claim Form ("UCF") with DWC form DWC-66 ("DWC-66") or other mutually agreed upon qualifying alternate billing form as the prescribed paper billing form for pharmacy services is necessary because the current NCPDP UCF is not effectively adaptable for use in the Texas workers' compensation system and would bring unnecessary inefficiencies and costs into that system.

  Readopting the DWC-66 as the prescribed billing form will prevent unnecessary inefficiencies and costs from being imposed upon the Texas workers' compensation system and will allow system participants to use their already established procedures and automated systems to process paper pharmacy bills. Further, this adopted amendment allows system participants to adopt an alternate billing form in lieu of the DWC-66 if there is a mutual agreement and the alternate billing form provides all the information required by the DWC-66. This will provide system participants with the flexibility to use other pharmacy billing forms such as other nationally standardized pharmacy billing forms that are effectively adaptable for use in the Texas workers' compensation system.

- **Dispute of Medical Bills, §§133.305, 133.307, and 133.308.** The amendments are necessary to implement statutory provisions of HB 724, HB 1003, and HB 2004 enacted by the 80th Legislature, Regular Session, effective September 1, 2007; and to clarify provisions of and ensure compliance with fee payment to IROs. The amendments incorporate administrative-level hearings into DWC's medical dispute resolution process as a step between medical dispute resolution or IRO review and judicial review in resolution of medical fee and medical necessity disputes. The amendments also address licensing and professional specialty requirements for doctors performing reviews for IROs.

  Changes to the Labor Code by HB 724 introduce SOAH and DWC's CCH process into the medical dispute resolution process as a level of appeal that occurs after MDR or IRO review and prior to judicial review. Changes to the Labor Code by HB 1003 require IROs that use doctors to perform reviews of health care services provided under the Texas Workers' Compensation Act to only use doctors licensed to practice medicine in Texas to perform the reviews. Changes to the Labor Code by HB 2004 require a doctor performing an independent review of a health care service provided to an injured employee, including a retrospective review, who reviews a specific workers' compensation case, to hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving.

- **General Rules for Medical Billing and Processing, §§133.2, 133.4, and 133.5.** The amendments to §133.2 are necessary to update existing rule definitions, and citations, and to add definitions recently enacted by Labor Code §413.0115. Adopted §133.4 is necessary to comply with Labor Code §413.011(d-2), effective September 1, 2007, which was enacted by HB 473, 80th Legislature, Regular Session. To remain consistent with the statutory provisions of Labor Code §413.011(d-2), new §133.4 specifies the time and manner of providing notice to the health care provider and allows the insurance carrier, the insurance carrier's authorized representative, or the informal or voluntary network the flexibility to determine which entity will provide the requisite notice to affected health care providers. This flexibility in adopted §133.4 allows the insurance carrier, the insurance carrier's authorized agent, or the informal or voluntary network to deliver and document the notice using whatever method best fits its business needs, so long as the notice contains the requisite information, is delivered in accordance with the stated timeframes, and can be reproduced at the request of DWC. Adopted §133.5 is necessary to specify additional reporting requirements by informal networks and voluntary networks to DWC and to include the reporting requirements established by Labor Code §413.0115.

- **Ombudsman Program, §276.11.** New §276.11 is necessary to fulfill OIEC's mission critical function to assist injured employees in DWC's administrative dispute resolution system pursuant to Labor Code §§404.101. Access to an injured employee's medical documentation is imperative to adequately assist an injured employee during a medical dispute resolution hearing. HB 724 as passed by the 80th Texas Legislature, Regular Session, 2007, provides for an administrative hearing subsequent to an IRO decision in DWC's medical dispute resolution system. OIEC's Ombudsmen are anticipated to assist a majority of injured employees in these medical dispute resolution hearings as a result of an attorney's limited ability to recover attorney's fees for services rendered on medical issues within the workers' compensation system. In claims where compensability is contested, health care providers will benefit from an Ombudsman's assistance to an injured employee in proving up a compensable injury. In these cases, a health care provider's payment for services is dependent upon a determination of compensability which is enhanced by an Ombudsman's access to medical documentation. Access to an injured employee's medical documentation is critical in disputed claims to establish a compensable injury, in turn providing an injured employee's access to necessary and appropriate medical care which will allow them to get well and back to work.

- **Health Facility Fees, Ambulatory Surgical Center Fee Guideline, §134.402.** In 2007 the Centers for Medicare and Medicaid Services (CMS) significantly revised the Medicare ASC reimbursement methodology. In order to maintain the stability of the ASC reimbursement, the Commissioner of Workers' Compensation (Commissioner) amended §134.402 and retained the current ASC guidelines while researching and preparing to implement the new Medicare ASC reimbursement methodology. The amendments continued the use of reimbursement structures and amounts of the Medicare ASC 2007 rates for ASC facility services provided on January 1, 2008 through August 31, 2008. This continuation has afforded additional time for the Commissioner to determine and establish the appropriate ASC reimbursement methodology. The amendments to the rule are needed to align with revised Medicare reimbursement methodologies, develop the most suitable reimbursement structure, and utilize appropriate conversion factors or other payment adjustment factors geared to the Texas workers' compensation system.

- **Subclaimant Rules, §§140.6, 140.7 and 140.8.** Adopted §140.6 establishes the procedures that apply to all subclaimants, including health care insurers and specifies a subclaimant's rights in relation to the injured employee and the circumstances in which a subclaimant may pursue a claim for reimbursement of a benefit without the participation of the injured employee.

  Adopted §140.7 applies to health care insurers and only applies to subclaims by a health care insurer. The section provides for the reimbursement of health care insurers for medical benefits provided to or paid on behalf of an injured employee with a compensable workers' compensation claim and specifies that it is not a defense to a subclaim by a health care insurer that: (1) the health care insurer has not sought reimbursement from a health care provider or the health care insurer's insured; (2) the health care insurer or the health care provider did not request preauthorization, or (3) the health care provider did not bill the workers' compensation insurance carrier, as provided by §408.027, before the 95th day after the date the health care for which the health care insurer paid was provided.

  Adopted §140.8 establishes the process for health care insurers seeking reimbursement from a workers' compensation insurance carrier when pursuing a claim for reimbursement of medical benefits under §409.0091. The section also requires the health care insurer to provide a notice of the reimbursement request to the injured employee and the health care provider that performed the services that are the subject of the reimbursement request.

  Section 140.8 provides that a workers' compensation insurance carrier must either pay, reduce, or deny a reimbursement request and provides the procedures to follow with each response, and requires a health care provider to refund to the injured employee all payments received from the injured employee for care relating to the claim within 45 days of receipt of the notice that the claim is compensable. The section also sets forth the following procedures: 1) for filing

a request for dispute resolution, based on the reasons for the denial of the reimbursement request, and 2) when multiple entities seek reimbursement for the same services.

Claim for Death Benefits, §122.100. The adopted amendments amend §122.100(e)(2) to state that the good cause exception to the one year filing deadline applies to a legal beneficiary other than an eligible parent. The adopted amendments add §122.100(e)(3) which provides that an eligible parent's failure to file a claim for death benefits within the one year time period does not bar the parent's claim if the parent submits proof satisfactory to the Commissioner of a compelling reason for the delay in filing the claim for death benefits.

Death Benefits, §§132.6, 132.9, and 132.11. New §132.6(b) defines "eligible parent" and provides when an "eligible parent" is entitled to receive death benefits. The adopted amendment to §132.6(c) requires a person applying for death benefits as an "eligible parent" to submit proof of relationship to the deceased. It also requires the person to submit proof of receipt of burial benefits unless the claim for death benefits is filed at the same time as the claim for burial benefits or the claim for burial benefits is pending at the time the claim for death benefits is filed.

The adopted amendment to §132.9 adds subsection (d) which sets out the duration of death benefits that are to be paid to an eligible parent. This adopted amendment also amends the title of this section to reflect its applicability to eligible parents. The adopted amendments to §132.11 amend subsection (d) of that section to clarify that subsection (d) applies to legal beneficiaries who are surviving dependents of the deceased. New subsection (e) provides for how death benefits are to be distributed to eligible parents.

OIEC is committed to reviewing every rule proposed by TDI and DWC to determine its impact, if any, on injured employees and to provide comments that protect the interests of injured employees.

Participation in Court Proceedings and Filing Amicus Curiae Briefs on behalf of Injured Employees. Labor Code §404.104(3) provides that OIEC "may appear or intervene, as a party or otherwise, as a matter of right, on behalf of injured employees as a class in any proceeding in which the public counsel determines that the interests of injured employees as a class are in need of representation . . ."

In September 2006, OIEC filed an Amicus Curiae (friend of the court) Brief in Opposition

to a Petition for Review with the Texas Supreme Court in Lockheed Martin Corp. v. Eunice Alexander, Case No. 06-0299. OIEC requested that the Texas Supreme Court deny the petition for review because the Second Court of Appeals had correctly interpreted the waiver provision of Labor Code §409.021(c). The petitioner had requested that the Supreme Court grant the petition and require that an injured employee prove that an injury occurred in the course and scope of employment, in addition to establishing coverage under a workers' compensation insurance policy and damage or harm to the physical structure of his or her body that the injured employee claimed was caused at work. OIEC argued that if the petitioner's argument were to prevail at the Texas Supreme Court, it would have the effect of judicially repealing Labor Code §409.021(c). On December 1, 2006, the Texas Supreme Court denied the petition for review. A Motion for Rehearing was filed and on February 2, 2007, the Texas Supreme Court denied rehearing.

On February 29, 2008, OIEC filed a second Amicus Curiae Brief in Opposition to Specific Portions of the Petition for Review, with the Texas Supreme Court in Bison Building Material, Ltd. V. Lloyd Aldridge, Case No. 06-1084. OIEC requested that fair notice, conspicuousness, and express negligence doctrines be applied to post-injury waivers executed by injured employees in non-subscriber cases just as they are applied to pre-injury waivers executed by employees of non-subscribers. The petition for review in this case remains pending at the Texas Supreme Court.

OIEC is currently drafting an *amicus curiae* brief in the case of *State Office of Risk Management v. Lawton*, No. 08-0363, requesting that that Supreme Court of Texas deny the petition for review filed by the State Office of Risk Management. At issue in this case is the interplay between § 409.021(c) of the Texas Labor Code and § 124.3 of the Texas Administrative Code. The Waco Court of Appeals adopted an analysis that has been applied in the administrative dispute resolution process at the Texas Department of Insurance, Division of Workers' Compensation since September 2004. That analysis strikes an appropriate balance between the two provisions and also gives meaning to both the waiver provision of § 409.021(c) and the provision of §124.3 that provides that waiver does not apply to extent of injury. Essentially, the analysis provides a mechanism for determining *if the question of* whether or not an injury or condition is part of the compensable injury presents a true extent-of-injury issue that is not subject to being waived. If the Supreme Court were to grant the petition for review and to adopt the position advanced by the State Office of Risk Management and Texas Mutual Insurance Company in its *amicus curiae* brief, it would have the effect of significantly undermining § 409.021(c) to the detriment of injured employees as a class.

OIEC is also reviewing two other cases where a petition for review has recently been filed with the Texas Supreme Court to determine if they present issues that require OIEC to speak on behalf of the injured employees of Texas. In making the decision of whether or not to file an *amicus* brief, OIEC is guided by our charge to represent the interests of injured employees as a class and a sense that our statutory mandate creates a unique perspective on the case.

G. Agency Budget Structure for FY 2007 – FY 2009

Goal 1 – To advocate effectively on behalf of injured employees participating in the Texas workers' compensation system in rulemaking or other public forums involving workers' compensation matters.

Objective 1.1 – In each year, review 100% of the workers' compensation rules informally or formally proposed and identify rules that impact injured employees and provide informal comments and/or Public Comment to ensure rules adequately protect injured employees and to act as a resource in legislative proceedings or other public forums addressing workers' compensation.

1.1 OC 1 Percentage of workers' compensation formal or informal rules analyzed by OIEC

1.1 OC 2 Percentage of Workers' Compensation Formal or Informal Rulemaking Processes in which the Office of Injured Employee Counsel Participated

1.1 OC 3 Percentage of Rules Changed for the Benefit of Injured Employees as a Result of the Office of Injured Employee Counsel Participation

Strategy 1.1.1 – To actively participate in the workers' compensation rulemaking process regarding the Texas workers' compensation system on behalf of injured employees. To provide information, research assistance, and testimony to the Legislature and Executive Branch including testimony regarding ad hoc reports, special research, or analytical projects for current workers' compensation issues or trends impacting injured employees participating in the workers' compensation system.

1.1.1 OP 1 Number of Rules (informal and formal) Analyzed by the Office of Injured Employee Counsel

1.1.1 OP 2 Number of Rulemaking Processes in which the Office of Injured Employee Counsel Participated

1.1.1 OP 3 Number of Data Analysis Projects performed by the Office of Injured Employee Counsel

Goal 2 – To increase effective injured employee education regarding their rights and responsibilities within the Texas workers' compensation system, provide injured employees with referrals to other state agencies or services available to assist them, to assist injured employees with filing complaints regarding healthcare providers, and to educate all system participants regarding the role of OIEC.

Objective 2.1 – To inform all injured employees by efficient means about their rights and responsibilities by reaching 75% of those injured employees each year whose claims were reported to the Division of Workers' Compensation. To refer injured employees to agencies or service entities that can assist them or to licensing boards regarding complaints received against healthcare providers. To educate all system participants regarding the role of OIEC to ensure a balanced system.

2.1 OC 1 Percentage of injured employees educated regarding their Rights & Responsibilities

Strategy 2.1.1 – To contact injured employees regarding their rights and responsibilities and regarding their insight and experience on the workers' compensation system and to assist injured employees who contact OIEC regarding their rights and responsibilities. To educate all system participants regarding the role of OIEC to ensure a balanced system.

2.1.1 OP 1 Number of Injured Employees Educated Regarding their Rights and Responsibilities

2.1.1 OP 2 Number of Injured Employees Assisted by Telephone

2.1.1 OP 3 Number of Injured Employees Assisted at Field Office Locations

2.1.1 OP 4 Number of Public Presentations Performed by the Office of Injured Employee Counsel

2.1.1 EF 1 Average Time from Date of Injury to the Date an Injured Employee is Sent Their Rights and Responsibilities

Strategy 2.1.2 – Credentialing/Certification: To refer injured employees to local, state, and federal programs offering financial assistance, rehabilitation, and work placement programs, or other social services. To assist injured employees with filing complaints to the licensing boards regarding healthcare providers.

2.1.2 OP 1 Number of Referrals to the Department of Assistive and Rehabilitative Services

2.1.2 OP 2 Number of Referrals to Texas Workforce Commission or Other Programs

2.1.2 EX 1 Number of Health Care Provider Complaints Received

Goal 3 – To assist injured employees participating in the Texas workers' compensation system through the Ombudsman Program and throughout the workers' compensation dispute resolution process.

Objective 3.1 – Each year, offer assistance to 100% of the injured employees who are not represented by attorneys and provide assistance at proceedings to 100% of injured employees not represented by attorneys who accept the assistance of an Ombudsman.

3.1 OC 1 Percentage of Proceedings Held before the Division of Workers' Compensation in which the Injured Employee was assisted by an Ombudsman

3.1 OC 2 Percentage of Issues Raised at Contested Case Hearings where the Injured Employee Prevailed When Assisted by an Ombudsman

3.1 OC 3 Percentage of Issues Raised on Appeal where the Injured Employee Prevailed When Assisted by an Ombudsman

3.1 OC 4 Average Indemnity Cost Avoided per Injured Employee Assisted by an Ombudsman

Strategy 3.1.1 – Prepare injured employees for Benefit Review Conferences and Contested Case Hearing proceedings and attend proceedings with injured employees as requested. Prepare injured employees for appeals and assist them with resolving disputes.

3.1.1 OP 1 Number of Injured Employees Prepared for a Benefit Review Conference (BRC) by an Ombudsman

3.1.1 OP 2 Number of Benefit Review Conferences with Ombudsman Assistance

3.1.1 OP 3 Number of Injured Employees Prepared for a Contested Case Hearing by an Ombudsman

3.1.1 OP 4 Number of Contested Case Hearings with Ombudsman Assistance

3.1.1 OP 5 Number of Injured Employees Prepared for an Appeal by an Ombudsman

3.1.1 EF 1 Average Time from the Date a Benefit Review Conference is Scheduled to the Date of First Injured Employee Contact with an Ombudsman

3.1.1 EF 2 Average Time from the Date a Contested Case Hearing is Scheduled to First Injured Employee Contact with an Ombudsman

3.1.1 EX 1 Number of Workers' Compensation Health Care Network Complaints Received

H. Agency Strategic Plan Performance Measures FY 2007 – FY 2008

Key Measures are Highlighted

Table 1

		FY 2007		FY 2008	
		Year-To-Date	% of Target	Year-To-Date	% of Target
Outcome Measures					
	Outcome Measure 1.1 oc 1 Percentage of Workers' Compensation Formal or Informal Rules Analyzed by OIEC	100.00%	100.00%	100.00%	100.00%
	Outcome Measure 1.1 oc 2 Percentage of Workers' Compensation Formal or Informal Rulemaking Processes in which OIEC Participated	96.00%	120.00%	70.83%	83.33%
Key	*Outcome Measure 1.1 oc 3* Percentage of Workers' Compensation Rules Changed for the Benefit of the Injured Employee as a Result of OIEC Participation	100.00%	142.86%	58.33%	116.67%
	Outcome Measure 2.1 oc 1 Percentage of Injured Employees Educated Regarding their Rights & Responsibilities.	92.00%	122.67%	95.91%	127.89%
Key	*Outcome Measure 3.1 oc 1* Percentage of proceedings Held before the Division of Workers' Compensation in which the Injured Employee was assisted by an Ombudsman	41.00%	91.11%	40.09%	89.08%

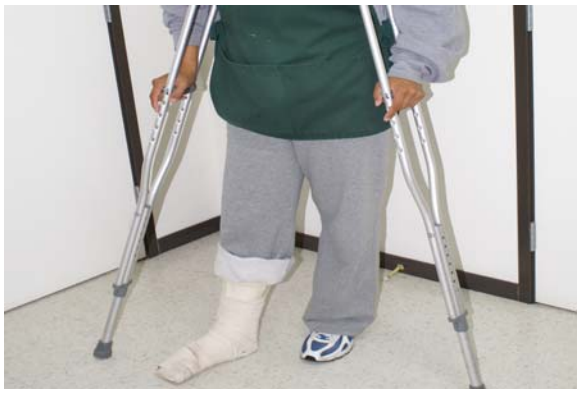
Key	*Outcome Measure 3.1 oc 2* Percentage of Issues Raised at Contested Case Hearings (CCH) where the Injured Employee Prevailed When Assisted by an Ombudsman	43.00%	107.50%	41.77%	104.43%
Key	*Outcome Measure 3.1 oc 3* Percentage of Issues Raised on Appeal where the Injured Employee Prevailed When Assisted by an Ombudsman	29.00%	72.50%	31.59%	78.98%
	Outcome Measure 3.1 oc 4 Average Indemnity Cost Avoided per Injured Employee Assisted by an Ombudsman	$2,135	426.95%	$2,215	443.05%
	Output Measures				
Key	*Output Measure 1.1.1 op 1* Number of Rules Analyzed by OIEC (informal and formal)	12	54.55%	24	109.09%
Key	*Output Measure 1.1.1 op 2* Number of Rulemaking Processes (informal and formal) in Which OIEC Participated	13	76.47%	17	100.00%
	Output Measure 1.1.1 op 3 Number of Data Analysis Projects performed by OIEC for Inclusion in its Legislative Report	5	100.00%	5	100.00%
	Output Measure 2.1.1 op 1 Number of Injured Employees Educated Regarding their Rights and Responsibilities	196,078	156.86%	211,173	168.94%

	Output Measure 2.1.1 op 2 Number Injured Employees Assisted by Telephone	31,430	142.86%	188,403	88.87%
	Output Measure 2.1.1 op 3 Number of Injured Employees Assisted at Field Office Locations	1,854	24.72%	8,725	32.02%
	Output Measure 2.1.1 op 4 Number of presentations performed by OIEC	36	144.00%	36	144.00%
	Output Measure 2.1.2 op 1 Number of injured employees referred to Department of Assistive and Rehabilitative Services (DARS)	493	246.50%	778	222.29%
	Output Measure 2.1.2 op 2 Number of injured employees referred to the Texas Workforce Commission or Other Programs.	52	52.00%	1,085	542.50%
	Output Measure 3.1.1 op 1 Number of Injured Employees Prepared for a Benefit Review Conference (BRC) by an Ombudsman	5,913	59.13%	5,241	49.91%
Key	*Output Measure 3.1.1 op 2* Number of Benefit Review Conferences (BRC) with Ombudsman assistance	6,636	94.80%	5,013	62.66%
	Output Measure 3.1.1 op 3 Number of Injured Employees Prepared for a Contested Case Hearing (CCH) by an Ombudsman	1,884	41.87%	1,717	36.15%

Key	*Output Measure 3.1.1 op 4* Number of Contested Case Hearings (CCH) with Ombudsman assistance	2,178	87.12%	2,025	75.00%
Key	*Output Measure 3.1.1 op 5* Number of Injured Employees Prepared for an Appeal by an Ombudsman	604	71.06%	552	63.09%
	Efficiency Measures				
	Efficiency Measure 2.1.1 ef 1 Average Time from Date of Injury to the Date an Injured Employee is Sent Their Rights and Responsibilities	27.9	79.71%	24.81	70.89%
	Efficiency Measure 3.1.1 ef 1 Average Time from the Date a BRC is Scheduled to the Date of First Injured Employee Contact with an Ombudsman	17.4	87.00%	17.97	89.85%
	Efficiency Measure 3.1.1 ef 2 Average Time from the Date a CCH is Scheduled to First Injured Employee Contact with an Ombudsman	16.8	84.00%	14.91	74.55%
	Explanatory Measures				
	Explanatory Measure 2.1.2 ex 1 Number of Workers' Compensation Health Care Provider Complaints Received	27	67.50%	71	43.03%
	Explanatory Measure 3.1.1 ex 1 Number of Workers' Compensation Healthcare Network Complaints Received	67	446.67%	92	36.80%

III. Adequacy of Income and Medical Benefits for Injured Employees in the Workers' Compensation System

This section of the legislative report provides an analysis of the ability of the workers' compensation system to provide adequate, equitable, and timely benefits to injured employees at a reasonable cost to employers as required by Texas Labor Code §404.106.



A. Texas Employer Coverage and Cost

Every state except Texas has mandatory workers' compensation coverage. In Texas, coverage is voluntary, but employers not providing coverage are not protected from tort suits. An employee not covered by workers' compensation insurance or an approved self-insurance plan is allowed to file suit claiming the employer is liable for his or her work-related injury or illness in every state.

Some states exempt employers from mandatory coverage if they have fewer than five employees or certain categories of workers, such as those in very small firms, certain agricultural workers, household workers, employees of charitable or religious organizations, or employees of some units of state and local government.

The rules for agricultural workers vary among states. In eleven states (in addition to Texas), farm employers are exempt from mandatory workers' compensation coverage altogether. In other states, coverage is compulsory for some or all farm employers.[2]

According to the 2008 study conducted by TDI's Workers' Compensation Research and Evaluation Group of employer participation in the workers' compensation system, approximately 67 percent of Texas employers carry workers' compensation insurance in 2008, which is the highest percentage of employers carrying workers' compensation coverage since the first study was conducted in 1993. Follow up studies were conducted in 1995, 1996, 2001, 2004, 2006, and 2008.

The 2008 study also found that 75 percent of Texas employees are employed by Texas employers that carry workers' compensation insurance, which is the lowest percentage of covered employees in the last fifteen years.[3]

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[2] Source: Workers' Compensation: Benefits, Coverage, and Cost, 2006. National Academy of Social Insurance Washington D.C.; August 2008.
[3] Source: Employer Participation in the Texas Workers' Compensation System: 2008 Estimates. Texas Department of Insurance Workers' Compensation Research and Evaluation Group; September, 2008.

Figures 3 and 4 show the percentage of Non-subscribers in Texas and the percentage of employees that are employed by Non-subscribers within the last 15 years.

Figure 3

Percentage of Texas Employers That Are Non-subscribers, 1993-2008

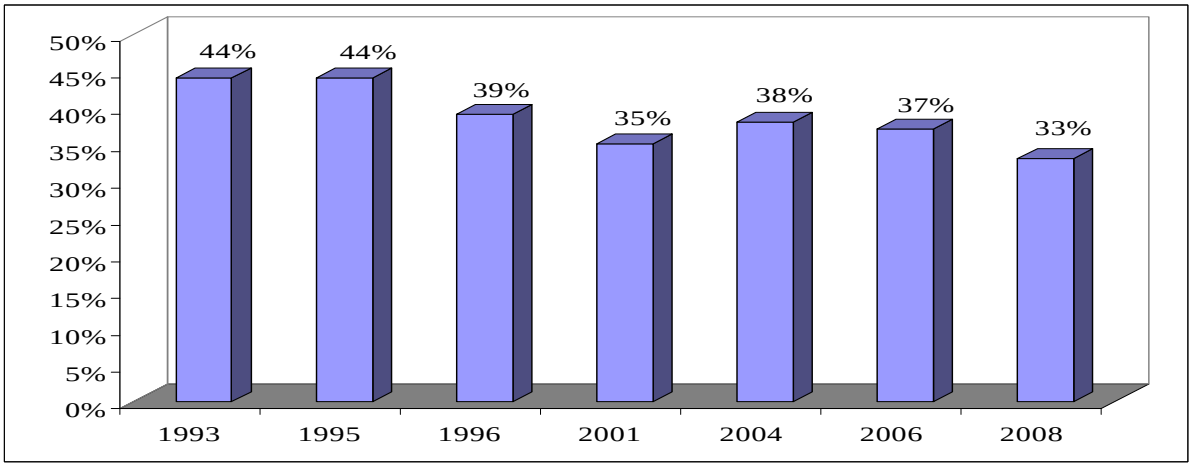
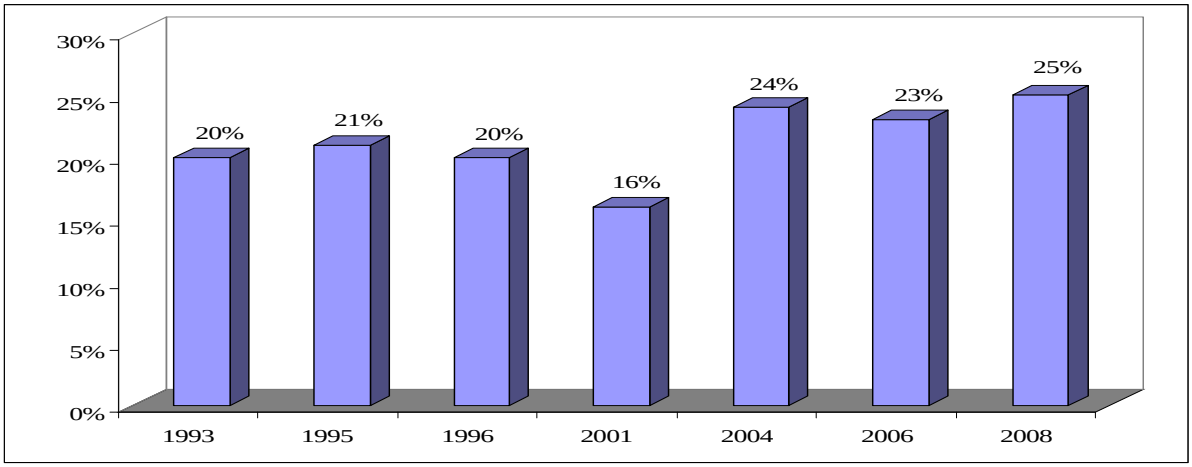


Figure 4

Percentage of Texas Employees That Are Employed by Non-subscribers, 1993-2008



Source: *Survey of Employer Participation in the Texas Workers' Compensation System*, 1993 and 1995 estimates from the Texas Workers' Compensation Research Center and the Public Policy Research Institute (PPRI) at Texas A&M University; 1996 and 2001 estimates from the Research and Oversight Council on Workers' Compensation and PPRI; and 2004 - 2008 estimates from the Texas Department of Insurance Workers' Compensation Research and Evaluation Group and PPRI.

