CHAPTER 126. GENERAL PROVISIONS APPLICABLE TO ALL BENEFITS

§126.1. Definitions Applicable to All Benefits.

The following terms shall have the following meanings unless the context clearly indicates otherwise:

(1) Employer Initiation of Benefits - Money paid by an employer to the employee to compensate the employee for lost wages or paid by the employer for medical expenses during a period in which the carrier has either:

(A) contested compensability of the injury;

(B) contested liability for the injury; or

(C) has not completed its initial investigation of the injury which is limited to seven days after the carrier receives first written notice of the injury as defined in §124.1 of this title (relating to Notice of Injury).

(2) Nonpecuniary Wages--Wages paid to an employee in a form other than money. Examples of nonpecuniary wages include but are not limited to:

(A) Health insurance premiums;

(B) Laundry/cleaning;

(C) Clothing/uniforms;

(D) Lodging/housing/rent;

(E) Payment of professional license fees;

(F) Food/Meals; and

(G) Provision of a vehicle/fuel.

(3) Pecuniary Wages--Wages paid to an employee in the form of money. Examples of pecuniary wages include, but are not limited to:

(A) Hourly, weekly, biweekly, monthly (etc.) wages;

(B) Salary;

(C) Piecework compensation;

(D) Any monetary allowance such as for health insurance premiums, vehicle/fuel, food/meals, clothing/uniforms, laundry/cleaning, or lodging/housing/rent;

(E) Monetary bonuses earned or accrued by the employee; and

(F) Commissions.

(4) Unrecoupable overpayment--The amount of benefits paid by the carrier to the claimant which were not owed and which were not recoverable or convertible from other income benefits.

The provisions of this §126.1 adopted to be effective December 26, 1999, 24 TexReg 11399.

§126.2. Payment of Benefits to Minors.

(a) If an injured employee is a minor, benefits will be paid by the carrier to the custodial parent or guardian, for the use and benefits of the minor, until the minor turns 18 year of age, except as otherwise provided in this section.

(b) If a court-ordered relationship that affects the minor exists and is brought to the attention of the carrier or the commission, the carrier will pay benefits in accordance with that order.

(c) A parent, managing conservator, or guardian may agree, in writing, for direct payment of benefits to the minor.

(d) An injured employee who is a minor may petition the commission for direct payment of benefits. The carrier shall pay benefits directly to the minor if so ordered by the executive director, after a hearing, and a reasonable attempt is made to locate the parent or guardian for purpose of the hearing.

(e) When the carrier and commission receive proof that a minor has attained the age of 18 years, or that a guardianship has ended, benefits will be paid directly to the injured employee.

(f) This section will also apply to payment of death benefits to legal beneficiaries who are minors.

The provisions of this §126.2 adopted to be effective January 1, 1991, 15 TexReg 6747.

§126.3. Payment of Benefits to Legally Incompetent Persons.

(a) Benefits for an injured employee found to be legally incompetent shall be paid by the carrier to the court-appointed guardian for the use and benefit of the injured employee, in accordance with the terms of any court order.

(b) If the carrier and the commission receive a certified copy of the court order declaring the injured employee legally competent, benefits shall once again be paid directly to the injured employee.

(c) The Ombudsman Program may provide information to the parties to a claim about available options if no court has declared an employee to be legally incompetent.

(d) This rule will also apply to payment of death benefits to legally incompetent beneficiaries of deceased employees.

The provisions of this §126.3 adopted to be effective January 1, 1991, 15 TexReg 6747.

§126.4. Advance of Benefits Based on Financial Hardship.

(a) An injured employee seeking an advance of income benefits based on financial hardship shall submit a written application to the Commission in the form and manner prescribed by the Commission that states the basis for the hardship The application must state the employee understands that if an advance is granted the amount of future weekly benefit payments will be reduced as directed by the Commission.

(b) The Commission shall forward a copy of the employee's application to the insurance carrier and shall consider the employee's application and may order an advance if it determines that both a hardship exists for the employee and the employee is likely to be entitled to income benefits sufficient to cover the amount of the advance.

(c) An advance will not be granted to an employee whose combined post-injury earnings, as defined by §129.2 of this title (relating to Entitlement to Temporary Income Benefits), and income benefits under this Act equals or exceeds 90% of the employee's net pre-injury wage. In the absence of specific evidence to

the contrary, the net pre-injury wage of an employee shall be presumed to be 80% of the average weekly wage, for this section.

(d) The Commission shall notify the carrier and the employee in writing when an advance is ordered. The notice shall include the amount of the advance to be paid; this amount shall not exceed four times the maximum weekly benefit for temporary income benefits as computed under the Act, §408.061(a). The carrier shall pay an advance ordered by the Commission within seven days of the receipt of notice from the Commission by the carrier's Austin representative.

(e) After the carrier has paid an advance, it shall reduce the amount of the weekly income benefits in an amount set by the Commission, which takes into account the amount advanced and the number of weeks that benefits are likely to be paid in the future. The weekly benefits may be paid in this reduced amount until the carrier has recouped the amount advanced.

(f) The total amount of benefits paid to the employee through weekly payments and advances based on hardship shall not exceed the amount the employee would have received under a normal payment schedule. No more than three advances shall be granted based on the same injury.

The provisions of this §126.4 adopted to be effective January 30, 1991, 16 TexReg 313; amended to be effective December 26, 1999, 24 TexReg 11399.

§126.5. Entitlement and Procedure for Requesting Required Medical Examinations.

(a) A doctor who has contracted with or is employed by an authorized workers' compensation health care network established under Insurance Code Chapter 1305, (network doctor) may not perform a required medical examination, as those terms are used under the Texas Workers' Compensation Act (the Act), for an employee receiving medical care through the same network. It is the responsibility of the requesting party to ensure the doctor selected does not have a disqualifying association.

