28 TAC §124.2 and §124.3

The Texas Department of Insurance, Division of Workers' Compensation (DWC) adopts amendments to §124.2 (concerning General Rules for Written Communications to and from the Commission) and §124.3 (concerning Investigation of an Injury and Notice of Denial/Dispute). The proposed amendments were published on October 25, 2019, at 44 TexReg 6214. The amendments are adopted with changes.

REASONED JUSTIFICATION

These rules are adopted as required under Senate Bill (SB) 2551, 86th Legislature (2019). Senate Bill 2551 amended both the Workers' Compensation Act, Labor Code Title 5 (Act), and Government Code Chapter 607, Subchapter B (Subchapter B) (relating to Diseases and Illnesses Suffered by Firefighters, Peace Officers, and Emergency Medical Technicians (EMTs) (collectively "first responders")). A separate bill, SB 1582, added peace officers to the list of first responders covered by Subchapter B. As these adopted rules will apply uniformly to all first responders covered by Subchapter B, no additional rulemaking is required to implement SB 1582. These amendments address both an insurance carrier's obligation to investigate and the notification process for presumption claims for first responders. These amendments are adopted concurrently with amendments to Chapter 180, which address enforcement. The reasoned justifications for the amendments to Chapters 124 and 180 are meant to be read together, and each is incorporated by reference into the other.

Subchapter B applies to certain occupational diseases or illnesses suffered by first responders who meet the qualifications set forth. Subchapter B applies to first responders who received a physical examination upon or during employment that did not reveal evidence of the illness or disease for which benefits or compensation is sought, who have been employed for five years or more as a first responder, and who seek benefits or compensation for a disease or illness covered by the subchapter that is discovered during employment as a first responder. Gov't Code §607.052(a). The diseases and illnesses covered by Subchapter B are smallpox, reactions to vaccinations, tuberculosis or other respiratory illness, cancer (firefighters and EMTs only), and acute myocardial infarction or stroke. §§607.053-607.056.

The presumptions under Subchapter B do not apply to a determination of a survivor's eligibility for benefits under Government Code Chapter 615 (relating to Financial Assistance to Survivors of Certain Law Enforcement Officers, Fire Fighters, and Others), in a cause of action brought in court except for judicial review of a grant or denial of employment-related benefits or compensation, to a determination regarding benefits or compensation under a life or disability insurance policy. Furthermore, a presumption does not apply if the disease or illness for which benefits or compensation is sought is known to be caused by the use of tobacco and if either the first responder is or has been a user of tobacco or if their spouse has, during the marriage, smoked tobacco. §607.052(b). The presumptions under Subchapter B apply to a determination

of whether a first responder's disability or death resulted from a disease or illness contracted in the course and scope of employment for purposes of benefits or compensation. §607.057.

Senate Bill 2551 amended Subchapter B to direct that four specified types of cancer and cancers originating in seven specified organs might trigger the presumption under Government Code §607.055. Senate Bill 2551 also amended the requirements for rebutting a presumption. A presumption can be rebutted through showing, by a preponderance of the evidence, that a risk factor, accident, hazard, or other cause not associated with an individual's service as a first responder was a substantial factor in bringing about the individual's disease or illness, without which the disease or illness would not have occurred. §607.058(a). A rebuttal must include a statement that describes, in detail, the evidence that the person reviewed before making the determination that a cause not associated with the individual's service as a first responder was a substantial factor in bringing about the individual's disease or illness, without which the disease or illness would not have occurred. §607.058(b).

Senate Bill 2551 also amended the Act to provide an insurance carrier with an additional option at the 15th day after receiving written notice of a first responder's disability or death for which a presumption may be applicable under Subchapter B. Labor Code §409.021(a-3). Generally, at the 15th day, an insurance carrier must either begin the payment of benefits or notify the injured employee and DWC in writing of its

refusal to pay. §409.021(a). An insurance carrier now has the option, at the 15th day, of providing a first responder and DWC with a notice, referred to in these rules as a "Notice of Continuing Investigation," that describes all steps taken by the insurance carrier to investigate the disability or death before notice was given and the information the insurance carrier reasonably believes is necessary to complete its investigation of the compensability of the injury. §409.021(a-3).

The bill also amended Labor Code §415.021 to require that the commissioner consider whether an injured employee cooperated with the insurance carrier's investigation of the claim and whether the employee timely authorized access to relevant medical records when determining whether to assess an administrative penalty involving a claim in which the insurance carrier provided a Notice of Continuing Investigation. The commissioner shall also consider whether the insurance carrier conducted an investigation of the claim, applied the statutory presumptions under Subchapter B, and expedited medical benefits under Labor Code §504.055 (relating to Expedited Provision of Medical Benefits for Certain Injuries Sustained by First Responder in Course and Scope of Employment).

An insurance carrier's existing duty to investigate a claim is described under the Act. Labor Code 409.021 establishes the foundation for an insurance carrier's duty to investigate a claim prior to a refusal to pay benefits. Section 409.021(a-3) specifically provides that a Notice of Continuing Investigation must "describe all steps taken by the

insurance carrier to investigate the injury before the notice was given and the evidence that the carrier reasonably believes is necessary to complete its investigation of the compensability of the injury." Section 409.021(c) provides that an insurance carrier has a right to continue to investigate the compensability of an injury during the 60-day period. Section 409.021(d) provides that an insurance carrier may reopen the issue of compensability if evidence is later found that could not be reasonably discovered earlier. This language plainly reflects a recognized obligation to reasonably investigate a claim in a timely manner. Upon receipt of written notice of injury, an insurance carrier shall conduct an investigation relating to the compensability of the injury, the insurance carrier's liability for the injury, and the accrual of benefits. A notice of refusal to pay benefits must specify the reasonable grounds for the refusal. §409.022(a) and (c).

If an insurance carrier intends to rely on information discovered after the denial of a claim to support a reason for denial not described in the notice of denial, the insurance carrier must show that the information could not have been reasonably discovered at an earlier date. §409.022(b). When reviewing a health care provider's claim, an insurance carrier can request additional documentation necessary to clarify the provider's charges and, when disputing payment, an insurance carrier must submit a report that sufficiently explains the reasons for the reduction or denial of payment. §408.027(b) and (e). An insurance carrier commits an administrative violation for any of 22 specified actions, including failing to process claims promptly and in a reasonable and prudent manner, misrepresenting the reason for not paying benefits or terminating or reducing payments

of benefits, controverting a claim if the evidence clearly indicates liability, and failing to comply with the Act. §415.002(a). Conversely, an insurance carrier is authorized to allow an employer to assist in the investigation and evaluation of a claim. §415.002(b)(2). The unambiguous meaning of these statutory provisions is that an insurance carrier is expected to conduct a reasonable investigation to establish grounds for refusing to pay benefits. Rule 124.3(a) sets forth the procedures for carrying out these statutory requirements for investigating claims.

As noted by the Texas Supreme Court in *Texas Mutual Insurance Company v. Ruttiger*, 381 SW3d 430, 448-449 (Tex. 2012), an insurance "carrier has statutory and regulatory duties to promptly conduct adequate investigations and reasonably evaluate and expeditiously pay workers' legitimate claims or face administrative penalties." The court further noted, "The Act's requirements include time limits for payment of benefits, giving notice of a compensability contest and the specific reason for the contest, and necessarily subsume the requirement of proper investigation and claims processing." *Id.* at 445 (citing §409.021(a)). The court observed that "[k]ey parts of the [workers' compensation] system are the amount and types of benefits, the delivery systems for benefits, the dispute resolution processes for inevitable disputes that arise among participants, the penalties imposed for failing to comply with legislatively mandated rules, and the procedures for imposing such penalties." *Id.* at 450. The court recognized that DWC's pervasive authority to regulate and penalize insurance carriers for

inadequate investigations eliminated the need for private causes of action. *Id.* at 449-450.

