RULES OF THE TEXAS WORKERS' COMPENSATION COMMISSION
(OLD LAW)

TEXAS ADMINISTRATIVE CODE

TITLE 28. INSURANCE

PART II

Texas Workers' Compensation Commission 1990

(REV.7/90)

Published 3/89
1st Revision 2/90
2nd Revision 7/90

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SUBCHAPTER A. COMMUNICATIONS

Sec. 41.1. Name change. Pursuant to Senate Bill 1 (71st Legislature, 2nd Called Session, 1989), the following revisions are effective April 1, 1990:

(a) The state agency known since 1913 as the Industrial Accident Board is re-named the Texas Workers' Compensation Commission. Wherever the term "Industrial Accident Board," "Board," or "board," meaning the agency, appears in these rules, it shall mean "Texas Workers' Compensation Commission".

(b) The executive director of the Texas Workers' Compensation Commission exercises all authority necessary to administer Texas Civil Statutes, Articles 8306 through 8309-1. Wherever the terms "Industrial Accident Board" or "Board," meaning one or more members of Industrial Accident Board, appears in these rules, the terms shall mean the executive director or delegatee.

The provisions of this Sec. 41.1 adopted on an emergency basis to be effective April 2, 1990, 15 TexReg 1922.

Sec. 41.5. Compliance and Suspension of Rules.

All parties seeking any action of the board shall comply with these rules, unless in its judgment the board determines that compliance with any of the rules under particular circumstances will result in injustice to either or both parties. Accordingly, rules may be suspended at the discretion of the board and additional hearings held or cases scheduled for hearing out of their regular order.

The provisions of this Sec. 41.5 adopted to be effective November 20, 1977, 2 TexReg 4315.

Sec. 41.8. Contents of Rule-Making Petitions.

(a) Changes to these rules may be petitioned by any party. Rule-making petitions shall contain the following:

(1) a brief statement summarizing the proposed section;

(2) the text of the proposed section:

(A) if an existing section, state the title and code number, and prepare the text to indicate the words and punctuation to be added, changed, or deleted;

(B) if a new section, prepare the text in the exact form proposed for adoption;

(3) a statement of the statutory source of the section;

(4) a suggested effective date;

(5) a cost-benefit analysis, estimating the public benefits to be expected as a result of adoption of the proposed section, and the probable economic cost to persons who are required to comply with the section. This provision is optional;

(6) any other matter required by law;

(7) the petitioner's name, complete mailing address, and telephone number; and

(8) the petitioner's signature.

(b) Five copies of the petition shall be filed with the board by certified mail.

(c) Within 60 days after the petition is submitted, the board shall either initiate rulemaking procedures, or notify the petitioner in writing, stating the reasons for denial.

The provisions of this Sec. 41.8 adopted to be effective November 6, 1986, 11 TexReg 4429.

Sec. 41.25. Attorney Identification.

Each attorney engaged by either a claimant, insurance carrier, or self-insured in connection with the handling of a workers' compensation claim shall provide the board with his/her permanent State Bar Identification number promptly upon retention in the claim.

The provisions of this Sec. 41.25 adopted to be effective November 11, 1983, 8 TexReg 4491.

Sec. 41.27. Employer's Identification.

Each carrier and employer shall provide the employer's federal tax identification number on:

(1) the employer's first report of injury;

(2) the employer's supplemental report of injury;

(3) the wage statement;

(4) a Form A-1, A-2, and A-4 (initial filing only);

(5) a statement of controversion;

(6) a notice that employer has become subscriber, Form IAB-20;

(7) a cancellation or nonrenewal notice for workers' compensation insurance, Form IAB-9; and

(8) other forms as the board shall direct.

The provisions of this Sec. 41.27 adopted to be effective December 21, 1987, 12 TexReg 4528.

Sec. 41.30. Self-Insureds.

Unless otherwise specifically noted herein, whenever a board rule makes reference to an insurance carrier or association, this shall be interpreted to include all self-insured entities as well.

The provisions of this Sec. 41.30 adopted to be effective November 11, 1983, 8 TexReg 4191.

Sec. 41.35. Designation of Insurance Carrier's Austin Representative.

All insurance carriers writing and issuing workers' compensation insurance policies effective in Texas shall designate in writing to the board their Austin, Texas, representative to the Industrial Accident Board for purposes of communication with the board. The name, business address, and phone number of such representative shall be supplied and kept current at all times. Written notification or communication by the board with such representative shall be deemed notification to the carrier for all purposes.

The provisions of this Sec. 41.35 adopted to be effective November 11, 1983, 8 TexReg 4491.

Sec. 41.40. General Policy Concerning Communications.

The board hereby promulgates its general policy concerning communications to and from the Industrial Accident Board:

(1) The carrier shall send a copy of all written communications relating to a pending claim before the board to the claimant, or if claimant is represented by counsel, directly to his attorney, and to the board. Without limiting the generality of the foregoing, the term "written communications" shall include board approved Forms A-1, A-2, A-4, and A-2 Lump Sum Transmittal Letter, Statements of Controversion, and Notices of Intention to Appeal.

(2) The attorney representing the claimant shall send a copy of all written communications relating to a pending claim before the board to the insurance carrier and to the board.

Without limiting the generality of the foregoing, the term "written communication" shall include written claim for compensation, affidavit of hardship, power of attorney, and notice of appeal.

The provisions of this Sec. 41.40 adopted to be effective November 11, 1983, 8 TexReg 4491.

Sec. 41.45. Communication to Claimants.

All notices and written communications to claimant will be mailed to the last address supplied, either on the employer's first report of injury or by claimant's letter. If the board is notified that claimant is represented by an attorney, copies of forms, notices, and correspondence will thereafter be mailed to his attorney and not to the claimant. However, copies of compromise settlement approval notices, pre-hearing setting, and awards of the board will be mailed to the claimant and his attorney.

The provisions of this Sec. 41.45 adopted to be effective November 11, 1983, 8 TexReg 4491.

Sec. 41.50. Carrier's Address.

Unless otherwise approved by the board, all notices and communications to insurance carriers will be addressed to the carrier at an address designated by the carrier as its Texas mailing address.

The provisions of this Sec. 41.50 adopted to be effective November 20, 1977, 2 TexReg 4315.

Sec. 41.55. Communication to Employers.

All notices and written communications to employers, including notice of conduct which may result in the imposition of a statutory penalty by the board, will be mailed to the last address supplied either on the employer's first report of injury form or on the notice that the employer has become a subscriber form.

The provisions of this Sec. 41.55 adopted to be effective November 11, 1983, 8 TexReg 4491.

Sec. 41.60. Communication to Insurance Carriers.

Unless otherwise required by statute, or provided by a board rule, all notices and other communications to insurance carriers will be sent either to an address designated by the carrier as its principal Texas mailing address or to its designated Austin representative.

The provisions of this Sec. 41.60 adopted to be effective November 11, 1983, 8 TexReg 4491.

Sec. 41.65. Communication to Health Care Provider.

A health care provider shall send a copy of all written communications relative to a pending claim for compensation and the treatment thereof or concerning a statement for professional services rendered to the insurance carrier and to the claimant or his attorney, if represented.

The provisions of this Sec. 41.65 adopted to be effective November 11, 1983, 8 TexReg 4491.

Sec. 41.70. Filing of Instruments.

(a) The following shall be filed only with the board in Austin:

(1) Notice of injury and claim for compensation (Texas Civil Statutes, Article 8307, Sec. 4a);

(2) Employer's first report of injury (Texas Civil Statutes, Article 8307, Sec. 7);

(3) Employer's response to board request for information (Texas Civil Statutes, Article 8307, Sec. 7);

(4) Notice that employer has become subscriber (Texas Civil Statutes, Article 8308, Sec. 18a);

(5) Response to request for notice that employer has become subscriber (Texas Civil Statutes, Article 8308, Sec. 18a);

(6) Notice of cancellation or nonrenewal of compensation insurance (Texas Civil Statutes, Article 8308, Sec. 20a);

(7) Form A-1, Report of Initial Payment of Compensation (Texas Civil Statutes, Article 8306, Sec. 3b);

(8) Statement of controversion (Texas Civil Statutes, Article 8306, Sec. 18a(a));

(9) Application to suspend compensation (Texas Civil Statutes, Article 8306, Sec. 12a, and Article 8307, Sec. 4);

(10) Formal statements of position (Texas Civil Statutes, Article 8307, Sec. 10);

(11) Statement of position in death cases (Texas Civil Statutes, Article 8306, Sec. 18a(a));

(12) Notice of intention to appeal (Texas Civil Statutes, Article 8307, Sec. 5);

(13) Response to notice of possible violation (Texas Civil Statutes, Article 8306, Sec. 18a(a));

(14) Carrier's designation of board representative (Texas Civil Statutes, Article 8306, Sec. 18a).

(b) All other correspondence and forms relating to claims arising under the Workers' Compensation Law must be filed with the proper regional office or the proper resident reviewer of the board in Austin.

(c) Forms and printed materials used by any person or state agency which incorporate the term "Industrial Accident Board" shall be modified to substitute the term "Texas Workers' Compensation Commission" after the present supply of forms and materials is exhausted. Parties are encouraged to use revised forms by June 1, 1990.

The provisions of this Sec. 41.70 adopted to be effective November 11, 1983, 8 TexReg 4491; amended on an emmergency basis to be effective April 2, 1990, 15 TexReg 1922.

Sec. 41.75. Timely Filing.

Forms, reports, and other documents required to be filed before a specified time will be considered timely only if received by the board at Austin or at an appropriate regional office prior to or during business hours on the last permissible day of filing. When the last day for filing is a legal holiday, or is Sunday, then the time is extended so as to include the next succeeding business day.

The provisions of this Sec. 41.75 adopted to be effective November 11, 1983, 8 TexReg 4491.

Sec. 41.80. Filing Subsequent to Final Order or Award.

In order for it to continue monitoring a claim for future medical and compensation benefits after a final award, carriers must continue filing with the board in Austin, and in accordance with existing board rules, the following documents: A-1, A-2, A-4, notice of suspension of medical benefits, a copy of the instruments reflecting final disposition of the case, whether by compromise settlement agreement, court judgment, or dismissal without judgment entry, and upon request a copy of all available medical information.

The provisions of this Sec. 41.80 adopted to be effective November 11, 1983, 8 TexReg 4491.

Sec. 41.85. Translation of Documents.

Whenever a party submits or files a medical report, witness statement, or other instrument written in a foreign language, a true and correct English translation shall be filed simultaneously.

The provisions of this Sec. 41.85 adopted to be effective November 11, 1983, 8 TexReg 4491.

Sec. 41.90. Responsibility of Translators.

Whenever a non-English speaking party appears before the board or any member thereof at a prehearing conference or a formal hearing, a translator who is proficient in the English language must accompany the party. The responsibility for providing an interpreter rests with the party producing the non-English speaking witness.

The provisions of this Sec. 41.90 adopted to be effective November 11, 1983, 8 TexReg 4491.

Sec. 41.95. Wage Information.

The board will accept in lieu of other wage information a stipulated wage agreement executed by the injured employee and the insurance carrier which establishes by mutual agreement an average weekly wage and a weekly compensation rate on a standard form approved by the board. Such stipulation may be considered by the Industrial Accident Board, along with any other evidence concerning the wage rate, but it will not necessarily be binding upon the board. No action by the board on the claim shall be taken as formal approval of such stipulation, and the same shall be regarded only as an informal waiver of proof for purposes of the hearing before the board.

The provisions of this Sec. 41.95 adopted to be effective November 11, 1983, 8 TexReg 4491.

Subchapter B. Access to Board Records

Sec. 41.101. Purpose.

The purpose of this chapter governing inspection of board records is to ensure compliance with Texas Civil Statutes, Article 8307, Sec. 9a, and Texas Civil Statutes, Article 6252-17a, the Open Records Act.

The provisions of this Sec. 41.101 adopted to be effective October 7, 1988, 13 TexReg 4979.

Sec. 41.105. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

Custodian of the records of the Texas Industrial Accident Board--The executive director of the Texas Industrial Accident Board.

Deputy custodian of the records of the Texas Industrial Accident Board--A board employee authorized by the custodian to act in his behalf.

Records of the Texas Industrial Accident Board--

(A) Public records--All information collected, assembled, or maintained by the board that is not otherwise confidential by law.

(B) Confidential records--All information collected, assembled, or maintained by the board that is confidential by law, including but not limited to claim file information.

The provisions of this Sec. 41.105 adopted to be effective October 7, 1988, 13 TexReg 4979.

Sec. 41.110. Availability.

(a) The board's records shall be made available for inspection or duplication by applying in writing on a board-approved form to the custodian in Austin. The application must identify the document(s) to be disclosed, and the name and address of the applicant. All requests, including subpoenas, for confidential claim files must be accompanied by a statement of eligibility provided on a board-approved form. All applications for release of records must be approved by an authorized employee.

(b) Public records shall be made available for inspection or duplication pursuant to the provisions of the Open Records Act.

(c) Confidential claim file records shall be made available for inspection or duplication under the following conditions:

(1) If a claim is open or pending before the board; on appeal to a court; or the subject matter of a subsequent suit where the carrier has a right to subrogation, and the requestor is:

(A) the claimant;

(B) the claimant's attorney of record;

(C) the carrier;

(D) the employer against whom the claim was filed;

(E) third-party litigants in subsequent suits where the cause of action arises from the same occurrence that gave rise to the claim;

(F) the State Board of Insurance;

(G) the Department of Human Services;

(H) any other party entitled by law to the records.

(2) If the requestor files the claimant's signed waiver of confidentiality on a board-approved form.

(3) If the claimant has been finally adjudicated to be a fraudulent claimant.

The provisions of this Sec. 41.110 adopted to be effective October 7, 1988, 13 TexReg 4979.

Sec. 41.115. Inspection.

(a) The custodian shall designate an inspection area in the board's Austin office, and in the regional offices, as necessary, where persons inspecting records may be assisted by an employee. Inspection of the board's records shall be allowed during regular business hours.

(b) In the event the requested records are in active use, or in storage, the applicant shall be notified, and a date and hour set within a reasonable time when the requested materials will be available.

(c) There shall be no charge for inspection of the board's public records.

(d) The charge for inspection of claim files shall be $2.00 per file in the following instances only:

(1) the requested claim file is maintained on microfilm or microfiche, necessitating a film reader; or

(2) the requested claim file must be retrieved from the inactive records storage facility.

The provisions of this Sec. 41.115 adopted to be effective October 7, 1988, 13 TexReg 4979.

Sec. 41.120. Duplication and Related Services.

(a) Copies of any document on file with the board shall be furnished to eligible persons upon payment of the established fee.

(b) Payment must be made by cash, check, or money order. There will be no refund for less than $5.00 of monies paid by actual mistake in excess of the correct fee, or for copies of instruments not in the board's file, unless specifically requested in writing.

(c) The minimum time for processing requests for duplications of board records shall be five (5) working days from the date received. 24-hour expedited handling is available upon request for an additional charge.

(d) No copies or certified copies of confidential records will be furnished between seven days prior to the date of the formal hearing and the date of the board's award.

(e) Postage. If copies are mailed, the cost of postage shall be added to the charge, unless otherwise provided.

(f) Sales tax. Sales tax shall be charged on publications as required.

The provisions of this Sec. 41.120 adopted to be effective October 7, 1988, 13 TexReg 4979.

Sec. 41.125. Duplicating Charges.

(a) Photocopies of standard sized pages.

(1) Readily available public records:

(A) 50 pages or less .... $ .10 per page

(B) over 50 pages .... $ .85 for the 1st page; $ .15 for subsequent pages

(2) Not readily available public records ... $1.00 for the 1st page; $ .30 for subsequent pages

(3) Confidential records .... $1.00 for the 1st page; $ .30 for subsequent pages

(b) Copies of records maintained in computer banks.

(1) Equipment costs:

CPU time:	Batch	$28.75/hr.
	TP	$16.80/hr.
Printer		$1.00/1000 lines

(2) Personnel costs:

Programming	$20.30/hr.
Data entry and/or control	$10.65/hr.
Systems analysis	$20.30/hr.

(c) Copies of microfilm or microfiche records.

(1)	Standard sized pages	$1.00 for the 1st page; $ .30 for subsequent pages
(2)	Fiches	$4.00 each

(d) Copies of audiotapes .... $6.25 each

(e) Expedited handling. Upon request, the board will provide 24-hour expedited handling of requests for photocopies. The charge for this service shall be $25.00.

The provisions of this Sec. 41.125 adopted to be effective October 7, 1988, 13 TexReg 4979.

Sec. 41.130. Certified Copies.

(a) Upon request, the board shall certify a copy of any record provided. Such certification complies with statutory requirements regarding authentication and admissibility. The charge for certification shall be $1.00. If the record to be certified consists of duplicated pages, the charge shall be $1.00 per page of the record, plus $1.00 for the certificate.

(b) If an award has been appealed, the board shall, upon request of any interested party, furnish at no cost a certified copy of the notice that an employer has become a subscriber.

The provisions of this Sec. 41.130 adopted to be effective October 7, 1988, 13 TexReg 4979.

Sec. 41.135. Subpoenas For Confidential Records.

(a) The board shall comply with valid subpoenas for confidential records from eligible persons. A statement of eligibility must accompany the subpoena.

(b) Subpoenas must be addressed to the subpoena clerk, board's Austin office.

(c) The minimum reasonable time for processing subpoenaed records is five working days.

(d) Authentication. Certification by the records custodian, as authorized by the workers' compensation act, complies with statutory requirements for authentication and admissibility. If additional authenticating instruments are desired, the charge for handling and notarization shall be $5.00 per instrument.

The provisions of this Sec. 41.135 adopted to be effective October 7, 1988, 13 TexReg 4979.

Sec. 41.140. Record Checks.

The board shall provide eligible persons with certain information regarding individuals' claims records. The charges for record checks are as follows:

(1) 5 year record check
(excludes No Lost Time Claims) .... $ 5.00

(2) 10 year record check
(excludes NLT's) $20.00

(3) Lifetime record check
(1960-present; includes NLTs) $50.00

These charges include postage.

The provisions of this Sec. 41.140 adopted to be effective October 7, 1988, 13 TexReg 4979.

Sec. 41.150. Publications.

The following are charges for specified board publications.

(1) Procedure Manual chapters .... standard charge for copies of public records, according to length

(2) Board rules .... " "

(3) SDS tables .... " "

(4) "Facts for Injured Workers" .... $40.00 per 1000

(5) "Official Medical Fee Guidelines" $12.50

(6) "Official Hospital Fee Guidelines" $12.50

(7) "Official Pharmaceutical Fee Guidelines" .. $ 1.00

(8) Summary of Legislation. Subsequent to each legislative session, the board publishes summaries of workers' compensation-related legislation. The charge shall be set each year, at the standard charge for copies of public records, according to the length of the summary.

The provisions of this Sec. 41.150 adopted to be effective October 7, 1988, 13 TexReg 4979.

Sec. 41.155. Service of Process.

The chairman of the Industrial Accident Board is agent for service of process on nonresident employers. The charge for effecting service of process is the actual cost. Upon request, the chairman will certify performance of this statutory duty. The charge for such certification shall be $25.00.

The provisions of this Sec. 41.155 adopted to be effective October 7, 1988, 13 TexReg 4979.

Sec. 41.160. Annual Review of Charges.

The charges established in this subchapter shall be subject to annual review, and revision as needed.

The provisions of this Sec. 41.160 adopted to be effective October 7, 1988, 13 TexReg 4979.

CHAPTER 42. MEDICAL BENEFITS

SUBCHAPTER A. GENERAL MEDICAL PROVISIONS

Sec. 42.5. Applicability and Scope of Rules.

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SUBCHAPTER B. MEDICAL COST EVALUATION

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SUBCHAPTER A. GENERAL MEDICAL PROVISIONS

Sec. 42.5. Applicability and Scope of Rules.

(a) General. These rules govern all providers of health care services and supplies covered under the Texas Workers' Compensation Act ("the Act").

(b) Out-of-state providers. Out-of-state providers of health care services and supplies covered under the Act are governed by these rules.

(c) Effective date. These rules shall be applicable to all services and supplies provided subsequent to November 1, 1988.

The provisions of this Sec. 42.5 adopted to be effective October 20, 1988, 13 TexReg 4990.
See Texas Civil Statutes, Article 8306, Sec. 7b; Article 8307, Sec. 4.

Sec. 42.10. Acceptance of Rules and Guidelines.

The filing by a health care provider of a report, the submitting of a bill for services or supplies, or the rendering of treatment to an injured worker entitled to benefits under the Act constitutes acceptance of and agreement to comply with these rules.

The provisions of this Sec. 42.10 adopted to be effective October 20, 1988, 13 TexReg 4990.

Sec. 42.15. Definitions.

The following words and terms, when used in this part, shall have the following meanings, unless the context clearly indicates otherwise:

Accrual of medical benefits--The right to medical benefits for a compensable injury accrues as of the date of injury and continues for the life of the injured worker, or until terminated by agreement between the injured worker and the carrier, and is limited in amount only according to the reasonableness of the expense and the necessity of the treatment.

Act--Texas Civil Statutes, Articles 8306 through 8309i.

Association--See "carrier."

Billing by report--The billing procedure to be used by a health care provider when:

(A) no procedural definition and/or dollar value is established in the board's fee guidelines for the treatment or service rendered; or

(B) when the provider determines that the procedural definition and/or dollar value established in the fee guidelines does not adequately describe the treatment or service rendered. (See Sec. 42.145 of this chapter, relating to Billing.)

Board--The Industrial Accident Board of the State of Texas.

Carrier--Shall be synonymous with "association," as defined in Texas Civil Statutes, Article 8309, Sec. 1, to mean any insurance company or entity authorized to insure payment of workers' compensation, including political subdivisions, the State of Texas, the University of Texas, Texas A & M University, and the State Department of Highways and Public Transportation.

Carrier review and audit of individual provider's bills--

(A) *Carrier review of individual provider's bill*--A careful screening of a bill, as submitted, with minimal supporting medical documentation. Attention is given to relation of date of accident to date of treatment; relation of treatment to injury; proper itemization; correct/appropriate coding; duplicate charges; correct addition; and compliance with fee and utilization guidelines. May result in audit. Performed at the office of the carrier or carrier-audit representative.

(B) *Carrier audit of individual provider's bill*--A detailed, line-by-line examination of billed charges, comparing charges to services rendered, using maximum medical documentation such as daily PT, and progress and/or clinic notes. Performed at the office of the carrier or carrier-audit representative. Also known as a "desk audit."

Carrier review and audit of hospital bills--

(A) *Carrier review of hospital's bill*--A careful, selective screening of a hospital bill, as submitted, with minimal supporting medical documentation. Attention is given to correct/appropriate coding; computer errors; duplicate charges; potential unrelated charges; and compliance with fee and utilization guidelines. May result in audit. Performed at the office of the carrier or carrier-audit representative.

(B) *Carrier audit of hospital's bill*--A line-by-line examination of billed charges, comparing the doctor's orders with supporting medical documentation in the patient's chart. Performed either at the office of the carrier or carrier-audit representative ("desk audit") or at the hospital ("on-site audit").

Claimant--The worker or health care provider making a claim. The health care provider may be a derivative or independent claimant.

Compensable injury--Any injury having to do with and originating in the work, business, trade, or profession of the subscriber, received by an employee while engaged in or about the furtherance of the affairs or business of the subscriber, either upon the subscriber's premises or elsewhere.

Consulting doctor--A licensed doctor who examines a worker, or the worker's medical record, at the request of the treating doctor to aid in diagnosis and/or treatment, and who may, at the request of the treating doctor, provide specialized treatment of the compensable injury or illness.

Doctor--A licensed practitioner of medicine, osteopathy, chiropractic, or podiatry.

Health care provider ("provider")--A health care provider is:

(A) a doctor or other person duly licensed to practice one or more of the healing arts within the limits of the license of the licentiate;

(B) a health facility; and

(C) an entity providing health care which is covered under the act.

Health facility--A health facility is:

(A) a general or specialty hospital providing inpatient and outpatient services, whether licensed by the Texas Department of Health or the Texas Department of Mental Health and Mental Retardation;

(B) an outpatient surgery center not covered by a hospital's license, other than a physician's office, and licensed by the Texas Department of Health; and

(C) an outpatient imaging center not covered by a hospital's license, other than a physician's office, which provides radiographic, computerized tomography, magnetic resonance imaging, or other diagnostic imaging services.

Independent medical exam--See "medical exam order."

Injured worker's representative--Any person designated in writing by the injured worker to assist him or her in pursuing a claim for compensation.

Liability for medical services--This is the sole responsibility of the carrier prior to final disposition of a claim to pay fair and reasonable charges for necessary medical services rendered to an injured worker. This is the responsibility of the injured worker:

(A) after final disposition of a claim for services that are not related to the compensable injury;

(B) for services not related to the compensable injury; and

(C) for services rendered after the liability of the carrier has been terminated.

Maximum medical recovery--Exists when no further improvement in the injured worker's health is reasonably expected from additional medical treatment or the passage of time.

Medical exam order (also known as "independent medical exam")--An order of the board requiring a claimant to present him or herself to be examined by a physician or chiropractor. The board may enter a medical exam order either on its own motion, or at the carrier's request. The claimant has the right to have his or her doctor present during a carrier-requested examination, the cost of which shall be borne by the carrier.

Medical report--A board-approved form or narrative letter that transmits medical information. Reports must include all relevant information. (See Secs. 42.35 - 42.50 of this subchapter, relating to required reports.)

Small rural hospital--A general hospital licensed for less than 100 beds which is located in a county classified as rural by the Health Care Financing Administration for purposes of Medicare reimbursement.

Subscriber--Any employer who has obtained workers' compensation insurance coverage. This includes all political subdivisions, the State of Texas, the University of Texas, Texas A & M University, and the State Department of Highways and Public Transportation.

Treating doctor--A doctor who is primarily responsible for the treatment of a worker's compensable injury or illness.

The provisions of this Sec. 42.15 adopted to be effective October 20, 1988, 13 TexReg 4990; amended on an emergency basis to be effective February 7, 1989; amended to be effective May 11, 1989, 14 TexReg 2082.

See Texas Civil Statutes, Article 8306, Secs. 6 and 7; Article 8307, Sec. 4; Article 8309, Secs. 1 and 6; Articles 8309b, 8309d, 8309g, 8309g-1, 8309h, and 6674s.

Sec. 42.20. Who May Treat.

(a) Licensed doctors of medicine, osteopathy, chiropractic and podiatry may act as treating doctors for injured workers entitled to benefits under the Act.

(b) Treating doctors may prescribe treatment to be rendered by other persons licensed to provide health care, or by persons not licensed to provide health care who work under the direct supervision and control of the treating doctor.

(c) Treating doctors may prescribe nursing care to be rendered by unlicensed persons, including but not limited to members of the injured worker's family.

The provisions of this Sec. 42.20 adopted to be effective October 20, 1988, 13 TexReg 4990.

See Texas Civil Statutes, Article 8306, Sec. 7; Article 8309, Sec. 6.

Sec. 42.25. Prohibited Practices.

(a) The following, when committed knowingly or willfully, shall be deemed prohibited practices by health care providers, and may result in action by the board, including referral to professional grievance committees, licensing agencies, or the Attorney General's office:

(1) Failing, neglecting, or refusing to observe and comply with the board's rules.

(2) Failing, neglecting, or refusing to submit complete, adequate, and detailed reports, when required, or to respond to requests by the carrier, the claimant or claimant's representative, or the board for additional reports or other claim-related information. (See Sec. 42.33(c) of this subchapter, relating to Health Care Providers' Reporting Requirements.)

(3) Submitting false or misleading reports, or colluding with other persons in the submission of false or misleading reports.

(4) Submitting inaccurate or misleading bills.

(5) Repeated overcharging.

(6) Knowingly submitting a bill to an injured worker for treatment of a compensable injury or illness.

(7) Charging or attempting to charge fees for required reports, handling fees, interest, or any surcharge whatsoever to an injured worker for treatment of a compensable injury or illness.

(8) Persistently using contraindicated or hazardous treatment measures.

(9) Repeated overutilization.

(10) Using or prescribing narcotic, addictive or dependency-inducing drugs for other than therapeutic purposes.

(11) Practicing after suspension or revocation of a provider's practice privilege by the appropriate licensing agency, after conviction in any court of any offense involving moral turpitude, or after a declaration of mental incompetency by a court of competent jurisdiction.

(b) Written allegations of repeated overcharging (<u>See</u> (5) of subsection (a) of this section), or repeated overutilization (<u>See</u> (9) of subsection (a) of this section) shall be referred to appropriate regulatory agencies, pursuant to Texas Civil Statutes, Article 8306, Sec. 7b(m). Allegations should be accompanied by appropriate documentation.

The provisions of this Sec. 42.25 adopted to be effective October 20, 1988, 13 TexReg 4990.
<u>See</u> Texas Civil Statutes, Article 8306, Secs. 7 and 7b; Article 8307, Sec. 9a.

Sec. 42.28. Confirmation of Coverage.

The carrier shall confirm medical benefits coverage upon the request of a health care provider when no bona fide dispute exists as to liability.

The provisions of this Sec. 42.28 adopted to be effective December 6, 1988, 13 TexReg 5826.

Sec. 42.30. Written Communications.

(a) A health care provider shall send copies of all written communications related to a claim, including reports, to the carrier and, except for bills, to the injured worker or his or her representative. The provider may require written evidence of representative capacity from the claimant's representative.

(b) A provider shall submit bills for services or supplies to the carrier only. A provider shall send copies of bills to the injured worker, or his or her representative, only upon request.