(b) The Division may authorize a required medical examination (RME) for any reason set forth in the Act, Texas Labor Code §408.004, §408.0041, or §408.151 at the request of the insurance carrier (carrier). The request shall be made in the form and manner prescribed by the Division. A carrier is not entitled to take action with respect to benefits based on, and the Division shall not consider, a report of an RME doctor that was not approved or obtained in accordance with this section.

(c) Carriers are entitled to RMEs by a doctor of their choice in accordance with this subsection as follows:

(1) Pursuant to Texas Labor Code §408.004, once every 180 days, to resolve any questions about the appropriateness of the health care received by the injured employee (employee). The carrier's first RME may be requested at any time after the date of injury. A subsequent examination may be requested once every 180 days after the first examination and must be performed by the same doctor unless otherwise approved by the Division. This paragraph only applies to requests for required medical examinations of employees not receiving medical treatment through an authorized workers' compensation health care network.

(2) For the purpose of evaluating a designated doctor's determination on the issues listed under Labor Code §408.0041, a carrier is entitled to an examination under this subsection only after a Designated Doctor exam under §126.7 of this title (relating to Designated Doctor Examinations: Requests and General Procedures).

(3) For the purpose of evaluating a designated doctor's determination pursuant to Texas Labor Code §408.151, to determine if the employee's medical condition resulting from the compensable injury has improved sufficiently to allow the employee to return to work. For the purposes of this paragraph, the carrier may not require an employee to submit to an RME more than once per year if:

(A) an employee is receiving supplemental income benefits on or after the second anniversary of the date of the employee's initial entitlement to supplemental income benefits, and

(B) in the year preceding the request for the RME, the employee's medical condition resulting from the compensable injury had not improved sufficiently to allow the employee to return to work during that year.

(d) The doctor selected to perform an RME must be on the Division's approved doctors list and, if the purpose of the examination is to evaluate maximum medical impairment (MMI) and/or permanent impairment following a designated doctor examination, be authorized to assign impairment ratings under §130.1(a) of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment).

(e) Except for an examination under subsection (c)(2) and (3) of this section, the Division shall not require an employee to submit to a medical examination at the carrier's request until the carrier has made an attempt to obtain the agreement of the employee for the examination as required by this subsection. The carrier shall notify the Division in the form and manner prescribed by the Division of any agreement or non-agreement by the employee regarding the requested examination. An examination of an employee by a doctor selected by the carrier shall be requested as follows:

(1) Prior to requesting an RME from the Division, the carrier shall send a copy of the request to the employee and the employee's representative (if any) in the manner prescribed by subsection (g) of this section in an attempt to obtain the employee's agreement to the examination.

(2) The carrier shall give the employee 15 days to agree to the examination. The 15 - day period begins on the date the carrier sends the request to the employee and the employee's representative (if any). Though the employee has 15 days to respond to the request, the carrier is not prohibited from contacting the employee or the employee's representative (if any) by telephone to discuss the request and obtain the employee's or the representative's response.

(3) The carrier shall send the request to the Division after either obtaining the employee's answer to the request or when the employee fails to respond after the 15-day period.

(f) The carrier shall send a copy of the request for a required medical examination required by subsection (e) of this section to the employee and the employee's representative (if any) by facsimile or electronic transmission if the carrier has been provided with a facsimile number or email address for the recipient, otherwise, the carrier shall send the request by other verifiable means.

(g) The carrier shall maintain copies of the request for a required medical examination and shall also maintain verifiable proof of successful transmission of the information. For these purposes, verifiable proof includes, but is not limited to, a facsimile confirmation sheet, certified mail return receipt, delivery confirmation from the postal or delivery service, or a copy of the electronic submission.

(h) This section is effective on January 1, 2007 and a request for an RME under this section may be made on or after January 1, 2007.

The provisions of this §126.5 adopted to be effective January 30, 1991, 16 TexReg 313; amended to be effective January 1, 1998, 22 TexReg 11693; amended to be effective December 26, 1999, 24 TexReg 11399; amended to be effective January 2, 2002, 26 TexReg 10899 ; amended to be effective January 1, 2007, 31 TexReg 6351

§126.6. Required Medical Examination.

(a) When a request is made by the insurance carrier (carrier), or the Division, for a medical examination, the Division shall determine if an examination should occur. The Division shall grant or deny the request

within seven days of the date the request is received by the Division. A copy of the action of the Division shall be sent to the injured employee (employee), the employee's representative (if any), and the carrier. The notice shall explain the circumstances under which an employee may experience loss of benefits and penalty exposure for failing to attend the examination as well as the need to reschedule a missed examination. An agreement between the parties for an examination under §126.5 of this title (relating to Entitlement and Procedure for Requesting Required Medical Examinations) that the carrier has a right to has the same effect as the action of the Division.

(b) All examinations required under this section must be scheduled to occur within 30 days after receipt of the notice, with at least 10 days notice to the employee and the employee's representative (if any). If a scheduling conflict exists, the employee and the doctor shall contact each other. The doctor or the employee who has the scheduling conflict must make contact at least 24 hours prior to the appointment. The 24-hour requirement will be waived in an emergency situation (such as a death in the immediate family or a medical emergency). The rescheduled examination shall be set for a date within seven days of the originally scheduled examination, unless an extension is agreed upon by the employee and doctor. The extension may not be to a date later than the 30th day after the originally scheduled examination. In this event, the examining doctor shall notify the carrier and the 10 days notice requirement does not apply to a rescheduled examination.

