CHAPTER 130. IMPAIRMENT AND SUPPLEMENTAL INCOME BENEFITS

SUBCHAPTER A. IMPAIRMENT INCOME BENEFITS

§130.1. Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment.

(a) Authorized Doctor.

(1) Only an authorized doctor may certify maximum medical improvement (MMI), determine whether there is permanent impairment, and assign an impairment rating if there is permanent impairment.

(A) Doctors serving in the following roles may be authorized as provided in subsection (a)(1)(B) of this section.

(i) the treating doctor (or a doctor to whom the treating doctor has referred the injured employee for evaluation of MMI and/or permanent whole body impairment in the place of the treating doctor, in which case the treating doctor is not authorized);

(ii) a designated doctor; or

(iii) a required medical examination (RME) doctor selected by the insurance carrier and approved by the commission to evaluate MMI and/or permanent whole body impairment after a designated doctor has performed such an evaluation.

(B) Prior to September 1, 2003 a doctor serving in one of the roles described in subsection (a)(1)(A) of this subsection is authorized to determine whether an injured employee has permanent impairment, assign an impairment rating, and certify MMI. On or after September 1, 2003, a doctor serving in one of the roles described in subsection (a)(1)(A) of this section is authorized as follows:

(i) a doctor whom the commission has certified to assign impairment ratings or otherwise given specific permission by exception to, is authorized to determine whether an injured employee has permanent impairment, assign an impairment rating, and certify MMI; and

(ii) a doctor whom the commission has not certified to assign impairment ratings or otherwise given specific permission by exception to is only authorized to determine whether an injured employee has permanent impairment and, in the event that the injured employee has no impairment, certify MMI.

(2) Doctors who are not authorized shall not make findings of permanent impairment, certify MMI, or assign impairment ratings and shall not be reimbursed for the examination, certification, or report if one does so. A certification of MMI, finding of permanent impairment, and/or impairment rating assigned by an unauthorized doctor are invalid. If a treating doctor finds that the injured employee has permanent impairment but is not authorized to assign an impairment rating, the doctor is also not authorized to certify MMI and shall refer the injured employee to a doctor who is so authorized.

(3) A doctor who is authorized under this subsection to certify MMI, determine whether permanent impairment exists, and assign an impairment rating and who does, shall be referred to as the “certifying doctor.”

(b) Certification of Maximum Medical Improvement.

(1) Maximum medical improvement (MMI) is:

(A) the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated;

(B) the expiration of 104 weeks from the date on which income benefits begin to accrue; or

(C) the date determined as provided by Texas Labor Code §408.104.

(2) MMI must be certified before an impairment rating is assigned.

(3) Certification of MMI is a finding made by an authorized doctor that an injured employee has reached MMI as defined in subsection (b)(1) of this section.

(4) To certify MMI the certifying doctor shall:

(A) review medical records;

(B) perform a complete medical examination of the injured employee for the explicit purpose of determining MMI (certifying examination);

(C) assign a specific date at which MMI was reached.

(i) The date of MMI may not be prospective or conditional.

(ii) The date of MMI may be retrospective to the date of the certifying exam.

(D) Complete and submit required reports and documentation.

(c) Assignment of Impairment Rating.

(1) An impairment rating is the percentage of permanent impairment of the whole body resulting from the current compensable injury. A zero percent impairment may be a valid rating.

(2) A doctor who certifies that an injured employee has reached MMI shall assign an impairment rating for the current compensable injury using the rating criteria contained in the appropriate edition of the AMA Guides to the Evaluation of Permanent Impairment, published by the American Medical Association (AMA Guides).

(A) The appropriate edition of the AMA Guides to use for all certifying examinations conducted before October 15, 2001 is the third edition, second printing, dated February, 1989.

(B) The appropriate edition of the AMA Guides to use for certifying examinations conducted on or after October 15, 2001 is:

(i) the fourth edition of the AMA Guides (1st, 2nd, 3rd, or 4th printing, including corrections and changes as issued by the AMA prior to May 16, 2000). If a subsequent printing(s) of the fourth edition of the AMA Guides occurs, and it contains no substantive changes from the previous printing, the commission by vote at a public meeting may authorize the use of the subsequent printing(s); or

(ii) the third edition, second printing, dated February, 1989 if, at the time of the certifying examination, there is a certification of MMI by a doctor pursuant to subsection (b) of this section

made prior to October 15, 2001 which has not been previously withdrawn through agreement of the parties or previously overturned by a final decision.

(C) This subsection shall be implemented to ensure that in the event of an impairment rating dispute, only ratings using the appropriate edition of the AMA Guides shall be considered. Impairment ratings assigned using the wrong edition of the AMA Guides shall not be considered valid.

(3) Assignment of an impairment rating for the current compensable injury shall be based on the injured employee's condition as of the MMI date considering the medical record and the certifying examination. The doctor assigning the impairment rating shall:

(A) identify objective clinical or laboratory findings of permanent impairment for the current compensable injury;

(B) document specific laboratory or clinical findings of an impairment;

(C) analyze specific clinical and laboratory findings of an impairment;

(D) compare the results of the analysis with the impairment criteria and provide the following:

(i) A description and explanation of specific clinical findings related to each impairment, including zero percent (0%) impairment ratings; and

(ii) A description of how the findings relate to and compare with the criteria described in the applicable chapter of the AMA Guides. The doctor's inability to obtain required measurements must be explained.

(E) assign one whole body impairment rating for the current compensable injury;

(F) be responsible for referring the injured employee to another doctor or health care provider for testing, or evaluation, if additional medical information is required. The certifying doctor is responsible for incorporating all additional information obtained into the report required by this rule:

(i) Additional information must be documented and incorporated into the impairment rating and acknowledged in the required report.

(ii) If the additional information is not consistent with the clinical findings of the certifying doctor, then the documentation must clearly explain why the information is not being used as part of the impairment rating.

(4) After September 1, 2003, if range of motion, sensory, and strength testing required by the AMA Guides is not performed by the certifying doctor, the testing shall be performed by a health care practitioner, who within the two years prior to the date the injured employee is evaluated, has had the impairment rating training module required by §180.23 (relating to Commission Required Training for Doctors/Certification Levels) for a doctor to be certified to assign impairment ratings. It is the responsibility of the certifying doctor to ensure the requirements of this subsection are complied with.

(5) If an impairment rating is assigned in violation of subsection (c)(4), the rating is invalid and the evaluation and report are not reimbursable. A provider that is paid for an evaluation and/or report that is invalid under this subsection shall refund the payment to the insurance carrier.

