

§126.14

1. INTRODUCTION. The Commissioner of the Division of Workers' Compensation, Texas Department of Insurance adopts new §126.14, concerning the treating doctor examination to define the compensable injury. The new section is adopted with changes to the proposed text as published in the February 3, 2006 issue of the Texas Register (31 TexReg 671).

2. REASONED JUSTIFICATION. The new section is necessary as a result of House Bill 7, 79th Legislature, Regular Session, effective September 1, 2005, which created Labor Code §408.0042 for the purpose of defining an injured employee's compensable injury. Labor Code §408.0042 requires the injured employee to attend one examination per workers' compensation claim with the injured employee's treating doctor at the request of the insurance carrier. This examination is a voluntary option for insurance carriers to utilize as a tool in managing claims. The examination's purpose is to have the injured employee's treating doctor identify the specific injuries that were caused or aggravated by the work-related incident or activities. The insurance carrier will make a determination as to whether the injuries and diagnoses identified by the doctor are accepted as part of the compensable injury. The adopted rules also provide direction for participants in a workers compensation health care network established under Insurance Code Chapter 1305.

The rule has been restructured and incorporates editorial and grammatical changes. Changes have also been made as a result of public comment; however, no substantive changes were made to the rule as proposed. Proposed subsection (d) has been deleted as a result of concerns regarding electronic reporting in TXCOMP and accessibility to all appropriate parties and the subsections have been relettered appropriately. The various references to TXCOMP in the section have been deleted.

3. HOW THE SECTION WILL FUNCTION. Subsection (a) relates to the scheduling of a single examination to define the compensable injury. An insurance carrier electing to utilize this provision must contact the treating doctor and schedule an appointment for the injured employee. The time period of 15 days from the date the notice is sent to the date of the examination was selected to provide ample time for mailing and to inform the injured employee that an examination had been scheduled. This time period allows adequate time for an injured employee to make any scheduling arrangements for the examination to accommodate time off work, transportation and other accommodations.

Subsection (b) provides that the insurance carrier shall schedule the examination with the injured employee's treating doctor. The insurance carrier will need to check with the injured employee, the injured employee's legal representative (if any), the workers' compensation health care network, and/or the Division to verify that the doctor with whom the examination is being scheduled is the treating doctor and that no requests for change of treating doctor have been received or are pending. If there is a question, the examination should be delayed until the correct doctor is verified. In

paragraph (1), additional changes were made to clarify the penalties associated with an insurance carrier's failure to schedule the examination with the injured employee's treating doctor of record. If a change in treating doctor occurs, the timing of the doctor change will impact how the results of the examination will be considered. If a doctor change is requested prior to the examination notice, the results of the examination from the previous treating doctor may not be used to define the compensable injury. The insurance carrier may make a new request for an examination with the correct treating doctor. If the doctor change is requested after the examination notice, the examination results may be used because the results came from the treating doctor at the time the notice was sent.

Subsection (c) requires an insurance carrier to send a written notice of examination. Minor changes were made to the compulsory language based on public comment. Paragraph (4)(A) complies with the requirement to provide injured employees with information in plain language and to inform injured employees that they are required to attend this examination. Paragraph (4)(B) adds a requirement that the insurance carrier includes the name and phone number of the person to be contacted if the doctor named in the notice of examination is not the treating doctor. The injured employee should not attempt to change treating doctors after being informed the insurance carrier has scheduled this examination. Paragraph (4)(C) adds language informing the injured employee of the requirement that a rescheduled examination take place within seven days of the originally scheduled examination or at the treating

doctor's first available appointment time, if no appointments are available during the seven-day period.

Subsection (d) addresses the rescheduling of the examination if the injured employee is unable to attend at the time scheduled by the insurance carrier. Latitude has been provided for rescheduling of the examination if the doctor does not have an available appointment time during that period. Subsection (e) details the consequences if the injured employee fails to attend the examination.

Subsection (f) provides the minimum required information that shall be included in the treating doctor's narrative report. This includes direction for situations where additional testing is required to ascertain the full extent of the injury. New mailing requirements have been provided. The subsection also outlines how compensable injuries and diagnoses are to be identified in the treating doctor's narrative. As a result of public comment, subsection (f)(3) requires that the treating doctor explain how the mechanism of injury caused a worsening of a condition if an aggravation of an ordinary disease of life or a preexisting condition is identified as part of the compensable injury.

Subsection (g) clarifies the process when diagnostic testing is required to define the compensable injury. Subsection (h) clarifies the allotted time and distribution requirements for the treating doctor to submit the narrative report from this examination.