(c) The employee's treating doctor may be present at an examination scheduled with a doctor selected by the carrier. The employee's treating doctor may observe the conduct of the examination, and may consult with the examining doctor about the course of the employee's treatment. The employee's treating doctor shall not otherwise participate in, impede, or advise the employee not to cooperate with the examination. In initially scheduling the examination, a reasonable attempt shall be made to accommodate the schedule of the treating doctor if the employee wants the treating doctor to attend the examination and the treating doctor is willing to do so. However, once an examination is scheduled based on the treating doctor's availability, the examination shall not be delayed, canceled, or rescheduled due to the treating doctor's scheduling conflicts unless:

(1) the required medical examination (RME) doctor agrees to the rescheduling; or

(2) the examination was canceled by the RME doctor.

(d) If the RME doctor, selected by a carrier, refuses to allow the treating doctor to attend the examination, the carrier shall cancel the appointment and request that another doctor be approved for the RME. If reasonable notice is not provided to the employee and the employee's representative (if any), the carrier shall be liable for any reasonable travel expenses incurred by the employee and for the payment for the treating doctor's attendance at a refused appointment. This subsection shall not apply to situations where the treating doctor is not able to attend the examination due to any form of scheduling conflict.

(e) An RME doctor, selected by the carrier or the Division, who conducts an examination regarding the appropriateness of the health care received by the employee, shall complete a medical report that includes objective findings of the examination and an analysis that explains how the medical condition and objective findings lead to the conclusion reached by the doctor. In addition, the RME doctor shall file the report with the insurance carrier by facsimile or electronic transmission, and shall file the report with the employee and the employee's representative (if any) by facsimile or by electronic transmission if the RME doctor has been provided with a facsimile number or email address for the recipient, otherwise, the RME doctor shall send the report by other verifiable means. Written notice is verifiable when it is provided from any source in a manner that reasonably confirms delivery to the party. This may include an acknowledged receipt by the injured employee or insurance carrier, a statement of personal delivery, confirmed by e-mail, confirmed delivery by facsimile, or some other confirmed delivery to the home or business address. The goal of this requirement is not to regulate how a system participant makes delivery of a report or other information to another system participant, but to ensure that the system participant filing the report or providing the information has verifiable proof that it was delivered.

(f) An RME doctor who, subsequent to a designated doctor's examination, determines the employee has reached maximum medical improvement (MMI) or who assigns an impairment rating, shall complete and file the report as required by §130.1 and §130.3 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment and Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment by Doctor Other than the Treating Doctor). Otherwise, the RME doctor shall not certify MMI or assign an impairment rating. If the RME doctor disagrees with the designated doctor's opinion regarding MMI, the RME doctor's report shall explain why the RME doctor believes the designated doctor was mistaken or why the designated doctor's opinion is no longer valid. Other reports shall be completed in the form and manner prescribed by the Division and shall be sent to the carrier, the employee, the employee's representative, if any, the treating doctor, and Division no later than 10 days after the examination.

(g) An RME doctor who, subsequent to a designated doctor's examination, determines that the employee can return to work immediately with or without restrictions is required to file a Work Status Report, as described in §129.5 of this title (relating to Work Status Reports) within seven days of the date of the examination of the employee. This report shall be filed with the treating doctor and the carrier by facsimile or electronic transmission. In addition, the RME doctor shall file the report with the employee and the employee's representative (if any) by facsimile or by electronic transmission if the RME doctor has been provided with a facsimile number or email address for the recipient, otherwise, the RME doctor shall send the report by other verifiable means.

(h) An RME doctor who, subsequent to a designated doctor's examination, addresses issues other than those listed in subsections (f) and (g) of this section, shall file a narrative report within seven days of the date of the examination of the employee. This report shall be filed with the treating doctor and the carrier by facsimile or electronic transmission. In addition, the RME doctor shall file the report with the employee and the employee's representative (if any) by facsimile or by electronic transmission if the RME doctor has been provided with a facsimile number or email address for the recipient, otherwise, the RME doctor shall send the report by other verifiable means.

(i) A doctor who conducts an examination solely under the authority of this rule shall not be considered a designated doctor under the Labor Code §408.0041, §408.122 or §408.125. Examinations with a designated doctor are not subject to any limitations under the provisions for RMEs.

(j) A carrier may suspend temporary income benefits (TIBs) if an employee, without good cause, fails to attend an RME required pursuant to Labor Code §408.0041(f).

(1) In the absence of a finding by the Division to the contrary, a carrier may presume that the employee did not have good cause to fail to attend the examination if by the day the examination was originally scheduled to occur the employee has both:

(A) failed to submit to the examination; and

(B) failed to contact the RME doctor's office to reschedule the examination in accordance with subsection (b) of this section.

(2) If, after the carrier suspends TIBs pursuant to this section, the employee contacts the RME doctor to reschedule the examination, the RME doctor shall reschedule the examination as soon as possible, but not later than the 30th day after the employee contacted the doctor. The insurance carrier shall re-initiate TIBs effective as of the date the employee submitted to the examination. The re-initiation of TIBs shall occur no later than the seventh day following:

(A) the date the carrier was notified that the employee attended the examination; or

(B) the date that the carrier was notified that the Division found that the employee had good cause for not attending the examination.

(3) An employee is not entitled to TIBs for a period during which the carrier was entitled to suspend benefits pursuant to this section unless the employee later submits to the examination and the Division finds or the carrier determines that the employee had good cause to fail to attend the appointment.

(k) An employee who, without good cause, fails or refuses to appear at the time scheduled for an examination authorized by this section may be assessed an administrative penalty under Labor Code §§408.004 and 408.0041. An employee who fails to submit to an examination at the carrier's request when the carrier selected doctor refuses to allow the treating doctor to attend the examination or when the RME doctor cancels the examination does not commit an administrative violation.