Table 2 identifies the percentage of Texas employers that are non-subscribers by industry for years 2004, 2006, and 2008. The Finance/Real Estate/Professional Services is the only industry which increased in the non-subscription rate from 2004 to 2008. All other industries reflect a lower non-subscription rate in 2008 compared to 2004. However, the Mining/Utilities/Construction industry's non-subscription rate increased 7 percent from 2006 to 2008, as well as the Agriculture/Forestry/Fishing/ Hunting industry, which increased by 2 percent from 2006 to 2008. One of the reasons for the increase in the non-subscription rate for the construction industry may be due to the Entergy decision, which has not yet been set for rehearing.

Table 2

Percentage of Texas Employers That Are Non-subscribers by Industry, 2004 - 2008 Estimates

Industry Type	Non-subscription Rate		
	2004	2006	2008
Agriculture/Forestry/Fishing/Hunting	39%	25%	27%
Mining/Utilities/Construction	32%	21%	28%
Manufacturing	42%	37%	31%
Wholesale Trade/ Retail Trade/Transportation	40%	37%	29%
Finance/Real Estate/Professional Services	32%	33%	33%
Health Care/Educational Services	41%	44%	39%
Arts/Entertainment/Accommodation/Food Services	54%	52%	46%
Other Services Except Public Administration	39%	42%	36%

Note: Industry classifications were based on the 2002 North American Industry Classification System (NAICS) developed by the governments of the U.S., Canada and Mexico, which replaced the Standard Industrial Classification (SIC) system previously used in the U.S. As a result of this change in industry classifications, industry non-subscription rates for 2004 - 2008 cannot be compared to previous years.

Source: *Survey of Employer Participation in the Texas Workers' Compensation System*, Public Policy Research Institute at Texas A&M University and the Texas Department of Insurance Workers' Compensation Research and Evaluation Group, 2008.

As shown in Table 3, the primary reason why non-subscribing employers said they did not purchase workers' compensation coverage, according to the Workers' Compensation Research and Evaluation Group 2008 survey, was that workers' compensation insurance premiums were too high. However, as indicated in Table 3, the percentage of employers that made this statement decreased by nine percent from 2006 to 2008.

Table 3

Primary Reasons Why Non-subscribing Employers Said They Did Not Purchase Workers' Compensation Coverage

Primary Reasons Given by Surveyed Employers	Percentage of Non-subscribing Employers Surveyed	
	2006	2008
Workers' compensation insurance premiums were too high	35%	26%
Employer had too few employees	21%	26%
Employers not required to have workers' compensation insurance by law	9%	11%
Medical costs in the workers' compensation system were too high	4%	4%
Employer had few on-the-job injuries	9%	9%

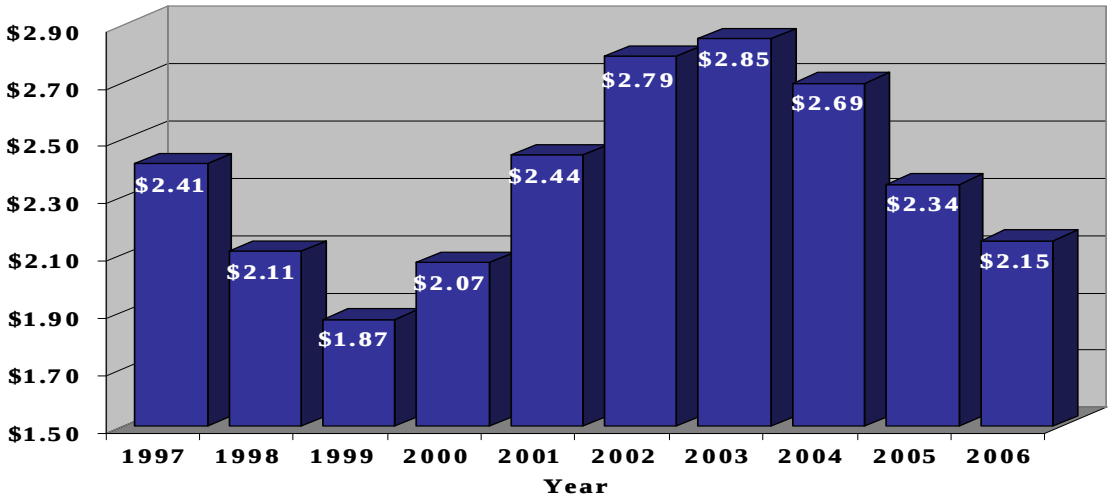
Source: *Survey of Employer Participation in the Texas Workers' Compensation System*, Public Policy Research Institute at Texas A&M University and the Texas Department of Insurance Workers' Compensation Research and Evaluation Group, 2008.

One reason for the decrease may be that workers' compensation premiums have decreased in the last few years. The average workers' compensation premium cost for Texas employers per $100 payroll has decreased 25 percent since 2003 as illustrated in Figure 5.

Overall, the percentage of Texas employers who do not participate in the workers' compensation system decreased since 2006 (from 37 percent in 2006 to 33 percent in 2008); however, the percentage of Texas employees who are employed by nonsubscribers increased during this time (from 23 percent in 2006 to 25 percent in 2008). Texas continues to see a trend of large employers (i.e., 500+ employees) leaving the workers' compensation system, while at the same time more small and mid-sized employers have re-entered the system, primarily due to premium decreases.[4]

Figure 5

Average Workers' Compensation Premium Costs for Texas Employers Per $100 Payroll, 1997 – 2006 (including all premium deductibles except deductibles)



Notes:

- The average premiums reflect insurers' manual rate deviations, experience rating, schedule rating, expense and loss constants, the effect of retrospective rating and premium discounts.
- Since workers' compensation is an audit line (that is, premiums are based on audited payrolls), the indicated average premiums may change over time, especially for the most recent years.
- The average premiums do not reflect the effect of discounts due to deductible policies, nor do they reflect policyholder dividends.
- The average premiums are based on data reported in the 12/31/2006 Texas Workers' Compensation Financial Data Call and material taken from the 2006 Class Relativity Study.

Source: Texas Department of Insurance, Property and Casualty Actuarial Division, 2008.

[4]Source: Employer Participation in the Texas Workers' Compensation System: 2008 Estimates. Texas Department of Insurance Workers' Compensation Research and Evaluation Group; September, 2008.

B. Income Benefits

There are five types of income benefits payable under the Texas Workers' Compensation Act:

- **Temporary Income Benefits (TIBs) –** paid during the period of temporary disability (lost time from work) while the worker is recovering from an on-the-job injury;

- **Impairment Income Benefits (IIBs) –** paid to injured employees for permanent impairment when the injured employee reaches maximum medical improvement (impairment evaluations are currently based on the *Guides to the Evaluation of Permanent Impairment*, 4th Edition, published by the American Medical Association);

- **Supplemental Income Benefits (SIBs) –** paid to injured employees for ongoing disability after IIBs have been exhausted, with all eligibility for SIBs ending at 401 weeks after the date of injury; Only workers with a 15 percent impairment rating and who are unemployed or underemployed as a result of their work-related injuries are eligible to receive SIBs;

- **Lifetime Income Benefits (LIBs) –** paid for the life of the injured employee for specific catastrophic injuries as set forth in Section 408.161 of the Texas Labor Code; and

- **Death Benefits (DBs) and Burial Benefits –** paid to the deceased workers' spouse or eligible beneficiaries as a result of a death from a compensable injury.

1. Financial Impact of Work-Related Injuries

OIEC believes it is important to note that the purpose of income benefits is to either replace the income that an injured employee loses because of time lost or reduced earning potential or to compensate the injured employee for the permanent impairment resulting from the injury. Many injured employees receiving income benefits contact OIEC reporting difficulties in meeting financial obligations, such as mortgages, automobile loans, and household bills. This financial burden is compounded for injured employees should there be a change in employment status.

Frequently, the difficulty in meeting financial obligations results from the delay in receiving income benefits in contested cases where benefits are not paid by the insurance carrier during the period that the dispute is proceeding through the indemnity dispute resolution process.

Table 4 provides the maximum (max) and minimum (min) weekly benefits established in the Texas Workers' Compensation Act applicable to dates of injuries on or after January 1, 1991.

Table 4

Maximum and Minimum Weekly Benefits											
Fiscal Year	SAWW* State Average Weekly Wage	TIBs Temporary Income Benefits		IIBs Impairment Income Benefits		SIBs Supplemental Income Benefits		LIBs Lifetime Income Benefits		Death Benefits	
		max	min	max	min	max	min	max	min	max	min
2009 (10/1/08-09/30/09)	$749.63	750.00	112.00	525.00	112.00	525.00	N/A	750.00	112.00	750.00	N/A
2008 (10/1/07-09/30/08)	$712.11	712.00	107.00	498.00	107.00	498.00	N/A	712.00	107.00	712.00	N/A
2007 (10/1/06-9/30/07)	$673.80	674.00	101.00	472.00	101.00	472.00	N/A	674.00	101.00	674.00	N/A
2006 (9/1/05-9/30/06)	$540.00	540.00	81.00	378.00	81.00	378.00	N/A	540.00	81.00	540.00	N/A
2005 (9/1/04-8/31/05)	$539.00	539.00	81.00	377.00	81.00	377.00	N/A	539.00	81.00	539.00	N/A
2004 (9/1/03-8/31/04)	$537.00	537.00	81.00	376.00	81.00	376.00	N/A	537.00	81.00	537.00	N/A
2003 (9/1/02-8/31/03)	$536.74	537.00	81.00	376.00	81.00	376.00	N/A	537.00	81.00	537.00	N/A
2002 (9/1/01-8/31/02)	$535.62	536.00	80.00	375.00	80.00	375.00	N/A	536.00	80.00	536.00	N/A
2001 (9/1/00-8/31/01)	$533.00	533.00	80.00	373.00	80.00	373.00	N/A	533.00	80.00	533.00	N/A
2000 (9/1/99-8/31/00)	$531.00	531.00	80.00	372.00	80.00	372.00	N/A	531.00	80.00	531.00	N/A
1999 (9/1/98-8/31/99)	$523.31	523.00	78.00	366.00	78.00	366.00	N/A	523.00	78.00	523.00	N/A
1998 (9/1/97-8/31/98)	$508.26	508.00	76.00	356.00	76.00	356.00	N/A	508.00	76.00	508.00	N/A
1997 (9/1/96-8/31/97)	$490.92	491.00	74.00	344.00	74.00	344.00	N/A	491.00	74.00	491.00	N/A
1996 (9/1/95-8/31/96)	$480.13	480.00	72.00	336.00	72.00	336.00	N/A	480.00	72.00	480.00	N/A
1995 (9/1/94-8/31/95)	$471.66	472.00	71.00	330.00	71.00	330.00	N/A	472.00	71.00	472.00	N/A
1994 (9/1/93-8/31/94)	$464.10	464.00	70.00	325.00	70.00	325.00	N/A	464.00	70.00	464.00	N/A
1993 (9/1/92-8/31/93)	$456.36	456.00	68.00	319.00	68.00	319.00	N/A	456.00	68.00	456.00	N/A
1992 (9/1/91-8/31/92)	$437.65	438.00	66.00	306.00	66.00	306.00	N/A	438.00	66.00	438.00	N/A
1991 (1/1/91-8/31/91)	$428.25	428.00	64.00	300.00	64.00	300.00	N/A	428.00	64.00	428.00	N/A

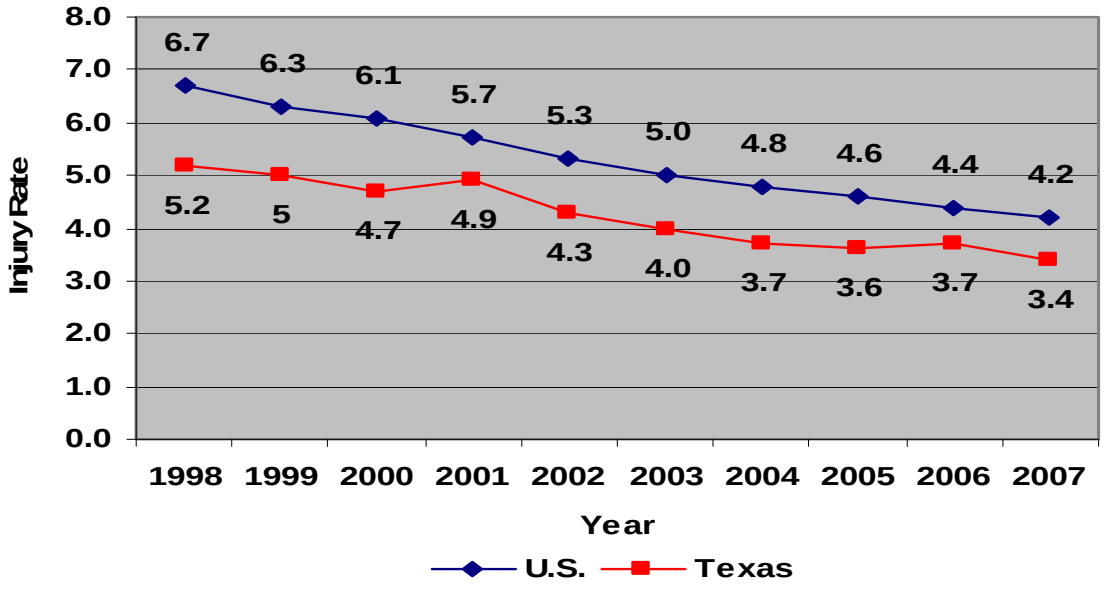
* The state average weekly wage (SAWW) for fiscal year 2007 is 88% of the average weekly wage in covered employment for the preceding year as computed by the Texas Workforce Commission (TWC). TWC determined the average weekly wage in covered employment for 2005 was $765.68. The SAWW in 2004, 2005, and 2006 were established statutorily. Prior to 2004, the SAWW was based on the average weekly wage of manufacturing production workers in Texas.

Source: Texas Department of Insurance, Division of Workers' Compensation; September 29, 2008.

The nonfatal occupational injury and illness rate decreased to 3.4 in Texas in 2007, down from 3.7 in 2006. The rate of 3.4 cases per 100 equivalent full-time employees marks a five-year low. The rate of injuries and illnesses reflects a 15% decrease from 4.0 in 2003, when data collection began under the North American Industry Classification System (NAICS). The Texas rate remains lower than the overall injury and illness rate of the United States as shown in Figure 6. OIEC notes that over a quarter million Texans sustained a work-related injury in 2006 and in 2007 and that significant social and financial burdens have resulted from those work-related injuries.

Figure 6

Nonfatal Occupational Injury and Illness Rates Per 100 Full-Time Workers (1998 - 2007)



Source: Texas Department of Insurance, Division of Workers' Compensation and U.S. Department of Labor Statistics, Annual Survey of Occupational Injuries and Illnesses, 2008.

In 2006, the number of nonfatal occupational injuries and illnesses involving days away from work in private industry in Texas increased by nearly five percent compared to 2005. Although 3,230 more of these types of injuries and illnesses were reported in 2006 compared to 2005, the 2006 total is less than the numbers reported in 2004 and 2003 according to TDI's February 26, 2008 press release.

Table 5

Nonfatal Occupational Injuries and Illnesses Involving Days Away From Work, Private Industry, 2003 - 2006

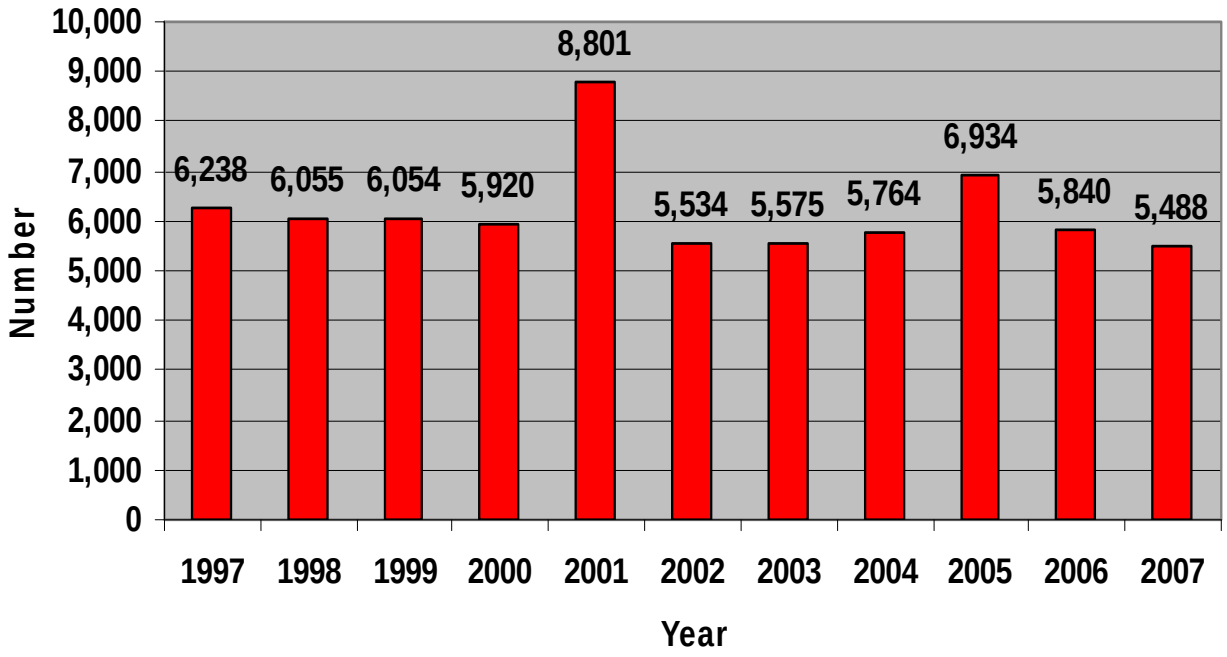
	Texas				National
	2003	2004	2005	2006	2006
Number of nonfatal occupational injuries and illnesses involving days away from work [5]	82,110	74,080	69,340	72,660	1,183,500
Incidence rates of nonfatal occupational injuries and illnesses involving days away from work [6]	125.1	110.0	100.9	104.4	128.0
Median days away from work [7]	10	9	9	8	7

[5] Days away from work cases include those that result in days away from work with or without job transfer or restriction.
[6] Incidence rates represent the number of injuries and illnesses per 10,000 full-time workers and were calculated as:
(N / EH) X 20,000,000 where, N = number of injuries and illnesses, EH = total hours worked by all employees during the calendar year, 20,000,000 = base for 10,000 full-time equivalent workers (working 40 hours per wee, 50 weeks per year).
[7] Median days away from work is the measure used to summarize the varying lengths of absences from work among the cases with days away from work. Half the cases involved more days and half involved less days than a specific median. Median days away from work are represented in actual values.

Texas recorded 527 work-related fatalities in 2007, an eight percent increase compared to 2006 when 489 fatalities occurred. Nationally, there were 5,488 fatal work injuries in 2007, a decrease of six percent from the revised total of 5,840 in 2006, according to the most recently available data released August 20, 2008 by the Census of Fatal Occupational Injuries (CFOI). Figure 7 illustrates the number of fatalities recorded in the nation since 1997.

Figure 7

Number of Fatal Occupational Injuries in the Nation
Calendar Years 1997 - 2007



Source: Texas Department of Insurance, Department of Workers' Compensation website http://www.tdi.state.tx.us/wc/safety/sis/fathomepage.html visited September 16, 2008

Figure 8 illustrates the number of fatalities recorded in Texas since 1997.

Among the causes of occupational fatalities in Texas in 2007:

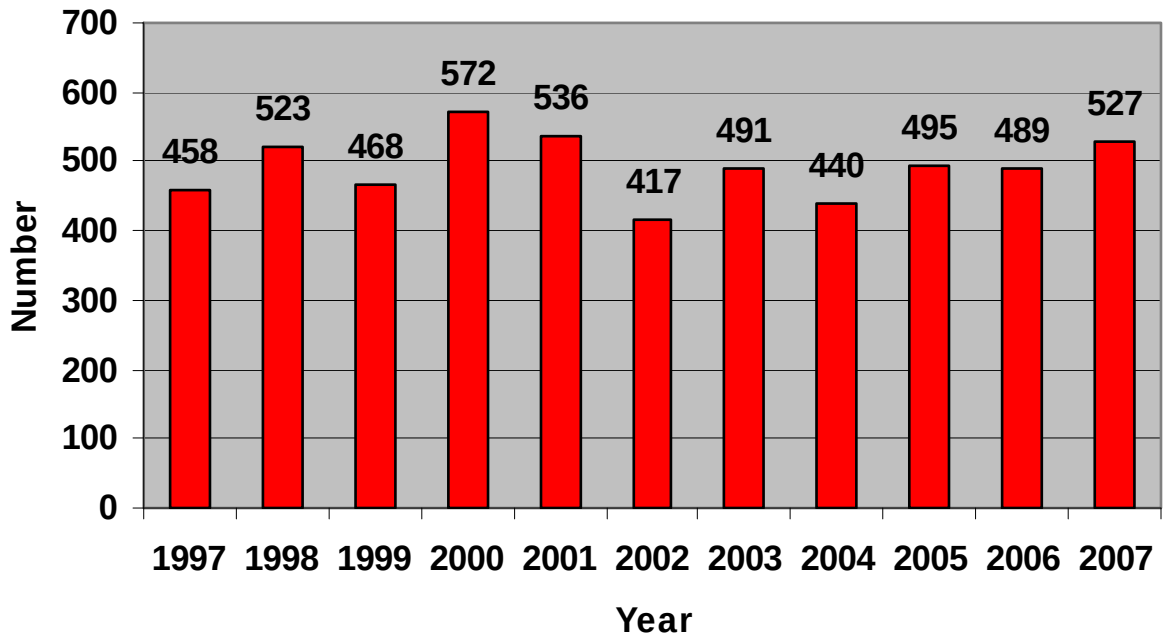
• over one-third (36 percent) of fatalities were related to transportation incidents;

• workplace homicides experienced a 56 percent increase in fatalities compared to 2006; and

• nearly one-third (29 percent) of all fatalities occurred in the construction and extraction occupation group.

Figure 8

Number of Fatal Occupational Injuries in Texas
Calendar Years 1997 - 2007



Source: Texas Department of Insurance, Department of Workers' Compensation website http://www.tdi.state.tx.us/wc/safety/sis/fathomepage.html visited September 16, 2008

As a result of working one-on-one with injured employees through OIEC's Ombudsman Program, OIEC has determined that a work-related injury can be detrimental socially, financially, and psychologically to Texas' injured employees and their families. It is important to understand that a work-related injury is often a life-altering event. The Legislature recognized and addressed this issue by reducing the statutory waiting period for paying benefits back to the first day of disability from four weeks to two weeks pursuant to Texas Labor Code §408.0082. Also HB 7 provides that on or after October 1, 2006, the Statutory Average Weekly Wage is equal to 88 percent of the Average Weekly Wage as computed by the Texas Workforce Commission. While this increase in the maximum compensation rate is beneficial, it does not impact a great number of injured employees because of the limited number of injured employees that are paid at such a level as to qualify for that rate.

According to a report on return-to-work outcomes conducted by TDI's Workers' Compensation Research and Evaluation Group in August 2007, and as shown in Table 6, the percentage of injured employees that sustained a work-related injury in 2001 through 2005 and went back to work for three successive quarters earning a wage equal or more than their pre-injury wages six months to three years after sustaining a work-related injury is less than or equal to 50 percent.

Table 6

Sustained Return-to-Work Rate With Equal or More Than Pre-Injury Wages

Percentage of Injured employees Back At Work
For Three Successive Quarters and
Earned a Wage Equal or More Than Their Pre-injury Wages
6 Months to 3 Years Post-Injury

Injury Year	Within 6 Months Post Injury	Within 1 Year Post Injury	Within 1.5 Years Post Injury	Within 2 Years Post Injury	Within 3 years Post Injury
2001	46%	46%	45%	45%	45%
2002	45%	45%	45%	45%	45%
2003	45%	45%	45%	45%	
2004	47%	47%	47%		
2005	50%				

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2007.

Additionally, the percentage of injured employees that sustained a work-related injury in 2001 through 2005 and went back to work for three successive quarters

earning a wage less than 70 percent of their pre-injury wages six months to three years post-injury is as high as 25 percent, as shown in Table 7.

Table 7

Sustained Return-to-Work Rate With Less Than 70 Percent of Pre-Injury Wages

Percentage of Injured employees Back At Work For Three Successive Quarters and Earned a Wage Less Than 70 Percent of Their Pre-injury Wages 6 Months to 3 Years Post-Injury

Injury Year	Within 6 Months Post Injury	Within 1 Year Post Injury	Within 1.5 Years Post Injury	Within 2 Years Post Injury	Within 3 years Post Injury
2001	23%	24%	24%	25%	25%
2002	22%	23%	24%	25%	25%
2003	22%	23%	23%	24%	
2004	22%	22%	22%		
2005	20%				

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2007.

Statutory changes made by HB 7 in 2005 to the calculation of the statutory maximum weekly benefit increased the maximum weekly IIBs and SIBs payments from $378 in FY 2006 to $498 in FY 2008. According to a report by TDI's Workers' Compensation Research and Evaluation Group, this increase should result in a lower percentage of workers being capped at the statutory maximum in future years. Although the statute allows injured employees to receive up to 401 weeks of income benefits, few workers receiving SIBs (approximately 10 percent) reach the 401-week threshold.