(d) Reporting.

(1) Certification of MMI, determination of permanent impairment, and assignment of an impairment rating (if permanent impairment exists) for the current compensable injury requires completion, signing, and submission of the Report of Medical Evaluation and a narrative report.

(A) The Report of Medical Evaluation must be signed by the certifying doctor. The certifying doctor may use a rubber stamp signature or an electronic facsimile signature of the certifying doctor's personal signature.

(B) The Report of Medical Evaluation includes an attached narrative report. The narrative report must include the following:

(i) date of the certifying examination;

(ii) date of MMI;

(iii) findings of the certifying examination, including both normal and abnormal findings related to the compensable injury and an explanation of the analysis performed to find whether MMI was reached;

(iv) narrative history of the medical condition that outlines the course of the injury and correlates the injury to the medical treatment;

(v) current clinical status;

(vi) diagnosis and clinical findings of permanent impairment as stated in subsection (c)(3);

(vii) the edition of the AMA Guides that was used in assigning the impairment rating (if the injured employee has permanent impairment); and

(viii) a copy of the authorization if, after September 1, 2003, the doctor received authorization to assign an impairment rating and certify MMI by exception granted from the commission.

(2) A Report of Medical Evaluation under this rule shall be filed with the commission, injured employee, injured employee's representative, and the insurance carrier no later than the seventh working day after the later of:

(A) date of the certifying examination; or

(B) the receipt of all of the medical information required by this section.

(3) The report required to be filed under this section shall be filed as follows:

(A) The Report of Medical Evaluation shall be filed with the insurance carrier by facsimile or electronic transmission; and

(B) The Report of Medical Evaluation shall be filed with the commission, the injured employee and the injured employee's representative by facsimile or electronic transmission if the doctor has been provided the recipient's facsimile number or email address; otherwise, the report shall be filed by other verifiable means.

(e) Documentation. The certifying doctor shall maintain the original copy of the Report of Medical Evaluation and narrative as well as documentation of:

(1) the date of the examination;

(2) the date any medical records necessary to make the certification of MMI were received, and from whom the medical records were received; and

(3) the date, addressees, and means of delivery that reports required under this section were transmitted or mailed by the certifying doctor.

The provisions of this §130.1 adopted to be effective June 7, 2000, 25 TexReg 5352; amended to be effective January 2, 2002, 26 TexReg 10910; amended to be effective March 14, 2004, 29 TexReg 2337.

§130.2. Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment by the Treating Doctor.

(a) A treating doctor shall either examine the injured employee (employee) and determine if the employee has any permanent impairment as a result of the compensable injury as soon as the doctor anticipates that the employee will have no further material recovery from or lasting improvement to the work-related injury or illness, based on reasonable medical probability, or have another authorized doctor do so.

(1) A treating doctor who finds that the employee has permanent impairment but who is not authorized to assign impairment ratings as provided in §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment), shall make a referral to a doctor who is authorized to do so on behalf of the treating doctor. Even if the treating doctor is so authorized, the doctor may choose to have another authorized doctor evaluate the employee for maximum medical improvement (MMI) and impairment in the place of the treating doctor. However, this evaluation shall be considered to be the report of the treating doctor.

(2) Other than subsections (c) and (d) of this section, nothing in this section requires a treating doctor to schedule an examination if the employee has been released from treatment and is not receiving temporary income benefits (TIBs). For example, when the patient is treated and released without further treatment for a minor injury, the treating doctor is not required to schedule and conduct an examination for MMI and permanent impairment.

(3) At the conclusion of an examination in which the treating doctor, or the certifying doctor in the event that the treating doctor is not authorized to certify MMI and assign an impairment rating, determines that the employee has reached maximum medical improvement and assigns an impairment rating, the doctor shall provide the employee with a written notice that the certification may be disputed. The notice shall be provided as a separate document included with the Report of Medical Evaluation provided in accordance with §130.1 of this title. The notice must be provided in English, Spanish, or other language common to the employee, and shall include the following information:

(A) the date of maximum medical improvement;

(B) the assigned impairment rating;

(C) a statement that the impairment rating may become final if not disputed within 90 days, and if the employee, or the employee's representative, disagrees with the certification, they may dispute the certification by contacting the Division of Workers' Compensation and requesting a benefit review conference;

(D) the address and phone number of the local field office of the Division of Workers' Compensation (Division); and

(E) a statement that the employee may contact the Division for more information at 1- 800-252-7031.

(b) A certification of MMI and assignment of an impairment rating shall be performed and reported in accordance with the requirements of §130.1 of this title.

(c) The Division shall mail a notice to a treating doctor, the employee, the employee's representative, if any, and the insurance carrier on the expiration of 98 weeks from the date the employee's TIBs began to accrue if the employee is still receiving TIBs. The Division's notice shall advise the treating doctor of the requirements under Chapter 408, Subchapter G of the Texas Workers' Compensation Act, and this section, and require that an impairment rating report be mailed to the Division no later than 104 weeks from the date TIBs began to accrue.

(d) Upon receipt of the Division's notice required in subsection (c) of this section, the treating doctor shall schedule and conduct an examination of the employee in accordance with §130.1 of this title to certify a MMI date (if earlier than the statutory MMI date as defined in §130.4 of this title (relating to Presumption that Maximum Medical Improvement (MMI) has been Reached and Resolution when MMI has not been Certified) and to assign an impairment rating. A treating doctor who is not authorized to certify MMI and assign impairment ratings, shall make a referral to a doctor who is authorized to do so on behalf of the treating doctor.

(e) If the carrier has not received a report of medical evaluation by the date of statutory MMI:

(1) the carrier may suspend TIBs and is not required to initiate impairment income benefits (IIBs) until such time as it receives a report of an impairment rating assigned in accordance with §130.1 of this title;

(2) the carrier or the employee may request the appointment of a designated doctor under §126.7 of this title (relating to Designated Doctor Examinations: Requests and General Procedures); and/or

(3) a carrier may make a reasonable assessment of what it believes the true impairment rating should be and, if it does so, shall initiate IIBs within five days of making the assessment. The carrier shall continue to pay IIBs until the assessment is paid in full or is superceded by an impairment rating assigned in accordance with §130.1 of this title.

The provisions of this §130.2 adopted to be effective March 7, 1991, 16 TexReg 1194; amended to be effective January 2, 2002, 26 TexReg 10910; amended to be effective January 1, 2007, 31 TexReg 6366.