Subsection (i) outlines information regarding the reimbursement associated with this type of examination. The reimbursement is \$350, equivalent to the reimbursement for a required medical examination. Since this examination is for administrative purposes that require additional documentation and its results have significant bearing

on the claim, it is deserving of a higher reimbursement than for treatment examinations. Testing necessary to define the compensable injury shall be reimbursed in accordance with the Medical Fee Guideline §134.202. Testing for network claims shall be reimbursed in accordance with the contract between the health care provider and the network. Testing necessary to confirm or rule out a diagnosis shall not be retrospectively reviewed for compensability if the treating doctor has documented the necessity for the test in defining the injury.

Subsection (j) outlines the insurance carrier's responsibilities once the treating doctor has submitted the narrative report defining the injuries and diagnoses the doctor determines were caused by the mechanism of injury. Changes were made to clarify the intent of this subsection as it pertains to other rules and the Act. The revised process (using PLNs rather than TXCOMP) requires that any specific diagnoses or injuries documented in the treating doctor's narrative report that the insurance carrier does not accept as part of the compensable injury must be denied in accordance with §124.2. Any injury or diagnosis documented in the treating doctor's narrative report that is not specifically denied via a Plain Language Notice (PLN), PLN-1 or PLN-11 will be considered accepted by the insurance carrier as part of the compensable injury. The terms "symptoms and conditions" were deleted from subsection (j)(1). Changes to this paragraph also address the concerns of commenters regarding the 60-day waiver period. The language clarifies the intent of the paragraph that the insurance carrier may not use this examination to diminish an injury established under Labor Code §409.021.

Subsection (j)(2) reflects the requirements of §124.3(e) and Insurance Code §1305.153(e).

Subsection (k) informs the injured employee of the right to request a benefit review conference if the insurance carrier denies the compensability of specific injuries or diagnoses listed in the treating doctor's report.

Subsection (l) outlines the preauthorization requirements for any treatment for an injury or diagnosis identified from this examination and denied by the insurance carrier. Language was added to the subsection to clarify that the preauthorization requirement continues only until an injury or diagnosis denied by the insurance carrier is determined through dispute resolution or agreement of the parties to be part of the compensable injury.

Subsection (m) outlines when a health care provider has the right to pursue dispute resolution for an injury or diagnosis identified from this examination that the insurance carrier has denied. The subsection was restructured to clarify the circumstances when a health care provider may pursue an extent of injury dispute.

Subsection (n) indicates that once the insurance carrier accepts specific injuries and diagnoses as related to the compensable injury, treatment for these injuries and diagnoses shall not be reviewed for compensability.

4. SUMMARY OF COMMENTS AND AGENCY'S RESPONSE TO COMMENTS.

General Comment: Some commenters expressed concern that this rule leaves the door open for the injury to expand and build when it appears the statute was intended to

end the cycle where a clear-cut injury begins to “morph” into other regions of the body.

The commenters suggested that the insurance carrier should be able to obtain a commitment from the treating doctor's findings, as to what the injury is and all parties should be bound to this assessment.

Agency Response: The Labor Code §408.0042 has not changed or superseded §409.021. Section 408.0042 provides a tool to the insurance carrier for defining the compensable injury at the time of the examination. However, injured employees are entitled to all health care reasonably required by the nature of the injury. There are circumstances where a compensable injury legitimately progresses beyond the initial diagnosis. Treatment for these new diagnoses cannot be restricted simply because the diagnosis had not developed at the time of the treating doctor's examination. If a carrier does not believe that the new diagnoses are a legitimate progression of the compensable injury, it can dispute the diagnoses using the extent of injury process.

Comment: Some commenters believe this rule moves beyond the direction of Labor Code §408.0042(f), which says the Division may adopt rules “relating to requirements for a report under this section.” Other commenters suggested the Division not attempt to micro-manage the process and only be involved in the process when there is a dispute.

Agency Response: The rule provisions only address the parameters of the process to ensure that the mandates of the Act are accomplished. For the process to operate efficiently, it is necessary that a uniform process and procedure be put in place to

ensure all participants are aware of their rights and responsibilities, as well as to minimize the likelihood of disputes. The Division is only involved when dispute resolution is requested and the rule does not insert unnecessary regulatory intervention into the process. Certain requirements such as timeframes, content and distribution are necessary to minimize the potential for disputes and ensure a timely process. Labor Code §§402.00114(a), 402.021 and 402.061 provide the rationale, as well as the authority, for development of a uniform process.

TXCOMP Comment: Numerous commenters indicated concern about conducting business in TXCOMP at this point in time, from concern over certain participants not having internet or claim-specific access, to operational issues when the system is down, as well as confidentiality issues. Several commenters recommended that the Division develop a form that uniformly handles the process instead.