(c) A provider shall send copies of all written communications, including reports and bills, to the board upon the board's request.

(d) All written communications from providers shall contain the following identifying information, if known:

(1) the patient's full name, address, and social security number;

(2) the patient's IAB claim number;

(3) the date and nature of the injury or illness;

(4) the employer's name and address;

(5) the carrier's name;

(6) the provider's name, address, and Federal Tax Identification number.

(e) A separate report or bill shall be filed for each injury.

(f) All written communications must be legible and reproducible.

The provisions of this Sec. 42.30 adopted to be effective October 20, 1988, 13 TexReg 4990.
See Texas Civil Statutes, Article 8306, Sec. 7.

Sec. 42.33. Health Care Providers' Reporting Requirements.

(a) Providers shall prepare written reports according to the specifications set out in the sections of this subchapter relating to required reports, and shall submit them to the carrier and the injured worker, or his or her representative, as provided in Sec. 42.30 of this subchapter (relating to Written Communications).

(b) All required reports shall contain the identifying information required by Sec. 42.30(d) of this subchapter (relating to Written Comminications).

(c) A provider who fails to comply with the reporting requirements, when applicable, as determined by the board, shall lose his or her right to payment for treatment or services rendered under the Act, pursuant to Texas Civil Statutes, Article 8306, Sec. 7.

(d) The board may prescribe forms for reporting purposes.

The provisions of this Sec. 42.33 adopted to be effective December 6, 1988, 13 TexReg 5826.

Sec. 42.35. Required Reports: First Report.

(a) The treating doctor shall make an initial report, and submit it to the carrier and the injured worker, or his or her representative, as provided in Sec. 42.30 of this subchapter (relating to Written Communications) no later than seven working days after the injured worker's first visit.

(b) The first report shall contain the following information:

(1) All identifying information required by Sec. 42.30(d) of this subchapter (relating to Written Communications);

(2) complete history, as related by the claimant, of the occupational accident or illness;

(3) complete listing of positive physical findings;

(4) specific diagnosis with appropriate procedural and diagnostic code(s) and narrative definition(s) relating to the injury;

(5) type of treatment rendered;

(6) anticipated date the worker may achieve maximum medical recovery, if possible; and

(7) anticipated date of release to return to work, if possible.

The provisions of this Sec. 42.35 adopted to be effective October 20, 1988, 13 TexReg 4990.
See Texas Civil Statutes, Article 8306, Sec. 7.

Sec. 42.40. Required Reports: Subsequent Reports.

(a) Subsequent reports shall be submitted to the carrier and the injured worker, or his or her representative, as provided in Sec. 42.30 of this subchapter (relating to Written Communications), and shall contain the following information:

(1) all identifying information required by Sec. 42.30(d) of this subchapter (relating to Written Communications);

(2) type of treatment rendered;

(3) anticipated date the worker will achieve maximum medical recovery, if possible; and

(4) anticipated date of release to return to work, if possible.

(b) If treatment continues, the provider shall submit a report:

(1) 60 days from the date treatment began; and

(2) 120 days from the date treatment began.

The provisions of this Sec. 42.50 adopted to be effective October 20, 1988, 13 TexReg 4990.
See Texas Civil Statutes, Article 8306, Sec. 7.

Sec. 42.55. Required Reports: Change of Status Reports.

(a) The treating doctor shall submit a change of status report to the carrier and the injured worker, or his or her representative, as provided in Sec. 42.30 of this subchapter (relating to Written Communications) within seven days of:

(1) determining that the patient has achieved maximum medical recovery;

(2) releasing the patient to return to work; or

(3) receiving notice that the patient has changed treating doctors.

(b) If there is no permanent medical impairment, this shall be noted. If there is permanent impairment, the treating doctor may elect to perform an examination prior to writing the change of status report.

(c) The change of status report shall contain the following information:

(1) all identifying information required by Sec. 42.30(d) of this subchapter (relating to Written Communications); and

(2) all pertinent objective findings such as loss of member, description of scars or deformities, visual acuity, measured ranges of motion, strength, measurable atrophy, muscle spasm, reflex changes, sensory changes, and physical and occupational restrictions.

The provisions of this Sec. 42.55 adopted to be effective October 20, 1988, 13 TexReg 4990.
See Texas Civil Statutes, Article 8306, Sec. 7.

Sec. 42.60. Required Reports: Special Reports.

(a) All special reports shall contain all identifying information required by Sec. 42.30(d) of this subchapter (relating to Written Communications).

(b) The provider shall submit special reports to the carrier and the injured worker, or his or her representative, as provided in Sec. 42.30 of this subchapter (relating to Written Communications) under the following circumstances:

(1) Hospitalization. A report shall be submitted when the patient is discharged from a hospital.

(2) Amputation. When all or part of any limb or digit is amputated, the treating doctor shall submit a report and a chart showing the exact point of amputation.

(3) Vision loss.

(A) Loss of vision shall be calculated on the actual loss of vision as a result of an injury, and not on loss of vision after restoration of vision by proper fitting glasses.

(B) The board considers "loss of an eye" to have occurred when loss of vision reaches 90%.

(C) A change of status report for a patient who has suffered vision loss shall be based on the board's "Table of Visual Losses of One Eye," published in the Appendix to this chapter. (See Sec. 55.25 of this title, relating to Loss of an Eye.)

(4) Hearing Impairment.

(A) Hearing tests for use in compensation ratings shall be derived from the pure-tone audiogram calculated to ANSI-S3.6-1969 standards. Examination should be performed by a medical specialist who does hearing evaluations or by an audiologist having the Certificate of Clinical Competence from the American Speech-Language-Hearing Association upon referral. Hearing handicap will be based on the functional state of both ears.

(B) A change of status report for a patient who has suffered hearing impairment shall be based on the board's "Table of Monaural Hearing Impairment," published in the Appendix to this chapter. (See Sec. 55.30 of this title, relating to Hearing Impairment.)

(5) Medical Examination Orders.

(A) The examining doctor shall submit a report within seven days of examining a claimant under board order.

(B) If the examination was ordered on the board's own motion, the original report and the bill shall be sent to the board. Copies shall be sent to the claimant, or claimant's representative, and the carrier.

(C) If the examination was ordered at the carrier's request, the original report and the bill shall be sent to the carrier. Copies shall be sent to the claimant, or claimant's representative, and the board. (See Chapter 69 of this part, relating to Medical Examination Orders.)

(6) Demand for surgery. The report accompanying a demand for surgery shall etablish that, in all reasonable medical probability:

(A) the requested surgical procedure will either effect a cure, or materially and beneficially improve and relieve the patient's condition; and

(B) the surgery is medically advisable.

The provisions of this Sec. 42.60 adopted to be effective October 20, 1988, 13 TexReg 4990.
See Texas Civil Statutes, Article 8306, Secs. 7 and 12e; Article 8307, Sec. 4.

Sec. 42.65. Changing Treating Doctors.

(a) When an injured worker elects to change treating doctors, the subsequent doctor shall make a diligent effort to secure from the prior doctor or from the carrier all available medical information. The prior doctor shall immediately forward, upon proper request, all requested information, including x-rays, to the new treating doctor.

(b) The carrier shall identify all prior treating doctors and provide all relevant medical records in its claim file to the subsequent doctor upon request.

(c) All reasonable costs incurred in transferring records under this section shall be borne by the carrier.

(d) The subsequent doctor is responsible for submitting all required reports.

The provisions of this Sec. 42.65 adopted to be effective October 20, 1988, 13 TexReg 4990.
See Texas Civil Statutes, Article 8306, Sec. 7.

Sec. 42.75. Excess Recovery from Third Party Actions.

(a) When an injured worker has received an excess recovery in a third party action, pursuant to Texas Civil Statutes, Article 8307, Sec. 6a(c), the carrier shall immediately:

(1) notify all providers of the date of the judgment or agreed judgment, and the amount of the excess; and

(2) file a copy of the judgment or agreed judgment with the board.

(b) The provider shall continue to submit reports as required by these rules.

(c) Bills for services and supplies provided after the judgment date shall be sent to the injured worker, or his or her representative. Copies of such bills shall be filed with the carrier.

(d) The claimant shall notify the board, the carrier, and current health care providers when the amount of the excess has been reduced to zero. Upon receipt of such notice, the provider(s) shall resume billing only the carrier, pursuant to Sec. 42.30 of this subchapter (relating to Written Communications).

The provisions of this Sec. 42.75 adopted to be effective October 20, 1988, 13 TexReg 4990.
See Texas Civil Statutes, Article 8307, Sec. 6a.

Sec. 42.78. Reports to Be Filed by the Carrier.

The carrier shall file current medical reports with the board under the following conditions:

(1) after the expiration of four weeks of disability;

(2) when filing a notice of controversion based on medical grounds;

(3) upon receipt of narrative reports submitted by the treating doctor pursuant to Sec. 42.40 of this subchapter (relating to Required Reports: Subsequent Reports);

(4) when filing an A-2 giving return to work date or release to return to work date;

(5) when filing an A-4 showing additional lost time;

(6) when requesting a pre-hearing conference;

(7) when filing a CSA;

(8) when filing an A-2 lump sum showing payment for permanent partial disability resulting from a specific injury; and

(9) when requested by the board.

The provisions of this Sec. 42.78 adopted to be effective December 6, 1988, 13 TexReg 5826.

Sec. 42.80. Assignment of Medical Benefits.

A health or accident insurance company which has been assigned an injured worker's right to medical benefits under the Act shall file a true copy of the assignment with the carrier and the board within five days of said assignment.

The provisions of this Sec. 42.80 adopted to be effective October 20, 1988, 13 TexReg 4990.
See Texas Civil Statutes, Article 8306, Sec. 3.

Sec. 42.85. Voluntary Arbitration.

The board shall establish procedures for selection of voluntary arbitration panels to assist the board in regulating fees and charges submitted by health care providers to the full extent authorized by Texas Civil Statutes, Article 8306, Sec. 7.

(1) The executive director of the board shall prepare by-laws subject to the final approval of the board governing the operation and functions of the various voluntary arbitration panels.

(2) The executive director of the board shall implement the procedures so adopted by the board. The executive director or designee shall supervise the arbitration panels established by the board, and shall serve as chairman of each panel. However, the executive director may from time to time designate the assistant executive director of the board or other person to act as chairman in his or her place.

(3) The procedures for selection of panels and the by-laws shall be available to all parties.

The provisions of this Sec. 42.85 adopted to be effective December 6, 1988, 13 TexReg 5826.

Sec. 42.90. Demand for Surgical Operation.

Any written demand for a surgical operation under Texas Civil Statutes, Article 8306, Sec. 12e, or any application for reduction or suspension of compensation pursuant to Article 8307, Sec. 4, must be filed with the board at least seven calendar days prior to the date of hearing. However, where good cause for waiving strict compliance is approved by the board, parties may file demand for or tender of surgery on or before the scheduled date of hearing.

The provisions of this Sec. 42.90 adopted to be effective December 6, 1988, 13 TexReg 5826.

Sec. 42.95. Scars and Deformities.

In all cases involving severe and disfiguring burns or lacerations, a descriptive medical report of the scars or deformity shall be submitted by either the carrier or the claimant. In all such cases involving scars to the face, arms, or hands, a color photograph taken after maximum healing has occurred must be submitted at or prior to any final board action on the claim.

The provisions of this Sec. 42.95 adopted to be effective December 6, 1988, 13 TexReg 5826.

SUBCHAPTER B. MEDICAL COST EVALUATION

Sec. 42.101. Purpose.

The fee guidelines promulgated in this subchapter are intended to establish presumptively fair and reasonable charges for health care services and supplies which may be covered under the Act.

The provisions of this Sec. 42.101 adopted to be effective December 6, 1988, 13 TexReg 5827.

Sec. 42.105. Official Medical Fee Guidelines.

(a) The "Official Medical Fee Guideline for Services Rendered Under the Texas Workers' Compensation Act" is the lesser of:

(1) the provider's usual fees and charges; or

(2) the fees and charges established by the Relative Value Scale, a subsection of the Official Medical Fee Guideline.

(b) The Relative Value Scale is adapted from the "1988 Official Medical Fee Schedule for Services Rendered under the California Workers' Compensation Laws," and is adopted by reference.

(c) The board will publish the Relative Value Scale as the "Official Medical Fee Guideline for Services Rendered Under the Texas Workers' Compensation Act." The Guideline will be reviewed and revised periodically, as necessary.

(d) Copies of the Guideline will be available upon written request to the Administrator, Medical Cost Evaluation Division; Industrial Accident Board; 200 East Riverside Drive, 1st Floor; Austin, Texas 78704-1287.

(e) The charge for the Guideline shall be $12.50. This charge may be revised periodically, as necessary.

The provisions of this Sec. 42.105 adopted to be effective September 1, 1988, 13 TexReg 4131.
See Texas Civil Statutes, Article 8306, Sec. 7b.

Sec. 42.110. Official Health Facility Fee Guidelines.

(a) Amount of reimbursement due. The amount of reimbursement to which a health facility is entitled for compensable services and items shall be that amount that is fair and reasonable and does not exceed the fees and charges for similar treatment of injured persons of a like standard of living where the cost of the treatment is paid by the injured person or someone acting for the injured person.

(b) Official guideline for establishing amount of reimbursement due. The guideline to assist the parties in determining the amount of reimbursement shall be as follows: prices for compensable services and items as listed on the facility's adjusted chargemaster multiplied by the facility's workers' compensation ratio.

(c) Calculation of health facility workers' compensation ratio.

(1) Based on information filed pursuant to subsection (f) of this section, the board will calculate and assign a specific health facility workers' compensation ratio for each health facility seeking reimbursement for compensable services and items.

(2) A health facility workers' compensation ratio is calculated as follows:

$$\text{Ratio} = \frac{\text{total operating expenses}}{\text{adjusted net revenue}}$$

(3) The ratio shall not be less than .85 and shall not be greater than 1.00.

(d) Limitations on amount billed for compensable services and items. On any bill for reimbursement submitted by a health facility, the health facility shall state the unit price for each service or item as listed on the facility's adjusted chargemaster; provided, however, that nothing in this section shall prevent a health facility from billing any amount for a particular service or item.

(e) Limitations on adjusting the base chargemaster.

(1) At any time between January 1, 1990 and December 31, 1990, inclusive, a health facility may adjust a unit price as listed on its base chargemaster to create an adjusted charge-master; however, at no time between January 1, 1990 and December 31, 1990, inclusive, shall the sum total of all unit prices listed on the adjusted chargemaster be greater than the sum total of all unit prices on the base chargemaster multiplied by 1.07.

(2) If a new service or item provided by the health facility is added to the facility's adjusted chargemaster after December 1, 1989, the initial unit price for the new service or item shall be added to the sum total of all unit prices listed on the base chargemaster for the purpose of determining whether the adjusted chargemaster complies with the limitations specified in this subsection.

(f) Ratio report required to be filed by each health facility.

(1) No later than December 31, 1989, a health facility shall file with the board a complete and correct Health Facility Ratio Report, consisting of a board-prescribed package of forms, the charge for which shall be established by the board; and supporting documentation, including,

but not limited to, the facility's most recent audited financial statement; the facility's most recently filed Medicare cost report, if applicable; or the facility's most recently filed Medicaid cost report.

(2) The information filed with the board shall be based on the health facility's most recent fiscal year ending prior to September 1, 1989.

(3) All data and audited financial statements that are required to be filed, excluding the Medicare or Medicaid cost reports, shall be prepared in accordance with generally accepted accounting principles and generally accepted auditing standards if applicable.

(4) The health facility's chief executive officer shall certify that all information required to be filed complies with this subsection.

(5) A facility failing to timely file the information required by this subsection will be assigned a workers' compensation ratio of .85 for the period established in subsection (h) of this section.

(g) Base chargemaster required to be filed by each health facility.

(1) No later than December 31, 1989, a health facility shall file with the board a copy of its base chargemaster, certified as true and correct by the health facility's chief executive officer.

(2) To comply with this subsection, a health facility shall file a magnetic tape of its base chargemaster, in a form and manner prescribed by the board, if the facility has the capability of creating such a tape; otherwise, the health facility shall file a paper copy of its base chargemaster.

(3) A facility failing to timely file the information required by this subsection will be assigned a workers' compensation ratio of .85 for the period established in subsection (h) of this section.

(h) Effective date of guidelines and limitations. The guidelines and limitations established in subsections (b), (d) and (e) of this section apply to all compensable services and items provided from January 1, 1990 through December 31, 1990, inclusive.

(i) Appeal of a board-assigned ratio.

(1) A facility or carrier may challenge a board-assigned ratio by filing a written appeal with the board no later than 30 calendar days after the ratio is assigned. The board will promptly set a hearing to consider the appeal.

(2) A ratio becomes final if no appeal is filed as provided.

(j) Special provisions for certain health facilities.

(1) Small rural hospitals. A small rural hospital, as defined in sec.42.15 of this title (relating to Definitions), may elect to use the guideline of fair and reasonable for reimbursement for compensable services and items as an alternative to the official guideline. This election shall be made on a board-prescribed form, to be included in the facility's ratio report, as provided by subsection (f)(1) of this section. A small rural hospital is subject to the filing requirements established in subsections (f) and (g) of this section.

(2) New health facilities. A health facility that has not completed its first fiscal year by September 1, 1989, is considered a new health facility, and shall be assigned a ratio of .90. A new health facility is not subject to the filing requirements established in subsections (f) and (g) of this section, but shall file a true and correct copy of its base chargemaster no later than the latter of December 31, 1989, or 30 days after the date the facility initiated services.

(3) Multi-facility systems.

(i) A multi-facility system may elect to file a single ratio report based on financial information for all Texas facilities within the system, and be assigned a composite ratio applicable to all facilities within the system.

(ii) The multi-facility system ratio report shall include the name, address, and calculated ratio of each facility within the system.

(iii) Each facility within the system is subject to the filing requirement established in subsection (g) of this section.

(k) Definitions. The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

(1) *Adjusted chargemaster*--The health facility's base chargemaster, as it exists between December 2, 1989 and December 31, 1990, inclusive, adjusted as permitted by subsection (e) of this section, if applicable.

(2) *Adjusted net revenues*--Total patient revenues plus other operating revenues, minus deductions for uncompensated care, Medicare contractual allowances, Medicaid contractual allowances, and other governmental contractual allowances.

(3) *Audited financial statement*--A presentation of financial data, including accompanying notes, derived from accounting records and intended to communicate a health facility's economic resources or obligations at a point in time, or the changes therein for a period of time, in accordance with generally accepted accounting principles.

(4) *Base chargemaster*--The list maintained by a health facility of services and items provided by the facility with accompanying unit prices reflecting the health facility's expected amount of reimbursement, as it existed on December 1, 1989, or as it existed on the date the health facility initiated services, if later. This is not a chargemaster reflecting any negotiated or mandated charges.

(5) *Compensable services and items*--Those services and items provided by a health facility to cure and relieve an injured worker from the effects naturally resulting from a compensable injury, as defined in sec.42.15 of this title (relating to Definitions).

(6) *Generally accepted accounting principles*--Accounting principles or standards generally accepted in the United States, including, but not limited to, Accounting Principles Board Opinions, as published by the American Institute of Certified Public Accountants, and Statements of Financial Accounting Standards, and interpretations thereof, as published by the Financial Accounting Standards Board.

(7) *Generally accepted auditing standards*--The 10 generally accepted auditing standards adopted by the American Institute of Certified Public Accountants, together with interpretations thereof, as set forth in Statements on Auditing Standards as published by the American Institute of Certified Public Accountants.

(8) *Medicaid contractual allowances*--Gross patient charges at established rates minus the amounts received or to be received from the Medicaid Program under the contract between the participating health facility and the United States Department of Health and Human Services.

(9) *Medicare contractual allowances*--Gross patient charges at established rates minus the amounts received or to be received from the Medicare Program under the contract between the participating health facility and the United States Department of Health and Human Services.

(10) *Multi-facility system*--An aggregation of health facilities, however legally organized, under common ownership or governance.

(11) *Other allowances*--Gross patient charges at established rates minus amounts received or to be received:

(A) under contractual agreements with non-governmental third party payors; or

(B) under courtesy discounts.

(12) *Other governmental contractual allowances*--Unreimbursed charges for contractual allowances from such governmental entities as CHAMPUS, the Veterans Administration, and the Texas Rehabilitation Commission.

(13) *Other operating revenues*--Revenues received from patients for non-patient care services to patients, and sales and activities to persons other than patients minus grants, gifts, and investment income including, but not limited to, revenues from educational programs, rental of hospital space, sales to employees, physicians, or non-patients, fees charged for transcripts or reproduction of medical records; cafeteria sales; recovery of charges for personal telephone calls; proceeds from sale of metal scrap and x-ray file; and proceeds from gift shops, parking, and other services operated by the health facility.

(14) *Total deductions from revenue*--The sum of uncompensated care, Medicare contractual allowances, Medicaid contractual allowances, and other governmental contractual allowances.

(15) *Total operating expenses*--The sum of health facility operating expenses, as recorded on an accrual basis, including, but not limited to, salaries and wages; employee benefits; professional fees; supplies; depreciation; amortization; interest; state and local taxes paid, excluding any income tax; and administrative and facility overhead expenses.

(16) *Total patient revenues*--Revenues recorded on an accrual basis at established rates for routine and ancillary services, both inpatient and outpatient.

(17) *Uncompensated care*--Deductions from total patient revenues for charity care and bad debt as recorded in a health facility's audited financial statement.

(18) *Unit price*--The price listed on a health facility's chargemaster for a particular service or item.

The provisions of this Sec. 42.110. adopted to be effective November 21, 1989, 14 TexReg 5867.

Sec. 42.110. Official Hospital Fee Guideline and Method for Determining Per Diem and RCC Rates.

Repealed effective February 7, 1989

[See Appendix]

Sec. 42.110. Official Health Facility Fee Guidelines.

Repealed effective November 21, 1989
[See Appendix]

Sec. 42.111. Official Hospital Fee Guidelines for Services Rendered Under the Texas Workers' Compensation Act for 1988.

Expired December 31, 1988
[See Appendix]

Sec. 42.112. Official Interim Hospital Fee Guidelines for Services Rendered Under the Texas Workers' Compensation Act.

Expired February 4, 1989
[See Appendix]

Sec. 42.115. Official Pharmaceutical Fee Guidelines.

(a) The "Official Pharmaceutical Fee Guidelines for Services Rendered Under the Texas Workers'Compensation Act" is the lesser of:

(1) the provider's usual charge; or

(2) the charges established in the brand-name and generic formulas adopted by the board.

(b) The formulas adopted by the board for establishing fair and reasonable fees and charges for brand-name and generic pharmaceuticals are:

(1) Brand-name Pharmaceutical Formula:

Average wholesale price (AWP) times 1.1 plus $4.00

(2) Generic Pharmaceutical Formula:

Average wholesale price (AWP) times 1.4 plus $7.50

(c) The board will determine the average wholesale price (AWP) for brand-name and generic pharmaceuticals through the monthly Medi-Span publications, *Prescription Pricing Guide* and *Generic Buying and Reimbursement Guide*.

(d) The charge for the Pharmaceutical Fee Guideline shall be $1.00. This charge may be revised periodically, as necessary.

(e) The board encourages the prescription of generic equivalents to brand-name drugs when such prescription is medically appropriate and available.

(f) All injured employees entitled to benefits under the Texas Workers' Compensation Act are entitled to immediate access to pharmaceutical goods and services.

The provisions of this Sec. 42.115 adopted to be effective September 1, 1988, 13 TexReg 4131.

See Texas Civil Statutes, Article 8306, Sec. 7b; Appendix: Advisory No. 8.

Sec. 42.135. Liability for Covered Health Care.

(a) The carrier is solely liable to pay a provider for health care which is covered under the Act.

(b) The injured worker shall not be billed for covered health care, nor for any amounts in excess of the amount adjudicated as fair and reasonable. The injured worker shall not be billed for reports, handling fees, interest, or any other surcharge related to the covered health care. The provider shall not refer the injured worker to a collection agency or a retail credit organization.

(c) This section does not apply if the injured worker has received an excess recovery from a third party, pursuant to Texas Civil Statutes, Article 8307, Sec. 6a, and Sec. 42.60 of this chapter (relating to Excess Recovery From Third Party Actions).

The provisions of this Sec. 42.135 adopted to be effective October 20, 1988, 13 TexReg 4990.

See Texas Civil Statutes, Article 8306, Sec. 7; Article 8307, Sec. 6a.

Sec. 42.137. Utilization Review.

(a) The claimant and the carrier may jointly request the board for an informal review and determination of the necessity of proposed medical treatment.

(b) The application shall be accompanied by supporting documentation from one or more health care providers.

(c) The determination of necessity shall be informal, for the purpose of resolving disputes, and shall not be binding on either party.

(d) The carrier shall bear the cost of a review provided under this section.

The provisions of this Sec. 42.137 adopted to be effective January 1, 1990, 14 TexReg 6671.

Sec. 42.140. Amount of Payment.

(a) General. A provider will be paid an amount that is fair and reasonable. It shall be presumed that fair and reasonable amounts are those established in the fee guidelines. Any adjudication by the board as to fair and reasonable amount will be consistent with the fee guidelines unless evidence has been properly filed with the board indicating that a different amount is fair and reasonable. The board will consider any request for payment in excess of the fee guidelines when filed by report.

(b) Payment for services billed by report. The carrier shall base payment for services billed by report upon review of the submitted documentation and recommendations from the carrier's medical consultant.

The provisions of this Sec. 42.140 adopted to be effective October 20, 1988, 13 TexReg 4990.

See Texas Civil Statutes, Article 8306, Sec. 7b.

Sec. 42.145. Billing.

(a) General. All bills submitted to carriers shall:

(1) contain the identifying information required by Sec. 42.30(d) of this chapter (relating to Written Communications), if available;

(2) itemize services and goods provided;

(3) after January 1, 1989, identify services and goods provided by appropriate procedural and diagnostic codes, with descriptions, as established in the fee guidelines.

(b) Billing by report.

(1) A provider shall bill by report when no procedural definition and/or dollar value is established for a procedure, or when a provider seeks payment in excess of that established in the fee guidelines.

(Blank)

(2) The report shall:

(A) describe the procedure in sufficient detail to permit evaluation;

(B) contain substantiating documentation to establish the fairness and reasonableness of the charge(s); and

(C) include correct diagnostic codes and descriptions, when appropriate.

(3) The report shall be attached to the bill.

(c) Failure to comply with billing requirements shall suspend the carrier's obligation to review the bill. The carrier shall return a noncompliant bill to the provider within three working days of receipt.

(d) The board may prescribe forms for billing purposes.

The provisions of this Sec. 42.145 adopted to be effective October 20, 1988, 13 TexReg 4990.

See Texas Civil Statutes, Article 8306, Sec. 7b.

Sec. 42.155. Carrier Review of Bills.

(a) General. The carrier shall promptly date stamp each health care provider bill with the date the same was received by the carrier. Failure on the carrier's part to comply with this rule shall create a rebuttable presumption that such health care provider bill was received by the carrier within five business days of the date of such bill.

(b) Time for review.

(1) General. The carrier shall complete its review of a bill within 30 days of receipt. The review may include an audit, as described by Sec. 42.160 of this subchapter (relating to Carrier Desk Audit of Bills). A bill may not be reduced unless the carrier conducts an audit.

(2) Pharmaceutical bills. The carrier shall complete its review of a pharmaceutical bill within 10 days of receipt.

(3) Hospital bills; on-site audit. If the carrier decides to conduct an on-site audit of a hospital bill, the carrier shall proceed according to the provisions of Sec. 42.165 of this subchapter (relating to Carrier On-Site Audit of Hospital Bills). The time for review shall be extended until completion of the on-site audit.

(c) Completion of review. Within 10 days of completion of the review, or, if a pharmaceutical bill, within five days of completion of the review, the carrier shall:

(1) remit to the provider full payment of the bill as submitted; or

(2) remit to the provider the amount of payment the carrier has determined to be appropriate. If the carrier remits to the provider an amount less than the amount billed, or remits no payment, the carrier shall immediately send the provider and the claimant or claimant's representative copies of the appropriate medical audit summary sheet, as described in Secs. 42.160 and 42.165 of this subchapter (relating to Carrier Desk Audit of Bills and Carrier On-Site Audit of Hospital Bills). The copies sent to the provider and the claimant or claimant's representative shall contain the following statement:

> The insurance carrier and not the claimant/patient or employer, is solely liable for all reasonable and necessary medical treatment rendered in connection with the injury, and no billing for any unpaid amounts should be directed to the claimant/patient or employer, nor should any attempt be made to collect any unpaid amount from the claimant/patient or employer, unless the claim has been denied by the board or the court.

(d) The carrier's failure to comply with the requirements of subsection (c) of this section within the time indicated constitutes suspension of medical benefits, pursuant to Texas Civil Statutes, Article 8306, Sec. 18a(b).

(e) 40 days after posting, the health care provider may request assistance from the board in compelling the carrier to file reasons for reducing a bill.

The provisions of this Sec. 42.155 adopted to be effective October 20, 1988, 13 TexReg 4990; notice of non-enforcement of the requirement established in subsection (c)(2) that the insurance carrier file a copy of the medical audit summary sheet with the board issued November 1, 1989, 14 TexReg 5960; amended to be effective May 30, 1990, 15 TexReg 2803.

See Texas Civil Statutes, Article 8306, Sec. 18a.

Sec. 42.160. Carrier Desk Audit of Bills.

