Texas Workers' Compensation Rules
Texas Administrative Code
Title 28, Chapters 102-180

The Texas Department of Insurance, Division of Workers' Compensation (DWC) is providing these rules as a courtesy. While we make every effort to ensure the information is accurate and complete, the official versions of adopted rules are filed with the Secretary of State. Click here to go to 28 TAC Part 2.

If you have any questions, please contact DWC Legal Services at 512-804-4703 or email RuleComments@tdi.texas.gov.

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 102	PRACTICES AND PROCEDURES--GENERAL PROVISIONS

RULE §102.2 Gifts, Grants, and Donations

(a) The division may accept and use gifts, grants, and donations in accordance with applicable law, including the Labor Code and the Government Code.

(b) On receiving a gift, grant, or donation of $500 or more, the division will post on the public website for at least five years from the date it was received:
(1) The date the division received the gift, grant, or donation.
(2) The identity of the donor.
(3) The amount of the gift, grant, or donation.
(4) If applicable, the stated purpose of the gift, grant, or donation.

(c) A donor may direct the use of the gift, grant, or donation in writing. The division will follow this direction as nearly as practicable, and in accordance with state and federal law.

(d) The division may not accept a gift or donation of $500 or more from a person who is a party to a contested case before the agency until the 30th day after the decision in the case becomes final under §2001.144 of the Texas Government Code. For purposes of this rule, "contested case" has the meaning assigned by §2001.003 of the Texas Government Code.

Source Note: The provisions of this §102.2 adopted to be effective January 1, 1991, 15 TexReg 6746; amended to be effective December 2, 1997, 22 TexReg 11691; amended to be effective March 13, 2000, 25 TexReg 2078; amended to be effective July 11, 2024, 49 TexReg 4920

RULE §102.3 Computation of Time

(a) Due dates and time periods under this Act shall be computed as follows:
(1) computing a period of days. In counting a period of time measured by days, the first day is excluded and the last day is included.
(2) computing a period of months. If a number of months is to be computed by counting the months from a particular day, the period ends on the same numerical day in the concluding month as the day of the month from which the computation is begun,

unless there are not that many days in the concluding month, in which case the period ends on the last day of that month.
(3) unless otherwise specified, if the last day of any period is not a working day, the period is extended to include the next day that is a working day.

(b) A working day is any day, Monday-Friday, other than a national holiday as defined by Texas Government Code, §662.003(a) and the Friday after Thanksgiving Day, December 24th and December 26th. Use in this title of the term "day," rather than "working day" shall mean a calendar day.

(c) Normal business hours in the Texas workers' compensation system are 8:00 a.m. to 5:00 p.m. Central Standard Time with the exception of the Commission's El Paso field office whose normal business hours are 8:00 a.m. to 5:00 p.m. Mountain Standard Time.

(d) Any written or telephonic communications received other than during normal business hours on working days are considered received at the beginning of normal business hours on the next working day.

(e) Unless otherwise specified by rule, any written or telephonic communications required to be filed by a specified time will be considered timely only if received prior to the end of normal business hours on the last permissible day of filing.

(f) If there is a conflict between this rule and a specific provision of another rule that is applicable to a specific type of benefit, the other rule prevails.

Source Note: The provisions of this §102.3 adopted to be effective January 1, 1991, 15 TexReg 6747; amended to be effective August 29, 1999, 24 TexReg 6488; amended to be effective April 28, 2005, 30 TexReg 2396

RULE §102.4 General Rules for Non-Division Communications

(a) All written communications to a claimant (who is either an employee, an employee's legal beneficiary, or a subclaimant) must be sent to the most recent address or fax number supplied by the claimant. If an address has not been supplied by the claimant, the most recent address provided by the employer must be used.

(b) After an insurance carrier, employer, or health care provider is notified in writing that a claimant is represented by an attorney or other representative, copies of all written communications related to the claim or to the claimant must be mailed or

delivered to the representative as well as the claimant, unless the claimant requests delivery to the representative only.

(c) Insurance carriers must provide a toll-free telephone number for receipt of communication from claimants or their representatives with a sufficient quantity of lines to service their volume of business.

(d) Insurance carriers and health care providers must provide telephone numbers, fax numbers, and email addresses sufficient to service the volume of business for receiving required verbal and written communications on workers' compensation claims.

(e) Insurance carriers must ensure effective and timely communication with claimants and other parties in the system. If a claimant is unable to communicate with an insurance carrier due to a language barrier, and the claimant is unable to provide a person that he or she trusts to serve as a translator, the insurance carrier must provide a means to translate except as needed for a division proceeding. The claimant must not be required to contract with or otherwise employ a translator.

(f) When a claimant contacts an insurance carrier and requests a response on their claim, the response must be verbally provided or sent in writing by the insurance carrier within five working days of receiving the request, unless the request is redundant or the response duplicates information previously provided.

(g) Insurance carriers must employ or provide a sufficient number of personnel, including adjusters appropriately licensed by the Texas Department of Insurance, to meet their obligations under the Act and this title.

(h) Unless the great weight of evidence indicates otherwise, written communications will be deemed to have been sent on:
(1) the date received if sent by fax, personal delivery, or electronic transmission; or
(2) the date postmarked if sent by mail through United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent must be the next previous day that is not a Sunday or legal holiday.

(i) An insurance carrier must maintain adjuster's notes on activities and verbal communications involved with the administration of a claim, with the exception of privileged attorney-client communications. The adjuster's notes must, at a minimum, include the date of the activity or communication, the identity of the insurance carrier

staff involved in the contact, the person contacted by or contacting the insurance carrier, and a summary of the activity or communication.

(j) An insurance carrier, employer, or health care provider that receives a written communication related to a workers' compensation claim must date stamp or otherwise note on the document the date the written communication was received.

(k) Written communications include all records, reports, notices, filings, submissions, and other information contained either on paper or in an electronic format.

(l) For purposes of this title, if a written communication is required to be filed with both the division and another person by the Act or division rules, the other person will be presumed to have received the written communication on the date the division received its copy, unless the other person noted the date of receipt as provided in subsection (j) of this section, or the means of delivery of the communication was different. In this situation, the other person has the burden of proving that they did not receive or timely receive the written communication.
(m) Electronic transmission is defined as transmission of information by fax, electronic mail, electronic data interchange (EDI), or any other similar method and does not include telephonic communication.

(n) If the division receives an allegation that an insurance carrier or health care provider has failed to provide sufficient toll-free telephone numbers, telephone numbers, fax numbers, or email addresses, or that an insurance carrier has not provided a sufficient number of adjusters as required by this section, unless the violation appears to be willful or intentional, the division will not issue a monetary penalty or other sanctions before:
(1) notifying the alleged violator of the allegation;
(2) affording the alleged violator the opportunity to either disprove the allegation or provide mitigating information; and
(3) if the violator is unable to disprove the allegation, issuing a written warning to the violator allowing a reasonable grace period of not less than 30 days to correct the noncompliance. The grace period may be less than 30 days if the noncompliance prevents the violator from fulfilling other obligations under this title.

(o) A violation as described in subsection (n) will be considered willful or intentional if the violator has been advised of complaints such that the violator knew or should have known that the toll-free telephone numbers, telephone numbers, fax numbers, email addresses, or number of adjusters was insufficient, and the violator cannot establish

that it made good faith efforts to correct the deficiency or if the violator otherwise exhibited willful or intentional conduct.

(p) For purposes of determining the date of receipt for non-division written communications, unless the great weight of evidence indicates otherwise, the division will deem the received date to be five days after the date mailed through United States Postal Service regular mail, or the date faxed or electronically transmitted.

(q) This section is effective on adoption.

Source Note: The provisions of this §102.4 adopted to be effective January 11, 1991, 16 TexReg 114; amended to be effective August 29, 1999, 24 TexReg 6488; amended to be effective April 28, 2005, 30 TexReg 2396; amended to be effective March 9, 2022, 47 TexReg 1093

RULE §102.5 General Rules for Written Communications to and from the Division

(a) After the division is notified in writing that a claimant is represented by an attorney or other representative, all copies of written communications to the claimant will be sent to the representative as well as the claimant. Copies of settlements, notices setting benefit review conferences and hearings, and orders of the division will always be sent to the claimant regardless of representation status. All written communications to the claimant or claimant's representative will be sent to the most recent address or fax number supplied on either the employer's first report of injury, any verbal or written communication from the claimant, or any claim form filed by the insurance carrier through written notice or electronic transmission.

(b) All written communications to people other than insurance carriers and claimants will be sent to the most recent address or fax number reported to the division by the intended recipient or, in the absence of an address or fax number supplied by the intended recipient, to an address or fax number identified by the division.

(c) Unless otherwise specified by rule, written communications required to be filed with the division may be sent to the division headquarters or any division field office.

(d) For purposes of determining the date of receipt for written communications sent by the division, which require the recipient to perform an action by a specific date after receipt unless the great weight of evidence indicates otherwise, the division will deem the received date to be the earliest of: five days after the date mailed through United States Postal Service regular mail, the first working day after the date the written

communication was placed in an insurance carrier's Austin representative's electronic box, or the date faxed or electronically transmitted as defined in subsection (h) of this section.

(e) EDI and other required notices must be filed or submitted in the format, form, and manner prescribed by the division under §124.2 of this title (concerning Insurance Carrier Notification Requirements), and Chapter 134, Subchapter I of this title (concerning Medical Bill Reporting).

(f) Unless the great weight of evidence indicates otherwise, written communications received by the division will be deemed to have been sent on:
(1) the date received if sent by fax, personal delivery, or electronic transmission; or
(2) the date postmarked if sent by United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent will be the next previous day that is not a Sunday or legal holiday.

(g) Written communications include all records, reports, notices, filings, submissions, and other information contained either on paper or in an electronic format.

(h) Electronic transmission is defined as transmission of information by fax, electronic mail, EDI, or any other similar method and does not include telephonic communication.

(i) Subsection (e) is effective July 26, 2023. All other subsections are effective on adoption.

Source Note: The provisions of this §102.5 adopted to be effective July 29, 1991, 16 TexReg 3939; amended to be effective March 15, 1995, 20 TexReg 1418; amended to be effective August 29, 1999, 24 TexReg 6488; amended to be effective April 28, 2005, 30 TexReg 2396; amended to be effective March 9, 2022, 47 TexReg 1093

RULE §102.7 Abbreviations

When used in this title, the following terms may be abbreviated as follows:
(1) Additional Lost Time - ALT;
(2) Average Weekly Wage - AWW;
(3) Benefit Review Conference - BRC;
(4) Contested Case Hearing (also Benefit Contested Case Hearing) - CCH.
(5) Death Benefits - DBs;

(6) Texas Department of Insurance, Division of Workers' Compensation - division or DWC;
(7) Electronic Data Interchange - EDI
(8) Health Care Provider - provider or HCP;
(9) Impairment Income Benefits - IIBs;
(10) Impairment Rating - IR;
(11) Injured Employee - employee;
(12) Insurance Carrier - carrier;
(13) Lifetime Income Benefits - LIBs;
(14) Maximum Medical Improvement - MMI;
(15) Office of Injured Employee Counsel - OIEC;
(16) Post Injury Earnings (also Weekly Earnings After the Injury) - PIE;
(17) Required Medical Exam - RME;
(18) Return to Work - RTW;
(19) Supplemental Income Benefits - SIBs;
(20) Temporary Income Benefits - TIBs;
(21) Texas Workers' Compensation Act - the Act or the Statute; and
(22) Texas Workers' Compensation Commission - TWCC or the Commission.

Source Note: The provisions of this §102.7 adopted to be effective August 29, 1999, 24 TexReg 6488; amended to be effective January 7, 2019, 44 TexReg 98

RULE §102.8 Information Requested on Written Communications to the Division

(a) Unless the division-prescribed form, format, or manner of a written communication specifies otherwise, all written communications to the division about an injured employee or claim for benefits must include the following information, if known:
(1) the injured employee's full name, date of injury, address, and Social Security number. If no Social Security number has been assigned, insert the numerical digits "999" followed by the claimant's birth date or if unknown, the claimant's date of injury listed by the month, day, and year (MMDDYY). Do not use "999" in place of a valid Social Security number to meet timeliness of reporting requirements;
(2) the name and address of the claimant, if other than the injured employee;
(3) the workers' compensation number assigned to the claim by the division;
(4) the employer's name and address;
(5) the employer's Federal Employer's Identification Number;
(6) the insurance carrier's name;
(7) the insurance carrier's policy number; and
(8) the insurance carrier's claim number.

(b) Written communications filed by claim EDI under §124.2 of this title (concerning Insurance Carrier Notification Requirements) must comply with the requirements of Chapter 124, Subchapter B of this title (concerning Insurance Carrier Claim Electronic Data Interchange Reporting to the Division).

(c) Subsection (a) is effective on adoption. Subsection (b) is effective July 26, 2023.

Source Note: The provisions of this §102.8 adopted to be effective October 1, 1992, 17 TexReg 6361; amended to be effective March 15, 1995, 20 TexReg 1418; amended to be effective August 29, 1999, 24 TexReg 6488; amended to be effective December 12, 2013, 38 TexReg 8910; amended to be effective March 9, 2022, 47 TexReg 1093

RULE §102.9 Submission of Information Requested by the Commission

(a) In addition to information required by the Act or Commission rules, the Commission shall require those subject to the Act to provide information at such times and in such manner and format as necessary to effectively and efficiently administer the Act or Commission rules. This request for information shall:
(1) be communicated by telephone, electronically, or in writing;
(2) inform the participant of:
(A) where the information is to be sent;
(B) when the information must be submitted; and
(C) the specific information to be submitted.

(b) If the request for information is communicated by telephone, the request must be followed up in writing before any order is issued pursuant to subsection (e) of this section.

(c) Upon receipt of the request for information from the Commission, those subject to the Act will have a reasonable period of time to provide the requested information to the Commission considering factors that include:
(1) accessibility of the information;
(2) amount of information requested;
(3) any other circumstances affecting the person's ability to supply the requested information, such as the format in which the information is required to be provided.

(d) In the absence of an emergency, the reasonable period for responding to the request for information shall not be less than one day if the requested information is needed to administer a benefit issue on a claim. For other requested information, the reasonable period for response shall not be less than three working days.

(e) Failure to provide the information may result in a written order requested and issued by staff designated by the Executive Director to issue an order to produce the information. The written order shall be mailed through certified mail, return receipt requested, sent by personal delivery with receipt acknowledged, or for a carrier, placed in an Austin Representative Box with receipt acknowledged. A person receiving a written communication from the Commission which requests receipt acknowledgment shall accept and acknowledge receipt including the date of receipt in the manner prescribed by the Commission.
(f) Nothing in this section limits the authority of the Executive Director to enter orders pursuant to the Act.

Source Note: The provisions of this §102.9 adopted to be effective April 1, 1993, 18 TexReg 1357; amended to be effective March 15, 1995, 20 TexReg 1418; amended to be effective August 29, 1999, 24 TexReg 6488

RULE §102.10 Interest, General

Unless otherwise specified by law, the term "interest" when applied to workers' compensation benefits shall mean simple interest (interest computed on the same amount of principal for each interest period).

Source Note: The provisions of this §102.10 adopted to be effective March 14, 2001, 26 TexReg 2031

RULE §102.11 Electronic Formats for Electronic Claim Data Request and Report

(a) The Division prescribes standard electronic formats by utilizing implementation guides for data requests and data reports for the purpose of exchanging data between the Division and insurance carriers, as defined in Labor Code §402.084.

(b) In this section, the following definitions apply:
(1) Claim Data Request and Report Implementation Guide (Guide)--The division specification document for the Claim Data Request and the Claim Data Report that defines specific data requirements, data set transactions, data mapping, data edits, and fees per record available at www.tdi.texas.gov/wc.
(2) Claim Data Report--The electronic report generated by the Division in the format specified by the Guide. The report contains data for claims meeting confidence match criteria defined in the Guide.
(3) Claim Data Request--The electronic request submitted by a requester in the format specified by the Division in the Guide.

(4) Record--An electronic representation of one insured person containing a set of unique identifiers including the full name, date of birth, gender, and social security number, if available. Each set of individual identifiers included in a Claim Data Request represents a separate record.
(5) Requester--An insurance carrier that has adopted an antifraud plan under Labor Code §402.084(b)(8) and qualifies as an insurance carrier under Labor Code §402.084(c-1) or its authorized representative.

(c) A Claim Data Request must contain the following elements:
(1) all fields required in the applicable Guide as defined in subsection (b) of this section;
(2) complete, current, and correct values as described in the applicable Guide; and
(3) records of persons who are or were valid members of the requesters' benefit programs and whose claims may be related to a workers' compensation claim.

(d) A Claim Data Report must contain:
(1) all fields required in the applicable Guide; and
(2) complete, current, and correct values as described in the applicable Guide.

(e) A Claim Data Request may be submitted by a requester.

(f) The Division will match the records submitted by a requester against the Division's claim data using a matching methodology published in the Guide. The search will include all claims on record with the Division relating to injuries sustained on or after September 1, 2002. For each record submitted, the Division will report:
(1) the existence of a positive match with one or more workers' compensation claims; or
(2) the failure to match the record to any recorded workers' compensation claim.

(g) File transfers between requesters and the Division shall be sent using secured file transfer protocol (SFTP) with access controlled by a unique username and password.

(h) The data shall not be shared or disclosed to any other person or entity, except as necessary to document and pursue reimbursement with the appropriate workers' compensation carrier or claims administrator or through Division dispute resolution procedures. Requesters shall destroy all electronic or paper records related to Claim Data Requests that are not needed to pursue subclaimant status or recovery of reimbursement by an insurance carrier as defined by Labor Code §402.084(c-1).

(i) A requester may submit a Claim Data Request once every 30 days for each covered individual.
(j) Unless waived by the Division, the requester shall pay to the Division a fee for each record included in a request. The fee will be established in the Guide, but shall be no more than $.05 for each record included in the Claim Data Request. Claim Data Requests that include previously submitted requests for records would also be charged a fee of up to $.05 for each record.

(k) Prior to submitting a Claim Data Request, the requester shall execute a trading partner agreement with the Division in the form and manner prescribed by the Division. The trading partner agreement shall contain:
(1) a statement that the requester agrees to abide by all applicable federal and state laws and regulations;
(2) an agreement to submit only names and identifying information related to bona fide beneficiaries of the requester's benefit plans;
(3) an agreement to comply with Division standards for secure transfer and storage of workers' compensation claim information;
(4) an agreement to comply with Division standards regarding the confidentiality of workers' compensation claim information and the approved uses of that information; and
(5) an agreement to pay applicable fees.

(l) After a match of a record has been determined, the information may be used by the requester as the basis for identification and filing of a subclaim under Labor Code §409.009. When a match has been determined and a subclaim filed, the requester shall contact the injured employee who received the health care and is the subject of the subclaim. The requester shall provide the injured employee written notice, which includes the following:
(1) the name of the subclaimant;
(2) the dates of service;
(3) the name of the injured employee;
(4) a statement declaring, "As the injured employee in this matter, you will receive notice of all proceedings related to this matter and may participate in those proceedings. To determine whether to take any action in this matter, you may wish to consult with an attorney. You can also contact the Office of Injured Employee Counsel (OIEC) for ombudsman assistance."; and
(5) the phone number and website address of OIEC.

Source Note: The provisions of this §102.11 adopted to be effective December 31, 2006, 31 TexReg 10310; amended to be effective March 14, 2023, 48 TexReg 1450

TITLE 28 **INSURANCE**
PART 2 **TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION**
CHAPTER 104 **GENERAL PROVISIONS--RULE-MAKING**

RULE §104.1 Contents of Rulemaking Petitions

(a) Changes or additions to the Texas Administrative Code, Title 28, Part 2 may be petitioned by an interested person under Government Code, §2001.021(d). Rulemaking petitions shall be in the form of a letter that contains the following:
(1) a brief statement summarizing the proposed section;
(2) the text of the proposed section, in the exact form proposed for adoption;
(3) a statement setting forth the statutory reference that authorizes the proposed rule;
(4) a suggested effective date;
(5) any other matter which may be required by law;
(6) the petitioner's name, mailing address, and telephone number; and
(7) a statement that the petitioner is an interested person under Government Code, §2001.021(d).

(b) The petitioner may also include a cost-benefit analysis, estimating the public benefit expected as a result of adoption of the proposed section, and the probable economic cost to persons required to comply with the proposed section. This provision is optional.

(c) The petition shall be filed with the commissioner by personal delivery, certified mail, or by email to rulecomments@tdi.texas.gov.

(d) Within 60 days after the petition is submitted, the division shall either initiate rulemaking procedures, or shall deny the petition and provide the petitioner with reasons for denial in writing.

Source Note: The provisions of this §104.1 adopted to be effective March 18, 1991, 16 TexReg 1366; amended to be effective March 10, 2016, 41 TexReg 1711

TITLE 28 **INSURANCE**
PART 2 **TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION**
CHAPTER 109 **WORKERS' COMPENSATION COVERAGE FOR STATE EMPLOYEES**

RULE §109.1 State Agencies: General Provisions

(a) In administering and enforcing the applicable provisions of the Texas Labor Code as set out in §501.002, a state agency shall act in the capacity of employer.

(b) In administering and enforcing the applicable provisions of the Texas Labor Code as set out in §501.002, the State Office of Risk Management shall act in the capacity of insurance carrier.

(c) As an employer, each state agency shall file, in the form and manner prescribed by the Texas Workers' Compensation Commission (commission), a single administrative address with the commission for the purpose of administering workers' compensation claims. All workers' compensation claim notices or written communications to the agency as an employer will be sent to the agency's single administrative address, unless otherwise specified by rule. When the state agency's single administrative address changes, the sate agency shall submit the new address at least 30 days prior to the change, in the form and manner prescribed by the commission.

Source Note: The provisions of this §109.1 adopted to be effective February 2, 1996, 21 TexReg 511; amended to be effective October 9, 2002, 27 TexReg 9348

TITLE 28 **INSURANCE**
PART 2 **TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION**
CHAPTER 110 **REQUIRED NOTICES OF COVERAGE**

SUBCHAPTER A CARRIER NOTICES

RULE §110.1 Insurance Carrier Requirements for Notifying the Division of Insurance Coverage

(a) An approved workers' compensation insurance policy, as referenced in Labor Code §401.011(44)(A), includes a binder, which serves as evidence of a temporary agreement that legally provides workers' compensation insurance coverage until the approved insurance policy is issued or the binder is canceled.

(b) As used in this section, "workers' compensation insurance coverage information" includes information regarding whether or not an employer has workers' compensation insurance coverage and, if so, information about the method of workers' compensation insurance coverage used.

(c) This rule applies to an insurance company, certified self-insurer, workers' compensation self-insurance group under Labor Code Chapter 407A, and a political subdivision. Certified Self-Insurers are also subject to requirements specified in Chapter 114 of this title (relating to Self-Insurance). Self-Insurance Groups are also subject to requirements specified in Chapter 5, Subchapter G, Division 2 of this title (relating to Group Self-Insurance Coverage). Self-insured political subdivisions are also subject to requirements specified in §110.7 of this title (relating to Self-Insured Political Subdivision Requirements for Notifying the Division of Election to Provide Medical Benefits).

(d) An insurance company, certified self-insurer, workers' compensation self-insurance group under Labor Code Chapter 407A, and a political subdivision shall submit to the division, or its designee, workers' compensation insurance coverage information in the form and manner prescribed by the division. The division may designate and contract with a data collection agency to collect and maintain insurance coverage information.

(e) Workers' compensation insurance coverage information for insured Texas employers shall be provided to the division in accordance with subsection (d) of this rule as follows:
(1) by the insurance company, certified self-insurer, workers' compensation self-insurance group under Labor Code Chapter 407A, and political subdivision, within 10

days after the effective date of coverage or endorsement and annually thereafter no later than 10 days after the anniversary date of coverage;

(2) by the insurance company, 30 days prior to the date on which cancellation or non-renewal becomes effective if the insurance company cancels the workers' compensation insurance coverage, does not renew the workers' compensation insurance coverage on the anniversary date, or cancels a binder before it issues a workers' compensation insurance policy;

(3) by the insurance company, 10 days prior to the date on which the cancellation becomes effective if the insurance company cancels an employer's workers' compensation insurance coverage in accordance with Labor Code, §406.008(a)(2); or

(4) by the insurance company, within 10 days after receiving notice of the effective date of termination from the covered employer because the employer switched workers' compensation insurance carriers.

(f) Cancellation or non-renewal of a workers' compensation insurance policy by an insurance company takes effect on the later of:

(1) the end of the workers' compensation insurance policy period; or

(2) the date the division and the employer receive the notification from the insurance company of coverage cancellation or non-renewal and the later of:

(A) the date 30 days after receipt of the notice required by Labor Code, §406.008(a)(1);

(B) the date 10 days after receipt of the notice required by Labor Code, §406.008(a)(2); or

(C) the effective date of the cancellation if later than the date in paragraph (1) or (2) of this subsection.

(g) "Claim administration contact" as it applies to this chapter is the person responsible for identifying or confirming an employer's coverage information with the division. An insurance company, a certified self-insurer, a workers' compensation self-insurance group under Labor Code Chapter 407A, and a political subdivision shall file a notice with the division of their designated claim administration contact not later than the 10th day after the date on which the coverage or claim administration agreement takes effect. A single administration address for the purpose of identifying or confirming an employer's coverage status shall be provided. If the single claims administration contact address changes, the new address shall be provided to the division at least 30 days in advance of the change taking effect. This information shall be filed in the form and manner prescribed by the division.

(h) An insurance company, certified self-insurer, workers' compensation self-insurance group under Labor Code Chapter 407A, and a political subdivision may elect to have a servicing agent process and file all coverage information, but the insurance company,

certified self-insurer, workers' compensation self-insurance group under Labor Code Chapter 407A, or political subdivision remains responsible for meeting all filing requirements of this rule.

(i) Notwithstanding the other provisions of this section, if an employer switches workers' compensation insurance carriers, the original policy is considered canceled as of the date the new coverage takes effect. Employers shall notify the prior insurance carrier of the cancellation date of the original policy, in writing, within 10 days of the effective date.

(j) This section is effective January 1, 2013.

Source Note: The provisions of this §110.1 adopted to be effective September 15, 1993, 18 TexReg 5884; amended to be effective March 13, 2000, 25 TexReg 2080; amended to be effective June 5, 2003, 28 TexReg 4284; amended to be effective January 1, 2013, 37 TexReg 5577

RULE §110.7 Self-Insured Political Subdivision Requirements for Notifying the Division of Election to Provide Medical Benefits

(a) A health plan, for purposes of this section, is defined as a political subdivision contracting with health care providers under Labor Code §504.053(b)(2).

(b) A political subdivision as defined by Labor Code §504.001(3) that self-insures either individually or collectively and that pursuant to Labor Code §504.053(b)(2) elects to provide medical benefits to its injured employees by directly contracting with health care providers or by contracting through a health benefits pool established under Local Government Code Chapter 172 shall provide to the division notice of the method by which its employees will receive medical benefits. Political subdivisions are also subject to requirements specified in §110.1 of this title (relating to Insurance Carrier Requirements for Notifying the Division of Insurance Coverage).

(c) The notice of the method by which its employees will receive medical benefits required by subsection (b) of this section shall be filed with the division in writing or electronically and in the form and manner prescribed by the division. The notice shall include:
(1) the name, address, and the federal employer identification number (FEIN) of the political subdivision;
(2) the political subdivision's contact information;

(3) the name of the health plan elected under Labor Code §504.053(b)(2) for the political subdivision;
(4) the contact information for the health plan elected under Labor Code §504.053(b)(2); and
(5) the beginning and ending date(s) of the election under subsection (b) of this section, as applicable.

(d) A self-insured political subdivision that provides medical benefits to its injured employees in the manner described by Labor Code §504.053(b)(2) as of the effective date of this section shall provide the notice required by this section not later than December 31, 2012.

(e) A self-insured political subdivision that begins to provide medical benefits to its injured employees in the manner described by Labor Code §504.053(b)(2) after the effective date of this section shall provide the notice required by this section not later than the 30th day after the date the political subdivision begins to provide the medical benefits in that manner.

(f) A self-insured political subdivision shall notify the division of any change in any information required by this section not later than the 30th day after the date of the change.

Source Note: The provisions of this §110.7 adopted to be effective August 2, 2012, 37 TexReg 5577

SUBCHAPTER B EMPLOYER NOTICES

RULE §110.101 Covered and Non-Covered Employer Notices to Employees

(a) In addition to the posted notice required by subsection (e) of this section, employers, as defined by Labor Code §406.001, shall notify their employees of workers' compensation insurance coverage status, in writing. This additional notice:
(1) shall be provided at the time an employee is hired, meaning when the employee is required by federal law to complete both a W-4 form and an I-9 form or when a break in service has occurred and the employee is required by federal law to complete a W-4 form on the first day the employee reports back to duty;
(2) shall be provided to each employee, by an employer whose workers' compensation insurance coverage is terminated or cancelled, not later than the 15th day after the date on which the termination or cancellation of coverage takes effect;

(3) shall be provided to each employee, by an employer who obtains workers' compensation insurance coverage, not later than the 15th day after the date on which coverage takes effect, as necessary to allow the employee to elect to retain common law rights under Labor Code Chapter 406;

(4) shall include the text required in the posted notice; and

(5) if the employer is covered by workers' compensation insurance (subscriber) or becomes covered, whether by commercial insurance or through self-insurance as provided by the Texas Workers' Compensation Act (Act), shall include the following statement: "You may elect to retain your common law right of action if, no later than five days after you begin employment or within five days after receiving written notice from the employer that the employer has obtained workers' compensation insurance coverage, you notify your employer in writing that you wish to retain your common law right to recover damages for personal injury. If you elect to retain your common law right of action, you cannot obtain workers' compensation income or medical benefits if you are injured."

(b) Notices required to be posted by this rule shall be posted:

(1) by the non-subscribing employer as provided in subsection (c) of this section;

(2) by the employer who is terminating workers' compensation insurance coverage, at the time the employer's termination of coverage takes effect, unless a new policy will maintain continuous coverage in which case the employees will be notified at the time the new workers' compensation insurance policy takes effect;

(3) by the self-insurer as provided by the Act, who is withdrawing from self-insurance, at the time the withdrawal takes effect;

(4) by the employer who becomes covered either by a workers' compensation insurance policy or through self-insurance as provided by the Act, at the time coverage or certification takes effect; and

(5) by the employer whose workers' compensation insurance policy is canceled by the insurance carrier, at the time the cancellation becomes effective if no new workers' compensation insurance policy is obtained.

(c) On or after the effective date of this rule, notices shall contain the specific text required by this rule. Any time the information regarding workers' compensation insurance coverage status, insurance carrier, or third party administrator changes, the notice shall be updated to reflect current information.

(d) An employer who recruits an employee in Texas to perform services outside of Texas, actually hires outside of Texas, and has notices of workers' compensation insurance coverage posted conspicuously at the place of hire and at the business location where

the employee will perform services, is not required to provide the additional notice required in subsection (a) of this section to the employee.

(e) Employers shall post notices in the workplace to inform employees about workers' compensation issues as required by this rule. These notices shall be posted in the personnel office, if the employer has a personnel office, and in the workplace where each employee is likely to see the notice on a regular basis. The notices shall be printed with a title in at least 26 point bold type, subject in at least 18 point bold type, and text in at least 16 point normal type, and shall include ENGLISH, SPANISH, and any other LANGUAGE common to the employer's employee population. The text for the notices shall be the text provided by the division on the sample notice without any additional words or changes.

(1) Employers insured through a commercial insurance company shall post the following notice:

Attached Graphic

(2) Employers who become certified self-insurers under Labor Code Chapter 407 shall post the following notice:

Attached Graphic

(3) Employers who are a member of a self-insurance group under Labor Code Chapter 407A shall post the following notice:

Attached Graphic

(4) Employers who are not covered by workers' compensation (non-subscriber) shall post the following notice:

Attached Graphic

(f) Failure to post or to provide notice as required in this rule is an administrative violation.

(g) This section is effective January 1, 2013.

Source Note: The provisions of this §110.101 adopted to be effective January 1, 1994, 18 TexReg 9195; amended to be effective August 1, 2000, 25 TexReg 3986; amended to be effective January 1, 2013, 37 TexReg 5577

RULE §110.103 Employer Requirements for Notifying the Division of Non-Coverage

(a) Applicability. This subsection applies to notices required to be submitted by non-subscribing employers to the division before January 1, 2013. An employer, as defined by Labor Code §406.001, that does not have workers' compensation insurance coverage

(non-subscriber) and whose employees are not exempt from coverage under the Workers' Compensation Act (Act) shall provide the division a notice of non-coverage, in the form and manner prescribed by the division. The notice required by this subsection shall be provided, the earlier of the following:

(1) 30 days after receiving a division request for the filing of a notice of non-coverage and annually thereafter on the anniversary date of the original filing; or

(2) 30 days after hiring an employee who is subject to coverage under the Act, and annually thereafter on the anniversary date of the original filing.

(b) Applicability. This subsection applies to notices required to be submitted by non-subscribing employers to the division on or after January 1, 2013.

(1) A non-subscriber whose employees are not exempt from workers' compensation insurance coverage under the Act shall submit a notice of non-coverage to the division annually between February 1st and not later than April 30th of each calendar year. The period of the notice shall cover from May 1st of the same year the notice is submitted through the end of April of the subsequent year.

(2) In addition to the notice required by paragraph (1) of this subsection, a non-subscriber shall submit to the division a notice of non-coverage not later than the 30th day after the date the employer hired its first employee who is subject to coverage under the Act, unless this due date falls within the same time period described by paragraph (1) of this subsection and the employer submits the notice within that time period. A non-subscriber shall also provide the division with a notice of non-coverage not later than the 10th day after receipt of a division request for the information.

(3) The notices required by paragraphs (1) and (2) of this subsection shall be filed with the division in writing or electronically in the form and manner prescribed by the division and shall contain:

(A) a statement that the employer does not have workers' compensation insurance coverage;

(B) a statement of whether the employer had a death, injuries that resulted in the injured employee's absence from work for more than one day, or knowledge of an occupational disease since the last report of no coverage;

(C) the employer's business name;

(D) the federal employer identification number (FEIN);

(E) the employer's business mailing address;

(F) the employer's business type;

(G) the employer's North American Industry Classification System (NAICS) code(s);

(H) additional business locations (including name, FEIN, and address concerning each additional location); and

(l) the date the form was completed and the name, title, telephone number, email address, and signature of the person providing the information required by this subsection.

(c) Employers are responsible for timely and accurate notice under this section. A notice required by this section is considered filed with the division only when it accurately contains all of the data elements specified under subsection (b) of this section and is received by the division.

Source Note: The provisions of this §110.103 adopted to be effective August 2, 2012, 37 TexReg 5577

RULE §110.105 Employer Requirements for Notifying the Division of Termination of Coverage

(a) An employer, as defined by Labor Code §406.001, who terminates workers' compensation insurance coverage shall file written notice of the termination of coverage with the division not later than the 10th day after the date on which the employer notified the insurance carrier under Labor Code §406.007 to terminate the coverage.

(b) The employer shall file the notice of termination required by subsection (a) of this section in the form and manner prescribed by the division. The notice shall contain:
(1) a statement of no workers' compensation insurance coverage, including policy termination effective date, policy number, insurance company name, date the termination notice was sent to the insurance company, and date employees were or will be notified;
(2) a statement of whether the employer had a death, injuries that resulted in the injured employee's absence from work for more than one day, or knowledge of an occupational disease since the last report of no coverage;
(3) the employer business name;
(4) the federal employer identification number (FEIN);
(5) the employer's business mailing address;
(6) the employer's business type;
(7) the employer's North American Industry Classification System (NAICS) code;
(8) additional business locations (including name, FEIN, and address concerning each additional location); and
(9) the signature date and the name, title, telephone number, email address, and signature of the person providing the information required by this subsection.

(c) Termination of coverage by an employer takes effect on the later of:

(1) the 30th day after the date of filing the notice with the division under this section; or
(2) the cancellation date of the policy.

(d) Coverage shall be extended until the date on which the termination of coverage takes effect and the employer is obligated for premiums due for that period.

(e) Notwithstanding the other provisions of this section, if an employer switches workers' compensation insurance carriers, the original policy is considered canceled as of the date the new coverage takes effect. Employers shall notify the prior insurance carrier of the cancellation date of the original policy, in writing, within 10 days of the effective date.

(f) This section is effective January 1, 2013.

Source Note: The provisions of this §110.105 adopted to be effective January 1, 2013, 37 TexReg 5577; amended to be effective April 15, 2018, 43 TexReg 2150

RULE §110.108 Employer Notice Regarding Work-Related Exposure to Communicable Disease/HIV: Posting Requirements; Payment for Tests

(a) Each employer covered by workers' compensation insurance, including state and political subdivision employers, which employ emergency medical service employees, paramedics, fire fighters, law enforcement officers or correctional officers must post the notice contained in subsection (d) of this section, in its workplace to inform employees about Health and Safety Code requirements which may affect qualifying for workers' compensation benefits following a work-related exposure to a reportable communicable disease. The notice shall be posted in the personnel office, if the employer has a personnel office, and in the workplace where employees are likely to read the notice on a regular basis. Specific guidance for employers and employees covered by this subsection is found in §122.3 of this title (relating to Exposure to Communicable Diseases: Reporting and Testing Requirements for Emergency Responders).

(b) Each state agency must post the notice contained in subsection (d) of this section, in its workplace to inform employees about requirements which may affect qualifying for workers' compensation benefits following a work-related exposure to human immunodeficiency virus (HIV). The notice shall be posted in the personnel office and in the workplace where employees are likely to read the notice on a regular basis. Specific guidance for state employers and employees covered by this subsection is found in

§122.4 of this title (relating to State Employees: Exposed to Human Immunodeficiency Virus (HIV): Reporting and Testing Requirements).

(c) The cost of testing for exposure to a reportable communicable disease for emergency medical service employees, paramedics, fire fighters, law enforcement officers and correctional officers shall be paid by the employer's workers' compensation insurance carrier, including state and political subdivision employers.

(d) The following notice shall be printed with a title in at least 15 point bold type and the text in at least 14 point normal type, in English and Spanish or in English and any other language common to the employer's affected employee population. The text of the notice shall be as follows without any additional words or changes:
Attached Graphic

Source Note: The provisions of this §110.108 adopted to be effective October 15, 1997, 22 TexReg 9678; amended to be effective December 14, 2015, 40 TexReg 8899

RULE §110.110 Reporting Requirements for Building or Construction Projects for Governmental Entities

(a) The following words and terms, when used in this rule, shall have the following meanings, unless the context clearly indicates otherwise. Terms not defined in this rule shall have the meaning defined in the Texas Labor Code, if so defined.
(1) Certificate of coverage (certificate)--A copy of a certificate of insurance, a certificate of authority to self-insure issued by the division, or a workers' compensation coverage agreement (DWC Form-81, DWC Form-82, DWC Form-83, or DWC Form-84), showing statutory workers' compensation insurance coverage for the person's or entity's employees (including those subject to a coverage agreement) providing services on a project, for the duration of the project.
(2) Building or construction--Has the meaning defined in the Texas Labor Code, §406.096(e)(1).
(3) Contractor--A person bidding for or awarded a building or construction project by a governmental entity.
(4) Coverage--Workers' compensation insurance meeting the statutory requirements of the Texas Labor Code, §401.011(44).
(5) Coverage agreement--A written agreement on DWC Form-81, DWC Form-82, DWC Form-83, or DWC Form-84, filed with the Division of Workers' Compensation which establishes a relationship between the parties for purposes of the Texas Workers' Compensation Act, pursuant to the Texas Labor Code, Chapter 406, Subchapters F and

G, as one of employer/employee and establishes who will be responsible for providing workers' compensation coverage for persons providing services on the project.

(6) Duration of the project--Includes the time from the beginning of work on the project until the work on the project has been completed and accepted by the governmental entity.

(7) Persons providing services on the project ("subcontractor" in §406.096 of the Act)--With the exception of persons excluded under subsections (h) and (i) of this section, includes all persons or entities performing all or part of the services the contractor has undertaken to perform on the project, regardless of whether that person contracted directly with the contractor and regardless of whether that person has employees. This includes but is not limited to independent contractors, subcontractors, leasing companies, motor carriers, owner-operators, employees of any such entity, or employees of any entity furnishing persons to perform services on the project. "Services" includes but is not limited to providing, hauling, or delivering equipment or materials, or providing labor, transportation, or other service related to a project. "Services" does not include activities unrelated to the project, such as food/beverage vendors, office supply deliveries, and delivery of portable toilets.

(8) Project--Includes the provision of all services related to a building or construction contract for a governmental entity.

(b) Providing or causing to be provided a certificate of coverage pursuant to this rule is a representation by the insured that all employees of the insured who are providing services on the project are covered by workers' compensation coverage, that the coverage is based on proper reporting of classification codes and payroll amounts, and that all coverage agreements have been filed with the appropriate insurance carrier or, in the case of a self-insured, with the division. Providing false or misleading certificates of coverage, or failing to provide or maintain required coverage, or failing to report any change that materially affects the provision of coverage may subject the contractor or other person providing services on the project to administrative penalties, criminal penalties, civil penalties, or other civil actions.

(c) A governmental entity that enters into a building or construction contract on a project shall:

(1) include in the bid specifications, all the provisions of paragraph (7) of this subsection, using the language required by paragraph (7) of this subsection;

(2) as part of the contract, using the language required by paragraph (7) of this subsection, require the contractor to perform as required in subsection (d) of this section;

(3) obtain from the contractor a certificate of coverage for each person providing services on the project, prior to that person beginning work on the project;

(4) obtain from the contractor a new certificate of coverage showing extension of coverage:

(A) before the end of the current coverage period, if the contractor's current certificate of coverage shows that the coverage period ends during the duration of the project; and

(B) no later than seven days after the expiration of the coverage for each other person providing services on the project whose current certificate shows that the coverage period ends during the duration of the project;

(5) retain certificates of coverage on file for the duration of the project and for three years thereafter;

(6) provide a copy of the certificates of coverage to the division upon request and to any person entitled to them by law; and

(7) use the language contained in the following figure for bid specifications and contracts, without any additional words or changes, except those required to accommodate the specific document in which they are contained or to impose stricter standards of documentation:

Attached Graphic

(d) A contractor shall:

(1) provide coverage for its employees providing services on a project, for the duration of the project based on proper reporting of classification codes and payroll amounts and filing of any coverage agreements;

(2) provide a certificate of coverage showing workers' compensation coverage to the governmental entity prior to beginning work on the project;

(3) provide the governmental entity, prior to the end of the coverage period, a new certificate of coverage showing extension of coverage, if the coverage period shown on the contractor's current certificate of coverage ends during the duration of the project;

(4) obtain from each person providing services on a project, and provide to the governmental entity:

(A) a certificate of coverage, prior to that person beginning work on the project, so the governmental entity will have on file certificates of coverage showing coverage for all persons providing services on the project; and

(B) no later than seven days after receipt by the contractor, a new certificate of coverage showing extension of coverage, if the coverage period shown on the current certificate of coverage ends during the duration of the project;

(5) retain all required certificates of coverage on file for the duration of the project and for one year thereafter;

(6) notify the governmental entity in writing by certified mail or personal delivery, within ten days after the contractor knew or should have known, of any change that

materially affects the provision of coverage of any person providing services on the project;

(7) post a notice on each project site informing all persons providing services on the project that they are required to be covered, and stating how a person may verify current coverage and report failure to provide coverage. This notice does not satisfy other posting requirements imposed by the Act or other division rules. This notice must be printed with a title in at least 30 point bold type and text in at least 19 point normal type, and shall be in both English and Spanish and any other language common to the worker population. The text for the notices shall be the following text provided by the division on the sample notice, without any additional words or changes:

Attached Graphic

(8) contractually require each person with whom it contracts to provide services on a project to:

(A) provide coverage based on proper reporting of classification codes and payroll amounts and filing of any coverage agreements for all of its employees providing services on the project, for the duration of the project;

(B) provide a certificate of coverage to the contractor prior to that person beginning work on the project;

(C) include in all contracts to provide services on the project the language in subsection (e)(3) of this section;

(D) provide the contractor, prior to the end of the coverage period, a new certificate of coverage showing extension of coverage, if the coverage period shown on the current certificate of coverage ends during the duration of the project;

(E) obtain from each other person with whom it contracts, and provide to the contractor:

(i) a certificate of coverage, prior to the other person beginning work on the project; and

(ii) prior to the end of the coverage period, a new certificate of coverage showing extension of the coverage period, if the coverage period shown on the current certificate of coverage ends during the duration of the project;

(F) retain all required certificates of coverage on file for the duration of the project and for one year thereafter;

(G) notify the governmental entity in writing by certified mail or personal delivery, within ten days after the person knew or should have known, of any change that materially affects the provision of coverage of any person providing services on the project; and

(H) contractually require each other person with whom it contracts, to perform as required by subparagraphs (A) - (H) of this paragraph, with the certificate of coverage to be provided to the person for whom they are providing services.

(e) A person providing services on a project, other than a contractor, shall:

(1) provide coverage for its employees providing services on a project, for the duration of the project based on proper reporting of classification codes and payroll amounts and filing of any coverage agreements;

(2) provide a certificate of coverage as required by its contract to provide services on the project, prior to beginning work on the project;

(3) have the following language in its contract to provide services on the project: "By signing this contract or providing or causing to be provided a certificate of coverage, the person signing this contract is representing to the governmental entity that all employees of the person signing this contract who will provide services on the project will be covered by workers' compensation coverage for the duration of the project, that the coverage will be based on proper reporting of classification codes and payroll amounts, and that all coverage agreements will be filed with the appropriate insurance carrier or, in the case of a self-insured, with the division. Providing false or misleading information may subject the contractor to administrative penalties, criminal penalties, civil penalties, or other civil actions."

(4) provide the person for whom it is providing services on the project, prior to the end of the coverage period shown on its current certificate of coverage, a new certificate showing extension of coverage, if the coverage period shown on the certificate of coverage ends during the duration of the project;

(5) obtain from each person providing services on a project under contract to it, and provide as required by its contract:

(A) a certificate of coverage, prior to the other person beginning work on the project; and

(B) prior to the end of the coverage period, a new certificate of coverage showing extension of the coverage period, if the coverage period shown on the current certificate of coverage ends during the duration of the project;

(6) retain all required certificates of coverage on file for the duration of the project and for one year thereafter;

(7) notify the governmental entity in writing by certified mail or personal delivery, of any change that materially affects the provision of coverage of any person providing services on the project and send the notice within ten days after the person knew or should have known of the change; and

(8) contractually require each other person with whom it contracts to:

(A) provide coverage based on proper reporting of classification codes and payroll amounts and filing of any coverage agreements for all of its employees providing services on the project, for the duration of the project;

(B) provide a certificate of coverage to it prior to that other person beginning work on the project;

(C) include in all contracts to provide services on the project the language in paragraph (3) of this subsection;

(D) provide, prior to the end of the coverage period, a new certificate of coverage showing extension of the coverage period, if the coverage period shown on the current certificate of coverage ends during the duration of the project;

(E) obtain from each other person under contract to it to provide services on the project, and provide as required by its contract:

(i) a certificate of coverage, prior to the other person beginning work on the project; and

(ii) prior to the end of the coverage period, a new certificate of coverage showing extension of the coverage period, if the coverage period shown on the current certificate of coverage ends during the duration of the contract;

(F) retain all required certificates of coverage on file for the duration of the project and for one year thereafter;

(G) notify the governmental entity in writing by certified mail or personal delivery, within ten days after the person knew or should have known, of any change that materially affects the provision of coverage of any person providing services on the project; and

(H) contractually require each person with whom it contracts, to perform as required by this subparagraph and subparagraphs (A) - (G) of this paragraph, with the certificate of coverage to be provided to the person for whom they are providing services.

(f) If any provision of this rule or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this rule that can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

(g) This rule is applicable for building or construction contracts advertised for bid by a governmental entity on or after September 1, 1994. This rule is also applicable for those building or construction contracts entered into on or after September 1, 1994, which are not required by law to be advertised for bid.

(h) The coverage requirement in this rule does not apply to motor carriers who are required pursuant to Texas Civil Statutes, Article 6675c, to register with the Texas Department of Transportation and who provide accidental insurance coverage pursuant to Texas Civil Statutes, Article 6675c, §4(j).

(i) The coverage requirement in this rule does not apply to sole proprietors, partners, and corporate officers who meet the requirements of the Act, §406.097(c), and who are explicitly excluded from coverage in accordance with the Act, §406.097(a) (as added by

House Bill 1089, 74th Legislature, 1995, §1.20). This subsection applies only to sole proprietors, partners, and corporate executive officers who are excluded from coverage in an insurance policy or certificate of authority to self-insure that is delivered, issued for delivery, or renewed on or after January 1, 1996.

Source Note: The provisions of this §110.110 adopted to be effective September 1, 1994, 19 TexReg 5715; amended to be effective November 6, 1995, 20 TexReg 8609; amended to be effective December 14, 2015, 40 TexReg 8899

TITLE 28 **INSURANCE**
PART 2 **TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION**
CHAPTER 112 **SCOPE OF LIABILITY FOR COMPENSATION**

RULE §112.101 Agreement Regarding Workers' Compensation Insurance Coverage Between General Contractors and Subcontractors

(a) An agreement between a general contractor and a subcontractor made in accordance with Texas Labor Code §406.123(a), (d), (e), or (l) must:
(1) be in writing;
(2) state that the subcontractor and the subcontractor's employees are employees of the general contractor for the sole purpose of workers' compensation coverage;
(3) indicate whether the general contractor will make a deduction for the premiums;
(4) specify whether this is a blanket agreement or if it applies to a specific job location and, if so, list the location;
(5) contain the signatures of both parties;
(6) indicate the date the agreement was made, the term the agreement will be effective, and estimated number of workers affected by the agreement.

(b) The workers' compensation insurance coverage provided by the general contractor under the agreement will take effect no sooner than the date the agreement was executed, and deductions for the premiums must not be made for coverage provided before that date.

(c) If a person who is covered by a subcontractor agreement signed under this section is found to be an employee of the general contractor, the person:
(1) is covered under the general contractor's workers' compensation policy; and
(2) must receive a refund from the general contractor for all amounts improperly deducted as premium.

(d) The general contractor must maintain the original and file a legible copy of the agreement with the general contractor's workers' compensation insurance carrier within 10 days of the date of execution. An agreement is not considered filed if it is illegible or incomplete. If a general contractor and subcontractor enter into a written agreement in which the subcontractor assumes the responsibilities of an employer as provided in Texas Labor Code §406.122(b), the general contractor must provide a copy of the agreement to its insurance carrier within 10 days of execution. After January 1, 1993, a general contractor who is a certified self-insurer must file a copy of the agreement with

the division within 10 days of the date of execution. The filing must be made in the form and manner prescribed by the division.
(e) The general contractor must give the subcontractor's employees the notice required under Texas Labor Code §406.005 when such an agreement is made.

(f) If a subcontractor makes an agreement in accordance with this rule, an employee of the subcontractor may elect to retain his common law rights as provided by the Texas Labor Code, §406.034.

Source Note: The provisions of this §112.101 adopted to be effective February 27, 1991, 16 TexReg 985; amended to be effective March 13, 2000, 25 TexReg 2082; amended to be effective April 15, 2018, 43 TexReg 2151; amended to be effective February 10, 2021, 46 Texreg 922

RULE §112.102 Agreements between Motor Carriers and Owner Operators

(a) A motor carrier and an owner operator may enter into an agreement which requires the owner operator to assume the responsibilities of an employer for the performance of work.

(b) An agreement made under subsection (a) of this section must be made at or before the time the contract for the work is made and must:
(1) be in writing;
(2) state that the owner operator assumes the responsibilities of an employer for the performance of work;
(3) contain the signatures of both parties;
(4) indicate the date the agreement was made, the term the agreement will be effective, the estimated number of workers affected by the agreement, the federal tax identification number of the parties; and
(5) be provided to the insurance carrier of the motor carrier within 10 days of execution.

(c) A motor carrier and an owner operator may enter into an agreement under which the motor carrier provides workers' compensation insurance coverage to the owner operator and the owner operator's employees.

(d) An agreement made under subsection (c) of this section must be made at or before the time the contract for the work is made and must:
(1) be in writing;
(2) indicate whether the motor carrier will make a deduction for the premiums;

(3) contain the signatures of both parties;
(4) indicate the date the agreement was made, the term the agreement will be effective, the estimated number of workers affected by the agreement, the federal tax identification number of the parties; and
(5) be filed with the insurance carrier of the motor carrier within 10 days of execution.

(e) The workers' compensation insurance coverage provided by the motor carrier under the agreement must take effect no sooner than the date the agreement was executed, and deductions for the premiums must not be made for coverage provided before that date.

(f) The motor carrier must be required to give the owner operator's employees the notice required under Texas Labor Code §406.005 when such an agreement is made.

Source Note: The provisions of this §112.102 adopted to be effective February 27, 1991, 16 TexReg 985; amended to be effective June 9, 2005, 30 TexReg 3230; amended to be effective April 15, 2018, 43 TexReg 2151; amended to be effective February 10, 2021, 46 TexReg 922

RULE §112.200 Definition of Residential Structures

For purposes of the Texas Workers' Compensation Act (the Act), §406.142, "residential structures" are buildings used as a family dwelling or multi-family dwelling, limited to a single-family residence, a duplex, a triplex, and a quadraplex. All other types of structures used for living purposes shall be considered commercial structures, and shall only be included within the scope of the Act, §406.142, if they do not exceed three stories or 20,000 square feet.

Source Note: The provisions of this §112.200 adopted to be effective June 3, 1991, 16 TexReg 2830; amended to be effective June 9, 2005, 30 TexReg 3230

RULE §112.201 Agreement To Establish Employer-Employee Relationship for Certain Building and Construction Workers

(a) This section applies only to building and construction projects as provided by the Texas Labor Code, §406.142.

(b) An independent contractor and a hiring contractor, as defined in the Texas Labor Code, §406.141, may enter into a written agreement:

(1) to allow the hiring contractor to withhold the cost of workers' compensation insurance from the contract price; and

(2) to stipulate that, for the sole purpose of providing workers' compensation insurance, the hiring contractor will be the employer of the independent contractor and the independent contractor's employees.

(c) An agreement made under subsection (b) of this section shall be filed in the form and manner prescribed by the division.

(d) The agreement shall:

(1) be in writing;

(2) indicate whether the hiring contractor will make a deduction for the premiums;

(3) specify that the hiring contractor will be the employer of the independent contractor and the independent contractor's employees for the sole purpose of providing workers' compensation insurance;

(4) specify the location of the job sites subject to the contract and the agreement;

(5) contain the signatures of both parties; and

(6) indicate the date the agreement was made, the term the agreement will be effective, and the estimated number of employees affected by the agreement.

(e) The workers' compensation insurance coverage provided by the hiring contractor under the agreement shall take effect no sooner than the date on which the agreement was executed and deductions for the premiums shall not be made for coverage provided prior to that date.

(f) If a person who is covered by an independent contractor agreement signed under this section is found to be an employee of the hiring contractor, the person:

(1) is covered under the hiring contractor's workers' compensation policy; and

(2) shall receive a refund from the hiring contractor for all amounts improperly deducted as premium.

(g) The hiring contractor must maintain the original and file a legible copy of the agreement with the hiring contractor's workers' compensation insurance carrier within 10 days of the date of execution. An agreement is not considered filed if it is illegible or incomplete.

(h) A hiring contractor electing to provide workers' compensation insurance coverage through an agreement under subsection (b) of this section shall be deemed to have accepted the rights and responsibilities of an employer imposed under the Act as of the effective date of the workers' compensation insurance coverage.

(i) If an independent contractor makes an agreement under this rule, the employee of the independent contractor may elect to retain his common law rights as provided by the Texas Labor Code, §406.034.

(j) For purposes of the Texas Labor Code, §406.142, 20,000 square feet is measured on the outside perimeter of the structure.

Source Note: The provisions of this §112.201 adopted to be effective February 26, 1991, 16 TexReg 896; amended to be effective March 13, 2000, 25 TexReg 2082; amended to be effective April 15, 2018, 43 TexReg 2151

RULE §112.202 Joint Agreement To Affirm Independent Relationship for Certain Building and Construction Workers

(a) An independent subcontractor and a hiring contractor may enter into an agreement which states that the subcontractor is an independent contractor and is not an employee of the hiring contractor.

