



# Office of Injured Employee Counsel Rule Comments

# Memorandum

**To:** Kevin Haywood; Brian White  
**CC:** Laurie Biscoe  
**From:** Norman Darwin, Public Counsel  
**Date:** 1/10/06  
**Re:** Rule Proposals: Designated Doctor and Peer Review

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I have reviewed the following rules and am providing comment. If you would like to discuss any of my comments further, please do not hesitate to contact Dorian or me.

- 1) §126.7. Entitlement and Procedure for Requesting Designated Doctor Examinations:
  - (a) states “The Commissioner shall order a medical examination....” It is suggested that the language conform to §408.0041 which states that the Commissioner “may” order a medical examination.
  - (f)(1) states the conditions for a carrier to presume that the injured employee did not have good cause for failure to attend the examination. (f)(1)(B) does not refer to the situation where an injured employee has had an emergency situation as referred to in (e). It is suggested that (f)(1)(B) include language at the end of the sentence to indicate the situation that is presented in (e). Perhaps the end of the sentence could include “or as provided by (e).”
  - (g)(3) states the Division shall select the next available doctor on the Division’s DD List who: has credentials appropriate to the issue in question and the injured employee’s medical condition. §408.0041 states similar language: shall be performed by the next available doctor on the Division’s list of designated doctors whose credentials are appropriate for the issue in question and the injured employee’s medical condition as determined by commissioner rule [Emphasis added]. It is suggested that there be some specifics provided in the rule as to what “credentials appropriate” means.
  - (i) states that the designated doctor shall review the information provided by the insurance carrier and treating doctor, but it does not include what the injured employee may provide to the designated doctor for review per §408.0041(d). The following change is suggested: The designated doctor shall review the employee’s medical records, including an analysis of the injured employee’s medical condition, functional abilities and return to work opportunities provided by the insurance carrier and treating doctor, the employee’s medical condition and history, and shall perform a hands-on examination.
  - It is suggested that (r)(2) be changed as follows: the date the insurance carrier or the injured employee is found by the Division to have good cause, such as the inclusion of additional body parts (~~extent of injury~~).
  - It is suggested that (v) be changed as follows: Parties may file a request with the Division for clarification ~~from~~ of the designated doctor’s ~~with the Division~~ report.
- 2) §180.21. Division Designated Doctor List:
  - (m)(9) refers to notifying the Division of any disqualifying association. It is suggested that (m)(9) be changed as follows: failure to notify the Division ~~field office~~ of any disqualifying association.

- 2) §180.22. Health Care Provider Roles and Responsibilities: no comment
- 3) §180.28. Peer Review Requirements, Reporting, and Sanctions:
  - It is suggested that under (a), there be an additional requirement listed for the peer reviewer: the peer reviewer shall maintain copies of all peer review reports written and make them available to the Division upon request.

# Memorandum

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**To:** Kevin Haywood; Brian White  
**CC:** Laurie Biscoe  
**From:** Norman Darwin, Public Counsel  
**Date:** 11/28/2011  
**Re:** Rule Proposals: Interlocutory Orders and Preauthorization

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I have reviewed the following rules and am providing comment. If you would like to discuss any of my comments further, please do not hesitate to contact Dorian or me.

## Interlocutory Orders

Injured workers need a simple process to request interlocutory orders. The request is time sensitive and needs to be acted upon as quickly as possible. At the Stakeholder meeting, I suggested that at a Benefit Review Officer should be able to reduce an oral request for an interlocutory order to written form at the Benefit Review Conference. The carrier would be on immediate notice that the request was made and the request could then be acted upon by the appropriate Division staff. I believe the rule needs to address a request for an interlocutory order that is made before a Benefit Review Conference, at a Benefit Review Conference, and after a Benefit Review Conference.

The Preamble states that the Division anticipates that 300-500 requests for interlocutory orders will be processed within one year. In the past, interlocutory orders were verbally requested at the Benefit Review Conference. The number of requests is unknown, but it is substantially higher than the number actually ordered. The System Data Report shows that for the year 2003, there were 631 orders issued and for 2004, there were 554 issued. The average from 2000-2004 is 668 per year. Therefore, I believe the number stated should be substantially higher.

Prior to HB7 an interlocutory order was requested and issued within three days of the benefit review conference. While HB7 has indicated that the benefit review officer who presided, or who will preside, over the benefit review conference cannot issue an interlocutory order, the time for issuance should not be substantially impacted by the change in the statute.

- 1) §141.5. Description of the Benefit Review Conference: no comment
- 2) §141.6. Requesting Interlocutory Orders:
  - (a) states that an interlocutory order may be requested within 10 days of the conclusion of a benefit review conference in which the unresolved issues were scheduled for a contested case hearing. It is suggested that the language state that the request can be made “at a benefit review conference or within 10 days of the conclusion of a benefit review conference....”
  - (b) states that the request shall be in writing and in the form and manner prescribed by the Division and shall be specific as to the benefits sought. It is suggested that this section indicate that the request may be made at any Division location. The concern is that the “form and manner prescribed” will indicate

- that the interlocutory order request is to be sent to the Division's Central Office. An injured worker should be able to present or file a request for interlocutory order in the field office.
- (c) seems to indicate that the request for an interlocutory order must always be "sent" to the Division. The following language is suggested: At the time a request for interlocutory order is made with the Division ~~When a request is sent to the Division~~, the party making the request shall ~~send~~ provide, either by hand delivery, mail or electronically, a copy of the request with all supporting documentation directly to the representative that appeared for the carrier at the benefit review conference. Failure to ~~send~~ provide a copy to the carrier representative ~~shall~~ may result in a delay of the processing of the request.
  - If the process is going to be expedited, the request should be able to be made (along with supporting documentation provided) at the benefit review conference. The carrier will receive notice of the request at the benefit review conference and be able to provide a response with any supporting documentation at the benefit review conference. A different provision should be made for handling a request made after a benefit review conference. If the carrier receives notice and fails to respond, the Division should act on the request. The following language is suggested for (d): Upon receipt of a request for an interlocutory order at a benefit review conference, a carrier representative ~~shall~~ may at the benefit review conference file an immediate a response with any supporting documentation but no later than three days after the benefit review conference, ~~and submit any additional documentation for consideration.~~ Upon receipt of a request for an interlocutory order after the conclusion of the benefit review conference, The Division shall contact the carrier representative that appeared at the benefit review conference, electronically or by telephone, to request a response if proof of service has not been established and a response one has not been received within ~~five~~ three days. The Division may provide a copy of the request to a carrier representative if necessary.
  - (e) provides for 10 days for the Division to act on the request. If the request is made at a benefit review conference and the carrier's response made the same day, 10 days is too long of a delay. It is suggested 5 days. Subsection (e) provides the Division shall either deny the request, issue an order or schedule a teleconference. If a teleconference is scheduled, there is no timeframe indicated for the teleconference to be held or timeframe thereafter for the Division to take action on the request. The teleconference should be held within the number of days the division has to act on the request and the action should be taken within 3 days thereafter.
  - (l) last word in the sentence should state "conference".

#### Preauthorization

§134.600(g)(1)(B): I *strongly* disagree with language indicating that the injured worker will initial a statement that the injured worker could be responsible for the charges related to these services if the injury/diagnosis is not work related. This puts the injured worker who is seeking medical treatment in a difficult situation. The injured worker will sign the document (a document that they may not understand) because they need medical treatment and it removes the provider's incentive to seek payment from the carrier. The injured worker should not be required to self diagnose the causal relationship between the symptoms and the on-the-job occurrence. This subsection is unnecessary and should be omitted.



## MEMORANDUM

**DATE: March 31, 2006**

**TO: Laurie Biscoe; Norma Garcia; Kaylene Ray; Allen McDonald; Virginia May; & Rule Comments**

**FROM: Brian White**

**RE: OIEC comments on Chapter 137/Disability Management Rule Package**

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to provide input on preproposed Chapter 137, Disability Management rules.

OIEC strongly recommends developing case management rules prior to formally proposing treatment guidelines, treatment planning, and return to work guidelines. OIEC has concerns on how treatment guidelines, treatment planning, and return to work guidelines will interact. Case management is imperative in putting the other pieces of disability management into action. OIEC feels that it is extremely difficult to examine the interplay between the guidelines and provide thoughtful comment on these rules without any development of case management rules. OIEC respectfully requests the Division of Workers' Compensation (Division) to go through a second but shorter preproposal rulemaking stage to provide stakeholders an opportunity to fully examine the concept of disability management.

OIEC specifically requests that the following terms and phrases be defined in Subchapter A of this chapter or that clarification on the term or phrase is provided in the text of the rule where appropriate: return to work guidelines; treatment guidelines; treatment planning; disability duration expectancy; and lost time parameters.

OIEC requests that clarification is provided in the text of the rule in §137.10(c) with regard to the "presumed reasonable length of disability duration." Specifically, what is the effect of this presumption? Pursuant to §137.10(c)(2), if designated doctors resolve a return to work issue and declares that an injured employee is able to return to work, is the carrier permitted to terminate temporary income benefits? Also, if health care providers offer treatment that is not addressed in the treatment guidelines or exceed the treatment suggested in the guidelines, does the health care provider get paid by the carrier for the health care services that are delivered to the injured employee? If not, why should the injured employee be held liable for health care costs that were both medically necessary and compensable but fall outside the umbrella of the guidelines?

OIEC suggests that enforcement language be added to §137.10(e). A carrier should be issued an administrative penalty if the carrier uses the guidelines as a justification for stopping payment of income benefits to an injured employee.



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NORMAN DARWIN, PUBLIC COUNSEL

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OIEC recommends replacing the phrase, “prior authorization” with the term, “preauthorization.” Referencing §134.600 in §137.100(c)(2) of the treatment guideline rule may provide additional clarity.

In §137.100(c)(3), OIEC recommends that an independent review organization’s decision alone is enough to establish that a variance from the guideline was reasonably required to relieve the injured employee from the effects of the compensable injury. OIEC feels that the health care provider should not be required to submit additional scientific medical evidence. This provision places an unnecessary burden on health care providers, and injured employees may receive disparate treatment as a result of some health care providers unwillingness to provide the Division with additional scientific medical evidence. An independent review organization’s decision that establishes a variance from the guideline should be the only item needed.

OIEC recommends that the term “best” be removed in §137.100(e). “Best” is a relative term and is likely to be the sole cause of future disputes. OIEC recommends that if the term, “best,” is left in the text of the rule, then the Division should define “best available medical evidence” in Subchapter A of this chapter. The term, “convincing medical evidence,” may be more appropriate.

OIEC requests general clarification on how a treatment plan will be used with the treatment and return to work guidelines. OIEC has concerns that the adopted preauthorization and concurrent review rule (§137.600) does not currently provide sufficient information to determine how treatment planning will function. OIEC suggests that more information is needed in the treatment planning rule text in order to provide thoughtful comment.

With regards to treatment planning pursuant to §137.300(b), OIEC recommends that treating doctors be the only provider authorized to submit a treatment plan. OIEC suggests that approved treatment plans should not be binding, particularly if there is a change in treating doctor. Injured employees may change treating doctors for a variety of reasons and should not be bound by a decision of a prior treating doctor. OIEC suggests that treatment plans not be based upon a single injury diagnosis but should consider all the injuries/diagnoses in order to provide the most effective treatment plan for the injured employee, and treatment plans should cover a significant portion of time.

Also, OIEC notes that the specific diagnosis listed in §137.300(c)(1)(A) may have a substantial effect on both the injured employee and the entire workers’ compensation system. Requiring treatment planning for several, commonly used diagnosis may have a significant negative financial impact on the workers’ compensation system. OIEC requests clarification on the diagnosis that will be listed in §137.300(c)(1)(A) and feels this clarification may be most appropriate in a second preproposal rulemaking stage.

Finally, OIEC strongly recommends the removal of §137.300(c)(2)(B). While some cost savings may occur as a result of adopting guidelines in the system and requiring treatment planning in particular instances, OIEC believes that the Division should focus on the health care delivery to the injured employee, not on singling out particular claims based on health care costs. Rising



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health care costs are a significant national problem. Placing a blanket cost as a trigger point for a treatment plan is likely to be troublesome as health care costs increase. OIEC believes that §137.300 may need to be continuously amended to prevent injured employees from receiving increasingly substandard health care as health care costs increase.

Thank you again for the opportunity to provide comment on this rule package.

Sincerely,

Brian White  
Counsel for Policy Development  
Office of Injured Employee Counsel



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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Date: March 13, 2006

To: Norma Garcia, General Counsel  
Texas Department of Insurance

From: Norman Darwin, Public Counsel  
Office of Injured Employee Counsel

Re: Rule Comments

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### §133.240. Medical Payments and Denials

(e) provides that when the carrier makes payment or denies payment on a medical bill, the carrier is required to send the explanation of benefits to the health care provider and the injured employee. While providing this information may allow injured employees to understand the reimbursement status of medical associated with their care, it is suggested that at minimum an explanation of benefits be provided whenever a medical bill is being denied for relatedness.

### §133.270. Injured Employee Reimbursement for Health Care Paid

(d) provides that the injured employee may seek reimbursement for any payment made above the applicable Division fee guideline or contract amount from the health care provider who received the overpayment. It is suggested that out of pocket costs should be reimbursed to the injured employee and the carrier should obtain the difference from the health care provider.

### §134.110. Reimbursement of Injured Employee for Travel Expenses Incurred

This section provides the injured employee reimbursement for travel if greater than 30 miles one way. It is suggested that reimbursement for travel remain at 20 miles one way from the injured employee's residence for the reason that this distance has traditionally been the accepted length that justified reimbursement. There is no economic justification for increasing it to 30 miles that would offset the hardship imposed on injured employees by having to absorb the cost of an additional 20 miles for a round trip to a health care provider. The cost of transportation has increased significantly in recent years and costs should not have to be borne by injured employees.

### §134.120. Reimbursement for Medical Documentation

(d) provides that if the injured employee, or the injured employee's representative, requests creation of medical documentation, such as a medical narrative, the requestor shall reimburse the health care provider for this additional information. It is suggested that if the carrier has filed a denial of benefits based upon a lack of documentation and such documentation can be produced, the injured employee or the carrier may request such documentation and the carrier is responsible for the costs.

(e) provides that the health care provider shall provide copies of any requested or required documentation to the Division at no charge. When assisting injured employees, it is necessary for ombudsman to obtain access to medical documentation without delay. The following language is suggested: The health care provider shall provide copies of any requested or required documentation to the Division and the Office of Injured Employee Counsel upon request, at no charge.

§134.600. Preauthorization, Concurrent Review, and Voluntary Certification of Health Care

(g) addresses preauthorization when a health care provider wants to treat an injury or diagnosis that is not accepted by the carrier in accordance with §408.0042. Subsection (1)(B) provides that the request shall contain an initialed statement by the injured employee. This requirement is unnecessary because in accordance with §413.042, a health care provider has the ability to pursue a private claim against an injured employee if the injury is finally adjudicated as not compensable. This subsection of the rule only serves as notification and encouragement to health care providers to seek payment from injured employees (shifting the cost to the person least able to bear the cost). Placing the injured employee on the spot at the time when medical care is being provided may have a negative impact on return to work outcomes (one of HB7's primary goals). Injured employees that are unable to pay for the medical care may be intimidated by the medical cost and deny the care (even if the injury was compensable). The lack of care may result in longer recovery period and negatively impact return to work outcomes. It is suggested that (g)(1)(B) be deleted.

Subsection (g) provides that the statement initialed by the employee indicate that the injured employee could be responsible for the charges "if the injury/diagnosis is not work-related." This subsection does not qualify the time in which the injury/diagnosis is determined to be not work-related. It is suggested that if the Division requires this, that the provision indicate a time certain such as "if the injury/diagnosis is finally adjudicated as not work related."

Additionally, (g) does not indicate who is to retain a copy of the initialed statement and does not provide for a copy to be provided to the injured employee. It is suggested that if the Division requires the injured employee to initial a statement, then that statement should be provided in a variety of languages. For example, while Spanish is the majority, minority language spoken in Texas, there are large portions of Houston where an employee's primary language is Vietnamese or Cantonese.



## MEMORANDUM

**DATE:** March 29, 2006

**TO:** Norma Garcia; Kaylene Ray; Karen Thrash; Brenda Caldwell; Amy Rich; & Heidi Jackson

**FROM:** Elaine Chaney; Brian White

**RE:** Preproposal Comment on Medical Dispute Resolution Rules

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The Office of Injured Employee (OIEC) thanks you for the opportunity to provide public comment on the preproposal drafts of the Medical Dispute Resolution rules.

OIEC would like to see clarification in the rule text that a claimant can be a requestor in the medical dispute resolution process as well as the preauthorization and concurrent review processes. Specifically, §133.308(c)(2) of the medical dispute resolution rule defines party by referring to §134.600, the preauthorization, concurrent review, and voluntary certification rule. However, the term “party” is not defined in §134.600. The term “requestor,” however, is defined but does not include an injured employee as a requestor. This seems to conflict with §133.307(b)(2), which includes an injured employee as a party in medical dispute resolution of medical fee disputes. Additionally, in reviewing §134.600, it seems that an injured employee may be a party in a preauthorization request but the language is unclear as to whether an injured employee could be a party in the concurrent review process. OIEC strongly recommends that an injured employee should be able to be a party in both the preauthorization and concurrent review processes pursuant to §134.600 as well as in medical dispute resolution since the basis of all three processes center on the injured employee’s health care.

OIEC recommends that the injured employee receive all notices and responses of a request of an independent review organization (IRO) review, regardless of whether the injured employee is considered a party in the process. OIEC feels that it is imperative to keep the injured employee informed of disputes based on health care rendered to that particular injured employee. OIEC believes that keeping the injured employee informed at the various stages of the medical dispute resolution process aids in communication for all workers’ compensation system participants and provides injured employees with necessary information about their individual claim and appellate rights.

After the injured employee has received two adverse determinations from the carrier (ie. the injured employee’s preauthorization request and subsequent request for reconsideration was denied), the rule should allow the requestor or injured employee 60 days to gather the necessary information to request an independent review. OIEC suggests extending the time period in



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§133.308(e)(2) from 45 days to 60 days to allow sufficient time for the requestor/injured employee to gather the necessary documentation to request an IRO.

OIEC recommends clarification within the text of the rule in §133.308(f) to require the carrier to request an IRO if a requestor asks for one, unless there is a pending compensability/extent issue. Carriers should be specifically required to seek an IRO review upon an injured employee's request. Once the requestor/injured employee has made the request for IRO review with the carrier, the rule should require the carrier, subject to an administrative violation, to respond/confirm in writing to the injured employee within five days (or some other specified time period) that a request for an IRO assignment has been made. It is also recommended that this notice to the injured employee/requestor also include a list of documents that the carrier plans to send to the IRO for review. This would allow the injured employee/requestor the opportunity to contact the carrier and coordinate the necessary documentation for an IRO review. Additionally, carriers should be held liable for the IRO fee if a request and confirmation of the request is not made within the five-day timeframe.

OIEC believes it may be clearer if §133.308(f) was self-contained and identified the form for requesting an IRO in the rule itself rather than referring to Chapter 19, Subchapter R, relating to Utilization Review Agents (URA). Keeping the rule self-contained is likely to clarify the process and prevent future administrative burdens, particularly if there is a plan to substantially amend the URA rules in the near future. Further, OIEC recommends the process to request an IRO from a carrier be as simple as possible for the requestor/injured employee. The OIEC asks that forms that are developed later to aid in this process be in plain language form (8<sup>th</sup> Grade Reading Level) and available in both English and Spanish.

At the conclusion of the IRO process, the independent review organizations (IRO) should be required to send the injured employee both the decision and notice of the injured employee's right to appeal the IRO decision, regardless of whether the injured employee is the requestor or is considered to be a party. OIEC recommends that the notice of the injured employee's right to appeal should be required by rule and should be attached to the body of the IRO decision. Failure to provide such notice should result in an administrative violation. The notice should explain that the IRO's decision is binding during the appeal process and should specifically explain in plain language the procedural process as described in Texas Labor Code §413.031 for appealing an IRO decision as well as the procedure for appealing an IRO decision regarding spinal surgery. An appropriate customer assistance telephone number should be required as a part of the required notice (within the body of the IRO decision) to field questions regarding the dispute process, particularly for spinal surgery cases. OIEC suggests, at a minimum, requiring IRO decisions to publish our website/contact information ([www.oiec.state.tx.us](http://www.oiec.state.tx.us)) in order to assist employee's through this complex process. OIEC believes ushering injured employees to our agency may relieve additional customer assistance burdens that Texas Department of Insurance, Division of Worker's Compensation may experience.

When disputing an IRO spinal surgery determination, a request for hearing should be sent to the carrier, health care provider, and injured employee for whom the fee for the health care rendered



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is in dispute, in addition to the Chief Clerk of Proceedings of Texas Department of Insurance, Division of Workers' Compensation.

Please do not hesitate to contact me should you have questions regarding this comment or if I can be of any assistance. Thank you.

Sincerely,

Brian M. White  
Counsel for Policy Development  
Office of Injured Employee Counsel  
(512) 804-4186



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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Date: March 6, 2006

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

From: Norman Darwin, Public Counsel  
Office of Injured Employee Counsel

Re: Rule Comments

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### **Rule 126.14 . Treating Doctor Exams:**

(b)(1) last sentence: The results of the improper examination shall not be used for the purpose of defining the injury. The word "compensable" should be inserted before "injury."

(c)(4) addresses the notice of appointment and required language. (A) states that the insurance carrier *may* request.... Since the insurance carrier *is* requesting, the sentence should reflect that the carrier has requested the appointment and the Division is requiring the attendance.

(e) addresses a scheduling conflict. It states that if a scheduling conflict exists, the injured employee shall immediately contact the treating doctor to reschedule the appointment. The appointment must be rescheduled to take place within seven working days of the original appointment. (c)(4)(C) addresses the notice of appointment and required language. It states that the injured employee is responsible for contacting the doctor to reschedule, but does not indicate that the rescheduled exam must be within seven working days. The content of (e) should be included in the notice requirements of (c)(4)(C).

(d) states that required information for the notice shall be entered online into TXCOMP and the final summary screen shall be printed as the notice of appointment. It is unclear what information will be included in the TXCOMP notice of appointment. It is suggested that TXCOMP incorporate all of the minimum requirements identified in (c) so they are all included in the notice of appointment.

(i) states that the carrier will accept or deny injuries and diagnoses identified in the examination via TXCOMP and any notification of denial must include a PLN statement. It is unclear how the injured employee without internet access will receive notice of the acceptance and/or denial via TXCOMP. A written notice of the injuries accepted and denied by the carrier needs to be sent to the injured employee, the injured employee's treating doctor and the injured employee's representative, if any. Please note, the provisions of subsection (i)(2) require notice to the treating doctor as well.

**Rule 126.6. Required Medical Examination:**

(j) addresses failure to attend an RME. It states that a carrier may suspend TIBs if an employee without good cause, fails to attend an RME required pursuant to Labor Code §408.0041(f). It is suggested than an additional reference be made to §408.004(a).

(j)(2) addresses the date of reinitiation of temporary income benefits. It is unclear how the carrier will be notified of the date the employee contacted the doctor's office to reschedule the examination. The following language is suggested: If, after the carrier suspends TIBs pursuant to this section, the employee submits to the required medical examination, the carrier shall reinitiate temporary income benefits effective as of the date the employee contacted the doctor's office to reschedule the examination. The doctor's office shall notify the carrier of the date the employee contacted the doctor's office to reschedule the examination.

**Rule 126.7. Designated Doctor Examinations: Requests and General Procedures:**

(h)(3) states the Division shall select the next available doctor on the Division's DD List who: has credentials appropriate to the issue in question and the injured employee's medical condition. §408.0041 states similar language: shall be performed by the next available doctor on the Division's list of designated doctors whose credentials are appropriate for the issue in question and the injured employee's medical condition as determined by commissioner rule [Emphasis added]. It is suggested that there be specifics provided in the rule pursuant to the statutory requirement to define "credentials appropriate." Without the term being defined, the Division has the ability to appoint any doctor as a designated doctor. The following language is suggested: Credentials appropriate is defined as training and experience with the treatment and procedures used by the doctor in treating the patient's medical condition.

(j) states that the designated doctor shall review the information provided by the insurance carrier and treating doctor, but it does not include what the injured employee may provide to the designated doctor for review per §408.0041(d). The following change is suggested: The designated doctor shall review the employee's medical records, including an analysis of the injured employee's medical condition, functional abilities and return to work opportunities provided by the insurance carrier and treating doctor, the employee's medical condition and history as provided by the injured employee, and shall perform a hands-on examination.

(w) addresses requests for clarification from the designated doctor. While the designated doctor has a response date of five days if he/she has to reexamine, there is no response date requirement when the designated doctor does not need to reexamine. Additionally, the opposing party should not only be provided a copy of the request for clarification, but should also be provided an opportunity to respond to the request for the letter of clarification. By providing time to the opposing party to respond to the request, it may ultimately result in a reduction in the number of multiple letters of clarification issued, if the opposing party replies and has additional questions that can be asked in the same letter. The following comments are suggested: Parties ~~may~~ shall 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 and the opposing party shall be provided an opportunity to respond. 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 and set forth a response date of five working days.

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

(a)(3) addresses the requirements for written notice that the certification may be disputed. This section does not address providing a time frame for disputing the certification. It is suggested that subsection (C) be changed to incorporate the 90 day timeframe provided by Section 408.123 of the Texas Labor Code. The following language is suggested for subsection (C): a statement that if the employee disagrees with the certification, they must dispute the certification within 90 days by contacting the Division of Workers' Compensation.

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

(b)(1) It is suggested that the last phrase of (b)(1) be deleted as it requires the designated doctor to estimate the date that the injured employee will reach MMI when the designated doctor does not believe the claimant has reached MMI. There is no legal consequence to be attached to an estimate of MMI due to the fact that Rule 130.1(b)(4)(C)(i) prohibits a prospective finding of MMI. Proposed Rule 130.6 (b)(4) provides for a re-examination within 60 days and any estimate beyond 60 days increases the lack of certainty. The following change is suggested: "When there has been no prior certification of MMI, the designated doctor shall evaluate the injured employee for MMI, and if the doctor finds that the injured employee reached MMI, assign an impairment rating. If the designated doctor finds that the injured employee has not reached MMI, the doctor shall identify the reason that the designated doctor does not believe the injured employee to have reached MMI ~~and estimate the date that the injured employee will reach MMI.~~"



## MEMORANDUM

**DATE: April 4, 2006**

**TO: Laurie Biscoe; Norma Garcia; Kaylene Ray; & Allen McDonald**

**FROM: Brian White**

**RE: Comments regarding Preauthorization and Concurrent Review and Medical Billing Rules**

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The Office of Injured Employee Counsel (OIEC) has three recommendations regarding the adoption of both the preauthorization and concurrent review and medical billing rule packages.

First, OIEC recommends that the injured employee be given the opportunity to be a party in the concurrent review process pursuant §134.600. While the preauthorization process provides the injured employee with the opportunity to be a party, the rule language does not extend the same opportunity to injured employees in the concurrent review process. OIEC sees no distinction between the two processes and recommends that the rule should reflect an injured employee's right to be a party in all matters where the delivery of healthcare to that particular injured employee is an issue.

Second, OIEC recommends a revision in Chapter 134 of the medical billing rules. In the summary of comments and agency response portion of the adoption order (page 12), OIEC suggests that §134.120(e) require health care providers to submit documentation to OIEC upon request. This request is made in an effort by OIEC to provide injured employees thoughtful representation through the ombudsmen program and assistance with complex medical bills. The Division's agency response provides:

The Division declines to make this change. The Division believes such a directive to be more appropriate within future Office of Injured Employee Counsel rules. Although Chapter 404 of the Labor Code provides broad access to information in the hands of the Division, it does not provide for access to information held by health care providers.

OIEC agrees with the second sentence of this response. Labor Code §404.107 provides the public counsel access to information to Division of Workers' Compensation (Division) and Texas Department of Insurance (TDI) records. However, OIEC notes that the Division or TDI may not requests records, which may be pertinent to OIEC's statutory obligation to assist injured employees. OIEC disagrees that this directive may be more appropriate in OIEC's rulemaking initiative because as noted by the Division, OIEC does not have the statutory authority pursuant



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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to Chapter 404 of the Labor Code to request information from health care providers. OIEC feels that giving OIEC access to such information may reduce customer assistance burdens placed on the Division and asks the Division to reconsider its position regarding this matter.

Finally, OIEC recommends that the qualification requirement for travel reimbursement remain at 20 miles one-way pursuant to §134.110. OIEC feels that there is no economic justification for imposing this additional hardship on injured employees, and this burden is compounded by the recent significant increase in transportation costs. Further, OIEC notes that the network rule requirement that establishes the distance of 30 miles as a standard for a network service area has no correlation to an increase in the travel reimbursement mileage standard. OIEC believes as long as the reimbursement rate is consistent in network, out of network, and in non-network claims, a disparity does not exist. OIEC would appreciate if the Division would reconsider this matter and leave the travel reimbursement rate at 20 miles one-way.

Thank you for the opportunity to provide comment on these rules. Please do not hesitate to contact me should you have any questions or if I can be of assistance. Thank you.

Sincerely,

Brian White  
Counsel for Policy Development  
Office of Injured Employee Counsel



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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**Public Hearing before Texas Department of Insurance, Division of Workers' Compensation  
Interlocutory Order Rules: §§141.5 – 141.6  
May 10, 2006**

The Office of Injured Employee Counsel (OIEC) strongly believes that the injured employees of Texas need a simple and efficient process to request interlocutory orders. An interlocutory order request is time sensitive and needs to be acted upon as quickly as possible to assure that injured employees are given their rightful benefits. At the interlocutory order stakeholder meeting, OIEC suggested that at a Benefit Review Officer should be able to reduce an oral request for an interlocutory order to written form at the Benefit Review Conference. This would place the insurance carrier on immediate notice that the request was made, and the request could then be acted upon by the appropriate Division of Workers' Compensation staff. The proposed interlocutory order rule currently only addresses the procedure for when interlocutory orders are requested *after* a benefit review conference. OIEC strongly recommends that the rule should address a request for an interlocutory order that is made both before and at a benefit review conference.

The proposal preamble states that the Division of Workers' Compensation anticipates that 300-500 requests for interlocutory orders will be processed within one year. In the past, interlocutory orders were verbally requested at the Benefit Review Conference. The number of requests is unknown, but it is substantially higher than the number actually ordered. The System Data Report shows that for the year 2003, there were 631 orders issued and for 2004, there were 554 issued. The average from 2000-2004 is 668 per year. Therefore, OIEC believes the number of Interlocutory Orders that the Division should expect is substantially higher. OIEC recommends that the Division of Workers' Compensation be prepared to process the numerous interlocutory requests without making the process less efficient. In order to do so, the rule should address requests made before and at the benefit review conference. All parties and appropriate



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documentation is made available at this time, and the statute does not prohibit such exchange of information and request for an interlocutory order either before or during a benefit review conference.

Prior to House Bill (HB) 7, an interlocutory order was requested and issued within three days of the benefit review conference. While HB7 has indicated that the benefit review officer who presided, or who will preside, over the benefit review conference cannot issue an interlocutory order, the time for issuance should not be substantially impacted by the change in the statute.

OIEC offers the following changes to the text of the proposed interlocutory rule to implement the suggestions noted above:

- 1) §141.5. Description of the Benefit Review Conference: No comment.
- 2) §141.6. Requesting Interlocutory Orders:
  - Subsection (a) states that an interlocutory order may be requested within 10 days of the conclusion of a benefit review conference in which the unresolved issues were scheduled for a contested case hearing. OIEC recommends that the language state that the request can be made “at a benefit review conference or within 10 days of the conclusion of a benefit review conference....”
  - Subsection (b) states that the request shall be in writing and in the form and manner prescribed by the Division and shall be specific as to the benefits sought. OIEC recommends this section indicate that the request may be made at any Division of Workers’ Compensation location. The concern is that the “form and manner prescribed” will indicate that the interlocutory order request is to be sent to the Division of Workers’ Compensation’s Central Office. An injured employee should be able to present or file a request for interlocutory order in the field office. Response to an interlocutory request



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should be given at the same time. This will cut down on administrative processing time and provide a more efficient interlocutory order process.

- Subsection (c) seems to indicate that the request for an interlocutory order must always be “sent” to the Division of Workers’ Compensation. The following language is suggested: “At the time a request for interlocutory order is made with the Division ~~When a request is sent to the Division~~, the party making the request shall ~~send~~ provide, either by hand delivery, mail or electronically, a copy of the request with all supporting documentation directly to the representative that appeared for the carrier at the benefit review conference. Failure to ~~send~~ provide a copy to the carrier representative ~~shall~~ may result in a delay of the processing of the request.”
- If the process is going to be expedited, the request should be able to be made (along with supporting documentation provided) at the benefit review conference. The carrier will receive notice of the request at the benefit review conference and be able to provide a response with any supporting documentation at the benefit review conference. A different provision should be made for handling a request made after a benefit review conference. If the carrier receives notice and fails to respond, the Division should act on the request. The following language is suggested for (d): “Upon receipt of a request for an interlocutory order at a benefit review conference, a carrier representative ~~shall~~ may at the benefit review conference file ~~an immediate~~ a response with any supporting documentation but no later than three days after the benefit review conference. ~~and submit any additional documentation for consideration.~~ Upon receipt of a request for an interlocutory order after the conclusion of the benefit review conference, The Division shall contact the carrier representative that appeared at the benefit review conference, electronically or by telephone, to request a response if proof of service has not been established and a response ~~one~~ has not been received within ~~five~~ three days. The Division may provide a copy of the request to a carrier representative if necessary.”



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- Subsection (e) provides for 10 days for the Division of Workers' Compensation to act on the request. If the request is made at a Benefit Review Conference and the carrier's response made the same day, 10 days is too long of a delay. OIEC recommends this process take no longer than 5 days. Subsection (e) provides the Division of Workers' Compensation shall either deny the request, issue an order, or schedule a teleconference. If a teleconference is scheduled, there is no timeframe indicated for the teleconference to be held or timeframe thereafter for the Division of Workers' Compensation to take action on the request. The teleconference should be held within the number of days the Division of Workers' Compensation has to act on the request and the action should be taken within 3 days thereafter.

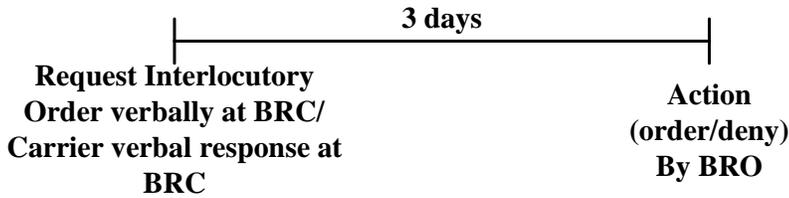


\*Exact Figures unavailable. Totals for requested Interlocutory Orders based on estimate of 10% greater than the number of Interlocutory Orders issued

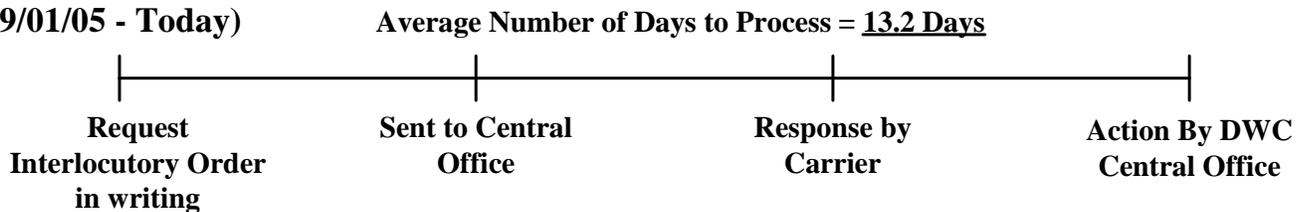


# Interlocutory Order Process

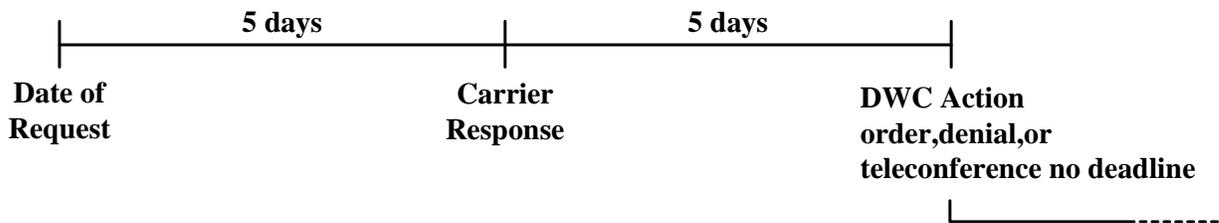
## Prior to 9/01/05 Process :



## Current Process : (9/01/05 - Today)



## Proposed Rule :





## MEMORANDUM

**DATE:** May 25, 2006

**TO:** Norma Garcia; Karen Thrash; Brenda Caldwell; Amy Rich; & Jeannie Ricketts

**FROM:** Brian White

**RE:** Medical Dispute Resolution Rules

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The Office of Injured Employee (OIEC) thanks you for the opportunity to provide public comment and provides the following recommendations for the proposal medical dispute resolution (MDR) rule.

OIEC recommends that an injured employee may be a requestor in the MDR process, and the Texas Department of Insurance, Division of Workers' Compensation (Division) comply with Labor Code §413.031(a), which states, "A party, including a health care provider, is entitled to a review of a medical service provided or for which authorization of payment is sought. . ." Further, subsection (b) states, "A claimant is entitled to a review of a medical service for which preauthorization is sought by the health care provider and denied by the insurance carrier. As such, OIEC suggests that proper due process be given to all injured employees and that all injured employees have the procedural right to be considered a "party" or "requestor" in the medical dispute resolution process. While OIEC recognizes the Division's reasoning behind only designated particular injured employees as parties/requestors in the MDR process, OIEC strongly believes that §§133.307(b)(3) and (4) and §133.308(f)(3) as currently written do not pass constitutional muster, and the Division does not have statutory authority to carve out due process for only a portion of Texas' injured employees. OIEC agrees it is unlikely that many injured employees will exercise their right to appeal within the administrative process without assistance from their health care provider; however, injured employees should not be deprived of due process simply because of their lack of frequency to exercise such rights.

OIEC recommends the process to request an IRO pursuant to §133.308(g) be as simple as possible for the requestor/injured employee. The OIEC asks that forms that are developed later to aid in this process be in plain language form (8<sup>th</sup> Grade Reading Level) and available in both English and Spanish.

After the injured employee has received two adverse determinations from the carrier the rule should allow the requestor or injured employee 60 days to gather the necessary information to request an independent review. OIEC suggests extending the time period in §133.308(h) from



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45 days to 60 days to allow sufficient time for the requestor/injured employee to gather the necessary documentation to request an IRO from TDI.

OIEC recommends that the injured employee receive all notices and responses of a request of an independent review organization (IRO) review, regardless of whether the injured employee is considered a party in the process. OIEC feels that it is imperative to keep the injured employee informed of disputes based on health care rendered to that particular injured employee. OIEC believes that keeping the injured employee informed at the various stages of the medical dispute resolution process aids in communication for all workers' compensation system participants and provides injured employees with necessary information about their individual claim and appellate rights. At the conclusion of the IRO process, the independent review organizations (IRO) should be required to send the injured employee both the decision and notice of the injured employee's right to appeal the IRO decision, regardless of whether the injured employee is the requestor or is considered to be a party. OIEC recommends that the notice of the injured employee's right to appeal should be required by rule and should be attached to the body of the IRO decision. Failure to provide such notice should result in an administrative violation. The notice should explain that the IRO's decision is binding during the appeal process and should specifically explain in plain language the procedural process as described in Texas Labor Code §413.031 for appealing an IRO decision as well as the procedure for appealing an IRO decision regarding spinal surgery. An appropriate customer assistance telephone number should be required as a part of the required notice (within the body of the IRO decision) to field questions regarding the dispute process, particularly for spinal surgery cases. OIEC suggests, at a minimum, requiring IRO decisions to publish our website/contact information ([www.oiec.state.tx.us](http://www.oiec.state.tx.us)) in order to assist injured employees through this complex process. OIEC believes ushering injured employees to our agency allows OIEC to service injured employees as charged by House Bill 7. Specifically, OIEC recommends adding the following underlined language:

- §133.307(f)(5) (page 14, lines 289 – 290): “The Division shall send a decision to the disputing parties and injured employee and post the decision on the Department Internet Website.”
- §133.308(o) (page 23, lines 468 – 469): “The decision shall [~~must~~] be mailed or otherwise transmitted to the parties, and the injured employee and transmitted by facsimile to the Department. . .”

When disputing an IRO spinal surgery determination pursuant to §133.308(t), the written appeal should be sent to the carrier, health care provider, and injured employee for whom the fee for the health care rendered is in dispute, in addition to the Division's Chief Clerk.

OIEC highly recommends placing a time frame for appealing for judicial review in both §§133.307(g) and 133.308(s). It is often extremely difficult for injured employees to find an attorney to take their case to district court. Providing a time frame to file for judicial review clarifies a confusing process for injured employees, gives them a time frame to gather information and find an attorney, and assures an injured employee's case is not discarded due to a technicality. Making injured employees aware of the 30-day filing period helps injured



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employees assert their appellate rights and reduces complaints from injured employees dissatisfied with the results at the administrative level.

OIEC suggests clarification regarding dismissals pursuant to §133.307(f) (page 13). Specifically, what happens if an injured employee disagrees with the Division as to whether the MDR request is timely. A dismissal is not a final decision, so what is the process for disputing such determination? Could the injured employee seek judicial review upon such dismissal?

OIEC suggests replacing the phrase, “convincing evidence” with “a statement” in §133.307(d)(3)(D) (page 9, lines 177 – 179) to clarify the type of evidence that may be submitted in lieu of receipt of a denial.

OIEC recommends the following non-substantive changes to increase the readability and comprehension for injured employees. First, §133.307(d)(1)(B) (page 6, line 121) OIEC recommends adding the term, “administrative,” to clarify that the medical necessity dispute must be filed within 60 days from the time the requestor received the final decision and is “inclusive of all administrative appeals.” Adding the term “administrative” clarifies the types of appeals needed to file a timely MDR. Second, §133.307(d)(2) (page 6, line 127), OIEC recommends adding the term, “Health care” before the term “provider.” Such addition provides clarification for injured employees not familiar with the workers’ compensation system. Third, §133.308(k)(4) and (5) (page 21, lines 423 - 425) may need clarification. Paragraph (4) seems to include paragraph (5). If not, perhaps clarification is needed on the type of appeal that is to be included in the documentation to the IRO. Fourth, the term, “provider” should be replaced by the term, “carrier” in §133.307(d)(3) (page 8, line 168). Fifth, OIEC suggests §133.307(f)(5) (page 14, lines 289 – 290) comply with §413.301, which requires MDR decisions to be placed on the Division’s internet website, not the Department’s internet website as currently stated in the rule text. Sixth, OIEC suggests adding the term, “medical” to §133.307(1)(A) and (B) to distinguish between the two different types of disputes to which the rule text refers. Finally, §133.308(v) should be underlined for the *Texas Register* submission because this is new language.

Please do not hesitate to contact me should you have questions regarding this comment or if I can be of any assistance. Thank you.

Sincerely,

Brian M. White  
Counsel for Policy Development  
Office of Injured Employee Counsel  
(512) 804-4186



## MEMORANDUM

**DATE: June 1, 2006**

**TO: Kevin Haywood; Laurie Biscoe**

**FROM: Brian White**

**RE: Electronic Claims Request/HB 251**

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the Texas Department of Insurance, Division of Workers' Compensation's (Division) concept paper on electronic claims request pursuant House Bill (HB) 251.

The Labor Code §402.084 provides insurance carriers the opportunity to submit on a monthly basis a written request for full claims data. The Division is then required to produce electronically information described in §402.084(c-3).

OIEC's initial concern is that the Division release information based on a correct match. For example, an insurance carrier may ask for claims data for a "Brian White." There may be numerous Brian White's in the Division's system that currently meet the requirements of Labor Code §402.084(a)(1) and whose claim information may be accessed. OIEC encourages the Division to take extra precautions to ensure that the only the proper claim information is accessed by the appropriate insurance carrier.

OIEC suggests developing a process to both assure that the insurance carrier that is requesting information on an injured employee is indeed the carrier that provided coverage to the injured employee as mandated in §402.084(c-3) as well as establishing a system for verifying that the individual requesting the information is an authorized representative of the insurance carrier. Also, OIEC recommends that this rule be specific as to what elements are required from the insurance carrier to ensure a correct match. Perhaps at a minimum the injured employee's name, date of birth, social security number, and address should be required to avoid the issue of inadvertently releasing confidential data, particularly in cases where the injured employee may have a common name.

Thank you for the opportunity to provide initial feedback on the concept paper regarding electronic claims requests. Please do not hesitate to contact me should you have any questions regarding this matter or if I can be of any assistance.

Sincerely,

Brian White  
Counsel for Policy Development



## MEMORANDUM

**DATE:** July 24, 2006

**TO:** Norma Garcia

**FROM:** Brian White

**RE:** Medical Dispute Resolution Rules

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The Office of Injured Employee (OIEC) commends the Texas Department of Insurance, Division of Workers' Compensation (Division) on a thoughtful medical dispute resolution proposal that allows injured employees to be a party in the process. OIEC thanks you for the opportunity to provide additional public comment and provides the following recommendations for the proposed medical dispute resolution (MDR) rule.

OIEC recommends the process to request an IRO pursuant to §133.308(f) and (g) be as simple as possible for the requestor/injured employee. OIEC suggests that forms that are developed later to aid in this process be in plain language form (8<sup>th</sup> Grade Reading Level) and available in both English and Spanish. Also, OIEC suggests offering a telephone number in §133.308(f) to request the form for an IRO, in addition to obtaining it on the Department's website or by mail. Many injured employees may not have internet access and making such a request via telephone may save the injured employee time in requesting an IRO (as opposed to mailing out a request and waiting for the Department's response via mail).

OIEC recommends that the injured employee receive all notices and responses of a request of an independent review organization (IRO) review, regardless of whether the injured employee is considered a party in the process. OIEC feels that it is imperative to keep the injured employee informed of disputes based on health care rendered to that particular injured employee and is critical in achieving one of House Bill 7's system goals to increase communication in the workers' compensation system. OIEC believes that keeping the injured employee informed at the various stages of the medical dispute resolution process aids in communication for all workers' compensation system participants and provides injured employees with necessary information about their individual claim and appellate rights. Specifically, OIEC recommends adding the following underlined language:

- §133.307(e)(5) (page 28): "The Division shall send a decision to the disputing parties and injured employee and post the decision on the Department internet website."



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NORMAN DARWIN, PUBLIC COUNSEL

- §133.308(n) (page 37): “The decision shall be mailed or otherwise transmitted to the parties, and the injured employee and transmitted by facsimile to the Department within the time frames specified in this section.”

At the conclusion of the IRO process, the independent review organizations (IRO) should be required to send the injured employee both the decision and notice of the injured employee’s right to appeal the IRO decision, regardless of whether the injured employee is the requestor or is considered to be a party. OIEC recommends that the notice of the injured employee’s right to appeal should be required by rule, should be attached to the body of the IRO decision, and should include the timeframe in which the IRO decision can be appealed. OIEC commends the IROs in the workers’ compensation system currently providing such information to injured employees and encourages the Division to require this practice by rule to ensure quality control of IRO decisions.

An appropriate customer assistance telephone number should be required as a part of the required notice (within the body of the IRO decision) to field questions regarding the dispute process, particularly for spinal surgery cases. OIEC suggests, at a minimum, requiring IRO decisions to publish either the Texas Department of Insurance’s contact information or OIEC’s contact information in order to assist injured employees through this complex process.

When disputing an IRO spinal surgery determination pursuant to §133.308(s), the written appeal should be sent to the injured employee’s treating doctor, in addition to both parties to the proceeding (the carrier and injured employee) and the Division’s Chief Clerk as required by §142.5(c). Providing the written appeal to the health care provider/treating doctor increases communication within the workers’ compensation system, which is likely to prevent injured employees from being barred from the dispute resolution system based on a technicality.

OIEC highly recommends requiring the IRO to publish the time frame to seek judicial review as a part of the IRO decision pursuant to §133.308(n) so that the injured employee may take appropriate action to obtain attorney and file a petition in district court within 30 days. It is often extremely difficult for injured employees to find an attorney to take their case to district court. Providing a time frame to file for judicial review clarifies a confusing process for injured employees, gives them a time frame to gather information and find an attorney, and assures an injured employee’s case is not discarded due to a technicality. Making injured employees aware of the 30-day filing period helps injured employees assert their appellate rights and reduces complaints from injured employees dissatisfied with the results at the administrative level.

OIEC suggests clarification regarding dismissals pursuant to §133.307(e)(4) (page 27). Specifically, OIEC suggests incorporating into the rule text a procedure to address cases where an injured employee disagrees with the Division as to whether the MDR request is timely. Further, because a dismissal is not a final decision, there is no process in the rule in which an injured employee may dispute a determination. Perhaps a basic statement explaining whether the injured employee may seek judicial review upon such dismissal would clarify the MDR process (ie. Is a dismissal an exhaustion of administrative remedies? If not, what other remedies are there at the administrative level?). Or perhaps requiring a statement and a time period to cure the



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deficiency in the filing would be helpful. Such clarification would help prevent injured employees from getting lost in the system and provides for a clear procedure for disputing a determination.

OIEC recommends clarification in §133.307(c)(1)(A) by adding the term, "Division" before decision. OIEC would recommend borrowing language used in subsection (e)(2) for consistency.

Please do not hesitate to contact me should you have questions regarding this comment or if I can be of any assistance. Thank you.

Sincerely,

Brian M. White  
Counsel for Policy Development  
Office of Injured Employee Counsel  
(512) 804-4186

1  
2 **§120.2. Notice of Injured Employee Rights and Responsibilities and**  
3 **Employer's First Report of Injury**

4 (a) At the time the employer is informed of an injury, death, or  
5 occupational disease, the employer shall provide a copy of publication CS06-  
6 007A entitled "Notice of Injured Employee Rights and Responsibilities in the  
7 Texas Workers' Compensation System" to the injured employee or, in the case of  
8 an employee's death, the deceased employee's last known mailing address.

9 Publication CS06-007A shall be provided to the employee in English and  
10 Spanish, or in English and any other language common to the employee. This  
11 does not preclude the employer or carrier from providing the employee with  
12 additional information, but such information must be separate from and in  
13 addition to the text contained in publication CS06-007A and may not infer that the  
14 additional information is being provided or required by the Division.

15 (b) The employer shall report to the employer's insurance carrier each  
16 death, each occupational disease of which the employer has received notice of  
17 injury or has knowledge, and each injury that results in more than one day's  
18 absence from work for the injured employee. As used in this section, the term,  
19 "knowledge" includes means receipt of written or verbal information regarding  
20 diagnosis of an occupational disease by any health care provider, or the

1 ~~diagnosis of an occupational disease through direct examination or testing by a~~  
2 ~~doctor employed by the employer.~~

3 (c) ~~[(b)]~~ The employer's report to the insurance carrier shall contain:

4 (1) the information required by §120.1(a) of this chapter title  
5 (relating to Employer's Record of Injuries);~~;~~

6 (2) any additional information prescribed by the Division of Workers'  
7 Compensation (Division) ~~[commission]~~ in accordance with ~~the~~ [Texas] Labor  
8 Code §402.00128(b)(10) ~~[\$402.042(b)(11)]~~; and

9 (3) shall contain the information necessary for an insurance carrier  
10 to electronically transmit a first report of injury to the Division ~~[commission]~~. The  
11 Division ~~[commission]~~ shall prescribe the form, format, and manner of the report.

12 (d) ~~[(e)]~~ The report shall be filed with the insurance carrier not later than the  
13 eighth day after having received ~~[the receipt of notice of injury or the acquisition~~  
14 ~~of]~~ knowledge of an occupational disease; or death, or not later than the eighth  
15 day after the employee's absence from work for more than one day ~~[from work]~~  
16 due to an work-related injury or death ~~[or death]~~. For purposes of this section, a  
17 report is filed when personally delivered, mailed, reported via telephone tele-  
18 claims, electronically submitted, or sent via facsimile. The employer shall  
19 maintain a record of the date the report of injury is filed with the insurance carrier.

20 (e) ~~[(d)]~~ The employer shall provide a written copy of the report to the  
21 injured employee or to the employee's last known mailing address; at the time

1 the report is filed with the insurance carrier. The written report may be the report  
2 specified in subsection (c) [~~(b)~~] of this section, or at a minimum shall contain the  
3 information listed in §120.1(a) of this title (relating to Employer's Record of  
4 Injuries).

5 (f) (e) At the time the employer provides a written copy of the report of  
6 injury to the injured employee, the employer shall also provide a copy of  
7 publication CS06-007A entitled "Notice of Injured Employee Rights and  
8 Responsibilities in the Texas Workers' Compensation System" to the employee.

9 ~~Publication CS06-007A The Employer shall also provide the employee a~~  
10 ~~summary of rights and responsibilities at the time the report required in~~  
11 ~~subsection (c) of this section is filed with the insurance carrier. The text for the~~  
12 ~~summary shall be in English and Spanish, or in English and any other language~~  
13 ~~common to the employee. This does not preclude the employer or carrier from~~  
14 ~~providing the employee with additional information, but such information must be~~  
15 ~~separate from and in addition to the text contained in publication CS06-007A [this~~  
16 ~~section] and may not infer that the additional information is being provided or~~  
17 ~~required by the Division [Commission]. [The following English text and the~~  
18 ~~Spanish text provided by the commission must be used without any additional~~  
19 ~~words or changes.]~~

21 ~~**[YOUR RIGHTS IN THE TEXAS WORKERS' COMPENSATION SYSTEM]**~~

1 ~~1. **You may have the right to receive benefits.**~~

2 ~~You may receive benefits regardless of who caused or helped cause your injury.~~

3 ~~You may not receive benefits if your injury occurred while you were intoxicated,~~

4 ~~you injured yourself intentionally or while unlawfully attempting to injure someone~~

5 ~~else, you were injured by another person for personal reasons, you were injured~~

6 ~~while voluntarily participating in an off-work activity, you were injured by an act of~~

7 ~~God, or your injury occurred during horseplay.~~

8 ~~2. **You have the right to receive the medical care reasonable and necessary**~~

9 ~~**to treat your work-related injury or illness for the rest of your life.**~~

10 ~~3. **You have the right to the initial choice of doctor.**~~

11 ~~You may not change doctors except with the approval of the Commission. You~~

12 ~~do not need to get approval to go to a different doctor for emergency treatment, if~~

13 ~~you or your doctor moves or if your doctor is unable to continue treating you.~~

14 ~~4. **You have the right to hire an attorney to help you get benefits or to help**~~

15 ~~**you resolve disputes.**~~

16 ~~5. **You have the right to receive assistance from appropriate, qualified**~~

17 ~~**Commission staff and, in the event of a dispute resolution proceeding,**~~

18 ~~**from a Commission ombudsman free of charge. To request assistance,**~~

19 ~~**contact the field office handling your claim, or call 1-800-252-7031.**~~

20 ~~You have the right to receive information and assistance regarding your claim.~~

21 ~~Commission staff will explain your rights and responsibilities under the Texas~~

1 ~~Workers' Compensation Act. Additionally, you have the right to be assisted by a~~  
2 ~~Commission ombudsman in informal dispute resolutions and in administrative~~  
3 ~~proceedings if you are not represented. However, an ombudsman cannot serve~~  
4 ~~as a legal representative or attorney for you.~~

5 ~~**6. You have the right to confidentiality.**~~

6 ~~Only people who need to know -- such as your doctor, your employer or your~~  
7 ~~employer's insurance carrier -- may see information in the commission's files. A~~  
8 ~~prospective employer may get limited information from the commission about~~  
9 ~~your claims. If you wish someone who is assisting you to have access to your~~  
10 ~~file, you must provide written approval for them to do so.]~~

11

12 ~~**[YOUR RESPONSIBILITIES UNDER THE TEXAS WORKERS'**~~  
13 ~~**COMPENSATION SYSTEM**~~

14 ~~**1. You have the responsibility to tell your employer about your injury or**~~  
15 ~~**illness.**~~

16 ~~You must tell your employer **within 30 days** of the date you were injured, or~~  
17 ~~**within 30 days** of the date you first knew your illness might be work-related.~~

18 ~~You, or someone helping you, may either talk with or write your employer or any~~  
19 ~~supervisor where you work.~~

20 ~~**If you do not tell your employer within 30 days, you could lose your right to**~~  
21 ~~**get benefits.**~~

1 ~~2. You have the responsibility to fill out a claim form and send it to the~~  
2 ~~Commission.~~

3 You must send a completed claim form, called a TWCC-41, to the Commission  
4 ~~within one year~~ of the date you were injured, or ~~within one year~~ of the date you  
5 first knew your illness might be work-related.

6 Send the completed claim form to the Commission even if you are already  
7 getting benefits.

8 ~~If you do not send the form within one year, you could lose your right to get~~  
9 ~~benefits.~~ For a copy of the form, call the field office handling your claim, or call  
10 1-800-252-7031.

11 ~~3. You have the responsibility to tell the Commission and the insurance~~  
12 ~~carrier any time your income changes.~~

13 If you are NOT getting benefits and you have changed employers since your  
14 injury, tell the Commission if your injury causes you to miss work or lose income.  
15 Call 1-800-252-7031.

16 If you ARE getting benefits and you have changed employers since your injury,  
17 tell the commission and the insurance carrier paying your benefits if your income  
18 changes. Tell the commission and the insurance carrier regardless of whether  
19 your income went up or down.

20 If you have stopped working since your injury, tell the commission and the  
21 insurance carrier if you start working again or if you have a job offer.

1 ~~4. You have the responsibility to tell your doctor how you were injured and~~  
2 ~~if you believe it may be work-related.~~

3 If possible, tell the doctor before the doctor treats you.

4 ~~5. You have the responsibility to tell the commission and the insurance~~  
5 ~~carrier how to contact you.~~

6 You should contact the commission and the insurance carrier if your home  
7 address, work address, or phone number change, so the commission and the  
8 insurance carrier will be able to contact you when necessary.]

9 (g) [(f)] The employer shall maintain a record of the date the copy of the  
10 report of injury and the date(s) publication CS06-007A [summary of rights and  
11 responsibilities] were provided to the employee.

12 (h) [(g)] If the insurance carrier has not received the [a] report [has not  
13 been received by the insurance carrier], the employer has the burden of proving  
14 that the report was filed within the required time frame. If the carrier receives the  
15 report by mail, it will be presumed that the report was mailed four days prior to  
16 the date received by the carrier. The employer has the burden of proving that  
17 good cause exists if the employer failed to timely file or provide the report.

18 (i) [(h)] An employer who fails to comply with this section commits an  
19 administrative violation, unless good cause exists. [Failure of an employer to file  
20 the report as required with the insurance carrier or to provide a copy of the report  
21 as required to the employee without good cause is subject to a penalty not to

1 ~~exceed \$500, pursuant to Texas Labor Code, §409.005, and may be subject to a~~  
2 ~~penalty not to exceed \$10,000 pursuant to Texas Labor Code, §415.021, for~~  
3 ~~repeated violation. An employer who fails to file the report as required by this rule~~  
4 ~~and by the Texas Labor Code, §409.005, waives the right to reimbursement of~~  
5 ~~voluntary benefits even if no administrative penalty is assessed.]~~



## MEMORANDUM

**DATE: August 14, 2006**

**TO: Stan Strickland**

**FROM: Brian White**

**RE: §120.2. Notice of Injured Employee Rights and Responsibilities and Employer's First Report of Injury**

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to provide comment on the above-referenced rule. The purpose of this document is to offer an explanation to the specific text changes that have been provided in red (via tracked changes) in the accompanying attached document.