(a) During the audit, the carrier and the provider shall make reasonable attempts to resolve any questions or problems regarding the bill under audit. The provider shall submit to the carrier any additional information requested that is relevant to the audit. If a hospital bill is under review, the hospital shall submit the medical record at the carrier's request.

(b) Every audit shall be documented on the medical audit summary sheet, which shall include the following information:

(1) claimant's name;

(2) IAB claim number;

(3) provider's name, address, and Federal Tax Identification number;

(4) health care provider-reviewer's report;

(5) for each audited item, the following: applicable code; code description; amount billed; amount paid; and, if appropriate, amount reduced or denied, accompanied by a sufficient explanation for each reduction or denial.

The provisions of this Sec. 42.160 adopted to be effective October 20, 1988, 13 TexReg 4990.

Sec. 42.165.Carrier On-Site Audit of Hospital Bills.

(a) The carrier may request an on-site audit of a hospital bill.

(b) The request shall:

(1) be made in writing;

(2) be made no later than 40 days after receipt of the bill; and

(3) be accompanied by payment of either 75% of the bill as submitted, or a $50.00 audit fee.

(c) The audit shall be conducted according to the *"Instructions for On-Site Audit of Hospital Charges by Workers' Compensation Carrier,"* hereby adopted by reference [Appendix]. Copies of this document will be made available upon written request to: Administrator, Medical Cost Evaluation Division; Industrial Accident Board; 200 East Riverside, First Floor; Austin, Texas 78704-1287.

(d) Every audit shall be documented on the medical audit summary sheet, which shall include the following information:

(1) claimant's name;

(2) IAB claim number;

(3) provider's name, address, and Federal Tax Identification number;

(4) health care provider-reviewer's report; and

(5) for each audited item, the following: applicable code; code description; amount billed; amount paid; and, if appropriate, amount reduced or denied, accompanied by a sufficient explanation for each reduction or denial.

The provisions of this Sec. 42.165 adopted to be effective October 20, 1988, 13 TexReg 4990.

See Appendix: "Instructions for On-Site Audit of Hospital Charges by Workers' Compensation Carrier."

Sec. 42.175.Miscellaneous Covered Services.

(a) Medical reports.

(1) The carrier shall pay the fair and reasonable charges of the provider for the preparation and submission of all required medical reports, records, and information. There shall be no additional charge made to the patient or the patient's representative for copies of these documents except clinical reports (hospital) when a separate request is made. There shall be no additional charge made to the board for copies of any of these documents.

(2) The following shall serve as guidelines for fair and reasonable charges for required reports and records under this chapter:

Form reports (preparation)	$15.00
Narrative reports (preparation)	
--one to two pages	$50.00
--subsequent pages	$20.00 per page
Copies of reports	$ .50 per page
Hospital records	Not to exceed $15.00 per record (1 - 20 pages), and $ .30 per page for records in excess of 20 pages. Not to exceed $ .50 per page in case of microfilm.

(b) Travel expenses. Whenever it becomes reasonably necessary for an injured worker to travel outside the city or county of residence in order to obtain medical care covered under the Act, the reasonable costs thereof shall be reimbursed by the carrier. This would include, where appropriate, the reasonable costs of meals and lodging. All travel by private conveyance shall be based upon the mileage expense allowance then current for travel by state employees.

(c) Eyeglasses. *Reserved.*

(d) Hearing aids. *Reserved.*

The provisions of this Sec. 42.175 adopted to be effective October 20, 1988, 13 TexReg 4990.
See Texas Civil Statutes, Article 8306, Sec. 7.

SUBCHAPTER D. DISPUTE RESOLUTION

Sec. 42.305. Requesting Dispute Review and Resolution.

(a) Either the carrier or the provider may request board review and resolution of a dispute arising over a medical bill under the following conditions:

(1) the charge has been incurred; and

(2) the carrier has admitted liability for compensation.

(b) For the purposes of this chapter, as required by Texas Civil Statutes, Article 8306, Sec. 7b(q), the carrier will be deemed to have admitted liability for compensation until the carrier files with the board proper notice of a *bona fide* liability dispute.

The provisions of this Sec. 42.305 adopted to be effective October 20, 1988, 13 TexReg 4990.
See Texas Civil Statutes, Article 8306, Sec. 7b.

Sec. 42.307. Procedure for Requesting Dispute Review.

(a) A request for dispute review shall be made in writing, and filed with the administrator of the Medical Cost Evaluation Division.

(b) The request shall be made no later than 365 days after the date the disputed bill was submitted to the carrier.

(c) The request shall include the following:

(1) all identifying information required by Sec. 42.30(d) of this title (relating to Written Communications);

(2) the bill as originally submitted to the carrier;

(3) copies of all written communications relating to the dispute; and

(4) written documentation that all reasonable efforts to resolve the dispute have been exhausted.

(d) The board may request addditional information, and may compel production of documents, if necessary.

(e) A carrier requesting review shall:

(1) file the original request in person with the Medical Cost Evaluation Division;

(2) tender the review fee to the board at the time of filing, unless the provider is responsible for the fee, as provided in Sec. 42.309 of this subchapter (relating to Payment for the Review); and

(3) send simultaneously, by certified mail, a copy of the request to the provider.

(f) A health care provider requesting review shall:

(1) file the original and one copy of the request by mail or in person with the Medical Cost Evaluation Division; and

(2) tender the review fee to the board, if responsible, as provided in Sec. 42.309 of this subchapter (relating to Payment for the Review).

(g) When a health care provider requests review, the board will notify the carrier's Austin board representative to appear in person to accept the carrier's copy of the request and tender the review fee, unless the provider is responsible for the fee, as provided in Sec. 42.309 of this subchapter (relating to Payment for the Review).

The provisions of this Sec. 42.307 adopted to be effective February 17, 1989, 14 TexReg 694.

Sec. 42.308. Procedure for Responding to a Request for Dispute Review.

(a) The respondent may file a response with the administrator of the Medical Cost Evaluation Division no later than 30 days after receiving the request. A copy of the response shall be sent simultaneously to the requester.

(b) The response shall include, but shall not be limited to, the items set out in subsection (c) of Sec. 42.307 of this subchapter (relating to Procedure for Requesting Dispute Review).

(c) The board may request additional information, and may compel production of documents, if necessary.

(d) If the respondent is a health care provider who is responsible for the review fee, as provided in Sec. 42.309 of this subchapter (relating to Payment for the Review), he or she shall tender the fee to the board when filing the response. If such provider fails or refuses to tender the fee, the board will notify the carrier to tender the fee or withdraw the request.

The provisions of this Sec. 42.308 adopted to be effective February 17, 1989, 14 TexReg 694.

Sec. 42.309. Payment for the Review.

(a) The board shall set reasonable fees for reviewing fee and utilization disputes. The board may adjust these fees periodically, as necessary.

(b) The review fee shall be paid by check or money order, payable to "Industrial Accident Board."

(c) The carrier, whether requester or respondent, shall be responsible to pay for the review, unless the board has found that the provider has overutilized the board's review system.

(d) A provider shall be found to have overutilized the board's review system after three separate disputes within a 12 month period involving the provider have been presented to the board for review, and have been resolved by the board against the provider. The board will notify a provider when such finding is made, and shall maintain a record of such findings. In all subsequent reviews of that provider's bills, the provider, whether requester or respondent, shall be responsible to pay for the review.

The provisions of this Sec. 42.309 adopted to be effective February 17, 1989, 14 TexReg 694.

Sec. 42.310. Board Review and Resolution.

(a) After all required information has been filed, the board will commence to review the dispute.

(b) No later than 31 days after commencing the review, the executive director or designee shall issue findings and conclusions in writing to the disputing parties.

(c) If the merits of the injured worker's claim have not been previously resolved by final award, judgment or settlement, the findings and conclusions of the executive director or designee will be issued as a recommendation, to be filed pending final resolution of the merits of the injured worker's claim.

(d) If the merits of the injured worker's claim have been previously resolved by final award, judgment or settlement, or if the injured worker is entitled to lifetime benefits under Texas Civil Statutes, Article 8306, Sec. 10(b), the board may, upon request of a disputing party, issue an award of medical benefits, based on the findings and conclusions of the executive director or designee.

(e) If the award is entered against the carrier on the issue of fees and charges only, it shall include an assessment of the statutory interest due.

The provisions of this Sec. 42.310 adopted to be effective October 20, 1988, 13 TexReg 4990.
See Texas Civil Statutes, Article 8306, Secs. 7, 7b, and 10.

Sec. 42.315. Appeal.

An award entered under this chapter may be appealed pursuant to the provisions of Texas Civil Statutes, Article 8307, Sec. 5.

The provisions of this Sec. 42.315 adopted to be effective October 20, 1988, 13 TexReg 4990.
See Texas Civil Statutes, Article 8307, Sec. 5.

CHAPTER 43. INSURANCE COVERAGE

Sec. 43.5.	Notice That Employer Has Become Subscriber.
Sec. 43.10.	Termination of Coverage.
Sec. 43.15.	Sanctions.
Sec. 43.20.	Required Information to Insureds.

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Sec. 43.5. Notice That Employer Has Become Subscriber.

The notice that employer has become subscriber shall be filed with the board's Austin office by certified mail or in person within 30 days of the effective date of the policy and the notice must be completed in detail and shall include:

(1) name, address, and occupation of insured;

(2) effective date of the policy;

(3) signature of the insurance company representative;

(4) complete name of the insurance company;

(5) policy number, and if notice is a rewrite of an existing policy, this information must be included on the notice;

(6) area or location of the business;

(7) Form 154, which shall be filed for divided risk coverage;

(8) the employer's federal tax identification number.

The provisions of this Sec. 43.5 adopted to be effective November 20, 1977, 2 TexReg 4316; amended to be effective September 25, 1979, 4 TexReg 3230; amended to be effective November 11, 1983, 8 TexReg 4492; amended to be effective October 1, 1985, 10 TexReg 3506; amended to be effective December 21, 1987, 12 TexReg 4529.

Sec. 43.10. Termination of Coverage.

(a) Definitions. The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise:

(1) *Termination of coverage*--Occurs when either party withdraws from a policy of workers' compensation insurance, either by canceling the policy in the middle of its term, or by declining to renew the policy on its anniversary date.

(2) *Rejection of the workers' compensation system*--Occurs when a subscriber terminates coverage and fails or refuses to purchase a policy of workers' compensation insurance.

(b) Carrier's notice to the Industrial Accident Board. The carrier shall notify the board when coverage is terminated by filing Board Form IAB-9, "Cancellation or Non-Renewal Notice." The notice shall be:

(1) filed in person or by certified mail; and

(2) filed on or before the effective date of termination.

(c) Carrier's notice to subscriber. The carrier shall notify the subscriber when the carrier terminates coverage. No notice is required when the subscriber terminates coverage. Notice to the subscriber shall be:

(1) in writing;

(2) sent by certified mail; and

(3) mailed no later than the 30th day before the effective date of termination; or

(4) mailed no later than the 10th day before the effective date of termination if termination is due to:

(A) fraud in obtaining coverage;

(B) failure to pay a premium when payment is due;

(C) an increase in the hazard for which the subscriber seeks coverage that results from an action or omission of the subscriber and that would produce an increase in the rate; or

(D) a determination by the commissioner of insurance that coverage would be illegal or hazardous to the interests of subscribers, creditors, or the general public.

(d) Effective date of termination of coverage.

(1) Termination by the carrier shall be effective on the latest of the following dates:

(A) the 31st day after the carrier notifies the subscriber as provided in subsection (c) of this section, or, if the termination is due to one of the conditions set out in subsection (c)(4) of this section, on the 11th day after the carrier notifies the subscriber as provided in subsection (c) of this section;

(B) the day the carrier files notice of termination with the board, as provided in subsection (b) of this section; or

(C) the actual termination date recited on the notice.

(2) Termination by the subscriber shall be effective on the actual termination date recited on the notice.

(3) Termination shall be deemed effective on the date a subsequent carrier files notice of inception of coverage for the subscriber.

(e) Duties of a subscriber who terminates coverage and rejects the workers' compensation system.

(1) A subscriber who terminates coverage and rejects the workers' compensation system shall, on or before the effective date of termination:

(A) post copies of notice of noncoverage, on a board-prescribed form, in three places around each work site affected; and

(B) file a copy of the notice of noncoverage with the board.

(2) Failure to comply renders the subscriber liable for statutory benefits to injured employees.

The provisions of this Sec. 43.10 adopted to be effective December 20, 1989, 14 TexReg 6419.

Sec. 43.10. Termination of Coverage.

Repealed effective December 20, 1989.
[See Appendix]

Sec. 43.15. Sanctions.

In the event a carrier fails to file notice that employer has become subscriber, as required by statute, the board will notify the carrier of its delinquency pursuant to Chapter 41 of this title (relating to Communications and General Medical Provisions).

(1) If the carrier requests a hearing, the matter will be heard by the board within 10 days of the request.

(2) If the carrier does not timely request a hearing and does not timely make the required filing of notice, the board may then impose the penalty authorized by Texas Civil Statutes, Article 8308, Sec. 18a(b). The carrier will be promptly notified in writing of any board imposition of penalty.

(3) However, the board may consider a request for extension of time to provide the requested information if the carrier makes the request and in addition shows good cause therefore with 10 days of receipt of notice from the board.

The provisions of this Sec. 43.15 adopted to be effective November 11, 1983, 8 TexReg 4492.

Sec. 43.20. Required Information to Insureds.

(a) Except as otherwise provided, no later than August 1 of each year, a workers' compensation insurance carrier shall provide each insured with written information regarding the insured's rights and responsibilities under the workers' compensation laws. The document shall include, but no be limited to, information required by the board. A copy of the document shall be filed with the board no later than August 1.

(b) In 1989, the date for providing the information required in this section shall be December 1.

The provisions of this Sec. 43.20 adopted to be effective October 17, 1989, 14 TexReg 5259; notice of non-enforcement of subsection (b) issued November 1, 1989, 14 TexReg 5960.

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CHAPTER 45. EMPLOYER'S REPORT OF INJURY OR DISEASE

Sec. 45.5. Forms.

Sec. 45.10. Employer's Report of Injury and Disease.

Sec. 45.13. Wage Statement.

Sec. 45.20. Board Request for Additional Information.

Sec. 45.25. Employer's Supplemental Report of Injury.

Sec. 45.30. Sanctions.

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Sec 45.5. Forms.

The employer's first report of injury and supplemental report of injury shall be completed on standardized forms approved by the board for that purpose. Every insurance carrier writing workers' compensation coverage effective in Texas shall provide an adequate number of the current forms in use to each insured employer.

The provisions of this Sec. 45.5 adopted to be effective November 11, 1983, 8 TexReg 4493.

Sec. 45.10. Employer's Report of Injury and Disease.

(a) Since the efficient operation of workers' compensation depends so greatly upon the insurance carrier and Industrial Accident Board receiving prompt notice of possible claims, the employer shall report injuries and occupational diseases by completing board form E-1, "Employer's First Report of Injury," and sending the original to the Industrial Accident Board and a copy to the employer's insurance carrier no later than eight days after:

(1) the employer has notice or knowledge of an injury to an employee resulting in absence from work for more than one day; or

(2) the employer receives notice from an employee of the manifestation of an occupational disease.

(b) The E-1 must be completed and filed regardless of the employer's position on the occurrence of the injury or occupational disease; it shall not be deemed an admission of liability for the claim. If the employer denies the injury or occupational disease, this position may be stated on the report.

(c) Noncompliance with this requirement may result in imposition of a civil penalty not to exceed $500.

The provisions of this Sec. 45.10 adopted to be effective November 11, 1983, 8 TexReg 4493; amended to be effective October 17, 1989, 14 TexReg 5260; amended to be effective October 17, 1989, 14 TexReg 5260.

Sec. 45.13. Wage Statement.

(a) When requested by the board or carrier, the employer shall immediately complete board form IAB-150, "Employer's Wage Statement," and file the original with the board and a copy with the carrier.

(b) Noncompliance with this requirement may result in imposition of a civil penalty not to exceed $500.00.

The provisions of this Sec. 45.13 adopted to be effective October 17, 1989, 14 TexReg 5260.

Sec. 45.15. Filing of Employer's First Report of Injury.

Repealed effective October 17, 1989
[See Appendix]

Sec. 45.20. Board Request for Additional Information.

When requested in writing by the board, the employer shall promptly furnish to the board the information requested if such information is either known to the employer or reasonably available to said employer and which is pertinent to the compensation claim in question.

The provisions of this Sec. 45.20 adopted to be effective November 11, 1983, 8 TexReg 4493.

Sec. 45.25. Employer's Supplemental Report of Injury.

When the employee returns to work or is no longer incapacitated as a result of the injury or occupational disease, the employer shall file an employer's supplemental report of injury promptly with the board and shall simultaneously deliver a copy thereof to the insurance carrier.

The provisions of this Sec. 45.25 adopted to be effective November 11, 1983, 8 TexReg 4493.

Sec. 45.30. Sanctions.

If the employer fails to timely submit any information to the board which the board is entitled to request under the authority of the Workers' Compensation Act, the board shall notify the employer by certified mail with a copy sent to the employer's insurance carrier to either file the requested information or request a hearing by the board within 10 days of notice. If the employer timely requests a hearing, the matter will be heard by the board in Austin within 10 days of the request. If the employer does not timely request a hearing and does not timely provide the requested information, the board may impose a penalty authorized by Texas Civil Statutes, Article 8307, Sec. 7. The employer will be promptly notified of any imposition of penalty by the board. The board may consider a request for extension of time to provide the requested information if the employer makes the request in writing and shows good cause therefore within 10 days of the receipt of notice from the board.

The provisions of this Sec. 45.30 adopted to be effective November 11, 1983, 8 TexReg 4493.

CHAPTER 47. EMPLOYEE NOTICE OF INJURY OR DEATH AND CLAIM FOR BENEFITS

Sec. 47.5. Information Constituting Claim.

Sec. 47.10. Signature of Claimant.

Sec. 47.15. Employer Advances Compensation.

Sec. 47.20. Beneficiaries Filing Claim.

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Sec. 47.5. Information Constituting Claim.

The prescribed claim form or any written communications from an injured employee claiming either medical care or compensation payments, giving his name, the date and the general nature of injury, and the name of his employer, shall constitute a claim.

The provisions of this Sec. 47.5 adopted to be effective November 20, 1977, 2 TexReg 4317.

Sec. 47.10. Signature of Claimant.

All claim forms must be personally signed by the injured employee and give his home address. If the employee is unable to write, he must make an "X" for his signature, and his mark must be witnessed by at least one credible witness.

The provisions of this Sec. 47.10 adopted to be effective November 20, 1977, 2 TexReg 4317.

Sec. 47.15. Employer Advances Compensation.

Where an employer advances compensation in accordance with Texas Civil Statutes, Article 8309, Sec. 4b, it is necessary the IAB Form EAC-70 be completed and forwarded by the employer within 10 days to the board in Austin, and such form shall also be furnished within 10 days to the employee and the insurance carrier advising the date first payment was made.

The provisions of this Sec. 47.15 adopted to be effective November 20, 1977, 2 TexReg 4317; amended to be effective September 23, 1979, 4 TexReg 3231.

Sec. 47.20. Beneficiaries Filing Claim.

In cases of injury resulting in death, the claim form or any written communication claiming compensation payments giving the employee's name, the employer's name, the date of the employee's death, and the name of the claimant shall constitute a claim. One of several beneficiaries may file claim for all beneficiaries. The names of all beneficiaries should be listed on the claim.

The provisions of this Sec. 47.20 adopted to be effective November 20, 1977, 2 TexReg 4317.

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CHAPTER 49. PROCEDURES FOR FORMAL HEARINGS BY THE BOARD

FORMAL HEARINGS

Sec. 49.5.	Schedule of Hearings.
Sec. 49.10.	Timely Acceptance of Evidence.
Sec. 49.15.	Formal Statement of Position.
Sec. 49.20.	Request for Cancellation.
Sec. 49.25.	Delay or Postponement of Hearing.
Sec. 49.30.	Filing of Medical Bills.
Sec. 49.35.	Filing of Medical Reports and Records.
Sec. 49.40.	Carrier Attendance.
Sec. 49.45.	Contents of Formal Statement of Position.
Sec. 49.50.	Sanctions.

SPECIAL FORMAL AND OTHER INVESTIGATIVE HEARINGS

Sec. 49.105.	Procedures.
Sec. 49.110.	Commencement of Hearings.
Sec. 49.115.	Notice.
Sec. 49.120.	Special Statutory Notice.
Sec. 49.125.	Notice of Special Formal Hearing.
Sec. 49.130.	Personal Appearance Hearings in Austin.
Sec. 49.131.	Withdrawal of Attorney.
Sec. 49.135.	Use of Court Reporters.
Sec. 49.140.	Continuance.
Sec. 49.145.	Recess.
Sec. 49.150.	Complaint Specifications.
Sec. 49.155.	Documentary Evidence.

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Sec. 49.160. Filing of Formal Statement of Position.

Sec. 49.165. Subpoenas and Subpoenas Duces Tecum.

FORMAL HEARINGS

Sec. 49.5. Schedule of Hearings.

Formal hearing before the board will be scheduled the first Friday following the expiration of 14 days from the date of pre-hearing conference. If the Friday upon which a hearing would otherwise be scheduled is a legal holiday or follows a legal holiday, the hearing will be scheduled for the following Monday. A claimant or his attorney must give the board and all parties seven days written notice if they intend to be present for such formal hearing. Hearings will begin at 9:30 a.m. in the board's Austin office and cases normally will be heard by the board in the order registered with the receptionist.

The provisions of this Sec. 49.5 adopted to be effective November 20, 1977, 2 TexReg 4317.

Sec. 49.10. Timely Acceptance of Evidence.

All interested parties required to file evidence with the board for consideration in a claim scheduled for a hearing must file this evidence not later than 5:00 p.m. on date of hearing. The board will consider requests for delayed evidence filing from any interested party. The request must be filed with the board in writing no later than 5:00 p.m. on the date of hearing and it must include a statement of the facts showing good cause and necessity for the delay. If delayed evidence is filed by any party after permission has been granted by the board, copies of such evidence must be simultaneously furnished to the opposing party.

The provisions of this Sec. 49.10 adopted to be effective November 20, 1977, 2 TexReg 4317.

Sec. 49.15. Formal Statement of Position.

The insurance carrier and attorney representing the claimant shall file their formal statement of position in the board's Austin office on or before the date of formal hearing.

The provisions of this Sec. 49.15 adopted to be effective September 22, 1979, 4 TexReg 3231.

Sec. 49.20. Request for Cancellation.

Upon written request by claimant or all claimant beneficiaries, the board, at its discretion, may at any time prior to the entry of an award, cancel a scheduled hearing when good cause is shown. Request for cancellation of a scheduled hearing shall be by written notice and filed with the board's Austin office.

The provisions of this Sec. 49.20 adopted to be effective November 20, 1977, 2 TexReg 4317; amended to be effective September 22, 1979, 4 TexReg 3231.

Sec. 49.25. Delay or Postponement of Hearing.

On the date of hearing, the board will review the case; in accordance with the provisions of Article 8309a of the Act, the Industrial Accident Board may delay or postpone the hearing of the claim, provided that within its discretion the board deems it to be the best interest of the injured employee that the case not be heard at that time; and such hearing may be delayed or postponed until the carrier discontinues payment of compensation or the furnishing of hospitalization, chiropractic service, or medical treatment or until the board deems it to the best interest of such employee for an award to be rendered.

The provisions of this Sec. 49.25 adopted to be effective November 20, 1977, 2 TexReg 4317.

Sec. 49.30. Filing of Medical Bills.

All bills unpaid by the insurance carrier or copies of receipts for medical services for claim for reimbursement must be filed with the board at the pre-hearing conference or attached to the formal statement of position. There must be a clear itemization of all prescriptions or incidentals, date of purchase, treatment rendered, and physician prescribing same on items furnished.

The provisions of this Sec. 49.30 adopted to be effective November 20, 1977, 2 TexReg 4317; amended to be effective September 22, 1979, 4 TexReg 3231.

Sec. 49.35. Filing of Medical Reports and Records.

If not previously filed pursuant to other board rules, all medical reports and records shall be filed at the time of formal hearing.

The provisions of this Sec. 49.35 adopted to be effective November 11, 1983, 8 TexReg 4495.

Sec. 49.40. Carrier Attendance.

The carrier's designated Austin representative must be available to the board on the day a claim is scheduled for formal hearing. In the event the Industrial Accident Board needs a copy of the carrier's file, or a portion thereof, the carrier's designated Austin representative shall obtain the file, or portion thereof, as requested by the board, from the carrier by suitable overnight mail or delivery service.

The provisions of this Sec. 49.40 adopted to be effective November 11, 1983, 8 TexReg 4495.

Sec. 49.45. Contents of Formal Statement of Position.

The formal statement of position shall be responsive to the pre-hearing officer's recommendations and shall be sufficiently detailed to apprise the board of all controverted issues. Legal contentions should be supported by citations to applicable authorities.

The provisions of this Sec. 49.45 adopted to be effective November 11, 1983, 8 TexReg 4495.

Sec. 49.50. Sanctions.

Failure to file a formal statement of position or filing a formal statement of position that does not comply with the requirements of board rule Sec. 49.45 (relating to Contents of Formal Statement of Position) may be punishable by appropriate sanctions of the board.

The provisions of this Sec. 49.50 adopted to be effective November 11, 1983, 8 TexReg 4495.

SPECIAL FORMAL AND OTHER INVESTIGATIVE HEARINGS

Sec. 49.105. Procedures.

These hearings will only generally follow the Texas Rules of Civil Procedure. Evidence will be received in accordance with the Texas Rules of Evidence as generally applied in Texas judicial proceedings, although not with the same degree of strictness. The procedures used in these hearings shall generally follow that used in judicial proceedings in the courts of this state.

The provisions of this Sec. 49.105 adopted to be effective November 11, 1983, 8 TexReg 4495.

Sec. 49.110. Commencement of Hearings.

Upon its own motion, or upon the written request or complaint of either a party or employer, the board may schedule a special formal hearing, fraud hearing, or investigative hearing to be conducted by the board, or any member thereof under the authority of applicable provisions of the Workers' Compensation Law of Texas.

The provisions of this Sec. 49.110 adopted to be effective November 11, 1983, 8 TexReg 4494.

Sec. 49.115. Notice.

All hearings shall be commenced by written notice, in accordance with the provisions of Chapter 41 of these rules (relating to Communications and General Medical Provisions) to the individuals and businesses or agencies directly concerned with the subject of the hearing. Sufficiency of the notice shall be presumed unless the issue is raised by an interested party on or before the hearing date.

The provisions of this Sec. 49.115 adopted to be effective November 11, 1983, 8 TexReg 4494.

Sec. 49.120. Special Statutory Notice.

In the event of hearings conducted by the board pursuant to the provisions of Texas Civil Statutes, Article 8306, Sec. 18, or Texas Civil Statutes, Article 8307, Sec. 7, and Sec. 9a, or Texas Civil Statutes, Article 8308, Sec. 18a, the notice requirements of those statutes will prevail whether same or inconsistent with any other provisions of these board rules pertaining to notice.

The provisions of this Sec. 49.120 adopted to be effective November 11, 1983, 8 TexReg 4494.

Sec. 49.125. Notice of Special Formal Hearing.

In all other hearings except for those described in Sec. 49.120 of this title (relating to Special Statutory Notice), and unless waived by the board upon its own motion, or for good cause shown, no less than 14 days written notice of the date, time, and place of such hearing will be given to the parties concerned.

The provisions of this Sec. 49.125 adopted to be effective November 11, 1983, 8 TexReg 4494; amended to be effective June 16, 1988, 13 TexReg 2752.

Sec. 49.130. Personal Appearance Hearings in Austin.

A party desiring to make a personal appearance hearing before the board on a claim which is scheduled for formal hearing by the board in Austin shall give the board and all other interested parties not less than seven days written notice thereof. The claimant's attendance at such hearing is required unless waived by the board for good cause shown. Hearings will begin at 9:30 a.m. in the board's Austin office, and cases normally will be heard by the board in the order they are registered with the receptionist. Strict compliance with the notice provisions of this rule may be waived for good cause.

The provisions of this Sec. 49.130 adopted to be effective November 11, 1983, 8 TexReg 4494.

Sec. 49.131. Withdrawal of Attorney.

After a compensation claim has been scheduled for a special formal hearing, or other hearing as provided in Sec. 53.65 of this title (relating to Certification Procedures), et seq., an attorney may not voluntarily withdraw as counsel for a claimant, except upon written request therefor as approved by the Industrial Accident Board.

The provisions of this Sec. 49.131 adopted to be effective October 1, 1985, 10 TexReg 3506.

Sec. 49.135. Use of Court Reporters.

Testimony will be recorded under the direction and control of the board member conducting the hearing. It will be permissible for any party to have a court reporter record the proceedings, conditioned upon:

(1) notification thereof shall be made to the presiding board member not less than three days before the scheduled hearing; and

(2) the original of the transcript shall be promptly furnished by the court reporter to the board, without cost to the board; and

(3) a true copy of the transcript shall be made available to the opposing party or parties at the usual and customary charge therefor.

The provisions of this Sec. 49.135 adopted to be effective November 11, 1983, 8 TexReg 4494.

Sec. 49.140. Continuance.

After a hearing is scheduled and notice is given to the party or parties as herein provided, a postponement or cancellation may be had by any party only for good cause. A request for postponement or cancellation shall be first and promptly made by telephone or in person to the presiding board member. If the request is granted, the party shall confirm the request and the grounds therefor by letter to the board member, with a copy thereof being delivered to the opposing party/parties or counsel.