Agency Response: The Division acknowledges commenters' concerns and will not be implementing the treating doctor examination to define the compensable injury process electronically at this time. It is anticipated that as technology advances, this process may be incorporated into an electronic system to reduce paper usage and promote higher levels of service some time in the future. At this time, a paper process will be used. The Division declines to create a new form, but is specifying in the rule the information and contents required for the various submissions. This includes compulsory language, minimum required information, contents of reports and

distribution requirements. The information requested does not include any information that would not have been required by TXCOMP.

Subsection (a): Several commenters stated that because of scheduling restrictions, the insurance carrier will have to pay a minimum of 24 days of benefits before the examination may take place making it more cost effective to simply dispute the questionable portions of the claim or to deny the claim in its entirety. During this 24-day period, the health care provider may be providing treatment for non-compensable parts of the injury for which the provider may not receive reimbursement, which is not in keeping with the intent of the statute.

Agency Response: The Division disagrees. This examination does not have to occur before an insurance carrier may dispute all or part of an injury. Labor Code §408.0042 is just one tool available to insurance carriers to help define the compensable injury. There are potential advantages and disadvantages the insurance carrier must weigh to determine when and how to use this tool. If an insurance carrier identifies questionable portions of a claim, it may file a contest of compensability without the added expense and delay that may be associated with this examination. The only restriction is the requirement that the injured employee be at least eight days post-injury when the examination is requested. The requirement that an examination not be scheduled to occur earlier than 15 days from when the notice of examination is sent is to allow the injured employee time to receive sufficient notice that an examination has been

scheduled to make arrangements for time off work, transportation, or other accommodations.

Subsection (b): Several commenters requested information on how an insurance carrier was to know if a change of treating doctor had been requested and expressed concern over the ability to verify the treating doctor. A commenter suggested adding the language included in the preamble of the proposed rule regarding use of the examination results.

Agency Response: An insurance carrier has the responsibility to communicate with the injured employee, the representative (if any), the injured employee's network and/or the Division (for non-network claims) to verify if a request to change doctor has been submitted. The Division concurs with the suggestion and has added language indicating the examination results may be used to define the compensable injury in situations where a change of treating doctor is requested after the notice of the examination has been sent by the insurance carrier.

Comment: Some commenters suggested that the burden should be on the injured employee to notify the insurance carrier of a change to treating doctor when a request for an examination has been sent. Numerous commenters recommended adding a subsection (b)(3) to reflect language from the preamble advising the injured employee not to change doctors during the treating doctor examination process. The commenters also suggested clarifying that requesting a doctor change after notice of the treating

doctor examination was sent will not invalidate the examinations results and will not be a violation.

Agency Response: If the injured employee has requested to change treating doctors, he/she should notify the insurance carrier immediately upon receipt of notice of the examination. Other rules establish the procedures an injured employee must follow to change doctors. The Division reminds an insurance carrier that it remains responsible for exercising due diligence in ascertaining whether an injured employee has changed doctors prior to scheduling an examination. The Division does not have the authority to impose a moratorium on treating doctor changes, especially when there is a workers' compensation health care network involved; however, it has added the recommended language to the compulsory language required on the notice of examination. Subsection (b)(2) was changed to clarify when the report of the examination may be used.

Subsection (b)(1): Several commenters suggested the Division remove the administrative penalty associated with failure to verify the treating doctor, indicating the inability to use the report should be sufficient penalty.

Agency Response: Labor Code §408.0042(b) specifically provides "A medical examination...shall be performed by the employee's treating doctor." It is only reasonable that if the examination is to be performed by the treating doctor then it is necessary that the insurance carrier schedule the examination with the treating doctor and the language of subsection (b) has been changed to clarify this point. An insurance

carrier has the duty to communicate with the injured employee, the representative (if any), the injured employee's network and/or the Division (for non-network claims) to verify if a request to change doctors has been submitted. The Division reminds insurance carriers that if the examination is scheduled with a doctor other than the treating doctor, then the insurance carrier is not in compliance with the Act as well as the rules and administrative penalties may be assessed. It is not necessary for the Division to specify in the text of a rule that it can take administrative action against insurance carriers for violations of the statute and/or rules and that language has been removed as unnecessary. The Division has been provided statutory authority to take enforcement action for violations of the statute and rules, as necessary.

Subsection (b)(2): A commenter indicated the word "compensable" should be inserted before "injury" in the second sentence of this paragraph since it provides that the results of an improper examination shall not be used.

Agency Response: The Division agrees and has made the change.

Subsection (c)(4)(A): A commenter suggested that the compulsory language required in the notice of examination be changed to comply with plain language requirements, specifically to clarify for the injured employee the meaning of "compensable." The commenter pointed out this subsection provides compulsory language that informs the injured employee of rights and responsibilities related to this examination. The

commenter believes that since this letter is notification that the examination has been scheduled, the sentence should be changed to an affirmative directive.

Agency Response: The Division agrees and has made the suggested changes. The rule has been changed to indicate the examination's purpose is to define the injuries and diagnoses "that resulted from the work-related incident or activities."