Audrey Seldon, Texas Department of Insurance's Senior Associate Commissioner of Consumer Protection, is currently coordinating all translation efforts of the Injured Employee Rights and Responsibilities. Audrey has indicated that she would post the document in various languages on the Texas Department of Insurance website. Perhaps including a statement in the rule text that notifies employers of the availability of various translated Injured Employee Rights and Responsibilities would be helpful to employers and encourage compliance with the section.

OIEC suggests the removal of language in §120.2(a) (page 1, lines 10 – 14) to ensure the clear delivery of the Injured Employee Rights and Responsibilities document. OIEC recommends deleting such language from subsection (a) to provide for a simple distribution of the Rights and Responsibilities without the potential of this necessary information being confused with other information produced by the employer. This recommended change is also applicable to subsection (f) (page 3, lines 13 – 17) where the rule text was identical to subsection (a).

In §120.2(b), OIEC is concerned about the definition of the term, "knowledge." Specifically, OIEC feels that the existing rule language precludes actual knowledge from the definition. The replacement of the term, "means" with "includes" (page 1, line 19) rectifies this issue. Further, OIEC believes that any health care provider that provides a diagnosis to an employer should qualify as knowledge of an injury, not just doctors who are employed by the employer (page 1, line 20).

Non-substantive changes are recommended in §120.2(c) and (d) to clarify the employer's obligation to report to its insurance carrier and the substance that should be contained in the report. OIEC suggests such changes to ensure an employer's timely submission of a report of injury to the insurance carrier.



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NORMAN DARWIN, PUBLIC COUNSEL

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Thank you again for the opportunity to provide feedback on §120.2 on behalf of the injured employees of Texas. Please do not hesitate to contact me should you have any questions or if I can be of any assistance.

Brian M. White  
Counsel for Policy Development  
(512) 804-4186



## MEMORANDUM

**DATE: August 24, 2006**

**TO: Division of Workers' Compensation; Form Work Group**

**FROM: Dorian Ramirez**

**RE: Interlocutory Order Form**

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Thank you for providing OIEC with an opportunity to comment on the draft Request for Interlocutory Order.

OIEC suggests that the draft form, Box 1, identify the ombudsman's name. In paragraph 4 of the Instructions, it is unclear if the Division plans on contacting the ombudsman if it requests additional information or is scheduling a telephone conference. OIEC believes that the ombudsman should be contacted if the Division is requesting additional information or scheduling a telephone conference with an unrepresented injured employee. The ombudsman can then coordinate with the injured employee so as to provide an appropriate response. By identifying the ombudsman's name in Box 1, this will be easily identified.

In paragraph 5 of the instructions, the Division notifies the parties of the Division's decision, however it is unclear whether a copy of the notification is provided to the ombudsman, if assisting an injured employee. OIEC requests that the Division send a copy of the notification of the IO decision to the ombudsman as well as the injured employee.

The detailed address to submit the form is contained in the instructions, but not on the form. OIEC requests that the address on the form contain the specific information for submitting the form.

Please let me know if you have any questions regarding these comments.

Thanks, Dorian



## MEMORANDUM

**DATE: September 14, 2006**

**TO: Stan Strickland**

**FROM: Brian White**

**RE: Inpatient/Outpatient Hospital Fee Guidelines**

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the Texas Department of Insurance, Division of Workers' Compensation's (Division) preproposal inpatient and outpatient hospital fee guideline rule.

In accordance to Texas Labor Code §413.011, the Division of Workers' Compensation Commissioner is required to promulgate health care reimbursement policies and guidelines that reflect standardized reimbursement structures found in other health care delivery systems with minimum modifications to meet occupational injury requirements. Further, to achieve such standardization, the Division is required to adopt current reimbursement methodologies, models, and values or weights used by the federal Centers for Medicare and Medicaid Services and may deviate from Medicare policies where appropriate. OIEC understands the difficulty in undertaking this task and cordially requests that the Division keep in mind the following issues and possible solutions.

One concern OIEC would like to relay is the inherent difference between both the type of patients and patient reimbursement methodology in the workers' compensation system and the Medicare program. Medicare centers around the Diagnosis Related Group (DRG) classification system, which sorts patients into more than 500 groups. In doing so, cases with related clinical issues are assumed to have similar costs. It is also assumed that hospitals will see a variety of cases. Cases where the reimbursement rate is insufficient to cover the cost of treatment will be offset by those DRG's that are reimbursed at a higher rate. In workers' compensation, injured employees are likely to have similar types of injuries, which do not require the same breadth of treatment as group health patients. Because hospitals will not see a variety of DRGs from workers' compensation patients, hospitals are likely to be unable to offset their losses from DRGs reimbursed at higher rates. In addition, paramount workers' compensation issues pose further complications. For example, a health care provider is not likely to share the same emphasis of returning a Medicare patient back to work as would a health care provider treating a workers' compensation patient (due to the different demographics of a Medicare patient and workers' compensation patient; eg. age).

Second, there are more administrative burdens processing a workers' compensation patient than in processing a Medicare patient. Recently, OIEC had the opportunity to take an extensive tour



through an orthopedic, sports, and rehabilitation center to examine the differences of processing a workers' compensation patient compared to processing a group health/Medicare patient. This experience brought to life the overwhelming amount of additional paperwork, time, and staff needed to process a workers' compensation patient compared to processing a Medicare patient. Administrative support spent an extensive amount of time determining the coverage issues, determining the network status of the patient, coordinating physician schedules for preauthorization consultation between the peer review doctor and treating doctor, and making several telephone calls due to the limited ability to view workers' compensation claims online. There is no adjustment factor for reimbursement in Medicare that takes into account the additional resources needed to attend to the extensive administrative requirements for billing and processing of a workers' compensation patient.

Noting these distinctions as well as the current access to health care crisis for an injured employee, OIEC has the following recommendations:

- The Medicare facility specific reimbursement amount multiplier currently proposed at 162% pursuant §134.403(c)(1) to determine maximum allowable reimbursement (MAR) for outpatient care is substandard. OIEC strongly recommends adopting a higher multiplier, such as anywhere from 200 – 266%, to adequately reimburse health care facilities. At first blush, OIEC understands that this suggested multiplier might be considered extremely high. However, according to Ingenix's study pursuant to the Division's request (RFQ No. 453-05-02090), Commercial HMOs are reimbursed at 200% of Medicare and Commercial PPOs are reimbursed at 266% of Medicare in 2006. *See* attached Exhibit A. And while OIEC concedes that both group health products have fundamental differences than workers' compensation, the health care received by both health care vehicles should be substantially similar. Keeping in mind House Bill (HB) 7's goal of tendering each injured employee access to prompt, high-quality medical care, OIEC is skeptical as to how the Division intends to assure quality health care for injured employees when health care facilities are reimbursed at a multiplier 100 percentage points less than the reimbursement multiplier in group health (PPO) for a workers' compensation system that is more cumbersome and costly to participate. *See id.*
- Likewise, the Medicare facility specific reimbursement amount multiplier currently proposed at 111% pursuant §134.404(c)(1) to determine MAR for inpatient care is insufficient. OIEC recommends adopting a higher multiplier ranging from 117 – 140 % to closer align reimbursement rates to Commercial HMOs and PPOs, respectively. *See* attached Exhibit A. OIEC recommends that the Division consider a higher Medicare multiplier for inpatient care to assure that injured employees receive the appropriate health care deserved. At the proposed reimbursement rate of 111% of Medicare, health care facilities are likely to turn away injured employees simply because it does not make sound business sense to treat them. Health care facilities will most certainly lose money by treating injured employees. Accordingly, the access to health care crisis for injured employees is most likely to be compounded.
- In addition to increasing the health care facility reimbursement multiplier, OIEC suggests that the Division consider Medicare's payment adjustment factors (PAF) so as to provide appropriate reimbursement to health care facilities. For example, OIEC believes that teaching hospitals may need special consideration in terms of reimbursement due to the fact that such facilities often treat more sophisticated cases. OIEC recommends a



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NORMAN DARWIN, PUBLIC COUNSEL

disproportionate share adjustment for those health care facilities that treat a disproportionate number of workers' compensation patients. A flat workers' compensation reimbursement rate will not work for every health care facility because of varying business models/operations and the types of patients that are treated. OIEC suggests the Division carefully consider PAFs in determining the most appropriate reimbursement for health care facilities.

- Finally, currently implants are reimbursed at cost, which often causes health care facilities to lose money when treating patients that need implants. Hospitals treat the injured employees that have sustained the most serious injuries. At times, health care facilities must treat patients for extended periods and may turn to implants for pain management. OIEC recommends carving out a reimbursement methodology for implants, such as the cost of the implant plus 10 - 15 percent. Accordingly, health care facilities will not lose money treating critically injured employees, and it assures health care facilities will continue to participate in the workers' compensation system.

Some workers' compensation stakeholders may feel that increasing health care reimbursement rates (via increasing Medicare multiplier) and consideration of PAFs is unnecessary for health care facilities to be appropriately reimbursed. However, OIEC believes that with the Division's soon to be adopted disability management rules, specifically the treatment guidelines, overutilization in the workers' compensation system and health care costs will be significantly reduced. OIEC believes that once the overutilization issue is addressed, assuring appropriate reimbursement for health care providers and facilities is paramount for an efficient and effective workers' compensation system. OIEC's overarching concern is that health care facilities are appropriately paid so that there are simply enough health care facilities in Texas to service workers' compensation patients and that injured employees will have access to quality medical treatment without having to undergo unnecessary and burdensome travel to receive appropriate health care.

OIEC thanks you for inviting us to be to be a part of your rulemaking initiatives by including us in work groups and allowing the opportunity to provide comment prior to formal rule proposal. Please do not hesitate to contact me should you have any questions or if I can be of any assistance.

Sincerely,

Brian White  
Counsel for Policy Development



## MEMORANDUM

**DATE: October 5, 2006**

**TO: Commissioner Betts; Stan Strickland; and Norma Garcia**

**FROM: Brian White**

**RE: Public Comment on Proposed Disability Management Rules**

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The Office of Injured Employee Counsel (OIEC) thanks you for the opportunity to provide public comment on the proposed disability management rules, including both the treatment and return to work guidelines. OIEC commends the Texas Department of Insurance, Division of Workers' Compensation (DWC) in developing a set of rules that provide for enhanced communication between system participants at the ultimate benefit of assuring that the injured employees of Texas receive prompt and appropriate health care.

OIEC thanks DWC staff in their hard work and careful consideration of public comment. OIEC believes the return to work guidelines are a tool to be used by physicians in rendering opinions based on their medical judgment, not a tool to be used by lay persons in making disability determinations. Accordingly, OIEC supports §137.10(e), which states, "An insurance carrier may not use the Division return to work guidelines as justification for reducing or denying income benefits to an injured employee." OIEC believes this necessary provision that was incorporated since the preproposal draft provides for a balanced system in which return to work guidelines are used as a communication tool providing system participants with average disability durations. OIEC supports this provision that prevents the return to work guidelines from being used as a justification to reduce or deny injured employees income benefits in any part of the workers' compensation system, including the indemnity dispute resolution process.

OIEC also supports and recommends adoption of DWC's selection of both the *Official Disability Guidelines* and *Medical Disability Advisor* as the adopted treatment and return to work guidelines in the Texas Workers' Compensation System. However, OIEC has one recommended change regarding §137.300(d) concerning treatment guidelines. Subsection (d) and (f) provide that a health care provider may submit a treatment plan for treatments and services that fall *within* the treatment guidelines in order to assure payment and avoid retrospective review on the issue of medical necessity. OIEC believes that this provision is contrary to legislative intent. OIEC believes that the rationale behind HB 7's requirement (Texas Labor Code §413.011) that DWC adopt a treatment guideline was to provide the workers' compensation system with a communication tool whereby both health care providers and insurance carriers would have a mutual understanding that health care provided *within* the guidelines is considered appropriate and medically necessary. As such, both the administrative burden and certainty of payment problems that haunt health care providers participating in the workers' compensation system and



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that have driven so many of Texas' physicians out of the system would be significantly reduced. OIEC is concerned that if §137.300 is adopted as currently written, with the inclusion of subsection (d), health care providers would be forced to seek preauthorization of a treatment plan for every single patient they treated to assure payment for health care services rendered. In doing so, the administrative burden of processing a workers' compensation patient is only exacerbated, and injured employees cannot afford further depletion of qualified health care providers in our workers' compensation system. To introduce this administrative burden into the system is unacceptable in light of the fact that the carrier's ability to deny payment for treatment based on relatedness still exists. OIEC highly recommends the removal of these provisions so that all health care rendered within the treatment guidelines are considered reasonable and appropriate.

OIEC would again like to thank you and your staff for careful consideration of these comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE: October 20, 2006**

**TO: Jennifer Arhrens and Margaret Lazaretti**

**FROM: Brian White**

**RE: Workers' Compensation Health Care Network Rules**

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to provide comment on the Workers' Compensation Health Care Network (network) Rules relating to network coverage in metropolitan divisions and the accessibility and availability of health care services in such network service areas. OIEC supports the Texas Department of Insurance (TDI) in its efforts to assure the availability of health care services in networks and requests thoughtful consideration of the following comments on behalf of injured employees of Texas.

OIEC supports proposed amendments to §10.80(f) that provide that if a network chooses to establish a service area in an area designated as a Metropolitan division by the OMB, that service area may not encompass any portion of a contiguous Metropolitan division in order to meet access requirements. OIEC supports this modification of network rules to assure that each certified network has an adequate number of health care providers, including specialist, to service injured employees in the service area. Further, OIEC feels that by preventing networks from dividing up Metropolitan areas in their service area, all system participants will benefit from the positive impact of knowing whether a particular injured employee falls within the service area. This clarification may also be helpful to TDI's enforcement of networks' requirements to provide appropriate health care to injured employees that fall within their service area.

With regard to TDI's request for comment regarding rural and non-rural mileage requirements for networks, OIEC supports TDI's efforts to get more networks certified that have a larger service area as long as there is sufficient health care services available in such service areas. In TDI's effort to retrieve further network penetration throughout the State, TDI may inadvertently cause more injured employees to travel more to get appropriate medical attention. By reclassifying counties from non-rural to rural, more injured employees will be forced to travel the maximum of 60 miles (for rural) as opposed to 30 miles (for nonrural) to obtain health care from a treating doctor or emergency care from a hospital. This may pose additional burdens on injured employees who cannot travel due to their work-related injury. OIEC cordially requests that TDI consider a solution via rule development for those injured employees that find it painful to travel. This issue is particularly exacerbated by this proposed increase in travel requirements for injured employees.



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In considering various approaches to restructure the rural and non-rural mileage requirements, OIEC supports option (a) to determine the population based on the United States Census Bureau. While option (a) also suggests determining the population based on the number of workers in a particular county, OIEC believes mileage requirements should be based on the total census population for two reasons. First, OIEC believes it was the legislative intent of §1305.004(a)(22) to define “rural” as to the population (not workforce) based on the United States Census Bureau (not the Department of Labor) [note §1305.004(a)(22)(B)]. Second, TDI may be better served by basing network certification on population as opposed to workforce. This is particularly true for counties where the population of minors or children is large. As the population of minors mature, the county may see an increase in the number of individuals participating in the workforce, as Texas has seen in its southern counties.

OIEC believes basing mileage requirements on option (b) or (c) is less attractive. In regard to option (b), basing network service area requirements on drive time may be too subjective and is subject to change. Depending on the time of travel or change in Texas’ roadway infrastructure, drive time can vary drastically. In regard to option (c), census blocks appear to be unnecessarily complex and may divide areas without regard to roadways or city blocks. Both options (b) and (c) appear less attractive because they are more technical and difficult for networks to comply with mileage requirements based on these methods.

OIEC thanks you for the opportunity to provide comment on the proposed changes to the network rules and commends TDI’s efforts in refining the network certification process. Please do not hesitate to contact me should you have any questions or if I can be of any assistance.

Sincerely,

Brian White  
Counsel for Policy Development  
(512) 804-4186



## MEMORANDUM

**DATE:** May 10, 2007

**TO:** Norma Garcia; Stan Strickland; Patricia Gilbert

**FROM:** Brian White

**RE:** Rule 120.2 (relating to the Injured Employee's Rights and Responsibilities)

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The Office of Injured Employee Counsel (OIEC) has concerns regarding Rule 120.2 as currently drafted. Specifically, §120.2(d) provides that the employer is the responsible party for distributing the "Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System" (R&R). OIEC believes that the Texas Department of Insurance, Division of Workers' Compensation (DWC) should be the responsible party for distributing the R&R as the regulator of the workers' compensation system.

OIEC believes the R&R should be distributed by DWC for the following reasons:

1. House Bill (HB) 7's legislative intent and the mission of DWC as statutorily mandated in Texas Labor Code § 402.021 requires DWC to:
  - Minimize the likelihood of disputes and resolve them promptly and fairly when identified [TEX. LAB. CODE §402.021(b)(5)];
  - Effectively educate and clearly inform each person who participates in the system as a claimant, employer, insurance carrier, health care provider, or other participant of the person's rights and responsibilities under the system and how to appropriately interact with in the system [TEX. LAB. CODE §402.021(b)(8)];
  - Take maximum advantage of technological advances to provide the highest levels of service possible to system participants and to promote communication among system participants [TEX. LAB. CODE §402.021(b)(9)].
2. The employer is likely to be the workers' compensation stakeholder that is *least* equipped to ensure a proper and timely distribution of the R&R. This factor may be further exacerbated by:
  - a small employer that does not have the business process to properly distribute the document (e.g. most employers have the carrier file the notice of injury due to limited business processes and general lack of knowledge about workers' compensation laws and rules);
  - an employer's potential adversarial relationship with the injured employee;
  - PEOs and staff leasing company's participation in the workers' compensation system, which often makes it difficult for even the employee to determine their true employer; and



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- DWC's limited ability to assure distribution of the R&R with a decentralized distribution process (as opposed to a centralized distribution center). This is further complicated by employers oscillating between subscriber and non-subscriber status in Texas.
3. The R&R is the only document that informs the injured employees of Texas about the existence of OIEC as a state agency to assist, educate, and advocate on behalf of injured employees. Failure to ensure proper distribution of the R&R is contrary to Texas Labor Code §402.022(b), is likely to harm injured employees, and may unnecessarily limit OIEC's ability to reach and assist injured employees. Should DWC not feel that the distribution of the R&R is appropriate under its regulatory umbrella and is not considered appropriate materials to make available to the public as required by Texas Labor Code §402.022(b), OIEC believes it may be a more appropriate entity, as a state agency, to distribute the document than employers in the workers' compensation system.
  4. One of OIEC's performance measures is the number of injured employees educated regarding the R&R. Should DWC rely on the employers to distribute the R&R and without DWC's distribution of the R&R in the DWC 41 packet, OIEC will have no viable method to calculate the number of R&R sent to the injured employees of Texas.

Thank you in advance for keeping open communications with OIEC in an effort to keep injured employees properly educated regarding their rights and responsibilities in the workers' compensation system. Please do not hesitate to contact me if I can be of further assistance.



## MEMORANDUM

**DATE:** June 21, 2007

**TO:** Teresa Carney

**FROM:** Brian White

**RE:** Performance Based Oversight/Preproposal Comment

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The Office of Injured Employee Counsel (OIEC) thanks you for the opportunity to provide feedback on the informal draft performance-based oversight rule. OIEC has the following suggestions:

1. **§180.XX(a)(3):** OIEC recommends moving the definitions section to the beginning of subsection (a). This will provide the reader with necessary definitions for the section prior to reading the substantive portions of the section. Moving the definitions to the beginning of the section to increase reader comprehension is also consistent with prior Texas Department of Insurance (TDI) and Division of Workers' Compensation (DWC) rulemaking initiatives.
2. **§180.XX(a)(2):** OIEC believes this paragraph is unnecessary and suggests it be deleted. It is duplicative of §180.XX(a).
3. **§180.XX(e):** OIEC suggests providing additional clarity when formally proposing this rule regarding which incentives apply to a particular tier. Texas Labor Code §402.075(e) provides that the division *by rule* shall develop incentives *within each tier* under Subsection (d) that promote greater overall compliance and performance.” (*Emphasis added*). Do all incentives apply to each tier? Also, OIEC believes that the above-referenced statute requires the Commissioner to identify all incentives by rule. As such, OIEC recommends removing “but not limited to” language in §180.XX(e). Failure to identify all incentives as required by statute in the performance-based oversight rule may be seen as subjective or unfair as the Commissioner may offer a system participant an incentive not specifically listed in the rule text.
4. **§180.XX(g):** OIEC recommends the following addition (as underlined below) to provide clarity:  
“If the Commissioner finds that an insurance carrier’s or health care provider’s overall compliance no longer supports a high or average tier designation, the Commissioner may conduct a re-assessment and assign a new tier designation before the biennial date. A re-assessment may be based on, but is not limited to the following factors. . .” 28 TAC §180.XX(g) (draft rule).



5. **§180.XX(g)(2):** OIEC recommends removing the word “confirmed” because it unnecessarily limits the regulatory action DWC is able to take. The term, “confirmed,” is vague and may be used against DWC in the future by a system participant to prevent a re-assessment. For example, a “confirmed” fraudulent activity may be heard in district court. If the district court issues an opinion stating a fraudulent activity did in fact occur, is the fraudulent activity really “confirmed”? What if the system participant appeals the issue to the court of appeals? Is it a “confirmed” activity after the court of appeals issues a decision? Or is it at the Supreme Court level? OIEC believes the term “confirmed” is unnecessary and requests its removal.
6. **Complaint data:** OIEC recommends including the term “complaint data” in §180.XX(g)(3) to more effectively comply with Texas Labor Code §402.075(c), which states:

“The division shall examine overall compliance records and dispute resolution *and complaint resolution practices* to identify insurance carriers and health care providers who adversely impact the workers’ compensation system and who may require enhanced regulatory oversight.” (*Emphasis added*). TEX. LAB. CODE §402.075(c).

OIEC believes the complaints both directly received by DWC and referred from OIEC may be important indicators of compliance. Complaint data that reveals a high volume of complaints on a particular health care provider or insurance carrier should trigger a re-assessment of that particular system participant.

Thank you again for the opportunity to provide comment on this informal rule initiative. Please do not hesitate to contact me if you have any questions or if I can be of assistance.



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NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** July 16, 2007

**TO:** Norma Garcia and Stan Strickland

**FROM:** Brian White

**RE:** §120.2 Employer's First Report of Injury and  
Notice of Injured Employee Rights and Responsibilities

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The Office of Injured Employee Counsel (OIEC) recommends the adoption of 28 TAC §120.2 as proposed in the *Texas Register* on June 29, 2007. OIEC appreciates the opportunity to provide comment on §120.2.



## MEMORANDUM

**DATE: July 25, 2007** **DRAFT: NEEDS TO BE SUBSTANTIALLY REVISED**

**TO: Norma Garcia**

**FROM: Brian White**

**RE: PRME (§134.650) and Treatment Guideline (§137.300) Repeals**

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to provide public comment on the repeals of §134.650 and §137.300.

OIEC understands that since publication of the adopted disability management rules, workers' compensation system participants have expressed the need for additional time to establish systems and processes to appropriately address required treatment planning. And while OIEC agrees that additional time may be needed for the Texas Department of Insurance, Division of Workers' Compensation (DWC) to work further with system participants to develop required treatment planning guidelines that effectively achieve the goals and intent of the Legislature in Labor Code §413.011, OIEC is concerned that DWC's effective repeal of §134.650 regarding the Prospective Review of Medical Care on June 18, 2007 with no formal repeal publication in the *Texas Register* as required by Chapter 2001 of the Texas Government Code is likely to provide a barrier for necessary medical care for injured employees.

OIEC believes that formal rulemaking procedures in accordance with Chapter 2001 of the Texas Government Code, which provide certain notice requirements with the Secretary of State via the *Texas Register* allow workers' compensation stakeholders to communicate to DWC the ramifications of a particular rulemaking action. In this instance, DWC has implemented both treatment and return to work guidelines on May 1, 2007. Approximately six weeks later, DWC announced that on June 18, 2007, PRME requests pursuant to §134.650 would no longer be accepted. This action effectively repeals the §134.650 without satisfying the rulemaking requirements of Chapter 2001 of the Government Code, and comes almost six weeks after DWC's adopted guidelines are effective.

OIEC has concerns over the simultaneous repeal of §§134.650 and 137.300. OIEC believes the repeal of §134.650 will substantially limit an injured employee's access to medical care, specifically prescription medications. OIEC has met several times with DWC's executive management to seek input on how injured employees would receive medically necessary prescriptions in light of the dual repeal of §§134.650 and 137.300. OIEC has not received a satisfactory answer to date, which is of great concern to both OIEC and the injured employees of Texas.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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OIEC is hopeful that the following example will elucidate the issue: An injured employee is in need of appropriate medical attention to get well and back to work. The injured employee visits his treating doctor who prescribes A, B, and C medications. B medication is only to be taken after A medication is completed. The first issue is that the treating doctor is likely to be unaware of which medications need to be preauthorized due to the repeal of §137.300, ambiguity within the treatment guidelines, and a lack of an adopted closed formulary as required by HB 7. The second issue is that the treating doctor is likely not to know what an acceptable duration of medication is appropriate because the treatment guidelines DWC adopted do not speak to duration. While DWC has communicated to OIEC that duration of medication is determined by referring to the *Official Disability Guidelines* (ODG) return to work pathways and add 30 days for acute treatment, DWC has yet to communicate this necessary information to other system participants, including physicians and insurance carriers despite that the treatment guidelines have been in effect almost four months. Further, DWC's educational information and rule adoption preamble specifically exclude system participants from referring to ODG's return to work pathways. It is likely that confusion will result from DWC's explanation to OIEC that directly conflicts with DWC's disability management educational information. In addition, this formula to determine the appropriate duration of prescription medication is nowhere in either of DWC's guidelines.

The second issue is that physicians in the workers' compensation system are not reimbursed for prescription medications. This becomes an issue when the treating doctor seeks preauthorization for prescriptions, and the insurance carrier denies preauthorization. DWC's position is that the injured employee should return to his treating doctor to enter medical dispute resolution. However, DWC's adopted treatment guideline requires preauthorization for the injured employee to make an additional office visit to resolve this issue. What happens if the carrier denies preauthorization to clarify the issue? Rule 134.650 would normally be used to resolve this issue to assure injured employees receive necessary prescriptions. However, with the simultaneous repeal of this §134.650, injured employees are left injured, out of work, and without necessary medical attention to get well and back to work.



## MEMORANDUM

**DATE: July 26, 2007**

**TO: Norma Garcia**

**FROM: Brian White**

**RE: Treatment Planning (§137.300) Repeal**

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to provide public comment on the repeal of §137.300 regarding treatment planning.

OIEC understands that since publication of the adopted disability management rules, workers' compensation system participants have expressed the need for additional time to establish systems and processes to appropriately address required treatment planning. And while OIEC agrees that additional time may be needed for the Texas Department of Insurance, Division of Workers' Compensation (DWC) to work further with system participants to develop required treatment planning guidelines that effectively achieve the goals and intent of the Texas Legislature in Labor Code §413.011, OIEC remains concerned with the implementation of disability management.

With the repeal of treatment planning, OIEC is concerned with the unanticipated consequences of having both the treatment and return to work guidelines in effect without having a systematic communication tool where a treating doctor can outline and obtain preauthorization for an injured employee's course of treatment. OIEC believes the repeal of treatment planning at this time is likely to result in an ineffective, piecemeal approach to providing injured employees necessary medical care. Without a tool to trigger communication between the health care provider and the insurance carrier, OIEC believes that miscommunication is likely to occur whereby some medical treatments and services that are an integral part of the course of treatment are approved while other treatments and services are denied. If this scenario were to occur, the overall effectiveness of the treating doctor's proposed treatment would be significantly undermined.

The repeal of treatment planning §137.300 is likely to force a large majority of individual medical treatment and services through preauthorization without context of the entire scope/series of medical treatment recommended by the treating doctor. OIEC believes that a large number of services will be denied and individual treatments will be forced to into the preauthorization process as a result of the repeal of §137.300. In effect, OIEC believes that the large increase in services undergoing preauthorization will positively correlate with an increase in administrative burdens health care providers will undergo trying to obtain approval for appropriate medical care for injured employees. For those injured employees that do not give up



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on their pursuit of medical treatment in the workers' compensation system, the result is likely to be an increase in medical dispute resolution (MDR) disputes, which only further compounds delays in delivery of necessary medical care.

OIEC suggests leaving §137.300 in place until an alternative treatment planning rule can be proposed. OIEC believes this will encourage system participant communication and help system participants work toward the full implementation the goals and intent of the Legislature in Labor Code §413.011.

As formally relayed to DWC in OIEC's informal comments regarding disability management on March 31, 2006, OIEC remains concerned with the piecemeal adoption of disability management rules. OIEC recommends the adoption of all five parts of disability management (treatment planning, treatment guidelines, return to work guidelines, treatment protocols, and case management rules) with an extended effective date (perhaps one year) to allow system participants the opportunity to make business process improvements to fully implement disability management. OIEC believes that this method of implementing disability management allow for system participants to fully understand the goals and objectives of disability management and DWC to receive informed and constructive feedback in order to develop a disability management system that satisfies those goals and objectives.

Please do not hesitate to contact me should you have any questions or if I can be of further assistance. Thank you.



## MEMORANDUM

**DATE:** August 8, 2007  
**TO:** Norma Garcia  
**FROM:** Brian White  
**RE:** 28 TAC §§134.1, 134.203, 134.204 concerning Medical Fee Guidelines

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On behalf of the injured employees of Texas, the Office of Injured Employee Counsel (OIEC) requests your consideration of the following comments regarding the revision of Medical Fee Guidelines (MFG) in the workers' compensation system. OIEC's comments have been divided into two parts: specific text recommendations and general recommendations. This format is used in an effort to provide helpful feedback to DWC in this rulemaking initiative.

### **Text Recommendations:**

1. §134.203(a)(7): OIEC recommends posting Independent Review Organization (IRO) decisions on the agency's website to communicate to the injured employee and other system participants the IRO's findings. However, injured employee's claimant information should be held confidential as required by Texas Labor Code §402.083. OIEC believes that communicating the IRO's findings will be vital to OIEC as it provides assistance to injured employees in medical dispute resolution as a result of House Bill (HB) 724, 80<sup>th</sup> Texas Legislature, Regular Session, 2007.
  - *Rule text recommendation:*  
§134.203(a)(7): Specific provisions contained the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program, including but not limited to timed procedures and other limitations. Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to Medical Dispute Resolution by an Independent Review Organization), which are made on a case-by-case basis shall be documented and posted to the Division's website and shall take precedence in that case only over any Division rules and Medicare payment policies.
2. §134.1(d) - (f), §134.203(f) and (g), and §134.204(c): OIEC asserts that Texas Labor Code §413.011 contemplates that the Commissioner of Workers' Compensation will adopt reimbursement methodologies and not delegate such action to a single system participant. Failure to adequately provide regulatory direction beyond the Center for Medicare and Medicaid Services (CMS) reimbursement methodology is likely to result in



a substantial number of medical fee disputes. OIEC believes medical fee disputes are a factor that substantially contributes to health care providers dissatisfaction with the workers' compensation system. As health care providers grow dissatisfied and leave the system, OIEC is concerned that the current access to care issues for injured employees will likely be compounded if more health care providers leave or choose not to participate in the system.

- *Rule text recommendation:*

§134.1(d): Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:

- (1) the Division's fee guidelines; or
- (2) a negotiated contract~~;~~~~or~~
- (3) ~~in the absence of an applicable fee guideline, a fair and reasonable reimbursement amount as specified in subsection (e) of this section].~~

§134.1(e) and (f): Delete subsections.

§134.203(f): for products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid, or the Division, the Commissioner ~~[carrier]~~ shall designate a single~~[- nationally recognized, and published]~~ relative value system (RVS) that will be used ~~[by the carrier to establish a relative value unit or payment. The carrier's designated RVS will be posted on the Division's website].~~

§134.203(g) and §134.204(c): When there is no negotiated or contracted amount that complies with §413.011 of the Labor Code, reimbursement shall be the least of the:

- (1) maximum allowable reimbursement (MAR) amount;
- (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount~~;~~~~or~~
- ~~(3) fair and reasonable amount consistent with the standards of §134.1 of this title (relating to Medical Reimbursement)].~~

### **General Recommendations:**

In addition to the specific text recommendations above, OIEC requests your consideration of the following when adopting a MFG:

1. Access to Care:

OIEC is concerned about the lack of participating health care providers in the workers' compensation system that service injured employees. When determining appropriate reimbursement for physician medical care in the workers' compensation system, OIEC recommends examining the issue of access to care within the system. OIEC believes that to adequately measure access to care, one should examine whether or not patients can seek and find health care providers within a reasonable geographical area and not the number of physicians registered to provide care on the Approved Doctor List (ADL).



According to Texas Medical Association's 2002 Biennial Survey, overall workers' compensation patient access to care was very poor with only 46% of physicians openly accepting all workers' compensation patients compared to:

- 49% for Medicaid,
- 74% for Medicare, and
- 83% for patients covered by PPO plans.

Further, when injured employees cannot find a treating physician in their geographical area, patients are forced to seek medical treatment at local health care facilities for non-emergency care. Non-emergency medical care provided in hospitals is more costly than outpatient visits with a treating physician. This additional, unnecessary cost is passed to insurance carriers that may, in return, pass costs to participating employers, who may leave the workers' compensation system due increasing premium cost.

OIEC believes that a MFG increase is needed to bring more physicians back to a complex workers' compensation system and to assure injured employees receive first-rate health care that is deserved. Further, OIEC believes that there should be no distinction in terms of access to care between group health and workers' compensation health care models. As such, OIEC encourages the DWC to adopt a MFG that reimburses physicians at a similar rate that is paid in group health or other commercial insurance plans.

### 2. Administrative Burdens and Additional Provider Duties:

OIEC requests that physicians in Texas be paid at least the national average or 155% of Medicare for Evaluation and Management codes and 190% of Medicare for Surgical codes. See WCRI's 42 state report, "Benchmarks for Designing Workers' Compensation Medical Fee Schedules." The conversion factors provided in §134.203(c) expressed in dollars (e.g. \$51.90, \$65.15) adjust to approximately 137% of Medicare for Evaluation and Management codes and 172% of Medicare for Surgical codes. While OIEC believes that this figure is a good start for discussion purposes, it does not compensate physicians for the additional administrative hassles and burdens inherent in the workers' compensation system, such as seeking preauthorization for services, prescribing medical services in accordance with DWC-adopted treatment guidelines, reporting requirements, return to work efforts, and compensability issues which are non-existent in Medicare or other commercial plans. These supplemental demands may require additional staff to manage the DWC's reporting requirements and return to work efforts.

### 3. Incentive Payment for Underserved Areas:

Rule 134.204(b)(3) provides and OIEC supports a 10% incentive payment to be added to the maximum allowable reimbursement (MAR) for areas underserved by health care providers. The Center for Medicare and Medicaid Services (CMS) designates areas that are underserved using the Medicare Health Professional Shortage Area (HPSA) designation. In accordance with the methodology set forth in Summary of the Informal Working Draft Rule Proposal for MFG, there are approximately 452 zip codes with the HPSA designation. In determining the Workers' Compensation Shortage Areas (WCSA), DWC excluded the 452 zip codes with the HPSA designation from the total 2,198 zip codes in Texas. OIEC believes that such action is



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contrary to DWC's efforts to encourage provider participation by offering a 10% incentive to any zip code that is underserved by health care providers.

DWC's criteria for establishing WCSA is:

- A non-HPSA designated zip code;
- A zip code where there was at least one approved case-by-case exception; and
- A zip code where there is no ADL provider.

OIEC believes that HPSA designated areas should be included, not excluded, as criteria for establishing WCSA. OIEC understands that DWC has examined the HPSA and believes that most physicians in these areas are not serving or are not the type of physicians that would service workers' compensation patients. However, OIEC asserts that the entire purpose of offering the incentive is to encourage physicians in these areas to start participating and treating workers' compensation patients. In addition, if the assumption is correct that most physicians in the HPSA zip codes will not participate in the workers' compensation system then the cost of offering the incentive in a larger geographical area would be minimal. Therefore, OIEC believes that including the HPSA designated zip codes in the WCSA is more consistent with DWC's objective than excluding those areas designated by CMS.

OIEC appreciates the opportunity to provide feedback on this important rulemaking initiative. Please do not hesitate to contact me if I can be of assistance or answer any questions.



## MEMORANDUM

**DATE:** October 17, 2007

**TO:** Norma Garcia and Rule Team

**FROM:** Brian White

**RE:** Informal Draft Medical Dispute Resolution Rules;  
§§133.305, 133.307, & 133.308

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to provide the following feedback the Division of Workers' Compensation's (DWC) draft §§ 133.305, 133.307, and 133.308, which implement House Bill (HB) 724:

**1. §133.305:**

- Page 2, Line 2: OIEC suggests the following language: "The dispute is resolved by the Texas Department of Insurance, Division of Workers' Compensation (Division) pursuant to. . ."

**2. §133.307:**

- Page 5, Line 10: OIEC recommends the following language to capture all disputes pending at DWC: "pending at any stage of the MDR process on September 1, 2007.
- Page 6: OIEC recommends adding a statement on how to obtain a DWC-60, similar to §133.308(h) (Page 23, Lines 15-20) on obtaining the Texas Department of Insurance's (TDI) form for requesting an IRO.
- Page 15, Lines 3 and 5: OIEC requests the term "calendar" (as opposed to business days) be inserted after "14" and before "days" to clarify the time period to request additional information. OIEC believes this addition will reduce system participant confusion.
- Page 15, Lines 18-19: Paragraph (C) uses reconsideration as a trigger for dismissal. This is in direct conflict with §133.270(f), which does not require an injured employee to seek reconsideration for reimbursement for health care services paid by the injured employee.
- Page 17, Lines 1-5: OIEC recommends amending subsection (f) in order not to unnecessarily limit the Commissioner of Workers' Compensation's authority to correct clerical errors pursuant to Labor Code §402.00128(b)(11). OIEC believes subsection (f) as currently written is too narrow. OIEC believes some issues may arise whereby the Commissioner of Workers' Compensation may wish to correct a substantive issue (e.g. IRO mixed up several injured employees medical records and issues a substantively incorrect decision). OIEC recommends the following revisions:



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(f). Letter of Clerical Correction. Upon receipt of a MDR decision, either party may request a clerical correction of an error in a decision, which is subject to only the Division's approval. ~~[Clerical errors are non-substantive and include but are not limited to typographical or mathematical calculation errors. Only the Division can determine if a clerical correction is required.]~~ A request for clerical correction does not alter the deadlines for appeal.

- Page 17, Lines 15-21: OIEC recommends that subsection (g) provide requirements for parties to exchange evidence. There are no exchange requirements referenced in the medical dispute resolution rules. Section 133.307(g)(1) provides that hearings shall be conducted in accordance with Chapters 140 and 142 of the Texas Administrative Code, Title 28. However, §142.13(c)(1) provides for parties to exchange evidence no later than 15 days after the benefit review conference (BRC), and HB 724 specifically provides that a medical dispute resolution hearing shall not be preceded by a BRC. Specifically, if the trigger for the exchange requirement is a BRC and there is no BRC in medical dispute resolution, then there simply is no exchange requirement before the hearing. OIEC believes exchange requirements are necessary for parties to be prepared and to have an efficient and complete contested case hearing.
- Page 18, Lines 13-14: OIEC recommends the following text changes to comply with HB 724 and the bifurcation of jurisdiction based on the amount in controversy. Also, DWC does not prescribe the manner in which judicial review is sought; it's statutory pursuant to the Labor Code §413.0311.

(h) Judicial Review. A party to a medical fee dispute who has exhausted all administrative remedies may seek judicial review of the Division's or SOAH's decision pursuant to Labor Code § 413.0311.

- Page 18, Line 15: OIEC recommends leaving the language inserting "Travis County" as the venue for seeking judicial review for clarification. Specifying the location and time frame for appeal to judicial review, when appropriate, provides clear communication to parties and reduces confusion. Such clarification in the rule text is believed to reduce inquiries to both DWC and OIEC.
- Page 19, Lines 13-16: OIEC recommends waiving the costs DWC has incurred to prepare the certified record for those injured employees financially unable to afford the cost to obtain a certified record. OIEC suggests that DWC consider an in forma pauperis (IFP) policy as not to unjustly deny injured employees their right to access the court system based on financial limitations.

### 3. §133.308:

- Page 20: OIEC *strongly* recommends limiting an insurance carrier's ability to raise new disputes after entering MDR for medical necessity. OIEC believes it is unreasonable for insurance carriers to dispute a claim for a particular issue (e.g. extent of injury) and then assert another reason for the dispute (e.g. compensability) in the middle of the MDR process. New denial reasons and defenses are limited for MDR fee disputes as currently drafted in accordance with §133.307(d)(2)(B) (Lines 13 and 14). OIEC suggests the addition of this idea in MDR for medical necessity. This may be accomplished by adding the following text in §133.308: "Any new denial reasons or defenses raised shall not be considered in review." Authorizing



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- parties to raise new denial reasons delays injured employees from receiving necessary medical care as well as receiving prompt resolution to the dispute.
- Page 21, Line 1: OIEC recommends the following text addition in order to capture all pending disputes in accordance with HB 724:
    - (A) pending at any MDR stage on September 1, 2007.
  - Page 21: OIEC recommends requiring IRO decisions to state the health care provider's professional license number. Noting the Texas license number on the IRO will assist in ensuring compliance with the requirements of HB 1003 and HB 1006 that all health care providers be professionally licensed in Texas.
  - Page 22, Lines 4-5: OIEC recommends clarifying "qualified by education, training, and experience" instead of parroting the statute. Does this provision mean that only an orthopedic surgeon can review another orthopedic surgeon? OIEC requests that DWC provide clarification to the issue of whether it is sufficient that the reviewing health care provider has the same licensure as the health care provider being reviewed or if the reviewer is actually required to perform the health care being reviewed as a part of his or her practice.
  - Page 23, Lines 10-12: OIEC suggests striking paragraph (B) and replacing it with the text provided on page 23, lines 4-5 for consistency.
  - Page 24, Line 5: OIEC suggests striking the term "immediately" and replacing it with a specific time frame. The term "immediately" is subjective and unenforceable. Carriers should be given a specific time frame for notifying TDI upon receipt of request for an independent review.
  - Page 26, Lines 3-6: OIEC recommends requiring the carrier to send a copy of the information provided to the IRO to the other party. This allows the opposing party to supplement and provide all necessary medical records to the IRO for a complete and accurate independent review. OIEC believes this change will make the independent review process more meaningful. OIEC suggests the following text addition:
    - (1) Carrier Document Submission. The carrier or the carrier's URA shall submit the documentation required in paragraphs 1-6 of this subsection to the IRO not later than the third business [working] day after the date the carrier receives the notice of IRO assignment and supply the other party with a copy of the submission.
  - Page 27, Lines 1-2: (1) The party or providers with relevant records shall deliver the requested information to the IRO as directed by the IRO and provide a copy to the other party.
  - Page 33, Lines 3-7: OIEC notes that it may be extremely difficult (if not impossible) to obtain evidence-based medical evidence to establish that an injured employee is an outlier. Evidence-based medical evidence provides the typical or medical norm. Finding evidence-based medical evidence to establish an injured employee's need for the recommended care may be extremely difficult. If the term "evidence-based" were removed from page 33, line 6, the standard for overcoming the IRO would be consistent with the standard for overcoming a DD's opinion.
  - Page 33, Line 16: A typographical error may be corrected in the following manner:
    - (i) The appeal must be filed no later than 20 days from the date the ~~[party the date the]~~ IRO decision is sent to the appealing party.



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- Page 35, Lines 15-19: OIEC recommends allowing the other party an opportunity to respond to a letter of clarification.
- Page 36: OIEC recommends striking subsection (v). Limiting the evidence parties may submit into evidence is analogous to a paper review, which has been held unconstitutional. In order to provide adequate due process, parties should be allowed their day in court and to submit additional evidence. Providing new evidence at this stage of MDR supports the goal of having the injured employee receive necessary and appropriate medical care. Once one limits the admissibility of new evidence, the contested case hearing becomes meaningless as it is simply a review of whether the IRO decision is correct (regardless of whether all necessary information was given to the IRO in the first place). Further, the insurance carrier or only one of the parties is providing the IRO with the information to review. Denying the other party or the injured employee an opportunity to provide additional evidence beyond what the IRO reviewed raises serious due process concerns. Instead of determining whether the IRO decision is correct based on the information that IRO had to review, a medical necessity dispute ought to be focused on making a determination of whether the proposed healthcare is necessary and appropriate based on a full review of all relevant evidence.
- Page 37, Line 10: OIEC recommends providing clarification to the appeal standard set forth in Subchapter G, Chapter 2001, Government Code. Injured employees are not likely to have access to the Government Code. OIEC believes it is DWC's responsibility to clearly establish the time frame and venue of appeal throughout the MDR rules. This may be accomplished in this instance by the following text addition:
  - (vi) A party who has exhausted all of its applicable administrative remedies under this subparagraph and who is aggrieved by a final decision of the hearing officer may see judicial review of the decision by filing an appeal in Travis County District Court within 30 days [in the form and manner prescribed by the Division]. Judicial review under this. . .
- Page 38, Lines 14-17: OIEC suggests considering an IFP policy as previously recommended for MDR fee disputes. Injured employees should not be denied access to due process and the courts because of financial limitations.
- Page 41, Line 3: OIEC recommends striking "Non-Network" because appeals for spinal surgery are the same regardless of network status.
- Page 41, Lines 19-21: OIEC recommends striking the term "health care provider" and replacing it with the term "requestor." Such an amendment allows injured employees to file a medical fee dispute request for out-of-pocket expenses and is consistent with §§133.305 and 133.307 as currently written.

Thank you for the opportunity to provide feedback on the MDR draft rules. Please do not hesitate to contact me if I can provide clarification on the above comments.



## MEMORANDUM

**DATE:** November 5, 2007

**TO:** Commissioner Betts, Norma Garcia, and Rule Team

**FROM:** Brian White

**RE:** 28 TAC §§134.1, 134.203, 134.204 concerning Medical Fee Guidelines

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On behalf of the injured employees of Texas, the Office of Injured Employee Counsel (OIEC) requests your consideration of the following comments regarding the revision of Medical Fee Guidelines (MFG) in the workers' compensation system. OIEC recommends that §§134.1, 134.203, and 134.204 be adopted as proposed with the following changes.

The Texas Department of Insurance, Division of Workers' Compensation's (DWC) proposed Professional Medical Fee Guideline Rules currently setting health care provider reimbursement fees at a conversion factor of \$52.93 for most service categories, including surgeries in a health care provider's office setting, and \$66.45 for surgeries performed in a health care facility. OIEC recommends a higher conversion factor of \$56.85 for most services and \$68.22 for surgeries regardless of setting for the following reasons.

### Access to Care:

OIEC is concerned about the lack of participating health care providers in the workers' compensation system that service injured employees and believes an increased health care reimbursement rate is the only incentive that will keep health care providers in and bring other health care providers back into the workers' compensation system. When determining appropriate reimbursement for physician medical care in the workers' compensation system, OIEC recommends examining the issue of access to care within the system. OIEC believes that to adequately measure access to care, one should examine whether or not patients can seek and find health care providers within a reasonable geographical area and not the number of physicians registered to provide care on the Approved Doctor List (ADL), which is an abolished, outdated list and has not been revised in the past few years. If a survey were completed that actually measured the number of health care providers that treat workers' compensation patients, OIEC believes that access to care issues in workers' compensation would become evident whereby many health care providers listed on the ADL are in actuality turning away workers' compensation patients.



According to Texas Medical Association's 2002 Biennial Survey, overall workers' compensation patient access to care was very poor with only 46% of physicians openly accepting all workers' compensation patients compared to:

- 49% for Medicaid,
- 74% for Medicare, and
- 83% for patients covered by PPO plans.

In Texas Medical Association's follow-up Biennial Survey in 2004, the percentage of physicians who would accept all new patients had declined to less than one-third for almost all specialties.

Further, when injured employees cannot find a treating physician in their geographical area, patients are forced to seek medical treatment at local health care facilities for non-emergency care. Non-emergency medical care provided in health care facilities/hospitals is more costly than outpatient visits with a treating physician. This additional, unnecessary cost is passed to insurance carriers that may, in return, pass costs to participating employers, who may leave the workers' compensation system due increasing premium costs.

Recognizing that health care provided in facilities is more costly, OIEC recommends that health care provider reimbursement for surgeries should not be dependent on setting. Health care providers should be encouraged to save costs when appropriate. Offering higher reimbursement for providers to conduct minor surgical procedures in health care facilities may unnecessarily increase costs to the workers' compensation system. OIEC believes that offering higher reimbursement rates for surgeries, regardless of setting, will allow health care providers to accept workers' compensation patients and treat them in the most medically appropriate setting.

OIEC believes that a MFG increase is needed to bring more physicians back to a complex workers' compensation system and to assure injured employees receive first-rate health care that is deserved. Further, OIEC believes that there should be no distinction in terms of access to care between group health and workers' compensation health care models. As such, OIEC encourages DWC to adopt a MFG that reimburses physicians at a similar rate that is paid in group health or other commercial insurance plans.

#### Administrative Burdens and Additional Provider Duties:

OIEC requests that physicians in Texas be paid close to the national average or 155% of Medicare for Evaluation and Management codes and 190% of Medicare for Surgical codes. See WCRI's 42 state report, "Benchmarks for Designing Workers' Compensation Medical Fee Schedules." The conversion factors provided in §§134.202 and 134.203 expressed in dollars (e.g. \$52.93, \$66.45) adjust to approximately 137% (140% with the Medicare Economic Index (MEI) adjustment) of Medicare for Evaluation and Management codes and 172% (175% with the MEI adjustment) of Medicare for Surgical codes. OIEC believes that this rate does not compensate physicians for the additional administrative hassles and burdens inherent in the workers' compensation system, such as:

- seeking preauthorization for services,



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- prescribing medical services in accordance with DWC-adopted treatment guidelines,
- numerous reporting requirements,
- return to work efforts and duties, and
- compensability issues, which are non-existent in Medicare or other commercial plans.

These supplemental demands may require additional staff to manage the DWC's reporting requirements and return to work efforts. In addition, DWC's proposed health care reimbursement rates are the same rates health care providers have been provided since August 2003 with simple MEI adjustments to reflect the increase in inflation. The rate of pay for providing care to an injured employee remains the same with an adjustment for inflation while the workers' compensation system has increased in terms of complexity (e.g. disability management), required health care duties, and reporting requirements. OIEC believes health care provider reimbursement rates need to be increased to encourage providers to accept workers' compensation patients who are currently being turned away in great numbers.

OIEC commends DWC in its efforts to provide additional compensation for treating doctors for new responsibilities as a result of disability management and the adoption of treatment and return to work guidelines. OIEC supports the concept of special carve outs or reimbursements for health care providers performing treating doctor duties in the workers' compensation system, such as filing DWC-73 Work Status Report. Further, OIEC recommends the adoption of §134.204(i) without changes and supports the idea of new modifiers that are associated with the expanded duties and important role of a designated doctor.

### Incentive Payment for Underserved Areas:

Rule 134.203(b)(2) provides and OIEC supports a 10% incentive payment to be added to the maximum allowable reimbursement (MAR) for areas underserved by health care providers. The Center for Medicare and Medicaid Services (CMS) designates areas that are underserved using the Medicare Health Professional Shortage Area (HPSA) designation. In accordance with the methodology set forth in the rule preamble, there are approximately 452 zip codes with the HPSA designation. In determining the Workers' Compensation Shortage Areas (WCSA), DWC excluded the 452 zip codes with the HPSA designation from the total 2,198 zip codes in Texas. OIEC believes that such action is contrary to DWC's efforts to encourage provider participation by offering a 10% incentive to any zip code that is underserved by health care providers.

DWC's criteria for establishing WCSA is:

- A non-HPSA designated zip code;
- A zip code where there was at least one approved case-by-case exception; and
- A zip code where there is no ADL provider.

OIEC believes that HPSA designated areas should be included, not excluded, as criteria for establishing WCSA. OIEC understands that DWC has examined the HPSA and believes that most physicians in these areas are not serving or are not the type of physicians that would service workers' compensation patients. However, OIEC asserts that the entire purpose of offering the incentive is to encourage physicians in these areas to start participating and treating workers'



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compensation patients. In addition, if the assumption is correct that most physicians in the HPSA zip codes will not participate in the workers' compensation system then the cost of offering the incentive in a larger geographical area would be minimal. Therefore, OIEC believes that including the HPSA designated zip codes in the WCSA is more consistent with DWC's objective to provide an incentive payment for areas underserved by health care providers than excluding those areas designated by CMS.

Further, DWC is basing its WCSA on the dated and no longer existent ADL. OIEC recommends using more current and reliable data to establish underserved areas. Additionally, OIEC suggests that WCSA areas be based on whether an injured employee has access to a health care provider and not on the number of available health care providers in that specific geographical region. The rationale behind this suggestion is simply that there may be many health care providers in a particular geographical area but such providers may not participate in the workers' compensation system due to the additional reporting requirements and limited reimbursement for services as discussed above.

OIEC appreciates the opportunity to provide feedback on this important rulemaking initiative on behalf of injured employees as a class. Please do not hesitate to contact me if I can be of assistance or answer any questions.



## MEMORANDUM

**DATE:** October 3, 2007

**TO:** Commissioner Albert Betts; Stan Strickland; Norma Garcia; Jaelene Fayhee; & Teresa Carney

**FROM:** Brian White

**RE:** Performance-Based Oversight/Proposed Rule 180.19

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to provide feedback on Rule 180.19 regarding Performance-Based Oversight (PBO) and recommends §180.19 be adopted as proposed (with no changes).

OIEC commends the Texas Department of Insurance, Division of Workers' Compensation (DWC) in its first PBO assessment and tiering pursuant to Labor Code §402.075. OIEC recommends that the current Bell-curve methodology continue to be used and requests DWC not to consider a target-based methodology as recently discussed at DWC's educational conference. OIEC believes that the Bell-curve methodology is easy for injured employees to understand and provides results more consistent with purpose of PBO, namely one-on-one comparison among system participants. Target methodology does not serve the same purpose of permitting meaningful performance comparison.

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

Please do not hesitate to contact me if I can be of assistance or provide clarification on the above comments. Thank you.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** November 26, 2007  
**TO:** Commissioner Betts and DWC Rule Team  
**FROM:** Brian White  
**RE:** Ambulatory Surgical Centers (ASCs); §134.402

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to provide public comment on behalf of the injured employees of Texas. OIEC recommends adoption of §134.402 as proposed without changes.

Current §134.402 provides for ASCs to be paid at 213.3% of the Medicare ASC reimbursement amount as well as requires surgical implantable devices to be reimbursed separately at the amount actually paid for the device by the ASC. OIEC understands that in the absence of adopting the amendments to §134.402, new Medicare rules relating to reimbursement for ASCs will cause significant increase in costs to the workers' compensation system. Further, the list of procedures eligible for payment under the Medicare ASC payment system will be greatly expanded.

OIEC supports the proposed amendments to §134.402 that extend the use of the current 2007 Medicare reimbursement methodology for services provided on or after January 1, 2008 through August 31, 2008. This action will maintain the status quo for a period of time to provide the Texas Department of Insurance, Division of Workers' Compensation (DWC) with an opportunity to thoroughly research Medicare's new reimbursement methodology so that it may be properly integrated into the workers' compensation system to satisfy the overall objective of providing appropriate reimbursement to ASCs for services. OIEC also supports the concept of examining this issue after the adoption of new §134.403 regarding Outpatient Hospital Facility Fee Guidelines. The establishment of that reimbursement structure will also provide useful information for establishing an appropriate reimbursement structure for ASC services.

Please do not hesitate to contact me should you have any questions. Thank you.



## MEMORANDUM

**DATE: November 8, 2007**

**TO: Norma Garcia and DWC Rule Team**

**FROM: Brian White**

**RE: Inpatient and Outpatient Hospital Fee Guidelines / §§134.403 and 134.404**

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the Texas Department of Insurance, Division of Workers' Compensation's (DWC) proposed inpatient and outpatient hospital fee guideline rule.

In accordance to Texas Labor Code §413.011, the Workers' Compensation Commissioner is required to promulgate health care reimbursement policies and guidelines that reflect standardized reimbursement structures found in other health care delivery systems with minimum modifications to meet occupational injury requirements. Further, to achieve such standardization, the DWC is required to adopt current reimbursement methodologies, models, and values or weights used by the Centers for Medicare and Medicaid Services and may deviate from Medicare policies where appropriate. OIEC understands the difficulty in undertaking this task.

OIEC commends DWC on obtaining various independent reports to base the proposed inpatient and outpatient hospital fee guidelines and recommends the adoption of §§134.403 and 134.404 without changes.

Please do not hesitate to contact me should you have any questions or if I can be of assistance.



## MEMORANDUM

**DATE:** December 19, 2007  
**TO:** Norma Garcia and DWC Rule Team  
**FROM:** Brian White  
**RE:** Rule Comments on 28 TAC §§137.41 and 137.49

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to provide public comment on Texas Department of Insurance, Division of Workers' Compensation (DWC) §§137.41 and 137.49 concerning an optional preauthorization plan for eligible small employers to return an injured employee back to work.

House Bill (HB) 886 and its amendments to the Return-to-Work Pilot Program for Small Employers provides small employers a process whereby workplace modifications can be approved prior to the employer incurring an out-of-pocket expenditure. OIEC believes the revision of the pilot program will provide a more certain prospect of obtaining reimbursement and may provide increased participation, which will aid in the return of injured employees back to work.

OIEC supports the adoption of §§137.41 and 137.49 as proposed with the following changes:

- Section 137.49(c) provides that "An incomplete proposal plan may be denied or returned to the employer for additional information." OIEC recommends that incomplete proposals should be returned to the employer with an explanation of deficiencies from DWC. This allows the employer to correct the deficiencies and resubmit the application with the ultimate goal to make workplace modifications to return an employee back to work. OIEC suggests that DWC should deny an application for incompleteness only after the employer received DWC's explanation of deficiencies and failed to correct those deficiencies upon resubmission. OIEC recommends the following text changes to implement this suggestion:
  - "An incomplete proposal plan shall ~~[may]~~ be ~~[denied or]~~ returned to the employer for additional information with an explanation of how or why the proposed plan is deficient or incomplete. An incomplete or deficient proposal plan may be denied upon resubmission to the Division.
- Rule 137.49(f) provides that in order to get reimbursement after the preauthorized modifications are completed the employer has to complete the Application for Reimbursement in Rule 137.46 that contains the information in Rule 137.47 (relating to the criteria for evaluation of applications). Thus, the employer that received preauthorization for a workplace modification is required to resubmit much of the same information in order to get reimbursed for the workplace modification, which represents



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NORMAN DARWIN, PUBLIC COUNSEL

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an unnecessary duplication of effort. In addition, the employer who has obtained preauthorization has to do exactly the same thing to obtain reimbursement as the employer who did not obtain preauthorization, which also seems to undermine the purpose and effectiveness of the preauthorization plan. OIEC recommends a simplified preauthorization process whereby eligible employers:

- propose a workplace modification with supporting documentation;
- are approved by DWC (or DWC offers a explanation of how the plan is deficient/incomplete and requests the employer to correct the deficiencies and resubmit the plan); and
- submit a certification to DWC stating that the workplace modification has been completed in accordance to the DWC-approved preauthorization plan and that the criteria of §137.47(1)(2) and (3) has been satisfied prior to receiving reimbursement.

Thank you for your careful consideration of OIEC's public comments on behalf of the injured employees of Texas. Please do not hesitate to contact me if you have any questions or if I can be of assistance.