The provisions of this Sec. 49.140 adopted to be effective November 11, 1983, 8 TexReg 4494.

Sec. 49.145. Recess.

After a hearing has commenced, circumstances may develop which, in the best interest of equity and justice, require the presiding board member to recess the hearing until a later time or date. If this occurs, the parties and all subpoenaed witnesses shall be entitled to notice of the date, time, and place of the resumption of hearing, in accordance with the same provisions as herein before provided for in these rules for the initial notice, except not less than 10 days written notice thereof shall be given to the party or parties.

The provisions of this Sec. 49.145 adopted to be effective November 11, 1983, 8 TexReg 4494.

Sec. 49.150. Complaint Specifications.

For all hearings for which complaint and allegation of violation of any provision of the Workers' Compensation Law or of Industrial Accident Board rules, the written notice herein provided for shall describe in detail the areas of investigation or complaint so as to fairly inform the party under investigation.

The provisions of this Sec. 49.150 adopted to be effective November 11, 1983, 8 TexReg 4494.

Sec. 49.155. Documentary Evidence.

If documentary evidence is to be tendered at the hearing, true copies thereof shall be prepared in advance by the party offering such evidence, sufficient in number for all interested parties to the hearing.

The provisions of this Sec. 49.155 adopted to be effective November 11, 1983, 8 TexReg 4494.

Sec. 49.160. Filing of Formal Statement of Position.

Although no formal statement of position is required to be filed in these types of hearings, any party may file a written brief concerning the facts, law, or argument which a party may desire to present in written form to the board.

The provisions of this Sec. 49.160 adopted to be effective November 8, 1983, 8 TexReg 4494.

Sec. 49.165. Subpoenas and Subpoenas Duces Tecum.

(a) Upon its own motion, or upon the written request of any party to a hearing, the board member presiding over the scheduled hearing may issue a subpoena for attendance of a witness or issue a subpoena duces tecum in order to examine any part of the books, files, and records of the parties or other witnesses as relate to the matters in dispute.

(b) It is urged that all requests for subpoenas be promptly made and correctly identify the name and address of the person to be subpoenaed, and a description of the books, records, etc., to be produced by subpoena duces tecum.

(c) Although the board will issue a subpoena upon request and in accordance with this rule, the requesting party should be aware the board is unable to enforce its subpoena authority unless the request is accompanied by $1.00 cash for each subpoena to be served, and, in addition, the party requesting the subpoena may be called upon to pay witness travel expense pursuant to Texas Civil Statutes, Article 3708.*

(d) No subpoena will be directed to a witness residing more than 100 miles from the county courthouse in the county where the hearing is held.

(e) A true copy of the request for subpoena/subpoena duces tecum shall be promptly mailed by the requesting party to all other parties to the hearing.

(f) Any objection to a subpoena or to a subpoena duces tecum, or any portion thereof, shall be made in writing to the board member conducting the hearing and shall state with certainty the grounds of objection. If the written objection is presented to the board not less than seven days prior to the hearing, then a majority of the board shall rule upon the same. If presented less than seven days in advance of the hearing, or at the time of the hearing, the objection may be determined by the board member scheduled to conduct the hearing.

(g) Any subpoena duces tecum issued by the board, or any member thereof, shall be restricted in the documents, instruments, and other writings discoverable thereby, to the provisions of the Texas Rules of Civil Procedure. Rule 186a, as now written, or hereafter amended. In the event of an unresolved dispute concerning the applicability of a subpoena duces tecum to a particular document, instrument, or other writing, the board or board member conducting the hearing shall examine the instrument *in camera* to determine whether or not the same is discoverable in whole or in part.

(h) Insofar as practicable, and also in conformity with the board rules herein provided, of the Texas Rules of Civil Procedure, Rules 176, 177, 177a, 178 and 179, as now written, or hereafter amended, shall be applicable to subpoena practice before the board.

The provisions of this Sec. 49.165 adopted to be effective November 11, 1983, 8 TexReg 4494.

* *Presently appears as Tex. Civ. Prac. & Rem. Code Ann. Sec. 22.001 (Vernon 1986).*

CHAPTER 51. AWARD OF THE BOARD

Sec. 51.10. Joint Payment of Award.

Sec. 51.15. Periodic Installments.

Sec. 51.20. Lump Sum Payment.

Sec. 51.25. Request for Review.

Sec. 51.30. Review of Award.

Sec. 51.50. Payments of Attorney's Fees.

(Blank)

Sec. 51.5. Power of Attorney.

***Repealed effective April 4, 1990.*
[See Appendix]

Sec. 51.7. Representation in Fatal Cases

Repealed effective January 1, 1990.
[See Appendix]

Sec. 51.10. Joint Payment of Award.

Any payment by an insurance carrier of an award of the board to a claimant represented by counsel shall be made payable jointly to the claimant and to his attorney.

The provisions of this Sec. 51.10 adopted to be effective September 18, 1981, 6 TexReg 3274.

Sec. 51.15. Periodic Installments.

When an award is made for payment of compensation in periodic installments, the carrier will notify the board of payment of the award by filing Form A-1 (report of initial payment of compensation), or A-4 (report of resumption of compensation), whichever is appropriate. An A-2 (report of suspension of compensation) will be filed with the board when the carrier discharges its obligation.

The provisions of this Sec. 51.15 adopted to be effective September 18, 1981, 6 TexReg 3274.

Sec. 51.20. Lump Sum Payment.

When an award is made for payment of compensation in a lump sum the carrier will notify the board of payment of the award by filing Form A-2 (report of suspension of compensation).

The provisions of this Sec. 51.20 adopted to be effective September 18, 1981, 6 TexReg 3274.

Sec. 51.25. Request for Review.

Requests for review shall be filed in writing with the board stating the reason for which the award is sought to be modified or set aside. The board in its discretion may set a date on which the request may be considered and will give notice of the hearing to all parties. As soon as possible after the hearing is held, the board will affirm, set aside, or modify the award on the basis of the information available to it at the time from any source. The board may on its own motion correct typographical errors at any time.

The provisions of this Sec. 51.25 adopted to be effective September 18, 1981, 6 TexReg 3274.

Sec. 51.30. Review of Award.

Review may be granted if any erroneous award was made because of fraud or mistake, or if a change has occurred in the physical condition of the injured employee requiring modification of the award as to amount or duration of payments.

The provisions of this Sec. 51.30 adopted to be effective September 18, 1981, 6 TexReg 3274.

Sec. 51.35. Unauthorized Attorney's Fee.

Repealed effective January 1, 1990.
[See Appendix]

Sec. 51.40. Attorneys Not Licensed in Texas.

Repealed effective January 1, 1990.
[See Appendix]

Sec. 51.45. Attorney's Fees and Expenses on Fatal Cases.

Repealed effective January 1, 1990.
[See Appendix]

Sec. 51.50. Payments of Attorney's Fees.

The parties may agree after the board's award, and with the approval of the board, to a different method of payment of attorney's fees as provided by law. Any such agreement shall be submitted to the board in writing, and when approved, shall be binding on all parties.

The provisions of this Sec. 51.50 adopted to be effective September 18, 1981, 6 TexReg 3274.

Sec. 51.55. Attorney's Expenses.

Repealed effective January 1, 1990.
[See Appendix]

Sec. 51.60. Deductible Expenses.

Repealed effective January 1, 1990.
[See Appendix]

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CHAPTER 53. CARRIER'S REPORT OF INITIATION AND SUSPENSION OF COMPENSATION PAYMENTS

Sec. 53.5. Payment of Benefits Without Prejudice.

Sec. 53.10. Written Notice of Injury Defined.

Sec. 53.15. Board Notice to Carrier of Injury.

Sec. 53.20. Notice of Initiation of Compensation; Mode of Payment of Compensation.

Sec. 53.22. Application to Change the Benefits Payment Period.

Sec. 53.25. Contents of Statement of Controversion or Statement of Position.

Sec. 53.30. Filing of Wage Statement.

Sec. 53.35. Notice of Suspension of Compensation.

Sec. 53.40. Transmittal Letters.

Sec. 53.45. Maximum Payment to Minor.

Sec. 53.47. Payment of Partial Benefits for Specific Injuries.

Sec. 53.48. Payment of Partial Benefits for General Injuries.

Sec. 53.50. Resumption of Compensation.

Sec. 53.55. Payment for Amputation.

Sec. 53.60. Application for Suspension of Compensation

Sec. 53.63. Suspension of Weekly Compensation.

Sec. 53.64. Nonpayment of Compensation Based on Another Carrier's Liability.

Sec. 53.65. Certification Procedure.

(Blank)

Sec. 53.5. Payment of Benefits Without Prejudice.

It being the policy of the Industrial Accident Board to encourage the prompt delivery of compensation and medical benefits to an injured worker, neither the payment of periodic benefits nor of the health provider care shall be considered an admission of liability by the insurance carrier.

The provisions of this Sec. 53.5 adopted to be effective November 11, 1983, 8 TexReg 4495.

Sec. 53.10. Written Notice of Injury Defined.

(a) Written notice of injury as used in Texas Civil Statutes, Article 8306, Sec. 18a, shall consist of either:

(1) employer's first report of injury (IAB Form E-1); or

(2) any other instrument in writing, regardless of its source, which fairly informs the carrier of the name of the injured worker, the identity of the employer, the approximate date of injury, and facts showing compensable lost time or the probability of compensable lost time.

(b) Every carrier shall promptly and legibly date stamp every written notice of injury received by it, showing the date such notice was received.

The provisions of this Sec. 53.10 adopted to be effective November 11, 1983, 8 TexReg 4495.

Sec. 53.15. Board Notice to Carrier of Injury.

The board shall furnish a dated written notification of any injury which may produce compensable lost time to the carrier's designated Austin representative. This notice shall begin the 20-day period for commencement of the payment of compensation, or the filing of the statement of controversion, as required in Texas Civil Statutes, Article 8306, Sec. 18a, unless the carrier has already received earlier written notice thereof from another source.

The provisions of this Sec. 53.15 adopted to be effective November 11, 1983, 8 TexReg 4495.

Sec. 53.20. Notice of Initiation of Compensation; Mode of Payment of Compensation.

(a) Every insurance carrier shall report to the Industrial Accident Board and to the claimant or the claimant's attorney on Form A-1 the initial payment of compensation to the claimant within 10 days from the date of:

(1) issuance of a draft, check, or other evidence of payment; or

(2) transfer of funds electronically to the claimant's account.

(b) If such payment represents both initial and final payment, that fact shall be stated on the face of the Form A-1.

(c) Except as otherwise provided, all payments of compensation, whether periodic payments, advances, A-2 lump sum payments, or settlement payments, shall be by United States legal tender, checks, or negotiable drafts drawn on a Texas financial institution.

(d) The claimant and the carrier may agree to payment of income benefits by electronic transfer of funds from any financial institution in the United States directly into an account designated by the claimant.

(e) A carrier which routinely pays benefits by instruments drawn on out-of-state financial institutions shall:

(1) arrange for negotiation of said instruments with a Texas financial institution having offices in the major Texas cities; and

(2) file the name and locations of this financial institution with the board.

(f) Whenever a payment of compensation is made through the use of a negotiable draft or a check drawn on an out-of-state bank, the carrier shall accompany the instrument with written advice to the claimant of the carrier's office location and phone number where the claimant may call, at carrier's expense, to obtain help if necessary in cashing the instrument.

The provisions of this Sec. 53.20 adopted to be effective November 11, 1983, 8 TexReg 4495; amended to be effective January 1, 1990, 14 TexReg 6671.

Sec. 53.22. Application to Change the Benefits Payment Period.

(a) While a claim is pending before the board, the claimant and the carrier, with board authorization, may agree to change the weekly payment of benefits to one of the following payment periods: every two weeks, every four weeks, monthly, or quarterly.

(b) Application for board authorization shall be made in writing on a form approved by the board.

The provisions of this Sec. 53.22 adopted to be effective April 18, 1988, 13 TexReg 1539.

Sec. 53.25. Contents of Statement of Controversion or Statement of Position.

A statement of position or a statement of controversion as provided for in Texas Civil Statutes, Article 8306, Sec. 18a(a), shall state fully and in writing the grounds for refusal to commence paying compensation. These grounds must be based on actual investigation of the claim and stated in sufficient detail so as to be compared with the position taken by the carrier at the pre-hearing conference. It is insufficient to simply state a conclusion, for example, "liability in question," "compensability in dispute," or "under investigation."

When a carrier files an insufficient statement of controversion or statement of position, the board will issue a complaint report to the carrier through its designated Austin Industrial Accident Board representative. The carrier will have 30 days from the date of receipt of the complaint report to respond in writing to the charge. The board will evaluate the carrier's response. If a majority of the board members determine that a violation has occurred, the violation may be used to establish a record of general business practice, in accordance with Texas Civil Statutes, Article 8306, Sec. 18a(d). A failure to respond to the complaint report within 30 days will constitute an automatic violation.

The provisions of this Sec. 53.25 adopted to be effective July 20, 1984, 9 TexReg 3733; amended to be effective October 1, 1985, 10 TexReg 3507.

Sec. 53.30. Filing of Wage Statement.

(a) In cases in which the reported weekly compensation rate is less than the maximum prescribed by law, the insurance carrier shall file with the board and the claimant or his attorney a wage statement reporting the wages upon which the compensation rate is based. The wage statement shall accompany the Form A-1, report of initial payment of compensation, or in the event a wage statement is not available at the time of filing Form A-1, the carrier shall indicate on Form A-1 that a wage statement has been requested and shall file said form within a reasonable time, not to exceed 30 days from the date of initial payment of compensation.

(b) When an employer fails or refuses to promptly complete and return the wage statement to the carrier, the carrier shall notify the board of that fact and additionally shall supply the employer's current address to the board. The board will thereafter contact the employer pursuant to the provisions of Texas Civil Statutes, Article 8307, Sec. 7, and of these rules, and may impose appropriate sanctions against the employer for a continuing unexcused failure to respond to the request.

(c) If the carrier does not notify the board of the employer's failure to comply within 30 days of the carrier's first request for a wage statement, the board shall set the compensation rate based upon evidence in the file, and the carrier shall be required to pay the rate determined by the board beginning with the date that the initial payment of compensation was due and continuing until the wage statement is filed with the board or until the carrier is authorized to stop or suspend compensation.

The provisions of this Sec. 53.30 adopted to be effective November 11, 1983, 8 TexReg 4495.

Sec. 53.35. Notice of Suspension of Compensation.

(a) In every instance in which an insurance carrier has paid compensation to a claimant, the carrier shall report to the board and to the claimant or his attorney on Form A-2 (notice of suspension of compensation payments) within 10 calendar days from the date of last payment. The reasons for suspension of payment shall be stated fully on the notice. When Form A-2 is filed stating compensation suspended because case settled with third party, the carrier shall accompany the notice with a copy of the judgment(s) or settlement papers.

(b) If a carrier suspends or stops the payments of indemnity compensation or medical benefits, and notifies the board in writing thereof pursuant to Texas Civil Statutes, Article 8306, Sec. 18a(b), and Article 8307, Sec. 11, such notice shall state fully the reason(s) for suspending or stopping such payments. This statement must contain sufficient substantive information to enable the board to evaluate the carrier's position on the claim. It is insufficient to simply state the carrier's position with such phrases as "abandoned medical treatment," "disability in dispute," etc. When a carrier files an insufficient statement of reasons for suspension of payment of benefits, the board will issue a complaint report to the carrier through its designated Austin Industrial Accident Board representative. The carrier will have 30 days from the date of receipt of the complaint report to respond in writing to the charge. The board will evaluate the carrier's response. If a majority of the board members determine that a violation has occurred, the violation may be used to establish a record of general business practice, in accordance with Texas Civil Statutes, Article 8306, Sec. 18a(d). A failure to respond to the complaint report within 30 days will constitute an automatic violation.

The provisions of this Sec. 53.35 adopted to be effective November 11, 1983, 8 TexReg 4495; amended to be effective July 20, 1984, 9 TexReg 3733; amended to be effective October 1, 1985, 10 TexReg 3507.

Sec. 53.40. Transmittal Letters.

In cases where the carrier tenders a lump sum payment to claimant based upon medical disability, the carrier shall accompany the payment with the A-2 and a transmittal letter which shall read as follows:

(1) "Enclosed is our payment of compensation of $________ for injuries received on ________. This payment is based on the medical reports contained in our file. Your case remains open before the Industrial Accident Board. This payment does not represent a settlement of your compensation claim. However, there are certain requirements of the law and of the Industrial Accident Board rules with which you must comply in order to protect your claim in the future. Please call our office or the board if you require additional medical treatment or become further disabled as a result of your injury."

(2) The insurance carrier shall file an amended A-2 not later than 10 days after the carrier has received a rejected lump sum payment from the claimant or has itself cancelled for any reason the lump sum payment.

The provisions of this Sec. 53.40 adopted to be effective November 11, 1983, 8 TexReg 4495.

Sec. 53.45. Maximum Payment to Minor.

In cases of specific injury or injuries resulting in death, permanent total incapacity, or a high degree of permanent partial disability, where the injured employee is a minor, the compensation rate per week shall be fixed at the maximum allowed by the law unless the evidence clearly dictates the contrary.

The provisions of this Sec. 53.45 adopted to be effective November 11, 1983, 8 TexReg 4495.

Sec. 53.47. Payment of Partial Benefits for Specific Injuries.

(a) When a claimant who has incurred a specific injury reaches maximum medical improvement, as established by the claimant's treating physician, the treating physician shall file a medical disability rating in writing with the carrier, and send a copy to the board and to the claimant.

(b) No later than 10 days after receiving the treating physician's disability rating, the carrier shall:

(1) pay partial benefits based on the treating physician's disability rating, periodically or in a lump sum, filing the appropriate notice with the board; or

(2) request a second disability rating, either by medical examination order, pursuant to Chapter 69 of these rules, or by a board-selected health care provider.

(c) No later than 10 days after receiving the second disability rating, the carrier shall pay partial benefits based on the lower disability rating, periodically or in a lump sum, filing the appropriate notice with the board.

(d) If the carrier fails or refuses to comply with this section, the claim shall be set for a hearing on the board's next available formal hearing docket.

(e) Physicians will adhere to and follow the instructions set out in the latest edition of the American Medical Association's *Guides to Evaluation of Permanent Impairment* when rating medical disability as provided in this section.

The provisions of this Sec. 53.47 adopted to be effective January 1, 1990, 14 TexReg 6672.

Sec. 53.48. Payment of Partial Benefits for General Injuries.

(a) When a carrier believes that a claimant is no longer entitled to temporary total benefits because the claimant has returned to work, or has been released to return to work without restrictions, the carrier shall:

(1) initiate payment of partial benefits based on a determination of the claimant's lost wage earning capacity, either periodically or in a lump sum; and

(2) file the appropriate notice with the board.

(b) If the carrier fails or refuses to comply with this section, the claim shall be set for a hearing on the board's next available formal hearing docket.

The provisions of this Sec. 53.48 adopted to be effective January 1, 1990, 14 TexReg 6673.

Sec. 53.50. Resumption of Compensation.

In the event the carrier shall, after reporting suspension of payment on Form A-2, subsequently resume the payment of compensation, it shall report such resumption on Form A-4 within 10 days from date of first payment after resumption, and a copy of such Form A-4 shall be furnished to the claimant or his attorney.

The provisions of this Sec. 53.50 adopted to be effective November 11, 1983, 8 TexReg 4495.

Sec. 53.55. Payment for Amputation.

When an industrial injury occurring prior to September 1, 1973, results in the amputation or partial amputation of a finger, thumb, or toe, the insurance carrier shall file with the board, with copy to the claimant or his attorney, a signed medical report and a chart showing the exact point of amputation at the time a Form A-2, compromise or lump sum payment, is submitted.

The provisions of this Sec. 53.55 adopted to be effective November 11, 1983, 8 TexReg 4495.

Sec. 53.60. Application for Suspension of Compensation.

Where application is made by the carrier for suspension of compensation pursuant to either Texas Civil Statutes, Article 8306, Sec. 12a, or Texas Civil Statutes, Article 8307, Sec. 4, the question of suspension will be set by the board for hearing within two weeks of said application. No suspension of compensation benefits will be approved by the board, under Texas Civil Statutes, Article 8307, Sec. 4, unless statutory grounds exist for suspension. No suspension of compensation benefits will be approved by the board, under Texas Civil Statutes, Article 8306, Sec. 12a, unless:

(1) the injured employee has returned to work; or

(2) the injured employee refuses light duty work procured for him in the locality where he was injured or at a place agreeable to him; or

(3) the treating physician has released the employee to return to work without physical restrictions relating to the compensable injuries involved.

The provisions of this Sec. 53.60 adopted to be effective November 11, 1983, 8 TexReg 4495.

Sec. 53.63. Suspension of Weekly Compensation.

(a) A carrier may not suspend payment of weekly or other periodic benefits pending final adjudication until there exists evidence justifying suspension. However, in no event, unless directed otherwise by the board, shall a carrier suspend benefits until:

(1) the injured employee returns to work;

(2) the injured employee is released by a physician to return to work without restrictions;

(3) the employee refused employment offered him or her consistent with any restrictions;

(4) the statutory maximum benefit has been paid;

(5) the claim is resolved by settlement, A-2 lump sum payment, or matured award;

(6) evidence exists showing that the carrier has no liability for the employee's injury; or

(7) there is a third-party settlement which relieves the carrier of its liability.

(b) Medical evidence indicating that a worker can perform work with restrictions or evidence existing showing that the injured employee has engaged in activities inconsistent with his or her impairment shall constitute good cause under Sec. 61.25 of this title (relating to Setting at Carrier's Request).

(c) Nothing in this section shall conflict with the provisions of Texas Civil Statutes, Article 8307, Sec. 4(b).

The provisions of this Sec. 53.63 adopted to be effective July 18, 1988, 13 TexReg 3512.

Sec. 53.64. Nonpayment of Compensation Based on Another Carrier's Liability.

(a) When the carrier fails or refuses to initiate, or suspends, payment of income or medical benefits based on evidence that another carrier is liable for the claimant's disability, the carrier or the claimant's attorney, if any, shall immediately request a formal hearing before the board.

(b) The claim will be set for a hearing on the board's next available formal hearing docket.

The provisions of this Sec. 53.64 adopted to be effective December 13, 1989, 14 TexReg 6279.

Sec. 53.65. Certification Procedure.

In cases where it appears that the carrier willfully fails, or refuses without justification to pay compensation, the following procedure will apply:

(1) If, on suspension or stoppage of workers' compensation payments, it appears to the board that the carrier has not fully discharged its obligation to the claimant, the board will notify the carrier through its Austin Industrial Accident Board representative of the deficiency, and copies of such notice shall be sent to the claimant or his attorney.

(2) The board will specify a reasonable period of time in which a carrier may either pay the deficiency and submit a correct report or submit information to the board justifying the amount of its payment.

(3) If the carrier fails to pay the deficiency or fails to submit information justifying the amount of its payment, the board shall set the case for formal hearing to be held by a majority of the board within 100 miles of the claimant's residence. The provision of Sec. 49.105 of this title (relating to Special Formal Hearing and Other Investigative Hearings), et seq., shall apply.

(4) At such hearing, if it is determined that compensation benefits are due, the board shall so order. If the carrier fails to obey such order within 10 days the board may certify such fact to the commissioner of insurance for proceedings, according to Texas Civil Statutes, Article 8306, Sec. 18.

The provisions of this Sec. 53.65 adopted to be effective October 1, 1985, 10 TexReg 3507.

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CHAPTER 55. LUMP SUM PAYMENTS

Sec. 55.3. Request for Advance Payment of Compensation.

Sec. 55.5. Lump Sum Payments.

Sec. 55.10. Settlements Final When Approved.

Sec. 55.15. Compromise Settlement Agreements.

Sec. 55.20. Execution of Compromise Settlement Agreement.

Sec. 55.25. Loss of an Eye.

Sec. 55.30. Hearing Impairment.

Sec. 55.35. Stipulation of Medical Payments.

Sec. 55.40. Attorney's Signature.

Sec. 55.45. Percent of Medical Impairment.

Sec. 55.50. Attorney's Fees and Expenses.

Sec. 55.55. Compromise Settlement Agreement to Set Aside Award.

Sec. 55.60. Consent Withdrawn.

Sec. 55.65. Withdrawal of Consent by Death.

Sec. 55.75. Tender Payment Time Period.

Sec. 55.80. Waiving of Approval Appearance.

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Sec. 55.3. Request for Advance Payment of Compensation.

(a) A claimant who suffers financial hardship because of loss of wages due to an uncontested injury may request of the carrier an advance payment of compensation ("advance") to be credited against future compensation benefits.

(b) A request for an advance shall be:

(1) prepared on a board-approved form;

(2) signed by the claimant unless waived for good cause; and

(3) submitted in the original to the carrier, with a copy filed with the board.

(c) If, within 10 days of receipt of the request, the carrier fails to tender an advance, the board may set a hearing and notify the parties in writing.

(d) If an advance is sought at a pre-hearing conference, in the absence of a formal request for an advance under this section, and the advance is either denied by the adjuster at that time or deemed inadequate by the claimant, the board may set a hearing on the first available formal hearing docket.

(e) After the hearing the board may direct the carrier to make an advance if the board determines that:

(1) an emergency or impending necessity exists; and

(2) the future compensation benefits due the claimant exceed the amount of the advance directed.

The provisions of this Sec. 55.3 adopted to be effective January 1, 1990, 14 TexReg 6674.

Sec. 55.5. Lump Sum Payments.

No lump sum payment of fatal benefits may be made without prior board approval. No lump sum payment of fatal benefits may be made to beneficiaries, unless there exists a *bona fide* dispute as to the liability of the insurance carrier, and no lump sum payment of benefits for injuries enumerated in Texas Civil Statutes, Article 8306, Sec. 11a, shall be made unless there is also a *bona fide* dispute as to the liability of the insurance carrier (Texas Civil Statutes, Article 8306, Secs. 8(d) and 10(d)).

(1) When authorized by statute, a lump sum payment for a minor's compensation in fatal cases will be considered by the board upon receipt of a certified copy of letters of guardianship. If the carrier requests an order of a probate court directing a lump sum payment, the cost thereof shall be borne by the carrier.

(2) All lump sum payment agreements submitted to the board must be submitted in four parts--the original must be white, the second copy pink, third copy yellow, and fourth copy white. The forms must either be on NCR paper or be submitted with carbon left intact. A copy of the lump sum payment agreement will be furnished to the parties listed below in lieu of a separate approval notice:

(A) The pink copy will be mailed to the claimant (in an envelope of like color) by the board;

(B) the yellow copy will be mailed to the claimant's attorney if one has been employed (in an envelope of like color); and

(C) the final copy will be placed in the Austin board representative's box.

The provisions of this Sec. 55.5 adopted to be effective November 20, 1977, 2 TexReg 4320; amended to be effective November 11, 1983, 8 TexReg 4496.

Sec. 55.10. Settlements Final When Approved.

Compromise settlement agreements between insurance carriers and persons claiming benefits under the Texas Workers' Compensation Law are not final until approved by the board.

The provisions of this Sec. 55.10 adopted to be effective November 20, 1977, 2 TexReg 4320.

Sec. 55.15. Compromise Settlement Agreements.

A compromise settlement agreement must contain the following information:

(1) that the agreement is executed on a form approved by the board;

(2) that the agreement is accompanied by physician's signed report of the findings of a recent examination of the employee;

(3) that the employee has achieved maximum recovery, or that good reason exists for settlement prior to maximum recovery;

(4) that in the event of serious injury to claimant's eye, healing has occurred and the board furnished with a medical report on whether the other eye is or may be affected;

(5) that in all instances of severe and disfiguring burns or lacerations, a descriptive medical report of the scars will be submitted by either the association or claimant. In all such cases involving injury to the face, arms, or hands, a color photograph taken after maximum healing must be submitted to the board by either the claimant or carrier;

(6) all compromise settlement agreements submitted to the board must be submitted in four parts--the original must be white, the second copy pink, the third copy yellow, and fourth copy white. The forms must either be on NCR paper or be submitted with carbon left intact. A copy of the compromise settlement agreement will be furnished to the parties listed below in lieu of a separate approval notice:

(A) The pink copy will be mailed to the claimant (in an envelope of like color) by the board;

(B) the yellow copy will be mailed to the claimant's attorney if one has been employed (in an envelope of like color); and

(C) the final copy will be placed in the Austin representative's box.

The provisions of this Sec. 55.15 adopted to be effective November 20, 1977, 2 TexReg 4320; amended to be effective September 25, 1979, 4 TexReg 3232; amended to be effective September 18, 1981, 6 TexReg 3340.

Sec. 55.20. Execution of Compromise Settlement Agreement.

A compromise settlement agreement must be signed by the claimant personally, unless sufficient good cause is found by the board to excuse strict compliance with this section. Only in extraordinary circumstances will the board approve a compromise settlement agreement in which the attorney signs the claimant's name under a power of attorney.

The provisions of this Sec. 55.20 adopted to be effective September 18, 1981, 6 TexReg 3274; amended to be effective November 11, 1983, 8 TexReg 4496.

Sec. 55.25. Loss of an Eye.

The board considers "loss of an eye" when loss of vision reached 90%. Permanent partial loss of vision in an eye will be calculated on the actual loss of vision as a result of an injury, and not on loss of vision after restoration of vision by proper fitting glasses. The following table for the estimate of compensation to be paid workers who have suffered partial or complete loss of vision in one eye, through accident or occupation, is adopted by the board.