(l) The Division shall require examinations requiring travel of up to 75 miles from the employee's residence, unless the treating doctor certifies that such travel may be harmful to the employee's recovery. Travel over 75 miles may be authorized if good cause exists to support such travel. The carrier shall pay reasonable travel expenses incurred by the employee in submitting to any required medical examination, as specified in Chapter 134 of this title (relating to Benefits – Guidelines For Medical Service, Charges, and Payments).

(m) This section is effective on January 1, 2007 and a request for an RME under this section may be made on or after January 1, 2007.

The provisions of this §126.6 adopted to be effective January 30, 1991, 16 TexReg 313; amended to be effective January 1, 1998, 22 TexReg 11693; amended to be effective December 26, 1999, 24 TexReg 11399; amended to be effective January 2, 2002, 26 TexReg 10899; amended to be effective January 1, 2007, 31 TexReg 6351.

§126.7. Designated Doctor Examinations: Requests and General Procedures.

(a) The Division may require a medical examination by a designated doctor at the request of the insurance carrier, an injured employee (employee), the employee's representative, if any, the medical advisor, or on its own motion. A doctor who has contracted with or is employed by an authorized workers' compensation health care network established under Chapter 1305, Insurance Code, (network doctor) may not perform a designated doctor examination, as those terms are used under the Texas Workers' Compensation Act, for an employee receiving medical care through the same network.

(b) The request shall be made in the form and manner prescribed by the Division.

(c) A designated doctor examination shall be used to resolve questions about the following:

(1) the impairment caused by the employee's compensable injury;

(2) the attainment of maximum medical improvement (MMI);

(3) the extent of the employee's compensable injury;

(4) whether the employee's disability is a direct result of the work-related injury;

(5) the ability of the employee to return to work (RTW); or

(6) issues similar to those described by paragraphs (1) – (5) of this subsection.

(d) The report of the designated doctor is given presumptive weight regarding the issue(s) in question and/or dispute, unless the preponderance of the evidence is to the contrary.

(e) The Division, within 10 days after approval of a valid request, shall issue a written notice that assigns a designated doctor; requires an exam to be conducted on a date no earlier than 14 days, but no later than 21 days from the date of the written notice; and notify the designated doctor, the employee, the employee's representative, if any, and the insurance carrier that the designated doctor will be directed to examine the employee. The written notice shall:

(1) indicate the designated doctor's name, license number, practice address and telephone number, and the date and time of the examination or the date range for the examination to be conducted;

(2) explain the purpose of the designated doctor examination;

(3) require the employee to submit to an examination by the designated doctor; and

(4) require the treating doctor and insurance carrier to forward all medical records in compliance with subsection (i)(3) of this section.

(f) The designated doctor's office and the employee shall contact each other if there exists a scheduling conflict for the designated doctor appointment. The designated doctor or the employee who has the scheduling conflict must make the contact at least 24 hours prior to the appointment. The 24-hour requirement will be waived in an emergency situation (such as a death in the immediate family or a medical emergency). The rescheduled examination shall be set to occur within 21 days of the originally scheduled examination. Within 24 hours of rescheduling, the designated doctor shall contact the Division's field office and the insurance carrier with the time and date of the rescheduled examination. If the examination cannot be rescheduled within 21 days, the designated doctor shall notify the Division and the Division shall select a new designated doctor.

(g) An insurance carrier may suspend temporary income benefits (TIBs) if an employee, without good cause, fails to attend a designated doctor examination.

(1) In the absence of a finding by the Division to the contrary, an insurance carrier may presume that the employee did not have good cause to fail to attend the examination if by the day the examination was originally scheduled to occur the employee has both:

(A) failed to submit to the examination; and

(B) failed to contact the designated doctor's office to reschedule the examination in accordance with subsection (f) of this section.

(2) If, after the insurance carrier suspends TIBs pursuant to this subsection, the employee contacts the designated doctor to reschedule the examination, the designated doctor shall schedule the examination to occur as soon as possible, but not later than the 21st day after the employee contacted the doctor. The insurance carrier shall reinstate TIBs effective as of the date the employee submitted to the examination unless the report of the designated doctor indicates that the employee has reached MMI or is otherwise not eligible for income benefits. The re-initiation of TIBs shall occur no later than the seventh day following:

(A) the date the insurance carrier was notified that the employee submitted to the examination; or

(B) the date that the carrier was notified that the Division found that the employee had good cause for not attending the examination.

(3) An employee is not entitled to TIBs for a period during which the insurance carrier suspended benefits pursuant to this subsection unless the employee later submits to the examination and the Division finds or the insurance carrier determines that the employee had good cause for failure to attend the examination.

(h) If at the time the request is made, the Division has previously assigned a designated doctor to the claim, the Division shall use that doctor again, if the doctor is still qualified and available. Otherwise, the Division shall select the next available doctor on the Division's Designated Doctor List (DDL) who:

(1) has not previously treated or examined the employee within the past 12 months and has not examined or treated the employee with regard to a medical condition being evaluated in the designated doctor examination;

(2) does not have any disqualifying associations as described in §180.21 of this title (relating to Division Designated Doctor List); and

(3) has credentials appropriate to the issue in question and the employee's medical condition.-

(i) The designated doctor is authorized to receive the employee's confidential medical records to assist in the resolution of a dispute under this section without a signed release from the employee.

(1) The treating doctor and insurance carrier shall provide to the designated doctor copies of all the employee's medical records in their possession relating to the medical condition to be evaluated by the designated doctor. For subsequent examinations with the same designated doctor, only those medical records not previously sent must be provided.