## MEMORANDUM

**DATE:** January 14, 2008

**TO:** DWC Rule Team

**FROM:** Brian White

**RE:** Medical Dispute Resolution Rules; §§133.305, 133.307, and 133.308

The Office of Injured of Employee Counsel (OIEC) appreciates the opportunity to provide public comment on the Texas Department of Insurance, Division of Workers' Compensation's Medical Dispute Resolution (MDR) Rules, which implement House Bill (HB) 724 from the 80<sup>th</sup> Texas Legislature, 2007. OIEC requests the consideration of the following comments on behalf of the injured employees of Texas:

### §133.307. MDR of Fee Disputes.

1. Page 34; §133.307(d)(1): This paragraph provides that a response is deemed timely if received by the DWC within 14 calendar days after the date the respondent *received* the requestor's dispute. OIEC asserts that determining timeliness based on when documents are received is likely to become a disputed issue. OIEC recommends changing all time frames to a set time frame that DWC can actually verify should a dispute over timeliness arise (e.g. basing the time frame on when the documents are filed and not when received by the respondent).
2. Page 36; §133.307(d)(2)(B): OIEC supports the concept of prohibiting new issues and defenses from being raised subsequent to a filing of a response to a dispute. OIEC recommends the adoption of this paragraph without changes.
3. Page 37 - 38; §133.307(e)(1): OIEC recommends clarifying whether DWC must receive additional information 14 business or 14 calendar days after the receipt of the request.
4. Page 38; §133.307(e)(3)(C): Paragraph (C) uses reconsideration as a trigger for dismissal. This provision conflicts with §133.270(f), which does not require an injured employee to seek reconsideration for reimbursement for health care services paid by the injured employee. As such, dismissing a case from medical dispute resolution for failure to submit the dispute to the carrier for reconsideration would be improper.
5. Page 41; §133.307(f)(2)(B): This provision provides that appeals may be submitted at DWC's field offices. However, §133.308 provides that appeals for medical necessity disputes may only be sent to DWC's Chief Clerk. OIEC recommends consistency in the place and manner one files a dispute in both fee and medical necessity disputes by allowing injured employees to file disputes in local field offices, which may then be forwarded to DWC's Chief Clerk for processing.



6. Page 41; §133.307(f)(2)(D): OIEC recommends the removal of this provision, which limits parties to documentary evidence and witnesses disclosed in the medical fee dispute except on a showing of good cause. OIEC believes that by limiting evidence at this CCH, an injured employee will not have the opportunity to submit evidence in addition to the carrier's submission. OIEC believes that the rule as currently written deprives injured employees of due process and is contrary to both the *HCA Healthcare Corp. v. Texas Dept. of Ins. and Division of Workers' Compensation* (Cause No. D-1-GN-06-000176) decision and to the legislative intent of HB 724. OIEC believes that subsection (f)(2)(D) of proposed Rule 133.307 is contrary to the intent of the HB 724 to provide for an appeal proceeding that allows the parties to establish a record of review prior to proceeding to judicial review in a district court. OIEC does not see the purpose in limiting evidence at the CCH. It seems that the focus of the CCH should be on making the correct decision based on all relevant evidence whether it was submitted during the dispute or not.
7. Page 41; §133.307(f)(2)(F): OIEC recommends offering both the time frame and venue for appeal within the text of the rule. Many injured employees and other system participants do not have access to the Texas Government Code. Providing the 30-day time frame and Travis County venue in the text of the rule properly informs injured employees of their right to appeal.

### **§133.308. MDR by Independent Review Organizations.**

1. Page 46; §133.308(c): OIEC recommends that the subsection clarify that a Texas medical license is required to perform reviews of health care services by an Independent Review Organization (IRO). OIEC recommends adding the term "medicine" after "practice" to implement this change. OIEC believes §133.308(c) should include the requirement of a certification that the IRO doctor is licensed in Texas just as §133.308(e) requires a certification that there are no known conflicts of interest.
2. Page 46; §133.308(d): OIEC recommends the removal of the phrase "until further material recovery from or lasting improvement to the injury can no longer reasonably be anticipated." OIEC does not believe such a phrase concerning maximum medical improvement (MMI) is necessary nor is it related to professional specialty requirements in accordance with HB 2004. The above-referenced language is not derived or mandated by HB 2004, and OIEC believes it is unnecessary in defining professional specialty requirements. The requirement of Labor Code §408.0043 that the reviewer hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving was clearly intended to apply regardless of the point in time in the claim that the care is provided. To limit the requirement that the reviewer only to review of health care provided before MMI is contrary to the statute. In addition, OIEC believes that the legislative intent behind HB 2004 was to limit reviews of health care services to those health care providers with the same specialty. As such, OIEC recommends clarification in the rule text by adding the term "licensure" as a necessary requirement. As an alternative to this language, the rule should provide a definition of the phrase "hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving." Essentially,



the rule does not do anything except parrot the language of the statute, which should be clarified by rule. As it is drafted, OIEC believes that the rule does not provide sufficient guidance on what specialty a doctor is required to hold in any given case.

3. Page 47; §133.308(e): OIEC recommends requiring the IRO to send a certified statement that the reviewing physician is licensed to practice medicine in Texas. OIEC believes that requiring such a certification is helpful to TDI's monitoring efforts under subsection (f) of this rule as well as TDI's enforcement efforts.
4. Page 48; §133.308(i): OIEC recommends language be added to this subsection to correct the issue of carriers/URAs not forwarding a request for IRO because the carrier/URA believes the request is not timely. OIEC believes the issue of timeliness should be decided by TDI, the regulating entity, and not one of the parties of a dispute (i.e. the carrier/URA).
  - OIEC recommends the following text addition to implement this change: "The carrier shall notify the Department of a request for an independent review on the same day the request is received by the carrier or its URA regardless of whether the carrier or URA believes the request to be timely."
5. Page 49; §133.308(j)(5) and (6): OIEC believes clarity is needed within the rule text to assure dismissals are properly made by TDI.
  - OIEC recommends the following text additions:
    - (j)(5): "the Department determines the request for dispute resolution is untimely pursuant to subsection (i) of this section;"
    - (j)(6): "the Department determines the request for medical necessity dispute resolution was not submitted in compliance with the provisions of this subchapter or;"
6. Page 50; §133.308(l): OIEC strongly recommends a process whereby the carrier submits to the injured employee a list and *detailed* description of the medical records that the carrier submitted to the IRO for review. OIEC believes that by providing injured employees with a detailed listing of the information being filed with the IRO, carriers are not as likely to incur copy costs from health care providers when OIEC requests medical records for a contested case hearing (CCH) on medical issues. In addition, OIEC strongly recommends a process whereby the injured employee/health care provider has the opportunity to supplement the carrier's submission. OIEC asserts that the injured employee should be notified of the opportunity to supplement the carrier's submission when TDI notifies both parties of the IRO assignment. The notice should give injured employees a set time frame to supplement the information for IRO review. OIEC believes in order for the IRO review to be a meaningful administrative review, both parties (not just the carrier) must be able to submit information to the IRO for a decision. Limiting one party from submitting information for an independent review is a violation of due process, even with a process where a DWC hearing officer can request clarification from the IRO pursuant to §133.308(m). In a medical necessity dispute, the carrier and injured employee are adverse parties. OIEC believes that the information the carrier believes is relevant to the dispute is often different than the information the injured employee believes is relevant to the dispute. Accordingly, injured employees should be given the opportunity to supplement the carrier's submission to ensure a meaningful administrative review by the IRO.



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7. Page 53; §133.308(p)(1)(D): OIEC recommends requiring the IRO decision to include an affirmative statement that the reviewing physician holds a license to practice medicine in Texas. OIEC believes this will assist in TDI's compliance efforts of HB 1003 and HB 1006.
8. Page 53; §133.308(p)(1)(G)(ii): OIEC recommends requiring the IRO decision to affirmatively state the name of the treatment guideline within a network because each network may have a different treatment guideline than the one adopted by DWC. This provides the injured employee with necessary information should one choose to appeal the IRO decision.
9. Page 54; §133.308(p): In §133.307(d)(2)(B), the medical fee dispute resolution rule prohibits any new denial reasons or defenses from being raised once a requestor files a dispute. OIEC recommends that this same protection be given in the medical dispute resolution rules regarding medical necessity. OIEC believes that all parties should be required to assert issues for dispute early in the claim to achieve an earlier resolution of the dispute. Failing to limit carrier issues for dispute after one has requested resolution from TDI causes confusion in the dispute resolution process, unnecessarily requires additional use of State resources, and may be used as a tactic to delay medical care to the injured employee.
10. Page 57; §133.308(t)(1)(A): OIEC recommends this subparagraph should state the 20-day time frame to appeal an IRO decision. OIEC does not believe injured employees will have always have access to §148.3 and stating the time frame within the text properly informs injured employees of their ability to appeal a decision. OIEC believes inserting the time frame is also likely to reduce system participant confusion.
11. Page 57; §133.308(t): OIEC asserts that DWC has no statutory authority to state that an IRO decision carries presumptive weight nor that the presumptive weight is overcome by a preponderance of evidence-based medical evidence to the contrary. Neither the Labor Code nor the Insurance Code provides for a basis for assigning presumptive weight to the IRO's decision. Further, the statutes do not provide a requirement that evidence-based medicine must be presented to overcome the presumptive weight. As such, OIEC believes that the IRO decision should be treated like any other evidence that is submitted at a CCH: once the party challenging the IRO decision presents evidence contrary to that decision, the Hearing Officer has to consider all the evidence and decide where the preponderance of evidence lies. Finally, OIEC believes it may prove extremely difficult to find evidence-based medicine to establish that a particular injured employee is an outlier from the treatment guidelines, which are evidence-based. OIEC recommends the removal of the term "evidence-based" from this subsection because there is no statutory authority for its inclusion, and it establishes a standard of proof that is nearly impossible to meet.
12. Page 58; §133.308(t)(1)(B)(ii): OIEC recommends that the MDR rules assert a time frame to exchange information. OIEC believes this will assure that the exchange of information is made systematically and appeals are made in a timely fashion.
13. Page 59; §133.308(t)(1)(v): OIEC recommends the removal of this subsection. OIEC believes the legislative intent behind HB 724 was to give parties a meaningful administrative hearing respecting due process concerns. As currently written, the MDR rules have one party submitting information to the IRO (namely, the carrier) and then the rules limit the evidence admissible to the appeal of an IRO. OIEC has grave concerns



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about these provisions which have a total disregard of an injured employee's due process right to a meaningful administrative hearing. OIEC recommends that there should be no evidentiary limit at the CCH, particularly in light that the injured employee is not provided any opportunity to submit evidence throughout the process (as the rules are currently written). OIEC believes that by limiting evidence at this CCH, an injured employee will not have the opportunity to submit evidence in addition to the carrier's submission. OIEC believes that the rule as currently written deprives injured employees of due process and is contrary to both the *HCA Healthcare Corp. v. Texas Dept. of Ins. and Division of Workers' Compensation* (Cause No. D-1-GN-06-000176) decision and to the legislative intent of HB 724. OIEC believes that this subsection as currently written is contrary to the intent of the HB 724 to provide for an appeal proceeding that allows the parties to establish a record of review prior to proceeding to judicial review in a district court. OIEC does not see the purpose in limiting evidence at the CCH. It seems that the focus of the CCH should be on making the correct decision (namely, is the medical treatment medically necessary for this injured employee) based on all relevant evidence whether it was submitted to the IRO or not. OIEC's concern about this provision is compounded by the fact that medical necessity hearings are currently proceeding with an issue of whether the IRO's decision is supported by the preponderance of the evidence rather than the resolution of the proper issue: namely, whether the treatment is medically necessary.

14. Page 60; §133.308(t)(1)(vi): OIEC recommends offering both the time frame and venue for appeal within the text of the rule. Many injured employees and other system participants do not have access to the Texas Government Code. Providing the 30-day time frame and Travis County venue in the text of the rule provides for a clear manner and properly informs injured employees of their right to appeal.
15. Page 62; §133.308(t)(1)(vii)(III): OIEC supports this provision and recommends the following addition to authorize the waiving of obtaining a certified record: "If DWC determines that a party is unable to pay such costs, DWC may waive the cost to produce the certified record in part or whole."

Thank you for your careful consideration of the above comments. Please do not hesitate to contact me if I can be of assistance or clarify any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** January 11, 2008

**TO:** DWC Rule Team

**FROM:** Brian White

**RE:** Subclaimant Rules; §§140.6 and 140.7

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The Office of Injured Employee Counsel (OIEC) appreciates your careful consideration of the following comments concerning §§140.6 and 140.7 on behalf of the injured employees of Texas:

- OIEC has concerns regarding the provision for permitting a subclaimant to pursue a claim at a contested case hearing (CCH) without the participation of the injured employee if the subclaimant proves "it has contacted the employee, and the employee is not pursuing the dispute with reasonable diligence" or "it has been unable to locate and contact the employee through the exercise of reasonable diligence." See §140.6(e)(2). OIEC believes that the phrase "not pursuing the dispute with reasonable diligence" should be defined. OIEC asserts that there is a distinction between subclaimants not being satisfied with the pace at which the injured employee is pursuing the claim as opposed to the injured employee not pursuing the claim at all. OIEC recommends that the case should not be pursued prior to the time the injured employee wishes it to go forward. In accordance with §140.6 and Labor Code §409.009, it is ultimately the injured employees case and subclaimant's rights are derivative of the injured employee's. The injured employee ought to be able to dictate the time table of the case going forward.
- OIEC's other concern is that by making the subclaimant "prove" that the injured employee is not pursuing the claim with reasonable diligence, the Texas Department of Insurance, Division of Workers' Compensation (DWC) is going to abandon the practice of sending a 10-day letter to the injured employee if the subclaimant comes to a CCH without the injured employee being present. OIEC believes that it is essential that the regulatory body (namely DWC) continue to send a warning to injured employees, which states that if they do not participate in the CCH, the issue may be resolved against them and a decision will be binding against them even though they did not participate in the CCH. OIEC believes such notice is vital to due process while again noting: the subclaimant's rights derive from the injured employee's rights to pursue the claim. OIEC believes that failure of DWC to give notice to the injured employee and a clear finding that the injured employee is not diligently pursuing the claim encroaches on the interest of the injured employee and is contrary to DWC's regulatory duties to ensure injured employees have access to a fair and accessible dispute resolution system pursuant to Labor Code §402.021(a)(2).

Thank you again for your consideration of the above suggestions, and please do not hesitate to contact me if I can be of assistance.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** February 8, 2008  
**TO:** DWC Rule Comment Folder  
**FROM:** Elaine Chaney  
**RE:** Ambulatory Surgical Center (ASC) Fee Guideline §134.402

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After reviewing the proposed rule concerning ASC Fee Guideline, it was determined that there were no issues with the rule that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no formal comment was submitted by OIEC to this proposed rule.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** February 21, 2008

**TO:** DWC Rule Comment Folder

**FROM:** Gloria Medina

**RE:** TDI Division of Workers' Compensation Proposed Health Care Provider Billing Procedures Rule 28 TAC 133.10.

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Upon reviewing the proposed rule concerning The Proposed Health Care Provider Billing Procedure, it has been determined that there are no issues with the rule. Therefore, the Office of Injured Employee Counsel (OIEC) will not be participating in the above referenced rulemaking initiative on behalf of the injured employees of Texas.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** April 4, 2008  
**TO:** DWC Rule Comment Folder  
**FROM:** Elaine Chaney  
**RE:** Informal and Voluntary Network Rules §§ 133.2, 133.4 and 133.5

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After reviewing the proposed rules concerning Informal and Voluntary Network, it was determined that there were no issues with those rules that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no formal comment was submitted by OIEC to these proposed rules.



## MEMORANDUM

**DATE:** May 28, 2008  
**TO:** DWC Rule Team  
**FROM:** Brian White, Deputy Public Counsel  
**RE:** Subclaimant Rules §§ 140.6, 140.7, and 140.8

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The Office of Injured of Employee Counsel (OIEC) appreciates the opportunity to provide public comment on the Texas Department of Insurance, Division of Workers' Compensation's (DWC) Subclaimant Rules, which implement House Bill (HB) 724 from the 80<sup>th</sup> Texas Legislature, 2007. OIEC requests the consideration of the following comments on behalf of the injured employees of Texas:

### **§140.6 Subclaimant Status: Establishment, Rights, and Procedures.**

1. Page 17; §140.6(d): In light of the significant rights affected by the disposition of disputes before DWC, OIEC believes additional procedural safeguards are required to prevent employees from being unfairly surprised or prejudiced by a subclaimant that pursues a claim without the injured employee's participation under Rule 140.6(d). For example, Rule 140.6(d) appears to permit a subclaimant to pursue a claim where the carrier has denied compensability without the injured employee's participation. All entitlements to worker's compensation benefits flow from the resolution of a compensability issue. While subclaimants have a financial interest in the cost associated with medical care, the injured employee faces the prospect of the loss of a lifetime entitlement to medical treatment for the compensable injury, as well as, the loss of entitlement to all indemnity benefits including, temporary income benefits, impairment income benefits, supplemental income benefits and lifetime income benefits. The injured employee has a much larger potential interest in the outcome of the dispute and thus every effort should be made to protect the injured employee's interest in cases where the employee is not present at the hearing.
2. Page 17; 140.6(d)(2): OIEC is concerned that this section places no obligation on the subclaimant to notify an injured employee prior to pursuing a claim for reimbursement. The earliest mention of any notice requirement in section 140.6(d) is a requirement that the subclaimant show that the employee was notified at the time of the contested case hearing. *See* §140.6(d)(3)(A). OIEC is concerned that the date of the contested case hearing is too advanced in the dispute resolution process for DWC to determine whether the subclaimant took appropriate steps to notify the employee of its pursuit of the claim. OIEC recommends that prior to attempting to pursue a dispute with DWC, without the



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participation of the injured employee, the subclaimant should be required to certify that the it contacted the injured employee "in writing, by verifiable means." That written notice should include conspicuous text advising the injured employee of the consequences of a dispute decision and informing the injured employee that free assistance in the dispute resolution process is available to the injured employee through OIEC. Requiring written notification at the beginning of the dispute resolution process or at a stage prior to the contested case hearing reduces the potential for unfair surprise and maximizes opportunities for the injured employee to participate at the earliest stages of dispute resolution.

3. Page 17; 140.6(d)(2)(C): This section implies that a subclaimant, dissatisfied with the pace of an injured employee's pursuit of a claim, could move forward without the participation of the injured employee upon showing that the employee is not pursuing the claim with "reasonable diligence." OIEC believes that the case should not be pursued prior to the time that the injured employee wishes it to go forward. As the subclaimant's rights are derivative of the injured employee's pursuant to §140.6 and Labor Code § 409.009, the injured employee ought to be able to dictate the time table of the case going forward. OIEC recommends that injured employees be guaranteed a one-time automatic stay of all proceedings before DWC for sixty (60) days at any stage of the dispute resolution process. This stay would guarantee that injured employees who wish to participate in dispute resolution were not rushed and provide a disincentive for subclaimants to pursue a dispute at a pace that leaves an injured employee unprepared.

- OIEC recommends the following text addition to implement this recommendation:

§140.6(d)(4)(A): The Division shall continue a hearing once, if the Division receives a request for a continuance from the employee no later than five calendar days before the date of the scheduled contested case hearing. The Division shall reschedule the hearing to a date no sooner than sixty days (60) after the scheduled hearing date, unless the parties otherwise agree. The Division shall immediately notify the subclaimant and the carrier of a continuance that was granted or denied under this subsection.

§140.6(d)(4)(B): The exchange deadlines, set out in Chapter 142, shall be extended in cases stayed under Section 140.6(d)(4)(A). Any evidence obtained by the employee during the stay is admissible at the contested case hearing, without a showing of good cause, where the employee exchanges that evidence no later than 5 business days following taking possession of the evidence.

4. Page 18; §140.6(d)(2)(C): This section permits a subclaimant to pursue a claim at a contested case hearing without the participation of the injured employee if the subclaimant proves "it has contacted the employee, and the employee is not pursuing the dispute with reasonable diligence" or "it has been unable to locate and contact the employee through the exercise of reasonable diligence." OIEC asserts that there is a distinction between subclaimants not being satisfied with the pace at which the injured



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employee is pursuing the claim as opposed to the injured employee not pursuing the claim at all. OIEC believes that the phrase "not pursuing the dispute with reasonable diligence" should be defined. Similarly, OIEC recommends that the phrase "unable to contact the employee through the exercise of reasonable diligence" also be defined. If those phrases remain undefined, OIEC believes that there will be significant disparity among hearing officers concerning what must be shown to establish reasonable diligence in both the pursuit of the claim and in efforts to contact the injured employee. Consistency in the application of this rule would seem of paramount importance; however, by failing to establish a definition that goal will almost certainly not be served.

5. Page 18; §140.6(d)(2)(C): This paragraph permits a dispute to move forward without the approval or participation of an injured employee if, in the subclaimant's subjective opinion, with the approval of the Division, the employee is not pursuing dispute resolution "with reasonable diligence." This section implies that even in cases where employees may be participating, the subclaimant is permitted to press forward without the employee's permission. OIEC recommends adding an additional subsection to §140.6(d)(2), §140.6(d)(2)(D) to read: "An employee is presumed to be pursuing a dispute with reasonable diligence, unless the subclaimant provides clear and convincing evidence to the contrary."
6. Page 18; §140.6(d)(3)(A): In light of the significant legal consequences for employees in disputes before DWC and the employees' due process right to notice and to be heard, OIEC recommends that the contact requirement in §140.6(d)(3)(A) be strengthened to require that contact with the employee be in writing, by verifiable means or in writing, via certified mail, return receipt requested. OIEC further recommends that the written notice contain a conspicuous warning that the decision will be binding against the employee even if the employee does not participate in the hearing and text informing the injured employee that free assistance in the dispute resolution process is available to the injured employee through OIEC.
7. Page 18; §140.6(d)(3)(A): OIEC is concerned that by making the subclaimant "prove" that the injured employee is not pursuing the claim with reasonable diligence, DWC is going to abandon the practice of sending a 10-day letter to the injured employee if the subclaimant comes to a contested case hearing without the injured employee being present. OIEC believes that it is essential that DWC, as the regulatory body, continue to send a warning to injured employees, which states that if they do not participate in the hearing, the issue may be resolved against them and a decision will be binding against them even though they did not participate in the hearing. OIEC believes such notice is vital to due process while again noting: the subclaimant's rights derive from the injured employee's rights to pursue the claim. OIEC believes that failure of DWC to give notice to the injured employee and a clear finding that the injured employee is not diligently pursuing the claim encroaches on the interest of the injured employee and is contrary to DWC's regulatory duties to ensure injured employees have access to a fair and accessible dispute resolution system pursuant to Labor Code §402.021(a)(2) .



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- OIEC recommends the following text addition to address the aforementioned concerns: §140.6(d)(3)(C): Following the conclusion of a hearing under this section, the Division shall send written notice to a nonparticipating employee offering the employee an opportunity to request resetting to present evidence. The notice shall explain that resolution of the issues will be binding upon the injured employee.
8. Pages 23 and 24; §§ 140.8(d)(1)(E) and 140.8(e): OIEC believes that reimbursement in this circumstance ought to come from the workers' compensation carrier rather than the health care provider because that procedure is consistent with Rule 133.270. In addition, if reimbursement is made by the health care provider, no meaningful mechanism for dispute resolution exists in the event that the health care provider and the injured employee do not agree on the amount of money paid by the injured employer for health care. OIEC proposes the following change in the text of the proposed rules:
- OIEC recommends the following change in the text of the proposed rule: §140.8(d)(1)(E): Notice to Employee and Health Care Provider. The workers' compensation carrier must give notice of its response to the reimbursement request to the employee and the health care provider that performed the services that are the subject of the reimbursement request. The notice shall include an explanation that the claim is compensable and that the workers' compensation insurance carrier must reimburse the employee for any amounts paid to the health care provider by the employee.
  - OIEC recommends the following change in the text of the proposed rule: §140.8(e): Reimbursement of Employee. If the employee's medical care costs are reimbursable under Title 5 of the Labor Code, the workers' compensation carrier must reimburse to the employee any payments made by the employee to the health care provider, including but not limited to, copays and deductibles. Reimbursement must be made within 45 days of receipt of documentation or evidence (such as itemized receipts) of the amount that the injured employee paid the health care provider.

Thank you for your careful consideration of the above comments. Please do not hesitate to contact me if I can be of assistance or clarify any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** June 13, 2008

**TO:** DWC Rule Team

**FROM:** Brian White

**RE:** OIEC Comments on DWC Informal Draft of Chapter 180 Rules

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the Texas Department of Insurance, Division of Workers' Compensation's (Division) informal draft of the Chapter 180 rules concerning enforcement. Please consider the following suggestions on behalf of the injured employees of Texas:

1. Pages 8 - 12, §180.1:
  - (25): OIEC recommends retaining the definition of NOV in this section. The rule refers to NOV on page 16, and OIEC feels it is most appropriate to leave the definition in the definition section to alleviate reader confusion.
  - (23), (24), and (35): OIEC recommends removing the definitions of "intentional," "knowingly," and "willful" because intent is no longer needed for the agency to provide an administrative penalty to a system participant. House Bill (HB) 7 specifically removed the system participant's intent in order to commit a violation. Further, OIEC recommends leaving these terms to the Penal Code to define and not varying from the definitions offered in the Penal Code should it be necessary to define.
2. Page 9, §180.1(27):
  - The definition of "professional certification" in §180.1(27) is a critical definition because it establishes the specialization required of doctors in the system that perform as peer reviewers, utilization reviewers, independent reviewers, designated doctors, required medical examination doctors, and members of the medical quality review panel. However, OIEC is concerned that the definition fails to provide sufficient guidance on what is actually required to satisfy the definition. In other words, OIEC believes that the phrase "is qualified by education, training and experience to provide the health care reasonably required by the nature of the specific injury to treat the condition until further material from or lasting improvement to the injury can no longer reasonably be anticipated" fails to clearly identify the criteria to be used to determine a doctor's qualification to serve in any given role in the workers' compensation system. Our concern is heightened by an awareness of historical difficulties in implementing a requirement other than licensure in the designated doctor selection process. When the "training and experience" and "scope of practice"



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requirements were added to Labor Code §408.0041, the former Texas Workers' Compensation Commission ultimately issued an advisory stating that licensure and scope of practice were "synonymous" in order to make the selection process function. The language included in §180.1(27) appears to reintroduce a requirement beyond licensure in order to establish the qualification of a doctor to serve in various roles in the system without the problems that the "training and experience" and "scope of practice" requirements created having been addressed.

- The definition of professional certification does not seem to describe the term defined. Instead, the term currently describes a type of doctor, which seems inaccurate. Perhaps the Division was trying to describe the type of training needed by a doctor to service an injured employee. If so, OIEC recommends the following definition:
  - Professional certification: the education, training, and experience required by a doctor, except for a dentist or chiropractor, required to provide appropriate medical care to an injured employee.
- OIEC further notes that professional certification has nothing to do with maximum medical improvement. Therefore, OIEC recommends striking the reference of MMI: "until further material recovery from or lasting improvement to the injury can no longer reasonably be anticipated."
- OIEC recommends moving the last sentence in the section to a more appropriate place. The last sentence (starting with "Nothing in this section. . .") is not a definition and does not seem to clarify "Professional certification" in any manner.

### 3. Page 34, §180.21(b)(3):

- OIEC recommends for the sake of uniformity that after the words "Medical Association Guides" this subsection track the same language as used in subsection (e)(7) that follows on page 36.

### 4. Page 41, §180.21:

- OIEC would recommend adding to the laundry list for sanctions the following: "Having a pattern of practice of denigrating injured employees by alleging that they are less than honest, malingering, or lacking of effort while undergoing examinations." A Workers' Compensation System goal as outlined in §402.012 are as follows:
  - Each employee shall be treated with dignity and respect when injured on the job; and
  - Each injured employee shall have access to a fair and accessible dispute resolution system.

Health care providers routinely describing patients as malingerers or dishonest is contrary to House Bill (HB) 7's system goals as referenced above. Moreover, such statements bring into question the professionalism of the health care provider and issues of libel and slander of the injured employee.

### 5. Page 44, §180.22(4)(C):

- OIEC requests that this subparagraph be reworded for reader clarity. Specifically, OIEC is unsure how patient satisfaction data has any correlation to comorbidity.



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- Perhaps the list in (C) should be further tabulated and the paragraphs be numbered (C) through (F).
- OIEC requests that functional health outcomes be defined. It is unclear to the reader what is required upon Division request.
6. Page 47, §180.22(g):
- OIEC believes the wording of this subsection is confusing. OIEC recommends redrafting the provision as follows:
    - “A peer review is an administrative review performed at the insurance carrier’s request and/or as required by Division rules of the injured employee’s health care without a physical examination of the injured employee.
7. Page 53 - 56, §180.23: HB 1003 and HB 1006, 80<sup>th</sup> Legislative Session, 2007, provided legislative direction that health care providers either examining or reviewing an injured employees medical records should be medically licensed by Texas. OIEC requests that the term “medical” be included in the following subsections to alleviate any confusion that a “medical” license is required, not a URA license or other certification.
- (e)(1): OIEC recommends this subsection should read as follows:
    - “a doctor who performs utilization review and/or peer reviews for an insurance carrier or its agent shall have a medical license issued by this State and comply with all applicable provisions of the Act and this section.
  - (f)(2)(A)(4): OIEC recommends this subsection should read as follows:
    - “verification of medical licensure;”
8. Page 71 §180.26(b)(3)(iv):
- OIEC believes that the interest of the injured employee is better served by making this subsection less liberal. Three convictions for medical malpractice are too many for any patient to endure. An injured employee should not be required to see any health care provider that may pose a danger to the employee, is not qualified to provide adequate treatment, and that the injured employee would not chose to go to outside of the system. It is doubtful that one would willingly choose a doctor with three medical malpractice convictions for his private health care. OIEC recommends lowering the standard to one malpractice conviction. Please note this standard is based on proven convictions and not claims or allegations.
9. Page 87 §180.28(c): OIEC believes that this subsection should remain as originally written with the exception that if an Ombudsman is assisting the injured employee, the Ombudsman should be provided with a copy of the report. OIEC believes that often times the injured employee does not fully understand the ramifications of the peer review report and providing the Ombudsman with a copy of the report will facilitate communication among all interested parties. OIEC suggest the subsection read as follows:
- "The insurance carrier shall submit a copy of a peer review report to the treating doctor and the health care provider who rendered or requested the health care, as well as the injured employee and the injured employee's representative or assisting



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Ombudsman (if any) when the insurance carrier uses the report to reduce income or medical benefits of an injured employee."



The State of Texas  
House of Representatives

BURT R. SOLOMONS

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June 3, 2008

Commissioner Albert Betts  
Texas Department of Insurance  
Division of Workers' Compensation  
7551 Metro Center Drive, Ste. 100  
Austin, TX 78744

Dear Commissioner Betts:

I appreciate your and the Division of Workers' Compensation (Division) staff's efforts on the rule making required by 80R HB 724, which I authored in the last regular session. As we have discussed, I had concerns about the draft rules for 28 TAC §§1403.6, 140.7 and 140.8 and are not alleviated by the proposal for adoption. It is my hope that the Division will see fit to withdraw the rule, and to propose language which will be more closely aligned with the statutory language and legislative intent.

**I. Lack of Clear Direction for the Parties in the Submission of Request for Reimbursement under Tex. Labor Code §409.0091**

Although the Division's proposed rule attempts to address the process for dispute resolution at the Division, it is entirely void of any direction for parties on the proper way to submit, evaluate, process and possibly pay a request for reimbursement under Tex. Labor Code §§409.0091(f-j). While the statute is clear what information must be included on a Request for Reimbursement,<sup>1</sup> there is no guidance to workers' compensation carriers on (1) how to handle Request for Reimbursements they receive from multiple authorized agents of a health care insurer; (2) how to ensure the validity of the agent's authorization to collect this debt on behalf of the health care insurer or how to close out a claim if payment has been processed to one authorized agent, but an additional authorized agent seeks additional payments for the same claim. On the other hand, there is no direction to health care insurers about (1) the appropriate way to authorize an agent to collect a debt which may be owed by

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<sup>1</sup> Tex. Labor Code §409.0091(f)

a workers' compensation carrier; (2) whether they may contract with more than one authorized agent and if they do so, how this will be handled.

The Division's proposed rule does recognize that multiple authorized agents may cause confusion as it sets forth a first come right to dispute resolution for multiple authorized agents in proposed 28 TAC §140.8(h)(2), yet provides no guidance for the parties before the dispute process begins. Tex. Labor Code §409.0091( r) specifically grants rule making authority to both the Commissioner of Insurance and the Commissioner of the Division of Workers' Compensation "to clarify the processes required by, fulfill the purpose of, or assist the parties in the proper adjudication of subclaims under this subtitle" as this statute has implications on the business processes for both health care insurers and workers' compensation insurers. Yet, as proposed 28 TAC §§140.6-8, the only proposed rule to enact 80R HB 724's provisions for subclaims, specifically obfuscates the issue of how the process is supposed to work before a dispute resolution. Tex. Labor Code §402.021(b)(5) specifically directs the Division of Workers' Compensation to "minimize the likelihood of disputes and resolve them promptly and fairly when identified," However, the Division's proposed rule does not take into account the responsibility under the statute to minimize disputes by providing appropriate guidance for the process of handling Requests for Reimbursement prior to a dispute.

Further, despite similar provisions for other required forms, there is no administrative penalty for not completely and accurately filling out the Request for Reimbursement by the health care insurer. This is extremely short-sighted as Tex. Labor Code §409.0091(p) granted workers' compensation carriers a reprieve from submitting reporting requirements for the claim payments processed under this process. Eventually the agency will need to develop how workers' compensation carriers are to report that information in September, 2011 and if workers' compensation carriers are not in possession of complete data required for these claims, then the accuracy of the Texas Department of Insurance's data could be in question for the next decade.

## **II. Lack of Appropriate Applicability of Texas Labor Code §§ 409.009 and 409.0091 for Separate, Distinct and Mutually Exclusive Dispute Resolution Processes**

The Division's proposed rule 28 TAC §§ 1403.6, 140.7 and 140.8 lacks any separation of disputes under Texas Labor Code §§409.009 and 409.0091. 80R HB 724 amended the Texas Labor Code to provide for a separate, distinct and mutually exclusive dispute resolution process for subclaims (1) filed by health care insurers or their authorized representatives (2) in cases where compensability has already been determined or has never been denied and (3) which occur after September 1, 2007 or are the result of a data match under Tex. Labor Code §402.084 (c-3) between September 1, 2005 and January 1, 2007 as long as it was filed with the Division by March 1, 2008<sup>2</sup>.

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<sup>2</sup> 80R HB 724 SECTION 5 Tex. Labor Code § 409.0091(b-c) and SECTION 11 Instructional Provisions "The change in law made by this Act applies only to a subclaim based on a compensable injury that occurred on or after September 1, 2007, and to reimbursement requests and subclaims pursuant to Section 409.0091(s), Labor Code, as added by this Act. The changes made by this Act apply only to subclaims based on an injury that has not been denied for compensability or that has been determined by the division to be compensable."

Tex. Labor Code §409.0091 was added to the statute at the request of health care insurer's authorized representatives as a dispute resolution process separate, distinct and mutually exclusive from Tex. Labor Code §409.009 which applies to all subclaimants, yet the Division's proposed rule intermingles disputes under either statute as appropriate to the dispute processes in proposed 28 TAC §140.8. This ignores statutory direction and legislative intent.

Tex. Labor Code §409.009 has many differences from Tex. Labor Code §409.0091 which, by its plain language, clearly establishes applicability to different parties, sets forth different standards for filing a claim, applicability to claims in different periods of time and a different set of defenses for the workers' compensation carrier — all of which the proposed rule ignores.

First, Tex. Labor Code §409.009(1) recognizes a person as a subclaimant who "has provided compensation, including health care provided by a health care insurer, directly or indirectly, to or for an employee or legal beneficiary." Although this does recognize a health care insurer, it does not recognize the right of a health care insurer's authorized representative as described in Tex. Labor Code §402.084(c-1) as does Tex. Labor Code §409.0091(a). Since a health care insurer's authorized representative is merely a debt collector and has not provided any compensation to an employee or legal beneficiary, they would not have standing in a dispute under Tex. Labor Code §409.009. Yet, the Division's proposed rule 28 TAC §140.6, which is subsection (a) is stated to apply to "a subclaim pursued under Labor Code §409.009," applies to a health care insurer "as defined in Tex. Labor Code §402.084(c-1), and an authorized representative of an insurance carrier." There is absolutely no statutory authority to apply the definition of an health care insurer under Tex. Labor Code §402.084(c) to Tex. Labor Code §409.009, nor to grant subclaim status to an authorized representative. In fact, granting subclaim status to an authorized representative for a dispute under proposed 28 TAC §140.6 would be in direct conflict with Tex. Labor Code §409.009(1). Thus, the Division's proposed rule clearly ignores the specific differences as to whom is a qualified subclaimant under Tex. Labor Code §§409.009 versus 409.0091.

Not only does the Division's rule ignore the difference in types of subclaimants these sections in the Tex. Labor Code apply, but the proposed rule ignores the different standards for filing a claim. The only standard for a qualified subclaimant to file a subclaim under Tex. Labor Code §409.009 is that they have provided compensation and have sought and been refused reimbursement from the insurance carrier. However, for a qualified subclaimant to file a claim under Tex. Labor Code §409.0091 they must show that not only is the claim for health care been determined as compensable, but also has not previously been denied by the workers' compensation carrier as not medically necessary.

The standard of compensability is evident in many sections of Tex. Labor Code §409.0091. First, Tex. Labor Code §409.0091(c) states that "health care paid by a health care insurer may be reimbursable as a *medical benefit*." [emphasis added] Medical Benefit is defined by Tex. Labor Code §401.011(31) as "payment for health care reasonably required by the nature of a *compensable injury* [emphasis added]" thus under Tex. Labor Code §409.0091, a health care insurer is only entitled to reimbursement for health care provided in relation to a compensable injury. This is further

substantiated in Tex. Labor Code §§409.0091(d)<sup>3</sup>, 409.0091(h)<sup>4</sup>, and in Sections 10<sup>5</sup> and 11<sup>6</sup> of 80R HB 724. Despite these marked differences in the statute, the Division’s proposed rule provides for a single dispute resolution process for claims under Tex. Labor Code §409.009 and §409.0091. The compromise which was established during the legislative session on these subclaims under Tex. Labor Code §409.0091, was that although the workers’ compensation carriers would give up three (3) substantial and legitimate defenses against these Requests for Reimbursement, the claims would be limited only to claims where compensability had never been challenged. To preserve this legislative intent for the record, I provided a clear statement of legislative intent which specified that it was my “intent that the workers’ compensation carrier be responsible for reimbursing the health care insurer for any liability which the workers’ compensation carrier has under the Texas Workers’ Compensation Act if the injury and treatment has been determined to be related to *an established compensable injury*.”<sup>7</sup> [emphasis added] Not that an injury could later be determined compensable, but that an injury was connected to a claim which had never been challenged by the carrier for compensability. Although the plain language of the statute is the primary source of legislative intent, I believe that I have discussed in depth the statutory provisions which show the intent that Tex. Labor Code §409.0091 applies only to an established compensable injury, *Magnolia Petroleum Co. V. Walker* instructs it is also necessary and prudent to review the history of the subject matter when determining legislative intent<sup>8</sup>.

Without providing distinct and mutually exclusive dispute resolution processes for each statute, there is no provision which meets legislative intent under the proposed rule for a subclaimant seeking reimbursement under Tex. Labor Code §409.0091 to declare that they are seeking reimbursement under Tex. Labor Code §409.0091 versus §409.009 or to prove that the health care for which the seek reimbursement is a medical benefit or that the health care was not previously denied. In fact, the Division’s proposed 28 TAC §140.8(g) specifically lists the issues which must be resolved prior

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<sup>3</sup> Tex. Labor Code §409.0091(d) “Except as provided by subsection (e), this section does not prohibit or limit a substantive defense by a workers’ compensation insurance carrier that they health care paid for by the health care insurer was not a *medical benefit* or not a correct payment.” [emphasis added]

<sup>4</sup> Tex. Labor Code §409.0091(h) “For each *medical benefit* paid, the workers’ compensation insurance carrier shall pay to the health care insurer the lesser of the amount payable under the applicable fee guideline as of the date of service or the actual amount paid by the health care insurer.” [emphasis added]

<sup>5</sup> 80R HB 724 SECTION 10. Chapter 408, Labor Code, as amended by this Act, applies only to a claim for workers’ compensation benefits based on a *compensable injury* that occurs on or after the effective date of this Act. A claim based on a *compensable injury* that occurs before that date is governed by the law in effect on the date that the compensable injury occurred, and the former law is continued in effect for that purpose.” [emphasis added]

<sup>6</sup> 80R HB 724 SECTION 11. The change in law made by this Act applies only to a subclaim based on a *compensable injury* that occurred on or after September 1, 2007, and to reimbursement requests and subclaims pursuant to Section 409.0091(s), Labor Code, as added by this Act. *The changes made by this Act apply only to a subclaim based on an injury that has not been denied for compensability or that has been determined by the division to be compensable.*” [emphasis added]

<sup>7</sup> “Statement of Legislative Intent,” *Texas House Journals for the 80<sup>th</sup> Legislature*, May 23, 2007, pg. 5518

<sup>8</sup> “No inflexible rule can be announced for the construction of statutes. However, the dominant rule to be observed is to give effect to the intention of the Legislature. Generally the intent and meaning is [sic] to be obtained primarily from the language of the statute. In arriving at the intent and purpose of the law, it is proper to consider the history of the subject-matter involved, the end to be attained, the mischief to be remedied and the purposes to be accomplished.” *Magnolia Petroleum Co. V. Walker*, 83 S.W. 2d 929, 934 (Tex. 1935)

to a subclaimant dispute; not only does it not mention compensability, but allows a subclaimant to seek medical dispute resolution. This is a right which is not granted a subclaimant under Tex. Labor Code §409.0091. Since the proposed 28 TAC §140.8(g) applies to subclaims filed under Tex. Labor Code §§409.009 and 409.0091 it further exacerbates the inclusion of a health care insurer's authorized agent in Division's proposed 28 TAC §140.6 as it not only grants a right not in statute to a subclaimant, but also to an individual which does not have the right as a subclaimant.

Beyond granting dispute resolution rights to subclaimants and individuals which are not granted those rights in statute, the Division's proposed rule disregards the applicability of Tex. Labor Code §409.0091 to a defined set of claims in time. Tex. Labor Code §409.009 is applicable to all qualifying subclaims under that section since September 1, 1993 proceeding forward. Tex. Labor Code §409.0091 is only applicable to compensable injuries which occur after September 1, 2007 or are the result of a data match under Tex. Labor Code §402.084 (c-3) between September 1, 2005 and January 1, 2007 as long as it was filed with the Division by March 1, 2008<sup>9</sup>. For the sake of discussion, I will refer to those claims which are the result of a data match under Tex. Labor Code §402.084(c-3) as the "retroactive claims."

Since the Division's proposed rule provides no provision under the proposed rule for a subclaimant seeking reimbursement under Tex. Labor Code §409.0091 to declare that they are seeking reimbursement under Tex. Labor Code §409.0091 versus §409.009 the rule is severely deficient in meeting statutory requirements by not having a method by which to ensure that only compensable injuries within the allowed time frames are submitted for dispute under Tex. Labor Code §409.0091. This is especially crucial for retroactive claims. The proposed rule fails to require the subclaimant to provide evidence of the date of the injury or that the data match was conducted before January 1, 2007, and that it was filed with the Division before March 1, 2008. The proposed rule simply neglects the applicability requirements in statute in the proposed rule in clear violation of statutory construction principles<sup>10</sup>. The rule should be clear that any claim prior to the effective date of the bill which was not filed by the March 1, 2008 deadline must utilize the 409.009 process and has no opportunity to utilize the 409.0091 process. Unfortunately, the proposed rule not only fails to recognize this legislative instruction, but by combing the dispute processes for both statutory sections into one the proposed rule makes it impossible to ensure compliance with the statute.

The Division's disregard for the instructional provisions in Section 10 of 80R HB 724<sup>11</sup> is critical

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<sup>9</sup> 80R HB 724 SECTION 5 Tex. Labor Code § 409.0091(b-c) and SECTION 11 Instructional Provisions "The change in law made by this Act applies only to a subclaim based on a compensable injury that occurred on or after September 1, 2007, and to reimbursement requests and subclaims pursuant to Section 409.0091(s), Labor Code, as added by this Act. The changes made by this Act apply only to subclaims based on an injury that has not been denied for compensability or that has been determined by the division to be compensable."

<sup>10</sup> "Courts must always consider a statute as a whole rather than its isolated provisions and all of its parts should be harmonized if possible, so as to give effect to the entire act according to the evident intention of the legislature." Statutes, Section 122, Tex. Jur. 3d, pages 640-641

<sup>11</sup> 80R HB 724 SECTION 10. Chapter 408, Labor Code, as amended by this Act, applies only to a claim for workers' compensation benefits based on a compensable injury that occurs on or after the effective date of this Act. A claim based on a compensable injury that occurs before that date is governed by the law in effect on the date that the compensable injury occurred, and the former law is continued in effect for that purpose."

for two reasons. First, Section 10 is clear that the amended sections Tex. Labor Code §408 is applicable only to a compensable injury which occurs after the effective date of the legislation and that for all compensable injuries which occur prior to that date, the prior language is continued in effect. For Tex. Labor Code §408.027(d) the unamended language recognizes the right of an accident insurance carrier, health insurance carrier or other person to recover costs of health care paid for an injury which was the insurance carrier denied, but was later determined to be compensable. Whereas, Tex. Labor Code §409.0091(d) specifically states that health care insurers or their authorized agents may not seek recovery for health care previously denied. The amended language of Tex. Labor Code §408.027(d) states:

“If an accident or health insurance carrier or other person obligated for the cost of health care services has paid for health care services for an employee for an injury for which the workers’ compensation carrier or the employer has not disputed compensability, the accident or health insurance carrier or other person *may recover reimbursement from the insurance carrier in the manner described by Section 409.009 or 409.0091, as applicable.*” [emphasis added]

This amended language is important as it introduces clear direction to allow for recovery of healthcare which has not been previously denied, but “in a manner described by Section 409.009 or 409.0091, as applicable.” Therefore, under Tex. Labor Code §408.027(d) a subclaimant seeking reimbursement for health care related to a compensable injury must choose to seek reimbursement under either §409.009 or §409.0091, but not both as they are, under the plain language of the amended law, distinct, separate and mutually exclusive options. This is further evidenced by the last to words in Tex. Labor Code §408.027(d) — “as applicable.” Tex. Labor Code §408.027(d) recognizes in this short phrase that although there may be a recovery to be sought, not every dispute resolution will be eligible for recovery under Tex. Labor Code §409.0091. This section alone highlights that the statutory construction intends two separate and mutually exclusive dispute processes rather than the combined dispute process proposed in the Division’s rule.

Moreover, the Division’s proposed rule’s combined dispute process does not clearly allow for the differences in the defenses for the workers’ compensation carrier between disputes under Tex. Labor Code §409.009 versus §409.0091, which will inevitably cause confusion in the dispute process for not only the parties, but for the Division’s Hearing Officers. For dispute resolutions filed under Tex. Labor Code §409.0091, health care insurers lost three important defenses<sup>12</sup> which are still applicable under dispute resolutions filed under Tex. Labor Code §409.009. While, the Division’s proposed rule gives a preliminary nod to these differences in proposed 28 TAC §140.7, there is no provision in §140.8 to designate which chapter of the Tex. Labor Code dispute resolution is sought, no means to inform the parties of which chapter and which defenses do or do not apply. It is my understanding that the Division is currently holding dispute resolutions for subclaimants without notifying the parties as to whether the dispute falls under Tex. Labor Code §§409.009 versus 409.0091 and it has

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<sup>12</sup> Tex. Labor Code §409.0091(e) lists lost defenses to include 1) That the health care insurer has not sought reimbursement from the injured employee; 2) that neither the health care insurer nor the health care provider sought preauthorization; or 3) that the health care provider did not bill the workers’ compensation carrier within 90 days.

caused confusion among the parties as how to prepare for the hearing. If the parties are confused, how can the hearing officer expect to be any better prepared to make an informed ruling which complies with the statute? The Division's proposed rule does nothing to alleviate this situation and only compounds the problem by sanctioning only one dispute process in direct contradiction to the statutory construction.

### **III Provisions in Proposed 28 TAC §140.8 are Wholly Inadequate to Adequately Provide Guidance to Group Health Care Providers and Injured Employees as to the Process Required and Dispute Resolution over Reimbursements for Out-of-Pocket Expenses of the Injured Employee and Could Ultimately Lead to Further Disputes.**

Proposed 28 TAC §140.8 provides a deficient system by which the group health care provider and the injured employee may be notified of and must process reimbursements of any owed copays, deductibles and coinsurance collected from an injured employee for a compensable injury. These provisions are completely inadequate guidance to these parties and may actually lead to increased disputes, although the rules do not provide for guidance on how one of these parties is to proceed in a dispute.

Although I support that a health care provider would owe any copays, deductibles and coinsurance collected from an injured employee for health care provided by a health care insurance carrier for a compensable injury, I have concerns over the timing of the notice to the health care provider and the injured employee of the possible need for reimbursement. Proposed 28 TAC §140.8(e) provides that a health care provider shall reimburse any owed copays, deductibles and coinsurance collected from an injured employee within 45 days of receipt of the notice that the claim is compensable. Yet, there is no definitive notice that a claim has been determined to be compensable and monies are actually owed.

A notice to the group health care provider and the injured employee is required twice in the Division's proposed rule. The first is required by the health care insurer at the time a Request for Reimbursement has been provided to the workers' compensation carrier<sup>13</sup>. The second is required by the workers' compensation carrier at the time of a response to a Request for Reimbursement by a health care insurer.<sup>14</sup> However, I see no notice requirement after a dispute resolution at the Division of Workers' Compensation.

The first notice required by the health care insurer is sent when only a Request for Reimbursement exists and the second notice, while the workers' compensation carrier may pay the full amount requested in the Request for Reimbursement, they have the option to deny any and all parts of the request under Tex. Labor Code §409.0091(k), therefore neither notice is a guarantee that money *is* owed to an injured employee, rather than *may* be owed.

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<sup>13</sup> Proposed 28 TAC §140.8(b)(2)

<sup>14</sup> Proposed 28 TAC §140.8(d)(1)(E)

The early notices in proposed 28 TAC §140.8(b)(2) and possibly proposed 28 TAC 140.8(d)(1)(E) before a final adjudication of the recovery of payments could lead to confusion and ill-will between the injured employee and their primary treating doctor in Group Health, or worse, a dispute between the injured employee and the group health provider, who is likely to be ignorant of workers' compensation regulations.

This is further exacerbated by the fact that proposed 28 TAC §140.8 requires the health care provider to submit reimbursement for all copays, deductibles and coinsurance collected from an injured employee within 45 days of receipt of the notice that the claim is compensable — could either of these notices be said to be receipt that the claim is compensable? Further, proposed 28 TAC §140.8 is completely void of any guidance as to the responsible party for documenting the amount paid by the injured employee — the injured employee, the health care provider or is this supposed to be in the Explanation of Benefits required by the workers' compensation carrier under proposed 28 TAC §140.8(d)(1)(E) and if so, how is the workers' compensation carrier supposed to discover that information?

Adding to the confusion over documentation is what happens when there is conflicting documentation or just a straight refusal to reimburse by the health care provider. The proposed 28 TAC §140.8(e) is completely void of any direction as to which Division within the Texas Department of Insurance a dispute would be directed and how it would be handled. Is this an issue for the Division of Workers' Compensation, despite the fact that it involves a health care provider who may have never treated in the system and is over copays, coinsurance and deductibles which the Division of Workers' Compensation is completely unfamiliar or does it more appropriately belong to the Division of Life, Health and Licensing. There is no guidance on this issue and since there is none, there will be unnecessary confusion among the parties and disputes will likely be filed with both Divisions.

Again, Tex. Labor Code §402.021(b)(5) specifically directs the Division of Workers' Compensation to "minimize the likelihood of disputes and resolve them promptly and fairly when identified," and Tex. Labor Code §409.0091(r) specifically grants rule making authority to both the Commissioner of Insurance and the Commissioner of the Division of Workers' Compensation "to clarify the processes required by, fulfill the purpose of, or assist the parties in the proper adjudication of subclaims under this subtitle" as this statute has implications on the business processes for both health care insurers and workers' compensation insurers. However, the Division's proposed rule completely shirks the responsibility under the statute to minimize disputes by providing timely and accurate information to injured employees and health care providers and to identify and promptly and fairly resolve them.

It seems that a more prudent approach would be to require the health care insurance carrier to provide the notice upon receipt of reimbursement requested through a Request for Reimbursement and to specify a dispute process for any conflicts between a health care provider and an injured employee.

## IV Conclusion

The Division's proposed 28 TAC §§140.6-8 rule has considerable fatal flaws which render it unacceptable for adoption by the Division of Workers' Compensation. It ignores the plain language of the statute, proposes provisions in direct conflict with the Texas Labor Code, fails to provide direction which is required to meet the Division's statutory goals and duties, and fails to recognize legislative intent for 80R HB 724.

The rule provides little or no direction for health care insurers and workers' compensation carriers for the appropriate process in submitting, processing and paying a Request for Reimbursement, which will only add to the amount of disputes filed with the Division. This is in direct violation of Tex. Labor Code §§ 402.021(b)(5) and §409.0091 (r). The proposed rule violates the same statutory requirements by not providing explicit guidance for health care providers and injured employees on the proper process to prove a claim for reimbursement of copays, deductibles and coinsurance under proposed 28 TAC §140.8(e).

Most egregiously and irreversible is the possible *ultra vires* act the Division's proposed rule makes by combining the dispute processes for what are clearly separate, distinct and mutually exclusive dispute processes under Tex. Labor Code §§ 409.009 and 409.0091<sup>15</sup>. By ignoring the different effect dates and applicability of each section of the Tex. Labor Code and by ignoring the differences in who may qualify as a subclaimant under each statute as well as the differences in what types of claims may qualify under each statute, the Division's proposed rule has directly contradicted the legislative intent and statutory direction.

At this point, I can not see where the Division has any choice but to withdraw the proposed rule as to substantially rewrite the proposed rule to address potential conflicts with the statute would create a possible Deffebach challenge<sup>16</sup> to the adopted rule.

I implore the Division to withdraw this proposal and attempt to address the concerns which you and I have discussed privately and which I have outlined above. I fear that adoption of this rule would lead to confusion among the stakeholders, a perversion of the statutory construction and even a possible legal challenge which would delay these subclaims from being finally adjudicated.

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<sup>15</sup> *Texas Dept. Of Insur., Div. Of Workers' Comp. V. Lumberman's Mut. Cas. Co.* 212 S.W. 3d 870, 874-875 (Tex. App. – Austin 2006, pet. denied) and *Texas Alcoholic Beverage Comm. V. Amusement & Music Operators of Texas, Inc.* 997, S.W.2d 651, 658 (Tex. App. – Austin 1999, pet. dismissed w.o.j.)

<sup>16</sup> “Conversely, should the proposed rules, as originally published, be ignored and others adopted or should other subjects or persons be affected by the altered rule, a new round of notice and comment should be required.” *State Board of Insurance of Texas v. Deffebach*, 631 S.W.2d 794 (Tex. App. – Austin 1982)

Sincerely,

A handwritten signature in black ink that reads "Burt R. Solomons". The signature is written in a cursive, flowing style.

Burt R. Solomons  
State Representative  
District 65 - Carrollton

BRS/bb

By Email and Interagency Mail

cc: Commissioner Mike Geeslin, Texas Department of Insurance  
Ms. Victoria Ortega, DWC Legal Services



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** August 14, 2008  
**TO:** Melinda Schulze, Reporting Analyst  
**FROM:** Brian White, Deputy Public Counsel  
**RE:** Division of Workers Compensation Proposed Rules – Chapter 134

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The proposed rules referenced below were reviewed and analyzed. The Office of Injured Employee Counsel did not participate in the rulemaking process because the rules have limited impact on injured employees of Texas.

Chapter 134- Benefits – Guidelines for medical Services, Charges, Payments  
Subchapter E. Health Facility Fees  
Section 134.402 – Ambulatory Surgical Center Fee Guideline



## MEMORANDUM

**DATE:** August 4, 2008  
**TO:** DWC Rule Team  
**FROM:** Brian White  
**RE:** OIEC Comments on DWC Informal Draft of 28 Texas Admin. Code §§ 180.1-180.2

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the Texas Department of Insurance, Division of Workers' Compensation's (Division) informal draft of 28 Texas Admin. Code §§108.1-180.2 concerning complaints against system participants. Please consider the following suggestions on behalf of the injured employees of Texas:

1. Page 1, §180.1(11):
  - The definition of "complaint" is overly broad. The proposed definition of complaint appears to include general statements of dissatisfaction and anger with the system, which would then become subject to enforcement action. It is common for injured employees to send letters expressing dissatisfaction because of their inability to obtain income and medical benefits. Those letters are generally based on a belief that the carrier is attempting to wrongly deprive them of benefits. In the instances where the injured employee is mistaken as to their entitlement to benefits, an acknowledgment letter with an explanation of why the injured employee is not entitled to the benefits he or she is seeking would seem the appropriate response. An injured employee's mistaken belief that he or she is entitled to some benefit should not provide a basis for an administrative violation. Under the proposed definition of complaint, it seems that it would be.
  - OIEC recommends that the term complaint be defined as completion and submission of a complaint form. OIEC further recommends that the complaint form include a written certification that the complainant believe the complaint to be true along with an admonition that pursuit of a "frivolous complaint" may result in an administrative penalty. In other words, OIEC believes that a system participant should only risk liability for an administrative violation, if the participant files of a formal complaint on a Division form.
2. Page 1, §180.1(23):
  - The definition of "frivolous" should be expanded to include the language of Texas Labor Code § 415.009 exempting from enforcement actions good faith arguments for extension, modification or reversal of existing law. Specifically OIEC recommends that the italicized language be added to the definition Frivolous complaint – means a



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complaint that the Division determines has no basis in fact or evidence; is not warranted by the Act or Division rules or a good faith argument for the extension, modification, or reversal of existing law . . . .

- The definition of “frivolous complaint” also needs to be modified where it states “is outside the timeframe for filing a complaint as described in Subsection (h).” The reference to Subsection (h) is unclear. This rule should reference the provision that establishes the timeframes for filing complaints. They are not included in either §180.1 or § 180.2 and those timeframes must be apparent, particularly if failure to comply with them results in an administrative violation.



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### MEMORANDUM

**DATE:** August 28, 2008

**TO:** TDI Rule Comment Folder

**FROM:** Elaine Chaney

**RE:** Informal Comments Proposed Amendments to 28 Tex. Admin. Code §10.22, 10.24, and 10.26 Relating to Workers' Compensation Health Care Networks

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After reviewing the working draft of the proposed amendments to rules relating to workers' compensation health care networks, it was determined that there were no issues with the informal working draft of the rule that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no informal comment was submitted by OIEC to the informal working draft of these rules.



## MEMORANDUM

**DATE:** September 2, 2008

**TO:** DWC Rule Team

**FROM:** Brian White, Deputy Public Counsel

**RE:** OIEC Comments on Compensation Procedure Rule §122.100 and Death and Burial Benefits Rules §132.6, §132.9, and §132.11

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (DWC) proposal of Chapters 122 and 132 concerning compensation procedure and death and burial benefits, which implement House Bill (HB) 724 from the 80th Texas Legislature, 2007. Please consider the following suggestions on behalf of the injured employees of Texas:

**1. §122.100. Claim for Death Benefits.**

- Page 11; §122.100(e)(3): OIEC request that the phrase "submits proof satisfactory to the Commissioner of Workers' Compensation of a compelling reason for the delay in filing the claim for death benefits" be defined. By simply parroting the language of the statute, DWC has failed to provide any guidance to potential "eligible parent" beneficiaries as to the showing they would have to make in order to qualify for benefits, if their claim is filed more than one year after the date of death. OIEC agrees that it appears that the Legislature intended to create a more stringent standard to excuse the legal consequence of an eligible parent's failure to timely file a claim. And, although OIEC appreciates the challenges facing DWC in providing an exhaustive definition of what would constitute "proof satisfactory of a compelling reason for delay in filing the claim for death benefits," it nevertheless seems that some explanation of the type of evidence that the "eligible parent" would submit in an effort to meet the requirement is necessary.