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TABLE OF VISUAL LOSSES OF ONE EYE

20/20 indicates 100% of visual efficiency and no loss of vision.

	RETAINED	LOST
20/30	94.5%	5.5%
20/40	89.0%	11.0%
20/50	83.5%	16.5%
20/60	78.0%	22.0%
20/70	72.5%	27.5%
20/80	67.0%	33.0%
20/90	61.5%	38.5%
20/100	56.0%	44.0%
20/110	50.0%	50.0%
20/120	41.0%	59.0%
20/130	36.5%	63.5%
20/140	32.0%	68.0%
20/150	28.5%	71.5%
20/160	23.0%	77.0%
20/170	18.5%	81.5%
20/180	14.0%	86.0%
20/190	12.0%	88.0%
20/200	Total Loss	Total Loss

The provisions of this Sec. 55.25 adopted to be effective November 20, 1977, 2 TexReg 4320.

Sec. 55.30. Hearing Impairment.

(a) Hearing tests for use in compensation ratings shall be derived from the pure-tone audiogram calculated to ANSI-S3.6-1969 standards. Examination should be performed by a medical specialist who does hearing evaluations or by an audiologist having the Certificate of Clinical Competence from the American Speech-Language-Hearing Association upon referral. Hearing handicap will be based on the functional state of both ears.

(b) The average of the hearing threshold levels at 500 Hz, 1,000 Hz, 2,000 Hz, and 3,000 Hz should be calculated for each ear. The percent of impairment for each ear should be calculated by multiplying by 1.5 the amount by which the above average hearing threshold level exceeds 25 dB up to a maximum of 100% which is reached at 92 dB. The hearing handicap, a bilateral assessment, should then be calculated by multiplying the smaller percentage (better ear), by five, adding this figure to the larger percentage (poorer ear), and dividing the total by six.

(c) Since there is no exact scientific test by which non-industrial hearing losses can be distinguished from induced impairment, the opinion as to the amount of loss due to such other causes shall be made by the examining medical specialist.

(d) No consideration shall be given to possible improvements through use of prosthesis. Where artificial appliances would materially and beneficially improve the future usefulness and occupational opportunities of the employee, the insurer shall provide same, and shall continue to furnish the needed artificial appliance or appliances until a satisfactory fit is obtained in the judgment of the attending physician or physicians. The association shall be liable for replacing or repairing any artificial appliances so furnished.

(e) Such prosthesis shall be prescribed upon proper evaluation by a medical specialist who does hearing aid evaluations or by an audiologist having the Certificate of Clinical Competence from the American Speech-Language-Hearing Association upon referral. Such hearing and speech centers shall have no commercial properties.

(f) The above formula should be used in calculating the percentage of loss hearing, but the doctor giving the report shall state specifically the exact loss of hearing in percentage, and not decibels.

(g) See examples and chart.

EXAMPLES

A. MILD TO MARKED BILATERAL SENSORINEURAL HEARING LOSS

	500 Hz	1000 Hz	2000 Hz	3000 Hz
R EAR	15	25	45	55
L EAR	30	45	60	85

1. TO CALCULATE THE AVERAGE HEARING THRESHOLD LEVEL (HTL)

$$\text{R EAR} = \frac{15 + 25 + 45 + 55}{4} = \frac{140}{4} = 35 \text{ dB}$$

$$\text{L EAR} = \frac{30 + 45 + 60 + 85}{4} = \frac{220}{4} = 55 \text{ dB}$$

2. TO CALCULATE MONAURAL IMPAIRMENT

R EAR = 35 dB - 25 dB = 10 dB; 10 x 1.5 = 15%

L EAR = 55 dB - 25 dB = 30 dB; 30 x 1.5 = 45%

3. TO CALCULATE HEARING HANDICAP

SMALLER NUMBER (BETTER EAR) 15% x 5 = 75
LARGER NUMBER (POORER EAR) 45% x 1 = 45

TOTAL: 120 divided by 6 = 20%

THEREFORE, A PERSON WITH THE HEARING THRESHOLD LEVELS SHOWN IN THE AUDIOGRAM ABOVE WOULD HAVE A 20% HEARING HANDICAP.

B. <u>SLIGHT BILATERAL SENSORINEURAL HEARING LOSS</u>

	500 Hz	1000 Hz	2000 Hz	3000 Hz
R EAR	15	15	20	30
L EAR	20	20	30	40

1. AVERAGE HTL

$$R\ EAR = \frac{15 + 15 + 20 + 30}{4} = \frac{80}{4} = 20\ dB$$

$$L\ EAR = \frac{20 + 20 + 30 + 40}{4} = \frac{110}{4} = 27.5\ dB$$

2. MONAURAL IMPAIRMENT

R EAR = 20 dB - 25 dB = -5 dB; 0 x 1.5 = 0%

L EAR = 27.5 dB - 25 dB = 2.5 dB; 2.5 x 1.5 = 3.75%

3. HEARING HANDICAP

SMALLER NUMBER (BETTER EAR)	0% X 5 = 0.00
LARGER NUMBER (POORER EAR)	3.75% X 1 = <u>3.75</u>

TOTAL: 3.75 divided by 6 = 1%
(Rounded Off)

THEREFORE, THE HEARING HANDICAP IS 1%.

C. <u>SEVERE TO EXTREME BILATERAL SENSORINEURAL HEARING LOSS</u>

	500 Hz	1000 Hz	2000 Hz	3000 Hz
R EAR	80	90	100	110
L EAR	75	80	90	95

1. AVERAGE HTL

$$R\ EAR = \frac{80 + 90 + 100 + 110}{4} = \frac{380}{4} = 95\ dB$$ (USE 92 dB MAXIMAL VALUE)

$$L\ EAR = \frac{75 + 80 + 90 + 95}{4} = \frac{340}{4} = 85\ dB$$

2. MONAURAL IMPAIRMENT

R EAR = 92 dB (MAXIMUM) - 25 dB = 67 dB; 67 x 1.5 = 100%

L EAR = 85 dB - 25 dB = 60 dB; 60 x 1.5 = 90%

3. HEARING HANDICAP

SMALLER NUMBER (BETTER EAR)	90% X 5 = 450
LARGER NUMBER (POORER EAR)	100% X 1 = 100

TOTAL: 550 divided by 6 = 92%

THEREFORE, THE HEARING HANDICAP IS 92%.

TABLE 1. TABLE OF MONAURAL HEARING IMPAIRMENT*

AVERAGE DSHL	%	AVERAGE DSHL	%
100	0.0		
105	1.9	245	54.4
110	3.8	250	56.3
115	5.6	255	58.1
120	7.5	260	60.0
125	9.4	265	61.9
130	11.3	270	63.8
135	13.1	275	65.6
140	15.0	280	67.5
145	16.9	285	69.4
150	18.8	290	71.3
155	20.6	295	73.1
160	22.5	300	75.0
165	24.4	305	76.9
170	26.3	310	78.8
175	28.1	315	80.6
180	30.0	320	82.5
185	31.9	325	84.4
190	33.8	330	86.3
195	35.6	335	88.1
200	37.5	340	90.0
205	39.4	345	90.9
210	41.3	350	93.8
215	43.1	355	95.6
220	45.0	360	97.5
225	46.9	365	99.4
230	48.8	370 or greater	100.0
235	50.6		
240	52.5		

**AUDIOMETERS ARE CALIBRATED TO ANSI-1969 STANDARD REFERENCE LEVELS. AVERAGE DECIBEL SUM OF THE HEARING THRESHOLD LEVELS AT 500, 1000, 2000, AND 3000 HERTZ.*

1. FROM THE AUDIOGRAM OR NUMERICAL RECORD OF THE AUDIOMETRIC TEST, FIND THE DECIBEL SUM OF THE HEARING THRESHOLD LEVELS (DSHL) OF 500, 1000, 2000, AND 3000 HERTZ (Hz).

EXAMPLE:		
	500	20
	1000	25
	2000	35
	3000	40

TOTAL: 120 DSHL

2. UNDER THE DSHL HEADING, 120 DSHL (COL. 1, LINE 5) = 7.5%

3. COMPUTATION OF % OF HEARING HANDICAP:
IF THE MONAURAL % FIGURE IS THE SAME FOR BOTH EARS, THAT FIGURE EXPRESSES THE % HEARING HANDICAP. IF THE PERCENTAGE MONAURAL HEARING IMPAIRMENTS ARE NOT THE SAME, APPLY THE FORMULA:

$$\frac{(5 \text{ X \% [BETTER EAR]}) + (1 \text{ X \% [POORER EAR]})}{6} = \text{\% HEARING HANDICAP}$$

The provisions of this Sec. 55.30 adopted to be effective November 20, 1977, 2 TexReg 4320; amended to be effective September 18, 1981, 6 TexReg 3340; amended to be effective November 11, 1983, 8 TexReg 4496.

Sec. 55.35. Stipulation of Medical Payments.

Where an insurance company agrees to pay accrued medical and hospital expenses in a compromise settlement agreement, any exceptions or special stipulations agreed upon by the parties must be clearly stated on the face of the compromise settlement agreement or an attached affidavit.

The provisions of this Sec. 55.35 adopted to be effective November 20, 1977, 2 TexReg 4320.

Sec. 55.40. Attorney's Signature.

Settlement agreements entered into by claimants who are represented by an attorney must be signed by the attorney. The attorney's name and address shall be on the face of the agreement.

The provisions of this Sec. 55.40 adopted to be effective November 20, 1977, 2 TexReg 4320.

Sec. 55.45. Percent of Medical Impairment.

Where the amount of compensation due is covered by Texas Civil Statutes, Article 8306, Sec. 12, the board may consider percentage of medical impairment as only one element in arriving at percentage of legal disability as distinguished from medical disability.

The provisions of this Sec. 55.45 adopted to be effective November 20, 1977, 2 TexReg 4320.

Sec. 55.50. Attorney's Fees and Expenses.

Sections 51.5; 51.7; 51.10; 51.35; 51.40; 51.45; 51.50; 51.55; and 51.60 of this title (relating to Power of Attorney; Representation in Fatal Cases; Joint Payment of Award; Unauthorized Attorney's Fee; Attorney Fees and Expenses on Fatal Cases; Payments of Attorney's Fees; Attorney's Expenses; and Deductible Expenses) shall be applied by the board to claims disposed of by settlement agreement.

The provisions of this Sec. 55.50 adopted to be effective November 20, 1977, 2 TexReg 4320; amended to be effective April 18, 1988, 13 TexReg 1539.

Sec. 55.55. Compromise Settlement Agreement to Set Aside Award.

A compromise settlement agreement, properly executed between or among all parties to the claim, when filed in any board office in the period after an award has been entered but before it becomes final, or suit is filed, will serve to set aside the award as of the date the compromise settlement agreement is filed. If the board subsequently fails to approve the compromise settlement agreement, then the original award will be immediately re-entered.

The provisions of this Sec. 55.55 adopted to be effective November 6, 1986, 11 TexReg 4430.

Sec. 55.60. Consent Withdrawn.

The board's approval of a compromise settlement agreement shall be final at the time the approval is signed by the board unless the board has received a request in writing prior to entry of the approval order that one or more parties to the agreement wishes to withdraw their consent to the agreement, and the board permits the withdrawal of such consent. Any such written request to the board for permission to withdraw consent to an agreement must fully set out the reason or reasons for such request.

The provisions of this Sec. 55.60 adopted to be effective November 20, 1977, 2 TexReg 4320; amended to be effective September 18, 1981, 6 TexReg 3274; amended to be effective October 1, 1985, 10 TexReg 3506.

Sec. 55.65. Withdrawal of Consent by Death.

If the claimant has died after signing the compromise settlement agreement before the board approved the same, the claimant's death will be considered as effectively terminating claimant's continuing consent to the compromise settlement agreement.

The provisions of this Sec. 55.65 adopted to be effective September 18, 1981, 6 TexReg 3274.

Sec. 55.75. Tender Payment Time Period.

An insurance carrier shall have 20 days from and after the date of approval of a compromise settlement agreement in which to pay or tender payment to the injured employee of the amount approved by the board, and shall have 20 days from the receipt of bills in which to tender all accrued medical expenses resulting from the injury. Failure to tender payment within such time shall cause the board to immediately set such case for formal hearing for the purpose of invoking proper sanctions.

The provisions of this Sec. 55.75 adopted to be effective November 20, 1977, 2 TexReg 4320.

Sec. 55.80. Waiving of Approval Appearance.

Personal appearance of the claimant shall be required prior to recommendation by the board representative for approval of compromise settlement agreements, unless upon the showing of good cause said personal appearance is waived by the board representative.

The provisions of this Sec. 55.80 adopted to be effective November 20, 1977, 2 TexReg 4320.

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CHAPTER 56. STRUCTURED COMPROMISE SETTLEMENT AGREEMENTS

Sec. 56.5.	Definitions.
Sec. 56.10.	Form.
Sec. 56.15.	Execution.
Sec. 56.20.	Personal Appearance by Claimant.
Sec. 56.25.	Medical Benefits.
Sec. 56.30.	Consent of Parties--Withdrawal.
Sec. 56.35.	Attorney's Signature.
Sec. 56.40.	Attorney's Fees and Expenses.
Sec. 56.45.	Tender Payment Time Period.
Sec. 56.50.	Final When Approved.
Sec. 56.55.	Annuity Company.
Sec. 56.60.	Payments Guaranteed.
Sec. 56.65.	Cost of the Annuity.
Sec. 56.70.	Structured Settlement Agreement to Set Aside Award.

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Sec. 56.5. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

Annuity company--The company from which the carrier is purchasing an annuity for the claimant. The annuity company may be the carrier if the carrier meets the tests provided below for annuity companies.

Structured settlement--Structured compromise settlement agreement.

The provisions of this Sec. 56.5 adopted to be effective December 21, 1987, 12 TexReg 4529.

Sec. 56.10. Form.

A structured settlement must:

(1) be submitted on a form approved by the board;

(2) be accompanied by a physician's signed report of the findings of a recent examination of the employee;

(3) be accompanied, in the event of serious injury to claimant's eye, by a medical report indicating that healing has occured and whether the other eye is or may be affected;

(4) be accompanied, in the event of severe and disfiguring burns or lacerations, by a descriptive medical report of the scars. In all cases involving injury to the face, arms, or hands, a color photograph taken after maximum healing must be submitted to the board;

(5) be submitted in five parts. The original must be white, the second part pink, the third yellow, the fourth white, and the fifth goldenrod. The forms must be submitted with carbon left intact. The board will furnish the following parties with approved copies of the forms.

(A) The claimant will receive the pink copy.

(B) The attorney, if any, will receive the yellow copy.

(C) The Austin board representative will receive the final two copies.

The provisions of this Sec. 56.10 adopted to be effective December 21, 1987, 12 TexReg 4529.

Sec. 56.15. Execution.

A structured settlement must be signed by the claimant personally, unless the board finds good cause to excuse strict compliance with this section. Only in extraordinary circumstances will the board approve a structured settlement in which the attorney signs the claimant's name under a power of attorney.

The provisions of this Sec. 56.15 adopted to be effective December 21, 1987, 12 TexReg 4529.

Sec. 56.20. Personal Appearance by Claimant.

A personal appearance of the claimant may be required by the board prior to approval. The personal meeting is to be set up by the board, not by the carrier. A carrier representative is required to be present.

The provisions of this Sec. 56.20 adopted to be effective December 21, 1987, 12 TexReg 4529.

Sec. 56.25. Medical Benefits.

Where a carrier agrees to pay accrued medical and hospital expenses in a structured settlement, any exceptions or special stipulations must be clearly stated on the face of the structured settlement or on an attached affidavit.

The provisions of this Sec. 56.25 adopted to be effective December 21, 1987, 12 TexReg 4529.

Sec. 56.30. Consent of Parties--Withdrawal.

The board's approval of a structured settlement shall be final at the time the approval is signed by the board unless the board has received a request in writing prior to entry of the approval order that one or more parties to the agreement wishes to withdraw their consent to the settlement, and the board permits the withdrawal of such consent. Any such written request to the board for permission to withdraw consent to a settlement must fully set out the reason or reasons for such request.

The provisions of this Sec. 56.30 adopted to be effective December 21, 1987, 12 TexReg 4529.

Sec. 56.35. Attorney's Signature.

A structured settlement entered into by a claimant who is represented by an attorney must be signed by the attorney. The attorney's name and address must be on the face of the settlement.

The provisions of this Sec. 56.35 adopted to be effective December 21, 1987, 12 TexReg 4529.

Sec. 56.40. Attorney's Fees and Expenses.

Sections 51.5; 51.7; 51.10; 51.35; 51.40; 51.45; 51.50; 51.55; and 51.60 of this title (relating to Power of Attorney; Representation in Fatal Cases; Joint Payment of Award; Unauthorized Attorney's Fee; Attorneys Not Licensed in Texas; Attorney Fees and Expenses on Fatal Cases; Payments of Attorney's Fees; Attorney's Expenses; and Deductible Expenses) shall be applied by the board to claims disposed of by structured settlement.

The provisions of this Sec. 56.40 adopted to be effective December 21, 1987, 12 TexReg 4529; amended to be effective April 18, 1988, 13 TexReg 1539.

Sec. 56.45. Tender Payment Time Period.

The carrier shall have 20 days after the date of approval of a structured settlement to pay or tender any approved lump sum payment to the injured employee or approved fees and expenses to any attorney(s), and shall have 20 days from the receipt of bills in which to tender all reasonable accrued medical expenses necessarily resulting from the injury. Failure to tender payment within such time shall cause the board to immediately set such case for formal hearing for the purpose of invoking proper sanctions.

The provisions of this Sec. 56.45 adopted to be effective December 21, 1987, 12 TexReg 4529.

Sec. 56.50. Final When Approved.

A structured settlement is not final until the settlement is approved by the board. Board approval is deemed to have occured at 5 p.m. of the day the approval is signed.

The provisions of this Sec. 56.50 adopted to be effective December 21, 1987, 12 TexReg 4529.

Sec. 56.55. Annuity Company.

An annuity company providing an annuity under the terms of a structured settlement must be licensed to do business in Texas and must have a Best's rating of A+, with a financial size category of VII or above, according to the most recent information available.

The provisions of this Sec. 56.55 adopted to be effective December 21, 1987, 12 TexReg 4529.

Sec. 56.60. Payments Guaranteed.

The workers' compensation carrier shall guarantee the payments provided by the annuity company in the event of default.

The provisions of this Sec. 56.60 adopted to be effective December 21, 1987, 12 TexReg 4529.

Sec. 56.65. Cost of Annuity.

(a) The carrier shall submit to the board with the structured settlement, *in camera*, the cost of the annuity.

(b) The cost of the annuity to a carrier that does not purchase an annuity from a third party is the discounted value of the periodic payments to be provided.

The provisions of this Sec. 56.65 adopted to be effective December 21, 1987, 12 TexReg 4529.

Sec. 56.70. Structured Settlement Agreement to Set Aside Award.

A structured settlement, properly executed between or among all parties to the claim, when filed in the board's office in the period after an award has been entered but before it becomes final, or suit is filed, will serve to set aside the award as of the date the structured settlement is filed. If the board subsequently fails to approve the settlement, then the original award will be re-entered immediately.

The provisions of this Sec. 56.70 adopted to be effective December 21, 1987, 12 TexReg 4529.

CHAPTER 57. REQUEST FOR CASE FOLDERS AND CERTIFICATIONS OF ACTIONS OF THE BOARD

Sec. 57.5. Request for Copies or Statistical Information.

Sec. 57.10. Written Request for Public Information.

Sec. 57.15. Telephone Request for Public Information.

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Sec. 57.5. Request for Copies or Statistical Information.

Written requests for public information by persons entitled thereto under Texas Civil Statutes, Article 8307, Sec. 9 and Sec. 9a, shall be mailed or presented in person to the board's Austin office. Copies and certified copies of files or portions thereof or statistical information will be furnished only upon receipt of the correct payment. Fees and charges for requested reproduced copies or statistical information may be obtained from the Industrial Accident Board. There will be no refund for less than $5.00 of monies paid by actual mistake in excess of the correct amount or for copies of instruments not in the board's file, unless specifically requested in writing. No copies or certified copies of instruments will be furnished between seven days prior to the date of formal hearing and the date of the board's award.

The provisions of this Sec. 57.5 adopted to be effective November 20, 1977, 2 TexReg 4322; amended to be effective June 9, 1980, 5 TexReg 2111; amended to be effective September 18, 1981, 6 TexReg 3274.

Sec. 57.10. Written Request for Public Information.

All written requests for public information under Texas Civil Statutes, Article 8307, Sec. 9a, from prospective employers must be accompanied by a written authorization from the prospective employee.

The provisions of this Sec. 57.10 adopted to be effective November 20, 1977, 2 TexReg 4322.

Sec. 57.15. Telephone Request for Public Information.

All telephone inquiries from prospective employers seeking public information under Texas Civil Statutes, Article 8307, Sec. 9a, must be directed to the board's Austin office. Written authorizations required under this statute must also be directed to the board's Austin office.

The provisions of this Sec. 57.15 adopted to be effective November 20, 1977, 2 TexReg 4322.

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CHAPTER 59. NOTICES OF INTENTION TO APPEAL

Sec. 59.5. Filing of Notice.

Sec. 59.10. Receipt of Notice.

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Sec. 59.5. Filing of Notice.

Notices of intention to appeal from a final order or award of the board shall be filed with the board in Austin and must be in writing, clearly and accurately identify the compensation claim to which it pertains, including the board file number, and delivered to the board's office in Austin, either:

(1) in person, or

(2) by mail, or

(3) by wire or telegram, or

(4) by comparable means.

The provisions of this Sec. 59.5 adopted to be effective November 20, 1977, 2 TexReg 4323; amended to be effective November 11, 1983, 8 TexReg 4497.

Sec. 59.10. Receipt of Notice.

Receipt of the Notice of Intention to Appeal shall be acknowledged by a board member, the executive director of the board, or by persons duly designated by the board for such purpose, who shall immediately stamp and sign each such notice. Acknowledgment will subsequently be made by mail to all interested parties.

The provisions of this Sec. 59.10 adopted to be effective November 20, 1977, 2 TexReg 4323.

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CHAPTER 61. PRE-HEARING CONFERENCES

Sec. 61.5. Request for Pre-hearing Conference.

Sec. 61.7. Notice of Pre-hearing Conference.

Sec. 61.15. Setting Under Texas Civil Statutes, Article 8306, Sec. 18a.

Sec. 61.20. Setting on Hardship.

Sec. 61.25. Setting at Carrier's Request.

Sec. 61.30. Filing of Medical Information.

Sec. 61.35. Exchange of Medical Information.

Sec. 61.40. Additional Medical.

Sec. 61.45. Charges for Reports.

Sec. 61.50. Representatives Must Be Qualified.

Sec. 61.55. Supply of Forms.

Sec. 61.60. Attendance at Conference.

Sec. 61.65. Request for Cancellation of Pre-hearing Conference.

Sec. 61.70. Maintain Setting.

Sec. 61.75. Failure to Appear.

Sec. 61.80. Participation at Conference.

Sec. 61.85. Carrier Self-Audit of Pre-hearing Conference.

Sec. 61.90. Conduct at Pre-hearing Conference.

Sec. 61.95. Consular Officers.

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Sec. 61.5. Notice of Pre-hearing Setting.

Repealed to be effective December 13, 1989.
[See Appendix]

Sec. 61.5. Request for Pre-hearing Conference.

(a) Except as otherwise provided, a request for a pre-hearing conference must be submitted on a board-approved form.

(b) Failure to provide the information requested may constitute grounds for rejecting the request.

(c) An unrepresented claimant may request a pre-hearing conference by contacting the board in any manner.

The provisions of this Sec. 61.5 adopted to be effective December 13, 1989, 14 TexReg 6279.

Sec. 61.7. Notice of Pre-hearing Conference.

(a) Except as otherwise provided, the board will give at least 30 days written notice of the pre-hearing conference date to all interested parties.

(b) If income or medical benefits are not being paid, the board may set a pre-hearing conference with less than 30 days notice.

The provisions of this Sec. 61.7 adopted to be effective December 13, 1989, 14 TexReg 6279.

Sec. 61.10. Setting on Nonpayment.

Repealed to be effective December 13, 1989.
[See Appendix]

Sec. 61.15. Setting Under Texas Civil Statutes, Article 8306, Sec. 18a.

(a) If the carrier, having received written notice of a compensable lost time injury as provided in Texas Civil Statutes, Article 8306, Sec. 18a, is not timely paying compensation, or ceases the payment of such benefits, the board shall set the claim for a pre-hearing conference on the first available docket.

(b) If a Texas Civil Statutes, Article 8306, Sec. 18a penalty (Sec. 18a penalty) appears due, initiation or reinstatement of compensation shall not be grounds for cancellation of a pre-hearing conference set under this section. However, the board may waive the claimant's appearance at the pre-hearing conference upon request.

(c) In the event a dispute arises over the suspension of medical benefits as defined in these board rules, a health care provider may file with the board a written request to attend a pre-hearing conference, as a party and participant therein, and in such event the health care provider shall attend the pre-

hearing conference, either in person or by a representative. In the request, the health care provider shall certify the charges have been itemized and that timely reports have been made in accordance with Texas Civil Statutes, Article 8306, Sec. 7, and these board rules.

The provisions of this Sec. 61.15 adopted to be effective November 11, 1983, 8 TexReg 4497; amended to be effective December 13, 1989, 14 TexReg 6280.

Sec. 61.20. Setting on Hardship.

(a) If the board determines that financial hardship may exist and the carrier has failed to tender an adequate advance or acceleration of benefits within 10 days from the filing of a hardship affidavit with the board, the board shall schedule such case for pre-hearing conference on the next docket following 30 days from the date of the filing of the hardship affidavit.

(b) Hardship affidavits must contain sufficient factual information to support the allegations of hardship, and shall be signed and sworn by the claimant personally, unless otherwise waived by the board for good cause shown.

(c) A copy of the hardship affidavit shall be forwarded to the insurance carrier by the claimant at the same time the original is filed with the board.

The provisions of this Sec. 61.20 adopted to be effective November 11, 1983, 8 TexReg 4497.

Sec. 61.25. Setting at Carrier's Request.

Upon a showing of good cause, pre-hearing will be set by the board on the insurance carrier's request. It shall be presumed the payment of compensation benefits for a period of consecutive 52 weeks or longer constitutes a case of "extended disability", and in such cases the carrier, upon written request therefor, approved by the board, shall be entitled to a pre-hearing conference in order to review the claimant's physical and medical condition and the treatment thereof.

The provisions of this Sec. 61.25 adopted to be effective November 11, 1983, 8 TexReg 4497.

Sec. 61.30. Filing of Medical Information.

All available medical information that has a bearing on the claim at hand must be filed with the board at or before the pre-hearing in accordance with Article 8309a(b).

The provisions of this Sec. 61.30 adopted to be effective January 1, 1976; amended to be effective November 20, 1977, 2 TexReg 4323.

Sec. 61.35. Exchange of Medical Information.

Claimant or claimant's attorney and carrier shall exchange all available medical information promptly after expiration of six weeks disability or earlier upon written request of either party. Thereafter, all medical information will be exchanged promptly upon receipt. If received less than seven days prior to a pre-hearing conference, it shall be brought to the pre-hearing conference for exchange. Both parties shall bring to the pre-hearing conference all available medical information.

The provisions of this Sec. 61.35 adopted to be effective January 1, 1976; amended to be effective November 20, 1977, 2 TexReg 4323; amended to be effective September 18, 1981, 6 TexReg 3274.

Sec. 61.40. Additional Medical.

Where the pre-hearing officer determines that additional medical examination will probably assist in settlement, he may order such additional medical examination at the expense of the board, provided no undue delay shall occur thereby, and the pre-hearing officer shall reset the pre-hearing conference.

The provisions of this Sec. 61.40 adopted to be effective January 1, 1976; amended to be effective November 20, 1977, 2 TexReg 4323.

Sec. 61.45. Charges for Reports.

Reasonable charges shall be allowed by the board for narrative reports required under Texas Civil Statutes, Article 8306, Sec. 7, and such charges shall be considered necessary expenses to be paid by the carrier.

The provisions of this Sec. 61.45 adopted to be effective January 1, 1976; amended to be effective November 20, 1977, 2 TexReg 4323.

Sec. 61.50. Representatives Must Be Qualified.

The success of the pre-hearing conference system depends upon a high level of expertise in workers' compensation matters by representatives of carriers and claimants. Carriers should be represented either by an attorney licensed to practice in this state, or by individuals who can demonstrate a continuing proficiency in compensation law and procedure. Negotiation of a settlement in a workers' compensation case constitutes the practice of law, and no attorney's fees or expenses will be authorized by the board to any representative of the claimant other than an attorney licensed to practice in this state.

The provisions of this Sec. 61.50 adopted to be effective November 11, 1983, 8 TexReg 4497.

Sec. 61.55. Supply of Forms.

The carrier's representative shall have a sufficient supply of proper forms to enable him to complete settlements at the pre-hearing conference.

The provisions of this Sec. 61.55 adopted to be effective January 1, 1976; amended to be effective November 11, 1983, 8 TexReg 4497.

Sec. 61.60. Attendance at Conference.

(a) The claimant and the claimant's attorney or authorized agent, if any, and the carrier's representative must attend all pre-hearing conferences pertaining to the claim under consideration.

(b) A request for a pre-hearing conference shall constitute an agreement by the requesting party to appear personally or arrange for substitute representation in the event of a scheduling conflict.

(c) Claimant's attendance may be waived for good cause.