§130.3. Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment by A Doctor Other Than The Treating Doctor.

(a) A doctor, other than a treating doctor, who is authorized to certify that an employee has reached maximum medical improvement (MMI), must do so in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment). In addition to complying with the filing requirements of §130.1, the certifying doctor shall file a copy of the Report of Medical Evaluation and the narrative with the treating doctor within the same timeframes for filing with the other persons that §130.1 requires.

(b) Upon receipt of the report identified in subsection (a) of this section, the treating doctor shall:

(1) indicate on the report either agreement or disagreement with the certification of maximum medical improvement and with the impairment rating assigned by the certifying doctor, and, in the case of a disagreement, explain the reasons for this disagreement; and

(2) within seven days of receipt, send a signed copy of the report indicating agreement or disagreement and including any required explanation to the commission, the employee and the employee's representative (if any), and the carrier.

(c) A treating doctor's agreement or disagreement under subsection (b) of this section does not require a separate examination of the employee prior to the issuance of the opinion and shall not be considered a certification as that term is used in §130.1 of this title.

(d) The reports required under this section to be filed with a doctor and carrier shall be filed by facsimile or electronic transmission. In addition, the doctor shall file the report with the employee and the employee's representative by facsimile or electronic transmission if the doctor has been provided the employer's facsimile number or email address; otherwise, the report shall be sent by other verifiable means.

(e) A doctor required to file a report under this section shall maintain the original copy of the Report of Medical Evaluation and narrative and documentation of the date, addressees, facsimile numbers/email addresses and means of delivery that the reports required under this section were transmitted or mailed including proof of successful transmission. In addition:

(1) a certifying doctor shall maintain documentation of:

(A) The date of the examination of the employee; and

(B) The date any medical records necessary to make the certification of MMI were received, and from whom the medical records were received; and

(2) a treating doctor who receives the certifying doctor's report shall maintain documentation of the date the report was received and the means by which the report was delivered to the treating doctor.

The provisions of this §130.3 adopted to be effective March 7, 1991, 16 TexReg 1194; amended to be effective December 26, 1999, 24 TexReg 11442; amended to be effective January 2, 2002, 26 TexReg 10910.

§130.4. Presumption that Maximum Medical Improvement (MMI) has been Reached and Resolution when MMI has not been Certified.

(a) This section does not apply if statutory maximum medical improvement (MMI) has been reached. Statutory MMI is the later of:

(1) the end of the 104th week after the date that temporary income benefits (TIBs)began to accrue; or

(2) the date to which MMI was extended by the commission through operation of Texas Labor Code §408.104.

(b) If there has not been a certification in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment) that an injured employee has reached MMI, an insurance carrier (carrier) may follow the procedure outlined in this section to resolve whether an employee has reached MMI. The carrier shall presume, only for purposes of invoking this procedure, that an employee has reached MMI, if:

(1) it appears that the employee has failed to attend two or more consecutively scheduled health care appointments and the number of days between the two examinations is greater than 60 except for laminectomy, spinal fusion or diskectomy in which case the number of days between the two examinations is greater than 90;

(2) the treating doctor has examined the employee at least twice for the same compensable injury after the date on which TIBs began to accrue, and the doctor's medical reports as filed with the insurance carrier for all examinations and reports conducted after the first of the two examinations, indicate a lack of medical improvement in the employees condition since the date of the first of the two examinations;

(3) the employee was previously found not to be at MMI by a designated doctor but the employee has reached the date the designated doctor estimated that the employee would reach MMI; or

(4) the employee is four weeks past the point that the claim has become a Work Release Outlier Claim as defined by commission rule.

(c) A carrier permitted by subsection (b) of this section to invoke this procedure may request the treating doctor to provide a report on the employee's medical status as it relates to MMI. Note - nothing in this section prohibits the carrier from contacting the treating doctor about whether the employee has reached MMI.

(d) The treating doctor shall evaluate the employee's condition within 14 days of receiving the request from the carrier under subsection (c) of this section. The evaluation shall be conducted in accordance with §130.1 of this title and the report filed within seven working days of the date of the examination. If the treating doctor determines that the employee has permanent impairment but is not authorized to certify MMI or assign an impairment rating, the doctor shall refer the employee to a doctor who is so authorized and this doctor shall comply with the requirements of this section, §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 by Doctor Other Than Treating Doctor).

(e) If the treating doctor fails to respond as required by this rule, or if the treating doctor certifies that the employee has not reached MMI, the carrier may request a designated doctor under §130.5 (relating to Entitlement and Procedure for Requesting Designated Doctor Examinations Related to Maximum Medical Improvement and Impairment Rating).

The provisions of this §130.4 adopted to be effective March 8, 1991, 16 TexReg 1296; amended to be effective January 2, 2002, 26 TexReg 10910.

§130.6. Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings.

(a) Any evaluation relating to either maximum medical improvement (MMI), an impairment rating, or both, shall be conducted in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment).

(b) The designated doctor shall address the issue(s) in question and any issues the Division may request the designated doctor to consider and confine the report to only those issues.

(1) When there has been no prior certification of MMI, the designated doctor shall evaluate the injured employee (employee) for MMI, and if the doctor finds that the employee reached MMI, assign an impairment rating. If the designated doctor finds that the employee has not reached MMI, the doctor shall identify the reason(s) that the designated doctor does not believe the employee to have reached MMI.

(2) When there has been a prior certification of MMI and impairment rating and only the MMI date is in question, the designated doctor shall evaluate the date the employee reached MMI and shall not assign an impairment rating. If the certification of MMI in question was the treating doctor's certification and the designated doctor finds that the employee either was not at MMI or reached MMI on a date later than the treating doctor's certification, the designated doctor shall provide an explanation with clinical documentation to support why the employee had not reached MMI as of the date certified by the treating doctor.

(3) When the impairment rating is the only issue in question, the doctor shall assign an impairment rating based on the employee’s medical condition on the MMI date.

(4) When MMI and permanent whole body impairment are in question and the designated doctor determines that the employee has not reached MMI, the designated doctor shall not assign an impairment rating.

(5) When the extent of the injury may not be agreed upon by the parties (based upon documentation provided by the treating doctor and/or insurance carrier or the comments of the employee regarding his/her injury), the designated doctor shall provide multiple certifications of MMI and impairment ratings that take into account the various interpretations of the extent of the injury so that when the Division resolves the dispute, there is already an applicable certification of MMI and impairment rating from which to pay benefits as required by the Act.