**2. §132.6. Eligibility of Other Surviving Dependents and Eligible Parents to Receive Death Benefits.**

- Page 10; §132.6(b): OIEC believes that the rule, as drafted, improperly interprets the definition of "eligible parent" in Texas Labor Code § 408.182(f)(4). That section provides "'Eligible parent' means the mother or father of a deceased employee, including an adoptive parent or a stepparent, who receives burial benefits under Section 408.186." OIEC worked closely with the Legislature on House Bill (HB) 724 and based on that experience, it is our understanding that the legislative intent of HB 724 was to decrease the instances where only the subsequent injury fund would receive death benefits. In other words, the purpose of HB 724 was to create another



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class of potential beneficiaries to ensure that, whenever possible, a family member of the deceased employee would receive some death benefits when there is no eligible spouse, no eligible child, no eligible grandchild, and no surviving dependents of the deceased. However, by conditioning receipt of death benefits on the eligible parent being able to establish receipt of burial benefits, §132.6(b) significantly undermines the intent of providing eligible parents with 104 weeks of death benefits. As a practical matter, it is rare that parents pay the burial benefits for their children who are alleged to have died as a result a work-related injury. In most instances, those expenses are either paid by the employer or the workers' compensation carrier and; therefore, the "eligible parents" are not entitled to burial benefits and cannot demonstrate receipt of the same. As §132.6(b) is currently written, the "eligible parents" would also not be entitled to death benefits. OIEC believes that the phrase "who receives burial benefits" is only applicable to an adoptive parent or stepparent who is attempting to establish entitlement to death benefits as an "eligible parent." The issue of whether biological parents are entitled to receive death benefits as an "eligible parent" should be made without the biological parents having to demonstrate receipt of burial benefits as long as their parental rights have not been terminated. OIEC recommends that §132.6(b) be amended to clarify that only adoptive parents and stepparents are required to submit proof of receipt of burial benefits in order to establish entitlement to death benefits as an "eligible parent."

- Page 10; §132.6(b): OIEC also recommends that the term "eligible parent" be more clearly defined. OIEC is concerned that the definition fails to provide sufficient guidance on what is actually required to satisfy the definition. OIEC requests that DWC provide clarification of whether the stepparent is required to be married to the natural or adoptive parent at the time of the injured employee's death in order to be considered an "eligible parent."
- Page 11; §132.6(c): If the language in §132.6(b) is changed such that only adoptive parents and stepparents are required to establish receipt of burial benefits in order to establish entitlement to death benefits as an "eligible parent" then the language of §132.6(c) would also have to be modified to reflect that only adoptive parents and stepparents are required to submit proof of receipt of burial benefits with their claim for death benefits.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact me if I can be of assistance or clarify any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** November 3, 2008  
**TO:** DWC Rule Team  
**FROM:** Brian White, Deputy Public Counsel  
**RE:** OIEC Comments on Supplemental Income Benefits Rules §§ 130.101-130.109

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (DWC) proposal of §§ 130.101-130.109 concerning supplemental income benefits (SIBs), which implement statutory provisions of House Bill 7 enacted by the 79<sup>th</sup> Legislature, Regular Session, effective September 1, 2005. Please consider the following suggestions on behalf of the injured employees of Texas:

### 1. § 130.101 (1)(D):

OIEC recommends including the examples of generally accepted accounting principles (GAAP) in this section. OIEC feels it is appropriate to include examples in the provision so that system participants can have a clear idea of what supporting documentation reflecting GAAP would be sufficient and acceptable to establish self-employment income earned during the qualifying period.

GAAP is a basic framework of guidelines for financial accounting which may have a specific meaning for accountants and auditors but fails to present clear guidance to the majority of system participants; particularly, injured employees who are likely to be unfamiliar with the documentation of income required under GAAP. It would be very helpful, practical, and clear for evaluators (DWC and Carriers in assessing SIBS entitlement) and SIBS applicants if the regulatory language in this provision provided examples of what supporting documentation reflecting GAAP may be acceptable. Without the provision of some examples, would the SIBS applicants be required to consult with accountants regarding whether their supporting documentation is in line with GAAP standards? OIEC requests that DWC provide practical guidance to system participants by including language giving examples of the kind of documentation that is required under GAAP to establish self-employment income. In addition, OIEC requests that in giving examples of the documentation that would satisfy GAAP, DWC use the phrase "**including, but not limited to**" rather than "**such as**" to provide clarity that the list provides examples and does not create an exhaustive list. OIEC believes this is important because "*such as*" language in the 4<sup>th</sup> edition of the AMA Guides to the Evaluation of Permanent Impairment has been interpreted by the Appeals Panel to establish absolute requirements to



establish entitlement to a radiculopathy rating, as opposed to identifying examples of objective signs of radiculopathy.

By giving specific examples of acceptable documentation, DWC would be furthering the stated objective of providing a “**clearly defined process**” for applying for SIBs included on page 13 of the Preamble:

The Division does not anticipate an increase in disputes relating to SIBs as a result of these proposed amended sections. A decrease in the number of disputes relating to SIBs is expected because the rule will include strict numerical requirements and no longer require a subjective standard in order to apply and qualify for SIBs.

The proposed amended sections benefit both injured employees and insurance carriers by outlining a **more clearly defined process** for establishing entitlement to SIBs and by providing identifiable compliance standards. The identification of compliance standards will also provide guidelines for a quicker determination of an injured employee’s entitlement/non-entitlement to SIBs. (Emphasis added.)

**2. §130.101-OIEC recommends adding a definition for the phrases “work search contacts” and “work search efforts.”**

It is important that the Division provide clear guidance on the various acceptable ways of establishing the appropriate level of work search activity to demonstrate an “active effort to obtain employment in accordance with work search compliance standards” pursuant to Labor Code § 408.1415 (which would be consistent with the Preamble objectives).

**OIEC proposes that the following definitions be added as 130.101 (10) and (11), respectively:** OIEC believes that in order for DWC to give clear guidance to system participants it must define and describe “*the types of activities that may constitute a work search contact*” (as noted in the Preamble, Page 4). Instead of merely referencing 40 TAC § 815.28 in the Preamble, it would be helpful, practical, and clear for DWC to provide guidelines that describe the types of activities that may constitute a work search contact. As such, OIEC strongly recommends that a definition of the phrases “work search contact” and “work search effort” be added to § 130.101 by including subsection (10) and (11) as follows:

(10) "Work search contact" means an activity for purposes of a productive search for suitable work. Examples of such activities include, but are not limited to:

(A) utilizing employment resources available at Texas Workforce Centers that directly lead to obtaining employment (including, but not limited to: (i) using local labor market information; (ii) identifying skills the claimant possesses that are consistent with targeted or demand occupations in the local workforce development area; (iii) attending job search seminars, or other employment workshops that offer instruction in developing effective work search or interviewing techniques; and (iv) obtaining job postings and seeking employment for suitable positions needed by local employers);



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(B) attending job search seminars, job clubs, or other employment workshops that offer instruction in improving individuals' skills for finding and obtaining employment;

(C) interviewing with potential employers, in-person or by telephone;

(D) registering for work with a private employment agency, placement facility of a school, or college or university if one is available to the injured employee in his or her occupation or profession; and

(E) other work search activities as may be provided in Texas Workforce Commission guidelines.

(11) "Work search efforts" means any appropriate level of activity that may be demonstrated as described in Subsection (10) which may lead to obtaining employment in accordance with §408.1415.

### **§130.102(d)**

1. §130.102(d)(3) – OIEC requests clarification of the phrase “work search efforts” as it is used in proposed subsection (d)(3) of §130.102. The question is whether that phrase is limited to job applications or whether it is synonymous with the phrase “work search contacts” as it is defined in Chapter 40 of the Texas Administrative Code §815.28, which encompasses other activities of a productive search for employment other than completing job applications.
2. §130.102(d)(5) – OIEC also requests clarification of the Phrase “has performed active work search efforts documented by job applications” as it is used in proposed subsection §130.102(d)(5). From the language of this proposed subsection, it appears that an injured employee, who engages in a job search in an effort to establish SIBs entitlement outside of TWC, is required to document work search efforts by submitting completed job applications and that other job search activities will not be sufficient to establish SIBs entitlement. If subsections (d)(3) and (d)(5) indeed create the distinction of the type of documentation that is required to establish “work search efforts” for injured employees depending on whether they conduct their search through TWC or on their own, OIEC requests that DWC more clearly articulate that difference.

### **§130.102(e)**

1. The need for clarification of §§130.102(d)(3) and (d)(5) is exacerbated by the language in subsection (e). Specifically, as it is proposed, subsection (e) states, “As provided in subsection (d)(3) and (5) of this section regarding active work search efforts, an injured employee shall provide documentation sufficient to establish that he or she has, during the qualifying period, made the minimum number of work search contacts required for unemployment compensation for the injured employee’s county of residence pursuant to the TWC Local Workforce Development Board requirements.” The phrase “work search



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contacts” is defined by TWC to include activities beyond completion of job applications and subsection (e) requires an injured employee to submit documentation that the required number of work search contacts has been completed in order to establish an active work search effort. By using terms interchangeably that do not have the same meaning, this section falls short of satisfying the goal of the rule identified in the preamble of “outlining a more clearly defined process for establishing entitlement to SIBs and by providing identifiable compliance standards.” OIEC requests that the rules be modified to clarify if the work search efforts that an employee is required to document includes activities other than completing a job application and, if so, whether those other activities are only sufficient for injured employees who conduct their job search through TWC.

2. OIEC also recommends that subsection (e) include language that the work search requirements may vary from place to place based upon the requirements established by the TWC Local Workforce Development Boards. Injured employees that are familiar with the process for obtaining unemployment benefits may be aware that not all areas of the State have the same work search requirements. However, many injured employees would not have that information. If language were included in the explaining that work search requirements are set by region, it would serve the goal of creating more certainty in what is required to establish SIBs eligibility. It would also provide much needed guidance to injured employees who relocated in the middle of the process.

### §130.102(g)

OIEC requests the following change in the language of § 130.102 (g):

- (g) Maximum Medical Improvement and Impairment Rating Disputes. If there is no ~~pending~~ active dispute regarding the date of maximum medical improvement or the impairment rating raised by the party intending to avoid the application of this subsection prior to the expiration of the first quarter, the date of maximum medical improvement and the impairment rating shall be final and binding.

There are many instances where an insurance carrier has paid SIBs for several quarters and then has challenged entitlement to a later SIBs quarter based on a previously filed dispute of the 15% or greater impairment rating (IR) that was not actively pursued by the carrier. In other words, the carrier files a dispute of the IR but then essentially abandons the dispute. The case proceeds with the injured employee applying for and receiving SIBs for several quarters only to have the carrier resurrect its dispute and to challenge SIBs entitlement on the ground that the injured employee does not have a 15% or greater IR. If “pending” were changed to “active,” the insurance carrier would be required to be affirmatively pursuing the dispute of the IR at the time of the expiration of the first quarter or lose its right to do so. Once the injured employee establishes an IR of 15% or greater and that the injured employee did not commute the impairment income benefits to establish first quarter eligibility, those two SIBs criteria are intended to be forever established. By changing “pending” to “active” and requiring that the



dispute be that of the party seeking to avoid finality, this rule would be more consistent with that objective.

### **§130.102**

Finally, OIEC recommends that proposed §130.102 be modified to include a good cause exception for failure to comply with the work search requirements TWC Rule 815.28(b)(5) provides, “Failure to comply with work search requirements, without good cause, could result in an ineligibility determination that may result of a loss of benefits.” There are occasions when circumstances beyond the control of the injured employee, such as an illness unrelated to the compensable injury, a death in the family, or a natural disaster, might result in the failure to comply with the work search requirements for a portion of the qualifying period. If the injured employee demonstrates compliance with the work search requirements for the balance of the qualifying period and the hearing officer determines that the injured employee has good cause for the failure to comply with the work search requirements in the other portion of the qualifying period, it would seem appropriate for the injured employee to still qualify for SIBs. Accordingly, OIEC recommends the following language be added to §130.102 as subsection (i):

- (i) Failure to comply with work search requirements, without good cause, may result in an ineligibility determination that may result in loss of SIBs benefits.

### **§130.103(b)(5)**

OIEC is concerned because the proposed SIBs rules do not clearly establish how the injured employee is going to be given the information about the work search requirements that are applicable to them. It is imperative that the injured employee have the information concerning the work search efforts in which documentation is required in order to serve the legislative objective of HB 7 to provide certainty in the process for establishing SIBs entitlement. Accordingly, OIEC recommends that §130.103(5) be modified to clarify that the notice of determination will include the applicable work search requirement applicable to the injured employee as established by the TWC Local Workforce Development Board.

### **§130.104(b)**

OIEC also recommends that proposed §130.104(b) be modified to require that when the insurance carrier sends a SIBs application to the injured employee that the carrier identify the work search requirement applicable to the injured employee in addition to providing information about the number of the applicable quarter; the dates of the qualifying period; the dates of the quarter; and the deadline for filing the application with the insurance carrier. As noted in the comment to §130.103(b)(5), it is critical that the injured employee have this information if the legislative mandate of Texas Labor Code §408.1415 is to be realized; however, it appears that the information may not be readily available to injured employees. Since the carrier will have to know this information in order to evaluate a SIBs application, it seems appropriate for the carrier to be required to include that information with the SIBs application in order to ensure that it is provided to the injured employee.



**§133.108**

Texas Labor Code §408.147(b) states, “If an insurance carrier fails to make a request for a benefit review conference within 10 days after the date of the expiration of the impairment income benefits period or within 10 days after receipt of the employee’s statement, the insurance carrier waives the right to contest entitlement to supplemental income benefits and the amount of supplemental income benefits for that period of supplement income benefits.” Subsections (c) and (d) of §133.108 implement Labor Code §408.147(b); however, they provide that the carrier only waives its right to contest SIBs entitlement in those instances where the carrier paid SIBs in the immediately preceding quarter. Under §133.308(d), if the insurance carrier did not pay SIBs in the immediately preceding quarter, it is not required to request a BRC within 10 days following receipt of the SIBs application in order to avoid waiver. There is no language in Labor Code §408.147 to indicate that the waiver provision is limited to only those instances where the carrier paid SIBs in the immediately preceding quarter. To the contrary, the statutory language is clear. If the insurance carrier fails to request a BRC within 10 days of receipt of the injured employee’s statement (application), it waives its right to contest entitlement to SIBs for that quarter. OIEC recommends that subsection (d) of §130.108 be removed and that subsection (c) be modified to provide that the insurance carrier waives the right to contest entitlement to a SIBs quarter for any quarter that it fails to request a BRC within 10 days after the date it receive the injured employee’s application for SIBs. In other words, once the insurance carrier receives an injured employee’s application for SIBs, it has 10 days to decide whether to contest entitlement to those benefits without regard to whether it paid benefits in the immediately preceding quarter. If the insurance carrier fails to request the BRC within 10 days of the date it received the application, it waives its right to contest SIBs entitlement for that quarter. OIEC believes that this change to §133.308 is required to make the rule consistent with Labor Code §408.147(b).

Finally, OIEC is concerned about several logistical issues that are likely to arise in applying the TWC work search standards for determining SIBs eligibility. Initially, it does not appear that the requirements established by the TWC Local Workforce Development Boards are archived and readily available to system participants. This will be particularly problematic in the cases where the determination of SIBs entitlement is delayed due to the fact that the administrative resolution of the IR issue was that the injured employee did not have a 15% or greater IR; however, on judicial review the injured employee prevails and establishes an IR of 15% or more. OIEC believes that provisions must be made to make current and past work search requirements readily available on the DWC website. If that information is not available, then it is unclear how the parties will access the standards necessary to resolve many of the issues of SIBs entitlement. In addition, OIEC seeks clarification of the effect of changes made in the work search requirement during the course of the qualifying period. If a TWC Local Workforce Development Board changes the work search requirement in the county where an injured employee lives or if the injured employee moves to a county with a different work search requirement during the qualifying period, what will be the consequence? How will the information about the change be conveyed to the injured employee and the carrier? OIEC recommends that the work search requirement be established at the beginning of the qualifying period and that it not be subject to change until the next qualifying period because it does not appear that a mechanism exists to apprise injured employees and other system participants of ongoing changes in the work search requirements over the course of a qualifying period. The resulting level of uncertainty about the



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standards necessary to establish SIBs entitlement that would result if the work search requirements were to change during the qualifying period would be wholly inconsistent with the recognized objective of adopting SIBs compliance standards.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact me if I can be of assistance or clarify any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** January 21, 2009  
**TO:** DWC Rule Team  
**FROM:** Brian White  
**RE:** OIEC Comments on Informal Draft of 28 Texas Admin. Code §§ 134.500 and 134.506-134.509

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) informal draft of 28 Texas Admin. Code §§134.500 and 134.506-134.509 concerning a pharmacy closed formulary.

OIEC's initially requests that the Division consider adopting a closed formulary that designates as excluded specific drugs within a class of drugs requiring preauthorization, but not including preferred medications within the class. OIEC believes that if such a formulary were adopted, it would strike an appropriate balance between the objectives of addressing issues of overutilization of ineffective prescription medications and ensuring that injured employees have prompt access to the prescription medications that their health care provider prescribes. It is presumed that the list of excluded medications on the formulary would be limited to those medications that evidence-based medicine have demonstrated are not the best choices in helping injured employees recover from their injury or illness. While OIEC acknowledges that cost containment is an important objective, it should not be achieved by requiring that less effective and lower-cost alternatives are mandated by the formulary. OIEC's goal is to ensure that if an injured employee leaves a pharmacy without the medication prescribed by his or her health care provider, it is because significant evidence exists that the prescribed medication is not generally the most effective treatment option available and not because it was required due to cost.

OIEC believes that the primary tool for addressing overutilization of prescription medication is the treatment guidelines contained in the Official Disability Guidelines (ODG). When ODG provides that treatment with a class of medication is recommended, the decision of the specific medication within that class to prescribe is a decision that should be left to the medical judgment of the prescribing doctor; subject to the limitation that if the doctor prescribes a medication excluded by the formulary, then that prescription will require preauthorization. OIEC is concerned that if the formulary creates preferred medications, it will unnecessarily restrict the pharmaceutical treatment options available to injured employees. In addition, OIEC is concerned that the preferred medication list creates a one-size-fits-all remedy that does not permit tailoring drug treatment to the injured employee's unique injuries or conditions. For example, in a circumstance where an injured employee is allergic to the preferred drugs within a



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drug class, it would seem absurd to require preauthorization for a readily available substitute that was neither excluded nor preferred by the formulary. In summary, OIEC recommends that the Division adopt a formulary that identifies medications within a category that require preauthorization but does not give preferred status to any medications. Such a formulary would serve the objective of limiting access to inappropriate medications while still ensuring that a broad range of medication remains available to treat the injured employees of Texas.

In the event that the Division decides to adopt the rules as currently proposed, OIEC has recommendations about specific provisions. In proposed §§134.508(b)(1)(C) and (D), preauthorization is required for all off-label use of drugs and for all drugs as a result of compounding as defined in §134.500(3). OIEC understands that in certain circumstances, ODG has already addressed and recommended off-label use of medication and compounding. However, the proposed rule seems to require that such treatment would nevertheless require preauthorization. OIEC believes that to require preauthorization for treatment that is included in ODG introduces unnecessary complication and delay in the process of providing prescription medication to injured employees. Accordingly, OIEC recommends that §§134.508(b)(1)(C) and (D) be modified to require that only off-label use and compounding not recommended in ODG require preauthorization.

Proposed §§134.508(b)(2) and 134.509(d) permit retrospective review of drugs prescribed in accordance with §134.501 for claims not subject to certified networks and claims subject to certified networks, respectively. The purpose of §134.501 is to provide acute access to medications within the first seven days following the date of injury. OIEC believes that permitting retrospective review of medication decisions made during that period has the potential to significantly undermine the rule. It could be argued that the injured employee would already have the medication and, therefore, that he or she does not have an interest in ensuring that the pharmacy is paid for the medication. However, such an argument fails to consider the interest that injured employees have in ensuring that pharmacies remain willing to participate in the workers' compensation system. When a pharmacist fills a prescription from a doctor, he or she does not have access to information that would permit him or her to legitimately question that the medication is reasonably required by the injury, particularly in the seven-day period immediately following the date of injury. However, the pharmacy is the entity that is required to go without payment if the medication is ultimately denied in retrospective review. OIEC is concerned that this creates a disincentive for pharmacies to participate in workers' compensation. As a result, OIEC recommends that the provisions permitting retrospective review of medication provided in the initial seven days following the date of injury be deleted. In the alternative, OIEC recommends that the Division consider permitting insurance carriers to obtain reimbursement from the subsequent injury fund for medication provided in accordance with §134.501 that is later determined in retrospective review not to have been reasonable and necessary.

Finally, OIEC is concerned that the adoption of the ODG drug formulary may create conflicts in claims subject to certified networks. Certified health care networks already employ prescription drug formularies. It is anticipated that those formularies may not be entirely consistent with the ODG formulary. From our reading of §134.509, it appears that the ODG formulary would trump whatever formulary had been adopted by the individual network; however, OIEC believes that clarification of what would happen in the event of such a conflict is required.



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Thank you in advance for your careful consideration of the above comments. OIEC believes all other sections not referenced herein should be adopted as proposed. Please do not hesitate to contact me if I can be of assistance or clarify any of OIEC's comments on behalf of the injured employees of Texas.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** January 13, 2009

**TO:** TDI Rule Comment Folder

**FROM:** Elaine Chaney

**RE:** 28 Tex. Admin. Code §133.20 – Medical Bill Submission by Health Care Providers

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After reviewing the text of this proposed rule relating to medical bill submission by health care providers, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to proposed Rule 133.20.



## MEMORANDUM

**DATE:** July 15, 2009  
**TO:** DWC Rule Team  
**FROM:** Brian White  
**RE:** OIEC's Comments on Informal Draft of the Chapter 180 Rules

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) informal draft of the Chapter 180 Rules, 28 Texas Admin. Code §§ 180.1-180.30. OIEC requests the consideration of the following comments on behalf of the injured employees of Texas:

### **§ 180.1-180.3, 180.5, 180.8, and 180.10 -- General Rules for Enforcement.**

1. Page 3; § 180.1(a)(8): OIEC recommends the removal of the phrase "until further material recovery from or lasting improvement to the injury can no longer reasonably be anticipated." OIEC does not believe that such a phrase concerning maximum medical improvement (MMI) is necessary or is related to the definition of the phrase "appropriate credentials." The above-referenced language is not derived or mandated by the statute, and OIEC believes it is irrelevant to the definition. The requirement of Labor Code §§ 408.0043 and 408.0046 that a doctor hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving was clearly intended to apply regardless of the point in time in the claim that the care is provided. To limit the need for appropriate credentials only to health care provided prior to the date of MMI is contrary to the statute. If it is the Division's position that the inclusion of the language "until further material recovery from or lasting improvement to the injury can no longer reasonably be anticipated" does not limit the requirement that the provider have appropriate credentials only to health care provided prior to the date of MMI, OIEC requests an explanation of the purpose of including this language in this section and in proposed § 180.1(b).
2. Page 8; § 180.1(a)(21): To clarify the rule, OIEC recommends including the definition of "frivolous" contained in Labor Code § 402.092(e) and § 415.009 in the text of the Rule itself. OIEC believes that it is essential that system participants be able to understand the rules without having to reference statutory provisions.
3. Page 16; § 180.3(c): OIEC agrees with the decision to change the mandatory advance notice of a Compliance Audit to discretionary because we believe that in some instances, the Division is more likely to obtain an accurate picture of whether or not an insurance carrier is in compliance if the insurance carrier has not been given advanced notice.



4. Page 19; § 180.5(c): OIEC requests that injured employees be exempted from the requirement of providing documentation at no cost to the Department or Division. Historically, injured employees have been exempted from incurring costs associated with the administration of the workers' compensation system because of the undue burden such costs impose on them, and OIEC believes that it is appropriate to continue this practice.
5. Page 22; § 180.8: OIEC recommends that the Notice of Violation (NOV) include cautionary language advising that the failure to respond to the NOV within 20 days of receipt constitutes consent to the proposed penalty.

**§§ 180.20, 180.22, and 180.24 -- Doctor Requirements and Responsibilities.**

1. Page 36; § 180.20(b): OIEC disagrees with the decision to make it discretionary whether or not information about doctors who have been sanctioned will be posted on the Division's website. It is essential that such information be readily accessible to system participants to ensure that complete information is available in making decisions about health care providers.
2. Page 42; § 180.22(f)(1): OIEC recommends that the language of this subsection be modified to state "licensed to practice medicine in Texas." OIEC believes it is necessary to include this language to satisfy the Legislative mandates of HB 1003 and HB 1006 from the 80<sup>th</sup> Legislature, 2007. Previously, the Department and the Division had taken the position that if a doctor was associated with a Utilization Review Agent that was licensed in Texas, it satisfied the licensure requirement. However, it is apparent that the Legislature intended that doctors functioning in the workers' compensation system were to be licensed to practice medicine in this State. OIEC believes this change is also consistent with §§ 180.22(f)(2)(A) and (B) which state, respectively, "dentist's license to practice dentistry" and "chiropractor's license to engage in the practice of chiropractic."
3. Page 42; §§ 180.22(f)(2)(A) and (B): OIEC recommends that the language "in Texas" be added to both of these sections. The Legislature clearly intended that doctors, dentists, and chiropractors be licensed in Texas and subject to regulation by their respective Texas disciplinary boards.
4. Page 46; § 180.22(h)(4): OIEC recommends that language be added to this subsection to clarify that carriers are subject to an administrative penalty if they do not use doctors licensed to practice medicine in Texas, dentists licensed to practice dentistry in Texas, and chiropractors licensed to engage in the practice of chiropractic in Texas to perform peer review. OIEC believes this language needs to be included for the reasons outlined in our comment to § 180.22(f)(1), above.
  - OIEC recommends the following addition to implement this change: "An insurance carrier or its agent commits and administrative violation if it uses a doctor not licensed to practice medicine in Texas, a dentist not licensed to practice dentistry in Texas, or a chiropractor not licensed to engage in practice of chiropractic in Texas and who does not hold appropriate credentials as required by the Act and Division Rules to perform a peer review of a workers' compensation claim."
5. Page 48; § 180.24(b)(1): OIEC believes the language of this subsection needs to be clarified. In the first sentence it appears that the health care provider is required to file



the disclosure information when the injured employee is referred to a health care practitioner in which the referring provider has a financial interest. However, the second sentence provides that the disclosure “shall be filed for each health care provider to whom an injured employee is referred . . . .”

**§§ 180.25-180.30 – Sanctionable Violations and Procedures**

1. Page 68; § 180.26(d)(11): OIEC recommends the addition of language permitting the Division to recommend the restriction, suspension, or revocation of an insurance adjuster’s license. In many instances, the wrongdoer is the insurance adjuster and it would seem appropriate in those cases to sanction the adjuster either in addition to or instead of the insurance carrier.
  - OIEC recommends the following addition to implement this change: “referral and petition to the appropriate licensing authority for appropriate disciplinary action, including, but not limited to, the restriction, suspension, or revocation of the health care provider’s, insurance carrier’s, or insurance adjuster’s license.”
2. Page 74; § 180.28(a)(11): OIEC recommends that this subsection be modified to make clear that the licensure required is either a medical license, a dental license, or a chiropractic license. This change would be consistent with our earlier comments and with the language used in § 180.28(e)(4).
  - OIEC recommends the following addition to implement this change: “the peer reviewer’s name, professional Texas medical, dental, or chiropractic license number.”

Thank you in advance for your careful consideration of the above comments. OIEC believes all other sections not referenced herein should be adopted as proposed. Please do not hesitate to contact me if I can be of assistance in clarifying any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** July 10, 2009

**TO:** DWC Rule Team

**FROM:** Brian White

**RE:** OIEC Comments on Informal Draft of 28 Texas Admin. Code §§ 134.500 and 134.506-134.509

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) informal draft of 28 Texas Admin. Code §§ 134.500 and 134.506-134.509 concerning a pharmacy closed formulary.

OIEC initially requests that the Division consider adopting a closed formulary that designates as excluded, specific drugs within a class of drugs requiring preauthorization, but not including preferred medications within the class. OIEC believes that if such a formulary were adopted, it would strike an appropriate balance between the objectives of addressing issues of overutilization of ineffective prescription medications and ensuring that injured employees have prompt access to the prescription medications that their health care provider prescribes. It is presumed that the list of excluded medications on the formulary would be limited to those medications that evidence-based medicine has demonstrated are not the best choices in helping injured employees recover from their injuries or illnesses. While OIEC acknowledges that cost containment is an important objective, it should not be achieved by requiring that less effective, lower-cost alternatives are mandated by the formulary. OIEC's goal is to ensure that if an injured employee leaves a pharmacy without the medication prescribed by his or her health care provider, it is because significant evidence exists that the prescribed medication is not generally the most effective treatment option available and not because the medication is more expensive than other medications.

OIEC believes that the primary tool for addressing overutilization of prescription medication is the treatment guidelines contained in the Official Disability Guidelines (ODG). When ODG provides that treatment with a class of medication is recommended, the decision of the specific medication within that class to prescribe is a decision that should be left to the medical judgment of the prescribing doctor; subject to the limitation that if the doctor prescribes a medication excluded by the formulary, then that prescription will require preauthorization. OIEC is concerned that if the formulary creates preferred medications, it will unnecessarily restrict the pharmaceutical treatment options available to injured employees. In summary, OIEC recommends that the Division adopt a formulary that identifies medications within a category that require preauthorization but does not give preferred status to any medications. Such a



formulary would serve the objective of limiting access to inappropriate medications while still ensuring that a broad range of medication remains available to treat the injured employees of Texas.

In the event that the Division decides to adopt the rules as currently proposed, OIEC has recommendations about specific provisions. The Division has solicited comment concerning its two proposed options for § 134.507(b). OIEC believes that Option 1 is superior to Option 2. Option 1 provides for the closed formulary to be phased-in over time depending on the date of injury to allow for continuity of care. Option 2 provides for the closed formulary to apply to all drugs prescribed and dispensed on or after March 1, 2010. OIEC believes that providing for no transition period would disrupt the continuity of care of injured employees in many cases by requiring sudden changes in drug regimens in use for many years. In some cases this could not only disrupt care but result in serious side effects, such as drug withdrawal symptoms. For this reason, OIEC believes that Option 2 should not be adopted. OIEC, in fact, believes that rather than adopting Option 1 as proposed, there should be additional language added to provide that a carrier should provide reasonable and necessary treatment during the transition periods in Option 1 to mitigate the side effects from changes in an injured employees' drug regimen, including withdrawal symptoms. An additional benefit of phased-in implementation of the formulary is that it would permit system participants to identify and correct problems associated with the formulary before it applies to all prescriptions in the workers' compensation system.

OIEC strongly supports § 134.508(c)(2) because it permits drugs included in the closed formulary that exceed or are not addressed by the treatment guidelines to nevertheless be prescribed and dispensed without preauthorization. Access to medication without the delay associated with the preauthorization process is always in the best interests of injured employees. Although OIEC hopes there will be few instances where the retrospective review provision of § 134.508(c)(3) will result in non-payment to a pharmacy, ensuring timely access to medication is a laudable goal advanced by not requiring preauthorization for drugs included in the closed formulary.

OIEC seeks clarification of §§ 134.508(d)(2) and 134.509(d)(2). While we agree that a statement of Medical Necessity will facilitate the preauthorization process, it is unclear who will request that statement. The fact that no other system participant needs a rule to make such a request suggests that the Division would be the requestor. OIEC would agree with that approach because if the Division were the requestor, there would be a greater chance that the Statement of Medical Necessity would be provided and, accordingly, that information essential to making the correct preauthorization decision would be considered. If the Division is going to be the requestor, the rule should be revised to clearly state that and to explain how an injured employee or a non-prescribing doctor requestor would ask the Division to request the Statement of Medical Necessity.

The Division has invited comment concerning proposed §§ 134.508(e) and 134.509(d). OIEC agrees with these rules as proposed in that they provide drugs prescribed for initial pharmaceutical coverage in accordance with Labor Code § 413.0141 would not be subject to retrospective review. The purpose of Labor Code § 413.0141 is to provide access to medications within the first seven days following the date of injury. OIEC believes that permitting



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retrospective review of medication decisions made during that period would have the potential to significantly undermine the rule. It could be argued that the injured employee would already have the medication and, therefore, that he or she does not have an interest in ensuring that the pharmacy will be compensated for the medication. However, such an argument fails to consider the interest that injured employees have in ensuring that pharmacies remain willing to participate in the workers' compensation system. When a pharmacist fills a prescription from a doctor, he or she does not have access to information that would permit him or her to legitimately question that the medication is reasonably required by the injury, particularly in the seven-day period immediately following the date of injury. However, the pharmacy is the entity that is required to go without payment if the medication is ultimately denied in retrospective review. OIEC is concerned that this creates a disincentive for pharmacies to participate in workers' compensation. As a result, OIEC agrees with the recommendation that there be no retrospective review of medication provided in the initial seven days following the date of injury.

Thank you in advance for your careful consideration of the above comments. OIEC believes all other sections not referenced herein should be adopted as proposed. Please do not hesitate to contact me if I can be of assistance in clarifying any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** August 24, 2009

**TO:** DWC Rule Team

**FROM:** Brian White, Deputy Public Counsel

**RE:** OIEC Comments on Proposed Appeal Rules, 28 Texas Admin. Code §§ 143.2-143.5

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) proposal of 28 Texas Admin. Code §§143.2-143.5 concerning appeals proceedings.

OIEC recommends that Rule 143.3(b) be changed to provide a specific time limit, for example three business days, for the Division to provide a copy of the request for review to a party or parties when it is not clear that the party or parties have been served rather than merely stating that it will be provided "expeditiously." All the other actions in the appeal process have specific time limits and there appears to be no reason not to provide a specific time limit for this action. By having a specific time limit, it will be easier to calculate the timeliness of a response to a request for review. In the same vein and for much the same reasons, OIEC recommends that Rule 143.4(b) be changed to provide a specific time limit for the division to provide a copy of the response to a party or parties when it is not clear that the party or parties have been served with a copy of the response. OIEC recommends substituting "within three business days", or another specific time period, for "expeditiously" in Rules 143.3(b) and 143.4(b).

Thank you in advance for your careful consideration of the above comments. OIEC believes all other sections not referenced herein should be adopted as proposed. Please do not hesitate to contact me if I can be of assistance or clarify any of OIEC's comments on behalf of the injured employees of Texas.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** August 24, 2009

**TO:** DWC Rule Comment Folder

**FROM:** Elaine Chaney

**RE:** Comments on Informal Draft of 28 Texas Admin. Code §§ 116.11-116.12

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After reviewing the proposed rule changes concerning the Subsequent Injury Fund, 28 Texas Admin. Code §§ 116.11-116.12, it was determined that there were no issues with these rules that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no formal comment was submitted by OIEC to these proposed rule changes.



**MEMORANDUM**

**DATE:** September 4, 2009

**TO:** TDI Rule Team

**FROM:** Brian White

**RE:** OIEC Comments on Informal Draft of 28 Texas Admin. Code §§ 12.1-12.5, 12.101-12.110, 12.301-12.303, and 12.501-12.502

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review the Texas Department of Insurance's informal draft of 28 Texas Admin. Code §§ 12.1-12.5, 12.101-12.110, 12.301-12.303, and 12.501-12.502 concerning independent review organizations. OIEC believes all sections of the informal draft rules should be adopted as proposed. Please do not hesitate to contact me if I can be of assistance on this matter.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** September 15, 2009

**TO:** TDI Rule Comment Folder

**FROM:** Elaine Chaney

**RE:** 28 Tex. Admin. Code §133.2, 133.10, 133.210, 133.500, 133.501 and 134.120 –  
Informal Working Draft of eBilling Rules

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After reviewing the text of the informal working draft of proposed rules relating to eBilling, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to proposed Rules 133.2, 133.10, 133.210, 133.500, 133.501, and 134.120.



## MEMORANDUM

**DATE:** September 14, 2009

**TO:** Gene C. Jarmon, General Counsel and Chief Clerk, Texas Department of Insurance and Debra Diaz-Lara, Deputy Commissioner, Health and Workers' Compensation Network Certification and Quality Assurance Division

**FROM:** Brian White, Deputy Public Counsel

**RE:** OIEC Comment on Proposed Utilization Review Agents Rules, 28 Texas Admin. Code § 19.1722

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the Texas Department of Insurance proposal of 28 Texas Admin. Code §19.1722, re-establishing a Utilization Review Advisory Committee.

OIEC recommends that Rule 19.1722(d)(1) be changed to provide that the Utilization Review Advisory Committee include an OIEC representative in its membership. OIEC is the Texas agency statutorily charged with representing the interests of injured employees as a class. As such, OIEC believes it should have input in the process of developing the utilization review rules, particularly because the utilization review process has become increasingly important in the workers' compensation system. Further, OIEC believes its experience and expertise in assisting injured employees in the Texas workers' compensation system will allow it to provide useful insights to the process of utilization review rule development.

Thank you in advance for your careful consideration of the above comment. OIEC believes all other sections not referenced herein should be adopted as proposed. Please do not hesitate to contact me if I can be of assistance or clarify any of OIEC's comment on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** December 14, 2009

**TO:** DWC Rule Team

**FROM:** Brian White, Deputy Public Counsel

**RE:** OIEC Comments on 28 Texas Administrative Code § 141.1, § 141.2, § 141.4, § 141.7, and § 141.8

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) informal working draft of 28 Texas Administrative Code § 141.1, § 141.2, § 141.4, § 141.7, and § 141.8 regarding benefit review conferences (BRC). Please consider the following suggestions on behalf of the injured employees of Texas:

**1. § 141.1(d)(2):**

OIEC recommends that the Division clarify how the document exchange that is to be offered to demonstrate efforts made by the requesting party to resolve the disputed issues prior to requesting the BRC differs from the exchange of pertinent information required in § 141.1(e). Requiring the requesting party to provide copies of the document exchange with the other parties in order to establish that an effort was made to resolve the issue before the BRC was requested appears to be redundant of the requirement to send pertinent information with the request to both the Division and the opposing party.

**2. § 141.1(f):**

OIEC recommends that the Division clarify whether the submission of an incomplete request for a BRC will be sufficient to stop the first certification of maximum medical improvement (MMI) and impairment rating (IR) from becoming final under Texas Labor Code § 408.123(e). Under the current practice, when an injured employee is required to request a BRC in order to stop the 90-day clock because the first certification of MMI and IR is from a designated doctor or because the first certification is made by the treating doctor after a designated doctor has already been appointed to address MMI and IR, the injured employee requests a BRC and advises the Division that he or she is not ready to proceed because the evidence needed to dispute the certification is not yet available. Once the evidence necessary to go forward with the challenge to the initial certification is received, the injured employee contacts the Division and the BRC is scheduled. It is critical that this procedure remain available in this circumstance to ensure that an initial certification of MMI and IR not become final simply because the evidence needed to



move forward with the dispute may not be obtained within 90 days following the date that the injured employee received the first certification of MMI and IR by verifiable means. The finality provision of § 408.123(e) has the potential to severely restrict an injured employee's entitlement to benefits. OIEC believes that to require the injured employee to obtain the evidence necessary to pursue the dispute of the first certification of MMI and IR before he or she can request a BRC to defeat finality is unduly burdensome. The injured employee must either obtain an alternate certification or seek clarification from the designated doctor in order to have the necessary evidence to proceed with the dispute, and while the injured employee has some control over the request for an alternate rating or a letter of clarification, he or she has no ability to control whether and when the required evidence will be forthcoming.

OIEC also recommends that a requirement be added to § 141.1(f) that when the Division notifies the requesting party that the request is incomplete, the Division will detail what additional documentation has to be submitted in order to get the BRC request approved. Alternatively, OIEC recommends that the Division identify the employee who determined that the request was incomplete in the notice to the requesting party. If the decision maker is identified, the requesting party could contact that person in order to discuss what additional documentation is required before the request for a BRC will be granted.

Finally, OIEC requests that the Division provide clarification of how an injured employee can have a request for a BRC granted in a case where the injured employee is going to rely on testimony in order to establish entitlement to benefits. It is well-settled that injured employees can meet their burden of proving injury and disability in many instances based on testimony alone. In such a circumstance, there are due process implications if the injured employee is not permitted an opportunity to have a BRC because he or she elected to rely on testimony rather than documentary evidence to meet his or her burden of proof.

### **3. § 141.2(b)**

OIEC recommends that the phrase "the docket clerk" not be removed from this section. It is important that the parties know the correct person to contact in order to request that a BRC be canceled or rescheduled. In the absence of a contact person, it is difficult for parties to know who to contact in order to make a request or to obtain information about a pending request. If the concern is that there is not a docket clerk in every field office, OIEC recommends the alternative language that the parties be required to give notice of the request for cancellation or rescheduling to the person responsible for docketing in the filed office managing the claim.

### **4. § 141.2(c)**

Initially, OIEC believes that an "and" was inadvertently added to the language of this subsection. The second sentence states "The request shall ~~will~~ be granted only and on a showing of good cause." The "and" does not seem to be needed in this sentence and its insertion makes the sentence awkward. OIEC recommends that the "and" be removed from this sentence.

OIEC also recommends that the Division clarify that a benefit review officer will make the determination of whether good cause has been shown for a continuance outside of the



unrestricted period for granting a request to cancel or reschedule a BRC established in § 141.2(b). OIEC believes that if the good cause determination is vested with the benefit review officers, it is more likely that consistent standards will be applied in making good cause determinations. As the rule is currently written, it does not identify who will make the good cause determination. OIEC is concerned that if this responsibility is not placed with a single group of Division employees, consistency in decision making will be sacrificed.

**5. § 141.4(a)**

OIEC believes that the lists incorporated from the Division's website provide useful examples of the kind of information that an injured employee and/or beneficiaries should bring to the BRC where compensability issues, liability issue, income benefit issues, average weekly wage issues, and death and burial benefit issues are discussed. However, OIEC does not believe that these lists should be interpreted as establishing the minimum documentation that is required before a request for a BRC on one of those issues will be granted. In other words, while these lists identify the kinds of documentation that an injured employee or beneficiary would introduce in an attempt to establish entitlement to benefits, OIEC does not believe that an injured employee or beneficiary is required to produce evidence from each category identified in these lists to prevail and certainly should not be required to produce evidence from each of these categories in order to be given a BRC. The Division needs to clarify that the request for a BRC on one of the issues for which a list of "pertinent information" exists does not need to include documentation from every category of information identified.

**6. § 141.4(b)**

OIEC believes that the requirement that the opposing party must send all pertinent information in its possession to the requesting party, any other parties, and the Division within five days after receiving the request for a BRC is unduly burdensome. In many, if not most, of the instances where the injured employee is not the requesting party, an unrepresented injured employee who requests OIEC assistance with the BRC, does not even contact OIEC within five days of receiving the request. Therefore, those injured employees would potentially be subject to an administrative penalty before they ever received any assistance. OIEC also believes that five days is too short a period to require the opposing party to make an exchange. This is particularly true in those instances where the request is received immediately before a weekend or holiday. In order to reduce the possibility that the injured employee is subject to an administrative violation before he ever has contact with us, OIEC recommends that five business days be substituted for five days in proposed § 141.4(b).

OIEC also recommends that the Division establish the starting date of the exchange period, as the date notice of the BRC setting is received rather than the date of receipt of the request for a BRC. The date that the opposing party receives the request is not a date that is readily known with certainty. OIEC has concerns about imposing an administrative penalty on an injured employee for failure to act within a period of time following a date that is not readily identifiable. However, in § 141.2(b), the date the notice of the setting is received is "deemed to be the fifth day after the date of the notice." Therefore, if the duty for the opposing party to exchange were triggered upon receipt of the notice of the setting, that date would be known to all



parties. That date would also seem to be a more appropriate date to be used to trigger the exchange requirement because the obligation to exchange documents would not be triggered in those instances where the BRC request is denied by the Division. In addition, use of the date of notice of the setting would increase the likelihood that an unrepresented injured employee would have contact with OIEC before the time to exchange documents with the requesting party had passed and he or she was subject to an administrative violation. OIEC receives notice of BRCs that are set at the request of a carrier, employer, or subclaimant where the injured employee is unrepresented. When OIEC receives such notice, it contacts the injured employee and asks if he or she wants OIEC assistance. In that telephone call, OIEC would be able to advise unrepresented injured employees of the obligation to exchange pertinent information, the deadline for doing so, and the consequence for failure to exchange, even in those cases where the unrepresented injured employee elected to proceed without OIEC assistance.

**7. § 141.4(c)**

Due to the reduced number of BRCs that are being held, there are instances where a BRC is scheduled significantly earlier than 40 days after the request is received. OIEC recommends that if the BRC is set within 20 days of the request, the 5-day deadline to exchange additional pertinent information not previously exchanged applicable to an expedited BRC be applied, even if an expedited BRC was not requested.

**8. § 141.4(g)**

Initially, OIEC believe that the Division needs to provide clarification of whether the parties are required to resubmit the pertinent documents to the Division in those instances where the BRC is rescheduled more than 90 days after the BRC. It seems that the pertinent information would have to be resent or the benefit review officer would not be in a position to mediate the claim. However, it does not seem like an effective use of time or resources for the parties to resubmit documents that were in the Division's possession and then purged.

OIEC recommends that the Division scan the documents prior to disposing of them when the contested case hearing is set and when the parties fail to reschedule a second BRC within at least 90 days after the first BRC. This would make the documents available to the benefit review officer in those instances where the BRC is rescheduled more than 90 days after the initial BRC. In addition, if the documents were scanned prior to disposal, all parties could readily establish what documents were exchanged prior to the BRC and which are, therefore, not subject to objection at the hearing for not having been timely exchanged.

Alternatively, OIEC recommends that rather than purging the information exchanged by the parties in the cases where the unresolved issues are set for a contested case hearing, the benefit review officer attach those documents to his or her report. This practice would also permit the parties to establish what documents were exchanged and to counter objections to the admission of any of those documents at the contested case hearing based on the failure to timely exchange.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact me if I can clarify any of OIEC's comments on behalf of the injured employees of Texas.



**MEMORANDUM**

**DATE:** December 9, 2009

**TO:** D. C. Campbell, Director Workers' Compensation Research and Evaluation Group

**FROM:** Brian White, Deputy Public Counsel

**RE:** OIEC Comment on Proposed FY 2010 Research Agenda for the Workers' Compensation Research and Evaluation Group

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the proposed fiscal year 2010 Research Agenda for the Workers' Compensation Research and Evaluation Group (REG). OIEC recommends that the REG consider adding a research initiative to analyze injured employees' access to medical care provided by specialists in non-network claims. OIEC's belief, based on anecdotal evidence, is that injured employees who require the care of a specialist often encounter significant difficulty in finding a doctor that is willing to provide their care in the workers' compensation system. In a November 6, 2009, article in WorkCompCentral, former workers' compensation commissioner Albert Betts noted that this issue needed to be "looked at carefully" as it was likely a topic that would be raised in the sunset process. The sixth topic on the proposed research agenda is an analysis of injured employee access to care. OIEC believes that such an analysis would be more complete and would provide better information, if a component of the research specifically focuses on access to medical care by specialists in non-network claims. OIEC supports the other research agenda items as proposed.

Please do not hesitate to contact me if I can be of assistance.



**MEMORANDUM**

**DATE:** December 7, 2009

**TO:** Amy Lee, Special Deputy for Policy and Research

**FROM:** Brian White, Deputy Public Counsel

**RE:** **OIEC Comment on 28 Texas Administrative Code § 5.6601 and the *Texas Detailed Claim Information Statistical Plan, 2010 Edition***

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the informal draft of § 5.6601 of the Texas Administrative Code and the *Texas Detailed Claim Information Statistical Plan, 2010 Edition*. OIEC believes that 28 Texas Administrative Code § 5.6601 and the *Texas Detailed Claim Information Statistical Plan, 2010 Edition* should be adopted as proposed.

Please do not hesitate to contact me if I can be of assistance.



**MEMORANDUM**

**DATE:** January 11, 2010

**TO:** DWC Rule Team

**FROM:** Brian White, Deputy Public Counsel

**RE:** OIEC Comment on Proposed 28 Tex. Admin. Code § 137.5 Certified Case Managers

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the proposed 28 Tex. Admin. Code § 137.5 concerning Certified Case Managers. OIEC does not believe that the proposed rule language materially expands the statutory requirements of § 413.021(a) of the Texas Labor Code. Section 413.021 requires that a case manager be “appropriately certified” and proposed § 137.5 serves to provide a clear definition of the certification requirements. Since case managers are going to be involved in resolving issues of appropriate medical care and return to work, the Legislature clearly recognized the importance that these individuals have demonstrated knowledge, skills, and experience. Controlling medical costs, while ensuring receipt of necessary care, and facilitating appropriate return to work are two critical goals of the workers’ compensation system. Labor Code § 413.021 envisions that case managers will play an important role in furthering those goals. OIEC believes that proposed §137.5 defines certification broadly enough to ensure that sufficient case managers are available, while also advancing the goal of having qualified individuals perform this important function. Therefore, OIEC recommends that §137.5 be adopted as proposed. Please do not hesitate to contact me if I can be of assistance.



## MEMORANDUM

**DATE:** January 14, 2010

**TO:** Maria Jimenez, Legal Services, Texas Department of Insurance, Division of Workers' Compensation

**FROM:** Brian White, Deputy Public Counsel

**RE:** OIEC Comments on Death and Burial Benefits Rules §132.6 and §132.11 and Claim Procedure for Beneficiaries of Injured Employees Rule 122.100

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the Texas Department of Insurance, Division of Workers' Compensation's (DWC) proposals concerning Chapters 132 and 122, which implement House Bill (HB) 1058, enacted by the 81<sup>st</sup> Legislature, Regular Session, effective September 1, 2009. OIEC comments as follows:

### 1. §132.6 and 132.11

OIEC recommends both these rules be adopted as proposed. Both rules are consistent with previous OIEC legislative proposals and rules comments. Their adoption will implement HB 1058's goal of providing compensation to the parents of deceased employees.

### 2. §122.100

OIEC believes that in §122.100(e)(3) the word fragment "NonDe" is a typographical error and should be removed. With this change OIEC recommends that rule be adopted as proposed.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** February 1, 2010

**TO:** DWC Rules Team

**FROM:** Brian White

**RE:** §120.2 Employer's First Report of Injury and Notice of Injured Employee Rights and Responsibilities

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to provide comment on the proposed amendments to 28 Texas Admin. Code §120.2. The amendments to §120.2 are necessary to implement HB 673, which was a legislative recommendation of OIEC. Accordingly, OIEC recommends the adoption of §120.2 as proposed in the *Texas Register* on January 1, 2010.



## MEMORANDUM

**DATE:** March 5, 2010

**TO:** DWC Rule Team

**FROM:** Brian White

**RE:** OIEC Comments on Informal Draft of 28 Texas Admin. Code §§ 134.500 and §§134.506-134.511 Regarding a Pharmacy Closed Formulary; and Informal Proposal to Amend §133.306 Regarding Interlocutory Orders for Medical Benefits

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) informal draft of 28 Texas Admin. Code §§ 134.500 and 134.506-134.511 concerning a pharmacy closed formulary and 28 Texas Admin. Code §133.306 Regarding Interlocutory Orders for Medical Benefits.

OIEC's initial concern with adopting the *ODG Workers' Compensation Drug Formulary* is whether there will be sufficient "Y" drugs in all categories. It is critical that sufficient drug options are available in each category to provide medication alternatives when some medications prove ineffective or when the injured employee has an adverse reaction to a drug prescribed. OIEC lacks the expertise to assess whether the *ODG Workers' Compensation Drug Formulary* meets this objective in each drug category; however, we believe this factor must be considered and urge the Division to do so before adopting the proposed formulary. OIEC believes the formulary must serve the goal of limiting access to inappropriate medications while still ensuring that a broad range of medication remains available to treat the injured employees of Texas.

In the event that the Division decides to adopt the rules as currently proposed, OIEC has comments and/or recommendations about specific provisions. In regard to §134.500(3)(A), OIEC requests clarification. It is OIEC's understanding that when the *ODG Workers' Compensation Drug Formulary* is updated, drugs are sometimes reclassified from "Y" to "N" status. OIEC would like clarification as to the effect when an injured employee receives a prescription with several refills of a drug with "Y" status, and then, before all of the refills are filled, the drug is reclassified to "N" status.

Also, OIEC is concerned about §134.500(7). OIEC understands that the symptoms of a medical emergency are described as "including severe pain." If this provision were to be interpreted as limiting a medical emergency to only situations where there is severe pain, OIEC believes that interpretation would be too restrictive. That is, OIEC believes that not every medical emergency will include severe pain.



OIEC submits that in §134.500(13) the phrase “and supporting evidence-based documentation” is unnecessary and unduly onerous. OIEC contends that the information required by §134.500(13)(F) is more than sufficient to show medical necessity and that requiring “supporting evidence-based documentation” would make it significantly more difficult for an injured employee to obtain necessary medication. OIEC would further emphasize that any medications dealt with in §134.500(13) would have received FDA approval based upon valid scientific study of their safety and efficacy. While the prescribing doctor might not have these studies in his or her possession, they certainly exist for the drug to have been approved by the FDA. The evidence-based medicine of the safety and efficacy of medications approved by the FDA are the studies that led to the drug receiving FDA approval. A prescription should be filled, if the injured employee or prescribing doctor establishes that the medication satisfies the requirements of §134.500(13)(F).

OIEC strongly agrees with the decision of the Division to phase-in the closed drug formulary over time to allow for continuity of care. As stated in its earlier comments to the last draft of the preproposal, OIEC believes that providing for no transition period would disrupt the continuity of care of injured employees in many cases by requiring sudden changes in drug regimens in use for many years. In some cases this could not only disrupt care but result in serious side effects, such as drug withdrawal symptoms. For this reason, OIEC also strongly agrees with the concept of medical providers and carriers cooperating to plan some additional transition in such cases as provided in §134.510. As also pointed out in our comments to the last draft of the preproposal, an additional benefit of phased-in implementation of the formulary is that it will permit system participants to identify and correct problems associated with the formulary before it applies to all prescriptions in the workers’ compensation system.

OIEC strongly supports §134.508(c)(2) because it permits drugs included in the closed formulary that exceed or are not addressed by the treatment guidelines to nevertheless be prescribed and dispensed without preauthorization. Access to medication without the delay associated with the preauthorization process is always in the best interests of injured employees. Although OIEC hopes there will be few instances where the retrospective review provision of §134.508(c)(3) will result in non-payment to a pharmacy, ensuring timely access to medication is a laudable goal advanced by not requiring preauthorization for drugs included in the closed formulary.

OIEC seeks clarification of §§134.508(d)(2) and 134.509(d)(2). While we agree that a statement of medical necessity will facilitate the preauthorization process, it is unclear who will request that statement. The fact that no other system participant needs a rule to make such a request suggests that the Division would be the requestor. OIEC would agree with that approach because if the Division were the requestor, there would be a greater chance that the statement of medical necessity would be provided and, accordingly, that information essential to making the correct preauthorization decision would be considered. If the Division is going to be the requestor, the rule should be revised to clearly state that and to explain how an injured employee or a non-prescribing doctor requestor would ask the Division to request the statement of medical necessity. If the Division is not to be the requestor, the rule should delineate sufficient consequences for the prescribing doctor’s failure to comply to ensure that the statement can be obtained.



OIEC agrees with §§ 134.508(e) and 134.509(d) as proposed in that they provide drugs prescribed for initial pharmaceutical coverage in accordance with Labor Code § 413.0141 would not be subject to retrospective review. The purpose of Labor Code § 413.0141 is to provide access to medications within the first seven days following the date of injury. OIEC believes that permitting retrospective review of medication decisions made during that period would have the potential to significantly undermine the rule. It could be argued that the injured employee would already have the medication and, therefore, that he or she does not have an interest in ensuring that the pharmacy will be compensated for the medication. However, such an argument fails to consider the interest that injured employees have in ensuring that pharmacies remain willing to participate in the workers' compensation system. When a pharmacist fills a prescription from a doctor, he or she does not have access to information that would permit him or her to legitimately question that the medication is reasonably required by the injury, particularly in the seven-day period immediately following the date of injury. However, the pharmacy is the entity that is required to go without payment if the medication is ultimately denied in retrospective review. OIEC is concerned that this creates a disincentive for pharmacies to participate in workers' compensation. As a result, OIEC agrees with the recommendation that there be no retrospective review of medication provided in the initial seven days following the date of injury.

While OIEC commends the Division's efforts in §134.511 and in §133.306 to provide a process where injured employees may obtain medications through interlocutory orders, OIEC is concerned that the process may be too complex. OIEC believes that the process should be streamlined such that once a prima facie showing has been made that the potential for a medical emergency exists if the medication is suddenly withdrawn, the medical interlocutory order should be entered.

OIEC has a number of concerns about the proposed medical interlocutory order process. The first of these is that it is not clear that an injured employee can request a medical interlocutory order. OIEC strongly argues that injured employees should be allowed to make such a request because they are the people most affected, if medication is withheld.

OIEC also seeks clarification of §134.511(c)(9). OIEC does not understand how the statement required by this section differs from a statement of medical necessity.

Finally, OIEC does not understand why §134.511(n) seems to be providing for a second hearing process when an interlocutory order is entered. It is axiomatic that in any case where a medical interlocutory order is being sought, the medical dispute process has already been invoked and the case is headed toward a hearing. Yet §134.511(n) provides that if a medical interlocutory is entered the carrier may request a hearing. This would seem to be redundant unless it envisions a separate hearing process where the medical interlocutory order is granted. If this is the case what happens if the results of the two separate hearings are inconsistent? In addition, it is unclear why the insurance carrier would need a hearing because §134.511(m) already provides for reimbursement from the subsequent injury fund if the medical interlocutory order is reversed.



## OFFICE OF INJURED EMPLOYEE COUNSEL

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Thank you in advance for your careful consideration of the above comments. OIEC believes all other sections not referenced herein should be adopted as proposed. Please do not hesitate to contact me if I can be of assistance in clarifying any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** March 1, 2010

**TO:** DWC Rule Team

**FROM:** Brian White

**RE:** **OIEC Comments on Informal Draft of 28 Texas Admin. Code § 130.1  
Regarding Certification of Maximum Medical Improvement and Evaluation  
of Permanent Impairment**

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) informal draft of 28 Texas Admin. Code § 130.1 concerning certification of maximum medical improvement and evaluation of permanent impairment.

The primary focus of the proposed informal draft is which edition of the AMA Guides (4<sup>th</sup>, 5<sup>th</sup>, or 6<sup>th</sup>) the Division should require to be used in evaluating impairment. In commenting on this, the Division has requested that several broad categories be addressed. While OIEC has not conducted an exhaustive study of the impact of each of the editions of the Guides on all of the factors listed by the Division, we have commented on how the various editions of the Guides would impact each of the broad categories about which the Division seeks comment. OIEC's comments in regard to each of these categories are as follows:

### **Impact of the Adequacy of Income Benefits:**

#### **1. Which edition most adequately compensates injured workers?**

There continues to be questions as to whether any of the editions of the AMA Guides adequately compensates injured workers for permanent impairments resulting from a compensable injury under the current statutory income benefit structure in Texas. However, OIEC understands that those questions are beyond the scope of the proposed rules changes and are really matters more properly addressed as legislative recommendations.