Insurance carriers have additional investigative responsibilities specific to designated claims advanced by first responders or their beneficiaries. As provided by SB 2551, an insurance carrier is relieved of the duty to either initiate payment or provide notice of its refusal to pay within 15 days of receiving written notice of a qualifying injury to a first responder, if it provides a Notice of Continuing Investigation "that describes all steps taken by the insurance carrier to investigate the injury before notice was given and the evidence that the carrier reasonably believes is necessary to complete its investigation of the compensability of the injury." §409.021(a-3). An insurance carrier's notice of refusal to pay benefits must explain why a presumption under Subchapter B, does not apply and must describe the evidence that the carrier reviewed in making that determination. §409.022(d). In determining whether to assess an administrative penalty for a claim involving a first responder, the commissioner must consider whether "the insurance company conducted an investigation of the claim [and] applied the statutory presumption under Subchapter B." §415.021(c-2).

For claims concerning first responders, Subchapter B provides elements necessary to qualify for a presumption under the subchapter, as well as a disqualification for tobacco use. Gov't Code §607.052(a) and (b)(4). At a later hearing, an insurance carrier may rebut any presumption established under Subchapter B "through a showing by a

preponderance of the evidence that a risk factor, accident, hazard, or other cause not associated with the individual's service as a firefighter, peace officer, or [EMT] was a substantial factor in bringing about the individual's disease or illness, without which the disease or illness would not have occurred." §607.058. These provisions establish the evidentiary standard applicable to rebuttal of the presumption and require that an insurance carrier investigate a first responder's qualification for a presumption under Subchapter B.

The Legislature has directed that DWC adopt rules necessary to implement SB 2551 no later than January 1, 2020. The implementation of SB 2551 will provide an amended process for claim notification including an allowance for issuance of a Notice of Continuing Investigation. Upon issuance of a Notice of Continuing Investigation, an insurance carrier will have more time to investigate a claim before taking action. The adopted amendments also describe an insurance carrier's obligation to investigate when it receives notice of an injury for which a presumption may apply on a claim and the process the carrier must follow when investigating a presumption claim under Subchapter B.

The changes in law made by SB 2551 apply to a claim for benefits filed on or after June 10, 2019, the effective date of SB 2551. Section 8 of SB 2551 provides that the amendments to Government Code §607.055 and §607.058 apply only to a claim for benefits filed on or after June 10, 2019. Section 10 of SB 2551 provides that Labor

Code §504.053(e)(1) applies only to administrative violations that occur filed on or after June 10, 2019. The amendments will not apply to a claim for benefits filed before June 10, 2019.

DWC posted an informal draft of these amendments on its website for comment and hosted a stakeholder meeting on Wednesday, August 21, 2019. Subsequently, and in response to the comments received, DWC published proposed amendments in the *Texas Register* and held a public hearing on Wednesday, November 20, 2019.

Section 409.021(a-3), as amended by SB 2551, directs that an insurance carrier need not comply with the established 15-day pay or deny obligation if it issues a described notice. As adopted, Rule 124.2 identifies this notice as a Notice of Continuing Investigation and requires that insurance carriers use a plain language format and no less than a 12-point font.

The adopted amendments to Rule 124.2 add subsections (f)-(h) to establish the notice requirements provided for under §409.021(a-3). Subsection (f) details the choice of actions that an insurance carrier may take during the first 15 days following receipt of a written notice of injury. Subsection (f)(3) provides that notice must be provided to both the claimant and DWC, as required under §409.021(a-3). This requirement is also consistent with DWC's responsibility to monitor the workers' compensation system, as

set forth in Chapter 414 (relating to Enforcement of Compliance and Practice Requirements).

Subsection (g) clarifies that a "claim for benefits" means the first written notice of injury as provided in Rule 124.1 (concerning Notice of Injury). A written notice of injury can include DWC Form-001, *Employer's First Report of Injury or Illness*, or if that form has not been filed, any other written communication, regardless of the source, which informs the carrier of the name of the injured employee, the identity of the employer, the approximate date of the injury, and information which asserts the injury is work related. The filing of a DWC Form-041, *Employee's Claim for Compensation for a Work-related Injury or Occupational Disease,* or a DWC Form-042, *Claim for Workers' Compensation Death Benefits*, by an injured employee or their beneficiary would fulfill this requirement if it is the first written notice of injury.

Subsection (h) describes what must be included in a Notice of Continuing Investigation. The elements of a Notice of Continuing Investigation provide an outline for what constitutes a reasonable investigation and the relevant and necessary information for that investigation. An insurance carrier may request that an injured employee provide releases required to obtain information and specified information or documents within their custody or control reasonably believed to be necessary to complete its investigation of the compensability of an injury. An insurance carrier must continue to pursue its own investigation, seeking to obtain information directly from health care

providers, employers, and other sources. This is consistent with an insurance carrier's existing duty under law to investigate a claim as discussed above. Senate Bill 2551 did not create any additional duty for an injured employee to respond to production requests from an insurance carrier.

Subsection (h)(3) provides a description of information or documents that may not be identified by the insurance carrier as reasonably necessary to complete its investigation through a Notice of Continuing Investigation, such as a request for additional diagnostic testing, mental health records, generic requests, or requests for records that are not directly related to either the disease or illness or eligibility for a statutory presumption under Subchapter B. The workers' compensation system provides other opportunities for an insurance carrier to obtain additional diagnostic testing. Mental health records have no apparent relevance to an investigation involving any of the diseases or illnesses identified under Subchapter B. As described under §409.021(a-3), the Notice of Continuing Investigation provides an insurance carrier with the opportunity to identify the claim-specific information that the insurance carrier reasonably believes is necessary to complete its investigation of the compensability of an injury.

Subsection (j) describes additional requirements for an insurance carrier when issuing a denial notice on a claim where the insurance carrier issued a Notice of Continuing Investigation. Subsection (j)(2) clarifies if the insurance carrier concludes that a statutory presumption applies, but still denies the claim, the notice of denial must

include a statement explaining why and describing the claim-specific evidence or documentation reviewed prior to issuance of the notice. The notice of denial should demonstrate a rational conclusion based on claim-specific evidence or documentation as justification for denial of the claim for benefits. These requirements are consistent with §409.022 and §415.021.

Subsection (s) establishes minimum standards for plain language notices including that a minimum font size of 12-point be used in all plain language notices. The requirement for a 12-point font is consistent with other guidelines and requirements for readability and plain language. For example, the Texas Department of Insurance requires that a notice of network requirements and employee information form must "be printed in not less than 12-point type." 28 TAC §10.63; *see also* Federal Plain Language Guidelines (May 2011), available at plainlanguage.gov. The requirements for 12-point font will apply to all plain language notices. The requirements in Subsection (s) will go into effect on April 1, 2020, providing insurance carriers with additional time to update their automated systems.

Throughout Rule 124.2, additional non-substantive editorial changes are adopted to correct errors of grammar and punctuation, clarify wording, and to conform to the agency's style guidelines.

The amendments to Rule 124.3(a)(1-4) address the use of the Notice of Continuing Investigation as now allowed under §409.021(a-3). As provided by SB 2551, by issuing a timely Notice of Continuing Investigation, an insurance carrier is allowed additional time to investigate a claim before deciding to pay or deny a claim on or before the 60th day from written notice of injury. §409.021(a-3). Under Rule 124.3(a)(4), if a Notice of Continuing Investigation is issued after the 15th day from receipt of written notice of injury, the insurance carrier is liable for accrued or payable income and medical benefits prior to a timely denial.

The amendments to Rule 124.3 delete penalty provisions in subsection (a)(4)(A-C) in order to conform with House Bill (HB) 7, enacted by the 79th Legislature, Regular Session, effective September 1, 2005. House Bill 7 amended Labor Code §415.021 to delete a limitation that an administrative penalty should not exceed $10,000. Section 415.021 permits DWC to assess administrative penalties of up to $25,000 per violation in addition to any other sanctions authorized by the Act. Section 415.021 also states that each day of noncompliance constitutes a separate violation and lists the factors that DWC must use when determining penalty amounts. Additionally, §415.025 provides that a reference in the Labor Code or other law to a particular class of violation or administrative penalty must be construed as a reference to an administrative penalty, and except as otherwise provided in the Act, an administrative penalty may not exceed $25,000 per day per occurrence, and each day of noncompliance constitutes a separate violation in accordance with §415.021.