(c) When performing range of motion testing, if the AMA Guides specify that additional testing be performed because of consistency requirements, the designated doctor shall reschedule testing within seven days of the first date of testing unless there is no clinical basis for retesting, and then, the designated doctor shall document this in the narrative notes with the clinical explanation for not recommending re-examination.

(d) Range of motion, sensory, and strength testing should be performed by the designated doctor, when applicable. If this testing is not performed by the designated doctor, the health care provider performing the testing must have successfully completed Division approved training, must not have previously treated or examined the employee within the past 12 months, and must not have examined or treated the employee with regard to the medical condition being evaluated by the designated doctor. Use of another health care provider to perform testing under this subsection shall not extend the amount of time the designated doctor has to file the report and the designated doctor is responsible for ensuring that the requirements of this chapter are complied with.

(e) For testing other than that listed in subsection (d) of this section, the designated doctor may perform additional testing or refer the employee to other health care providers when deemed necessary to assess an impairment rating. Any additional testing required for the evaluation and rating, is not subject to preauthorization requirements in accordance with Labor Code §413.014 (relating to Preauthorization) and additional testing must be completed within ten working days of the designated doctor's physical examination of the employee. Use of another health care provider to perform testing under this subsection can extend the amount of time the designated doctor has to file the report by ten working days.

(f) If the designated doctor provided multiple certifications of MMI/impairment ratings by operation of subsection (b)(5) of this section, the insurance carrier shall pay benefits based on the conditions that have not been disputed, or have been finally adjudicated by the Division, to be part of the compensable injury.

(g) This section is effective 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 §130.6 adopted to be effective January 25, 1991, 16 TexReg 177; amended to be effective July 17, 2001 26 TexReg 5263; amended to be effective January 2, 2002, 26 TexReg 10910; amended to be effective March 14, 2004, 29 TexReg 2341; amended to be effective January 1, 2007, 31 TexReg 6366; Correction of Error effective January 1, 2007, 31 TexReg 10178.

§130.7. Acceleration of Impairment Income Benefits.

(a) An employee seeking an acceleration of impairment income benefits shall submit a request in writing to commission, on a form prescribed by the commission, and send a copy to the insurance carrier. The form shall explain subsection (d) of this section.

(b) The commission shall approve the request for acceleration of impairment benefits pursuant to the Texas Workers' Compensation Act, §4.321. The commission shall notify the insurance carrier when a request for acceleration is approved, and of the amount and number of accelerated payments which shall be made.

(c) The insurance carrier shall initiate the accelerated payment schedule no later than seven days after receiving notice of the commission's approval.

(d) Acceleration of payment of impairment income benefits does not reduce the impairment period for purposes of the date that entitlement to supplemental income benefits begins.

The provisions of this §130.7 adopted to be effective March 7, 1991, 16 TexReg 1194.

§130.8. Initiating Payment of Impairment Income Benefits.

(a) Impairment income benefits accrue on the day after the injured employee reaches maximum medical improvement, regardless of whether the employee has suffered seven or more days of disability.

(b) When the date of maximum medical improvement is not disputed, the carrier shall initiate payment of impairment income benefits on or before the fifth day after:

(1) the date of receipt of the employee's treating doctor's medical evaluation report, as described in §130.1 of this title (relating to Reports of Medical Evaluation: Maximum Medical Improvement and Permanent Impairment); or

(2) the last day of the 104th week after the employee's accrual date, as defined in §124.7 of this title (relating to Initial Payment of Temporary Income Benefits).

(c) When the date of maximum medical improvement is disputed, the carrier shall initiate payment of impairment income benefits on or before the fifth day after:

(1) the date of entry of an interlocutory order to begin payment of impairment income benefits;

(2) the date of execution of an agreement on a dispute over date of maximum medical improvement; or

(3) the date of receipt of a commission-approved settlement of a dispute over date of maximum medical improvement.

The provisions of this §130.8 adopted to be effective February 11, 1992, 17 TexReg 689.

§130.10. Commission Review of Employment Status during the Impairment Income Benefits Period.

(a) The commission shall review the employment status of each injured employee who received an impairment rating of 15% or greater, and who has not commuted any impairment income benefits, to determine:

(1) whether the employee is unemployed, or underemployed as defined in §130.101 of this title (relating to Definitions); and, if so;

(2) whether the unemployment or underemployment is a direct result of the impairment from the compensable injury.

(b) The commission shall conduct this review:

(1) at least annually during the impairment income benefits period; and

(2) no later than the 10th day before the last day of the impairment income benefits period.

(c) To conduct its review, the commission may require:

(1) periodic reports from the employee, including the Statement of Employment Status described in §130.101 of this title (relating to Definitions);

(2) periodic reports from the carrier;

(3) physical or other examinations;

(4) vocational assessments; and

(5) other necessary tests and diagnoses.

(d) To conduct the review under subsection (b)(2) of this section, the commission shall send the employee a copy of the Statement of Employment Status with filing instructions and a description of the consequences of late filing and failing to file. The commission shall use the results of this review to make the initial determination of entitlement to supplemental income benefits, as provided by §130.103 of this title (relating to Initial Entitlement to Supplemental Income Benefits).

The provisions of this §130.10 adopted to be effective April 17, 1992, 17 TexReg 2400.

§130.11. Agreement for Monthly Payment of Impairment Income Benefits.

(a) Upon the request of the injured employee, the insurance carrier and an employee entitled to impairment income benefits (IIBs) may agree to change the frequency of IIBs payments from the standard weekly period to a monthly period. The agreement to change the payment frequency must be in writing and is only required to be filed with the Commission if the Commission requests a copy. To relieve the insurance carrier of the responsibility to pay IIBs weekly, a valid written agreement must include the following terms and conditions:

(1) the agreement for the monthly payment of IIBs payments shall be effective the first calendar day of the month following the month in which the written agreement was entered into by the insurance carrier and the injured employee;

(2) monthly IIBs payment shall be issued on or before the seventh day of the month for which benefits are due;

(3) weekly IIBs payments shall continue through the end of the month in which the agreement was signed.;

(4) payment of the last week of IIBs to transition from weekly payment of IIBs to monthly payments shall be prorated to the end of the month to ensure the injured employee receives IIBs through the last day of the month;

(5) if less than the maximum weekly compensation rate in effect on the date of the compensable injury is being paid, a completed Employer's Wage Statement must be included with the injured employee's copy of the written agreement;

(6) the monthly benefit amount shall be equal to the weekly compensation rate for IIBs that the injured employee is entitled to multiplied by 4.34821; and

(7) the impairment rating and source of the impairment rating upon which payment of IIBs is being based.