In regard to the specific question of which of the three editions of the Guides most adequately compensates injured workers for impairment, it appears that this would be the 5<sup>th</sup> edition. The 4<sup>th</sup> and 5<sup>th</sup> editions are in many ways similar in their methodology for determining impairment ratings. The 5<sup>th</sup> edition does correct some of the defects of the 4<sup>th</sup> edition. A specific and important example of this concerns radiculopathy. The way in which the Appeals Panel has interpreted the 4<sup>th</sup> edition of the AMA Guides makes it impossible to establish eligibility for a radiculopathy rating through standard medical tests that doctors generally employ to determine



the existence of radiculopathy such as EMGs and NCVs. The Appeals Panel has interpreted the 4<sup>th</sup> edition to require a showing of atrophy or loss of reflexes in order to establish entitlement to a radiculopathy rating. The 5<sup>th</sup> edition states more clearly that the objective signs of radiculopathy include more than atrophy or loss of reflexes. As such, it appears that documented cases of radiculopathy would more likely be rated under the 5<sup>th</sup> edition than are currently rated under the 4<sup>th</sup>.

This change alone is significant. Many of the most common and serious injuries in workers' compensation are injuries to the spine. Whether or not radiculopathy exists can significantly affect the impairment ratings in these cases. By making it easier to establish the existence of radiculopathy, the 5<sup>th</sup> edition provides higher ratings and therefore more adequate compensation to injured employees than the 4<sup>th</sup> edition. This is merely an example of where corrections of the 4<sup>th</sup> edition found in the 5<sup>th</sup> edition would result in injured employees being more adequately compensated.

The 6<sup>th</sup> edition embodies a significant change in methodology of assessing impairment than that found in the 4<sup>th</sup> and 5<sup>th</sup> editions. While in some instances use of the 6<sup>th</sup> edition may result in higher impairment ratings than under the 4<sup>th</sup> and 5<sup>th</sup> editions, in the majority of cases, use of the 6<sup>th</sup> edition will result in significantly lower impairment ratings. Also, those instances in which the 6<sup>th</sup> edition provides higher ratings than the 4<sup>th</sup> and 5<sup>th</sup> are where it provides small ratings (1% or 2%) for relatively minor injuries (which are rated at 0% using the 4<sup>th</sup> and 5<sup>th</sup> editions). The types of injuries for which the 6<sup>th</sup> edition provides lower impairment ratings are more serious injuries such as those requiring cervical fusion. The 5<sup>th</sup> edition also permits up to a 3% increase to an impairment rating due to pain; however, the 6<sup>th</sup> edition limits the use of the 3% pain rating to those instances where no other ratable impairment exists.

OIEC submits that providing lower rating for more serious injuries while providing higher ratings for relatively minor injuries would adversely affect the adequacy of income benefits for more seriously injured employees. At the same time there would possibly be little or no cost savings to the system because many less seriously injured workers would be compensated more than presently. This has certainly been one of the reasons that other jurisdictions have declined to adopt the 6<sup>th</sup> edition and OIEC submits it is a sufficient reason for Texas to also decline to do so.

In addition, while the 4<sup>th</sup> Edition and the 5<sup>th</sup> Edition focus on rating diagnoses, the 6<sup>th</sup> Edition appears to focus on function. There is some concern that in focusing on function, the 6<sup>th</sup> Edition is inconsistent with the current statutory scheme in Texas. Furthermore, there has been some controversy, in other states such as Iowa, regarding whether the 6<sup>th</sup> Edition ventures beyond rating impairment and encroaches into the area of disability, which is a legal determination.

The 5th edition states:

Impairment percentages derived from the guides criteria should not be used as direct estimates of disability. Impairment percentages estimate the extent of the impairment on whole-person functioning and account for basic activities of daily living, not including



work. The complexity of the work activities requires individual analyses. Impairment assessment is a necessary first step for determining disability.”

The sixth edition in Section 1.3d, has an ongoing discussion about impairment disability and impairment rating. It notes in part:

The relationship between impairment and disability remains both complex and difficult, if not impossible, to predict. In some conditions there is a strong association between the level of injury and the degree of functional loss expected in one’s personal sphere of activity (mobility and ADL’s). The same level of injury is in no way predictive of an affected individual’s ability to participate in major life functions including work (when appropriate motivation, technology and sufficient accommodations are available). Disability may be influenced by physical, psychological, and psychosocial factors that can change over time.

If the Division intends to adopt the 6<sup>th</sup> edition, it should conduct a thorough review of the rules, statutes, advisories and all other legal aspects of the system to insure that there is harmony between the 6<sup>th</sup> edition and the ways in which the rating derived from the 6<sup>th</sup> edition will be used in the State of Texas. No such review would likely be required if the Division adopted the 5<sup>th</sup> edition or elected to retain the 4<sup>th</sup> edition.

As far as the adequacy of income benefits is concerned OIEC believes that the 5<sup>th</sup> edition provides an improvement over the 4<sup>th</sup> edition, while the 6<sup>th</sup> edition does not. This is one reason that OIEC urges that the Division should adopt the 5<sup>th</sup> edition for use in evaluating impairment in Texas.

## **2. What impact, if any, will a change in the *AMA Guides* have on the average impairment rating?**

This is something that simply is not easily determined. Under each version of the Guides some impairment ratings will go up and some will go down. While it is possible to point to specific types of impairments that will result in higher or lower ratings under the various versions of the Guides, to determine how the average impairment rating in Texas would differ under each version of the Guides is something that could only really be determined based upon data actually using each edition in Texas. Since of the three versions under consideration, only the 4<sup>th</sup> edition has been used in Texas, there is only Texas data on the 4<sup>th</sup> edition. Thus, any opinion of how the 5<sup>th</sup> or 6<sup>th</sup> edition would change the average impairment rating in Texas would be conjectural at best. While looking to loss data from other jurisdictions that have moved from the 4<sup>th</sup> edition to the 5<sup>th</sup> edition or from the 4<sup>th</sup> edition to the 6<sup>th</sup> edition could arguably have some utility in answering this question, to really be of much use such data would need to be adjusted for the differences in what types of injuries are compensable under the laws of these jurisdictions as well as what types of injuries are actually taking place in these jurisdictions as opposed to what types of injuries are compensable and are taking place in Texas. Absent such adjustment, it is difficult to see how such data could accurately predict what might happen in Texas.



**3. Are there categories of injuries that will be overcompensated or undercompensated when using a certain edition of the *AMA Guides*?**

As explained above, the Appeals Panel interpretation of the 4<sup>th</sup> edition in regard to radiculopathy has led to a number of injured employees with spinal injuries not receiving a radiculopathy rating although testing positive for radiculopathy in the medical tests that are generally considered valid diagnostic tests in the medical community. The 5<sup>th</sup> edition corrects this problem by clarifying the evidence necessary to show radiculopathy. This is but one example of the way in which the 5<sup>th</sup> edition corrects defects found in the 4<sup>th</sup> edition, while maintaining the basic methodology of the 4<sup>th</sup> edition. The 6<sup>th</sup> edition on the other hand uses a new methodology which tends to provide higher impairments for relatively minor injuries while significantly reducing impairments for some more serious injuries. OIEC submits that by correcting the deficiencies of the 4<sup>th</sup> edition without making the radical departures of the 6<sup>th</sup>, the 5<sup>th</sup> edition strikes the best balance of the three editions in compensating injured workers.

**4. What effect impact will a change in the *AMA Guides* have on the number of injured workers qualifying for Supplemental Income Benefits?**

Again, this is a difficult question to answer because for the reasons stated above, it is difficult to determine the effect the use of each edition of the Guides would have on the average impairment rating. The answer is further complicated by the fact that qualifying for Supplemental Income Benefits involves a number of other factors besides the injured employee's impairment rating. Further, there is even less relevant data from other jurisdictions bearing on this because the Texas statutory scheme regarding supplemental income benefits is unique.

**5. What impact, if any, will a change in the *AMA Guides* have on Maximum Medical Improvement (MMI) determinations?**

Which edition of the Guides is used should have no effect on MMI determinations. The Guides are used to determine the impairment rating, and not the MMI date. MMI is defined by statute in the Texas Labor Code and it is this statutory definition, and not the *AMA Guides*, which doctors are supposed to use to determine the date of maximum medical improvement.

**6. Will the impact, if any, on the adequacy of income benefits be immediate or will there be a graduated impact over time?**

The answer to this question is somewhat conjectural. If the experience of the transition between the using the 3<sup>rd</sup> edition and moving to the 4<sup>th</sup> edition in Texas is any guide, there will probably be a transition period in which there is some confusion on how to properly apply a new edition. Once this transition period has passed it would be anticipated that whatever new version of the Guides is adopted would be properly applied.

**Impact on return-to-work outcomes:**

OIEC would not anticipate which edition of the Guides is used to determine impairment would have any effect on return-to-work outcomes. This is because return-to-work is not a function of



the impairment rating. It is a function of such factors as disability, maximum medical improvement, and how loss of function affects an injured workers' ability to perform his/her functional job duties.

**Impact on cost:**

Any change in which edition of the Guides is used will involve some system costs in that DWC, OIEC, insurance personnel and medical providers will have to be trained in the use of a new edition of the Guides. Other than these transitional costs, it is not possible to predict what effects a change will have on costs for the same reasons that it is not possible to predict the effect a change in the edition used would have on the average impairment rating.

While it is possible to point to specific types of impairments that will result in higher or lower ratings under the various versions of the Guides, and thus in higher or lower income benefits, to determine how the overall costs in Texas would be differ under each version of the Guides is simply something that could only really be determined based upon data actually using each edition in Texas. As of the three versions under consideration, only the 4<sup>th</sup> edition has been used in Texas, there is only Texas data on the 4<sup>th</sup> edition. Thus, any opinion of how the 5<sup>th</sup> or 6<sup>th</sup> edition would change costs in Texas would be conjectural at best. While looking to loss data from other jurisdictions that have moved from the 4<sup>th</sup> edition to the 5<sup>th</sup> edition or from the 4<sup>th</sup> edition to the 6<sup>th</sup> edition could arguably have some utility in answering this question, to really be of much use such data would need to be adjusted for the differences in what types of injuries are compensable under that laws of these jurisdictions as well as what types of injuries are actually taking place in these jurisdictions as opposed to what types of injuries are compensable and are taking place in Texas. Absent such adjustment, it is difficult to see how such data could accurately predict what might happen in Texas.

**Impact on disputes:**

Again, OIEC submits that there would initially be an increase in disputes and a decrease in inter-rater consistency during the transition period followed a change to another edition of the Guides. This again would be due the fact that it would take time to train all system participates and to get all raters on the same page. This was reflected in the experience from transitioning from the 3<sup>rd</sup> edition to the 4<sup>th</sup> edition. Also, as there would be new provisions of another version of the Guides which have not yet been interpreted in Texas by the Appeals Panel and/or the Texas courts, one would anticipate an increase in the number of disputes as the parties seek the proper interpretations of these new provisions. One would anticipate that as system participants were trained in a new edition of the Guides and its provisions were interpreted by the Appeals Panel and/or the courts that the number such disputes would decline. One would also anticipate that inter-rater consistency would improve over time. Theoretically, over time, if properly applied, any version of the Guides should result in a high level of inter-rater consistency since this is one of the main purposes in using the Guides to rate impairment. However, this assumption is premised upon their being adequate training provided to the physicians about using the Guides and the Division engaging in quality control and oversight.



**Impact on health care providers:**

If the edition of the Guides used is changed health care providers will need to be trained in the use of a new edition. OIEC does not have opinion on the amount of time this will take or what testing will be need to insure that such training is effective. OIEC does believe that DWC may look to its experience in transitioning from the 3<sup>rd</sup> edition to the 4<sup>th</sup> edition as guide in making these determinations. In addition, OIEC anticipates that a greater amount of time and training would be required to transition from the 4<sup>th</sup> edition to the 6<sup>th</sup> edition than to transition from the 4<sup>th</sup> edition to the 5<sup>th</sup> edition. This is because the 5<sup>th</sup> edition is far more similar to the 4<sup>th</sup> edition than the 6<sup>th</sup> edition is.

**General impact:**

The main advantage of staying with the 4<sup>th</sup> edition would be to avoid all the costs and uncertainties involved with changing editions. The main drawback of staying with the 4<sup>th</sup> edition is that it involves the continued reliance on an increasingly out-of-date edition.

The main advantage of moving to the 5<sup>th</sup> edition is it would allow the system to use a more up-to-date Guides that has corrected many of the deficiencies found in the 4<sup>th</sup> edition. The main drawback is that it would involve transitional costs in having to train system personnel and participants in the use of new edition of the Guides and would at least for a time result in increased disputes. These would be mitigated by the fact that the 5<sup>th</sup> edition shares a similar methodology to the 4<sup>th</sup> edition.

Arguably the main advantage of moving the 6<sup>th</sup> edition would be to move to the most recent edition of the Guides and thus in theory what is the most current way to determine impairment. However, the drawbacks to moving to the 6<sup>th</sup> edition are quite numerous. Its radical departure from the methodology of the 4<sup>th</sup> and 5<sup>th</sup> editions means that the transitional cost of retraining and increased disputes will be much greater than the costs of moving from the 4<sup>th</sup> to the 5<sup>th</sup>. Also, the 6<sup>th</sup> edition has been subject to widespread criticism which has caused a number of jurisdictions after considerable study to reject adopting it. It appears that the 6<sup>th</sup> edition is still in transition and undergoing corrections so it really seems to represent more of a work in progress than a completed work. Indeed a 52-page errata sheet was issued in August 2008 that corrected and clarified the 6<sup>th</sup> edition. The 2008 Iowa AMA Guides Task Force Report raises concerns about the difficulty in incorporating the 52 page of changes into the text in order to ensure that the reliability of the resulting ratings.

As far as evidence-based medicine is concerned, it is clear that none of the three editions under consideration is evidence-based. Indeed, the Iowa Task Force Report explains that the variables within occupational medicine/work injury practice limit the possibility of conducting controlled studies. This led one Iowa commentator to observe “[t]hat fact impedes the goal of making any impairment assessment guide highly evidence-based.”

Considering all relevant factors, OIEC’s recommendation is that the Division adopt the 5<sup>th</sup> edition as it represents a move to a more modern and corrected version of the Guides without moving to the radically different and arguably incomplete 6<sup>th</sup> edition. OIEC also submits that by



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providing lower rating for more serious injuries while providing higher ratings for relatively minor injuries adoption of the 6<sup>th</sup> edition would adversely affect the adequacy of income benefits for more seriously injured employees. At the same time there would possibly be little or no cost savings to the system because many less seriously injured workers would be compensated more under the 6<sup>th</sup> edition than under either the 4<sup>th</sup> or 5<sup>th</sup> editions.

Thank you in advance for your careful consideration of the above comments. OIEC believes all other sections not referenced herein should be adopted as proposed. Please do not hesitate to contact me if I can be of assistance in clarifying any of OIEC's comments on behalf of the injured employees of Texas.



**MEMORANDUM**

**DATE:** March 8, 2010

**TO:** Gene C. Jarmon, General Counsel and Chief Clerk, Texas Department of Insurance  
D. C. Campbell, Director Workers' Compensation Research and Evaluation Group

**FROM:** Brian White, Deputy Public Counsel

**RE:** OIEC Comment on Proposed FY 2010 Research Agenda for the Workers' Compensation Research and Evaluation Group

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the proposed fiscal year 2010 Research Agenda for the Workers' Compensation Research and Evaluation Group (REG). OIEC recommends that the REG consider adding a research initiative to analyze injured employees' access to medical care provided by specialists in non-network claims. OIEC's belief, based on anecdotal evidence, is that injured employees who require the care of a specialist often encounter significant difficulty in finding a doctor that is willing to provide their care in the workers' compensation system. In a November 6, 2009, article in WorkCompCentral, former workers' compensation commissioner Albert Betts noted that this issue needed to be "looked at carefully" as it was likely a topic that would be raised in the sunset process. The sixth topic on the proposed research agenda is an analysis of injured employee access to care. OIEC believes that such an analysis would be more complete and would provide better information, if a component of the research specifically focuses on access to medical care by specialists in non-network claims. OIEC supports the other research agenda items as proposed.

Please do not hesitate to contact me if I can be of assistance.



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NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** March 8, 2010

**TO:** DWC Rules Team

**FROM:** Brian White

**RE:** 28 Texas Admin. Code §§137.41-137.51 concerning the Return-to Work Reimbursement Program

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to provide comment on the proposed amendments to 28 Texas Admin. Code §§137.41 - 137.51. The amendments to these sections are necessary to implement Senate Bill 1814 enacted by the 81<sup>st</sup> Legislature, Regular Session, effective September 1, 2009. In our 2006 Legislative Report, OIEC recommended that Labor Code §413.022 be modified to permit employers to apply for and receive funding for workplace modification to facilitate return to work before incurring the cost of the modification. OIEC believes that providing for the release of the money upfront in appropriate circumstances will enhance the program and may lead to additional employers availing themselves of the program to make necessary modifications so that injured employees are able to make an early and sustained return to work. Accordingly, OIEC recommends the adoption of §§137.41 - 137.51 as proposed in the *Texas Register* on February 5, 2010.



## MEMORANDUM

**DATE:** April 5, 2010

**TO:** DWC Rule Team

**FROM:** Brian White

**RE:** **OIEC Comments on Informal Draft of 28 Texas Admin. Code §126.7 Regarding Designated Doctor Examinations: Requests and General Procedures and New 28 §§126.7 – 126.75 Regarding Designated Doctor Scheduling and Examination Procedures**

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) informal draft of 28 Texas Admin. Code §126.7 Regarding Designated Doctor Examinations: Requests and General Procedures and New §§126.7 - 126.75 Regarding Designated Doctor Scheduling and Examination Procedures.

OIEC's initial response is that the operation of the designated doctor system has been a matter for concern for some time and OIEC believes that the informal draft proposal overall represents an excellent attempt to address many of the problems which have been plaguing the program. While generally applauding the informal proposal, OIEC does have some comments and/or recommendations about specific portions of the proposal.

OIEC has in the past communicated its concern to the Division about a party inaccurately describing the nature and extent of an injury to obtain the appointment of a second designated doctor. As OIEC's Public Counsel stated in a letter to the Division's Commissioner, this is exactly what occurred in a prior case without any consequences. It appears that §§126.7(b)(3), 126.7(e), and 126.71(c) are designed to address this problem. OIEC supports the Division's efforts to discourage parties from providing inaccurate information to obtain another designated doctor. OIEC particularly commends the Division for providing a mechanism to void the order and/or report when it is established that a subsequent designated doctor was obtained based on the inclusion of inaccurate information in the Request for a Designated Doctor (DWC032).

OIEC disagrees with changing the language of §126.71(e) concerning the Division's use of a previously assigned designated doctor from being mandatory to permissive. Other provisions of the informal proposal appear to be designed to reduce the number of designated doctors in a claim. Whereas this proposed provision seems to run counter to that objective. Accordingly, OIEC recommends maintaining the use of the word "shall" in this provision.



In regard to §126.72, OIEC has concerns about the analysis that an insurance carrier may send to the designated doctor. Carriers seem to increasingly be using the analyses to lobby for their position rather than merely providing information to the designated doctor. The addition of a requirement that these analyses be “neutral,” similar to the requirement in §126.74(b)(2) that letter of clarification questions be neutral, might help mitigate this problem. Another safeguard might be to require that any such analysis be provided to the other parties before it is sent to the designated doctor. Sending it at the same time means that by the time the other parties receive it, the designated doctor has also received it. Thus, if the document was designed to prejudice the designated doctor, the harm has been done before anyone has an opportunity to object to the contents of the analysis.

OIEC strongly supports §126.72(h). OIEC believes that the added language provides necessary clarification that the carrier is required to pay medical benefits in accordance with the designated doctor’s report in addition to indemnity benefits. OIEC believes that adding medical benefits to the rule language is positive because of the importance of prompt medical treatment to curing illness and returning injured employees to meaningful work.

Also, OIEC suggests that §126.73(a)(2) be changed to add the phrase “and not by deposition on written questions” at the end of the provision. OIEC is concerned that carriers sometimes resort to the use of a deposition on written questions rather than a letter of clarification to obtain reconsideration of designated doctors’ opinions. OIEC thinks this is counterproductive for several reasons. First, it undermines the use of the letter of clarification process, which OIEC submits is the process in place to obtain such reconsideration. This unnecessarily increases system costs as the deposition on written question procedure is more costly than the letter of clarification process. Second, use of the deposition on written question process gives an unfair advantage to the carrier, which is far more able than an injured employee to afford to seek a deposition on written questions of designated doctor. In addition, use of a deposition on written questions essentially constitutes a back-door unilateral contact between the carrier and the designated doctor. Finally, the deposition on written question procedure puts a greater burden on designated doctors than the letter of clarification procedure, increasing the “hassle factor” about which doctors often complain is a disincentive for them to participate in the workers’ compensation system. This is a real concern as the system over time has continued to lose qualified designated doctors.

OIEC also seeks clarification of §126.74(b)(3). OIEC certainly agrees that the request for clarification should contain “neutral” questions for the same reasons that OIEC believes that the analyses in §126.72 should be neutral. OIEC’s concern is uncertainty about the meaning of the term “specific” in this context. It has been OIEC’s experience that questions that might be characterized as being “general” can be useful in letters of clarification in some situations. For example, would this provision preclude attaching medical records for treatment provided after the designated doctor’s examination and then asking whether they change the designated doctor’s opinion on the issue of maximum medical improvement (MMI) and/or impairment rating (IR)? If so, it appears that, as a practical matter, it would be very difficult to seek clarification of MMI in those instances where subsequent treatment has proven effective. OIEC believes that additional explanation of the phrase “specific questions” should be provided.



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Finally, OIEC would like to address a concern it has long had about the designated doctor process. This is the difficulty injured employees have in obtaining medical evidence to try to overcome a first certification of MMI and IR from a designated doctor while the carrier has the statutory right in §408.0041 to a post-designated doctor required medical examination. In the past, OIEC has made legislative recommendations that a carrier be required to pay for a post-designated doctor examination by the treating doctor or a referral doctor to address the issue of MMI and IR when the first certification in from a designated doctor. The Division expressed the opinion to the Legislature that the statute already provides for this. As it has been OIEC's experience that many carrier do not interpret the statute this way, OIEC recommends that the Division clarify in these rules that when an injured employee disagrees with a first certification of MMI and IR from a designated doctor, the carrier is required to pay for an alternate MMI and IR certification examination by the injured employee's treating doctor or a referral doctor.

Thank you in advance for your careful consideration of the above comments. OIEC believes all other sections not referenced herein should be adopted as proposed. Please do not hesitate to contact me if I can be of assistance in clarifying any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** June 7, 2010

**TO:** Maria Jimenez, DWC Rules Team

**FROM:** Brian White, Deputy Public Counsel

**RE:** OIEC Comments on Proposed 28 Texas Administrative Code § 141.1, § 141.2, § 141.4, and § 141.7

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) proposed draft of 28 Texas Administrative Code § 141.1, § 141.2, § 141.4, and § 141.7 regarding benefit review conferences (BRC). Please consider the following suggestions on behalf of the injured employees of Texas:

**1. § 141.1(d)(2):**

OIEC commends the Division for clarifying that the requirement to provide documentation of efforts to resolve the dispute prior to requesting a BRC does not include the exchange of pertinent documents required in § 141.4. OIEC believes that this clarification establishes that the parties need not make a redundant exchange of information in order to comply with the proposed rules.

**2. §141.(d)(3):**

OIEC recommends that the Division clarify that a Request for a Benefit Review Conference (DWC045) filed by an OIEC Ombudsman on behalf of an injured employee is sufficient to satisfy the signature requirement of this subsection. OIEC policy requires that when the injured employee is available to sign the BRC request, he or she does so. However, in those instances where the injured employee is unavailable to sign the request, an Ombudsman files the request with the express permission of the injured employee, which is memorialized in the Dispute Resolution Information System.

**3. § 141.1(f):**

OIEC recommends that the Division clarify that the submission of an incomplete request for a BRC will be sufficient to stop the first certification of maximum medical improvement (MMI) and impairment rating (IR) from becoming final under Texas Labor Code § 408.123(e). Currently, when an injured employee is required to request a BRC in order to stop the 90-day



clock because the first certification of MMI and IR is from a designated doctor or because the first certification is made by the treating doctor after a designated doctor has already been appointed to address MMI and IR, the injured employee requests a BRC and advises the Division that he or she is not ready to proceed because the evidence needed to dispute the certification is not yet available. Once the evidence necessary to go forward with the challenge to the initial certification is received, the injured employee contacts the Division and the BRC is scheduled. It is critical that this procedure remain available in this circumstance to ensure that an initial certification of MMI and IR not become final simply because the evidence needed to move forward with the dispute may not be obtained within 90 days following the date that the injured employee received notice of the first certification of MMI and IR by verifiable means. The finality provision of § 408.123(e) has the potential to severely restrict an injured employee's entitlement to benefits. OIEC believes that to require the injured employee to obtain the evidence necessary to pursue the dispute of the first certification of MMI and IR before he or she can request a BRC to defeat finality is unduly burdensome. The injured employee must either obtain an alternate certification or seek clarification from the designated doctor in order to have the necessary evidence to proceed with the dispute, and while the injured employee has some control over the request for an alternate rating or a letter of clarification, he or she has no ability to control whether and when the required evidence will be forthcoming.

OIEC also recommends that a requirement be added to § 141.1(f) that when the Division notifies the requesting party that the request is incomplete, the Division will detail what additional documentation has to be submitted in order to get the BRC request approved. Alternatively, OIEC recommends that the Division identify the employee who determined that the request was incomplete in the notice to the requesting party. If the decision maker is identified, the requesting party could contact that person in order to discuss what additional documentation is required before the request for a BRC will be granted.

Finally, OIEC requests that the Division provide clarification of how an injured employee can have a request for a BRC granted in a case where the injured employee is going to rely on testimony in order to establish entitlement to benefits. It is well-settled that injured employees can meet their burden of proving injury and disability in many instances based on testimony alone. In such a circumstance, there are due process implications if the injured employee is not permitted an opportunity to have a BRC because he or she elected to rely on testimony rather than documentary evidence to meet his or her burden of proof.

#### **4. § 141.2(b)**

OIEC recommends that the Division identify a specific contact person to whom the request for cancellation or rescheduling of the BRC should be directed. In the absence of an identified contact person, it is difficult for parties to know who to contact in order to make a request or to obtain information about a pending request. OIEC recommends the alternative language that the parties be required to give notice of the request for cancellation or rescheduling to the person responsible for docketing in the filed office managing the claim.



**5. § 141.2(c)**

OIEC recommends that the Division clarify that a benefit review officer will make the determination of whether good cause has been shown for a continuance outside of the unrestricted period for granting a request to cancel or reschedule a BRC established in § 141.2(b). OIEC believes that if the good cause determination is vested with the benefit review officers, it is more likely that consistent standards will be applied in making good cause determinations. As the rule is currently written, it does not identify who will make the good cause determination. OIEC is concerned that if this responsibility is not placed with a single group of Division employees, consistency in decision making will be sacrificed.

**6. § 141.4(d)**

OIEC appreciates the Division's decision to provide opposing parties 10 calendar days to send the pertinent information in their possession to the party requesting the BRC, rather than the previously proposed 5 days. This change makes it more likely that unrepresented injured employees will be aware of the exchange requirement and, consequently, increase compliance.

OIEC also recommends that the Division establish the starting date of the exchange period, as the date notice of the BRC setting is received rather than the date of receipt of the request for a BRC. The date that the opposing party receives the request is not a date that is readily known with certainty. However, in § 141.2(b), the date the notice of the setting is received is "deemed to be the fifth day after the date of the notice." Therefore, if the duty for the opposing party to exchange were triggered upon receipt of the notice of the setting, that date would be known to all parties. That date would also seem to be a more appropriate date to be used to trigger the exchange requirement because the obligation to exchange documents would not be triggered in those instances where the BRC request is denied by the Division. In addition, use of the date of notice of the setting would increase the likelihood that an unrepresented injured employee would have contact with OIEC before the time to exchange documents with the requesting party had passed. OIEC receives notice of BRCs that are set at the request of a carrier, employer, or subclaimant where the injured employee is unrepresented. When OIEC receives such notice, it contacts the injured employee and asks if he or she wants OIEC assistance. In that telephone call, OIEC would be able to advise unrepresented injured employees of the obligation to exchange pertinent information, the deadline for doing so, and the consequence for failure to exchange, even in those cases where the unrepresented injured employee elected to proceed without OIEC assistance.

**7. § 141.4(e)**

Due to the reduced number of BRCs that are being held, there are instances where a BRC is scheduled significantly earlier than 40 days after the request is received. OIEC recommends that if the BRC is set within 20 days of the request, the 5-day deadline to exchange additional pertinent information not previously exchanged applicable to an expedited BRC be applied, even if an expedited BRC was not requested.



**8. § 141.4(h)**

Initially, OIEC believe that the Division needs to provide clarification of whether the parties are required to resubmit the pertinent documents to the Division in those instances where the BRC is rescheduled more than 90 days after the BRC. It seems that the pertinent information would have to be resent or the benefit review officer would not be in a position to mediate the claim. However, it does not seem like an effective use of time or resources for the parties to resubmit documents that were in the Division's possession and then purged.

OIEC recommends that the Division scan the documents prior to disposing of them when the contested case hearing is set and when the parties fail to reschedule a second BRC within at least 90 days after the first BRC. This would make the documents available to the benefit review officer in those instances where the BRC is rescheduled more than 90 days after the initial BRC. In addition, if the documents were scanned prior to disposal, all parties could readily establish what documents were exchanged prior to the BRC and which are, therefore, not subject to objection at the hearing for not having been timely exchanged.

Alternatively, OIEC recommends that rather than purging the information exchanged by the parties in the cases where the unresolved issues are set for a contested case hearing, the benefit review officer attach those documents to his or her report. This practice would also permit the parties to establish what documents were exchanged and to counter objections to the admission of any of those documents at the contested case hearing based on the failure to timely exchange.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact me if I can clarify any of OIEC's comments on behalf of the injured employees of Texas.



**MEMORANDUM**

**DATE:** June 1, 2010

**TO:** Gene C. Jarmon, General Counsel & Chief Clerk, Texas Department of Insurance and Gary Gola, Director, Data Services, Property and Casualty Program

**FROM:** Brian White, Deputy Public Counsel

**RE:** OIEC Comment on 28 Texas Administrative Code § 5.6601 and the *Texas Detailed Claim Information Statistical Plan, 2010 Edition*

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the informal draft of § 5.6601 of the Texas Administrative Code and the *Texas Detailed Claim Information Statistical Plan, 2010 Edition*. OIEC believes that 28 Texas Administrative Code § 5.6601 and the *Texas Detailed Claim Information Statistical Plan, 2010 Edition* should be adopted as proposed.

Please do not hesitate to contact me if I can be of assistance.



## MEMORANDUM

**DATE:** July 12, 2010

**TO:** Gene C. Jarmon, General Counsel and Chief Clerk and Debra Diaz-Lara, Deputy Commissioner, Health and Workers' Compensation Network Certification and Quality Assurance Division

**FROM:** Brian White, Deputy Public Counsel

**RE:** OIEC Comments on the Proposal of 28 Texas Admin. Code §§ 12.1-12.6, 12.101-12.110, 12.201-12.208, 12.301-12.303, 12.402-12.406, and 12.501-12.502

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review the Texas Department of Insurance's proposal of 28 Texas Admin. Code §§ 12.1-12.6, 12.101-12.110, 12.201-12.208, 12.301-12.303, 12.402-12.406, and 12.501-12.502 concerning independent review organizations.

OIEC recommends that §12.5(1), the definition of adverse determination, be changed to recognize that an adverse determination may be made by a workers' compensation insurance carrier in addition to a utilization review agent. 28 Texas Admin. Code § 133.308(i) addresses timeliness of a request for an IRO in a workers' compensation claim and it provides in relevant part: "A requestor shall file a request for independent review **with the insurance carrier (carrier) that actually issued the adverse determination** or the carrier's utilization review agent (URA) that actually issued the adverse determination no later than the 45 calendar day after receipt of the denial of reconsideration." (Emphasis added.) Although it appears that a URA generally makes the adverse determination, even in workers' compensation cases, the plain language of §133.308(i) demonstrates that the insurance carrier may also issue the adverse determination. Accordingly, OIEC recommends that the language of §12.5(1) be changed, as follows: "Adverse determination – a determination **by an insurance carrier or by a utilization review agent** made on behalf of any payor that health care services provided or proposed to be provided to a patient are not medical necessary or appropriate, or are experimental or investigational."

OIEC also recommends that §12.205(f) be modified to clarify that an OIEC Ombudsman assisting an injured employee is also permitted to send pertinent records to the IRO conducting the independent review. An OIEC Ombudsman provides assistance to an injured employee and is statutorily prohibited from providing representation. Since there is no provision for payment of attorney's fees in medical dispute resolution cases in workers' compensation, OIEC Ombudsmen provide assistance in the vast majority of those cases. A significant part of providing effective assistance to the injured employee is helping to ensure that the IRO receives



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pertinent records and modifying the rule language to permit the Ombudsman to send those records would further that objective.

OIEC fully supports the change in proposed §12.207(b) that reduces the time to return a telephone call made outside of business hours to one working day from the date the call was received rather than two working days. Timely receipt of medical care is critical to an injured employee's physical recovery and ability to return to work. And, as such, any provision that hastens an IRO determination is beneficial.

OIEC also fully supports the provisions of §12.208 which serve to protect patient confidentiality. There appears to be universal agreement that maintaining the confidentiality of medical information is paramount. Accordingly, OIEC agrees that a strong confidentiality provision, such as one in §12.208, is imperative.

OIEC applauds §12.303 that requires an IRO to surrender its registration upon the request of the department while the IRO is under investigation. This provision gives greater emphasis to the protection of the patient than to the interests of a suspect IRO. It is expected that the department would have a solid basis for pursuing an investigation of an IRO and, as a result, it is appropriate that the department would also have the discretion to limit the IRO's authority to operate during that period.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact me if I can be of assistance or clarify any of OIEC's comment on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** August 16, 2010

**TO:** Maria Jimenez, Texas Department of Insurance, Division of Workers' Compensation

**FROM:** Brian White

**RE:** OIEC Comments on Proposal to Amend 28 TAC §134.500 and §134.506 and Add New TAC §§134.510, 134.520, 134.530, 134.540, and 134.550 Regarding the Pharmacy Closed Formulary and to Amend 28 TAC §133.306 Regarding Interlocutory Orders for Medical Benefits

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) proposal to amend 28 Texas Admin. Code §134.500 and §134.506 and to add new 28 Texas Admin. Code §§134.510, 134.520, 134.530, 134.540, and 134.550, concerning a pharmacy closed formulary and to amend 28 Texas Admin. Code §133.306, regarding Interlocutory Orders for medical benefits.

OIEC's initial concern with adopting the *ODG Workers' Compensation Drug Formulary* is whether there will be sufficient "Y" drugs in all categories. It is critical that sufficient drug options are available in each category to provide medication alternatives when some medications prove ineffective or when the injured employee has an adverse reaction to a drug prescribed. OIEC lacks the expertise to assess whether the *ODG Workers' Compensation Drug Formulary* meets this objective in each drug category; however, we believe this factor must be considered and are concerned that the Division has not adequately addressed this issue in the proposal. OIEC believes the formulary must serve the goal of limiting access to inappropriate medications while still ensuring that a broad range of medication remains available to treat the injured employees of Texas.

OIEC also has comments and/or recommendations about specific provisions. In regard to §134.500(3)(A), OIEC requests clarification. It is OIEC's understanding that when the *ODG Workers Compensation Drug Formulary* is updated, drugs are sometimes reclassified from "Y" to "N" status. OIEC would like clarification as to the effect when an injured employee receives a prescription with several refills of a drug with "Y" status, and then, before all of the refills are filled, the drug is reclassified to "N" status.

Also, OIEC is concerned about §134.500(7). OIEC understands that the acute symptoms of a medical emergency are defined as "including severe pain." If this provision were to be interpreted as limiting a medical emergency to only situations where there is severe pain, OIEC



believes that interpretation would be too restrictive. OIEC believes that not every medical emergency will include severe pain. If it can reasonably be expected that a patient's health or bodily function is placed in serious jeopardy or that serious dysfunction of a body organ or part will result, but there is no severe pain, it would seem that immediate medical attention would still be required.

OIEC submits that in §134.500(13) the phrase "and supporting evidence-based documentation" is unnecessary and unduly onerous. OIEC contends that the information required by §134.500(13)(F) is more than sufficient to show medical necessity and that requiring "supporting evidence-based documentation" would make it significantly more difficult for an injured employee to obtain necessary medication. OIEC would further emphasize that any medications dealt with in §134.500(13) would have received FDA approval based upon valid scientific study of their safety and efficacy. While the prescribing doctor might not have these studies in his or her possession, they certainly exist for the drug to have been approved by the FDA. The evidence-based medicine of the safety and efficacy of medications approved by the FDA are the studies that led to the drug receiving FDA approval. A prescription should be filled, if the injured employee or prescribing doctor establishes that the medication satisfies the requirements of §134.500(13)(F).

OIEC agrees with the decision of the Division to phase-in the closed drug formulary over time to allow for continuity of care. As stated in its earlier comments to the preproposal, OIEC believes that providing for no transition period would disrupt the continuity of care of injured employees in many cases by requiring sudden changes in drug regimens in use for many years. In some cases this could not only disrupt care but result in serious side effects, such as drug withdrawal symptoms. For this reason, OIEC also strongly agrees with the concept of medical providers and carriers cooperating to plan some additional transition in such cases as provided in §134.510. An additional benefit of phased-in implementation of the formulary is that it will permit system participants to identify and correct problems associated with the formulary before it applies to all prescriptions in the workers' compensation system.

OIEC supports §134.530(c)(2) because it permits drugs included in the closed formulary that exceed or are not addressed by the treatment guidelines to nevertheless be prescribed and dispensed without preauthorization. Access to medication without the delay associated with the preauthorization process is always in the best interests of injured employees. Although OIEC hopes there will be few instances where the retrospective review provision of §134.530(c)(3) will result in non-payment to a pharmacy, ensuring timely access to medication is a laudable goal advanced by not requiring preauthorization for drugs included in the closed formulary.

OIEC feels that §§134.530(d)(2) and 134.540(d)(2) should be modified to state that the Division will request the statement of medical necessity from the prescribing doctor. While we agree that a statement of medical necessity will facilitate the preauthorization process, we are concerned that these provisions will be of limited effectiveness if the Division is not the requestor. If the Division were the requestor, there would be a greater chance that the statement of medical necessity would be provided and, accordingly, that information essential to making the correct preauthorization decision would be obtained and considered. The only apparent consequence of a prescribing doctor not providing the statement of medical necessity would be a referral for an



administrative violation. However, that enforcement mechanism cannot feasibly be pursued by injured employees against their treating doctors due to the negative consequences such a referral would pose to the doctor-patient relationship. If the Division is going to be the requestor, the rule should be revised to clearly state that and to explain how an injured employee or a non-prescribing doctor requestor would ask the Division to request the statement of medical necessity. Alternatively, if the Division is not to be the requestor, the rule should delineate sufficient consequences of the prescribing doctor's failure to comply to ensure that the statement can be obtained.

OIEC agrees with § 134.530(e)(1) as proposed in that it provides drugs prescribed for initial pharmaceutical coverage in accordance with Labor Code § 413.0141, and which are in the approved formulary, would not be subject to retrospective review. The purpose of Labor Code § 413.0141 is to provide access to medications within the first seven days following the date of injury. OIEC believes that permitting retrospective review of medication decisions made during that period would have the potential to significantly undermine the statute. It could be argued that the injured employee would already have the medication and, therefore, that he or she does not have an interest in ensuring that the pharmacy will be compensated for the medication. However, such an argument fails to consider the interest that injured employees have in ensuring that pharmacies remain willing to participate in the workers' compensation system. When a pharmacist fills a prescription from a doctor, he or she does not have access to information that would permit him or her to legitimately question that the medication is reasonably required by the injury, particularly in the seven-day period immediately following the date of injury. However, the pharmacy is the entity that is required to go without payment if the medication is ultimately denied in retrospective review. OIEC is concerned that this creates a disincentive for pharmacies to participate in workers' compensation.

OIEC disagrees with proposed § 134.530(e)(2). The existence of § 413.0141 of the Labor Code demonstrates the legislative intent to provide broad access to medication during the first seven days following an injury. OIEC believes that retrospective review runs counter to that objective and intent; therefore, OIEC recommends that this provision be modified so there is no retrospective review of medication provided in the initial seven days following the date of injury, even those drugs not included in the formulary.

While OIEC commends the Division's efforts in §134.550 and in §133.306 to provide a process where injured employees may obtain medications through interlocutory orders, OIEC is concerned that the process may be too complex. OIEC believes that the process should be streamlined such that once a prima facie showing has been made that the potential for a medical emergency exists if the medication is suddenly withdrawn, the medical interlocutory order should be entered.

OIEC has a number of concerns about the proposed medical interlocutory order process. The first of these is that it is unclear why an injured employee cannot request a medical interlocutory order under § 134.550. OIEC strongly argues that injured employees should be allowed to make such a request because they are the people most affected, if medication is withheld.



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OIEC also seeks clarification of §134.550(c)(9). OIEC is unclear how the statement required by this section differs from a statement of medical necessity.

OIEC requests clarification of the consequences of treating withdrawal as acceptance of the preauthorization denial in § 134.550(k). Specifically, OIEC requests clarification of how the effects of acceptance of the denial differ from an adverse decision in a preauthorization medical necessity dispute resolution proceeding.

Finally, OIEC does not understand why §134.550(p)(2) seems to be providing for a second hearing process when an interlocutory order is entered. It is axiomatic that in any case where a medical interlocutory order is being sought, the medical dispute process has already been invoked and the case is headed toward a hearing. Yet §134.550(p)(2) provides that if a medical interlocutory is entered the carrier may request a hearing. This would seem to be redundant unless it envisions a separate hearing process where the medical interlocutory order is granted. If this is the case what happens if the results of the two separate hearings are inconsistent? In addition, it is unclear why the insurance carrier would need a hearing because §134.511(n) already provides for reimbursement from the subsequent injury fund if the medical interlocutory order is reversed.

Regarding proposed Form DWC 064, OIEC suggests that the document be retitled. If the form is only meant to be used for drugs that were once "approved" but are now "excluded" because of the adoption of the closed formulary, then the title should make that clear by inserting the word "then" between "and" and "excluded" in the last line of the title. In addition the words "From In" in the last line of the title appear to be a typographical error. Finally, a box should be added to the form that reflects that an injured employee may be a requester consistent with our earlier comment that injured employees should be permitted to be a requester under § 134.550 because they are the people most affected, if medication is withheld.

Thank you in advance for your careful consideration of the above comments. OIEC believes all other sections not referenced herein should be adopted as proposed. Please do not hesitate to contact me if I can be of assistance in clarifying any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** October 16, 2010

**TO:** DWC Rule Team

**FROM:** Brian White

**RE:** OIEC Comments on the Proposal to Repeal 28 Texas Admin. Code §126.7 and to Adopt 28 Texas Admin. Code §§ 127.1, 127.5, 127.10, 127.15, 127.20, and 127.25 Regarding Designated Doctor Scheduling and Examinations

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) proposal of 28 Texas Admin. Code §§127.1, 127.5, 127.10, 127.15, 127.20, and 127.25 Regarding Designated Doctor Scheduling and Examinations.

OIEC's initial response is that the operation of the designated doctor system has been a matter for concern for some time and OIEC believes that the informal draft proposal overall represents an attempt to address some of the problems which have been plaguing the program. While generally supporting the proposal, OIEC does have some comments and/or recommendations about specific provisions.

OIEC has in the past communicated its concern to the Division about a party inaccurately describing the nature and extent of an injury to obtain the appointment of a second designated doctor. As OIEC's Public Counsel stated in a letter to the Division's Commissioner, this is exactly what occurred in a prior case without any consequences. It appears that §§127.1(b)(3) and 127.1(e) are designed to address this problem. However, OIEC is concerned about the Division's decision to remove the language of §126.71(c) of the informal proposal which gave the Division the authority to void an order for a designated doctor and any reports issued pursuant to that order if the requester submitted inaccurate information in the request for a designated doctor examination. By eliminating this provision, the Division has removed a powerful tool to rectify the problems created when a party uses inaccurate information to obtain another designated doctor. The only available mechanism in this proposal is the process to challenge the appointment under §127.1(e). That section provides an important first line of defense; however, because of the restrictive time deadlines associated with that procedure, OIEC believes that there will be abuses of the designated doctor process that it will not correct. Accordingly, OIEC recommends that the Division add subsection (c) in §127.5 adopting the previously proposed language, as follows "The division may void an order for a designated doctor and any designated doctor reports issued pursuant to that order if the requester submitted inaccurate information in the request for a designated doctor examination." Parties should never benefit from gaming the designated doctor system and the inclusion of this subsection would



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ensure that a party would not benefit from such conduct simply because the opposing party did not timely challenge the appointment. In the absence of the ability to void the report, the Division is left with issuing an administrative violation, which provides an inadequate remedy because the offending party still may enter that improperly obtained report in evidence.

In order to effectively assist injured employees with designated doctor issues, OIEC believes that it is critical that the Ombudsman assisting the injured employee receive all notices provided for in the proposal. The importance of the Ombudsmen receiving notice is magnified by the fact that OIEC Ombudsmen assist nearly half of the injured employees in the dispute resolution process. OIEC recommends that where the phrase "injured employee's representative" is used that the language "person acting on behalf of the injured employee" be substituted. Specifically we request that this change be made in §§127.1(a), 127.5(a), 127.5(e), 127.10(a)(2), 127.10(e), 127.10(f), and 127.15(b).

OIEC recommends that the Division add a new subsection (6) to §127.1(a) that states "whether there is an injury resulting from the claimed incident" as a question that a designated doctor can be appointed to address. In a Memorandum to System Participants dated June 18, 2007, the Division clarified that it would appoint a designated doctor in a denied/disputed claim to address the "medical issue of whether there is an injury related to the claimed incident, and if so, the extent of the injury." OIEC would also noted that the language in §127.1(b)(6)(iii) "if the requester seeks an examination on the extent of the compensable injury or **an examination regarding the causation of the claimed injury . . .**" recognizes that a designated doctor can be appointed on the issue of causation. By adding this subsection, the Division would be formalizing the existing procedure detailed in the memorandum.

OIEC disagrees with the decision to remove the language from the proposal for an expedited hearing process to determine whether good cause exists to schedule a designated doctor examination that would occur within 60 days of the previous examination. The informal draft included such language in §126.7(c). It would seem that in order to resolve a good cause issue, a hearing where both parties are permitted to submit evidence and make argument, is essential. In addition, hearing officers at the Division are accustomed to making good cause determinations and, therefore, they are best suited for resolving such issues.

OIEC objects to the language in §127.1(d)(2) that the Division shall deny the request, if the request would require the division to schedule and examination in violation of Labor Code §408.123. OIEC believes that if a designated doctor examination should not be ordered because a previous certification has become final under §408.123(e), it is incumbent upon a party to raise this issue in a challenge to the appointment under §127.1(e). The problem with the Division making a determination that the first certification of MMI and IR is final is that it cannot identify with certainty the date the parties received written notice of the certification by verifiable means as required by statute to begin the 90-day dispute period. Rather, the Division uses the date of the certification to assume finality and to deny a designated doctor request. The regulatory agency should not be in the position of raising an issue for a party, especially when the issue is often based on an inaccurate calculation of a time deadline.



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While OIEC supports the procedure in §127.1(e) to dispute a designated doctor appointment in an expedited hearing, we are concerned that the request is required to be filed “within three days of receiving the order of the designated doctor examination under §127.5(a) of this title . . . .” There are instances, such as three-day holiday weekends, where this time period would expire before and injured employee could ever contact the Ombudsman. This problem is multiplied by the fact that the proposal does not currently provide notice of the appointment to the Ombudsman. A three-day time limit is simply unrealistic. In order to ensure that injured employees can avail themselves of the procedure to challenge a designated doctor appointment, OIEC recommends that the period be changed to five working days after receipt of the order. Alternatively, we request that the period be three working days rather than three days.

OIEC disagrees with changing the language of §127.5(d) concerning the Division’s use of a previously assigned designated doctor from being mandatory to permissive. Current §126.7(h) provides that a previously assigned designated doctor “shall be used again if he remains qualified and available” while §127.5(e) states that the division “may use that doctor again if the doctor meets the requirements of subsections(d)(1)-4) of this section.” Other provisions of the proposal appear to be designed to reduce the number of designated doctors in a claim. In addition, as the preamble noted, the Sunset Advisory Commission noted the problems of having multiple designated doctors in the same claim. The permissive language of subsection (d) runs counter to that objective. Accordingly, OIEC recommends maintaining the use of the word “shall” in this provision.

In regard to §127.10(a)(2), OIEC has concerns about the analysis that an insurance carrier may send to the designated doctor. Carriers seem to increasingly be using the analyses to lobby for their position rather than merely providing information to the designated doctor. This is illustrated by a recent case in which an insurance carrier stated in its “analysis” to the designated doctor that post-traumatic stress disorder (PTSD) was not part of the compensable despite the fact that it had earlier executed a Benefit Dispute Agreement (DWC024) agreeing that PTSD was part of the compensable injury. As a result of the analysis, the designated doctor did not consider PTSD in certifying maximum medical impairment and assessing an impairment rating. Because of this type of abuse, OIEC believes that an insurance carrier’s analysis should be subject to the same scrutiny and process as a letter of clarification.

OIEC has two concerns about §127.10(c). Initially, we disagree with the decision to include the language that the designated doctor “is not qualified to fully resolve the issue in question” before he can make a referral to another health care provider. OIEC believes that the designated doctor should be permitted to exercise his discretion in making the decision of whether or not a referral is appropriate and should not be required to indicate that he is unqualified before being allowed to do so. Secondly, OIEC strongly disagrees with the decision to include language that the additional testing is subject to retrospective review of medical necessity. Testing performed to assess an impairment rating is not treatment. It is designed to facilitate the determination of an impairment rating, it does nothing to cure and relieve the effects of an injury. As such, OIEC believes that retrospective review will have a chilling effect on referrals essential to the accurate determination of impairment. Once a referral doctor is not paid for testing, he will likely refuse future referrals. If the Division is concerned that a doctor has a pattern of making unnecessary



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referrals, the appropriate mechanism for addressing those concerns would seem to be removal from the designated doctor list or an enforcement action.

OIEC supports the inclusion of §127.10(f)(7). OIEC believes that the added language provides increased protection against designated doctors with disqualifying associations.

OIEC supports §127.10(h) to the extent that it clarifies that the insurance carrier is required to pay both medical benefits and indemnity benefits in accordance with the designated doctor's report. However, OIEC disagrees with giving the insurance carrier 21 days from the receipt of the designated doctor's report to reprocess medical bills because that time period is excessive. OIEC recommends that the period be reduced to 10 days.

OIEC objects to the prohibition on leading questions in §127.20(b)(3). Generally, in legal proceedings when questioning an expert witness not chosen by a party, the party is allowed to use leading questions to cross-examine the witness. This procedure facilitates understanding particularly where the questioning is in writing, as opposed to live testimony, where follow-up questions could be posed. OIEC agrees that the questions should not be inflammatory, but non-inflammatory leading questions should be permitted to elicit the truth.

Finally, OIEC would like to address a concern it has long had about the designated doctor process. This is the difficulty injured employees have in obtaining medical evidence to try to overcome a first certification of MMI and IR from a designated doctor while the carrier has the statutory right in §408.0041 to a post-designated doctor required medical examination. In the past, OIEC has made legislative recommendations that a carrier be required to pay for a post-designated doctor examination by the treating doctor or a referral doctor to address the issue of MMI and IR when the first certification in from a designated doctor. The Division expressed the opinion to the Legislature that the statute already provides for this. As it has been OIEC's experience that many carrier do not interpret the statute this way, OIEC recommends that the Division clarify in these rules that when an injured employee disagrees with a first certification of MMI and IR from a designated doctor, the carrier is required to pay for an alternate MMI and IR certification examination by the injured employee's treating doctor or a referral doctor.

Thank you in advance for your careful consideration of the above comments. OIEC believes all other sections not referenced herein should be adopted as proposed. Please do not hesitate to contact me if I can be of assistance in clarifying any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** August 30, 2011

**TO:** Brent Hatch, Director Return to Work, Outreach, and Special Initiatives

**FROM:** Brian White, Deputy Public Counsel/Chief of Staff

**RE:** OIEC's Answers to the Questions Posed in the Working Draft of the Rules Regarding the Procedures Governing the Recoupment of Overpaid Income Benefits and the Payment of Underpaid Income Benefits

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New Rule § Process for Resolution of Underpayment of Income Benefit.

- (a) There should be a form to give notice of underpayment. The best way to ensure that an injured employee provides the necessary information is to identify it on a form. The injured employee cannot be expected to know what information is required without it being specifically identified. The form should include an explanation and supporting information detailing the underpayment.
- (b) Seven days seems like a reasonable time to pay the underpayment whether or not the carrier is currently paying benefits.
- (c) The carrier should notify the injured employee of its disagreement that an underpayment had been made within 7 days of receipt of notice. The PLN-11 would be fine to give notice of the carrier's disagreement that underpayment occurred. All time periods should be the same. If the dispute period is shorter than the period to make a payment, it would seem to encourage disputes.
- (d) Arguably, the payment deadline should be shorter when the carrier determines that an underpayment has been made rather than those instances where the carrier has to make a determination following notice; however, making all periods 7 days will result in consistency and administrative efficiency.
- (e) Although we know it happens, OIEC does not keep statistics on how often underpayments are made. In our experience injured employees receive a check for a different amount and don't know why. Thus, it seems they either were not notified of the change or did not understand the notice. Instead, the injured employees come to OIEC asking questions as to why the benefit amount changed.

New Rule Process for Resolution of Overpayment of Income Benefit.

- (a) – (c) OIEC recommends that the automatic recoupment percentage be reduced to 10% for all injured employees. We believe that such a percentage is acceptable particularly in light of the fact that most overpayments are the result of carrier business errors. The consequence of such business errors should be addressed in the same manner as other



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business errors where shareholders hold management accountable. In no instance does OIEC support automatic percentages above current law. Although OIEC is mindful that these limitations may result in less than full recoupment, that is not unlike the situation faced by attorneys who represent injured employees who often do not receive full attorney's fees based on similar limitations on the rate of their recovery. In addition, OIEC would note that the carrier is better able to bear the financial burden of receiving less than full recoupment than the financial hardship that would be suffered by injured employees if a higher rate of recoupment were automatically permitted.

- (d) – (e) OIEC believes that either the carrier should be required to send notice of overpayment to OIEC in those instances where overpayment has been made to an unrepresented injured employee. In the alternative, OIEC recommends that our contact information be added to the PLN form advising unrepresented injured employees to contact us with questions about the notice.



## MEMORANDUM

**DATE:** September 27, 2010

**TO:** DWC Rule Team

**FROM:** Brian White, Deputy Public Counsel  
Elaine Chaney, Director of Legal Services

**RE:** OIEC's Comments on Proposal of the Chapter 180 Rules

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) proposal of the Chapter 180 Rules, 28 Texas Admin. Code §§ 180.1-180.50. OIEC requests the consideration of the following comments on behalf of the injured employees of Texas:

### § 180.1-180.3, and 180.8 -- General Rules for Enforcement.

1. Page 79; § 180.2(i): OIEC recommends modifying this section to add an intent requirement. Specifically, OIEC recommends that subsection (i) be changed to state "A person commits an administrative violation if the person *knowingly* submits a complaint to the division that is . . . ." Injured employees are generally not as sophisticated about the workers' compensation system, the statute, and the rules as other system participants. As a result, they are more likely to file complaints that are not as well grounded in the law as the complaints of other system participants. By adding a requirement that a person "knowingly" submit a frivolous or groundless complaint, OIEC believes that the Division can target its enforcement resources toward pursuing more serious violations. If the Division does not add an intent requirement, it is hoped that the sophistication level of the injured employee who files a frivolous complaint would be a factor that the Division will consider in assigning a priority to its pursuit of an administrative violation against that employee.
2. Page 81; § 180.3(h): OIEC disagrees with the decision to make publishing of the final audit report on the Division's Internet website discretionary. Although OIEC agrees that it is significant if an auditee takes corrective action based on the audit and achieves standards, that action does not eliminate the fact that the auditee was not originally in compliance with standards. Making information about system participants who are not in compliance with standards available to other system participants seems to be one of the primary reasons for conducting a compliance audit. However, that educational benefit will be lost if the existence of an audit demonstrating noncompliance is not made public. OIEC appreciates that posting the results of a follow-up audit permits a system participant to demonstrate its efforts to come into compliance. However, OIEC does not



believe that taking corrective action should result in excusing the original noncompliance, which will be the result if the findings of the original audit are not made public. OIEC believes that the system works best when system participants have access to complete information and that goal will be undermined if the results of the original audit demonstrating noncompliance are not published.

3. Page 82; §180.8(b): OIEC recommends that the Notice of Violation (NOV) include cautionary language advising of the requirement to file a written answer to the NOV not later than the twentieth day after the date of receipt. The cautionary language should also explain that even if the party fails to respond and request a hearing, a hearing will nevertheless be set at the State Office of Administrative Hearings (SOAH).
4. Page 83; § 180.8(c): OIEC believes there is a typographical error in this subsection. It appears that the Division intended to change “system participant” to “party” however, the word system was not removed. This section should be changed from “The charged system party” to “The charged party.”
5. Page 83; § 180.8(d): OIEC recommends that the notice of the hearing at SOAH include cautionary language explaining that the charged party has twenty days from the date of receipt of the hearing notice to file and answer or responsive pleading or risk being in default for failing to do so. It is fairly exacting to establish a default based on the failure to answer and in order to mitigate the negative consequences of default, it is essential that charged parties be notified of the requirement to respond and the consequence of failing to do so.
6. Pages 83-84; §§ 180.8(e) and (f): OIEC requests that this provision be modified to make clear that a party who appears at the hearing will not be in default because the party failed to file an answer. The harm associated with failing to file an answer can be corrected if the party appears and participates in the SOAH hearing. Accordingly, OIEC does not believe it is appropriate for the Division to seek informal disposition of an administrative violation due to the failure to file an answer, if the party appears at the hearing. As it is proposed § 180.8(f) provides that the Division can seek informal disposition against a party who is in default either by failing to file an answer or by failing to appear at the hearing. OIEC believes that § 180.8(e) should be a revised to limit default only to those charged parties who fail to appear at the hearing.
7. Page 85; § 180.8(h): OIEC recommends that this subsection clearly state the deadline for a party to file a motion to set aside a default order rather than stating that a party is required to file such a motion “prior to the time that the order of the commissioner becomes final pursuant to the provisions of the Government Code Chapter 2001.” In order to limit the impact of the default provisions and to minimize the number of instances where administrative penalties are imposed without the benefit of a hearing, OIEC believes that the time frame for filing a motion to set aside the default order should be specifically identified rather than referring the parties to a Chapter in the Government Code to identify this critical deadline.