The amendments to subsections (d) and (e) are required to provide for the use of a Notice of Continuing Investigation in claims involving death or burial benefits. Subsection (d) is amended to clarify, for purposes of death benefits, when an insurance carrier may issue a Notice of Continuing Investigation in accordance with the provisions of §124.2(f) and §124.3. Subsection (e) provides that, notwithstanding the requirements of §132.13 (concerning Burial Benefits), when an insurance carrier issues a Notice of Continuing Investigation, the insurance carrier must either pay or deny a claim for burial benefits within seven days from the initiation of benefits or the issuance of a notice of denial.

The transition language in prior subsection (f) is now obsolete and has been deleted as all claims prior to September 1, 2003, have exceeded the 15 days provided in subsection (a).

Subsection (g) provides that if an insurance carrier receives written notice of injury for a disease or illness identified by Subchapter B, it is required to investigate the applicability of the statutory presumption in addition to investigating the compensability of the injury, liability for the injury, and the accrual of benefits. Subsection (g)(1) provides that a claimant is not required to expressly claim the applicability of a statutory presumption in order for the statutory presumption to apply.

As described in subsection (g)(2), a presumption under Subchapter B is claimed to be applicable upon a first responder's written notice of injury for a disease or illness identified by Subchapter B. As a written notice of injury constitutes a claim for any presumption under Subchapter B, an insurance carrier has the duty of investigating whether a presumption does or does not apply to an individual claim. This is consistent with the provisions of Government Code §607.057 and §607.058 and Labor Code §409.021 and §415.021, as well as with an insurance carrier's duty to investigate a claim as discussed above. Subsection (g)(2) is also consistent with the Legislature's intent that DWC "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 within the system." Labor Code §402.021 (relating to Goals; Legislative Intent; General Workers' Compensation Mission of Department).

As described in subsection (g)(3), whether a presumption does or does not apply has no direct bearing on issues relating to compensability, liability for the injury, and the accrual of benefits. For instance, if an injured employee is a smoker, the employee nonetheless may have suffered a compensable injury even if the presumption under Government Code §607.054 does not apply. Accordingly, as set forth in subsection (g)(3), an insurance carrier has a continuing obligation to conduct a reasonable investigation even when a presumption does not apply or may be rebuttable.

Throughout Rule 124.3, additional non-substantive editorial changes are adopted to correct errors of grammar and punctuation, clarify wording, renumber subsections, and to conform to the agency's style guidelines.

Finally, SB 2551 required that DWC adopt rules necessary to implement the bill. DWC adopts these amendments to implement SB 2551.

SUMMARY OF COMMENTS AND AGENCY RESPONSE

Texas Mutual Insurance Company and the Office of Injured Employee Counsel submitted comments offering general support of the implementation of SB 2551 and against the adoption of certain specific provisions.

The City of San Antonio, Insurance Council of Texas, and Liberty Mutual Insurance Company offered comments against specific statements in the preamble and rule provisions.

General Comments

Comment: Two commenters offered general support for the proposed rules.

Response: DWC appreciates the supportive comments.

Comment: One commenter challenged the following statement in the preamble regarding Labor Code §409.022(b): "If an insurance carrier intends to rely on evidence discovered after the denial of a claim, the insurance carrier must show that the evidence could not have been reasonably discovered at an earlier date." The commenter characterized this statement as an incorrect evidentiary bar and stated that §409.022(b) does not bar new evidence based on different arguments that may be raised to address the certified issues and that failure to comply with such requirements is an administrative violation.

Response: DWC agrees in part. Section 409.022(b) reads "The grounds for the refusal specified in the notice [of refusal to pay benefits] *constitute the only basis* for the insurance carrier's defense on the issue of compensability in a subsequent proceeding, *unless the defense is based on newly discovered evidence* that could not reasonably have been discovered at an earlier date" (emphasis added). Statutes are to be read according to their plain meaning, "giv[ing] effect to the Legislature's intent as expressed by the language of the statute." *State Office of Risk Management v. Martinez*, 539 SW3d 266, 270 (Tex. 2017), *quoting City of Rockwell v. Hughes*, 246 SW3d 621, 625 (Tex. 2008); *see also* Code Construction Act, Government Code §§311.021, 311.023. The plain meaning of §409.022(b) is that the grounds for refusing to pay benefits is the only basis for a defense of compensability in a subsequent proceeding, "unless the defense is based on newly discovered evidence that could not reasonably have been discovered at an earlier date." The Legislature expanded the basic rules for a notice of

refusal to pay benefits in SB 2551 by adding §409.021(a-3) and §409.022(d-1) to provide for the Notice of Continuing Investigation. Section 409.021(a-3) provides that "a notice … describes all steps taken by the insurance carrier to investigate the injury before the notice was given and the evidence the carrier reasonably believes is necessary to complete its investigation of the compensability of the injury."

DWC does, however, recognize the need to clarify this statement from the preamble. So, it has been revised to note that "[i]f an insurance carrier intends to rely on information discovered after the denial of a claim to support a reason for denial not described in the notice of denial, the insurance carrier must show that the information could not have been reasonably discovered at an earlier date." During the dispute resolution process, parties have the opportunity to continue to investigate and develop evidence in support of stated reasons for denial.

Comment: One commenter asked DWC to address an apparent conflict between Labor Code §409.021(a-3), as added by SB 2551, and §408.027 (relating to Payment of Health Care Provider) to reconcile the 60 days an insurance carrier is allowed to investigate a claim under §409.021(a-3) with the requirement that an "insurance carrier must pay, reduce, deny, or determine to audit the health care provider's claim not later than the 45th day after the date of receipt by the carrier of the provider's claim" in §408.027. The commenter recommended that DWC read the requirements of §409.021(a-3) to override the requirements of §408.027, arguing that the former

provision is both more specific in nature and more recently enacted. The commenter also requested that DWC add language to allow an insurance carrier an additional 45 days to process a medical bill following the 60 days provided through issuance of a Notice of Continuing Investigation.

Response: DWC appreciates the comment. The statutes referenced by the commenter can be reconciled. The statutorily mandated time frames have different triggers and run independently. The 60 days to investigate a claim under §409.021(a-3) is measured from the first written report of injury. Under Rule 124.1, first written report of injury could take several forms, including the employer first report of injury, notification to an insurance carrier by DWC, or other communications, including a medical bill. The 45 days to process a medical bill under §408.027 is triggered by receipt of a complete medical bill from a health care provider. Insurance carriers are not required to take the full time allowed. Currently, insurance carriers may process and make payments for some medical services while they continue to investigate a claim for compensability, For network claims under Insurance Code Chapter 1305 (relating to Workers' Compensation Health Care Networks), insurance carriers have an existing duty to notify health care providers of compensability denials and must pay for medically necessary services that are provided to an injured employee before notification of a compensability dispute.

If DWC were to accept the commenter's suggestion, that a medical bill need not be paid until 45 days after a decision to initiate benefits, it would conflict with the Legislative intent expressed in §408.027. Under that scenario, a health care provider might wait up to 105 days for a medical bill to be processed by an insurance carrier. That would clearly contradict the prompt payment intent of §408.027. Statutes are to be read as a whole, giving effect to every part. *Railroad Comm'n of Texas v. Texas Citizens for a Safe Future and Clean Water*, 336 SW3d 619, 628 (Tex. 2011). In a complex administrative scheme, such as the workers' compensation system, deference is to be granted to an agency's construction of the statute as long as that construction is reasonable and in alignment with the statute's meaning. *Id.* at 629-630; *see Martinez*, 539 SW3d at 270-271. No change was made in response to this comment.

§124.2

Comment: One commenter said DWC exceeded its statutory authority by equating "claim for benefits" with the insurance carrier's first written notice of injury, noting that "claim" is an affirmative act. The commenter further argued that the definition of "claim for benefits" in §124.2(g) exceeded the statutory authority, noting that "claim for benefits" was not previously defined in either the Act or Subchapter B. The commenter noted that Merriam-Webster's definition of "claim" as an affirmative act is more analogous to §409.003, and as such, Subchapter B claims should have a different trigger than all other workers' compensation claims.