(2) The treating doctor and insurance carrier may also send the designated doctor an analysis of the employee's medical condition, functional abilities, and return-to-work opportunities. The analysis may include supporting information such as videotaped activities of the employee, as well as marked copies of medical records. If the insurance carrier sends an analysis to the designated doctor, the insurance carrier shall send a copy to the treating doctor, the employee, and the employee's representative, if any. If the treating doctor sends an analysis to the designated doctor, the treating doctor shall send a copy to the insurance carrier, the employee, and the employee's representative, if any.

(3) The treating doctor and insurance carrier shall ensure that the required records and analyses (if any) are mailed to the designated doctor no later than the fifth working day prior to the date of the designated doctor examination.

(4) If the designated doctor has not received the medical records or any part thereof at least one working day prior to the examination, the designated doctor shall:

(A) report this violation to the Division's Compliance and Practices section; and

(B) reschedule the examination in accordance with subsection (f) of this section. The doctor shall conduct the rescheduled examination regardless of whether or not the complete medical record has been timely received.

(j) The designated doctor shall review the employee's medical records, including an analysis of the employee's medical condition, functional abilities and return to work opportunities provided by the insurance carrier and treating doctor, as well as the employee's medical condition and history as provided by the injured employee, and shall perform a complete physical examination. The designated doctor shall give the medical records reviewed the weight the doctor determines to be appropriate.

(k) The designated doctor shall perform additional testing or refer an employee to other health care providers when necessary to determine the issue in question. Any additional testing required for the evaluation is not subject to preauthorization requirements in accordance with the Labor Code §413.014 or Insurance Code, Chapter 1305. Any additional testing must be completed within 10 working days of the designated

doctor's physical examination of the employee. The need for additional testing under this subsection extends the amount of time the designated doctor has to file the report by 10 working days.

(l) To avoid undue influence on the designated doctor:

(1) except as provided by subsection (i) of this section, only the employee or appropriate Division staff may communicate with the designated doctor prior to the examination of the employee by the designated doctor regarding the employee's medical condition or history;

(2) after the examination is completed, communication with the designated doctor regarding the employee's medical condition or history may be made only through appropriate Division staff; and

(3) the designated doctor may initiate communication with any doctor who has previously treated or examined the employee for the work-related injury or with a peer review doctor identified by the insurance carrier who examined the employee's claim.

(m) The insurance carrier, treating doctor, employee, or employee's representative, if any, may contact the designated doctor's office to ask about administrative matters such as whether the designated doctor received the records, whether the exam took place, or whether the report has been filed, or similar matters.

(n) A designated doctor who determines the employee has reached maximum medical improvement (MMI) or who assigns an impairment rating, or who determines the employee has not reached MMI, shall complete and file the report as required by §§130.1 and 130.3 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment and Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment by Doctor Other than the Treating Doctor). The report shall be completed in the form and manner prescribed by the Division and shall be sent to the carrier, the employee, the employee's representative, if any, the treating doctor, and Division.

(o) A designated doctor who determines that the employee can return to work immediately with or without restrictions is required to file a Work Status Report, as described in §129.5 of this title (relating to Work Status Reports) within seven days of the date of the examination of the employee. This report shall be filed with the treating doctor and the carrier by facsimile or electronic transmission. In addition, the designated doctor shall file the report with the employee and the employee's representative (if any) by facsimile or by electronic transmission if the designated doctor has been provided with a facsimile number or email address for the recipient, otherwise, the designated doctor shall send the report by other verifiable means.

(p) A designated doctor who addresses issues other than those listed in subsections (n) and (o) of this section, shall file a narrative report within seven days of the date of the examination of the employee. This report shall be filed with the treating doctor and the carrier by facsimile or electronic transmission. In addition, the designated doctor shall file the report with the employee and the employee's representative (if any) by facsimile or by electronic transmission if the designated doctor has been provided with a facsimile number or email address for the recipient, otherwise, the designated doctor shall send the report by other verifiable means.

(q) The designated doctor shall maintain accurate records, including the employee records, analysis (including supporting information), and narratives provided by the insurance carrier and treating doctor, to reflect:

(1) the date and time of any designated doctor appointments scheduled with an employee;

(2) the circumstances regarding a cancellation, no-show or other situation where the examination did not occur as initially scheduled or rescheduled;

(3) the date of the examination;

(4) the date medical records were received from the treating doctor or any other person or organization;

(5) the date the medical evaluation report, including the narrative report described in subsection (n) of this section, was submitted to all parties;

(6) the name of all referral health care providers, date of appointments and reason for referral by the designated doctor; and

(7) the date the doctor contacted the Division for assistance in obtaining medical records from the insurance carrier or treating doctor.

(r) The insurance carrier shall pay any accrued income benefits, and shall begin or continue to pay weekly income benefits, in accordance with the designated doctor's report for the issue(s) in dispute, no later than five days after receipt of the report or five days after receipt of notice from the Division, whichever is earlier.

(s) The insurance carrier, the employee, and the employee's representative (if any) is not entitled to a subsequent designated doctor examination until the earlier of:

(1) the 60th day after the prior designated doctor examination was held; or

(2) the date the insurance carrier or the employee is found by the Division to have good cause, such as the inclusion of additional body parts (extent of injury).

(t) On or after the second anniversary of the initial award of Supplemental Income Benefits (SIBs), the insurance carrier may not require an employee who is receiving SIBs to submit to a designated doctor examination more than annually, if in the preceding year, the employee's medical condition resulting from the compensable injury has not improved sufficiently to allow the employee to return to work.