In terms of specific injuries, a significant percentage of workers reaching the 401-week threshold tend to have low back nerve compression injuries (i.e., herniated discs) and low back soft tissue injuries (i.e, strains and sprains). These workers also tend to work Wholesale/Retail Trade; Transportation; Manufacturing; Public Administration; Professional Services; Mining/Utilities; and Construction industries.[8]

[8] Permanent Impairment Income Benefits in the Texas Workers' Compensation System. Texas Department of Insurance Workers' Compensation Research and Evaluation Group, April 2008.

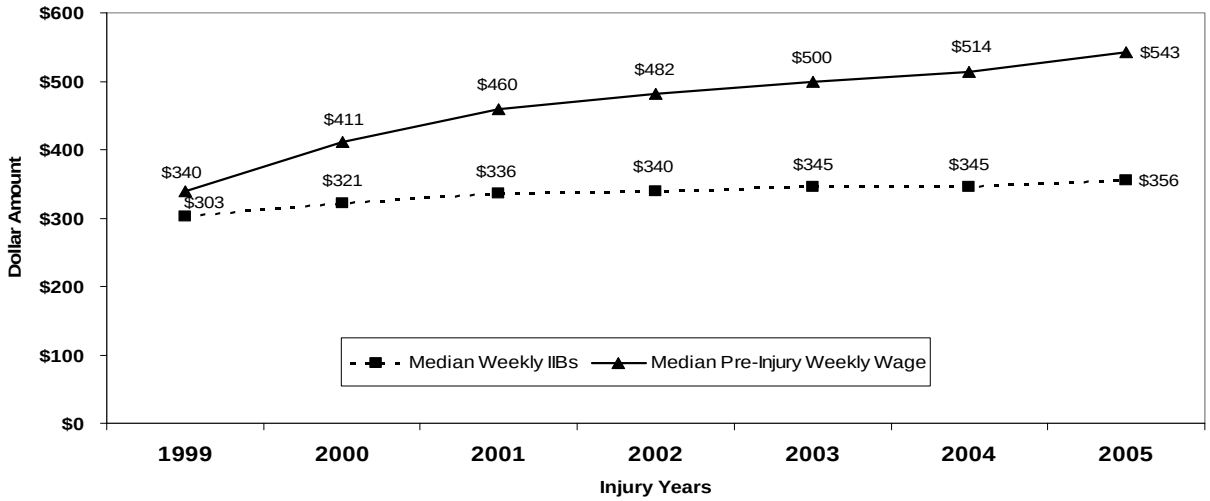
a. Impairment Income Benefits (IIBs)

An injured employee becomes eligible for IIBs the day after the employee reaches maximum medical improvement (MMI). Injured employees may receive IIBs once they have reached MMI and TIBs have ended. Employees may receive IIBs (unlike TIBs) while back at work at their full pre-injury average weekly wage. IIBs are generally paid weekly and are equal 70 percent of the employee's average weekly wage.

Employees receive three weeks of IIBs for every percentage point of impairment assigned. For example, if an injured employee has an impairment rating of six percent, the employee would receive 18 weeks of impairment income benefits.

Figure 9

Median Weekly IIBs Payment and Pre-Injury Weekly Wage Received Per Injured Employee, Injury Years 1999-2005



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2008.
Notes:

- Injury year 2005 data should be interpreted with caution since data may not be complete. Median pre-injury wage data was not available for injury years 1996-1998.
- Claims that did not have a valid claim, benefit and impairment rating record on file with the Division of Workers' Compensation were excluded from this analysis.
- Prior to 2003, the statutory method for calculating the maximum weekly IIBs payment allowed by statute was based on 70 percent of the "average weekly wage of manufacturing production workers" by TWC. However, the industry classification codes used by TWC to calculate these wages changed and in response, the 78th and the 79th Legislatures froze the maximum weekly IIB payment allowed for fiscal years 2004 , 2005 and 2006 at 2003 levels to allow the legislature additional time to consider a new calculation method. In 2005, HB 7 based the calculation on 70 percent of 88 percent of the State Average Weekly Wage as determined by TWC.

b. Supplemental Income Benefits (SIBs)

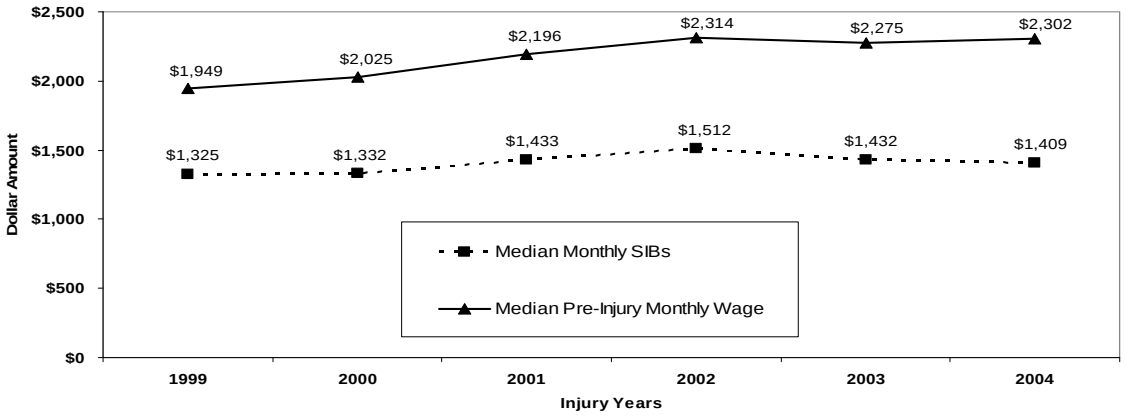
An injured employee may receive SIBs if:

- the employee has an impairment rating of 15 percent or more;
- the employee has not returned to work because of the impairment, or has returned to work but is earning less than 80 percent of his pre-injury average weekly wage because of the impairment;
- the employee did not take a lump sum payment of impairment income benefits; and
- the employee has complied with the requirements adopted under Labor Code §408.1415.

Injured employees must meet SIBs eligibility requirements on a quarterly basis (the first quarter DWC makes the SIBs eligibility determination; all subsequent quarters, the injured employee must apply to the insurance carrier for eligibility, but may dispute to DWC if denied). SIBs are paid on a monthly basis and equal 80 percent of the difference between 80 percent of the employee's average weekly wage and the weekly wage after the injury. An injured employee becomes eligible for SIBs the day after IIBs end.

Figure 10

Median Monthly SIBs and Pre-Injury Wage Received Per Employee in Injury Year 1999-2004



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2008.
Notes:

- Injury year 2004 data should be interpreted with caution since data may not be complete. Median pre-injury wage data was not available for injury years 1996-1998. Injury Year 2005 was excluded from this analysis since few workers injured in 2005 have exhausted their IIBs and are eligible to receive SIBs.
- Claims that did not have a valid claim, benefit and impairment rating record on file with the Division of Workers' Compensation were excluded from this analysis.
- Prior to 2003, the statutory method for calculating the maximum SIBs payments allowed by statute was based on 70 percent of the "average weekly wage of manufacturing production workers" by TWC. However, the industry classification codes used by TWC to calculate these wages changed and in response, the 78th Legislature in 2003 (SB 1574) froze the maximum weekly SIBs payment allowed for fiscal years 2004 and 2005 at 2003 levels to allow the legislature additional time to consider a new calculation method. In 2005, HB 7 based the calculation on 70 percent of 88 percent of the State Average Weekly Wage as determined by TWC.

C. Medical Benefits

1. Workers' Compensation Health Care Networks

Prior to HB 7, there was dissatisfaction with the Texas workers' compensation system. There were concerns about employers and health care providers leaving the system. HB 7 provided workers' compensation health care networks as a solution in response to those concerns. Under the Workers' Compensation Health Care Network Act pursuant to Article 4 of HB 7, insurance carriers may establish or contract with workers' compensation health care networks certified by TDI to provide health care for injured employees. Workers' compensation health care networks (WCNs) are similar to managed care plans offered by health maintenance organizations (HMOs) and preferred provider organizations (PPOs). The central component of these plans is the use of provider networks, which are groups of physicians, hospitals, and other providers who work cooperatively to provide patient care.

The plans control costs by contracting with health care providers to perform health services at prenegotiated rates and by closely supervising patient care and progress under treatment. Certified WCNs also incorporate the use of return-to-work guidelines to monitor an employee's medical progress and ability to return to the job, and a quality improvement program to evaluate the network's overall effectiveness.

If an employer purchases a workers' compensation insurance policy that requires the use of a certified WCN, the network generally provides all the health care associated with any work-related injuries or illnesses suffered by the employer's workers. The insurance company pays for the cost of health care and any income benefits due to the worker for lost wages or permanent physical impairment.

Insurance companies may either operate networks directly or contract with independent networks to provide health care services to their policyholders' injured employees. Certified self-insured employers, groups of certified self-insured employers, and political subdivisions also may contract directly with a network or establish their own networks to treat their injured employees. If policyholders choose to participate in certified networks, the employees who live in the network's service area and receive a copy of the network's notice must seek all medical care within the certified network. Informal or voluntary networks are situations where the insurance carrier has contracted with a provider for a fee that is inconsistent with the DWC fee guidelines (usually lower). The difference is that injured workers cannot be required to receive medical care from informal or voluntary networks the same way

they can within certified networks. As of September 1, 2007, the informal networks were required to register with TDI and be certified by January 1, 2011. To date, the following workers' compensation health care networks have been approved by TDI:

- Aetna Workers' Comp Access (AWCA)
- Argus Provider Network
- Bunch & Associates, Inc. TX HCN
- Bunch Coventry TX HCN dba Bunch & Associates
- Bunch HCN-First Health
- Corvel Healthcare Corporation/Corcare
- Coventry Health Care Workers Compensation Inc.
- First Health/AIGCS TX HCN
- First Health/CSS HCN
- First Health/Travelers HCN
- First Health TX HCN
- Forte/Compkey Plus
- Genex Health Care Network
- Genex Services, Inc./Genex Care for Texas' Comp Access
- IMO Med Select Network / Injury Management Organization, Inc.
- International Rehabilitation Associates, Inc. / Intracorp
- Interplan Health Group, Inc, / Zenith Health Care Network (ZHCN)
- Intracorp / Lockheed Martin Aero Employee Select Network
- Liberty Health Care Network
- Majoris Health Systems
- Memorial Hermann Health Network Providers, Inc. / Worklink
- National ChoiceCare, NCC ChoiceNet
- North Texas Innovative Healthcare Network, Inc.
- Sedgwick Claims Management Services, Inc./Southwest Medical Provider Network
- SHA, LLC / Firstcare Network
- Specialty Risk Services Texas Workers' Compensation Health Care Network (First Health)
- Texas Star Network
- The Hartford Workers Compensation Health Care Network-FH
- The Lone Star Network
- Zurich Services Corporation Healthcare Network
- Zurich Services Corporation Healthcare Network / Corvel
- Zurich Services Corporation Healthcare Network (HCN)-First Health

In March 2006, TDI began certifying workers' compensation networks. Currently 32 networks covering over 231 Texas counties are certified to provide workers' compensation health care services to insurance carriers.

Figures 11 and 12 provide a comparison of the penetration of workers' compensation networks by county in 2008 compared to 2006.

Penetration of Workers' Compensation Networks by Texas County

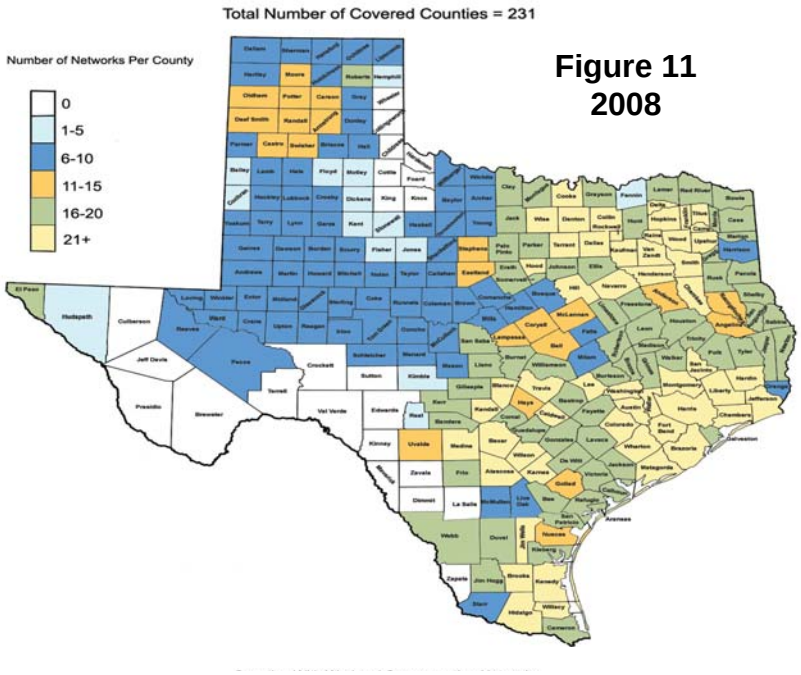


Figure 11
2008

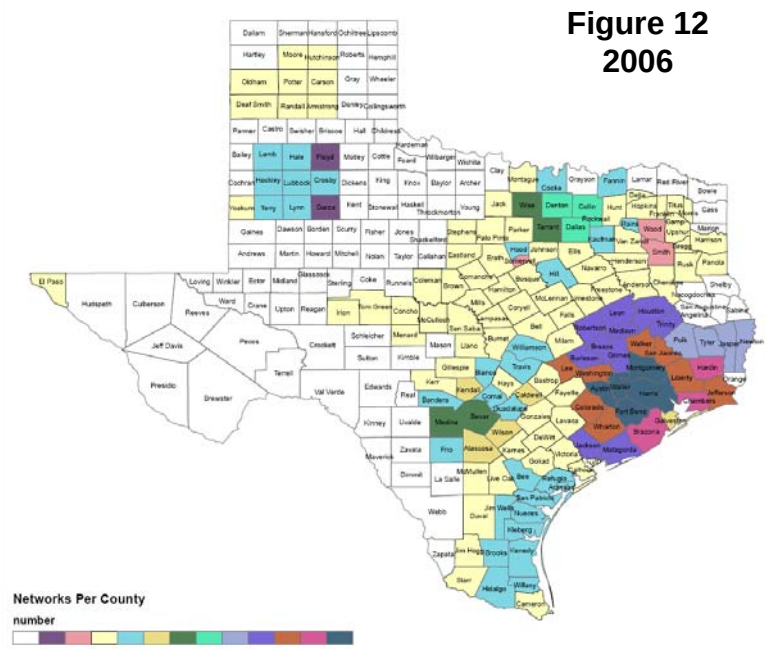


Figure 12
2006

Source: Texas Department of Insurance

2. Access to Medical Care

According to the 2008 Workers' Compensation Network Report Card Results Report produced by TDI's Workers' Compensation Research and Evaluation Group, network injured employees reported more access to care problems and were less satisfied with the medical care they received than non-network injured employees.

The network and non-network difference in perceived access to care problems was greatest among Corvel Corcare and Liberty HCN when measured as "getting need care." *See* Figure 13.

"Getting Needed Care" is defined as getting:

1) a personal doctor they like,

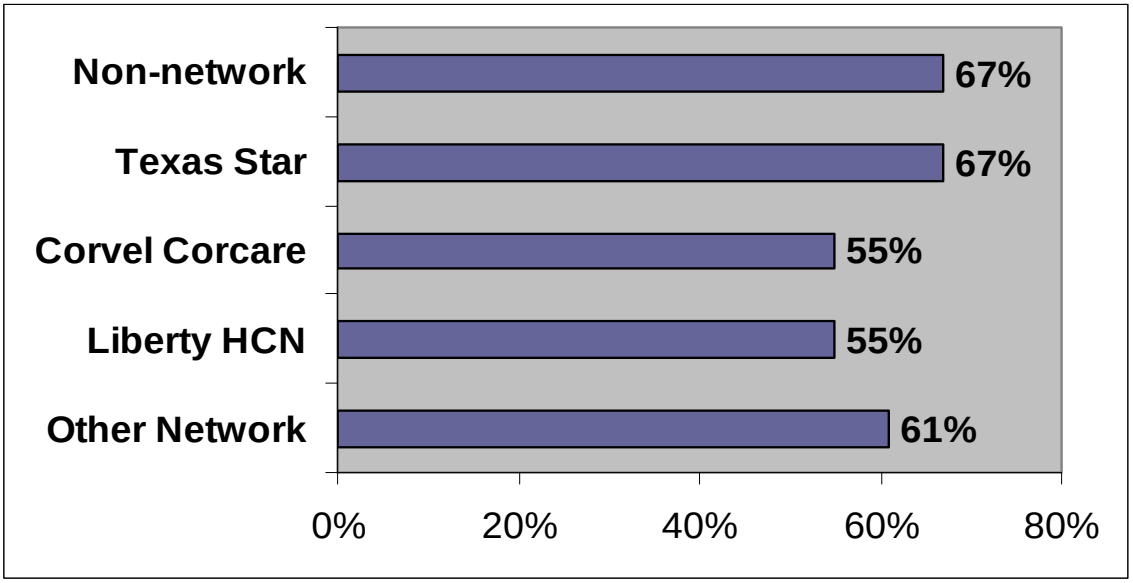
2) to see a specialist,

3) necessary tests or treatment, and

4) timely approvals for care.

Figure 13

Percent of Injured Employees Who Reported No Problem Getting Needed Care



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2008.

Note: Differences between non-network and Corvel Corcare, Liberty HCN, and other networks are statistically significant. The figures presented above are adjusted for injury type, type of claim, race/ethnicity, gender, age, education, age of injury at the time of the survey, insurance coverage, and self-rated health differences that may exist between the groups

The 2008 Workers' Compensation Network Report Card Results also indicate that the network and non-network difference in perceived problems with "getting care quickly" was greatest for Corvel Corcare and other networks. *See* Figure 14.

"Getting Care Quickly" is defined as:

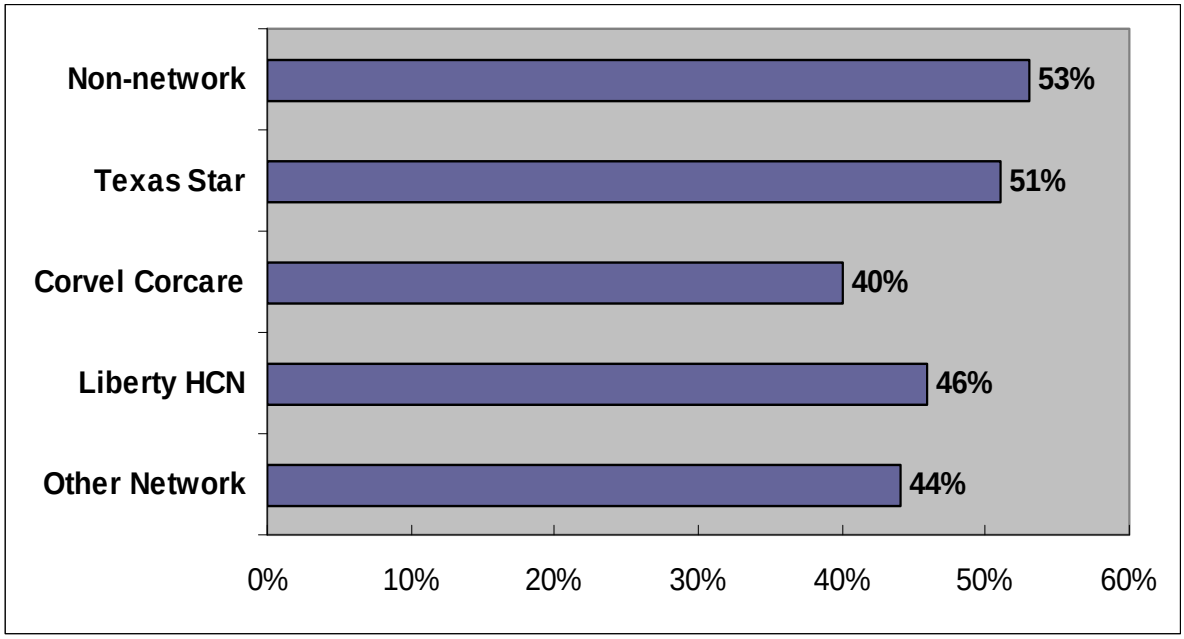
1) receiving care as soon as they wanted,

2) getting an appointment as soon as they wanted, and

3) taken to the exam room within 15 minutes of their appointment.

Figure 14

Percent of Injured Employees Who Reported No Problem Getting Care Quickly



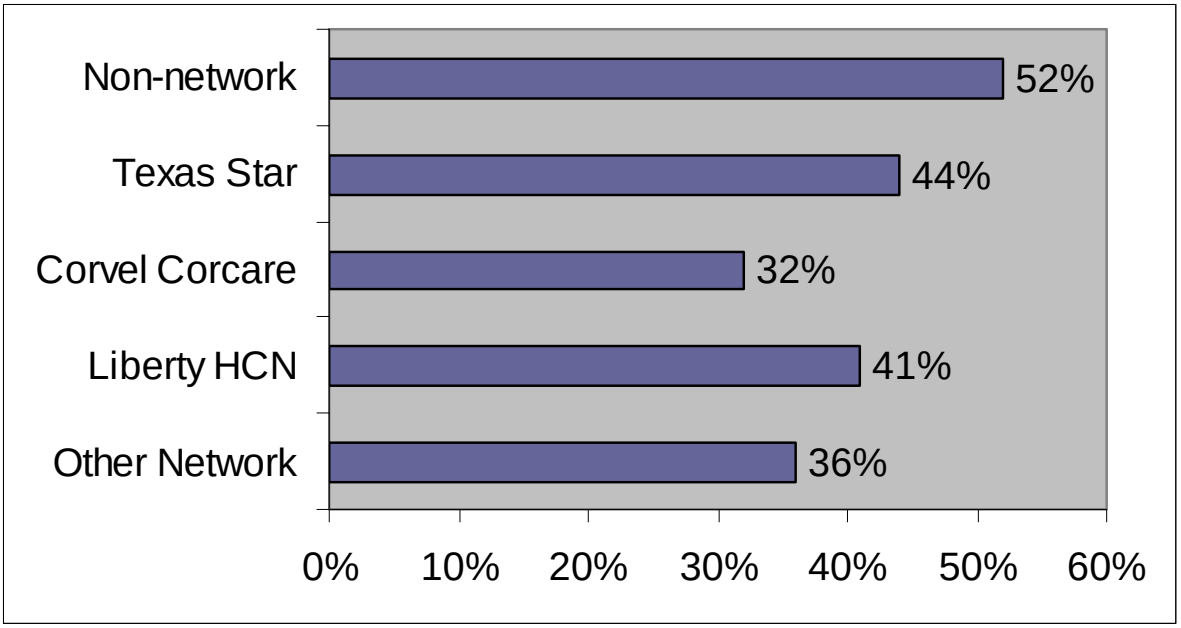
Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2008.

Note: Differences between non-network and Texas Star, Corvel Corcare, Liberty HCN, and other networks are statistically significant. The figures presented above are adjusted for injury type, type of claim, race/ethnicity, gender, age, education, age of injury at the time of the survey, insurance coverage, and self-rated health differences that may exist between the groups

Figure 15 identifies the percent of injured employees who indicated that they were "extremely satisfied" with the quality of the medical care received by their treating doctor. More than 50 percent of non-network injured employees were extremely satisfied with the quality of the medical care received by their treating doctor while less than 50 percent of network injured employees were extremely satisfied.

Figure 15

Satisfaction with Treating Doctor



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2008.

Note: Differences between non-network and Texas Star, Corvel Corcare, Liberty HCN, and other networks are statistically significant. The figures presented above are adjusted for injury type, type of claim, race/ethnicity, gender, age, education, age of injury at the time of the survey, insurance coverage, and self-rated health differences that may exist between the groups.

Figure 16 represents the percent of injured employees who "agreed" or "strongly agreed" that their treating doctor:

1) took their medical condition seriously,

2) gave them a thorough exam,

3) explained the medical condition,

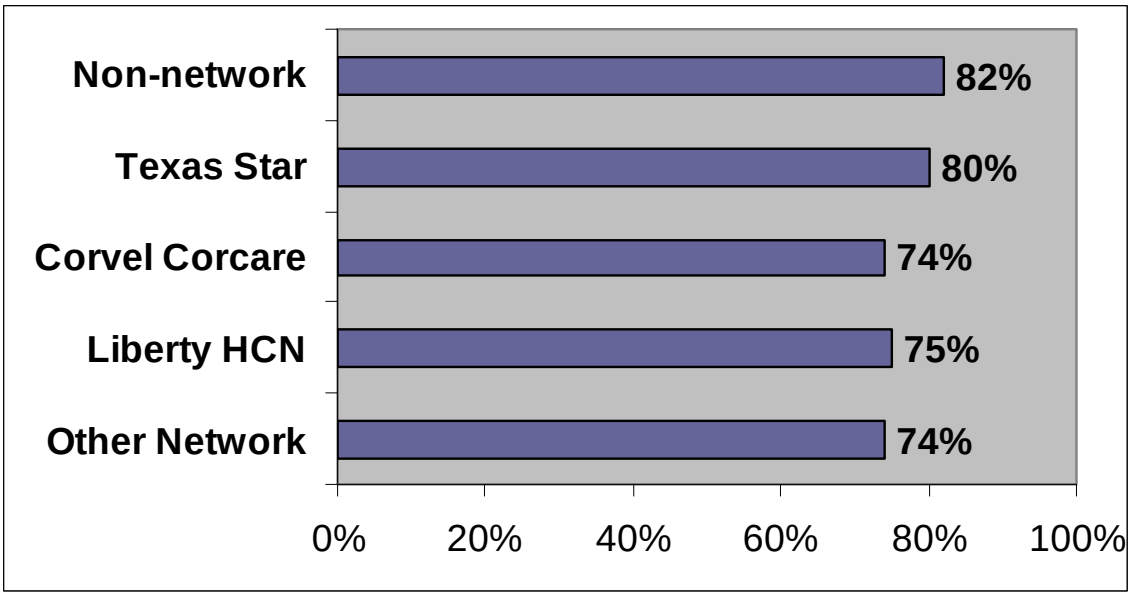
4) was willing to answer questions,

5) talked to them about a return-to-work date, and

6) provided good medical care that met their needs.