Response: DWC appreciates the comment. The provision for a Notice of Continuing Investigation created by SB 2551 clearly attaches to receipt of the written notice of injury. Section 402.00128 describes the general powers and duties of the commissioner, including assessing and enforcing penalties and prescribing the form, manner, and procedure for the transmission of information to DWC. Section 402.061 provides that the commissioner shall adopt rules as necessary for the implementation and enforcement of the Act. Furthermore, the Texas Supreme Court has held that "an agency's interpretation of a statute it is charged with enforcing is entitled to 'serious consideration,' so long as the construction is reasonable and does not conflict with the statute's language" and courts should defer to an agency's interpretation of a statute it is charged with enforcing. *Railroad Comm'n*, 336 SW3d at 624. An agency, such as DWC, with expertise in a certain area is usually granted latitude in the methods used to accomplish its administrative functions. *Mid-Century Insurance Co. v. Texas Workers' Compensation Comm'n*, 187 SW3d 754, 757-758 (Tex. App. – Austin 2006).

Under the Act and DWC rules, specifically §124.1, an insurance carrier must initiate claim processing upon receipt of notice of an injury. A notice of injury may take the form of an employer's first report of injury, notification from DWC, or any other communication, regardless of source, which fairly informs the carrier of pertinent information surrounding an injury including a bill from a health care provider. Revising the language as suggested, from first notice of injury to a "claim for compensation," would result in requiring injuries under Subchapter B to be noticed through a specific

DWC Form-041, *Employee's Claim for Compensation for a Work-Related Injury or Occupational Disease*, which can be filed up to one year from the date of injury. Using the suggested language would allow an insurance carrier to delay investigation up to one year after the date of injury. This would conflict with the general premise in §415.002 that an insurance carrier must process claims promptly and with the prioritization of claims for medical benefits to first responders under §504.055 (relating to Expedited Provision of Medical Benefits for Certain Injuries Sustained by First Responder in Course and Scope of Employment). No change was made in response to this comment.

Comment: A commenter states that DWC has exceeded its statutory authority by requiring that the Notice of Continuing Investigation be received by DWC since Labor Code §409.021(a-3) states that the insurance carrier must "provide" the notice to the injured employee and DWC and that "provided" and "received" are different concepts. The commenter further states that the insurance carrier does not have to prove when DWC receives the notice and that DWC Rule 102.5 adequately addresses written communications to and from DWC. The commenter recommends revising §124.2(h) to say: "The notification requirements of this section are not considered complete until the insurance carrier provides a copy of the notice to both the claimant and the division."

Response: DWC appreciates the comment. The requirement in Subsection (h) that the notification requirements for a Notice of Continuing Investigation are not considered

complete until a copy of the notice is received by DWC is the same as the notification requirements for claim denials under Subsection (k) that have been in place since 1999. DWC must be able to monitor Notices of Continuing Investigation submitted by insurance carriers the same way it monitors claim denials, ensuring that these notices comply with the statute and DWC rules. DWC notes that §402.00128 outlines the commissioner's authority to "prescribe the form, manner, and procedure for the transmission of information to the division" and §§414.002-414.003 outline DWC's authority to monitor insurance carriers for compliance with DWC rules and to compile and maintain information as necessary to detect noncompliance. Rule 102.5 clarifies the requirements for written communications to and from DWC, including the requirement that electronic communications, including facsimile, shall be filed in the "format, form, and manner prescribed" by DWC and are considered filed or sent on the date received by DWC. Section 409.021(a-3) states that "the insurance carrier has provided notice to the employee and the division." DWC has the authority to interpret and define this statutory language consistent with the Act and DWC rules. *Railroad Comm'n*, 336 SW3d at 629-630; *Mid-Century*, 187 SW3d at 758-759. No change was made in response to this comment.

Comment: One commenter asked that DWC clarify whether a description is required for all claim-specific evidence or documentation the insurance carrier believes relevant and necessary to complete its investigation or if the duty to describe evidence is limited to

the additional claim-specific evidence or documentation the insurance carrier reasonably believes is both relevant and necessary to complete its investigation.

Response: DWC appreciates the comment but disagrees that clarification of the rule text is needed. The requirements for an insurance carrier's Notice of Continuing Investigation are stated in §409.021(a-3). Relatedly, §124.2(h)(1)(A) requires a description of all investigative steps taken prior to the issuance of a Notice of Continuing Investigation. Paragraph (B) requires "a list of any claim-specific evidence, releases, or documentation the insurance carrier reasonably believes is both relevant and necessary to complete its investigation." An insurance carrier is only required to identify or list the missing information needed to complete its investigation. No change was made in response to this comment.

Comment: One commenter said that proposed §124.2(h)(2) could be interpreted to impose an "unduly burdensome" deadline for an injured employee to "marshal all claim-specific evidence and documentation an insurance carrier reasonably believes to be reasonable and necessary," and that an injured employee's failure to respond to the notice could result in a denial of claim, loss of benefits (medical and income), and preclude any administrative violation against the insurance carrier.

Response: DWC appreciates the comment. Subsection (h)(2) directly reflects the statutory command and does not impose burdens or consequences upon an injured

employee. Under SB 2551, §409.021(a-3) requires that an insurance carrier's Notice of Continuing Investigation describe "the evidence the carrier reasonably believes is necessary to complete its investigation of the compensability of the injury," and §415.021(c-2) provides that, before assessing an administrative penalty, DWC must "consider whether (1) the employee cooperated with the insurance carrier's investigation of the claim; (2) the employee timely authorized access to the applicable medical records before the insurance carrier's deadline to: (A) begin payment of benefits; or (B) notify the division and the employee of the insurance carrier's refusal to pay benefits." Senate Bill 2551 placed no affirmative duty on an injured employee to provide requested information or to do so within a specified timeframe. Senate Bill 2551 simply states that, for an enforcement action, DWC must consider if the injured employee "timely authorized access." What is now required under §409.021(a-3) is notice to a first responder of the evidence the insurance carrier reasonably believes is necessary to complete its investigation of the compensability of the injury. Accordingly, this rule places no new or additional requirement on an injured employee to respond to a request for information from an insurance carrier. The rule simply specifies that if an insurance carrier issues a Notice of Continuing Investigation, the first responder must be offered a reasonable amount of time to respond, should the injured first responder choose to do so. No change was made in response to this comment.

Comment: One commenter challenged proposed §124.2(h)(3) and its directive that the statement of evidence that the insurance carrier reasonably believes is necessary may

not be limited by a "directly related" standard. Medical records, the commenter asserts, generally may contain information that may be admissible in a dispute resolution proceeding or that may lead to identification of other records that are relevant and admissible. In addition, medical records frequently contain references to the existence of risk factors for the development of an injury or disease, including references to the occurrence or cause of the disease, injury, or cause of death of family members.

Response: DWC appreciates the comment. A Notice of Continuing Investigation is not a discovery request, does not create a discovery request standard nor does it limit the discovery process available to parties throughout the dispute resolution process or subsequent litigation. The purpose of a Notice of Continuing Investigation is to provide an injured first responder with notice of matters remaining to be investigated. In accordance with §409.021(a-3), a Notice of Continuing Investigation must explain the steps the insurance carrier has taken to date regarding their investigation of a claim under Subchapter B and what additional information is necessary to complete the investigation of that claim. The investigation occurs outside of, and before, any dispute resolution process and does not include the full array of discovery that is available during formal dispute resolution. To state, as Rule 124.2(h) does, that a Notice of Continuing Investigation may not request additional diagnostic testing, mental health records or include a generic request to "send all your healthcare records" does not prescribe any limitations on a party's opportunity to assert in subsequent contested case proceedings that a given request for production is or is not reasonably calculated

to lead to the discovery of admissible evidence. No change was made in response to this comment.

Comment: One commenter said that DWC's discussion of proposed §124.2(h)(3) in the preamble misstates the test for relevance in the investigation or discovery process, arguing that the test for relevance in this context is whether the request is "reasonably calculated to lead to the discovery of admissible evidence." The commenter requested that DWC revise this statement to reflect the correct test for relevance in the carrier's investigation or discovery process to read: "Subsection (h)(3) provides a description of information or documents that may not be identified by the insurance carrier as reasonably necessary to complete its investigation through a Notice of Continuing Investigation such as a request ... for records that are not reasonably calculated to lead to the discovery of admissible evidence in a claim for a disease or illness or for eligibility for a statutory presumption under Government Code, Chapter 607, Subchapter B."