(u) Parties may file a request with the Division for clarification of the designated doctor's report. A copy of the request must be provided to the opposing party. The Division may contact the designated doctor if it determines that clarification is necessary to resolve an issue regarding the designated doctor's report. The Division, at its discretion, may request clarification from the designated doctor on issues the Division deems appropriate. To respond to the request for clarification, the designated doctor must be on the Division's DDL at the time the request is received by the Division. The designated doctor shall respond to the letter of clarification within five days of receipt. If, in order to respond to the request for clarification, the designated doctor has to reexamine the injured employee, the doctor shall:

(1) respond to the request for clarification advising of the need for an additional examination within five days of receipt and provide copies of the response to the parties specified in subsection (p) of this section; and

(2) conduct the reexamination within 21 days from the request by the Division at the location of the original examination.

(v) Upon receipt of a request for a benefit review conference, the Division shall resolve a dispute of the opinion of a designated doctor through the dispute resolution processes outlined in Chapters 140 - 147 of this title (relating to Dispute Resolution).

(w) This section is effective on January 1, 2007 and a request for a designated doctor under this section may be made on or after January 1, 2007.

The provisions of this §126.7 adopted to be effective January 1, 2007, 31 TexReg 6351.

§126.8. Commission Approved Doctor List.

(a) On or after January 1, 1993, except in emergency situations, injured employees must receive medical treatment from a doctor on the commission approved doctor list (the list). This list initially includes all doctors licensed in Texas on or after January 1, 1993, and doctors licensed in other jurisdictions who have been added to the list by the commission.

(b) Doctors licensed in other jurisdictions may ask to be added to the list by submitting a written request containing information prescribed by the commission. Unless the doctor has been deleted from the list by the commission, a carrier shall not withhold reimbursement to doctors licensed in other jurisdictions when the only reason for nonpayment is that the doctor is not presently on the list.

(c) This section is no longer effective on or after September 1, 2003.

The provisions of this §126.8 adopted to be effective July 1, 1993, 18 TexReg 3755; amended to be effective June 7, 2001, 26 TexReg 3941; amended to be effective March 14, 2002, 27 TexReg 1810.

§126.9. Choice of Treating Doctor and Liability for Payment.

(a) The injured employee is entitled to the employee's initial choice of treating doctor from the list of doctors approved by the Texas Workers' Compensation Commission. As of January 1, 1993, any change in treating doctor after the initial choice requires approval from the commission. The term "doctor," as used in this section, has the meaning defined in Texas Civil Statutes, Article 8308-1.03(17).

(b) The commission shall include, with the information mailed to the employee as required by the Act, §5.09, the requirements related to the selection of a treating doctor from the commission-approved doctor list and to changing treating doctors as described in this section.

(c) The first doctor who provides health care to an injured employee shall be known as the injured employee's initial choice of treating doctor. The following do not constitute an initial choice of treating doctor:

  (1) a doctor salaried by the employer;

  (2) a doctor recommended by the carrier or employer, unless the injured employee continues, without good cause as determined by the commission, to receive treatment from the doctor for a period of more than 60 days; or

  (3) any doctor providing emergency care unless the injured employee receives treatment from the doctor for other than follow-up care related to the emergency treatment.

(d) If an injured employee wants to change treating doctors, other than exceptions as described in Texas Civil Statutes, Article 8308-4.64, or removal of the doctor from the list, the employee shall submit to the field office handling the claim, reasons why the current treating doctor is unacceptable. Unless medical necessity exists for an immediate change, the submission shall be in writing on a form prescribed by the commission. If the need for an immediate change exists, then the injured employee may notify the field office by telephone. Injured employees who change doctors because the doctor is removed from the list or for one of the exceptions listed in Texas Civil Statutes, Article 8308-4.64, shall immediately notify the commission of the change in the form and format prescribed by the commission.

(e) Reasons for approving a change in treating doctor include, but are not limited to:

  (1) the reasons listed in Texas Civil Statutes, Article 8308-4.63(d); and

  (2) the selected doctor chooses not to be responsible for coordinating injured employee's health care as described in §133.3 of this title (relating to Responsibilities of Treating Doctor).

(f) The commission shall issue an order approving or denying a change of doctor request. This order shall be issued within 10 days after receiving the request and, if a change is approved, shall include an order for the insurance carrier to pay for treatment provided by the approved doctor unless superseded by a subsequent order.

(g) With good cause, the injured employee or carrier may dispute the order regarding a change to an alternate treating doctor within 10 days after receiving the order. That dispute will be handled through the dispute resolution process described in Chapters 140-143 of this title (relating to Dispute Resolution/General Provisions, Benefit Review Conference, Benefit Contested Case Hearing, and Review by the Appeals Panel).

(h) The commission may, after holding a benefit contested case hearing as provided by Chapter 142 of this title (relating to Benefit Contested Case Hearing), relieve the carrier of liability for health care furnished by a doctor or health care provider at the doctor's direction if:

(1) the doctor chosen by the employee is not on the list at the time the medical treatments or services are rendered; or

(2) the employee failed to comply with commission rules regarding a change in treating doctor.

(i) If the carrier is relieved of liability for the costs of health care, the employee may be billed for medical treatments or services provided the health care provider billing the employee had no knowledge of the violation by the employee at the time the medical treatments or services were rendered.

(j) The commission shall relieve the carrier of liability by an order which identifies the health care provider(s) and expressly states the time period for which the carrier is relieved of liability and whether the health care provider may submit the bill to the employee for those treatments or services. Provided, however, that a doctor removed from the list may not seek reimbursement under workers' compensation for treatments or services rendered.

The provisions of this §126.9 adopted to be effective July 1, 1993, 18 TexReg 3755.

§126.11 Extension of the Date of Maximum Medical Improvement for Spinal Surgery.