Subsection (c)(4)(C): A commenter pointed out that no penalty amount is defined for an injured employee that fails to attend this examination without good cause. The commenter questions whether a specific penalty amount should be identified, and if so, who would administer the penalty.

Agency Response: The Division will make a determination as to whether there was good cause and will assess any penalty found to be appropriate based on Labor Code §§408.0042, 415.021 and Division rules.

Comment: A commenter suggested that language directing that the examination be rescheduled within seven days of the original examination date be included in the notice requirements of subsection (c)(4)(C).

Agency Response: The Division agrees that the timeframe for rescheduling the examination is an important requirement that the injured employee should be made aware of and has made the suggested change.

Subsection (e): A commenter suggested the penalty for failure to attend this examination be consistent with the penalties for missed required medical examinations and designated doctor examinations, allowing an insurance carrier to stop temporary income benefits until the injured employee attends.

Agency Response: The Division disagrees. Application of this form of penalty for failing to attend the treating doctor examination to define the compensable injury was not included in the statute. The Division points out the legislature amended the penalties associated with failure to attend examinations. Temporary income benefits may only be stopped if an injured employee fails to attend a designated doctor appointment without good cause. This penalty option was removed from required medical examinations.

Subsection (f)(3): A commenter suggested when a doctor includes a diagnosis that is typically an ordinary disease of life, the doctor must describe how the condition has been worsened by the compensable injury in his report. Another commenter expressed favor for requiring a treating doctor to describe the mechanism of injury and how the diagnoses and injuries the doctor is treating were caused by the mechanism of injury.

Agency Response: The Division agrees this will be valuable information and has changed subsection (f)(3) to indicate the report shall explain how the mechanism of injury caused a worsening or exacerbation of the condition when the doctor identifies an aggravation of a preexisting condition, which includes an ordinary disease of life.

Comment: A commenter indicated there was no provision in the rule that a doctor cannot withhold a known diagnosis or what the penalty would be if such occurred.

Agency Response: Labor Code §408.0042(c) requires a doctor to list all injuries and diagnoses related to the compensable injury. Section 126.14 has been changed to clarify this requirement in subsection (f)(3). The Division reminds doctors that failure to accurately report all diagnoses identifiable at the time of the examination could be an administrative violation.

Subsection (g): Some commenters noted that the Division acknowledged their concerns regarding the time necessary to order and complete diagnostic testing by increasing the testing timeframe from seven to 10 days in the proposed rule. Some of the commenters recommended the Division consider a longer period of 14 days and one recommended 20 days.

Agency Response: The Division wishes to clarify that the rule provides for 10 working days, which is equivalent to two full business weeks, for testing to be performed. Changing the period to 14 calendar days from 10 working days could shorten rather than lengthen the period for testing, for example when there are intervening holidays. Based on comments received, a period of 10 working days appears to be sufficient time to order and complete diagnostic testing.

Comment: Some commenters indicated that diagnostic testing under this provision should adhere to the same preauthorization standards as in any other circumstance to

determine if the testing is clinically indicated and that the insurance carrier will need to be notified of any testing recommendation to provide the authorization.

Agency Response: The Division disagrees. It is necessary to eliminate the preauthorization requirement for diagnostic testing required to define the compensable injury. The treating doctor may require tests to confirm or rule out suspected diagnoses. Denial of preauthorization for diagnostic testing could prevent the treating doctor from defining the injury.

Comment: Some commenters expressed concern that doctors may include every diagnosis they can think of because it may be needed later. The commenters feel that this will lead insurance carriers to dispute more diagnoses on claims that would not necessarily have had a dispute arise.

Agency Response: The Division reminds participants that the doctor will need to confirm the injuries and diagnoses that are being defined. A suspected injury or diagnosis cannot be included. The treating doctor shall list only specific, confirmed injuries and diagnoses that are part of the compensable injury. If the doctor does document confirmed injuries, the insurance carrier should deny any that it feels are not related to the compensable injury so that the dispute may be resolved earlier in the claim process.

Subsection (j): A commenter suggested the language in subsection (j) be changed to state, "within 60 days of the date written notice of the injury or diagnosis is received..."

Another commenter suggested after “within the later of 60 days of the date written notice of the injury” adding “or the date the diagnosis is received.”

Agency Response: The Division declines to make the suggested changes. It is not necessarily notice of a specific diagnosis that triggers the 60-day period. It is notice of an injury that triggers the 60-day period. The insurance carrier shall respond to the treating doctor’s report within 10 working days of receipt of the treating doctor’s report unless the 10 working days expires prior to the end of the 60 days after receipt of the written notice of injury.

Comment: A commenter expressed concern that 60 days is too long a time to make a determination on what is being accepted as the compensable injury and questioned if this is in conflict with subsection (j)(1) and (2).