Response: DWC appreciates the comment but disagrees that 124.2(h)(3) should be revised or that it reflects an inappropriate discovery standard. Although DWC does limit the use of a Notice of Continuing Investigation to request certain records and information, such notice is issued prior to the initiation of a formal dispute and, as previously addressed, a Notice of Continuing Investigation is not a discovery request, does not create a discovery request standard, nor limit the discovery process available to parties throughout the dispute resolution process or subsequent litigation. As part of

the Act's dispute resolution and discovery process, an insurance carrier can seek medical records, evidence, or other documentation, including through application of Rule 142.13 (concerning Discovery).

The purpose of a Notice of Continuing Investigation is to provide an injured first responder with notice of matters remaining to be investigated. The notice is an option for insurance carriers to delay the requirement in §409.021(a) to either, within 15 days of written notice of injury, initiate payment or refuse to make payment and provide the injured employee with notice of the opportunity to request a benefit review conference and of how to obtain additional information from DWC. As part of a Notice of Continuing Investigation, an insurance carrier must describe the evidence it reasonably believes is necessary to complete its investigation. No change was made in response to this comment.

Comment: One commenter asserted that the phrase "reasonable steps" in proposed §124.2(h)(4) and §124.3(g)(3) is too vague. The commenter stated that the facts and circumstances of each claim determine what is reasonable and pointed out that DWC has previously declined to mandate the manner in which insurance carriers conduct investigations. The commenter recommended DWC revise §124.2(h)(4) to use "investigate the claim" in place of "taking reasonable steps to acquire claim-specific evidence and documentation necessary to complete its investigation of the claim" and that, in §124.3(g)(3), "reasonable" should be deleted as a modifier of "investigation."

Response: DWC appreciates the comment. First, DWC believes that the language of §415.002(a) encourages reasonable and prudent conduct by an insurance carrier when handling claims, including during the investigation of claims. *See also* §409.021; *Ruttiger*, 381 SW3d at 448-449 ("The carrier has statutory and regulatory duties to promptly conduct adequate investigations and reasonably evaluate and expeditiously pay workers' legitimate claims or face administrative penalties). Through the Act, the Legislature has "remove[d] insurer's exclusive control over the processing of claims." *Ruttiger*, *Id.* at 449. Furthermore, because "reasonable" is a generally accepted legal and insurance concept that has been used by the Legislature to describe insurance carrier conduct, DWC disagrees that "reasonable steps" is an impermissibly vague direction relating to the investigation of a claim. *See* BLACK'S LAW DICTIONARY 1272-1273 (7th ed. 1999). DWC agrees that the facts and circumstances of each claim determine what is reasonable to investigate a claim.

Rules 124.2(h)(4) and 124.3(g)(3) merely direct that an insurance carrier's investigation be a systematic inquiry into the specific facts and circumstances of a claim. Last, and fundamentally, DWC disagrees with the commenter's observation that §124.2(h)(4) "mandates the manner in which insurance carriers conduct investigations." To direct, as the rules does, that insurance carriers continue to take reasonable steps to acquire claim-specific evidence and documentation does not mandate the manner in which they

do so. Subject to oversight by DWC, an insurance carrier is free to conduct a claim investigation as it sees fit.

However, upon full consideration of the comment, DWC recognizes that the phrase "evidence and documentation" as used in the rule may suggest that a reasonable investigation must produce more developed information than is necessary for making an initial decision on a claim. Consequently, in §124.2(h)(4), "information" has been substituted for "evidence and documentation."

Comment: Two commenters asserted that DWC exceeded its statutory authority by requiring an insurance carrier to provide the detail specified under proposed Rule 124.2(j) at the time of the denial notice when claiming an applicable statutory presumption has been rebutted. The commenters acknowledge that §409.022(d) requires that an insurance carrier include additional detail in its Notice of Denial that explains "why the insurance carrier determined a presumption under that subchapter does not apply to the claim for compensation." However, one commenter argued that neither §409.022 nor §607.058 require an insurance carrier to provide the detail required by proposed Rule 124.2(j)(2) at the time of the denial notice. The commenters urged that Rule 124.2(j)(2) be deleted.

Response: DWC appreciates the comment but disagrees that the challenged statements must be removed from the preamble or that the subsection (j)(2) should be

deleted. The statutory authority for implementing these rules includes §§402.061, 409.021, and 409.022. Appropriate and reasonable notice to injured employees of the reasons a carrier is denying or not paying a claim is necessary information regarding the status of their claim and provides injured employees with an informed opportunity to dispute a denial.

The requirements of appropriate and reasonable notice are clear in §§409.021(a) and (c), 409.022(d)(1), and within the amendments to §409.021(a)(3) in SB 2551, as well as additional guidance specified in Subchapter B for first responders. An insurance carrier has the right to refuse to initiate benefits after receiving a notice of injury, but under the Act and rules, an insurance carrier must also communicate the reasons for its actions with sufficient information and clarity.

However, DWC has concluded that the comments indicate that the duty under proposed Rule 124(j) was unclear. Where a statutory presumption under Subchapter B applies, in a notice of denial, an insurance carrier must provide the injured first responder with notice of the claim-specific information supporting denial. Accordingly, the rule has been amended to better align rule text with §409.022 and to delete reference to Government Code §607.058.

Comment: One commenter said that there appeared to be no statutory authority for the requirement in §124.2(s) on the use of an insurance company's letterhead on a plain language notice.

Response: DWC appreciates the comment but disagrees. As described in the discussion of statutory authority in the preamble for the proposed rule, §409.013 authorizes DWC to develop plain language information to provide the public with information on the benefit process and compensation procedures, §402.00128 describes the commissioner's powers and duties to prescribe the form, manner, and procedure for the transmission of information to DWC, §402.061 provides the commissioner with the authority to adopt rules as necessary for the implementation and enforcement of the Act, and §414.002 provides that DWC shall monitor the workers' compensation system for compliance with the Act. These provisions authorize DWC to adopt rules regarding the form and manner of plain language notices. No change was made in response to this comment, but as described elsewhere, the letterhead requirement is no longer included in the rule as adopted.

Comment: Three commenters urged that the requirement in proposed §124.2(s) for the use of an insurance carrier's letterhead for plain language notices be deleted. They argued that it would be costly and inefficient, particularly for insurance carriers that operate in more than one jurisdiction and for third-party administrators that work with more than one insurance carrier. Two commenters suggested that the requirement

might create confusion for injured employees when an insurance carrier is working with a third-party representative.

Response: DWC agrees in part. DWC believes that an insurance carrier's notice to an injured employee regarding a claim action should be on the insurance carrier's letterhead because it makes it clear to the injured employee who is taking the action on their claim. DWC recognizes that some insurance carriers use third party administrators to perform claims adjusting responsibilities on their behalf, but it is the insurance carrier's responsibility under the Act to ensure that a claim is processed correctly and that benefits are paid to the injured employee as and when they are due. DWC recognizes that requiring the addition of the insurance carrier's letterhead on all notices presents certain implementation challenges and the current notices require the name of the insurance carrier to be inserted in the body of the notice. As a result, DWC has removed the letterhead requirement from §124.2(s). However, DWC's long-standing recommendation will remain in place that the insurance carrier's letterhead be used for plain language notices to injured employees. DWC may revisit this issue in the future.

Comment: One commenter stated that the requirements of §124.2(s) seem to ignore that the plain language notices are DWC forms that an insurance carrier is required to complete and share with an injured worker.

Response: DWC appreciates the comment. The plain language notices issued by insurance carriers are distinct from DWC's forms which are designed to facilitate communication within the workers' compensation system. Plain language notices are templates for an insurance carrier to use when communicating with an injured employee. The forms used by DWC are standardized to facilitate communication by system participants, many of them professionals. The DWC forms and plain language notices also are distinctly numbered and grouped on the DWC web site (compare DWC Form-153 with PLN-14). No change was made in response to this comment.