(b) The agreement shall be filed in the form and manner prescribed by the division and shall:
(1) be in writing;
(2) state that the subcontractor meets the qualifications of an independent contractor under the Texas Labor Code, §406.141(2);
(3) state that the subcontractor is an independent contractor and is not an employee of the hiring contractor;
(4) contain the signatures of both parties;
(5) indicate the date the agreement was made; and
(6) state that: "Once this agreement is signed, the subcontractor and the subcontractor's employees shall not be entitled to workers' compensation coverage from the hiring contractor unless a subsequent written agreement is executed, and filed according to division rules, expressly stating that this agreement does not apply."

(c) If a person who is covered by an independent contractor agreement signed under this section is found to be an employee of the hiring contractor, the person is covered under the hiring contractor's workers' compensation policy.

(d) The hiring contractor shall maintain the original and file a legible copy of the agreement with the hiring contractor's workers' compensation insurance carrier, if any, within 10 days of the date of execution. An agreement is not considered filed if it is illegible or incomplete.

(e) If the agreement is made in compliance with subsections (a) through (d) of this section and a separate agreement has not been made in accordance with §112.201 of this title (relating to Agreement to Establish Employer-Employee Relationship for Certain Building and Construction Workers):
(1) the subcontractor and the subcontractor's employees shall not be entitled to workers' compensation coverage from the hiring contractor; and
(2) the hiring contractor's workers' compensation insurance carrier shall not require premiums to be paid by the hiring contractor for coverage of the independent contractor or the independent contractor's employees, helpers, or subcontractors.

(f) An agreement signed under subsection (a) applies to each hiring agreement executed by the parties until the first anniversary of the date the agreement was filed with the hiring contractor's workers' compensation insurance carrier, unless a subsequent agreement is executed expressly stating that the agreement does not apply.

Source Note: The provisions of this §112.202 adopted to be effective February 26, 1991, 16 TexReg 896; amended to be effective March 13, 2000, 25 TexReg 2082; amended to be effective April 15, 2018, 43 TexReg 2151

RULE §112.203 Exception to Application of Agreement to Affirm Independent Relationship for Certain Building and Construction Workers

(a) If a subsequent hiring agreement is made that expressly states that the joint statement made under §112.202 of this title (relating to Joint Agreement To Affirm Independent Relationship for Certain Building and Construction Workers) does not apply to that hiring agreement, the hiring contractor must maintain the original and file a legible copy of the agreement with the hiring contractor's insurance carrier. Nothing in this section otherwise nullifies the joint statement as it applies to other hiring agreements made during the term of the joint statement.

(b) The notification must be filed in the form and manner prescribed by the division and must:
(1) specify the date the agreement to affirm an independent relationship was made;
(2) specify the parties to the agreement and the location of the job site(s);
(3) specify the date this agreement was made;
(4) contain the signatures of both parties.

(c) If a person who is covered by an independent contractor agreement signed under this section is found to be an employee of the hiring contractor, the person:

(1) is covered under the hiring contractor's workers' compensation policy;
(2) must receive a refund from the hiring contractor for all amounts improperly deducted as premium.

(d) The notification must be provided in the form and manner prescribed by the division no later than 10 days from the date the subsequent hiring agreement was executed. An agreement is not considered filed if it is illegible or incomplete.

RULE §112.301 Labor Agent's Notification of Coverage to Certain Farm or Ranch Employees

(a) A labor agent must notify each person the labor agent contracts with to provide the services of migrant and seasonal workers whether or not the labor agent has workers' compensation insurance coverage.

(b) The notification must be in writing and must be given at the time the contract for the services of the migrant or seasonal workers is made. The notification must be signed and dated by both parties and each party must retain a copy of the notice.

(c) If the labor agent does have workers' compensation insurance coverage, the labor agent must present evidence of the workers' compensation insurance coverage to each person the agent contracts with to provide the services of migrant and seasonal workers. The evidence of coverage must be in writing and must be presented at the time the notification of coverage is made. Each party must retain a copy of the evidence of coverage with the copy of the notice. A certificate of insurance is considered adequate evidence of coverage.

(d) The notice and evidence of coverage, if applicable, must be given each time a labor agent makes a contract with a person to provide migrant or seasonal workers. Any notice and evidence of coverage provided for a prior contract between the parties is considered insufficient to meet the requirements of this section.

(e) If coverage is terminated during the period of the contract for employment, the labor agent must notify:
(1) the person with whom the agent contracted to provide the services of migrant and seasonal workers; and
(2) the migrant and seasonal workers affected that the workers' compensation insurance coverage has been terminated.

Source Note: The provisions of this §112.301 adopted to be effective February 26, 1991, 16 TexReg 899; amended to be effective February 10, 2021, 46 TexReg 922

RULE §112.401 Election of Coverage by Certain Professional Athletes

(a) A professional athlete employed by a franchise with workers' compensation insurance coverage and subject to Texas Labor Code §406.095 must elect to receive either the benefits available under the Act or the equivalent benefits available under the athlete's contract or collective bargaining agreement. The election must be made not later than the 15th day after the athlete sustains an injury in the course and scope of employment. If the athlete fails to make an election, the athlete will be presumed to have elected the option which provides the highest benefits.

(b) When a contract is signed by a professional athlete, the employer must give the athlete a copy of the following statement: "(Name of employer) has workers' compensation coverage from (name of insurance carrier). If the benefits available to you under your contract and any applicable collective bargaining agreement are equivalent to or greater than those available to you under Texas Labor Code §406.095, you are required to elect whether to receive the benefits available to you under the Act or the benefits available to you under your contract and any applicable collective bargaining agreement. You must make this election no later than 15 days after sustaining an injury. If you elect to receive the benefits available to you under your contract and any applicable collective bargaining agreement, you cannot obtain workers' compensation income or medical benefits if you are injured. You can get more information about your workers' compensation rights and the benefits available to you under the Act from any office of the Texas Department of Insurance, Division of Workers' Compensation, or by calling 1-800-252-7031."

(c) The election must be in writing and must:
(1) indicate the date of the injury for which the election is being made;
(2) indicate whether the athlete elects to receive the benefits available under the Act or the benefits provided under the contract or agreement; and
(3) be signed by the athlete and the employer.

(d) If the athlete elects to receive the benefits available under the Act, a legible copy of the election must be provided to the division in the form and manner prescribed by the division within 10 days of the date of execution. A copy must also be provided to the franchise's workers' compensation insurance carrier within 10 days of the date of execution. The franchise must maintain the original election and provide a copy to the athlete.

(e) If the athlete elects to receive the benefits available under the contract and any agreement, the election must be filed with the franchise's workers' compensation insurance carrier within 10 days of the date of execution. An agreement is not considered filed if it is illegible or incomplete. Both the athlete and the franchise must keep a copy of the election.

(f) An election made under this section is irrevocable and binding on the athlete and the athlete's legal beneficiaries for a compensable injury incurred on the date specified in the election.

Source Note: The provisions of this §112.401 adopted to be effective October 1, 1992, 17 TexReg 6362; amended to be effective March 13, 2000, 25 TexReg 2082; amended to be effective February 10, 2021, 46 TexReg 922

RULE §112.402 Determination of Equivalent Benefits for Professional Athletes

(a) Medical care available to a professional athlete subject to the Texas Workers' Compensation Act (the Act), Texas Labor Code, §406.095, is equal to or greater than medical benefits under the Act if:

(1) the athlete is entitled to all health care reasonably required by the nature of the work-related injury as and when needed, including all health care that:

(A) cures or relieves the effects naturally resulting from the work-related injury;

(B) promotes recovery; or

(C) enhances the ability of the employee to return to or retain employment; and

(2) the employer's liability for health care is not limited or terminated in any way by the contract or collective bargaining agreement.

(b) When the athlete is not eligible for lifetime income benefits or when the athlete's legal beneficiaries are not eligible for death benefits under the Act, weekly benefits available to a professional athlete subject to the Act, §406.095, are equal to or greater than the income benefits provided under the Act if the total amount of the payments provided for in the contract or collective bargaining agreement is equal to or greater than the maximum weekly benefit available under the Act multiplied by 104.

(c) When the athlete is entitled to lifetime income benefits under the Act, weekly benefits available to a professional athlete subject to the Act, §406.095, are equal to or greater than the income benefits provided under the Act if equal to or greater than the maximum weekly benefit available under the Act.

(d) When the athlete's legal beneficiaries are entitled to death benefits under the Act, weekly benefits available to the legal beneficiaries of a professional athlete subject to the Act, §406.095, are equal to or greater than the death benefits provided under the Act if equal to or greater than the maximum weekly benefit available under the Act.

Source Note: The provisions of this §112.402 adopted to be effective October 1, 1992, 17 TexReg 6362; amended to be effective June 9, 2005, 30 TexReg 3231

TITLE 28 **INSURANCE**
PART 2 **TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION**
CHAPTER 114 **SELF-INSURANCE**

RULE §114.1 Purpose

(a) The provisions of this chapter are promulgated pursuant to Texas Labor Code, Chapter 407, to explain and enforce provisions related to the self-insuring of liability and to guarantee full and timely payment of compensation benefits by certified self-insurers.

(b) The provisions of this chapter apply to private employers in the State of Texas. They do not apply to the state or to political subdivisions, as made clear by Texas Labor Code §401.011(6).

(c) These rules provide guidance and requirements in addition to those requirements imposed by the Texas Workers' Compensation Act and other division rules.

Source Note: The provisions of this §114.1 adopted to be effective January 1, 1993, 17 TexReg 7896; amended to be effective May 9, 2004, 29 TexReg 4186; amended to be effective January 6, 2019, 44 TexReg 99

RULE §114.2 Definitions

(a) The following words and terms are defined in the Texas Labor Code §407.001, and are used in this chapter:
(1) Association;
(2) Impaired employer;
(3) Incurred liabilities for compensation; and
(4) Qualified claims servicing contractor.

(b) The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:
(1) Applicant--an employer that applies for an initial certificate of authority to self-insure or, once initially certified, any subsequent certificate of authority to self-insure.
(2) Certificate--A certificate of authority to self-insure issued by the commissioner under Texas Labor Code §407.042, which entitles an employer to be a certified self-insurer and is valid only for the persons, firms, or corporations named on the certificate. For a certificate of authority to self-insure delivered, issued for delivery, or renewed on

or after January 1, 1996, a sole proprietor, partner, or corporate executive officer of a business may be specifically excluded from coverage under Texas Labor Code §406.097.

(3) Certified self-insurer--A private employer that has been granted a certificate of authority to self-insure for payment of compensation, either currently or for a prior period except if withdrawn with an insuring agreement under Labor Code §407.045(a-1).

(4) Claims Contractor--A qualified claims servicing contractor.

(5) Division--The Texas Department of Insurance, Division of Workers' Compensation.

(6) Excess Insurance--Insurance that an employer purchases to pay claim costs that exceed the employer's retention amount up to a specified limit.

(7) Retention--All payments that must be paid by a certified self-insurer before an excess insurance policy will respond to a loss for claims filed under the Workers' Compensation Act including indemnity benefits, medical payments, death benefits, and all other related claims expenses not otherwise covered by insurance.

(8) Trust Fund--The Texas certified self-insurer guaranty trust fund created by the fee assessed by the Association for emergency payment of the compensation liabilities of an impaired employer.

Source Note: The provisions of this §114.2 adopted to be effective January 1, 1993, 17 TexReg 7896; amended to be effective November 6, 1995, 20 TexReg 8612; amended to be effective May 9, 2004, 29 TexReg 4186; amended to be effective January 6, 2019, 44 TexReg 99

RULE §114.3 Application Form and Financial Information Requirements

(a) Employers shall submit an application by filing a completed and signed application in the form and manner prescribed by the commissioner and must include:

(1) if required to file a Form 10-K by the U.S. Securities and Exchange Commission (SEC), the applicant's Form 10-K for the preceding three fiscal years; and

(2) the applicant's independently audited financial statements according to Generally Accepted Auditing Standards of the American Institute of Certified Public Accountants with the accompanying footnotes and the auditor's opinion for the preceding three fiscal years.

(b) Incomplete applications may be returned to the applicant.

(c) An incomplete application may be treated as voluntarily withdrawn if the applicant fails to respond to any request for information by the division for more than 90 days from the date the request is deemed received by the applicant, as provided by division rule.

(d) The sworn affidavit required on any self-insurance application or other document requiring a sworn affidavit also applies to all attachments, additions, and any subsequent amendments to those documents.

(e) If the financial statements under subsection (a)(2) of this section are dated more than six months prior to the date of the application, interim financial statements may be required.

(f) Applicants will be evaluated for stability and financial strength. Applicants shall provide information relevant to the factors specified in Texas Labor Code §407.061 and §407.062 and shall ensure that a credit or debt rating and an analysis of that rating have been prepared by one of the following:

(1) Dun & Bradstreet or other recognized credit reporting agency's ratings; or
(2) debt ratings from Standard & Poor's or Moody's.

(g) In addition to reviewing the information required in subsection (f) of this section, the commissioner shall consider the applicant's:

(1) liquidity ratio;
(2) ratio of current assets to current liabilities;
(3) ratio of tangible net worth to long-term debt;
(4) ratio of tangible net worth to total liabilities;
(5) cash flow;
(6) working capital;
(7) profitability; and
(8) one of the following:
    (A) Dun & Bradstreet or other recognized credit reporting agency's ratings; or
    (B) debt ratings from Standard & Poor's or Moody's.

Source Note: The provisions of this §114.3 adopted to be effective January 1, 1993, 17 TexReg 7896; amended to be effective May 9, 2004, 29 TexReg 4186; amended to be effective January 6, 2019, 44 TexReg 99

RULE §114.4 Security Deposit Requirements

(a) A security deposit shall be one or a combination of any of the following:

(1) surety bond. The surety bond must be issued by a company authorized to conduct such business in Texas and possess either a current A.M. Best rating of B+ or better or a Standard & Poor's rating of claims paying ability of A or better;
(2) cash, bonds, or other evidence of indebtedness issued, assumed or guaranteed by the United States of America or the State of Texas. Any such securities shall be

deposited with the Comptroller of Public Accounts pursuant to a trust agreement prescribed by the commissioner; or
(3) irrevocable letter of credit issued by a Texas state chartered bank or a federally chartered bank with a branch office in Texas. The bank shall have a long-term debt rating of at least A or better in the current monthly edition of "Moody's Statistical Handbook" or a long-term investment grade rating of at least A or better in the current edition of "Global Ratings Handbook" prepared by Standard & Poor's Corporation. If the bank's rating subsequent to issuing the letter of credit falls below the acceptable rating, the certified self-insurer shall replace the letter of credit within 60 days with a new letter of credit issued by a bank with an acceptable rating.

(b) Bonds and irrevocable letters of credit must be in a form approved by the commissioner.

(c) A security deposit in the form of cash must be in United States currency.

(d) The amount of the security deposit shall in no case be less than the retention amount of the excess insurance required by the commissioner.

(e) The commissioner will not issue a certificate before the guarantor of the security has submitted to the division a security deposit that meets the requirements of this section.

(f) The certified self-insurer shall notify the division if the security bond or letter of credit no longer meets the requirements of subsection (a) of this section. This notice shall be provided in writing to the division within 30 days of that change.

(g) The division may require a substitution of the security deposit in the event that the certified self-insurer's surety or guarantor no longer meets the requirements of subsection (a) of this section.

Source Note: The provisions of this §114.4 adopted to be effective January 1, 1993, 17 TexReg 7896; amended to be effective December 2, 1997, 22 TexReg 11692; amended to be effective May 9, 2004, 29 TexReg 4186; amended to be effective January 6, 2019, 44 TexReg 99

Rule §114.5 Excess Insurance Requirements

(a) The upper limit of liability for a contract or policy of excess insurance shall be in the amount required by the commissioner. The minimum amount the commissioner may require is $5 million per occurrence.

(b) A contract or policy of excess insurance must be issued by an insurance company authorized by the State of Texas to transact such business and shall include the following provisions:

(1) cancellation requires notice to the division in the form and manner prescribed by the commissioner at least 60 days before termination;
(2) non-renewal requires notice to the division, in the form and manner prescribed by the commissioner at least 60 days before the end of the policy;
(3) the Association must be named as an additional insured on the excess policy and may assume the rights and responsibilities of the certified self-insurer under the policy when the certified self-insurer is declared to be impaired; and
(4) all of the following benefits to which the injured employee is entitled under the Texas Workers' Compensation Act must be applied toward reaching the retention amount:
(A) payments made by the certified self-insured employer;
(B) payments due and owing by the certified self-insured employer;
(C) payments made on behalf of the certified self-insured employer by any form of security as required by the Act or division rules; and
(D) payments made by the Association pursuant to Texas Labor Code §407.121 and §407.127.

(c) The commissioner will not issue a certificate before the excess insurance carrier has submitted to the division evidence of a qualifying excess insurance policy that meets the requirements of this section.

(d) The certified self-insurer who elects to cancel or chooses not to renew a policy of excess insurance shall notify the division 60 days prior to the cancellation or termination in the form and manner prescribed by the commissioner.

Source Note: The provisions of this §114.5 adopted to be effective January 1, 1993, 17 TexReg 7896; amended to be effective March 13, 2000, 25 TexReg 2088; amended to be effective May 9, 2004, 29 TexReg 4186; amended to be effective January 6, 2019, 44 TexReg 99

Rule §114.6 Safety Program Requirements

To qualify as an effective safety program under Texas Labor Code §407.061(d), an applicant's safety program must include the following components at a minimum:

(1) A management component that includes:
(A) a clearly written safety policy distributed to all employees;

(B) a written assignment of safety responsibilities and delegation of authority which includes oversight of implementation of the safety program and the authority to communicate directly with the employer's top management regarding health and safety issues;
(C) a method of receiving, evaluating, and responding to employee input regarding workplace health and safety; and
(D) a process to ensure review and revision of the safety program when changes in processes, procedures, operations, or equipment are implemented or anticipated, to ensure continued effectiveness of the safety program.

(2) An analysis component that:
(A) facilitates the recognition of injury and illness trends, and
(B) facilitates the focus of corrective action on identified trends.

(3) A records component that requires documentation of:
(A) analysis results and any consequent improvement effort or corrective action;
(B) safety-related employee training, including the training topic and date trained;
(C) internal or external safety audits or inspections of facilities, equipment, practices, and procedures;
(D) accident investigations;
(E) safety committee meeting minutes, if such a committee is present in the workplace; and
(F) any other safety-related records deemed appropriate by the applicant.

(4) A safety-training component that provides employees with initial and recurring training on all topics required to perform assigned duties safely.

(5) An audit or inspection component that requires:
(A) periodic inspections of facilities, equipment, and safety-related practices and procedures; and
(B) periodic evaluation and monitoring of industrial hygiene exposures.

(6) An accident investigation component that focuses on the identification and mitigation of causal factors.

Source Note: The provisions of this §114.6 adopted to be effective January 1, 1993, 17 TexReg 7896; amended to be effective May 9, 2004, 29 TexReg 4186; amended to be effective January 6, 2019, 44 TexReg 99

Rule §114.7 Certification Process

(a) The division shall request review and approval of the Association by forwarding a summary of the relevant application information after the division deems the application complete and finds the applicant's financial information required under §114.3 of this title (relating to Application Form and Financial Information Requirements) reflects one of the following qualifying financial ratings:

(1) Dun & Bradstreet rating of 3A1 or better;
(2) Standard & Poor's rating of BBB or better;
(3) Moody's rating of Baa or better; or
(4) minimum tangible net worth of $5 million with a ratio of tangible net worth to long-term debt of 1.5 to one or greater.

(b) The division may audit information supplied by an employer applying for a certificate.

(c) The division shall recommend an applicant for certification only with approval of the application by the Association. Failure of the Association to respond within 120 days after the Association's receipt of the information provided for in subsection (a) of this section will be deemed as the Association's approval of an applicant to be a certified self-insurer.

(d) Within a reasonable time after approval by the Association of a completed application, the division will recommend to the commissioner approval or denial of the application at a public meeting for self-insurance business (generally quarterly) that follows the completion of an application and the approval process described in subsection (c) of this section.

Source Note: The provisions of this §114.7 adopted to be effective January 1, 1993, 17 TexReg 7896; amended to be effective May 9, 2004, 29 TexReg 4186; amended to be effective January 6, 2019, 44 TexReg 99

Rule §114.8 Refusal To Certify an Employer

(a) When the commissioner determines an application should be denied, the applicant will be notified of the following:

(1) the specific reasons for the denial;
(2) the specific conditions, if any, the applicant must meet to become certified;
(3) that the applicant has a 30-day period from the date the applicant receives the notice to meet the conditions required or provide compelling information to the division to rebut the reasons for denial; and

(4) the form and format required to notify the division of the actions taken by the applicant to overcome the denial.

(b) The notice described in subsection (a) of this section shall be:
(1) in writing; and
(2) sent to the contact person, return receipt requested.

(c) The denial becomes final on the 31st day after the applicant receives the notice of denial if the applicant has not responded.

(d) When the applicant timely responds to the denial, the commissioner may grant or deny the application within 130 days after the applicant received the notice of denial, and such action shall be final immediately. If the commissioner fails to take action within 130 days after the applicant received the notice of denial, the denial becomes final on the 131st day.

Source Note: The provisions of this §114.8 adopted to be effective January 1, 1993, 17 TexReg 7896; amended to be effective January 6, 2019, 44 TexReg 99

Rule §114.9 Required Safety Program Inspections

(a) An employer seeking to obtain a certificate shall have its safety program reviewed or inspected by the division before the issuance of its initial certificate and thereafter, as appropriate, to demonstrate the existence of an effective safety program for each location.

(b) To facilitate the review or inspection process, the employer shall provide the division with access to all of the documents related to its safety program and its workers' compensation claims and shall permit the inspection of any of its work sites during working hours. Unreasonable refusal to provide access to the required information or facilities may be considered as:
(1) submission of an incomplete application or grounds for revocation of a certificate; and
(2) an administrative penalty with each day of noncompliance constituting a separate violation.

(c) Unless significant deficiencies are noted in a safety program review or inspection, the division is not required to issue a review or inspection report.

Source Note: The provisions of this §114.9 adopted to be effective January 1, 1993, 17 TexReg 7896; amended to be effective May 9, 2004, 29 TexReg 4186; amended to be effective January 6, 2019, 44 TexReg 99

Rule §114.10 Claims Contractor Requirements

(a) Claims administration must be performed by an adjuster licensed in Texas to handle workers' compensation claims.

(b) Each proposed contract to provide claims services to a certified self-insurer must be approved by the division prior to recommending approval of an application to self-insure or, if a certified self-insurer is changing from one claims contractor to another, prior to the effective date of the new contract.

(c) An applicant must ensure that a current signed claims administration contract remain on file with the division at all times.

(d) The claims contractor must promptly investigate each reportable injury and either pay benefits or controvert, as required by the Texas Workers' Compensation Act and division rules.

Source Note: The provisions of this §114.10 adopted to be effective January 1, 1993, 17 TexReg 7896; amended to be effective May 9, 2004, 29 TexReg 4186; amended to be effective January 6, 2019, 44 TexReg 99

Rule §114.11 Audit Program

(a) The division shall audit certified self-insurers as frequently as necessary to assure compliance with the Texas Workers' Compensation Act and division rules, but shall audit each certified self-insurer at least once every three years.

(b) An audit may include, but not be limited to:
- (1) any representation made on an application or in an annual report required by §114.15(b) of this title (relating to Revocation of Certificate of Authority to Self-Insure);
- (2) payroll and classification;
- (3) loss history;
- (4) claims administration;
- (5) loss reserves;

(6) interviews of the certified self-insurer, its agents, or employees regarding any matter within their knowledge and pertaining to the obligations of the certified self-insurer under the Act or division rules; and
(7) any other issue deemed appropriate by the division.

(c) A written report shall be provided to the certified self-insurer within 30 days after the audit is completed.

(d) A certified self-insurer's unreasonable refusal to make the required information available constitutes:

(1) grounds for revocation of the certificate; and

(2) a Class A administrative violation, with each day of noncompliance constituting a separate violation.

Source Note: The provisions of this §114.11 adopted to be effective January 1, 1993, 17 TexReg 7896; amended to be effective May 9, 2004, 29 TexReg 4186; amended to be effective January 6, 2019, 44 TexReg 99

Rule §114.12 Required Reporting

(a) Each certified self-insurer shall file with the division an annual application or, if required by §114.15(b) of this title (relating to Revocation of Certificate of Authority to Self-Insure), an annual report, according to a schedule established by the division. The division may require an annual application or annual report to include the following:
(1) claims information, such as loss run information, in the form and manner prescribed by the commissioner;
(2) an information report, in the manner prescribed by the commissioner, that includes an analysis of accident trends which:
(A) identifies losses by location, occupation, or job function; and
(B) provides an analysis of those losses based on:
(i) nature, source, and severity of the injury;
(ii) cause of the injury;
(iii) parts of the body affected;
(iv) equipment involved in the injury;
(v) number of injuries and fatalities other than occupational diseases; and
(vi) identification of the number of occupational diseases;
(3) independently audited financial statements according to Generally Accepted Auditing Standards of the American Institute of Certified Public Accountants; and

(4) any substantive policy or procedure changes in the certified self-insurer's safety program.

(b) If any of the information required by this section is more than six months old, it may be considered incomplete and the division may require the certified self-insurer to provide updated information.

(c) An application, annual report required by §114.15(b) of this title (relating to Revocation of Certificate of Authority to Self-Insure), or other designated document will not be complete until all parts of the document, including all required attachments and any required updates, are filed.

Source Note: The provisions of this §114.12 adopted to be effective January 1, 1993, 17 TexReg 7896; amended to be effective May 9, 2004, 29 TexReg 4186; amended to be effective January 6, 2019, 44 TexReg 99

Rule §114.13 Required Notices to the Division

(a) A certified self-insurer that amends its charter, articles of incorporation, or partnership agreement to change its identity or business structure, or in any other manner materially alters its status as it existed at the time of issuance of its certificate shall, within 30 days after the amendment or other action, notify the division of such action in the form and manner prescribed by the commissioner and provide the division with a copy of such amendment or other action.

(b) A certified self-insurer that ceases doing business entirely, ceases doing business in Texas, or disposes of, by sale or otherwise, the controlling interest of the business for which the certificate was issued, shall immediately notify the division in the form and manner prescribed by the commissioner of such action and the division will act on the notice pursuant to Texas Labor Code, §407.045.

(c) A certified self-insurer shall give notice to the division in the form and manner prescribed by the commissioner of any change in contact person within 10 working days of this change. The notice shall include the name, title, office address, and telephone number, facsimile number and email address of the new contact person.

(d) A certified self-insurer shall give notice to the division in the form and manner prescribed by the commissioner at least 30 days prior to any change in the claims contractor. The notice shall include the name, title, office address, and telephone number, facsimile number and email address of the person or persons appointed to

administer both the existing cases and the new cases and the location or locations of records required to be kept and maintained pursuant to Texas Labor Code, §407.082.

(e) A certified self-insurer shall notify the division in the form and manner prescribed by the commissioner of any change or expected change which will significantly alter the liability or solvency of the certified self-insurer within 30 days of the certified self-insurer's knowledge of the change.

(f) For purposes of §406.006 of the Texas Labor Code, coverage takes effect upon approval by the commissioner. Approval by the commissioner fulfills the certified self-insurer's requirement to file notice of coverage and claim administration contact information as required by §406.006.

Source Note: The provisions of this §114.13 adopted to be effective January 1, 1993, 17 TexReg 7896; amended to be effective March 13, 2000, 25 TexReg 2088; amended to be effective January 6, 2019, 44 TexReg 99

Rule §114.14 Impaired Employer

If a certified self-insurer becomes an impaired employer, the commissioner shall protect the employees of such employer by promptly:

(1) calling the security deposit and placing the funds in an account for the impaired employer;

(2) notifying the Association or other entity designated by the commissioner to assume the liabilities of the impaired employer; to begin paying, pursuant to Texas Labor Code §407.127, benefits out of the impaired employer's account; and, if necessary, to notify the Association to begin paying benefits out of its trust fund; and

(3) estimating the amount of any additional funds needed to supplement the security deposit and available assets of the impaired employer and advise the Association of the amount the Association will need to assess each certified self-insurer to cover the estimated liabilities once the impaired employer's security account has been expended.

Source Note: The provisions of this §114.14 adopted to be effective January 1, 1993, 17 TexReg 7896; amended to be effective May 9, 2004, 29 TexReg 4186; amended to be effective January 6, 2019, 44 TexReg 99

Rule §114.15 Revocation or Suspension of Certificate of Authority to Self-Insure

(a) The commissioner may revoke the certificate of a certified self-insurer who fails to comply with requirements or conditions established by Chapter 407 of the Texas Labor Code or any rule within Chapter 114 of this title (regarding Self-Insurance), including:

(1) failure to maintain financial strength;
(2) failure to implement and maintain an effective safety program;
(3) failure to maintain acceptable claim services;
(4) failure to obtain and maintain the required security deposit;
(5) failure to obtain and maintain excess insurance as required by the commissioner;
(6) failure to file any required information under §114.12 of this title (relating to Required Reporting);
(7) unreasonable refusal to make information available as required under §114.11 of this title (relating to Audit Program);
(8) failure to provide notice as required in §114.13 of this title (relating to Required Notices to the Division); or
(9) failure to comply with any provision of the Texas Workers' Compensation Act or with any division rule.

(b) The commissioner may suspend or revoke the certificate of a certified self-insurer due to the certified self-insurer's failure to pay an assessment as required by Texas Labor Code §407.124(b) and §407.125.

(c) A certified self-insurer whose certificate has been revoked, suspended, withdrawn, or denied must file an annual report, in the form and manner prescribed by the commissioner.

(d) Pursuant to Texas Labor Code §§407.046, 407.047, and 407.082, the division shall continue to audit the claims of any certified self-insurer whose certificate has been revoked, suspended, withdrawn, or denied.

(e) Prior to revoking a certificate, the commissioner shall refer the matter to the State Office of Administrative Hearings, which shall hold a hearing to determine if the certificate should be revoked.

Source Note: The provisions of this §114.15 adopted to be effective January 1, 1993, 17 TexReg 7896; amended to be effective December 4, 1995, 20 TexReg 9698; amended to be effective May 9, 2004, 29 TexReg 4186; amended to be effective January 6, 2019, 44 TexReg 99

Rule §114.16 Withdrawal from Self-Insurance

(a) Insuring agreements under Labor Code §407.045(a-1) filed for the commissioner's approval as a part of an adequate program to withdraw from self-insurance must meet the following criteria:

(1) The form of an insuring agreement must be that of a standard workers' compensation policy providing statutory limits with an approved company specific endorsement under Texas Insurance Code §2052.002(b) providing coverage for all open, reopened, and incurred but not reported claims against the self-insured employer for the entire period of time it operated as a certified self-insurer.

(2) The insurance policy must be issued by an insurance company as defined by Texas Labor Code §401.011(28) that has not been determined to be in hazardous financial condition by the commissioner of insurance pursuant to Chapter 8 of this title (relating to Hazardous Condition).

(3) The policy period must be retrospective providing coverage for the entire period of time the employer operated as a certified self-insurer.

(4) The policy as endorsed must be noncancelable by either the insurance company or the certified self-insured employer for any reason.

(5) The insurance company issuing an insuring agreement that covers all the workers' compensation liabilities of a certified self-insurer becomes the workers' compensation insurance carrier for the liabilities covered for all purposes of the Texas Workers' Compensation Act and division rules.

(b) Withdrawals from self-insurance must comply with all applicable statutes and all applicable rules promulgated by the commissioner of insurance and the commissioner of workers' compensation.

(c) Notwithstanding the security deposit requirements in §114.4 of this title (relating to Security Deposit Requirements), the commissioner may review and approve modifications to previously approved withdrawals from self-insurance, including modifications to security deposit requirements.

(d) The commissioner retains discretionary authority to approve, disapprove, or require modification of any proposed program for withdrawal from self-insurance presented by a certified self-insurer.

Source Note: The provisions of this §114.16 adopted to be effective January 6, 2019, 44 TexReg 99

TITLE 28 **INSURANCE**
PART 2 **TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION**
CHAPTER 116 **GENERAL PROVISIONS--SUBSEQUENT INJURY FUND**

RULE §116.11 Request for Reimbursement from the Subsequent Injury Fund

(a) An insurance carrier may request:
(1) reimbursement from the Subsequent Injury Fund (SIF) under Labor Code §403.006(b)(2) for an overpayment of income, death, or medical benefits when the insurance carrier has made an unrecoupable overpayment pursuant to the decision of an administrative law judge, the Appeals Panel, or an interlocutory order, and that decision or order is reversed or modified by final arbitration, order, or decision of the commissioner, State Office of Administrative Hearings, or a court of last resort;
(2) reimbursement from the SIF under Labor Code §403.007(d) for death benefits paid to the SIF before a legal beneficiary was determined to be entitled to receive death benefits;
(3) for a compensable injury that occurs on or after July 1, 2002, reimbursement from the SIF for the amount of income benefits paid to an injured employee based on multiple employment and paid under Labor Code §408.042;
(4) for a compensable injury that occurs on or after September 1, 2007, reimbursement from the SIF for the amount of income, death benefits, or a combination paid to an injured employee or a legal beneficiary based on multiple employment and paid under Labor Code §408.042;
(5) reimbursement from the SIF, under Labor Code §408.0041(f) and (f-1), for an overpayment of benefits made by the insurance carrier based on the opinion of the designated doctor if that opinion is reversed or modified by a final arbitration award or a final order or decision of the commissioner or a court; or
(6) reimbursement from the SIF made in accordance with rules adopted by the commissioner under Labor Code §413.0141. For purposes of this subsection only, an injury is determined not to be compensable following:
(A) The final decision of the commissioner or the judgment of the court of last resort; or
(B) A claimant's failure to respond within one year of a timely dispute of compensability filed by an insurance carrier. In this instance only, the effective date of the determination of noncompensability is one year from the date the insurance carrier filed the dispute with the division.
(i) A determination under this paragraph does not constitute final adjudication. It does not preclude a party from pursuing their claim through the division's dispute

resolution process, and it does not permit a health care provider to pursue a private claim against the claimant.

(ii) If the claim is later determined to be compensable, the insurance carrier must reimburse the SIF for any initial pharmaceutical payment that the SIF previously reimbursed to the insurance carrier. The insurance carrier's reimbursement of the SIF must be paid within the timeframe the insurance carrier has to comply with the agreement, decision and order, or other judgment that found the claim to be compensable.

(b) The amount of reimbursement the insurance carrier may be entitled to is equal to the amount of unrecoupable overpayments paid and does not include any amounts the insurance carrier overpaid voluntarily or as a result of its own errors. An unrecoupable overpayment of income or death benefits for the purpose of reimbursement from the SIF only includes those benefits that were overpaid by the insurance carrier pursuant to an interlocutory order, a designated doctor's opinion, or a decision, which were finally determined to be not owed and which, in the case of an overpayment of income or death benefits to the injured employee or legal beneficiary, were not recoverable or convertible from other income or death benefits.

(c) To request reimbursement under subsection (a)(1) of this section for insurance carrier claims of benefit overpayments made under an interlocutory order or decision of the commissioner that is later reversed or modified by final arbitration, order, decision of the commissioner, the State Office of Administrative Hearings, or court of last resort, an insurance carrier must:

(1) submit the request electronically in the form and manner prescribed by the division;

(2) provide a claim-specific summary of the reason the insurance carrier is seeking reimbursement and the total amount of reimbursement requested, including how it was calculated;

(3) provide a detailed payment record showing the dates and amounts of the payments, payees, type of benefits and periods of benefits paid, all plain language notices (PLNs) about the payment of benefits, all certifications of maximum medical improvement and assignments of impairment rating, and documentation that shows the overpayment was unrecoupable as described in subsection (b) of this section, if applicable;

(4) provide the name, address, and federal employer identification number of the payee (insurance carrier) for any reimbursement that may be due;

(5) provide copies of all relevant orders and decisions (benefit review conference reports, interlocutory orders, contested case hearing decisions and orders, Appeals Panel decisions, and court orders) relating to the requested reimbursement and show which document is the final decision on the matter;

(6) provide copies of all relevant reports and DWC forms the employer filed with the insurance carrier; and

(7) provide copies of all medical bills, preauthorization request documents, relevant independent review organization (IRO) decisions, medical fee dispute decisions, contested case hearing decisions and orders, Appeals Panel decisions, and court orders on medical disputes associated with the overpayment, if the request is based on an overpayment of medical benefits.

(d) To request reimbursement under subsection (a)(2) of this section for reimbursement of death benefits paid to the SIF before a legal beneficiary is determined to be entitled to receive death benefits, an insurance carrier must:

(1) submit the request electronically in the form and manner prescribed by the division;

(2) provide a claim-specific summary of the reason the insurance carrier is seeking reimbursement and the total amount of reimbursement requested, including how it was calculated;

(3) provide a detailed payment record showing the dates and amounts of payments, payees, and periods of benefits paid;

(4) provide the name, address, and federal employer identification number of the payee (insurance carrier) for any reimbursement that may be due;

(5) provide the documentation the legal beneficiary submitted with the claim for death benefits under §122.100 of this title (relating to Claim for Death Benefits); and

(6) provide the final award of the commissioner or the final judgment of a court of competent jurisdiction determining that the legal beneficiary is entitled to the death benefits.

(e) To request reimbursement under subsections (a)(3) or (4) of this section regarding multiple employment, the requester must submit the request on an annual basis for the payments made during the same or previous fiscal year. The fiscal year begins each September 1 and ends on August 31 of the next calendar year. For example, insurance carrier payments made during the fiscal year from September 1, 2009, through August 31, 2010, must be submitted by August 31, 2011. Any claims for insurance carrier payments related to multiple employment that are not submitted within the required timeframe will not be reviewed for reimbursement. To request reimbursement under subsections (a)(3) or (4) of this section, an insurance carrier must:

(1) submit the request electronically in the form and manner prescribed by the division;

(2) provide a claim-specific summary of the reason the insurance carrier is seeking reimbursement and the total amount of reimbursement requested, including how it was calculated;

(3) provide a detailed payment record showing the dates and amounts of payments, payees, type of benefits and periods of benefits paid, all PLNs about the payment of

benefits, and documentation that shows the overpayment was unrecoupable as described in subsection (b) of this section, if applicable;

(4) provide the name, address, and federal employer identification number of the payee (insurance carrier) for any reimbursement that may be due;

(5) provide information documenting the injured employee's average weekly wage amounts paid from all nonclaim employment held at the time of the work-related injury under §122.5 of this title (relating to Employee's Multiple Employment Wage Statement); and

(6) provide information documenting the injured employee's average weekly wage amounts paid based on employment with the claim employer.

(f) To request reimbursement under subsection (a)(5) of this section, for insurance carrier claims of benefit overpayments made pursuant to a designated doctor's opinion that is later reversed or modified by a final arbitration award or a final order or decision of the commissioner or a court, an insurance carrier must:

(1) submit the request electronically in the form and manner prescribed by the division;

(2) provide a claim-specific summary of the reason the insurance carrier is seeking reimbursement and the total amount of reimbursement requested, including how it was calculated;

(3) provide a detailed payment record showing the dates and amounts of payments, payees, type of benefits and periods of benefits paid, PLNs about the payment of benefits, and all certifications of maximum medical improvement and assignments of impairment rating;

(4) provide the name, address, and federal employer identification number of the payee (insurance carrier) for any reimbursement that may be due;

(5) provide copies of all relevant designated doctors' opinions (including responses to letters of clarification) and orders and decisions (IRO decisions, interlocutory orders, contested case hearing decisions and orders, arbitration awards, Appeals Panel decisions, and court orders) relating to the designated doctor's opinion and the payment made pursuant to the designated doctor's opinion for which reimbursement is being requested, and indicate which document is the final decision on the matter;

(6) provide copies of all relevant reports and DWC forms the employer filed with the insurance carrier; and

(7) provide copies of all medical bills and preauthorization request documents associated with an overpayment of medical benefits.

(g) To request reimbursement under subsection (a)(6) of this section regarding initial pharmaceutical coverage, a requester must submit the request in the same or following fiscal year after a determination that the injury is not compensable. The fiscal year begins each September 1 and ends on August 31 of the next calendar year. For example,

if an injury is determined to be not compensable during the fiscal year from September 1, 2009, through August 31, 2010, the request for reimbursement under Labor Code §413.0141 must be submitted by August 31, 2011. Any claims for insurance carrier payments related to initial pharmaceutical coverage that are not submitted within the required timeframe will not be reviewed for reimbursement. An insurance carrier must:

(1) submit the request electronically in the form and manner prescribed by the division;

(2) provide a claim-specific summary of the reason the insurance carrier is seeking reimbursement and the total amount of reimbursement requested;

(3) provide a detailed payment record showing the dates of payments, including documentation on dates of payment of initial pharmaceutical coverage (i.e., during the first seven days following the date of injury), payment amounts, and payees;

(4) provide the name, address, and federal employer identification number of the payee (insurance carrier) for any reimbursement that may be due;

(5) provide documentation that the pharmaceutical services were provided during the first seven days following the date of injury, not counting the actual date the injury occurred, and identify the prescribed pharmaceutical services; and

(6) provide documentation of:

(A) the final resolution of any dispute either from the commissioner or court of last resort that determines the injury is not compensable; or

(B) a claimant's failure to respond in accordance with subsection (a)(6)(B) of this section.

(h) The prescribed forms under this section are on the division's website at www.tdi.texas.gov/wc/index.html. An insurance carrier seeking reimbursement from the SIF must timely provide to the SIF administrator by electronic transmission, as that term is used in §102.5(h) of this title (relating to General Rules for Written Communications to and from the Commission), all forms and documentation reasonably required by the SIF administrator to determine entitlement to reimbursement or payment from the SIF and the amount of reimbursement to which the insurance carrier is entitled. The insurance carrier must also provide notice to the SIF of any relevant pending dispute, litigation, or other information that may affect the request for reimbursement.

Source Note: The provisions of this §116.11 adopted to be effective February 11, 1992, 17 TexReg 689; amended to be effective March 13, 2000, 25 TexReg 2090; amended to be effective August 15, 2002, 27 TexReg 7123; amended to be effective January 7, 2010, 35 TexReg 100; amended to be effective January 7, 2019, 44 TexReg 102; amended to be effective February 11, 2021, 46 TexReg 925

RULE §116.12 Subsequent Injury Fund Payment/Reimbursement Schedule

(a) Claims against the Subsequent Injury Fund (SIF) shall be paid in the following priority:
(1) claims by insurance carriers for reimbursement made pursuant to Labor Code §403.007 and §132.10(g) of this title (relating to Payment of Death Benefits to the Subsequent Injury Fund);
(2) claims by injured employees for lifetime benefits, as provided by Labor Code §408.162;
(3) claims by insurance carriers for reimbursement, made pursuant to Labor Code §§408.0041, 410.209, and 413.055 and §116.11 of this title (relating to Request for Reimbursement from the Subsequent Injury Fund); and
(4) claims by insurance carriers for reimbursement made pursuant to Labor Code §408.042(g) relating to multiple employment and those in accordance with division rule(s) adopted pursuant to Labor Code §413.0141.

(b) The SIF uses the fiscal year September 1 through August 31.

(c) Claims described in subsection (a) of this section should be reviewed and, if appropriate, paid in the fiscal quarter following the quarter in which the request was submitted and no later than one year following the submission.

(d) In accordance with Labor Code §403.006(d), if the commissioner determines that partial payments of the claims described in subsection (a)(4) of this section are necessary, partial payments shall be calculated in the following manner:
(1) The total amount of completed eligible requests for reimbursement submitted under subsection (a)(4) of this section that are received during the previous fiscal year will be used to establish a baseline amount.
(2) The baseline amount will be divided by the total amount of SIF funding available as determined in accordance with the Labor Code.
(3) The resulting fraction will be equally applied to all claims submitted under subsection (a)(4) of this section to determine the partial reimbursement amount.
(4) If reimbursement requests are paid with partial payments, no further future recovery is available from the SIF for the non-reimbursed portion of that particular request.

(e) If reimbursement requests are paid with partial payments, the SIF administrator shall, no later than October 30 of the following fiscal year, enter appropriate orders for claims described in subsection (a)(4) of this section. The order shall specify the amount the SIF shall pay to the insurance carrier.

(f) The SIF administrator will refrain from acting on an insurance carrier's request for reimbursement from the SIF until final resolution of all disputes affecting the request for reimbursement.

Source Note: The provisions of this §116.12 adopted to be effective February 11, 1992, 17 TexReg 689; amended to be effective March 13, 2000, 25 TexReg 2090; amended to be effective August 15, 2002, 27 TexReg 7123; amended to be effective January 7, 2010, 35 TexReg 100

TITLE 28 **INSURANCE**
PART 2 **TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION**
CHAPTER 120 **COMPENSATION PROCEDURE—EMPLOYERS**

RULE §120.1 Employer's Record of Injuries

(a) An employer shall keep a record of all injuries and fatal injuries to employees as reported to an employer, or otherwise made known to an employer. The record shall include:
(1) the name, address, date of birth, sex, wage, length of service, social security number, and occupation of the employee;
(2) the reported cause and nature of the injury, the part of the body affected, and a description of any equipment involved;
(3) the date, time, and location where the injury occurred;
(4) the name of the employee's immediate supervisor;
(5) the names of any witnesses (if known);
(6) the name and address of the treating health care provider, if known; and
(7) any voluntary benefits paid by the employer under the Texas Workers' Compensation Act (Act), §4.06.

(b) These records shall be open to inspection by the commission, upon at least five working days notice to the employer, at a reasonable time and place.

(c) The employer shall retain a record of an injury until the expiration of five years from the last day of the year in which the injury occurred or the period of time required by Occupational Safety and Health Administration standards and regulations, whichever is greater.

(d) An employer who does not maintain a record, or who refuses to make the record available to the commission, may be assessed an administrative penalty not to exceed $500.

Source Note: The provisions of this §120.1 adopted to be effective January 11, 1991, 16 TexReg 115

RULE §120.2 Employer's First Report of Injury and Notice of Injured Employee Rights and Responsibilities

(a) The employer shall report to the employer's insurance carrier each death, each occupational disease of which the employer has received notice of injury or has knowledge, and each injury that results in more than one day's absence from work for the injured employee. As used in this section, the term "knowledge" includes receipt of written or oral information regarding diagnosis of an occupational disease, or the diagnosis of an occupational disease through direct examination or testing by a doctor employed by the employer.

(b) The Division shall prescribe the form, format, and manner of the employer's first report of injury (report). The report shall contain:
(1) the information required by §120.1(a) of this title (relating to Employer's Record of Injuries);
(2) any additional information prescribed by the Division in accordance with the Labor Code §402.00128(b)(10); and
(3) the information necessary for an insurance carrier to electronically transmit a first report of injury to the Division.

(c) The report shall be filed with the insurance carrier not later than the eighth day after having received notice of or having knowledge of an occupational disease or death, or not later than the eighth day after the employee's absence from work for more than one day due to a work-related injury. For purposes of this section, a report is filed when personally delivered, mailed, reported via tele-claims, electronically submitted, or sent via facsimile.

(d) The employer shall provide a written copy of the report and a written copy of the Notice of Injured Employee Rights and Responsibilities in the Texas Workers' Compensation System (Notice of Rights and Responsibilities) adopted by the Public Counsel of the Office of Injured Employee Counsel (Public Counsel) to the injured employee by personal delivery, mail, electronic submission or facsimile. The Notice of Rights and Responsibilities shall be in English and Spanish, or in English and any other language common to the employee. The written report may be the report specified in subsection (b) of this section, or at a minimum shall contain the information listed in §120.1(a) of this title.

(e) The Public Counsel must adopt the Notice of Rights and Responsibilities after consultation with the commissioner of workers' compensation. Until the Public Counsel adopts any new notice in accordance with Labor Code §404.109, the notice previously

adopted under this section will remain in effect. A copy of the Notice of Rights and Responsibilities adopted by the Public Counsel will be distributed through or provided at:

(1) the department's website at www.tdi.texas.gov;

(2) the Office of Injured Employee Counsel's website at www.oiec.texas.gov;

(3) The Texas Department of Insurance, Division of Workers' Compensation, 1601 Congress Avenue, Austin, Texas, 78701 or any office of the Texas Department of Insurance, Division of Workers' Compensation; or

(4) The Office of Injured Employee Counsel, 1601 Congress Avenue, Austin, Texas, 78701 or any office of the Office of Injured Employee Counsel.

(f) The employer shall maintain a record of the date the copy of the report of injury and the date the Notice of Rights and Responsibilities were provided to the employee. The employer shall also maintain a record of the date the report of injury is filed with the insurance carrier.

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

(h) A party who fails to comply with this section commits an administrative violation.

Source Note: The provisions of this §120.2 adopted to be effective January 11, 1991, 16 TexReg 115; amended to be effective January 1, 1993, 17 TexReg 8295; amended to be effective December 4, 1995, 20 TexReg 9698; amended to be effective October 14, 2007, 32 TexReg 7065; amended to be effective March 22, 2010, 35 TexReg 2188; amended to be effective March 26, 2025, 50 TexReg 2076.

RULE §120.3 Employer's Supplemental Report of Injury

(a) As used in this section, the term "employer" means the employer for whom the injured employee (employee) was working when injured and the filing requirements apply during the time the employee is entitled to temporary income benefits. The employer's duty to file reports required by this section continues until the employee reaches maximum medical improvement (MMI) or is no longer employed by the employer and the employer has made the report required by subsection (b) of this section. The employer may contact the insurance carrier (carrier) for information regarding the employee's MMI status.

(b) As provided in §129.4 of this title (relating to Adjustment of Temporary Income Benefit Amount), the employer shall file the Supplemental Report of Injury, in the form, format and manner prescribed by the Commission. The report shall be filed with the employer's carrier and provided to the employee within ten days after the end of each pay period in which the employee has a change in earnings as a result of the injury or within ten days after the employee resigns or is terminated. The requirement to report a change of earnings under this subsection includes reporting all post-injury earnings as that term is used in Chapter 129 of this title (relating to Temporary Income Benefits).

(c) For injuries requiring an Employer's First Report of Injury, unless the information required in this subsection is provided on the Employer's First Report of Injury, the employer shall file the Supplemental Report of Injury with the employer's carrier and provide a copy to the employee within three days after:
(1) the employee begins to lose time from work as a result of the injury;
(2) the employee returns to work; or
(3) the employee, after returning to work, experiences an additional day(s) of disability as a result of the injury.

(d) The employer shall file the supplemental report of injury with the carrier by personal delivery, telephone, facsimile or electronic transmission. The employer shall provide a copy of the report to the employee by facsimile or electronic transmission if the employee has identified a personal facsimile number or a personal email address to be used and the employer has the means of sending such a transmission. Otherwise the report shall be provided by personal delivery or sent by mail.

(e) The employer shall maintain a record of the date the Supplemental Report of Injury is filed with the carrier and provided to the employee. If a report required by this section has not been received by the required recipient, the employer has the burden of proving that the report was filed within the required time frame. The employer has the burden of proving that good cause exists if the employer failed to file the report.

Source Note: The provisions of this §120.3 adopted to be effective January 1, 1993, 17 TexReg 8296; amended to be effective December 4, 1995, 20 TexReg 9698; amended to be effective December 26, 1999, 24 TexReg 11394

RULE §120.4 Employer's Wage Statement

(a) The employer is required to timely file a complete wage statement in the form and manner prescribed by the commission. As used in this section, the term "filed" means "received."

(1) The wage statement shall be filed with the carrier, the claimant, and the claimant's representative (if any) within 30 days of the earliest of:

(A) the date the employer is notified that the employee is entitled to income benefits;

(B) the date of the employee's death as a result of a compensable injury.

(2) A subsequent wage statement shall be filed with the carrier, claimant, and the claimant's representative (if any) within seven days of a change in any wage information provided on the previous wage statement (such as because the employer has discontinued providing a nonpecuniary wage that was originally continued after the injury).

(3) The wage statement shall be filed with the commission within seven days of receiving a request from the commission.

(b) The employer shall ensure timely delivery of the written wage statement, however, if agreed upon by the employer and the carrier, the wage statement filed with the carrier may be filed orally. The carrier may also agree to provide the wage statement to the claimant and the claimant's representative, if any. However, the employer remains responsible for ensuring timely delivery of the wage statement and the employer has the burden of proving that the wage statement was timely filed. Therefore, employers should file the wage statement by verifiable means and maintain a record of the:

(1) information provided;

(2) date filed; and

(3) means of filing with each recipient required to receive the report.

(c) The wage statement shall include:

(1) the employee's name, address, and social security number;

(2) the date of the employer's hire of the employee;

(3) the date of injury;

(4) the employer's name, address, and federal tax identification number;

(5) an identification of the employment status (e.g. if the employee works full-time, part-time, etc.);

(6) the name of the person submitting the report;

(7) the wage information required by subsection (d) of this section; and

(8) a certification that the wage information provided includes all wage information required by subsection (d) of this section and that the information is complete and accurate.

(d) The employer shall provide wage information in accordance with this subsection.

(1) Employers other than school districts shall report the employee's wage, as defined in §128.1 of this title (relating to Average Weekly Wage: General Provisions), earned by the employee during the 13 weeks immediately preceding the date of injury and the number of hours the employee worked to earn the wages being reported.

(2) School district employers shall report the wages that would be deducted from the employee's salary if the employee were absent from work for one week and did not have personal leave available to compensate for the wages lost that week.

(A) For employees employed through a written contract, the employer shall report the full value of the contract that would be paid (including any stipend the employee was earning or scheduled to receive) if the employee were to fully complete the terms of the contract and:

(i) the number of days that the employee was required to work under that contract; or

(ii) the number of months that the employee was required to work under that contract (whichever is applicable).

(B) For employees who are NOT employed through a written contract, the employer shall report the pecuniary wages earned by the employee during the 13 weeks immediately preceding the date of injury and the number of hours the employee worked to earn the wages being reported.

(C) For all employees, the employer shall report the pecuniary wages earned by the employee in the 12 months immediately preceding the injury.

(3) This subsection applies if the employer is required to report 13 weeks of wage information under subsection (d)(1) or (d)(2)(B) of this section (i.e. it does not apply if the employee was an employee of a school district employed through a written contract).

(A) If the employee is paid on a monthly or a semi-monthly basis, the employer may provide the wages earned in the three months immediately preceding the injury; if the employee is paid on a biweekly basis, the employer may provide the wages earned in the 14 weeks immediately preceding the injury; otherwise the employer shall provide the wages earned in the 13 weeks immediately preceding the injury.

(B) If the employee was not employed for 13 continuous weeks before the date of injury and the employee was not employed by a school district through a written contract:

(i) the employer shall identify a similar employee performing similar services, as those terms are defined in §128.3 of this title (relating to Average Weekly Wage Calculation For Full-Time Employees, and For Temporary Income Benefits For All Employees), and list the wages of that similar employee; however if

(ii) the employer does not have a similar employee who has been employed for 13 continuous weeks prior to the injured employee's date of injury, the employer shall provide the wages earned by the employee during the period the employee was employed.

Source Note: The provisions of this §120.4 adopted to be effective May 16, 2002, 27 TexReg 4027

TITLE 28 **INSURANCE**
PART 2 **TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION**
CHAPTER 122 **COMPENSATION PROCEDURE—CLAIMANTS**

SUBCHAPTER A CLAIMS PROCEDURE FOR INJURED EMPLOYEES

RULE §122.1 Notice to Employer of Injury or Occupational Disease

(a) Except as provided in subsection (b) of this section, an injured employee, or a person acting on that employee's behalf, shall notify an employer of an injury not later than the 30th day after the date on which the injury occurs. The notice of injury should include the following information:
(1) the name, address, and telephone number (if any) of the injured employee;
(2) the date, time, and place the injury occurred;
(3) a description of the circumstances and the nature of the injury;
(4) the names of any witnesses (if known);
(5) the name and location of the health provider that has treated the employee for the injury; and
(6) the name of the person (if any) acting on behalf of the injured employee.