Figure 16

Agreement with Treating Doctor



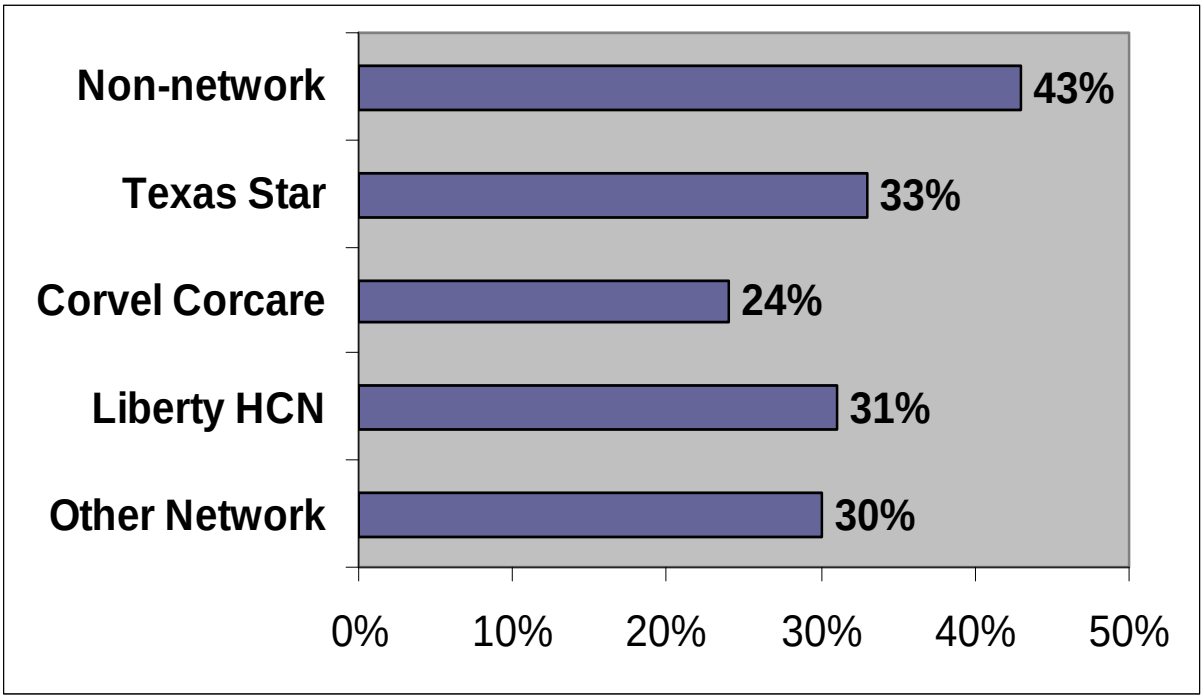
Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2008.

Note: Differences between non-network and Texas Star, Corvel Corcare, Liberty HCN, and other networks are statistically significant. The figures presented above are adjusted for injury type, type of claim, race/ethnicity, gender, age, education, age of injury at the time of the survey, insurance coverage, and self-rated health differences that may exist between the groups.

OIEC believes that an injured employee's access to appropriate health care is paramount to a successful workers' compensation system. Figure 17 represents the percent of injured employees who indicated that they were "extremely satisfied" with the quality of the medical care received for their work-related injury.

Figure 17

Overall Satisfaction of Medical Care



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2008.

Note: Differences between non-network and Texas Star, Corvel Corcare, Liberty HCN, and other networks are statistically significant. The figures presented above are adjusted for injury type, type of claim, race/ethnicity, gender, age, education, age of injury at the time of the survey, insurance coverage, and self-rated health differences that may exist between the groups.

3. Fee and Treatment Guidelines

In 2007 the Centers for Medicare and Medicaid Services (CMS) significantly revised the Medicare Ambulatory Surgical Center (ASC) reimbursement methodology. In order to maintain the stability of the ASC reimbursement, the Commissioner of Workers' Compensation amended §134.402 and retained the current ASC guidelines while researching and preparing to implement the new Medicare ASC reimbursement methodology. The amendments continued the use of reimbursement structures and amounts of the Medicare ASC 2007 rates for ASC facility services provided on January 1, 2008 through August 31, 2008.

In December 2007, the Commissioner of Workers' Compensation adopted new inpatient and outpatient hospital fee guidelines, which incorporated a Medicare-based reimbursement structure as required by Labor Code, §413.011, while allowing inpatient and outpatient facilities the option of being reimbursed on a "cost plus" basis for surgically implanted devices.[9]

TDI-DWC adopted the *Official Disability Guidelines – Treatment in Workers' Comp* (ODG) as the treatment guidelines, effective May 1, 2007, for non-network health care services for workers' compensation injuries. ODG recently incorporated a draft Workers' Compensation Drug Formulary (Appendix A) into its treatment guidelines; however, TDI-DWC has not adopted ODG's Appendix A as its pharmacy closed formulary pursuant to Labor Code §408.028(b).

Until a pharmacy closed formulary and associated rules are developed, system participants should continue to use the ODG treatment guidelines and continue to seek preauthorization for treatment, including prescriptions, when services fall outside or in excess of the ODG treatment guidelines. Appendix A, whether in draft or not, should be considered a tool and not a substitute for the evidence based pharmaceutical guidance included in the ODG. It is also important to understand that insurance carriers may not deny treatment or benefits solely based on a drug's status in Appendix A of the ODG.

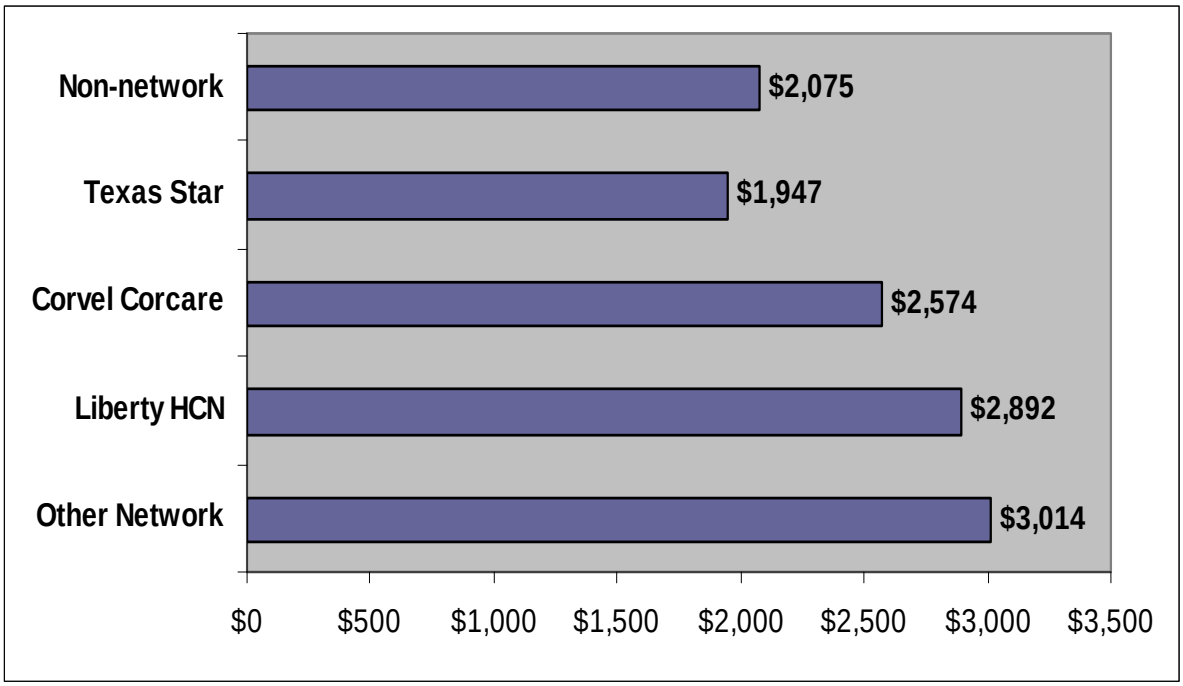
[9] Source: 28 TAC §134.403 and §134.404; effective for services rendered on or after March 1, 2008.

4. Medical Benefit Costs

a. Overall Costs

Figure 18

Average Medical Cost per Claim, 6 Months Post Injury



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2008.

Note: Medical cost differences between non-network and Corvel Corcare, Liberty HCN, and other networks are statistically significant. The figures presented above are adjusted for injury type and type of claim differences that may exist between the groups.

b. Surgically Implanted Devices (Implantables)

Implantables include devices such as prosthetic/orthotic devices, pacemakers and intraocular lenses. According to a study conducted by TDI, the total amount paid for surgically implanted devices (implantables) was over $25,000,000 in 2005. Inpatient hospitals received the majority of the payments, approximately four times the amount paid to outpatient hospitals and over thirteen times the amount paid to

ASCs.[10] Based on the study, Tables 8 and 9 indicate the most frequent injury types for implantable claims for inpatient and outpatient settings in 2005.

Table 8

Most Frequent Injury Types for Implantable Claims in an Inpatient Setting

	Cases	Charged Amount	Paid Amount	Average Charged	Average Paid
Nerve compression (low back – disk protrusion with root compression)	675	$48,411,360	$12,114,335	$71,720	$17,947
Disc displacement (neck – nerve compression)	315	$12,295,092	$2,449,298	$39,032	$7,775
Skeletal trauma (ankle, foot including lower leg - fracture	193	$5,198,495	$2,346,217	$26,935	$12,157
Degenerative disease (low back – degenerative disc disease)	170	$14,007,810	$4,077,849	$82,398	$23,987

Table 9

Most Frequent Injury Types for Implantable Claims in an Outpatient Setting

	Cases	Charged Amount	Paid Amount	Average Charged	Average Paid
Hernia - gastrointestinal	495	$4,382,908	$1,696,280	$8,854	$3,427
Skeletal trauma (hand, wrist including forearm) - fracture	430	$3,626,869	$1,334,101	$8,434	$3,102
Soft tissue complaints (shoulder – strain, sprain)	399	$6,069,670	$1,881,536	$15,212	$4,715
Soft tissue complaints (shoulder – enthesopathy)	287	$4,458,034	$1,614,369	$15,533	$5,624

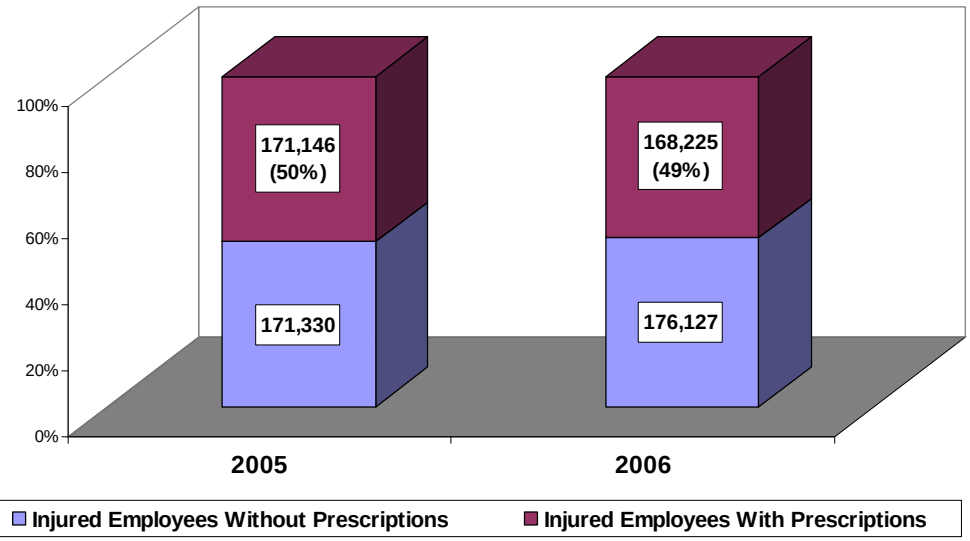
[10] Source: Implantable Devices Study: A Report to the Texas Legislature; Texas Department of Insurance, Division of Workers' Compensation; April 2008.

c. Pharmaceuticals

Figure 19 and Table 10 indicate the utilization of pharmaceuticals based on a study conducted by TDI's, Workers' Compensation Research and Evaluation Group in 2008.

Figure 19

Injured Employees Receiving Prescriptions in the Texas Workers' Compensation System Prescription Years 2005 - 2006



Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2008.

Table 10

Distribution of Pharmaceutical Utilization and Payments by Injury Year Prescription Year 2006

Injury Years	% of Injured Employees	% of Prescriptions	% of Drug Days	% of Payments
1991 - 2000	13%	33%	40%	46%
2001- 2004	15%	28%	31%	29%
2005	14%	15%	14%	11%
2006	58%	24%	15%	13%

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2008.

d. Peer Reviews

According to TDI's Workers' Compensation Research and Evaluation Group, Analysis of Division's Peer Review Data Call conducted in 2008, the vast majority of peer reviews are requested by insurance carriers for medical necessity determinations (81 percent for preauthorization and 8 percent for retrospective review).

Most peer reviews cost between $100-$150 each, with the exception of reviews involving an entire course of care which generally cost more than $250 each.

Table 11
Percentage of Peer Reviews Conducted by Cost Range and Primary Reason

Primary Reason Peer Review Was Requested	Less than $100	$100 - $150	$151 - $200	$201 - $250	More than $250
Preauthorization/concurrent review of medical necessity	4%	63%	12%	6%	15%
Retrospective review of medical necessity	31%	33%	4%	6%	26%
Extent of injury/compensability/validation of injured employee's diagnosis	<1%	1%	3%	31%	64%
Ability to return to work	0%	6%	22%	33%	39%
Treatment planning/appropriateness of course of care or medications/duration of care projections	<1%	<1%	2%	22%	76%
Other reasons	0%	1%	17%	52%	29%

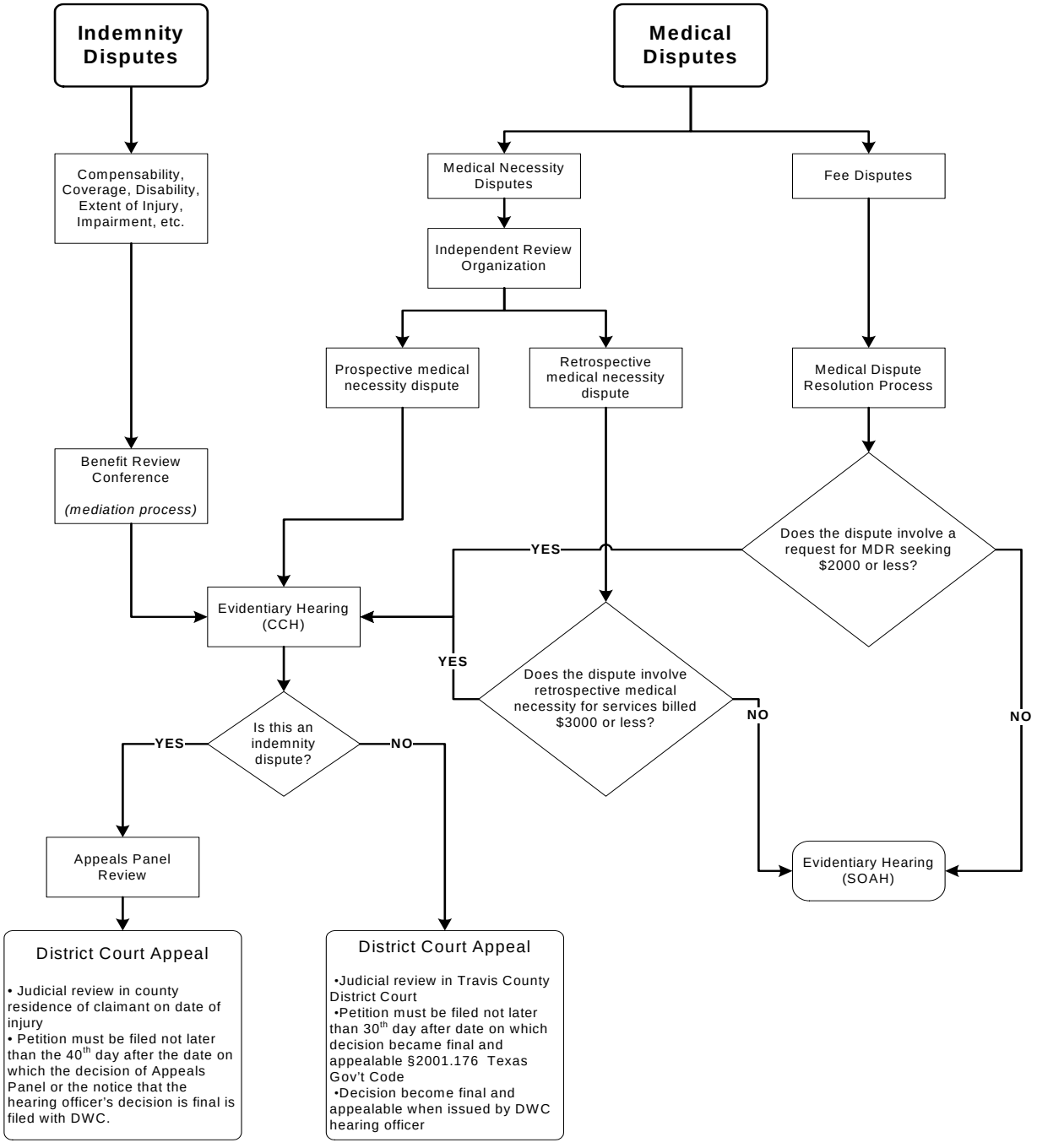
Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, Analysis of Division's Peer Review Data Call, 2008.
Notes:

- Ten peer reviews were missing information indicating the "primary reason" they were conducted or the cost of the review.
- "Other reasons" include reviews of impairment ratings, adjustment to reserves, etc.

D. Texas Workers' Compensation Dispute Resolution Process

The following flowchart, Figure 20, illustrates the indemnity (income benefit) and medical benefit dispute resolution processes.

Figure 20



1. Income Benefit Disputes

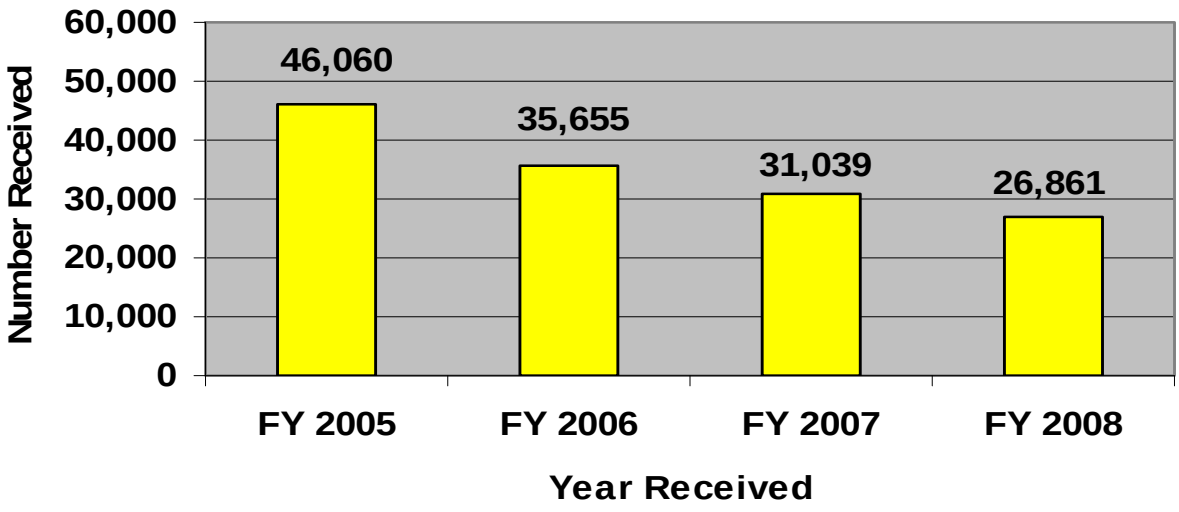
If a disagreement occurs after an injury has been reported, OIEC staff discusses the disagreement with the injured employee and other parties that may be involved and attempts to resolve the issue(s). If the disputed issues are not resolved, a BRC is scheduled. The injured employee may or may not request Ombudsman assistance or representation by an attorney.

If an agreement is not reached prior to or at the BRC, then a CCH is scheduled. If either party is not satisfied with the result of the CCH, the CCH decision can be appealed. A review of the appealed decision is conducted by the Appeals Panel. If either party is not satisfied with the result of the Appeals Panel, the decision can be appealed to district court.

The number of income benefit disputes received by DWC has decreased in the past few years as shown in Figure 21.

Figure 21

Number of Income Benefit Disputes Received
Data as of September 2008



Source: Texas Department of Insurance, Division of Workers' Compensation, Information Management Services, 2008.
Note: Figure 21 may not take into account the approximate 700 disputes resolved prior to a proceeding in FY 2008 whereby the dispute was not sent to or received by DWC.

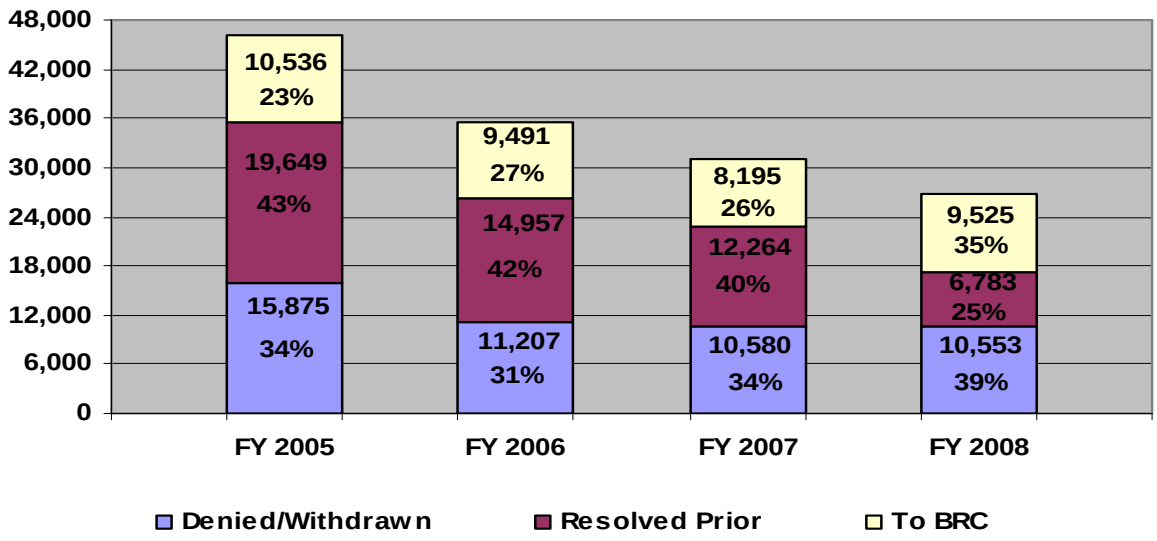
In 2007, a total of 31,039 disputes were received by DWC regarding income benefits and were scheduled for a BRC. Approximately 34 percent (10,580) of the income benefit disputes received were denied or withdrawn, and almost 40 percent (12,264) were resolved prior to a BRC. Approximately 26 percent proceeded to a BRC for resolution.

In 2008, a total of 26,861 income benefit disputes were received by DWC and schedule for a BRC. Of these, almost 40 percent (10,553) were denied or withdrawn, while 25 percent were resolved prior to a BRC. Thirty-five percent proceeded to a BRC.

OIEC's outreach efforts and attempts to resolve disputes prior to scheduling a BRC began in September 2007. Almost 700 disputes were resolved by OIEC prior to referring the issue to DWC and scheduling a BRC. OIEC believes that the percentage of income benefit disputes resolved after a BRC is scheduled but prior to holding the BRC will decrease in the next few years as a result of the additional staff appropriated to OIEC in FY 2008. OIEC's Customer Service staff, along with the Ombudsman Program, strives to resolve issues at the earliest level of the dispute resolution process, which is many times prior to DWC receiving or knowing about the dispute.

Figure 22

Distribution of Income Benefit Disputes Received
Data as of September 2008



Source: Texas Department of Insurance, Division of Workers' Compensation, Information Management Services, 2008.
Note: Figure 22 may not take into account the approximate 700 disputes resolved prior to a proceeding in FY 2008 whereby the dispute was not sent to or received by DWC.

The top ten most disputed issues received by DWC in FY 2008 and the level in which they were resolved are identified in Table 12. The top ten disputed issues may vary from year to year as well as the level at which the issues are resolved.

For instance, the top two most disputed issues in FY 2008 were issues related to the designated doctor's impairment rating and the designated doctor's maximum medical improvement date. Approximately 90 percent of these types of disputes were either withdrawn or denied, or resolved prior to a BRC. However, only about 37 percent of disputed issues involving the existence, duration, or extent of injury were withdrawn or denied or resolved prior to a BRC. A relatively small percentage of disputed issues continue through the dispute resolution process and are resolved by an Appeals Panel decision.

Table 12

Top Ten Disputed Issues Received by DWC From 09/01/2007 through 08/31/08 and the Level Where They Were Resolved [1]

Issue Type	Percent Withdrawn or Denied	Prior to BRC[2]	At BRC	At CCH	Concluded at Appeals Panel
Designated Doctor's Impairment Rating	71.2%	18.0%	1.5%	1.2%	.7%
Designated Doctor's Maximum Medical Improvement Date	73.1%	17.3%	2.0%	.8%	.4%
Existence/Duration/Extent of Disability	7.3%	29.8%	14.6%	13.7%	4.5%
Extent of Injury	13.9%	31.8%	10.0%	8.6%	3.4%
Existence of Compensable Injury	7.8%	31.5%	12.3%	13.3%	4.6%
Amount of Average Weekly Wage	5.6%	47.4%	25.2%	1.0%	0.4%
Supplemental Income Benefits/ Subsequent Quarters	48.4%	18.8%	10.4%	6.6%	2.7%
Timely Contested by Carrier	8.2%	42.9%	19.7%	3.1%	1.3%
IR Finality/90 Day Disputes	53.1%	21.2%	5.8%	2.6	1.9%
Impairment Rating	58.9%	36.2%	0.7%	0.0%	0.0%

Source: Texas Department of Insurance, Division of Workers' Compensation, Dispute Resolution Information System (DRIS), 2008.

Notes:

[1] Percentages do not add to 100 percent due to pending disputes at various levels of the indemnity dispute resolution process.