Agency Response: The Division believes there may have been some confusion regarding the time period for an insurance carrier to deny injuries and diagnoses on the treating doctor’s report. It will only be in those cases when the examination is requested very early in the claim and the 10 working day period expires prior to the 60th day after the date written notice of the injury was received, that the period is extended. The period for responding to the treating doctor’s report is extended to the 60th day so it will not interfere with the statutory timeframe for investigating and accepting the compensability of the claim.

There is no conflict within subsection (j). The Division reads Labor Code §408.0042 and this rule in concert with §409.021. A key element of statutory

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construction is that if various statutes can be read in harmony with each other so that all provisions can be given effect then that is the interpretation that should be utilized. That is what has been done in this situation. There is no conflict between Labor Code §408.0042 and §409.021 and this rule and full effect can be given to all. Additionally, the subsection indicates the insurance carrier shall not begin denying medical payments on the basis of compensability until it has given written notice that it is denying the compensability of the diagnosis for which the treatment was rendered, in accordance with §124.3(e) and Insurance Code §1305.153(e).

Subsection (j)(1): Some commenters questioned the purpose of subsection (j)(1) and suggested deletion. They contend it is inconsistent with the changes made to the statute by House Bill 7 and re-creates a “Downs”-like situation (Continental Casualty Co. v. Downs, 81 S.W. 3d 803 (Tex. 2002)) as well as a disincentive for the insurance carrier to use a tool created by the Legislature for them. A commenter suggested that if it was the Division’s concern that subsection (j)(1) may be used to revive a waived injury, a wording change that simply says, “the insurance carrier may not use this examination to circumvent its responsibilities to dispute compensability under §409.021” should be sufficient. A commenter noted the insurance carrier must be fairly informed of the injury it is waiving into before it can be compelled to accept that injury under the doctrine of waiver and suggested the rule has ignored the ‘written notice’ requirement for a more subjective ‘reasonably discoverable’ standard. Another commenter stated

that it was not the insurance carrier's burden to deny non-discovered, non-reported injuries.

Agency Response: The Division has modified subsection (j)(1) to provide that no injury or diagnosis, established under Labor Code §409.021, can be taken away by a subsequent definition of the injury under this section. The Division disagrees with the assessment that the rule is inconsistent with changes made by House Bill 7 because Labor Code §409.021 must be read in concert with new Labor Code §408.0042. Neither §408.0042 nor this section creates a waiver. Although there is no waiver reference in §408.0042, §409.021, which is applicable to §408.0042, states the insurance carrier has specific responsibilities and deadlines with regard to liability for a compensable injury. The treating doctor examination to define the compensable injury process may not be used to avoid these responsibilities or correct an omission. The Division is not attempting to expand on provisions spelled out in other rules; rather it is merely giving full effect to the various provisions of the Act and showing how other rules work in concert with this provision. The subsection clarifies that the intent of the paragraph is to give full effect to both §§409.021 and 408.0042 and the results defined by the treating doctor examination cannot diminish any injury established by a waiver determination. The Division concurs that the insurance carrier must receive written notice of an injury to trigger its duty to investigate the claim and a reasonable investigation would fairly inform the insurance carrier of the injuries. The commenter is incorrect in stating the insurance carrier has no duty to investigate the injury.

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Comment: Some commenters disagreed with the use of the words “symptoms and conditions” as these words do not qualify as injuries under the Act and Labor Code §408.0042 addresses only “injuries and diagnoses.” Some commenters recommended the rule be confined to the scope of the statute and these terms be removed.

Agency Response: The Division has removed the terms “symptoms and conditions” from subsection (j)(1) but notes that symptoms and conditions are compensable if they are related to the compensable injury.

Comment: Several commenters stated that subsection (j) implies that a causative link between work and the injuries and diagnoses did not have to be made, exposing insurance carriers to liability for every health condition ever suffered by the injured employee. As a result, insurance carriers would be inclined to generate blanket denials on every claim, which conflicts with the intent of House Bill 7.

Agency Response: The Division clarifies that the purpose of subsection (j)(1) is to clarify that the findings of a treating doctor examination do not change compensability established as a result of waiver under Labor Code §409.021.

Subsection (j)(2): Several commenters expressed concern over the requirement that insurance carriers not deny reimbursement for medical care on the basis of compensability prior to filing a written denial of compensability. Their concern was not only about making an insurance carrier liable for non-compensable medical costs, but also that a doctor may increase the amount of treatment provided during this “free”

period when it is anticipated that the insurance carrier will deny a condition. Several commenters suggested insurance carriers be given at least 10 days from the date the doctor's report is received, to evaluate the report, before the insurance carrier is required to pay for medical treatment.