§124.3

Comment: One commenter asserted that proposed 124.3(g) is inconsistent with the conjunctive nature of the eligibility standard under Subchapter B. The commenter stated that if an insurance carrier determines that a claim fails to meet one required element, then the insurance carrier should not be required to investigate the other elements of the presumption since, generally, a claimant must meet all elements for a presumption to apply. Further, the commenter asserts that the reference to "each element" obligates an insurance carrier to expend unnecessary time and resources during the course of an investigation. The commenter recommended that DWC revise the rule to remove "each element of the applicable statutory presumption" and replace it with "the applicability of the statutory presumption."

Response: DWC agrees in part. Per §415.002 (relating to Administrative Violation by Insurance Carrier), insurance carriers are expected to process claims "promptly in a reasonable and prudent manner" and not misrepresent "the reasons for not paying benefits." DWC also notes that SB 2551 amended §415.021 to require DWC to consider, when determining whether to assess an administrative violation, whether the insurance carrier "applied the statutory presumptions under Subchapter B" among other factors. As such, it is the insurance carrier's responsibility to conduct a proper investigation when it receives a written notice of injury, apply any applicable presumptions under Subchapter B, and to accordingly initiate or deny benefits.

In addition, §409.022(b) and (c) require an insurance carrier to have reasonable grounds for not paying benefits and to communicate those reasons as part of its decision to not pay benefits. If an insurance carrier chooses not to evaluate the applicability of a statutory presumption holistically and bases its determination on only one element of the presumption, then the insurance carrier risks limiting its ability to later argue other reasons why the presumption should not apply. However, to keep the language of §124.3(g) consistent with the language of §415.021, DWC agrees to make the recommended change.

Comment: One commenter asserted that Rule 124.3(g)(1) is contrary to statutory language in §607.052 and unnecessary. More specifically, the assertion is that the presumption applies only to a first responder who affirmatively seeks benefits. The

commenter further asserted that a statutory presumption applies "regardless of an assertion of its applicability."

Response: DWC appreciates the comment but disagrees that there is a conflict between the requirements of §607.052 and Rule 124.3(g)(1). The requirement for a first responder to seek benefits or claim compensation is distinct from the applicability of a presumption. A statutory presumption applies regardless of whether it is asserted. DWC also disagrees that this rule should be deleted and continues to believe that system participants would benefit from the rule.

Last, if a first responder "seeks benefits or compensation for a disease or illness covered by [Subchapter B]," as described under §607.052(a)(3), they have made a claim for all of the benefits available under Subchapter B, triggering any available presumption. *See* §409.021(a-3). Any other interpretation would be contrary to the plain meaning of the Act and Subchapter B. *See also* our response to the comment on Rule 124.2(g), regarding "claim for benefits." No change was made in response to this comment.

STATUTORY AUTHORITY

The adopted rules are authorized by Texas Labor Code §§402.00111, 402.00116, 402.00128, 402.021, 402.061, 409.013, 409.021, 409.022, 414.002, and 415.021; Government Code §607.052 and §607.058; and SB 2551 §9.

Section 402.00111(a) provides that the commissioner of workers' compensation "shall exercise all executive authority, including rulemaking authority under [the Act]."

Section 402.00116 provides that the commissioner is the chief executive and administrative officer of the agency with all the powers and duties vested under the Act.

Section 402.00128 describes the general powers and duties of the commissioner, including assessing and enforcing penalties, prescribing the form, manner, and procedure for the transmission of information to DWC, and exercising other powers and duties as necessary to implement and enforce the Act.

Section 402.021 provides that a basic goal of the Texas workers' compensation system is that each employee shall be treated with dignity and respect when injured on the job and that it is the intent of the Legislature that the workers' compensation system must minimize the likelihood of disputes and resolve them promptly and fairly when identified and effectively educate and clearly inform each system participant of their rights and responsibilities under the system and how to appropriately interact within the system.

Section 402.061 provides that "[t]he commissioner shall adopt rules as necessary for the implementation and enforcement of [the Act]."

Section 409.013 authorizes DWC to develop plain language information to provide the public with information on the benefit process and compensation procedures.

Section 409.021(a) sets forth the general rule that "[n]ot later than the 15th day after the date on which an insurance carrier receives written notice of injury, the insurance carrier shall [either]: (1) begin payment of benefits as required by [the Act]; or (2) notify the division and the employee in writing of its refusal to pay and [their procedural rights]." Section 409.021(a-3) provides that "[a]n insurance carrier is not required to comply with Subsection (a) if the claim results from an injured employee's disability or death for which a presumption is claimed to be applicable under Subchapter B … and, not later than the 15th day after the date on which the insurance carrier received written notice of the injury, the insurance carrier has provided the employee and the division with a notice that describes all steps taken by the insurance carrier to investigate the injury. Section 409.021(a-3) also requires the commissioner to adopt rules as necessary to implement that subsection. Section 409.021(d) provides that "[a]n insurance carrier may reopen the issue of the compensability of an injury if there is a finding of evidence that could not reasonably have been discovered earlier."

Section 409.022(c) provides that "[a]n insurance carrier commits an administrative violation if the insurance carrier does not have reasonable grounds for a refusal to pay benefits, as determined by the commissioner. Section 409.022(d) provides that, "if an insurance carrier's notice of refusal to pay benefits under Section 409.021 is sent in

response to a claim for compensation resulting from [a first responder's] disability or death for which a presumption is claimed to be applicable under Subchapter B, … the notice must include a statement by the insurance carrier that: (1) explains why the carrier determined a presumption under that subchapter does not apply to the claim for compensation; and (2) describes the evidence that the carrier reviewed in making the determination described by Subdivision (1)."

Section 414.002 provides that DWC shall monitor the system for compliance with the Act and rules as well as other laws relating to workers' compensation.

Section 415.021(c-2) provides that "[i]n determining whether to assess an administrative penalty involving a claim in which the insurance carrier provided notice under Section 409.021(a-3), the commissioner shall consider whether: (1) the employee cooperated with the insurance carrier's investigation of the claim; and (2) the employee timely authorized access to the applicable medical records."

Government Code §607.052(a) provides that "[n]otwithstanding any other law, this subchapter applies only to a firefighter, peace officer, or [EMT] who: (1) on becoming employed or during employment as a firefighter, peace officer, or [EMT], received a physical examination that failed to reveal evidence of the illness or disease for which benefits or compensation are sought using a presumption established by this subchapter; (2) is employed for five or more years as a firefighter, peace officer, or

[EMT]; and (3) seeks benefits or compensation for a disease or illness covered by this subchapter that is discovered during employment as a firefighter, peace officer, or [EMT]."

Section 607.052(b) provides that "[a] presumption under this subchapter does not apply: (1) to a determination of a survivor's eligibility for benefits under Chapter 615; (2) in a cause of action brought in a state or federal court except for judicial review of a proceeding in which there has been a grant or denial of employment-related benefits or compensation; (3) to a determination regarding benefits or compensation under a life or disability insurance policy purchased by or on behalf of the firefighter, peace officer, or [EMT] that provides coverage in addition to any benefits or compensation required by law; or (4) if the disease or illness for which benefits or compensation is sought is known to be caused by the use of tobacco and: (A) the firefighter, peace officer, or [EMT] is or has been a user of tobacco; or (B) their spouse has, during the marriage, been a user of tobacco that is consumed through smoking."

Section 607.058(a) provides that "[a] presumption under §§607.053, 607.054, 607.055, or 607.056 may be rebutted through a showing by a preponderance of the evidence that a risk factor, accident, hazard, or other cause not associated with the individual's service as a firefighter, peace officer, or [EMT] was a substantial factor in bringing about the individual's disease or illness, without which the disease or illness would not have occurred." Subsection (b) provides that "[a] rebuttal offered under [§607.058] must

include a statement by the person offering the rebuttal that describes, in detail, the evidence that the person reviewed before making the determination that a cause not associated with the individual's service as a firefighter, peace officer, or [EMT] was a substantial factor in bringing about the individual's disease or illness without which the disease or illness would not have occurred."