(b) An injured employee and insurance carrier may not agree to the monthly payment of IIBs until the impairment rating has been agreed to or has become final. The entering into an agreement under this section may not be used for the purpose of finalizing an impairment rating

(c) The agreement for the monthly payment of IIBs shall expire upon the suspension or termination of IIBs in accordance with the Act and Commission rules. The last monthly payment shall be prorated to ensure the insurance carrier pays the appropriate amount of IIBs.

(d) At any time after signing the agreement for the monthly payment of IIBs, the injured employee or the insurance carrier may notify the other party in writing that it no longer agrees to the monthly payment of IIBs. In this case, the insurance carrier shall pay all accrued but unpaid IIBs at the end of the current monthly cycle and shall continue paying IIBs weekly as and when they accrue and are due.

(e) Effective Date. This section applies only to agreements entered into on or after January 1, 2000, for payment of IIBs under the provisions of the Act.

The provisions of this §130.11 adopted to be effective December 26, 1999, 24 TexReg 11447.

§130.12. Finality of the First Certification of Maximum Medical Improvement and/or First Assignment of Impairment Rating.

(a) The certifications and assignments that may become final are:

(1) The first valid certification of MMI and/or IR assigned or determination of no impairment;

(2) The first valid assignment of IR after the expiration of 104 weeks from the date income benefits begin to accrue or the expiration date of any extension under Section 408.104, if the employee has not been certified as having reached MMI; or

(3) The first valid subsequent certification of MMI and/or assignment of an IR or determination of no impairment received after the date a certification of MMI and/or assignment of an IR or determination of no impairment is overturned, modified or withdrawn by agreement of the parties or by a final decision of the commission or a court.

(4) A designated doctor may provide multiple IRs if there is a dispute over extent of injury. Whichever rating from the designated doctor applies to the compensable injury once an extent of injury (EOI) dispute has been resolved may become final if not disputed. An EOI dispute does not constitute a dispute of the MMI/IR for purposes of finality under this subsection.

(b) A first MMI/IR certification must be disputed within 90 days of delivery of written notice through verifiable means, including IRs related to EOI disputes. The notice must contain a copy of a valid Form TWCC 69, Report of Medical Evaluation, as described in subsection (c). The 90-day period begins on the day after the written notice is delivered to the party wishing to dispute a certification of MMI or an IR assignment, or both. The 90-day period may not be extended.

(1) Only an insurance carrier, an injured employee, or an injured employee's attorney or employee representative under 150.3(a) may dispute a first certification of MMI or assigned IR under §141.1 (related to Requesting and Setting a Benefit Review Conference) or by requesting the appointment of a designated doctor, if one has not been appointed.

(2) Use of the TWCC 69's non-concurrence section is not a prescribed form and manner for a dispute.

(3) A dispute may not be revoked or withdrawn to allow the first valid certification of MMI and/or the first valid assignment of IR to become final except by agreement of the parties.

(4) The first certification of maximum medical improvement and/or impairment rating may be disputed after the 90-day period as provided in §408.123(e) of the Texas Labor Code.

(c) A certification of MMI and/or IR assigned as described in subsection (a) must be on a Form TWCC 69, Report of Medical Evaluation. The certification on the Form TWCC 69 is valid if:

(1) There is an MMI date that is not prospective;

(2) There is an impairment determination of either no impairment or a percentage impairment rating assigned; and

(3) There is the signature of the certifying doctor who is authorized by the Commission under §130.1(a) to make the assigned impairment determination.

(d) This section applies only to those claims with initial MMI/IR certifications made on or after June 18, 2003.

The provisions of this §130.12 adopted to be effective March 14, 2004, 29 TexReg 2342.

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SUBCHAPTER B. SUPPLEMENTAL INCOME BENEFITS

§130.100. Applicability.

(a) Effectiveness. Entitlement or non-entitlement to supplemental income benefits shall be determined in accordance with the rules in effect on the date a qualifying period begins.

(b) Claims Service. Sections 130.101 - 130.109 of this chapter (relating to Impairment and Supplemental Income Benefits) define certain aspects of claims service under the provisions of Texas Labor Code, §406.010.

The provisions of this §130.100 adopted to be effective January 31, 1999, 24 TexReg 399.

§130.101. Definitions.

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

(1) Application for Supplemental Income Benefits--The Division form required pursuant to Labor Code §408.143(b) containing the following information:

(A) a statement, with supporting payroll documentation, that the employee has earned less than 80% of the employee's average weekly wage as a direct result of the impairment from the compensable injury;

(B) the amount of the employee's wages during the qualifying period;

(C) a statement, with supporting documentation, that the employee has complied with Labor Code §408.1415 and this subchapter, and

(D) for self-employed individuals, copies of all supporting documentation to establish the amount of self-employment income earned during the qualifying period and any other pertinent documentation of efforts to establish or maintain a self-employed enterprise during the qualifying period.

(2) First Quarter--The 13 weeks beginning on the day after the last day of the impairment income benefits period.

(3) Impairment income benefits period--The number of weeks computed under Labor Code §408.121 for which the injured employee is entitled to receive impairment income benefits, starting with the day after the date the employee reached maximum medical improvement.

(4) Qualifying period--A period of time for which the employee's activities and wages are reviewed to determine eligibility for supplemental income benefits. The qualifying period ends on the 14th day before the beginning date of the quarter and consists of the 13 previous consecutive weeks. In accordance with §130.100(a) of this title (relating to Applicability), a qualifying period that begins on or after July 1, 2009, is subject to the provisions of this subchapter, and a qualifying period that begins prior to July 1, 2009, remains subject to the rules in effect on the date the qualifying period begins.

(5) Reviewing authority--The person who reviews the Application for Supplemental Income Benefits and other information to make the determination of entitlement or non-entitlement to supplemental income benefits including Division staff for the first quarter determination and the insurance adjuster for subsequent quarter determinations.

(6) Subsequent Quarter--A 13-week period beginning on the day after the last day of a previous quarter. The term subsequent quarter applies to all quarters after the first quarter.