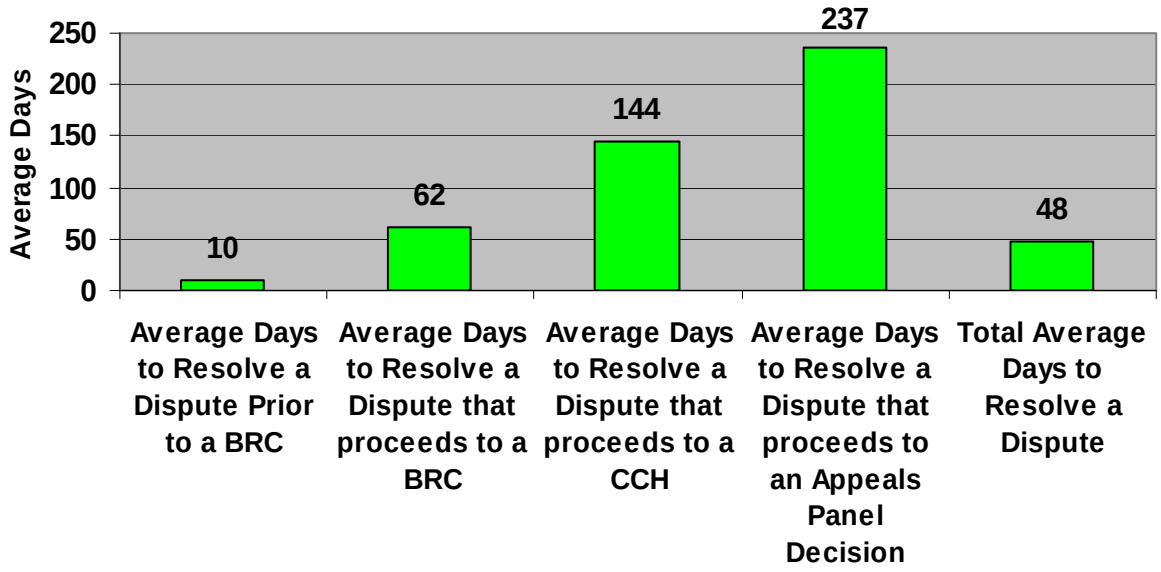
[2] "Resolved prior to BRC" does not include issues included in disputes that were withdrawn or denied or those that were received and resolved by OIEC.

Injured employees often suffer financial hardships in those cases where the insurance carrier denies entitlement to income benefits. For many employees, particularly those employees that provide the only source of income for their families, any period of time without income has devastating consequences. By the time the benefits are paid following a final decision in the indemnity dispute resolution process, the damage has already occurred because injured employees likely fall behind in their payments. The money they ultimately receive is insufficient to permit them to catch up as a result of late payments and interest accrued on the unpaid balance.

The average number of days it takes to resolve a dispute has been relatively stable for the past few years. In FY 2008, as shown in Figure 23, the average number of days to resolve a dispute through all levels of the administrative dispute resolution process is 48 days. However, the dispute resolution process can take from an average of 10 days to resolve a dispute prior to a BRC to an average of 237 days to resolve an income benefit dispute that goes through to an Appeals Panel decision.

Figure 23

Average Number of Days to Resolve an Income Benefit Dispute FY 2008



Source: Texas Department of Insurance, Division of Workers' Compensation, Information Management Services, 2008.
Note: In Figure 23, Average Days to Resolve a dispute prior to a BRC does not include the approximate 700 disputes resolved prior to a proceeding in FY 2008 whereby the dispute was not sent to or received by DWC.

a. Interlocutory Orders

Historically, interlocutory orders have been used in the workers' compensation system to authorize the payment of benefits to an injured employee who sustains a work-related injury while an issue on which an injured employee is likely to prevail is proceeding through the indemnity dispute resolution process. Should DWC issue an interlocutory order, the injured employee begins receiving income benefits, which may alleviate the financial hardship of having to wait months until the dispute is resolved through the system. A final decision in favor of the insurance carrier, which reverses an interlocutory order, may be reimbursed from the Subsequent Injury Fund. This ensures carriers do not incur a financial loss if an interlocutory order is issued and eventually overturned in the dispute resolution process.

After the passage of HB 7, Texas Labor Code §410.032 provided that DWC staff, other than the Benefit Review Officer that presided or will preside over the BRC shall consider a request and issue an interlocutory order. To implement the provision, DWC adopted Rule 141.6 and established an interlocutory request form, which required an injured employee to file the form with the DWC Central Office in Austin with a copy to the insurance carrier. Rule 141.6 provided that within 10 days of receipt of the request, DWC shall approve the request, deny the request, or schedule a teleconference. DWC's Interlocutory Order Rule required injured employees to submit written documentation to support the request, which is understandable considering that the claim file is not located in the Austin Central Office.

OIEC strongly believed that the injured employees of Texas needed a simple and efficient process to request interlocutory orders. An interlocutory order request is time-sensitive and needs to be acted upon as quickly as possible to ensure that injured employees have easy access to requesting and obtaining an interlocutory order.

Rule 141.6 only addressed the procedure for requesting interlocutory orders after a BRC and when a CCH is scheduled. OIEC strongly recommended that DWC's Interlocutory Order Rule should address a request for an interlocutory order that is made both before and at a BRC. This recommendation was not incorporated in the adopted interlocutory order rule. As a result, injured employees underwent continued financial hardship as no procedure was in place to process an interlocutory order request before a BRC, at a BRC, or in those circumstances when the BRC is reset rather than sending the issues to a CCH for resolution.

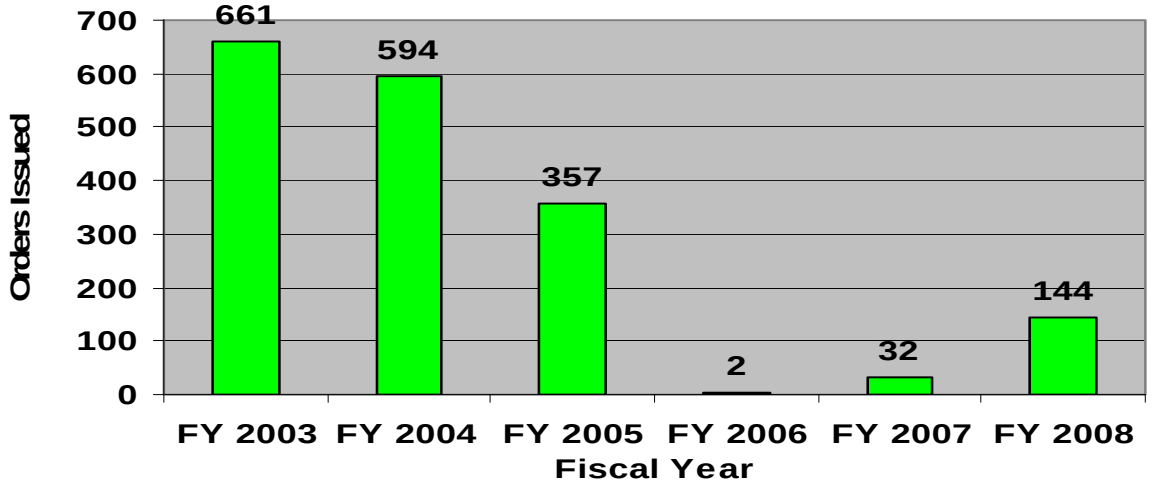
OIEC believed legislative action was necessary to provide that interlocutory orders may be requested and issued at a BRC. The time frame between when the interlocutory order is requested until it is issued should not take over three days. By shortening the time frame, injured employees who are likely entitled to benefits will obtain essential income and medical benefits in a more timely fashion.

As a result of OIEC's legislative recommendations, HB 473 and SB 1169, were enacted by the 80th Legislature (2007), which amended Labor Code §410.032 and rendered Rule 141.6 outdated. House Bill 473 restored authority to presiding benefit review officers to issue interlocutory orders, gave the opposing party an opportunity to respond, and clarified that the authority to issue interlocutory orders includes the authority to order the payment or the suspension of benefits, or both. Senate Bill 1169 required the benefit review officer to issue an order no later than the third day after the receipt of a request for the order. These amendments to §410.032 facilitate requests for interlocutory orders to be acted on in an expedited manner and thereby provided for the prompt initiation or suspension of benefits during a period of dispute resolution.

Figure 24 shows the significant decrease in the actual number of interlocutory orders issued since 2005 and the passage of HB 7. OIEC was concerned that the decrease was due to the fact that DWC's Rule 141.6 created a burdensome process and discouraged injured employees from requesting interlocutory orders. OIEC believes that because of the repeal of DWC's Rule 141.6, the number of interlocutory orders will continue to increase and injured employees may receive benefits sooner while an issue on which an injured employee is likely to prevail is proceeding through the indemnity dispute resolution process.

Figure 24

Number of Interlocutory Orders Issued By DWC
FY 2003-2008



Source: Texas Department of Insurance, Division of Workers' Compensation, Information Management Services, 2008.

b. Ombudsman Program - Customer Satisfaction

OIEC contracted with the University of North Texas Survey Research Center (SRC) in the Spring of 2008 to conduct a customer satisfaction survey pursuant to Section 2114 of the Government Code. The survey was designed to measure the satisfaction of injured employees who have had a dispute with their workers' compensation claims or were assisted by an Ombudsman. The objectives of the survey were to measure injured employees' opinions of:

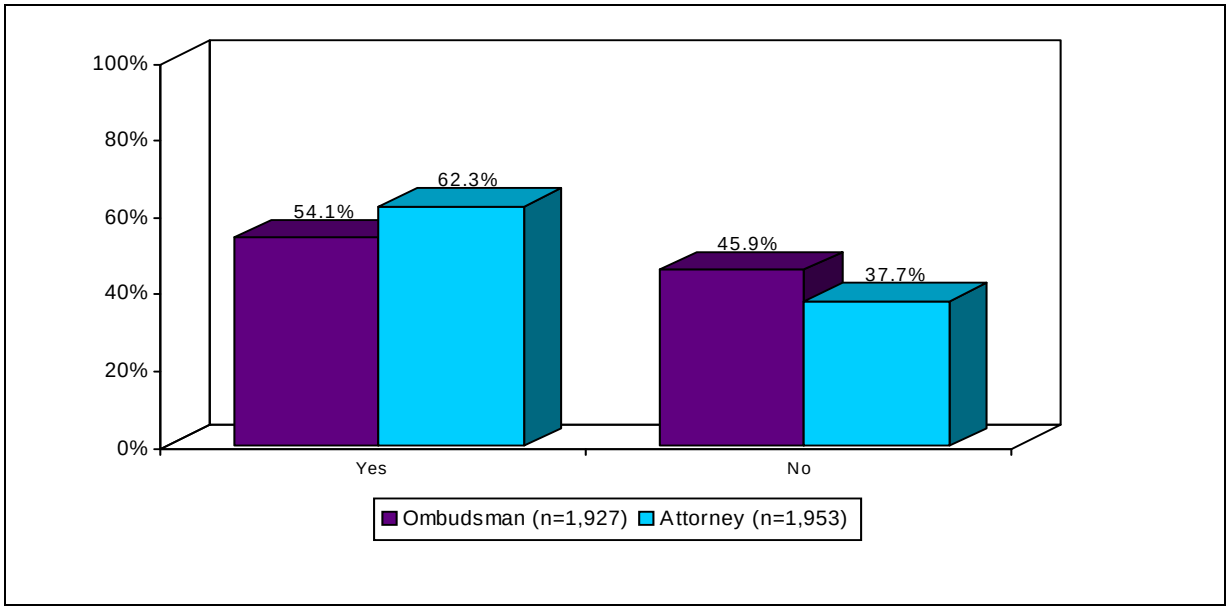
- The fairness of the Workers' Compensation dispute process;
- Assistance they may have received from an Ombudsman employed by OIEC; and
- Assistance they may have received from an attorney during the dispute process.

The survey serves as a comparison against a previous survey conducted in 1997 by the Research and Oversight Council on Workers' Compensation (ROC), which is now a part of TDI's Workers' Compensation Research and Evaluation Group.

Respondents were asked if they received any assistance from an ombudsman or hired an attorney during their dispute. As shown in Figure 25, 54.1 percent of the injured employees had received assistance from an ombudsman and 62.3 percent had hired an attorney during their dispute.

Figure 25

Received Assistance from Ombudsman/Attorney during Dispute



As shown in Table 13, the most common reason for choosing assistance by an ombudsman was difficulty in getting medical treatment or the weekly check (69.8 percent). The second most common reason was that the ombudsman program is free (67.8 percent).

Table 13

Reason Chose Representation by an Ombudsman/Attorney

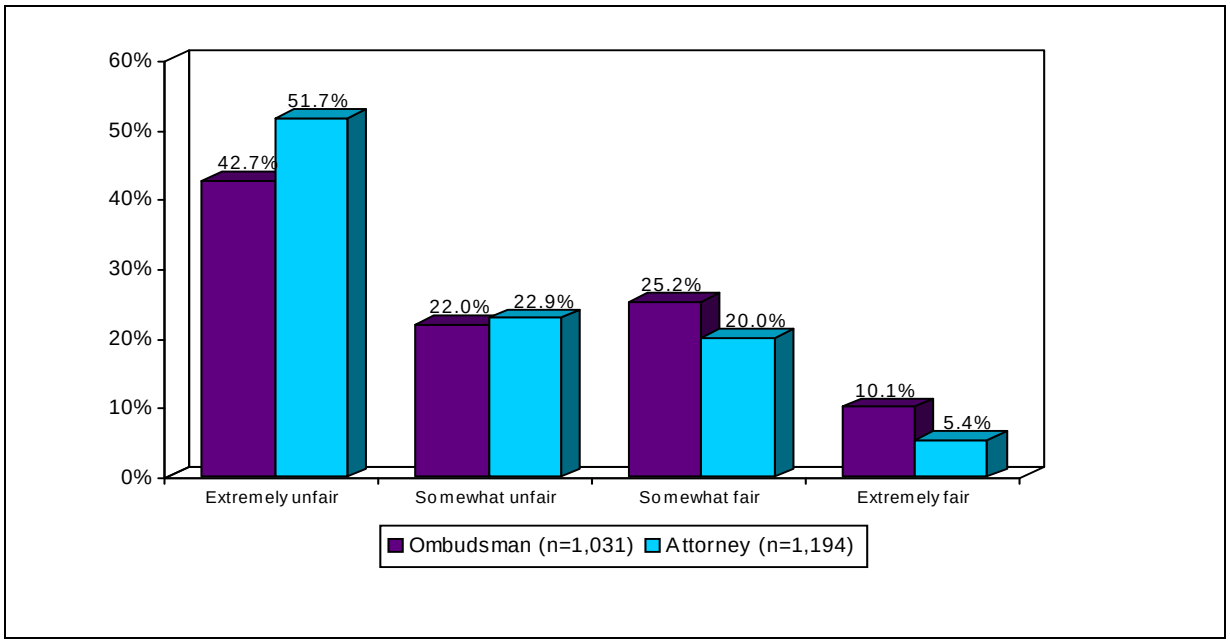
Reason	Percentage responding	
	Ombudsman	Attorney
You had difficulty getting medical treatment or your weekly check	69.8	84.2
The ombudsman program is free	67.8	-
You didn't understand how the workers' compensation system worked	66.4	66.7
Someone told you to use an ombudsman/hire an attorney	46.5	41.5
You couldn't find an attorney to take your case	44.3	-
Your employer said that your injury was work-related	38.6	37.7
Your employer fired you	20.6	33.2
Because insurance company had an attorney and you felt you needed one	-	64.4
Some other reason, specify	16.8	38.4

Note: Because respondents could give more than one answer, the percentages will not total to 100.0 percent.

Injured employees with attorney representation were more likely to report that the workers' compensation dispute process was extremely unfair (51.7 percent) or somewhat unfair (22.9 percent) to injured employees than injured employees with ombudsman assistance (extremely unfair-42.7 percent; somewhat unfair-22.0 percent) as shown in Figure 26.

Figure 26

Fairness Ratings of Workers' Compensation Dispute Process



The most common reasons given for why the dispute process was unfair to injured employees were the length of time it takes to resolve a dispute (89.8 percent with ombudsman assistance; 92.1 percent with attorney representation), and the hearing officer paid too much attention to the insurance company (72.7 percent with ombudsman assistance; 73.6 percent with attorney representation) as shown in Table 14.

Table 14

Reason Chose Representation by an Ombudsman/Attorney

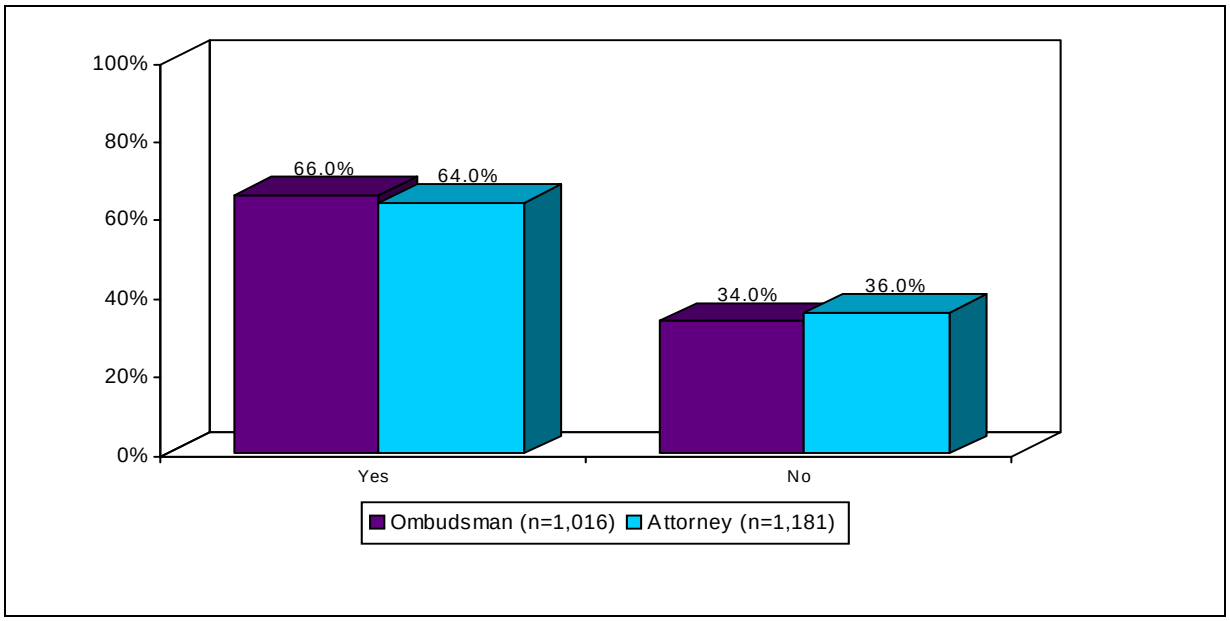
Reason	Percentage responding	
	Ombudsman assistance	Attorney representation
It takes too long to resolve a dispute	89.8	92.1
No one explained to you how the dispute process works	51.2	52.3
No one would listen to you or hear your side of the dispute	59.3	63.0
The insurance company had an attorney and you were unable to find an attorney to take your case	55.8	28.4
The hearing officer paid too much attention to the insurance company	72.7	73.6
Other reason	59.7	60.8

Note: Because respondents could give more than one answer, the percentages will not total to 100.0 percent.

Respondents were asked if they felt they were adequately prepared for their dispute hearing. As shown in Figure 27, two-thirds (66.0 percent) of injured employees with ombudsman assistance and 64.0 percent of those with attorney representation reported feeling adequately prepared for their dispute hearing.

Figure 27

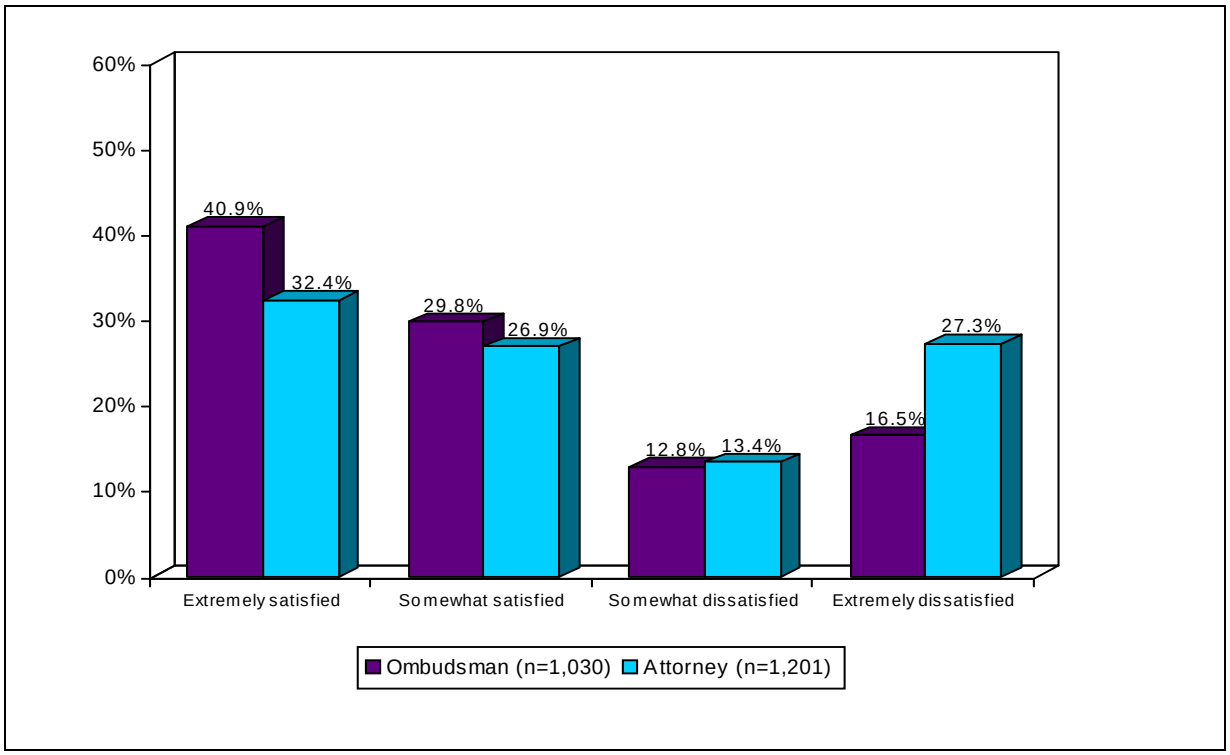
Felt Adequately Prepared for Dispute Hearing(s)



Respondents were asked, overall, how satisfied they were with their ombudsman or attorney. As shown in Figure 28, a greater percentage of injured employees with ombudsman assistance (70.7 percent) were either extremely satisfied or somewhat satisfied compared to respondents with attorney representation (59.3 percent).

Figure 28

Overall Satisfaction with Ombudsman/Attorney



According to the survey, 38.7 percent of the respondents who did not hire an attorney said that they tried to hire an attorney. Some of the reasons that attorneys were unwilling to take their case include:

- No financial incentive to take the case,
- Not familiar with workers' compensation,
- Did not feel the case was strong,
- Not accepting new cases, and
- Attorney was not accepting workers' compensation cases.

Comparisons were made between the 1997 and the 2007 survey. Figures 29 and 30 represent these comparisons.

Figure 29

Workers' Compensation Disputes Are Settled Fairly and Equally

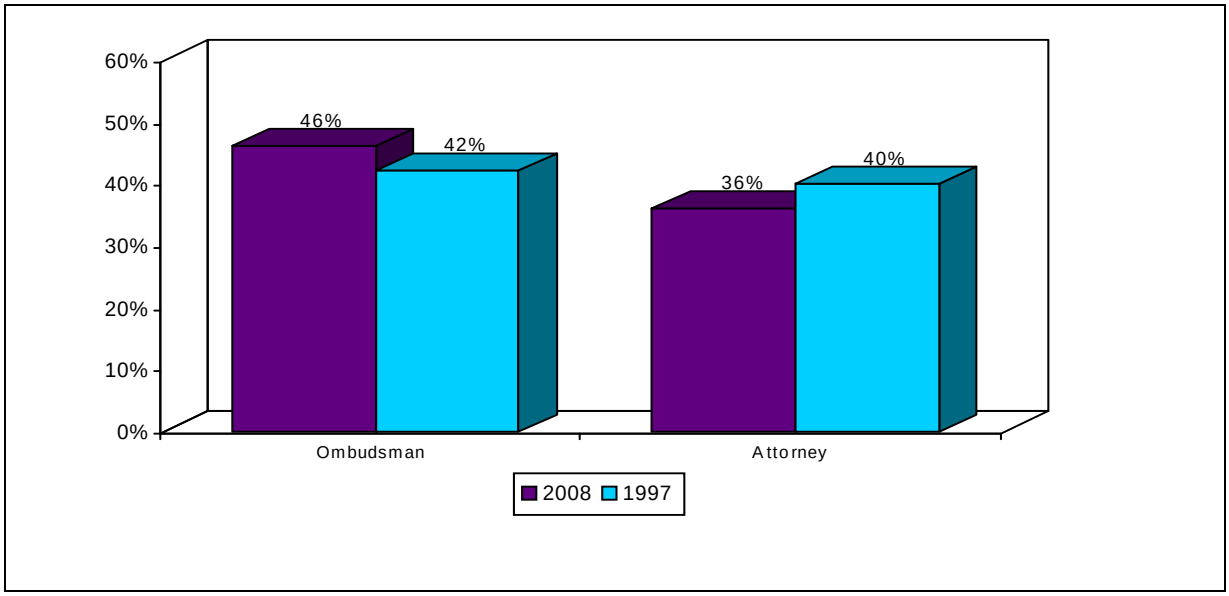
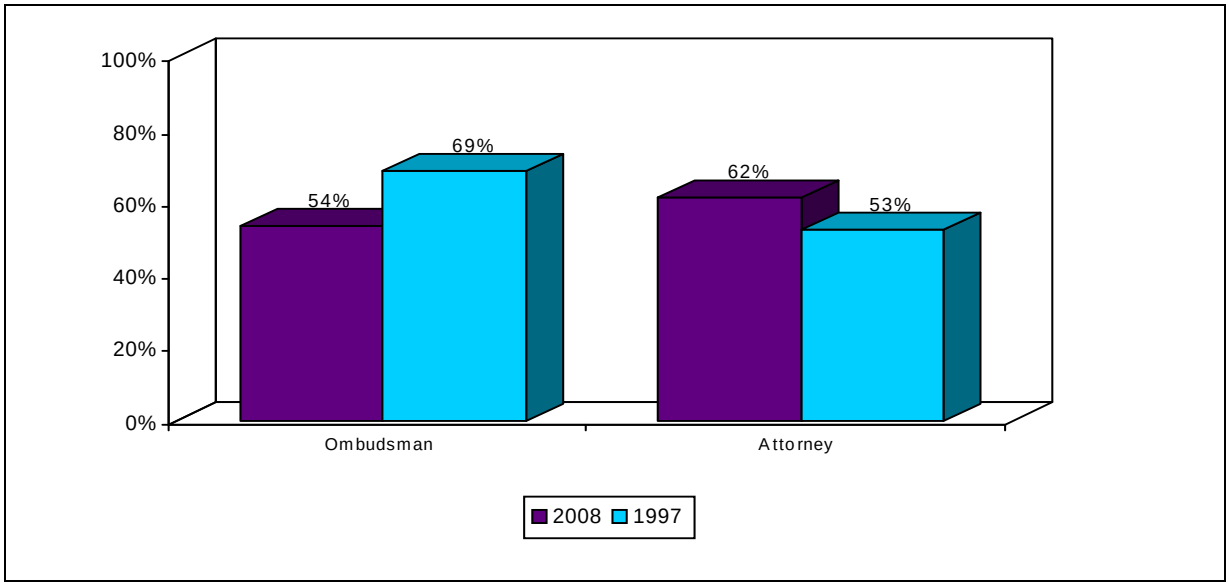