The provisions of this Sec. 61.60 adopted to be effective January 1, 1976; amended to be effective November 20, 1977, 2 TexReg 4323; amended to be effective December 13, 1989, 14 TexReg 6280.

Sec. 61.65. Postponement and Continuance.

Repealed to be effective December 13, 1989.

[See Appendix]

Sec. 61.65. Request for Cancellation of Pre-hearing Conference.

(a) The board may cancel a pre-hearing conference:

(1) at the request of the party who initially requested the pre-hearing conference;

(2) at the request of any party required to attend the pre-hearing conference, with the agreement of the party who initially requested the pre-hearing conference; or

(3) on the board's own motion.

(b) Cancellation shall be requested by notifying the resident reviewer or the pre-hearing officer in writing within 10 days from the date notice of the setting is received. The date notice of the setting is received is deemed to be the third day after the date of the notice. Cancellation requests during this 10-day period are unrestricted unless a pattern of abuse is detected.

(c) Cancellation requests after the unrestricted cancellation period defined in subsection (b) of this section will be considered only for good cause. As used in this subsection, good cause for cancellation means the following:

(1) compensation has been initiated or reinstated, unless a Sec. 18a penalty may be due, as provided in Sec. 61.15 of this title (relating to Setting Under Texas Civil Statutes, Article 8306, Sec. 18a);

(2) liability previously in dispute is accepted by the carrier, unless a Sec. 18a penalty may be due, as provided in Sec. 61.15 of this title (relating to Setting Under Texas Civil Statutes, Article 8306, Sec. 18a);

(3) medical previously in dispute is provided, unless a Sec. 18a penalty may be due, as provided in Sec. 61.15 of this title (relating to Setting Under Texas Civil Statutes, Article 8306, Sec. 18a);

(4) an adequate advance is tendered and accepted;

(5) the claim is set against the wrong carrier;

(6) the injured worker dies and no additional benefits appear due;

(7) the injured worker no longer desires to pursue the claim; or

(8) an A-2 lump sum payment or compromise settlement agreement is tendered and accepted by the parties.

(d) Failure to comply with the cancellation provisions of this section may result in sanctions as provided by Sec. 61.75 of this title (relating to Failure to Appear).

The provisions of this Sec. 61.65 adopted to be effective December 13, 1989, 14 TexReg 6279.

Sec. 61.70. Maintain Setting.

Where the request for continuance or postponement is based upon the payment of compensation and furnishing of medical aid, the resident reviewer or the pre-hearing officer may still maintain the setting where there is a showing of hardship on the part of the claimant.

The provisions of this Sec. 61.70 adopted to be effective January 1, 1976; amended to be effective November 11, 1983, 8 TexReg 4497.

Sec. 61.75. Failure to Appear.

(a) Where the claimant fails to make a personal appearance at the pre-hearing conference without good cause, such failure to appear shall result in postponement until the board is assured in writing of appearance.

(b) Where the attorney or carrier representative fails to comply with the cancellation requirements of Sec. 61.65 of this title (relating to Request for Cancellation of Pre-hearing Conference) or fails to attend a scheduled pre-hearing conference, the pre-hearing officer shall prepare a rule violation complaint report as provided by Sec. 65.10 of this title (relating to Actions by Carrier, Claimant's Attorney, and/or Agent). Violation of this rule may be grounds for sanctions, including reduction of fees, written reprimand, or suspension from practice before the board.

The provisions of this Sec. 61.75 adopted to be effective January 1, 1976; amended to be effective November 11, 1983, 8 TexReg 4497; amended to be effective December 13, 1989, 14 TexReg 6280.

Sec. 61.80. Participation at Conference.

Although no testimony will be taken at a pre-hearing conference, nevertheless, the claimant, carrier's representative, and any other witnesses in attendance must, if called upon by the pre-hearing examiner or the adverse party, fully participate by responding to requests for information reasonably necessary in the evaluation or defense of the claim presented. A violation of this rule by claimant may result in a continuance of the pre-hearing conference until a subsequent date, and a violation of the rule by any other party or witness may result in appropriate sanctions by the board.

The provisions of this Sec. 61.80 adopted to be effective January 1, 1976; amended to be effective November 11, 1983, 8 TexReg 4487.

Sec. 61.85. Carrier Self-Audit of Pre-hearing Conference.

A viable pre-hearing conference system is important to the efficient functioning of the workers' compensation program in this state. This necessarily includes a good faith effort on the part of both claimant or his/her attorney and of the carrier to negotiate in good faith. In order that the board might monitor the designed function of the pre-hearing conference in all claims which are the subject of a pre-hearing conference, except fatals, statutory total and permanent claims, and second injury fund claims, and where no A-2 payment is made or compromise settlement agreement is entered into at the pre-hearing conference:

(1) The carrier shall make and keep a written record of each compensation file which has been the subject of a pre-hearing conference, and an award recommendation has been made by the pre-hearing examiner, the following information: the name of the claimant; the name and permanent State Bar number of the claimant's attorney, if known to the carrier; the board file number; the carrier file number; the date of the pre-hearing conference held on the claim; the amount of the final demand of the claimant or his/her attorney at the pre-hearing conference; the amount of the final offer made by the carrier; and the net award by the board.

(2) Such record shall also include the date of final disposition, the net amount thereof, and whether by way of compromise settlement agreement, judgment, or dismissal without judgment entry.

(3) The record described in this rule shall be retained by the carrier for not less than five years following its completion, and shall be made available to the board, upon its request therefore.

(4) Neither the carrier nor claimant's attorney shall ever be required to file such information as directed herein by the board, and such information shall never become a part of the records of the board. A carrier or an attorney shall, at the request of the board, make these records available to the board for the purpose of the board and carrier or attorney evaluating the negotiation record of the carrier or the attorney at pre-hearing conferences. No board member or officer or employee of the board shall ever disclose such information, or any part thereof, to any other person, corporation, or agency.

The provisions of this Sec. 61.85 adopted to be effective November 11, 1983, 8 TexReg 4497.

Sec. 61.90. Conduct at Pre-hearing Conference.

Abusive, threatening, and vulgar language or gestures will not be tolerated at a pre-hearing conference. Violation of this board rule by any party or witness may result in a continuation of the hearing until a later date, sanctions, or, in appropriate instances, charges of unethical conduct under Sec. 65.5 of this title (relating to Practicing Before the Board).

The provisions of this Sec. 61.90 adopted to be effective November 11, 1983, 8 TexReg 4497.

Sec. 61.95. Consular Officers.

Consular officers and their attorneys shall comply with all board rules and shall attend any pre-hearing conference or board hearing set on any compensation claim where such consular officers or their attorneys shall purport to represent the interests of any resident or nonresident alien beneficiary in a workers' compensation claim under the Workers' Compensation Laws of Texas. No attorney's fees or other expenses shall be deducted or withheld from any compensation paid without prior authorization of the board pursuant to the provisions of Texas Civil Statutes, Article 8306, Sec. 7c. The board shall be provided with proper documentation, as it may request, from time to time, of the remission of compensation benefits paid through any consular office pursuant to the provisions of Texas Civil Statutes, Article 8306, Sec. 17.

The provisions of this Sec. 61.95 adopted to be effective January 1, 1976; amended to be effective November 11, 1983, 8 TexReg 4497.

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CHAPTER 63. PROMPTNESS OF FIRST PAYMENT

Sec. 63.5. Quarterly Report.

Sec. 63.10. Sanctions for Late Payment.

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Sec. 63.5. Quarterly Report.

The executive director of the Industrial Accident Board shall make a report, based on each quarter year's performance of all the insurance carriers writing workers' compensation insurance in Texas, which report will reflect the promptness of first payment of each such carrier of benefits due and payable under the Texas Workers' Compensation Act covering all cases occurring after May 18, 1969.

The provisions of this Sec. 63.5 adopted to be effective November 20, 1977, 2 TexReg 4324.

Sec. 63.10. Sanctions for Late Payment.

Any insurance carrier writing workers' compensation insurance under the provisions of the Texas Workers' Compensation Act who, on the average, shall fail to make compensation payments due claimants within a reasonable length of time after the same become due and payable, but in no event later than 30 days on the average from the date of incapacity, shall be subject to appropriate sanctions to be invoked by the Texas Industrial Accident Board.

The provisions of this Sec. 63.10 adopted to be effective November 20, 1977, 2 TexReg 4324.

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CHAPTER 64. REPRESENTING CLAIMANTS BEFORE THE BOARD.

Sec. 64.25 Discharged Attorney.

Sec. 64.30. Adverse Representation in Claims for Death Benefits.

(Blank)

Sec. 64.5. Requirement for Written Contract.

Repealed effective April 4, 1990
[See Appendix]

Sec. 64.10. Attorney Fees.

Repealed effective April 4, 1990
[See Appendix]

Sec. 64.15. Expenses.

Repealed effective April 4, 1990
[See Appendix]

Sec. 64.20. Disbursement Statement.

Repealed effective April 4, 1990
[See Appendix]

Sec. 64.25. Discharged Attorney.

(a) A claimant may discharge an attorney at any time. The claimant shall notify the board in writing, and explain the reasons for the discharge.

(b) When a dispute arises between or among two or more attorneys employed by a claimant, the attorney presenting the earliest-executed attorney contract will be deemed the attorney of record unless the claimant or a subsequently-retained attorney establishes good cause for discharge.

The provisions of this Sec. 64.25 adopted to be effective April 4, 1990, 15 TexReg 1629.

Sec. 64.30. Adverse Representation in Claims for Death Benefits.

(a) An attorney may not represent two or more beneficiaries with adverse claims for death benefits, since such representation constitutes a conflict of interest.

(b) An attorney who violates this section will be ordered to withdraw entirely, and may be subjected to disciplinary action.

The provisions of this Sec. 64.30 adopted to be effective January 1, 1990, 14 TexReg 6280.

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CHAPTER 65. UNETHICAL OR FRAUDULENT CLAIMS PRACTICES

Sec. 65.5. Practicing Before the Board.

Sec. 65.10. Actions by Carrier, Claimant's Attorney, and/or Agent.

Sec. 65.15. Filing of Violation Report.

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Sec. 65.5. Practicing Before the Board.

Whenever the board receives evidence that a person practicing before the board is guilty of unethical or fraudulent conduct, such person shall be cited by certified mail to appear before the board in person to show cause why he or she should not be barred from practicing before the board because of such conduct. In all such cases, the board's citation shall contain a detailed description of charges to be considered at such hearing, and a reasonable time to secure and prepare evidence shall be given any such person as cited.

The provisions of this Sec. 65.5 adopted to be effective November 20, 1977, 2 TexReg 4324.

Sec. 65.10. Actions by Carrier, Claimant's Attorney, and/or Agent.

The following willful acts shall be deemed unethical or fraudulent conduct by the board:

(1) **Carrier representatives:**

(A) misrepresenting to claimants, employers, or health providers the provisions of the Workers' Compensation Law of Texas;

(B) failing to submit to the board any settlement agreement executed by the parties;

(C) failing to immediately notify the board of the suspension or stopping of compensation and the reason for such suspension or stopping of compensation;

(D) stopping or suspending compensation without substantiating evidence that such action is authorized by law;

(E) misrepresenting that one is employed by the State of Texas or any agency thereof;

(F) instructing employers not to file Employer's First Reports of Injury with the board when such filing is required by statute;

(G) instructing employers to violate the claimant's rights guaranteed by Texas Civil Statutes, Article 8306, Sec. 7;

(H) failing to promptly tender full death benefits where *no bona fide* dispute exists as to the liability of the carrier;

(I) allowing an employer to dictate the methods by which and the terms on which a claim is handled and settled. Nothing in the foregoing shall prohibit the free discussion of a claim prior to pre-hearing conference, prohibit the employer's assistance in the investigation and evaluation of a claim prior to pre-hearing conference, or prohibit the employer's attendance at a pre-hearing conference and participation therein as a witness/observer;

(J) failing to confirm medical benefits coverage to any persons or facility providing medical treatment to a claimant where *no bona fide* dispute exists as to the liability of the carrier;

(K) failing, without good cause, to attend a pre-hearing conference;

(L) attending a pre-hearing conference without complete authority or failing to exercise authority to effectuate settlement;

(M) adjusting workers' compensation claims in any manner contrary to the provisions of the Adjusters Licensing Act or the rules and regulations of the State Board of Insurance;

(N) failing to promptly process claims in a reasonable and prudent manner;

(O) failing to initiate or reinstate compensation when due where *no bona fide* dispute exists as to the liability of the carrier;

(P) misrepresenting the reason for not paying compensation or for the suspension of compensation;

(Q) misdating the Form A-1 so as to distort the true date of the initial payment of compensation;

(R) making notations on drafts or other instruments so as to indicate that the draft or instrument represents a final settlement of a claim when in fact the claim is still open and pending before the board;

(S) failing and refusing to pay compensation from week to week as and when the same matures and accrues directly to the person entitled thereto;

(T) failing to pay an award of the board as directed by the board when no appeal is perfected;

(U) violating any rule of the board;

(V) controverting claims when evidence clearly indicates compensability;

(W) failing to file with the board, immediately upon receipt, originals of the E-1, "Employer's First Report of Injury or Illness"; E-2, "Employer's Supplemental Report of Injury"; and IAB-150, "Employer's Wage Statement".

(2) **Claimant's attorney and/or agents:**

(A) failing, without good cause, to attend a pre-hearing conference;

(B) committing an act of barratry as defined by the laws of this state;

(C) soliciting workers' compensation claims;

(D) withholding sums not authorized by the board from claimant's weekly compensation or from advancements;

(E) entering into a compromise settlement agreement without the knowledge, consent, and signature of the claimant or beneficiary;

(F) taking a fee or withholding expenses in excess of such sums authorized by the board;

(G) refusing or failing to make prompt delivery to claimant (client) of the funds belonging to claimant as a result of a compromise settlement agreement, A-2 payment, or award;

(H) violating the Code of Professional Responsibility of the State Bar of Texas;

(I) violating any rule of the board.

The provisions of this Sec. 65.10 adopted to be effective November 20, 1977, 2 TexReg 4324; amended to be effective September 25, 1979, 4 TexReg 3232; amended to be effective September 18, 1981, 6 TexReg 3274; amended to be effective October 26, 1981, 6 TexReg 3819; amended to be effective November 11, 1983, 8 TexReg 4499; amended to be effective October 1, 1985, 10 TexReg 3506; amended to be effective October 17, 1989, 14 TexReg 5260.

Sec. 65.15. Filing of Violation Report.

Whenever an authorized representative of the board believes any party to a compensation claim has been or is in violation of either the Workers' Compensation Act, or any part thereof, or of these board rules, a written violation report shall be sent to the executive director with a copy to the party concerned. Said party shall promptly report in writing and shall direct his reply to the executive director. This board may impose sanctions for failure of said party to respond to the violation report within 30 days from receipt thereof.

The provisions of this Sec. 65.15 adopted to be effective November 11, 1983, 8 TexReg 4499.

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CHAPTER 67. ALLEGATIONS OF FRAUD

Sec. 67.5. Referral to Attorney General.

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Sec. 67.5. Referral to Attorney General.

The board, upon its findings of probable cause, shall promptly refer any written allegation of fraud regarding an employer, employee, attorney, person or facility furnishing medical services, insurance company or its representative to the Attorney General.

The provisions of this Sec. 67.5 adopted to be effective November 20, 1977, 2 TexReg 4325; amended to be effective September 25, 1979, 4 TexReg 3232.

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CHAPTER 69. MEDICAL EXAMINATION ORDERS

Sec. 69.5. Application of Chapter.

Sec. 69.10. Definitions.

Sec. 69.15. Carrier May Apply for Order From Board.

Sec. 69.20. Application.

Sec. 69.25. Bases for Denial.

Sec. 69.30. Appeal.

Sec. 69.33. Claimant's Medical Records.

Sec. 69.35. Claimant's Expenses.

Sec. 69.40. Attendance of Claimant's Health Care Provider.

Sec. 69.45. Unreasonable Delay.

Sec. 69.50. Reports of Examinations.

Sec. 69.55. Failure to Attend Examination.

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Sec. 69.5. Application of Chapter.

(a) This chapter shall not apply to medical examinations ordered pursuant to Texas Civil Statutes, Article 8309b, Sec. 10, and 8309d, Sec. 10.

(b) Nothing in this chapter shall be construed to limit the rights of the parties to agree on treatment or an examination by a mutually agreed health care provider. The agreement must be in writing if either party intends to take advantage of the protections offered by this chapter.

The provisions of this Sec. 69.5 adopted to be effective February 19, 1988, 13 TexReg 617.

Sec. 69.10. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

Carrier's prior choice of health care provider--A health care provider who has examined the claimant in regard to the injury in question as provided in Texas Civil Statutes, Article 8307, Sec. 4, because:

(A) the board ordered the claimant to be examined by a health care provider of the carrier's choice; or

(B) the claimant granted permission for an examination by a carrier's tendered choice of a health care provider.

Health care provider--A physician, chiropractor, or podiatrist.

180 day period--The elapse of 180 days after an examination conducted by the carrier's choice of health care provider.

The provisions of this Sec. 69.10 adopted to be effective February 19, 1988, 13 TexReg 617.

Sec. 69.15. Carrier May Apply for Order From Board.

It shall be the policy of the board to issue an order for an examination by a health care provider of the carrier's choice within 30 days after initial date of filing with the board a combination form entitled carrier's request for permission or requested medical examination order.

(1) The carrier shall send the properly completed combination form to the claimant or his attorney by certified mail, with a copy to the board.

(2) The claimant or attorney is required to respond to the request for permission within 10 days from receipt of the request in the space provided at the bottom of the combination form. The response by claimant's attorney shall be returned to the carrier by certified mail with a copy forwarded to the board. An unrepresented claimant may use a return envelope provided by the carrier, and the carrier shall immediately file the claimant's response with the board.

(3) An order will not be necessary if the claimant or his attorney agrees to the examination. An examination by agreement will have the same force and effect as a formal board order. If permission is neither granted nor refused within 10 days from receipt by the claimant or his attorney, the board shall enter a formal order directing the examination as requested by the carrier.

(4) All examinations available under this section must be scheduled as soon as possible, with at least 10 days notice to the claimant or his attorney.

(5) If the examiner of the carrier's choice finds that the claimant is able to return to work and compensation is being paid, the case will be set on the next available pre-hearing docket, but in no event will the scheduled pre-hearing conference be more than 30 days from receipt of the carrier's request for pre-hearing conference if the request is accompanied by the carrier's examiner's report.

The provisions of this Sec. 69.15 adopted to be effective February 19, 1988, 13 TexReg 617.

Sec. 69.20. Application.

The application for permission or order shall be made on a combination form approved by the board and shall contain all information required by the board as detailed on the form.

The provisions of this Sec. 69.20 adopted to be effective February 19, 1988, 13 TexReg 617.

Sec. 69.25. Bases for Denial.

(a) Time limit after injury. No examination shall be ordered if the combination form is signed or submitted 60 or fewer days after the date of an injury.

(b) Health care providers limited. No examination shall be ordered if the license of the health care provider is under suspension by the appropriate licensing agency on the date of application.

(c) Ability to travel. No examination will be ordered unless a statement is attached to the request setting out whether the claimant's condition will allow travel to and attendance at the examination. The statement shall affirm that travel expenses will be tendered to the claimant in advance of any travel.

(d) One hundred and eighty day period. No examination shall be ordered if the claimant has been examined by the carrier's prior choice of health care provider in a 180-day period.

(e) Same health care provider. No examination shall be ordered if the claimant has been examined for the injury by the carrier's choice of health care provider and the prior health care provider is not the same as the requested health care provider.

(f) Good cause. The board may waive any of the bases for denial in subsections (a)-(e) of this section or deny an application for a medical examination order if the board determines that good cause exists.

The provisions of this Sec. 69.25 adopted to be effective February 19, 1988, 13 TexReg 617; amended to be effective June 4, 1990, 15 TexReg 2852.

Sec. 69.30. Appeal.

The carrier or the claimant may appeal a decision by the board staff in writing to the executive director or the full board. The appeal must be received no later than 10 days after the order or denial is mailed or delivered to the parties.

The provisions of this Sec. 69.30 adopted to be effective February 19, 1988, 13 TexReg 617.

Sec. 69.33. Claimant's Medical Records.

A claimant's health care provider shall timely release any and all medical records relating to the injury or disease in question, including x-rays and results of other diagnostic tests, when requested by the carrier pursuant to this chapter. A carrier shall report to the board the provider's name and the circumstances surrounding a refusal to release records.

The provisions of this Sec. 69.33 adopted to be effective June 7, 1988, 13 TexReg 2555.

Sec. 69.35. Claimant's Expenses.

Prior to the date the claimant attends an examination ordered by the board or permitted by the claimant, the carrier shall tender to the claimant travel expenses in accordance with Sec. 42.175(b) of this title (relating to Transportation Costs As Medical Expenses).

The provisions of this Sec. 69.35 adopted to be effective February 19, 1988, 13 TexReg 617.

Sec. 69.40. Attendance of Claimant's Health Care Provider.

In accordance with Texas Civil Statutes, Article 8307, Sec. 4, the claimant shall have the right to have a health care provider of his or her choice present at the examination at the carrier's expense.

The provisions of this Sec. 69.40 adopted to be effective February 19, 1988, 13 TexReg 617.

Sec. 69.45. Unreasonable Delay.

The claimant shall be entitled to a prompt examination. Any examination that fails to commence within two hours after the claimant timely reports for the examination should be reported to the executive director.

The provisions of this Sec. 69.45 adopted to be effective February 19, 1988, 13 TexReg 617.

Sec. 69.50. Reports of Examinations.

The carrier's choice of health care provider shall immediately submit a written report of the results of the examination to all parties.

The provisions of this Sec. 69.50 adopted to be effective February 19, 1988, 13 TexReg 617.

Sec. 69.55. Failure to Attend Examination.

(a) A claimant who agrees or is ordered to submit to an examination as requested by the carrier under this chapter is required to attend the examination.

(b) When a claimant fails to attend an examination permitted or ordered under this chapter, the carrier may notify the board in writing on a board-aproved form and request a formal hearing. The board shall set the hearing on the first Friday following 10 days from receipt of the carrier's written request, and shall provide written notice to all parties.

(c) The claimant may be heard at this hearing by:

(1) making a personal appearance in Austin;

(2) appearing by telephone conference call; or

(3) filing a written brief.

(d) If a majority of the board determines there was no good cause for the claimant's failure to attend the medical examination, the board shall order the carrier to suspend compensation during the continuance of the claimant's refusal.

(e) The carrier may not terminate compensation because of the claimant's failure to attend a medical examination permitted or ordered under this chapter until ordered by the board.

The provisions of this Sec. 69.55 adopted to be effective February 19, 1988, 13 TexReg 617; amended to be effective June 16, 1988, 13 TexReg 2752.

CHAPTER 89. CRIME VICTIMS COMPENSATION ACT.

Sec. 89.5. Compliance and Suspension of Rules.

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Sec. 89.110. Suspended Payments.

Sec. 89.115. Subrogation.

Sec. 89.120. Filing Suit.

Sec. 89.125. Compensation Recovered.

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Sec. 89.130. Attorney's Fee.

Sec. 89.135. Will and Trust Instruments.

Sec. 89.140. Practicing Before the Board.

Sec. 89.145. "Other Persons."

Sec. 89.150. "Texas Residents."

Sec. 89.155. "Interested Persons."

Sec. 89.160. "Lacked Capacity to Commit the Crime."

Sec. 89.165. "Reports."

Sec. 89.170. "Accomplice."

Sec. 89.175. Victim's Compliance Necessary.

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Sec. 89.5. Compliance and Suspension of Rules.

Chapter 89 of these rules applies solely to the administration of the Crime Victims Compensation Act (Chapter 189, 66th Legislature, Regular Session). All parties seeking any action of the board shall comply with these rules, unless in its judgment the board determines that compliance with any of the rules under particular circumstances will result in injustice to any party. Accordingly, rules may be suspended at the discretion of the board and additional hearings held or cases scheduled for hearing out of their regular order.

The provisions of this Sec. 89.5 adopted to be effective January 1, 1980, 4 TexReg 4660.
See Texas Civil Statutes, Article 8309-1.

Sec. 89.10. Social Security Number.

All forms, reports, and other documents filed with the board which pertain to a claim shall include the social security number of the claimant.

The provisions of this Sec. 89.10 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.15. General Communications.

All applications and communications concerning the Crime Victims Compensation Act shall be filed with the Austin office of the Industrial Accident Board.

The provisions of this Sec. 89.15 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.20. Claimant's Address.

All communications from the board to the claimant will be directed to the claimant's last known mailing address. The claimant must promptly advise the board of any change in address.

The provisions of this Sec. 89.20 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.25. Reporting the Crime.

In determining the time period for the victim's reporting the crime, the board will consider the 72 hours to begin with the last known event which constituted the criminally injurious conduct for which compensation is sought.

The provisions of this Sec. 89.25 adopted to be effective January 1, 1980, 4 RexReg 4660.
See Texas Civil Statutes, Article 8309-1, Sec. 4(b).

Sec. 89.30. Filing of Application.

In determining the time period for the victim's filing of an application with the board under Sec. 4(c), the board will consider the one year to begin with the last known event which constituted the criminally injurious conduct for which compensation is sought. For crimes or incidents occurring on or after Septemebr 1, 1985, the limitation period will not include that period of physical incapacity which reasonably prevented the claimant from filing an application for compensation according to Sec. 4(c). It is the claimant's responsibility to provide the board with written medically documented evidence of such physical incapacity.

The provisions of this Sec. 89.30 adopted to be effective January 1, 1980, 4 TexReg 4660; amended to be effective November 11, 1983, 8 TexReg 4499; amended to be effective November 5, 1985, 10 TexReg 4124.

See Texas Civil Statutes, Article 8309-1, Sec. 4(c).

Sec. 89.35. Loss of Earnings.

In computing the actual loss of past earnings and the anticipated loss of future earnings, the board will consider the weekly earnings, including all other remuneration resulting from the employment agreement at the time of the crime. Neither the award for actual loss of past earnings nor the award for anticipated loss of future earnings shall exceed the statutory limitation of $150 per week.

The provisions of this Sec. 89.35 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.40. Readily Available.

Benefits which are readily available are those which the claimant may reasonably expect to receive. (By contract or application.)

The provisions of this Sec. 89.40 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.45. Medical Reports.

The claimant shall file with the board current medical reports outlining treatment, diagnosis, and prognosis including estimate of any disability or physical impairment setting forth claimant's ability to be gainfully employed.

The provisions of this Sec. 89.45 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.50. Board Ordered Exams.

Medical reports which appear to be inadequate or in conflict will be considered good cause for the board to order additional medical or psychological exams by practitioners of the board's choice. Charges for examinations and reports will be fair and reasonable.

The provisions of this Sec. 89.50 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.55. Payment of Bills.

All bills rendered for medical care, chiropractic care, psychiatric and psychological care, and all bills rendered by duly licensed practitioners rendering remedial treatment to the claimant for the condition resulting from the crime, must provide a clear itemization of all prescriptions and incidentals, dates of purchase, treatment rendered, and attending practitioner prescribing same on items furnished. Approved payments of unpaid bills will be directed to the creditors.

The provisions of this Sec. 89.55 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.60. Funeral Bills.

Regarding funeral and burial expenses submitted for approval, the board will consider only those items deemed reasonable and necessary.

The provisions of this Sec. 89.60 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.65. Autopsy Report.

If the cause of death is material to the claim, the board may require an autopsy report. The claimant's refusal to permit an autopsy may result in the denial of benefits.

The provisions of this Sec. 89.65 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.70. Certificate of Death.

It is the responsibility of the claimant to provide the board with a certificate of death.

The provisions of this Sec. 89.70 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.75. Care of Minor Children.

A birth certificate is necessary for each child for whom compensation is sought. Payments for care of minor children are made for the sole purpose of enabling a victim or spouse to engage or continue in lawful and gainful employment. Payments as authorized by law will be made upon notification that the victim or spouse is seeking or is engaged in lawful and gainful employment.

The provisions of this Sec. 89.75 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.80. Lump Sum Payments.

The claimant may apply for lump sum payment of anticipated loss of future earnings by filing with the board an affidavit setting forth the specific reasons why payment in a lump sum would be beneficial and why the failure to lump sum the payments would be detrimental. Allowable expenses incurred after the award will be paid in installments.

The provisions of this Sec. 89.80 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.85. Insufficient Funds.

When the Compensation to Victims of Crime Fund contains no funds or insufficient funds to make payments to awarded victims, the board will make such award payments as funds become available on the following basis:

(1) In all applications for injuries sustained on or after January 1, 1984 and approved by the board during calendar year 1984 and each calendar year thereafter, wherein funds are insufficient to pay the total amount approved, the board will award benefits first to victims entitled to emergency grants, loss of wages and dependents of deceased victims for loss of support. Other approved benefits will be adjusted (pro-rated) and awarded quarterly for an amount not to exceed the monies deposited within the same calendar period. None of the benefits, other than emergency grants, loss of wages and support will be awarded and paid until all claims on the waiting list have been awarded and paid.

(2) The board may make emergency awards under Sec. 8 or lump sum or installments awards in cases of extreme need and urgency without regard to priority of such awards in time.

The provisions of this Sec. 89.85 adopted to be effective January 1, 1980, 4 TexReg 4660; amended to be effective November 11, 1983, 8 TexReg 4499.

Sec. 89.90. Continuing Jurisdiction.

The board shall have continuing jurisdiction of all awards and may amend, terminate, suspend, or extend payments under this law upon a showing of mistake, change of condition, or for other good cause.

The provisions of this Sec. 89.90 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.95. Emergency Awards.