Finally, §9 of SB 2551 requires that the commissioner adopt rules as required by or necessary no later than January 1, 2020.

The adopted amendments support implementation of the Workers' Compensation Act, Labor Code Title 5, Subtitle A

Chapter 124. Insurance Carriers: Required Notices and Mode of Payment

§124.2. Insurance Carrier Reporting and Notification Requirements

(a) An insurance carrier shall notify the division and the claimant of actions taken on or events occurring in a claim as required by this title.

(b) The division shall prescribe the form, format, and manner of required electronic submissions through publications such as advisory(ies), instructions, specifications, the Texas Electronic Data Interchange Implementation Guide, and trading partner agreements. Trading partners will be responsible for obtaining a copy of the International Association of Industrial Accident Boards and Commissions (IAIABC) Electronic Data Interchange Implementation Guide.

(c) The insurance carrier shall electronically file, as that term is used in §102.5(e) of this title (concerning General Rules for Written Communications to and from the Commission), with the division:

(1) the information from the original Employer's First Report of Injury; the insurance carrier's Federal Employer Identification Number (FEIN); and the policy number, policy effective date, and policy expiration date reported under §110.1 of this title (concerning Insurance Carrier Requirements for Notifying the Division) for the employer associated with the claim, not later than the seventh day after the later of:

(A) receipt of a required report where there is lost time from work or an occupational disease; or

(B) notification of lost time if the employer made the Employer's First Report of Injury prior to the employee experiencing absence from work as a result of the injury;

(2) any correction of division-identified errors in a previously accepted electronic record as provided in §102.5(e) of this title. (Correction);

(3) information regarding a compensable death with no beneficiary (Compensable Death No Beneficiaries/Payees) not later than the 10th day after determining that an employee whose injury resulted in death had no legal beneficiary; and

(4) a change in an electronic record initiated by the insurance carrier (Change), the coverage information required by paragraph (1) of this subsection if not

available when the First Report of Injury was submitted to the division and any change in a claimant or employer mailing address within seven days of receipt of the new address.

(d) The insurance carrier shall notify the division and the claimant of a denial of a claim (Denial) based on non-compensability or lack of coverage in accordance with this section and as otherwise provided by this title.

(e) The insurance carrier shall notify the division and the claimant of the following:

(1) first payment of indemnity benefits on a claim (Initial Payment) within 10 days of making the first payment;

(2) change in the net benefit payment amount caused by a change in the employee's post-injury earnings (Reduced earnings) within ten days of making the first payment reflecting the change;

(3) change in the net benefit payment amount that was not caused by a change in employee's post-injury earnings, this includes but is not limited to subrogation, attorney fees, advances, and contribution (Change in Benefit Amount), and the notice must be made within 10 days of making the first payment which reflects the change;

(4) change from one income benefit type to another or to death benefits (Change in Benefit Type) within 10 days of making the first payment reflecting the change;

(5) resumption of payment of income or death benefits (Reinstatement of Benefits) within 10 days of making the first payment;

(6) termination or suspension of income or death benefits (Suspension) within 10 days of making the last payment for the benefits; or

(7) employer continuation of salary equal to or exceeding the employee's Average Weekly Wage as defined by this title (Full Salary) within:

(A) seven days of receipt of the Employer's First Report of Injury or a Supplemental Report of Injury (if the report included information that salary would be continued) if the insurance carrier has not initiated temporary income benefits; or

(B) 10 days of making the last payment of temporary income benefits due to the employer's continuation of full salary.

(f) If an insurance carrier receives a written notice of injury for a disease or illness identified by Texas Government Code, Chapter 607, Subchapter B (relating to Diseases or Illnesses Suffered by Firefighters, Peace Officers, or Emergency Medical Technicians), the insurance carrier shall take one of the following actions no later than the 15th day following receipt of the notice of injury:

(1) initiate benefits as required by the Workers' Compensation Act and the division's rules;

(2) file a notice of denial as described in this section; or

(3) provide the claimant and the division with notice as required under Labor Code §409.021(a-3) (Notice of Continuing Investigation) for a claim for benefits received on or after June 10, 2019.

(g) When applying subsection (f) of this section and Government Code, Chapter 607, Subchapter B, a "claim for benefits" means the first written notice of injury as provided in §124.1 of this title (concerning Notice of Injury).

(h) The insurance carrier shall issue a Notice of Continuing Investigation as a plain language notice in the form and manner prescribed by the division. The notification requirements of this section are not considered complete until a copy of the notice provided to the claimant is received by the division.

(1) A Notice of Continuing Investigation shall include the following:

(A) a statement describing all steps taken by the insurance carrier to investigate the disease or illness before the notice was given;

(B) a list of any claim-specific evidence, releases, or documentation the insurance carrier reasonably believes is both relevant and necessary to complete its investigation; and

(C) contact information for the adjuster, including the adjuster's email address, facsimile number, and telephone number.

(2) An insurance carrier shall provide a reasonable amount of time for a claimant to respond to the notice.

(3) The notice may not include a request for additional diagnostic testing, mental health records, generic requests (such as "the claimant's medical records"), or requests for records that are not directly related to either the disease or illness or eligibility for application of a statutory presumption.

(4) Notwithstanding the issuance of a Notice of Continuing Investigation, an insurance carrier must continue taking reasonable steps to acquire claim-specific information necessary to complete its investigation of the claim.

(i) Notification to the claimant as required by subsections (d)-(h) of this section requires the insurance carrier to use plain language notices in the form and manner prescribed by the division. These notices shall provide a full and complete statement describing the insurance carrier's action and rationale. The statement must contain sufficient claim-specific substantive information to enable the claimant to understand the insurance carrier's position or action taken on the claim. A generic statement that simply states the insurance carrier's position with phrases such as "employee returned to work," "adjusted for light duty," "liability is in question," "compensability in dispute," "under investigation," or other similar phrases with no further description of the factual basis for the action taken does not satisfy the requirements of this section.

(j) In addition to the denial notice requirements in subsection (i), if the insurance carrier receives a written notice of injury for a disease or illness identified by Texas Government Code, Chapter 607, Subchapter B (relating to Diseases or Illnesses Suffered by Firefighters, Peace Officers, or Emergency Medical Technicians), the denial must also include the following:

(1) If the insurance carrier asserts that a statutory presumption does not apply, a statement explaining why and describing the claim-specific information that the insurance carrier reviewed.

(2) Alternatively, based upon its investigation, if the insurance carrier concludes that a statutory presumption applies, but that a notice of denial will be issued, a statement explaining why and describing the claim-specific information reviewed prior to issuance of the notice, that supports a reasonable belief that risk factors, accidents, hazards, or other causes not associated with their employment were a substantial factor in bringing about the injured employee's disease or illness, without which the disease or illness would not have occurred.

(3) If the insurance carrier provided a timely Notice of Continuing Investigation as permitted by law, the denial notice must also include a statement describing whether the claimant provided a timely response to the notice.

(k) Notification to the division as required by subsections (c)–(h) of this section requires the insurance carrier to use electronic filing, as that term is used in §102.5(e) of this title (concerning General Rules for Written Communications to and from the Commission).

(1) In addition to the electronic filing requirements of this subsection, when an insurance carrier notifies the division of a denial as required by this section, it must provide the division a written copy of the notice provided to the claimant as described under subsections (i) – (j) of this section, as applicable.

(2) The notification requirements of this section are not considered completed until the copy of the notice provided to the claimant is received by the division.

(l) Notification to the division and the claimant of a dispute of disability, extent of injury, or eligibility of a claimant to receive death benefits shall be made as otherwise prescribed by this title and requires the insurance carrier to use plain language notices

in the form and manner prescribed by the division. These notices shall provide a full and complete statement describing the insurance carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the claimant to understand the insurance carrier's position or action taken on the claim. A generic statement that simply states the insurance carrier's position with phrases such as "no medical evidence to support disability," "not part of compensable injury," "liability is in question," "under investigation," "eligibility questioned," or other similar phrases with no further description of the factual basis for the action taken does not satisfy the requirements of this section.