Figure 30

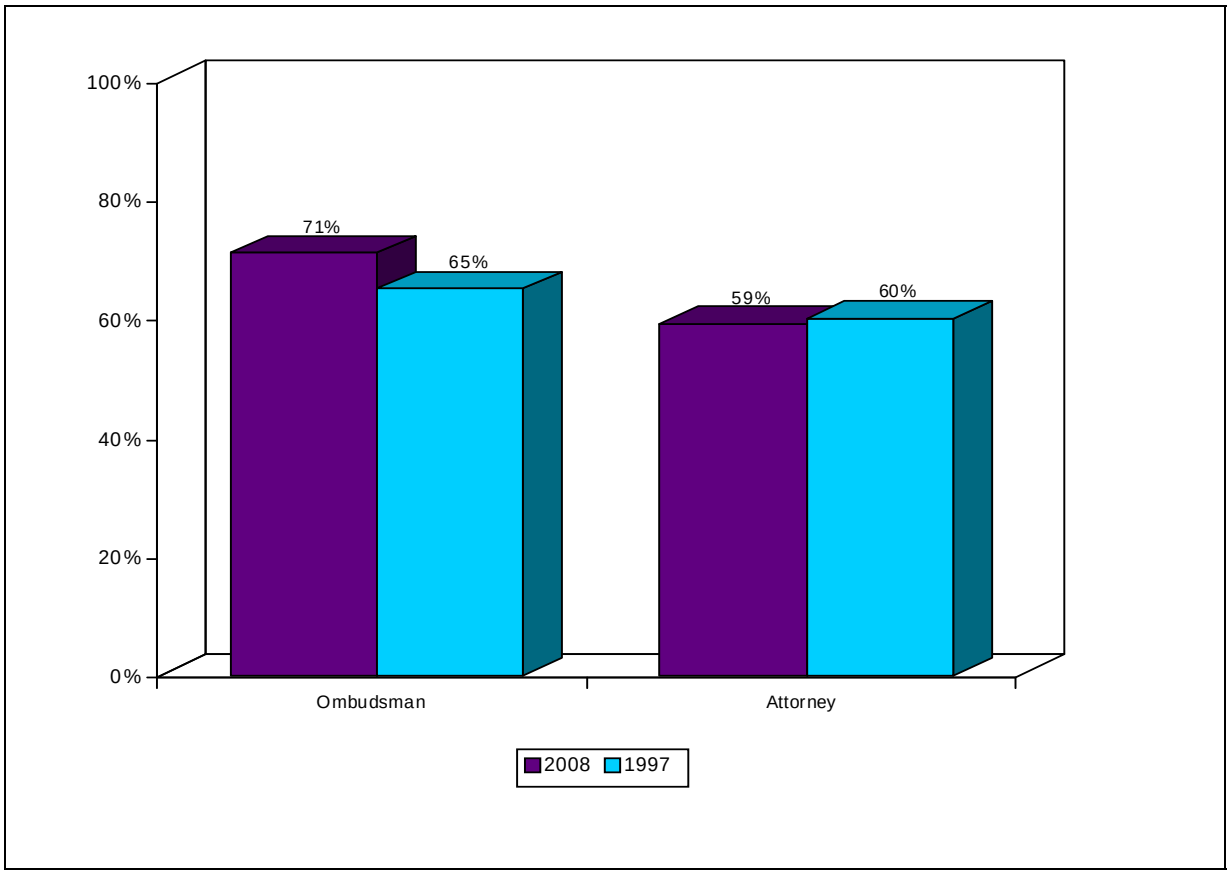
Received Assistance from Ombudsman/Attorney during Dispute



OIEC takes pride in the customer service provided to the injured employees of Texas and continues its efforts to improve this service. One of the indications that OIEC is improving its customer service is represented in Figure 31. Since 1997, the level of satisfaction of injured employees regarding the Ombudsman Program has increased six percent, and OIEC expects this trend to continue.

Figure 31

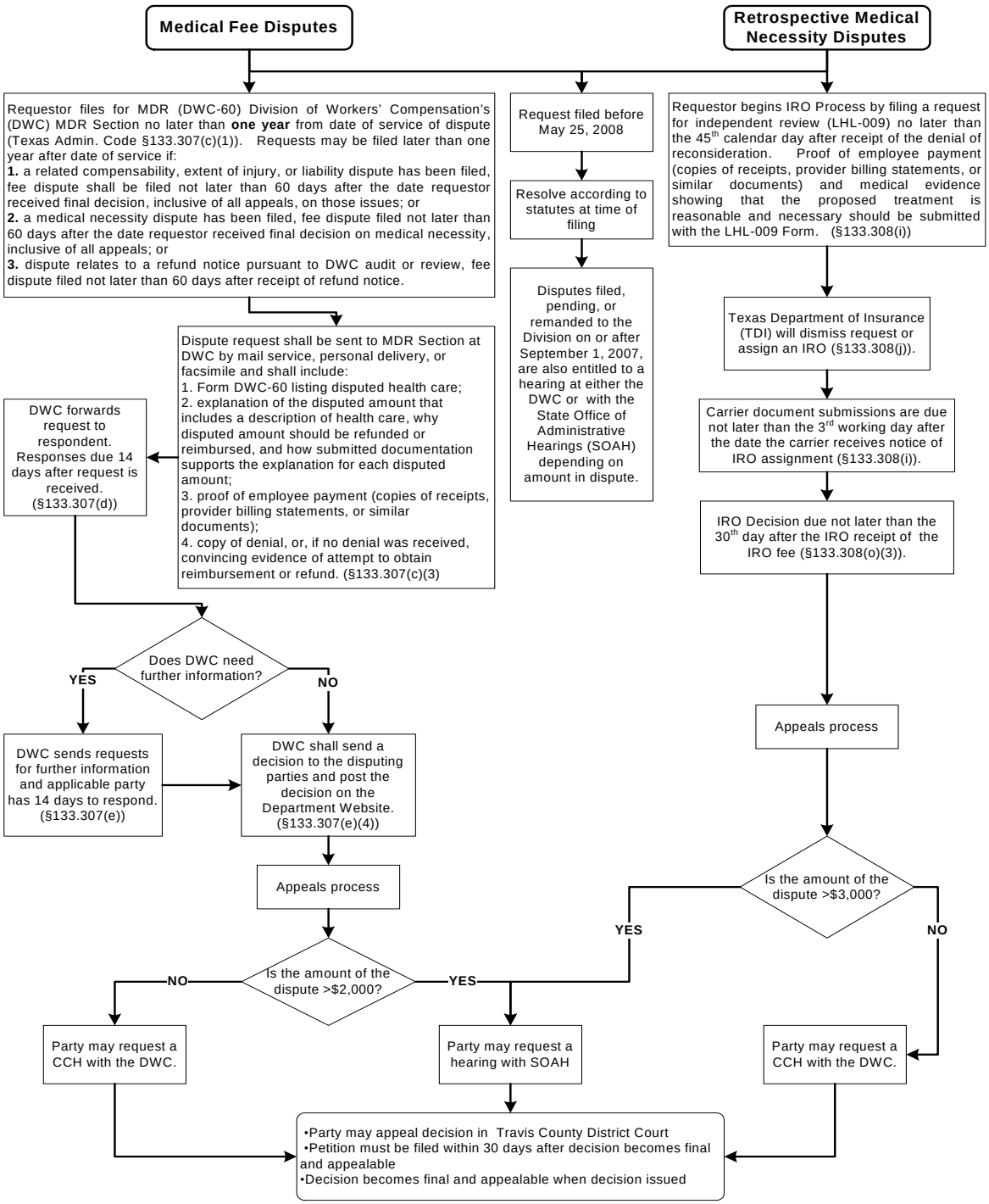
Overall Satisfaction with Ombudsman/Attorney



2. Medical Disputes

The following flowchart, Figure 32, illustrates the medical fee and retrospective medical necessity dispute resolution processes.

Figure 32



a. Medical Fee Disputes

A medical fee is a dispute that involves an amount of payment for non-network health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. The dispute is resolved by DWC.

The following types of disputes can be a medical fee dispute:

1) a health care provider, or a qualified pharmacy processing agent dispute of an insurance carrier reduction or denial of a medical bill;

2) an injured employee dispute of reduction or denial of a refund request for health care charges paid by the injured employee; and

3) a provider dispute regarding the results of a DWC or carrier audit or review which requires the provider to refund an amount for health care services previously paid by the carrier.

A request for medical fee dispute resolution must be filed no later than one year after the date(s) of service in dispute, unless:

1) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;

2) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the carrier previously denied payment based on medical necessity; or

3) the dispute relates to a refund notice issued pursuant to a DWC audit or review, the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice.

To appeal the DWC decision, a party to a medical fee dispute in which the amount of reimbursement sought by the requestor in its request for medical dispute resolution is greater than $2000.00, may request a CCH before the State Office of Administrative Hearings (SOAH).

A party to a medical fee dispute in which the amount of reimbursement sought by the requestor is equal to or less than $2000.00 may request a CCH conducted by a DWC hearing officer. A BRC is not held. Ombudsman assistance is available for injured employees.

b. Retrospective Medical Necessity Disputes

A retrospective medical necessity dispute is a dispute that involves a review of the medical necessity of health care already provided. For medical necessity disputes filed on or after January 15, 2007, a request for a review by an IRO is handled through TDI's Health and WC Network Certification & QA Division (HWCN).

For network health care services, injured employees, persons acting on behalf of the employee, health care providers, or qualified pharmacy processing agents acting on behalf of a pharmacy, may request dispute resolution for retrospective medical necessity disputes.

For non-network health care services, health care providers, or qualified pharmacy processing agents acting on behalf of a pharmacy, may request dispute resolution for retrospective medical necessity disputes.

Injured employees may request dispute resolution for retrospective medical necessity when reimbursement was denied for health care paid by the injured employee.

If an insurance carrier or the carrier's utilization review agent (URA) denies the medical necessity of the health care, a request for reconsideration is submitted to the carrier. After reconsideration, if the insurance carrier or URA denies the medical necessity again, then no later than 45 calendar days after receiving the denial after reconsideration, the injured employee or person acting on behalf of the injured employee or the health care provider of injured employee must submit the request for an IRO review of the dispute to the carrier or URA on the appropriate form. The carrier or URA then submits a request to the HWCN Division for assignment to an IRO. An employee with a life-threatening condition is entitled to an immediate review by an IRO and is not required to comply with the procedures for reconsideration.

If a requestor withdraws the request for an IRO decision after the IRO has been assigned, but before the IRO sends the case to an IRO reviewer, the requestor pays the IRO a withdrawal fee of $150 within 30 days of the withdrawal. If a requestor withdraws the request for an IRO decision after the case is sent to a reviewer, the requestor pays the IRO the full review fee within 30 days of the withdrawal. An injured employee is not required to pay for any part of a review.

For a non-network dispute in which the amount billed is greater than $3,000 a party may appeal the decision by requesting a hearing before SOAH. If the amount billed is less than or equal to $3,000, a party may appeal the IRO decision by requesting a DWC CCH. Ombudsman assistance is available for injured employees.

For network disputes, a party may appeal by seeking judicial review of the decision**.**

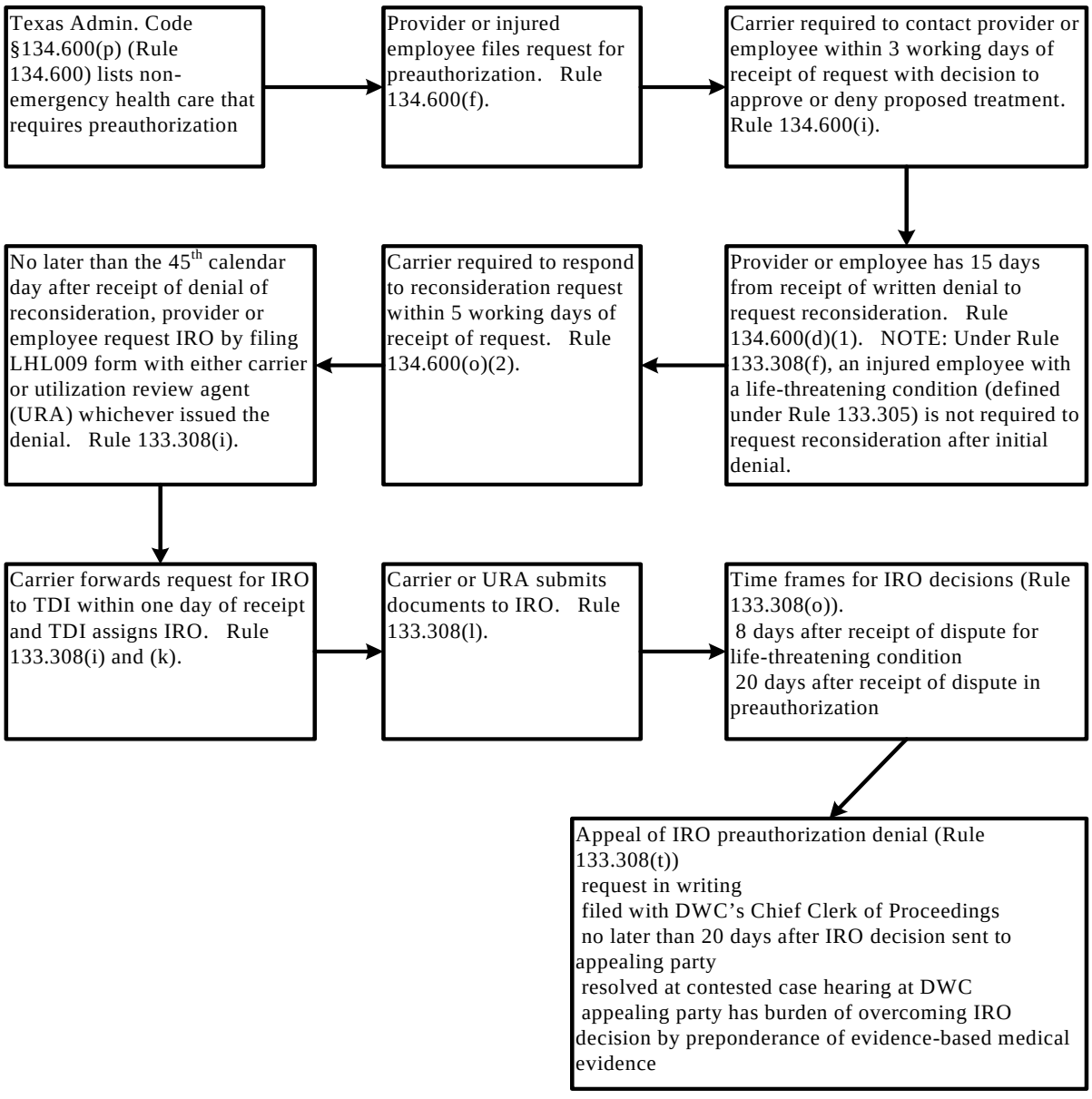
c. Preauthorization Disputes

A preauthorization or concurrent medical necessity dispute is a dispute that involves a review of adverse determination of network or non-network health care requiring preauthorization or concurrent review. The dispute is reviewed by an IRO. An IRO decision may be appealed by requesting a CCH. Ombudsman assistance is available for injured employees.

The following flowchart, Figure 33, illustrates the preauthorization process.

Figure 33

Preauthorization Process



E. Return-To-Work

According to a 2007 study conducted by TDI's Workers' Compensation Research and Evaluation Group on Return-to-Work Outcomes for Texas Injured Workers, approximately 75 percent of injured employees who receive TIB's return to work for the first time within six months of their injury, and approximately 90 percent of injured employees return to work for the first time after sustaining an injury within three years, as shown in Table 15.

Table 15
Percentage of Injured Workers Back At Work for the First Time
6 Months to 3 Years Post-Injury

Injury Year	Within 6 Months Post Injury	Within 1 Year Post Injury	Within 1.5 Years Post Injury	Within 2 Years Post Injury	Within 3 years Post Injury
2001	70%	79%	83%	85%	88%
2002	71%	80%	84%	86%	89%
2003	72%	81%	85%	87%	90%
2004	74%	83%	86%	88%	
2005	75%	84%			

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2007.
Notes:

- The study population includes 329,986 workers injured in 2001-2005 who also received Temporary Income Benefits (TIBs).
- Although the increases of initial RTW rates were small, they were statistically significant at the 0.01 significance level.

However, less than 70 percent of injured employees return to work for the employer with whom they were working at the time of their injury, as shown in Table 16.

Table 16
Percentage of Injured Workers Initially Returned to Their At-Injury Employers
6 Months to 3 Years Post-Injury

Injury Year	Within 6 Months Post Injury	Within 1 Year Post Injury	Within 1.5 Years Post Injury	Within 2 Years Post Injury	Within 3 years Post Injury
2001	58%	62%	63%	63%	64%
2002	60%	65%	65%	66%	66%
2003	62%	66%	67%	68%	68%
2004	63%	67%	68%	69%	
2005	63%	67%			

Source: Texas Department of Insurance, Workers' Compensation Research and Evaluation Group, 2007.
Note: The study population includes 329,986 workers injured in 2001-2005 who also received Temporary Income Benefits (TIBs).

Return-to-Work Pilot Program for Small Employers in Texas. One of the fundamental goals for the Texas workers' compensation system established by HB 7 is to ensure that each injured employee receives services to facilitate his or her return to work as soon as it is considered safe and appropriate by the employee's health care provider. The same legislation created a RTW pilot program for eligible small employers to reimburse them for allowable expenses that they incur, up to $2,500, to make workplace modifications necessary to accommodate an injured employee's return to modified or alternative work (Texas Labor Code §413.022). Workplace modifications may include special equipment, tools, furniture or devices, or other associated adjustments that can allow an injured employee to stay at or return to work. The legislation also established a reimbursement fund of $100,000 per year; and the fund is financed through administrative penalties.

HB 886, as proposed by OIEC and passed during the 80th Legislature, Regular Session, 2007, modified the RTW pilot program to include a preauthorization option for employers that guarantees reimbursement of the expenses incurred by the employer in implementing the modifications and changes, unless DWC determines that the modifications and changes differ materially from what was preauthorized. The current RTW pilot program funding expires on September 1, 2009.

Since the implementation of the RTW pilot program in February 2006, DWC has received five applications for reimbursement. Two applications did not meet the statutory requirements for eligibility, one application was withdrawn due to some unexpected medical issues that arose for the injured employee, and two were successfully reimbursed. Feedback from both employers after their reimbursements were complete indicated that they were very pleased with the process and outcome of using the RTW pilot program.

DWC suggests the following recommendations that may increase employer participation in the program:

- The RTW Pilot Program for Small Employers should be extended for two years.

- Increase the current maximum reimbursement amount for workplace modifications from $2,500 to $5,000. This may encourage participation by small employers who may need more extensive or sophisticated modifications in order to return an injured employee to meaningful employment.

- Restructure the program to allow employers to receive some or all of the funding in advance. If this is allowed, DWC envisions that agency staff would need to verify the modifications that are made by the employer to ensure that the funds were used for the intended modifications.[11]

[11] Source: Report on the Implementation of the Return-to-Work Pilot Program for Small Employers in Texas, Texas Department of Insurance, October 2008.

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IV. Regulatory and Legislative Recommendations Addressing Current Workers' Compensation System Factors Impacting Injured Employees

With HB 7's overhaul of the workers' compensation system, the focus and goals of the system have also changed. The new workers' compensation goals are:

- Each employee shall be treated with dignity and respect when injured on the job;
- Each injured employee shall have access to a fair and accessible dispute resolution system;
- Each injured employee shall have access to prompt, high-quality medical care within the framework established by the Workers' Compensation Act; and
- Each injured employee shall receive services to facilitate the employee's return to employment as soon as it is considered safe and appropriate by the employee's health care provider. TEX. LAB. CODE §402.021(a).

With these goals in mind, this section of the legislative report offers both regulatory and legislative recommendations on behalf of injured employees of Texas.

A. Designated Doctor Disputes

Pursuant to Labor Code §§408.0041 and 408.004, which became effective January 1, 2007, the role of the designated doctor in the workers' compensation system was expanded, and the role of the required medical examination doctor (RME) was purportedly limited to disputes regarding appropriateness of medical care. Labor Code §408.0041(f) reintroduces the RME doctor into the process on all of the issues that the designated doctor addresses:

- impairment caused by the compensable injury;
- attainment of maximum medical improvement;
- extent of the compensable injury;
- whether disability is the direct result of the work-related injury;
- the ability of the employee to return to work; and
- similar issues.

However, this statutory provision only allows the insurance carrier the opportunity to request an RME. The relevant portion of Labor Code §408.0041(f) provides:

> *If an insurance carrier is not satisfied with the opinion rendered by a designated doctor under this section, the carrier may request the commissioner to order an employee to attend an examination by a doctor selected by the insurance carrier.*

There are instances where the designated doctor makes the first certification of maximum medical improvement (MMI) and impairment rating (IR). When that occurs and the injured employee disagrees with the designated doctor's opinion, the insurance carrier in practice does not pay for an examination by the treating doctor to address the issues of MMI and IR. Thus, the injured employee does not have a realistic opportunity to obtain another medical opinion on the issues of MMI and IR because of the inability to pay for the examination. By only permitting the insurance carrier to have meaningful access to another doctor's opinion to dispute a designated doctor's opinion, the current version of Labor Code §408.0041 has made it significantly more difficult for the injured employee to challenge the opinion of the designated doctor while giving the insurance carrier access to evidence to challenge the designated doctor's opinion.

Legislative Recommendation: In order to level the playing field, OIEC recommends that in those cases where the injured employee disagrees with the opinion of the designated doctor and either the treating doctor or a referral doctor has not conducted an examination to assess MMI and IR prior to the issuance of a designated doctor's report on those issues, that the statute be amended to require the insurance carrier to pay the cost of an examination by the treating doctor, if the treating doctor is qualified and willing to conduct the examination, or a referral doctor, in those instances where the treating doctor is either unable or unwilling to conduct an MMI/IR examination. The current version of Labor Code §408.0041 has made it significantly more difficult for the injured employee to obtain any evidence to challenge the opinion of the designated doctor regarding MMI/IR while creating a mechanism for the insurance carrier to access the evidence it needs to challenge the designated doctor's opinion. As a result, the designated doctor's opinion is effectively the opinion that resolves the MMI/IR issue when the injured employee is challenging the designated doctor's opinion. However, the insurance carrier has a good chance of overcoming the designated doctor's opinion by producing the preponderance of medical evidence contrary to that report pursuant to the mechanism that is provided only to the insurance carrier in Labor Code §408.0041(f).

In the alternative, OIEC suggests that Labor Code §408.0041(f) be repealed so that the insurance carriers will no longer be permitted to obtain an RME to dispute the designated doctor findings. The argument can be made that by creating the designated doctor process, it was envisioned that the designated doctor's opinion would be used to resolve the issues of MMI and IR. If neither the injured employee nor the insurance carrier is able to obtain a contrary medical opinion resulting from an examination of the injured employee, the designated doctor's opinion would almost certainly be the opinion that would be used to resolve issues of MMI and IR.

A copy of the proposed bill follows.

Bill Number: _____ Date: _____

Author: _____

A BILL TO BE ENTITLED

AN ACT

relating to an injured employee's ability to obtain a physical examination to determine maximum medical improvement and an impairment rating by the injured employee's treating doctor or a referral doctor in the workers' compensation system.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subtitle A, Title 5, Labor Code, Chapter 408 is amended by amending Section 408.0041(f) to read as follows:

Sec. 408.0041. Designated Doctor Examination.

(f). If the insurance carrier is not satisfied with the opinion rendered by a designated doctor under this section, the insurance carrier may request the commission to order an employee to attend an examination by a doctor selected by the insurance carrier. If the designated doctor's opinion is the injured employee's first evaluation of maximum medical improvement or impairment rating and the injured employee is not satisfied with the opinion rendered by the designated doctor, the injured employee may request a maximum medical improvement or impairment rating examination either from the treating doctor or from a doctor to whom the injured employee is referred by the treating doctor, and such an examination shall be paid by the insurance carrier. The Division ~~commission~~ shall allow the insurance carrier and the injured employee reasonable time to obtain and present the opinion of the doctor selected under this subsection before the Division ~~commission~~ makes a decision on the merits of the issue in question.

SECTION 2. This Act takes effect September 1, 2009.

B. Judicial Review

Through the Ombudsman Program and injured employees seeking assistance beyond the workers' compensation administrative process, the issue of injured employees' ability to pursue their claim at district court has been brought to OIEC's attention. Many injured employees contact OIEC seeking assistance at the judicial review level. This is beyond the administrative jurisdiction of the Ombudsman Program, and OIEC recommends contacting the Texas Bar Attorney Referral Service and local legal aid clinics for attorney representation. Unfortunately, after following such guidance, many injured employees contact OIEC explaining that the attorneys referred from the Texas Bar Attorney Referral Service will not represent them in district court despite Texas Labor Code §408.221(c) that provides for reasonable attorney fees to be paid for by the insurance carrier should the injured employee prevail. In addition, the three largest legal aid clinics in Texas do not take workers' compensation cases.

Since its establishment, OIEC has worked with Texas' three largest legal aid clinics, the Texas Bar, and the Texas Equal Justice Center to attempt to rectify the lack of attorney representation at the judicial review level. However, OIEC believes legislative action may be needed to provide a permanent solution. Perhaps the Texas Legislature may consider extending Texas' court appointment system to injured employee's who prevailed at the workers' compensation administrative level.

Below is an article written by Allen Cooper of the Texas Equal Justice Center.

Injustice Added to Injury: Judicial Review in the Texas Workers Compensation System:

<u>Judicial Review is Out of Reach for Most Injured Workers</u>

When the Texas workers compensation system was reformed in 1989, a basic goal of the reform was to make the system simple enough so that injured workers could represent themselves in the workers compensation process without needing legal counsel. The belief was that more money should go to aid injured workers and less to the attorneys who represent them. Attorney incentives were reduced and injured workers were guaranteed lifetime medical benefits. An ombudsman program was created to assist injured workers in representing themselves in the administrative appeals process, whereas insurance carriers continue to hire legal counsel to represent them.[12] This assistance program was strengthened in 2005 when the Texas Legislature created the Office of Injured Employee Counsel to direct the ombudsman program and represent the interests of injured employees as a class.[13]

But whatever parity that exists between injured employees and insurance carriers at the administrative level is wiped out when insurance carriers exercise their right to have unfavorable administrative decisions reviewed by a state district court in a process known as judicial review. Insurance carriers are always represented by legal counsel at

[12] Tex. Lab. Code § 401.001.
[13] Tex. Lab. Code § 404.001.

judicial review, usually by highly qualified law firms that specialize in workers compensation administrative law, because they have funds to pay lawyers. But the Office of Injured Employee Counsel is prohibited by statute from aiding injured employees facing judicial review, and frequently it is impossible for injured workers to find legal representation, either because they do not have funds to pay an attorney, or because they simply cannot find an attorney qualified and willing to take their cases.[14]

Instead of serving as a check on the administrative process, judicial review often allows an insurance carrier to win what it lost in the administrative process by the simple fact that it can find and hire an attorney to represent it while the injured worker usually cannot. When injured workers can't find legal representation they often lose the right to lifetime medical treatment for a workplace injury through an uncontested ruling. Also, the State of Texas is required to reimburse carriers hundreds of thousands of dollars a year for services provided in cases that are overruled in uncontested hearings.