(a) The commission may approve an extension of the date of maximum medical improvement, subject to subsection (f) of this section, if the injured employee has had spinal surgery or has been approved for spinal surgery in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care), 12 weeks or less before the expiration of 104 weeks from the date income benefits began to accrue. Only one extension of the date of maximum medical improvement pursuant to this section may be granted. Approval for spinal surgery is either the notification from the insurance carrier (carrier) that the spinal surgery has been preauthorized or a decision from the appeal process finding the insurance carrier liable for the reasonable costs of spinal surgery. Any extension of the date of maximum medical improvement ordered by the commission must be to a specific and certain date.

(b) Upon application by either the injured employee or the insurance carrier, the commission may by order extend the date of maximum medical improvement past the period of 104 weeks from the date income benefits began to accrue as described in the Texas Labor Code, §401.011(30)(B). The request shall be made in the form and manner prescribed by the commission. The commission shall issue an order approving or denying the request for an extension of the date of maximum medical improvement within ten days of the date the request is received by the commission.

(c) Prior to submission to the commission of a request for an extension of the date of maximum medical improvement, the requestor shall request from the treating doctor or surgeon the information listed in subsection (f) of this section. The request shall also be sent to the injured employee, the injured employee's

representative, and the insurance carrier by first class mail on the same day it is submitted to the treating doctor or surgeon. The treating doctor or surgeon shall provide to the injured employee, the injured employee's representative, and the insurance carrier the information requested in subsection (f) of this section within ten days of the date the request is received. If the requesting party has not received the information from the treating doctor or surgeon within 15 days, the request may be submitted to the commission without this information.

(d) After the actions in subsection (c) have been completed, a request for an extension of the date of maximum medical improvement shall be filed at the commission field office managing the claim by personal delivery or first class mail. A request is deemed filed upon receipt at the appropriate field office. In addition, the request shall be sent to the injured employee, the injured employee's representative, and the insurance carrier on the same date it is sent to the commission. If the information from the treating doctor or surgeon is absent when the request is received, commission staff may invoke the provisions of §102.9 of this title (relating to Submission of Information Requested by the Commission) to secure any necessary information.

(e) A request for an extension of the date of maximum medical improvement shall be filed no earlier than 12 weeks before the expiration of 104 weeks after the date income benefits began to accrue. The commission shall deny any request for an extension of the date of maximum medical improvement that is received by the commission prior to 12 weeks before the expiration of 104 weeks after the date income benefits began to accrue or is received on or after the expiration of 110 weeks from the date income benefits began to accrue.

(f) In making the determination to approve or deny a request for an extension of the date of maximum medical improvement, the commission shall consider:

1) typical recovery times for the specific spinal surgery procedure;

2) projected date and information regarding when the condition may be medically stable as provided by the treating doctor or the surgeon;

3) case specific information regarding any extenuating circumstances that may have resulted in variances from conservative treatment protocols and time frames that may impact recovery times as provided by the treating doctor or the surgeon;

4) information from any source regarding intentional or non-intentional delays in securing the surgery or medical treatment for the compensable injury;

5) any pending, unresolved disputes regarding the date of maximum medical improvement; and

(6) any pertinent information provided by the insurance carrier, injured employee, and/or the injured employee's representative regarding the extension being requested under this section.

(g) An injured employee or an insurance carrier may dispute the approval, denial, or the length of the extension granted by the commission order by filing a request for a benefit review conference in accordance with §141.1 of this title (relating to Requesting and Setting a Benefit Review Conference) no later than ten days after the date the order is received. Any proceedings and further appeals shall be conducted in accordance with Chapters 140-143 of this title (relating to Dispute Resolution/General Provisions, Benefit Review Conference, Benefit Contested Case Hearing, and Review by the Appeals Panel). Any agreement which resolves a dispute regarding extension of the date of maximum medical improvement in accordance with this section shall be in writing and approved by the commission. Approval shall not be granted if any party rescinds the agreement by notifying the commission within three working days of signing the agreement.

(h) If a request for benefit review conference is not received by the commission within ten days after the date the order granting or denying the extension was received by the disputing party, the parties waive their right to dispute the commission order. In the event that an order is timely disputed, the order shall remain binding pending final resolution of the dispute.

(i) If the injured employee is certified by a doctor to have reached maximum medical improvement between the date the extension order was issued and the extended date of maximum medical improvement specified in the order, any dispute regarding the date of maximum medical improvement shall be resolved through the selection of a designated doctor consistent with the provisions of the Texas Labor Code, §408.122, concerning Eligibility for Impairment Income Benefits; Designated Doctor, and §130.6 of this title (relating to Designated Doctor; General Provisions). If the certification of maximum medical improvement during this time period is not disputed and the date certified is prior to the date of maximum medical improvement specified in the order for the extension, the date of maximum medical improvement from that certification shall apply. If the certification was timely disputed and the resolution of such a dispute determines that the injured employee reached maximum medical improvement at a date which is different than the date of maximum medical improvement specified in the order for the extension, the earlier date shall apply.

(j) In the event that the extension of the date of maximum medical improvement is granted based on a finding of liability for spinal surgery within the 12 week period and a party appeals the preauthorized approval to a benefit contested case hearing, any extension of the date of maximum medical improvement ordered by the commission shall be conditional pending final decision under the commission's jurisdiction of the liability for spinal surgery. If spinal surgery is not performed within six weeks after the date the final decision of the commission is issued, the order for the extension of the date of maximum medical improvement shall be null and void.

(k) This section applies only to compensable claims with a date of injury on or after January 1, 1998. This section does not apply to an employee who has reached maximum medical improvement prior to requesting an extension under this section. An employee has reached maximum medical improvement in accordance with the Texas Labor Code, §401.011(30)(A), when either a finding of the date of maximum medical improvement is not disputed, or the date of maximum medical improvement has been finally resolved.

The provisions of this §126.11 adopted to be effective January 29, 1998, 23 TexReg 552; amended to be effective June 5, 2003, 28 TexReg 4291

§126.12. Payment of Interest on Accrued but Unpaid Income Benefits.