(7) Vocational Rehabilitation Services--Services which can reasonably be expected to benefit the employee in terms of employability including, but not limited to, identification of the employee's physical and vocational abilities, training, physical or mental restoration, vocational assessment, transferable skills assessment, development of and modifications to an individualized vocational rehabilitation plan, or other services necessary to enable an injured employee to become employed in an occupation that is reasonably consistent with his or her strengths, physical abilities including ability to travel, educational abilities, interest, and pre-injury income level.

(8) Vocational rehabilitation program--Any program, provided by the Texas Department of Assistive and Rehabilitative Services (DARS), a comparable federally-funded rehabilitation program in another state under the Rehabilitation Act of 1973, as amended, or a private provider of vocational rehabilitation services that is included in the Registry of Private Providers of Vocational Rehabilitation Services, for the provision of vocational rehabilitation services designed to assist the injured employee to return to work that includes a vocational rehabilitation plan. A vocational rehabilitation plan, also known as an Individual Plan for Employment at DARS, includes, at a minimum, an employment goal, any intermediate goals, a description of the services to be provided or arranged, the start and end dates of the described services, and the injured employee's responsibilities for the successful completion of the plan.

(9) Wages--All forms of remuneration payable for personal services rendered during the qualifying period as defined in Labor Code §401.011(43), including the wages of a bona fide offer of employment which was not accepted.

The provisions of this §130.101 adopted to be effective January 31, 1999, 24 TexReg 399; amended to be effective November 28, 1999, 24 TexReg 10339; amended to be effective July 1, 2009, 34 TexReg 2138.

§130.102. Eligibility for Supplemental Income Benefits; Amount.

(a) General. An injured employee is not entitled to supplemental income benefits until the expiration of the impairment income benefit period.

(b) Eligibility Criteria. An injured employee who has an impairment rating of 15% or greater, who has not commuted any impairment income benefits, who has not permanently lost entitlement to supplemental income benefits and who has completed and filed an Application for Supplemental Income Benefits in accordance with this subchapter is eligible to receive supplemental income benefits if, during the qualifying period, the injured employee:

(1) has earned less than 80% of the injured employee's average weekly wage as a direct result of the impairment from the compensable injury; and

(2) has demonstrated an active effort to obtain employment in accordance with Labor Code §408.1415 and this section.

(c) Direct Result. An injured employee has earned less than 80% of the injured employee's average weekly wage as a direct result of the impairment from the compensable injury if the impairment from the compensable injury is a cause of the reduced earnings.

(d) Work Search Requirements.

(1) An injured employee demonstrates an active effort to obtain employment by meeting at least one or any combination of the following work search requirements each week during the entire qualifying period:

(A) has returned to work in a position which is commensurate with the injured employee's ability to work;

(B) has actively participated in a vocational rehabilitation program as defined in §130.101 of this title (relating to Definitions);

(C) has actively participated in work search efforts conducted through the Texas Workforce Commission (TWC);

(D) has performed active work search efforts documented by job applications; or

(E) has been unable to perform any type of work in any capacity, has provided a narrative report from a doctor which specifically explains how the injury causes a total inability to work, and no other records show that the injured employee is able to return to work.

(2) An injured employee who has not met at least one of the work search requirements in any week during the qualifying period is not entitled to SIBs unless the injured employee can demonstrate that he or she had reasonable grounds for failing to comply with the work search requirements under this section.

(e) Vocational Rehabilitation. As provided in subsection (d)(1)(B) of this section, regarding active participation in a vocational rehabilitation program, an injured employee shall provide documentation sufficient to establish that he or she has actively participated in a vocational rehabilitation program during the qualifying period.

(f) Work Search Efforts. As provided in subsections (d)(1)(C) and (D) of this section regarding active participation in work search efforts and active work search efforts, an injured employee shall provide documentation sufficient to establish that he or she has, each week during the qualifying period, made the minimum number of job applications and or work search contacts consistent with the work search contacts established by TWC which are required for unemployment compensation in the injured employee's county of residence pursuant to the TWC Local Workforce Development Board requirements. If the required number of work search contacts changes during a qualifying period, the lesser number of work search contacts shall be the required minimum number of contacts for that period. If residing out of state, the minimum number of work search contacts required will be the number required by the public employment service in accordance with applicable unemployment compensation laws for the injured employee's place of residence.

(g) Calculation of amount. Subject to any approved reduction for the effects of contribution, the monthly supplemental income benefit payment is calculated quarterly as follows:

(1) multiply the injured employee's average weekly wage by 80% (.80);

(2) add the injured employee's wages for all 13 weeks of the qualifying period;

(3) divide the total wages by 13;

(4) subtract this figure from the result of paragraph (1) of this subsection;

(5) multiply the difference by 80% (.80);

(6) if the resulting amount is greater than the maximum rate under the Act, Labor Code, §408.061, use the maximum rate; and,

(7) multiply the result by 4.34821.

(h) Maximum Medical Improvement and Impairment Rating Disputes. If there is no pending dispute regarding the date of maximum medical improvement or the impairment rating prior to the expiration of the first quarter, the date of maximum medical improvement and the impairment rating shall be final and binding.

(i) Services Provided by a Carrier Through a Private Provider of Vocational Rehabilitation Services. The insurance carrier may provide vocational rehabilitation services through a provider of such services provided that the individual is registered as a private provider in accordance with §136.2 of this title (relating to Registry of Private Providers of Vocational Rehabilitation Services) and that the insurance carrier will be responsible for reasonable travel expenses incurred by the injured employee if the employee is required to travel in excess of 20 miles one way from the injured employee's residence to obtain vocational rehabilitation services.

The provisions of this §130.102 adopted to be effective January 31, 1999, 24 TexReg 399; amended to be effective November 28, 1999, 24 TexReg 10339; amended to be effective July 1, 2009, TexReg 2138.

§130.103. Determination of Entitlement or Non-entitlement for the First Quarter.

(a) Division Determination. For each injured employee with an impairment rating of 15% or greater, and who has not commuted any impairment income benefits, the Division will make the determination of entitlement or non-entitlement for the first quarter of supplemental income benefits. This determination shall be made not later than the last day of the impairment income benefit period and the notice of determination shall be sent to the injured employee and the insurance carrier by first class mail, electronic transmission, or personal delivery.

(b) Determination of Entitlement. If the Division determines that the injured employee is entitled to supplemental income benefits for the first quarter, the notice of determination shall include:

(1) the beginning and end dates of the first quarter;

(2) the amount of the monthly payments;

(3) the amount of the wages used to calculate the monthly payment;

(4) instructions for the parties of the procedures for contesting the Division’s determination as provided by §130.108 of this title (relating to Contesting Entitlement or Amount of Supplemental Income Benefits; Attorney Fees); and

(5) an Application for Supplemental Income Benefits, filing instructions, a filing schedule, and a description of the consequences of failing to timely file.