Under the benefit dispute resolution process of the Texas workers' compensation system, an employee or carrier wishing to dispute a benefit decision must first bring the dispute to a series of administrative review bodies. If the party is not satisfied with the decision at the final administrative level, called the Appeals Panel, they may seek judicial review of administrative decisions by filing suit against the other party in state district court.[15]

In 2004 twice as many judicial review cases were brought by insurance carriers as were brought by injured employees.[16] This is not surprising because injured employees usually do not have funds available to hire an attorney because once they are injured, they are typically unemployed and subsisting on a benefit payment equal to 70 percent of their usual weekly pay. Also, since few attorneys represent injured workers in workers compensation cases, it is difficult to find an attorney competent to take this sort of case.

In 2001 the Texas legislature acted to remedy this problem of injured worker representation by requiring insurance carriers to pay the reasonable legal fees of injured workers who prevail at the level of judicial review when they are sued by insurance carriers.[17]

Unfortunately, injured workers still are frequently unable to find legal representation despite this economic incentive, probably because of the short time they have to find an attorney, and because so few attorneys represent injured workers in workers compensation cases.

An injured employee who is sued by an insurance carrier receives notice that they have been sued, and has 20 days within which to find an attorney and to file an answer to the suit with the court. They have all of the difficulties listed above with finding legal counsel. As a consequence injured employees often do not respond to the suit, and the carrier takes a default or summary judgment in their favor.[18] Even though the worker is

[14] Tex. Lab. Code § 404.105
[15] Tex. Lab. Code § 410.002 et seq.
[16] Data taken from Texas Workers' Compensation System Data Report, June 30, 2005.
[17] Tex. Lab. Code § 408.221.
[18] (No good data exists on the frequency of default and summary judgments since the State of Texas has no relevant reporting requirements.)

not able to or does not choose to contest the suit, the court is obligated to issue a ruling in favor of the carrier.

Often this holding has no immediate impact on the worker, since in many cases salary replacement benefits will have already been paid and medical treatment will already have been received. But the injured worker will lose his right to lifetime medical treatment for the workplace injury, so if a problem arises in the future, the worker will have to pay for treatment him or herself.

Judicial Review is Costly to the State of Texas

A summary judgment holding can be very expensive to the State of Texas. The State of Texas is required to reimburse insurance carriers for benefits previously paid, whenever the order to pay benefits is overturned in judicial review on a judgment on the merits.[19] Since 2000 the State of Texas has paid more than $2.6 million to insurance carriers in response to motions for summary judgment in judicial review cases. In most of these cases the injured employers were unrepresented by legal counsel and the insurance carriers won a judgment on the merits even though the case was uncontested.

The number of cases and amounts paid to insurance carriers are increasing at a rapid rate. In the first 11 months of 2006 insurance carriers were reimbursed more than $750,000 in 20 cases, more than double the number and amount for all of 2005.

Payments to Insurance Carriers in Judicial Review Cases[20]

Year	Total Paid	Number	Highest Single Case
2000	$152,688.08	7	$99,271.34
2001	$225,235.45	13	$44,337.00
2002	$268,846.31	8	$142,571.77
2003	$625,372.78	10	$429,054.23
2004	$263,093.58	18	$39,861.93
2005	$333,308.96	10	$106,118.30
2006	$751,760.29	20	$174,532.54
Total	**$2,620,305.00**	**86**	

An additional inequality is caused by the difficulty of injured workers who lose an administrative appeal to hire legal counsel to represent them in judicial review. Current law only requires that carriers pay reasonable legal costs for injured workers who prevail at the highest administrative level and in judicial review. This means that an injured employee who loses at the administrative level has no practical way to contest that finding, since they usually do not have funds to pay attorney's fees. This undermines the point of judicial review, which is to provide a judicial check on the administrative process which is equally available to all parties.

[19] Tex. Lab. Code § 410.209.
[20] Texas Department of Insurance, Division of Workers' Compensation, Open Records Request #56703, "Request concerning a report of reimbursements paid to insurance carriers from subsequent injury fund."

Policy Recommendations

The judicial review process as it currently operates is unfair to injured workers and costly to the State of Texas. Reforms are needed to restore fairness to the judicial review process.

1) Legislation should be passed limiting insurance carrier reimbursements from the Subsequent Injury Fund to judicial review cases where the injured employee is represented by counsel and the lawsuit is contested. Carriers should not be reimbursed pursuant to motions for summary judgment.

2) Public defenders should be provided to injured employees who are sued by insurance carriers, as recommended by the Office of Injured Employee Counsel and as proposed by Texas Senate Bill 287.

3) The State Bar of Texas and all Bar Associations operating legal referral services should redouble their efforts to identify attorneys willing to represent injured workers in judicial review cases.

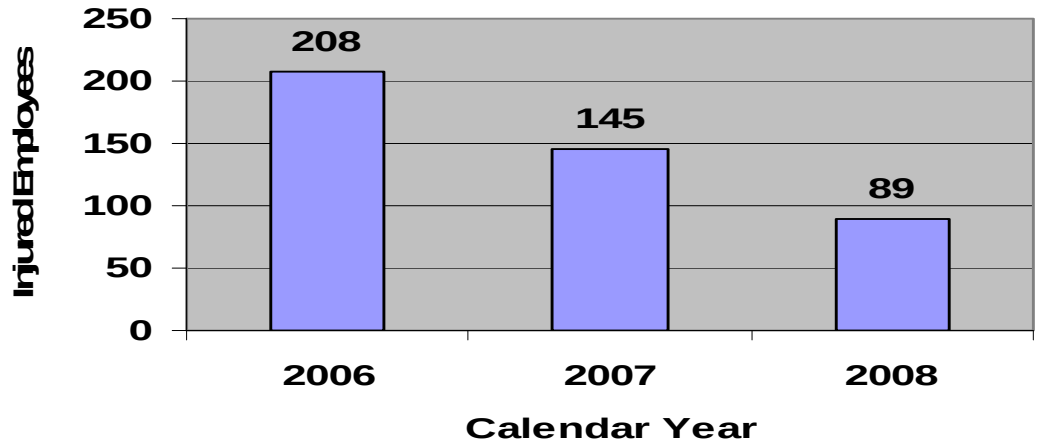
4) To assure equal access to legal representation, legislation should be passed requiring insurance carriers to pay reasonable legal fees of attorneys representing injured workers who prevail in judicial review, regardless of whether the employee won or lost in the administrative process.

Source: Cooper, Allen. "Injustice Added to Injury: Judicial Review in the Texas Workers Compensation System." Equal Justice Center. 2006.

Figure 34 identifies the number of injured employees that would benefit from receiving a court-appointed attorney.

Figure 34

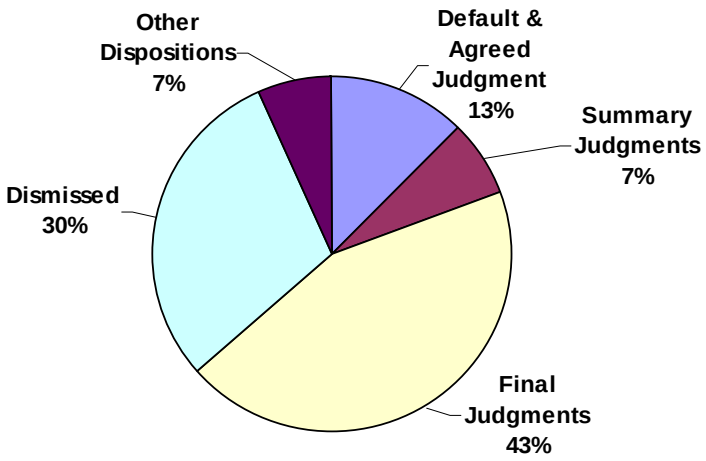
Number of Injured Employees Where the Injured Employee is Plaintiff



Source: Texas Department of Insurance, Division of Workers' Compensation, Information Management Services, 2008.

Figure 35

Distribution of Workers' Compensation Civil Activity
September 1, 2006 to August 31, 2007



Source: Office of Court Administration (OCA); http://www.courts.state.tx.us/pubs/AR2007/dc/14-dc-cv-activity-by-county-fy07.xls

Legislative Recommendation: Injured employees give up their Constitutional right to sue their employer for work-related injuries. As such, OIEC recommends legislative action to authorize Texas courts to appoint an attorney ad litem to either represent an injured employee or refer the case to another attorney to provide competent representation at the district court if the final administrative decision was in favor of the injured employee. However, OIEC also recommends that the district judge be required to conduct a hearing to determine that the injured employee has sought representation in good faith and has been unsuccessful in obtaining representation. In cases where the injured employee does prevail at district court, Labor Code §408.221(c) provides for attorney's fees to be paid by the insurance carrier. If the injured employee does not prevail in district court with the representation of a court appointed attorney ad litem, OIEC recommends a provision be added in Chapter 408 of the Labor Code to provide that the injured employee's attorney's fees should be paid from the Subsequent Injury Fund. OIEC also recommends that the attorney ad litem may be paid for services rendered on the claim, such as allowing for reimbursement for time spent referring the case to an attorney competent in the field of workers' compensation should the ad litem decline to represent the injured employee. However, OIEC recommends that a statutory provision be included to restrict attorney fees in order to safeguard the Subsequent Injury Fund.

A copy of the proposed bill follows.

Bill Number: _____ Date: _____

Author: _____

A BILL TO BE ENTITLED

AN ACT

relating to the appointment of an attorney for a workers' compensation claimant in certain judicial review proceedings initiated by a workers' compensation insurance carrier.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subchapter G, Chapter 410, Labor Code, is amended by adding Section 410.309 to read as follows:

Sec. 410.309. APPOINTMENT OF ATTORNEY FOR CLAIMANT IN PROCEEDING INITIATED BY INSURANCE CARRIER. (a) In a trial initiated by an insurance carrier under this subchapter, at the request of the claimant the court shall appoint an attorney to represent the claimant before the court. The court may hold a pre-trial hearing to determine whether the claimant made a good faith effort to obtain representation by an attorney prior to the appointment of an attorney.

(b) The insurance carrier is liable for the attorney's reasonable and necessary fees in accordance with Section 408.221(c) on any issue on which the claimant prevails. The claimant attorney may not bill for more hours than the hours the carrier attorney billed.

(c) The subsequent injury fund is liable for the attorney's reasonable and necessary fees in accordance with Section 408.221(c-1) on any issue on which the insurance carrier prevails.

SECTION 2. Section 408.221, Labor Code, is amended by amending Subsections (b) and (i) and adding Subsection (c-1) to read as follows:

(b) Except as otherwise provided, an attorney's fee under this section is based on the attorney's time and expenses according to written evidence presented to the division or

court. Except as provided by Subsection (c) or (c-1) or Section 408.147(c), the attorney's fee shall be paid from the claimant's recovery.

(c-1) In a judicial review proceeding initiated by an insurance carrier under Subchapter G, Chapter 410, in which the court has appointed an attorney for the claimant under Section 410.309, the subsequent injury fund is liable for the attorney's reasonable and necessary fees as provided by Subsection (d) on any issue on which the insurance carrier prevails. If the insurance carrier appeals multiple issues and the insurance carrier prevails on some, but not all, of the issues appealed, the court shall apportion and award fees to the claimant's court-appointed attorney from the subsequent injury fund only for issues on which the insurance carrier prevails. In making that apportionment, the court shall consider the factors prescribed by Subsection (d). An award of attorney's fees under this subsection is not subject to commissioner rules adopted under Subsection (f).

(i) Except as provided by Subsection (c) or (c-1) or Section 408.147(c), an attorney's fee may not exceed 25 percent of the claimant's recovery.

SECTION 3. Section 403.006(b), Labor Code, is amended to read as follows:

(b) The subsequent injury fund is liable for:

(1) the payment of compensation as provided by Section 408.162;

(2) reimbursement of insurance carrier claims of overpayment of benefits made under an interlocutory order or decision of the commissioner as provided by this subtitle, consistent with the priorities established by rule by the commissioner; [~~and~~]

(3) reimbursement of insurance carrier claims as provided by Sections 408.042 and 413.0141, consistent with the priorities established by rule by the commissioner; and

(4) the payment of court-appointed attorney's fees as provided by Section 408.221(c-1).

SECTION 4. The change in law made by this Act applies only to a judicial review proceeding initiated under Subchapter G, Chapter 410, Labor Code, on or after the effective date of this Act. A proceeding initiated before that date is governed by the law in effect on the date the proceeding was initiated, and the former law is continued in effect for that purpose.

SECTION 5. This Act takes effect September 1, 2009.

C. Political Subdivisions and Health Care Networks' Requirements in the Workers' Compensation System

OIEC is concerned that injured employees employed by political subdivisions do not receive adequate notice of potential entitlements in the workers' compensation system. OIEC believes it is essential to alleviate any due process concerns by mandating that political subdivisions give the same notice certified networks are required to give to their employees.

Currently, there is no venue to resolve a dispute regarding the issue of notice should an employee be subject to network requirements. The existing statutory system provides that an injured employee may file a complaint with TDI or the network. However, an issue of whether the injured employee received proper notice is one for a fact-finder. Should an injured employee file a complaint within TDI's workers' compensation health care network division, the employee waives the very issue (namely, the issue of notice) and becomes subject to network provisions.

Legislative Recommendation: Political subdivisions should be required to give notice to their employees, just as every other employee subject to a workers' compensation networks. The following bill requires political subdivisions to give employees necessary information, including:

- give a written description of the terms and conditions for obtaining health care in the political subdivision's network;
- provide the description in English, Spanish, or any other language common to the employee;
- give the network's toll-free telephone;
- describes how the employee can obtain a treating doctor, referral doctor, or be treated for an emergency; and
- how an employee may file a complaint.

DWC's dispute resolution system is the appropriate venue to adjudicate a dispute on whether an injured employee received proper notice. DWC already has a system in place whereby these disputes may be adjudicated with a fact finder and any due process concerns would be alleviated.

A copy of the proposed bill follows.

Bill Number: _____ Date: _____

Author: _____

A BILL TO BE ENTITLED

AN ACT

relating to a political subdivisions' and health care networks' requirements in the workers' compensation system.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subtitle A, Title 5, Labor Code, Chapter 504 is amended by amending Section 504.018(b) to read as follows:

Sec. 504.018(b). Notice to Division and Employees; Effect Common-Law or Statutory Liability.

(b). A political subdivision shall notify its employees of the method by which the employees will receive benefits and the effective date of the coverage. A political subdivision shall also provide its employees with a notice that meets the network requirements set forth in Insurance Code §1305.103 and §1305.451. The issue of whether and when an employee of a political subdivision received proper notice may be resolved in the division's dispute resolution process. Employees of a political subdivision are conclusively considered to have accepted the compensation provisions instead of common-law or statutory liability or cause of action, if any, for injuries received in the course of employment or death resulting from injuries received in the course of employment.

SECTION 2. Insurance Code, Chapter 1305 is amended by amending Sections 1305.103(c) to read as follows:

Sec. 1305.103. Treating Doctor; Referrals.

(c). An employee who lives within the service area of a network and who is being treated by a non-network provider for an injury that occurred before the employer's

insurance carrier established or contracted with the network, shall select a network treating doctor on notification by the carrier that the health care services are being provided through the network. The carrier shall provide to the employee all information required by Section 1305.451. If the employee fails to select a treating doctor on or before the 14th day after the date of receipt of the information required by Section 1305.451, the network may assign the employee a network treating doctor. The issue of whether an employee received proper notice pursuant to this section and Section 1305.451 shall be adjudicated in the division's dispute resolution system.

SECTION 3. This Act takes effect September 1, 2009.

D. Eligible Parents Receipt of Death Benefits

In the 80th Legislative Session, Labor Code §408.182 was amended to permit eligible parents to recover 104 weeks of death benefits in cases where the deceased employee did not have an eligible spouse, eligible child, eligible grandchild, or any surviving dependents. The term "eligible parent" is defined in Labor Code §408.182(f)(4) as "the mother or the father of a deceased employee, including an adoptive parent or a stepparent, who receives burial benefits under Section 408.186. The term does not include a parent whose parental rights have been terminated." Thus, the statutory language establishes a requirement that a parent receive burial benefits in order to establish eligibility for death benefits. By doing so, the Legislature significantly reduced the number of parents who could collect death benefits as "eligible parents." In most instances, the burial benefits are paid by someone other than the parents of the deceased employee. As a result, the parents are not able to establish entitlement to either burial benefits or death benefits.

Legislative Recommendation: The legislative intent in amending Labor Code §408.182 was to create another category of potential beneficiaries to ensure that, whenever possible, a family member of the deceased employee would receive some death benefits and consequently to reduce the number of instances where only the subsequent injury fund would receive death benefits. The current statutory language undermines the legislative intent. Therefore, OIEC recommends that the statutory definition of eligible parents be amended to remove the language that requires receipt of burial benefits as a prerequisite for the receipt of death benefits. The issue of whether parents can establish entitlement to 104 weeks of death benefits should be made without regard to whether or not the parents can establish entitlement to burial benefits.

OIEC also recommends that the language that permits the Commissioner of Workers' Compensation to extend the time for eligible parents to file a claim be amended. In order to be granted an extension under Labor Code §408.182(d-2), the eligible parents have to submit "proof satisfactory to the commissioner of a compelling reason for the delay." Under Labor Code §409.007, other beneficiaries, except minors and incompetents, who fail to file a claim for death benefits within one year of the date of the employee's death are required to establish good cause for the failure to timely file a claim. Good cause is a standard with long-standing meaning in the workers' compensation statute. Parties attempting to establish good cause can clearly identify the standard and garner an understanding of the showing that is required to satisfy the standard. This permits parties to make an informed decision of whether or not to proceed when they did not timely file a claim. The "compelling reason for delay" standard does not have a similar well-established meaning. By changing Labor Code §408.182 to incorporate a good cause exception, the legislature would introduce consistency into the statute and into the decision-making process because the hearing officers, who will be called upon to resolve the issue of whether the delayed filing can be excused, would resolve that issue by applying the same standard that they apply in resolving other issues of whether or not the failure to comply with a time requirement can be excused.

A copy of the proposed bill follows.

Bill Number: _____ Date: _____

Author: _____

A BILL TO BE ENTITLED

AN ACT

relating to eligible parent's receipt of death benefits in the workers' compensation system.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 408.182, Labor Code, is amended to read as follows:

Sec. 408.182. DISTRIBUTION OF DEATH BENEFITS.

(a) – (d1) No Change.

(d-2) Except as otherwise provided by this subsection, to be eligible to receive death benefits under Subsection (d-1), an eligible parent must file with the division a claim for those benefits not later than the first anniversary of the date of the injured employee's death from the compensable injury. The claim must designate all eligible parents and necessary information for payment to the eligible parents. The insurance carrier is not liable for payment to any eligible parent not designated on the claim. Failure to file in the time required bars the claim unless good cause exist for the failure to file a claim under this section. ~~The commissioner may extend the time for filing a claim under this subsection only if the eligible parent submits proof satisfactory to the commissioner of a compelling reason for the delay.~~

(e) If an employee is not survived by legal beneficiaries or eligible parents, the death benefits shall be paid to the subsequent injury fund under Section 403.007.

(f) In this section:

(1) "Eligible child" means a child of a deceased employee if the child is:

(A) a minor;

(B) enrolled as a full-time student in an accredited educational institution and is less than 25 years of age; or

(C) a dependent of the deceased employee at the time of the employee's death.

(2) "Eligible grandchild" means a grandchild of a deceased employee who is a dependent of the deceased employee and whose parent is not an eligible child.

(3) "Eligible spouse" means the surviving spouse of a deceased employee unless the spouse abandoned the employee for longer than the year immediately preceding the death without good cause, as determined by the division.

(4) "Eligible parent" means the mother or the father of a deceased employee, including an adoptive parent or a stepparent~~, who receives burial benefits under Section 408.186~~. The term does not include a parent whose parental rights have been terminated.

SECTION 2. This Act takes effect September 1, 2009.

E. Ombudsman Program and the Injured Employees' Rights and Responsibilities

As a fairly new agency, specific issues arise, which necessitate statutory modifications to provide clarity. OIEC has identified several issues discussed below, which can be easily addressed by amending the agency's enabling statute.

First, Ombudsmen have historically assisted injured employees in both income and medical disputes before DWC's dispute resolution system. An Ombudsman's assistance with a medical dispute resolution system is particularly helpful to injured employees due to an attorney's inability to be paid for services rendered when representing an injured employee for a medical dispute. HB 724, 80th Texas Legislature, 2007, changed the venue for medical disputes to the State Office of Administrative Hearings (SOAH) for injured employees based on the amount in controversy. As such, OIEC recommends adding SOAH to the agency's enabling statute to provide clarity.

Second, OIEC's Ombudsmen assist and educate injured employees as they pursue their dispute throughout the dispute resolution system. Ombudsmen are not licensed attorney's and do not have attorney-client privilege. Because Ombudsmen are not attorneys, the court views them as potential witnesses. Employees need to have open communications with an injured employee so that Ombudsman can provide accurate assistance and education to the customer. OIEC recommends that Ombudsman and employee communication should be held confidential, much like an attorney-client privilege. Holding communications between Ombudsman and injured employees confidential protects OIEC and the State of Texas from having to defend unnecessary accusations from parties who call an Ombudsman as a witness.

Third, OIEC is responsible for publishing a list of injured employees' rights and responsibilities in the workers' compensation system. The statute currently provides that the notice should be adopted and distributed by both the Insurance and Workers' Compensation Commissioners. This unusual statutory construction may lead to technical problems regarding administrative rulemaking. OIEC believes the notice of injured employees' rights and responsibilities should be a document that is easily amended so that is can reflect the latest legislative and regulatory rule changes. OIEC recommends providing the Public Counsel of OIEC the authority to adopt this notice pursuant to the existing rulemaking authority of Labor Code §404.006.

Fourth, OIEC is proud to assist, educate, and advocate on behalf of all the injured employees of Texas. There are, however, the few occasions where an injured employee threatens or is abusive to OIEC's employees. On other occasions, there are a few injured employees that may try to fraudulently obtain benefits to which they may not be entitled. OIEC does not wish to be associated with such behavior. OIEC requests the authority to deny agency services in limited circumstances, such

as in cases where a customer is abusive, threatens agency staff, or pursues a criminal act.

Finally, OIEC has broad access to TDI's files, which otherwise may be held confidential. Such access provides OIEC the ability to monitor field staff, conduct research initiatives, and effectively provide customer service. However, OIEC is not the regulator of the workers' compensation system and understands that it is a system participant that represents the interests of one party, namely injured employees. To ensure the integrity of OIEC's services and to produce a more balanced workers' compensation system, OIEC recommends that it should not have access to TDI's attorney work-product. Taking away this privilege ensures that OIEC's Ombudsmen may assist an injured employee at an administrative hearing without having unfair access to information. OIEC believes this change is critical to ensuring the integrity of the dispute resolution system and OIEC's services.

Legislative Recommendation: OIEC recommends amending its enabling statute to:

- Clarify an injured employee's right to seek assistance with a dispute before SOAH;
- Hold Ombudsman and injured employee communications confidential to protect the agency's staff from information revealed by the injured employee;
- Change the statutory authority to adopt OIEC's notice to injured employee s' rights and responsibilities from the Commissioners of Insurance and Workers' Compensation to the Public Counsel to allow for flexibility in the notice;
- Refuse service to threatening or abusive injured employees or injured employees pursuing a criminal act; and
- Limit the agency from being able to access the regulator's attorney-work product to protect the integrity of the agency and other agency's administrative dispute resolution processes.

A copy of the proposed bill follows.

Bill Number: _____ Date: _____

Author: Solomons

A BILL TO BE ENTITLED

AN ACT

relating to certain services provided by the office of injured employee counsel under the workers ' compensation program of this state.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subchapter C, Chapter 404, Labor Code, is amended by adding Section 404.101 to read as follows:

Sec. 404.101. REFUSAL TO PROVIDE OR TERMINATION OF SERVICES. (d) The public counsel may refuse to provide or may terminate the services of the office to any claimant who:

(1) is abusive or violent to or who threatens any employee of the office;

(2) makes unreasonable demands for office services or for assistance in claiming benefits not provided by law; or

(3) commits or threatens to commit a criminal act in pursuit of a workers' compensation claim.

(e) If the public counsel determines under Subsection (d) that the services of the office should be refused or terminated, the office shall inform the affected claimant in writing and notify the division.

(f) The office shall notify the appropriate law enforcement authority if the office becomes aware that the claimant or a person acting on the claimant's behalf commits or threatens to commit a criminal act.

SECTION 2. Section 404.105, Labor Code, is amended to read as follows:

Sec. 404.105. AUTHORITY TO ASSIST INDIVIDUAL INJURED EMPLOYEES IN ADMINISTRATIVE PROCEDURES. (a) The office, through the ombudsman program, may

appear before the commissioner, [~~or~~] division, or State Office of Administrative Hearings to provide assistance to ~~on behalf of~~ an individual injured employee during:

(1) a workers' compensation [~~an~~] administrative dispute resolution process; or

(2) ~~an enforcement action pending before the department or division regarding an injured employee~~ an enforcement action by the division or the department against an employee for violations of the Texas Workers' Compensation Act.

(b) This chapter may not be construed as requiring or allowing legal representation for an individual injured employee by an office attorney or ombudsman in any proceeding.

SECTION 3. Section 404.109, Labor Code, is amended to read as follows:

Sec. 404.109. INJURED EMPLOYEE RIGHTS; NOTICE. The public counsel shall adopt, in the form and manner prescribed by the public counsel, [~~submit to the division and the department for adoption by the commissioners~~] a notice of injured employee rights and responsibilities to be distributed by the division as provided by commissioner or [~~and~~] commissioner of insurance rules.