### **§§ 180.22, 180.24, 180.26, 180.27, and 180.28 – Medical Benefit Regulation**

1. Page 87; § 180.22(c): OIEC recommends that a new subsection (5) be added to the list of responsibilities of the treating doctor to clarify that the treating doctor is required to examine the injured employee to certify a date of maximum medical improvement and



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assign an impairment rating or refer the injured employee to another authorized doctor to do so. OIEC believes that the addition of clear language in § 180.22(c) that a treating doctor is required to either perform the certification examination for the injured employee or refer the injured employee to another authorized doctor to do so would address a concern we have long had about the designated doctor process. This is the difficulty injured employees have in obtaining medical evidence to try to overcome a first certification of MMI and IR from a designated doctor while the carrier has the statutory right in §408.0041 to a post-designated doctor required medical examination. Texas Administrative Code § 130.2 currently states that a treating doctor shall perform an MMI/IR certification examination on an injured employee or refer the injured employee to another authorized doctor to do so. Insurance carriers often take the position that this provision is only mandatory, if there is not already a certification of MMI and IR from a designated doctor. If § 180.22(c) were modified to establish that the treating doctor is required to perform this examination for the injured employee or refer the patient to another doctor, whether or not there is a certification from a designated doctor, then the rule language could be emphasized to either a treating doctor or an insurance carrier to demonstrate that the certification examination is required and, as such, the carrier is liable for the cost of that examination. Specifically, OIEC recommends that subsection (5) be added to § 180.22(c) to state “examine an injured employee to determine a date of maximum medical improvement and to assign an impairment rating for any permanent impairment resulting from a compensable injury or refer the injured employee to another authorized doctor to perform the certification examination. The requirement that the treating doctor perform the certification examination or refer the injured employee to another authorized doctor for a certification examination continues even if the certification examination will occur after a designated doctor has already certified MMI and IR.”

2. Page 94; § 180-.24(b): OIEC requests clarification of the event that triggers the need to file the disclosure. Under the existing provision, the disclosure was required within 30 days of the referral. Under the rule as proposed, the provider is required to file an annual report, but it does not appear to be tied making the referral. In the absence of tying the need to disclose to the referral, the objective of this provision seems to be undermined.
3. Page 97; § 180.25(a): The second sentence of this provision is a sentence fragment. As it is proposed the second sentence of this subsection states “Improper attempts to influence the delivery of benefits to an injured employee, including improper threats.” This sentence needs to be changed to be a complete sentence.
4. Page 109; § 180.28(c): OIEC recommends that the language of this section be modified to require that a copy of the peer review report also be sent to the OIEC Ombudsman assisting the injured employee. Specifically, OIEC recommends that the language “person acting on behalf of the injured employee” be substituted for the phrase “injured employee’s representative” in § 180.28(c). This change will permit the OIEC Ombudsman to more effectively assist the injured employee in a dispute where the peer review doctor is being asked to provide an opinion.

Thank you in advance for your careful consideration of the above comments. OIEC believes all other sections not referenced herein should be adopted as proposed. Please do not hesitate to



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contact us if we can be of assistance in clarifying any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** September 29, 2010

**TO:** DWC Rule Team

**FROM:** Brian White, Deputy Public Counsel  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comment on the Informal Proposal of 28 Tex. Admin. Code §§ 136.1 and 136.2

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the informal proposal of 28 Tex. Admin. Code §§ 136.1 and 136.2. OIEC's only substantive comment to the informal proposal concerns § 136.2(b)(6) which requires a statement that only the credentialed private provider will provide vocational rehabilitation services, but also states "although related services (such as initial claimant intake, providing job search skills, verifying job search efforts, liaison with potential employers) may be performed by non-credentialed individuals under their direction." Initially, it is difficult to understand how "verifying job search efforts" qualifies as vocational rehabilitation. Insurance carriers have long used vocational rehabilitation providers to verify job applications in the supplemental income benefits process, but that activity seems more akin to investigation than vocational rehabilitation. However, OIEC's primary concern with § 132.6(b)(6) is that the exception that non-credentialed individuals under the direction of the credentialed provider can perform "related services" will significantly undermine the legislative intent that vocational rehabilitation services be performed by qualified individuals. The parenthetical phrase in the draft language includes "providing job search skills" and "liaison with potential employers" as examples of such "related services." The functions of educating injured employees about job search skills and contacting potential employers about return to work opportunities would seem to be critical components of vocational rehabilitation services. Thus, OIEC is concerned that the "related services" exception will result in an unacceptable erosion of the protection that only appropriately credentialed providers will perform vocation rehabilitation services. Our concern in this regard is only heightened by the push back expressed by insurance carrier representatives at the case management public hearings where they claimed it will be very difficult to find sufficient properly credentialed providers of these services.

It also appears that you overlooked a conforming correction in § 136.2(b). The first sentence of that subsection states "A private provider who wishes to be included in the registry shall complete a Commission approved registration form." The word "Commission" should be changed to "division" for purposes of clarity and consistency.



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NORMAN DARWIN, PUBLIC COUNSEL

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Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** October 18, 2011

**TO:** Maria Jimenez, DWC Rules Team

**FROM:** Brian White, Deputy Public Counsel  
Elaine Chaney, Director of Legal Services

**RE:** OIEC's Comment on Proposal of 28 TAC § 137.5--Regarding Case Manager Certification

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the proposal of 28 Tex. Admin. Code § 137.5 regarding case manager certification. Texas Labor Code § 413.021(a) requires that case managers be “appropriately certified.” Because case managers are going to be involved in resolving issues of appropriate medical care and return to work, the Legislature clearly recognized the importance that these individuals have demonstrated knowledge, skills, and experience. Controlling medical costs, while ensuring receipt of necessary care, and facilitating appropriate return to work are two critical goals of the workers’ compensation system. By adopting § 413.021, the Legislature clearly envisioned that case managers will play an important role in furthering those goals. OIEC is concerned that the rule proposal significantly undermines the requirement that case managers hold appropriate certifications. Therefore, OIEC opposes the rule as proposed and requests that the Division carefully consider the following comments and recommendations.

OIEC objects to the rule not going into effect until September 1, 2011. OIEC understands that the Texas Department of Insurance, Division of Workers’ Compensation (Division) received comments from some system participants arguing that it was not possible to comply quickly with the rule. However, the legislative requirement that case managers be appropriately licensed was passed in 2005. Thus, it is unclear how either case managers or insurance carriers could have been unaware of the requirements of the proposed rule or why it would take nearly six years to comply with the legislative mandate. OIEC notes that a student can complete medical school in four years, thus it is difficult to understand how a case management certification cannot have been obtained by January 2011 for a requirement that was created in September 2005. Finally, OIEC notes that § 413.021 gives the insurance carrier discretion to determine if skilled case management is necessary for the injured employee’s case. In those instances where the insurance carrier determines that it is, the insurance carrier should not be permitted to delay compliance with a statutory requirement created in 2005 until 2011.

OIEC’s position is that the use of unqualified case managers is potentially worse than having no case management. OIEC recommends January 1, 2011, as a more reasonable effective date. Accordingly, OIEC requests that § 137.5(a) be modified to state “This section applies to all case



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management services as defined by Labor Code § 401.011(5-a) that are provided under Labor Code Title 5 to injured employees by an insurance carrier on or after *January 1, 2011.*”

OIEC’s objection to the effective date is exacerbated by the inclusion of subsections (d) and (f) in proposed § 137.5. Subsection (d) establishes that a certified case manager must be used to determine if case management services are required. However, under subsection (f) non-certified case managers can be used to perform all other case management services. Therefore, all case management services actually directed to the injured employee can be provided by a non-certified case manager. OIEC asserts that it is not best practice to have the actual delivery of case management services to injured employees being provided by non-certified case managers. Indeed, it seems contrary to the statutory intent.

It appears that there is an attempt to mitigate the impact of subsection (f) with the inclusion of subsection (g), which provides that the non-certified case manager can only conduct case management services for 18 months. However, OIEC does not believe that this provision effectively mitigates the impact of subsection (f). Initially, OIEC believes that if an insurance carrier were to use a non-certified case manager for the 18-month period following the proposed effective date, the bulk of case management services would actually continue to be provided by non-certified case managers until March 2013, nearly eight years after § 413.021 was amended to include the certification requirement. Further, it appears that an insurance carrier could almost wholly circumvent the requirement that case management services be provided by a certified case manager by using a series of non-certified case managers for consecutive 18-month periods. That is, there is no prohibition against an insurance carrier continuously replacing a non-certified case manager whose 18 months have expired with another non-certified case manager, who could then perform case management services for another 18 months. OIEC believes that the legislative intent that case management services only be provided by appropriately certified case managers is clear. Therefore, OIEC requests that subsection (d) be modified to require that all case management services must be provided by a case manager certified in accordance with § 137.5(c). OIEC further requests that subsections (d) through (h) be removed based upon our belief that these provisions are inconsistent with the statute.

Please do not hesitate to contact us, if we can be of assistance or clarify OIEC’s comments on behalf of the injured employees of Texas.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** November 16, 2010

**TO:** DWC Rule Comment Folder

**FROM:** Elaine Chaney

**RE:** Informal Proposal of 28 TAC § 134.503 regarding the Pharmacy Fee Guideline

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After reviewing the informal proposal of the temporary rule concerning the Pharmacy Fee Guideline, it was determined that there were no issues with the rule that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no written comment was submitted by OIEC to this informal proposal.



## MEMORANDUM

**DATE:** November 17, 2010

**TO:** Utilization Review Rule Team  
Debra Diaz-Lara

**FROM:** Brian White, Deputy Public Counsel, Chief of Staff  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comments on Informal Working Draft of 28 Texas Administrative Code §§19.2001-19.2021 Regarding Utilization Reviews for Health Care Provided Under Workers' Compensation Insurance Coverage

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comments on the Texas Department of Insurance's informal draft rules relating to utilization review for health care provided under workers' compensation insurance coverage 28 Texas Admin. Code §§ 19.2001-19.2021.

OIEC's initial concern relates to the definition of adverse determination in §19.2003(3), which states "A determination by a utilization review agent made on behalf of any payor that the health care services provided or proposed to be provided to an injured employee are not medically necessary or appropriate, or are experimental or investigational." This definition seems to provide that a utilization review agent (URA) can make an adverse determination either because the treatment is not medically necessary or appropriate or because it is experimental or investigational. In other words, the URA can issue an adverse determination for treatment that is experimental or investigational merely because it is so classified. However, 28 Texas Administrative Code § 134.600(p)(6) identifies "any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care" as health care requiring preauthorization. By identifying experimental or investigational treatment as requiring preauthorization in workers' compensation, §134.600(p)(6) clearly envisions that the experimental or investigational nature of the treatment is not a basis in and of itself for denying the treatment. Rather, the focus is on whether the experimental or investigational treatment is necessary or appropriate treatment. OIEC therefore recommends that the definition of adverse determination in §19.2003(3) be modified to be consistent with §134.600(p)(6) and clearly establish that experimental or investigational treatment that is determined to be medically necessary or appropriate will be provided in the workers' compensation system.

OIEC also recommends that the definition of "medical emergency" in §19.2003(23) be modified to be consistent with the definition of "emergency care" in §19.2003(12). The definition of



emergency care includes “serious disfigurement” and “in the case of a pregnant woman, serious jeopardy to the health of the fetus” as the results of the failure to get immediate treatment that constitute emergency care. However, those consequences are omitted from the definition of medical emergency.

OIEC believes that a word was omitted from §19.2005(d) which discusses screening criteria. That subsection provides “Each utilization review agent shall utilize written screening criteria that are evidence-based, scientifically valid, outcome focused, or if evidence is not available, generally accepted standards of medical practice recognized in the medical community . . . .” This language largely tracks the definition of “health care reasonably required in Texas Labor Code §401.011(22-a); however, OIEC notes that a word that was inadvertently omitted when the definition was copied. Thus, OIEC recommends that this provision be modified to include the word “that” in the clause “or if **that** evidence is not available . . . .” Failure to include the word that in this text leaves it unclear that it is the absence of evidence-based medical evidence which permits consideration of generally accepted standards of medical practice as screening criteria.

OIEC suggests that all references to providing notice to or permitting action by injured employees, their representatives, and health care providers also include persons acting on behalf of injured employees. Because of the unavailability of attorneys’ fees in medical dispute resolution, a significant number of injured employees proceed through this process with the assistance of OIEC Ombudsmen. In addition, the medical dispute resolution process is replete with relatively tight time deadlines; therefore, it is critical that the Ombudsmen receive notice and be permitted to act on behalf of the injured employee in order to satisfy the statutory mandate of Texas Labor Code § 404.151(b)(5) to “assist unrepresented claimants to enable those persons to protect their right in the workers’ compensation system.” These references are found in §19.2005(g), §19.2010(a), §19.2010(c)(10), §19.2012(a)(2)(B), §19.2010(a)(2)(E), §19.2015(a), §19.2015(b), §19.2015(c)(10), §19.2021(a)(1), and §19.2021(a)(5).

OIEC recommends that §19.2010(c) and §19.2015(c) be changed to require the URA to include a list of the documentation reviewed in making the adverse determination. Proposed §19.2010(c)(3) and §19.2015(c)(3) require the written notice to include “a description of documentation or evidence, if any, that can be submitted by the provider of record, that upon reconsideration or appeal, might lead to a different utilization review decision.” If that information were supplemented with the list of documentation reviewed, it would permit the provider to determine if such evidence already exists and simply was not provided to the URA or whether additional evidence must be obtained before reconsideration is requested. The determination of how to supplement the initial request has to be made quickly in order to ensure compliance with the deadlines for requesting reconsideration. The inclusion of a requirement that the URA list the documentation reviewed would provide greater efficiency in the process.

OIEC opposes the removal of the subsection of §19.2010 that required the written notification of the adverse determination to include “a description of the procedure for the complaint process to the Department and appeal process to TWCC.” Including information about the complaint process serves an important educational function and permits the parties to have single document to reference in those instances where they have complaints or concerns about the URA process that are properly raised with the Department.



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OIEC believes it is necessary to clarify the last sentence of §19.2010(c)(10), which states “The independent review request form prescribed by the commissioner shall be completed by the injured employee, the injured employee representative, or the injured employee’s provider of record and be returned to the utilization review agent to begin the independent review process.” However, 28 Texas Administrative Code §133.308 MDR by Independent Review Organization, provides that the request for independent review shall be filed “with the insurance carrier (carrier) that actually issued the adverse determination or the carrier’s utilization review agent (URA) that actually issued the adverse determination no later than the 45<sup>th</sup> calendar day after receipt of the denial of reconsideration.” Section 133.308 recognizes those instances where the insurance carrier conducts utilization review in-house as opposed to contracting with a URA. Section 19.2010(c)(10) should be amended to include similar language directing that the request for independent review is to be filed with either the carrier or the URA, whichever actually issued the denials.

OIEC believes that the written procedure for appeal that the URA is required to maintain in §19.2012(2)(A)(ii) must actually include the timeframes for filing the appeal of the adverse determination rather than simply referencing §134.600 and Chapter 133. In order for a written procedure concerning the appeal process to be meaningful, that document must include actual time deadlines. Providing a reference to the applicable rule provisions is insufficient to serve the function of the document, particularly because injured employees often have limited ability to access to the Texas Administrative Code. The problem of limited access becomes more pronounced because the time frames for seeking reconsideration and requesting independent review are relatively short and require prompt action by the injured employee.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can be of assistance in clarifying any of OIEC's comments on behalf of the injured employees of Texas.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** December 28, 2010

**TO:** DWC Rule Comment Folder

**FROM:** Elaine Chaney

**RE:** Proposal 28 Texas Admin. Code §§ 133.10, 133.500, 133.501, and 133.502  
Regarding Medical Bill Processing

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After reviewing the proposal of 28 Texas Admin. Code §§ 133.10, 133.500, 133.501, and 133.502 regarding medical bill processing, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to this proposal.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** December 7, 2010

**TO:** DWC Rule Comment Folder

**FROM:** Elaine Chaney

**RE:** Informal Proposal 28 Texas Admin. Code §§ 134.800, 134.801, and 134.803 - 134.808 Regarding Medical Bill Reporting

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After reviewing the informal proposal of 28 Texas Admin. Code §§ 134.800, 134.801, and 134.803 -134.808 regarding Medical Bill Reporting, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to this informal proposal.



## MEMORANDUM

**DATE:** December 14, 2010

**TO:** Donald Patrick, M.D., J.D., Medical Advisor, Texas Department of Insurance, Division of Workers' Compensation

**FROM:** Brian White, Deputy Public Counsel  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comment on Medical Quality Review Audit Plan Group

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the development of a new Medical Quality Review Audit Plan.

Initially, OIEC requests that the Medical Advisor consider appointing an OIEC representative to the Quality Assurance Committee (QAC). OIEC asserts that under Texas Labor Code §§404.104(3) and (4), the Public Counsel is given the authority to intervene as a matter of right on behalf of injured employees as a class in any proceeding where it determines that the interests of injured employees as a class are in need of representation. OIEC believes that a matter as significant as ensuring the quality of medical care provided to injured employees is most certainly one of the areas where the interests of injured employees require representation. OIEC would note that any confidentiality concerns associated with appointing an OIEC representative to the QAC are mitigated by the fact that OIEC operates under substantially similar confidentiality requirements as the Division. *See* Texas Labor Code § 404.110 and §404.111.

OIEC also requests clarification that the statement that the Medical Advisor will seek Medical Quality Review Panel (MQRP) candidate input from "labor, business and insurance organizations" means that the Medical Advisor will also seek input from OIEC on MQRP candidates. It is axiomatic that injured employees have a significant interest in having representation and being given voice on the composition of the MQRP given the importance of the work that that entity performs in ensuring access to quality health care for injured employees.

OIEC's final recommendation on the draft Medical Quality Review Procedure concerns Section VI—the expert recommendation process. OIEC believes that the disagreeing expert's written opinion should be included in the report that is ultimately provided to the QAC or the Medical Advisor. Consideration of the disagreeing doctor's opinion would seem more appropriate in that the decision to either close the review with no action or to proceed with a possible enforcement action would be made based on a review of complete information. Reviewing the recommendation in the report in light of the disagreeing doctor's opinion would permit a more meaningful review of the report and lead to more balanced decision making.

Please do not hesitate to contact us, if we can be of assistance or clarify OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** December 1, 2010

**TO:** Christopher Bean, Section Chief, Workers' Compensation Counsel  
DWC Rule Team

**FROM:** Brian White, Deputy Public Counsel, Chief of Staff  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comments on Informal Proposal of 28 Texas Administrative Code §§133.2, 133.240, 133.250, and 134.600 Regarding Definitions; Medical Payments and Denials; Reconsideration for Payment of Medical Bills; and Preauthorization, Concurrent Review, and Voluntary Certification

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's informal proposal of 28 Texas Admin. Code §§133.2, 133.240, 133.250, and 134.600.

OIEC's initial concern relates to the definition of utilization review in §133.2(9) and §134.600(a)(9) and the definition of adverse determination in §134.600(a)(1). Both of these definitions seem to provide that a utilization review agent (URA) can make an adverse determination either because the treatment is not medically necessary or appropriate or because it is experimental or investigational. In other words, the URA can issue an adverse determination for treatment that is experimental or investigational merely because it is so classified. However, proposed § 134.600(q)(6) identifies "any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care" as health care requiring preauthorization. By identifying experimental or investigational treatment as requiring preauthorization in workers' compensation, §134.600(q)(6) clearly envisions that the experimental or investigational nature of the treatment is not a basis in and of itself for denying the treatment. Rather, the focus is on whether the experimental or investigational treatment is necessary or appropriate treatment. OIEC therefore recommends that the definitions of utilization review and adverse determination be modified to be consistent with §134.600(q)(6) and clearly establish that experimental or investigational treatment that is determined to be medically necessary or appropriate will be provided in the workers' compensation system. OIEC also made the recommendation that the definition of adverse determination in the informal proposal of §19.2003(3) be similarly modified. In order to ensure consistency, if the change in the definitions of adverse determination and utilization review are made, the phrase "or determined to be experimental or investigational" should be removed from proposed §§133.240(e)(2)(A), 133.250(g), 134.600(p)(3), and 134.600(r)(4).



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NORMAN DARWIN, PUBLIC COUNSEL

OIEC requests that a new subsection (j) be added to §133.240 to detail the requirements that the injured employee has to follow in requesting reconsideration of a medical bill before requesting dispute resolution. Under §133.270(f), an injured employee “may request, but is not required to request, reconsideration prior to requesting medical dispute resolution in accordance with §133.305 of this chapter.” There are instances where it is appropriate for an injured employee to request reconsideration before pursuing dispute resolution and OIEC believes that this rule needs to provide guidance and detail of what the injured employee must do in those instances. Whether or not this change is made, currently proposed §133.240(j) needs to be modified to include injured employees as a party that can request medical dispute resolution if they are dissatisfied with the reconsideration outcome. Specifically, proposed §133.240(j) should state “If dissatisfied with the reconsideration outcome, the health care provider **or injured employee** may request medical dispute resolution in accordance with §§ 133.305, 133.307, 133.308 of this title. . . .”

OIEC objects to the decision to define preauthorization in §134.600(8) in terms of the process of utilization review as opposed to the approval obtained from the insurance carrier obtained by the requestor or injured employee prior to providing the health care treatment or service. OIEC believes that the definition proposed for the term “preauthorization” would more properly define “prospective utilization review.” If the proposed definition for “preauthorization” were actually the definition of “prospective medical review” it would be consistent with the definition of “concurrent utilization review” proposed in §134.600(a)(3). OIEC believes that the term “preauthorization” is understood as the “approval” and not the process and would also note that the term preauthorization is given precisely that meaning in §134.600(c)(1)(B).

OIEC requests that injured employees be added to the definition of requestor in §134.600(a)(9). We acknowledge that injured employees are permitted to pursue preauthorization in the rules as proposed; however, in those instances where the injured employee pursues preauthorization it is because the health care provider requestor is not doing so. Therefore, OIEC believes it is more accurate and straightforward to include the injured employee as the requestor because he or she is acting in that capacity.

OIEC recommends that §134.600(h) be modified to require the insurance carrier to specifically consider unresolved issues of compensability, extent of or relatedness to the compensable injury and the insurance carrier’s liability for the injury in reviewing preauthorization requests. One of the biggest problems of the preauthorization process is that because an insurance carrier can raise an extent, relatedness, or compensability issue after a treatment or service is preauthorized, preauthorization in workers’ compensation does not have the meaning it has in the group health context. Both preauthorization issues and compensability issues are resolved at contested case hearings at the Division of Workers’ Compensation and it would promote efficiency and certainty in the process if both issues were resolved concurrently. OIEC recommends that the insurance carrier be required to raise challenges to compensability and relatedness in addition to raising any challenge to whether the proposed treatment is health care reasonably required in the preauthorization process. This would make a preauthorization determination more closely mirror a preauthorization determination in group health and would help reduce the hassle factor that is often cited by health care providers as a reason for their reluctance to participate in the workers’ compensation system.



Finally, OIEC requests the §134.600(p)(5) be removed. The requirement of proving substantial change of condition to allow a request for preauthorization to be resubmitted creates a procedural barrier to having medical treatment decisions based upon the merits. This is particularly true because the IRO's determination that the injured worker is not entitled to a particular treatment is often based upon incomplete documentation or incomplete testing rather than a determination that the treatment is not reasonably required.

A good example of this is found in the case of APD 100379-s. In this case, the IRO denied a spinal surgery because the IRO did not have records that psychological testing had been done. The IRO determined that such testing was required under the Official Disability Guidelines before surgery could be performed. At the contested case hearing, evidence of the psychological testing demonstrating that the injured employee was indeed a surgical candidate was placed before the hearing officer. The hearing officer ruled that the preponderance of the evidence was contrary to the IRO's decision and ordered the insurance carrier to pay for the surgery. On appeal, the Division's Appeals Panel reversed the hearing officer and rendered a decision that the carrier was not liable for the cost of the surgery because the evidence of psychological testing was not before the IRO. Even if the injured employee had submitted the psychological testing to the IRO when it was completed, the IRO would not have been permitted to change the decision that the surgery was not reasonably required under §133.308(t)(1)(B)(iv).

Pursuant to §134.600(p)(5) the requestor would have to establish a substantial change of condition in order to resubmit the request to have the surgery preauthorized. The difficulty in doing so is that the injured employee's condition has not changed. It is only the information that can be provided to the IRO that has changed. Thus, §134.600(p)(5) and §133.308(t)(1)(B)(iv) work in tandem to prevent medical decisions based upon the merits by creating a procedural quagmire that precludes injured employees from receiving reasonable and necessary medical treatment. OIEC submits that the Division should rectify this by removing §134.600(p)(5) from the proposed rules.

Additionally, OIEC would note that the requirement for a requestor to establish a substantial change in condition is grounded in concepts of administrative efficiency as opposed to evidence-based medicine. Actually providing health care that is reasonably required takes precedence over administrative efficiency. Removal of the substantial change requirement before a preauthorization request could be resubmitted would ensure that injured employees would receive reasonably required medical treatment as the statute promises rather than being thwarted by an unnecessary procedural hurdle.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can be of assistance in clarifying any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** December 10, 2010

**TO:** Gene C. Jarmon, General Counsel and Chief Clerk, Texas Department of Insurance  
D. C. Campbell, Director Workers' Compensation Research and Evaluation Group

**FROM:** Brian White, Deputy Public Counsel

**RE:** OIEC Comment on Proposed FY 2011 Research Agenda for the Workers' Compensation Research and Evaluation Group

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the proposed fiscal year 2011 Research Agenda for the Workers' Compensation Research and Evaluation Group (REG). OIEC supports the research agenda items as proposed and believes that completion of these research projects will be beneficial to the workers' compensation system.

Please do not hesitate to contact me if I can be of assistance.



## MEMORANDUM

**DATE:** December 31, 2010

**TO:** Rule Team, Texas Department of Insurance, Division of Workers' Compensation

**FROM:** Brian White, Deputy Public Counsel  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comment on Proposed 28 Tex. Admin. Code §§ 136.1 and 136.2

The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on proposed 28 Tex. Admin. Code §§ 136.1 and 136.2. OIEC's only comment to the proposal concerns § 136.2(b)(6) which requires a statement that only the credentialed private provider will provide vocational rehabilitation services, but also states "although related services (such as initial claimant intake, providing job search skills, verifying job search efforts, liaison with potential employers) may be performed by non-credentialed individuals under their direction." Initially, it is difficult to understand how "verifying job search efforts" qualifies as vocational rehabilitation. Insurance carriers have long used vocational rehabilitation providers to verify job applications in the supplemental income benefits process, but that activity seems more akin to investigation than vocational rehabilitation. However, OIEC's primary concern with § 132.6(b)(6) is that the exception that non-credentialed individuals under the direction of the credentialed provider can perform "related services" will significantly undermine the legislative intent that vocational rehabilitation services be performed by qualified individuals. The parenthetical phrase in the draft language includes "providing job search skills" and "liaison with potential employers" as examples of such "related services." The functions of educating injured employees about job search skills and contacting potential employers about return to work opportunities would seem to be critical components of vocational rehabilitation services. Indeed, the list of "related services" appears to permit a significant portion of the direct interaction with injured employees to be done by non-credentialed individuals. Thus, OIEC is concerned that the "related services" exception will result in an unacceptable erosion of the protection that only appropriately credentialed providers will perform vocation rehabilitation services. Our concern in this regard is only heightened by the push back expressed by insurance carrier representatives at the case management public hearings where they claimed it will be very difficult to find sufficient properly credentialed providers of these services. To the degree this concern is valid, it would seem to have been resolved by the addition of licensed social workers to the list of credentialed providers of vocational rehabilitation services.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC's comments on behalf of the injured employees of Texas.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** February 11, 2011  
**TO:** TDI Rule Comment Folder  
**FROM:** Elaine Chaney  
**RE:** Independent Review Organization Plan-Based Audit

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After reviewing the text of the proposed Independent Review Organization Plan-Based Audit, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to the Office of the Medical Advisor regarding the Independent Review Organization Plan-Based Audit.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** February 28, 2011

**TO:** TDI Rule Comment Folder

**FROM:** Elaine Chaney

**RE:** 28 Tex. Admin. Code §§134.802, 134.800, 134.801, 134.803, 134.804, 134.805, 134.806, 134.807, and 134.808—Proposed Medical Bill Reporting Rules

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After reviewing the text of proposed rules relating to medical bill reporting, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to proposed Rules 134.802, 134.800, 134.801, 134.803, 134.804, 134.805, 134.806, 134.807, and 134.808.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** April 11, 2011

**TO:** TDI Rule Comment Folder

**FROM:** Elaine Chaney

**RE:** DWC Form-026, *Request for Reimbursement of Payment Made by Health Care Insurer*

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After reviewing the text of the proposed DWC Form-026, *Request for Reimbursement Made by Health Care Insurer*, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to the Office of the Division of Workers' Compensation regarding DWC Form-026, *Request for Reimbursement of Payment Made by Health Care Insurer*.



## MEMORANDUM

**DATE:** May 11, 2011

**TO:** Maria Jimenez  
DWC Forms Team

**FROM:** Brian White, Deputy Public Counsel  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comment on Proposed DWC022 Required Medical Examination  
Notice or Request for Order

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the draft of the Required Medical Examination Notice or Request for Order (DWC022). OIEC has no recommendations concerning the form itself; however, we request that additional language be added to the section entitled "Instructions for Injured Employees." The instructions currently state "Please read these documents carefully. If you have questions about this form, please contact your adjuster." OIEC recommends that language be added that the injured employee might also wish to contact his or her representative or OIEC if he or she is not represented. Specifically, OIEC requests that the second sentence of the instructions be revised to state "If you have questions about this form, please contact your adjuster, **your attorney or representative, or the Office of Injured Employee Counsel at 1-866-393-6432, if you are not represented in your workers' compensation claim.**"

Please do not hesitate to contact us, if we can be of assistance.



## MEMORANDUM

**DATE:** May 11, 2011

**TO:** Maria Jimenez  
DWC Forms Team

**FROM:** Brian White, Deputy Public Counsel  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comment on Proposed DWC022 Required Medical Examination  
Notice or Request for Order

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the draft of the Required Medical Examination Notice or Request for Order (DWC022). OIEC has no recommendations concerning the form itself; however, we request that additional language be added to the section entitled "Instructions for Injured Employees." The instructions currently state "Please read these documents carefully. If you have questions about this form, please contact your adjuster." OIEC recommends that language be added that the injured employee might also wish to contact his or her representative or OIEC if he or she is not represented. Specifically, OIEC requests that the second sentence of the instructions be revised to state "If you have questions about this form, please contact your adjuster, **your attorney or representative, or the Office of Injured Employee Counsel at 1-866-393-6432, if you are not represented in your workers' compensation claim.**"

Please do not hesitate to contact us, if we can be of assistance.



## MEMORANDUM

**DATE:** June 4, 2011

**TO:** Maria Jimenez, DWC Rules Team

**FROM:** Brian White, Deputy Public Counsel

**RE:** OIEC's Comment on Informal Proposal of 28 TAC § 137.5--Regarding Case Manager Certification

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the informal proposal of 28 Tex. Admin. Code § 137.5 regarding case manager certification. OIEC does not believe that the proposed rule language materially expands the statutory requirements of § 413.021(a) of the Texas Labor Code. Section 413.021 requires that a case manager be "appropriately certified" and proposed § 137.5 serves to provide a clear definition of the certification requirements. Since case managers are going to be involved in resolving issues of appropriate medical care and return to work, the Legislature clearly recognized the importance that these individuals have demonstrated knowledge, skills, and experience. Controlling medical costs, while ensuring receipt of necessary care, and facilitating appropriate return to work are two critical goals of the workers' compensation system. Labor Code § 413.021 envisions that case managers will play an important role in furthering those goals. OIEC believes that proposed §137.5 defines certification broadly enough to ensure that sufficient case managers are available, while also advancing the goal of having qualified individuals perform this important function. Therefore, OIEC recommends that §137.5 be adopted as proposed, except in regard to the effective date of the proposed rule.

OIEC objects to the rule not going into effect until January 1, 2013. OIEC notes that the earlier proposed version of this rule had an effective date of September 1, 2010. OIEC understands that the Division received comments from some system participants arguing that it was not possible to comply so quickly with rule. However, the legislative requirement that case managers be appropriately licensed was passed in 2005. Thus, it is difficult to understand how either case managers or carriers could have been caught unawares by the requirements of the proposed rule or why it would take nearly eight years to comply with the legislative mandate. Also, preliminary research by OIEC reveals that most of the certifications enumerated in § 137.5 are obtained by passing an examination and that the testing opportunities to obtain such certifications are readily available. Finally, OIEC notes that § 413.021 gives the insurance carrier discretion to determine if skilled case management is necessary for the injured employee's case. In those instances where the carrier determines that it is, it is difficult to understand why the carrier should be permitted to delay compliance with a statutory requirement created in 2005 until 2013. OIEC's position is that the use unqualified case managers is



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potentially worse than having no case management. OIEC recommends January 1, 2011, as a more reasonable effective date.

Please do not hesitate to contact me if I can be of assistance.



## MEMORANDUM

**DATE:** July 18, 2011

**TO:** Maria Jimenez, DWC Rules Team

**FROM:** Brian White, Deputy Public Counsel  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comments on Informal Proposal to Amend 28 Texas Administrative Code § 141.2, § 141.3, and § 143.2

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) informal proposal to amend 28 Texas Administrative Code § 141.2, § 141.3, and § 143.2, regarding canceling or rescheduling a benefit review conference (BRC), failure to attend a BRC, and description of the appeal proceeding. Please consider the following comments on behalf of the injured employees of Texas:

**1. § 141.2(a)(1)(C):**

OIEC seeks clarification of this portion of the definition of good cause. OIEC is unclear how there can be "objective facts beyond the control of a party" that demonstrate that the case has been resolved by settlement or agreement or the requestor's lack of interest in pursuing the issue. The confusing part of the definition is that the facts have to be "beyond the control of a party." The decisions of whether to resolve a case by settlement or agreement and whether the requestor no longer wants to pursue an issue seem to be matters wholly within the control of the parties. Accordingly, OIEC asks that the Division consider whether it has properly imposed the requirement for objective facts beyond the control of the party to establish good cause because the BRC is "unnecessary" under subsection (C).

**2. §141.2(a)(2):**

OIEC recommends that the Division clarify that the benefit review officer will only make a determination of whether rescheduling or canceling the BRC will unduly prejudice the rights of the other party in those instances where the party objects to the request to reschedule or cancel a BRC. OIEC believes that it is the responsibility of the opposing party to make the case that it will be prejudiced by rescheduling or canceling a BRC. If the benefit review officer were to consider and make a determination on such an issue based on his or her own understanding of the potential prejudice imposed by that decision, he or she would be abandoning his or her role as a mediator and would take on the role of an advocate.



**3. § 141.2(d)(1) and § 141.3(d)(2):**

OIEC requests clarification as to whether the phrase “in the form prescribed by the division” means that forms will be created to request or cancel BRCs. The creation of such forms would be useful to educate the requestor on the information that needs to be included with the request and will help to ensure that the benefit review officer has the information needed to make a decision on the request.

OIEC’s overall concern with the provisions for rescheduling or canceling a BRC outside the 10-day unrestricted period in § 141.2(c) stems from the requirement that a request for a BRC must be filed to avoid finality of the first certification of maximum medical improvement (MMI) and impairment rating (IR) under Texas Labor Code § 408.123(e). OIEC anticipates that the amendment of Texas Labor Code § 408.0041 giving the injured employee access to an alternate certification of MMI and IR from the treating doctor or a referral doctor when the designated doctor has provided the first certification of MMI and IR is a positive step toward mitigating this problem. However, in those instances where the injured employee first contacts OIEC later in the 90-day dispute period following receipt of the first certification, it is likely that necessary evidence to pursue the dispute may not be available before the time to dispute expires. Therefore, OIEC may have to file a request for a BRC before the injured employee is actually ready to proceed in order to preserve his or her right to do so. The informal proposal makes clear that requests for canceling or rescheduling are not favored and OIEC is concerned that, as such, BRCs will go forward prematurely in certain cases. That outcome is not beneficial for any system participant.

OIEC has previously requested that the Division consider permitting a party to file a written dispute, rather than requiring the party to request a BRC, in order to dispute a first certification of MMI and IR in those instances where that dispute cannot be made by requesting a designated doctor. Specifically OIEC filed a rule petition to request this change; however, the petition was denied. OIEC would have no problem with the Division’s restrictive rescheduling and cancellation policies for BRCs if it were possible for an injured employee to avoid finality and protect his or her right to pursue the dispute of the first certification of MMI and IR without having to request a BRC.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact me if I can clarify any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** July 29, 2011

**TO:** DWC Rule Team

**FROM:** Brian White, Deputy Public Counsel  
Elaine Chaney, Director of Legal Services

**RE:** OIEC's Comments on Informal Proposal to Add 28 TAC §§ 180.4, 180.9, and 180.10 and to Amend 28 TAC 180.1, 180.3, 180.5, 180.8, and 180.27

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) informal proposal to add 28 Texas Admin. Code §§ 180.4, 180.9, 180.10 and to amend §§ 180.1, 180.3, 180.5, 180.8, and 180.27. OIEC requests the consideration of the following comments on behalf of the injured employees of Texas:

1. **§ 180.3(c)(2) and § 180.4:** OIEC agrees with the decision to provide for both unannounced on-site visits compliance audits and unannounced on-site visits. OIEC believes that in some instances, the Division is more likely to obtain accurate information in those instances where the insurance carrier has not been given advanced notice of the visit or compliance audit.
2. **§ 180.3(h):** OIEC disagrees with the decision to make publishing of the final audit report on the Division's Internet website discretionary. Although OIEC agrees that it is significant if an auditee takes corrective action based on the audit and comes into compliance, that action does not eliminate the original noncompliance. Making information about system participants who are not in compliance with standards available to other system participants seems to be one of the primary reasons for conducting a compliance audit. However, that educational benefit will be lost if the existence of an audit demonstrating noncompliance is not made public. OIEC appreciates that posting the results of a follow-up audit permits a system participant to demonstrate its efforts to come into compliance. However, OIEC does not believe that taking corrective action should result in excusing the original noncompliance, which will be the result if the findings of the original audit are not made public. OIEC believes that the system works best when system participants have access to complete information and that goal will be undermined if the results of the original audit demonstrating noncompliance are not published.
3. **§ 180.8(d):** OIEC recommends that the notice of the hearing at SOAH include cautionary language explaining that the charged party has twenty days from the date of receipt of the hearing notice to file an answer or responsive pleading or risk being in default for failing to do so. It is fairly exacting to establish a default based on the failure to answer and in



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order to mitigate the negative consequences of default, it is essential that charged parties be notified of the requirement to respond and the consequence of failing to do so.

4. **§§ 180.8(e), (f) and (g):** OIEC requests that this provision be modified to make clear that a party who appears at the hearing will not be in default because the party failed to file an answer. The harm associated with failing to file an answer can be corrected if the party appears and participates in the SOAH hearing. Accordingly, OIEC does not believe it is appropriate for the Division to seek informal disposition of an administrative violation due to the failure to file an answer, if the party appears at the hearing. As it is proposed § 180.8(f) provides that the Division can seek informal disposition against a party who is in default either by failing to file an answer or by failing to appear at the hearing. OIEC believes that § 180.8(e) should be a revised to limit default only to those charged parties who fail to appear at the hearing.
5. **§ 180.8(h):** OIEC requests clarification as to whether there will be a deadline for a party to file a motion to set aside a default and reopen the record. If so, OIEC requests that it be specifically identified. In order to limit the impact of the default provisions and to minimize the number of instances where administrative penalties are imposed without the benefit of a hearing, OIEC believes that it is important to clearly identify this critical deadline.
6. **§ 180.10:** OIEC agrees with the creation of a procedure for the Commissioner to issue an emergency cease and desist order in those instances where the Commissioner believes that a system participant is engaged in conduct that violates a law, rule, or order and further believes that the alleged conduct will result in harm to the health, safety, or welfare of another person. OIEC requests that this provision be modified to include a mechanism for a system participant to file a request for an emergency cease and desist order in a circumstance where the system participant believes that the criteria for such an order exist. OIEC believes that the development of such a process would help ensure that the full benefit of this provision is recognized.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can be of assistance in clarifying any of OIEC's comments on behalf of the injured employees of Texas.



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### MEMORANDUM

**DATE:** July 19, 2011  
**TO:** TDI Rule Comment Folder  
**FROM:** Elaine Chaney  
**RE:** Treating Doctors Lumbar Spinal Fusions Plan-Based Audit

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After reviewing the text of the proposed Treating Doctors Lumbar Spinal Fusions Plan-Based Audit, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to the Office of the Medical Advisor regarding the Treating Doctors Lumbar Spinal Fusions Plan-Based Audit.



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### MEMORANDUM

**DATE:** August 1, 2011

**TO:** DWC Rule Comment Folder

**FROM:** Elaine Chaney

**RE:** Proposal of 28 TAC §§ 134.503 and 134.504 regarding the Pharmacy Fee Guideline and Pharmaceutical Expenses Incurred by the Injured Employee

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After reviewing the proposal of 28 TAC §§ 134.503 and 134.504 regarding the Pharmacy Fee Guideline and Pharmaceutical Expenses Incurred by the Injured Employee, it was determined that there were no issues with the proposal that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no written comment was submitted by OIEC to this proposal.



## MEMORANDUM

**DATE:** August 30, 2011

**TO:** Brent Hatch

**FROM:** Brian White, Deputy Public Counsel  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comment on

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New Rule Process for Resolution of Underpayment of Income Benefit.

- (a) There should be a form to give notice of underpayment. The best way to ensure that an injured employee provides the necessary information is to identify it on a form. The injured employee cannot be expected to know what information is required without it being specifically identified. The form should include an explanation and supporting information detailing the underpayment.
- (b) Seven days seems like a reasonable time to pay the underpayment whether or not the carrier is currently paying benefits.
- (c) The carrier should notify the injured employee of its disagreement that an underpayment had been made within 7 days of receipt of notice. The PLN-11 would be fine to give notice of the carrier's disagreement that underpayment occurred. All time periods should be the same. If the dispute period is shorter than the period to make a payment, it would seem to encourage disputes.
- (d) Arguably, the time period for paying when the carrier determines that an underpayment has been made should be less than those instances where the carrier has to make a determination following notice; however, making all periods 7 days will result in consistency and administrative efficiency.
- (e) Although we know it happens, OIEC does not keep statistics on how often this happens. In our experience the injured employee receives a check for a different amount and doesn't know why. Thus, they either were not notified of the change or did not understand the notice. Instead, the injured employee comes to OIEC asking questions as to why the benefit amount changed.

New Rule Process for Resolution of Overpayment of Income Benefit.

- (a) – (c) Higher percentages would be unacceptable particularly in light of the fact that most overpayments are the result of carrier errors. Although OIEC is mindful that these limitations may result in less than full recoupment, that is not unlike the situation faced by attorneys who represent injured employees who often do not receive full attorney's fees based on similar limitations on the rate of their recovery. In addition, OIEC would



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note that the carrier is better able to bear the financial burden of receiving less than full recoupment than the financial hardship that would be suffered if a higher rate of recoupment were automatically permitted.

(d) – (e) OIEC does not anticipate that any changes to the PLNs would be required.



**MEMORANDUM**

**DATE:** August 22, 2011

**TO:** DWC Rule Team

**FROM:** Brian White, Deputy Public Counsel  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comment on Review of Self-Insurance Rules 28 Tex. Admin. Code §  
114.1-114.15

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to provide comment on the review of 28 Tex. Admin. Code §§ 114.1-114.15 concerning Self-Insurance. OIEC believes that these rules were initially adopted to insure that self-insured employers are financially able to pay claims and committed to workplace safety. The need for those requirements to be met before an employer is authorized to self-insure still exist. It is also critical that the Division closely monitor certified self-insureds to ensure continued compliance with solvency and workplace safety requirements. OIEC believes that no basis exists for the repeal or weakening of these rules. Indeed, the fact that these rules have been effective in creating and regulating self-insurance in Texas argues for their continuation. Protection of the injured employees of Texas demands that these rules remain at least as strong as they presently are. If these rules were to be changed at all, they should only be strengthened. Please do not hesitate to contact us if we can be of assistance on this matter.



## MEMORANDUM

**DATE:** September 30, 2011

**TO:** DWC Rules Team

**FROM:** Brian White, Deputy Public Counsel  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comments on Proposal to Amend 28 Texas Administrative Code § 141.2, § 141.3, and § 143.2

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) proposal to amend 28 Texas Administrative Code § 141.2, § 141.3, and § 143.2, regarding canceling or rescheduling a benefit review conference (BRC), failure to attend a BRC, and description of the appeal proceeding. Please consider the following comments on behalf of the injured employees of Texas:

**1. §141.2(b)(1):**

OIEC recommends that the Division clarify that the benefit review officer will only make a determination of whether rescheduling or canceling the BRC will unduly prejudice the rights of the other party in those instances where the party objects to the request to reschedule or cancel a BRC. OIEC believes that it is the responsibility of the opposing party to make the case that it will be prejudiced by rescheduling or canceling a BRC. If the benefit review officer were to consider and make a determination on such an issue based on his or her own understanding of the potential prejudice imposed by that decision, he or she would be abandoning his or her role as a mediator and would take on the role of an advocate.

**3. § 141.2(b)(5):**

OIEC has serious concerns about equating cancellation of the BRC without simultaneous rescheduling with withdrawal of the dispute. This concern is exacerbated by the inclusion of the requirement that a request to cancel a BRC subject to § 130.12 must comply with the provisions of § 130.12(b)(3). Although the language is not entirely clear, it appears that what the second sentence of § 141.2(b)(5) requires is that the parties agree that the first certification is final before a BRC concerning a dispute of a first certification of MMI and IR can be canceled. In most instances, the request to cancel a BRC that is requested to avoid finality under Texas Labor Code § 408.123(e) and Rule 130.12 is not being made because the party agrees with the certification. Rather, the party with the burden of proof in challenging the first certification is



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requesting a cancellation to have more time to obtain the evidence necessary to pursue the dispute. Typically, the only reason the BRC was requested is because it was the only mechanism available to prevent finality of the first certification of MMI and IR.

OIEC has previously requested that the Division consider permitting a party to file a written dispute, rather than requiring the party to request a BRC, in order to dispute a first certification of MMI and IR in those instances where that dispute cannot be made by requesting a designated doctor. Specifically, OIEC filed a rule petition to request this change; however, the petition was denied. OIEC would have no problem with the Division's restrictive rescheduling and cancellation policies for BRCs if it were possible for an injured employee to avoid finality and protect his or her right to pursue the dispute of the first certification of MMI and IR without having to request a BRC.

OIEC is baffled by the Division's belief that the Legislature has mandated expeditious resolution of a dispute of a first certification of MMI and IR at the expense of correct resolution. The legislative focus is that the parties be prepared when they pursue dispute resolution, not that they be prematurely pushed into dispute resolution. It would seem that concerns of due process and accurate dispute resolution should trump "the need for speed." We would note that in the instance of the finality of an IR because a dispute was not pending prior to the expiration of the first quarter of supplemental income benefits (SIBs) found in Rule 130.102(h) (formerly Rule 130.102(g)), premature resolution has not been forced. Instead, the Appeals Panel has determined that either a filed Request for a Designated Doctor (DWC032) or a Request for a Benefit Review Conference (DWC045) was sufficient to constitute a "pending dispute" even though the actual resolution of the IR issue comes in a subsequent SIBs quarter. See Appeals Panel Decisions 072277, 061788, and 041649. In those cases, insurance carriers did not pursue the dispute of MMI and IR at the time of the certification, but they were nevertheless permitted to challenge the IR during SIBs because they raised the dispute prior to the expiration of the first quarter. In the same way, the claimant files the DWC045 to preserve the right to move forward once he or she has the evidence to do so. Ultimately, the parties have an interest in bringing the MMI and IR issues to resolution because the statute requires the carrier to pay on the designated doctor's certification during the pendency of the dispute.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** September 30, 2011

**TO:** DWC Rules Team

**FROM:** Brian White, Deputy Public Counsel  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comments on the Informal Proposed Revisions to the DWC Form-045, *Request for a Benefit Review Conference*

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the proposed revisions to the DWC Form-045, *Request for a Benefit Review Conference*. Please consider the following comments on behalf of the injured employees of Texas:

OIEC requests that the language on pages 2 and 3 of the form stating that cancelling a BRC without simultaneously rescheduling is considered a withdrawal of the dispute on the issue. OIEC has serious concerns about equating cancellation of a BRC with withdrawal of the dispute. This concern is exacerbated by the inclusion of the requirement that a request to cancel a BRC subject to § 130.12 must comply with the provisions of § 130.12(b)(3). Although the language is not entirely clear, it appears that what the second sentence of § 141.2(b)(5) requires is that the parties agree that the first certification is final before a BRC concerning a dispute of a first certification of MMI and IR can be canceled. In most instances, the request to cancel a BRC that was requested to avoid finality under Texas Labor Code § 408.123(e) and Rule 130.12 is not being made because the party agrees with the certification. Rather, the party with the burden of proof in challenging the first certification is requesting a cancellation to have more time to obtain the evidence necessary to pursue the dispute. Typically, the only reason the BRC was requested is because it was the only mechanism available to prevent finality of the first certification of MMI and IR.

OIEC has previously requested that the Division consider permitting a party to file a written dispute, rather than requiring the party to request a BRC, in order to dispute a first certification of MMI and IR in those instances where that dispute cannot be made by requesting a designated doctor. Specifically, OIEC filed a rule petition to request this change; however, the petition was denied. OIEC would have no problem with the Division's restrictive rescheduling and cancellation policies for BRCs if it were possible for an injured employee to avoid finality and protect his or her right to pursue the dispute of the first certification of MMI and IR without having to request a BRC.



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OIEC is baffled by the Division's belief that the Legislature has mandated expeditious resolution of a dispute of a first certification of MMI and IR at the expense of correct resolution. The legislative focus is that the parties be prepared when they pursue dispute resolution, not that they be prematurely pushed into dispute resolution. It would seem that concerns of due process and accurate dispute resolution should trump "the need for speed." We would note that in the instance of the finality of an IR because a dispute was not pending prior to the expiration of the first quarter of supplemental income benefits (SIBs) found in Rule 130.102(h) (formerly Rule 130.102(g)), premature resolution has not been forced. Instead, the Appeals Panel has determined that either a filed Request for a Designated Doctor (DWC032) or a Request for a Benefit Review Conference (DWC045) was sufficient to constitute a "pending dispute" even though the actual resolution of the IR issue comes in a subsequent SIBs quarter. See Appeals Panel Decisions 072277, 061788, and 041649. In those cases, insurance carriers did not pursue the dispute of MMI and IR at the time of the certification, but they were nevertheless permitted to challenge the IR during SIBs because they raised the dispute prior to the expiration of the first quarter. In the same way, the claimant files the DWC045 to preserve the right to move forward once he or she has the evidence to do so. Ultimately, the parties have an interest in bringing the MMI and IR issues to resolution because the statute requires the carrier to pay on the designated doctor's certification during the pendency of the dispute.

Finally, we would note that the language that the cancellation "must comply with TDI-DWC Rule 130.12" should also be removed from the form. When the parties want to cancel a BRC in instances other than disputes of the first certification of MMI and IR, they cannot comply with Rule 130.12 because it is inapplicable.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** September 27, 2011

**TO:** DWC Rule Team

**FROM:** Brian White, Deputy Public Counsel, Chief of Staff  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comments on Proposal to Amend 28 TAC §§133.2, 133.240, 133.250, §133.270, §133.305, Regarding General Medical Provisions, and 28 TAC §134.600, regarding Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's proposal to amend 28 Texas Admin. Code §§133.2, 133.240, 133.250, 133.270, 133.305, and 134.600.

OIEC suggests adding a provision (v) to §133.240(e)(3)(B) stating "a treating doctor or referral doctor performing an alternate certification in accordance with Labor Code 408.0041 (f-2).

OIEC objects to the decision to define preauthorization in §134.600(8) in terms of the process of utilization review as opposed to the approval obtained from the insurance carrier obtained by the requestor or injured employee prior to providing the health care treatment or service. OIEC believes that the definition proposed for the term "preauthorization" would more properly define "prospective utilization review." If the proposed definition for "preauthorization" were actually the definition of "prospective medical review" it would be consistent with the definition of "concurrent utilization review" proposed in §134.600(a)(3). OIEC believes that the term "preauthorization" is understood as the "approval" and not the process and would also note that the term preauthorization is given precisely that meaning in §134.600(c)(1)(B).

OIEC requests that injured employees be added to the definition of requestor in §134.600(a)(9). We acknowledge that injured employees are permitted to pursue preauthorization in the rules as proposed; however, in those instances where the injured employee pursues preauthorization it is because the health care provider requestor is not doing so. Therefore, OIEC believes it is more accurate and straightforward to include the injured employee as the requestor because he or she is acting in that capacity.

OIEC objects to §134.600(a)(11)(A) because this sounds like a definition for group health, but not for workers' compensation. OIEC recommends that the language in §134.600(a)(11)(A) be changed to "an entity that provides workers' compensation coverage in this state."



OIEC recommends that §134.600(h) be modified to require the insurance carrier to specifically consider unresolved issues of compensability, extent of or relatedness to the compensable injury and the insurance carrier's liability for the injury in reviewing preauthorization requests. One of the biggest problems of the preauthorization process is that because an insurance carrier can raise an extent, relatedness, or compensability issue after a treatment or service is preauthorized, preauthorization in workers' compensation does not have the meaning it has in the group health context. Both preauthorization issues and compensability issues are resolved at contested case hearings at the Division of Workers' Compensation and it would promote efficiency and certainty in the process if both issues were resolved concurrently. OIEC recommends that the insurance carrier be required to raise challenges to compensability and relatedness in addition to raising any challenge to whether the proposed treatment is health care reasonably required in the preauthorization process. This would make a preauthorization determination more closely mirror a preauthorization determination in group health and would help reduce the hassle factor that is often cited by health care providers as a reason for their reluctance to participate in the workers' compensation system.

OIEC seeks clarification of §134.600(p)(2)(A) in that OIEC does not understand why the requirement for the insurance carrier to respond to a request for reconsideration is being changed from 5 to 30 days after receiving the request. This is a substantial change for which the justification is not clear. The provision also seems to contradict §134.600(p)(3) which states that the carrier's reconsideration procedures must include a provision that the reconsideration period must be based on medical or clinical immediacy but may not exceed one calendar day from the date of receipt of all information necessary to complete the reconsideration. OIEC requests clarification of how this one-day requirement reconciles with the 30-day time limit in §134.600(p)(2)(A).

Finally, OIEC requests the §134.600(p)(6) be removed. The requirement of proving substantial change of condition to allow a request for preauthorization to be resubmitted creates a procedural barrier to having medical treatment decisions based upon the merits. This is particularly true because the IRO's determination that the injured worker is not entitled to a particular treatment is often based upon incomplete documentation or incomplete testing rather than a determination that the treatment is not reasonably required.

A good example of this is found in the case of APD 100379-s. In this case, the IRO denied a spinal surgery because the IRO did not have records that psychological testing had been done. The IRO determined that such testing was required under the Official Disability Guidelines before surgery could be performed. At the contested case hearing, evidence of the psychological testing demonstrating that the injured employee was indeed a surgical candidate was placed before the hearing officer. The hearing officer ruled that the preponderance of the evidence was contrary to the IRO's decision and ordered the insurance carrier to pay for the surgery. On appeal, the Division's Appeals Panel reversed the hearing officer and rendered a decision that the carrier was not liable for the cost of the surgery because the evidence of psychological testing was not before the IRO. Even if the injured employee had submitted the psychological testing to



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the IRO when it was completed, the IRO would not have been permitted to change the decision that the surgery was not reasonably required under §133.308(t)(1)(B)(iv).

Pursuant to §134.600(p)(6) the requestor would have to establish a substantial change of condition in order to resubmit the request to have the surgery preauthorized. The difficulty in doing so is that the injured employee's condition has not changed. It is only the information that can be provided to the IRO that has changed. Thus, §134.600(p)(6) and §133.308(t)(1)(B)(iv) work in tandem to prevent medical decisions based upon the merits by creating a procedural quagmire that precludes injured employees from receiving reasonable and necessary medical treatment. OIEC submits that the Division should rectify this by removing §134.600(p)(6) from the proposed rules.

Additionally, OIEC would note that the requirement for a requestor to establish a substantial change in condition is grounded in concepts of administrative efficiency as opposed to evidence-based medicine. Actually providing health care that is reasonably required takes precedence over administrative efficiency. Removal of the substantial change requirement before a preauthorization request could be resubmitted would ensure that injured employees would receive reasonably required medical treatment as the statute promises rather than being thwarted by an unnecessary procedural hurdle.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can be of assistance in clarifying any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** September 30, 2011

**TO:** DWC Rules Team

**FROM:** Brian White, Deputy Public Counsel  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comments on Informal Proposal to add new 28 Texas Administrative Code §§ 126.15 and 125.16 and to amend 28 Texas Administrative Code § 128.1

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) informal proposal to add new 28 Texas Administrative Code §§ 126.15 and 125.16 and to amend 28 Texas Administrative Code § 128.1. Please consider the following comments on behalf of the injured employees of Texas:

**1. §§ 126.16(a)(2) and (3):**

HB 2089 added Texas Labor Code § 408.0815(c) which states "the procedure for recouping overpayments under Subsection (a)(1) must take into consideration the cause of the overpayment and minimize the financial hardship to the injured employee." OIEC acknowledges that proposed subsection §126.16(d) provides that the division will consider those factors in determining whether to approve an increase or decrease in the recoupment rate. However, OIEC believes that the statute requires they also be considered in setting the initial limits for the rate of recoupment. In order to more closely track the intent of HB 2089, OIEC recommends the following subsections be included in § 126.16(b):

(2) If the injured employee's income benefits are not concurrently being reduced to pay approved attorney's fees or to recoup a division approved advance and the overpayment was caused by the carrier, the insurance carrier may recoup the overpayment under this subsection in an amount not to exceed 10% of the income benefit payment to which the injured employee is entitled, except as provided by subsection (c) of this section.

(3) If the injured employee's income benefits are not concurrently being reduced to pay approved attorney's fees or to recoup a division approved advance and the overpayment was caused by the injured employee, the insurance carrier may recoup the overpayment under this subsection in an amount not to exceed 25% of the income benefit payment to



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which the injured employee is entitled, except as provided by subsection (c) of this section.

(4) If the injured employee's income benefits are concurrently being reduced to pay approved attorney's fees or to recoup a division approved advance and the overpayment was caused by the carrier, the insurance carrier may recoup the overpayment under this subsection in an amount not to exceed 5% of the income benefit payment to which the injured employee is entitled, except as provided by subsection (c) of this section.

(5) If the injured employee's income benefits are concurrently being reduced to pay approved attorney's fees or to recoup a division approved advance and the overpayment was caused by the injured employee, the insurance carrier may recoup the overpayment under this subsection in an amount not to exceed 10% of the income benefit payment to which the injured employee is entitled, except as provided by subsection (c) of this section.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** September 6, 2011

**TO:** Gene C. Jarmon, General Counsel and Chief Clerk Team  
Debra Diaz-Lara, Deputy Commissioner, Health and Workers'  
Compensation Network Certification and Quality Assurance Division

**FROM:** Brian White, Deputy Public Counsel, Chief of Staff  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comments on the Proposal of 28 Texas Administrative Code  
§§19.2001-19.2021 Regarding Utilization Reviews for Health Care Provided  
Under Workers' Compensation Insurance Coverage

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comments on the Texas Department of Insurance's proposal of rules relating to utilization review for health care provided under workers' compensation insurance coverage 28 Texas Admin. Code §§ 19.2001-19.2021.

As a general comment, OIEC suggests that all references to providing notice to or permitting action by injured employees, their representatives, and health care providers also include persons acting on behalf of injured employees. Because of the unavailability of attorneys' fees in medical dispute resolution, a significant number of injured employees proceed through this process with the assistance of OIEC Ombudsmen. In addition, the medical dispute resolution process is replete with relatively tight time deadlines; therefore, it is critical that the Ombudsmen receive notice and be permitted to act on behalf of the injured employee in order to satisfy the statutory mandate of Texas Labor Code § 404.151(b)(5) to "assist unrepresented claimants to enable those persons to protect their right in the workers' compensation system."