(b) An employee whose injury results from an occupational disease, or a person acting on that employee's behalf, must give notice as required in subsection (a) of this section not later than the 30th day after the date on which the employee knew or should have known that the disease may be related to the employment. This notice must be given to the employer for whom the employee worked on the date of the last injurious exposure to the hazards of the disease.

(c) Any notice to the employer may be given to any employee of the employer who holds a supervisory or management position.

(d) Failure to notify the employer shall relieve the employer and the employer's insurance carrier from liability under the Texas Workers' Compensation Act unless:
(1) the employer, or person eligible to receive notice under subsection (c) of this section, or the insurance carrier, had actual knowledge of the injury;
(2) good cause exists for failure to give notice in a timely manner; or
(3) the employer or insurance carrier does not contest the claim.

Source Note: The provisions of this §122.1 adopted to be effective January 28, 1991, 16 TexReg 228

RULE §122.2 Injured Employee's Claim for Compensation

(a) An injured employee, or a person acting on the injured employee's behalf, shall file with the commission a written claim for compensation within one year after the date of the injury's occurrence, except as provided in subsection (b) of this section.

(b) An employee whose injury results from an occupational disease, or a person acting on that employee's behalf, shall file with the commission a written claim for compensation within one year after the date the employee knew or should have known that the disease was related to the employment.

(c) The claim should be submitted to the commission either on paper or via electronic transmission, in the form, format, and manner prescribed by the commission, and should include the following:
(1) the name, address, telephone number (if any), occupation, wage, and social security number of the injured employee;
(2) the length of time the employee worked for the employer prior to the date of injury;
(3) the date, time, and location the injury occurred (or the date the employee knew or should have known that the occupational disease was related to the employment);
(4) a description of the circumstances and nature of the injury;
(5) the names of witnesses (if any);
(6) the name and location of the employer at the time of the injury (or, if the injury claimed is an occupational disease, the name and location of the employer at the time of the last injurious exposure to the hazards of the occupational disease);
(7) the name of the employee's immediate supervisor;
(8) the name and address of at least one health care provider that has treated the employee for the injury; and
(9) the identity of the person (if any) acting on behalf of the injured employee.

(d) Failure to file a claim for compensation with the commission no later than one year from the incident shall relieve the employer and the employer's insurance carrier from liability under the Act unless:
(1) good cause exists for failure to file a claim in a timely manner; or
(2) the employer or insurance carrier does not contest the claim.

Source Note: The provisions of this §122.2 adopted to be effective January 25, 1991, 16 TexReg 173; amended to be effective September 12, 2004, 29 TexReg 8560

RULE §122.3 Exposure to Communicable Diseases: Reporting and Testing Requirements for Emergency Responders

(a) This section applies to all law enforcement officers, fire fighters, emergency medical service employees, paramedics, and correctional officers who are either state employees or employees covered under workers' compensation insurance (to include those who are providing services as a volunteer and are covered by workers' compensation insurance).

(b) For purposes of this section "reportable disease" means communicable diseases and health conditions required to be reported to the Texas Department of Health by the Texas Health and Safety Code, §81.041, as amended, including: acquired immune deficiency syndrome (AIDS); amebiasis; anthrax; botulism--adult and infant; brucellosis; campylobacteriosis; chancroid; chickenpox; Chlamydia trachomatis infection; cholera; cryptosporidiosis; dengue; diphtheria; ehrlichiosis; encephalitis; Escherichia coli 0157:H7; gonorrhea; Hansen's disease (leprosy); Heamophilus influenzae type b infection, invasive; hantavirus infection; hemolytic uremic syndrome (HUS); hepatitis, acute viral; human immunodeficiency virus (HIV) infection; legionellosis; listeriosis; Lyme disease; malaria; measles (Rubeola); meningitis; meningococcal infection, invasive; mumps; pertussis; plague; poliomyelitis, acute paralytic; rabies in man; relapsing fever; Rocky Mountain spotted fever; rubella (including congenital); salmonellosis, including typhoid fever; shigellosis; streptococcal disease, invasive Group A; syphilis; tetanus; trichinosis; tuberculosis; tuberculosis infection in persons less than 15 years of age; typhus; Vibrio infection; viral hemorrhagic fevers; and yellow fever. This list of diseases may change from time to time. To determine the most current list of reportable diseases and exposure criteria refer to Texas Department of Health rules, 25 TAC Chapter 97, Communicable Diseases.

(c) An employee listed in subsection (a) of this section will not be entitled to workers' compensation benefits for a reportable disease unless the employee:
(1) had a test performed within 10 days of an exposure to the reportable disease that indicated the absence of the reportable disease (Exposure criteria and testing protocol must conform to Texas Department of Health requirements. This rule does not prohibit a decision-maker's consideration of other factors.); and
(2) provided the employer with a sworn affidavit of the date and circumstances of the exposure and a copy of the results of the test required by paragraph (1) of this subsection.

(d) The employer's insurance carrier, including state and political subdivision employers, shall be liable for the costs of test(s) required by subsection (c) of this section, regardless

of the results of the test(s), in addition to any other benefits required to be paid by the Texas Workers' Compensation Act or administrative rules. The cost of a state employee's testing, regardless of the results of the test, shall be paid from funds appropriated for payment of workers' compensation benefits to state employees.

(e) Section 110.108 of this title (relating to Employer Notice Regarding Work-Related Exposure to Communicable Diseases/HIV: Posting Requirements; Payment for Tests) requires each employer with employees covered by this section to post the notice contained in subsection (d) of that section in its workplace to inform employees of the requirements of this section.

(f) Emergency responders and employers of emergency responders should also refer to the Texas Health and Safety Code, Chapter 81 and Texas Department of Health rules, 25 TAC Chapter 97, Communicable Diseases, to ensure compliance with all applicable requirements.

Source Note: The provisions of this §122.3 adopted to be effective October 15, 1997, 22 TexReg 9682

RULE §122.4 State Employees Exposed to Human Immunodeficiency Virus (HIV): Reporting and Testing Requirements

(a) This section applies to all employees of the state of Texas.

(b) A state employee shall not be entitled to workers' compensation benefits for a work-related exposure to human immunodeficiency virus (HIV) infection unless the employee:
(1) had a test performed within 10 days of an exposure to HIV that indicated the absence of HIV infection (Exposure criteria and testing protocol must conform to Texas Department of Health requirements.); and
(2) provided the employer with a written statement of the date and circumstances of the exposure to HIV and a copy of the results of the test required by paragraph (1) of this subsection.

(c) The cost of a state employee's test(s) required by subsection (b) of this section, regardless of the results of the test(s), shall be paid from funds appropriated for payment of workers' compensation benefits to state employees, in addition to any other benefits required to be paid by the Texas Workers' Compensation Act or administrative rules.

(d) Section 110.108 of this title (relating to Employer Notice Regarding Work Related Exposure to Communicable Disease/HIV: Posting Requirements; Payment for Tests) requires each state agency to post the notice contained in subsection (d) of that section in its workplace to inform employees of the requirements of this section.

(e) State employers and state employees should also refer to the Texas Health and Safety Code, Chapter 85 and Texas Department of Health rules, 25 TAC Chapter 97, Communicable Diseases, to ensure compliance with all applicable requirements.

Source Note: The provisions of this §122.4 adopted to be effective October 15, 1997, 22 TexReg 9682

RULE §122.5 Employee's Multiple Employment Wage Statement

(a) Definitions. The following words and terms, when used in this subchapter, will have the following meanings, unless the context clearly indicates otherwise.
(1) Claim Employer -- Employer with whom the claimant filed a claim for workers' compensation benefits and for whom the injured employee (employee) was working at the time of the on-the-job injury.
(2) Non-Claim Employers -- Employers other than the claim employer by whom the employee was employed at the time of the on-the-job injury.

(b) For an injury which occurs on or after July 1, 2002, a claimant may file a Multiple Employment Wage Statement for each employer the employee was working for on the date of injury.

(c) If a claimant who is permitted by subsection (b) of this section chooses to file a Multiple Employment Wage Statement, it is the claimant's responsibility to obtain the required wage information from the Non-Claim Employer(s), providing any necessary corrections to the wage information, and filing the information on the Multiple Employment Wage Statement with the insurance carrier and commission. The carrier is not required to make an adjustment to AWW until the employee provides a complete Multiple Employment Wage Statement as described in subsections (d) and (e) of this section.

(d) The Multiple Employment Wage Statement shall include:
(1) the employee's name, address, and social security number;
(2) the date of the Non-Claim Employer's hire of the employee;
(3) the date of injury;
(4) the Non-Claim Employer's name, address, and federal tax identification number;

(5) the name and phone number of a person at the Non-Claim Employer who can be contacted to verify the wage information (unless the wage information was not provided by a person at the Non-Claim Employer - such as if the wage information came from the Texas Workforce Commission or the employee's pay stubs);
(6) the wage information required by subsection (e) of this section with documentation that supports the wage information being reported; and
(7) a certification that the wage information provided includes all wage information required by subsection (e) of this section and that the information is complete and accurate.

(e) The wage information required to be provided in a Multiple Employment Wage Statement includes the employee's Non-Claim Employer wages, as defined in §128.1 of this title (relating to Average Weekly Wage: General Provisions), earned during the 13 weeks immediately preceding the date of injury and the number of hours the employee worked to earn the wages being reported. The wages are limited to those reportable for federal income tax purposes.
(1) If the employee is paid by the Non-Claim Employer:
(A) on a monthly or a semi-monthly basis, the claimant may provide the wages earned in the three months immediately preceding the injury;
(B) on a biweekly basis, the claimant may provide the wages earned in the 14 weeks immediately preceding the injury;
(C) on other than a monthly, semi-monthly, or biweekly basis, the claimant shall provide the wages earned in the 13 weeks immediately preceding the injury.
(2) If the employee was not employed for 13 continuous weeks before the date of injury:
(A) the claimant shall report the wages of a similar employee performing similar services, as those terms are defined in §128.3 of this title (relating to Average Weekly Wage Calculation For Full-Time Employees, and For Temporary Income Benefits For All Employees); or
(B) if the Non-Claim Employer does not have a similar employee who has been employed for 13 continuous weeks prior to the employee's date of injury (or the claimant is unable to obtain the wage information on a similar employee), the claimant shall provide the wages earned by the employee during the period the employee was employed.

(f) Employees who file Multiple Employment Wage Statements are required to report all changes in employment status and/or earnings at the Non-Claim Employer to the carrier until the employee reaches Maximum Medical Improvement.

(1) The employee shall report all changes in employment status at the Non-Claim Employer including termination or resignation within 7 days of the date the change takes place.
(2) The employee shall report within 7 days of the end of the pay period in which a change in earnings at the Non-Claim Employer related to the compensable injury took place. This would include both reductions and increases in wages as compared to the prior week as long as the difference was caused by the compensable injury such as because the employee's ability to work changed or the employer was more or less able to provide work that met the employee's work restrictions.

Source Note: The provisions of this §122.5 adopted to be effective May 16, 2002, 27 TexReg 4032

SUBCHAPTER B CLAIMS PROCEDURE FOR BENEFICIARIES OF INJURED EMPLOYEES

RULE §122.100 Claim for Death Benefits

(a) Filing. For a legal beneficiary, other than the subsequent injury fund, to receive the benefits available because of the death of an employee that results from a compensable injury, a person must file a written claim for death benefits within one year after the date of the employee's death.

(b) An insurance carrier that receives a claim for death benefits under this section must comply with §124.8 of this title (relating to Receipt, Records, and Notice of Death or Claim for Death Benefits).

(c) Form and information requirements. The claim should be submitted to the division or insurance carrier either on paper or via electronic transmission, in the form, format, and manner prescribed by the division, and should include the following:
(1) the potential beneficiary's name, address, telephone number (if any), Social Security number, and relationship to the deceased employee;
(2) the deceased employee's name, last address, Social Security number (if known), and workers' compensation claim number (if any); and
(3) other information, as follows:
(A) a description of the circumstances and nature of the injury (if known);
(B) the name and location of the employer at the time of the injury;
(C) the date of the compensable injury, and date of death; and
(D) other known legal beneficiaries.

(d) Required documents. A potential beneficiary must file with the division or insurance carrier a copy of the deceased employee's death certificate and any additional documentation or other evidence that establishes that the potential beneficiary is a legal beneficiary of the deceased employee. The required documents or additional evidence may be filed separately either on paper or by electronic transmission, as defined in §102.5(h) of this title.

(e) One claim per person. Each person must file a separate claim for death benefits, unless the claim expressly includes or is made on behalf of another person.

(f) Deadline. Failure to file a claim for death benefits within one year after the date of the employee's death bars the claim of a legal beneficiary, other than the subsequent injury fund, unless:

(1) that legal beneficiary is a minor or otherwise legally incompetent;

(2) except as provided by paragraph (3) of this subsection, good cause exists for failure to file the claim on time; or

(3) for a legal beneficiary who is an eligible parent as defined by §132.6(e) of this title (relating to Eligibility of Other Surviving Dependents and Eligible Parents To Receive Death Benefits), the parent submits proof satisfactory to the commissioner of a compelling reason for the delay in filing the claim for death benefits

Source Note: The provisions of this §122.100 adopted to be effective January 25, 1991, 16 TexReg 174; amended to be effective September 12, 2004, 29 TexReg 8560; amended to be effective October 12, 2008, 33 TexReg 8393; amended to be effective March 21, 2010, 35 TexReg 2190; amended to be effective December 11, 2023, 48 TexReg 7172

TITLE 28 **INSURANCE**
PART 2 **TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION**
CHAPTER 124 **INSURANCE CARRIERS: NOTICES, PAYMENTS, AND REPORTING**

SUBCHAPTER A INSURANCE CARRIERS: REQUIRED NOTICES AND MODES OF PAYMENT

RULE §124.1 Notice of Injury

(a) Except as provided in subsections (b) and (c) of this section, written notice of injury, as used in the Texas Workers' Compensation Act, §409.021, consists of the insurance carrier's earliest receipt of:
(1) the Employer's First Report of Injury as described in §120.2 of this title (relating to Employer's First Report of Injury);
(2) the notification provided by the Commission under subsection (e) of this section; or
(3) if no Employer's First Report of Injury has been filed, any other communication regardless of source, which fairly 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.

(b) Written notice of injury for a certified self-insurer is received on the date the qualified claims servicing contractor designated by the self-insurer under Texas Labor Code §407.061(c) receives the notice.

(c) Written notice of injury for a political subdivision that self-insures under Texas Labor Code §504.011, either individually or through an interlocal agreement with other political subdivisions, is received on the date the intergovernmental risk pool or other entity responsible for administering the claim receives the notice.

(d) The carrier shall immediately create a written record on paper or in an electronic format of the earliest notice of injury as defined in subsection (a) of this section that is not received in writing. The date of receipt of a written notice of injury shall be deemed to be the earliest date the carrier receives the information identified in subsections (a)(1), (2), or (3) of this section. Upon request of the Commission, a carrier shall provide an affidavit indicating the receipt or non-receipt of a notice of injury received and the receipt date.

(e) The Commission shall furnish written notification to the carrier when a source other than the carrier reports:

(1) an injury that may cause the employee eight days or more of disability or has resulted in an impairment;
(2) a death; or
(3) an occupational disease.

(f) If a carrier is notified of an injury for which it has not received an Employer's First Report of Injury, from the employer, the carrier shall contact the employer regarding the injury within seven days of notification.

(g) Subsections (b) and (c) of this section apply only to compensable injuries with a date of injury on or after September 1, 2003.

Source Note: The provisions of this §124.1 adopted to be effective August 29, 1999, 24 TexReg 6503; amended to be effective March 14, 2004, 29 TexReg 2321

RULE §124.2 Insurance Carrier Reporting and Notification Requirements

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

(b) The insurance carrier must electronically file, as that term is used in §102.5(e) of this title (concerning General Rules for Written Communications to and from the Division) with the division, according to the requirements in Subchapter B of this title (concerning Insurance Carrier Claim Electronic Data Interchange Reporting to 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 of Insurance Coverage) 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, an occupational disease, or a fatality; or
(B) notification of lost time if the employer made the Employer's First Report of Injury before the employee experienced absence from work as a result of the injury;
(2) information about an acquired claim no later than the 37th day after the acquiring claim administrator has knowledge of claim-specific information from the previous claim administrator;
(3) any correction of an electronic record accepted with errors, as provided in §102.5(e) of this title (concerning General Rules for Written Communications to and from the Division), within 30 days of the notification from the division detailed in §124.104(b) of this title (concerning Reporting Requirements);

(4) information about a compensable death with no beneficiary no later than the 10th day after determining that an employee whose injury resulted in death had no legal beneficiary; and

(5) a change in an electronic record initiated by the insurance carrier, 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 receiving the new address.

(c) The insurance carrier must notify the division and the claimant of its denial of a claim based on noncompensability or lack of coverage in accordance with this section and as otherwise provided by this title.

(d) The insurance carrier must notify the division and the claimant of the following:

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

(2) first payment of indemnity benefits on an acquired claim within 10 days of making the first payment;

(3) a change in the net benefit payment amount without a change to the benefit type within 10 days of making the first payment reflecting the change;

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

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

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

(7) employer continuation of salary, as defined in §129.1(1) (concerning Definitions for Temporary Income Benefits) of this title, equal to or exceeding the employee's average weekly wage as defined by this title within:

(A) seven days of receiving the information that salary would be continued in lieu of the insurance carrier initiating temporary income benefits;

(B) ten days of making the last payment of temporary income benefits due to the employer's salary continuation; or

(C) ten days of resuming payment of the employer's salary continuation;

(8) lump sum payment of income or death benefits within 10 days of making the payment; or

(9) refusal to pay accrued income benefits due to dispute of disability.

(e) 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, and Emergency Medical

Technicians), the insurance carrier must take one of the following actions no later than the 15th day after receiving the notice of injury:
(1) initiate benefits as required by the Texas 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.

(f) When applying subsection (e) 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).

(g) The insurance carrier must 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 must 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, fax number, and telephone number.
(2) An insurance carrier must 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.

(h) Notification to the claimant as required by subsections (c) - (e) of this section requires the insurance carrier to use plain language notices in the form and manner prescribed by the division. These notices must 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.

(i) In addition to the denial notice requirements in subsection (h), 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), 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 on its investigation, if the insurance carrier concludes that a statutory presumption applies, but a notice of denial will be issued, a statement explaining why and describing the claim-specific information reviewed before issuing 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; and

(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.

(j) Notification to the division as required by subsections (b) - (e) 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 Division) with the division, according to the requirements in Subchapter B of this title (concerning Insurance Carrier Claim Electronic Data Interchange Reporting to the Division).

(1) In addition to the electronic filing requirements of this subsection, when an insurance carrier notifies the division of a denial, Notice of Continuing Investigation, or dispute of disability as required by this section, it must provide the division a written copy of the notice provided to the claimant as described under subsections (g) - (i) and (k) 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.

(k) Notification to the division and the claimant of a dispute of disability, extent of injury, or eligibility of a claimant to receive death benefits must 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 must provide a full and complete statement describing the insurance carrier's action and its reasons 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.

(l) Except as otherwise provided by this title, insurance carriers must 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 must not be provided to anyone in the system).

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

(n) Each insurance carrier must 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 must include mailing address, telephone number, fax 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. The claim service administration functions requiring contact information to be reported are:
(A) coverage verification (policy issuance and effective dates of the policy);

(B) claim adjustment;
(C) medical billing;
(D) pharmacy billing (if different from medical billing);
(E) preauthorization; and
(F) workers' compensation health care network.

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

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

(o) 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.

(p) The section is effective July 26, 2023.

Source Note: The provisions of this §124.2 adopted to be effective August 29, 1999, 24 TexReg 6503; amended to be effective June 5, 2003, 28 TexReg 4285; amended to be effective January 12, 2020, 45 TexReg 348; amended to be effective July 26, 2023, 47 TexReg 1095

RULE §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.

Source Note: The provisions of this §124.3 adopted to be effective March 13, 2000, 25 TexReg 2096; amended to be effective March 14, 2004, 29 TexReg 2322; amended to be effective January 12, 2020, 45 TexReg 348

RULE §124.5 Mode of Payment Made by Insurance Carriers

(a) The insurance carrier shall make all medical benefit and burial payments by:
(1) check or other readily negotiable instrument; or
(2) electronic transfer by mutual agreement to an account designated in writing by the payee.

(b) Except as provided by §126.2 of this title (relating to Payment of Benefits to Minors), insurance carriers shall make all payments of income or death benefits by:
(1) check or other readily negotiable instrument to the order of the claimant; or
(2) electronic transfer if required to under subsection (f) of this section or by mutual agreement between the insurance carrier and the claimant including an access card under §124.6 of this title (relating to Electronic Transfer Payments Made Through an Access Card).

(c) An insurance carrier that routinely pays benefits by check or other negotiable instrument to the claimant drawn on an out-of-state financial institution shall accompany each instrument with written information about the insurance carrier's office location and telephone number where the claimant may call, at the insurance carrier's expense, to obtain help with cashing the instrument, if necessary.

(d) A claimant may request that the insurance carrier make benefit payments by electronic transfer to a personal bank account by providing the insurance carrier in writing: the name and routing transit number of the financial institution and the account number and type of account that the claimant wants the benefits electronically transferred to. The insurance carrier shall provide the claimant with a form to fill out the information required by this subsection within seven days of receiving a request for such a form from the claimant.

(e) Subsections (f) - (i) of this section apply to income or death benefit payments due on or after September 1, 2000.

(f) Unless relieved by subsection (g) of this section, the insurance carrier shall make income or death benefit payments by electronic transfer if the claimant:
(1) requests in writing that payment be made by electronic transfer;
(2) provides the information required by subsection (d) of this section; and
(3) is reasonably expected to be entitled to receive income or death benefits for a period of eight weeks or more from the point that paragraphs (1) and (2) of this subsection are satisfied.

(4) This subsection does not apply to electronic transfer payments made through an access card under §124.6 of this title.

(g) An insurance carrier is relieved of the responsibility to make payment of temporary income benefits, impairment income benefits, and supplemental income benefits by electronic transfer if the mode of payment has been switched at the request of the claimant three times after initially changing to electronic payments.

(h) The insurance carrier shall initiate payment by electronic transfer starting with the first income or death benefit payment due on or after the 21st day after the requirements of subsection (f) of this section are met but shall continue to timely make payments by check until the insurance carrier initiates benefit delivery by electronic transfer.

(i) If the claimant has previously been receiving income or death benefit payments by electronic transfer and wants to receive benefits by check, the insurance carrier shall initiate income or death benefit delivery by check starting with the first benefit payment due to the claimant on or after the 7th day after receiving a written request.

(j) Effective date. Unless otherwise specified, this section is effective for income or death benefit payments due on or after June 1, 2015.

Source Note: The provisions of this §124.5 adopted to be effective January 11, 1991, 16 TexReg 116; amended to be effective November 28, 1999, 24 TexReg 10333; amended to be effective June 1, 2015, 40 TexReg 332

RULE §124.6 Electronic Transfer Payments Made Through an Access Card

(a) Access card. In this chapter, access card means any card or other payment method that may be used by a claimant to initiate an electric fund transfer from an insurance carrier's bank account. The term "access card" does not include stored value cards or prepaid cards that store funds directly on the card and that are not linked to an insurance carrier's bank account.

(b) Mutual agreement. An insurance carrier may pay income or death benefits through an access card to a claimant if there is written mutual agreement signed by the insurance carrier and the claimant. The insurance carrier shall maintain accurate records of the mutual agreement for, at a minimum, 401 weeks from the date of injury. The written mutual agreement shall contain an acknowledgement that the claimant received and agreed to the written disclosure in subsection (f) of this section.

(c) Agent of the insurance carrier. Any person with whom an insurance carrier utilizes or contracts for the purpose of providing service or fulfilling duties under this section is an agent of the insurance carrier under §180.1(3) of this title (relating to Definitions).

(d) Requirements and prohibited fees. An insurance carrier shall:
(1) permit the claimant to withdraw the entire amount of the balance of an access card in one transaction;
(2) not reduce income or death benefits paid to a claimant through an access card for the following fees, surcharges, and adjustments:
(A) overdraft services under which a financial institution pays a transaction (including a check or other item) when the claimant has insufficient or unavailable funds in the account;
(B) ATM withdrawal or a point of sale purchase for more than the card holds and the transaction is denied;
(C) ATM balance inquiries;
(D) withdrawing money from network ATMs;
(E) withdrawing money from a teller;
(F) customer service calls;
(G) activating the card;
(H) fees for card inactivity;
(I) closing account;
(J) access card replacement through standard mail;
(K) withdrawing the entire payment in one transaction;
(L) point of sale purchases; or
(M) any other fees or charges that are not authorized under subsection (e) of this section.

(e) Permitted fees. The claimant may be charged for the following:
(1) access card replacement through an expedited mail service;
(2) international transaction fees; and
(3) out-of-network ATM fees.

(f) Required disclosure. Insurance carriers shall provide a written disclosure to the claimant contemporaneously with the written mutual agreement under subsection (a) of this section. The written disclosure shall include:
(1) a summary of the claimant's liability for unauthorized electronic fund transfers;
(2) the telephone number and address of the person or office to be notified when the claimant believes that an unauthorized electronic fund transfer has been or may be made;

(3) the type of electronic fund transfers that the claimant may make and any limitations on the frequency of transfers;
(4) any fees imposed for electronic fund transfers or for the right to make transfers including a statement that fees may be imposed by ATM operator that is out-of-network;
(5) fees for expedited card replacement or international transaction fees will be removed from the balance maintained in the bank account linked to the access card;
(6) a summary of the claimant's right to receipts and periodic statements;
(7) all bank locations and network ATMs in the United States where the claimant may access his or her funds at no cost;
(8) a statement informing the claimant that they have a right to receive payments directly into their personal bank account through direct deposit.

(g) Plain language requirement. An insurance carrier shall provide a written disclosure and notice of term or condition changes under this section that:
(1) are printed in not less than 12-point font;
(2) include the full text in English, Spanish, and any other language common to the claimant population;
(3) are written in a clear and coherent manner and wherever practical, words with common and everyday meaning shall be used to facilitate readability; and
(4) are appropriately divided and captioned in a meaningful sequence such that each section contains an underlined, boldfaced, or otherwise conspicuous title or caption at the beginning of the section that indicates the nature of the subject matter included in or covered by the section.

(h) Access card information. An access card issued to the claimant under the section:
(1) shall not bear any information that could reasonably identify the claimant as a participant in the workers' compensation system.
(2) shall include on the front or back of the access card a toll-free customer service number and website address. Customer service personnel shall be available by phone Monday through Friday, during normal business hours as outlined in §102.3 of this title (relating to Computation of Time).

(i) Written notice of term or condition changes. The insurance carrier shall provide a written notice to the claimant at least 21 days before the effective date of any change in a term or condition of the mutual agreement or disclosure, including terminating the access card program, increased fees, or liability for unauthorized electronic fund transfers. Any terms or conditions that violate the requirements of this section are null and void and may result in administrative penalties for the insurance carrier. An insurance carrier shall provide a written notice of term or condition changes that:

(1) provides a comparison of the current terms and the changes; and
(2) references the claimant's ability to request a change in payment outlined in §124.5(i) of this title (relating to Mode of Payment Made by Carriers).

(j) Account closure. An insurance carrier may close the account by issuing a check to the claimant with the remaining balance of the access card if the account has been inactive for 12 months or longer.

(k) Recoupment of payment. The insurance carrier shall not remove money from the claimant's account or access card except to remove permitted fees under subsection (e) of this section or to close the account for inactivity of a period of 12 months or more. An insurance carrier seeking to recoup overpayments shall follow the procedures outlined in §126.16 of this title (relating to Procedures for Recouping Overpayments of Income Benefits).

(l) Paid date. An insurance carrier is considered to have made an income or death benefit payment the date the payment is available on the claimant's access card.

(m) No granting of rights. Nothing in the section shall be construed to grant any rights otherwise prohibited under federal law.

(n) Effective date. This section is effective for income or death benefit payments due on or after June 1, 2015.

Source Note: The provisions of this §124.6 adopted to be effective June 1, 2015, 40 TexReg 332

RULE §124.7 Initial Payment of Temporary Income Benefits

(a) As used in this section, the following terms have the following meanings, unless the context clearly indicates otherwise: "Accrual date" means the day an injured worker's income benefits begin to accrue. "Day of disability" means a day when the worker is unable to obtain and retain employment at wages equivalent to the pre-injury wage because of a compensable injury. Intermittent days of disability shall be cumulated to calculate the accrual date.

(b) An injured worker's accrual date is the worker's eighth day of disability.

(c) A carrier who has received written notice of an injury and has not disputed the claim shall initiate income benefits no later than the seventh day after the accrual date.

(d) Nothing in this section is intended to limit a carrier's discretion to initiate payment of temporary income benefits before the time limit established in subsection (c) of this section.

Source Note: The provisions of this §124.7 adopted to be effective September 30, 1991, 16 TexReg 5071; amended to be effective March 1, 1993, 18 TexReg 472; amended to be effective June 5, 2003, 28 TexReg 4290

RULE §124.8 Receipt, Records, and Notice of Death or Claim for Death Benefits

(a) Definition. In this section, "claim for death benefits" means a claim that is filed under Chapter 122, Subchapter B, §122.100 of this title.

(b) General requirements. An insurance carrier that receives a notice of death in accordance with §132.17 of this title, or a claim for death benefits must comply with all of the requirements in this chapter.

(c) Recordkeeping and notice. An insurance carrier in subsection (b) of this section must:
(1) send the division a copy of the plain-language notice that the insurance carrier must provide to the potential beneficiary under §132.17 of this title.
(2) on receiving a claim for death benefits, create and maintain a record documenting receipt of the claim for death benefits. The record must include all of the information in the claim for death benefits. The insurance carrier must maintain the record in accordance with Chapter 102, §102.4 of this title.
(3) send the division a copy of a claim for death benefits the insurance carrier receives from the potential beneficiary not later than the seventh day after receiving it and include any other documents and information the insurance carrier received.

Source Note: The provisions of this §124.8 adopted to be effective December 11, 2023, 48 TexReg 7174

SUBCHAPTER B INSURANCE CARRIER CLAIM ELECTRONIC DATA INTERCHANGE REPORTING TO THE DIVISION

RULE §124.100 Applicability

(a) This subchapter applies to any claim transactions required to be reported to the division under §124.105 on or after July 26, 2023.

(b) This subchapter applies to all insurance carriers as defined in Labor Code §401.011(27). All insurance carriers are required to report information prescribed by the commissioner under Labor Code §§401.024, 402.082, 411.012, 411.031, 411.032, and 411.033 for each workers' compensation claim. All insurance carriers are required to notify injured employees and the division about claim actions as provided in §124.2 of this title (concerning Insurance Carrier Notification Requirements).

(c) This subchapter is effective July 26, 2023. Insurance carriers and trading partners must continue to submit claim EDI records to the division in the International Association of Industrial Accident Boards and Commissions (IAIABC) Claims Electronic Data Interchange (EDI) Release 1.0 standard before this effective date.

Source Note: The provisions of this §124.100 adopted to be effective July 26, 2023, 47 TexReg 1095

RULE §124.101 Purpose

The purpose of this subchapter is to prescribe the reporting requirements for information and data submitted to the division and adopt by reference the implementation guide and specifications necessary for successful EDI transaction processing. The reporting of information and data is necessary to maintain information on every compensable injury; maintain a repository for statistical information on workers' health and safety; and compile, maintain, and use statistical data to detect practices or patterns of misconduct by system participants as required by Labor Code §§402.082, 411.033, and 414.003.

Source Note: The provisions of this §124.101 adopted to be effective July 26, 2023, 47 TexReg 1095

RULE §124.102 Definitions

The following words and terms when used in this subchapter will have the following meanings, unless the context clearly indicates otherwise:

(1) Application acknowledgment code--A code used to identify the accepted or rejected status of the transaction being acknowledged.
(2) Claim EDI record--The accurate data associated with a single claim reported in a claim EDI transaction (first report of injury or subsequent report of injury) obtained from all sources, including the report of incident or injury and the insurance carrier's claim file.
(3) Claim EDI transmission--The data that is contained within the interchange envelope.

(4) Division--The Texas Department of Insurance, Division of Workers' Compensation or its data collection agent.
(5) EDI--Electronic data interchange.
(6) Edit Matrix--A table containing the edits applied to Texas' first report of injury and subsequent report of injury records.
(7) Element requirement table--A table containing data elements used in Texas' first report of injury and subsequent report of injury record layouts defining required and conditional data elements and how data edits apply to the elements.
(8) Event table--A table containing the reportable claim events for Texas' first report of injury and subsequent report of injury records and timeframes for reporting the information.
(9) Insurance carrier claim number--An identifier that distinguishes a specific claim within an insurance carrier's claim processing system and is used throughout the life of the claim.
(10) IAIABC--The International Association of Industrial Accident Boards and Commissions.
(11) Person--A person, partnership, corporation, hospital district, insurance carrier, organization, business trust, estate trust, association, limited liability company, limited liability partnership, or other entity. This term does not include an injured employee.
(12) Trading partner--A person entering into an agreement with the insurance carrier to format electronic data for transmission to the division, transmit electronic data to the division, and respond to any technical issues related to the contents or structure of an EDI file.

Source Note: The provisions of this §124.102 adopted to be effective July 26, 2023, 47 TexReg 1095

RULE §124.103 Reporting Standards

(a) Except as provided in this subchapter, the commissioner adopts by reference the IAIABC EDI Implementation Guide for Claims, Release 3.1.4, dated January 1, 2021, published by the IAIABC.

(b) The commissioner adopts by reference the:
(1) Texas Claim EDI Release 3.1.4 Implementation Guide, Version 1.0;
(2) Texas Claim EDI Release 3.1.4 Element Requirement Table, Version 1.0;
(3) Texas Claim EDI Release 3.1.4 Edit Matrix, Version 1.0, dated June 30, 2023; and
(4) Texas Claim EDI Release 3.1.4 Event Table, Version 1.0. The Texas Claim EDI Release 3.1.4 Implementation Guide, tables, and the matrix are published by the division.

(c) The adopted division tables are on the division's website at www.tdi.texas.gov/wc/edi/index.html.

(d) In the event of a conflict between the IAIABC EDI Implementation Guide for Claims and the Labor Code or division rules, the Labor Code or division rules will prevail.

Source Note: The provisions of this §124.103 adopted to be effective July 26, 2023, 47 TexReg 1095

RULE §124.104 Reporting Requirements

(a) Insurance carriers must submit timely and accurate claim EDI records to the division. For the purpose of this section, a claim EDI record is considered accurately submitted when the record:
(1) receives an accepted application acknowledgment code;
(2) contains accurate claim EDI data, which may be obtained from all sources, including the report of incident or injury and the insurance carrier's claim file; and
(3) to the extent supported by the format, contains all data elements necessary to identify activity on a claim.

(b) Insurance carriers are responsible for correcting and resubmitting claim EDI records accepted with errors within 30 days of the acknowledgement or other action that required reporting. The resubmitted claim EDI record must contain the same insurance carrier claim number as the previously accepted claim EDI record.

(c) The insurance carrier's receipt of a rejection does not modify, extend, or otherwise change the date the transaction is required to be reported to the division. The resubmitted rejected claim EDI record must contain the same insurance carrier claim number as the previously rejected claim EDI record.

Source Note: The provisions of this §124.104 adopted to be effective July 26, 2023, 47 TexReg 1095

RULE §124.105 Records Required to be Reported

(a) Insurance carriers must submit claim EDI records when the insurance carrier:
(1) takes action on or events occur in a claim as described in §124.2 of this title (concerning Insurance Carrier Notification Requirements);

(2) corrects division-identified errors in a previously accepted electronic record as provided in §124.104(b) of this title (concerning Reporting Requirements);
(3) corrects insurance carrier-identified errors in a previously accepted electronic record as provided in §124.2(b)(4) of this title;
(4) discovers that a claim EDI record should not have been submitted to the division, and the division had previously accepted the claim EDI record; or
(5) receives a request from the division for claim EDI records.

(b) Regardless of the application acknowledgment code returned in an acknowledgment, claim EDI records are not considered received by the division if the claim EDI record:
(1) contains data, which does not accurately reflect the code value or actions taken when the insurance carrier processed information or acted on the claim; or
(2) fails to contain a conditional data element and the mandatory trigger condition existed at the time the insurance carrier acted on the claim.

(c) Claim EDI records submitted in the test environment are not considered received and do not comply with the reporting requirements of this section.

(d) Claims with a date of injury on or after January 1, 1991, must be reported in accordance with the requirements of this chapter (concerning Insurance Carriers: Notices, Payments, and Reporting).

Source Note: The provisions of this §124.105 adopted to be effective July 26, 2023, 47 TexReg 1095

RULE §124.106 Records Excluded from Reporting

Insurance carriers must not report claim EDI records for:

(1) claims where the jurisdiction state is not Texas;
(2) claims that do not meet the requirements of §124.2(b);
(3) claims involving benefits payable under federal workers' compensation laws; and
(4) claims with dates of injury before January 1, 1991.

Source Note: The provisions of this §124.106 adopted to be effective July 26, 2023, 47 TexReg 1095

RULE §124.107 State Specific Requirements

(a) Insurance carriers must submit claim EDI transactions according to the:
(1) IAIABC EDI Implementation Guide for Claims, Release 3.1.4;
(2) Texas Claim EDI Release 3.1.4 Implementation Guide, Version 1.0;
(3) Texas Claim EDI Release 3.1.4 Element Requirement Table, Version 1.0;
(4) Texas Claim EDI Release 3.1.4 Edit Matrix, Version 1.0, dated June 30, 2023; and
(5) Texas Claim EDI Release 3.1.4 Event Table, Version 1.0.

(b) In addition to the requirements adopted under §124.103 of this title (concerning Reporting Standards), when the injured employee's Social Security number is unknown for reporting claim EDI transactions, it must be reported in accordance with Texas Claim EDI Release 3.1.4 Element Requirement Table, Version 1.0, as adopted in §124.103 of this title.

Source Note: The provisions of this §124.107 adopted to be effective July 26, 2023, 47 TexReg 1095

RULE §124.108 Insurance Carrier EDI Compliance Coordinator and Trading Partners

(a) Insurance carriers may submit claim EDI records directly to the division or contract with an external trading partner to submit the records on the insurance carrier's behalf.

(b) Each insurance carrier, including those using external trading partners, must designate one person to the division as the EDI compliance coordinator and provide the person's name, working title, mailing address, email address, and telephone number in the form and manner prescribed by the division. The EDI compliance coordinator must:
(1) be an employee of the insurance carrier with knowledge and experience in EDI reporting, who is responsible for EDI reporting;
(2) receive and appropriately disperse data reporting information received from the division; and
(3) serve as the central compliance control for data reporting under this subchapter.

(c) At least five working days before sending its first transaction to the division under this subchapter, the insurance carrier must send a notice to the division. The notice must be in the form and manner prescribed by the division. The notice must include the name of the insurance carrier, the insurance carrier's FEIN, the insurance carrier's TXCOMP customer number, the name of the trading partners authorized to conduct claim EDI transactions on behalf of the insurance carrier, the FEIN of the trading partners, and the EDI compliance coordinator's signature.

(d) The insurance carrier must report changes required under subsections (b) and (c) within five working days of any amendment to data sharing agreements, including adding or removing any trading partners or changing the EDI compliance coordinator. Failure to timely submit updated information may result in the rejection of claim EDI records.

(e) At least five working days before sending its first test transaction to the division under this subchapter, the insurance carrier or trading partner sending the claim EDI transmission must send a notice to the division. The notice must be in the form and manner prescribed by the division. The notice must include the entity's name; FEIN; nine-digit postal code; address; and the technical contact's name, address, phone number, and email address. The insurance carrier or trading partner must report changes within five working days of any amendment to the information required to be reported.

(f) Insurance carriers and trading partners must successfully complete claim EDI Release 3.1.4 testing before transmitting any production claim EDI Release 3.1.4 data to the division. Trading partners must receive approval to submit data for at least one insurance carrier before initiating the testing process. Insurance carriers and trading partners must submit each transaction type during the testing process to ensure that it can be successfully processed by the division. The division will not approve an insurance carrier or trading partner for production submissions until the insurance carrier or trading partner has met the requirements for testing as described in the Texas Claim EDI Release 3.1.4 Implementation Guide.

(g) Once an insurance carrier or trading partner has met the requirements of subsection (f), the insurance carrier or trading partner is approved to report claim EDI data to the division. Only approved insurance carriers or trading partners may report claim EDI data to the division.

(h) The division may suspend the ability for an insurance carrier or trading partner to report claim EDI if it does not meet the requirements for an approved trading partner as described in the Texas Claim EDI Release 3.1.4 Implementation Guide. The division will notify the insurance carrier's claim EDI compliance coordinator in writing in advance of the suspension.

(i) Loss of approval to report claim EDI does not relieve an insurance carrier of the duty to report claim information or notices to the division under §124.2 of this title (concerning Insurance Carrier Notification Requirements).

(j) Insurance carriers are responsible for the acts or omissions of their trading partners. The insurance carrier commits an administrative violation if the insurance carrier or its trading partner fails to timely or accurately submit claim EDI records.

(k) An insurance carrier must provide to the division the EDI compliance coordinator's contact information required by this subsection no later than 90 days after the adoption of this subchapter. Except as otherwise provided by this subsection, an insurance company that obtains a certificate of authority to write workers' compensation insurance in Texas after the adoption of this subchapter, or an employer or group of employers who are authorized to self-insure by DWC or TDI after the adoption date of this subchapter, must provide the EDI compliance coordinator's contact information required by subsection (b) to the division no later than the 30th day after the insurance company's certificate of authority or authorization to self-insure becomes effective.

Source Note: The provisions of this §124.108 adopted to be effective July 26, 2023, 47 TexReg 1095

TITLE 28 **INSURANCE**
PART 2 **TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION**
CHAPTER 126 **GENERAL PROVISIONS APPLICABLE TO ALL BENEFITS**

RULE §126.1 Definitions Applicable to All Benefits

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

(1) Employer Initiation of Benefits - Money paid by an employer to the employee to compensate the employee for lost wages or paid by the employer for medical expenses during a period in which the carrier has either:
(A) contested compensability of the injury;
(B) contested liability for the injury; or
(C) has not completed its initial investigation of the injury which is limited to seven days after the carrier receives first written notice of the injury as defined in §124.1 of this title (relating to Notice of Injury).

(2) Nonpecuniary Wages--Wages paid to an employee in a form other than money. Examples of nonpecuniary wages include but are not limited to:
(A) Health insurance premiums;
(B) Laundry/cleaning;
(C) Clothing/uniforms;
(D) Lodging/housing/rent;
(E) Payment of professional license fees;
(F) Food/Meals; and
(G) Provision of a vehicle/fuel.

(3) Pecuniary Wages--Wages paid to an employee in the form of money. Examples of pecuniary wages include, but are not limited to:
(A) Hourly, weekly, biweekly, monthly (etc.) wages;
(B) Salary;
(C) Piecework compensation;
(D) Any monetary allowance such as for health insurance premiums, vehicle/fuel, food/meals, clothing/uniforms, laundry/cleaning, or lodging/housing/rent;
(E) Monetary bonuses earned or accrued by the employee; and
(F) Commissions.

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

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

RULE §126.2 Payment of Benefits to Minors

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

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

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

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

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

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

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

RULE §126.3 Payment of Benefits to Legally Incompetent Persons

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

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

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

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

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

RULE §126.4 Advance of Benefits Based on Financial Hardship

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

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

(c) An advance will not be granted to an employee whose combined post-injury earnings, as defined by §129.2 of this title (relating to Entitlement to Temporary Income Benefits), and income benefits under this Act equals or exceeds 90% of the employee's net pre-injury wage. In the absence of specific evidence to the contrary, the net pre-injury wage of an employee shall be presumed to be 80% of the average weekly wage, for this section.

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

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

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

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

RULE §126.5 Entitlement and Procedure for Requesting Required Medical Examinations

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

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

(c) Carriers are entitled to RMEs by a doctor of their choice in accordance with this subsection as follows:
(1) Pursuant to Texas Labor Code §408.004, once every 180 days, to resolve any questions about the appropriateness of the health care received by the injured employee (employee). The carrier's first RME may be requested at any time after the date of injury. A subsequent examination may be requested once every 180 days after the first examination and must be performed by the same doctor unless otherwise approved by the Division. This paragraph only applies to requests for required medical

examinations of employees not receiving medical treatment through an authorized workers' compensation health care network.

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

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

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

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

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

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

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

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

representative (if any) by telephone to discuss the request and obtain the employee's or the representative's response.
(3) The carrier shall send the request to the Division after either obtaining the employee's answer to the request or when the employee fails to respond after the 15-day period.

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

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

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

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

RULE §126.6 Required Medical Examination

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

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

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

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

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

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

(e) An RME doctor, selected by the carrier or the Division, who conducts an examination regarding the appropriateness of the health care received by the employee, shall complete a medical report that includes objective findings of the examination and an analysis that explains how the medical condition and objective findings lead to the

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

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

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

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

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

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

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

(A) failed to submit to the examination; and

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

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

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

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

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

(k) An employee who, without good cause, fails or refuses to appear at the time scheduled for an examination authorized by this section may be assessed an administrative penalty under Labor Code §408.004 and §408.0041. An employee who fails to submit to an examination at the carrier's request when the carrier selected

doctor refuses to allow the treating doctor to attend the examination or when the RME doctor cancels the examination does not commit an administrative violation.

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

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

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

RULE §126.8 Commission Approved Doctor List

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

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

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

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

RULE §126.9 Choice of Treating Doctor and Liability for Payment

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

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

(c) The first doctor who provides health care to an injured employee shall be known as the injured employee's initial choice of treating doctor. The following do not constitute an initial choice of treating doctor:
(1) a doctor salaried by the employer;
(2) a doctor recommended by the carrier or employer, unless the injured employee continues, without good cause as determined by the commission, to receive treatment from the doctor for a period of more than 60 days; or
(3) any doctor providing emergency care unless the injured employee receives treatment from the doctor for other than follow-up care related to the emergency treatment.

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

(e) Reasons for approving a change in treating doctor include, but are not limited to:
(1) the reasons listed in Texas Civil Statutes, Article 8308-4.63(d); and
(2) the selected doctor chooses not to be responsible for coordinating injured employee's health care as described in §133.3 of this title (relating to Responsibilities of Treating Doctor).

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

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

(h) The commission may, after holding a benefit contested case hearing as provided by Chapter 142 of this title (relating to Benefit Contested Case Hearing), relieve the carrier of liability for health care furnished by a doctor or health care provider at the doctor's direction if:
(1) the doctor chosen by the employee is not on the list at the time the medical treatments or services are rendered; or
(2) the employee failed to comply with commission rules regarding a change in treating doctor.

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

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

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

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

(a) The commission may approve an extension of the date of maximum medical

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

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

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

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

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

(f) In making the determination to approve or deny a request for an extension of the date of maximum medical improvement, the commission shall consider:
(1) typical recovery times for the specific spinal surgery procedure;
(2) projected date and information regarding when the condition may be medically stable as provided by the treating doctor or the surgeon;
(3) case specific information regarding any extenuating circumstances that may have resulted in variances from conservative treatment protocols and time frames that may impact recovery times as provided by the treating doctor or the surgeon;
(4) information from any source regarding intentional or non-intentional delays in securing the surgery or medical treatment for the compensable injury;
(5) any pending, unresolved disputes regarding the date of maximum medical improvement; and
(6) any pertinent information provided by the insurance carrier, injured employee, and/or the injured employee's representative regarding the extension being requested under this section.

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

(h) If a request for benefit review conference is not received by the commission within ten days after the date the order granting or denying the extension was received by the disputing party, the parties waive their right to dispute the commission order. In the

event that an order is timely disputed, the order shall remain binding pending final resolution of the dispute.

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

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

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

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

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

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

(1) have accrued during a period of dispute over insurance carrier (carrier) liability for the claim or injured employee entitlement to the benefits; or
(2) have not been paid by the date the carrier was required to pay them.

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

(c) Income benefits accrue in either weekly or monthly pay periods, as otherwise provided by the Texas Workers' Compensation Act and this title, and interest shall be calculated separately for each pay period based on the length of time the benefits for that pay period remained accrued and unpaid.
(1) For pay periods in which benefits accrued while in dispute as provided in subsection (a)(1) of this section, the carrier shall pay interest for number of days between the seventh day after the day the benefits accrued and the day the payment was made.
(2) For pay periods in which benefits accrued and were paid late by the carrier as provided in subsection (a)(2) of this section, the carrier shall pay interest for the number of days between the due date for the payment and the date the payment was made.

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

(e) The following method shall be used to calculate the simple interest to be paid:
(1) multiply the rate of interest by the amount in question (to create annual amount of interest);
(2) divide the annual amount of interest by 365 (to create daily interest amount); then
(3) multiply daily interest amount by the number of days of interest that are owed.

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

RULE §126.13 Employer Initiation of Benefits and Reimbursement

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

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

(A) contested compensability of the injury;

(B) contested liability for the injury; or

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

(b) Employer Entitlement to Reimbursement

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

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

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

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

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

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

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

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

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

(c) Reporting and Reimbursement Process

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

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

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

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

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

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

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

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

RULE §126.14 Treating Doctor Examination to Define the Compensable Injury

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

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

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

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

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

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

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

(1) general information identifying the claim;

(2) the name of the treating doctor;

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

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

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

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

(C) You are responsible for contacting your doctor to reschedule the examination if you have a conflict with the date and time that has been scheduled for you. The rescheduled examination shall take place within seven days of the originally scheduled date or the doctor's first available appointment date. If you fail to attend the examination at the time scheduled or rescheduled without good cause, an administrative penalty may be assessed.

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

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

(f) The treating doctor shall submit a narrative report after the conclusion of the examination. The report shall contain, at a minimum:
(1) general information that identifies the claim;
(2) a description of the mechanism of injury;
(3) a list of all specific, confirmed diagnoses, including ICD-9 codes and the narrative description, that the doctor considers to be related to the compensable injury. The explanation shall describe how the mechanism of injury is a cause of each diagnosis. If the doctor identifies an aggravation of any pre-existing condition, including an ordinary disease of life, the explanation shall describe how the mechanism of injury caused a worsening, acceleration, or exacerbation of that pre-existing condition; and
(4) a list of each diagnostic test performed, if required to establish a diagnosis, including an explanation of why it was appropriate to perform each test to define the compensable injury.

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

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

(i) A treating doctor may bill, and the insurance carrier shall reimburse, for an examination performed under this section.
(1) Treating doctors shall bill for the examination using the Healthcare Common Procedure Coding System (HCPCS) Level I code, Evaluation and Management Section, for work-related or medical disability evaluation services performed by a treating physician. A Division modifier of "TX" shall be added to the Level I code.

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

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

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

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

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

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

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

(m) A health care provider may request a benefit review conference, in accordance with §141.1 of this title, to address an extent of injury question if a request for

preauthorization has been denied for treatment of an injury or diagnosis that was denied as unrelated to the compensable injury under this section; unless:
(1) the injured employee has already requested a benefit review conference to pursue the extent of injury denial, or
(2) an agreement, filed in accordance with §147.4 of this title (relating to Filing Agreements with the Commission, Effective Dates) has been entered into by the insurance carrier and injured employee establishing the insurance carrier's liability on the disputed issues.

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

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

RULE §126.15 Procedures for Resolution of Underpayments of Income Benefits

(a) This section applies to insurance carrier underpayment of income benefits. It does not apply to:
(1) insurance carrier underpayment of death, burial, or medical benefits; or
(2) redesignation of income benefits.

(b) If the insurance carrier determines on its own that an underpayment of income benefits has occurred, the insurance carrier shall pay the full amount of the underpayment with interest on accrued but unpaid benefits in accordance with Chapter 408, Labor Code, applicable division rules related to payment of benefits, §102.10 of this title (relating to Interest, General), and §126.12 of this title (relating to Payment of Interest on Accrued but Unpaid Income Benefits) within seven days of the determination.

(c) If an injured employee determines that the injured employee has received less than the correct amount owed in income benefits and the injured employee wishes to resolve the underpayment under this section, the injured employee must notify the insurance carrier in writing to request the additional amount. The notice must include an explanation and information that supports the injured employee's determination of the underpayment.

(d) If the insurance carrier agrees with the injured employee that there has been an underpayment of income benefits, the insurance carrier shall pay the full amount of the

underpayment with interest on accrued but unpaid benefits in accordance with Chapter 408, Labor Code, applicable division rules related to payment of benefits, §102.10 of this title, and §126.12 of this title within seven days of receipt of the notice from the injured employee.

(e) If the insurance carrier disagrees that there has been an underpayment of income benefits, the insurance carrier must, within seven days of receipt of the notice from the injured employee, provide the injured employee with written notice of its determination. The insurance carrier notice must be in plain language, in English or Spanish, as appropriate, and include the reasons for the insurance carrier's determination, and a statement that the injured employee may request dispute resolution through the dispute resolution processes outlined in Chapters 140 - 144 and 147 of this title (relating to Dispute Resolution), including expedited dispute resolution.

(f) The insurance carrier must provide notice to the injured employee and the division of any change in the payment of an injured employee's income benefits in accordance with the requirements of §124.2 of this title (relating to Carrier Reporting and Notification Requirements).

(g) If an insurance carrier disagrees that there has been an underpayment of income benefits, the injured employee may request dispute resolution through the dispute resolution processes outlined in Chapters 140 - 144 and 147 of this title, including expedited dispute resolution.

(h) This section does not affect the division's authority to identify and take action on underpayments on its own motion.

Source Note: The provisions of this §126.15 adopted to be effective January 1, 2012, 36 TexReg 8854

RULE §126.16 Procedures for Recouping Overpayments of Income Benefits

(a) This section applies to insurance carrier overpayment of income benefits. It does not apply to:
(1) insurance carrier overpayment of death, burial, or medical benefits;
(2) redesignation of income benefits; or
(3) repayments pursuant to Labor Code §415.008.

(b) If an insurance carrier determines that it has overpaid income benefits to an injured employee, the insurance carrier may recoup the overpayment from future income benefit payments as follows:

(1) The insurance carrier must notify the injured employee in writing that it will begin withholding benefits to recoup an overpayment. The notice must be in plain language and in English or Spanish, as appropriate. The notice must also include the reason for the overpayment; the amount of the overpayment to be recouped from future income benefit payments; the date recoupment will begin; and relevant documentation that supports the insurance carrier's determination of an overpayment, such as a wage statement or a supplemental report of injury. The notice must also advise the injured employee that if the injured employee disagrees that there has been an overpayment, the injured employee may request dispute resolution through the dispute resolution processes outlined in Chapters 140 - 144 and 147 of this title (relating to Dispute Resolution), including expedited dispute resolution. The insurance carrier may not begin recoupment of the overpayment earlier than the second income benefit payment made after the written notice has been sent to the injured employee.

(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, the insurance carrier may recoup the overpayment under this subsection in an amount not to exceed 25% 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 concurrently being reduced to pay approved attorney's fees or to recoup a division approved advance, 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.

(c) If the insurance carrier wishes to recoup the overpayment in an amount greater than that permitted by subsection (b) of this section, the insurance carrier must attempt to enter into a written agreement with the injured employee and, if unable to do so, request dispute resolution through the dispute resolution processes outlined in Chapters 140 - 144 and 147 of this title. If the injured employee wishes to provide for recoupment of the overpayment in an amount less than the percentage chosen by the insurance carrier, the injured employee must attempt to enter into a written agreement with the insurance carrier and, if unable to do so, request dispute resolution through the dispute resolution processes outlined in Chapters 140 - 144 and 147 of this title.

(d) In determining whether to approve an increase or decrease in the recoupment rate, the division must consider the cause of the overpayment and minimize the financial hardship that may reasonably be created for the injured employee.

(e) The insurance carrier must provide notice to the injured employee and the division of any change in the payment of an injured employee's income benefits in accordance with the requirements of §124.2 of this title (relating to Carrier Reporting and Notification Requirements). The insurance carrier's notice to the injured employee must identify the amount that was overpaid.

(f) This section does not create an entitlement for an insurance carrier to seek reimbursement from the Subsequent Injury Fund except as provided by Labor Code §§403.006, 408.0041, 410.209, and applicable division rules.