Agency Response: An insurance carrier has 10 working days to evaluate the treating doctor's report before it must accept all the injuries or dispute specific diagnoses. The insurance carrier must deny the compensability of a diagnosis before it may deny reimbursement for treatment rendered for that diagnosis on the basis that it is non-compensable. This is consistent with existing rules and statute.

Subsection (k): A commenter recommends adding a requirement that the injured employee has only 30 days after receiving the denial to request a benefit review conference to ensure that disputes are brought early for resolution.

Agency Response: The Division believes it is unnecessary at this time to address a timeframe for requesting a benefit review conference. The Division also notes that the proposed rule did not propose a timeframe for this request and it is unable to make this type of change in the adopted rule.

Comment: Some commenters recommended that the insurance carrier be allowed to notify the treating doctor of any denials of diagnoses identified from this examination by any means, such as by phone, and not provide written notice.

Agency Response: The Division disagrees. An insurance carrier must provide the treating doctor with written notice when specific injuries or diagnoses, identified in the “exam to define the compensable injury” report, have been denied. The Division encourages written notice to be transmitted by facsimile or electronic transmission to the treating doctor when the doctor has the means to receive such transmissions.

Subsection (I): Several commenters requested clarification of the services/treatments that require preauthorization under §§126.14 and 134.600. Specifically, the commenters questioned whether all services listed in §134.600 require preauthorization regardless of the treating doctor exam; and whether all other services not subject to §134.600 require preauthorization under §126.14. One commenter asked the Division to reconsider this concept as it may result in significant costs associated with preauthorization.

Agency Response: For non-network claims, all the services listed in §134.600 must be preauthorized regardless of the results of a treating doctor examination. In network claims, §134.600 is not applicable and each network will establish its own list of services that require preauthorization. However, in both network and non-network claims, preauthorization is not required for diagnostic tests ordered by the treating doctor to establish a diagnosis under subsection (g).

Regardless of any network affiliation, all services and treatments related to a denied injury or diagnosis identified in the treating doctor’s examination under §126.14

require preauthorization. These preauthorization requirements are required by Labor Code §408.0042(d).

Comment: A commenter stated that it is not reasonable to provide a preauthorization process for treatment of injuries denied by the insurance carrier since preauthorization cannot comment on compensability.

Agency Response: The statutory provision that precipitated this rule requires the insurance carrier to accept all diagnoses identified in the examination as related to the compensable injury or to dispute the determination of a specific diagnosis. It goes on to require preauthorization for treatment of any diagnosis that was disputed to allow the possibility of care while dispute resolution is in process. The rule has been written to reflect the statutory language.

Subsection (m): A commenter suggested that the Division clarify that the treating doctor cannot later dispute his own assessment.

Agency Response: The health care provider may only pursue an extent of injury dispute under Labor Code §408.0042 or as a sub-claimant under Labor Code §409.009. There is no provision that permits a treating doctor, or a subsequent treating doctor, to change the contents of a previously filed report, changing the definition of the compensable injury. However, in accordance with §408.021, there can be no provision that keeps additional injuries from being established as part of the compensable injury.

Comment: A commenter questioned why a provider should be allowed to request a benefit review conference for an extent of injury dispute if the injured employee is not pursuing and the provider has not incurred charges.

Agency Response: Labor Code §408.0042(d) specifically allows an affected health care provider to file an extent of injury dispute if an insurance carrier denies preauthorization because the treatment is for an injury unrelated to the compensable injury. However, subsection (m)(1) has been changed to clarify that a health care provider may not request a benefit review conference to address an extent of injury dispute if the injured employee has already requested a benefit review conference for this issue.

Comment: A few commenters suggested a health care provider may only request a benefit review conference when the insurance carrier denies preauthorization based on an extent of injury dispute. The commenters noted that a dispute regarding medical necessity is subject to the provisions of §133.308 not Chapter 141.

Agency Response: The Division agrees that a health care provider may only request a benefit review conference under Labor Code §408.0042(d) to address an extent of injury denial. Questions related to medical necessity are handled through medical dispute resolution.

Subsection (n): A number of commenters requested the Division add a provision allowing an insurance carrier to contest extent of injury of an accepted condition at a

later time if newly discovered evidence was obtained. They suggested the rule was too absolute in this area and the statute does not provide the Division with the authority to limit the insurance carrier's ability to raise an extent issue.

Agency Response: The Division clarifies that the insurance carrier may reopen the issue of compensability for the claim as a whole as provided by Labor Code §409.021, but not for extent of injury issues. Labor Code §408.0042 states treatment for injuries or diagnoses that have been accepted are not subject to review for compensability but may be reviewed for medical necessity. Allowing the insurance carrier to contest an injury after accepting that injury or diagnosis would negate the intent of the provision to identify and resolve disputes early in the claim.