(m) The division shall send an acknowledgment to the transmitting trading partner detailing whether an electronically submitted record was accepted, accepted with errors, or rejected. The acknowledgment shall be provided directly to the trading partner submitting the transmission, not through the Austin representative box identified in §102.5 of this title. If the record was accepted with errors in conditional elements, the insurance carrier must correct the errors in accordance with §102.5 of this title.

(n) Except as otherwise provided by this title, insurance carriers shall not provide notices to the division that explain that:

(1) benefits will be paid as they accrue;

(2) a wage statement has been requested;

(3) temporary income benefits are not due because there is no lost time;

(4) the insurance carrier is disputing some or all medical treatment as not reasonable or necessary;

(5) compensability is not denied but the insurance carrier disputes the existence of disability (if there are no indications of lost time or disability and the employee is not claiming disability); or

(6) future medical benefits are disputed (notices of which shall not be provided to anyone in the system).

(o) Written requests for a waiver of the electronic filing requirement for the Employer's First Report of Injury may be submitted to the commissioner or their designee for consideration. Waivers must be requested at least annually, and the requests must include a justification for the waiver, the volume of the insurance carrier's claims and total premium amounts, current automation capabilities, Electronic Data Interchange (EDI) programming status, and a specific target date to implement EDI. Waivers require written approval and shall be granted at the discretion of and for the time frame noted by the commissioner or their designee.

(p) If specifically directed by the division, such as through division advisory or the Texas Electronic Data Interchange Guide, the insurance carrier may provide the information required in subsection (c)–(g) of this section to the division in hardcopy or paper format.

(q) Notifications to the claimant and the claimant's representative shall be filed by facsimile or electronic transmission unless the recipient does not have the means to receive such a transmission in which case the notifications shall be personally delivered or sent by mail.

(r) Each insurance carrier shall provide to the division, through its Austin representative in the form and manner prescribed by the division, the contact information for all

workers' compensation claim service administration functions performed by the insurance carrier either directly or through third parties.

(1) The contact information for each function shall include mailing address, telephone number, facsimile number, and email address as appropriate. This contact information may be provided either in the form of a single Uniform Resource Locator (URL) for a web page created and maintained by the insurance carrier that contains the required information or through an online submission to the division.

(A) Coverage verification (policy issuance and effective dates of policy);

(B) Claim adjustment;

(C) Medical billing;

(D) Pharmacy billing (if different from medical billing); and

(E) Preauthorization.

(2) If the web page option is used the page shall contain the date on which it was last updated and an email address or other contact information to which a user may report problems or inaccuracies.

(3) The insurance carrier shall update the contact information or URL within 10 working days after any such change is made.

(s) All notices to a claimant required under this section must be stated in plain language and in no less than 12-point font. This subsection applies to notices sent on or after April 1, 2020.

§124.3. Investigation of an Injury and Notice of Denial or Dispute

(a) Except as provided in subsection (b) of this section, upon receipt of written notice of injury as provided in §124.1 of this title (relating to Notice of Injury) the insurance carrier shall conduct an investigation relating to the compensability of the injury, the insurance carrier's liability for the injury, and the accrual of benefits. If the insurance carrier believes that it is not liable for the injury or that the injury was not compensable, the insurance carrier shall file the notice of denial of a claim (Notice of Denial) in the form and manner required by Labor Code §409.022 (relating to Refusal to Pay Benefits; Notice; Administrative Violation) and §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements).

(1) If the insurance carrier does not file a Notice of Denial by the 15th day after receipt of the written notice of injury or does not file a Notice of Continuing Investigation as described under Labor Code §409.021(a-3) (relating to Initiation of Benefits; Insurance Carrier's Refusal; Administrative Violation), the insurance carrier is liable for any benefits that accrue and shall initiate benefits in accordance with this section.

(2) If the insurance carrier files a Notice of Denial after the 15th day but on or before the 60th day after receipt of written notice of the injury:

(A) The insurance carrier is liable for and shall pay all income benefits that had accrued and were payable prior to the date the insurance carrier filed the Notice of Denial and only then is it permitted to suspend payment of benefits; and

(B) The insurance carrier is liable for and shall pay for all medical services, in accordance with the Act and rules, provided prior to the filing of the Notice of Denial.

(3) The insurance carrier shall not file notice with the division that benefits will be paid as and when they accrue with the division.

(4) An insurance carrier's failure to file a Notice of Denial or a Notice of Continuing Investigation by the 15th day after it receives written notice of an injury constitutes the insurance carrier's acceptance of the claim as a compensable injury, subject to the insurance carrier's ability to contest compensability on or before the 60th day after receipt of written notice of the injury. In the event of such a failure, the insurance carrier is liable for and shall pay all income and medical benefits that have accrued or become payable, subject to the insurance carrier's right to contest compensability on or before the 60th day.

(5) The insurance carrier commits an administrative violation if, not later than the 15th day after it receives written notice of the injury, it does not begin to pay benefits as required, file a Notice of Denial of the compensability of a claim, or file a Notice of Continuing Investigation in the form and manner required by §124.2 of this title. The division will send periodic notifications to all insurance carriers regarding the amount of penalties owed and the proper way to submit and document the payments.

(b) Except as provided by subsection (c), the insurance carrier waives the right to contest compensability of or liability for the injury, if it does not contest compensability on or before the 60th day after the date on which the insurance carrier receives written notice of the injury.

(c) If the insurance carrier wants to deny compensability of or liability for the injury after the 60th day after it received written notice of the injury:

(1) the insurance carrier must establish that it is basing its denial on evidence that could not have reasonably been discovered earlier; and

(2) the insurance carrier is liable for and shall pay all benefits that were payable prior to and after filing the Notice of Denial until the division has made a finding that the evidence could not have been reasonably discovered earlier.

(d) If the claim involves the death of an injured employee, investigations, denials of compensability or liability, and disputes of the eligibility of a potential beneficiary to receive death benefits are governed by §132.17 of this title (concerning Denial, Dispute, and Payment of Death Benefits). Notwithstanding §132.17(f)(1) and (2) of this title, the insurance carrier may issue a Notice of Continuing Investigation in accordance with the provisions of §124.2(f) and this section.

(e) Notwithstanding §132.13 of this title (concerning Burial Benefits), if an insurance carrier has issued a Notice of Continuing Investigation in accordance with the provisions of §124.2(f) and this section, the insurance carrier shall either pay or deny a claim for burial benefits within seven days from the date the insurance carrier either initiated benefits or filed a notice of denial in accordance with §124.2(f) of this title.

(f) Labor Code §409.021 and subsection (a) of this section do not apply to disputes of extent of injury. If an insurance carrier receives a medical bill that involves treatment(s) or service(s) that the insurance carrier believes is not related to the compensable injury, the insurance carrier shall file a notice of dispute of extent of injury (notice of dispute). The notice of dispute shall be filed in accordance with §124.2 of this title and be filed not later than the earlier of:

(1) the date the insurance carrier denied the medical bill; or

(2) the due date for the insurance carrier to pay or deny the medical bill as provided in Chapter 133 of this title (concerning General Medical Provisions).

(g) If the insurance carrier receives a written notice of injury for a disease or illness identified by Texas Government Code, Chapter 607, Subchapter B (relating to Diseases or Illnesses Suffered by Firefighters, Peace Officers, and Emergency Medical Technicians), it shall investigate the applicability of the statutory presumption as well as compensability of the injury, liability for the injury, and the accrual of benefits.

(1) A claimant is not required to expressly claim the applicability of a statutory presumption in order for the statutory presumption to apply.

(2) A presumption under Government Code, Chapter 607, Subchapter B, is claimed upon an insurance carrier's receipt of a written notice of injury which identifies:

(A) the injured or deceased employee's occupation as a firefighter, peace officer, or emergency medical technician, and

(B) the injured or deceased employee's disease or illness is a medical condition identified by Subchapter B.

(3) A determination that the statutory presumption does not apply does not relieve the insurance carrier of its continuing obligation to conduct a reasonable investigation relating to the compensability of the injury, liability for the injury, and accrual of benefits.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December _____, 2019.

_____

Cassie Brown
Commissioner
Texas Department of Insurance, Division of Workers' Compensation