(g) If an injured employee does not agree that the injured employee has received an overpayment of income benefits, the injured employee may request dispute resolution through the dispute resolution processes outlined in Chapters 140 - 144 and 147 of this title, including expedited dispute resolution.

(h) This section does not affect the division's authority to identify and take action on overpayments on its own motion.

Source Note: The provisions of this §126.16 adopted to be effective January 1, 2012, 36 TexReg 8854

RULE §126.17 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

(a) 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 the evaluation of permanent impairment may be appropriate after a designated doctor examination if:
(1) the designated doctor issued an opinion on the issue;
(2) the injured employee is not satisfied with the designated doctor's opinion; and
(3) 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 issue addressed by the designated doctor.

(b) The treating doctor or the referral doctor shall complete a narrative report. The report should include objective findings of the examination and an analysis that explains how the objective findings lead to the conclusion reached by the doctor. This report shall be filed with the insurance carrier, the injured employee and the injured

employee's representative. Notwithstanding §129.5 of this title (relating to Work Status Reports), if the treating doctor or the referral doctor examines the injured employee to address an issue relating to return to work, the doctor must also file a Work Status Report.

(c) The insurance carrier shall reimburse the injured employee for all reasonable travel expenses as specified in Chapter 134, Subchapter B of this title (relating to Miscellaneous Reimbursement) for attending an appropriate medical examination.

(d) Nothing in this section is construed to limit or prohibit the injured employee from obtaining reasonable and necessary medical care for the compensable injury or from obtaining a written report from a treating doctor or a referral doctor on any issue under Labor Code §408.0041(a)(3) - (6) prior to a designated doctor examination.

Source Note: The provisions of this §126.17 adopted to be effective January 6, 2013, 37 TexReg 10215

TITLE 28 **INSURANCE**
PART 2 **TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION**
CHAPTER 127 **DESIGNATED DOCTOR PROCEDURES AND REQUIREMENTS**
SUBCHAPTER A **DESIGNATED DOCTOR SCHEDULING AND EXAMINATIONS**

RULE §127.1 Requesting Designated Doctor Examinations

(a) Initiating an examination. At the request of the insurance carrier, an injured employee, the injured employee's representative, or on its own motion, the division may order a medical examination by a designated doctor to resolve questions about:
(1) the impairment caused by the injured employee's compensable injury;
(2) the attainment of maximum medical improvement (MMI);
(3) the extent of the injured employee's compensable injury;
(4) whether the injured employee's disability is a direct result of the work-related injury;
(5) the ability of the injured employee to return to work; or
(6) issues similar to those described by paragraphs (1) - (5) of this subsection.

(b) Requirements for a request. To request a designated doctor examination, a requester must:
(1) provide a specific reason for the examination;
(2) report the injured employee's current diagnosis or diagnoses and body part or body parts affected by the injury;
(3) provide general information about the identity of the requester, injured employee, treating doctor, and insurance carrier;
(4) identify the workers' compensation health care network certified under Insurance Code Chapter 1305 through which the injured employee is receiving treatment, if applicable;
(5) identify whether the claim involves medical benefits provided through a political subdivision under Labor Code §504.053(b)(2) and the name of the health plan, if applicable;
(6) submit the request on the form prescribed by the division under this section. A copy of the prescribed form is:
(A) on the division's website at www.tdi.texas.gov/wc; or
(B) at the division's headquarters in Austin, Texas, or any division field office location;
(7) submit the request to the division and a copy of the request to each party listed in subsection (a) of this section who did not request the designated doctor examination;
(8) provide all information listed in subparagraphs (A) - (G) of this paragraph that applies to the type of examination the requester seeks:

(A) if the requester seeks an examination on the attainment of MMI, include the statutory date of MMI, if any;

(B) if the requester seeks an examination on the impairment rating of the injured employee, include the date of MMI that has been determined to be valid by a final decision of the division or a court or by agreement of the parties, if any;

(C) if the requester seeks an examination on the extent of the compensable injury, include a description of the accident or incident that caused the claimed injury and a list of all injuries in question;

(D) if the requester seeks an examination on whether the injured employee's disability is a direct result of the work-related injury, include the beginning and ending dates for the claimed periods of disability and state if the injured employee is either not working or is earning less than pre-injury wages as defined by Labor Code §401.011(16);

(E) if the requester seeks an examination on the injured employee's ability to return to work in any capacity and the activities the injured employee can perform, include the beginning and ending dates for the periods to be addressed. If no dates are included, the designated doctor must examine the injured employee's work status as of the date of the examination;

(F) if the requester seeks an examination to determine whether an injured employee entitled to supplemental income benefits may return to work in any capacity for the identified period, include the beginning and ending dates for the qualifying periods to be addressed and whether this period involves the ninth quarter or a subsequent quarter of supplemental income benefits;

(G) if the requester seeks an examination on topics under subsection (a)(6) of this section, specify the issue in sufficient detail for the designated doctor to identify and answer the questions; and

(9) provide a signature to attest that every reasonable effort has been made to ensure the accuracy and completeness of the information in the request.

(c) Scheduling an examination within 60 days. The division will not schedule a designated doctor examination within 60 days of the most recent designated doctor examination absent a showing of good cause.

(1) Good cause requires the requester to show that the requested examination is reasonably necessary to resolve the submitted questions and that it will affect entitlement to benefits.

(2) If the requester already asked for an examination on the claim, they must also show that the submitted questions could not reasonably have been included in the previous examination.

(d) Denial of a request. The division will determine whether good cause exists on a case-by-case basis. The division will deny a request for a designated doctor examination and provide a written explanation for the denial to the requester if:

(1) the request does not comply with any of the requirements of subsection (b) or (c) of this section;

(2) the request would require the division to schedule an examination that violates Labor Code §§408.0041, 408.123, 408.151, or 408.1615;

(3) there is an unresolved dispute about compensability reported under §124.2 of this title (relating to Insurance Carrier Notification Requirements); or

(4) the request lacks any legal or factual basis that would reasonably merit approval.

(e) Examination ordered during a dispute. During a dispute on the compensability of a claim as a whole, if a division administrative law judge or benefit review officer determines that an expert medical opinion would be necessary to resolve a dispute about whether the claimed injury resulted from the claimed incident, the administrative law judge or benefit review officer may order the injured employee to attend a designated doctor examination to address that issue.

(f) Disputes about designated doctor requests. The dispute resolution processes in Chapters 140 - 144 and 147 of this title (relating to dispute resolution processes, proceedings, and procedures) govern disputes about designated doctor requests.

(1) The insurance carrier, an injured employee, or the injured employee's representative may dispute the division's approval or denial of a designated doctor examination request.

(2) Until the division has either approved or denied the request, a party may not dispute the designated doctor examination request itself or the accuracy of any information on the request.

(3) To dispute an approved or denied request for a designated doctor examination, a party may seek an expedited contested case hearing under §140.3 of this title (relating to Expedited Proceedings). The party must file the request within three working days of receiving the order under §127.5(b) of this title (relating to Scheduling Designated Doctor Appointments).

(4) If the division receives and approves a timely request for expedited proceedings to dispute a designated doctor examination, the division will stay the disputed examination pending the outcome of the expedited contested case hearing.

Source Note: The provisions of this §127.1 adopted to be effective February 1, 2011, 35 TexReg 11324; amended to be effective September 1, 2012, 37 TexReg 5422; amended to be effective November 4, 2018, 43 TexReg 7149; amended to be effective April 30, 2023, 48 TexReg 2123; amended to be effective November 21, 2024, 49 TexReg 9321

RULE §127.5 Scheduling Designated Doctor Appointments

(a) Order assigning a designated doctor. Within 10 days after approving a valid request, the division will issue an order that assigns a designated doctor and will notify the designated doctor, the treating doctor, if any, the injured employee, the injured employee's representative, if any, and the insurance carrier that the designated doctor is directed to examine the injured employee. The order will:

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

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

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

(4) require the designated doctor to perform the examination at the indicated examination address; and

(5) require the treating doctor, if any, and insurance carrier to forward all medical records to the designated doctor in compliance with §127.10(a)(3) of this title (relating to General Procedures for Designated Doctor Examinations).

(b) Change of examination address. The examination address indicated on the order in subsection (a)(4) of this section may not be changed by any party or by an agreement of any parties without good cause and the division's approval.

(c) Availability of designated doctor. Except as provided in subsection (g) of this section, the division will select the next available doctor on the designated doctor list for a medical examination requested under §127.1 of this title (relating to Requesting Designated Doctor Examinations). A designated doctor is available to perform an examination at any address the doctor has filed with the division if the doctor:

(1) does not have any disqualifying associations as described in §127.140 of this title (relating to Disqualifying Associations);

(2) is appropriately qualified to perform the examination in accordance with §127.130 of this title (relating to Qualification Standards for Designated Doctor Examinations);

(3) is certified on the day the examination is offered and has not failed to timely file for renewal under §127.100 of this title (relating to Designated Doctor Certification), if applicable;

(4) has not treated or examined the injured employee in a different health care provider role:

(A) within the past 12 months; or

(B) for a medical condition being evaluated in the designated doctor examination.

(d) Designated doctor lists. To select the next available doctor, the division will maintain two independent designated doctor lists for each county in Texas.
(1) One list will consist of designated doctors qualified to perform examinations under §127.130(b)(1) - (4) of this title.
(2) The other list will consist of designated doctors qualified to perform examinations under §127.130(b)(5) - (9) of this title.
(3) Nothing in this section prevents a qualified designated doctor from being on both lists.
(4) A designated doctor will be added to the appropriate designated doctor list for the county of each address the doctor has filed with the division.
(5) When a designated doctor adds an address for a county the doctor is not currently listed in, the doctor will be placed at the bottom of the appropriate list for that county.
(6) When a designated doctor removes the only address for a county the doctor is currently listed in, the designated doctor will be removed from the list for that county.

(e) Assignment of designated doctor examinations. Except as provided in subsection (f) of this section, the division will assign designated doctor examinations as follows:
(1) Each working day, all examination requests within a county will be sorted and distributed to the appropriate list based on the designated doctor qualification standards.
(2) Depending on the volume of requested examinations, the division will assign up to five examinations to the next available designated doctor at the top of the appropriate list.
(3) An examination assignment moves the designated doctor receiving the assignment to the bottom of the list from which the designated doctor was selected. Receipt of an assignment on one list does not change a designated doctor's position on the other list.
(4) The division may choose not to offer a designated doctor an examination if it is reasonably probable that the designated doctor will not be certified on the date of the examination.

(f) Exemptions. Nothing in this section prevents the division from exempting a designated doctor from the applicable qualification standard under §127.130(d) of this title. If there is no available designated doctor in the county of the injured employee, the division may assign a designated doctor as necessary.

(g) Subsequent examinations. If the division has previously assigned a designated doctor to the claim at the time a request is made, the division will assign the same doctor to a subsequent examination for that claim unless the division has authorized or required the doctor to stop providing services on the claim in accordance with §127.130 of this title. Examinations under this subsection must be conducted at the same examination

address as the designated doctor's previous examination of the injured employee or at another examination address approved by the division.

(h) Mutual agreement required to reschedule. The designated doctor's office and the injured employee must contact each other if there is a scheduling conflict. The designated doctor or the injured employee who has the scheduling conflict must contact the other at least one working day before the appointment. The one working day requirement is waived in an emergency situation. An examination cannot be rescheduled without the mutual agreement of the designated doctor and the injured employee. The designated doctor must maintain and document:

(1) the date and time of the designated doctor examination listed on the division's order;

(2) the date and time of the agreement to reschedule with the injured employee;

(3) how contact was made to reschedule, indicating the telephone number, fax number, or email used to make contact;

(4) the reason for the scheduling conflict; and

(5) the date and time of the rescheduled designated doctor examination.

(i) Documentation required. Failure to document and maintain the information in subsection (h) of this section creates a rebuttable presumption that the examination was rescheduled without mutual agreement of the designated doctor and injured employee.

(j) Rescheduling timeframes. The rescheduled examination must be set to occur no later than 21 days after the originally scheduled examination date. It may not be rescheduled to occur before the originally scheduled examination date.

(1) Within one working day of rescheduling, the designated doctor must provide the time and date of the rescheduled examination to the division, the injured employee or the injured employee's representative, if any, the injured employee's treating doctor, and the insurance carrier.

(2) If the examination cannot be rescheduled to occur within 21 days of the originally scheduled examination date, or if the injured employee fails to attend the rescheduled examination, the designated doctor must notify the division within 21 days of the originally scheduled examination date.

(3) After receiving this notice, the division may select a new designated doctor.

Source Note: The provisions of this §127.5 adopted to be effective February 1, 2011, 35 TexReg 11324; amended to be effective September 1, 2012, 37 TexReg 5422; amended to be effective November 4, 2018, 43 TexReg 7149; amended to be effective April 30, 2023, 48 TexReg 2123

RULE §127.10 General Procedures for Designated Doctor Examinations

(a) Authorization to receive documents. The designated doctor is authorized under Labor Code §408.0041(c) to receive the injured employee's confidential medical records and analyses of the injured employee's medical condition, functional abilities, and return-to-work opportunities without a signed release from the injured employee to help resolve a dispute under this subchapter. The following requirements apply to the designated doctor's receipt of medical records and analyses:

(1) The treating doctor and insurance carrier must provide the designated doctor copies of all the injured employee's medical records in their possession relating to the medical condition to be evaluated by the designated doctor.

(A) For subsequent examinations with the same designated doctor, the treating doctor and insurance carrier must provide only those medical records not previously sent.

(B) The cost of copying must be reimbursed in accordance with §134.120 of this title (relating to Reimbursement for Medical Documentation).

(2) The treating doctor and insurance carrier may also send the designated doctor an analysis of the injured employee's medical condition, functional abilities, and return-to-work opportunities.

(A) The analysis sent by any party may only cover the injured employee's medical condition, functional abilities, and return-to-work opportunities as provided in Labor Code §408.0041. The analysis may include supporting information, such as videotaped activities of the injured employee and marked copies of medical records.

(B) If the insurance carrier sends an analysis to the designated doctor, the insurance carrier must send a copy to the treating doctor, the injured employee, and the injured employee's representative, if any.

(C) If the treating doctor sends an analysis to the designated doctor, the treating doctor must send a copy to the insurance carrier, the injured employee, and the injured employee's representative, if any.

(3) The treating doctor and insurance carrier must ensure that the designated doctor receives the required records and analyses (if any) no later than three working days before the date of the designated doctor examination.

(A) If the designated doctor has not received the medical records or any part of them at least three working days before the examination, the designated doctor must report this violation to the division within one working day of not timely receiving the records.

(B) Once notified, the division will take action necessary to ensure that the designated doctor receives the records.

(C) If the designated doctor does not receive the medical records within one working day of the examination or does not have sufficient time to review the late medical

records before the examination, the designated doctor must reschedule the examination to occur no later than 21 days after receiving the records.

(b) Requirement to review information. Before examining an injured employee, the designated doctor must review the injured employee's medical records, including any analysis of the injured employee's medical condition, functional abilities, and return to work opportunities that the insurance carrier and treating doctor provide in accordance with subsection (a) of this section, and any materials the division submits to the doctor.

(1) The designated doctor must also review the injured employee's medical condition, history, and any medical records the injured employee provides and must perform a complete physical examination of the injured employee.

(2) The designated doctor must give the medical records reviewed the weight the designated doctor determines to be appropriate.

(c) Additional testing and referrals. The designated doctor must perform additional testing when necessary to resolve the issue in question. The designated doctor must also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question, and the designated doctor is not qualified to fully resolve it.

(1) Any additional testing or referrals required for the evaluation are not subject to preauthorization requirements.

(2) Payment for additional testing or referrals that the designated doctor has determined are necessary under this subsection must not be denied prospectively or retrospectively, regardless of any potential disagreements about medical necessity, extent of injury, or compensability.

(3) Any additional testing or referrals required for the evaluation are subject to the requirements of §180.24 of this title (relating to Financial Disclosure).

(4) Any additional testing or referrals required for the evaluation of an injured employee under a certified workers' compensation network under Insurance Code Chapter 1305 or a political subdivision under Labor Code §504.053(b):

(A) are not required to use a provider in the same network as the injured employee; and

(B) are not subject to the network or out-of-network restrictions in Insurance Code §1305.101 (relating to Providing or Arranging for Health Care).

(5) Any additional testing or referral examination and the designated doctor's report must be completed within 15 working days of the designated doctor's physical examination of the injured employee unless the designated doctor receives division approval for additional time before the 15 working days expire.

(6) If the injured employee fails or refuses to attend the designated doctor's requested additional testing or referral examination within 15 working days or within the additional

time the division approved, the designated doctor must complete the report based on the designated doctor's examination of the injured employee, the medical records received, and other information available to the doctor and indicate the injured employee's failure or refusal to attend the testing or referral examination in the report.

(d) MMI and impairment ratings. Any evaluation relating to either MMI, an impairment rating, or both, must be conducted in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment). For examinations conducted under this subsection on or after June 5, 2023, the designated doctor may provide multiple certifications of MMI and impairment ratings only when directed by the division.

(e) Reports on MMI and impairment ratings. A designated doctor who determines the injured employee has reached MMI, assigns an impairment rating, or determines the injured employee has not reached MMI, must complete and file a report as required by §130.1 and §130.3 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment by a Doctor Other than the Treating Doctor).

(1) If the designated doctor provides multiple certifications of MMI and impairment ratings, the designated doctor must file a Report of Medical Evaluation under §130.1(d) of this title for each assigned impairment rating and a designated doctor examination data report under §127.220 of this title (relating to the Designated Doctor Reports) for the doctor's extent of injury determination.

(2) The designated doctor must submit only one narrative report required by §130.1(d)(1)(B) of this title on all assigned impairment ratings and extent of injury findings.

(3) All designated doctor narrative reports submitted under this subsection must comply with the requirements of §127.220(a) of this title (relating to Designated Doctor Reports).

(f) Reports on return to work. A designated doctor who examines an injured employee for any question relating to return to work must complete a Work Status Report that complies with §129.5 of this title (relating to Work Status Reports) and a narrative report that complies with the requirements of §127.220(a) of this title. The designated doctor must file the work status report and the narrative report together within seven working days of the date the designated doctor examines the injured employee.

(1) The designated doctor must file the reports with the treating doctor, the division, and the insurance carrier by fax or electronic transmission.

(2) The designated doctor must file the reports with the injured employee and the injured employee's representative (if any) by fax or electronic transmission if the designated doctor has a fax number or email for the recipient.
(3) If the designated doctor has no fax number or email for a recipient, the designated doctor must send them the reports by other verifiable means.

(g) Report on other issues. A designated doctor who resolves questions on issues other than those listed in subsections (d), (e), and (f) of this section must file a designated doctor examination data report that complies with §127.220(c) of this title and a narrative report that complies with §127.220(a) of this title within seven working days of the date the designated doctor examines the injured employee.
(1) The designated doctor must file these reports with the treating doctor, the division, and the insurance carrier by fax or electronic transmission.
(2) The designated doctor must provide these reports to the injured employee and the injured employee's representative (if any) by fax or electronic transmission if the designated doctor has a fax number or email for the recipient.
(3) If no fax number or email is provided for the recipient, the designated doctor must send the reports by other verifiable means.

(h) Presumptive weight. The designated doctor's report is given presumptive weight on the issue or issues the designated doctor was properly appointed to address, unless the preponderance of the evidence is to the contrary.

(i) Payment of benefits during dispute. The insurance carrier must pay all benefits, including medical benefits, in accordance with the designated doctor's report for the issue or issues in dispute.
(1) If the designated doctor provides multiple certifications of MMI and impairment ratings, the insurance carrier must pay benefits based on the conditions to which the designated doctor determines the compensable injury extends.
(2) For medical benefits, the insurance carrier has 21 days from receipt of the designated doctor's report to reprocess all medical bills previously denied for reasons inconsistent with the designated doctor's findings. By the end of this period, insurance carriers must pay these medical bills in accordance with the Labor Code and Chapters 133 and 134 of this title.
(3) The insurance carrier must pay all other benefits no later than five days after receiving the report.

(j) Record retention. The designated doctor must maintain accurate records for, at a minimum, five years from the anniversary date of the date of the designated doctor's last examination of the injured employee.

(1) This requirement does not reduce or replace any other record retention requirements imposed on a designated doctor by an appropriate licensing board.

(2) These records must include the injured employee's medical records, any analysis the insurance carrier or treating doctor submits (including supporting information), reports the designated doctor generates as a result of the examination, and narratives the insurance carrier and treating doctor provide, to reflect:

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

(B) the circumstances for a cancellation, no-show, or other situation where the examination did not occur as initially scheduled or rescheduled, and if applicable, documentation of the agreement to reschedule the examination and the notice that the doctor provided to the division, the injured employee's treating doctor, and the insurance carrier within 24 hours of rescheduling an appointment;

(C) the date of the examination;

(D) the date the designated doctor received medical records from the treating doctor or any other person;

(E) the date the designated doctor submitted the reports described in subsections (d), (e), and (f) of this section to all required parties and documentation that these reports were submitted to the division, treating doctor, and insurance carrier by fax or electronic transmission and to other required parties by verifiable means;

(F) if applicable, the names of any referral health care providers the designated doctor used, the dates of referral health care provider appointments, and the reason the designated doctor referred them; and

(G) if applicable, the date the doctor contacted the division for assistance in getting medical records from the insurance carrier or treating doctor.

(k) Dispute resolution. Parties may dispute any entitlement to benefits affected by a designated doctor's report through the dispute resolution processes outlined in Chapters 140-144 and 147 of this title (relating to dispute resolution processes, proceedings, and procedures).

Source Note: The provisions of this §127.10 adopted to be effective February 1, 2011, 35 TexReg 11324; amended to be effective September 1, 2012, 37 TexReg 5422; amended to be effective November 4, 2018, 43 TexReg 7149; amended to be effective April 30, 2023, 48 TexReg 2123

RULE §127.15 Undue Influence on a Designated Doctor

(a) Communication about medical condition or history. To avoid undue influence on the designated doctor:

(1) except as provided by §127.10(a) of this title (relating to General Procedures for Designated Doctor Examinations), only the injured employee or appropriate division staff may communicate with the designated doctor about the injured employee's medical condition or history before the designated doctor examines the injured employee;

(2) after the examination is completed, only appropriate division staff may communicate with the designated doctor about the injured employee's medical condition or history; and

(3) the designated doctor may initiate communication with:

(A) any health care provider who previously treated or examined the injured employee for the work-related injury; or

(B) a peer review doctor that the insurance carrier identifies as having reviewed the injured employee's claim or any information about that claim.

(b) Communication about administrative matters. The insurance carrier, treating doctor, injured employee, or injured employee's representative, if any, may contact the designated doctor's office to ask about administrative matters, including, but not limited to, whether the designated doctor received the records, whether the exam took place, or whether the designated doctor has filed the report, or other similar matters.

Source Note: The provisions of this §127.15 adopted to be effective February 1, 2011, 35 TexReg 11324; amended to be effective April 30, 2023, 48 TexReg 2123

RULE §127.20 Requesting a Letter of Clarification Regarding Designated Doctor Reports

(a) Filing a clarification request. Parties may file a request with the division for clarification of the designated doctor's report.

(1) The requesting party must provide copies of the request to all parties.

(2) The division may contact the designated doctor if it determines that clarification is necessary to resolve an issue regarding the designated doctor's report.

(3) Parties may only request clarification on issues already addressed by the designated doctor's report or on issues that the designated doctor was ordered to address but did not.

(4) A designated doctor must only respond to the questions or requests submitted to the designated doctor in the request for clarification and must not reconsider their previous decision, issue a new or amended decision, or provide clarification on their previous decision.

(b) Requirements. Requests for clarification must:

(1) include the name of the designated doctor, the reason for the examination, the date of the examination, and the requester's name and signature;
(2) explain why clarification of the designated doctor's report is necessary and appropriate to resolve a future or pending dispute;
(3) include questions for the designated doctor to answer that are not inflammatory or leading; and
(4) provide any medical records that were not previously provided to the designated doctor and explain why these records are necessary for the designated doctor to respond to the request for clarification.

(c) Requests by the division. At its discretion, the division may also request clarification from the designated doctor on any issue or issues.

(d) Responses to requests. To respond to a request for clarification, the designated doctor must be on the division's designated doctor list on the date of the request.
(1) The designated doctor must respond in writing to the request for clarification within five working days of receipt and send copies of the response to the parties listed in §127.10(g) of this title (relating to General Procedures for Designated Doctor Examinations).
(2) If the designated doctor must reexamine the injured employee to respond to the request for clarification, the doctor must:
(A) respond to the request for clarification in writing, advising of the need for an additional examination within five working days of receiving the request and provide copies of the response to the parties specified in §127.10(g) of this title;
(B) conduct the reexamination within 21 days from the date the division issues the order for the reexamination at the same address as the original examination; and
(C) respond in writing to the request for clarification based on the additional examination within seven working days of the examination and provide copies of the response to the parties specified in §127.10(g) of this title.

(e) Administrative violation. Any refusal or failure by a designated doctor to conduct a reexamination that is necessary to respond to a request for clarification is an administrative violation.

Source Note: The provisions of this §127.20 adopted to be effective February 1, 2011, 35 TexReg 11324; amended to be effective September 1, 2012, 37 TexReg 5422; amended to be effective April 30, 2023, 48 TexReg 2123

RULE §127.25 Failure to Attend a Designated Doctor Examination

(a) Suspension of benefits. An insurance carrier may suspend temporary income benefits (TIBs), or lifetime income benefits under §408.1615, if an injured employee fails, without good cause, to attend a designated doctor examination or a referral examination under §127.10(c) of this title.

(b) No good cause. If there is no division finding that good cause exists, an insurance carrier may presume that the injured employee did not have good cause to fail to attend the examination if, by the day the examination was originally scheduled to occur, the injured employee has both:
(1) failed to submit to the examination; and
(2) failed to contact the designated doctor's office to reschedule the examination.

(c) Rescheduling timeframe. If the injured employee contacts the designated doctor within 21 days of the scheduled date of the missed examination to reschedule the examination, the designated doctor must schedule the examination to occur as soon as possible, but no later than 21 days after the injured employee contacted the doctor.

(d) New examination request required. If the injured employee fails to contact the designated doctor within 21 days of the missed examination date but wishes to reschedule the examination, the injured employee must request a new examination under §127.1 of this title (relating to Requesting Designated Doctor Examinations).

(e) Reinitiation of TIBs. The insurance carrier must reinitiate TIBs effective on the date the injured employee submitted to the rescheduled examination under subsection (c) of this section or the date the examination was scheduled at the injured employee's request under subsection (d) of this section, unless the designated doctor's report indicates that the injured employee has reached MMI or is otherwise not eligible for income benefits. The reinitiation of TIBs must occur no later than the seventh day following:
(1) the date the insurance carrier was notified that the injured employee submitted to the examination; or
(2) the date the insurance carrier was notified that the division found the injured employee had good cause for not attending the examination.

(f) Reinstatement of lifetime income benefits. The insurance carrier must reinstate lifetime income benefits under §408.1615 effective on the date the injured employee submitted to the rescheduled examination under subsection (c) of this section, or the date the examination was scheduled at the injured employee's request under subsection

(d) of this section, unless the designated doctor's report indicates that the injured employee is no longer eligible for lifetime income benefits. The reinstatement of lifetime income benefits must occur no later than the seventh day following:
(1) the date the insurance carrier was notified that the injured employee submitted to the examination; or
(2) the date the insurance carrier was notified that the division found the injured employee had good cause for not attending the examination.

(g) Benefits during suspension. An injured employee is not entitled to TIBs or lifetime income benefits under §408.1615 during the period when the insurance carrier suspended benefits under this section unless the injured employee later submits to the examination, and:
(1) the division finds that the injured employee had good cause for not attending the examination; or
(2) the insurance carrier determines that the injured employee had good cause for not attending the examination.

Source Note: The provisions of this §127.25 adopted to be effective February 1, 2011, 35 TexReg 11324; amended to be effective September 1, 2012, 37 TexReg 5422; amended to be effective April 30, 2023, 48 TexReg 2123; amended to be effective November 21, 2024, 49 TexReg 9321

SUBCHAPTER B DESIGNATED DOCTOR CERTIFICATION, RECERTIFICATION, AND QUALIFICATIONS

RULE §127.100 Designated Doctor Certification

(a) Qualifications to get or renew certification. The division will not assign examinations to a designated doctor who does not meet all requirements for certification or renewal. All designated doctors must:
(1) Have a complete designated doctor certification application as described in subsection (b) of this section on file with the division.
(2) Complete all division-required trainings within 12 months of the date of application and have current documentation confirming their completion on file with the division.
(3) Pass all division-required testing on the specific duties of a designated doctor under the Labor Code and division rules and have current documentation confirming their passage on file with the division. Required testing must have been completed on or after May 13, 2013, and includes demonstrated proficient knowledge of the currently adopted edition of:

(A) the American Medical Association Guides to the Evaluation of Permanent Impairment; and

(B) the division's adopted:

(i) treatment guidelines; and

(ii) return-to-work guidelines.

(4) Have maintained an active practice for at least three years during the doctor's career. For the purposes of this subsection, a doctor has an active practice if the doctor maintains or has maintained routine office hours of at least 20 hours per week for 40 weeks per year to treat patients.

(5) For the duration of the doctor's term as a designated doctor:

(A) be licensed in Texas;

(B) own or subscribe to the current edition of the American Medical Association Guides to the Evaluation of Permanent Impairment adopted by the division to assign impairment ratings and all return-to-work and treatment guidelines adopted by the division; and

(C) comply with financial disclosure requirements in §180.24 (relating to Financial Disclosure) of this title.

(b) Application. To be considered complete, an application for certification must include, and a renewal application must update or confirm:

(1) contact information for the doctor;

(2) information on the doctor's education;

(3) a description of the doctor's license or licenses, certifications, and professional specialty, if any;

(4) a description of the doctor's work history and hospital or other health care provider affiliations;

(5) a description of any affiliations the doctor has with a workers' compensation health care network certified under Insurance Code Chapter 1305 or political subdivision under Labor Code §504.053(b)(2);

(6) information on the doctor's current practice locations;

(7) detailed answers to disclosure questions on the doctor's professional background, education, training, and fitness to perform the duties of a designated doctor, including disclosure and summary of any disciplinary actions taken against the doctor by any state licensing board or other appropriate state or federal agency;

(8) the identity of any person the doctor has contracted with to assist in performing or administering the doctor's designated doctor duties;

(9) an attestation that:

(A) all information provided in the application is accurate and complete to the best of the doctor's knowledge;

(B) the doctor will inform the division of any changes to this information as required by §127.200(a)(8) of this title (relating to Duties of a Designated Doctor); and

(C) the doctor will consent to any on-site visits, as provided by §127.200(a)(15) of this title, by the division at facilities that the designated doctor uses or intends to use to perform designated doctor examinations for the duration of the doctor's certification.

(c) Retesting. If a doctor passes a division-required test, the doctor may not retest within a twelve-month period. If a doctor fails a division-required test, the doctor may not retest more than three times within a six-month period.

(1) After the first or second attempt, the doctor must wait 14 days before retaking the test.

(2) After the third attempt, the doctor must wait six months before retaking the test.

(d) Additional certification testing. On receipt of an application for designated doctor certification renewal, the division may require a designated doctor to complete additional certification testing to demonstrate proficient knowledge on the specific duties of a designated doctor under the Labor Code and division rules. Examples of circumstances that may require additional certification testing include, but are not limited to, individual need for retesting based on substandard performance, changes in the duties of a designated doctor, updates to the guidelines, and legislative changes.

(e) Notice of approval, denial, suspension, or revocation. The division will notify a doctor in writing of the commissioner's approval or denial of the doctor's application to be certified or renewed as a designated doctor; or of the division's suspension or revocation of the doctor's certification.

(f) Term and qualification. Approvals certify a doctor for a term of two years and will include:

(1) the effective date of the certification;

(2) the expiration date of the certification; and

(3) the designated doctor's examination qualifications under §127.130 of this title (relating to Qualification Standards for Designated Doctor Examinations).

(g) Renewal. A designated doctor who seeks to renew their certification immediately after their current term expires, without interruption, must apply for certification no later than 45 days before the end of the term.

(1) If the division does not receive all of the information required under subsection (b)(1) - (9) above no later than 45 days before the end of the designated doctor's term, the division will not assign examinations to the designated doctor during the last 45 days of an expiring term.

(2) The designated doctor may still provide services on claims the division had previously assigned to them during this 45-day period.

(h) Approval of renewal application with restrictions. An application for renewal may be approved with restrictions. The division may restrict a designated doctor's certification until the doctor complies with the requirements in the designated doctor's approval of certification. Designated doctors whose certification is restricted may dispute the restriction through the procedure described in subsection (k) of this section.

(i) Adverse certification actions. The division may deny, suspend, or revoke a designated doctor's certification for any of the following reasons:

(1) if the doctor did not submit a complete application for certification as required under subsection (b) of this section;

(2) for having a relevant restriction on their practice imposed by a state licensing board, certification authority, or other appropriate state or federal agency, including the division;

(3) if the doctor failed to update their application for certification properly; or

(4) for other activities, events, or occurrences that the commissioner determines warrant denial of a doctor's application for certification as a designated doctor, including, but not limited to:

(A) the quality of the designated doctor's past reports;

(B) the designated doctor's history of complaints;

(C) excess requests for deferral from the designated doctor list by the designated doctor;

(D) a pattern of overturned reports by the division or a court;

(E) a demonstrated lack of ability to apply or properly consider the American Medical Association Guides to the Evaluation of Permanent Impairment adopted by the division to assign impairment ratings and all return-to-work and treatment guidelines adopted by the division;

(F) a demonstrated lack of ability to consistently perform designated doctor examinations in a timely manner;

(G) a demonstrated failure to identify disqualifying associations;

(H) a demonstrated lack of ability to ensure the confidentiality of injured employee medical records and claim information provided to or generated by a designated doctor;

(I) a history of unnecessary referral examinations or testing;

(J) a failure to comply with the requirements of §180.24 of this title (relating to Financial Disclosure) when they requested referral examinations or additional testing;

(K) applying for certification less than a year from denial of a previous designated doctor certification application; or

(L) any grounds that would allow the division to sanction a health care provider under the Labor Code or division rules.

(j) Response to denial of certification. Within 15 working days after receiving a written denial, a doctor may file a written response with the division addressing the reasons the division gave to the doctor for its denial.

(1) If the division does not receive a written response by the 15th working day after the date the doctor received the notice, the denial will be final effective the next day. The division will not send further notice.

(2) If the division timely receives a written response that disagrees with the denial, the division will review the response and notify the doctor in writing of the commissioner's final decision.

(A) If the final decision is still a denial, the division's final notice will provide the reasons the doctor's response did not change the commissioner's decision to deny the doctor's application for certification as a designated doctor.

(B) The denial will be effective the day after the doctor receives notice of the denial, unless the notice specifies otherwise.

(k) Request for informal conference. A designated doctor whose renewal application is denied, or whose certification is suspended or revoked, may either respond in writing using the procedure in subsection (j) of this section or submit a written request for an informal conference before the division to address those reasons.

(1) If the division does not receive a written request for an informal conference by the 15th working day after the date the doctor received the notice, the denial, suspension, or revocation will be final effective the next day. The division will not send further notice.

(2) If the division timely receives a written request for an informal conference, it will set the informal conference to occur no later than 31 days after it received the request.

(A) At the informal conference, the designated doctor may present evidence that addresses the reasons the doctor was denied certification, or the reasons the doctor's certification was suspended or revoked, to the commissioner's designated representatives.

(B) The designated doctor may have an attorney present.

(C) At the end of the informal conference, the commissioner's designated representatives will provide the designated doctor with their final recommendation on the doctor's certification.

(i) If the final recommendation is still a denial, suspension, or revocation, the commissioner's designated representatives will provide the reasons for not certifying the doctor as a designated doctor.

(ii) After the informal conference, the commissioner's designated representatives will send their final recommendation to the commissioner, who will review it and all evidence presented at the informal conference and make a final decision.

(iii) The division will notify the designated doctor of the commissioner's final decision in writing.

(iv) The decision will be effective the day after the doctor receives notice of the decision, unless the notice specifies otherwise.

Source Note: The provisions of this §127.100 adopted to be effective September 1, 2012, 37 TexReg 5422; amended to be effective November 4, 2018, 43 TexReg 7149; amended to be effective April 30, 2023, 48 TexReg 2123

RULE §127.120 Exception to Certification as a Designated Doctor for Out-of-State Doctors

If the injured employee is temporarily located or resides out of state, the division may waive any of the requirements in this chapter for an out-of-state doctor to serve as a designated doctor to help timely resolve a dispute or perform a particular examination.

Source Note: The provisions of this §127.120 adopted to be effective September 1, 2012, 37 TexReg 5422; amended to be effective April 30, 2023, 48 TexReg 2123

RULE §127.130 Qualification Standards for Designated Doctor Examinations

a) Applicability. This section applies to designated doctor assignments made on or after June 5, 2023.

(b) Qualification standards by type of injury or diagnosis. A designated doctor is qualified to perform a designated doctor examination on an injured employee if the designated doctor meets the appropriate qualification standard for the area of the body affected by the injury and the injured employee's diagnosis and has no disqualifying associations under §127.140 of this title (relating to Disqualifying Associations). A designated doctor's qualification standards are as follows:

(1) To examine injuries and diagnoses relating to the hand and upper extremities, a designated doctor must be a licensed medical doctor, doctor of osteopathy, or doctor of chiropractic.

(2) To examine injuries and diagnoses relating to the lower extremities excluding feet, a designated doctor must be a licensed medical doctor, doctor of osteopathy, or doctor of chiropractic.

(3) To examine injuries and diagnoses relating to the spine and musculoskeletal structures of the torso, a designated doctor must be a licensed medical doctor, doctor of osteopathy, or doctor of chiropractic.

(4) To examine injuries and diagnoses relating to feet, including toes and heel, a designated doctor must be a licensed medical doctor, doctor of osteopathy, doctor of chiropractic, or doctor of podiatric medicine.

(5) To examine injuries and diagnoses relating to the teeth and jaw, including a temporomandibular joint, a designated doctor must be a licensed medical doctor, doctor of osteopathy, or doctor of dental surgery.

(6) To examine injuries and diagnoses relating to the eyes, including the eye and adnexal structures of the eye, a designated doctor must be a licensed medical doctor, doctor of osteopathy, or doctor of optometry.

(7) To examine injuries and diagnoses relating to mental and behavioral disorders, a designated doctor must be a licensed medical doctor or doctor of osteopathy.

(8) A designated doctor must be a licensed medical doctor or doctor of osteopathy to examine injuries and diagnoses relating to other body areas or systems, including, but not limited to:

(A) internal systems;

(B) ear, nose, and throat;

(C) head and face;

(D) skin;

(E) cuts to skin involving underlying structures;

(F) non-musculoskeletal structures of the torso;

(G) hernia;

(H) respiratory;

(I) endocrine;

(J) hematopoietic; and

(K) urologic.

(9) Notwithstanding paragraphs (1) - (8) of this subsection, a designated doctor must be a licensed medical doctor or doctor of osteopathy with the required board certification to examine any of the following diagnoses.

(A) For purposes of this section, a designated doctor is "board-certified" in a required specialty or subspecialty, as applicable, if they hold or previously held:

(i) a general certificate in the required specialty or a subspecialty certificate in the required subspecialty from the American Board of Medical Specialties (ABMS); or

(ii) a primary certificate in the required specialty and a certificate of special qualifications or certificate of added qualifications in the required subspecialty from the American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS).

(B) To examine traumatic brain injuries, including concussion and post-concussion syndrome, a designated doctor must be board-certified by the ABMS or AOABOS.

(i) Qualifying ABMS certifications are:
(I) neurological surgery;
(II) neurology;
(III) physical medicine and rehabilitation;
(IV) psychiatry;
(V) orthopaedic surgery;
(VI) occupational medicine;
(VII) dermatology;
(VIII) plastic surgery;
(IX) surgery;
(X) anesthesiology with a subspecialty in pain medicine;
(XI) emergency medicine;
(XII) internal medicine;
(XIII) thoracic and cardiac surgery; or
(XIV) family medicine.
(ii) Qualifying AOABOS certifications are:
(I) neurological surgery;
(II) neurology;
(III) physical medicine and rehabilitation;
(IV) psychiatry;
(V) orthopedic surgery;
(VI) preventive medicine/occupational-environmental medicine;
(VII) preventive medicine/occupational;
(VIII) dermatology;
(IX) plastic and reconstructive surgery;
(X) surgery (general);
(XI) anesthesiology with certificate of added qualifications in pain management;
(XII) emergency medicine;
(XIII) internal medicine;
(XIV) thoracic and cardiovascular surgery; or
(XV) family practice and osteopathic manipulative treatment.

(C) To examine spinal cord injuries and diagnoses, including a spinal fracture with documented neurological injury, or vascular injury, more than one spinal fracture, or cauda equina syndrome, a designated doctor must be board-certified by the ABMS or AOABOS.

(i) Qualifying ABMS certifications are:
(I) neurological surgery;
(II) neurology;
(III) physical medicine and rehabilitation;
(IV) orthopaedic surgery; or

(V) occupational medicine.

(ii) Qualifying AOABOS certifications are:

(I) neurological surgery;

(II) neurology;

(III) physical medicine and rehabilitation;

(IV) orthopedic surgery;

(V) preventive medicine/occupational-environmental medicine; or

(VI) preventive medicine/occupational.

(D) To examine severe burns, including chemical burns defined as deep partial or full thickness burns, also known as second, third, or fourth-degree burns, a designated doctor must be board-certified by the ABMS or AOABOS.

(i) Qualifying ABMS certifications are:

(I) dermatology;

(II) physical medicine and rehabilitation;

(III) plastic surgery;

(IV) orthopaedic surgery;

(V) surgery; or

(VI) occupational medicine.

(ii) Qualifying AOABOS certifications are:

(I) dermatology;

(II) physical medicine and rehabilitation;

(III) plastic and reconstructive surgery;

(IV) orthopedic surgery;

(V) surgery (general);

(VI) preventive medicine/occupational-environmental medicine; or

(VII) preventive medicine/occupational.

(E) To examine complex regional pain syndrome (reflex sympathetic dystrophy), a designated doctor must be board-certified by the ABMS or AOABOS.

(i) Qualifying ABMS certifications are:

(I) neurological surgery;

(II) neurology;

(III) orthopaedic surgery;

(IV) plastic surgery;

(V) anesthesiology with a subspecialty in pain medicine;

(VI) occupational medicine; or

(VII) physical medicine and rehabilitation.

(ii) Qualifying AOABOS certifications are:

(I) neurological surgery;

(II) neurology;

(III) orthopedic surgery;

(IV) plastic surgery;
(V) preventive medicine/occupational-environmental medicine;
(VI) preventive medicine/occupational;
(VII) anesthesiology with certificate of added qualifications in pain management; or
(VIII) physical medicine and rehabilitation.

(F) To examine any joint dislocation, one or more fractures with vascular injury, one or more pelvis fractures, or multiple rib fractures, a designated doctor must be board-certified by the ABMS or AOABOS.

(i) Qualifying ABMS certifications are:
(I) emergency medicine;
(II) orthopaedic surgery;
(III) plastic surgery;
(IV) physical medicine and rehabilitation; or
(V) occupational medicine.

(ii) Qualifying AOABOS certifications are:
(I) emergency medicine;
(II) orthopedic surgery;
(III) plastic surgery;
(IV) physical medicine and rehabilitation;
(V) preventive medicine/occupational-environmental medicine; or
(VI) preventive medicine/occupational.

(G) To examine complicated infectious diseases requiring hospitalization or prolonged intravenous antibiotics, including blood borne pathogens, a designated doctor must be board-certified by the ABMS or AOABOS.

(i) Qualifying ABMS certifications are:
(I) internal medicine; or
(II) occupational medicine.

(ii) Qualifying AOABOS certifications are:
(I) internal medicine;
(II) preventive medicine/occupational-environmental medicine; or
(III) preventive medicine/occupational.

(H) To examine chemical exposure, excluding chemical burns, a designated doctor must be board-certified by the ABMS or AOABOS.

(i) Qualifying ABMS certifications are:
(I) internal medicine;
(II) emergency medicine; or
(III) occupational medicine.

(ii) Qualifying AOABOS certifications are:
(I) internal medicine;
(II) emergency medicine;

(III) preventive medicine/occupational-environmental medicine; or
(IV) preventive medicine/occupational.
(I) To examine heart or cardiovascular conditions, a designated doctor must be board-certified by the ABMS or AOABOS.
(i) Qualifying ABMS certifications are:
(I) internal medicine;
(II) emergency medicine;
(III) occupational medicine;
(IV) thoracic and cardiac surgery; or
(V) family medicine.
(ii) Qualifying AOABOS certifications are:
(I) internal medicine;
(II) emergency medicine;
(III) preventive medicine/occupational-environmental medicine;
(IV) preventive medicine/occupational;
(V) thoracic and cardiovascular surgery; or
(VI) family practice and osteopathic manipulative treatment.

(c) Qualification to perform initial examination. To be qualified to perform an initial examination on an injured employee, a designated doctor, other than a chiropractor, must be qualified under Labor Code §408.0043. A designated doctor who is a chiropractor must be qualified to perform an initial designated doctor examination under Labor Code §408.0045.

(d) Exemption from qualification standards. If a designated doctor is not available with the qualifications listed in subsections (b)(9)(A) - (I), the division may exempt a medical doctor or doctor of osteopathy from any of the qualification standards specified in this chapter to serve as a designated doctor to help timely resolve a dispute or perform a particular examination.

(e) Continuity of examinations. A designated doctor who performs an initial designated doctor examination of an injured employee and meets the appropriate qualification standard to perform that examination under subsection (b) of this section will remain assigned to that claim and perform all subsequent examinations of that injured employee unless the division authorizes or requires the designated doctor to discontinue providing services on that claim.

(f) Removal of designated doctor from a claim. The division may authorize a designated doctor to stop providing services on a claim if the doctor does any of the following:
(1) decides to stop practicing in the workers' compensation system.

(2) decides to stop practicing as a designated doctor in the workers' compensation system.
(3) relocates their residence or practice.
(4) asks the division to indefinitely defer the doctor's availability on the designated doctor list.
(5) determines that examining the injured employee would exceed the scope of practice authorized by their license. The division's assignment of a designated doctor exam does not alter the scope of practice authorized by the designated doctor's professional license. Section 127.200(a)(12) of this title requires a designated doctor to notify the division if continuing to participate on a claim would exceed their scope of practice.
(6) can otherwise demonstrate to the division that their continued service on the claim would be impracticable or could impair the quality of examinations performed on the claim.

(g) Prohibition. The division will prohibit a designated doctor from providing services on a claim if:
(1) the doctor has failed to become certified as a designated doctor;
(2) the doctor no longer meets the appropriate qualification standard under subsection (b) of this section to perform examinations on the claim;
(3) the doctor has a disqualifying association specified in §127.140 of this title that is relevant to the claim;
(4) the doctor has repeatedly failed to respond to division appointment, clarification, or document requests or other division inquiries about the claim;
(5) the doctor's continued service on the claim could endanger the health, safety, or welfare of either the injured employee or doctor; or
(6) the division has revoked or suspended the designated doctor's certification.

(h) License revoked or suspended. The division will prohibit a designated doctor from performing examinations on all new or existing claims if the designated doctor's license has been revoked or suspended, and the suspension has not been probated by an appropriate licensing authority.

Source Note: The provisions of this §127.130 adopted to be effective September 1, 2012, 37 TexReg 5422; amended to be effective November 4, 2018, 43 TexReg 7149; amended to be effective April 30, 2023, 48 TexReg 2123

RULE §127.140 Disqualifying Associations

(a) Definition. A disqualifying association is any association that may reasonably be perceived as having potential to influence the conduct or decision of a designated doctor. Disqualifying associations may include:

(1) receipt of income, compensation, or payment of any kind not related to health care the doctor provides;

(2) shared investment or ownership interest;

(3) contracts or agreements that provide incentives, such as referral fees, payments based on volume or value, and waiver of beneficiary coinsurance and deductible amounts;

(4) contracts or agreements for space or equipment rentals, personnel services, management contracts, referral services, billing services agents, documentation management or storage services or warranties, or any other services related to managing or operating the doctor's practice;

(5) personal or family relationships;

(6) a contract with the same workers' compensation health care network certified under Insurance Code Chapter 1305 or a contract with the same political subdivision or political subdivision health plan under Labor Code §504.053(b)(2) that is responsible for providing medical benefits to the injured employee; or

(7) any other financial arrangement that would require disclosure under the Labor Code, the Insurance Code, or applicable rules, or any other association with the injured employee, the employer, or insurance carrier that may give the appearance of preventing the designated doctor from rendering an unbiased opinion.

(b) Disqualification of agent. A designated doctor also has a disqualifying association relevant to an examination or claim if an agent of the designated doctor has an association relevant to the claim that would constitute a disqualifying association under subsection (a) of this section.

(c) Prohibition. A designated doctor must not perform an examination if that doctor has a disqualifying association relevant to that claim.

(1) If a designated doctor learns of a disqualifying association relevant to a claim after accepting the examination, the designated doctor must notify the division of that disqualifying association within two working days of learning of the disqualifying association.

(2) A designated doctor who performs an examination even though the doctor has a disqualifying association relevant to that claim commits an administrative violation.

(d) Notice required. Within five days of receiving the division's order of designated doctor examination under §127.5(b) of this title (relating to Scheduling Designated Doctor Appointments), insurance carriers must notify the division of any disqualifying associations between the designated doctor and injured employee because of the network affiliations described under subsection (a)(6) of this section.

(e) Effect of disqualifying association. If the division determines that a designated doctor with a disqualifying association performed a designated doctor examination, all reports produced by that designated doctor as a result of that examination are stripped of their presumptive weight.

(f) Disputes about disqualifying associations. A party that seeks to dispute the selection of a designated doctor for a particular examination based on a disqualifying association or dispute the presumptive weight of a designated doctor's report based on a disqualifying association must do so through the division's dispute resolution processes in Labor Code Chapter 410 and Chapters 140-144 and 147 of this title (relating to dispute resolution processes, proceedings, and procedures).

Source Note: The provisions of this §127.140 adopted to be effective September 1, 2012, 37 TexReg 5422; amended to be effective November 4, 2018, 43 TexReg 7149; amended to be effective April 30, 2023, 48 TexReg 2123

SUBCHAPTER C DESIGNATED DOCTOR DUTIES AND RESPONSIBILITIES

RULE §127.200 Duties of a Designated Doctor

(a) Duties. All designated doctors must:
(1) Perform designated doctor examinations in a facility:
(A) currently used and properly equipped for medical examinations or other similar health care services; and
(B) that ensures safety, privacy, and accessibility for injured employees, injured employee medical records, and other records containing confidential claim information.
(2) Ensure the confidentiality of medical records, analyses, and forms provided to or generated by the designated doctor in the doctor's capacity as a designated doctor for the duration of the retention period specified in §127.10(i) of this title (relating to General Procedures for Designated Doctor Examinations) and ensure the destruction of these medical records after both this retention period expires and the designated doctor determines the information is no longer needed.

(3) Ensure that all agreements with persons that permit those parties to perform designated doctor administrative duties, including, but not limited to, billing and scheduling duties, on the designated doctor's behalf:

(A) are in writing and signed by the designated doctor and the persons with whom the designated doctor is contracting;

(B) define the administrative duties that the person may perform on behalf of the designated doctor;

(C) require the persons to comply with all confidentiality provisions of the Labor Code and other applicable laws;

(D) comply with all medical billing and payment requirements under Chapter 133 of this title (relating to General Medical Provisions);

(E) do not constitute an improper inducement relating to the delivery of benefits to an injured employee under Labor Code §415.0036 and §180.25 of this title (relating to Improper Inducements, Influence and Threats); and

(F) are made available to the division on request.

(4) Notify the division in writing and in advance if the designated doctor voluntarily defers their availability to receive any offers of examinations for personal or other reasons. The notice must specify the duration and reason for the deferral.

(5) Notify the division in writing and in advance if the designated doctor no longer wishes to practice as a designated doctor before the doctor's current certification as a designated doctor expires. A designated doctor who no longer wishes to practice before their current certification expires must expressly surrender their certification in a signed, written statement to the division.

(6) Be physically present in the same room as the injured employee for the designated doctor examination or any other health care service provided to the injured employee that is not referred to another health care provider under §127.10(c) of this title.

(7) Apply the appropriate edition of the American Medical Association Guides to the Evaluation of Permanent Impairment and division-adopted return-to-work guidelines under §137.10 (relating to Return to Work Guidelines) and consider division-adopted treatment guidelines under §137.100 (relating to Treatment Guidelines) or other evidence-based medicine when appropriate.

(8) Provide the division with updated information within 10 working days of a change in any information they provide to the division on their application for certification.

(9) Maintain a professional and courteous demeanor when performing the duties of a designated doctor, including, but not limited to, explaining the purpose of a designated doctor examination to an injured employee at the beginning of the examination and using non-inflammatory, appropriate language in all reports and documents they produce.

(10) Bill for designated doctor examinations and receive payment for those examinations in accordance with Chapters 133 and 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments).
(11) Respond timely to all division appointments, clarifications, document requests, or other division inquiries.
(12) Notify the division if their continued participation on a claim they have already been assigned would exceed the scope of practice authorized by their license.
(13) Not perform required medical examinations, utilization reviews, or peer reviews on a claim they have been assigned as a designated doctor.
(14) Identify themselves at the beginning of every designated doctor examination.
(15) Consent to and cooperate during any on-site visits by the division under §180.4 of this title (relating to On-Site Visits).
(A) Notwithstanding §180.4(e)(2) of this title, the division's purpose for these visits is to ensure the designated doctor's compliance with the Labor Code and applicable division rules.
(B) The notice provided to the designated doctor under §180.4 of this title, either in advance or at the time of the on-site visit, will specify the duties the division will investigate during that visit.
(16) Cooperate with all division compliance audits and quality reviews.
(17) Complete required training or pass required testing detailed in the designated doctor's approval of certification.
(18) Comply with all applicable laws and rules.

(b) Agents. For the purposes of this chapter, Chapter 180 of this title (relating to Monitoring and Enforcement), and all other applicable laws and division rules, any person with whom a designated doctor contracts or otherwise permits to perform designated doctor administrative duties on behalf of the designated doctor qualifies as the doctor's "agent" as defined under §180.1 of this title (relating to Definitions).

Source Note: The provisions of this §127.200 adopted to be effective September 1, 2012, 37 TexReg 5422; amended to be effective April 30, 2023, 48 TexReg 2123

RULE §127.210 Designated Doctor Administrative Violations

(a) Grounds for sanctions. In addition to the grounds for issuing sanctions against a doctor under §180.26 of this title (relating to Criteria for Imposing, Recommending and Determining Sanctions; Other Remedies), other division rules, or the Labor Code, the commissioner may revoke or suspend a designated doctor's certification as a designated doctor or sanction a designated doctor for noncompliance with requirements of this chapter for:

(1) refusing four times within a 90-day period to accept or perform a division-offered appointment or division-ordered appointment for which the doctor is qualified and that relates to a claim to which the doctor has not been previously assigned;

(2) refusing four consecutive times to perform a division-offered appointment within the required time frames or a division-ordered appointment for which the doctor is qualified and relates to a claim the doctor has not been previously assigned to;

(3) failing to attend a designated doctor examination;

(4) not complying with the rescheduling requirements of this chapter;

(5) refusing at any time to accept or perform a division-offered appointment or division-ordered appointment that relates to a claim on which the doctor has previously performed an examination;

(6) misrepresenting or omitting pertinent facts in medical evaluation and narrative reports;

(7) submitting unnecessary referrals to other health care providers to answer any question that the division submits to the designated doctor;

(8) ordering or performing unnecessary testing of an injured employee as part of a designated doctor's examination;

(9) submitting inaccurate or inappropriate reports due to insufficient medical history or physical examination and analysis of medical records;

(10) submitting designated doctor reports that fail to include all elements required by §127.220 of this title (relating to Designated Doctor Reports), §127.10 of this title (relating to General Procedures for Designated Doctor Examinations), and other division rules;

(11) failing to timely respond to a request for clarification from the division about an examination or any other information the division requests;

(12) failing to successfully complete training and testing requirements as specified in §127.100 of this title (relating to Designated Doctor Certification);

(13) self-referring, including referring to another health care provider with whom the designated doctor has a disqualifying association, for treatment or becoming the employee's treating doctor for the medical condition the designated doctor evaluated;

(14) behaving in an abusive or assaultive manner toward an injured employee, the division, or other system participant;

(15) failing to maintain the confidentiality of patient medical and claim file information;

(16) performing a designated doctor examination that the division did not order the doctor to perform;

(17) failing to complete required training or pass required testing detailed in the designated doctor's approval of certification; or

(18) violating other applicable statutes or rules while serving as a designated doctor.