OIEC seeks clarification over the purpose of defining "experimental or investigational" in § 19.2003(13) given that § 19.2003(2) provides that "[f]or purposes of this subchapter, an adverse determination does not include a determination that health care services are experimental or investigational." Specifically, OIEC requests clarification on the consequence or effect of a determination by a utilization review agent (URA) that the proposed treatment is experimental or investigational. Texas Labor Code § 413.014(c)(6) and 28 Texas Administrative Code § 134.600(p)(6) identify investigational or experimental services or devices as health care requiring preauthorization. By identifying such treatment as requiring preauthorization in workers' compensation, the statute and rule clearly envision that the experimental or investigational nature of the treatment is not a basis in and of itself for denying the treatment. Accordingly, OIEC believes further explanation is required as to the purpose and effect of



having a URA make a determination that the proposed treatment is experimental or investigational.

OIEC believes that the definition of “utilization review agent” in § 19.2003(41) needs to be modified to properly define that phrase for the purposes of workers’ compensation. Proposed § 19.2003(41)(A) defines utilization review agent as an entity that conducts utilization review for “an employer with employees in this state who are covered under a health benefit plan or health insurance policy.” This definition is a definition of utilization review agent for group health and not workers’ compensation. OIEC recommends that the language in §19.2003(41)(A) be changed to “an entity that provides workers’ compensation coverage in this state.”

OIEC disagrees with the language in § 19.2006(c) that addresses disqualifying associations for the doctor performing the appeal of the initial URA determination. Proposed § 19.2006(c) states “for purposes of this subsection, being employed by or under contract with the same utilization review agent as the physician or doctor who issued the initial adverse determination does not in itself constitute a disqualifying association.” OIEC believes that the fact that the reviewing doctor is employed by or under contract with the same URA that issued the initial adverse determination should be a disqualifying association. It is important for the efficacy of the system that the review of the initial determination be conducted by a person whose objectivity cannot be reasonably questioned. That goal would be significantly undermined if the review of the adverse determination can be made by someone who is employed or under contract with the same URA as issued the initial adverse determination. OIEC recommends that the second sentence of § 19.2006(c) be removed from the rule text.

OIEC recommends that §§ 19.2010(a)(1) and (2) and 19.2015(a)(1) and (2) be revised to specifically identify the parties to whom notice of the determination of prospective, concurrent, and retrospective utilization review must be given in both network and non-network claims rather than referencing other provisions in the administrative code. Similarly, OIEC recommends that the time deadlines for appealing the initial determination of the URA and for requesting IRO review of the second adverse determination be specifically identified in §§ 19.2010 (c)(1)(A)(ix)(II) and (III), 19.2012(a)(2)(E)(i) and (ii), and 19.2015(b)(2)(J)(ii) and (iii). The proposed URA rules are lengthy and complex and, as such, it would seem that they should include all of the information related to the process rather than referencing other rule sections. This change would ensure that system participants can more readily determine their responsibilities under the rules.

OIEC recommends that §19.2010(c) and §19.2015(c) be changed to require the URA to include a list of the documentation reviewed in making the adverse determination. Proposed §19.2010(c)(1)(A)(iii) and §19.2015(b)(2)(C) require the written notice to include “a description of documentation or evidence, if any, that can be submitted by the provider of record, that upon reconsideration or appeal, might lead to a different utilization review decision.” If that information were supplemented with the list of documentation reviewed, it would permit the provider to determine if such evidence already exists and simply was not provided to the URA or whether additional evidence must be obtained before reconsideration is requested. The determination of how to supplement the initial request has to be made quickly in order to ensure



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compliance with the deadlines for requesting reconsideration. The inclusion of a requirement that the URA list the documentation reviewed would provide greater efficiency in the process.

OIEC requests clarification of § 19.2012(a)(2)(B) of the process for determining good cause for having a particular type of specialty provider review the case. It appears that the URA will make the determination of whether good cause has been established for having a specialty provider. However, the rule does not address whether that determination is subject to review. OIEC believes that the determination should be subject to review and recommends that the language be added to this section identifying the process for requesting review of the determination concerning the need for specialty review. That language should detail the process for requesting review, and should identify the entity that will conduct the review.

§19.2015(b)(2)(J)(i) needs to be modified to state that the independent review request form LHL009 has to be returned to either the carrier or the URA, whichever issued the adverse determinations. As proposed § 19.2015(b)(2)(J)(i) states “The independent review request Form LHL009 must be completed by the injured employee, the injured employee representative, or the injured employee’s provider of record and be returned to the utilization review agent to begin the independent review process.” However, 28 Texas Administrative Code §133.308 MDR by Independent Review Organization, provides that the request for independent review shall be filed “with the insurance carrier (carrier) that actually issued the adverse determination or the carrier’s utilization review agent (URA) that actually issued the adverse determination no later than the 45<sup>th</sup> calendar day after receipt of the denial of reconsideration.” OIEC requested this change in our comment to the informal proposal of these rules in November 2010. Proposed §19.2010(c)(1)(A)(ix)(I) incorporated that recommendation. The text of that section states “Form No. LHL009 must be completed by the injured employee, the injured employee’s representative, or the injured employee’s provider of record and be returned to the insurance carrier or utilization review agent that made the adverse determination to begin the independent review process.” However, that revision was not made to § 19.2015(b)(2)(J)(i). OIEC recommends that the text of § 19.2010(c)(1)(A)(ix)(I) be substituted for the current language of § 19.2015(b)(2)(J)(i) to clarify that the request for independent review is to be filed with either the carrier or the URA, whichever actually issued the denials.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can be of assistance in clarifying any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** October 21, 2011

**TO:** DWC Rule Team

**FROM:** Brian White, Deputy Public Counsel/Chief of Staff  
Elaine Chaney, Director of Legal Services

**RE:** OIEC's Comments on Proposal to Add 28 TAC §§ 180.4, 180.9, and 180.10  
and to Amend 28 TAC §§ 180.1, 180.3, 180.5, 180.8, and 180.27 Regarding  
Monitoring and Enforcement

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) proposal to add 28 Texas Admin. Code §§ 180.4, 180.9, 180.10 and to amend 28 Texas Admin. Code §§ 180.1, 180.3, 180.5, 180.8, and 180.27. OIEC requests the consideration of the following comments on behalf of the injured employees of Texas:

1. **§180.1(3):** OIEC believes there is a typographical error in this subsection which defines the term agent. The first sentence currently states "[a] person with whom a system participant utilizes or contracts with for the purpose of providing claims services or fulfilling duties under Labor Code, Title 5 and rules." OIEC believes that the first with should be removed and the sentence should read, "[a] person whom a system participant utilizes or contracts with for the purpose of providing claims services or fulfilling duties under Labor Code, Title 5 and rules."
2. **§ 180.3 and § 180.4:** OIEC agrees with the decision to provide for both unannounced on-site visits. OIEC believes that in some instances, the Division is more likely to obtain accurate information in those instances where the insurance carrier has not been given advanced notice of the visit. Consequently, OIEC disagrees with the Division's decision to remove the language from §180.3 in its earlier proposal providing for unannounced compliance audits. At the public hearing on this proposal Commissioner Bordelon indicated that the unannounced visit provision would likely be used sparingly. OIEC acknowledges that unannounced compliance audits would be the exception. Nevertheless, OIEC believes that there are instances where the nature of the alleged violation would justify an unannounced audit. Accordingly, OIEC believes that §180.3 should continue to provide the Division with the authority to conduct an unannounced compliance audit.
3. **§ 180.3(h):** OIEC disagrees with the decision to make publishing of the final audit report on the Division's Internet website discretionary. Although OIEC agrees that it is significant if an auditee takes corrective action based on the audit and comes into compliance, that action does not eliminate the original noncompliance. Making



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information about system participants who are not in compliance with standards available to other system participants seems to be one of the primary reasons for conducting a compliance audit. However, that educational benefit will be lost if the existence of an audit demonstrating noncompliance is not made public. OIEC appreciates that posting the results of a follow-up audit permits a system participant to demonstrate its efforts to come into compliance. However, OIEC does not believe that taking corrective action should result in excusing the original noncompliance, which will be the result if the findings of the original audit are not made public. OIEC believes that the system works best when system participants have access to complete information and that goal will be undermined if the results of the original audit demonstrating noncompliance are not published.

4. **§§ 180.8(c) and (d):** OIEC recommends that the notice of the hearing at SOAH include cautionary language explaining that the charged party has twenty days from the date of receipt of the hearing notice to file an answer or responsive pleading or risk being in default for failing to do so. It is fairly exacting to establish a default based on the failure to answer and in order to mitigate the negative consequences of default, it is essential that charged parties be notified of the requirement to respond and the consequence of failing to do so.
5. **§§ 180.8(e), (f), and (g):** OIEC requests that this provision be modified to make clear that a party who appears at the hearing will not be in default because the party failed to file an answer. The harm associated with failing to file an answer can be corrected if the party appears and participates in the SOAH hearing. Accordingly, OIEC does not believe it is appropriate for the Division to seek informal disposition of an administrative violation due to the failure to file an answer, if the party appears at the hearing. As it is proposed § 180.8(f) provides that the Division can seek informal disposition against a party who is in default either by failing to file an answer or by failing to appear at the hearing. OIEC believes that § 180.8(e) should be revised to limit default only to those charged parties who fail to appear at the hearing.
6. **§ 180.10:** OIEC agrees with the creation of a procedure for the Commissioner to issue an emergency cease and desist order in those instances where the Commissioner believes that a system participant is engaged in conduct that violates a law, rule, or order and further believes that the alleged conduct will result in harm to the health, safety, or welfare of another person. OIEC requests that this provision be modified to include a mechanism for a system participant to file a request for an emergency cease and desist order in a circumstance where the system participant believes that the criteria for such an order exist. OIEC believes that the development of such a process would help ensure that the full benefit of this provision is recognized.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can be of assistance in clarifying any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** October 27, 2011

**TO:** Maria Jimenez, Office of Workers' Compensation Counsel

**FROM:** Brian White, Deputy Public Counsel  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comments on Informal Draft Rules Relating to Designated Doctor Procedures and Requirements

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) informal proposal to amend 28 Texas Administrative Code §§127.1, 127.5, 127.10, 127.20, 127.25, 130.6 and 180.23, to repeal §180.21, and to add new §§127.100, 127.110, 127.120, 127.130, 127.140, 127.200, 127.210, and 127.220, relating to designated doctor procedures and requirements. Please consider the following comments on behalf of the injured employees of Texas:

**1. §127.1(b)(9):**

OIEC suggests that an ombudsman assisting an injured worker be added to the list a requestor is required to submit a copy of the request for designated doctor. OIEC understands that as proposed the injured employee would receive a copy of the request. However, OIEC's experience is that injured workers often do not understand the request or appreciate the importance of promptly providing this document to their ombudsmen. The Division implicitly recognizes this when it provides in the proposed rule that the requests must be sent to both injured employees and to injured employee representatives. OIEC feels that is just as important to insure that the ombudsman receive a copy of the request for the designated doctor as it is to insure that the injured employee's representative receive it and for many of the same reasons.

**2. §127.1(d)(4):**

OIEC seeks clarification of this provision. OIEC is uncertain what this provision means and what circumstances the Division seeks to address with this provision. Specifically, it is unclear when an examination would not help resolve a dispute.



**3. §127.1(e):**

OIEC believes that it is equally important to be able to have an expedited contested case hearing where a request for a designated doctor has been denied as when one has been approved. OIEC submits that the proposed rule should be changed to read, “Additionally a party is entitled to seek an expedited contested case hearing under §140.3 of this title (relating to Expedited Proceedings) to dispute an approved or a denied request for designated doctor examination.”

**4. §127.5(a):**

OIEC requests that notice of the designated doctor appointment be sent to the injured worker’s ombudsman, if any. As with §127.1(b)(9), OIEC submits that it is equally important that the injured employee’s ombudsman receives this notice as it is for an injured employee’s representative to receive this information and for many of the same reasons. For one thing it is unlikely that an injured employee would be able to dispute the Division’s approval or denial of a designated doctor’s request without assistance of the ombudsman and failure to timely do so may preclude an injured worker from being able to do so. Further, an injured employee may not appreciate the importance of attending the designated doctor examination or the consequences of the failure to do so without the advice of an ombudsman.

**5. §127.5(d):**

OIEC agrees with changing the language of §127.5(d) concerning the Division’s use of a previously assigned designated doctor from being permissive to mandatory. This change appears designed to reduce the number of designated doctor in a claim. Believing this is desirable goal, OIEC agrees with the use of the word “shall” in this provision.

**6. §127.10(a)(2):**

OIEC requests that the carrier and treating doctor send any analyses to the injured worker’s ombudsman, if any. Again, we note that the proposed rule provides that these analyses be sent to the injured employee’s representative, if any. Ombudsmen need copies of these analyses for the same reasons that injured employees’ representatives need them.

Also, it has been OIEC’s experience that carriers often fail to send the analyses to anyone other than the designated doctor and that these analyses if discovered are sometimes one-sided documents designed to lobby, rather than to inform, the designated doctor. In fact, analyses appear to have taken the place of unilateral contact with the designated doctors which the Appeals Panel prohibited years ago to prevent the parties from unfairly biasing designated doctors. The addition of a requirement that these analyses be “neutral” might help mitigate this problem. Another safeguard might be to require that any such analysis be provided to the other parties before it is sent to the designated doctor. Sending it at the same time means that by the time the other parties receive it, the designated doctor has also received it. Thus, if the document was designed to prejudice the designated doctor, the harm has been done before anyone has an opportunity to object to the contents of the analysis.



**7. §127.10(c):**

OIEC agrees with the decision not to have testing or referrals by the designated doctor subject to retrospective review. OIEC believes that retrospective review of charges for such testing and referrals in the past led to non-payment for such services, making it less likely a designated doctor was able to get these services performed.

**8. §127.10(e) and (f):**

OIEC requests that the designated doctor be required to send copies of the reports referenced in these sections to an injured worker's ombudsman in the same manner such reports are required to be sent to an injured worker's representative. Again, the ombudsmen need these reports for the same reasons as representatives do.

**9. §127.20(a):**

OIEC objects to the new language in this rule that states that parties may not ask a designated doctor to reconsider the doctor's decision or to issue a new or amended decision unless the designated doctor failed to address an issue the designated doctor was ordered to address. This language prevents a party from asking a designated doctor to change an incorrect designated doctor report which greatly restricts the scope of letters of clarification and makes the letter of clarification process largely futile in most cases. If a party sees that a designated doctor has clearly made an error, it would seem that the most efficient way to get the error corrected is to permit the party to inquire about the error and to give the designated doctor an opportunity to correct the error or explain why there is no error. Otherwise, designated doctors' errors would go uncorrected or could only be corrected through litigation, which would not appear to be the most efficient means of correcting them.

**10. §127.20(b)(3):**

OIEC submits that leading questions are not always inflammatory, and, in fact, are often an essential means of reaching the truth. For instance, if a party believes that a doctor has not properly applied the AMA Guides, it is impossible to inquire about that without asking a leading question. Designated doctors are professionals and, as such, they seem more than capable of answering leading questions, which are largely designed to more efficiently get at the truth.

**11. §127.100(a)(2):**

OIEC believes that it is important that through the designated doctor training or otherwise that designated doctors be made aware of the fact that the Division's current return to work guidelines presuppose optimal medical treatment and therefore cannot be mechanically applied to cases where medical treatment has been denied.



**12. §127.100(a)(4):**

This section certainly attempts to address the problem of doctors with limited recent clinical experience providing “expert” opinions. The workers’ compensation system has long been plagued by “experts” whose primary expertise appears to be in providing “expert” opinions as opposed to the actual practice of any profession. OIEC commends the Division for attempting to address this problem with this provision. However, OIEC believes that this provision does not go far enough to remedy the problem. Only requiring that at the time of application to be a designated doctor that a doctor have practiced half time for three of the preceding 10 years would mean that a doctor who had no clinical practice for seven years could qualify to obtain designated doctor status. OIEC suggests the problem would be better addressed by requiring that during the five years preceding application the doctor have earned at least as much income from treating patients as from providing expert opinions, with the phrase “providing expert opinion” defined as fees for examining and reviewing records, providing written reports, and testifying at depositions, administrative and court proceedings concerning patients other than patients for whom the doctor has actually provided treatment.

**13. §127.110(e)(4)(E):**

OIEC submits that this requirement appears to be very subjective and wonders who will decide whether this criterion is met or how it will be determined if it is met.

**14. §127.130:**

OIEC is not certain that the Division is properly applying Section 408.0043 which provides that a designated doctor “who reviews a specific workers’ compensation case must hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving.” OIEC questions whether this language is consistent with some of the certifications list in Rule 127.130. For example, is certification in occupational medicine appropriate to traumatic brain and spinal cord injuries with documented neurological deficit (127.130(b)(8)(A)), to complicated infectious diseases requiring hospitalization or prolonged intravenous antibiotics (127.130(b)(8)(E)), or to heart or cardiovascular conditions (127.130(b)(8)(G)? OIEC doubts that a doctor of occupational medicine would or should undertake to treat these conditions and would therefore argue that this professional certification is not appropriate to the type of health care that the injured employee is receiving with these types of injury. OIEC suggests the Division review §127.130 to make it more closely conform to the requirements of Section 408.0043.

**15. §127.140(d):**

OIEC submits that merely stripping a designated doctor’s report tainted by a disqualifying association of its presumptive weight is insufficient. OIEC believes that such a tainted report should not be admitted into evidence at all or there will be a risk that a report tainted by a disqualifying association could still end up being adopted. The adoption of such tainted reports would undermine confidence in the fairness and impartiality of the dispute resolution process.



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### **16. 127.220(a)(9):**

OIEC commends the Division for proposing that the designated doctor include a record of the time taken to complete the designated doctor examination. Injured employees frequent contend that the designated doctor did not conduct a thorough examination. Having the designated doctor include this information is an important first step in addressing that concern and in making the designated doctors more aware of the fact that sufficient time needs to be expended to insure that designated doctor examinations are thorough and correctly performed.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC's comments on behalf of the injured employees of Texas.



**MEMORANDUM**

**DATE:** November 23, 2011

**TO:** DWC Rules Team

**FROM:** Brian White, Deputy Public Counsel/Chief of Staff  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comment on the Informally Proposed *Notice of Underpayment of Income Benefits*

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) informally proposed *Notice of Underpayment of Income Benefits*. OIEC's only recommendation concerning the proposed notice is to add a space for the DWC No. on the form. The inclusion of the DWC No. will make it easier for system participants to properly process the document since that number is a primary identifier on a workers' compensation claim.

Thank you in advance for your careful consideration of the above comment. Please do not hesitate to contact us if we can clarify any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** November 23, 2011

**TO:** DWC Rules Team

**FROM:** Brian White, Deputy Public Counsel/Chief of Staff  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comments on Proposal to add new 28 Texas Administrative Code §§ 126.15 and 125.16 and to amend 28 Texas Administrative Code § 128.1 Regarding Procedures for the Resolution of Underpayments and Overpayments of Income Benefits

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) proposal to add new 28 Texas Administrative Code §§ 126.15 and 125.16 and to amend 28 Texas Administrative Code § 128.1. Please consider the following comments on behalf of the injured employees of Texas:

**1. §§ 126.16(b)(2) and (3):**

HB 2089 added Texas Labor Code § 408.0815(c) which states "the procedure for recouping overpayments under Subsection (a)(1) must take into consideration the cause of the overpayment and minimize the financial hardship to the injured employee." OIEC acknowledges that proposed subsection §126.16(d) provides that the division will consider those factors in determining whether to approve an increase or decrease in the recoupment rate. However, OIEC believes that the statute requires they also be considered in setting the initial limits for the rate of recoupment. In order to more closely track the intent of HB 2089, OIEC recommends the following subsections be included in § 126.16(b):

(2) If the injured employee's income benefits are not concurrently being reduced to pay approved attorney's fees or to recoup a division approved advance and the overpayment was caused by the carrier, the insurance carrier may recoup the overpayment under this subsection in an amount not to exceed 10% of the income benefit payment to which the injured employee is entitled, except as provided by subsection (c) of this section.

(3) If the injured employee's income benefits are not concurrently being reduced to pay approved attorney's fees or to recoup a division approved advance and the overpayment was caused by the injured employee, the insurance carrier may recoup the overpayment under this subsection in an amount not to exceed 25% of the income benefit payment to



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which the injured employee is entitled, except as provided by subsection (c) of this section.

(4) If the injured employee's income benefits are concurrently being reduced to pay approved attorney's fees or to recoup a division approved advance and the overpayment was caused by the carrier, the insurance carrier may recoup the overpayment under this subsection in an amount not to exceed 5% of the income benefit payment to which the injured employee is entitled, except as provided by subsection (c) of this section.

(5) If the injured employee's income benefits are concurrently being reduced to pay approved attorney's fees or to recoup a division approved advance and the overpayment was caused by the injured employee, the insurance carrier may recoup the overpayment under this subsection in an amount not to exceed 10% of the income benefit payment to which the injured employee is entitled, except as provided by subsection (c) of this section.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** December 5, 2011

**TO:** DWC Rules Team

**FROM:** Brian White, Deputy Public Counsel/Chief of Staff  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comments on Informal Draft Rules Relating to Notice and Reporting Requirements for Subscribing and Non-Subscribing Employers; and Rules Relating to Notice of a Texas Labor Code §504.053(b)(2) Election by a Self-Insured Political Subdivision

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) informal proposal to add new 28 Texas Administrative Code (TAC) §§110.7, 110.103, 110.105, and 160.1, and to amend §§110.1, 110.101, 160.2, and 160.3. Please consider the following comments on behalf of the injured employees of Texas:

**1. §110.7(d):**

OIEC suggests that a self-insured political subdivision that begins to provide medical benefits to its employees in the manner described by Labor Code §504.053(b)(2) after the effective date of the section (July 1, 2012) be required to provide notice not later than the 30<sup>th</sup> day **before** the political subdivision begins to provide the medical benefits in that manner. OIEC believes that the requirement of prior notice would further the objective of Texas Labor Code §504.053(d)(4) of ensuring the continuity of treatment of injured workers. It would seem that a self-insured political subdivision is more likely to make a smooth transition in changing the way it is providing medical benefits if it is required to provide notice prior to the change rather than not having to provide notice until 30 days after the change.

**2. §110.101(a):**

OIEC recommends that a subsection be added requiring employers to notify their employees of coverage status in writing, whenever an employee reports an injury or the employer has actual knowledge of a potential claim. Specifically, OIEC recommends adding a new subsection (a)(2) stating "*shall be provided at the time an employee reports an injury to the employer or at the time an employer has actual knowledge of a potential claim.*"



**3. §110.101(c):**

OIEC suggests that some deadline for replacing notices posted prior to July 1, 2012, and for updating notices when the information regarding coverage status, insurance carrier, safety violations hotline number or third party administrator changes should be provided. Absent any deadline this rule really does not seem to have any teeth or to even be enforceable in any sense.

**4. §§ 110.101(e)(1), (e)(2), and (e)(3):**

OIEC disagrees with the deletion of the phrase “and assist in resolving disputes about a claim” from the text of the notices. OIEC’s statutory duties to injured employee are significantly greater than merely explaining their rights and responsibilities under the workers’ compensation system. The heart of OIEC’s statutory responsibility is to assist and advocate on behalf of the injured employees of Texas; therefore, we believe it is critical that this aspect of our agency’s mission be included in the notice of coverage.

**5. §110.103:**

OIEC is concerned about enforceability. To make sure that this rule is enforceable OIEC suggests the addition of a subsection (d) providing, “Failure to provide notice as required in this rule is an administrative violation.”

**6. §110.105:**

To make certain that this provision is enforceable, OIEC suggests that a subsection (f) be added to provide, “Failure to provide notice as required in this rule is an administrative violation.”

**7. §160.2:**

To ensure the enforceability of this provision OIEC suggests adding a subsection (e) providing, “Failure to file a report of injury as required by this rule is an administrative violation.”

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC's comments on behalf of the injured employees of Texas.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** December 21, 2011  
**TO:** TDI Rule Comment Folder  
**FROM:** Elaine Chaney  
**RE:** Utilization Review Agent Plan-Based Audit

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After reviewing the text of the proposed Utilization Review Agent Plan-Based Audit, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to the Office of the Medical Advisor regarding the Independent Review Organization Plan-Based Audit.



## MEMORANDUM

**DATE:** January 11, 2012

**TO:** Maria Jimenez, Office of Workers' Compensation Counsel

**FROM:** Brian White, Deputy Public Counsel/Chief of Staff  
Elaine Chaney, Director of Administration and Operations

**RE:** OIEC Comments on Informal Draft Rule 28 TAC §127.130(b) Regarding Designated Doctor Qualification Criteria

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) informal proposal to add new 28 Texas Administrative Code §127.130(b), regarding designated doctor qualification criteria. Please consider the following comments on behalf of the injured employees of Texas:

OIEC does not believe that the Division is properly applying Section 408.0043 which provides that a designated doctor "who reviews a specific workers' compensation case must hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving." OIEC contends that the statute requires the designated doctor to hold a comparable certification to someone who would treat the injury. Therefore, OIEC questions whether certain doctors included in Rule 127.300(b)(8) are properly included. Specifically, OIEC doubts that certification in occupational medicine is appropriate to traumatic brain and spinal cord injuries with documented neurological deficit (§ 127.130(b)(8)(A)), to severe burns (§ 127.130(b)(8)(B)), to complicated infectious diseases requiring hospitalization or prolonged intravenous antibiotics (§ 127.130(b)(8)(E)), or to heart or cardiovascular conditions (§ 127.130(b)(8)(G)). Similarly, OIEC questions whether a medical doctor or an osteopath board certified in family medicine is properly included in §§ 127.130(b)(8)(E), (F), or (G). It does not seem likely that a medical doctor or osteopath only certified in occupational or family medicine would or should undertake to treat these conditions; therefore, OIEC would argue that these professional certifications are not appropriate to the type of health care that the injured employee would receive with these conditions. OIEC recommends that the Division review §§ 127.130(b)(8)(A), (B), (E), (F), and (G) to make them more closely conform to the requirements of Section 408.0043.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** January 4, 2012

**TO:** DWC Rules Team

**FROM:** Brian White, Deputy Public Counsel  
Elaine Chaney, Director of Administration and Operations

**RE:** OIEC Comments on Informal Draft of Rules Relating to Medical Dispute Resolution

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) informal proposal to amend 28 Texas Administrative Code §133.307, §133.308, §§144.1-144.7, and §§144.9-144.16 . Please consider the following comments on behalf of the injured employees of Texas:

### 1. §133.307(b)(3) and (4)

OIEC suggests that both these sections be revised to read "the injured employee or person acting on behalf of an injured employee". OIEC notes that this language is included in §133.308(f)(1)(B) which deals with who may be a requestor in network medical necessity disputes. For purposes of consistency and clarity, OIEC believes that the definition of requestor should be the same in all types of medical disputes.

### 2. §133.308(f)(2)(B)

OIEC suggests this section be revised to read "injured employees or a person acting on behalf of an injured employee" rather than "injured employees or injured employee's representative". Again, OIEC notes that this language is included in §133.308(f)(1)(B) which deals with who may be a requestor in network medical necessity disputes. OIEC does not believe that a difference in the definition of requestor is required or warranted for non-network medical disputes.

### 3. §133.308(n)(1)

OIEC understands that an IRO cannot make an immediate determination in a case involving a life-threatening condition; however, it would seem that when a life-threatening condition is involved, the IRO should be able to make a determination in no more than three days.



**4. §133.308(r):**

OIEC seeks clarification of what is meant by “An insurance carrier may claim a defense to a medical necessity dispute”. What is the carrier claiming a defense to? If the purpose of the provision is to say that the carrier should comply with the IRO decision and provide care to the injured employee consistent with that decision why not just say that?

**5. §133.308(s)(1)(E):**

Again OIEC seeks clarification. What happens if the treatment guidelines adopted by the political division or pool do not meet the standards provided by Labor Code §413.011(e)? If this section means that when the guidelines do not meet those standards that the hearing officer should proceed as if the guidelines did not exist, wouldn't it be clearer just to say so?

**6. §144.11**

OIEC submits that for clarity this provision should provide to whom at the Division the request for continuance will be directed and who will rule on it. Alternatively, it seems that a continuance request might be more properly directed to the arbitrator.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC's comments on behalf of the injured employees of Texas.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** January 30, 2012  
**TO:** TDI Rule Comment Folder  
**FROM:** Elaine Chaney  
**RE:** 28 TAC §§ 133.250, 133.270, and 133.305

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After reviewing the text of proposed 28 TAC §§ 133.250, 133.270 and 133.305, regarding general medical provisions, it was determined that there were no issues with these provisions that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC concerning these sections. Comment was prepared and submitted to the Division on 28 TAC 133.2, 133.240, and 134.600, the portions of this rule proposal that impact injured employees. TAC



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** January 4, 2012  
**TO:** TDI Rule Comment Folder  
**FROM:** Elaine Chaney  
**RE:** Medical Quality Review CY 2012 Annual Audit Plan

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After reviewing the text of the proposed Medical Quality Review CY 2012 Annual Audit Plan, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to the Office of the Medical Advisor regarding the Medical Quality Review CY 2012 Annual Audit Plan.



## MEMORANDUM

**DATE:** January 30, 2012

**TO:** Maria Jimenez, Office of Workers' Compensation Counsel

**FROM:** Brian White, Deputy Public Counsel/Chief of Staff  
Elaine Chaney, Director of Administration and Operations

**RE:** OIEC Comments on Proposal to amend 28 TAC §133.2, §133.240, Regarding General Medical Provisions, and 28 TAC §134.600, Regarding Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) proposal to amend 28 Texas Administrative Code §§133.2, 133.240, and 134.600.

OIEC believes that there is a grammatical error in §133.2(1) as it is proposed. Specifically, it appears that the work "with" between person and whom in this definition is not properly included. OIEC believes that § 133.2(1) should state "Agent – A person or entity that a system participant utilizes or contract with for the purpose of providing claims service or fulfilling medical bill processing obligation under Labor Code, Title 5 and rules. The system participant who utilizes or contracts with the agent may also be responsible for the administrative violations of that agent. This definition does not apply to 'agent' as used in the term 'pharmacy processing agent'."

OIEC suggests adding a provision (v) to §133.240(e)(2)(B) stating "a treating doctor or referral doctor performing an alternate certification in accordance with Texas Labor Code §408.0041(f-2). §§ 133.240(e)(2)(B)(i) through (iv) identify the health care providers who are authorized to receive payment for medical opinions and/or treatment in the workers' compensation system. This list is not complete without including the health care providers authorized to give alternate certifications of maximum medical improvement and impairment rating in § 408.0041(f-2).

OIEC supports the decision to change the definition of "preauthorization" in §134.600(a)(7). This definition properly reflects that preauthorization is the approval of treatment as opposed to the process of prospective utilization review.

OIEC requests that injured employees be added to the definition of requestor in §134.600(a)(8). We acknowledge that injured employees are permitted to pursue preauthorization in the rules as proposed; however, in those instances where the injured employee pursues preauthorization it is because the health care provider requestor is not doing so. Therefore, OIEC believes it is more



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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accurate and straightforward to include the injured employee as the requestor because he or she is acting in that capacity.

OIEC recommends that §134.600(h) be modified to require the insurance carrier to specifically consider unresolved issues of compensability, extent of or relatedness to the compensable injury and the insurance carrier's liability for the injury in reviewing preauthorization requests. One of the biggest problems of the preauthorization process is that because an insurance carrier can raise an extent, relatedness, or compensability issue after a treatment or service is preauthorized, preauthorization in workers' compensation does not have the meaning it has in the group health context. Both preauthorization issues and compensability issues are resolved at contested case hearings at the Division of Workers' Compensation and it would promote efficiency and certainty in the process if both issues were resolved concurrently. OIEC recommends that the insurance carrier be required to raise challenges to compensability and relatedness in addition to raising any challenge to whether the proposed treatment is health care reasonably required in the preauthorization process. This would make a preauthorization determination more closely mirror a preauthorization determination in group health and would help reduce the hassle factor that is often cited by health care providers as a reason for their reluctance to participate in the workers' compensation system.

OIEC disagrees with the decision in § 134.600(o)(2)(A) to give an insurance carrier up to 30 days to respond to a reconsideration request. Although we understand that this change is being proposed to make the time period consistent with the reconsideration time period in network claims, we are not convinced that such a change is warranted because it comes at the expense of delaying reconsideration decisions by 25 days. Consistency between network claims and non-network claims is generally a valid goal; however, where as in this instance, it will delay the injured employee's receipt of medical treatment it does not seem appropriate.

Finally, OIEC applauds the decision to include language in § 134.600(o)(5) to permit resubmission of a request for preauthorization in those instances where an injured employee meets the clinical prerequisites for the requested health care that had not been met before the submission of the previous preauthorization request. OIEC believes this is an important change that will serve to ameliorate the unintended consequences of the requirement to prove a substantial change in the employee's medical condition before a preauthorization request can be resubmitted and will result in additional necessary health care being provided to injured employees.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC's comments on behalf of the injured employees of Texas.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** February 1, 2012  
**TO:** TDI Rule Comment Folder  
**FROM:** Elaine Chaney  
**RE:** DWC Form-047 and Form-053

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After reviewing the text of the proposed DWC Form-047 and proposed DWC Form-053, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to the Office of the Division of Workers' Compensation regarding DWC Form-026 or DWC Form-053.



## MEMORANDUM

**DATE:** March 26, 2012

**TO:** Maria Jimenez, Office of Workers' Compensation Counsel

**FROM:** Brian White, Deputy Public Counsel/Chief of Staff  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comments on Designated Doctor Procedures and Requirements Rules

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) proposal to amend 28 Texas Administrative Code §§127.1, 127.5, 127.10, 127.20, 127.25, 180.23, to repeal §130.6 and §180.21, and to add new §§127.100, 127.110, 127.120, 127.130, 127.140, 127.200, 127.210, and 127.220, relating to designated doctor procedures and requirements. Please consider the following comments on behalf of the injured employees of Texas:

**1. §127.1(a):**

OIEC suggests ombudsmen be added to the list of persons who may request an examination of the injured employee by the designated doctor. OIEC notes that an injured employee's representative (which would include a lay representative) is listed and ombudsmen need to be able to make such requests for the same reasons that injured employees' representatives do.

**2. §127.1(b)(9):**

OIEC believes that an ombudsman assisting an injured worker must be added to the list of people to whom a requestor is required to submit a copy of the request for designated doctor. OIEC understands that as proposed the injured employee would receive a copy of the request. However, OIEC's experience is that injured workers often do not understand the request or appreciate the importance of promptly providing this document to their ombudsmen. The Division implicitly recognizes this when it provides in the proposed rule that the requests must be sent to both injured employees and to injured employee representatives. OIEC feels that is just as important to insure that the ombudsman receive a copy of the request for the designated doctor as it is to insure that the injured employee's representative receive it and for many of the same reasons. In those cases where injured employees are assisted by OIEC, the reality is that the Ombudsmen serve the same function as a lay representative and their effectiveness is significantly undermined if they do not receive notice of the request for a designated doctor.



**3. §127.1(d)(4):**

OIEC supports the Division's decision to permit an injured employee to go to the designated doctor in a disputed claim to address the issue of whether the claimed incident caused the claimed injury. In a disputed claim, the injured employee often does not have access to medical treatment and certainly has limited ability to obtain a medical opinion concerning causation. This problem is even more pronounced in a network claim where the network doctor has strong disincentives to contradict the carrier's position on compensability and causation. In addition, as the Appeals Panel continues to expand the number of cases where medical evidence of causation is required, the negative impact on the system would only increase if the Division were to eliminate the only mechanism many injured employees have to obtain medical evidence of causation.

It seems axiomatic that the cost associated with getting to the bottom or whether an injured employee has sustained a work-related injury is a system cost that is properly borne by the carriers. The workers' compensation system has an interest in essential information being available for consideration in the dispute resolution system so that an informed decision can be made about whether an injury is compensable. If the injured employees cannot go the designated doctor to get a causation opinion in a denied claim there will be a category of cases where information needed to make that decision will not be readily available. The carrier should not be permitted to short circuit the search for the truth through its denial, particularly in light of the fact that carrier may request reimbursement for benefits paid based on the designated doctor's report if the report is overturned in the dispute resolution system.

**4. § 127.1(d)(5):**

OIEC agrees with the decision to deny the request for a designated doctor in those cases where the carrier's denial is based on §§ 406.032, 409.002, or 409.004 and properly reported to the Division. Medical evidence is not generally required to overcome a denial based on these sections of the Labor Code. Accordingly, the injured employee can obtain the evidence necessary to challenge the denial and if the injured employee prevails, the designated doctor can be appointed to move the case forward. However, if the injured employee loses, the cost of the designated doctor appointment can be saved.

**5. § 127.5(a):**

OIEC requests that notice of the designated doctor appointment be sent to the injured worker's ombudsman, if any. As with §127.1(b)(9), OIEC submits that it is equally important that the injured employee's ombudsman receives this notice as it is for an injured employee's representative to receive this information and for many of the same reasons. For one thing it is unlikely that an injured employee would be able to dispute the Division's approval or denial of a designated doctor's request without assistance of the ombudsman and failure to timely do so may preclude an injured worker from being able to do so. Further, an injured employee may not appreciate the importance of attending the designated doctor examination or the consequences of the failure to do so without the advice of an ombudsman



**6. §127.5(d):**

OIEC agrees with the use of mandatory language in §127.5(d) concerning the Division's use of a previously assigned designated doctor. This use of mandatory language appears to be designed to reduce the number of designated doctor in a claim. Believing this is desirable goal, OIEC agrees with the use of the word "shall" in this provision.

**7. §127.10(a)(2):**

OIEC requests that the carrier and treating doctor send any analyses to the injured worker's ombudsman, if any. Again, we note that the proposed rule provides that these analyses be sent to the injured employee's representative, if any. Ombudsmen need copies of these analyses for the same reasons that injured employees' representatives need them.

Also, it has been OIEC's experience that carriers often fail to send the analyses to anyone other than the designated doctor and that these analyses if discovered are sometimes one-sided documents designed to lobby, rather than to inform, the designated doctor. In fact, analyses appear to have taken the place of unilateral contact with the designated doctors which the Appeals Panel prohibited years ago to prevent the parties from unfairly biasing designated doctors. The addition of a requirement that these analyses be "neutral" might help mitigate this problem. Another safeguard might be to require that any such analysis be provided to the other parties before it is sent to the designated doctor. Sending it at the same time means that by the time the other parties receive it, the designated doctor has also received it. Thus, if the document was designed to prejudice the designated doctor, the harm has been done before anyone has an opportunity to object to the contents of the analysis.

**8. §127.10(c):**

OIEC agrees with the decision not to have testing or referrals by the designated doctor subject to retrospective review. OIEC believes that retrospective review of charges for such testing and referrals in the past led to non-payment for such services, making it less likely a designated doctor was able to get these services performed.

**9. §127.10(e) and (f):**

OIEC requests that the designated doctor be required to send copies of the reports referenced in these sections to an injured worker's ombudsman in the same manner such reports are required to be sent to an injured worker's representative. Again, the ombudsmen need these reports for the same reasons as representatives do.

**10. §127.20(a):**

OIEC objects to the new language in this rule that states that parties may not ask a designated doctor to reconsider the doctor's decision or to issue a new or amended decision unless the designated doctor failed to address an issue the designated doctor was ordered to address. This language prevents a party from asking a designated doctor to change an incorrect report which



greatly restricts the scope of letters of clarification and makes the letter of clarification process largely futile in most cases. If a party sees that a designated doctor has clearly made an error, it would seem that the most efficient way to get the error corrected is to permit the party to inquire about the error and to give the designated doctor an opportunity to correct the error or explain why there is no error. Otherwise, designated doctors' errors would go uncorrected or could only be corrected through litigation, which would not appear to be the most efficient means of correcting them.

Another problem with this is that the Appeals Panel has recently found in a number of cases that the designated doctor fails to provide sufficient detail to explain the designated doctor's opinion as to causation especially in extent of injury cases. Thus, under the proposed rule, if the designated doctor addresses extent, but the ombudsman realizes that the designated doctor reports fails to give sufficient detail to meet causation standards set out by the Appeals Panel, the ombudsman will be unable to get the Division to send the designated doctor a letter of clarification because the designated doctor has addressed the issue of extent, although not in sufficient detail that will meet the evidentiary standards set out by Appeals Panel that would allow the opinion of the designated doctor to be adopted. This places the injured worker in a true Catch-22 situation.

**11. §127.20(b)(3):**

OIEC submits that leading questions are not always inflammatory, and, in fact, are often an essential means of reaching the truth. For instance, if a party believes that a doctor has not properly applied the AMA Guides, it is impossible to inquire about that without asking a leading question. Designated doctors are professionals and, as such, they seem more than capable of answering leading questions, which are largely designed to more efficiently get at the truth. The potential impact of leading questions would also seem to be mitigated by the fact that LOC questions have to be submitted to the Division and, as a result, any leading questions that are inflammatory could be denied.

**12. §127.25(d):**

OIEC requests clarification. OIEC does not understand the rationale of requiring that the injured worker to request a new examination if the injured worker missed the designated doctor examination and fails to call within 21 days.

**13. §127.100(a)(2):**

OIEC believes that it is important that through the designated doctor training or otherwise that designated doctors be made aware of the fact that the Division's current return to work guidelines presuppose optimal medical treatment and therefore cannot be mechanically applied to cases where medical treatment has been denied.



**14. §127.100(a)(4):**

This section certainly attempts to address the problem of doctors with limited recent clinical experience providing “expert” opinions. The workers’ compensation system has long been plagued by “experts” whose primary expertise appears to be in providing “expert” opinions as opposed to the actual practice of any profession. OIEC commends the Division for attempting to address this problem with this provision. However, OIEC believes that this provision does not go far enough to remedy the problem. Only requiring that at the time of application to be a designated doctor that a doctor have practiced half time for three of the preceding 10 years would mean that a doctor who had no clinical practice for seven years could qualify to obtain designated doctor status. OIEC suggests the problem would be better addressed by requiring that during the five years preceding application the doctor have earned at least as much income from treating patients as from providing expert opinions, with the phrase “providing expert opinion” defined as fees for examining and reviewing records, providing written reports, and testifying at depositions, administrative and court proceedings concerning patients other than patients for whom the doctor has actually provided treatment.

**15. §127.110(e)(4)(E):**

OIEC submits that this requirement appears to be very subjective and wonders who will decide whether this criterion is met or how it will be determined if it is met.

**16. §127.130:**

OIEC is not certain that the Division is properly applying Section 408.0043 which provides that a designated doctor “who reviews a specific workers’ compensation case must hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving.” OIEC questions whether this language is consistent with some of the certifications list in Rule 127.130. For example, is certification in occupational medicine appropriate to traumatic brain and spinal cord injuries with documented neurological deficit (127.130(b)(8)(A)), to complicated infectious diseases requiring hospitalization or prolonged intravenous antibiotics (127.130(b)(8)(E)), or to heart or cardiovascular conditions (127.130(b)(8)(G)? OIEC doubts that a doctor of occupational medicine would or should undertake to treat these conditions and would therefore argue that this professional certification is not appropriate to the type of health care that the injured employee is receiving with these types of injury. OIEC recommends that the Division review §127.130 to make it more closely conform to the requirements of Section 408.0043. In that regard, OIEC believes that the testimony of Dr. Stephen Ringel at the public hearing concerning the specialties needed to review certain complex cases is instructive.

**17. §127.130(h):**

OIEC recommends that the Division add some an additional requirement here that the doctor not have pled guilty or been convicted of a felony. OIEC is aware of at least one case where a designated doctor who had pled guilty to medicare fraud continued to receive designated doctor appointments. It is not clear that the categories of this rule provide a basis for disqualifying such



a doctor from acting as a designated doctor and OIEC believes a doctor who has pled guilty or been convicted of a felony should be disqualified.

**18. §127.140(e):**

OIEC submits that merely stripping a designated doctor's report tainted by a disqualifying association of its presumptive weight is insufficient. OIEC believes that such a tainted report should not be admitted into evidence at all or there will be a risk that a report tainted by a disqualifying association could still end up being adopted. The adoption of such tainted reports would undermine confidence in the fairness and impartiality of the dispute resolution process.

**19. §127.220(a)**

The rule fails to state what the Division intends to do if the designated doctor fails to include any of the listed items in his or her report.

**20. 127.220(a)(6):**

OIEC commended the Division for proposing in the draft proposal (in §127.220(a)(9)) that the designated doctor include a record of the time taken to complete the designated doctor examination. However, OIEC is disappointed that the formal proposal only requires the designated doctor to state the time the examination began. Without requiring the doctor to note the end of time of the examination, there is no mechanism for determining the length of the designated doctor examination. Injured employees frequently contend that the designated doctor did not conduct a thorough examination. Having the designated doctor include the length of the examination is an important first step in addressing that concern and in making the designated doctors more aware of the fact that sufficient time needs to be expended to insure that designated doctor examinations are thorough and correctly performed. Having the designated doctor note the start time of the examination permits a check on whether appointments begin at the scheduled time, but it does nothing to address an oft-repeated criticism of the designated doctor process.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** March 19, 2012

**TO:** Maria Jimenez, Legal Services

**FROM:** Brian White, Deputy Public Counsel/Chief of Staff  
Elaine Chaney, Director of Administration and Operations

**RE:** OIEC Comments on Review of Rules Involving Title 28. Part 2, Texas Administrative Code (TAC), Chapter 142, Dispute Resolution-Benefit Contested Case Hearing

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) review of 28 Texas Administrative Code §142.1-142.20. Please consider the following comments on behalf of the injured employees of Texas:

### 1. General Comment

OIEC suggests that when the Division reopens these rules that it make conforming changes such as taking all the references to "Commission" and changing them to read "Division".

### 2. §142.2(11)

OIEC suggests that what appears to be a typographical error be corrected by changing the language "the rule of state agencies" to read "the rules of state agencies".

### 3. §142.4

OIEC suggest that ombudsmen be added to the list of people to whom copies shall be delivered. Ombudsmen need this information as much as representatives and attorneys do and for the same reasons. Injured workers often forget to bring documents to ombudsmen or misplace documents sent to them. For ombudsmen to have the information necessary to assist injured workers helps the system move more smoothly and effectively. The fact that copies of important documents often are not sent to ombudsmen has been partially mitigated by OIEC's access to the Division's computer system. However, once the agencies have separate computer systems, ombudsmen will not be able to access this information through the Division's computer system.



**4. §142.5(c)(2) and (f):**

OIEC seeks clarification as to whether the Division intends to retain the language “An unrepresented claimant may request a hearing by contacting the Commission in any manner” and that “An unrepresented claimant may respond by contacting the Commission in any manner”. The Division does not appear to have permitted this in some time. In those instances where an unrepresented injured employee is assisted by an ombudsman compliance with a requirement of a written request is not overly onerous; however, to expect a true pro se injured employee to comply with such a requirement is unreasonable.

**5. §142.7(e)(2):**

Again, OIEC seeks clarification. The provision states that an unrepresented claimant may request the additional disputes be included by contacting the Commission in any manner. However, the Division does not appear to have permitted additional disputes to be added in some time unless there is a written request. Again, OIEC believes that the requirement of a written request is particularly burdensome for those unrepresented injured employees who either decline OIEC assistance or for whom OIEC has terminated services.

**6. §142.8**

OIEC submits that a subsection (d) be added and that (d) state as follows, “Any party may submit written briefs any time after the benefit review conference through the closing of the record of the hearing.” OIEC submits the addition of this provision will allow the parties to use of briefs to streamline their presentations. Also, the provision is needed for uniformity as some hearing officer readily accept briefs and others do not. OIEC also recommends that the rule contain language requiring a carrier to send a copy any brief it files with both the injured employee and the ombudsman.

**7. §142.10(c)(2)**

Again, OIEC seeks clarification. The rule says an unrepresented claimant may request a continuance by contacting the Commission in any manner. The Division does not appear to be following this rule. OIEC again recommends that the Division consider that not all unrepresented injured employees are similarly situated and that the requirement of a written request is harsh for a lay person who does not have OIEC assistance.

**8. §142.12(c)(2)**

Once again, OIEC asks that the Division clarify whether a claimant may request a subpoena by contacting the Division in any manner. The Division has not been granting subpoenas without a written request. Also, OIEC requests as an explanation on how to request that the Division arrange for service in those instances where service can be made at no expense. In our experience, the Division rarely, if ever, arranges for service of subpoenas.



**9. §142.12(d)**

A problem that often arises with subpoenas is that they are granted before the opposing party has a chance to object. This is a particular problem for OIEC because the carrier often does not send the ombudsman a copy of its request for subpoena. OIEC submits that the ombudsman should be notified of the request for subpoena before a carrier's subpoena is granted.

**10. §142.12(e)(2)**

Clarification is needed on how a party can request that the Division actually arrange for service of subpoenas. OIEC is not aware of a single instance where the Division has done so.

**11. §142.12(f)**

Injured workers, particularly in cases where their claim has been denied, have no money to pay for the costs of service or for witness fees and expenses. OIEC suggest that the rule be amended to require the carrier to pay these costs, fees and expenses. The protection for the carrier would come from the fact that a hearing officer does not issue a subpoena unless he or she determines that the testimony is necessary for the proper resolution of the case. If the testimony of the witness or witnesses in question is necessary to the proper resolution of the issue, it is a valid cost for the proper administration of the system, and as such, should be borne by the carrier.

**12. §142.13(e)**

The problem that often arises here is that the hearing officer often rules upon a request for written deposition before the other party has a chance to object or to submit cross-questions. This is a particular problem for ombudsmen because carriers often do not send them copies of the request for written deposition. OIEC submits the latter problem could be solved by requiring carriers to send a copy of the request for written depositions to the ombudsmen and by always giving the opposing party sufficient time to respond to another party's request for written deposition before acting upon the request.

**13. §142.16(d)**

OIEC submits this section needs to be amended to provide that a copy of the hearing officer's decision be sent to the ombudsman. Ombudsmen need the decision to insure that if an appeal is required that it is timely filed. Injured workers do not always provided ombudsmen with the decision in a case and once the Division and OIEC have separate computer systems it will be much more difficult for OIEC to always obtain a copy of a decision to assist an injured employee with an appeal.

**14. §142.19**

The form Interrogatories need to brought up to date. They still reference the Texas Workers' Compensation Commission rather than the Texas Department of Insurance, Division of Workers' Compensation. They also provide a standard question as to whether the parties agree with the



## OFFICE OF INJURED EMPLOYEE COUNSEL

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benefit review officer's recommendations even though the benefit review officer no longer makes recommendations. This standard question needs to be deleted.

OIEC also submits that because extent of injury has become such a major factor in so many hearings, a stand interrogatory concerning extent should be added to Claimant's Interrogatories to Carrier. OIEC recommends that the question read, "Please list any and all injuries and diagnoses that the Carrier's accepts are part of the compensable and please list any and all injuries and diagnoses that the Carrier denies are part of the compensable injury?"

Further due to the increasing complexity of workers' compensation cases OIEC submits that the number of optional interrogatories each party is permitted to ask be increased from five to seven.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** March 26, 2012

**TO:** Maria Jimenez, Legal Services

**FROM:** Brian White, Deputy Public Counsel/Chief of Staff  
Elaine Chaney, Director of Administration and Operations

**RE:** OIEC Comments on informally proposed DWC Forms 032, 067 and 068

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) informally proposed Forms 032, 067 and 068. Please consider the following comments on behalf of the injured employees of Texas:

### 1. Form DWC-032:

OIEC believes that only the last four digits of the injured employee's social security number should be requested in box 2 of the DWC032 based on confidentiality concerns.

### 2. Form DWC-067:

Again, because of confidentiality concerns, OIEC recommends that only the last four digits of the applicants social security number be required in box 2 of the DWC067.

The first question in box 88 reads, "Have you ever been convicted of, pled guilty to, or pled *nolo contendere* to any felony that is reasonably related to your qualification, competence, functions, or duties as a medical professional?". OIEC suggests striking all the language after the word "felony" in this question. OIEC submits rather than wasting time parsing whether or not a felony plea or conviction reflects upon a doctor's fitness to practice medicine, the Division recognize, as the courts always have, that any felony conviction reflects negatively upon one's veracity. OIEC submits that any doctor who has been convicted or pled guilty to (and a plea of *nolo contendere* is legally equivalent to pleading guilty) a felony has no business being an expert whose opinion is given presumptive weight.

### 3. Form DWC-068:

As with the other two forms, OIEC believes that confidentiality concerns require that only the last four digits of the injured employee's social security number be required in box 3 of the DWC068.



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OIEC notes that Rule 127.220(a)(6) provides that the designated doctor will state the time the examination began. However, this information is not what the form asks the designated doctor to provide. Box 14 requests the "Date and Time of the Appointment". Unfortunately, part of the problem with many designated doctors examination is that the time of the appointment and the time of the examination are very different, as the injured worker often spends a lot time languishing in the waiting area. OIEC thought by requiring the beginning time of the examination that Rule 127.220(a)(6) was attempting to address this problem. However, Form DWC-068 does not deal with this problem at all.

Nor does the form deal with the related problem that injured employees often complain that the designated doctor's examination was too brief to be thorough. The informal draft of Rule 127.220(a)(9) required the designated to state the length of the designated doctor examination. Unfortunately, this requirement was removed in the formal proposed rule. OIEC suggest that Form DWC-068 require this information be provided by having box 4 read, "Date and Time the Examination Began and Ended".

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC's comments on behalf of the injured employees of Texas.



**MEMORANDUM**

**DATE:** March 26, 2012

**TO:** TDI Rule Comment Folder

**FROM:** Elaine Chaney

**RE:** No Comment Memo on informally proposed DWC Forms 005, 007 and 020SI

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After reviewing the text of the informal working draft of proposed DWC Forms 005, 007, and 020SI, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to proposed Forms DWC-005, DWC-007, and DWC-020SI.



## MEMORANDUM

**DATE:** March 26, 2012

**TO:** Maria Jimenez, Office of Workers' Compensation Counsel

**FROM:** Brian White, Deputy Public Counsel/Chief of Staff  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comments on Proposed Rules Relating to Notice and Reporting Requirements for Subscribing and Non-Subscribing Employers; and Rules Relating to Notice of a Texas Labor Code §504.053(b)(2) Election by a Self-Insured Political Subdivision

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) proposal to add new 28 Texas Administrative Code (TAC) §§110.7, 110.103, 110.105, and 160.1, and to amend §§110.1, 110.101, 160.2, and 160.3. Please consider the following comments on behalf of the injured employees of Texas:

**1. §110.1(b)**

OIEC suggests that it would be clearer if the language in this section that reads "and, if so, information about the means of workers' compensation insurance coverage used." be changed to read, "and, if so, the type of workers' compensation that is provided."

**2. §110.7(d):**

OIEC suggests that a self-insured political subdivision that begins to provide medical benefits to its employees in the manner described by Labor Code §504.053(b)(2) after the effective date of the section (July 1, 2012) be required to provide notice not later than the 30<sup>th</sup> day **before** the political subdivision begins to provide the medical benefits in that manner. OIEC believes that the requirement of prior notice would further the objective of Texas Labor Code §504.053(d)(4) of ensuring the continuity of treatment of injured workers. It would seem that a self-insured political subdivision is more likely to make a smooth transition in changing the way it is providing medical benefits if it is required to provide notice prior to the change rather than not having to provide notice until 30 days after the change.



**3. §110.101(a):**

OIEC recommends that a subsection be added requiring employers to notify their employees of coverage status in writing, whenever an employee reports an injury or the employer has actual knowledge of a potential claim. Specifically, OIEC recommends adding a new subsection (a)(2) stating *“shall be provided at the time an employee reports an injury to the employer or at the time an employer has actual knowledge of a potential claim.”*

**4. §110.101(c):**

OIEC suggests that some deadline for replacing notices posted prior to July 1, 2012, and for updating notices when the information regarding coverage status, insurance carrier, safety violations hotline number or third party administrator changes should be provided. Absent any deadline this rule really does not seem to have any teeth or to even be enforceable in any sense.

**5. §110.110(e)(1):**

For clarity, OIEC suggest that the first sentence after **COVERAGE** be changed to read as follows, “In the event of a work related injury or occupational disease [name of employer] has workers’ compensation insurance coverage from [name of commercial insurance company.] The fact of the work-related injury is the critical element of the notice and, as such, OIEC believes that it should be mentioned first.

**6. §§ 110.101(e)(1), (e)(2), and (e)(3):**

OIEC disagrees with the deletion of the phrase “and assist in resolving disputes about a claim” from the text of the notices. OIEC’s statutory duties to injured employee are significantly greater than merely explaining their rights and responsibilities under the workers’ compensation system. The heart of OIEC’s statutory responsibility is to assist and advocate on behalf of the injured employees of Texas; therefore, we believe it is critical that this aspect of our agency’s mission be included in the notice of coverage.

Also, OIEC believes that the last sentence under **EMPLOYEE ASSISTANCE** should be changed to read as follows, “You can obtain OIEC’s assistance by contacting an OIEC customer service representative in your local Division field office by calling 1-866-EZE-OIEC (1-866-393-6432).” This eliminates the step of calling the Division to ask OIEC and makes it clearer that we are separate agencies that share office space.

**7. §110.101(e)(4):**

OIEC suggests for clarity changing the sentence that reads, “In addition, you may have rights under the common law of Texas should you have an on the job injury or occupational disease.” to read, “In addition, you may have rights under the common law of Texas if you have an injury or occupational disease that is work related.”



**8. §110.103:**

OIEC is concerned about enforceability. To make sure that this rule is enforceable OIEC suggests the addition of a subsection (d) providing, "Failure to provide notice as required in this rule is an administrative violation."

**9. §110.105:**

To make certain that this provision is enforceable, OIEC suggests that a subsection (f) be added to provide, "Failure to provide notice as required in this rule is an administrative violation."

**10. §160.2:**

To ensure the enforceability of this provision OIEC suggests adding a subsection (e) providing, "Failure to file a report of injury as required by this rule is an administrative violation."

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** April 23, 2012

**TO:** DWC Rules Team

**FROM:** Brian White, Deputy Public Counsel  
Elaine Chaney, Director of Administration and Operations

**RE:** OIEC Comments on Proposed Amendments to 28 Texas Administrative Code (TAC) §§133.307, 133.308, 144.1–144.7, and 144.9–144.16.

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) proposed amendments to 28 Texas Administrative Code §133.307, §133.308, §§144.1-144.7, and §§144.9-144.16 . Please consider the following comments on behalf of the injured employees of Texas:

**1. §133.307(a)(1):**

OIEC disagrees with the decision to substitute “as authorized by the Texas Workers’ Compensation Act” for the phrase “non-network or certain authorized out-of-network health care not subject to a contract.” OIEC understands that network fee disputes are not subject to resolution under this provision, but the proposed language is not sufficiently clear on this point.

**2. § 133.307(a)(3):**

Section 133.307(a)(3) provides that the “first responder shall provide notice” to the Division that the request involves a first responder. OIEC suggests this section be revised to read “first responder or a person acting on behalf of the first responder.” The purpose of the Legislation giving priority handling to first responders would seem better served by letting more than just the first responder make the request to expedite.

**3. §133.307(b)(3) and (4):**

OIEC suggests that both these sections be revised to read “the injured employee or person acting on behalf of an injured employee”. OIEC notes that this language is included in §133.308(f)(1)(B) which deals with who may be a requestor in network medical necessity disputes. For purposes of consistency and clarity, OIEC believes that the definition of requestor should be the same in all types of medical disputes.



**4. §133.307(c)(3):**

The current proposed section now reads:

(3) Injured Employee Dispute Request. An injured employee who has paid for health care may request MFDR [~~medical fee dispute resolution~~] of a refund or reimbursement request that has been denied. The injured employee's dispute request shall be sent to the MFDR [~~MDR~~] Section in the form and manner prescribed by the division by mail service, personal delivery or facsimile and shall include:

OIEC suggests replacing the word “facsimile” with “electronic transmission.” This would make this provision consistent with other filing provisions in Division rules.