Comment: A commenter stated that subsection(n) is not mandated by statute. The commenter asserted that it must be made clear that while an insurance carrier is liable for accrued medical benefits after the insurance carrier has accepted some or all of the injuries or diagnoses in the treating doctor's report, the insurance carrier may subsequently dispute those injuries and not be liable for future treatment.

Agency Response: The Division disagrees as the subsection is mandated by Labor Code §408.0042(e), which provides that any treatment for an injury or diagnosis that is accepted by the insurance carrier may not be reviewed for compensability, only for medical necessity. It is accepted that this also allows review for compliance with fee guidelines. The purpose of this provision is to give all participants the opportunity to establish the nature of the injury and to resolve disputes over the nature of the injury

early in the claim. If the insurance carrier had the opportunity to subsequently dispute accepted conditions, it would negate the purpose of the provision.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.

For, with changes: Employers Claims Adjustment Services, Inc.; Texas Association of School Boards; Lockheed Martin Aeronautics Co.; Hammerman and Gainer; Flahive, Ogden and Latson; Office of Injured Employee Counsel; American Insurance Association; Texas Mutual Insurance Co.; The Boeing Co.; Insurance Council of Texas; Medical Equation, Inc.; Property Casualty Insurers of America; Association of Fire and Casualty Insurers of Texas.

Neither for or Against: Texas Medical Association; TIRR Systems; Fair Isaac Corp.; Healthsouth.

6. STATUTORY AUTHORITY. The new section is adopted under the Labor Code §§408.0042, 402.00111 and 402.061. Section 408.0042 provides for a medical examination by the treating doctor to define the compensable injury. Section 402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Section 402.061 authorizes the Commissioner to adopt rules necessary to administer the Act.

7. TEXT.

§126.14. Treating Doctor Examination to Define the Compensable Injury.

(a) On request of the insurance carrier, an injured employee is required to submit to a single examination per workers' compensation claim for the purpose of defining the compensable injury. The examination:

(1) shall not be requested prior to the eighth day after the date of injury, and

(2) shall be scheduled to occur no earlier than 15 days and no later than 30 days from the date the notice of examination is sent to the injured employee.

(b) The insurance carrier shall schedule the examination with the injured employee's treating doctor. If a request to change treating doctor has been filed by the injured employee, the insurance carrier shall not schedule this examination until after the treating doctor change has been processed.

(1) An insurance carrier that schedules the examination with a doctor other than the injured employee's treating doctor shall be liable for reimbursement of the examination and testing.

(2) The examination findings may only be used to define the compensable injury when provided by the treating doctor of record at the time the notice of examination was sent to the injured employee. The report by a doctor other than the treating doctor of record at the time the notice of examination was sent shall not be used for the purpose of defining the compensable injury.

(c) The insurance carrier shall send the injured employee a written notice of examination. A copy of a notice of examination shall be sent to the injured employee's representative (if any). The notice of examination, at a minimum, shall include:

(1) general information identifying the claim;

(2) the name of the treating doctor;

(3) the date, time, and the location of the scheduled examination with the treating doctor named; and

(4) the following statements in a bold font equal to the font size in the main body of the notice:

(A) The insurance carrier requests that you, the injured employee, attend a single examination for this workers' compensation claim for the sole purpose of defining the injuries and diagnoses that resulted from the work-related incident or activities. Section 408.0042 of the Labor Code requires you to attend.

(B) If the doctor named in this notice is not your treating doctor, immediately contact the insurance carrier (*add name and phone number of contact person*) or the Texas Department of Insurance, Division of Workers' Compensation. You are not required to attend this examination with a doctor other than your treating doctor, unless the doctor was your treating doctor on the day the notice of examination was sent to you. Once you receive notice of this examination, you should not request to change treating doctor until after the examination has been conducted.

(C) You are responsible for contacting your doctor to reschedule the examination if you have a conflict with the date and time that has been scheduled

for you. The rescheduled examination shall take place within seven days of the originally scheduled date or the doctor's first available appointment date. If you fail to attend the examination at the time scheduled or rescheduled without good cause, an administrative penalty may be assessed.

(d) If a scheduling conflict exists, the injured employee shall immediately contact the treating doctor to reschedule the examination. The examination must be rescheduled to take place within seven working days of the original examination or the doctor's first available appointment date.

(e) An injured employee who fails or refuses to appear at the time scheduled for an examination may be assessed an administrative penalty unless good cause exists for such failure. An injured employee who fails to submit to an examination at the insurance carrier's request does not commit an administrative violation if the doctor named on the notice of examination is not the injured employee's treating doctor.