(b) Responsibility for agents' actions. Designated doctors are liable for all administrative violations committed by their agents on the designated doctor's behalf under this section, other division rules, or any other applicable law.

(c) Notification and appeal. The process for notification and opportunity for appeal of a sanction is governed by §180.27 of this title (relating to Restoration) except that suspension, revocation, or other sanctions relating to a designated doctor's certification will be in effect during the pendency of any appeal.

Source Note: The provisions of this §127.210 adopted to be effective September 1, 2012, 37 TexReg 5422; amended to be effective April 30, 2023, 48 TexReg 2123

RULE §127.220 Designated Doctor Reports

(a) Format and submission. Designated doctor narrative reports must be filed in the form and manner required by the division. At a minimum, they must do all of the following:

(1) Identify the question or questions the division ordered to be addressed by the designated doctor examination.

(2) Provide a clearly defined answer for each question to be addressed by the designated doctor examination and only for each of those questions.

(3) Sufficiently explain how the designated doctor determined the answer to each question within a reasonable degree of medical probability.

(4) Demonstrate, as appropriate, application or consideration of the American Medical Association Guides to the Evaluation of Permanent Impairment, division-adopted return-to-work and treatment guidelines, and other evidence-based medicine, if available.

(5) Include general information about the identity of the designated doctor, injured employee, employer, treating doctor, and insurance carrier.

(6) State the date of the examination and the address where it took place.

(7) Summarize any additional testing conducted or referrals made as part of the evaluation, including:

(A) the identity of any health care providers to which the designated doctor referred the injured employee under §127.10(c) of this title (relating to General Procedures for Designated Doctor Examinations);

(B) the types of tests conducted or referrals made;

(C) the dates the testing or referral examinations occurred;

(D) an explanation of why the testing or referral was necessary to resolve a question at issue in the examination; and

(E) the date the testing or referral examination was completed.

(8) Include a narrative description of the medical history, physical examination, and medical decisions the designated doctor made, including the time the designated doctor began taking the medical history of the injured employee, physically examined the employee, and engaged in medical decision making, and the time the designated doctor completed these tasks.

(9) List the specific medical records or other documents the designated doctor reviewed as part of the evaluation, including the dates of those documents and which medical records were provided by the injured employee.

(10) Provide the total amount of time required for the designated doctor to review the medical records.

(11) Be signed by the designated doctor who performed the examination.

(12) Include a statement that there is no known disqualifying association as described in §127.140 of this title (relating to Disqualifying Associations) between the designated doctor and the injured employee, the injured employee's treating doctor, the insurance carrier, the insurance carrier's certified workers' compensation health care network, or a network established under Labor Code Chapter 504.

(13) Certify the date that the report was sent to all recipients as required and in the manner required by §127.10 of this title.

(14) Indicate on the report that the designated doctor reviewed and approved the final version of the report.

(b) Additional forms required. Designated doctors who perform examinations under §127.10(d) or (e) of this title must also complete and file the division forms required by those subsections with their narrative reports. Designated doctors must complete and file these forms in the manner required by applicable division rules.

(c) Designated doctor examination data report. Designated doctors who perform examinations under §127.10(f) of this title must, in addition to filing a narrative report that complies with subsection (a) of this section, also file a designated doctor examination data report in the form and manner required by the division. A designated doctor examination data report must:

(1) include general information regarding the identity of the designated doctor, injured employee, insurance carrier, as well as the identity of the certified workers' compensation health care network under Insurance Code Chapter 1305, if applicable, or whether the injured employee is receiving medical benefits through a political subdivision health care plan under Labor Code §504.053(b)(2) and the identity of that plan, if applicable;

(2) identify the question or questions the division ordered to be addressed by the designated doctor examination;

(3) provide a clearly defined answer for each question to be addressed by the designated doctor examination and only for each of those questions. For extent of injury

examinations, the designated doctor should also provide, for informational purposes only, a diagnosis code for each disputed injury;

(4) state the date of the examination, the time the examination began, and the address where the examination took place;

(5) list any additional testing conducted or referrals made as part of the evaluation, including the identity of any healthcare providers to which the designated doctor referred the injured employee under §127.10(c) of this title, the types of tests conducted or referrals made and the dates the testing or referral examinations occurred; and

(6) be signed by the designated doctor who performed the examination.

Source Note: The provisions of this §127.220 adopted to be effective September 1, 2012, 37 TexReg 5422; amended to be effective November 4, 2018, 43 TexReg 7149; amended to be effective April 30, 2023, 48 TexReg 2123

TITLE 28 **INSURANCE**
PART 2 **TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION**
CHAPTER 128 **BENEFITS--CALCULATION OF AVERAGE WEEKLY WAGE**

RULE §128.1 Average Weekly Wage: General Provisions

(a) The average weekly wage (AWW) calculation for an injured employee (employee) shall be calculated depending on whether the employee was employed in one of the following five courses of employment:
(1) full-time (see §128.3 of this title (relating to Average Weekly Wage Calculation for Full-Time Employees, And For Temporary Income Benefits For All Employees));
(2) part-time (see §128.4 of this title (relating to Average Weekly Wage Calculation For Part-Time Employees));
(3) seasonal (see §128.5 of this title (relating to Average Weekly Wage Calculation for Seasonal Employees));
(4) school district employed (see §128.7 of this title (relating to Average Weekly Wage for School District Employees)); and
(5) multiple employment (see Texas Labor Code §408.042 and subsection (h) of this section).

(b) Except as provided by §128.7, an employee's wage, for the purpose of calculating the AWW, shall include:
(1) all pecuniary wages (as defined by §126.1 of this title (relating to Definitions Applicable to All Benefits)) paid by the employer to the employee even if the employer has continued to provide the wages after the date of injury (in which case these wages could be considered post-injury earnings under §129.2 of this title (relating to Entitlement to Temporary Income Benefits)); and
(2) all nonpecuniary wages (as defined by §126.1 of this title) paid by the employer to the employee prior to the compensable injury but not continued by the employer after the injury (though only during a period in which the employer has discontinued providing the wages).

(c) An employee's wage, for the purpose of calculating the AWW, shall not include:
(1) payments made by an employer to reimburse the employee for the use of the employee's equipment, for paying helpers, for reimbursing actual expenses related to employment such as travel related expenses (e.g. meals, lodging, transportation, parking, tolls, and porters), or reimbursing mileage up to the state rate for mileage; or
(2) any nonpecuniary wages continued by the employer after the compensable injury. However, except as provided by §128.7 of this title and Texas Labor Code §408.042(e), if

the employer discontinues providing nonpecuniary wages, the AWW shall be recalculated and these discontinued nonpecuniary wages shall be included.

(d) The AWW shall be calculated using gross wages.

(e) If a carrier determines or is notified that the employee's AWW is different than what the carrier had previously determined (either as a result of subsection (c)(2) of this section, receipt of an updated wage statement, or by operation of other adjustments permitted/required under this title), the carrier shall adjust the AWW and begin payment of benefits based upon the adjusted AWW no later than the first payment due at least seven days following the date the carrier receives the new information regarding the AWW.

(f) The carrier shall provide notice to the employee and the division of any adjustments to the AWW and its affect on benefits in accordance with the requirements of §124.2 of this title (relating to Carrier Reporting and Notification Requirements).

(g) Additional adjustments to the AWW may be made in specific circumstances for seasonal employees and school district employees (see §128.5 and §128.7 of this title, respectively), and for employees who are also minors, apprentices, trainees, or students on the date of injury (see §128.6 of this title (relating to Average Weekly Wage Adjustment For Certain Employees Who Are Also Minors, Apprentices, Trainees, or Students)).

(h) For employees injured on or after July 1, 2002, who are employed by more than one employer on the date of injury and the employee submits the wage information from the other employer(s) in the form and manner prescribed by §122.5 of this title (relating to Employee's Multiple Employment Wage Statement), the carrier shall calculate the AWW using the wages from all the employers in accordance with this section. The employee's AWW shall be the sum of the AWWs for each employer.

(1) The portion of the AWW that is based upon employment with the "Claim Employer" (as the term is defined in §122.5 of this title) shall be calculated in accordance with the rule in this chapter which would be used to calculate the employee's AWW if the employee did not have multiple employment.

(A) This portion of the AWW may be different for calculating Temporary Income Benefits (TIBs) than it is for calculating other types of benefits as provided in other sections of this title (such as where the wages may be adjusted for a part-time employee under §128.4 of this title).

(B) This portion of the AWW shall be adjusted if the Claim Employer discontinues providing a nonpecuniary wage that the employer had previously continued after the date of injury.

(2) The portion of the employee's AWW based upon employment with each "Non-Claim Employer" (as the term is defined in §122.5 of this title) shall be calculated in accordance with §128.3 of this title (relating to Average Weekly Wage Calculations for Full-Time Employees, and for Temporary Income Benefits for All Employees) except that the employee's wages from the Non-Claim Employer(s) shall only include those wages that are reportable for federal income tax purposes.

(A) This portion of the AWW of an employee whose employment was limited by the Non-Claim Employer to less than full-time but whose employment was not so limited as a regular course of conduct shall be adjusted to the weekly wage level the employee would have attained by working a full-time workweek at the employee's average rate of pay.

(B) Once calculated correctly, the portion of the AWW based upon employment with the Non-Claim Employer(s) does not vary by benefit type.

Source Note: The provisions of this §128.1 adopted to be effective January 11, 1991, 16 TexReg 118; amended to be effective May 16, 2002, 27 TexReg 4036; amended to be effective January 1, 2012, 36 TexReg 8860

RULE §128.2 Carrier Presumption of Employee's Average Weekly Wage

(a) An insurance carrier (carrier) shall promptly initiate the payment of income benefits as required by the Workers' Compensation Act (Act). To expedite payment, the carrier shall presume that multiplying the employee's hourly rate times the average number of hours in the employee's standard work week, or, if such information is not available, that the employer's last payment to the employee for personal services based on a full week's work (a partial work week shall be prorated for a full week) accurately reflects the employee's average weekly wage (AWW) until:

(1) the employer files a complete wage statement required by §120.4 of this title (relating to Employer's Wage Statement); or

(2) the correct AWW is determined by other evidence (such as that described in subsections (b) and (c) of this section), if the employer does not file a complete wage statement or if the employee files an Employee's Multiple Employment Wage Statement in accordance with §122.5 of this title (relating to Employee's Multiple Employment Wage Statement).

(b) In the absence of a properly completed wage statement, the carrier shall calculate the correct wage by using available wage information in a manner which is fair, just, and

reasonable, and which involves a methodology that allows the closest approximation of a calculation based upon a 13 week average as required by this chapter (for example, pecuniary wages would be included regardless of whether the employer continues them and earnings after the date of injury would not be included). Subsection (c) of this section provides examples of how to do this.

(c) This subsection provides a non-inclusive list of methods that carriers can use to calculate the correct AWW using evidence other than a complete wage statement. There may be other, similar but unlisted methods that are also appropriate in a given situation.
(1) For a salaried employee, paid on monthly or semi-monthly basis, whose salary has not changed in the 13 weeks prior to the compensable injury, the carrier may presume that the AWW is equal to 3 months of wages divided by 13.
(2) For an employee on whom the carrier receives 14 weeks of wage information but is unable to identify the amount of the wages paid in the 14th week (thus leaving 13 usable weeks), the carrier may presume that the AWW is equal to the 14 weeks of wages divided by 14.
(3) For an employee on whom the carrier receives less than 13 weeks of wage information because the employee was not employed with the employer for 13 weeks prior to the injury, the carrier may presume that the AWW is equal to the amount of wages paid divided by the number of weeks for which the wages were earned.

(d) Upon receipt of a properly completed wage statement the carrier shall recalculate the AWW in accordance with the applicable rule(s).

(e) If, at the time that income or death benefits first accrue, the carrier has not received a complete wage statement as required by §120.4 of this title (relating to Employer's Wage Statement), the carrier shall notify the employer that the wage statement is now required under the Statute and Rules.

(f) If a carrier receives a wage statement that indicates that the employee was provided nonpecuniary wages prior to the date of injury but that does not indicate whether the employer is going to continue them or not, the carrier shall assume that the nonpecuniary wages are not being continued by the employer until and unless the carrier is able to verify that the nonpecuniary wages are being continued by the employer.

(g) In the event that the claimant or the carrier believes that the AWW computed by following the calculations in this rule does not reflect the true AWW, the claimant and carrier may enter into a written agreement on the AWW or request a benefit review conference.

Source Note: The provisions of this §128.2 adopted to be effective January 11, 1991, 15 TexReg 118; amended to be effective September 1, 1993, 18 TexReg 5213; amended to be effective May 16, 2002, 27 TexReg 4036

RULE §128.3 Average Weekly Wage Calculation for Full-Time Employees, and for Temporary Income Benefits for All Employees

(a) All income benefits for full-time employees are based upon an average weekly wage calculated according to this rule. A full-time employee is one who regularly works at least 30 hours per week and that schedule is comparable to other employees of that company and/or other employees in the same business or vicinity who are considered full-time.

(b) Temporary income benefits are based on an average weekly wage which is calculated according to this rule for all employees. However, the average weekly wage for determining temporary income benefits of seasonal employees may be periodically adjusted as set out in §128.5(c) of this title (relating to Average Weekly Wage Calculation for Seasonal Employees).

(c) The average weekly wage for impairment income, supplemental income, lifetime income, and death benefits shall be calculated according to this section concerning full-time employees, §128.4 of this title (relating to Average Weekly Wage Calculation for Part-Time Employees), or §128.5 of this title (relating to Average Weekly Wage Calculation for Seasonal Employees). The average weekly wage for an employee who is also a minor, an apprentice, a trainee, or a student shall be adjusted for determining these income benefits (but not temporary income benefits), according to the procedure described in §128.6 of this title (relating to Average Weekly Wage Adjustment for Certain Employees Who Are Also Minors, Apprentices, Trainees, or Students).
(d) If an employee has worked for 13 weeks or more prior to the date of injury, or if the wage at time of injury has not been fixed or cannot be determined, the wages paid to the employee for 13 weeks immediately preceding the injury are added together and divided by 13. The quotient is the average weekly wage for that employee.

(e) If an employee has worked for less than 13 weeks prior to the date of injury, the wages paid to that employee are not considered. Instead, the wages used for the average weekly wage calculation are those paid by the employer to a similar employee who performs similar services, but who earned wages for at least 13 weeks. If there is no similar employee at the employer's business, the calculation is based on wages paid to a similar employee who performed similar services in the same vicinity, for at least 13

weeks. When a similar employee is identified, the wages paid to that person for the 13 weeks immediately preceding the injury are added together, and divided by 13. The quotient is the average weekly wage for the injured employee.

(f) For purposes of computing average weekly wage under subsection (e) of this section, the following definitions apply:
(1) a similar employee is a person with training, experience, and skills and wages that are comparable to the injured employee. Age, gender, and race shall not be considered;
(2) similar services are tasks performed or services rendered that are comparable in nature to, and in the same class as, those performed by the injured employee, and that are comparable in the number of hours normally worked.

(g) If the methods set forth in this rule cannot be applied reasonably due to the irregularity of the employment or, if the employee has lost time from work, without remuneration, during the said 13-week period due to illness, weather, or other cause beyond the control of the employee, the commission may determine the employee's average weekly wage by any method that it considers fair, just, and reasonable to all parties and consistent with the methods established under this section.

Source Note: The provisions of this §128.3 adopted to be effective January 11, 1991, 16 TexReg 118.

RULE §128.4 Average Weekly Wage Calculation for Part-Time Employees

(a) The average weekly wage used to determine temporary income benefits for all part-time employees shall be calculated according to the basic calculation described in §128.3(d), (e), or (g) of this title (relating to Average Weekly Wage Calculation for Full-Time Employees, and for Temporary Income Benefits for All Employees).
(b) For purposes of calculating average weekly wage for all other income and death benefits, part-time employees are considered in two different categories: those who worked part-time as a regular course of conduct, and those who did not. A "regular course of conduct" for part-time work shall be determined by reviewing the work history of the employee for the 12-month period preceding the injury. If the employee only worked part-time during that period, the employee is presumed to have worked part-time as a regular course of conduct unless such presumption is rebutted by credible evidence.

(c) For an employee who worked part-time as a regular course of conduct, §128.3(d), (e), or (g) of this title (relating to Average Weekly Calculation for Full-Time Employees, and for Temporary Income Benefits for All Employees) shall be used to calculate average

weekly wage to determine impairment income, supplemental income, lifetime income, and death benefits.

(d) The average weekly wage for a part-time employee who did not work part-time as a regular course of conduct shall be calculated by using one of the two methods in subsection (e) or (f) of this section, depending upon the length of time the person was employed.

(e) For an employee who worked for the employer for 13 or more consecutive weeks before the date of injury, the person calculating benefits shall derive the average weekly part-time wage, and then adjust upward to a full-time average weekly wage, by this method:
(1) add together the wages for the 13 weeks immediately preceding the date of injury and divide the total by 13;
(2) then add together the number of hours worked by the employee during the same 13 weeks, and divide the total hours by 13 to calculate the average weekly number of hours worked. The adjustment factor is the ratio of the number of full-time hours generally worked by similar employees in the same employment, over the average weekly number of hours worked by the injured employee. (Example: if the usual full-time hours for the employment is 40, and the average number of hours worked by the injured part-time employee is 30, then the adjustment factor derived is 40/30, or 1.334.) For purposes of the adjustment factor, it shall be presumed that a full-time work week is 40 hours, unless and until evidence establishes that use of a different number of hours would be more just;
(3) finally, multiply the result of paragraph (1) of this subsection by the adjustment factor derived in paragraph (2) of this subsection; the product is the average weekly wage for this injured employee.

(f) For an employee who worked for the employer less than 13 weeks or whose wage at the time of injury cannot be fixed or determined, the average weekly wage will be calculated by using the method described in §128.3(e) of this title (relating to Average Weekly Wage Calculation for Full-Time Employees, and for Temporary Income Benefits for All Employees), based upon identification of a similar employee performing similar employment full-time.

Source Note: The provisions of this §128.4 adopted to be effective January 11, 1991, 16 TexReg 118.

RULE §128.5 Average Weekly Wage Calculation for Seasonal Employees

(a) A seasonal employee is an employee who as a regular course of conduct engages in seasonal or cyclical employment which may or may not be agricultural in nature, that does not continue throughout the year.

(b) The average weekly wage used to determine temporary income benefits for seasonal employees shall be determined according to the procedure described in §128.3(d) or (e) of this title (relating to Average Weekly Wage Calculation for Full-Time Employees, and for Temporary Income Benefits for All Employees), subject to the periodic adjustment described in this rule.

(c) The average weekly wage for computing temporary income benefits may be increased or decreased to more accurately reflect the seasonal nature of the employment, if such an adjustment would more accurately reflect the wages the employee could reasonably have expected to earn during the period that temporary income benefits are paid. Evidence of earnings shall be submitted at the time an adjustment is requested. The evidence should include proof of the employee's earnings in corresponding time periods of previous years. In case of a dispute, the commission shall set a benefit review conference to consider whether an adjustment should be made.

(d) The average weekly wage used to determine impairment income benefits, lifetime income benefits, supplemental income benefits, or death benefits for a seasonal employee shall be calculated by:
(1) adding together the total wages received by the employee in the 12 months preceding the date of injury and dividing the result by 50; or
(2) if it is impractical to compute the average weekly wage as provided by paragraph (1) of this subsection, another fair, just, and reasonable method as determined in a benefit review conference if requested by the person claiming income benefits or the insurance carrier.

Source Note: The provisions of this §128.5 adopted to be effective January 11, 1991, 16 TexReg 118.

RULE §128.6 Average Weekly Wage Adjustment for Certain Employees Who Are Also Minors, Apprentices, Trainees, or Students

(a) In order to adjust average weekly wage under this rule, for purposes of computing impairment income, supplemental income, lifetime income, and death benefits, an injured employee must come within one of the following definitions, on the date of injury:

(1) a minor is an employee less than 18 years of age and not emancipated by marriage or judicial action, and is also an apprentice, trainee, or student;
(2) an apprentice is an employee learning a skilled trade or art by practical experience under the direction of a skilled crafts person or artisan;
(3) a trainee is an employee undergoing systematic instruction and practice in some art, trade, or profession with a view towards proficiency in it; and
(4) a student is an employee enrolled in a course of study or instruction in a high school, college, university, or other institute of higher education or technical training.

(b) The average weekly wage used to determine temporary income benefits for a minor, apprentice, trainee, or student shall be computed according to §128.3 of this title (relating to Average Weekly Wage Calculation for Full-Time Employees and for Temporary Income Benefits for All Employees), and may not be adjusted. The basic average weekly wage for other income and death benefits shall be calculated depending upon whether the employee worked full-time, part-time, or as a seasonal employee, and may be adjusted as described in this section.

(c) The average weekly wage of an employee who is less than 18 years of a age, but not a minor as defined in this section, shall not be adjusted.

(d) The average weekly wage used to determine impairment income benefits, supplemental income benefits, lifetime income benefits, or death benefits for an employee defined under subsection (a) of this section shall be adjusted on the basis of this rule if the employee also proves that:
(1) the employee's employment or earnings at the time of the injury were limited primarily because of apprenticeship, continuing formal training, or education that can be reasonably calculated to enhance the employee's future wages; and
(2) the employee's wages would reasonably be expected to change during the period for which the impairment income, supplemental income, lifetime income, and death benefits are payable not to exceed three years after the date of injury.

(e) An insurance carrier and the person claiming income benefits may agree to adjust the average weekly wage used to compute impairment income benefits, lifetime income benefits, supplemental income benefits, or death benefits for an employee who meets the requirements of subsections (a) and (d) of this section. The adjustment shall not reflect the level of the expected wages for a period in excess of three years after the date of injury.

(f) If an insurance carrier and the person claiming income benefits dispute the need for, or the amount of, an adjustment for expected wage levels, the commission shall

schedule a benefit review conference. The commission shall then consider the evidence submitted by the insurance carrier and the claimant. Objective, documentary, or expert evidence is favored over testimony of interested parties, in determining an expected wage level which is fair and just.

Source Note: The provisions of this §128.6 adopted to be effective January 11, 1991, 16 TexReg 118.

RULE §128.7 Average Weekly Wage for School District Employees

(a) This rule applies only to school district employees injured on or after December 1, 2001. The calculations in this rule apply to the portion of the employee's average weekly wage (AWW) based upon the employee's employment with the school district where the school district is the "Claim Employer" as that term is used in §122.5 of this title (relating to Employee's Multiple Employment Wage Statement). The AWW of a school district employee injured before December 1, 2001, is computed using the law and commission rules in effect on the date of the injury.

(b) For determining the amount of temporary income benefits of school district employees under Texas Labor Code Chapter 504, the AWW is computed on the basis of wages earned in a week. "Wages earned in a week" are equal to the amount that would be deducted from an employee's salary if the employee were absent from work for one week and the employee did not have personal leave available to compensate the employee for lost wages for that week. For this calculation "wages" includes only pecuniary wages.

(c) For determining the amount of temporary income benefits of a school district employee, the AWW shall be computed as follows.
(1) For a school district employee working under a written contract with the school district, the AWW shall be computed by dividing the amount the employee would have been paid had the employee fully completed the terms of the contract (including any stipend the employee was earning or scheduled to receive under the contract) by:
(A) the number of days that the employee was required to work under that contract and multiplied by five (if the contract has specified the number of work days); or
(B) the number of months that the contract was to cover and then dividing the result by 4.34821.
(2) For a school district employee who is employed on a non-written contract basis (i.e. hourly, daily, salaried, or other basis), the AWW shall be computed by dividing the total gross wages earned in the previous 13-week period immediately preceding the date of injury by 13.

(d) The AWW for computing temporary income benefits may be increased or decreased to more accurately reflect wages the school district employee reasonably could expect to earn during the period for which temporary income benefits are paid.

(1) An insurance carrier (carrier) may adjust the AWW based on evidence of earnings.

(2) A school district employee may request adjustments by submitting evidence of earnings to the carrier.

(3) For a period a school district employee would not have earned wages, the AWW may be adjusted to zero and no minimum benefit payment may be required.

(e) For determining the amount of impairment income benefits, lifetime income benefits, supplemental income benefits, or death benefits, the AWW shall be computed in accordance with this subsection using only pecuniary wages.

(1) The carrier shall add together the total wages earned by the school district employee during the 12 months immediately preceding the injury and dividing the result by 50 weeks.

(2) If the school district employee provides wage information from other employers for whom the employee worked in the 12 months immediately preceding the injury, these wages shall be included in the calculation of the AWW. Note that for injuries on or after July 1, 2002, the effect of wages from a Non-Claim Employer (as the term is defined in §122.5 of this title (relating to Employee's Multiple Employment Wage Statement)) on the employee's AWW is governed by §128.1(h)(2) of this title (relating to Average Weekly Wage: General Provisions).

(f) In the event the school district employee and/or carrier believes that the AWW computed based on the calculations in this rule does not reflect the true AWW, the employee and carrier may enter into a written agreement regarding the AWW or request a benefit review conference.

Source Note: The provisions of this §128.7 adopted to be effective May 16, 2002, 27 TexReg 4036

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 129	INCOME BENEFITS--TEMPORARY INCOME BENEFITS

RULE §129.1 Definitions for Temporary Income Benefits

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

(1) Salary Continuation (also Wage Continuation)--Monies paid by the employer to compensate the injured employee (employee) for wages lost as a result of a compensable injury. Salary continuation does not include monies paid to an employee as compensation for work such as wages paid while an employee is on modified duty.
(2) Salary Supplementation (also Wage Supplementation)--Monies paid by the employer to supplement the amount of income benefits an insurance carrier pays to an employee with a compensable injury. This includes monies paid to the employee based on the employee's voluntary use of sick leave or annual leave in a supplementary manner.
(3) Weekly Earnings After the Injury--Post-Injury Earnings (PIE), further described in §129.2 of this title (relating to Entitlement to Temporary Income Benefits).

Source Note: The provisions of this §129.1 adopted to be effective December 26, 1999, 24 TexReg 11420

RULE §129.2 Entitlement to Temporary Income Benefits

(a) Once temporary income benefits (TIBs) accrue, an injured employee (employee) is entitled to TIBs to compensate the employee for lost wages due to the compensable injury during a period in which the employee has disability and has not reached maximum medical improvement.

(b) Lost wages are the difference between the employee's gross average weekly wage (AWW) and the employee's gross Post-Injury Earnings (PIE). If the employee's PIE equals or exceeds the employee's AWW, the employee has no lost wages.

(c) PIE shall include, but not be limited to, the documented weekly amount of:
(1) all pecuniary wages paid to the employee after the date of injury including wages based on work performed while on modified duty and pecuniary fringe benefits which are paid to the employee whether the employee has returned to work or not;

(2) any employee contribution to benefits such as health insurance that the employee normally pays but that the employer agrees to pay for the employee in order to continue the benefits (which does not include the portion of the benefits that the employer normally pays for);
(3) the weekly amount of any wages offered as part of a bona fide job offer which is not accepted by the employee which the insurance carrier (carrier) is permitted to deem to be PIE under §129.6 of this title (relating to Bona Fide Offers of Employment);
(4) the value of any full days of accrued sick leave or accrued annual leave that the employee has voluntarily elected to use after the date of injury;
(5) the value of any partial days of accrued sick leave or accrued annual leave that the employee has voluntarily elected to use after the date of injury that, when combined with the employee's TIBs, exceeds the AWW; and
(6) any monies paid to the employee by the employer as salary continuation based on :
(A) a contractual obligation between the employer and the employee including through a collective bargaining agreement;
(B) an employer policy; or
(C) a written agreement with the employee.

(d) PIE shall not include:
(1) any non-pecuniary wages paid to the employee by the employer after the injury;
(2) any accrued sick leave or accrued annual leave that the employee did not voluntarily elect to use;
(3) any wages paid by the employer as salary supplementation as provided by Texas Labor Code, §408.003(a)(2);
(4) any moneys paid by the employer which would otherwise be considered PIE under subsection (c) of this section but which the employer attempts or intends to seek reimbursement from the employee or carrier; or
(5) any money paid to an employee under an indemnity disability program paid for by the employee separate from workers' compensation.

Source Note: The provisions of this §129.2 adopted to be effective December 26, 1999, 24 TexReg 11420

RULE §129.3 Amount of Temporary Income Benefits

(a) The insurance carrier (carrier) shall pay an injured employee (employee) the temporary income benefits (TIBs) the employee is entitled to in accordance with this chapter.

(b) The carrier shall determine whether the employee earns less than $8.50 per hour for a workers' compensation claim with a date of injury before September 1, 2015, or less than $10 per hour for a workers' compensation claim with a date of injury on or after September 1, 2015, as follows:

(1) Once the carrier has received the Wage Statement required by this title, the carrier shall divide the average weekly wage (AWW) calculated from the Wage Statement by the average number of hours worked. The average hours worked is the total gross hours reported worked on the Wage Statement divided by the period in which the hours were worked;

(2) If the carrier has not received the Wage Statement, but has received the Employer's First Report of Injury, the carrier shall use the wage information provided by the employer through the first report; or

(3) If the carrier has not received the information necessary to perform the calculations required by subsection (b)(1) or (2) of this section, the carrier shall use wage information provided by the employee until the necessary information is obtained from the employer.

(c) The carrier shall calculate the AWW in accordance with Chapter 128 of this title (relating to Calculation of Average Weekly Wage) and shall calculate the Post-Injury Earnings (PIE) in accordance with §129.2 of this title (relating to Entitlement to Temporary Income Benefits). In determining the PIE, the carrier shall base its calculations on specific wage information reported by the employer and/or the employee. A generic statement by the employer indicating the employer is "continuing full salary" or "the employee is earning full salary" is not adequate documentation to be considered PIE.

(d) The carrier shall calculate the employee's lost wages by subtracting the PIE from the AWW (or AWW - PIE).

(e) The amount of TIBs an employee is entitled to is based on the lost wages. If the employee's PIE equals or exceeds the employee's AWW, the employee has no lost wages and the carrier shall not pay TIBs.

(f) Subject to the minimum and maximum TIBs rates as provided in subsection (g) of this section, an employee is entitled to TIBs as follows:

(1) for a workers' compensation claim with a date of injury before September 1, 2015,

(A) an employee who earns $8.50 or more per hour is entitled to TIBs in the amount of 70% of the lost wages; or

(B) an employee who earns less than $8.50 per hour is entitled to TIBs as follows:

(i) 75% of the lost wages for the first 26 weeks of TIBs due; and

(ii) 70% of the lost wages for all TIBs payments thereafter; and

(2) for a workers' compensation claim with a date of injury on or after September 1, 2015,

(A) an employee who earns $10 or more per hour is entitled to TIBs in the amount of 70% of the lost wages; or

(B) an employee who earns less than $10 per hour is entitled to TIBs as follows:

(i) 75% of the lost wages for the first 26 weeks of TIBs due; and

(ii) 70% of the lost wages for all TIBs payments thereafter.

(g) The carrier shall pay the TIBs in the amount calculated in subsection (f) of this section, unless:

(1) this amount is greater than the maximum weekly TIBs rate computed in accordance with Texas Labor Code, §408.061, in which case the carrier shall pay the maximum weekly TIBs rate; or

(2) this amount, when added to the employee's PIE, is less than the minimum weekly TIBs rate computed in accordance with Texas Labor Code, §408.062, in which case the carrier shall pay the minimum weekly TIBs rate.

Source Note: The provisions of this §129.3 adopted to be effective December 26, 1999, 24 TexReg 11420; amended to be effective February 28, 2016, 41 TexReg 1249

RULE §129.4 Adjustment of Temporary Income Benefit Amount

(a) The insurance carrier shall adjust the weekly amount of temporary income benefits paid to the injured employee as necessary to match the fluctuations in the employee's weekly earnings after the injury.

(b) If a seasonal employee's average weekly wage is adjusted, as described in §128.5 of this title (relating to Average Weekly Wage Calculations for Seasonal Employees), the carrier shall adjust the temporary income benefits paid to the seasonal employee.

(c) If the injured employee is still employed by the employer at the time of injury, the employer is responsible for informing the carrier of changes in the employee's weekly earnings after an injury, on Form TWCC 6, Supplemental Report of Injury, within 10 days after the end of each pay period, as provided by §120.3 of this title (relating to Employer's Supplemental Report of Injury).

(d) If the employee is no longer employed by the employer, the employee is responsible to provide information to the insurance carrier about the existence or amount of any earnings, or any offers of employment. The employee may use Form TWCC 6, Supplemental Report of Injury, for this purpose.

Source Note: The provisions of this §129.4 adopted to be effective January 24, 1991, 16 TexReg 175; amended to be effective April 3, 1992, 17 TexReg 2129.

RULE §129.5 Work Status Reports

(a) As used in this section:
(1) the term "doctor" means either the treating doctor or a referral doctor, as defined by §180.22(c) and (e) of this title (relating to Health Care Provider Roles and Responsibilities);
(2) "substantial change in activity restrictions" means a change in activity restrictions caused by a change in the injured employee's medical condition which either prevents the injured employee from working under the previous restrictions or which allows the injured employee to work in an expanded and more strenuous capacity than the prior restrictions permitted (approaching the injured employee's normal job);
(3) "change in work status" means a change in the injured employee's work status from one of the three choices listed in subsection (a)(4) of this section to another of the choices in that subsection; and
(4) the term "work status" refers to whether the injured employee's medical condition:
(A) allows the injured employee to return to work without restrictions (which is not equivalent to maximum medical improvement);
(B) allows the injured employee to return to work with restrictions; or
(C) prevents the injured employee from returning to work.

(b) If authorized under their licensing act, a treating doctor may delegate authority to complete, sign, and file a work status report to a licensed physician assistant or a licensed advanced practice registered nurse as authorized under Texas Labor Code §408.025(a-1). The delegating treating doctor is responsible for the acts of the physician assistant and the advanced practice registered nurse under this subsection.

(c) The doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file a Work Status Report in the form and manner prescribed by the division.

(d) The doctor, delegated physician assistant, or delegated advanced practice registered nurse shall be considered to have filed a complete Work Status Report if the report is filed in the form and manner prescribed by the division, signed, and contains at minimum:
(1) identification of the injured employee's work status;
(2) effective dates and estimated expiration dates of current work status and restrictions (an expected expiration date is not binding and may be adjusted in future

Work Status Reports, as appropriate, based on the condition and progress of the injured employee);
(3) identification of any applicable activity restrictions;
(4) an explanation of how the injured employee's workers' compensation injury prevents the injured employee from returning to work (if the doctor believes that the injured employee is prevented from returning to work); and
(5) general information that identifies key information about the claim (as prescribed on the report).

(e) The doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report:
(1) after the initial examination of the injured employee, regardless of the injured employee's work status;
(2) when the injured employee experiences a change in work status or a substantial change in activity restrictions; and
(3) on the schedule requested by the insurance carrier, its agent, or the employer requesting the report through its insurance carrier, which shall not exceed one report every two weeks and which shall be based upon the doctor's, delegated physician assistant's, or delegated advanced practice registered nurse's scheduled appointments with the injured employee.

(f) The Work Status Report filed as required by subsection (e) of this section shall be provided to the injured employee at the time of the examination by hand delivery or electronic transmission if the injured employee agrees to receive the report by electronic transmission, and shall be sent, not later than the end of the second working day after the date of examination, to the insurance carrier and the employer.

(g) In addition to the requirements under subsection (e) of this section, the treating doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report with the insurance carrier, employer, and injured employee within seven days of the day of receipt of:
(1) functional job descriptions from the employer listing available modified duty positions that the employer is able to offer the injured employee as provided by §129.6(a) of this title (relating to Bona Fide Offers of Employment); or
(2) a required medical examination doctor's Work Status Report that indicates that the injured employee can return to work with or without restrictions.

(h) Filing the Work Status Report as required by subsection (g) of this section does not require a new examination of the injured employee.

(i) The doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the Work Status Report as follows:

(1) A report filed with the insurance carrier or its agent shall be filed by electronic transmission;

(2) A report filed with the employer shall be filed by electronic transmission if the doctor, delegated physician assistant, or delegated advanced practice registered nurse has been provided the employer's facsimile number or email address; otherwise, the report shall be filed by personal delivery or mail; and

(3) A report filed with the injured employee shall be hand delivered to the injured employee or delivered by electronic transmission if the injured employee agrees to receive the report by electronic transmission, unless the report is being filed pursuant to subsection (g) of this section and the doctor, delegated physician assistant, or delegated advanced practice registered nurse is not scheduled to see the injured employee by the due date to send the report. In this case, the doctor, delegated physician assistant, or delegated advanced practice registered nurse shall file the report with the injured employee by electronic transmission if the doctor, delegated physician assistant, or delegated advanced practice registered nurse has been provided the injured employee's facsimile number or email address; otherwise, the report shall be filed by mail.

(j) Notwithstanding any other provision of this title, a doctor, delegated physician assistant, or delegated advanced practice registered nurse may bill for, and an insurance carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the insurance carrier, its agent, or the employer through its insurance carrier asks for an extra copy. The amount of reimbursement shall be $15. A doctor, delegated physician assistant, or delegated advanced practice registered nurse shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors, delegated physician assistants, or delegated advanced practice registered nurses are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors, delegated physician assistants, or delegated advanced practice registered nurses billing for Work Status Reports as permitted by this section shall do so as follows:

(1) CPT code "99080" with modifier "73" shall be used when the doctor, delegated physician assistant, or delegated advanced practice registered nurse is billing for a report required under subsections (e)(1), (e)(2), and (g) of this section;

(2) CPT code "99080" with modifiers "73" and "RR" (for "requested report") shall be used when the doctor, delegated physician assistant, or delegated advanced practice registered nurse is billing for an additional report requested by or through the insurance carrier under subsection (e)(3) of this section; and

(3) CPT code "99080" with modifiers "73" and "EC" (for "extra copy") shall be used when the doctor, delegated physician assistant, or delegated advanced practice registered nurse is billing for an extra copy of a previously filed report requested by or through the insurance carrier.

(k) As provided in §126.6(g) of this title (relating to Order for Required Medical Examinations), a doctor who conducts a required medical examination in which the doctor determines that the injured employee can return to work immediately with or without restrictions shall file the Work Status Report required by this section, but shall do so in accordance with the requirements of §126.6(g).

RULE §129.6 Bona Fide Offers of Employment

(a) An employer or insurance carrier (carrier) may request the treating doctor provide a Work Status Report by providing the treating doctor a set of functional job descriptions which list modified duty positions which the employer has available for the injured employee (employee) to work. The functional job descriptions must include descriptions of the physical and time requirements of the positions.

(b) An employer may offer an employee a modified duty position which has restricted duties which are within the employee's work abilities as determined by the employee's treating doctor. In the absence of a Work Status Report by the treating doctor an offer of employment may be made based on another doctor's assessment of the employee's work status provided that the doctor made the assessment based on an actual physical examination of the employee performed by that doctor and provided that the treating doctor has not indicated disagreement with the restrictions identified by the other doctor.

(c) An employer's offer of modified duty shall be made to the employee in writing and in the form and manner prescribed by the Commission. A copy of the Work Status Report on which the offer is being based shall be included with the offer as well as the following information:
(1) the location at which the employee will be working;
(2) the schedule the employee will be working;
(3) the wages that the employee will be paid;
(4) a description of the physical and time requirements that the position will entail; and
(5) a statement that the employer will only assign tasks consistent with the employee's physical abilities, knowledge, and skills and will provide training if necessary.

(d) A carrier may deem an offer of modified duty to be a bona fide offer of employment if:
(1) it has written copies of the Work Status Report and the offer; and
(2) the offer:
(A) is for a job at a location which is geographically accessible as provided in subsection (e) of this section;
(B) is consistent with the doctor's certification of the employee's work abilities, as provided in subsection (f) of this section; and
(C) was communicated to the employee in writing, in the form and manner prescribed by the Commission and included all the information required by subsection (c) of this section.

(e) In evaluating whether a work location is geographically accessible the carrier shall at minimum consider:
(1) the affect that the employee's physical limitations have on the employee's ability to travel;
(2) the distance that the employee will have to travel;
(3) the availability of transportation; and
(4) whether the offered work schedule is similar to the employee's work schedule prior to the injury.

(f) The following is the order of preference that shall be used by carriers evaluating an offer of employment:
(1) the opinion of a doctor selected by the Commission to evaluate the employee's work status;
(2) the opinion of the treating doctor;
(3) opinion of a doctor who is providing regular treatment as a referral doctor based on the treating doctor's referral;
(4) opinion of a doctor who evaluated the employee as a consulting doctor based on the treating doctor's request; and
(5) the opinion of any other doctor based on an actual physical examination of the employee performed by that doctor.

(g) A carrier may deem the wages offered by an employer through a bona fide offer of employment to be Post-Injury Earnings (PIE), as outlined in §129.2 of this title (relating to Entitlement to Temporary Income Benefits), on the earlier of the date the employee rejects the offer or the seventh day after the employee receives the offer of modified duty unless the employee's treating doctor notifies the carrier that the offer made by the employer is not consistent with the employee's work restrictions. For the purposes of this section, if the offer of modified duty was made by mail, an employee is deemed

to have received the offer from the employer five days after it was mailed. The wages the carrier may deem to be PIE are those that would have been paid on or after the date the carrier is permitted to deem the offered wages as PIE.

(h) Nothing in this section should be interpreted as limiting the right of an employee or a carrier to request a benefit review conference relating to an offer of employment. The Commission will find an offer to be bona fide if it is reasonable, geographically accessible, and meets the requirements of subsections (b) and (c) of this section.

Source Note: The provisions of this §129.6 adopted to be effective December 26, 1999, 24 TexReg 11420

RULE §129.7 Non-Reimbursable Employer Payments

(a) An employer who pays an injured employee (employee) salary continuation is not entitled to and shall not seek reimbursement from the employee or the insurance carrier (carrier).

(b) An employer who pays an employee salary supplementation to supplement income benefits paid by the carrier is not entitled to and shall not seek reimbursement from the employee or the carrier.

Source Note: The provisions of this §129.7 adopted to be effective December 26, 1999, 24 TexReg 11420

RULE §129.11 Agreement for Monthly Payment of Temporary Income Benefits

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

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

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

(3) weekly TIBs payments shall continue through the end of the month in which the agreement was signed;
(4) payment of the last week of TIBs to transition from weekly payment of TIBs to monthly payments shall be prorated to the end of the month to ensure the injured employee receives TIBs through the last day of the month; and
(5) if less than the maximum weekly compensation rate in effect on the date of the compensable injury is being paid, a completed Employer's Wage Statement must be included with the injured employee's copy of the written agreement.

(b) To calculate the amount of monthly TIBs to pay, the carrier shall determine the average monthly wage by multiplying the average weekly wage by 4.34821 and subtracting any Post-Injury Earnings the employee earned during the month for which the employee was entitled to TIBs to determine the lost wages. The carrier shall then pay the employee in monthly TIBs as follows:
(1) for a workers' compensation claim with a date of injury before September 1, 2015,
(A) if the employee earns $8.50 per hour or more, the carrier shall pay 70% of the lost wages; or
(B) if the employee earns less than $8.50 per hour, the carrier shall pay:
(i) 75% of the lost wages for the first 26 weeks of TIBs due; and
(ii) 70% of the lost wages for all TIBs payments thereafter; and
(2) for a workers' compensation claim with a date of injury on or after September 1, 2015,
(A) if the employee earns $10 per hour or more, the carrier shall pay 70% of the lost wages; or
(B) if the employee earns less than $10 per hour, the carrier shall pay:
(i) 75% of the lost wages for the first 26 weeks of TIBs due; and
(ii) 70% of the lost wages for all TIBs payments thereafter.

(c) Entering into an agreement under this section does not prohibit any party to the claim from raising disputes over periods, amounts of, or entitlement to TIBs. Disputes must be raised as and when they arise.

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

(e) At any time after signing the agreement for the monthly payment of TIBs, the injured employee or the insurance carrier may notify the other party in writing that it no longer agrees to the monthly payment of TIBs. In this case, the insurance carrier shall pay all

accrued but unpaid TIBs at the end of the current monthly cycle and shall continue to pay TIBs weekly as and when they accrue and are due.

Source Note: The provisions of this §129.11 adopted to be effective December 26, 1999, 24 TexReg 11439; amended to be effective February 28, 2016, 41 TexReg 1249

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 130	IMPAIRMENT AND SUPPLEMENTAL INCOME BENEFITS
SUBCHAPTER A	IMPAIRMENT INCOME BENEFITS

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

(a) Authorized Doctor.

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

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

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

(ii) a designated doctor; or

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

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

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

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

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

impairment but is not authorized to assign an impairment rating, the doctor is also not authorized to certify MMI and shall refer the injured employee to a doctor who is so authorized.

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

(b) Certification of Maximum Medical Improvement.

(1) Maximum medical improvement (MMI) is:

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

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

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

(2) MMI must be certified before an impairment rating is assigned and the impairment rating must be assigned for the injured employee's condition on the date of MMI. An impairment rating is invalid if it is based on the injured employee's condition on a date that is not the MMI date. An impairment rating and the corresponding MMI date must be included in the Report of Medical Evaluation to be valid.

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

(4) To certify MMI the certifying doctor shall:

(A) review medical records;

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

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

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

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

(D) Complete and submit required reports and documentation.

(c) Assignment of Impairment Rating.

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

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

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

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

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

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

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

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

(3) Assignment of an impairment rating for the current compensable injury shall be based on the injured employee's condition on the MMI date considering the medical record and the certifying examination. An impairment rating is invalid if it is based on the injured employee's condition on a date that is not the MMI date. An impairment rating and the corresponding MMI date must be included in the Report of Medical Evaluation to be valid. The doctor assigning the impairment rating shall:

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

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

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

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

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

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

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

(F) be responsible for referring the injured employee to another doctor or health care provider for testing, or evaluation, if additional medical information is required. The

certifying doctor is responsible for incorporating all additional information obtained into the report required by this rule:

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

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

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

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

(d) Reporting.

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

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

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

(i) date of the certifying examination;

(ii) date of MMI;

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

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

(v) current clinical status;

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

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

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

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

(A) date of the certifying examination; or

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

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

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

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

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

(1) the date of the examination;

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

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

Source Note: The provisions of this §130.1 adopted to be effective June 7, 2000, 25 TexReg 5352; amended to be effective January 2, 2002, 26 TexReg 10910; amended to be effective March 14, 2004, 29 TexReg 2328; amended to be effective August 25, 2013, 38 TexReg 5263

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

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

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

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

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

(A) the date of maximum medical improvement;

(B) the assigned impairment rating;

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

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

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

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

(c) The Division shall mail a notice to a treating doctor, the employee, the employee's representative, if any, and the insurance carrier on the expiration of 98 weeks from the date the employee's TIBs began to accrue if the employee is still receiving TIBSs. The Division's notice shall advise the treating doctor of the requirements under Chapter 408,

Subchapter G of the Texas Workers' Compensation Act, and this section, and require that an impairment rating report be mailed to the Division no later than 104 weeks from the date TIBs began to accrue.

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

(e) If the carrier has not received a report of medical evaluation by the date of statutory MMI:
(1) the carrier may suspend TIBs and is not required to initiate impairment income benefits (IIBs) until such time as it receives a report of an impairment rating assigned in accordance with §130.1 of this title;
(2) the carrier or the employee may request the appointment of a designated doctor under §126.7 of this title (relating to Designated Doctor Examinations: Requests and General Procedures); and/or
(3) a carrier may make a reasonable assessment of what it believes the true impairment rating should be and, if it does so, shall initiate IIBs within five days of making the assessment. The carrier shall continue to pay IIBs until the assessment is paid in full or is superceded by an impairment rating assigned in accordance with §130.1 of this title.

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

RULE §130.3 Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment by a Doctor other than the Treating Doctor

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

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

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

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

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

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

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

(1) a certifying doctor shall maintain documentation of:

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

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

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

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

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

(a) This section does not apply if statutory maximum medical improvement (MMI) has been reached. Statutory MMI is the later of:
(1) the end of the 104th week after the date that temporary income benefits (TIBs) began to accrue; or
(2) the date to which MMI was extended by the commission through operation of Texas Labor Code §408.104.

(b) If there has not been a certification in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment) that an injured employee has reached MMI, an insurance carrier (carrier) may follow the procedure outlined in this section to resolve whether an employee has reached MMI. The carrier shall presume, only for purposes of invoking this procedure, that an employee has reached MMI, if:
(1) it appears that the employee has failed to attend two or more consecutively scheduled health care appointments and the number of days between the two examinations is greater than 60 except for laminectomy, spinal fusion or diskectomy in which case the number of days between the two examinations is greater than 90;
(2) the treating doctor has examined the employee at least twice for the same compensable injury after the date on which TIBs began to accrue, and the doctor's medical reports as filed with the insurance carrier for all examinations and reports conducted after the first of the two examinations, indicate a lack of medical improvement in the employees condition since the date of the first of the two examinations;
(3) the employee was previously found not to be at MMI by a designated doctor but the employee has reached the date the designated doctor estimated that the employee would reach MMI; or
(4) the employee is four weeks past the point that the claim has become a Work Release Outlier Claim as defined by commission rule.

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

(d) The treating doctor shall evaluate the employee's condition within 14 days of receiving the request from the carrier under subsection (c) of this section. The evaluation shall be conducted in accordance with §130.1 of this title and the report filed within

seven working days of the date of the examination. If the treating doctor determines that the employee has permanent impairment but is not authorized to certify MMI or assign an impairment rating, the doctor shall refer the employee to a doctor who is so authorized and this doctor shall comply with the requirements of this section, §130.1 and §130.3 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment and Certification of Maximum Medical Improvement by Doctor Other Than Treating Doctor).

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

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

RULE §130.7 Acceleration of Impairment Income Benefits

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

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

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

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

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

RULE §130.8 Initiating Payment of Impairment Income Benefits

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

(b) When the date of maximum medical improvement is not disputed, the carrier shall initiate payment of impairment income benefits on or before the fifth day after:
(1) the date of receipt of the employee's treating doctor's medical evaluation report, as described in §130.1 of this title (relating to Reports of Medical Evaluation: Maximum Medical Improvement and Permanent Impairment); or
(2) the last day of the 104th week after the employee's accrual date, as defined in §124.7 of this title (relating to Initial Payment of Temporary Income Benefits).

(c) When the date of maximum medical improvement is disputed, the carrier shall initiate payment of impairment income benefits on or before the fifth day after:
(1) the date of entry of an interlocutory order to begin payment of impairment income benefits;
(2) the date of execution of an agreement on a dispute over date of maximum medical improvement; or
(3) the date of receipt of a commission-approved settlement of a dispute over date of maximum medical improvement.

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

RULE §130.11 Agreement for Monthly Payment of Impairment Income Benefits

(a) Upon the request of the injured employee, the insurance carrier and an employee entitled to impairment income benefits (IIBs) may agree to change the frequency of IIBs payments from the standard weekly period to a monthly period. The agreement to change the payment frequency must be in writing and is only required to be filed with the Commission if the Commission requests a copy. To relieve the insurance carrier of the responsibility to pay IIBs weekly, a valid written agreement must include the following terms and conditions:
(1) the agreement for the monthly payment of IIBs payments shall be effective the first calendar day of the month following the month in which the written agreement was entered into by the insurance carrier and the injured employee;
(2) monthly IIBs payment shall be issued on or before the seventh day of the month for which benefits are due;

(3) weekly IIBs payments shall continue through the end of the month in which the agreement was signed.;
(4) payment of the last week of IIBs to transition from weekly payment of IIBs to monthly payments shall be prorated to the end of the month to ensure the injured employee receives IIBs through the last day of the month;
(5) if less than the maximum weekly compensation rate in effect on the date of the compensable injury is being paid, a completed Employer's Wage Statement must be included with the injured employee's copy of the written agreement;
(6) the monthly benefit amount shall be equal to the weekly compensation rate for IIBs that the injured employee is entitled to multiplied by 4.34821; and
(7) the impairment rating and source of the impairment rating upon which payment of IIBs is being based.

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

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

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

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

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

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

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

(1) The first valid certification of MMI and/or IR assigned or determination of no impairment;
(2) The first valid assignment of IR after the expiration of 104 weeks from the date income benefits begin to accrue or the expiration date of any extension under Section 408.104, if the employee has not been certified as having reached MMI; or
(3) The first valid subsequent certification of MMI and/or assignment of an IR or determination of no impairment received after the date a certification of MMI and/or assignment of an IR or determination of no impairment is overturned, modified or withdrawn by agreement of the parties or by a final decision of the commission or a court.
(4) A designated doctor may provide multiple IRs if there is a dispute over extent of injury. Whichever rating from the designated doctor applies to the compensable injury once an extent of injury (EOI) dispute has been resolved may become final if not disputed. An EOI dispute does not constitute a dispute of the MMI/IR for purposes of finality under this subsection.
(b) A first MMI/IR certification must be disputed within 90 days of delivery of written notice through verifiable means, including IRs related to EOI disputes. The notice must contain a copy of a valid Form TWCC 69, Report of Medical Evaluation, as described in subsection (c). The 90-day period begins on the day after the written notice is delivered to the party wishing to dispute a certification of MMI or an IR assignment, or both. The 90-day period may not be extended.
(1) Only an insurance carrier, an injured employee, or an injured employee's attorney or employee representative under 150.3(a) may dispute a first certification of MMI or assigned IR under §141.1 (related to Requesting and Setting a Benefit Review Conference) or by requesting the appointment of a designated doctor, if one has not been appointed.
(2) Use of the TWCC 69's non-concurrence section is not a prescribed form and manner for a dispute.
(3) A dispute may not be revoked or withdrawn to allow the first valid certification of MMI and/or the first valid assignment of IR to become final except by agreement of the parties.
(4) The first certification of maximum medical improvement and/or impairment rating may be disputed after the 90-day period as provided in §408.123(e) of the Texas Labor Code.

(c) A certification of MMI and/or IR assigned as described in subsection (a) must be on a Form TWCC 69, Report of Medical Evaluation. The certification on the Form TWCC 69 is valid if:
(1) There is an MMI date that is not prospective;

(2) There is an impairment determination of either no impairment or a percentage impairment rating assigned; and
(3) There is the signature of the certifying doctor who is authorized by the Commission under §130.1(a) to make the assigned impairment determination.

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

Source Note: The provisions of this §130.12 adopted to be effective March 14, 2004, 29 TexReg 2328

SUBCHAPTER B SUPPLEMENTAL INCOME BENEFITS

RULE §130.100 Applicability

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

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

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

RULE §130.101 Definitions

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

(1) Application for Supplemental Income Benefits--The Division form required pursuant to Labor Code §408.143(b) containing the following information:
(A) a statement, with supporting payroll documentation, that the employee has earned less than 80% of the employee's average weekly wage as a direct result of the impairment from the compensable injury;
(B) the amount of the employee's wages during the qualifying period;
(C) a statement, with supporting documentation, that the employee has complied with Labor Code §408.1415 and this subchapter; and

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

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

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

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

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

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

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

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

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

Source Note: The provisions of this §130.101 adopted to be effective January 31, 1999, 24 TexReg 399; amended to be effective November 28, 1999, 24 TexReg 10339; amended to be effective July 1, 2009, 34 TexReg 2138; amended to be effective April 15, 2018, 43 TexReg 2153

RULE §130.102 Eligibility for Supplemental Income Benefits; Amount

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

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

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

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

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

reduced earnings.