All parties will be notified if the board suspends the proceedings pending disposition of a criminal prosecution and the board will consider making an emergency award upon request. All requests for emergency awards will be accompanied by a statement setting forth the reasons why a denial of an emergency award would create a hardship.

The provisions of this Sec. 89.95 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.100. Review of Award.

A claimant who is receiving installment payments under the Act must notify the board immediately upon employment, receipt of unemployment compensation, social security, or any other change of circumstance. Willful misrepresentation of fact or failure to notify the board of change of circumstance will be considered just cause for reconsideration of the award and implementation of other action as authorized under Sec. 9(a). The award is subject to review by the board at any time.

The provisions of this Sec. 89.100 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.105. Request for Hearing.

The board will notify the claimant and attorney general within 20 days after rejection of an application and either party may request a hearing and/or pre-hearing within a reasonable period of time thereafter.

The provisions of this Sec. 89.105 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.110. Suspended Payments.

Payments to claimant will be suspended immediately upon notification that suit to set aside the board's award has been filed.

The provisions of this Sec. 89.110 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.115. Subrogation.

Under the subrogation provision of Sec. 11, failure to notify the board in writing prior to filing suit to recover damages related to criminally injurious conduct will be just cause for reconsideration of the award.

The provisions of this Sec. 89.115 adopted to be effective January 1, 1980, 4 TexReg 4660.
See Texas Civil Statutes, Article 8309-1, Sec. 11.

Sec. 89.120. Filing Suit.

Upon notification that suit is to be brought under the provision of Sec. 11, the board will promptly notify the parties of its decision pertaining thereto.

The provisions of this Sec. 89.120 adopted to be effective January 1, 1980, 4 TexReg 4660.
See Texas Civil Statutes, Article 8309-1, Sec. 11.

Sec. 89.125. Compensation Recovered.

If the claimant brings action as trustee and recovers compensation awarded by the board, the amount deducted for reasonable expenses of the suit, including attorney's fee, is subject to the board's approval and may not exceed the state's proportionate share (pro rata).

The provisions of this Sec. 89.125 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.130. Attorney's Fee.

Any attorney representing a claimant and requesting a fee shall file with the board a written power of attorney with itemization of time and expenses incurred prior to the board entering an award. The amount awarded will be based on the services being reasonable and necessary.

The provisions of this Sec. 89.130 adopted to be effective January 1, 1980, 4 TexReg 4660; amended to be effective November 11, 1983, 8 TexReg 4499.

Sec. 89.135. Will and Trust Instruments.

In all cases in which the claimant is a dependent of a deceased victim of crime, such claimant shall file with the board a copy of all probated wills in which the claimant is a devisee and a copy of all executed trust instruments in which the claimant is a named beneficiary.

The provisions of this Sec. 89.135 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.140. Practicing Before the Board.

Whenever the board receives evidence that a person practicing before the board is guilty of unethical or fraudulent conduct, such person shall be cited by certified mail to appear before the board in person to show cause why he or she should not be barred from practicing before the board because of such conduct. In all such cases the board's citation shall contain a detailed description of charges to be considered at such hearing and a reasonable time to secure and prepare evidence shall be given any such person as cited.

The provisions of this Sec. 89.140 adopted to be effective January 1, 1980, 4 TexReg 4660.

Sec. 89.145. "Other Persons."

The term "other person" as used in Sec. 6(d)(3) does not include persons related to the claimant within the third degree of affinity or consanguinity; nor does it include purely donative contributors, such as community, civic, or religious organizations.

The provisions of this Sec. 89.145 adopted to be effective January 1, 1980, 4 TexReg 4660.
See Texas Civil Statutes, Article 8309-1, Sec. 6.

Sec. 89.150. "Texas Residents."

(a) The following persons are presumptively not "Texas residents" within the meaning of this Act:

(1) persons who are in Texas for less than 30 days;

(2) persons who are in Texas for the pursuit of temporary business or recreational opportunities who do not intend at the time of crime to make Texas their residence; or

(3) all other persons whose presence in Texas is of a transient nature and who do not intend at the time of crime to make Texas their residence.

(b) This section applies only to claims for compensation for crimes or incidents occurring between January 1, 1980, and August 31, 1985.

The provisions of this Sec. 89.150 adopted to be effective January 1, 1980, 4 TexReg 4660; amended to be effective November 5, 1985, 10 TexReg 4124.

Sec. 89.155. "Interested Persons."

The term "interested person" as used in Sec. 5(c) does not include the accused criminal offender or nonclaimant creditors.

The provisions of this Sec. 89.155 adopted to be effective January 1, 1980, 4 TexReg 4660.

See Texas Civil Statutes, Article 8309-1, Sec. 5.

Sec. 89.160. "Lacked Capacity to Commit the Crime."

The term "lacked capacity to commit the crime" used in Sec. 3(4)(C) refers only to those persons who by reason of minority or lack of mental capacity are not held liable for their criminal acts.

The provisions of this Sec. 89.160 adopted to be effective January 1, 1980, 4 TexReg 4660.

See Texas Civil Statutes, Article 8309-1, Sec. 3.

Sec. 89.165. "Reports."

The term "reports" used in Sec. 4(b) includes both written and oral reports.

The provisions of this Sec. 89.165 adopted to be effective January 1, 1980, 4 TexReg 4660.

See Texas Civil Statutes, Article 8309-1, Sec. 4.

Sec. 89.170. "Accomplice."

The term "accomplice" used in Sec. 6(c)(4) means a person who is criminally responsible as a party to an offense under Chapter 7 of the Texas Penal Code, as amended or as may hereafter be amended.

The provisions of this Sec. 89.170 adopted to be effective January 1, 1980, 4 TexReg 4660.

See Texas Civil Statutes, Article 8309-1, Sec. 6.

Sec. 89.175. Victim's Compliance Necessary.

All information requested by the attorney general's office and/or the Industrial Accident Board shall be promptly furnished by the claimant, his or her attorney, or agency representing the claimant. Any delay or refusal to promptly furnish the requested information may result in a delay in further action by the attorney general's office in its investigation or by the board in its processing of the claim.

The provisions of this Sec. 89.175 adopted to be effective November 11, 1983, 8 TexReg 4499.

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APPENDIX I

REPEALED AND EXPIRED RULES

Sec. 41.105.	Preparation and Filing of Initial Medical Reports.
Sec. 41.110.	Subsequent and Narrative Medical Reports.
Sec. 41.115.	Additional Filing of Medical Reports.
Sec. 41.125.	Cost of Medical Reports.
Sec. 41.130.	Assignment of Medical Benefits.
Sec. 41.140.	Demand for Surgical Operation.
Sec. 41.145.	Reports Accompanying Demand for Surgical Operation.
Sec. 41.150.	Scars and Deformities.
Sec. 41.155.	Transportation Costs as Medical Expenses.
Sec. 41.160.	Suspension of Medical Benefits Defined.
Sec. 41.165.	Notice of Suspension of Medical Benefits
Sec. 41.170.	Voluntary Arbitration.
Sec. 41.175.	Payment of Medical Benefits.
Sec. 42.110.	Official Hospital Fee Guideline and Method for Determining Per Diem and RCC Rates.
Sec. 42.110.	Official Health Facility Fee Guidelines.
Sec. 42.111.	Official Hospital Fee Guidelines for Services Rendered Under the Texas Workers' Compensation Act for 1988.
Sec. 42.112.	Official Interim Hospital Fee Guidelines for Services Rendered Under the Texas Workers' Compensation Act.
Sec. 43.10.	Termination of Coverage.
Sec. 45.15.	Filing of Employer's First Report of Injury.
Sec. 51.5.	Power of Attorney.
Sec. 51.7.	Representation in Fatal Cases.

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Sec. 51.35.	Unauthorized Attorney's Fees.
Sec. 51.40.	Attorneys Not Licensed in Texas.
Sec. 51.45.	Attorney Fees and Expenses on Fatal Cases.
Sec. 51.55.	Attorney's Expenses.
Sec. 51.60.	Deductible Expenses.
Sec. 61.5.	Notice of Pre-hearing Setting.
Sec. 61.10.	Setting When Compensation Not Paid.
Sec. 61.65.	Postponement and Continuance.
Sec. 64.5.	Requirement for Written Contract.
Sec. 64.10	Attorney Fees.
Sec. 64.15.	Expenses.
Sec. 64.20.	Disbursement Statement.

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APPENDIX I

REPEALED AND EXPIRED RULES

Sec. 41.105. Preparation and Filing of Initial Medical Reports.

(a) When a physician, chiropractor, or podiatrist renders care to an injured worker, he shall submit an initial report in accordance with Texas Civil Statutes, Article 8306, Sec. 7. This initial report may be a narrative report or a form report. If a form report is used for the initial report, it must contain as a minimum all or substantially all of the information required in the Physician's Report IAB-152.

(b) A copy of each and every initial medical report of the health provider shall be promptly and simultaneously sent to the insurance carrier and to the claimant or his attorney.

(c) Any party to a claim must file a copy of each and every medical report and/or hospital record with the board on request.

The provisions of this Sec. 41.105 adopted to be effective November 11, 1983, 8 TexReg 4491; repealed to be effective October 20, 1988, 13 TexReg 4990.

Sec. 41.110. Subsequent Narrative Medical Reports.

Subsequent narrative medical reports reasonably necessary to inform the insurance carrier, claimant, and board of the injury status of the claimant shall be periodically and simultaneously sent by the health provider to the insurance carrier, claimant or his attorney, and the board.

The provisions of this Sec. 41.110 adopted to be effective November 11, 1983, 8 TexReg 4491; repealed to be effective October 20, 1988, 13 TexReg 4990.

Sec. 41.115. Additional Filing of Medical Reports.

(a) All available medical reports and medical information shall be filed with the board by the insurance carrier after the expiration of four weeks of disability, or following the amputation of any member, or earlier if requested by the board.

(b) All available medical reports and medical information shall be filed with the board by the attorney for the claimant after the expiration of four weeks of disability, or following the amputation of any member, or earlier if requested by the board.

The provisions of this Sec. 41.115 adopted to be effective November 11, 1983, 8 TexReg 4491; repealed to be effective October 20, 1988, 13 TexReg 4990.

Sec. 41.120. Identifying Information in Medical Reports.

In addition to the information concerning the description of the injury or disease, the treatment thereof, and any known or estimated disability resulting therefrom, each medical report shall also contain sufficient information to enable the insurance carrier and board to identify the compensation claim to which the report refers. At a minimum, such identifying information shall include the name of the patient (claimant), his social security number, the date of injury, the name of the employer, and if known, the board and insurance company file numbers.

The provisions of this Sec. 41.120 adopted to be effective November 11, 1983, 8 TexReg 4491; repealed to be effective October 20, 1988, 13 TexReg 4990.

Sec. 41.125. Cost of Medical Reports.

The association shall pay the fair and reasonable charges of the health provider for the preparation and submission of both the initial and subsequent medical reports, records, and information. There shall be no additional charge made to the claimant, or his attorney, or to the board for copies of these reports and records.

The provisions of this Sec. 41.125 adopted to be effective November 11, 1983, 8 TexReg 4491; repealed to be effective October 20, 1988, 13 TexReg 4990.

Sec. 41.130. Assignment of Medical Benefits.

In the event an assignment of medical benefits is made by an injured employee to a health or accident insurance company, a true copy thereof shall be promptly and simultaneously filed by the health or accident insurance company with both the board and association.

The provisions of this Sec. 41.130 adopted to be effective November 11, 1983, 8 TexReg 4491; repealed to be effective October 20, 1988, 13 TexReg 4990.

Sec. 41.140. Demand for Surgical Operation.

Any written demand for a surgical operation under Texas Civil Statutes, Article 8306, Sec. 12e, or any application for reduction or suspension of compensation pursuant to Article 8307, Sec. 4, must be filed with the board at least seven calendar days prior to the date of hearing. However, where good cause for waiving strict compliance is approved by the board, parties may file demand for or tender of surgery on or before the scheduled date of hearing.

The provisions of this Sec. 41.140 adopted to be effective November 11, 1983, 8 TexReg 4491; repealed to be effective October 20, 1988, 13 TexReg 4990.

Sec. 41.145. Reports Accompanying Demand for Surgical Operation.

(a) Demand for surgery either by the claimant or by the insurance carrier shall be accompanied by a medical report which establishes, regardless of specific words used, that:

(1) in reasonable medical probability the requested surgical procedure will either effect a cure or will materially and beneficially improve and relieve the claimant's condition; and

(2) the surgery is medically advisable.

(b) In addition to the medical report described in subsection (a) of this section, the party demanding the surgery shall simultaneously file with the board all other medical reports pertinent to the injury or disease at issue.

The provisions of this Sec. 41.145 adopted to be effective November 11, 1983, 8 TexReg 4491; repealed to be effective October 20, 1988, 13 TexReg 4990.

Sec. 41.150. Scars and Deformities.

In all cases involving severe and disfiguring burns or lacerations, a descriptive medical report of the scars or deformity shall be submitted by either the carrier or the claimant. In all such cases involving scars to the face, arms, or hands, a color photograph taken after maximum healing has occurred must be submitted at or prior to any final board action on the claim.

The provisions of this Sec. 41.150 adopted to be effective November 11, 1983, 8 TexReg 4491; repealed to be effective October 20, 1988, 13 TexReg 4990.

Sec. 41.155. Transportation Costs as Medical Expenses.

Whenever it becomes reasonably necessary for a claimant to travel outside the city or county of his or her residence in order to obtain medical care under Texas Civil Statutes, Article 8306, Sec. 7, the reasonable costs thereof shall reimbursed by the insurance carrier. This would include, where appropriate, the reasonable costs of meals and lodging. All travel by private conveyance shall be based upon the mileage expense allowance then current for travel by state employees.

The provisions of this Sec. 41.155 adopted to be effective November 11, 1983, 8 TexReg 4491; repealed to be effective October 20, 1988, 13 TexReg 4990.

Sec. 41.160. Suspension of Medical Benefits Defined.

(a) A carrier will be deemed to have suspended medical benefits when:

(1) it has filed the notice required in board rule and Sec. 41.165 of this title (relating to Notice of Suspension of Medical Benefits); or

(2) it has failed to promptly direct the claimant to a health provider, following request therefore by the claimant pursuant to Texas Civil Statutes, Article 8306, Sec. 7; or

(3) it has failed or refused to pay an accrued and itemized health provider bill (medical expense), as submitted, and within 30 days from the carrier's receipt thereof. For the purpose of this rule, a health provider bill will be considered adequately itemized if it is in sufficient detail to permit the carrier and board to evaluate whether the charges thereon are fair and reasonable within the meaning of Texas Civil Statutes, Article 8306, Secs. 7 and 7b.

(b) All carriers shall promptly date stamp each health provider bill with the date the same was received by the carrier. Failure on the part of the carrier to comply with this section shall create a rebuttable presumption that such health provider bill was received by the carrier within five business days of the date of such bill.

The provisions of this Sec. 41.160 adopted to be effective November 11, 1983, 8 TexReg 4491; repealed to be effective October 20, 1988, 13 TexReg 4990.

Sec. 41.165. Notice of Suspension of Medical Benefits.

An insurance carrier shall notify the board in writing within 10 days following any decision to suspend or terminate medical benefits as provided in Texas Civil Statutes, Article 8306, Sec. 7, giving the reason or reasons therefore. A copy of this notice shall be simultaneously sent to the claimant or his attorney, if any, and to the health provider(s).

The provisions of this Sec. 41.165 adopted to be effective November 11, 1983, 8 TexReg 4491; repealed to be effective October 20, 1988, 13 TexReg 4990.

Sec. 41.170. Voluntary Arbitration.

The board shall establish procedures for selection of voluntary arbitration panels to assist the board in regulating fees and charges submitted by health care providers to the full extent authorized by Texas Civil Statutes, Article 8306, Secs. 7 and 7b.

(1) The executive director of the board shall prepare bylaws subject to the final approval of the board governing the operation and functions of the various voluntary arbitration panels.

(2) The executive director of the board shall implement the procedures so adopted by the board, and he or his designee shall supervise the arbitration panels established by the board and shall serve as chairman of each panel. However, the executive director may from time to time designate the assistant executive director of the board or other person to act as chairman in his place.

(3) The procedures for selection of panels and the bylaws shall be available to all parties.

The provisions of this Sec. 41.170 adopted to be effective November 11, 1983, 8 TexReg 4491; repealed to be effective October 20, 1988, 13 TexReg 4990.

Sec. 41.175. Payment of Medical Benefits.

In any case where the carrier has accepted liability for compensation benefits, if the carrier subsequently denies any part of a health care provider's bill, within 20 days after such denial, the carrier shall notify the board in writing and shall explain in detail the reason(s) for its refusal to pay each item. The carrier shall provide copies of the notification to the health care provider and to the claimant and his or her attorney. These copies shall include the following statement:

> The insurance carrier, and not the claimant/patient or employer, is solely responsible for all reasonable and necessary medical treatment rendered in connection with the injury, and no billing for any unpaid amounts should be directed to the claimant/patient or employer, nor should any attempt be made to collect any unpaid amount from the claimant/patient or employer, unless the claim has been denied by the board or the court.

The provisions of this Sec. 41.175 adopted to be effective October 1, 1985, 10 TexReg 3506; repealed to be effective October 20, 1988, 13 TexReg 4990.

Sec. 42.110. Official Hospital Fee Guideline and Method for Determining Per Diem and RCC Rates.

(a) The "Official Hospital Fee Guideline for Services Rendered Under the Texas Workers' Compensation Act" is the lesser of:

(1) the provider's usual fees and charges; or

(2) the fees and charges established by the method for determining per diem and ancillary service rates.

(b) The board adopts the following method for determining per diem and ancillary service rates for hospitals:

(1) Per diems: Charges for room rates ("per diems") will be paid according to the average cost per patient day for inpatient routine services (room, board, and general duty nursing) and/or the average cost per day in special care units submitted annually by Texas hospitals to the Health Care Financing Administration (Medicare Cost Reports, HCFA Form 2552, Supplemental Worksheet D-1, Part II) times the number of days billed.

(2) Ancillary Services:

(A) The board will compute for each hospital in Texas a combined ratio of total costs to total charges ("RCC Rate") for all ancillary services provided by an individual hospital based on the settled cost reports (Medicare Cost Reports, HCFA Form 2552, Worksheet C) submitted annually by Texas hospitals to the Health Care Financing Administration. The combined RCC Rate is computed by dividing total costs by total charges.

(B) The carrier will determine the fair and reasonable payment for ancillary services provided and billed by a hospital by multiplying the hospital's RCC Rate times the total charges billed, then increasing the adjusted total by 15%.

(c) The board will publish the per diems and RCC Rates in the "Official Hospital Fee Guideline for Services Rendered Under the Texas Workers' Compensation Act." The Guideline will be reviewed and revised periodically, as necessary.

(d) Copies of the Guideline will be made available upon written request to: Administrator, Medical Cost Evaluation Division; Industrial Accident Board; 200 East Riverside Drive, 1st Floor; Austin, Texas 78704-1287.

(e) The charge for the Guideline shall be $12.50. This charge may be revised periodically, as necessary.

The provisions of this Sec. 42.110 adopted to be effective September 1, 1988, 13 TexReg 4131; implementation postponed until January 1, 1989, 13 TexReg 5018; implementation postponed indefinitely, December 28, 1988, 14 TexReg 473; repealed on an emergency basis to be effective February 7, 1989, 14 TexReg 823; repealed to be effective February 28, 1989, 14 TexReg 845.

See Texas Civil Statutes, Article 8306, Sec. 7b.

Sec. 42.110. Official Health Facility Fee Guidelines.

(a) Definitions. The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

(1) *Adjusted Billed Charges*--A health facility's billed charges for goods and services rendered to one workers' compensation claimant, minus undocumented, unrelated, and inappropriate charges.

(2) *Adjusted Net Revenues [A.N.R.]*--Total patient revenues plus other operating revenues, minus deductions for uncompensated care, Medicare contractual allowances, Medicaid contractual allowances, and other governmental contractual allowances.

(3) *Audited Financial Statements*--A presentation of financial data, including accompanying notes, derived from accounting records and intended to communicate a health facility's economic resources or obligations at a point in time, or the changes therein for a period of time, in accordance with generally accepted accounting principles.

(4) *Generally Accepted Accounting Principles*--Accounting principles or standards generally accepted in the United States, including, but not limited to *Accounting Principles Board Opinions*, as published by the American Institute of Certified Public Accountants, and *Statements of Financial Accounting Standards*, and interpretations thereof, as published by the Financial Accounting Standards Board.

(5) *Generally Accepted Auditing Standards*--The ten generally accepted auditing standards adopted by the American Institute of Certified Public Accountants, together with interpretations thereof, as set forth in *Statements on Auditing Standards*, as published by the American Institute of Certified Public Accountants.

(6) *Maximum Allowable Rate of Increase (MARI)*--The maximum allowable rate at which a health facility may, within a period established by the board, increase its total charges for services and goods rendered to workers' compensation claimants.

(7) *Medicaid Contractual Allowances*--Gross patient charges at established rates minus the amounts received or to be received from the Medicaid program under the contract between the participating health facility and the U.S. Department of Health and Human Services.

(8) *Medicare Contractual Allowances*--Gross patient charges at established rates minus the amounts received or to be received from the Medicare program under the contract between the participating health facility and the U.S. Department of Health and Human Services.

(9) *Other Allowances*--Gross patient charges at established rates minus amounts received or to be received:

(A) under contractual agreements with non-governmental third party payors: or

(B) under courtesy discounts.

(10) *Other Governmental Contractual Allowances*--Unreimbursed charges for contractual allowances from such governmental entities as CHAMPUS, the Veterans Administration, and the Texas Rehabilitation Commission.

(11) *Other Operating Revenues*--Revenues received from patients for non-patient care services to patients, and sales and activities to persons other than patients minus grants, gifts, and investment income including, but not limited to revenues from educational programs, rental of hospital space, sales to employees, physicians, or non-patients, fees charged for transcripts or reproduction of medical records; cafeteria sales; recovery of charges for personal telephone calls; proceeds from sale of metal scrap and x-ray file; and proceeds from gift shops, parking, and other services operated by the health facility, as reported on line 26, less lines 7 and 8, of Worksheet G-3 of FORM HCFA-2552-85 (12/85).

(12) *Total Deductions from Revenue*--The sum of uncompensated care, Medicare contractual allowances, Medicaid contractual allowances, and other governmental contractual allowances.

(13) *Total Operating Expenses*--The sum of health facility operating expenses, as recorded on an accrual basis, including but not limited to salaries and wages, employee benefits, professional fees, supplies, depreciation, amortization, interest, and administrative and facility overhead expenses, as reported on line 4 of Worksheet G-3 of FORM HCFA-2552-85 (12/85).

(14) *Total Patient Revenues*--Revenues recorded on an accrual basis at established rates for routine and ancillary services, both inpatient and out-patient, as reported on line 1 of Worksheet G-3 of FORM HCFA-2552-85 (12/85).

(15) *Uncompensated Care*--Deductions from total patient revenue for charity care and bad debt as recorded in a health facility's audited financial statement.

(b) Official Health Facility Fee Guidelines and Methodology.

(1) Official guideline. Except as otherwise provided, the "Official Health Facility Fee Guideline for Services Rendered Under the Texas Workers' Compensation Act" shall be: adjusted billed charges times a health facility's ratio. The ratio shall not be less than .85, and shall not be greater than 1.00.

(2) Interim guideline for period from February 7, 1989 until publication of the facility's ratio. The interim guideline for goods and services rendered to workers' compensation claimants from February 7, 1989, until publication of a facility's ratio shall be: adjusted billed charges times a ratio of .90.

(c) Official Hospital Fee Guideline, October 1, 1988 through February 6, 1989. The guideline for goods and services rendered by hospitals to workers' compensation claimants (inpatient admissions only) from October 1, 1988, through February 6, 1989, shall be: adjusted billed charges times a ratio of .90.

(d)(1) Maximum Allowable Rate of Increase (MARI). A health facility may, within a period established by the board, increase its total charges for goods and services rendered to workers' compensation claimants by a rate not to exceed the MARI. The rate of increase shall be based on the charges shown on the facility's charge master on the last day of the preceding period.

(2) MARI, February 7, 1989 through February 6, 1990. For the period from February 7, 1989 through February 6, 1990, the MARI shall be a ratio of 1.07.

(3) Penalty for increasing charges over the MARI. If the board finds that a health facility increased charges over the MARI, as proscribed in subsection (1), the board may:

(A) order the health facility to adjust its charges to comply with the MARI;

(B) approve a ratio of .85;

(C) refer the health facility to the appropriate regulatory agency for investigation; and

(D) refer the health facility to the attorney general for investigation of fraud.

(4) Methodology for determining the health facility ratio. A health facility's ratio shall be determined by dividing Total Operating Expenses [T.O.E.] by Adjusted Net Revenues [A.N.R.], but shall not be less than .85 or more than 1.00. T.O.E. and A.N.R. shall be calculated on the Ratio Worksheet, Form MCE-5, hereby adopted by reference.

(e) Special provisions for certain health facilities.

(1) Small rural hospitals. A health facility defined as a "small rural hospital" in Sec. 42.15 of this chapter (relating to Definitions) may elect to use the guideline of fair and reasonable for services and goods rendered to workers' compensation claimants as an alternative to the official guideline. An eligible facility may make this election annually in the Health Facility Ratio Report.

(2) New health facilities. A health facility initiating services subsequent to the effective date of this guideline shall be subject to a ratio of .90 during its first full fiscal year of operation.

(f) General provisions regarding required reports. The following provisions apply to all health facilities filing reports required by this section:

(1) All data and audited financial statements, excluding the Medicare or Medicaid Cost Reports, submitted to the board shall be prepared in accordance with generally accepted accounting principles and generally excepted auditing standards. The health facility's chief executive officer shall certify that all data and audited financial statements comply with this subsection.

(2) All reports shall be submitted in a form and manner prescribed by the board.

(3) The board may require a health facility to file any information necessary to determine compliance with this section, including annual reports.

(4) When more than one health facility is operated by the reporting organization, separate reports shall be filed for each facility.

(5) If the board finds that a health facility has not complied with the reporting requirements established in this section, the board may:

(A) compel production of necessary documents;

(B) set the facility's ratio at no less than .85; and

(C) refer the facility to the attorney general for investigation of fraud.

(6) A facility may apply to the board for waiver of reporting requirements.

(g) Health Facility Ratio Report. Each health facility rendering services to workers' compensation claimants shall file with the board a Health Facility Ratio Report, using a package of forms prescribed by the board. The charge for the package shall be established by the board. The Health Facility Ratio Report shall include the following:

(1) "Health Facility Certification Form," Form MCE-1;

(2) "MARI Certification Form," Form MCE-2;

(3) "Health Facility General Information Form," Form MCE-3;

(4) if applicable, the "Small Rural Hospital and New Health Facility Special Provisions Form," Form MCE-4;

(5) "Ratio Worksheet," Form MCE-5; and

(6) Supporting documentation, including:

(A) the facility's most recent audited financial statement; and, if applicable,

(B) the facility's most recently filed Medicare Cost Report, FORM HCFA-2552, all worksheets; or, if inapplicable,

(C) the facility's most recently filed Medicaid Cost Report.

(h) Health Facility Ratio Report filing schedule. The following reporting requirements apply to all health facilities rendering goods and services to workers' compensation claimants:

(1) First required Health Facility Ratio Report--1989.

(A) All health facilities shall file a first Health Facility Ratio Report, based on the facility's most current full fiscal year of operation, no later than May 31, 1989.

(B) The board shall publish interim lists of approved ratios on or about March 1, April 1, May 1, and June 1, and a final, cumulative list on or about August 1.

(C) The board shall approve a ratio of .85 for each facility that failed to file timely.

(2) Regular required Health Facility Ratio Report. Each health facility shall file a regular Health Facility Ratio Report no later than the last day of the fourth month following the close of its fiscal year. The following schedule shall apply:

Fiscal Year Closing Date	Date Report Due
June 30	October 31
September 30	January 31
December 31	April 30
March 31	July 31

The first regular required Health Facility Ratio Report filing date in 1989 shall be October 31, 1989, for facilities with a fiscal year of July 1 to June 30.

(3) Fiscal year periods. The board establishes the following four fiscal year periods:

(A) January 1 to December 31;

(B) April 1 to March 31;

(C) July 1 to June 30; and

(D) October 1 to September 30.

A health facility with a fiscal year other than those established by the board shall elect to use the fiscal year period that most closely approximates its actual fiscal year, and shall report this election on the "General Health Facility Information Form."

(i) Health Facility Ratio.

(1) Determination of the ratio.

(A) Except as otherwise provided, the board will review a health facility's ratio report, and publish the approved ratio no later than the first day of the third month following the facility's filing deadline.

(B) The board may request the facility to revise submitted documentation, or file additional information. When such a request is made, the board shall publish the approved ratio no later than the 61st day following the date the facility complies with the board's request.

(2) Publication of ratios; charges. The board shall certify and regularly publish lists of approved health facility ratios. Charges for the lists shall be established by the board.

(3) Effective date of ratio. A health facility's ratio shall be effective on the date published by the board, and shall apply to charges for goods and services rendered on and after that date.

(4) Appeal of a board-approved ratio. A facility or carrier may challenge a board-approved ratio by filing a written appeal with the board no later than 15 calendar days after the ratio is published. A ratio becomes final if no appeal is filed as provided.