(f) The treating doctor shall submit a narrative report after the conclusion of the examination. The report shall contain, at a minimum:

- (1) general information that identifies the claim;
- (2) a description of the mechanism of injury;
- (3) a list of all specific, confirmed diagnoses, including ICD-9 codes and the narrative description, that the doctor considers to be related to the compensable injury. The explanation shall describe how the mechanism of injury is a cause of each diagnosis. If the doctor identifies an aggravation of any pre-existing condition, including

an ordinary disease of life, the explanation shall describe how the mechanism of injury caused a worsening, acceleration, or exacerbation of that pre-existing condition; and

(4) a list of each diagnostic test performed, if required to establish a diagnosis, including an explanation of why it was appropriate to perform each test to define the compensable injury.

(g) Any diagnostic testing necessary to define the compensable injury shall be performed no later than 10 working days after the examination and is not subject to the preauthorization requirements of either §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) or a worker's compensation health care network under Insurance Code Chapter 1305 or Chapter 10 of this title (relating to Workers' Compensation Health Care Networks).

(h) The treating doctor shall submit a copy of the narrative report to the insurance carrier, the injured employee, and the injured employee's representative (if any) no later than 10 days after the conclusion of the examination. If diagnostic testing is required to define the compensable injury, the filing of the report is extended to seven days after the conclusion of the testing.

(i) A treating doctor may bill, and the insurance carrier shall reimburse, for an examination performed under this section.

(1) Treating doctors shall bill for the examination using the Healthcare Common Procedure Coding System (HCPCS) Level I code, Evaluation and Management Section, for work-related or medical disability evaluation services

performed by a treating physician. A Division modifier of "TX" shall be added to the Level I code.

(2) Reimbursement for the examination shall be \$350. Reimbursement for the report is included in the examination fee. Doctors are not required to submit a copy of the report with the bill if the report was previously provided to the insurance carrier.

(3) Testing necessary to define the compensable injury shall be billed using the appropriate billing codes and reimbursed in addition to the examination fee. Reimbursement for testing shall not be retrospectively reviewed on the basis of compensability if the doctor has documented a rationale for why the testing was necessary for defining the compensable injury.

(j) An insurance carrier shall review the injuries and diagnoses identified in the treating doctor's report. If a specific injury or diagnosis is not accepted as part of the compensable injury, the insurance carrier shall file a denial in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements) within the later of 60 days after the date written notice of the injury is received or within 10 working days of receipt of the treating doctor's report. In addition to the distribution requirements outlined in §124.2 of this title, a copy of the written denial shall be sent to the treating doctor by fax or electronic transmission unless the recipient does not have the means to receive such transmission in which case the notice shall be personally delivered or sent by mail.

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(1) A compensable injury established as a result of a waiver determination under Labor Code §409.021, is not affected by a definition of the compensable injury under §408.0042.

(2) The insurance carrier shall not deny reimbursement for treatment of any injury or diagnosis listed in the treating doctor's report on the basis of compensability or relatedness prior to filing a denial as required by §124.2 of this title.

(k) The injured employee may initiate a request for a benefit review conference in accordance with Labor Code §410.023 and §141.1 of this title (relating to Requesting and Setting a Benefit Review Conference) upon receiving a denial regarding specific injuries or diagnoses.

(l) If the insurance carrier denies an injury or diagnosis identified in this examination, all treatment for that injury or diagnosis must be preauthorized prior to treatment occurring. For the treating doctor, the insurance carrier's denial is effective on the date the written notice of denial is received by the doctor. The preauthorization requirement continues until the injury or diagnosis is determined to be part of the compensable injury through dispute resolution or agreement of the parties.

(m) A health care provider may request a benefit review conference, in accordance with §141.1 of this title, to address an extent of injury question if a request for preauthorization has been denied for treatment of an injury or diagnosis that was denied as unrelated to the compensable injury under this section; unless:

(1) the injured employee has already requested a benefit review conference to pursue the extent of injury denial, or

(2) an agreement, filed in accordance with §147.4 of this title (relating to Filing Agreements with the Commission, Effective Dates) has been entered into by the insurance carrier and injured employee establishing the insurance carrier's liability on the disputed issues.

(n) Once the treating doctor has defined the compensable injury and the insurance carrier has accepted injuries or diagnoses as related, the insurance carrier shall not review treatment of the accepted injuries and diagnoses for compensability.

CERTIFICATION. This agency certifies that the adopted section has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on _____, 2006.

Norma Garcia
General Counsel
Division of Workers' Compensation
Texas Department of Insurance

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TITLE 28. INSURANCE

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IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that new §126.14, concerning the treating doctor examination to define the compensable injury is adopted.

AND IT IS SO ORDERED.

ALBERT BETTS
COMMISSIONER OF WORKERS' COMPENSATION
TEXAS DEPARTMENT OF INSURANCE

ATTEST:

Norma Garcia
General Counsel

COMMISSIONER'S ORDER NO. **DWC-06-0029**