SECTION 4. Section 404.110, Labor Code, is amended to read as follows:

Sec. 404.110. APPLICABILITY TO PUBLIC COUNSEL OF CONFIDENTIALITY REQUIREMENTS. (a) Confidentiality requirements applicable to examination reports and to the commissioner of insurance under Section 501.158, Insurance Code and [~~Article 1.18,~~] 401.105, 401.106, 401.058, 404.111 and 441.201 Labor [~~Insurance~~] Code, [~~and to the commissioner of insurance under Section 3A, Article 21.28-A, Insurance Code,~~] apply to the public counsel.

(b) An employee of the office may not be compelled to disclose information communicated to the employee by a claimant on any matter relating to the claimant 's claim. Nothing in this subsection shall prohibit or alter the office's duty to notify appropriate law enforcement pursuant to Section 404.101.

SECTION 5. Section 404.111, Labor Code, is amended to read as follows:

Sec. 404.111. ACCESS TO INFORMATION. (a) Except as otherwise provided by this section, the ~~The~~ office may access information from an executive agency that is otherwise confidential under a law of this state if that information is necessary for the performance of the duties of the office, including information made confidential under:

(1) Section 843.006, Insurance Code;

(2) Chapter 108, Health and Safety Code;

(3) Chapter 552, Government Code; and

(4) Sections 402.083, 402.091, and 402.092 of this code.

(b) The office may not access information under Subsection (a) that is an attorney-client communication or an attorney work product, or other information protected by a privilege recognized by the Texas Rules of Civil Procedure or the Texas Rules of Evidence.

(c) In the furtherance of assisting an employee pursuant to Subsection 404.105 (a)(2), the office may not access information under Subsection 404.111 (a) to which the employee would not otherwise be entitled. If the office possesses any information made confidential by the Texas Workers' Compensation Act or any other laws of this state to which the employee would not otherwise be entitled, that information may not be disclosed to the employee or any other party in the furtherance of assisting an employee pursuant to 404.105 (a)(2). Nothing in this subsection shall prohibit or alter the office's duty to notify appropriate law enforcement pursuant to Section 404.101,

(d) Except as provided by this subsection, ~~On request by the public counsel~~, the division or the department shall provide any information or data requested by the public counsel ~~office~~ in furtherance of the duties of the office under this chapter.

(e) [~~(c)~~] The office may not make public any confidential information provided to the office under this chapter. Except as otherwise provided by Subsection (c), the office ~~but~~ may disclose a summary of the information that does not directly or indirectly identify the

individual or entity that is the subject of the information. The office may not release, and an individual or entity may not gain access to, any information that:

(1) could reasonably be expected to reveal the identity of a health care provider or an injured employee;

(2) reveals the zip code of an injured employee 's primary residence;

(3) discloses a health care provider discount or a differential between a payment and a billed charge; or

(4) relates to an actual payment made by a payer to an identified health care provider.

(f) [~~(d)~~] Information collected or used by the office under this chapter is subject to the confidentiality provisions and criminal penalties of:

(1) Section 81.103, Health and Safety Code;

(2) Section 311.037, Health and Safety Code;

(3) Chapter 159, Occupations Code;

(4) Chapter 552, Government Code; and

(5) Sections 402.091 and 402.092 of this code.

(g) [~~(e)~~] Information on health care providers and injured employees that is in the possession of the office, and any compilation, report, or analysis produced from the information that identifies providers and injured employees is not:

(1) subject to discovery, subpoena, or other means of legal compulsion for release to any individual or entity; or

(2) admissible in any civil, administrative, or criminal proceeding.

(h) [~~(f)~~] Notwithstanding Subsection (d)(2) [~~(c)(2)~~], the office may use zip code information to analyze information on a geographical basis.

SECTION 6. This Act takes effect September 1, 2009.

F. Waiver for Injuries and Diagnoses Manifest After the Initial 60-Day Waiver Period

By creating a waiver period for evolving injuries and diagnoses that mirrors the waiver period of Labor Code §409.021(c), new subsection (f) would strike an appropriate balance between providing the carrier sufficient time to conduct an investigation to determine whether or not to challenge compensability or relatedness and to establish a shared understanding among workers' compensation system participants as to the nature and extent of the compensable injury.

An amendment to Labor Code §409.021 would create certainty that is currently lacking among system participants about which injuries or diagnoses are included in the compensable injury. The existence of that certainty would help to minimize the "hassle factor" for health care providers by reducing the instances where a provider has treated an injury or diagnosis for an extended period only to find that as the symptoms evolve, approval of a proposed treatment or service is denied.

Legislative Recommendation: OIEC recommends the amendment of Labor Code §409.021 to create a waiver period for injuries and diagnoses manifested after the expiration of the initial 60-day waiver period in Labor Code §409.021(c). If new subsection (f) is added to Labor Code §409.021, it will establish another 60-day waiver period for insurance carriers to make the determination of whether to contest compensability or relatedness of the late-manifesting injury or diagnosis. Once the insurance carrier receives written notice of an additional injury or diagnosis, it would have 60 days to make the decision of whether to challenge the compensability of that injury or diagnosis. If the carrier failed to act within 60 days of the date it received written notice of the additional injury or diagnosis, the additional injury or diagnosis would become compensable as a matter of law.

A copy of the proposed bill follows.

Bill Number: _____ Date: _____

Author: _____

A BILL TO BE ENTITLED

AN ACT

relating to an insurance carrier's pursuit of a compensability or relatedness issues in the workers' compensation system.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

Sec. 409.021. INITIATION OF BENEFITS; INSURANCE CARRIER'S REFUSAL; ADMINISTRATIVE VIOLATION. (a) An insurance carrier shall initiate compensation under this subtitle promptly. Not later than the 15th day after the date on which an insurance carrier receives written notice of an injury, the insurance carrier shall:

(1) begin the payment of benefits as required by this subtitle; or

(2) notify the division and the employee in writing of its refusal to pay and advise the employee of:

(A) the right to request a benefit review conference; and

(B) the means to obtain additional information from the division.

(a-1) An insurance carrier that fails to comply with Subsection (a) does not waive the carrier's right to contest the compensability of the injury as provided by Subsection (c) but commits an administrative violation subject to Subsection (e).

(a-2) An insurance carrier is not required to comply with Subsection (a) if the insurance carrier has accepted the claim as a compensable injury and income or death benefits have not yet accrued but will be paid by the insurance carrier when the benefits accrue and are due.

(b) An insurance carrier shall notify the division in writing of the initiation of income or death benefit payments in the manner prescribed by commissioner rules.

(c) If an insurance carrier does not contest the compensability of an injury on or before the 60th day after the date on which the insurance carrier is notified of the injury, the insurance carrier waives its right to contest compensability. The initiation of payments by an insurance carrier does not affect the right of the insurance carrier to continue to investigate or deny the compensability of an injury during the 60-day period.

(d) An insurance carrier may reopen the issue of the compensability of an injury if there is a finding of evidence that could not reasonably have been discovered earlier.

(e) An insurance carrier commits a violation if the insurance carrier does not initiate payments or file a notice of refusal as required by this section. A violation under this subsection shall be assessed at $500 if the carrier initiates compensation or files a notice of refusal within five working days of the date required by Subsection (a), $1,500 if the carrier initiates compensation or files a notice of refusal more than five and less than 16 working days of the date required by Subsection (a), $2,500 if the carrier initiates compensation or files a notice of refusal more than 15 and less than 31 working days of the date required by Subsection (a), or $5,000 if the carrier initiates compensation or files a notice of refusal more than 30 days after the date required by Subsection (a). The administrative penalties are not cumulative.

(f) After the expiration of the 60-day period identified in subsection (c) of this section, if the insurance carrier receives written notice of an new manifestation of the original injury, an additional injury, or an additional diagnosis and does not contest the compensability of such injury or diagnosis on or before the 60th day after the date on which it received notice thereof, the insurance carrier waives its right to contest compensability of the additional injury or diagnosis. Nothing in this section shall be construed to limit an insurance carrier's ability to reopen the issue of compensability based on newly discovered evidence under subsection (d) of this section.

~~Text of subsec. (f) as added by Acts 2003, 78th Leg., ch. 939, Sec. 1~~

~~(f) For purposes of this section, "written notice" to a certified self-insurer occurs only on written notice to the qualified claims servicing contractor designated by the certified self-insurer under Section 407.061(c).~~

Text of subsec. (g) ~~(f)~~ as added by Acts 2003, 78th Leg., ch. 1100, Sec. 1

(g) ~~(f)~~ For purposes of this section:

(1) a certified self-insurer receives notice on the date the qualified claims servicing contractor designated by the certified self-insurer under Section 407.061(c) receives notice; and

(2) a political subdivision that self-insures under Section 504.011, either individually or through an interlocal agreement with other political subdivisions, receives notice on the date the intergovernmental risk pool or other entity responsible for administering the claim for the political subdivision receives notice.

(h) ~~(i)~~ Each insurance carrier shall establish a single point of contact in the carrier's office for an injured employee for whom the carrier receives a notice of injury.

SECTION 5. This Act takes effect September 1, 2009.

G. Preauthorization and Compensability or Relatedness Issues

Currently, an insurance carrier can pursue a compensability or relatedness issue after the preauthorization process is concluded. In the event that the determination is made that the treatment or service was provided for an injury or diagnosis that was not part of the compensable injury, the insurance carrier is not liable for the cost of the treatment even though it was preauthorized. However, if the insurance carrier was required to either pursue its compensability or relatedness issue at the same time and in the same proceeding that addresses the medical necessity issue or waive the right to purse that issue for the proposed treatment or service, the medical necessity order would no longer be subject to such a collateral attack. If the amendment to Labor Code §413.014 is passed, it would reduce many complications for health care providers in the workers' compensation system and would likely encourage providers to return to the system.

The passage of the proposed amendment to Labor Code §413.014 would also have the benefit of adding efficiency to the dispute resolution system at DWC. The same hearing officers preside over both compensability/relatedness disputes and medical necessity disputes. As a result, the passage of the amendment to Labor Code §413.014 would result in only one hearing being held to resolve both issues rather than two separate hearings.

The amendment to Labor Code §413.031 would have the effect of ensuring that the independent review organization's (IRO) decision continues to address only the issue of whether a proposed treatment or health care service is reasonably required within the meaning of the workers' compensation statute, rather than permitting the IRO to give an opinion on compensability or relatedness. Because an examination of the injured employee is not part of the IRO process, the compensability or relatedness opinion would be of limited value. In addition, if the IRO were permitted to address compensability or relatedness issues, it could create a conflict with the opinion of a designated doctor that was appointed to address the issue of compensability or relatedness. Under Labor Code §413.031(m) "the decision of an independent review organization under Subsection (d) is binding during the pendency of a dispute." Similarly, Labor Code §408.0041(e) provides that "[t]he report of the designated doctor has presumptive weight unless the preponderance of the evidence is to the contrary" and subsection (f) states that the "insurance carrier

shall pay benefits based on the opinion of the designated doctor during the pendency of any dispute." In the event that the IRO and the designated doctor issue conflicting opinions on the issue of compensability or relatedness, the insurance carrier would be faced with conflicting decisions, both of which are binding during the pendency of the dispute. By specifying that the IRO decision cannot address the issue of compensability or relatedness, the potential for conflict between the opinion of the IRO and the designated doctor would be avoided.

Legislative Recommendation: OIEC recommends that Labor Code §413.014 be amended by adding a new subsection (f). The new subsection (f) would establish that an insurance carrier that does not raise a compensability or relatedness issue in either its initial denial or the denial of reconsideration of a requested treatment or service, it waives its right to raise a compensability or relatedness challenge to that specific treatment or service if the treatment or service is ultimately preauthorized in the medical dispute resolution process. The amendment further provides that if the insurance carrier raises compensability or relatedness in its preauthorization denials, the compensability or relatedness issue shall be resolved in the same hearing as the medical necessity issue at DWC.

This amendment would give a preauthorization decision in workers' compensation the same meaning that it has in group health. A health care provider could provide the preauthorized treatment or service with a certainty of payment that does not always accompany a preauthorization decision in workers' compensation.

A copy of the proposed bill follows.

Bill Number: _____ Date: _____

Author: _____

A BILL TO BE ENTITLED

AN ACT

relating to preauthorization of medical treatment in the workers' compensation system and medical dispute resolution by independent review organizations.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 413.014, Labor Code, is amended to read as follows:

Sec. 413.014. PREAUTHORIZATION REQUIREMENTS; CONCURRENT REVIEW AND CERTIFICATION OF HEALTH CARE. (a) In this section, "investigational or experimental service or device" means a health care treatment, service, or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care.

(b) The commissioner by rule shall specify which health care treatments and services require express preauthorization or concurrent review by the insurance carrier. Treatments and services for a medical emergency do not require express preauthorization.

(c) The commissioner's rules adopted under this section must provide that preauthorization and concurrent review are required at a minimum for:

(1) spinal surgery, as provided by Section 408.026;

(2) work-hardening or work-conditioning services provided by a health care facility that is not credentialed by an organization recognized by commissioner rules;

(3) inpatient hospitalization, including any procedure and length of stay;

(4) physical and occupational therapy;

(5) outpatient or ambulatory surgical services, as defined by commissioner rule; and

(6) any investigational or experimental services or devices.

(d) The insurance carrier is not liable for those specified treatments and services requiring preauthorization unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or ordered by the commissioner.

(e) If a specified health care treatment or service is preauthorized as provided by this section, that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service.

(f) If an insurance carrier does not include compensability or relatedness as a basis for either its initial denial of the preauthorization request or in the denial of reconsideration and the requested treatment or service is ultimately preauthorized as heath care reasonably required in medical dispute resolution, the insurance carrier waives the right to raise a future challenge to compensability or relatedness concerning the specific treatment or service at issue and approved in the preauthorization process. Nothing in this section should be construed as limiting an insurance carrier's ability to raise a compensability or relatedness challenge concerning income benefits or medical benefits not included in the preauthorization request. If the insurance carrier raises a compensability or relatedness issue in its denials of preauthorization, that issue shall be considered and resolved in the same hearing that addresses the issue of whether the requested treatment or service is health care reasonably required under the statute.

(g)~~(f)~~ The division may not prohibit an insurance carrier and a health care provider from voluntarily discussing health care treatment and treatment plans and pharmaceutical services, either prospectively or concurrently, and may not prohibit an insurance carrier from certifying or agreeing to pay for health care consistent with those agreements. The insurance carrier is liable for health care treatment and treatment plans and pharmaceutical

services that are voluntarily preauthorized and may not dispute the certified or agreed-on preauthorized health care treatment and treatment plans and pharmaceutical services at a later date.

SECTION 2. Section 413.031, Labor Code, is amended to read as follows:

Sec. 413.031. MEDICAL DISPUTE RESOLUTION.

(a) – (c) No Change.

(d) A review of the medical necessity of a health care service requiring preauthorization under Section 413.014 or commissioner rules under that section or Section 413.011(g) shall be conducted by an independent review organization under Chapter 4202, Insurance Code, in the same manner as reviews of utilization review decisions by health maintenance organizations. The independent review organization's decision is limited to whether or not the proposed treatment or service is health care reasonably required. The independent review organization shall not consider or address issues of compensability or relatedness. It is a defense for the insurance carrier if the carrier timely complies with the decision of the independent review organization.

(e) - (n) No Change.

SECTION 3. This Act takes effect September 1, 2009.

H. Confidentiality of Independent Review Organization (IRO) and Letters of Clarification to the IRO

HB 1003 and 1006, 80th Texas Legislature, 2007, provided clarification that all workers' compensation health care providers shall have a Texas license. This directive includes the doctors used by IROs to perform review of whether proposed health care treatment or services are reasonably required. Insurance Code §4204.009 currently provides that the identity of those doctors remains confidential. As a result, the parties to medical dispute resolution cannot verify that the IROs are complying with the legislative mandate. In HB 724, 80th Texas Legislature, 2007, the legislature also reintroduced an administrative medical dispute resolution process. As a part of this process, the qualifications of health care providers becomes essential information in resolving the dispute because the administrative judges who preside over medical dispute resolution hearings are required to make credibility determinations in deciding which health care provider's opinion to credit. A health care provider's identity and qualifications relative to qualifications of the other health care providers providing an opinion are critical to that process.

As per Texas Administrative Code §133.308(t)(1)(B)(iv), DWC created a process for seeking clarification of the IRO decision. The rule provides that the IRO shall not reconsider its decision and shall not issue a new decision in response to a request for clarification.

Legislative Recommendation: OIEC recommends that Insurance Code §4202.009 be repealed. Insurance Code §4204.009 currently provides that the identity of the doctors used by IROs to perform a review of whether proposed health care treatment or services are reasonably required is confidential. Therefore, the parties to medical dispute resolution cannot verify that the IROs are complying with the legislative mandate.

The current process for seeking clarification of the IRO decision is flawed and incomplete because DWC's rule provides that the IRO shall not reconsider its decision and shall not issue a new decision in response to a request for clarification. In most instances where clarification is sought, the IRO is either being asked to consider information that was not provided by the carrier or to consider other evidence-based medicine and to determine the effect of that information on the decision. However, if that information would result in a determination that the initial decision is incorrect, the IRO is prohibited from changing the decision. As a result, the process is meaningless. Therefore, OIEC recommends that a process for seeking clarification of the IRO decision be created.

A copy of the proposed bill follows.

Bill Number: _____ Date: _____

Author: _____

A BILL TO BE ENTITLED

AN ACT

relating to the decisions of independent review organizations in workers' compensation.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 4202.009 of the Insurance Code is repealed.

~~Sec. 4202.009. CONFIDENTIAL INFORMATION. Information that reveals the identity of a physician or other individual health care provider who makes a review determination for an independent review organization is confidential.~~

SECTION 2: Section 413.031(m), of the Labor Code is amended as follows:

(m) The decision of the independent review organization under Subsection (d) is binding during the pendency of a dispute. Prior to a contested case hearing, a party may submit a request for a letter of clarification by the independent review organization. A copy of the request for a letter of clarification shall be sent to all parties involved in a dispute. A request for clarification may ask the independent review organization to reconsider its decision or issue a new decision. Upon receiving such a request for clarification, the independent review organization shall reconsider the issue in dispute and issue a new decision.

SECTION 3. This Act takes effect September 1, 2009.

I. Repeal of 90-day Provision

Currently Labor Code §401.011(30) provides that "Maximum Medical Improvement" means the earlier of:

(A) the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated;
(B) the expiration of 104 weeks from the date on which income benefits begin to accrue; or
(C) the date determined as provided by Section 408.104 [spinal surgery after the expiration of 104 weeks].

The Supreme Court in the case of *Texas Workers' Compensation Commission v. Garcia*, considered an equal protection challenge to the statutory limitation of 104 weeks for a claimant to receive temporary income benefits. *Texas Workers' Compensation Commission v. Garcia*, 893 S.W.2d 504, Tex. S. Ct. (1995). At that time, the Texas Workers' Compensation Commission (TWCC) had not adopted a 90-day provision and neither was it part of the statute. The *Garcia* court stated:

> "First, it is not apparent that the Act's definition of "maximum medical improvement" creates any classification, as it merely establishes what is, in essence, a two-year cap on temporary income benefits for *all* claimants. Second, even if it could be viewed as creating a cognizable class, it is not irrational. The Legislature could have concluded that some absolute limit on temporary income benefits-*which constitute a major benefit under the Act,* -was a necessary component of an efficient compensation system. Two years is not an arbitrary place to draw the line, as there was medical testimony at trial that most workers will actually reach maximum medical recovery within that time period." (Emphasis added).

The Supreme Court has also stated that the "open courts" provision is "premised upon the rationale that the legislature has no power to make a remedy by due course of law contingent upon an impossible condition… The Legislature is not entitled to restrict or abrogate a common-law cause of action *without a reasonable basis and without providing an adequate substitute." Moreno v. Sterling Drug, Inc.*, 787 S.W.2d 348, (Tex. 1990). (Emphasis added).

In the case of *Fulton v. Associated Indem. Corp.*, the court considered a challenge to the 90 day rule that had been enacted by the TWCC. *Fulton v. Associated Indem. Corp.*, 46 S.W.3d 364 (Tex. App. - Austin 2001, pet. denied). The challenge asserted that the requirement that a claimant must dispute a determination of maximum medical improvement with a concurrent impairment rating within 90 days was beyond the Commission's rule making authority. The court stated:

> "The supreme court noted that temporary income benefits are "a major benefit" under the Act, and restricting those benefits to a two-year period was only justified by medical testimony that most workers' condition stabilize within that time frame. Under this rationale, a rule that cuts off temporary income benefits before the workers' condition has had two years to stabilize might be deemed arbitrary and might call into question the adequacy of the entire statutory quid pro quo approved in *Garcia*."

In the 78th Texas Legislature, 2003, Labor Code §408.123(e) was amended to state that an employee's first certification of maximum medical improvement (MMI) and impairment rating (IR) would be final if not disputed "prior to the 91st day after the date written notification is provided to the employee and the carrier by verifiable means." TEX. LAB. CODE §408.123(e). The statute did provide for the claimant to dispute MMI and IR after the 90th day if there was a "significant error" by the certifying doctor, there was a "mistaken diagnosis or a previously undiagnosed condition," or "improper or inadequate treatment of the injury."

Garcia clearly states that there is two-year cap on temporary income benefits for all injured employees. The *Garcia* and *Fulton* courts both recognized that having 104 weeks for the injury to stabilize is a major benefit to the injured employee. In essence, the *Fulton* court asserts that if the 104-week period were procedurally shortened, it would call into question the constitutionality of the Texas Workers' Compensation Act.

Legislative Recommendation: It is proposed that the 90-day provision be repealed. There is no discernable justification for the 90-day provision other than to deprive the injured employee the full 104-week period for their condition to stabilize. As the Supreme Court has stated, expert medical evidence was presented at the original *Garcia* trial finding that most injuries would stabilize within two years and that the opportunity to have that stabilization period was a major benefit considered in the quid pro quo determination of the constitutionality of the statute. A serious constitutional issue is presented by denying the injured employee an opportunity to receive a reasonable substitute for the loss of his constitutional right to seek redress for his injuries.

A copy of the proposed bill follows.

Bill Number: _____ Date: _____

Author: _____

A BILL TO BE ENTITLED

AN ACT

relating to certification of maximum medical improvement and evaluation of impairment in the workers' compensation system.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 408.123, Labor Code, is repealed.

~~Sec. 408.123. CERTIFICATION OF MAXIMUM MEDICAL IMPROVEMENT; EVALUATION OF IMPAIRMENT RATING. (a) After an employee has been certified by a doctor as having reached maximum medical improvement, the certifying doctor shall evaluate the condition of the employee and assign an impairment rating using the impairment rating guidelines described by Section 408.124. If the certification and evaluation are performed by a doctor other than the employee's treating doctor, the certification and evaluation shall be submitted to the treating doctor, and the treating doctor shall indicate agreement or disagreement with the certification and evaluation.~~

~~(b) A certifying doctor shall issue a written report certifying that maximum medical improvement has been reached, stating the employee's impairment rating, and providing any other information required by the commissioner to:~~

~~(1) the division;~~

~~(2) the employee; and~~

~~(3) the insurance carrier.~~

~~(c) The commissioner shall adopt a rule that provides that, at the conclusion of any examination in which maximum medical improvement is certified and any impairment rating is assigned by the treating doctor, written notice shall be given to the employee that the~~

~~employee may dispute the certification of maximum medical improvement and assigned impairment rating. The notice to the employee must state how to dispute the certification of maximum medical improvement and impairment rating.~~

~~(d) If an employee is not certified as having reached maximum medical improvement before the expiration of 102 weeks after the date income benefits begin to accrue, the division shall notify the treating doctor of the requirements of this subchapter.~~

~~(e) Except as otherwise provided by this section, an employee's first valid certification of maximum medical improvement and first valid assignment of an impairment rating is final if the certification or assignment is not disputed before the 91st day after the date written notification of the certification or assignment is provided to the employee and the carrier by verifiable means.~~

~~(f) An employee's first certification of maximum medical improvement or assignment of an impairment rating may be disputed after the period described by Subsection (e) if:~~

~~(1) compelling medical evidence exists of:~~

~~(A) a significant error by the certifying doctor in applying the appropriate American Medical Association guidelines or in calculating the impairment rating;~~

~~(B) a clearly mistaken diagnosis or a previously undiagnosed medical condition; or~~

~~(C) improper or inadequate treatment of the injury before the date of the certification or assignment that would render the certification or assignment invalid; or~~

~~(2) other compelling circumstances exist as prescribed by commissioner rule.~~

~~(g) If an employee has not been certified as having reached maximum medical improvement before the expiration of 104 weeks after the date income benefits begin to accrue or the expiration date of any extension of benefits under Section 408.104, the impairment rating assigned after the expiration of either of those periods is final if the~~

~~impairment rating is not disputed before the 91st day after the date written notification of the certification or assignment is provided to the employee and the carrier by verifiable means. A certification or assignment may be disputed after the 90th day only as provided by Subsection (f).~~

~~(h) If an employee's disputed certification of maximum medical improvement or assignment of impairment rating is finally modified, overturned, or withdrawn, the first certification or assignment made after the date of the modification, overturning, or withdrawal becomes final if the certification or assignment is not disputed before the 91st day after the date notification of the certification or assignment is provided to the employee and the carrier by verifiable means. A certification or assignment may be disputed after the 90th day only as provided by Subsection (f).~~

SECTION 2. This Act takes effect September 1, 2009.

V. Conclusion

HB 7's overhaul to the workers' compensation system encourages open communication between system participants in an effort to create a workers' compensation system that serves as a national model. HB 7 incorporated the Sunset Commission's recommendations to:

- abolish TWCC and transfer regulatory functions to TDI while transferring administrative functions for the injured employee to OIEC;
- streamline the system's processes;
- establish workers' compensation health care networks as the new vehicle for health care delivery for injured employees; and
- refine focus on return to work.

The Legislature added other provisions that enhance TDI's regulatory oversight over workers' compensation prices to the benefit of Texas' employers, address medical cost containment through requiring treatment and return to work guidelines, and limit the use of post-injury cause of action waivers, and create OIEC to protect the rights of the injured employees of Texas.

Through these system enhancements, HB 7 provides transparency to a complex workers' compensation system where injured employees struggled to navigate the system in an effort to obtain appropriate income and medical benefits. OIEC supports and is committed to HB 7's vision to encourage prompt and sustained return to work through the delivery of prompt and appropriate medical care. OIEC is proud to be a part of this reform that emphasizes the need for an advocacy agency to protect the interests of injured employees and the need for injured employees to be treated with dignity and respect. OIEC believes that the system changes implemented by HB 7 provide significant progress toward creating a fair and balanced workers' compensation system where injured employees receive necessary income and medical benefits, get better, and return to work.

> ***Creation of the Office of Injured Employee Counsel (OIEC).*** *For the first time, the State will have a dedicated agency with the sole focus of helping injured employees. OIEC will oversee the ombudsman program and advocate for the interests of injured employees on key rules and policies, to ensure balance and fairness for all in the system.*
>
> Source: Governor's Office Website