(a) Accrued but unpaid income benefits are those benefits which either:

(1) have accrued during a period of dispute over insurance carrier (carrier) liability for the claim or injured employee entitlement to the benefits; or

(2) have not been paid by the date the carrier was required to pay them.

(b) Carriers shall include simple interest in all payments for accrued but unpaid income benefits.

(c) Income benefits accrue in either weekly or monthly pay periods, as otherwise provided by the Texas Workers' Compensation Act and this title, and interest shall be calculated separately for each pay period based on the length of time the benefits for that pay period remained accrued and unpaid.

(1) For pay periods in which benefits accrued while in dispute as provided in subsection (a)(1) of this section, the carrier shall pay interest for number of days between the seventh day after the day the benefits accrued and the day the payment was made.

(2) For pay periods in which benefits accrued and were paid late by the carrier as provided in subsection (a)(2) of this section, the carrier shall pay interest for the number of days between the due date for the payment and the date the payment was made.

(d) The rate of interest to be paid on accrued but unpaid income benefits by carriers will be the rate calculated in accordance with the Texas Labor Code, §401.023 and in effect on the date the payment was made.

(e) The following method shall be used to calculate the simple interest to be paid:

(1) multiply the rate of interest by the amount in question (to create annual amount of interest);

(2) divide the annual amount of interest by 365 (to create daily interest amount); then

(3) multiply daily interest amount by the number of days of interest that are owed.

The provisions of this §126.12 adopted to be effective December 26, 1999, 24 TexReg 11399.

§126.13. Employer Initiation of Benefits and Reimbursement.

(a) Applicability

(1) This section applies only to the employer initiation of benefits as described in subsection (a)(2) of this section. Employer payments made after the insurance carrier has accepted or been found to be liable for a claim such as salary continuation, as defined in §129.1 (relating to Definitions for Temporary Income Benefits), are covered by Chapter 129 of this title (relating to Temporary Income Benefits).

(2) An employer may initiate benefits including medical benefits to compensate an employee during a period in which the carrier has:

(A) contested compensability of the injury;

(B) contested liability for the injury; or

(C) has not completed its initial investigation of the injury, which is limited to seven days after the carrier receives first written notice of the injury as defined in §124.1 of this title (relating to Notice of Injury).

(b) Employer Entitlement to Reimbursement

(1) An employer who initiates benefits as provided in subsection (a)(2) of this section is entitled to reimbursement from the carrier if the employer timely reported the injury to the carrier in compliance with §120.2 (relating to Employer's First Report of Injury).

(2) An employer who is entitled to reimbursement as provided in subsection (b)(1) of this section is entitled to the amount of those benefits which otherwise would have been paid by the carrier had the carrier immediately accepted compensability for the injury and began payment of income and medical benefits.

(A) For an employer initiation of indemnity benefits, the amount of reimbursement that the employer is entitled to is the amount that would have been paid by the carrier in income benefits. Chapters 128, (relating to Benefits - Calculation of Average Weekly Wage), 129 (relating to Benefits - Temporary Income Benefits), 130 (relating to Benefits - Impairment & Supplemental Income Benefits), and 131 (relating to Calculation of Lifetime Income Benefits) of this title govern carrier payments of income benefits.

(B) For an employer initiation of medical benefits, the amount of reimbursement that the employer is entitled to is the amount that would have been paid by the carrier in medical benefits. An employer is not entitled to and shall not seek reimbursement from either the carrier or the employee for amounts paid to a health care provider which are:

(i) in excess of the Commission's fee guidelines;

(ii) for treatment(s) or service(s) which was not reasonable or medically necessary; or

(iii) for treatment(s) or service(s) which was not related to the compensable injury.

(3) An employer who is entitled to reimbursement under subsection (b)(1) of this section but who paid more benefits to the employee than the carrier was required to pay in income benefits is entitled to be reimbursed for the difference if the employer initiated the benefits with the agreement of the employee and the agreement authorized the reimbursement of this difference. The difference is reimbursable out of impairment income benefits (IIBs) that the employee becomes entitled to, if any.

(4) An employer is not entitled to and shall not seek reimbursement from the employee for any benefits initiated by the employer which are not reimbursed under subsection (c) of this section.

(c) Reporting and Reimbursement Process

(1) An employer who initiates payment of benefits as provided in subsection (a) of this section shall report the initiation of benefits to the carrier within seven days of this initiation.

(2) A carrier who is notified by an employer that the employer has initiated benefits as provided in subsection (c)(1) of this section shall notify the employer in writing within seven days of the carrier either accepting or being found to be liable for a claim.

(3) Within seven days of being notified by the carrier that the carrier has accepted or been found liable for a claim, the employer shall report to the carrier in the form and manner prescribed by the Commission the amount of any benefits provided to the employee.

(4) A carrier who receives a report of benefits initiated by the employer as described in this section shall, not later than the seventh day after the carrier receives the report, reimburse the employer the compensation that the carrier would have otherwise paid.

(5) The carrier shall pay the employer a reimbursement out of IIBs as provided in subsection (b)(3) of this section in lump sum and shall apportion this amount equally across the employee's remaining weekly IIBs payments. The carrier shall pay this reimbursement in a lump sum not later than the seventh day after the later of:

(A) the date the carrier receives a certification of MMI with an impairment rating of greater than 0%; or

(B) the date an impairment rating dispute is resolved by a designated doctor's opinion, agreement, or final adjudication.

The provisions of this §126.13 adopted to be effective December 26, 1999, 24 TexReg 11399.

§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.

(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.

The provisions of this §126.14 adopted to be effective July 9, 2006, 31 TexReg 5458.