The provisions of this Sec. 42.110 adopted on an emergency basis to be effective February 7, 1989, 14 TexReg 823; adopted to be effective February 28, 1989, 14 TexReg 845; amended on an emergency basis to be effective April 20, 1989, 14 TexReg 2063; amended to be effective June 28, 1989, 14 TexReg 3007; repealed to be effective November 21, 1989, 14 TexReg 5867.

See Texas Civil Statutes, Article 8306, Sec. 7b.

Sec. 42.111. Official Hospital Fee Guidelines for Services Rendered Under the Texas Workers' Compensation Act for 1988.

(a) Payments for routine and ancillary hospital services provided by hospitals to individuals covered under the Act will be based on each hospital's gross charges in effect on September 1, 1988, less ten percent.

(b) The Official Hospital Fee Guidelines will only be applied to hospital services provided during admissions occurring on or after October 1, 1988 through December 31, 1988.

(c) The Official Hospital Fee Guidelines shall not affect existing agreements, contractual or otherwise.

The provisions of this Sec. 42.111 adopted on an emergency basis to be effective October 1, 1988 until January 1, 1989, 13 TexReg 4934.

Sec. 42.112. Official Interim Hospital Fee Guidelines for Services Rendered Under the Texas Workers' Compensation Act.

(a) Payments for routine and ancillary hospital services provided by hospitals to individuals covered under the Act will be based on each hospital's gross charges in effect on September 1, 1988, less 10%.

(b) The official hospital fee guidelines will only be applied to hospital services provided during admission occurring on or after October 1, 1988,-January 31, 1989.

(c) The official hospital fee guidelines shall not affect existing agreements, contractual or otherwise.

The provisions of this Sec. 42.112 adopted on an emergency basis to be effective January 1, 1989 until February 1, 1989, 14 TexReg 16; effectiveness exended until February 4, 1989, 14 TexReg 652.

Sec. 43.10. Termination of Coverage.

Once a carrier files Form IAB 20, Notice that Employer has Become Subscriber, that insurance carrier shall be deemed to have compensation coverage for the named employer until notice of cancellation or nonrenewal of compensation insurance is properly filed with the board by certified mail or in person and sent to the subscriber by certified mail or until another carrier files Form IAB 20, Notice that Employer

has Become Subscriber. In the latter instance, coverage by the prior carrier will terminate effective on the inception date of the policy written by the subsequent carrier, and not on the date such subsequent notice by such carrier is filed with the board. Notice of cancellation or nonrenewal of compensation insurance shall be provided to the employer on a form prescribed by the board.

The provisions of this Sec. 43.10 adopted to be effective November 11, 1983, 8 TexReg 4492; amended to be effective December 21, 1987, 12 TexReg 4529; repealed effective December 20, 1989, 14 TexReg 6419.

Sec. 45.15. Filing of Employer's First Report of Injury.

The employer shall send the original employer's first report of injury directly to the Industrial Accident Board in Austin and shall simultaneously deliver a copy thereof to its workers' compensation insurance carrier.

The provisions of this Sec. 45.15 adopted to be effective November 11, 1983, 8 TexReg 4493; repealed to be effective October 17, 1989, 14 TexReg 5260.

Sec. 51.7. Representation in Fatal Cases.

(a) Representation in fatal cases of multiple beneficiaries who stand in differing degrees of relationship to the decedent, and consequently have adverse claims for benefits, constitutes a conflict of interest, and is prohibited.

(b) An attorney who contracts such representation will be ordered to withdraw entirely, and may be subjected to disciplinary action.

The provisions of this Sec. 51.7 adopted to be effective April 18, 1988, 13 TexReg 1539; repealed to be effective January 1, 1990, 14 TexReg 6279.

Sec. 51.35. Unauthorized Attorney's Fee.

No attorney's fee shall be deducted from an award, compromise settlement agreement, periodic benefit payments, or A-2 (report of suspension of compensation) payment, unless first authorized by the board, and only in the amount so authorized.

The provisions of this Sec. 51.35 adopted to be effective September 18, 1981, 6 TexReg 3274; repealed to be effective January 1, 1990, 14 TexReg 6671.

Sec. 51.40. Attorneys Not Licensed in Texas.

Attorney's fees and/or expenses shall be authorized and paid only to attorneys who hold a valid license to practice law in the State of Texas. Attorneys licensed only in states other than Texas may appear as representatives of claimants but shall not be entitled to receive attorney's fee thereby.

The provisions of this Sec. 51.40 adopted to be effective September 18, 1981, 6 TexReg 3274; repealed to be effective January 1, 1990, 14 TexReg 6671.

Sec. 51.5. Power of Attorney.

Attorneys representing claimants will be authorized by the board to receive fees and expenses only when a power of attorney, contract of employment of attorney, or other document signed by the claimant is filed with the board. The attorneys' fees for representing claimants shall be specified within such power of attorney, contract of employment, or other signed document, and such fees are not to exceed 25% of the total recovery. All attorneys' fees for representing claimants before the board shall be subject to the approval of the board as provided in Texas Civil Statutes, Article 8306, Sec. 7(c). When a dispute arises as to the representation of the claimant by two or more attorneys, the board will require a signed and dated power of attorney or employment contract from each attorney, and the attorney first retained will be deemed to be the attorney of record, unless the board shall determine that the claimant has effected a change of attorneys.

The provisions of this Sec. 51.5 adopted to be effective September 18, 1981, 6 TexReg 3274; amended to be effective October 1, 1985, 10 TexReg 3506; repealed to be effective April 4, 1990, 15 TexReg 1629.

Sec. 51.45. Attorney Fees and Expenses on Fatal Cases.

Only those attorney's fees and expenses authorized by the board shall be deducted from the amount awarded the claimant. In all death cases where the carrier admits liability on all issues involved and tenders payment of maximum benefits in writing under the Workers' Compensation Act and no controversies arise, then no attorney's fee shall be allowed. The board is not, however, prohibited from allowing reasonable expenses incurred by the attorney in the preparation and presentation of said claim before the board, said expenses being allowed by Texas Civil Statutes, Article 8306, Sec. 7c.

The provisions of this Sec. 51.45 adopted to be effective September 18, 1981, 6 TexReg 3274; repealed to be effective January 1, 1990, 14 TexReg 6671.

Sec. 51.55. Attorney's Expenses.

No attorney expenses, in addition to the attorney's fees authorized by the board, will be allowed, unless the attorney submits to the board an itemized statement of such incurred expense showing its origin, date incurred or paid, and amount, with the request that such expense be authorized for deduction. The itemized list will be presented at the pre-hearing conference for approval by the hearing examiner, or accompany a compromise settlement agreement when it is sent to the board for its approval.

The provisions of this Sec. 51.55 adopted to be effective September 18, 1981, 6 TexReg 3274; repealed to be effective January 1, 1990, 14 TexReg 6279.

Sec. 51.60. Deductible Expenses.

Generally the board will allow as deductible all those expenses which the claimant's attorney pays (or incurs) and which were reasonably necessary in the investigation, preparation, and proof of the claimant's workers' compensation claim only.

The provisions of this Sec. 51.60 adopted to be effective September 18, 1981, 6 TexReg 3274; repealed to be effective January 1, 1990, 14 TexReg 6279.

Sec. 61.5. Notice of Pre-hearing Setting.

The board will give at least 30 days notice of pre-hearing conference to all interested parties, unless compensation or medical benefits are not being paid, in either of which event a pre-hearing conference may be set with less than 30 days' notice.

The provisions of this Sec. 61.5 adopted to be effective January 1, 1976; amended to be effective November 20, 1977, 2 TexReg 4323; amended to be effective November 11, 1983, 8 TexReg 4497; repealed to be effective December 13, 1989, 14 TexReg 6279.

Sec. 61.10. Setting When Compensation Not Paid.

If the carrier, having knowledge of the claim, has not paid weekly compensation benefits, the board, upon request of the claimant or his representative shall set the case for pre-hearing conference on the first

docket following such request. Provided further, that the institution of weekly compensation benefits by the carrier after the setting of the pre-hearing conference may or may not be available as a reason for cancellation of the pre-hearing conference.

The provisions of this Sec. 61.10 adopted to be effective January 1, 1976; amended to be effective November 20, 1977, 2 TexReg 4323; repealed to be effective December 13, 1989, 14 TexReg 6279.

Sec. 61.65. Postponement and Continuance.

If for any reason the case should not be heard at the designated time and place, any interested party shall notify the resident reviewer or the pre-hearing officer 10 days prior to pre-hearing, giving reasons for his objections and he shall furnish a copy of said objections to opposing counsel or party. The resident reviewer or pre-hearing officer may, after reviewing the objections, order the pre-hearing rescheduled or retained on the docket.

The provisions of this Sec. 61.65 adopted to be effective January 1, 1976; amended to be effective November 11, 1983, 8 TexReg 4497; repealed to be effective December 13, 1989, 14 TexReg 6279.

Sec. 64.5. Requirement for Written Contract.

(a) An attorney who wishes to represent for a fee a claimant making a claim for benefits must have a written contract evidencing representation signed by both parties.

(b) The board shall prescribe the form and content of all written contracts used for this purpose.

(c) A copy of the written contract shall be filed with the board within 30 days of execution, or sooner if appropriate.

The provisions of this Sec. 64.5 adopted to be effective January 1, 1990, 14 TexReg 6280; repealed by emergency action to be effective April 4, 1990, 15 TexReg 2075.

Sec. 64.10. Attorney Fees.

(a) Approval of the board. All attorney fees are subject to the approval of the board and shall be paid from the claimant's recovery. The claimant's recovery is the total of all indemnity or death benefits recovered by the claimant minus approved attorney expenses, benefits paid periodically, benefits voluntarily paid, and/or benefits offered to be paid prior to the attorney filing notice of representation under sec.64.5 of this chapter (relating to Requirement for Written Contract).

(b) Eligibility for fee. A fee may only be paid to an attorney licensed to practice law in Texas who has a contract on file with the board as provided in section 64.5 of this chapter (relating to Requirement for Written Contract).

(c) Amount of fees.

(1) Attorney fees shall not total more than 25% of the claimant's recovery.
(2) A percentage fee of more than 15% of the claimant's recovery will not be approved unless the board determines that a higher percentage is justified by the time expended by an attorney on the claim.

(d) Record of time. In the following cases, in order to be eligible for a fee, an attorney must provide the board with a detailed record of time expended on behalf of the claimant:

(1) when an attorney requests a percentage fee higher than 15%;

(2) when an attorney has been discharged from representation or undertakes representation of a claimant who has previously employed an attorney;

(3) in claims for fatal or lifetime benefits;

(4) in claims involving the second injury fund.

The provisions of this Sec. 64.10 adopted to be effective January 1, 1990, 14 TexReg 6674; repealed by emergency action to be effective April 4, 1990, 15 TexReg 2075.

Sec. 64.15. Expenses.

The board, upon review, may approve reimbursement for expenses incurred in preparing and presenting the claim before the board to an attorney who, before the resolution of claim:

(1) has notified the board of representation, as provided in sec.64.5; and

(2) files a statement of expenses on a board-approved form.

The provisions of this Sec. 64.15 adopted to be effective January 1, 1990, 14 TexReg 6280; repealed by emergency action to be effective April 4, 1990, 15 TexReg 2075.

Sec. 64.20. Disbursement Statement.

(a) On the date the attorney disburses the proceeds of a workers' compensation claim, the attorney shall present the claimant with a written disbursement statement, on a form prescribed by the board, setting out:

(1) the monetary amount received by the claimant(s); and

(2) the monetary amounts retained by the attorney, itemized by specific charge.

(b) The claimant(s) and the attorney shall sign the disbursement statement.

(c) The attorney shall retain the disbursement statement for four years from the date of disbursement.

(d) The board may request the disbursement statement at any time within the retention period established in subsection (c) of this section. The attorney shall comply within 10 days of receiving a request.

The provisions of this Sec.64.20 adopted to be effective January 1, 1990, 14 TexReg 6280; repealed by emergency action to be effective April 4, 1990, 15 TexReg 2075.

APPENDIX II

INSTRUCTIONS FOR ON-SITE AUDIT OF HOSPITAL CHARGES BY WORKERS'COMPENSATION CARRIER

The carrier has the right to conduct an on-site audit of hospital services related to a compensable injury or illness.

The following audit guidelines will be followed by hospitals and carriers:

A. <u>Hospital Responsibilities</u>

1. The hospital shall designate one person to serve as the primary liaison between the hospital and the carrier. That person should be knowledgeable about medical terminology and the claimant's chart.

2. The hospital shall respond to the carrier's written request for on-site audit within 10 days of receipt. The hospital's response shall set out three possible audit dates within the 30 day period following the date of hospital's response.

3. The hospital shall only allow access to that part of the patient's record that pertains to the charges billed.

4. The hospital's liaison shall acquaint carriers' representatives with its records system and charging practices.

5. Because the medical record does not serve to back up each individual charge on the patient's hospital bill, the hospital shall provide the chart and other documents as required. Needed materials will be provided and available for the audit.

6. The hospital's identified liaison will advise other hospital personnel or departments of the audit and will act as liaison between these personnel or departments and the carrier.

7. The hospital will allocate ample space for the carrier to conduct the audit.

8. The hospital liaison will be available to the carrier for an exit interview to discuss the preliminary findings on the day of the audit. The carrier must present an itemized list of discrepancies to the hospital on the day of the audit, i.e., work sheets. The hospital and carrier will resolve discrepancies the day of the audit. In the event that same day resolution is not possible, the hospital has five working days from the audit date to resolve differences of any unsupported or unbilled amounts resulting from the audit.

9. A hospital representative will review the carrier's final written report and notify the appropriate hospital personnel of the amount of final payment by the carrier, or the amount of overpayment due in refund to the carrier. Refunds due the carrier shall be paid within 30 days.

10. All substances administered to the patient in any form, as well as all treatments or medical services, must be specifically and accurately documented.

11. The hospital may reschedule an audit if all departmental documentation is not available at the time of the originally scheduled audit. The rescheduled audit date shall not exceed 30 days from the original audit date. Forty-eight hours notice will be given to the carrier of such cancellation unless cancellation is a result of uncontrollable events.

B. Carrier Responsibilities

1. The carrier shall notify the hospital in writing of their intent to audit within 40 days of receipt of the billing and indicate what is to be audited. The carrier shall remit payment of either 75% of the amount billed, or the $50.00 audit fee. After confirming an audit date with the hospital, a written confirmation will be sent to the hospital. Interim bills will not be audited.

2. The carrier's representative shall be a registered nurse or a licensed practical nurse who is familiar with medical terminology and general hospital charging and medical record documentation procedures.

3. The carrier's representative will personally appear at the scheduled date and time. Forty-eight hour notice of cancellation is required unless cancellation is a result of uncontrollable events. The rescheduled audit will occur on a mutually agreed upon date, not to exceed 30 days from the original audit date.

4. The carrier will arrange an exit interview on the day of the audit and be available to discuss and resolve discrepancies during the five working days following the audit.

APPENDIX III

BOARD ADVISORIES

Advisory 1.	Article 8306, Sec. 12, Specific Compensation
Advisory 2.	Calculation of Compensation Benefits for Specific Injuries
Advisory 3.	Payment Period in Workers' Compensation Claims
Advisory 4.	Current Board Policy on Settlements for Future Medical Benefits
Advisory 5.	Improper Withholding of Expenses by Attorneys and Improper Submission of Time and Expenses
Advisory 6.	Court Orders to Carriers for Withholding Compensation for Child Support Owed by Claimants
Advisory 7.	Filing Form A-2's, Notice of Suspension of Compensation, with Compromise Settlement Agreement
Advisory 8.	Subchapter B., Sec. 42.115, Official Pharmaceutical Fee Guidelines for Services Rendered Under the Workers' Compensation Act
Advisory 9.	Board Rule Sec. 53.20. Notice of Initiation of Compensation; Mode of Payment of Compensation
Advisory 10.	Article 8306, Sec. 8; Death Benefits; Definition of Enrollment as a Full-Time Student

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APPENDIX III

ADVISORY NO. 1

SUBJECT: ARTICLE 8306, SEC. 12, SPECIFIC COMPENSATION

In undisputed total loss or loss of use claims, the board often finds that weekly compensation benefits are suspended when the claimant is released to return to work even though additional weeks may be due for the amputation or total loss of the member. This is especially true in represented claims where the carrier usually waits for the board or the claimant's attorney to initiate action to obtain the balance due.

TEX. REV. CIV. STAT. ANN. Art. 8306, Sec. 12 (Vernon 1986) provides for the payment of "a weekly compensation equal to sixty-six and two thirds percent (66 2/3%) of the average weekly wages of such employee, but not less than the minimum weekly benefit per week nor exceeding the maximum weekly benefits set forth in Sec. 29 of the Article, for the respective periods stated herein, to wit: . . .". The respective number of weeks due are then scheduled for each member or combination of members.

Accordingly, in all compensable claims where the medical evidence confirms the total loss or total loss of use of a scheduled member, weekly compensation benefits shall continue without regard to the claimant's work status until the maximum number of weeks provided by TEX. REV. CIV. STAT. ANN. Art. 8306, Sec. 12 (Vernon 1986) have been paid, unless redeemed earlier by the claimant's acceptance of a lump sum payment for the balance due. Since this type of injury should usually be settled by A-2 or A-2 Lump Sum Payment Agreement, the procedures outlined in board rule 28 TAC, Sec. 53.40 (061.07.00.040) should be followed.

Therefore, the suspension or stoppage of weekly compensation payments for specific injuries shall be treated in accordance with board rule 28 TAC, Sec. 53.35 (061.07.00.035).

Signed the 19th day of May, 1986 by:

Joseph C. Gagen, Chairman
Bobby J. Barnes, Member
N. J. Huestis, Member

ADVISORY NO. 2

SUBJECT: CALCULATION OF COMPENSATION BENEFITS FOR SPECIFIC INJURIES

A recent opinion from the Dallas Court of Appeals, Charter Oak Fire Insurance Co. v. Pierce, 702 S.W.2d 259 (Tex. Civ. App.--Dallas 1985, writ ref'd n.r.e.) has raised some question regarding the accepted method of evaluating compensation payments for specific injuries.

The Pierce opinion does not affect this calculation. Pierce is restricted to evaluating a specific injury that extends to the larger member. The established rule, which the Dallas Court of Appeals only reiterated, is that such concurrent injuries constitute only injury to a single member, and may not be cumulated. Instead, compensation is possible only for the injury producing the greater incapacity. TEIA v. Thorn, 611 S.W.2d 140 (Tex. Civ. App.--Waco 1980, no writ); Soto v. TEIA, 598 S.W.2d 45 (Tex Civ. App.--Amarillo 1980, writ ref'd n.r.e.)

(Pierce was singular because the claimant had incurred a statutory loss of the second finger, and argued he was entitled to 30 weeks of TTD without any proof of lost time, plus 120 weeks of PPD for the hand. The Court refused.)

The proper method of calculating benefits for specific injuries is as follows:

Step I:

# of weeks scheduled for specific injury - # of weeks TTD = # of weeks PPD

Step II:

(# of weeks TTD x Comp rate) + (# of weeks PPD x % disability x Comp rate) = Benefits due

Signed the 7th day of July, 1986 by:

Joseph C. Gagen, Chairman
Bobby J. Barnes, Member
N. J. Huestis, Member

ADVISORY NO. 3

SUBJECT: PAYMENT PERIOD IN WORKERS' COMPENSATION CLAIMS

The Act requires that compensation be paid weekly. Art. 8306, Sec. 18. The board has the discretion to change the payment period to monthly or quarterly. In making this determination, the board must consider both the "welfare of the employee and the convenience of the carrier." Art. 8307, Sec. 12. A majority of the board members must approve a request to change the payment period. Art. 8307, Sec. 8.

Accordingly, the board advises all carriers of the following:

1. Effective immediately, application for permission to change the payment period shall be made in writing to the Executive Director. The grounds for the request should be set out in detail. If the applicant is the carrier, an affidavit from the claimant indicating approval should be included. The board will make a determination within sixty (60) days of receiving the application. All parties will be notified of the board's decision.

(This procedure applies only to an application to permanently change the payment period. Single lump sum advances to the claimant do not require approval of a majority of the board, and may be approved by reviewers and pre-hearing officers.)

2. In order to evaluate payment periods, the board hereby directs all carriers to file a complete list of all claims to date in which the payment period is other than weekly. The list should set out the following information: IAB number, claimant's name, payment period, date payment period was increased from weekly, reason for change, and finally, whether board approval was sought, and, if so, from who it was obtained.

This list must be filed with the board's Austin office, Enforcement Division, no later than 5:00 P.M., June 30, 1987.

Signed by:

Joseph C. Gagen, Chairman
Bobby J. Barnes, Member
N. J. Huestis, Member

ADVISORY NO. 4

SUBJECT: CURRENT BOARD POLICY ON SETTLEMENTS FOR FUTURE MEDICAL BENEFITS

On 1/5/88, the Texas Industrial Accident Board convened in open meeting, and considered the issue of board authority to approve settlements closing out future medical benefits left open under prior compromise settlement agreements, final awards, or judgments. After discussion, the board voted 2-1 to continue its policy of refusing to approve such settlements, pending resolution of the jurisdictional question by attorney general's opinion or court decision. All such settlements submitted to the board will be stamped "REJECTED" and returned to the submitting party with a cover letter explaining this policy.

Signed the 5th day of January, 1988, by:

Joseph C. Gagen, Chairman
Bobby J. Barnes, Member
James J. Kaster, Member

ADVISORY NO. 5

SUBJECT: IMPROPER WITHHOLDING OF EXPENSES BY ATTORNEYS AND IMPROPER SUBMISSION OF TIME AND EXPENSES

The board notices, with increasing frequency, withholding by attorneys of expenses not approved by the board. Also, the board has noted in several cases where, when time and expenses were requested due the nature of the case, the attorneys have misrepresented paralegal time as attorney time. The purpose of this advisory is to warn that such practices will not be tolerated.

The first is stealing; the second is lying. Both are prohibited by the Act, board rule and the Code of Professional Responsibility. Art. 8306, Sec. 7c, V.T.C.S.; 28 TAC, Sec. 65.10 (2)(F); DR 1-102 (A) (4); DR 7-106 (C) (7). The board will enforce these prohibitions rigorously by bringing disciplinary actions under Art. 8307, Sec. 4 (d), V.T.C.S., and by filing grievances with the State Bar.

Signed the 6th day of June, 1988, by:

Joseph C. Gagen, Chairman
Bobby J. Barnes, Member
James J. Kaster, Member

ADVISORY NO. 6

SUBJECT: COURT ORDERS TO CARRIERS FOR WITHHOLDING COMPENSATION BENEFITS FOR CHILD SUPPORT OWED BY CLAIMANTS

It has been brought to the board's attention that workers' compensation insurance carriers are uncertain how to proceed when they are served with income withholding orders entered by Texas courts for child support owed by claimants, pursuant to Sec. 14.43, Tex. Fam. Code. It appears that such orders are inconsistent with the Workers' Compensation Act, Art. 8306, Sec. 3, V.T.C.S., and the Texas Family Code, Sec. 14.30(a)(1).

The board suggest that, in order to protect its position, a carrier do the following:

Once a withholding order has been entered and served, the carrier must follow the procedure set out in Sec. 14.43(j), Tex Fam. Code, and move for a hearing on the applicability of the order within 20 days of service, or risk being held in contempt of court. At the hearing, the carrier may advise the court of this advisory opinion.

Further, the board requests carriers to notify the executive director of the resolution of all withholding orders entered against them.

Signed the 15th day of December, 1988, by:

Joseph C. Gagen, Chairman
Bobby J. Barnes, Member
James J. Kaster, Member

ADVISORY NO. 7

SUBJECT: FILING FORM A-2's, NOTICE OF SUSPENSION OF COMPENSATION, WITH COMPROMISE SETTLEMENT AGREEMENT

It has come to the board's attention that an unjustifiable amount of time is spent by the agency collecting Form A-2's after a Compromise Settlement Agreement even though board rule 28 TAC, Sec. 53.35 requires this filing.

The purpose of this advisory is to instruct carriers to file a final A-2 with any Compromise Settlement Agreement on a file in which compensation has been previously suspended. A Form A-2 should also be filed within 10 days from the date the draft is issued for payment of a Compromise Settlement Agreement.

Where compensation is continuing at the time of a Compromise Settlement Agreement, board rule 28 TAC, Sec. 53.35, requires a final A-2 to be filed no later than 10 days after compensation is suspended.

Signed the 16th day of December, 1988, by:

Joseph C. Gagen, Chairman
Bobby J. Barnes, Member
James J. Kaster, Member

ADVISORY NO. 8

SUBJECT: SUBCHAPTER B., SEC. 42.115, OFFICIAL PHARMACEUTICAL FEE GUIDELINES FOR SERVICES RENDERED UNDER THE WORKERS' COMPENSATION ACT

On January 24, 1989, the Texas Industrial Accident Board issued the following advisories regarding the Official Pharmaceutical Fee Guidelines for Services Rendered Under the Workers' Compensation Act:

1. Generic Equivalents Average Price (GEAP)

   In those instances when (1) there is no National Drug Code (NDC) number listing the Medi-span Generic and Pricing Guide for a manufacturer and/or (2) the pharmacist fails to list the NDC number on the bill submitted to the carrier for each generic pharmaceutical dispensed, the board will determine the fair and reasonable reimbursement for generic pharmaceuticals by the following formula:

   Generic Equivalents Average Price (GEAP) times 1.4 plus $7.50.

   The Generic Equivalents Average Price (GEAP) is listed for each generic pharmaceutical category in the Medi-span Generic and Pricing Guide.

2. Higher Prices for Generics than Branded Pharmaceuticals

   In those instances when a generic pharmaceutical costs more than a branded pharmaceutical under the board's pharmaceutical fee guidelines, the board will consider the fair and reasonable price to be the branded equivalent as calculated under the board's brand-name pharmaceutical formula.

Signed the 1st day of February, 1989, by:

Joseph C. Gagen, Chairman
Bobby J. Barnes, Member

ADVISORY NO. 9

SUBJECT: BOARD RULE SEC. 53.20 NOTICE OF INITIATION OF COMPENSATION; MODE OF PAYMENT OF COMPENSATION.

On January 16, 1990 the board in public meeting issued the following advisory:

> A major Texas city as referred to in Sec. 53.20 (e)(1) is defined as any city in Texas with a population of 1000,000 or more as of the latest census.

Signed the 16 day of January, 1990, by:

Joseph C. Gagen, Chairman
Bobby J. Barnes, Member
Milton E. Fox, Member

ADVISORY NO. 10

SUBJECT: ARTICLE 8306, SEC. 8; DEATH BENEFITS; DEFINITION OF ENROLLMENT AS A FULL-TIME STUDENT.

Due to public inquiry the Industrial Accident Board issues the following interpretation of Article 8306, sec. 8 (b), wherein "weekly benefits are payable to a child... until twenty-five years of age if enrolled as a full-time student in any accredited educational institution":

> A student ceases to be enrolled full-time if not taking twelve or more hours at an accredited educational institution for two consecutive semesters.

Signed this 30 day of January, 1990, by:

Joseph C. Gagen, Chairman
Bobby J. Barnes, Member
Milton E. Fox, Member

APPENDIX IV

POLICY STATEMENTS

Policy Statement 1. **Schedule for Reimbursing Health Care Providers Who Accompany Claimants to Examinations by Carrier-Chosen Providers**

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APPENDIX IV

POLICY STATEMENT NO. 1

SUBJECT: SCHEDULE FOR REIMBURSING HEALTH CARE PROVIDERS WHO ACCOMPANY CLAIMANTS TO EXAMINATIONS BY CARRIER-CHOSEN PROVIDERS

The board announces as policy the following schedule for reimbursing health care providers who accompany claimants to medical examinations conducted by the carrier's choice of provider, pursuant to TEX. REV. CIV. STAT. ANN. Art. 8307, Sec. 4(b) (Vernon Supp. 1988) and board rule 28 TAC Sec. 69.40. This schedule will be utilized until such time as the board adopts guidelines for such services, pursuant to TEX. REV. CIV. STAT. ANN. Art. 8306, Sec. 7b (Vernon Supp. 1988).

I. TIME.

A. Hourly rate:

1. Physicians & Osteopaths $100.00
2. Chiropractors . . . . $ 65.00
3. Podiatrists . . . . $ 65.00

B. Calculation. The accompanying provider's time will be calculated "portal to portal," commencing with the beginning of the travel and ending with the completion of the travel.

C. Limit. Compensable time is limited to four (4) hours. Prior approval from the carrier or the board is required for time in excess of this limit.

II. TRANSPORTATION.

A. Distance. Compensable distance is limited to 100 miles, one way. Prior approval from the carrier or the board is required for distance in excess of this limit.

B. Mode of transportation.

1. Personal vehicle. Reimbursement shall be calculated at $ .21 per mile. The shortest route between points must be used. Actual parking costs shall be reimbursed. Parking receipts must be filed.

2. Public transportation (except air travel). Reimbursement shall be calculated at actual cost. Receipts must be filed.

3. Air travel. Prior approval from the carrier or the board is required for reimbursed air travel. Public air travel shall be reimbursed at actual cost. Receipts must be filed. Private air travel shall be reimbursed at $ .21 per mile.

III. PROCEDURES.

A. **Obtaining prior board approval when required.** Staff is authorized to approve or deny all items requiring prior board approval. Appeal of staff's action may be taken to the board.

B. **Claiming reimbursement.** After accompanying the claimant to the examination, the provider shall request reimbursement in writing, itemizing time and expenses, by sending the original to the carrier, with copies to the claimant or attorney, and the board. All required receipts must be attached.

Issued June 22, 1988.