(d) Work Search Requirements.
(1) An injured employee demonstrates an active effort to obtain employment by meeting at least one or any combination of the following work search requirements each week during the entire qualifying period:
(A) has returned to work in a position which is commensurate with the injured employee's ability to work.
(B) has actively participated in a vocational rehabilitation program as defined in §130.101 of this title (Definitions).
(C) has actively participated in work search efforts conducted through the Texas Workforce Commission (TWC).
(D) has performed active work search efforts documented by job applications the injured employee submitted. For purposes of this section, "job application" means a physical or electronic form or other document that is submitted to an employer or its designated representative to provide information about a candidate to obtain a specific position.
(E) has been unable to perform any type of work in any capacity, has provided a narrative report from a doctor that specifically explains how the injury causes a total inability to work, and no other records show that the injured employee is able to return to work.
(2) An injured employee who has not met at least one of the work search requirements in any week during the qualifying period is not entitled to SIBs unless the injured employee can demonstrate that he or she had reasonable grounds for failing to comply with the work search requirements under this section.

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

(f) Work Search Efforts. As provided in subsection (d)(1)(C) and (D) of this section regarding active participation in work search efforts and active work search efforts, an injured employee must provide documentation sufficient to establish that he or she has, each week during the qualifying period, made the minimum number of work search efforts, including submitting the minimum number of job applications, consistent with the work search efforts established by TWC that are required for unemployment compensation in the injured employee's county of residence under the TWC Local Workforce Development Board requirements.

(1) If the required number of work search efforts changes during a qualifying period, the lesser number of work search efforts is the required minimum number of work search efforts for that period.
(2) If the injured employee is residing out of state, the minimum number of work search efforts required is the number required by the public employment service under applicable unemployment compensation laws for the injured employee's place of residence.

(g) Calculation of amount. Subject to any approved reduction for the effects of contribution, the monthly supplemental income benefit payment is calculated quarterly as follows:
(1) multiply the injured employee's average weekly wage by 80% (.80);
(2) add the injured employee's wages for all 13 weeks of the qualifying period;
(3) divide the total wages by 13;
(4) subtract this figure from the result of paragraph (1) of this subsection;
(5) multiply the difference by 80% (.80);
(6) if the resulting amount is greater than the maximum rate under the Act, Labor Code, §408.061, use the maximum rate; and
(7) multiply the result by 4.34821.

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

(i) Services Provided by a Carrier Through a Private Provider of Vocational Rehabilitation Services. The insurance carrier is responsible for reasonable travel expenses incurred by the injured employee if the employee is required to travel in excess of 20 miles one way from the injured employee's residence to obtain vocational rehabilitation services from a private provider

Source Note: The provisions of this §130.102 adopted to be effective January 31, 1999, 24 TexReg 399; amended to be effective November 28, 1999, 24 TexReg 10339; amended to be effective July 1, 2009, 34 TexReg 2138; amended to be effective April 15, 2018, 43 TexReg 2153; amended to be effective December 24, 2025, 50 TexReg 8335

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

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

(b) Determination of Entitlement. If the Division determines that the injured employee is entitled to supplemental income benefits for the first quarter, the notice of determination shall include:
(1) the beginning and end dates of the first quarter;
(2) the amount of the monthly payments;
(3) the amount of the wages used to calculate the monthly payment;
(4) instructions for the parties of the procedures for contesting the Division's determination as provided by §130.108 of this title (relating to Contesting Entitlement or Amount of Supplemental Income Benefits; Attorney Fees); and
(5) an Application for Supplemental Income Benefits, filing instructions, a filing schedule, and a description of the consequences of failing to timely file.

(c) Determination of non-entitlement. If the Division determines that the injured employee is not entitled to supplemental income benefits for the first quarter, the notice of determination shall include:
(1) the grounds for this determination;
(2) the beginning and end dates of the first quarter;
(3) instructions for the parties of the procedures for contesting the Division's determination as provided by §130.108 of this title (relating to Contesting Entitlement to Supplemental Income Benefits); and
(4) an Application for Supplemental Income Benefits, filing instructions, a filing schedule, and a description of the consequences of failing to timely file.

Source Note: The provisions of this §130.103 adopted to be effective January 31, 1999, 24 TexReg 399; amended to be effective November 28, 1999, 24 TexReg 10339; amended to be effective July 1, 2009, 34 TexReg 2138

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

(a) Subsequent Quarter Determination. After the Division has made a determination of entitlement or non-entitlement for supplemental income benefits for the first quarter,

the insurance carrier shall make determinations for subsequent quarters consistent with the provisions contained in §130.102 of this title (relating to Eligibility for Supplemental Income Benefits; Amount). The insurance carrier shall issue a determination of entitlement or non-entitlement within 10 days after receipt of the Application for Supplemental Income Benefits for a subsequent quarter.

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

(1) the number of the applicable quarter;
(2) the dates of the qualifying period;
(3) the dates of the quarter;
(4) the deadline for filing the application with the insurance carrier; and
(5) the minimum number of work search efforts required by §130.102(d)(1) and (f) of this title (relating to Eligibility for Supplemental Income Benefits; Amount) during the next qualifying period.

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

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

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

(f) Accrual date. If the injured employee is entitled to supplemental income benefits for a subsequent quarter, the benefits begin to accrue on the later of:
(1) the first day of the applicable quarter; or
(2) the date the Application for Supplemental Income Benefits is received by the insurance carrier, subject to the provisions of §130.105 of this title (relating to Failure to Timely File Application for Supplemental Income Benefits; Subsequent Quarters).
(g) Changes in Amount. A change in the monthly amount of supplemental income benefits from one quarter to the next does not constitute a dispute subject to §130.108 of this title (relating to Contesting Entitlement to Supplemental Income Benefits). An insurance carrier that does not contest the entitlement to supplemental income benefits for a subsequent quarter, but determines a different monthly amount is due, shall:
(1) send the notice as required in subsection (e) of this section;
(2) include instructions about the procedures for contesting the insurance carrier's determination as provided by §130.108 of this title (relating to Contesting Entitlement to Supplemental Income Benefits); and
(3) issue payment based on the newly calculated amount.

Source Note: The provisions of this §130.104 adopted to be effective January 31, 1999, 24 TexReg 399; amended to be effective July 1, 2009, 34 TexReg 2138

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

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

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

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

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

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

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

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

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

Source Note: The provisions of this §130.105 adopted to be effective January 31, 1999, 24 TexReg 399; amended to be effective July 1, 2009, 34 TexReg 2138

RULE §130.106 Loss of Entitlement to Supplemental Income Benefits

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

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

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

(c) Refusal of Vocational Rehabilitation Services. An injured employee, in a vocational rehabilitation program as defined in §130.101(8) of this title (relating to Definitions), who refuses vocational rehabilitation services or refuses to cooperate with services provided at any time during a qualifying period is not entitled to supplemental income benefits for the related quarter.
Source Note: The provisions of this §130.106 adopted to be effective January 31, 1999, 24 TexReg 399; amended to be effective July 1, 2009, 34 TexReg 2138

RULE §130.107 Payment of Supplemental Income Benefits

(a) First Quarter. After the Division's initial determination of entitlement, the insurance carrier shall pay supplemental income benefits as follows:
(1) the first payment shall be made on or before the tenth day after the day on which the insurance carrier received the Division determination of entitlement or the seventh day of the quarter, whichever is later;
(2) the second payment shall be made on or before the 37th day of the first quarter; and
(3) the last payment shall be made on or before the 67th day of the first quarter.

(b) Subsequent Quarters. For subsequent quarters, the insurance carrier shall pay supplemental income benefits as follows:
(1) the first payment shall be made on or before the tenth day after the day on which the insurance carrier received the Application for Supplemental Income Benefits, or the seventh day of the quarter, whichever is later;
(2) the second payment shall be made on or before the 37th day of the quarter; and
(3) the last payment shall be made on or before the 67th day of the quarter.

Source Note: The provisions of this §130.107 adopted to be effective January 31, 1999, 24 TexReg 399; amended to be effective July 1, 2009, 34 TexReg 2138

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

(a) Injured Employee Disputes. An injured employee may contest the determination by the Division or the insurance carrier regarding non-entitlement to, or the amount of, supplemental income benefits by requesting a benefit review conference as provided by Chapter 141 of this title (relating to Dispute Resolution--Benefit Review Conference).

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

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

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

(e) Liability. An insurance carrier who unsuccessfully contests a Division determination of entitlement to supplemental income benefits is liable for:
(1) all accrued, unpaid supplemental income benefits, and interest on that amount; and

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

Source Note: The provisions of this §130.108 adopted to be effective January 31, 1999, 24 TexReg 399; amended to be effective July 1, 2009, 34 TexReg 2138

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

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

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

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

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

Source Note: The provisions of this §130.109 adopted to be effective April 17, 1992, 17 TexReg 2400; amended to be effective July 1, 2009, 34 TexReg 2138

TITLE 28 **INSURANCE**
PART 2 **TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION**
CHAPTER 131 **BENEFITS--LIFETIME INCOME BENEFITS**

SUBCHAPTER A GENERAL PROVISIONS

RULE §131.1 Initiation of Lifetime Income Benefits; Notice of Denial

a) The insurance carrier must initiate the payment of lifetime income benefits without a final decision, order, or other action of the commissioner if an injured employee meets the eligibility criteria for lifetime income benefits listed under Labor Code §408.161 or §408.1615 as a result of the compensable injury.

(b) An injured employee may submit a written request for lifetime income benefits to the insurance carrier. The insurance carrier must either initiate lifetime income benefits or deny the injured employee's eligibility for lifetime income benefits considering all of the eligibility criteria listed under Labor Code §408.161 or §408.1615 within 60 days of receiving the injured employee's written request. An insurance carrier's failure to respond to the request for lifetime income benefits within the timeframes described in this subsection does not constitute a waiver of the insurance carrier's right to dispute the injured employee's eligibility for lifetime income benefits.

(c) The insurance carrier must make the first payment of lifetime income benefits on or before the 15th day after the date the insurance carrier reasonably believes that the injured employee is eligible for lifetime income benefits as a result of the compensable injury. The initiation of lifetime income benefits without a final decision, order, or other action of the commissioner does not waive the insurance carrier's right to contest the compensability of the injury under Labor Code §409.021(c).

(d) If the injured employee submits a written request for lifetime income benefits, and the insurance carrier denies that the injured employee is eligible for lifetime income benefits, the insurance carrier must deny eligibility by sending a plain-language notice of denial of eligibility to the division, the injured employee, and the injured employee's representative, if any, in the form and manner prescribed by the division up to the 60th day after it receives the written request. The notice of denial of eligibility must include:
(1) a full and complete statement describing the insurance carrier's reasons for denial. The statement must contain sufficient claim-specific substantive information to enable the injured employee to understand the insurance carrier's position or action taken under the claim. A generic statement that simply states the insurance carrier's position

with phrases such as "not part of compensable injury," "not meeting criteria," "liability is in question," "under investigation," "eligibility questioned," or other similar phrases with no further description of the factual basis for the denial does not satisfy the requirements of paragraph (1) of this subsection;

(2) contact information, including the adjuster's name, toll-free telephone and fax numbers, and email address; and

(3) a statement informing the injured employee of his or her right to request a benefit review conference to resolve the dispute.

(e) An injured employee may contest the insurance carrier's denial of eligibility for lifetime income benefits or failure to respond to the written request for lifetime income benefits by requesting dispute resolution as provided by Chapters 141 - 144 and 147 of this title (relating to Dispute Resolution).

(f) Nothing in this section is intended to limit an insurance carrier's duty to initiate payment of lifetime income benefits before the time limit established in subsection (c) of this section.

Source Note: The provisions of this §131.1 adopted to be effective June 1, 2015, 40 TexReg 929; amended to be effective November 21, 2024, 49 TexReg 9322

RULE §131.2 Calculation of Lifetime Income Benefits

(a) Lifetime income benefits shall be calculated by multiplying the employee's average weekly wage by .75. The lifetime income benefit payable each week under this formula shall not exceed the weekly maximum benefit under the Workers' Compensation Act, §4.11, for the first year of benefits.

(b) Each year on the anniversary date of the day lifetime income benefits began to accrue, the amount of those benefits being paid shall be increased by 3.0%. The employee is entitled to the annual increase without regard to the limits imposed by the maximum weekly benefit. The increase shall be paid without further action by the commission.

Source Note: The provisions of this §131.2 adopted to be effective April 15, 1991, 16 TexReg 1885.

RULE §131.3 Carrier's Petition for Payment of Benefits by the Subsequent Injury Fund

(a) When an insurance carrier reasonably believes that an injured employee may be eligible for lifetime benefits from the subsequent injury fund, the insurance carrier shall petition the commission for payment of lifetime income benefits from the subsequent injury fund. The petition shall be in writing and contain the following:
(1) the employee's name and social security number;
(2) the date of each injury;
(3) the workers' compensation number assigned to the claim (if any) for each injury;
(4) the name and address of the employer for whom the employee was working at the time of each injury; and
(5) any information upon which the carrier bases its request.

(b) The commission shall order the payment of lifetime income benefits from the subsequent injury fund if it finds that the effects of the two injuries combined entitle the employee to lifetime income benefits.

(c) The insurance carrier shall pay to the employee weekly benefits as ordered by the commission.

(d) The subsequent injury fund shall compensate the employee for the remaining lifetime income benefits for which the insurance carrier is not liable.

Source Note: The provisions of this §131.3 adopted to be effective April 15, 1991, 16 TexReg 1885.

RULE §131.4 Change in Payment Period; Purchase of Annuity for Lifetime Income Benefits

(a) Upon the request of an injured employee entitled to lifetime income benefits (LIBs) as defined in the Act, the insurance carrier and an injured employee may agree to change the frequency of LIBs payments from the standard weekly period to a monthly period. The agreement to change the payment frequency must be in writing and is only required to be filed with the Commission if the Commission requests a copy. To relieve the insurance carrier of the responsibility to pay LIBs weekly a valid written agreement must include the following terms and conditions:
(1) the agreement for the monthly payment of LIBs shall be effective the first calendar day of the month following the month in which the written agreement was entered into by the insurance carrier and the injured employee;
(2) monthly LIBs shall be issued on or before the seventh day of the month for which benefits are due;

(3) weekly LIBs payments shall continue through the end of the month in which the agreement was signed;
(4) payment of the last week of LIBs to transition from weekly payment of LIBs to monthly payments shall be prorated to the end of the month to ensure the injured employee receives LIBs through the last day of the month;
(5) the monthly compensation rate shall be calculated by multiplying the weekly compensation rate by 4.34821;
(6) if less than the maximum weekly compensation rate in effect on the date of the compensable injury is being paid, a completed Employer's Wage Statement must be included with the injured employee's copy of the written agreement; and
(7) A clear statement regarding the due date of the annual three percent increase in LIBs must be included.

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

(c) The insurance carrier and the injured employee entitled to LIBs may agree that the carrier will purchase an annuity for payment of LIBs. An application for payment of LIBs by annuity must be submitted to the Commission for approval in the form, format, and manner required by the Commission. If less than the maximum weekly compensation rate in effect on the date of the compensable injury is being paid, a complete Employer's Wage Statement must be included with the application.

(d) An annuity for the payment of LIBs shall meet the following terms and conditions.
(1) LIBs payments shall be initiated no later than the 45th day after the date the written agreement was approved by the Commission.
(2) The company providing an annuity for the payment of LIBs must be licensed to do business in Texas and must have a current A. M. Best rating of B+ or better or have a Standard & Poor's rating of claims paying ability of A or better.
(3) The workers' compensation insurance carrier must guarantee the payments provided by the annuity company in the event of default.
(4) The annuity contract must include funds for payment of the annual three percent increase in LIBs required by the Act, compounded annually.
(5) The injured employee, or guardian if applicable, shall not be allowed to assign the right to receive LIBs from an annuity. All LIBs must be paid to the order of the injured employee or the legal guardian, if applicable.

(6) An annuity cannot be purchased to fund the payment of medical costs incurred by an injured employee entitled to LIBs.

(7) The annuity company shall pay LIBs either weekly or monthly as indicated in the application for payment of LIBs by annuity.

(8) If monthly payments are agreed to by the insurance carrier and the injured employee, the transition from weekly to monthly benefits paid by annuity shall be the same as that for LIBs paid by the responsible insurance carrier set out in subsection (a) of this section.

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

Source Note: The provisions of this §131.4 adopted to be effective December 26, 1999, 24 TexReg 11449

RULE §131.5 Verification by the Subsequent Injury Fund

(a) The Subsequent Injury Fund must confirm the following information before making a payment to the injured employee:

(1) the injured employee is living;

(2) lifetime income benefits are being received; and

(3) the injured employee's contact information is correct.

(b) The injured employee must provide the information required by subsection (a)(1) - (3) to the Subsequent Injury Fund each month over a telephone call, video call, or other online verification system to receive the lifetime income benefit payment from the Subsequent Injury Fund. If the injured employee is unable to provide the information, the Subsequent Injury Fund will hold any pending payments until verification is complete.

Source Note: The provisions of this §131.5 adopted to be effective February 18, 2025, 50 TexReg 863

SUBCHAPTER B LIFETIME INCOME BENEFITS--CERTAIN FIRST RESPONDERS

RULE §131.10 Definitions

In Subchapter B of this chapter:

(1) "First responder" means "first responder" as defined in Labor Code §408.1615.
(2) "Serious bodily injury" means "serious bodily injury" as defined in Penal Code §1.07.

Source Note: The provisions of this §131.10 adopted to be effective November 21, 2024, 49 TexReg 9322

RULE §131.11 Applicability

This subchapter applies to a first responder who sustains a serious bodily injury:

(1) that is an injury described under Labor Code §408.1615;
(2) in the course and scope of the first responder's employment or volunteer service as a first responder; and
(3) that renders the first responder permanently unemployable.

Source Note: The provisions of this §131.11 adopted to be effective November 21, 2024, 49 TexReg 9322

RULE §131.12 First Responder's Annual Certification to Insurance Carrier

(a) Requirement. A first responder receiving lifetime income benefits under §408.1615 must file a certification with the insurance carrier annually.

(b) Content. The certification must state that the first responder was not employed in any capacity during the preceding year.

(c) Method and Timing. The first responder must submit the certification to the insurance carrier in the form and manner prescribed by the division:
(1) by first class mail, by personal delivery, or by electronic transmission; and
(2) no later than 30 days after the anniversary of the date the first responder's lifetime income benefits began to accrue.

(d) Notice. Every year, 30 days before the first responder's annual certification is due, an insurance carrier must send the annual certification to complete to the first responder. The certification must include the anniversary date the first responder's lifetime income benefits began to accrue and the date by which the first responder must return the certification to the insurance carrier.

Source Note: The provisions of this §131.12 adopted to be effective November 21, 2024, 49 TexReg 9322

RULE §131.13 Suspension and Reinstatement of Lifetime Income Benefits

(a) An insurance carrier may suspend the payment of lifetime income benefits to a first responder during and for a period in which:
(1) The first responder fails to complete the annual certification as required by §408.1615(e).
(2) The first responder, without good cause, fails to attend a designated doctor examination as required by §408.0041(j).
(3) The first responder is employed in any capacity.
(4) A designated doctor's report indicates that the first responder is no longer entitled to lifetime income benefits as provided in §408.0041(k-1).

(b) Before an insurance carrier may suspend lifetime income benefits under this section, the insurance carrier must send a plain-language notice to the first responder that explains the basis for the suspension.
(1) Within 20 days of receiving this notice, the first responder must respond to the insurance carrier's notice by:
(A) submitting the annual certification to the insurance carrier;
(B) notifying the insurance carrier of an examination under §127.25 of this title (relating to Failure to Attend a Designated Doctor Examination); or
(C) requesting dispute resolution under Chapters 140 - 144 and 147 of this title (relating to Dispute Resolution).
(2) If the first responder does not respond within 20 days of receiving this notice, the insurance carrier may suspend the first responder's benefits.

(c) If an insurance carrier suspends benefits under subsection (a)(1) of this section, the insurance carrier must reinstate benefits effective on the date the insurance carrier receives the first responder's annual certification. The reinstatement of benefits must occur no later than the seventh day following the date the insurance carrier receives the annual certification.

(d) If an insurance carrier suspends benefits under subsection (a)(2) of this section (failure to attend a designated doctor examination), the insurance carrier must follow §127.25 of this title for suspension and reinstatement of the first responder's benefits.

(e) If an insurance carrier suspends benefits under subsection (a)(3) of this section (employment in any capacity), the first responder must submit a new request for lifetime income benefits under §131.1 of this chapter (relating to Initiation of Lifetime Income Benefits; Notice of Denial).

(f) If the insurance carrier suspends or reinstates benefits under this section, the insurance carrier must also comply with the electronic notification requirements to DWC in §124.2 and Chapter 124, Subchapter B (relating to Insurance Carrier Claim Electronic Data Interchange Reporting to the Division).

Source Note: The provisions of this §131.13 adopted to be effective November 21, 2024, 49 TexReg 9322

RULE §131.14 Dispute of Continuing Entitlement of Lifetime Income Benefits

(a) If the insurance carrier disputes the accuracy of the first responder's annual certification under Labor Code §408.1615(g), the insurance carrier must provide a copy of the annual certification along with supporting evidence to the commissioner and to the first responder.

(b) Upon review of the information in subsection (a) of this section, the commissioner will issue an order stating whether the insurance carrier is entitled to an examination under Labor Code §408.1615(h).

(c) The parties may dispute the determination of the division through the dispute resolution processes outlined in Chapters 140 - 144 and 147 of this title (relating to Dispute Resolution).

(d) After receiving the designated doctor's report under Labor Code §408.1615(h), a party may dispute the designated doctor's opinion on continuing entitlement to lifetime income benefits through the dispute resolution processes outlined in Chapters 140 - 144 and 147 of this title (relating to Dispute Resolution).

Source Note: The provisions of this §131.14 adopted to be effective November 21, 2024, 49 TexReg 9322

TITLE 28 **INSURANCE**
PART 2 **TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION**
CHAPTER 132 **DEATH BENEFITS--DEATH AND BURIAL BENEFITS**

RULE §132.1 Calculation of Death Benefits

Death benefits shall be computed by multiplying the employee's average weekly wage by .75. The amount paid shall not exceed 100% of the state average weekly wage as determined by the Texas Workers' Compensation Commission and in effect on the date of injury. A claim for death benefits shall be filed as required by §122.100 of this title (relating to Claim for Death Benefits).

Source Note: The provisions of this §132.1 adopted to be effective January 1, 1991, 15 TexReg 7023.

RULE §132.2 Determination of Facts of Dependent Status

(a) This section applies to a person who claims death benefits as a dependent of the deceased employee.

(b) A benefit which flowed from a deceased employee, at the time of death, on an established basis in at least monthly intervals to the person claiming to be dependent, is presumed to be a regular or recurring economic benefit. This presumption may be overcome by credible evidence. The burden is on the claimant to prove that benefits, which flowed less frequently than once a month, were regular or recurring at the time of the employee's death.

(c) It shall be presumed that an economic benefit, whose value was equal to or greater than 20% of the person's net resources in the period (see subsection (d) of this section) for which the benefit was paid, is an economic benefit which contributed substantially to the person's welfare and livelihood. This presumption may be overcome by credible evidence. The burden is on the claimant to prove that benefits whose value was less than 20% of the person's net resources contributed significantly to the person's welfare and livelihood.

(d) Net resources for the purpose of subsection (b) of this section are 100% of all wage and salary income and all other income including nonpecuniary income and all income

of the individual's spouse, less 100% of social security taxes and federal income tax withholding.

(e) The person claiming to be a dependent shall furnish sufficient information to enable the commission to accurately identify the net resources and to establish the existence of the economic benefit claimed. This information may include, but is not limited to, tax returns, a financial statement of the individual, and check stubs.

(f) If an economic benefit was provided in the form of goods and services, the value shall be the market value of the same or similar goods and services in the same vicinity.

Source Note: The provisions of this §132.2 adopted to be effective January 1, 1991, 15 TexReg 7023.

RULE §132.3 Eligibility of Spouse To Receive Death Benefits

(a) The surviving spouse is entitled to receive death benefits, unless subsection (b) of this section applies. The surviving spouse shall submit a certified copy of the marriage license, or satisfactory evidence of common-law marriage to the deceased employee, to the insurance carrier.

(b) A surviving spouse who abandoned the employee, without good cause for more than one year immediately preceding the death, shall be ineligible to receive death benefits. The surviving spouse shall be deemed to have abandoned the employee if the surviving spouse and the employee had not been living in the same household for more than one year preceding the employee's death unless the spouse is:
(1) hospitalized;
(2) in a nursing home; or
(3) living apart due to career choices, military duty, or other reasons where it is established their separation is not due to the pending breakup of the marriage. The burden is on a person who opposes the claim of a surviving spouse to prove the spouse abandoned the deceased employee.

(c) If more than one person claims to be the surviving spouse of the deceased employee, the commission shall presume the most recent spouse is the surviving spouse. This presumption may be rebutted by an individual who presents proof of a prior valid marriage to the deceased employee.

Source Note: The provisions of this §132.3 adopted to be effective January 1, 1991, 15 TexReg 7023.

RULE §132.4 Eligibility of a Child To Receive Death Benefits

(a) A child eligible for death benefits is the son or daughter of a deceased employee, including an adoptive child, and including a dependent stepchild, who meets any of the conditions set out in the Texas Workers' Compensation Act (the Act), §4.42(g)(2).

(b) A person claiming benefits as the biological or adoptive son or daughter of a deceased employee shall submit proof of relationship to the deceased employee to the carrier or along with the claim for death benefits. The claimant shall submit a certified copy of the claimant's birth certificate or decree of adoption. If these documents do not exist, the claimant shall submit other proof of relationship, such as baptismal records, court orders establishing paternity, voluntary admissions of paternity, or affidavits of persons who have personal knowledge of the relationship to the deceased employee.

(c) If there are two parents listed on the claimant's birth certificate, but deceased employee is not listed, the claimant is presumed to be the child of the parents actually named and is presumed not eligible to receive death benefits. The presumption may be rebutted by credible evidence.

(d) A person claiming benefits as the dependent stepchild of the deceased employee shall prove that the employee was married to a parent of the claimant, and must also establish dependent status as set out in §132.2 of this title (relating to Determination of Facts of Dependent Status).
(e) A child under 18 years of age, who is married or has been emancipated from the disabilities of minority at the time of the employee's death, shall not be eligible to receive benefits as a minor under the Act, §4.42(g)(2)(A).

(f) A child who is a full-time student at the time of the employee's death and is less than 25 years old shall submit evidence of enrollment at an accredited educational institution. A child shall only be considered a full-time student if the child meets the educational institution's requirements for a full-time student in the child's course of study.

(g) An adult child claiming eligibility to receive benefits under the Act, §4.42(g)(2), shall be required to establish dependent status as set out in §132.2 of this title (relating to Determination of Facts of Dependent Status). A physically or mentally handicapped child also shall submit medical evidence of the handicap.

Source Note: The provisions of this §132.4 adopted to be effective January 1, 1991, 15 TexReg 7023.

RULE §132.5 Eligibility of a Grandchild To Receive Death Benefits

(a) A grandchild who was dependent on the deceased employee on the day of death shall be entitled to receive death benefits, unless the grandchild's own parent is eligible for benefits.

(b) A person claiming to be an eligible grandchild shall submit proof of the relationship to the deceased employee to the carrier or along with the claim for death benefits. The claimant shall submit a certified copy of the claimant's birth certificate or decree of adoption, and a certified copy of the birth certificate or decree of adoption of the parent who was a child of the deceased employee. If these documents do not exist, the claimant shall submit other proof of relationship, such as baptismal records, court orders establishing paternity, voluntary admissions of paternity, or affidavits of persons who have personal knowledge of the relationship to the deceased employee. In addition, the claimant must present evidence of dependent status on the deceased employee as defined by §132.2 of this title (relating to Determination of Facts of Dependent Status).

Source Note: The provisions of this §132.5 adopted to be effective January 1, 1991, 15 TexReg 7023.

RULE §132.6 Eligibility of Other Surviving Dependents and Eligible Parents To Receive Death Benefits

(a) A parent, stepparent, sibling, or grandparent of a deceased employee who was dependent on the employee on the day of death is entitled to receive death benefits, only if there is no eligible spouse, child, or grandchild.
(b) A surviving eligible parent is entitled to receive death benefits only if there is no eligible spouse, no eligible child, and no eligible grandchild, and there are no surviving dependents of the deceased employee who are parents, siblings, or grandparents of the deceased.

(c) A person claiming to be a beneficiary under subsection (a) or (b) of this section is required to present proof of the relationship to the deceased employee to the insurance carrier or along with the claim for death benefits. The evidence presented as proof of a relationship shall include certified copies of applicable birth certificates, or decrees of adoption, or proof of marriage. If these documents do not exist, the claimant shall submit other proof of relationship, such as baptismal records, court orders establishing paternity, voluntary admissions of paternity, or affidavits of persons who have personal knowledge of the relationship to the deceased employee. A person claiming to be a beneficiary under subsection (a) of this section shall submit evidence of dependence on

the deceased employee as defined in §132.2 of this title (relating to Determination of Facts of Dependent Status). A person claiming to be a beneficiary under subsection (b) of this section shall designate all eligible parents on the claim for death benefits. An insurance carrier is not liable for payment to any eligible parent not designated on the claim for death benefits. A person claiming to be a beneficiary under subsection (b) of this section who is required to receive burial benefits in order to qualify as an eligible parent as provided in subsection (e) of this section shall also submit proof of receipt of burial benefits unless the claim for burial benefits is filed with the insurance carrier pursuant to §132.13 of this title (relating to Burial Benefits) at the same time the claim for death benefits is filed with the division or the claim for burial benefits has been filed with the insurance carrier but is still pending at the time the claim for death benefits is filed with the division.

(d) The term "sibling" means a brother or sister who shares at least one parent, through birth or adoption, with the deceased employee.

(e) For a compensable injury occurring on or after September 1, 2007 but prior to September 1, 2009 that results in the death of the employee, the term "eligible parent" means the mother or the father of a deceased employee, including an adoptive parent or a stepparent, who receives burial benefits under §132.13 of this title, but does not include a parent whose parental rights have been terminated.

(f) For a compensable injury occurring on or after September 1, 2009 that results in the death of the employee, the term "eligible parent" means the mother or the father of a deceased employee, including an adoptive parent or a stepparent, but does not include a parent whose parental rights have been terminated.

Source Note: The provisions of this §132.6 adopted to be effective January 1, 1991, 15 TexReg 7023; amended to be effective October 12, 2008, 33 TexReg 8395; amended to be effective March 21, 2010, 35 TexReg 2191

RULE §132.7 Duration of Death Benefits for Eligible Spouse

(a) Except as provided in subsection (f) of this section, a spouse who is determined eligible for death benefits is entitled to receive benefits until the date of the spouse's death or until remarriage. The insurance carrier shall notify the eligible spouse of the requirements of this section within 60 days of initiating benefits to that spouse.

(b) An eligible spouse who enters into a ceremonial or informal marriage is entitled to receive a lump-sum payment of 104 weeks of death benefits.

(c) An eligible spouse shall notify the division and the insurance carrier in writing within 30 days of the date of remarriage. The notice shall include the name and social security number of the deceased employee, the date of death, the workers' compensation claim file number, and the date of remarriage.

(d) The amount of the lump-sum payment shall be calculated by multiplying the amount paid to the spouse the week prior to the remarriage by 104. If the insurance carrier paid any weekly benefits to the eligible spouse after the remarriage, the total amount of such payments shall be deducted from the amount of the commuted payment.

(e) An eligible spouse who knowingly accepts death benefits after remarriage in excess of the amount allowed by this section, and who does not notify the division or the insurance carrier of remarriage, may be subject to administrative penalties.

(f) An eligible spouse who remarries is eligible for death benefits for life if the employee was a first responder, as defined by Labor Code §504.055, or an individual described by Government Code §615.003(1) or Labor Code §501.001(5)(F), who died as a result of an injury in the course and scope of employment or while providing services as a volunteer. Subsections (b) - (e) of this section do not apply to an eligible spouse under this subsection. This subsection applies to:

(1) Eligible spouses of first responders, as defined by Labor Code §504.055:

(A) who remarry on or after September 1, 2017; and

(B) who remarried between September 1, 2015, and August 31, 2017, if the claim is based on a compensable injury that occurred on or after September 1, 2015; and

(2) Eligible spouses of individuals, as defined by Government Code §615.003(1) or Labor Code §501.001(5)(F), who remarry on or after September 1, 2019.

Source Note: The provisions of this §132.7 adopted to be effective January 1, 1991, 15 TexReg 7023; amended to be effective March 20, 2016, 41 TexReg 1857; amended to be effective December 20, 2018, 43 TexReg 8125; amended to be effective September 8, 2020, 45 TexReg 6237

RULE §132.8 Duration of Death Benefits for an Eligible Child

(a) A child, who is eligible to receive death benefits because the child is a minor on the date of the employee's death, is entitled to receive benefits until the date on which the child turns 18. However, if the child is enrolled as a full-time student in an accredited educational institution on that date, benefits continue as described in subsection (b) of this section.

(b) A child, who is eligible to receive death benefits as a full-time student in an accredited educational institution on the date of the employee's death or on the child's 18th birthday, is entitled to receive benefits until the earliest of:
(1) the date on which the child ceases, for the second consecutive semester (excluding summer semesters), to be enrolled as a full-time student;
(2) the date on which the child turns 25; or
(3) the date on which the child dies.

(c) The insurance carrier may request proof that a child eligible for benefits is enrolled as a full-time student in an accredited educational institution; the child shall furnish such proof within 20 days of receiving such request.

(d) A child, who is eligible to receive death benefits because the child had a mental or physical handicap and was dependent on the employee because of the handicap on the date of the employee's death, is entitled to receive benefits until the earlier of:
(1) the date on which the child is no longer handicapped; or
(2) the date on which the child dies.

(e) Once each year, the insurance carrier may request proof that a child eligible under subsection (d) of this section is still mentally or physically handicapped. The carrier shall pay all reasonable medical and travel related expenses incurred in obtaining the requested proof.
(f) A child, who is otherwise eligible to receive benefits because the child was dependent on the employee on the date of the employee's death, is entitled to receive benefits until the earlier of:
(1) the date on which the child dies; or
(2) the expiration of 364 weeks of death benefit payments.

(g) A person who knowingly or intentionally continues to receive benefits as an eligible child or on behalf of an eligible child when the person is no longer entitled to receive them, or who knowingly fails to disclose the facts of ineligibility to the carrier or the commission, may be assessed administrative penalties under the Texas Workers' Compensation Act, §10.04.

Source Note: The provisions of this §132.8 adopted to be effective January 1, 1991, 15 TexReg 7023.

RULE §132.9 Duration of Death Benefits for an Eligible Grandchild, Eligible Dependent, and Eligible Parent

(a) A grandchild, who is eligible to receive death benefits and is a minor at the time of the employee's death, is entitled to receive benefits until the earlier of:
(1) the date on which the grandchild turns 18; or
(2) the date of death of the grandchild.

(b) A grandchild, who is eligible to receive death benefits and is not a minor at the time of the employee's death, is entitled to receive benefits until the earlier of:
(1) the date of death of the grandchild; or
(2) the expiration of 364 weeks of death benefit payments.

(c) Any other dependent, including a parent, stepparent, sibling, or grandparent of the deceased employee, who is entitled to death benefits shall receive benefits until the earlier of:
(1) the date of death of the beneficiary; or
(2) the expiration of 364 weeks of death benefit payments.

(d) An eligible parent who is entitled to receive death benefits shall receive benefits until the earlier of:
(1) the date the eligible parent dies; or
(2) the date of the expiration of 104 weeks of death benefit payments.

Source Note: The provisions of this §132.9 adopted to be effective January 1, 1991, 15 TexReg 7023; amended to be effective October 12, 2008, 33 TexReg 8395

RULE §132.10 Payment of Death Benefits to the Subsequent Injury Fund

(a) If a compensable death occurs and the carrier's investigation, as described in §132.17 of this title (relating to Denial, Dispute, and Payment of Death Benefits), has confirmed that the deceased employee has no legal beneficiaries, or if a claim for death benefits is not made in a timely manner, the insurance carrier shall, without order from the Commission, pay to the administrator of the Subsequent Injury Fund (SIF) an amount equal to 364 weeks of death benefits for deposit in the SIF. This payment shall be accompanied by the Employer's First Report of Injury and the Wage Statement.

(b) If, after a carrier has paid death benefits to all legal beneficiaries, all legal beneficiaries cease to be eligible to receive death benefits prior to the carrier paying a full 364 weeks of benefits, the carrier shall, without order from the Commission, pay the

remainder of the 364 weeks of death benefits to the administrator of the SIF. The remainder to be paid to the SIF shall be computed by subtracting the total amount paid, including any applicable remarriage payment, from the 364 weeks of death benefits that the carrier is required to pay. This payment shall be accompanied by the Employer's First Report of Injury, the Wage Statement, a detailed payment record showing the dates of payments, the amounts of the payments, the payees, the periods of benefits paid, and any other documentation reasonably required by the SIF administrator.

(c) The payments required by subsections (a) and (b) shall be made no later than the seventh day after the latest of:

(1) the day that there has been final adjudication that a death is compensable and/or that the carrier is liable for death benefits (if a denial of compensability or liability had been filed in accordance with §132.17 and §124.2 of this title (relating to Carrier Reporting and Notification Requirements and Denials));

(2) the sixtieth day after the carrier received written notice of the injury;

(3) one year after the date of the employee's death, if no claims of beneficiary entitlement have been made;

(4) the day that beneficiary entitlement disputes are finally adjudicated with the beneficiary being found to not be entitled to death benefits; or

(5) the day that all previously eligible beneficiaries are no longer eligible to receive death benefits.

(d) If a carrier has denied compensability of or liability for a death pursuant to §124.2 of this title and §132.17, and no claim of entitlement has been filed by a potential beneficiary by the 60th day after the date the carrier received written notice of the injury/death, the carrier shall provide to the SIF administrator within 14 days: copies of all reports, notices, witness statements, and investigation notes relating to the compensability of the death or the carrier's liability for payment of death benefits.

(e) If a carrier has disputed compensability of or liability for a death and no claim of entitlement has been filed by a potential beneficiary by the 60th day after the date the carrier received written notice of the injury, the SIF may pursue the issue of compensability or liability through dispute resolution.

(f) The carrier may elect to commute the amount to be paid under subsections (a) and (b) in a lump sum payment. If the carrier does not elect to commute benefits, the Commission may order that the death benefits payable to the SIF be commuted to a lump sum payment. The amount of a commuted payment shall be discounted at the rate established under §401.023 of the Act compounded annually.

(g) If, after the carrier has paid the death benefits to the SIF, a beneficiary makes a claim for death benefits which the carrier accepts or a final award of the Commission or the final judgment of a court of competent jurisdiction determines that the beneficiary is entitled to the death benefits, the carrier shall pay benefits in accordance with the award or order and request a refund for the amount overpaid to the SIF as provided in §116.11 (relating to Request for Reimbursement or Refund from the Subsequent Injury Fund).
(h) If no claim for death benefits is filed with the Commission on or before the first anniversary of the death of the employee and the carrier's investigation has confirmed that the deceased has no legal beneficiaries, it shall be presumed, for the purpose of this section and §403.007 of the Act only, that no legal beneficiary survived the deceased employee.

(i) The presumption created under subsection (h) of this section does not apply against a minor beneficiary, or an incompetent beneficiary for whom no guardian has been appointed.

(j) The SIF as a potential beneficiary in the case of any fatality may bring or enter into any dispute as a party.

Source Note: The provisions of this §132.10 adopted to be effective January 1, 1991, 15 TexReg 7023; amended to be effective March 13, 2000, 25 TexReg 2106

RULE §132.11 Distribution of Death Benefits

(a) All of the death benefits shall be paid to the eligible spouse if the deceased employee had no eligible children or eligible grandchildren.

(b) Death benefits shall be paid in equal shares to each eligible child per capita and to each eligible grandchild per stirpes if there is no eligible spouse.

(c) If there is an eligible spouse and an eligible child or eligible grandchild, half of the death benefits shall be paid to the eligible spouse. The remaining half shall be paid:
(1) if there are no eligible grandchildren, in equal shares to the eligible children;
(2) if there are no eligible children, per stirpes to the eligible grandchildren; or
(3) if there are eligible children and eligible grandchildren, the eligible children shall be paid equal shares per capita and the eligible grandchildren shall be paid per stirpes.

(d) If there is no eligible spouse, child, or grandchild, the death benefits shall be paid in equal shares to any surviving dependents of the deceased employee who are parents, siblings, or grandparents of the deceased. The amount to be paid to each surviving

dependent shall be calculated by dividing the weekly death benefit by the number of surviving dependents.

(e) If there is no eligible spouse, no eligible child, and no eligible grandchild, and there are no surviving dependents of the deceased employee who are parents, siblings, or grandparents of the deceased, the death benefits shall be paid in equal shares to surviving eligible parents. The amount paid may not exceed one payment per household and total payments may not exceed 104 weeks regardless of the number of surviving eligible parents.

(f) If the deceased employee has no legal beneficiaries as defined by the rules and the Texas Workers' Compensation Act, the death benefits shall be paid to the subsequent injury fund, as set out in §132.10 of this title (relating to Payment of Death Benefits to the Subsequent Injury Fund).

(g) The term "per stirpes" means that the grandchildren shall be entitled to share in only the amount of benefits that the parent of those grandchildren would have received had the parent been alive or otherwise eligible to receive death benefits.

Source Note: The provisions of this §132.11 adopted to be effective January 1, 1991, 15 TexReg 7023; amended to be effective October 12, 2008, 33 TexReg 8395; amended to be effective March 21, 2010, 35 TexReg 2191

RULE §132.12 Redistribution of Death Benefits

(a) Death benefits shall be redistributed if a legal beneficiary dies or becomes ineligible to receive benefits. The benefits shall be redistributed to the remaining legal beneficiaries eligible to receive death benefits at the time of death of the employee.

(b) If an eligible spouse becomes disqualified from continued payment of death benefits because of remarriage, the amount of benefits paid to each remaining legal beneficiary shall remain the same for 104 weeks. At the expiration of 104 weeks, the amount of benefits paid to each remaining legal beneficiary shall be recalculated as provided in §132.11 of this title (relating to Distribution of Death Benefits).

(c) If 364 weeks of death benefit payments have not been paid and the only remaining legal beneficiary is the subsequent injury fund, the insurance carrier shall pay any remaining amounts to the subsequent injury fund in accordance with §132.10 of this title (relating to Payment of Death Benefits to the Subsequent Injury Fund).

(d) In no case shall the insurance carrier pay an amount less than the weekly death benefit multiplied by 364, taking into consideration the discount rate set out in the Texas Workers' Compensation Act, §1.04, for a commuted payment to the subsequent injury fund in subsection (c) of this section.

Source Note: The provisions of this §132.12 adopted to be effective January 1, 1991, 15 TexReg 7023.

RULE §132.13 Burial Benefits

(a) When an employee has died as the result of a compensable injury, a person claiming burial benefits shall file a request for payment of burial benefits and the bills showing the amount of burial and transportation costs incurred. The request and the documentation shall be filed with the insurance carrier within 12 months of the date of death of the employee.

(b) The person who incurred liability for the costs of burial is entitled to receive the lesser of:
(1) the actual costs incurred for reasonable burial expenses; or
(2) $2,500--if burial benefits are paid based on a compensable injury that occurs before September 1, 1999; or
(3) $6,000--if burial benefits are paid based on a compensable injury that occurs on or after September 1, 1999 and before September 1, 2015; or
(4) $10,000--if burial benefits are paid based on a compensable injury that occurs on or after September 1, 2015.

(c) The person who incurred liability for the costs of transporting the body of the employee is entitled to be reimbursed for the reasonable cost of transportation if the employee died away from the usual place of employment. The insurance carrier's liability for transportation costs under this subsection shall not exceed the cost equivalent to transporting the body from the place the employee died to the employee's usual place of employment.

(d) The insurance carrier shall review each claim for burial benefits. The insurance carrier must either pay or deny the claim within seven days of the date the claim was received by the carrier. If the claim is denied, the insurance carrier must notify the person claiming burial benefits and the division in writing of its denial and the facts supporting

the denial.

Source Note: The provisions of this §132.13 adopted to be effective January 1, 1991, 15 TexReg 7023; amended to be effective December 26, 1999, 24 TexReg 11452; amended to be effective March 20, 2016, 41 TexReg 1857

RULE §132.14 Autopsy

(a) In a claim for death benefits based on an occupational disease, an autopsy may be requested by:
(1) an insurance carrier or the commission; or
(2) any legal beneficiary if the claim for benefits is denied.

(b) The request shall be submitted in writing to the commission with a copy delivered to every other party. Any party that disputes the need for an autopsy shall request, within 10 days after an autopsy is requested, a contested case hearing in accordance with the Texas Workers' Compensation Act, §6.31. A benefit review conference is not required before the hearing is held.

(c) After opportunity for a hearing, the commission may order the legal beneficiaries of the deceased employee to permit an autopsy if an autopsy is deemed necessary to determine the cause of the employee's death.
(d) If an autopsy is ordered, a legal beneficiary is entitled to have a representative present at the autopsy.

(e) The insurance carrier shall pay the costs of an autopsy ordered under this rule.

Source Note: The provisions of this §132.14 adopted to be effective January 1, 1991, 15 TexReg 7023.

RULE §132.15 Definitions

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

(1) Accredited educational institution--An institution which provides a recognized course or courses of instruction and leads to the conference of a diploma, degree, or other recognized certification of completion at the conclusion of the course of study. The definition may include, but is not limited to, high schools, colleges and universities, and trade schools.

(2) Full-time student--A person enrolled in at least the minimum course load required to qualify as full-time at the particular educational institution and in the particular course of study.
(3) Semester--The periods by which the educational institution divides its academic year.

Source Note: The provisions of this §132.15 adopted to be effective January 1, 1991, 15 TexReg 7023.

RULE §132.16 Change in Payment Periods; Purchase of Annuity for Death Benefits

(a) Upon the request of the eligible beneficiaries, the insurance carrier and eligible beneficiaries entitled to death benefits may agree to change the frequency of death benefits payments from the standard weekly period to a monthly period. The agreement to change the payment frequency must be in writing. To relieve the insurance carrier of the responsibility to pay death benefits weekly:
(1) An application to change the frequency of payments must be submitted to the Commission with the written agreement for approval in the form, format and manner required by the Commission
(2) A separate application must be submitted to the Commission for each eligible beneficiary, and the application must state that a payment adjustment shall be made when there is a change in the individual beneficiary's eligibility status in accordance with the provisions of the Act.
(3) If less than the maximum weekly death benefit in effect at the time of death is being paid, a completed Employer's Wage Statement (Form TWCC-3) must be filed with the application to change the payment period.
(4) The written agreement for monthly payment of death benefits must include:
(A) the agreement for the monthly payment of death benefits will be effective the first calendar day of the month following the month in which the written agreement was approved by the Commission;
(B) payment of monthly death benefits shall be issued on or before the seventh day of the month for which benefits are due.
(C) continuation of weekly death benefits payments through the end of the month in which the agreement was approved;
(D) payment of the last week of death benefits to transition from weekly payment of death benefits to monthly payments shall be prorated to the end of the month to ensure the eligible beneficiaries receives death benefits through the last day of the month; and
(E) calculation of the monthly compensation rate by multiplying the weekly compensation rate by 4.34821.

(5) The Commission must approve the application to change the frequency of death benefit payments.

(b) With the exception of payments made by annuity under subsection (d)(7) of this section, at any time after signing the agreement for the monthly payment of death benefits, the eligible beneficiary or insurance carrier may notify the other party in writing that it no longer agrees to the monthly payment of death benefits. The last monthly payment shall be prorated to ensure the insurance carrier pays the appropriate amount of DBs. In this case, the insurance carrier shall pay all accrued but unpaid death benefits at the end of the current monthly cycle and shall continue to pay death benefits weekly as and when they accrue and are due.

(c) The insurance carrier and an eligible beneficiary may enter into a written agreement that the carrier shall purchase an annuity for that beneficiary for weekly or monthly payment of death benefits. An application for payment of death benefits by annuity must be submitted to the Commission for approval in the form, format and manner required by the Commission. If less than the maximum weekly death benefit in effect at the time of death is being paid, a completed Employer's Wage Statement (Form TWCC-3) must be filed with the application for payment by annuity.

(d) An annuity for the payment of death benefits shall meet the following terms and conditions.

(1) Monthly death benefit payments shall be initiated no later than the 45th day after the date on in which the written agreement was approved by the Commission.

(2) The company providing an annuity for the payment of death benefits must be licensed to do business in Texas and must have a current A. M. Best rating of B+ or better or have a Standard & Poor's rating of claims paying ability of A or better.

(3) The workers' compensation insurance carrier must guarantee the payments provided by the annuity company in the event of default.

(4) When benefits are paid to an eligible spouse of the deceased employee and the spouse subsequently remarries, the annuity contract must address the payment of a lump sum payment equal to 104 weeks of benefits to the eligible spouse and the redistribution of benefits at the end of 104 weeks to the remaining eligible beneficiaries, if any.

(5) If all beneficiaries become ineligible to receive death benefits and an amount equal to 364 weeks of death benefits has not been paid, the remaining benefits shall be paid by the annuity company without an order from the Commission to the Subsequent Injury Fund not later than 30 days after all beneficiaries' eligibility ends.

(6) A beneficiary, or the beneficiary's guardian if applicable, shall not be allowed to assign the right to receive death benefits from an annuity. All death benefits must be paid to the order of the eligible beneficiary or the legal guardian, if applicable.

(7) The annuity company shall pay death benefits either weekly or monthly as elected by the beneficiary in the application for payment of death benefits by annuity.
(8) If monthly payments are elected by the beneficiary, the transition from weekly to monthly benefits paid by annuity shall be the same as that for death benefits paid by the responsible insurance carrier set out in subsection (a) of this section.
(e) This section applies only to agreements entered into on or after January 1, 2000, for payment of death benefits under the provisions of the Act.

Source Note: The provisions of this §132.16 adopted to be effective December 26, 1999, 24 TexReg 11452

RULE §132.17 Denial, Dispute, and Payment of Death Benefits

(a) Upon being notified of a death resulting from an injury, the insurance carrier (carrier) shall: investigate whether the death was a result of the injury and, if the carrier has not already done so in compliance with §124.3 of this title (relating to Investigation of an Injury and Notice of Denial/Dispute) due to the injury being reported separately, conduct an investigation relating to the compensability of the death, the carrier's liability for the death, and the accrual of benefits. The carrier shall have 60 days from notification of the death or from written notice of the injury that resulted in the death (whichever is greater) to conduct its investigation.
(b) If the carrier believes that it is not liable for the death or that the death was not compensable, the carrier shall file the notice of denial of a claim (notice of denial) in the form and manner required by §124.2 of this title (relating to Carrier Reporting and Notification Requirements). If the notice of denial is not filed by the 60th day as required, the carrier may not raise an issue of compensability or liability and is liable for any benefits that accrued and shall initiate benefits in accordance with this section.
(c) A carrier that is made aware of a death under subsection (a) of this section shall attempt to identify all potential beneficiaries, other than the subsequent injury fund (SIF), and the carrier shall maintain documentation relating to its attempt to identify potential beneficiaries.
(d) A carrier that identifies or becomes aware of a potential beneficiary shall notify the potential beneficiary of potential entitlement to benefits, using a plain language notice containing language and content prescribed by the Commission. This notice shall be sent within seven days of the date the carrier identified or was otherwise made aware of the identity and means of contacting the potential beneficiary.
(e) If the carrier receives a claim for death benefits in accordance with §122.100 of this title (relating to Claim for Death Benefits), the carrier shall review the evidence provided by the beneficiary to determine whether the person is entitled to death benefits as provided in §132.2 through §132.6 of this title (relating to Determination of Facts of

Dependent Status; Eligibility of Spouse to Receive Death Benefits; Eligibility of a Child to Receive Death Benefits; Eligibility of a Grandchild to Receive Death Benefits; Eligibility of Other Surviving Dependents to Receive Death Benefits).

(f) If the carrier believes the claimant is eligible to receive death benefits, the carrier shall begin payment of death benefits. If the carrier believes that the claimant is not eligible to receive death benefits, the carrier shall file the notice of dispute of eligibility (notice of dispute) in the form and manner required by §124.2 of this title (relating to Carrier Reporting and Notification Requirements).

(1) The carrier shall either begin the payment of death benefits or file the notice of dispute not later than the 15th day after the latest of:

(A) receiving the claim for death benefits;

(B) final adjudication of the carrier's denial of compensability or liability under §124.2 and subsection (b) of this section; or

(C) the expiration of the carrier's right to deny compensability/liability under subsection (a) of this section.

(2) If the notice of dispute is not filed within 15 days as required, the carrier is liable for and shall pay all benefits that had accrued and were payable prior to the date the carrier files the notice of dispute and only then is the carrier permitted to suspend payment of benefits.

(g) If the carrier has filed a notice of denial prior to receipt of a claim for death benefits, the carrier shall provide a copy of the previously filed notice of denial to the claimant within seven days of receipt of the claim for death benefits.

(h) The 15-day timeframe provided for in subsection (f) of this section applies only to claims for benefits based on compensable injuries that occurred on or after September 1, 2003. For claims based on compensable injuries that occurred prior to September 1, 2003, the applicable timeframe in subsection (f) of this section is seven days.

TITLE 28 **INSURANCE**
PART 2 **TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION**
CHAPTER 133 **GENERAL MEDICAL PROVISIONS**
SUBCHAPTER A **GENERAL RULES FOR MEDICAL BILLING AND PROCESSING**

RULE §133.1 Applicability of Medical Billing and Processing

(a) This chapter applies to medical billing and processing for health care services provided to injured employees subject to a workers' compensation health care network established under Insurance Code Chapter 1305, and to injured employees not subject to such networks, with the following exceptions pertaining only to health care services provided to an injured employee subject to a workers' compensation health care network established under Chapter 1305:
(1) Subchapter D of this chapter (relating to Dispute of Medical Bills);
(2) §133.210(f) of this chapter (relating to Medical Documentation); and
(3) §133.240(b) and (i) of this chapter (relating to Medical Payments and Denials).

(b) This chapter applies to all health care provided on or after May 2, 2006. For health care provided prior to May 2, 2006, medical billing and processing shall be in accordance with the rules in effect at the time the health care was provided.

Source Note: The provisions of this §133.1 adopted to be effective May 2, 2006, 31 TexReg 3544

RULE §133.2 Definitions

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

(1) Adverse determination--A determination by a utilization review agent made on behalf of a payor that the health care services provided or proposed to be provided to an injured employee are not medically necessary or appropriate. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. An adverse determination does not include a determination that health care services are experimental or investigational.

(2) Agent--A person whom a system participant utilizes or contracts with for the purpose of providing claims service or fulfilling medical bill processing obligations 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."

(3) Bill review--Review of any aspect of a medical bill, including retrospective review, in accordance with the Labor Code, the Insurance Code, division or department rules, and the appropriate fee and treatment guidelines.

(4) Complete medical bill--A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter (relating to Required Billing Forms/Formats), or as specified for electronic medical bills in §133.500 of this chapter (relating to Electronic Formats for Electronic Medical Bill Processing).

(5) Emergency--Either a medical or mental health emergency as follows:

(A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

(i) placing the patient's health or bodily functions in serious jeopardy, or

(ii) serious dysfunction of any body organ or part;

(B) a mental health emergency is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

(6) Final action on a medical bill--

(A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or

(B) denying a charge on the medical bill.

(7) Pharmacy processing agent--A person or entity that contracts with a pharmacy in accordance with Labor Code §413.0111, establishing an agent or assignee relationship, to process claims and act on behalf of the pharmacy under the terms and conditions of a contract related to services being billed. Such contracts may permit the agent or assignee to submit billings, request reconsideration, receive reimbursement, and seek medical dispute resolution for the pharmacy services billed.

(8) Reasonable opportunity--At least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with the utilization review agent during normal business hours

prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination:

(A) no less than one working day prior to issuing a prospective utilization review adverse determination;

(B) no less than five working days prior to issuing a retrospective utilization review adverse determination; or

(C) prior to issuing a concurrent or post-stabilization review adverse determination.