(c) Determination of non-entitlement. If the Division determines that the injured employee is not entitled to supplemental income benefits for the first quarter, the notice of determination shall include:

(1) the grounds for this determination;

(2) the beginning and end dates of the first quarter;

(3) instructions for the parties of the procedures for contesting the Division’s determination as provided by §130.108 of this title (relating to Contesting Entitlement to Supplemental Income Benefits); and

(4) an Application for Supplemental Income Benefits, filing instructions, a filing schedule, and a description of the consequences of failing to timely file.

The provisions of this §130.103 adopted to be effective January 31, 1999, 24 TexReg 399; amended to be effective November 28, 1999, 24 TexReg 10339; amended to be effective July 1, 2009, TexReg 2138.

§130.104. Determination of Entitlement or Non-entitlement for Subsequent Quarters.

(a) Subsequent Quarter Determination. After the Division has made a determination of entitlement or non-entitlement for supplemental income benefits for the first quarter, the insurance carrier shall make determinations for subsequent quarters consistent with the provisions contained in §130.102 of this title (relating to Eligibility for Supplemental Income Benefits; Amount). The insurance carrier shall issue a determination of entitlement or non-entitlement within 10 days after receipt of the Application for Supplemental Income Benefits for a subsequent quarter.

(b) Application for Supplemental Income Benefits. An injured employee claiming entitlement to supplemental income benefits for a subsequent quarter must send the insurance carrier an Application for Supplemental Income Benefits as required under this section. With the first monthly payment of supplemental income benefits for any eligible quarter and with any insurance carrier determination of non-entitlement, the insurance carrier shall send the injured employee a copy of the Application for Supplemental Income Benefits and the proper address to file the subsequent application. On the Application for Supplemental Income Benefits sent by the insurance carrier, the insurance carrier shall include:

(1) the number of the applicable quarter;

(2) the dates of the qualifying period;

(3) the dates of the quarter;

(4) the deadline for filing the application with the insurance carrier; and

(5) the minimum number of work search efforts required by §130.102(d)(1) and (f) of this title (relating to Eligibility for Supplemental Income Benefits; Amount) during the next qualifying period.

(c) Filing the Application for Supplemental Income Benefits. The employee shall file the Application for Supplemental Income Benefits and any applicable documentation with the insurance carrier by first class mail, personal delivery or electronic transmission. Except as otherwise provided in this section, the Application for Supplemental Income Benefits shall be filed no later than seven days before, and no earlier than 20 days before, the beginning of the quarter for which the injured employee is applying for supplemental income benefits. If the Application for Supplemental Income Benefits is received by the insurance carrier more than 20 days before the beginning of the quarter, the insurance carrier shall return the form to the injured employee with detailed instructions on when the form is required to be filed. Any form returned to the injured employee because the form was filed early shall not be subject to the provisions of §130.108 of this title (relating to Contesting Entitlement to Supplemental Income Benefits).

(d) Date-Stamp. Upon receipt, the insurance carrier shall date-stamp all Application for Supplemental Income Benefits forms with the date the insurance carrier received the form.

(e) Notice of Determination. Upon making subsequent quarter determinations, the insurance carrier shall issue a notice of determination to the injured employee. The notice shall be sent by first class mail, personal delivery or electronic transmission and shall contain all the information required in the Notice of Entitlement or Non-entitlement portion of the Application for Supplemental Income Benefits. The notice of determination of non-entitlement shall contain sufficient claim specific information to enable the employee to understand the reason for the insurance carrier's determination. A generic statement such as “failure to satisfy the compliance standards of Labor Code §408.1415”, "not a direct result", or similar phrases without further explanation does not satisfy the requirements of this section.

(f) Accrual date. If the injured employee is entitled to supplemental income benefits for a subsequent quarter, the benefits begin to accrue on the later of:

(1) the first day of the applicable quarter; or

(2) the date the Application for Supplemental Income Benefits is received by the insurance carrier, subject to the provisions of §130.105 of this title (relating to Failure to Timely File Application for Supplemental Income Benefits; Subsequent Quarters).

(g) Changes in Amount. A change in the monthly amount of supplemental income benefits from one quarter to the next does not constitute a dispute subject to §130.108 of this title (relating to Contesting Entitlement to Supplemental Income Benefits). An insurance carrier that does not contest the entitlement to supplemental income benefits for a subsequent quarter, but determines a different monthly amount is due, shall:

(1) send the notice as required in subsection (e) of this section;

(2) include instructions about the procedures for contesting the insurance carrier's determination as provided by §130.108 of this title (relating to Contesting Entitlement to Supplemental Income Benefits); and

(3) issue payment based on the newly calculated amount.

The provisions of this §130.104 adopted to be effective January 31, 1999, 24 TexReg 399; amended to be effective July 1, 2009, TexReg 2138.

§130.105. Failure to Timely File Application for Supplemental Income Benefits; Subsequent Quarters.

(a) Failure to timely file. An injured employee who does not timely file an Application for Supplemental Income Benefits with the insurance carrier shall not receive supplemental income benefits for the period of time between the beginning date of the quarter and the date on which the form was received by the insurance carrier, unless the following apply:

(1) the failure of the insurance carrier to timely mail the form to the injured employee as provided by §130.104 of this title (relating to Determination of Entitlement or Non-entitlement for Subsequent Quarters);

(2) the failure of the Division to issue a determination of entitlement or non-entitlement for the first quarter and the quarter applied for immediately follows the first quarter; or,

(3) a finding of an impairment rating of 15% or greater in an administrative or judicial proceeding when the previous impairment rating was less than 15%.

(b) Calculation. If the injured employee has failed to timely file the Application for Supplemental Income Benefits and none of the exceptions listed in subsection (a) of this section apply, the payment of supplemental income benefits for that particular payment period shall be prorated as follows:

(1) divide the weekly amount of supplemental income benefits (as calculated pursuant to §130.102(g)(5) and (6) of this title (relating to Eligibility for Supplemental Income Benefits; Amount) by seven to determine the daily rate;

(2) calculate the number of days between the date the Application for Supplemental Income Benefits was received and the end of that particular payment period; and

(3) multiply the number of days and the daily rate to determine the amount of the payment.