**5. §133.307(g)(1)(C):**

§133.307(g)(1)(C) provides that the “first responder shall provide notice” to the Division that the case involves a first responder. OIEC suggests this section be revised to read “first responder or a person acting on behalf of the first responder shall provide notice.” The purpose of the Legislation giving priority handling to first responders would seem better served by letting more than just the first responder make the request to expedite.

**6. §133.307(g)(2):**

§133.307(g)(2) of this proposed rule states that a “first responder must provide notice” to the Division that the contested case involves a first responder”. OIEC suggests this section be revised to read “first responder or a person acting on behalf of the first responder shall provide notice.” The purpose of the Legislation giving priority handling to first responders would seem better served by letting more than just the first responder make the request to expedite.

**7. §133.308(f)(2)(B):**

OIEC suggests that this section be revised to read “injured employees or a person acting on behalf of an injured employee” rather than “injured employees or injured employee’s representative”. Again, OIEC notes that this language is included in §133.308(f)(1)(B) which deals with who may be a requestor in network medical necessity disputes. OIEC does not believe that a difference in the definition of requestor is required or warranted for non-network medical disputes.

**8. §133.308(n)(1):**

OIEC recommends that the IRO issue a decision concerning treatment for life threatening conditions no later than three days after receipt of the dispute as opposed to the eight days permitted by the current rule proposal. OIEC understands that an IRO cannot make an immediate determination in a case involving a life-threatening condition; however, it would seem that when



a life-threatening condition is involved, the IRO should be able to make a determination in no more than three business days.

**9. §133.308(r):**

OIEC seeks clarification of what is meant by “An insurance carrier may claim a defense to a medical necessity dispute if the insurance carrier timely complies with the IRO decision with respect to the medical necessity or appropriateness of health care for an injured employee”. What is the carrier claiming a defense to? If the purpose of the provision is to say that the carrier should comply with the IRO decision and provide care to the injured employee consistent with that decision, the rule should state that purpose explicitly.

**10. §133.308(s)(1)(D)(iii):**

Again OIEC seeks clarification. What happens if the treatment guidelines adopted by the political subdivision or pool do not meet the standards provided by Labor Code §413.011(e)? If this section means that when the guidelines do not meet those standards that the hearing officer should proceed as if the guidelines did not exist, then the section should state that explicitly.

**11. §133.308(s)(1)(E)(ii):**

OIEC disagrees with the decision to include language that a letter of clarification cannot “ask the IRO to reconsider its decision or to issue a new decision”. As proposed clarification will only be a request for information. In those instances where the clarification calls into question the accuracy of the IRO decision, it seems of little value to preclude the IRO from having the opportunity to make necessary corrections. The rule as proposed seems to provide a right without a remedy.

**12. §133.308 (u):**

This rule provides that the first responder shall provide notice to the division and independent review organization that the contested case hearing or appeal involves a first responder. OIEC suggests this section be revised to read “first responder or a person acting on behalf of the first responder shall provide notice.” The purpose of the Legislation giving priority handling to first responders would seem better served by letting more than just the first responder make the request to expedite.

**13. §144.11:**

OIEC appreciates the Division’s response to our previous comments regarding identifying, with specificity, where requests for continuances should be sent. In the current proposed amendment, the Chief Clerk of Proceedings has now been identified as the person responsible for receiving requests for continuances. However, the rule remains silent regarding who will be making a decision to grant or deny the request for continuance. In the interest of clarity, the Division should indicate whether the arbitrator or some other entity at the Division will be making the decision to grant or deny the continuance. It seems that a continuance request might be more



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properly directed to the arbitrator. As §144.1 grants the arbitrator procedural and administrative decision-making authority related to arbitration, giving the arbitrator the authority to grant and deny continuance requests under §144.11 would be consistent with other rules related to arbitration.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** April 23, 2012

**TO:** TDI Rule Comment Folder

**FROM:** Elaine Chaney

**RE:** No Comment Memo on proposed DWC Forms 044, 045M, 049 and 060

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After reviewing the text of the informal working draft of proposed DWC Forms 044, 045M, 049 and 060, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to proposed Forms DWC-044, DWC-045M, DWC-049 and DWC-060.



**MEMORANDUM**

**DATE:** April 27, 2012

**TO:** Donald Patrick, M.D., J.D., Medical Advisor, Texas Department of Insurance, Division of Workers' Compensation

**FROM:** Brian White, Deputy Public Counsel

**RE:** OIEC Comment on Health Care Providers Pain Management Services (Opioid) Plan-Based Audit

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the development of a Health Care Providers Pain Management Services (Opioid) Plan-Based Audit.

OIEC supports the Division's efforts to address the issue of prescription drug abuse and misuse in the workers' compensation system. The proposed audit plan appears to strike an appropriate balance between attempting to identify the providers who overprescribe pain medication and ensuring that injured employees receive medically necessary and appropriate pain medication for the treatment of their compensable injuries. OIEC believes that physicians need to make decisions about abuse and misuse of pain medications and therefore, agrees with the Division's decision to place the responsibility for identifying potential problems with the Office of the Medical Advisor and the Medical Quality Review Panel.

Please do not hesitate to contact me if I can be of assistance.



## MEMORANDUM

**DATE:** April 30, 2012

**TO:** Utilization Review Rule Team  
Debra Diaz-Lara

**FROM:** Brian White, Deputy Public Counsel, Chief of Staff  
Elaine Chaney, Director of Administration and Operations

**RE:** OIEC Comments on Informal Working Draft of 28 Texas Administrative Code §§19.1701-19.1719 and §§19.2001-19.2017 Relating to Utilization Review

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comments on the Texas Department of Insurance's informal draft rules relating to utilization review for health care 28 Texas Admin. Code §§ 19.1701-19.1719 and §§ 19.2001-19.2017.

As a general comment, OIEC suggests that all references to providing notice to or permitting action by injured employees, their representatives, and health care providers be changed to say injured employees, persons acting on behalf of injured employees, and health care providers. Because of the unavailability of attorneys' fees in medical dispute resolution, a significant number of injured employees proceed through this process with the assistance of OIEC Ombudsmen. In addition, the medical dispute resolution process is replete with relatively tight time deadlines; therefore, it is critical that the Ombudsmen receive notice and be permitted to act on behalf of the injured employee in order to satisfy the statutory mandate of Texas Labor Code § 404.151(b)(4) to "assist unrepresented claimants to enable those persons to protect their rights in the workers' compensation system." Further, a stated goal of the informal working draft of the URA rules is to make the process in workers' compensation as similar as possible as to other types of insurance. OIEC would note that § 19.1703(b)(2) provides that in health insurance that an "enrollee, **an individual acting on behalf of an enrollee**, or an enrollee's provider of record may request reconsideration of an adverse determination." (Emphasis added). Similarly, § 19.1709(a) provides that the URA must send notice of the determination to the enrollee or an individual acting on behalf of the enrollee.

OIEC requests that the phrase "person acting on behalf of the injured employees" be substituted for injured employee's representative in the utilization rules for workers' compensation. This will have the dual benefit of recognizing the reality that non-representatives provide the bulk of assistance to injured employees in medical dispute resolution and it also would make the URA rules in workers' compensation mirror those for group health.



In §19.2003(b)(30)(A) it provides that a reasonable opportunity means at least one documented good faith attempt to contact the provider of record no less than one working day prior to issuing a prospective utilization review adverse determination. OIEC requests that one working day be further defined as at least a 24-hour period in order to give the provider sufficient time to respond to an inquiry from the URA. This change would help ensure that the conversation between the URA and the provider actually takes place.

§ 19.2005(b) states that a utilization review determination must be made in a manner that takes into account special circumstances. The subsection then provides that “disability” is a special circumstance that is to be considered. However, the draft rules further provide that disability must not be construed to mean an injured employee who is off work or receiving income benefits. Of course, this is traditional definition of disability in the workers’ compensation setting. OIEC seeks clarification as to how disability will be defined for purposes of this section.

In regard to §19.2005(f) OIEC submits that the complaint system should include complaints filed by a person acting on the injured employee’s behalf. OIEC know of no reason to restrict the ability to complain to representatives and to exclude others acting on behalf of the injured employees.

OIEC disagrees with the language in § 19.2006(b) that addresses disqualifying associations for the doctor performing the appeal of the initial URA determination. Proposed § 19.2006(b) states “For purposes of this subsection, being employed by or under contract with the same URA as the physician, doctor, or other health care provider who issued the initial adverse determination does not in itself constitute a disqualifying association.” OIEC believes that the fact that the reviewing doctor is employed by or under contract with the same URA that issued the initial adverse determination should be a disqualifying association. It is important for the efficacy of the system that the review of the initial determination be conducted by a person whose objectivity cannot be reasonably questioned. That goal would be significantly undermined if the review of the adverse determination can be made by someone who is employed or under contract with the same URA as issued the initial adverse determination. Further, this provision seems to be inconsistent with the broad definition of disqualifying associations found in § 19.2003(b)(8).

OIEC seeks clarification of the purpose of § 19.2007(b)(1). The provision states that URAs may request billing codes because they are useful and increase the effectiveness of the communication. However, the proposed language also states that URAs may not routinely require doctors or hospitals to supply numerically codified diagnoses or procedures. As drafted, this section is unclear and OIEC believes that an explanation of the reason for this provision is needed.

OIEC also seeks clarification in regard to § 19.2007(b)(2). This provision states that a URA should not routinely request all medical records on an injured employee. OIEC does not understand how a URA can make an informed decision regarding medical treatment without having and reviewing the injured employee’s medical records. The provision goes on to say that records should be required only when difficulty develops in determining whether the health care is medically necessary or appropriate “or experimental or investigational in nature.” OIEC



believes that the reference to experimental or investigational treatment was inadvertently included in this section. Texas Labor Code § 413.014(c)(6) and 28 Texas Administrative Code § 134.600(p)(6) identify investigational or experimental services or devices as health care requiring preauthorization. By identifying such treatment as requiring preauthorization in workers' compensation, the statute and rule clearly envision that the experimental or investigational nature of the treatment is not a basis in and of itself for denying the treatment. The definition of adverse determination in § 19.2003(b)(1) states that it does not include experimental or investigational health care services. Therefore, OIEC requests that the phrase "or experimental or investigational in nature" be removed from this subsection.

In §§19.2009(a)(2), (3), and (4) OIEC objects to the references to other codes and rules and the cross-referencing to other sections of this title. The use of these references and cross-references make it difficult to understand what these sections mean without consulting other material. OIEC recommends that §§ 19.2009(a)(2) and (3) be revised to specifically identify the parties to whom notice of the determination of prospective, concurrent, and retrospective utilization review must be given in both network and non-network claims rather than referencing other provisions in the administrative code. Similarly, OIEC recommends that the time deadlines for appealing the initial determination of the URA and for requesting IRO review of the second adverse determination be specifically identified in §§ 19.2011(a)(1) and (2) and 19.2011(a)(8)(a) and (b). The proposed URA rules are lengthy and complex and, as such, it would seem that they should be self-contained rather than referencing other rule sections. This change would ensure that system participants can more readily determine their responsibilities under the rules.

OIEC recommends that §19.2009(b) be changed to require the URA to include a list of the documentation reviewed in making the adverse determination. Proposed §19.2010 requires the URA to provide the medical provider a reasonable opportunity to discuss "a description of documentation or evidence, if any, that can be submitted by the provider of record, that upon reconsideration or appeal, might lead to a different utilization review decision." If that information were supplemented with the list of documentation reviewed, it would permit the provider to determine if such evidence already exists and simply was not provided to the URA or whether additional evidence must be obtained before reconsideration is requested. The determination of how to supplement the initial request has to be made quickly in order to ensure compliance with the deadlines for requesting reconsideration. The inclusion of a requirement that the URA list the documentation reviewed would provide greater efficiency in the process.

OIEC seeks clarification of § 19.2009(b)(6). OIEC would like to know what happens in a case where the URA disagrees with the injured employee that the injured employee's condition is life-threatening and does not immediately forward the request for an IRO to TDI. What would the injured employee's recourse be in such a circumstance? Similarly, OIEC requests clarification of how an injured employee would proceed in the event that TDI disagreed with the determination that the condition was life-threatening. The concern is that the period to request reconsideration might pass before the injured employee was advised of the disagreement.

OIEC seeks clarification of §19.2016. Specifically, OIEC seeks to know how it will be determined that the proposed treatment will be reviewed by a specialty URA. It appears that the



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URA will make that determination, but it is unclear how that determination will be made and whether it will be subject to review.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can be of assistance in clarifying any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** May 24, 2012  
**TO:** TDI Rule Comment Folder  
**FROM:** Elaine Chaney  
**RE:** Draft Texas EDI Medical Difference Table

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After reviewing the text of informally proposed Draft Texas EDI Medical Difference Table, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to informally proposed Draft Texas EDI Medical Difference Table.



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### MEMORANDUM

**DATE:** May 24, 2012

**TO:** TDI Rule Comment Folder

**FROM:** Elaine Chaney

**RE:** 28 Tex. Admin. Code §§134.803, 134.804, and 134.807, Regarding Medical Bill Reporting

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After reviewing the text of informally proposed rules relating to medical bill reporting, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to proposed Rules 134.803, 134.804 and, 134.807.



## MEMORANDUM

**DATE:** June 6, 2012

**TO:** Maria Jimenez, Office of Workers' Compensation Counsel

**FROM:** Brian White, Deputy Public Counsel/Chief of Staff  
Elaine Chaney, Director of Administration and Operations

**RE:** OIEC Comments on Informal Draft Rule 28 TAC §§ 180.60-180.78,  
Regarding the Medical Quality Review Panel and Medical Quality Review  
Process

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) informal proposal to add new 28 Texas Administrative Code §§180.60-180.78.

OIEC recommends that the language in §180.60(2) be modified to "Medical Case Review—A review of medical services or professionalism in a particular case by an MQRP member regarding the delivery of health care, or the quality of a health care practitioner's opinion, recommendation or report. Medical case review may include the review of a peer review doctor, a designated doctor, another health care practitioner, an independent review organization, an insurance carrier, or a utilization review agent." OIEC believes this change will make it clear that a peer review doctor is subject scrutiny under these rules.

To maintain the high standards these rules aim for, OIEC also suggests adding a provision (A) to §180.62(d)(1) stating "must not have been censured by any relevant professional organization, any regulatory agency, or certifying authority, or subject to any regulatory action."

OIEC strongly suggests that §180.62(d)(3)(B) be deleted. By providing an exception to the requirement that a doctor have an active practice in Texas, this provision essentially guts that requirement. OIEC believes that a doctor serving on the MQRP needs recent clinical experience and in Texas to be most effective.

OIEC seeks clarification of §180.62(d)(4) in that OIEC does not understand why the requirements of subsections (c)(2) and (c)(3) of this section would need to be waived by the medical advisor and the commissioner and under what circumstances such waiver might take place.

OIEC suggests deleting the second sentence of §182.62(e)(2) which states, "Years served prior to an appointment on or after September 1, 2013 do not count toward the 10 year limit." It seems that by imposing a limit on the number of years that a doctor can service on the MQRP, the Division is furthering an objective that you have deemed important. However, by not



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counting years of service prior to September 1, 2013, it also seems that the goal of limiting the length of service of any given member of the MQRP is significantly undermined. OIEC believes that the best way to further this objective is to consider past service on the MQRP in determining whether another appointment can be made. If the decision is made not to consider past experience in counting the 10-year limit, OIEC recommends that the date in this provision be changed from September 1, 2013, to January 1, 2013, the proposed effective date of the rules. For purposes of clarity OIEC believes that the date in this provision should track the proposed effective date.

OIEC suggests adding a provision (4) to §180.62(g) stating “The Arbiter would be recused from sitting on the informal settlement conference for the subject the Arbiter reviewed.”

For clarity, OIEC recommends that the language in §180.64(i)(1) be modified to “Doctors – preparation and submission of medical case reviews, ad hoc work groups or special projects shall be paid \$150.00 per hour.

Also for clarity, OIEC recommends that the language in §180.64(i)(2) be modified to “Non-Doctors – preparation and submission of medical case reviews, ad hoc work groups or special projects shall be paid \$100.00 per hour.

OIEC recommends that the language in §180.72(b)(4) be modified to “has a financial interest in a matter as set forth in §180.24 of this title (relating to Financial Disclosure) or relationship with any subject matter, party, or witness that would give the appearance of a conflict of interest.”

OIEC suggests adding a provision (7) to §180.72(b) stating “has knowledge or information that has not been provided by TDI and the Member cannot set aside that knowledge and fairly and impartially consider the matter based solely on the information provided by TDI.”

Finally, OIEC requests that program monitoring and compliance be added in §180.74. OIEC believes at least on an annual basis, an independent review process in consultation with TDI-DWC Internal Audit program area be implemented to ensure adherence to the medical quality review process and that any deviations be documented and reported to the Commissioner. In addition, OIEC suggest that this process be used to recommend improvements to the process and increase accountability and transparency.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC’s comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** June 11, 2012

**TO:** Maria Jimenez, Legal Services

**FROM:** Brian White, Deputy Public Counsel/Chief of Staff  
Elaine Chaney, Director of Administration and Operations

**RE:** OIEC Comments on Review of Rules Involving Title 28 Texas  
Administrative Code (TAC), Chapter 150, Representation of Parties Before  
the Agency-Qualifications of Representatives

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) review of 28 Texas Administrative Code §150.1-150.3. Please consider the following comments on behalf of the injured employees of Texas:

### 1. General Comment

OIEC believes that these rules definitely need to be reopened as they have not been updated since 1991 and include a number of references that are no longer correct.

For instance, OIEC suggests that when the Division reopens these rules that it make conforming changes such as taking all the references to "Commission" and changing them to read "Division".

The statutory references also need to be updated as they refer to sections of the Act prior to codification. For example, the reference to Section 103(40) [found in Rule 150.3(a)] needs to be changed to Labor Code §401.011(37) and the reference to Section 2.09(e) [also found in Rule 150.3(a)] needs to be changed to Labor Code §402.071.

### 2. §150.3(a)(3)

OIEC requests that this rule be clarified to explicitly state that Office of Injured Employee Counsel Ombudsmen are lay representatives. OIEC believes that the Ombudsmen are representatives under the current terms of this provision and Labor Code § 401.011(37). OIEC is required under the Memorandum of Understanding Concerning Confidential Information with the Division to file written authorization from the claimant allowing the Ombudsmen access to confidential records. The only reason OIEC believes that the rule needs to explicitly state that Ombudsmen are representative is that when OIEC has raised the issue in the past, the Division has maintained that the Ombudsmen are not representatives. To clarify the status of the Ombudsmen OIEC suggests that § 150.3(a)(3) be amended to read, "the person ~~who is not either~~



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~~an adjuster or attorney, including an ombudsman,~~ files with the division a written power of attorney, or written authorization from the claimant, allowing that person access to confidential records. No fee or remuneration shall be received either directly or indirectly from a claimant. Ombudsmen with the Office of Injured Employee Counsel who receive a written authorization from an injured employee are included within the definition of representative in this subsection.”

Although OIEC Ombudsmen maintain an adjuster’s license, they do not function as an adjuster when they assist injured employees in the dispute resolution process. In fact, they are only required to have an adjuster’s license because the agency adopted that requirement as part of the training and continuing education standards for Ombudsmen. See 28 Texas Admin. Code § 276.10. Permitting OIEC Ombudsmen to serve as a lay representative even though they have an adjuster’s license is comparable to the Division’s long-standing policy of permitting licensed attorneys, who also maintain an adjuster’s license, to appear as adjusters in the dispute resolution process.

Another advantage of making the requested change is that it will make it clear to all parties that documents need to be exchanged with Ombudsmen. Ombudsmen need this information as much as lay representatives and attorneys do and for the same reasons. Injured workers often forget to bring documents to the Ombudsmen or misplace documents sent to them. For Ombudsmen to have the information necessary to assist injured workers helps the system move more smoothly and effectively. The fact that copies of important documents often are not sent to the Ombudsmen has been partially mitigated by OIEC’s access to the Division’s computer system. However, once the agencies have separate computer systems, the Ombudsmen will not be able to access this information through the Division’s computer system.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC's comments on behalf of the injured employees of Texas.



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### MEMORANDUM

**DATE:** July 5, 2012

**TO:** TDI Rule Comment Folder

**FROM:** Elaine Chaney

**RE:** Informal Working Draft: Rules Relating to Chapter 166 Workers' Health and Safety-Accident Prevention Services

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After reviewing the text of the informal working draft of Chapter 166 relating to Workers' Health and Safety Accident Prevention Services, it was determined that the Office of Injured Employee Counsel (OIEC) had no suggestions to improve the informal proposal for the benefit of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to the informal proposal.



## MEMORANDUM

**DATE:** August 27, 2012

**TO:** Maria Jimenez, Office of Workers' Compensation Counsel

**FROM:** Brian White, Deputy Public Counsel/Chief of Staff  
Elaine Chaney, Director of Administration and Operations

**RE:** OIEC's Comments on Proposal of 28 TAC §§ 180.60-180.78, Regarding the Medical Quality Review Panel

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) proposal to add new 28 Texas Administrative Code §§180.60-180.78 regarding the Medical Quality Review Panel (MQRP).

OIEC requests that subsection (F) be added to § 180.62(c)(2) to require the MQRP to include mental health professionals in its membership. The number of workers' compensation injuries that contain a mental health component seems to necessitate the inclusion of mental health professionals on the MQRP to provide meaningful oversight of the treatment provided for those injuries in the workers' compensation system.

To maintain the high standards these rules aim for, OIEC also recommends adding a provision (A) to §180.62(d)(1) stating that MQRP members "must not have been censured by any relevant professional organization, any regulatory agency, or certifying authority, or subject to any regulatory action."

OIEC strongly suggests that §180.62(d)(3)(B) be deleted. By providing an exception to the requirement that a doctor have an active practice in Texas, this provision essentially guts that requirement. OIEC believes that a doctor serving on the MQRP needs recent clinical experience in Texas to be most effective. Alternatively, OIEC seeks clarification of what it means to have "performed administrative, leadership, or advisory roles in the practice of medicine" and how that experience can meaningfully substitute for maintaining an active practice.

OIEC seeks clarification of §180.62(d)(4) in that OIEC does not understand why the requirements of subsections (c)(2) and (c)(3) of this section would need to be waived by the medical advisor and the commissioner and under what circumstances such waiver might take place.

OIEC suggests deleting the second sentence of §182.62(e)(2) which states, "Years served prior to an appointment on or after September 1, 2013 do not count toward the 10 year limit." It seems that by imposing a limit on the number of years that a doctor can service on the MQRP,



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the Division is furthering an objective that you have deemed important. However, by not counting years of service prior to September 1, 2013, it also seems that the goal of limiting the length of service of any given member of the MQRP is significantly undermined. OIEC believes that the best way to further this objective is to consider past service on the MQRP in determining whether another appointment can be made. If the decision is made not to consider past experience in counting the 10-year limit, OIEC recommends that the date in this provision be changed from September 1, 2013, to January 1, 2013, the proposed effective date of the rules. For purposes of clarity OIEC believes that the date in this provision should track the proposed effective date.

OIEC seeks clarification of §§ 180.64(i)(2) and (i)(5)(B) because it is unclear what role non-doctors will perform in the MQRP process. There is no description of their role in the proposal. In fact, there is no mention of non-doctor members of the MQRP before these provisions, which set their rate of compensation. The rule language and the Medical Quality Review Process Document seem to contemplate that the work in the MQRP process will be performed by doctors and that seems consistent with meaningful medical quality review. However, setting a rate of compensation for non-doctors, particularly in the area of hearings and trial preparation, creates uncertainty as to the role of non-doctors in the MQRP process that needs to be clarified.

OIEC suggests that the language in § 180.72(b)(3) be modified to “has ever treated the injured employee whose records are being reviewed or has served as a peer review doctor or a required medical examination doctor in the injured employee’s claim.” OIEC believes that the prohibition against having a doctor participate as an MQRP member needs to be expanded beyond doctors who have provided treatment. It would appear that sufficient question could be raised about the ability of a doctor who has served as a peer review doctor or a required medical examination doctor in a claim to maintain the objectivity necessary to effectively serve in that role. As such, OIEC recommends that they be specifically prohibited from serving on the MQRP for that claim in order to retain the integrity of the process.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC’s comments on behalf of the injured employees of Texas.



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### MEMORANDUM

**DATE:** August 31, 2012

**TO:** TDI Rule Comment Folder

**FROM:** Elaine Chaney

**RE:** Informal Working Draft: Rules Relating to Chapter 166 Workers' Health and Safety-Accident Prevention Services

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After reviewing the text of the informal working draft of Chapter 166 relating to Workers' Health and Safety Accident Prevention Services, it was determined that the Office of Injured Employee Counsel (OIEC) had no suggestions to improve the informal proposal for the benefit of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to the informal proposal.



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### MEMORANDUM

**DATE:** August 27, , 2012

**TO:** Rule Comment Folder

**FROM:** Elaine Chaney

**RE:** Proposed Medical Quality Review Process Document and Medical Quality Review Panel Application

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After reviewing the text of the proposed Medical Quality Review Process Document and the Medical Quality Review Panel Application, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to these documents.



## MEMORANDUM

**DATE:** August 31, 2012

**TO:** Maria Jimenez  
DWC Forms Team

**FROM:** Brian White, Deputy Public Counsel  
Elaine Chaney, Director of Legal Services

**RE:** OIEC Comment on the Draft of Plain Language Notice Relating to the Potential Entitlement to Workers' Compensation Death Benefits (PLN-12)

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comment on the draft of the Plain Language Notice Relating to the Potential Entitlement to Workers' Compensation Death Benefits (PLN-12). Initially, OIEC recommends adding language to the portion of the form addressing the exceptions to the one-year filing requirement. As proposed the second sentence of the form states "You must file a claim for workers' compensation death benefits with the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) **no later than one year** after the employee's death, except as provided by Texas Labor Code § 409.007(b)." OIEC believes it would be more in keeping with the goal of a plain language form if this sentence were changed to read "You must file a claim for workers' compensation death benefits with the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) **no later than one year** after the employee's death, unless the potential beneficiary is a minor or incompetent or unless good cause exists for the failure to timely file a claim."

OIEC also recommends that language be added that the injured employee might also wish to contact his or her representative or OIEC if he or she needs assistance. Specifically, OIEC requests that the sentence immediately following the adjuster's contact information be revised to state "**For further assistance, you may wish to contract the TDI-DWC field office at 1-800-252-7031, your attorney or representative, or the Office of Injured Employee Counsel at 1-866-393-6432, if you are not represented in your workers' compensation claim.**"

OIEC recommends that the PLN-12 become effective as soon as possible after it is finalized. There appears to be little reason why carriers could not begin sending this notice immediately following notification of the requirement to do so. Making the form effective immediately is consistent with the obvious purpose of the form to get information to potential beneficiaries quickly to ensure that they can protect their rights.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if you have any questions or if we can clarify any of our comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** August 22 2012

**TO:** Maria Jimenez, Office of Workers' Compensation Counsel

**FROM:** Brian White, Deputy Public Counsel/Chief of Staff  
Elaine Chaney, Director of Administration and Operations

**RE:** OIEC Comments on Informal Proposal of New 28 TAC §126.17 and to Amend § 130.2 Regarding Post Designated Doctor Treating Doctor Examination

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) informal proposal to add new 28 Texas Administrative Code §126.17 and to amend § 130.12, regarding post designated doctor treating doctor examination. Please consider the following comments on behalf of the injured employees of Texas:

**1. §126.17(a)(2):**

OIEC is concerned that the use of the term "issue" in this subsection is too broad. It appears that this provision may unnecessarily limit the ability of the treating doctor or a referral doctor to address some questions that a designated doctor addresses simply because the doctor has addressed a similar issue in the past. Specifically, OIEC is concerned that if a treating doctor has issued a report addressing disability, return to work, or ability to work for any period and then the designated doctor addresses one of those questions in a different period, the treating doctor or referral doctor may be precluded from addressing the question addressed by the designated doctor because he had previously provided a written report on the "issue" of disability, return to work, or ability to work. OIEC recommends that the Division clarify that a doctor's written report on an issue in one period will not prevent the doctor from addressing similar questions for a different period addressed by the designated doctor.

**2. § 126.17(a)(3):**

OIEC recommends that this subsection be eliminated. Initially, OIEC would note that it is unclear when a report from a treating doctor or referral doctor would not be "necessary" to dispute the designated doctor's report. In addition, it is unclear who would make the determination of whether the report is necessary to dispute the designated doctor's report. This subsection gives the impression that there is a requirement beyond disagreement with the designated doctor's report and that the treating doctor or referral doctor not have given an



opinion on the specific issue addressed by that report before the examination by the treating doctor or referral doctor is permitted. There is no statutory basis for such a requirement and OIEC believes that the introduction of this requirement would undermine the rule's objective and would likely introduce another point of dispute between the parties that is not contemplated.

**3. § 126.17(b):**

OIEC recommends that the Division strike the second sentence of the subsection. By making the report of the referral doctor the report of the treating doctor, this subsection leaves the impression that the treating doctor can no longer exercise independent medical judgment simply because he or she made a referral for the examination. While OIEC acknowledges that the referral doctor's examination would be the only one that the carrier would be required to pay for under this provision, we do not agree that the treating doctor is precluded from providing an opinion on an issue just because the treating doctor made a referral.

**4. § 126.7(c):**

OIEC recommends that the Division strike the language that the narrative report "include objective findings of the examination and an analysis that explains how the objective findings lead to the conclusion reached by the doctor." The report from the treating doctor or a referral doctor is designed to function in exactly the same way as the report from the post designated doctor required medical examination (RME) doctor. However, we would note that § 126.6(h), the subsection requiring that the RME file a narrative report, does not contain the same requirements of the narrative report. It is unclear why the report from the treating doctor or referral doctor should be held to a standard not required of the RME's report. In addition, we would note that the purpose of this provision is primarily to facilitate payment to the treating doctor or referral doctor when the injured employee needs a report to challenge a designated doctor's report. This subsection introduces subjectivity on the issue of the adequacy of the report that arguably calls into question whether the report will be paid for; thus, undermining the purpose of the rule.

**5. § 130.2(a)(3)(C)**

OIEC requests that the notice in this section also include the statement that the date of maximum medical improvement (MMI) will also become final if it is not disputed within the 90-day period. If the impairment rating becomes final because it is not timely disputed, the assigned MMI date likewise becomes final. OIEC recommends that the language in this section be changed to "a statement that the certification of maximum medical improvement and impairment rating may become final if not disputed within 90 days . . . ."

OIEC also believes that the statement that if the injured employee or their representative disagrees with the certification "they may dispute the certification by contacting the Division of Workers' Compensation (division) to request a benefit review conference" is incorrect. The first line in § 130.2(a) states that it addresses the situation where the first certification is from the treating doctor. In accordance with § 130.12(b)(1), the method used for disputing a first certification of MMI and IR from a treating doctor is to request a designated doctor. The only



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time a BRC is requested to dispute an initial certification from a treating doctor is if a designated doctor has already been appointed on the issue of MMI and IR, but had not issued a report prior to the treating doctor's certification. Requesting a designated doctor to dispute when the first certification is from a treating doctor is the preferred method of disputing an initial certification because the designated doctor's report will be critical to the resolution of the issue and should be available to the parties before they request a benefit review conference and enter the dispute resolution process.

### **6. § 130.2(a)(3)(E):**

OIEC recommends that the notice also include language that in addition to contacting the Division for more information, injured employees can also contact their attorney or, if they are unrepresented, the Office of Injured Employee Counsel at 1-866-393-6432.

### **7. § 130.2(a)(5):**

OIEC requests that the Division also mail a copy of the notice in this section to the Ombudsman assisting the injured employee. In order for the Ombudsmen to effectively assist injured employees, they must be aware of what is happening in the claim and the best way to ensure that they have critical information is to include them in the distribution of such information. Unfortunately, injured employees often are not as proactive as they should be about contacting their Ombudsman when they receive notices such as the one in this subsection. In order to ensure that OIEC can fulfill its mission to assist and educate the injured employees of Texas, we ask that the Ombudsman be provided a copy of this notice.

### **8. § 130.2(a)(7)(C):**

OIEC believes that the language that the insurance carrier "may" make a reasonable assessment should be changed to "shall" make a reasonable assessment. A carrier should not be able to cut off benefits without making a reasonable assessment and paying impairment income benefits based on that assessment to someone who is still receiving temporary income benefits at the 98<sup>th</sup> week. It would seem highly unlikely that someone receiving TIBs that far into the injury would not have any impairment from the injury. Accordingly, it would seem unreasonable to permit a carrier to stop paying income benefits altogether at the time of statutory MMI. The carrier should be required to make a reasonable assessment and to pay impairment income benefits based on that assessment until the issue of the impairment rating is resolved. By requiring the carrier to make a reasonable assessment it would also permit the carrier's action of making an assessment subject to review by the enforcement section. The existence of that oversight mechanism is an important part of ensuring the proper functioning of the administrative process.

### **9. §130.2(b)(3):**

Since Texas Labor Code §§ 408.0041(f-2) and (h) became effective OIEC has been requesting alternate certifications of MMI and IR from the treating doctor or a referral doctor. However, even though they cite the language of § 408.0041(h) requiring payment, the Ombudsmen have encountered resistance based on a fear that the doctor will not be paid for the examination. In



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many instances the doctors request a guarantee of payment letter, which OIEC cannot provide. OIEC requests clarification of whether the Division could provide some mechanism for facilitating the examination in such circumstances such as a guarantee of payment or an interlocutory order.

### **10. § 130.2(e):**

Finally, OIEC requests that subsection (e) of 130.2 be eliminated. This subsection seems to be telegraphing that the alternate rating from the treating doctor or the referral doctor cannot be the preponderance of the evidence contrary to the designated doctor and to the extent that it does so there is no basis for including such language. Initially, we note that there is no such language in the RME rule and it is unclear the purpose behind including that language here. Once there is an alternate rating offered from either a treating doctor, referral doctor, or from the RME, the presumption in favor of the designated doctor's report disappears and the hearing officer is required to weigh the conflicting evidence on the issues of MMI and IR and to decide which report he or she finds more persuasive. The report from the treating doctor or referral doctor should be treated just like the report of the RME and in order to ensure that it is so treated, this subsection should be removed.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC's comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** September 24, 2012

**TO:** Sara Waitt, General Counsel, Texas Department of Insurance  
Debra Diaz-Lara, Director, Managed Care Quality Assurance Office

**FROM:** Brian White, Deputy Public Counsel, Chief of Staff  
Elaine Chaney, Director of Administration and Operations

**RE:** OIEC Comments on Proposed 28 Texas Administrative Code, Subchapter R, §§19.1701-19.1719 and Subchapter U, §§19.2001-19.2017, Concerning Utilization Reviews for Health Care

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comments on the Texas Department of Insurance's proposed rules relating to utilization review for health care 28 Texas Admin. Code §§19.1701-19.1719 and §§19.2001-19.2017.

As a general comment, OIEC suggests that all references to providing notice to or permitting action by injured employees, their representatives, and health care providers also include ombudsmen as persons acting on behalf of injured employees. OIEC requests these references be clarified to explicitly state that Office of Injured Employee Counsel Ombudsmen are lay representatives. OIEC believes that the Ombudsmen are representatives under Rule 150.3(a)(3) and Labor Code §401.011(37). OIEC is required under the Memorandum of Understanding Concerning Confidential Information with the Division to file written authorization from the claimant allowing the Ombudsmen access to confidential records. OIEC Ombudsmen do not receive a fee or remuneration directly or indirectly from claimants. Although OIEC Ombudsmen maintain an adjuster's license, they do not function as an adjuster when they assist injured employees in the dispute resolution process. In fact, they are only required to have an adjuster's license because the agency adopted that requirement as part of the training and continuing education standards for Ombudsmen. See 28 Texas Admin. Code § 276.10. OIEC Ombudsmen serving as lay representatives, even though they have an adjuster's license, is comparable to the Division's long-standing policy of permitting licensed attorneys, who also maintain an adjuster's license, to appear as adjusters in the dispute resolution process.

There are also practical reasons for recognizing that ombudsmen are acting as lay representatives. Because of the unavailability of attorneys' fees in medical dispute resolution, a significant number of injured employees proceed through this process with the assistance of OIEC Ombudsmen. The medical dispute resolution process is replete with relatively tight time deadlines; therefore, it is critical that the Ombudsmen receive notices and be permitted to act on behalf of the injured employee in order to satisfy the statutory mandate of Texas Labor Code



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§ 404.151(b)(4) to “to enable [claimants] to protect their rights in the workers’ compensation system.”

Another advantage of making the requested change is that it will make it clear to all parties that documents need to be exchanged with Ombudsmen. Ombudsmen need this information as much as lay representatives and attorneys do and for the same reasons. Injured workers often forget to bring documents to the Ombudsmen or misplace documents sent to them. If Ombudsmen have the information necessary to assist injured employees, the system operates more smoothly and effectively. The fact that copies of important documents often are not sent to the Ombudsmen has been partially mitigated by OIEC’s access to the Division’s computer system. However, once the agencies have separate computer systems, the Ombudsmen will not be able to access this information through the Division’s computer system.

Further, the Texas Department of Insurance has stated that in promulgating these rules, it is trying to make the process in workers’ compensation as similar as possible as to other types of insurance. However, in §19.1703(b)(2) it provides that in health insurance that an “enrollee, **an individual acting on behalf of an enrollee**, or an enrollee’s provider of record may request reconsideration of an adverse determination.” (Emphasis added). Yet, in §19.2003(b)(2) it provides that an injured employee, an injured employee’s representative, or an injured employee’s provider of record may request reconsideration of an adverse determination. To make the URA process in workers’ compensation mirror the same process in group health, OIEC argues that the language in §19.1703(b)(2), should be used here. OIEC knows of no public policy reason that a person acting on the injured employee’s behalf should not be able to request reconsideration of an adverse determination of a URA in workers’ compensation cases, particularly when this can be done in all other types of cases.

OIEC has the additional following comments on specific sections of the proposed rules:

In §19.2003(b)(20) OIEC suggests that psychiatric disturbances and symptoms of substance abuse be added to the definition of medical emergency. With this change §19.2003(b)(20) would read, “(20) Medical emergency—The sudden onset of a medical condition, including psychiatric disturbances and symptoms of substance abuse, manifested by acute symptoms . . .”. OIEC points out that psychiatric disturbances and symptoms of substance abuse are specifically included in the definition of medical emergency in the federal regulations that apply to Medicare hospitals, 42 Code of Federal Regulations §489.24. OIEC would argue that to be complete the definition of medical emergency in these rules should also include these references.

OIEC seeks clarification of the purpose of including the phrase “as appropriate” in §19.2003(b)(23). It seems that the parameters of what a licensed professional can do is by the licensing board and, therefore, need not be included in this definition.

In §19.2003(b)(30)(A) it provides that a reasonable opportunity means at least one documented good faith attempt to contact the provider of record no less than one working day prior to issuing a prospective utilization review adverse determination. OIEC submits that one working day is inadequate time to allow the provider of record to get back to the URA. OIEC submits that the wording of this section should be changed to read “no less than three working days. . . “.



In § 19.2005(b) it states that disability must not be construed to mean an injured employee who is off work or receiving income benefits. Of course, that is traditional definition of disability in the workers' compensation setting. Since the term "disability" is not going to have the commonly understood definition, it would seem incumbent on this rule to provide a definition of the term in order to ensure that all system participants have the same understanding of its meaning.

In regard to §19.2005(f) OIEC submits that the complaint system should include complaints filed by a person acting on the injured worker's behalf. OIEC know of no reason to restrict the ability to complain to representatives and to exclude others acting on behalf of the injured worker.

OIEC disagrees with the language in §19.2006(b) that addresses disqualifying associations for the doctor performing the appeal of the initial URA determination. Proposed §19.2006(b) states "For purposes of this subsection, being employed by or under contract with the same URA as the physician, doctor, or other health care provider who issued the initial adverse determination does not in itself constitute a disqualifying association." OIEC believes that the fact that the reviewing doctor is employed by or under contract with the same URA that issued the initial adverse determination should be a disqualifying association. It is important for the efficacy of the system that the review of the initial determination be conducted by a person whose objectivity cannot be reasonably questioned. That goal would be significantly undermined if the review of the adverse determination can be made by someone who is employed or under contract with the same URA as issued the initial adverse determination. OIEC also suggests adding a §19.2006(b)(3) stating "any designated doctor or IRO doctor in the case." Giving this more expansive definition of disqualifying association will further the objective of avoiding impropriety or the appearance of impropriety.

OIEC also seeks clarification in regard to §19.2007(b)(2). This provision states that a URA should not routinely request all medical records on an injured employee. OIEC does not understand how a URA can make an informed decision regarding medical treatment without the injured employee's medical records. The provision goes on to say that records should be required only when difficulty develops in determining whether the health care is medically necessary or appropriate "or experimental or investigational in nature." OIEC does not understand the reference to treatment being experimental or investigational in nature since that status is not a basis for denying medical treatment in workers' compensation. Texas Labor Code § 413.014(c)(6) and 28 Texas Administrative Code §134.600(p)(6) identify investigational or experimental services or devices as health care requiring preauthorization. By identifying such treatment as requiring preauthorization in workers' compensation, the statute and rule clearly envision that the experimental or investigational nature of the treatment is not a basis in and of itself for denying the treatment. Accordingly, OIEC believes further explanation is required as to the purpose and effect of having a URA make a determination that the proposed treatment is experimental or investigational.

In §§19.2009(2), (3), and (4) OIEC objects to the references to other codes and rules and the cross-referencing to other sections of this title. The use of these references and cross-references



make it impossible to understand what these sections mean without consulting other material and thus makes this material difficult to follow, particularly by lay people.

OIEC recommends that §§19.2009(a)(2) and (3) be revised to specifically identify the parties to whom notice of the determination of prospective, concurrent, and retrospective utilization review must be given in both network and non-network claims rather than referencing other provisions in the administrative code. Similarly, OIEC recommends that the time deadlines for appealing the initial determination of the URA and for requesting IRO review of the second adverse determination be specifically identified in §§19.2011(a)(1) and (2) and 19.2011(a)(8)(A) and (B). The proposed URA rules are lengthy and complex and, as such, it would seem that they should include all of the information related to the process rather than referencing other rule sections. This change would ensure that system participants can more readily determine their responsibilities under the rules.

OIEC recommends that §19.2009(b) be changed to require the URA to include a list of the documentation reviewed in making the adverse determination. Proposed §19.2010 requires the URA to provide the medical provider a reasonable opportunity to discuss “a description of documentation or evidence, if any, that can be submitted by the provider of record, that upon reconsideration or appeal, might lead to a different utilization review decision.” If that information were supplemented with the list of documentation reviewed, it would permit the provider to determine if such evidence already exists and simply was not provided to the URA or whether additional evidence must be obtained before reconsideration is requested. The determination of how to supplement the initial request has to be made quickly in order to ensure compliance with the deadlines for requesting reconsideration. The inclusion of a requirement that the URA list the documentation reviewed would provide greater efficiency in the process.

OIEC seeks clarification of §19.2009(b)(6). OIEC would like to know what happens in a case where the URA disagrees with the injured employee that the injured employee’s condition is life-threatening and does not immediately forward an adverse determination to an IRO. What would the injured employee’s recourse be in such a circumstance?

OIEC seeks clarification of §19.2016. Specifically, OIEC requests an explanation of when a specialty URA would be required and whether that determination itself is subject to challenge and review.

OIEC seeks clarification of §19.2017(a)(2). As earlier, OIEC’s concern is what would be the result if the URA disagrees with the injured employee’s determination that a condition is life-threatening and how such a disagreement would be reviewed.

Finally, OIEC submits in regard to §19.2017(b) that the deadline to respond in regard to life-threatening conditions should be a matter of hours, not a matter of days. OIEC notes that other provisions have shorter deadlines and argues that this provision should also.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can be of assistance in clarifying any of OIEC’s comments on behalf of the injured employees of Texas.



## MEMORANDUM

**DATE:** October 31, 2012

**TO:** Maria Jimenez, Office of Workers' Compensation Counsel

**FROM:** Brian White, Deputy Public Counsel/Chief of Staff  
Elaine Chaney, Director of Administration and Operations

**RE:** OIEC Comments on Proposal of New 28 TAC §126.17 Concerning Guidelines for Examination by a Treating Doctor or Referral Doctor After a Designated Doctor Examination to address Issues Other Than Certification of Maximum Medical Improvement and the Evaluation of Permanent Impairment

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The Office of Injured Employee Counsel (OIEC) appreciates the opportunity to review and provide comments on the Texas Department of Insurance, Division of Workers' Compensation's (Division) proposal of new 28 Texas Administrative Code §126.17 concerning guidelines for examination by a treating doctor or referral doctor after a designated doctor examination to address issues other than certification of maximum medical improvement and the evaluation of permanent impairment. Please consider the following comments on behalf of the injured employees of Texas:

**1. §126.17(a)(3):**

OIEC is concerned that the use of the term "issue" in this subsection is too broad. It appears that this provision may unnecessarily limit the ability of the treating doctor or a referral doctor to address some questions that a designated doctor addresses simply because the doctor has addressed a similar issue in the past. Specifically, OIEC is concerned that if a treating doctor has issued a report addressing disability, return to work, or ability to work for any period and then the designated doctor addresses one of those questions in a different period, the treating doctor or referral doctor may be precluded from addressing the question addressed by the designated doctor because he had previously provided a written report on the "issue" of disability, return to work, or ability to work. OIEC recommends that the Division clarify that a doctor's written report on an issue in one period will not prevent the doctor from addressing similar questions for a different period addressed by the designated doctor. This clarification could be made by adding the word precise before issue. With that revision, the subsection would state "the treating doctor or the referral doctor has not already provided the injured employee with a written report that meets the standard described by subsection (b) of this section on the precise issue addressed by the designated doctor."



**2. § 126.7(b):**

OIEC recommends that the Division strike the language that the narrative report “include objective findings of the examination and an analysis that explains how the objective findings lead to the conclusion reached by the doctor.” The report from the treating doctor or a referral doctor is designed to function in exactly the same way as the report from the post designated doctor required medical examination (RME) doctor. However, we would note that § 126.6(h), the subsection requiring that the RME file a narrative report, does not contain the same requirements of the narrative report. It is unclear why the report from the treating doctor or referral doctor should be held to a standard not required of the RME’s report. In addition, we would note that the purpose of this provision is primarily to facilitate payment to the treating doctor or referral doctor when the injured employee needs a report to challenge a designated doctor’s report. This subsection introduces subjectivity on the issue of the adequacy of the report that arguably calls into question whether the report will be paid for; thus, undermining the purpose of the rule.

**3. §126.17(b):**

OIEC suggests that the requirement that the report be filed with the injured employee’s representative also include ombudsmen as lay representatives. OIEC believes that the Ombudsmen are representatives under Rule 150.3(a)(3) and Labor Code §401.011(37). OIEC is required under the Memorandum of Understanding Concerning Confidential Information with the Division to file written authorization from the claimant allowing the Ombudsmen access to confidential records. OIEC Ombudsmen do not receive a fee or remuneration directly or indirectly from claimants. Although OIEC Ombudsmen maintain an adjuster’s license, they do not function as an adjuster when they assist injured employees in the dispute resolution process. In fact, they are only required to have an adjuster’s license because the agency adopted that requirement as part of the training and continuing education standards for Ombudsmen. See 28 Texas Admin. Code § 276.10. OIEC Ombudsmen serving as lay representatives, even though they have an adjuster’s license, is comparable to the Division’s long-standing policy of permitting licensed attorneys, who also maintain an adjuster’s license, to appear as adjusters in the dispute resolution process.

OIEC believes that the requirement in this section should be clarified to reflect that that the report should be sent to ombudsmen by having the third sentence changed to read, “This report shall be filed with the insurance carrier, the injured employee and the injured employee’s representative, including ombudsman.” OIEC submits that this clarification is needed because ombudsmen need this report as much as other lay representatives and attorneys do and for the same reasons. Injured workers often forget to bring documents to the Ombudsmen or misplace documents sent to them. If ombudsmen have the information necessary to assist injured employees, the system operates more smoothly and effectively.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can clarify any of OIEC's comments on behalf of the injured employees of Texas.



The Division published an informal draft of the proposed section on the Division's website from August 2, 2012, until August 23, 2012, and received seven informal comments on the informal draft rule. Subsequent changes to the rule text were made based on the informal comments. The new section was proposed in the October 5, 2012, issue of the *Texas Register* (37 TexReg 7868). A public hearing on the proposal was heard on October 15, 2012. The public comment period closed on November 5, 2012. The Division received 12 public comments.

Proposed §126.17(a) is being adopted with a change to subsection (a) in response to public comment. The adopted change, however, does not materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice. The change is described below.

Based on public comment received, the Division has revised the text of §127.17(a) for clarity. The revised text clarifies that an examination by the injured employee's treating doctor or another doctor to whom the injured employee is referred by the treating doctor to determine any issue other than certification of maximum medical improvement and evaluation of permanent impairment may be appropriate after a designated doctor examination under the circumstances prescribed in §126.17(a)(1) - (3). As explained in the Division's response to comment §126.17(a) below, the Division addressed the commenter's concern with clarifying language because Labor Code §408.0041(f-2) governs post-designated doctor examinations on maximum medical improvement and impairment rating while Labor Code §408.0041(f-4) governs post-designated doctor examinations on issues other than certification of maximum medical improvement and the evaluation of permanent impairment.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** November 9, 2012

**TO:** Rule Comment Folder

**FROM:** Elaine Chaney

**RE:** Informal Working Draft: Rules Relating to Chapter 166 Workers' Health and Safety-Accident Prevention Services

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After reviewing the text of the informal working draft of Chapter 166 relating to Workers' Health and Safety Accident Prevention Services, it was determined that the Office of Injured Employee Counsel (OIEC) had no suggestions to improve the informal proposal for the benefit of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to the informal proposal.



## MEMORANDUM

**DATE:** November 7, 2012  
**TO:** TDI Rule Comment Folder  
**FROM:** Elaine Chaney  
**RE:** Designated Doctor Plan-Based Audit

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After reviewing the text of the proposed Designated Doctor Plan-Based Audit, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to the Office of the Medical Advisor regarding the Designated Doctor Plan-Based Audit.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** November 15, 2012

**TO:** TDI Rule Comment Folder

**FROM:** Elaine Chaney

**RE:** Informal Proposal of DWC057, *Request for Extension of Maximum Medical Improvement Date for Spinal Surgery*

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After reviewing the text of the informally proposed DWC057, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to the Division of Workers' Compensation regarding the DWC057.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** November 16, 2012  
**TO:** TDI Rule Comment Folder  
**FROM:** Elaine Chaney  
**RE:** Medical Quality Review CY 2013 Annual Audit Plan

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After reviewing the text of the proposed Medical Quality Review CY 2013 Annual Audit Plan, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to the Office of the Medical Advisor regarding the Medical Quality Review CY 2013 Annual Audit Plan.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** December 10, 2012

**TO:** TDI Rule Comment Folder

**FROM:** Elaine Chaney

**RE:** 28 Tex. Admin. Code §§134.803 and 134.807, Concerning Reporting Standards and State Specific Requirements

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After reviewing the text of the proposed rules concerning reporting standards and state specific requirements, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to proposed Rules 134.803 and 134.807.



## MEMORANDUM

**DATE:** December 14, 2012

**TO:** Maria Jimenez  
Office of Workers' Compensation Counsel

**FROM:** Brian White, Deputy Public Counsel, Chief of Staff  
Elaine Chaney, Director of Administration and Operations

**RE:** OIEC Comments on Informal Proposal to Amend 28 Texas Administrative Code §130.1 Regarding Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comments on the Texas Department of Insurance's informal proposal to amend 28 Texas Admin. Code §130.1 Regarding Certification of Maximum Medical Improvement and Evaluation of Impairment Rating.

As a general comment, OIEC suggests that this proposal is premature. A request for Petition for Review is pending before the Supreme Court of Texas in *State Office of Risk Management v. Joiner*, 363 S.W. 3d 242 (Tex. App. – Texarkana, 2012, pet. filed). If the Supreme Court grants the Petition it could end up reversing the decision of the Court of Appeals.

Further OIEC suggests it appears inappropriate for a state agency to attempt to influence pending litigation by changing its rules during the course of that litigation. OIEC submits a more appropriate course of action would be for DWC to file an amicus brief with the Supreme Court if it believes its rule was misinterpreted by the Court of Appeals.

Finally OIEC believes that the proposed rule change is ill-advised. Obviously, the statutory scheme envisions that when possible impairment rating (IR) should be assessed at the time of maximum medical improvement (MMI). However, this does not always prove possible. In some instances there is a long delay between the time of MMI and the time IR is assessed. For example, suppose the question of whether or not a compensable injury includes an injury to a hand is appealed to the courts and after a number of years the courts determine that the injury does include an injury to the hand. In that case, there may be an evaluation of the whole body impairment to the hand years after the injured employee has reached statutory MMI. Part of the examination of the hand to evaluate impairment would be range of motion testing, which would be conducted years after MMI. In a number of factual scenarios the examination for impairment rating (and impairment must be based upon a physical exam) is separated from the time of MMI and sometimes separated by a large distance. These types of problems are the reason that in a number of cases the Appeals Panel was forced to abandon its original position that MMI and IR "are inextricably intertwined." The proposed rule will not resolve these problems, but in fact



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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will complicate them because it fails to provide meaningful guidance on how reconcile the requirement that the IR be based on the condition on the date of MMI with the requirement of Rule 130.1(a)(3) that the IR also be based on the certifying examination.

Because this proposal is premature, inappropriate and ill-advised, OIEC recommends the Division not make this change, or at least in the alternative, table it until the Supreme Court rules in *Joiner*. OIEC would note that the issue in *Joiner* would have been better resolved had the treating doctor been informed of the correct date of statutory MMI, particularly because it seems likely that he provided a certification of MMI and IR under the provisions of Rule 130.2(c) and (d), which clearly envision that the treating doctor would be provided with that date in Division's notice.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can be of assistance in clarifying any of OIEC's comments.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** January 15, 2013  
**TO:** TDI Rule Comment Folder  
**FROM:** Elaine Chaney  
**RE:** DWC Form-105 and DWC Form-109

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After reviewing the text of proposed DWC Form-105 and DWC Form-109, it was determined that there were no issues that required comment from the Office of Injured Employee Counsel (OIEC) on behalf of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to the Office of the Division of Workers' Compensation regarding either DWC Form-105 or DWC Form-109.



## OFFICE OF INJURED EMPLOYEE COUNSEL

NORMAN DARWIN, PUBLIC COUNSEL

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### MEMORANDUM

**DATE:** January 15, 2013

**TO:** TDI Rule Comment Folder

**FROM:** Elaine Chaney

**RE:** Proposal: Rules Relating to Chapter 166 Workers' Health and Safety-Accident Prevention Services

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After reviewing the text of the informal working draft of Chapter 166 relating to Workers' Health and Safety Accident Prevention Services, it was determined that the Office of Injured Employee Counsel (OIEC) had no suggestions to improve the proposal for the benefit of the injured employees of Texas. Accordingly, no comment was submitted by OIEC to the proposal.



## MEMORANDUM

**DATE:** March 11, 2013

**TO:** Maria Jimenez  
Office of Workers' Compensation Counsel

**FROM:** Brian White, Deputy Public Counsel, Chief of Staff  
Elaine Chaney, Director of Administration and Operations

**RE:** OIEC Comments on Proposal to Amend 28 Texas Administrative Code §130.1 Regarding Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment

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The Office of Injured Employee Counsel (OIEC) is thankful for the opportunity to review and provide comments on the Texas Department of Insurance's proposal to amend 28 Texas Admin. Code §130.1 Regarding Certification of Maximum Medical Improvement and Evaluation of Impairment Rating.

As a general comment, OIEC suggests that this proposal is premature. A request for Petition for Review is pending before the Supreme Court of Texas in *State Office of Risk Management v. Joiner*, 363 S.W. 3d 242 (Tex. App. – Texarkana, 2012, pet. filed), and the Supreme Court has ordered briefing on the merits. If the Supreme Court grants the Petition it could end up reversing the decision of the Court of Appeals.

An attempt by a state agency to influence pending litigation by changing its rules during the course of that litigation might give the appearance of impropriety. OIEC submits that a more proper course of action would be for DWC to file an amicus brief with the Supreme Court if it believes its rule was misinterpreted by the Court of Appeals.

OIEC also believes that the proposed rule change is ill-advised. Obviously, the statutory scheme envisions that an impairment rating (IR) should be assessed at the time of maximum medical improvement (MMI). However, this does not always prove possible. In some instances there is a long delay between the time of MMI and the time IR is assessed. For example, suppose the question of whether or not a compensable injury includes a hand injury is appealed to the courts and after a number of years a determination is made that it does. In that case, there may be an evaluation of the whole body impairment to the hand years after the injured employee has reached statutory MMI. Part of the examination of the hand to evaluate impairment would be range of motion testing, which would have to be conducted at the time of the examination. In a number of factual scenarios the examination for impairment rating (and impairment must be based upon a physical exam) is separated from the time of MMI and sometimes separated by a large distance. These types of problems are the reason that in a number of cases the Appeals Panel was forced to abandon its original position that MMI and IR "are inextricably intertwined."



## OFFICE OF INJURED EMPLOYEE COUNSEL

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The proposed rule will not solve these problems because it fails to provide meaningful guidance on how reconcile the requirement that the IR be based on the condition on the date of MMI with the requirement of Rule 130.1(a)(3) that the IR also be based on the certifying examination in those instances where the examination is performed after the date of MMI. This problem is most prevalent in those cases where the certifying examination includes physical testing such as range of motion measurements, lung function testing, auditory testing, or vision testing.

As far as specific comments are concerned, OIEC suggests deleting §130.1(a)(1)(B)(ii). It seems inappropriate that a doctor should not have to be certified to determine that an injured employee is at MMI and has no impairment (essentially a 0% impairment rating). It has been OIEC's experience that some doctors who are not certified prematurely find injured workers at MMI with no impairment well before treatment has finished and, thus, before that determination is properly made. It is unclear why a doctor, who is not properly certified, is in a position to make a determination that an injured employee is at MMI and has no impairment when he or she is not in a position to assign an impairment rating. It seems that the same process should be used in making either determination and OIEC believes that the non-certified doctor is not qualified to make either determination.

In regard to §130.1(c)(4), OIEC suggests that the last sentence be deleted and the following sentence substituted for it: "If a health care practitioner other than the certifying doctor conducts motion, sensory, or strength testing, the health care practitioner shall be identified by name and a copy of a report from the health care practitioner shall be attached to the certifying doctor's certification of maximum medical improvement and impairment rating." OIEC believes that will better insure that the health care practitioner performing such testing has actually received the required training.

Because this proposal is premature and ill-advised, OIEC recommends the Division not make this change, or at least in the alternative, table it until the Supreme Court rules in *Joiner*. OIEC would note that the issue in *Joiner* would have been better resolved had the treating doctor been informed of the correct date of statutory MMI, particularly because it seems likely that he provided a certification of MMI and IR under the provisions of Rule 130.2(c) and (d), which clearly envision that the treating doctor would be provided with that date in Division's notice. The importance of accurately identifying the date of statutory MMI for both the treating doctor and the designated doctor is apparent when one considers that statutory MMI is a legal date and not a medical date. In the absence of information from the Division, a doctor simply does not have the information required to calculate the date.

If the Division does go ahead with this proposal, OIEC urges that the Division make the specific changes in the proposal which OIEC has suggested.

Thank you in advance for your careful consideration of the above comments. Please do not hesitate to contact us if we can be of assistance in clarifying any of OIEC's comments.