(9) Retrospective utilization review--A form of utilization review for health care services that have been provided to an injured employee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.

Source Note: The provisions of this §133.2 adopted to be effective May 2, 2006, 31 TexReg 3544; amended to be effective July 27, 2008, 33 TexReg 5701; amended to be effective July 1, 2012, 37 TexReg 2408; amended to be effective March 30, 2014, 39 TexReg 2095

RULE §133.3 Communication Between Health Care Providers and Insurance Carriers

(a) Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as "insurance carrier improperly reduced the bill" or "health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section.

(b) Communication between the health care provider and insurance carrier related to medical bill processing shall be made by telephone or electronic transmission unless the information cannot be sent by those media, in which case the sender shall send the information by mail or personal delivery.

(c) Health care providers and insurance carriers shall maintain, in a reproducible format, documentation of communications related to medical bill processing.

Source Note: The provisions of this §133.3 adopted to be effective May 2, 2006, 31 TexReg 3544

SUBCHAPTER B HEALTH CARE PROVIDER BILLING PROCEDURES

RULE §133.10 Required Billing Forms/Formats

(a) Health care providers, including those providing services for a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 or to political subdivisions with contractual relationships under Labor Code §504.053(b)(2), must submit medical bills for payment in an electronic format in accordance with §133.500 and §133.501 of this title (relating to Electronic Formats for Electronic Medical Bill Processing and Electronic Medical Bill Processing), unless the health care provider or the billed insurance carrier is exempt from the electronic billing process in accordance with §133.501 of this title.

(b) Except as provided in subsection (a) of this section, health care providers, including those providing services for a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 or to political subdivisions with contractual relationships under Labor Code §504.053(b)(2), must submit paper medical bills for payment on:
(1) the 1500 Health Insurance Claim Form Version 02/12 (CMS-1500);
(2) the Uniform Bill 04 (UB-04); or
(3) applicable forms prescribed for pharmacists, dentists, and surgical implant providers specified in subsections (c), (d), and (e) of this section.

(c) Pharmacists and pharmacy processing agents must submit bills using the division form DWC-066. A pharmacist or pharmacy processing agent may submit bills using an alternate billing form if:
(1) the insurance carrier has approved the alternate billing form prior to submission by the pharmacist or pharmacy processing agent; and
(2) the alternate billing form provides all information required on the division form DWC-066.

(d) Dentists must submit bills for dental services using the 2006 American Dental Association (ADA) Dental Claim form.

(e) Surgical implant providers requesting separate reimbursement for implantable devices must submit bills using:
(1) the form prescribed in subsection (b)(1) of this section when the implantable device reimbursement is sought under §134.402 of this title (relating to Ambulatory Surgical Center Fee Guideline); or

(2) the form prescribed in subsection (b)(2) of this section when the implantable device reimbursement is sought under §134.403 or §134.404 of this title (relating to Hospital Facility Fee Guideline--Outpatient and Hospital Facility Fee Guideline--Inpatient).

(f) All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form.

(1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care:

(A) patient's Social Security number (CMS-1500/field 1a) is required;

(B) patient's name (CMS-1500/field 2) is required;

(C) patient's date of birth and gender (CMS-1500/field 3) is required;

(D) employer's name (CMS-1500/field 4) is required;

(E) patient's address (CMS-1500/field 5) is required;

(F) patient's relationship to subscriber (CMS-1500, field 6) is required;

(G) employer's address (CMS-1500, field 7) is required;

(H) workers' compensation claim number assigned by the insurance carrier (CMS-1500/field 11) is required when known; the billing provider must leave the field blank if the workers' compensation claim number is not known by the billing provider;

(I) date of injury and "431" qualifier (CMS-1500, field 14) are required;

(J) name of referring provider or other source is required when another health care provider referred the patient for the services; no qualifier indicating the role of the provider is required (CMS-1500, field 17);

(K) referring provider's state license number (CMS-1500/field 17a) is required when there is a referring doctor listed in CMS-1500/field 17; the billing provider must enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX');

(L) referring provider's National Provider Identifier (NPI) number (CMS-1500/field 17b) is required when CMS-1500/field 17 contains the name of a health care provider eligible to receive an NPI number;

(M) diagnosis or nature of injury (CMS-1500/field 21) is required; at least one diagnosis code and the applicable ICD indicator must be present;

(N) prior authorization number (CMS-1500/field 23) is required in the following situations:

(i) Preauthorization, concurrent review, or voluntary certification was approved, and the insurance carrier provided an approval number to the requesting health care provider. Include the approval number in the prior authorization field (CMS-1500/field 23).

(ii) The division ordered a designated doctor examination and provided an assignment number. Include the assignment number in the prior authorization field (CMS-1500/field 23).

(iii) The designated doctor referred the injured employee for additional testing or evaluation, and the division provided an assignment number. Include the assignment number in the prior authorization field (CMS-1500/field 23).

(O) date or dates of service (CMS-1500, field 24A) is required;

(i) If the designated doctor referred the injured employee for additional testing or evaluation, the "From" date is the date of the designated doctor examination, and the "To" date is the date of service of the additional testing or evaluation.

(ii) If the designated doctor did not refer the injured employee for additional testing or evaluation, the "From" and "To" dates are the date of the designated doctor examination.

(P) place of service code or codes (CMS-1500, field 24B) is required;

(Q) procedure/modifier code (CMS-1500, field 24D) is required;

(R) diagnosis pointer (CMS-1500, field 24E) is required;

(S) charges for each listed service (CMS-1500, field 24F) is required;

(T) number of days or units (CMS-1500, field 24G) is required;

(U) rendering provider's state license number (CMS-1500/field 24j, shaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33; the billing provider must enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX');

(V) rendering provider's NPI number (CMS-1500/field 24j, unshaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33 and the rendering provider is eligible for an NPI number;

(W) supplemental information (shaded portion of CMS-1500/fields 24d - 24h) is required when the provider is requesting separate reimbursement for surgically implanted devices or when additional information is necessary to adjudicate payment for the related service line;

(X) billing provider's federal tax ID number (CMS-1500/field 25) is required;

(Y) total charge (CMS-1500/field 28) is required;

(Z) signature of physician or supplier, the degrees or credentials, and the date (CMS-1500/field 31) is required, but the signature may be represented with a notation that the signature is on file and the typed name of the physician or supplier;

(AA) service facility location information (CMS-1500/field 32) is required;

(BB) service facility NPI number (CMS-1500/field 32a) is required when the facility is eligible for an NPI number;

(CC) billing provider name, address, and telephone number (CMS-1500/field 33) is required;

(DD) billing provider's NPI number (CMS-1500/Field 33a) is required when the billing provider is eligible for an NPI number; and

(EE) billing provider's state license number (CMS-1500/field 33b) is required when the billing provider has a state license number; the billing provider must enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX').

(2) The following data content or data elements are required for a complete institutional medical bill related to Texas workers' compensation health care:

(A) billing provider's name, address, and telephone number (UB-04/field 01) is required;

(B) patient control number (UB-04/field 03a) is required;

(C) type of bill (UB-04/field 04) is required;

(D) billing provider's federal tax ID number (UB-04/field 05) is required;

(E) statement covers period (UB-04/field 06) is required;

(F) patient's name (UB-04/field 08) is required;

(G) patient's address (UB-04/field 09) is required;

(H) patient's date of birth (UB-04/field 10) is required;

(I) patient's gender (UB-04/field 11) is required;

(J) date of admission (UB-04/field 12) is required when billing for inpatient services;

(K) admission hour (UB-04/field 13) is required when billing for inpatient services other than skilled nursing inpatient services;

(L) priority (type) of admission or visit (UB-04/field 14) is required;

(M) point of origin for admission or visit (UB-04/field 15) is required;

(N) discharge hour (UB-04/field 16) is required when billing for inpatient services with a frequency code of "1" or "4" other than skilled nursing inpatient services;

(O) patient discharge status (UB-04/field 17) is required;

(P) condition codes (UB-04/fields 18 - 28) are required when there is a condition code that applies to the medical bill;

(Q) occurrence codes and dates (UB-04/fields 31 - 34) are required when there is an occurrence code that applies to the medical bill;

(R) occurrence span codes and dates (UB-04/fields 35 and 36) are required when there is an occurrence span code that applies to the medical bill;

(S) value codes and amounts (UB-04/fields 39 - 41) are required when there is a value code that applies to the medical bill;

(T) revenue codes (UB-04/field 42) are required;

(U) revenue description (UB-04/field 43) is required;

(V) HCPCS/Rates (UB-04/field 44):

(i) HCPCS codes are required when billing for outpatient services and an appropriate HCPCS code exists for the service line item; and

(ii) accommodation rates are required when a room and board revenue code is reported;

(W) service date (UB-04/field 45) is required when billing for outpatient services;

(X) service units (UB-04/field 46) is required;

(Y) total charge (UB-04/field 47) is required;

(Z) date bill submitted, page numbers, and total charges (UB-04/field 45/line 23) is required;

(AA) insurance carrier name (UB-04/field 50) is required;

(BB) billing provider NPI number (UB-04/field 56) is required when the billing provider is eligible to receive an NPI number;

(CC) billing provider's state license number (UB-04/field 57) is required when the billing provider has a state license number; the billing provider must enter the license number and jurisdiction code (for example, '123TX');

(DD) employer's name (UB-04/field 58) is required;

(EE) patient's relationship to subscriber (UB-04/field 59) is required;

(FF) patient's Social Security number (UB-04/field 60) is required;

(GG) workers' compensation claim number assigned by the insurance carrier (UB-04/field 62) is required when known, the billing provider must leave the field blank if the workers' compensation claim number is not known by the billing provider;

(HH) preauthorization number (UB-04/field 63) is required when:

(i) preauthorization, concurrent review, or voluntary certification was approved, and the insurance carrier provided an approval number to the health care provider; or

(ii) a designated doctor referred the injured employee for additional testing or evaluation, and the division provided an assignment number to the designated doctor.

(II) principal diagnosis code and present on admission indicator (UB-04/field 67) are required;

(JJ) other diagnosis codes (UB-04/field 67A - 67Q) are required when these conditions exist or subsequently develop during the patient's treatment;

(KK) admitting diagnosis code (UB-04/field 69) is required when the medical bill involves an inpatient admission;

(LL) patient's reason for visit (UB-04/field 70) is required when submitting an outpatient medical bill for an unscheduled outpatient visit;

(MM) principal procedure code and date (UB-04/field 74) is required when submitting an inpatient medical bill and a procedure was performed;

(NN) other procedure codes and dates (UB-04/fields 74A - 74E) are required when submitting an inpatient medical bill and other procedures were performed;

(OO) attending provider's name and identifiers (UB-04/field 76) are required for any services other than nonscheduled transportation services, the billing provider must report the NPI number for an attending provider eligible for an NPI number and the

state license number by entering the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX');

(PP) operating physician's name and identifiers (UB-04/field 77) are required when a surgical procedure code is included on the medical bill; the billing provider must report the NPI number for an operating physician eligible for an NPI number and the state license number by entering the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX'); and

(QQ) remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested.

(3) The following data content or data elements are required for a complete pharmacy medical bill related to Texas workers' compensation health care:

(A) dispensing pharmacy's name and address (DWC-066/field 1) is required;

(B) date of billing (DWC-066/field 2) is required;

(C) dispensing pharmacy's National Provider Identification (NPI) number (DWC-066/field 3) is required;

(D) billing pharmacy's or pharmacy processing agent's name and address (DWC-066/field 4) is required when different from the dispensing pharmacy (DWC-066/field 1);

(E) invoice number (DWC-066/field 5) is required;

(F) payee's federal employer identification number (DWC-066/field 6) is required;

(G) insurance carrier's name (DWC-066/field 7) is required;

(H) employer's name and address (DWC-066/field 8) is required;

(I) injured employee's name and address (DWC-066/field 9) is required;

(J) injured employee's Social Security number (DWC-066/field 10) is required;

(K) date of injury (DWC-066/field 11) is required;

(L) injured employee's date of birth (DWC-066/field 12) is required;

(M) prescribing doctor's name and address (DWC-066/field 13) is required;

(N) prescribing doctor's NPI number (DWC-066/field 14) is required;

(O) workers' compensation claim number assigned by the insurance carrier (DWC-066/field 15) is required when known; the billing provider must leave the field blank if the workers' compensation claim number is not known by the billing provider;

(P) dispensed as written code (DWC-066/field 19) is required;

(Q) date filled (DWC-066/field 20) is required;

(R) generic National Drug Code (NDC) code (DWC-066/field 21) is required when a generic drug was dispensed or if dispensed as written code '2' is reported in DWC-066/field 19;

(S) name brand NDC code (DWC-066/field 22) is required when a name brand drug is dispensed;

(T) quantity (DWC-066/field 23) is required;

(U) days supply (DWC-066/field 24) is required;

(V) amount paid by the injured employee (DWC-066/field 26) is required if applicable;

(W) drug name and strength (DWC-066/field 27) is required;
(X) prescription number (DWC-066/field 28) is required;
(Y) amount billed (DWC-066/field 29) is required;
(Z) preauthorization number (DWC-066/field 30) is required when:
(i) preauthorization, voluntary certification, or an agreement was approved, and the insurance carrier provided an approval number to the requesting health care provider; or
(ii) a designated doctor referred the injured employee for additional testing or evaluation, and the division provided an assignment number to the designated doctor.
(AA) for billing of compound drugs, refer to the requirements in §134.502 of this title (relating to Pharmaceutical Services).
(4) The following data content or data elements are required for a complete dental medical bill related to Texas workers' compensation health care:
(A) type of transaction (ADA 2006 Dental Claim Form/field 1);

(B) preauthorization number (ADA 2006 Dental Claim Form/field 2) is required when:
(i) preauthorization, concurrent review, or voluntary certification was approved, and the insurance carrier provided an approval number to the health care provider; or
(ii) a designated doctor referred the injured employee for additional testing or evaluation, and the division provided an assignment number to the designated doctor.
(C) insurance carrier name and address (ADA 2006 Dental Claim Form/field 3) is required;
(D) employer's name and address (ADA 2006 Dental Claim Form/field 12) is required;
(E) workers' compensation claim number assigned by the insurance carrier (ADA 2006 Dental Claim Form/field 15) is required when known; the billing provider must leave the field blank if the workers' compensation claim number is not known by the billing provider;
(F) patient's name and address (ADA 2006 Dental Claim Form/field 20) is required;
(G) patient's date of birth (ADA 2006 Dental Claim Form/field 21) is required;
(H) patient's gender (ADA 2006 Dental Claim Form/field 22) is required;
(I) patient's Social Security number (ADA 2006 Dental Claim Form/field 23) is required;
(J) procedure date (ADA 2006 Dental Claim Form/field 24) is required;
(K) tooth number or numbers or letter or letters (ADA 2006 Dental Claim Form/field 27) is required;
(L) procedure code (ADA 2006 Dental Claim Form/field 29) is required;
(M) fee (ADA 2006 Dental Claim Form/field 31) is required;
(N) total fee (ADA 2006 Dental Claim Form/field 33) is required;
(O) place of treatment (ADA 2006 Dental Claim Form/field 38) is required;
(P) treatment resulting from (ADA 2006 Dental Claim Form/field 45) is required; the provider must check the box for occupational illness/injury;

(Q) date of injury (ADA 2006 Dental Claim Form/field 46) is required;

(R) billing provider's name and address (ADA 2006 Dental Claim Form/field 48) is required;

(S) billing provider's NPI number (ADA 2006 Dental Claim Form/field 49) is required if the billing provider is eligible for an NPI number;

(T) billing provider's state license number (ADA 2006 Dental Claim Form/field 50) is required when the billing provider is a licensed health care provider; the billing provider must enter the license type, license number, and jurisdiction code (for example, 'DS1234TX');

(U) billing provider's federal tax ID number (ADA 2006 Dental Claim Form/field 51) is required;

(V) rendering dentist's NPI number (ADA 2006 Dental Claim Form/field 54) is required when different than the billing provider's NPI number (ADA 2006 Dental Claim Form/field 49) and the rendering dentist is eligible for an NPI number;

(W) rendering dentist's state license number (ADA 2006 Dental Claim Form/field 55) is required when different than the billing provider's state license number (ADA 2006 Dental Claim Form/field 50); the billing provider must enter the license type, license number, and jurisdiction code (for example, 'MDF1234TX'); and

(X) rendering provider's and treatment location address (ADA 2006 Dental Claim Form/field 56) is required when different from the billing provider's address (ADA Dental Claim Form/field 48).

(g) If the injured employee does not have a Social Security number as required in subsection (f) of this section, the health care provider must leave the field blank.

(h) Except for facility state license numbers, state license numbers submitted under subsection (f) of this section must be in the following format: license type, license number, and jurisdiction state code (for example 'MDF1234TX').

(i) In reporting the state license number under subsection (f) of this section, health care providers should select the license type that most appropriately reflects the type of medical services they provided to the injured employees. When a health care provider does not have a state license number, the field is submitted with only the license type and jurisdiction code (for example, DMTX). The license types used in the state license format must be one of the following:

(1) AC for Acupuncturist;

(2) AM for Ambulance Services;

(3) AS for Ambulatory Surgery Center;

(4) AU for Audiologist;

(5) CN for Clinical Nurse Specialist;

(6) CP for Clinical Psychologist;
(7) CR for Certified Registered Nurse Anesthetist;
(8) CS for Clinical Social Worker;
(9) DC for Doctor of Chiropractic;
(10) DM for Durable Medical Equipment Supplier;
(11) DO for Doctor of Osteopathy;
(12) DP for Doctor of Podiatric Medicine;
(13) DS for Dentist;
(14) IL for Independent Laboratory;
(15) LP for Licensed Professional Counselor;
(16) LS for Licensed Surgical Assistant;
(17) MD for Doctor of Medicine;
(18) MS for Licensed Master Social Worker;
(19) MT for Massage Therapist;
(20) NF for Nurse First Assistant;
(21) OD for Doctor of Optometry;
(22) OP for Orthotist/Prosthetist;
(23) OT for Occupational Therapist;
(24) PA for Physician Assistant;
(25) PM for Pain Management Clinic;
(26) PS for Psychologist;
(27) PT for Physical Therapist;
(28) RA for Radiology Facility; or
(29) RN for Registered Nurse.

(j) When resubmitting a medical bill under subsection (f) of this section, a resubmission condition code may be reported. In reporting a resubmission condition code, the following definitions apply to the resubmission condition codes established by the Uniform National Billing Committee:

(1) W3 - Level 1 Appeal means a request for reconsideration under §133.250 of this title (relating to Reconsideration for Payment of Medical Bills) or an appeal of an adverse determination under Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided Under Workers' Compensation Insurance Coverage);

(2) W4 - Level 2 Appeal means a request for reimbursement as a result of a decision issued by the division, an independent review organization, or a network complaint process; and

(3) W5 - Level 3 Appeal means a request for reimbursement as a result of a decision issued by an administrative law judge or judicial review.

(k) The inclusion of the appropriate resubmission condition code and the original reference number is sufficient to identify a resubmitted medical bill as a request for

reconsideration under §133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title provided the resubmitted medical bill complies with the other requirements contained in the appropriate section.

(l) Effective Date.
(1) This section is effective for medical bills submitted on or after June 1, 2024.
(2) For medical bills submitted as a result of an examination that was ordered or referred as the result of an order issued on or after June 1, 2024, the provisions of subsection (f) of this section are effective on and after June 1, 2024.

Source Note: The provisions of this §133.10 adopted to be effective May 2, 2006, 31 TexReg 3544; amended to be effective December 24, 2006, 31 TexReg 10097; amended to be effective May 1, 2008, 33 TexReg 3443; amended to be effective August 1, 2011, 36 TexReg 929; amended to be effective April 1, 2014, 38 TexReg 9594; amended to be effective June 1, 2024, 49 TexReg 1478

RULE §133.20 Medical Bill Submission by Health Care Provider

(a) The health care provider must submit all medical bills to the insurance carrier except when billing the employer in accordance with subsection (j) of this section.

(b) Except as provided in Labor Code §408.0272(b), (c), or (d), a health care provider must not submit a medical bill later than the 95th day after the date the services are provided.
(1) If a designated doctor refers an injured employee for additional testing or evaluation under §127.10 of this title, the 95-day period for timely submission of the bill begins on the date of service of the additional testing or evaluation.
(2) In accordance with subsection (c) of the statute, the health care provider must submit the medical bill to the correct workers' compensation insurance carrier no later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill.
(3) A health care provider who submits a medical bill to the correct workers' compensation insurance carrier must include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied. The medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A) - (H) of this title (relating to MDR of Fee Disputes), which establishes the generally acceptable standards for documentation.

(c) A health care provider must include correct billing codes from the applicable division fee guidelines in effect on the date or dates of service when submitting medical bills.

(d) The health care provider that provided the health care must submit its own bill, unless:
(1) the health care was provided as part of a return-to-work rehabilitation program in accordance with the division fee guidelines in effect for the dates of service;
(2) the health care was provided by an unlicensed individual under the direct supervision of a licensed health care provider, in which case the supervising health care provider must submit the bill;
(3) the health care provider contracts with an agent for purposes of medical bill processing, in which case the health care provider agent may submit the bill; or
(4) the health care provider is a pharmacy that has contracted with a pharmacy processing agent for purposes of medical bill processing, in which case the pharmacy processing agent may submit the bill.

(e) A medical bill must be submitted:
(1) for an amount that does not exceed the health care provider's usual and customary charge for the health care provided in accordance with Labor Code §§413.011 and 415.005; and
(2) in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care.

(f) Health care providers must not resubmit medical bills to insurance carriers after the insurance carrier has taken final action on a complete medical bill and provided an EOB except in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills).

(g) Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier.

(h) Not later than the 15th day after receipt of a request for additional medical documentation, a health care provider must submit to the insurance carrier:
(1) any requested additional medical documentation related to the charges for health care rendered; or
(2) a notice the health care provider does not possess requested medical documentation.

(i) The health care provider must indicate on the medical bill if documentation is submitted related to the medical bill.

(j) The health care provider may elect to bill the injured employee's employer if the employer has indicated a willingness to pay the medical bill or bills. Such billing is subject to the following:

(1) A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to:

(A) prompt payment, as provided by Labor Code §408.027;

(B) interest for delayed payment as provided by Labor Code §413.019; and

(C) medical dispute resolution as provided by Labor Code §413.031.

(2) When a health care provider bills the employer, the health care provider must submit an information copy of the bill to the insurance carrier, which clearly indicates that the information copy is not a request for payment from the insurance carrier.

(3) When a health care provider bills the employer, the health care provider must bill in accordance with the division's fee guidelines and §133.10 of this chapter (relating to Required Billing Forms/Formats).

(4) A health care provider must not submit a medical bill to an employer for charges an insurance carrier has reduced, denied, or disputed.

(k) A health care provider must not submit a medical bill to an injured employee for all or part of the charge for any of the health care provided, except as an informational copy clearly indicated on the bill, or in accordance with subsection (l) of this section. The information copy must not request payment.

(l) The health care provider may only submit a bill for payment to the injured employee in accordance with:

(1) Labor Code §413.042;

(2) Insurance Code §1305.451; or

(3) §134.504 of this title (relating to Pharmaceutical Expenses Incurred by the Injured Employee).

(m) A designated doctor must include the assignment number on the medical bill in accordance with §133.10 of this title (relating to Required Billing Forms/Formats).

(n) A designated doctor who refers the injured employee for additional testing or evaluation under §127.10 must provide the assignment number to the health care provider performing the testing or evaluation. The health care provider performing the testing or evaluation must include the assignment number on the medical bill in accordance with §133.10.

(o) This section is effective for medical bills submitted on or after June 1, 2024, including medical bills submitted as a result of an examination that was ordered or referred as the result of an order issued on or after June 1, 2024.

Source Note: The provisions of this §133.20 adopted to be effective May 2, 2006, 31 TexReg 3544; amended to be effective January 29, 2009, 34 TexReg 430; amended to be effective June 1, 2024, 49 TexReg 1478

RULE §133.30 Telemedicine, Telehealth, and Teledentistry Services

(a) This section applies to medical billing and reimbursement for telemedicine, telehealth, and teledentistry services provided on or after September 1, 2021, to injured employees in the Texas workers' compensation system, including injured employees subject to a workers' compensation health care network established under Insurance Code Chapter 1305.

(b) For the purposes of this section:

(1) "Telemedicine services" means telemedicine medical services as defined in Occupations Code §111.001.

(A) The term includes an examination by a treating doctor to certify maximum medical improvement (MMI), conducted on or after June 1, 2025, under §§130.1 and 130.2 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment) to determine whether an injured employee has reached MMI, that meets the following conditions:

(i) the injured employee has been examined by the treating doctor for the condition in question at least once before the examination to certify MMI;

(ii) the injured employee consents to the examination to certify MMI by telemedicine; and

(iii) the condition in question qualifies as a minor injury, such as §130.2(a)(2) of this title contemplates, requires no additional treatment, and has resulted in no impairment.

(B) The term does not include an examination to assign an impairment rating conducted under §130.1 of this title.

(2) "Telehealth services" means telehealth services as defined in Occupations Code §111.001.

(A) The term includes an examination by a treating doctor to certify MMI, conducted on or after June 1, 2025, under §§130.1 and 130.2 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment) to determine whether an injured employee has reached MMI, that meets the following conditions:

(i) the injured employee has been examined by the treating doctor for the condition in question at least once before the examination to certify MMI;

(ii) the injured employee consents to the examination to certify MMI by telehealth; and

(iii) the condition in question qualifies as a minor injury, such as §130.2(a)(2) of this title contemplates, requires no additional treatment, and has resulted in no impairment.

(B) The term does not include an examination to assign an impairment rating conducted under §130.1 of this title.

(3) "Teledentistry services" means teledentistry dental services as defined in Occupations Code §111.001.

(c) Except as provided in subsection (d) of this section, a health care provider must bill for telemedicine, telehealth, and teledentistry services according to applicable:

(1) Medicare payment policies, as defined in §134.203 of this title (relating to Medical Fee Guideline for Professional Services);

(2) Medicaid payment policies, in accordance with the dental fee guideline in §134.303 of this title (relating to 2005 Dental Fee Guideline);

(3) MMI billing requirements in §134.250 of this title (relating to Maximum Medical Improvement Evaluations and Impairment Rating Examinations by Treating Doctors); and

(4) provisions of Chapter 133 of this title.

(d) A health care provider may bill and be reimbursed for telemedicine, telehealth, or teledentistry services regardless of where the injured employee is located at the time the telemedicine, telehealth, or teledentistry services are provided.

(e) The provisions of this section take precedence over any conflicting provisions adopted or used by:

(1) the Centers for Medicare and Medicaid Services in administering the Medicare program; and

(2) the Texas Health and Human Services Commission in administering the Texas Medicaid Program.

Source Note: The provisions of this §133.30 adopted to be effective May 6, 2018, 43 TexReg 2587; amended to be effective August 22, 2023, 48 TexReg 4483; amended to be effective June 1, 2025, 50 TexReg 1030.

SUBCHAPTER C MEDICAL BILL PROCESSING/AUDIT BY INSURANCE CARRIER

RULE §133.200 Insurance Carrier Receipt of Medical Bills from Health Care Providers

(a) On receipt of medical bills submitted in accordance with §133.10 of this chapter (relating to Required Billing Forms/Formats), an insurance carrier must evaluate each medical bill for completeness as defined in §133.2 of this chapter (relating to Definitions).

(1) Insurance carriers must not return medical bills that are complete, unless the bill is a duplicate bill.

(2) Within 30 days after the day it receives a medical bill that is not complete as defined in §133.2 of this chapter, an insurance carrier must:

(A) complete the bill by adding missing information already known to the insurance carrier, except for the following:

(i) dates of service;

(ii) procedure or modifier codes;

(iii) number of units; and

(iv) charges; or

(B) return the bill to the sender, in accordance with subsection (c) of this section.

(3) The insurance carrier may contact the sender to get the information necessary to make the bill complete, including the information specified in paragraph (2)(A)(i) - (iv) of this subsection. If the insurance carrier gets the missing information and completes the bill, the insurance carrier must document the name and telephone number of the person who supplied the information.

(b) An insurance carrier must not return a medical bill except as provided in subsection (a) of this section. When returning a medical bill, the insurance carrier must include a document identifying the reasons for returning the bill. The reasons related to the procedure or modifier codes must identify the reasons by line item.

(c) The proper return of an incomplete medical bill in accordance with this section fulfills the insurance carrier's obligations with regard to the incomplete bill.

(d) An insurance carrier must not combine bills submitted in separate envelopes as a single bill or separate single bills spanning several pages submitted in a single envelope.

Source Note: The provisions of this §133.200 adopted to be effective May 2, 2006, 31 TexReg 3544; amended to be effective June 1, 2024, 49 TexReg 1478

RULE §133.210 Medical Documentation

(a) Medical documentation includes all medical reports and records, such as evaluation reports, narrative reports, assessment reports, progress report/notes, clinical notes, hospital records and diagnostic test results.
(b) When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents.

(c) In addition to the documentation requirements of subsection (b) of this section, medical bills for the following services shall include the following supporting documentation:
(1) the two highest Evaluation and Management office visit codes for new and established patients: office visit notes/report satisfying the American Medical Association requirements for use of those CPT codes;
(2) surgical services rendered on the same date for which the total of the fees established in the current Division fee guideline exceeds $500: a copy of the operative report;
(3) return to work rehabilitation programs as defined in §134.202 of this title (relating to Medical Fee Guideline): a copy of progress notes and/or SOAP (subjective/objective assessment plan/procedure) notes, which substantiate the care given, and indicate progress, improvement, the date of the next treatment(s) and/or service(s), complications, and expected release dates;
(4) any supporting documentation for procedures which do not have an established Division maximum allowable reimbursement (MAR), to include an exact description of the health care provided; and
(5) for hospital services: an itemized statement of charges.

(d) Any request by the insurance carrier for additional documentation to process a medical bill shall:
(1) be in writing;
(2) be specific to the bill or the bill's related episode of care;
(3) describe with specificity the clinical and other information to be included in the response;
(4) be relevant and necessary for the resolution of the bill;
(5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
(6) indicate the specific reason for which the insurance carrier is requesting the information; and
(7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.

(e) It is the insurance carrier's obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. The Division considers any medical billing information or documentation possessed by one entity to be simultaneously possessed by the other.

(f) Workers' compensation health care networks established under Insurance Code Chapter 1305 may decrease the documentation requirements of this section.

Source Note: The provisions of this §133.210 adopted to be effective May 2, 2006, 31 TexReg 3544

RULE §133.230 Insurance Carrier Audit of a Medical Bill

(a) An insurance carrier may perform an audit of a medical bill that has been submitted by a health care provider to the insurance carrier for reimbursement. The insurance carrier may not audit a medical bill upon which it has taken final action.

(b) If an insurance carrier decides to conduct an audit of a medical bill, the insurance carrier shall:
(1) provide notice to the health care provider no later than the 45th day after the date the insurance carrier received the complete medical bill. For onsite audits, provide notice in accordance with subsection (c) of this section;
(2) pay to the health care provider no later than the 45th day after receipt of the health care provider's medical bill, for the health care being audited:
(A) for a workers' compensation health care network established under Insurance Code Chapter 1305, 85 percent of the applicable contracted amount; or
(B) for services not provided under Insurance Code Chapter 1305, 85 percent of:
(i) the maximum allowable reimbursement amounts established under the applicable Division fee guidelines;
(ii) the contracted amount for services not addressed by Division fee guidelines; or
(iii) the fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) for services not addressed by clause (i) or (ii) of this subparagraph;
(3) make a determination regarding the relationship of the health care services provided for the compensable injury, the extent of the injury, and the medical necessity of the services provided; and
(4) complete the audit and pay, reduce, or deny in accordance with §133.240 of this chapter (relating to Medical Payments and Denials) no later than the 160th day after receipt of the complete medical bill.

(c) If the insurance carrier intends to perform an onsite audit, the notice shall include the following information for each medical bill that is subject to audit:
(1) employee's full name, address, and Social Security number;
(2) date of injury;
(3) date(s) of service for which the audit is being performed;
(4) insurance carrier's name and address;
(5) a proposed date and time for the audit, subject to mutual agreement; and
(6) name and telephone number of the person who will perform the onsite audit, has the authority to act on behalf of the insurance carrier, and shall personally appear for the onsite audit at the scheduled date and time.

(d) During the insurance carrier's onsite audit, the health care provider shall:
(1) make available to the insurance carrier: all notes, reports, test results, narratives, and other documentation the health care provider has relating to the billing(s) subject to audit; and
(2) designate one person with authority to: negotiate a resolution, serve as the liaison between the health care provider and the insurance carrier, and be available to the insurance carrier's representative.

(e) On the last day of the onsite audit, the health care provider's liaison and the insurance carrier's representative shall meet for an exit interview. The insurance carrier's representative shall present to the health care provider's liaison a list of unresolved issues related to the health care provided and the billed charges. The health care provider's liaison and the insurance carrier's representative shall discuss and attempt to resolve the issues.

Source Note: The provisions of this §133.230 adopted to be effective May 2, 2006, 31 TexReg 3544

RULE §133.240 Medical Payments and Denials

(a) An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation.

(b) For health care provided to injured employees not subject to a workers' compensation health care network established under Insurance Code Chapter 1305, the

insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments). For pharmaceutical services provided to any injured employee, the insurance carrier shall not deny reimbursement based on medical necessity for pharmaceutical services preauthorized or agreed to under Chapter 134, Subchapter F of this title (relating to Pharmaceutical Benefits).

(c) The insurance carrier shall not change a billing code on a medical bill or reimburse health care at another billing code's value.

(d) The insurance carrier may request additional documentation, in accordance with §133.210 of this title (relating to Medical Documentation), not later than the 45th day after receipt of the medical bill to clarify the health care provider's charges.

(e) The insurance carrier shall send the explanation of benefits in accordance with the elements required by §133.500 and §133.501 of this title (relating to Electronic Formats for Electronic Medical Bill Processing and Electronic Medical Bill Processing, respectively) if the insurance carrier submits the explanation of benefits in the form of an electronic remittance. The insurance carrier shall send an explanation of benefits in accordance with subsection (f) of this section if the insurance carrier submits the explanation of benefits in paper form. The explanation of benefits shall be sent to:

(1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill; and

(2) the injured employee when payment is denied because:

(A) of an adverse determination;

(B) the health care was provided by a health care provider other than:

(i) the treating doctor selected in accordance with Labor Code §408.022;

(ii) a health care provider that the treating doctor has chosen as a consulting or referral health care provider;

(iii) a doctor performing a required medical examination in accordance with §126.5 of this title (relating to Entitlement and Procedure for Requesting Required Medical Examinations) and §126.6 of this title (relating to Required Medical Examination);

(iv) a doctor performing a designated doctor examination in accordance with Labor Code §408.0041; or

(C) the health care was unrelated to the compensable injury, in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements).

(3) the prescribing doctor, if different from the health care provider identified in paragraph (1) of this subsection, when payment is denied for pharmaceutical services because of any reason relating to the compensability of, liability for, extent of, or

relatedness to the compensable injury, or for reasons relating to the reasonableness or medical necessity of the pharmaceutical services.

(f) The paper form of an explanation of benefits under subsection (e) of this section, §133.250 of this title (relating to Reconsideration for Payment of Medical Bills), or §133.260 of this title (relating to Refunds) shall include the following elements:

(1) division claim number, if known;

(2) insurance carrier claim number;

(3) injured employee's name;

(4) last four digits of injured employee's social security number;

(5) date of injury;

(6) health care provider's name and address;

(7) health care provider's federal tax ID or national provider identifier if the health care provider's federal tax ID is the same as the health care provider's social security number;

(8) patient control number if included on the submitted medical bill;

(9) insurance carrier's name and address;

(10) insurance carrier control number;

(11) date of bill review/refund request;

(12) diagnosis code(s);

(13) name and address of company performing bill review;

(14) name and telephone number of bill review contact;

(15) workers' compensation health care network name (if applicable);

(16) pharmacy, durable medical equipment, or home health care services informal or voluntary network name (if applicable) pursuant to Labor Code §408.0281 and §408.0284;

(17) health care service information for each billed health care service, to include:

(A) date of service;

(B) the CPT, HCPCS, NDC, or other applicable product or service code;

(C) CPT, HCPCS, NDC, or other applicable product or service code description;

(D) amount charged;

(E) unit(s) of service;

(F) amount paid;

(G) adjustment reason code that conforms to the standards described in §133.500 and §133.501 of this title if total amount paid does not equal total amount charged;

(H) explanation of the reason for reduction/denial if the adjustment reason code was included under subparagraph (G) of this paragraph and if applicable;

(18) a statement that contains the following text: "Health care providers shall not bill any unpaid amounts to the injured employee or the employer, or make any attempt to collect the unpaid amount from the injured employee or the employer unless the injury is finally adjudicated not to be compensable, or the insurance carrier is relieved of the

liability under Labor Code §408.024. However, pursuant to §133.250 of this title, the health care provider may file an appeal with the insurance carrier if the health care provider disagrees with the insurance carrier's determination";
(19) if the insurance carrier is requesting a refund, the refund amount being requested and an explanation of why the refund is being requested; and
(20) if the insurance carrier is paying interest in accordance with §134.130 of this title (relating to Interest for Late Payment on Medical Bills and Refunds), the interest amount paid through use of an unspecified product or service code and the number of days on which interest was calculated by using a unit per day.

(g) When the insurance carrier pays a health care provider for health care for which the division has not established a maximum allowable reimbursement, the insurance carrier shall explain and document the method it used to calculate the payment in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline).

(h) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §124.2 and §124.3 of this title (relating to Investigation of an Injury and Notice of Denial/Dispute) if the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that:
(1) the injury is not compensable;
(2) the insurance carrier is not liable for the injury due to lack of insurance coverage; or
(3) the condition for which the health care was provided was not related to the compensable injury.

(i) If dissatisfied with the insurance carrier's final action, the health care provider may request reconsideration of the bill in accordance with §133.250 of this title.

(j) If the health care provider is requesting reconsideration of an adverse determination, the request for reconsideration constitutes an appeal for the purposes of §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determinations). If dissatisfied with the reconsideration outcome, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).

(k) Health care providers, injured employees, employers, attorneys, and other participants in the system shall not resubmit medical bills to insurance carriers after the insurance carrier has taken final action on a complete medical bill and provide an explanation of benefits except as provided in §133.250 and Chapter 133, Subchapter D

of this title.

(l) All payments of medical bills that an insurance carrier makes on or after the 60th day after the date the insurance carrier originally received the complete medical bill shall include interest calculated in accordance with §134.130 of this title without any action taken by the division. The interest payment shall be paid at the same time as the medical bill payment.

(m) Except as provided by Insurance Code §1305.153, when an insurance carrier remits payment to a health care provider agent, the agent shall remit to the health care provider the full amount that the insurance carrier reimburses. If the insurance carrier remits payment under Insurance Code §1305.153, then the payment must be made in accordance with that section.

(n) When an insurance carrier remits payment to a pharmacy processing agent, the pharmacy processing agent's reimbursement from the insurance carrier shall be made in accordance with §134.503 of this title. The pharmacy's reimbursement shall be made in accordance with the terms of its contract with the pharmacy processing agent.

(o) An insurance carrier commits an administrative violation if the insurance carrier fails to pay, reduce, deny, or notify the health care provider of the intent to audit a medical bill in accordance with Labor Code §408.027 and division rules.

(p) For the purposes of this section, all utilization review must be performed by an insurance carrier that is registered with or a utilization review agent that is certified by the Texas Department of Insurance to perform utilization review in accordance with Insurance Code Chapter 4201 and Chapter 19 of this title.

(1) All utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Insurance Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in the course and scope of employment.

(2) An insurance carrier must accelerate and give priority to a claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury, under the following conditions:

(A) In accordance with Labor Code §501.028(b), the claim is by a member of the Texas military forces who, while on state active duty, sustains a serious bodily injury, as defined by Penal Code §1.07.

(B) In accordance with Labor Code §504.057(c), the claim is by a death investigation professional who sustains a serious bodily injury, as defined by Penal Code §1.07, in the course and scope of employment.

(q) When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title (relating to Notice of Determinations Made in Utilization Review). Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 if this title (relating to Requirements Prior to Issuing Adverse Determination), including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively.

Source Note: The provisions of this §133.240 adopted to be effective May 2, 2006, 31 TexReg 3544; amended to be effective July 1, 2012, 37 TexReg 2408; amended to be effective March 30, 2014, 39 TexReg 2095; amended to be effective December 28, 2023, 48 TexReg 7999; amended to be effective January 29, 2026, 51 TexReg 409.

RULE §133.250 Reconsideration for Payment of Medical Bills

(a) If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill, the health care provider may request that the insurance carrier reconsider its action. If the health care provider is requesting reconsideration of a bill denied based on an adverse determination, the request for reconsideration constitutes an appeal for the purposes of §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determinations) and may be submitted orally or in writing.

(b) The health care provider shall submit the request for reconsideration no later than 10 months from the date of service.

(c) A health care provider shall not submit a request for reconsideration until:
(1) the insurance carrier has taken final action on a medical bill; or
(2) the health care provider has not received an explanation of benefits within 50 days from submitting the medical bill to the insurance carrier.

(d) A written request for reconsideration shall:
(1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill;

(2) include a copy of the original explanation of benefits, if received, or documentation that a request for an explanation of benefits was submitted to the insurance carrier;
(3) include any necessary and related documentation not submitted with the original medical bill to support the health care provider's position; and
(4) include a bill-specific, substantive explanation in accordance with §133.3 of this title (relating to Communication Between Health Care Providers and Insurance Carriers) that provides a rational basis to modify the previous denial or payment.

(e) An oral request for reconsideration must clearly identify the health care services(s) denied based on an adverse determination and include a substantive explanation in accordance with §133.3 of this title that provides a rational basis to modify the previous denial or payment. Not later than the fifth working day after the date of receipt of the request for reconsideration, the insurance carrier must send to the requesting party a letter acknowledging the date of the receipt of the oral request that includes a reasonable list of documents the requesting party is required to submit. This subsection applies to reconsideration requests made on or after six months from the effective date of this rule.

(f) An insurance carrier shall review all written reconsideration requests for completeness in accordance with subsection (d) of this section and may return an incomplete written reconsideration request no later than seven days from the date of receipt. A health care provider may complete and resubmit its written request to the insurance carrier.

(g) The insurance carrier shall take final action on a reconsideration request within 30 days of receiving the request for reconsideration. The insurance carrier shall provide an explanation of benefits:
(1) in accordance with §133.240(e) - (f) of this title (relating to Medical Payments and Denial) for all items included in a reconsideration request in the form and format prescribed by the division when there is a change in the original, final action; or
(2) in accordance with §133.240(e)(1) and §133.240(f) of this title when there is no change in the original, final action.

(h) A health care provider shall not resubmit a request for reconsideration earlier than 35 days from the date the insurance carrier received the original request for reconsideration or after the insurance carrier has taken final action on the reconsideration request.

(i) If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title

(relating to Dispute of Medical Bills).

(j) For the purposes of this section, all utilization review must be performed by an insurance carrier that is registered with, or a utilization review agent that is certified by, the Texas Department of Insurance to perform utilization review in accordance with Insurance Code Chapter 4201 and Chapter 19 of this title.

(1) All utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Insurance Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in the course and scope of employment.

(2) An insurance carrier must accelerate and give priority to a claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury, under the following conditions:

(A) In accordance with Labor Code §501.028(b), the claim is by a member of the Texas military forces who, while on state active duty, sustains a serious bodily injury, as defined by Penal Code §1.07.

(B) In accordance with Labor Code §504.057(c), the claim is by a death investigation professional who sustains a serious bodily injury, as defined by Penal Code §1.07, in the course and scope of employment.

(k) In any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title (relating to Requirements Prior to Adverse Determination) and §19.2011 of this title, including the requirement that prior to issuance of an adverse determination on the request for reconsideration the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively.

Source Note: The provisions of this §133.250 adopted to be effective May 2, 2006, 31 TexReg 3544; amended to be effective July 1, 2012, 37 TexReg 2408; amended to be effective March 30, 2014, 39 TexReg 2095; amended to be effective December 28, 2023, 48 TexReg 7999; amended to be effective January 29, 2026, 51 TexReg 409.

RULE §133.260 Refunds

(a) An insurance carrier shall request a refund within 240 days from the date of service or 30 days from completion of an audit performed in accordance with §133.230 (relating

to Insurance Carrier Audit of a Medical Bill), whichever is later, when it determines that inappropriate health care was previously reimbursed, or when an overpayment was made for health care provided.

(b) The insurance carrier shall submit the refund request to the health care provider in an explanation of benefits in the form and manner prescribed by the Division.

(c) A health care provider shall respond to a request for a refund from an insurance carrier by the 45th day after receipt of the request by:
(1) paying the requested amount; or
(2) submitting an appeal to the insurance carrier with a specific explanation of the reason the health care provider has failed to remit payment.

(d) The insurance carrier shall act on a health care provider's appeal within 45 days after the date on which the health care provider filed the appeal. The insurance carrier shall provide the health care provider with notice of its determination, either agreeing that no refund is due, or denying the appeal.

(e) If the insurance carrier denies the appeal, the health provider:
(1) shall remit the refund with any applicable interest within 45 days of receipt of notice of denied appeal; and
(2) may request medical dispute resolution in accordance with §133.305 of this chapter (relating to Medical Dispute Resolution - General).

(f) The health care provider shall submit a refund to the insurance carrier when the health care provider identifies an overpayment even though the insurance carrier has not submitted a refund request.

(g) When making a refund payment, the health care provider shall include: a copy of the insurance carrier's original request for refund, if any; a copy of the original explanation of benefits containing the overpayment, if available; and a detailed explanation itemizing the refund. The explanation shall:
(1) identify the billing and rendering health care provider;
(2) identify the injured employee;
(3) identify the insurance carrier;
(4) specify the total dollar amount being refunded;
(5) itemize the refund by dollar amount, line item and date of service; and
(6) specify the amount of interest paid, if any, and the number of days on which interest was calculated.

(h) All refunds requested by the insurance carrier and paid by a health care provider on or after the 60th day after the date the health care provider received the request for the refund shall include interest calculated in accordance with §134.130 of this title (relating to Interest for Late Payment on Medical Bills and Refunds).

RULE §133.270 Injured Employee Reimbursement for Health Care Paid

(a) An injured employee may request reimbursement from the insurance carrier when the injured employee has paid for health care provided for a compensable injury, unless the injured employee is liable for payment as specified in:
(1) Insurance Code §1305.451, or
(2) Section 134.504 of this title (relating to Pharmaceutical Expenses Incurred by the Injured Employee).

(b) The injured employee's request for reimbursement shall be legible and shall include documentation or evidence (such as itemized receipts) of the amount the injured employee paid the health care provider.

(c) The insurance carrier shall pay or deny the request for reimbursement within 45 days of the request. Reimbursement shall be made in accordance with §134.1 of this title (relating to Medical Reimbursement).

(d) The injured employee may seek reimbursement for any payment made above the division fee guideline or contract amount from the health care provider who received the overpayment.

(e) Within 45 days of a request, the health care provider shall reimburse the injured employee the amount paid above the applicable division fee guideline or contract amount.

(f) The injured employee may request, but is not required to request, reconsideration prior to requesting medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).

(g) The insurance carrier shall submit injured employee medical billing and payment data to the division in accordance with Chapter 134, Subchapter I of this title (relating to Medical Bill Reporting).

(h) This section is effective July 1, 2012.

Source Note: The provisions of this §133.270 adopted to be effective May 2, 2006, 31 TexReg 3544; amended to be effective July 1, 2012, 37 TexReg 2408

RULE §133.280 Employer Reimbursement for Health Care Paid

(a) An employer may request reimbursement from the insurance carrier when the employer has paid for health care provided for a compensable injury, and provided notice of injury in compliance with Labor Code §409.005.

(b) The employer shall be reimbursed in accordance with §134.1.

(c) The employer may seek reimbursement for any payment made above the Division fee guideline or contract amount from the health care provider who received the overpayment.

(d) The employer's request for reimbursement shall be legible and shall include:
(1) a copy of the health care provider's required billing form;
(2) any supporting documentation submitted by the health care provider as required in §133.210 of this chapter (relating to Medical Documentation); and
(3) documentation of the payment to the health care provider.

(e) The insurance carrier shall submit employer medical bill and payment data to the Division in accordance with §134.802 of this title (relating to Insurance Carrier Medical Electronic Data Interchange to the Division).

Source Note: The provisions of this §133.280 adopted to be effective May 2, 2006, 31 TexReg 3544

SUBCHAPTER D DISPUTE OF MEDICAL BILLS

RULE §133.305 MD--General

(a) Definitions. The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise.
(1) First responder--As defined in Labor Code §504.055(a). (2) Life-threatening--A disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted, as defined in Insurance Code §4201.002.
(2) Life-threatening--A disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted, as defined in Insurance Code §4201.002.

(3) Medical dispute resolution (MDR)--A process for resolution of one or more of the following disputes:

(A) a medical fee dispute; or

(B) a medical necessity dispute, which may be:

(i) a preauthorization or concurrent medical necessity dispute; or

(ii) a retrospective medical necessity dispute.

(4) Medical fee dispute--A dispute that involves an amount of payment for nonnetwork health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that injured employee's compensable injury. The dispute is resolved by the division pursuant to division rules, including §133.307 of this title (relating to MDR of Fee Disputes). The following types of disputes can be a medical fee dispute:

(A) a health care provider, or a qualified pharmacy processing agent as described in Labor Code §413.0111, dispute of an insurance carrier reduction or denial of a medical bill;

(B) an injured employee dispute of reduction or denial of a refund request for health care charges paid by the injured employee; and

(C) a health care provider dispute regarding the results of a division or insurance carrier audit or review which requires the health care provider to refund an amount for health care services previously paid by the insurance carrier.

(5) Network health care--Health care delivered or arranged by a certified workers' compensation health care network, including authorized out-of-network care, as defined in Insurance Code Chapter 1305 and related rules.

(6) Non-network health care--Health care not delivered or arranged by a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 and related rules. "Non-network health care" includes health care delivered pursuant to Labor Code §408.0281 and §408.0284.

(7) Preauthorization or concurrent medical necessity dispute--A dispute that involves a review of adverse determination of network or non-network health care requiring preauthorization or concurrent utilization review. The dispute is reviewed by an independent review organization (IRO) pursuant to the Insurance Code, the Labor Code and related rules, including §133.308 of this title (relating to MDR of Medical Necessity Disputes).

(8) Requestor--The party that timely files a request for medical dispute resolution with the division; the party seeking relief in medical dispute resolution.

(9) Respondent--The party against whom relief is sought.

(10) Retrospective medical necessity dispute--A dispute that involves a review of the medical necessity of health care already provided. The dispute is reviewed by an IRO pursuant to the Insurance Code, Labor Code and related rules, including §133.308 of this title.

(11) Serious bodily injury--As defined by §1.07, Penal Code.
(12) State active duty--As defined by §437.001, Government Code.
(13) State training and other duty--As defined by §437.001, Government Code.
(14) Texas military forces--As defined by §437.001, Government Code.
(15) Death investigation professional--As defined by §504.057, Labor Code.z

(b) Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability, or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and §408.021.

(c) Division Administrative Fee. The division may assess a fee, as published on the division's website, in accordance with Labor Code §413.020 when resolving disputes pursuant to §133.307 and §133.308 of this title if the decision indicates the following:
(1) the health care provider billed an amount in conflict with division rules, including billing rules, fee guidelines or treatment guidelines;
(2) the insurance carrier denied or reduced payment in conflict with division rules, including reimbursement or audit rules, fee guidelines or treatment guidelines;
(3) the insurance carrier has reduced the payment based on a contracted discount rate with the health care provider but has not made the contract or the health care provider notice required under Labor Code §408.0281 available upon the division's request;
(4) the insurance carrier has reduced or denied payment based on a contract that indicates the direction or management of health care through a health care provider arrangement that has not been certified as a workers' compensation network, in accordance with Insurance Code Chapter 1305 or through a health care provider arrangement authorized under Labor Code §504.053(b)(2); or
(5) the insurance carrier or healthcare provider did not comply with a provision of the Insurance Code, Labor Code or related rules.

(d) Confidentiality. Any documentation exchanged by the parties during MDR that contains information regarding a patient other than the injured employee for that claim must be redacted by the party submitting the documentation to remove any information that identifies that patient.

(e) Severability. If a court of competent jurisdiction holds that any provision of §§133.305, 133.307, or 133.308 of this title is inconsistent with any statutes of this state, unconstitutional, or invalid for any reason, the remaining provisions of these sections remain in full effect.

(f) Texas Military Forces. For a claim under Labor Code §501.028, the travel of a member of the Texas military forces to or from the member's duty location is considered to be in the course and scope of the member's employment if the member is:
(1) serving on state active duty and engaged in authorized duty under written orders; or
(2) on state training and other duty.

Source Note: The provisions of this §133.305 adopted to be effective December 31, 2006, 31 TexReg 10314; amended to be effective May 25, 2008, 33 TexReg 3954; amended to be effective July 1, 2012, 37 TexReg 2408; amended to be effective March 30, 2014, 39 TexReg 2095; amended to be effective December 28, 2023, 48 TexReg 7999; amended to be effective January 29, 2026, 51 TexReg 409.

RULE §133.306 Interlocutory Orders for Medical Benefits

(a) The Commissioner of Workers' Compensation may delegate the authority to issue interlocutory orders for accrued and/or future medical benefits to division staff.
(b) The division may enter an interlocutory order for accrued or future medical benefits when:
(1) the division determines that an insurance carrier has disputed medical benefits as the result of a liability, compensability, or extent of injury dispute that an insurance carrier has raised in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements), and the division determines that those medical benefits are or were medically necessary and constitute health care reasonably required and are not subject to the medical dispute resolution process set forth in Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills);
(2) at the conclusion of the medical dispute resolution process:
(A) the division determines that an insurance carrier has disputed medical benefits as the result of a liability, compensability, or extent of injury dispute that an insurance carrier has raised in accordance with §124.2 of this title, and the division deems that the disputed medical benefits are or were medically necessary and constitute health care reasonably required; or
(B) the division determines that future medical benefits for which preauthorization is required are medically necessary and constitute health care reasonably required; or
(3) an insurance carrier makes an adverse determination for drugs prescribed on or after September 1, 2011 and excluded from the division's closed formulary as set forth in §§134.510, 134.530, 134.540, and 134.550 of this title (relating to Requirements for the Transition to the Use of the Closed Formulary for Claims with Dates of Injury Prior to September 1, 2011, Requirements for Use of the Closed Formulary for Claims Not Subject to Certified Networks, Requirements for Use of the Closed Formulary for Claims

Subject to Certified Networks, and Medical Interlocutory Order respectively) and the division determines that those medical benefits are or were medically necessary and constitute health care reasonably required.

(c) Absent the interlocutory order as set forth in subsections (a) and (b) of this section, the division shall enter an interlocutory order only when the injured employee would not receive medical benefits that are medically necessary and constitute health care reasonably required.
(d) A party shall comply with an interlocutory order entered in accordance with this section on the earlier of the seventh day after receipt of the order or the date the division establishes in the body of the order.

(e) The insurance carrier may dispute an interlocutory order entered under this title by filing a written request for a hearing in accordance with Labor Code §413.055 and §148.3 of this title (relating to Requesting a Hearing).

(f) An insurance carrier that makes an overpayment pursuant to an interlocutory order may be eligible for reimbursement from the Subsequent Injury Fund. An insurance carrier must make a request for reimbursement in accordance with §116.11 of this title (relating to Request for Reimbursement from the Subsequent Injury Fund).

Source Note: The provisions of this §133.306 adopted to be effective July 15, 2000, 25 TexReg 2115; amended to be effective September 1, 2011, 35 TexReg 11340

RULE §133.307 Medical Fee Dispute Resolution

(a) Applicability. This section applies to a request to the division for medical fee dispute resolution (MFDR) as authorized by the Texas Workers' Compensation Act.
(1) Dispute resolution requests must be resolved in accordance with the statutes and rules in effect at the time the request was filed.
(2) In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.
(3) In accordance with Labor Code §504.055 a request for medical fee dispute resolution that involves a first responder's request for reimbursement of medical expenses paid by the first responder will be accelerated by the division and given priority. The first responder shall provide notice to the division that the request involves a first responder.