The provisions of this §130.105 adopted to be effective January 31, 1999, 24 TexReg 399; amended to be effective July 1, 2009, TexReg 2138.

§130.106. Loss of Entitlement to Supplemental Income Benefits.

(a) 12-Month Provision. Except as provided in §130.109 of this title (relating to Reinstatement of Entitlement if Discharged with Intent to Deprive of Supplemental Income Benefits), an injured employee who is not entitled to supplemental income benefits for a period of four consecutive quarters permanently loses entitlement to such benefits.

(b) 401-Week Provision. An injured employee permanently loses entitlement to supplemental income benefits upon the expiration of the 401-week period calculated pursuant to Labor Code §408.083. Except for situations where the injured employee has previously permanently lost entitlement to supplemental income benefits, the insurance carrier shall send two notices to the injured employee prior to the expiration of the 401-week period if the injured employee has submitted an Application for Supplemental Income Benefits during the 12 months immediately preceding the expiration of the 401-week period. This notification shall be in the form and manner prescribed by the Division and shall be sent:

(1) no later than four months prior to the expiration of the 401-week period; and

(2) one month prior to the expiration of the 401-week period.

(c) Refusal of Vocational Rehabilitation Services. An injured employee, in a vocational rehabilitation program as defined in §130.101(8) of this title (relating to Definitions), who refuses vocational rehabilitation services or refuses to cooperate with services provided at any time during a qualifying period is not entitled to supplemental income benefits for the related quarter.

The provisions of this §130.106 adopted to be effective January 31, 1999, 24 TexReg 399; amended to be effective July 1, 2009, TexReg 2138.

§130.107. Payment of Supplemental Income Benefits.

(a) First Quarter. After the Division's initial determination of entitlement, the insurance carrier shall pay supplemental income benefits as follows:

(1) the first payment shall be made on or before the tenth day after the day on which the insurance carrier received the Division determination of entitlement or the seventh day of the quarter, whichever is later;

(2) the second payment shall be made on or before the 37th day of the first quarter; and

(3) the last payment shall be made on or before the 67th day of the first quarter.

(b) Subsequent Quarters. For subsequent quarters, the insurance carrier shall pay supplemental income benefits as follows:

(1) the first payment shall be made on or before the tenth day after the day on which the insurance carrier received the Application for Supplemental Income Benefits, or the seventh day of the quarter, whichever is later;

(2) the second payment shall be made on or before the 37th day of the quarter; and

(3) the last payment shall be made on or before the 67th day of the quarter.

The provisions of this §130.107 adopted to be effective January 31, 1999, 24 TexReg 399; amended to be effective July 1, 2009, TexReg 2138.

§130.108. Contesting Entitlement or Amount of Supplemental Income Benefits; Attorney Fees.

(a) Injured Employee Disputes. An injured employee may contest the determination by the Division or the insurance carrier regarding non-entitlement to, or the amount of, supplemental income benefits by requesting

a benefit review conference as provided by Chapter 141 of this title (relating to Dispute Resolution – Benefit Review Conference).

(b) Insurance Carrier Dispute; First Quarter. If an insurance carrier disputes a Division finding of entitlement to, or amount of, supplemental income benefits for the first quarter, the insurance carrier shall request a benefit review conference as provided by Chapter 141 of this title (relating to Dispute Resolution – Benefit Review Conference) within 10 days after receiving the Division determination of entitlement. An insurance carrier waives the right to contest the Division determination of entitlement to, or amount of, supplemental income benefits for the first quarter if the request is not received by the Division within 10 days after the date the insurance carrier received the determination.

(c) Insurance Carrier Dispute; Subsequent Quarter With Prior Payment. If an insurance carrier disputes entitlement to a subsequent quarter and the insurance carrier has paid supplemental income benefits during the quarter immediately preceding the quarter for which the Application for Supplemental Income Benefits is filed, the insurance carrier shall dispute entitlement to the subsequent quarter by requesting a benefit review conference as provided by Chapter 141 of this title (relating to Dispute Resolution – Benefit Review Conference) within 10 days after receiving the Application for Supplemental Income Benefits. An insurance carrier waives the right to contest the entitlement to supplemental income benefits for the subsequent quarter if the request is not received by the Division within 10 days after the date the insurance carrier received the Application for Supplemental Income Benefits. The insurance carrier does not waive the right to contest entitlement to supplemental income benefits if the insurance carrier has returned the injured employee's Application for Supplemental Income Benefits pursuant to §130.104(c) of this title (relating to Determination of Entitlement or Non-entitlement for Subsequent Quarters).

(d) Insurance Carrier Disputes; Subsequent Quarter Without Prior Payment. If an insurance carrier disputes entitlement to a subsequent quarter and the insurance carrier did not pay supplemental income benefits during the quarter immediately preceding the quarter for which the Application for Supplemental Income Benefits is filed, the insurance carrier shall send the determination to the injured employee within 10 days of the date the form was filed with the insurance carrier and include the reasons for the insurance carrier's finding of non-entitlement and instructions about the procedures for contesting the insurance carrier's determination as provided by subsection (a) of this section.

(e) Liability. An insurance carrier who unsuccessfully contests a Division determination of entitlement to supplemental income benefits is liable for:

(1) all accrued, unpaid supplemental income benefits, and interest on that amount, and;

(2) reasonable and necessary attorney's fees incurred by the injured employee as a result of the insurance carrier's dispute which have been ordered by the Division or court.

The provisions of this §130.108 adopted to be effective January 31, 1999, 24 TexReg 399; amended to be effective July 1, 2009, TexReg 2138.

§130.109. Reinstatement of Entitlement if Discharged with Intent to Deprive of Supplemental Income Benefits.

(a) An injured employee who has lost entitlement to supplemental income benefits under §130.106(a) of this title (relating to Loss of Entitlement to Supplemental Income Benefits), and is discharged from employment within 12 months of losing entitlement, will become re-entitled if the employer discharged the injured employee with intent to deprive the injured employee of supplemental income benefits.

(b) An injured employee seeking reinstated supplemental income benefits under this section shall request a benefit contested case hearing, as provided by Chapter 142 of this title (relating to Dispute Resolution – Benefit Contested Case Hearing).

(c) The injured employee bears the burden of proof of discharge with intent to deprive.

(d) Supplemental income benefits reinstated under this section begin to accrue on the day after the injured employee's discharge.

The provisions of this §130.109 adopted to be effective April 17, 1992, 17 TexReg 2400; amended to be effective July 1, 2009, TexReg 2138.

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