(4) The 2020 amendments regarding electronic submission of dispute requests are effective February 22, 2021.

(b) Requestors. The following parties may be requestors in medical fee disputes:
(1) the health care provider, or a qualified pharmacy processing agent, as described in Labor Code §413.0111, in a dispute over the reimbursement of a medical bill(s);
(2) the health care provider in a dispute about the results of a division or insurance carrier audit or review which requires the health care provider to refund an amount for health care services previously paid by the insurance carrier;
(3) the injured employee in a dispute involving an injured employee's request for reimbursement from the insurance carrier of medical expenses paid by the injured employee;
(4) the injured employee when requesting a refund of the amount the injured employee paid to the health care provider in excess of a division fee guideline; or
(5) a subclaimant in accordance with §140.6 of this title (relating to Subclaimant Status: Establishment, Rights, and Procedures), §140.7 of this title (relating to Health Care Insurer Reimbursement under Labor Code §409.0091), or §140.8 of this title (relating to Procedures for Health Care Insurers to Pursue Reimbursement of Medical Benefits under Labor Code §409.0091), as applicable.

(c) Requests. Requests for MFDR must be legible and filed in the form and manner prescribed by the division.
(1) Timeliness. A requestor must timely file the request with the division or waive the right to MFDR. The division will deem a request to be filed on the date the division receives the request. A decision by the division that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
(A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.
(B) A request may be filed later than one year after the date(s) of service if:
(i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;
(ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the insurance carrier previously denied payment based on medical necessity; or

(iii) the dispute relates to a refund notice issued pursuant to a division audit or review, the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice.

(2) Health Care Provider or Pharmacy Processing Agent Request. The requestor must send the request to the division in the form and manner prescribed by the division by any mail service, personal delivery, or electronic transmission as described in §102.5 of this title. The request must include:

(A) the name, address, and contact information of the requestor;

(B) the name of the injured employee;

(C) the date of the injury;

(D) the date(s) of the service(s) in dispute;

(E) the place of service;

(F) the treatment or service code(s) in dispute;

(G) the amount billed by the health care provider for the treatment(s) or service(s) in dispute;

(H) the amount paid by the workers' compensation insurance carrier for the treatment(s) or service(s) in dispute;

(I) the disputed amount for each treatment or service in dispute;

(J) a copy of all medical bills related to the dispute, as described in §133.10 of this chapter (concerning Required Billing Forms/Formats) or §133.500 (concerning Electronic Formats for Electronic Medical Bill Processing) as originally submitted to the insurance carrier in accordance with this chapter, and a copy of all medical bills submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (concerning Reconsideration for Payment of Medical Bills);

(K) each explanation of benefits or e-remittance (collectively "EOB") related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB;

(L) when applicable, a copy of the final decision regarding compensability, extent of injury, liability and/or medical necessity for the health care related to the dispute;

(M) a copy of all applicable medical records related to the dates of service in dispute;

(N) a position statement of the disputed issue(s) that shall include:

(i) the requestor's reasoning for why the disputed fees should be paid or refunded,

(ii) how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and

(iii) how the submitted documentation supports the requestor's position for each disputed fee issue;

(O) documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating

to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable;

(P) if the requestor is a pharmacy processing agent, a signed and dated copy of an agreement between the processing agent and the pharmacy clearly demonstrating the dates of service covered by the contract and a clear assignment of the pharmacy's right to participate in the MFDR process. The pharmacy processing agent may redact any proprietary information contained within the agreement; and

(Q) any other documentation that the requestor deems applicable to the medical fee dispute.

(3) Subclaimant Dispute Request.

(A) A request made by a subclaimant under Labor Code §409.009 (relating to Subclaims) must comply with §140.6 of this title (concerning Subclaimant Status: Establishment, Rights, and Procedures) and submit the required documents to the division.

(B) A request made by a subclaimant under Labor Code §409.0091 (relating to Reimbursement Procedures for Certain Entities) must comply with the document requirements of §140.8 of this title (concerning Procedures for Health Care Insurers to Pursue Reimbursement of Medical Benefits under Labor Code §409.0091) and submit the required documents to the division.

(4) Injured Employee Dispute Request. An injured employee who has paid for health care may request MFDR of a refund or reimbursement request that has been denied. The injured employee must send the request to the division in the form and manner prescribed by the division by mail service, personal delivery, or electronic transmission as described in §102.5 of this title and must include:

(A) the name, address, and contact information of the injured employee;

(B) the date of the injury;

(C) the date(s) of the service(s) in dispute;

(D) a description of the services paid;

(E) the amount paid by the injured employee;

(F) the amount of the medical fee in dispute;

(G) an explanation of why the disputed amount should be refunded or reimbursed, and how the submitted documentation supports the explanation for each disputed amount;

(H) proof of employee payment (including copies of receipts, health care provider billing statements, or similar documents); and

(I) a copy of the insurance carrier's or health care provider's denial of reimbursement or refund relevant to the dispute, or if no denial was received, convincing evidence of the injured employee's attempt to obtain reimbursement or refund from the insurance carrier or health care provider.

(5) Division Response to Request. The division will forward a copy of the request and the documentation submitted in accordance with paragraph (2), (3), or (4) of this subsection to the respondent. The respondent shall be deemed to have received the request on the acknowledgment date as defined in §102.5 of this title (relating to General Rules for Written Communications to and from the Commission).

(d) Responses. Responses to a request for MFDR must be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.

(1) Timeliness. The response will be deemed timely if received by the division through mail service, personal delivery, or electronic transmission, as described in §102.5 of this title, within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

(2) Response. On receipt of the request, the respondent must provide any missing information not provided by the requestor and known to the respondent. The respondent must also provide the following information and records:

(A) the name, address, and contact information of the respondent;

(B) all initial and appeal EOBs related to the dispute as originally submitted to the health care provider in accordance with this chapter, related to the health care in dispute not submitted by the requester, or a statement certifying that the respondent did not receive the health care provider's disputed billing before the dispute request;

(C) all medical bill(s) related to the dispute, submitted in accordance with this chapter if different from that originally submitted to the insurance carrier for reimbursement;

(D) any pertinent medical records or other documents relevant to the fee dispute not already provided by the requestor;

(E) a statement of the disputed fee issue(s), which includes:

(i) a description of the health care in dispute;

(ii) a position statement of reasons why the disputed medical fees should not be paid;

(iii) a discussion of how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues;

(iv) a discussion regarding how the submitted documentation supports the respondent's position for each disputed fee issues;

(v) documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable reimbursement in accordance with Labor Code §413.011 and §134.1 or §134.503 of this title if the dispute involves health care for which the division has not established a MAR or reimbursement rate, as applicable.

(F) The responses shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party.

Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section.

(G) If the respondent did not receive the health care provider's disputed billing or the employee's reimbursement request relevant to the dispute prior to the request, the respondent shall include that information in a written statement.

(H) If the medical fee dispute involves compensability, extent of injury, or liability, the insurance carrier must attach any related Plain Language Notice in accordance with §124.2 of this title (concerning Insurance Carrier Reporting and Notification Requirements).

(I) If the medical fee dispute involves medical necessity issues, the insurance carrier must attach documentation that supports an adverse determination in accordance with §19.2005 of this title (concerning General Standards of Utilization Review).

(e) Withdrawal. The requestor may withdraw its request for MFDR by notifying the division prior to a decision.

(f) MFDR Action. The division will review the completed request and response to determine appropriate MFDR action.

(1) Request for Additional Information. The division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the division no later than 14 days after receipt of this request. If the division does not receive the requested additional information within 14 days after receipt of the request, then the division may base its decision on the information available. The party providing the additional information shall forward a copy of the additional information to all other parties at the time it is submitted to the division.

(2) Issues Raised by the Division. The division may raise issues in the MFDR process when it determines such an action to be appropriate to administer the dispute process consistent with the provisions of the Labor Code and division rules.

(3) Dismissal. A dismissal is not a final decision by the division. The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of this section. The division may dismiss a request for MFDR if:

(A) the division determines that the medical bills in the dispute have not been submitted to the insurance carrier for an appeal, when required;

(B) the request contains an unresolved adverse determination of medical necessity;

(C) the request contains an unresolved compensability, extent of injury, or liability dispute for the claim; or

(D) the division determines that good cause exists to dismiss the request, including a party's failure to comply with the provisions of this section.

(4) Decision. The division shall send a decision to the disputing parties or to representatives of record for the parties, if any, and post the decision on the department's website.

(5) Division Fee. The division may assess a fee in accordance with §133.305 of this subchapter (relating to MDR--General).

(g) Appeal of MFDR Decision. A party to a medical fee dispute may seek review of the decision. Parties are deemed to have received the MFDR decision as provided in §102.5 of this title. The MFDR decision is final if the request for the benefit review conference is not timely made. If a party provides the benefit review officer or administrative law judge with documentation listed in subsection (d)(2)(H) or (I) of this section that shows unresolved issues regarding compensability, extent of injury, liability, or medical necessity for the same service subject to the fee dispute, then the benefit review officer or administrative law judge shall abate the proceedings until those issues have been resolved.

(1) A party seeking review of an MFDR decision must request a benefit review conference no later than 20 days from the date the MFDR decision is received by the party. The party that requests a review of the MFDR decision must mediate the dispute in the manner required by Labor Code, Chapter 410, Subchapter B and request a benefit review conference under Chapter 141 of this title (relating to Dispute Resolution--Benefit Review Conference). A party may appear at a benefit review conference via telephone. The benefit review conference will be conducted in accordance with Chapter 141 of this title.

(A) Notwithstanding §141.1(b) of this title (relating to Requesting and Setting a Benefit Review Conference), a seeking review of an MFDR decision may request a benefit review conference.

(B) At a benefit review conference, the parties to the dispute may not resolve the dispute by negotiating fees that are inconsistent with any applicable fee guidelines adopted by the commissioner.

(C) A party must file the request for a benefit review conference in accordance with Chapter 141 of this title and must include in the request a copy of the MFDR decision. Providing a copy of the MFDR decision satisfies the documentation requirements in §141.1(d) of this title. A first responder's request for a benefit review conference must be accelerated by the division and given priority in accordance with Labor Code §504.055. The first responder must provide notice to the division that the contested case involves a first responder.

(2) If the medical fee dispute remains unresolved after a benefit review conference, the parties may request arbitration as provided in Labor Code, Chapter 410, Subchapter C and Chapter 144 of this title (relating to Dispute Resolution). If arbitration is not elected, the party may appeal the MFDR decision by requesting a contested case hearing before

the State Office of Administrative Hearings. A first responder's request for arbitration by the division or a contested case hearing before the State Office of Administrative Hearings must be accelerated by the division and given priority in accordance with Labor Code §504.055. The first responder must provide notice to the division that the contested case involves a first responder.

(A) To request a contested case hearing before State Office of Administrative Hearings, a party shall file a written request for a State Office of Administrative Hearings hearing with the Division's Chief Clerk of Proceedings not later than 20 days after conclusion of the benefit review conference in accordance with §148.3 of this title (relating to Requesting a Hearing).

(B) The party seeking review of the MFDR decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute at the same time the request for hearing is filed with the division.

(3) A party to a medical fee dispute who has exhausted all administrative remedies may seek judicial review of the decision of the Administrative Law Judge at the State Office of Administrative Hearings. The division and the department are not considered to be parties to the medical dispute pursuant to Labor Code §413.031(k-2) and §413.0312(f). Judicial review under this paragraph shall be conducted in the manner provided for judicial review of contested cases under Chapter 2001, Subchapter G Government Code, except that in the case of a medical fee dispute the party seeking judicial review must file suit not later than the 45th day after the date on which the State Office of Administrative Hearings mailed the party the notification of the decision. The mailing date is considered to be the fifth day after the date the decision was issued by the State Office of Administrative Hearings. A party seeking judicial review of the decision of the administrative law judge shall at the time the petition for judicial review is filed with the district court file a copy of the petition with the division's chief clerk of proceedings.

(h) Billing of the non-prevailing party. Except as otherwise provided by Labor Code §413.0312, the non-prevailing party shall reimburse the division for the costs for services provided by the State Office of Administrative Hearings and any interest required by law.

(1) The non-prevailing party shall remit payment to the division not later than the 30th day after the date of receiving a bill or statement from the division.

(2) In the event of a dismissal, the party requesting the hearing, other than the injured employee, shall reimburse the division for the costs for services provided by the State Office of Administrative Hearings unless otherwise agreed by the parties.

(3) If the injured employee is the non-prevailing party, the insurance carrier shall reimburse the division for the costs for services provided by the State Office of Administrative Hearings.

Source Note: The provisions of this §133.307 adopted to be effective December 31, 2006, 31 TexReg 10314; amended to be effective May 25, 2008, 33 TexReg 3954; amended to be effective May 31, 2012, 37 TexReg 3833; amended to be effective February 22, 2021, 46 TexReg 826

RULE §133.308 MDR of Medical Necessity Disputes

(a) Applicability. The applicability of this section is as follows.
(1) This section applies to the independent review of medical necessity disputes that are filed on or after June 1, 2012. Dispute resolution requests filed prior to June 1, 2012 shall be resolved in accordance with the statutes and rules in effect at the time the request was filed.
(2) When applicable, retrospective medical necessity disputes shall be governed by the provisions of Labor Code §413.031(n) and related rules.
(3) All independent review organizations (IROs) performing reviews of health care under the Labor Code and Insurance Code, regardless of where the independent review activities are located, shall comply with this section. The Insurance Code, the Labor Code and related rules govern the independent review process.

(b) IRO Certification. Each IRO performing independent review of health care provided in the workers' compensation system shall be certified pursuant to Insurance Code Chapter 4202 and Chapter 12 of this title (relating to Independent Review Organizations).

(c) Professional licensing requirements. Notwithstanding Insurance Code Chapter 4202, an IRO that uses doctors to perform reviews of health care services provided under this section may only use doctors licensed to practice in Texas that hold the appropriate credentials under Chapter 180 of this title (relating to Monitoring and Enforcement). Personnel employed by or under contract with the IRO to perform independent review shall also comply with the personnel and credentialing requirements under Chapter 12 of this title.

(d) Conflicts. Conflicts of interest will be reviewed by the department consistent with the provisions of the Insurance Code §4202.008, Labor Code §413.032(b), §§12.203, 12.204, and 12.206 of this title (relating to Conflicts of Interest Prohibited, Prohibitions of Certain Activities and Relationships of Independent Review Organizations and Individuals or Entities Associated with Independent Review Organizations, and Notice of Determinations Made by Independent Review Organizations, respectively), and any other related rules. Notification of each IRO decision must include a certification by the IRO that the reviewing health care provider has certified that no known conflicts of

interest exist between that health care provider and the injured employee, the injured employee's employer, the insurance carrier, the utilization review agent, any of the treating health care providers, or any of the health care providers utilized by the insurance carrier to review the case for determination prior to referral to the IRO.

(e) Monitoring. The division will monitor IROs under Labor Code §§413.002, 413.0511, and 413.0512. The division shall report the results of the monitoring of IROs to the department on at least a quarterly basis. The division will make inquiries, conduct audits, receive and investigate complaints, and take all actions permitted by the Labor Code and other applicable law against an IRO or personnel employed by or under contract with an IRO to perform independent review to determine compliance with applicable law, this section, and other applicable division rules.

(f) Requestors. The following parties may be requestors in medical necessity disputes:
(1) In network disputes:
(A) health care providers, or qualified pharmacy processing agents acting on behalf of a pharmacy, as described in Labor Code §413.0111, for preauthorization, concurrent, and retrospective medical necessity dispute resolution;
(B) injured employees or a person acting on behalf of an injured employee for preauthorization, concurrent, and retrospective medical necessity dispute resolution; and
(C) subclaimants in accordance with §§140.6, 140.7, or 140.8 of this title, as applicable.
(2) In non-network disputes:
(A) health care providers, or qualified pharmacy processing agents acting on behalf of a pharmacy, as described in Labor Code §413.0111, for preauthorization, concurrent, and retrospective medical necessity dispute resolution;
(B) injured employees or injured employee's representative for preauthorization and concurrent medical necessity dispute resolution; and, for retrospective medical necessity dispute resolution when reimbursement was denied for health care paid by the injured employee; and
(C) subclaimants in accordance with §140.6 of this title (relating to Subclaimant Status: Establishment, Rights, and Procedures), §140.7 of this title (relating to Health Care Insurer Reimbursement under Labor Code §409.0091), or §140.8 of this title (relating to Procedures for Health Care Insurers to Pursue Reimbursement of Medical Benefits under Labor Code §409.0091), as applicable.

(g) Requests. A request for independent review must be filed in the form and manner prescribed by the department. The department's IRO request form may be obtained from:
(1) the department's website at http://www.tdi.texas.gov/; or

(2) the Managed Care Quality Assurance Office, Mail Code LH-MCQA, Texas Department of Insurance, P.O. Box 12030, Austin, Texas 78711-2030.

(h) Timeliness. A requestor shall file a request for independent review with the insurance carrier that actually issued the adverse determination or the insurance carrier's utilization review agent (URA) that actually issued the adverse determination no later than the 45th calendar day after receipt of the insurance carrier's denial of an appeal. The insurance carrier shall notify the department of a request for an independent review within one working day from the date the request is received by the insurance carrier or its URA. In a preauthorization or concurrent review dispute request, an injured employee with a life-threatening condition, as defined in §133.305 of this subchapter (relating to MDR--General), is entitled to an immediate review by an IRO and is not required to comply with the procedures for an appeal to the insurance carrier.

(i) Dismissal. The department may dismiss a request for medical necessity dispute resolution if:
(1) the requestor informs the department, or the department otherwise determines, that the dispute no longer exists;
(2) the requestor is not a proper party to the dispute pursuant to subsection (f) of this section;
(3) the department determines that the dispute involving a non-life-threatening condition has not been submitted to the insurance carrier for an appeal;
(4) the department has previously resolved the dispute for the date(s) of health care in question;
(5) the request for dispute resolution is untimely pursuant to subsection (h) of this section;
(6) the request for medical necessity dispute resolution was not submitted in compliance with the provisions of this subchapter; or
(7) the department determines that good cause otherwise exists to dismiss the request.

(j) IRO Assignment and Notification. The department shall review the request for IRO review, assign an IRO, and notify the parties about the IRO assignment consistent with the provisions of Insurance Code §4202.002(a)(1), §1305.355(a), Chapter 12, Subchapter F of this title (relating to Random Assignment of Independent Review Organizations), any other related rules, and this subchapter.

(k) Insurance Carrier Document Submission. The insurance carrier or the insurance carrier's URA shall submit the documentation required in paragraphs (1) - (6) of this subsection to the IRO not later than the third working day after the date the insurance carrier or URA receives the notice of IRO assignment. The documentation shall include:

(1) the forms prescribed by the department for requesting IRO review;
(2) all medical records of the injured employee in the possession of the insurance carrier or the URA that are relevant to the review, including any medical records used by the insurance carrier or the URA in making the determinations to be reviewed by the IRO;
(3) all documents, guidelines, policies, protocols and criteria used by the insurance carrier or the URA in making the decision;
(4) all documentation and written information submitted to the insurance carrier in support of the appeal;
(5) the written notification of the initial adverse determination and the written adverse determination of the appeal to the insurance carrier or the insurance carrier's URA; and
(6) any other information required by the department related to a request from an insurance carrier for the assignment of an IRO.

(l) Additional Information. The IRO shall request additional necessary information from either party or from other health care providers whose records are relevant to the review.
(1) The party or health care providers with relevant records shall deliver the requested information to the IRO as directed by the IRO. If the health care provider requested to submit records is not a party to the dispute, the insurance carrier shall reimburse copy expenses for the requested records pursuant to §134.120 of this title (relating to Reimbursement for Medical Documentation). Parties to the dispute may not be reimbursed for copies of records sent to the IRO.
(2) If the required documentation has not been received as requested by the IRO, the IRO shall notify the department and the department shall request the necessary documentation.
(3) Failure to provide the requested documentation as directed by the IRO or department may result in enforcement action as authorized by statutes and rules.

(m) Designated Doctor Exam. In performing a review of medical necessity, an IRO may request that the division require an examination by a designated doctor and direct the injured employee to attend the examination pursuant to Labor Code §413.031(g) and §408.0041. The IRO request to the division must be made no later than 10 days after the IRO receives notification of assignment of the IRO. The treating doctor and insurance carrier shall forward a copy of all medical records, diagnostic reports, films, and other medical documents to the designated doctor appointed by the division, to arrive no later than three working days prior to the scheduled examination. Communication with the designated doctor is prohibited regarding issues not related to the medical necessity dispute. The designated doctor shall complete a report and file it with the IRO, in the form and manner prescribed by the division no later than seven working days

after completing the examination. The designated doctor report shall address all issues as directed by the division.

(n) Time Frame for IRO Decision. The IRO will render a decision as follows:
(1) for life-threatening conditions, no later than eight days after the IRO receipt of the dispute;
(2) for preauthorization and concurrent medical necessity disputes, no later than the 20th day after the IRO receipt of the dispute;
(3) for retrospective medical necessity disputes, no later than the 30th day after the IRO receipt of the IRO fee; and
(4) if a designated doctor examination has been requested by the IRO, the above time frames begin on the date of the IRO receipt of the designated doctor report.

(o) IRO Decision. The decision shall be mailed or otherwise transmitted to the parties and to representatives of record for the parties and transmitted in the form and manner prescribed by the department within the time frames specified in this section.
(1) The IRO decision must include:
(A) a list of all medical records and other documents reviewed by the IRO, including the dates of those documents;
(B) a description and the source of the screening criteria or clinical basis used in making the decision;
(C) an analysis of, and explanation for, the decision, including the findings and conclusions used to support the decision;
(D) a description of the qualifications of each physician or other health care provider who reviewed the decision;
(E) a statement that clearly states whether or not medical necessity exists for each of the health care services in dispute;
(F) a certification by the IRO that the reviewing health care provider has no known conflicts of interest pursuant to the Insurance Code Chapter 4202, Labor Code §413.032, and §12.203 of this title; and
(G) if the IRO's decision is contrary to the division's policies or guidelines adopted under Labor Code §413.011, the IRO must indicate in the decision the specific basis for its divergence in the review of medical necessity of nonnetwork health care.
(2) The notification to the department shall also include certification of the date and means by which the decision was sent to the parties.

(p) Insurance Carrier Use of Peer Review Report after an IRO Decision. If an IRO decision determines that medical necessity exists for health care that the insurance carrier denied and the insurance carrier utilized a peer review report on which to base its denial, the peer review report shall not be used for subsequent medical necessity denials of the

same health care services subsequently reviewed for that compensable injury.

(q) IRO Fees. IRO fees will be paid in the same amounts as the IRO fees set by department rules. In addition to the specialty classifications established as tier two fees in department rules, independent review by a doctor of chiropractic shall be paid the tier two fee. IRO fees shall be paid as follows:

(1) In network disputes, a preauthorization, concurrent, or retrospective medical necessity dispute for health care provided by a network, the insurance carrier must remit payment to the assigned IRO within 15 days after receipt of an invoice from the IRO;

(2) In non-network disputes, IRO fees for disputes regarding non-network health care must be paid as follows:

(A) in a preauthorization or concurrent review medical necessity dispute or retrospective medical necessity dispute resolution when reimbursement was denied for health care paid by the injured employee, the insurance carrier shall remit payment to the assigned IRO within 15 days after receipt of an invoice from the IRO.

(B) in a retrospective medical necessity dispute, the requestor must remit payment to the assigned IRO within 15 days after receipt of an invoice from the IRO.

(i) If the IRO fee has not been received within 15 days of the requestor's receipt of the invoice, the IRO shall notify the department and the department shall dismiss the dispute with prejudice.

(ii) After an IRO decision is rendered, the IRO fee must be paid or refunded by the nonprevailing party as determined by the IRO in its decision.

(3) Designated doctor examinations requested by an IRO shall be paid by the insurance carrier in accordance with the medical fee guidelines under the Labor Code and related rules.

(4) Failure to pay or refund the IRO fee may result in enforcement action as authorized by statute and rules.

(5) For health care not provided by a network, the non-prevailing party to a retrospective medical necessity dispute must pay or refund the IRO fee to the prevailing party upon receipt of the IRO decision, but not later than 15 days regardless of whether an appeal of the IRO decision has been or will be filed.

(6) The IRO fees may include an amended notification of decision if the department determines the notification to be incomplete. The amended notification of decision shall be filed with the department no later than five working days from the IRO's receipt of such notice from the department. The amended notification of decision does not alter the deadlines for appeal.

(7) If a requestor withdraws the request for an IRO decision after the IRO has been assigned by the department but before the IRO sends the case to an IRO reviewer, the requestor shall pay the IRO a withdrawal fee of $150 within 30 days of the withdrawal. If a requestor withdraws the request for an IRO decision after the case is sent to a

reviewer, the requestor shall pay the IRO the full IRO review fee within 30 days of the withdrawal.

(8) In addition to department enforcement action, the division may assess an administrative fee in accordance with Labor Code §413.020 and §133.305 of this subchapter.

(9) This section shall not be deemed to require an employee to pay for any part of a review. If application of a provision of this section would require an employee to pay for part of the cost of a review, that cost shall instead be paid by the insurance carrier.

(r) Defense. 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. Upon receipt of an IRO decision for a retrospective medical necessity dispute that finds that medical necessity exists, the insurance carrier must review, audit, and process the bill. In addition, the insurance carrier shall tender payment consistent with the IRO decision, and issue a new explanation of benefits (EOB) to reflect the payment within 21 days upon receipt of the IRO decision. The decision of an IRO under Labor Code §413.031(m) is binding during the pendency of a dispute.

(s) Appeal of IRO decision. A decision issued by an IRO is not considered an agency decision and neither the department nor the division is considered a party to an appeal. In a division Contested Case Hearing (CCH), the party appealing the IRO decision has the burden of overcoming the decision issued by an IRO by a preponderance of evidence based medical evidence. A party to a medical dispute that remains unresolved after a review under Labor Code §504.053(d)(3) or Insurance Code §1305.355 is entitled to a contested case hearing in the same manner as a hearing conducted under Labor Code §413.0311. A party to a medical necessity dispute may seek review of a dismissal or decision at a division CCS as follows:

(1) A party to a medical necessity dispute may appeal the IRO decision by requesting a division CCH conducted by a division administrative law judge. A benefit review conference is not a prerequisite to a division CCH under this subsection.

(A) The written appeal must be filed with the division's Chief Clerk of Proceedings no later than the later of the 20th day after the effective date of this section or 20 days after the date the IRO decision is sent to the appealing party and must be filed in the form and manner required by the division. Requests that are timely submitted to a division location other than the division's Chief Clerk of Proceedings, such as a local field office of the division, will be considered timely filed and forwarded to the Chief Clerk of Proceedings for processing; however, this may result in a delay in the processing of the request.

(B) The party appealing the IRO decision shall send a copy of its written request for a hearing to all other parties involved in the dispute. The IRO is not required to participate in the division CCH or any appeal.

(C) Except as otherwise provided in this section, a division CCH shall be conducted in accordance with Chapters 140 and 142 of this title (relating to Dispute Resolution--General Provisions and Dispute Resolution--Benefit Contested Case Hearing).

(D) At a division CCH, the administrative law judge shall consider the treatment guidelines:

(i) adopted by the network under Insurance Code §1305.304, for a network dispute;

(ii) adopted by the division under Labor Code §413.011(e) for a non-network dispute; or

(iii) adopted, if any, by the political subdivision or pool that provides medical benefits under Labor Code §504.053(b)(2) if those treatment guidelines meet the standards provided by Labor Code §413.011(e).

(E) Prior to a division CCH, a party may submit a request for a letter of clarification by the IRO to the division's Chief Clerk of Proceedings. A copy of the request for a letter of clarification must be provided to all parties involved in the dispute at the time it is submitted to the division.

(i) A party's request for a letter of clarification must be submitted to the division no later than 10 days before the date set for hearing. The request must include a cover letter that contains the names of the parties and all identification numbers assigned to the hearing or the independent review by the division, the department, or the IRO.

(ii) The department may at its discretion forward the party's request for a letter of clarification to the IRO that conducted the independent review. The department will not forward to the IRO a request for a letter of clarification that asks the IRO to reconsider its decision or issue a new decision.

(iii) The IRO shall send a response to the request for a letter of clarification to the department and to all parties that received a copy of the IRO's decision within 5 days of receipt of the party's request for a letter of clarification. The IRO's response is limited to clarifying statements in its original decision; the IRO shall not reconsider its decision and shall not issue a new decision in response to a request for a letter of clarification.

(iv) A request for a letter of clarification does not alter the deadlines for appeal.

(F) A party to a medical necessity dispute who has exhausted all administrative remedies may seek judicial review of the division's decision. Judicial review under this paragraph shall be conducted in the manner provided for judicial review of contested cases under Chapter 2001, Subchapter G Government Code, and is governed by the substantial evidence rule. The party seeking judicial review under this section must file suit not later than the 45th day after the date on which the division mailed the party the decision of the administrative law judge. The mailing date is considered to be the fifth day after the date the decision of the administrative law judge was filed with the

division. A decision becomes final and appealable when issued by a division administrative law judge. If a party to a medical necessity dispute files a petition for judicial review of the division's decision, the party shall, at the time the petition is filed with the district court, send a copy of the petition for judicial review to the division's Chief Clerk of Proceedings. The division and the department are not considered to be parties to the medical necessity dispute pursuant to Labor Code §413.031(k-2) and §413.0311(e).

(G) Upon receipt of a court petition seeking judicial review of a division CCH held under this subparagraph, the division shall prepare and submit to the district court a certified copy of the entire record of the division CCH under review.

(i) The following information must be included in the petition or provided to the division by cover letter:

(I) Any applicable division docket number for the dispute being appealed;

(II) the names of the parties;

(III) the cause number;

(IV) the identity of the court; and

(V) the date the petition was filed with the court.

(ii) The record of the hearing includes:

(I) all pleadings, motions, and intermediate rulings;

(II) evidence received or considered;

(III) a statement of matters officially noticed;

(IV) questions and offers of proof, objections, and rulings on them;

(V) any decision, opinion, report, or proposal for decision by the officer presiding at the hearing and any decision by the division; and

(VI) a transcription of the audio record of the division CCH.

(iii) The division shall assess to the party seeking judicial review expenses incurred by the division in preparing the certified copy of the record, including transcription costs, in accordance with the Government Code §2001.177 (relating to Costs of Preparing Agency Record). Upon request, the division shall consider the financial ability of the party to pay the costs, or any other factor that is relevant to a just and reasonable assessment of costs.

(2) If a party to a medical necessity dispute properly requests review of an IRO decision, the IRO, upon request, shall provide a record of the review and submit it to the requestor within 15 days of the request. The party requesting the record shall pay the IRO copying costs for the records. The record shall include the following documents that are in the possession of the IRO and which were reviewed by the IRO in making the decision including:

(A) medical records;

(B) all documents used by the insurance carrier in making the decision that resulted in the adverse determination under review by the IRO;

(C) all documentation and written information submitted by the insurance carrier to the IRO in support of the review;

(D) the written notification of the adverse determination and the written determination of the appeal to the insurance carrier or the insurance carrier's URA;

(E) a list containing the name, address, and phone number of each health care provider who provided medical records to the IRO relevant to the review;

(F) a list of all medical records of other documents reviewed by the IRO, including the dates of those documents;

(G) a copy of the decision that was sent to all parties;

(H) copies of any pertinent medical literature or other documentation (such as any treatment guideline or screening criteria) utilized to support the decision or, where such documentation is subject to copyright protection or is voluminous, then a listing of such documentation referencing the portion(s) of each document utilized;

(I) a signed and certified custodian of records affidavit; and

(J) other information that was required by the department related to a request from an insurance carrier or the insurance carrier's URA for the assignment of the IRO.

(t) Medical Fee Dispute Request. If the requestor has an unresolved non-network fee dispute related to health care that was found medically necessary, after the final decision of the medical necessity dispute, the requestor may file a medical fee dispute in accordance with §133.305 and §133.307 of this subchapter (relating to MDR--General and MDR of Fee Disputes, respectively).

(u) First Responders. In accordance with Labor Code §504.055(d), an appeal regarding the denial of a claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury involving a first responder will be accelerated by the division and given priority. The party seeking to expedite the contested case hearing or appeal must provide notice to the division and independent review organization that the contested case hearing or appeal involves a first responder.

(v) Texas Military Forces. In accordance with Labor Code §501.028, the division will accelerate and give priority to an appeal from a denial of a claim for medical benefits.

(1) This subsection applies to a claim for medical benefits made by a member of the Texas military forces who, while on state active duty, sustains a serious bodily injury, as defined by Penal Code §1.07.

(2) The division will accelerate and give priority to actions involving all health care required to cure or relieve the effects naturally resulting from a compensable injury.

(3) The member must notify the division and IRO that the CCH or appeal involves a member of the Texas military forces.

(w) Death investigation professionals. In accordance with Labor Code §504.057, the division will accelerate and give priority to an appeal from a denial of a claim for medical benefits.

(1) This subsection applies to a claim for medical benefits made by a death investigation professional who sustains a serious bodily injury, as defined by Penal Code §1.07, in the course and scope of employment.
(2) The division will accelerate and give priority to actions involving all health care required to cure or relieve the effects naturally resulting from a compensable injury.
(3) The death investigation professional must notify the division and IRO that the CCH or appeal involves a death investigation professional.

(x) Enforcement. The department or the division may initiate appropriate proceedings under Chapter 12 of this title or Labor Code, Title 5 and division rules against an independent review organization or a person conducting independent reviews.

Source Note: The provisions of this §133.308 adopted to be effective December 31, 2006, 31 TexReg 10314; amended to be effective May 25, 2008, 33 TexReg 3954; amended to be effective May 31, 2012, 37 TexReg 3833; amended to be effective January 7, 2019, 44 TexReg 103; amended to be effective December 28, 2023, 48 TexReg 7999; amended to be effective January 29, 2026, 51 TexReg 409.

SUBCHAPTER G ELECTRONIC MEDICAL BILLING, REIMBURSEMENT, AND DOCUMENTATION

RULE §133.500 Electronic Formats for Electronic Medical Bill Processing

(a) For electronic transactions conducted before January 1, 2012, the division adopts by reference the following electronic medical bill processing standards as adopted by the United States Department of Health and Human Services in 45 CFR §162.1102(b) and §162.1602(b):
(1) Professional Billing--the ASC X12N 837, Health Care Claim: Professional, Volumes 1 and 2, Version 004010, May 2000, Washington Publishing Company, 004010X098 and Addenda to Health Care Claim: Professional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X098A1.
(2) Institutional/Hospital Billing--the ASC X12N 837, Health Care Claim: Institutional, Volumes 1 and 2, Version 004010, May 2000, Washington Publishing Company,

004010X096 and Addenda to Health Care Claim: Institutional, Volumes 1 and 2, Version 4010, October 2002, Washington Publishing Company, 004010X096A1.

(3) Dental Billing--the ASC X12N 837, Health Care Claim: Dental, Version 004010, May 2000, Washington Publishing Company, 004010X097 and Addenda to Health Care Claim: Dental, Version 4010, October 2002, Washington Publishing Company, 004010X097A1.

(4) Retail Pharmacy Billing--the Telecommunication Standard Implementation Guide Version 5, Release 1 (Version 5.1), September 1999, National Council for Prescription Drug Programs and the Batch Standard Batch Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000, supporting Telecommunication Standard Implementation Guide, Version 5, Release 1 (Version 5.1) for the NCPDP Data Record in the Detail Data Record, National Council for Prescription Drug Programs.

(5) Remittance--the ASC X12N 835, Health Care Claim Payment/Advice, Version 004010, May 2000, Washington Publishing Company, 004010X091, and Addenda to Health Care Claim Payment/Advice, Version 4010, October 2002, Washington Publishing Company, 004010X091A1.

(b) For electronic transactions conducted before January 1, 2012, the division adopts by reference the following electronic medical bill processing standards:

(1) Acknowledgment:

(A) Electronic responses to ASC X12N 837 transactions:

(i) the TA1 Interchange Acknowledgment contained in the standards adopted under subsection (a) of this section;

(ii) the 997 Functional Acknowledgment contained in the standards adopted under subsection (a) of this section; and

(iii) the ASC X12N 824--Application Advice, Version 004010, February 2006, Washington Publishing Company, 004010X161.

(B) Electronic responses to National Council for Prescription Drug Programs (NCPDP) transactions, the Response contained in the standards adopted under subsection (a) of this section.

(2) Documentation submitted with an electronic medical bill: ASC X12N 275--Additional Information to Support a Health Claim or Encounter, Version 004050, May 2004, Washington Publishing Company, 004050X151.

(c) For electronic transactions conducted on or after January 1, 2012, the division adopts by reference the following electronic medical bill processing standards as adopted by the United States Department of Health and Human Services in 45 CFR §162.1102(c) and §162.1602(c):

(1) Professional Billing--the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim: Professional (837), May 2006, ASC X12,

005010X222 and Type 3 Errata to Health Care Claim: Professional (837), June 2010, ASC X12, 005010X222A1.

(2) Institutional/Hospital Billing--the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim: Institutional (837), May 2006, ASC X12, 005010X223, Type 1 Errata to Health Care Claim: Institutional (837), ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, October 2007, ASC X12, 005010X223A1, and Type 3 Errata to Health Care Claim: Institutional (837), June 2010, ASC X12, 005010X223A2.

(3) Dental Billing--the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim: Dental (837), May 2006, ASC X12, 005010X224, Type 1 Errata to Health Care Claim: Dental (837), ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, October 2007, ASC X12, 005010X224A1, and Type 3 Errata to Health Care Claim: Dental (837), June 2010, ASC X12, 005010X224A2.

(4) Retail Pharmacy Billing--the Telecommunication Standard Implementation Guide, Version D, Release 0 (Version D.0), August 2007, National Council for Prescription Drug Programs and the Batch Standard Batch Implementation Guide, Version 1, Release 2 (Version 1.2), January 2006, National Council for Prescription Drug Programs.

(5) Remittance--the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim Payment/Advice (835), April 2006, ASC X12, 005010X221, and Type 3 Errata to Health Care Claim Payment/Advice (835), June 2010, ASC X12, 005010X221A1.

(d) For electronic transactions conducted on or after January 1, 2012, the division adopts by reference the following electronic medical bill processing standards:

(1) Acknowledgment:

(A) Electronic responses to ASC X12N 837 transactions:

(i) the ASC X12 Standards for Electronic Data Interchange TA1 Interchange Acknowledgment contained in the standards adopted under subsection (c) of this section;

(ii) the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Implementation Acknowledgment for Health Care Insurance (999), June 2007, ASC X12, 005010X231; and

(iii) the ASC X12 Standards for Electronic Data Interchange Technical Report Type 3, Health Care Claim Acknowledgment (277CA), January 2007, ASC X12, 005010X214.

(B) Electronic responses to NCPDP transactions, the Response contained in the standards adopted under subsection (c) of this section.

(2) Documentation submitted with an electronic medical bill: ASC X12N 275 - Additional Information to Support a Health Claim or Encounter, Version 005010, February 2008, Washington Publishing Company, 005010X210.

(e) Electronic medical billing transactions must:
(1) contain all fields required in the applicable standard as set forth in subsection (a) or (c) of this section and the data requirements contained in §133.502 of this title (relating to Electronic Medical Billing Supplemental Data Requirements); and
(2) be populated with current and valid values defined in the applicable standard as set forth in subsection (a) or (c) of this section, Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments), and the data requirements contained in §133.502 of this title.

(f) Insurance carriers and health care providers may exchange electronic data in a non-prescribed format by mutual agreement. All data elements required in the division prescribed formats must be present in a mutually agreed upon format.

(g) The implementation specifications for the ASC X12N and the ASC X12 Standards for Electronic Data Interchange may be obtained from the ASC X12, 7600 Leesburg Pike, Suite 430, Falls Church, VA 22043; Telephone (703) 970-4480; and FAX (703) 970-4488. They are also available through the internet at http://www.X12.org. A fee is charged for all implementation specifications.

(h) The implementation specifications for the retail pharmacy standards may be obtained from the National Council for Prescription Drug Programs, 9240 East Raintree Drive, Scottsdale, AZ 85260. Telephone (480) 477-1000; FAX (480) 767-1042. They are also available through the Internet at http://www.ncpdp.org. A fee is charged for all implementation specifications.

(i) The electronic medical bill processing standards adopted in this section are available for inspection at the main office of the Texas Department of Insurance, Division of Workers' Compensation, 7551 Metro Center Drive, Suite 100, Austin, TX 78744 or any subsequent address of the division's main office.

(j) This section is effective August 1, 2011.

Source Note: The provisions of this §133.500 adopted to be effective August 10, 2006, 31 TexReg 6230; amended to be effective August 1, 2011, 36 TexReg 929

RULE §133.501 Electronic Medical Bill Processing

(a) Applicability.
(1) This section applies to the exchange of electronic medical bill data in accordance with §133.500 of this title (relating to Electronic Formats for Electronic Medical Bill

Processing) for professional, institutional/hospital, pharmacy, and dental services. This section applies to all electronic medical bill processing, including transactions for medical services rendered under the provisions of Insurance Code Chapter 1305 or rendered to political subdivisions with contractual relationships under Labor Code §504.053(b)(2).

(2) Insurance carriers shall accept electronic medical bills from health care providers transmitted in accordance with §133.500 of this title unless the insurance carrier is exempt from the process in accordance with subsection (b) of this section.

(3) Health care providers shall submit electronic medical bills to insurance carriers in accordance with §133.500 of this title unless the health care provider or the billed insurance carrier is exempt from the process in accordance with subsection (b) of this section.

(b) Exemptions.

(1) A health care provider is exempt from the requirement to submit medical bills electronically to an insurance carrier if:

(A) the health care provider employs fewer than 10 full time employees;

(B) the health care provider provided services to 32 or fewer injured employees during the preceding calendar year; or

(C) the health care provider can sufficiently demonstrate electronic medical bill implementation will create an unreasonable financial hardship and can provide supporting documentation such as financial statements and other documentation which reflect the cost of implementation.

(2) A health care provider who asserts an exemption under this section must provide all supporting documentation to the division within 15 days of a division request for documentation.

(3) An insurance carrier is exempt from the requirement to receive medical bills electronically from health care providers if:

(A) the insurance carrier is placed in receivership;

(B) the insurance carrier was issued an initial license to write workers' compensation insurance by the Texas Department of Insurance during the current or preceding calendar year;

(C) the insurance carrier had less than 32 workers' compensation claims for which income or medical benefits were paid during the preceding calendar year;

(D) the insurance carrier no longer writes workers' compensation insurance in Texas and is only handling runoff claims;

(E) the insurance carrier was a certified self-insured employer under Labor Code, Chapter 407, or a self-insured group under Labor Code, Chapter 407A, which has withdrawn from the certified self-insurance program or group self-insurance; or

(F) the insurance carrier submits a request to the division with supporting documentation such as financial statements and other documents which reflect cost of implementation and sufficiently demonstrates that electronic medical bill implementation will create an unreasonable financial hardship and the Commissioner approves the request.

(4) An insurance carrier who asserts an exemption under this subsection must provide all supporting documentation to the division within 15 days of a division request for documentation.

(5) Insurance carriers shall submit notification to the division prior to the beginning of each calendar year for which they will assert an exemption to the electronic medical bill processing requirements. The required notification must include:

(A) federal tax identification number of the insurance carrier;

(B) contact information, including but not limited to the name, physical address, and telephone number; and

(C) a description regarding facts related to the exemption under paragraph (3) of this subsection asserted by the insurance carrier.

(c) Agents. Health care providers and insurance carriers may contract with other entities for electronic medical bill processing. Insurance carriers and health care providers are responsible for the acts or omissions of their agents executed in the performance of services for the insurance carrier or health care provider.

(d) Electronic medical bill.

(1) An electronic medical bill is a medical bill submitted electronically by a health care provider or its agent.

(2) An insurance carrier shall take final action not later than the 45th day after the date the insurance carrier received a complete electronic medical bill.

(e) Acknowledgment.

(1) An insurance carrier must acknowledge receipt of an electronic medical bill by returning an acknowledgment within two working days of receipt of the electronic submission. The time frame for returning an incomplete medical bill contained in §133.200 of this title (relating to Insurance Carrier Receipt of Medical Bills from Health Care Providers) does not apply to an electronic medical bill.

(A) Notification of a rejection is transmitted in an acknowledgment when an electronic medical bill does not meet the definition of a complete electronic medical bill or does not meet the edits defined in the applicable standard.

(B) A health care provider may not submit a duplicate electronic medical bill earlier than 45 days from the date submitted if an insurance carrier acknowledged receipt of the original complete electronic medical bill. A health care provider may submit a

corrected medical bill electronically to the insurance carrier after receiving notification of a rejection. The corrected medical bill is submitted as a new, original bill.
(2) Acknowledgment of a medical bill is not an admission of liability by the insurance carrier. The insurance carrier may subsequently deny a medical bill for liability or other issues within the 45-day medical bill processing timeframe contained in Labor Code §408.027.

(f) Electronic remittance notification.
(1) An electronic remittance notification is an explanation of benefits (EOB), submitted electronically regarding payment or denial of a medical bill, recoupment request, or receipt of a refund.
(2) An insurance carrier must provide an electronic remittance notification no later than 45 days after receipt of a complete electronic medical bill or within 5 days of generating a payment. This requirement applies only to the date the electronic remittance is sent and does not modify the medical bill processing timeframes contained in Labor Code §408.027.
(g) Electronic documentation. Electronic documentation consists of medical documentation submitted electronically that is related to an electronic medical bill.
(h) This section is effective August 1, 2011.

RULE §133.502 Electronic Medical Billing Supplemental Data Requirements

(a) In addition to the data requirements and standards adopted under §133.500(a) of this title (relating to Electronic Formats for Electronic Medical Bill Processing), all professional, institutional or hospital, and dental electronic medical bills submitted before January 1, 2012, must contain:
(1) the telephone number of the submitter;
(2) the workers' compensation claim number assigned by the insurance carrier or, if that number is not known by the health care provider, a default value of "UNKNOWN";
(3) the injured employee's Social Security number as the subscriber member identification number;
(4) the injured employee's date of injury;
(5) the rendering health care provider's state provider license number;
(6) the referring health care provider's state provider license number;
(7) the billing provider's state provider license number, if the billing provider has a state provider license number;
(8) the attending physician's state medical license number, when applicable;
(9) the operating physician's state medical license number, when applicable;
(10) the claim supplemental information, when electronic documentation is submitted with an electronic medical bill; and

(11) the resubmission condition code, when the electronic medical bill is a duplicate, request for reconsideration, or other resubmission.

(b) In reporting the injured employee Social Security number and the state license numbers under subsection (a) of this section, health care providers must follow the data content and format requirements contained in §133.10 of this title (relating to Required Billing Forms/Formats).

(c) In addition to the data requirements contained in the standards adopted under §133.500(c) of this title, all professional, institutional or hospital, and dental electronic medical bills submitted on or after January 1, 2012, must contain:
(1) the telephone number of the submitter;
(2) the workers' compensation claim number assigned by the insurance carrier or, if that number is not known by the health care provider, a default value of "UNKNOWN";
(3) the injured employee's date of injury;
(4) the claim supplemental information, when electronic documentation is submitted with an electronic medical bill;
(5) the resubmission condition code, when the electronic medical bill is a duplicate, request for reconsideration, or other resubmission; and
(6) for a designated doctor and a health care provider performing a test or evaluation as a result of a designated doctor's referral, the assignment number in the prior authorization field.

(d) In addition to the data requirements contained in the standards adopted under §133.500 of this title, all pharmacy electronic medical bills must contain:
(1) the dispensing pharmacy's National Provider Identification number;
(2) the prescribing doctor's National Provider Identification number; and
(3) for a health care provider performing a test or evaluation as a result of a designated doctor's referral, the assignment number in the prior authorization field.

(e) In reporting the resubmission condition code under this section, the resubmission condition codes must have the definitions specified in §133.10(j) of this title.

(f) This section does not apply to paper medical bills submitted for payment under §133.10(b) of this title.

(g) This section is effective for medical bills submitted on or after June 1, 2024, including medical bills submitted as a result of an examination that was ordered or referred as the result of an order issued on or after June 1, 2024.

Source Note: The provisions of this §133.502 adopted to be effective August 1, 2011, 36 TexReg 929; amended to be effective June 1, 2024, 49 TexReg 1478

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 134	BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES, AND PAYMENTS

SUBCHAPTER A MEDICAL REIMBURSEMENT POLICIES

RULE §134.1 Medical Reimbursement

(a) "Maximum allowable reimbursement" (MAR), when used in this chapter, is defined as the maximum amount payable to a health care provider in the absence of a contractual fee arrangement that is consistent with §413.011 of the Labor Code, and Division rules.

(b) Medical reimbursement for health care services provided to injured employees subject to a workers' compensation health care network established under Insurance Code Chapter 1305 shall be made in accordance with the provisions of Insurance Code Chapter 1305, except as provided in subsections (c) and (d) of this section.

(c) Examinations conducted pursuant to Labor Code §§408.004, 408.0041, and 408.151 shall be reimbursed in accordance with §134.204 of this chapter (relating to Medical Fee Guideline for Workers' Compensation Specific Services).

(d) Examinations conducted pursuant to Labor Code §408.0042 shall be reimbursed in accordance with §126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury).

(e) 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;
(2) a negotiated contract; or
(3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section.

(f) Fair and reasonable reimbursement shall:
(1) be consistent with the criteria of Labor Code §413.011;
(2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and

(3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

(g) The insurance carrier shall consistently apply fair and reasonable reimbursement amounts and maintain, in reproducible format, documentation of the insurance carrier's methodology(ies) establishing fair and reasonable reimbursement amounts. Upon request of the Division, an insurance carrier shall provide copies of such documentation.

Source Note: The provisions of this §134.1 adopted to be effective May 2, 2006, 31 TexReg 3561; amended to be effective March 1, 2008, 33 TexReg 364

RULE §134.2 Incentive Payments for Workers' Compensation Underserved Areas

(a) When required by Division rule, an incentive payment shall be added to the maximum allowable reimbursement (MAR) for services performed in a designated workers' compensation underserved area.

(b) The following list of ZIP Codes comprise the Division designated workers' compensation underserved areas: 75134, 75135, 75161, 75181, 75212, 75410, 75558, 75603, 75630, 75650, 75653, 75654, 75658, 75660, 75663, 75666, 75667, 75672, 75687, 75692, 75704, 75750, 75752, 75763, 75789, 75849, 75915, 75933, 75949, 75964, 75969, 75973, 75980, 76023, 76055, 76060, 76066, 76088, 76119, 76226, 76239, 76247, 76271, 76380, 76443, 76534, 76621, 76640, 76657, 76682, 76711, 76932, 76935, 77033, 77050, 77053, 77078, 77336, 77354, 77363, 77389, 77396, 77466, 77496, 77517, 77561, 77632, 77808, 77905, 77968, 78025, 78123, 78132, 78140, 78141, 78210, 78220, 78239, 78242, 78333, 78335, 78343, 78368, 78370, 78383, 78407, 78535, 78574, 78583, 78590, 78605, 78640, 78669, 78802, 78830, 78836, 78877, 78884, 78935, 78960, 79010, 79107, 79108, 79114, 79118, 79311, 79367, 79408, 79411, 79511, 79521, 79536, 79561, 79563, 79778, 79782, 79836, 79838, 79849, 79901, 79922, 79934.

Source Note: The provisions of this §134.2 adopted to be effective March 1, 2008, 33 TexReg 364

SUBCHAPTER B MISCELLANEOUS REIMBURSEMENT

RULE §134.100 Reimbursement of Treating Doctor for Attendance at Required Medical Examination

(a) When an injured employee's treating doctor is present at a required medical examination in accordance with §126.6 of this title (relating to Required Medical Examination), the insurance carrier shall reimburse the treating doctor for time as follows:
  (1) at a rate of $100 an hour limited to four hours, unless the insurance carrier pre-approves extended time; and
  (2) in quarter hour increments with any amount over 10 minutes considered an additional quarter hour.

(b) Reimbursement is limited to the time required to travel from the treating doctor's usual place of business to the place of the examination. In addition, it includes the duration of the examination and the time required to return from the examination location to the treating doctor's usual place of business. The travel shall be by the most direct route. This time does not include time spent for meals or other elective activities engaged in by the doctor.

(c) The treating doctor shall submit a request for reimbursement in accordance with §133.10 of this title (relating to Required Billing Forms/Formats).

(d) The injured employee's treating doctor shall be the only doctor permitted to attend and charge for the attendance at the examination.

(e) This section shall apply to all dates of travel on or after May 2, 2006.

Source Note: The provisions of this §134.100 adopted to be effective May 2, 2006, 31 TexReg 3561

RULE §134.110 Reimbursement of Injured Employee for Travel Expenses Incurred

(a) An injured employee may request reimbursement from the insurance carrier if the injured employee has incurred travel expenses when:
  (1) medical treatment for the compensable injury is not reasonably available within 30 miles from where the injured employee lives and the distance traveled to secure medical treatment is greater than 30 miles one-way; or

(2) the distance traveled to attend a designated doctor examination, required medical examination, or post designated doctor treating or referral doctor examination is greater than 30 miles one-way.

(b) The injured employee shall submit the request for reimbursement to the insurance carrier within one year of the date the injured employee incurred the expenses.

(c) The injured employee's request for reimbursement shall be in the form and manner required by the division and shall include documentation or evidence (such as itemized receipts) of the amount of the expense the injured employee incurred.

(d) The insurance carrier shall reimburse the injured employee based on the travel rate for state employees on the date travel occurred, using mileage for the shortest reasonable route.

(1) Travel mileage is measured from the actual point of departure to the health care provider's location when the point of departure is:

(A) the employee's home; or

(B) the employee's place of employment.

(2) If the point of departure is not the employee's home or place of employment, then travel mileage shall be measured from the health care provider's location to the nearest of the following locations:

(A) the employee's home;

(B) the place of employment; or

(C) the actual point of departure.

(3) Total reimbursable mileage is based on round trip mileage.

(4) When an injured employee's travel expenses reasonably include food and lodging, the insurance carrier shall reimburse for the actual expenses not to exceed the current rate for state employees on the date the expense is incurred.

(e) The insurance carrier shall pay or deny the injured employee's request for reimbursement submitted in accordance with subsection (c) of this section within 45 days of receipt.

(f) If the insurance carrier does not reimburse the full amount requested, partial payment or denial of payment shall include a plain language explanation of the reason(s) for the reduction or denial. The insurance carrier shall inform the injured employee of the injured employee's right to request a benefit review conference in accordance with §141.1 of this title (relating to Requesting and Setting a Benefit Review Conference).

Source Note: The provisions of this §134.110 adopted to be effective May 2, 2006, 31 TexReg 3561; amended to be effective March 30, 2014, 39 TexReg 2102

RULE §134.120 Reimbursement for Medical Documentation

(a) An insurance carrier is not required to reimburse initial medical documentation provided to the insurance carrier in accordance with §133.210 of this title (relating to Medical Documentation).

(b) An insurance carrier shall separately reimburse subsequent copies of medical documentation requested by the insurance carrier in accordance with §133.210 of this title.

(c) Upon request, the health care provider shall provide the injured employee, or the injured employee's representative, an initial copy of the medical documentation without charge. The requestor shall reimburse the health care provider for subsequent requests of the same medical documentation.

(d) 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.

(e) The health care provider shall provide copies of any requested or required documentation to the Division at no charge.

(f) The reimbursements for medical documentation are:
(1) copies of medical documentation--$.50 per page;
(2) copies of hospital records--an initial fee of $5.00 plus $.50 per page for the first 20 pages, then $.30 per page for records over 20 pages;
(3) microfilm--$.50 per page;
(4) copies of X-ray films--$8.00 per film;
(5) narrative reports:
(A) one to two pages--$100;
(B) each page after two pages--$40 per page.

(g) Narrative reports are defined as original documents explaining the assessment, diagnosis, and plan of treatment for an injured employee written or orally transcribed and created at the written request of the insurance carrier or the Division. Narrative reports shall provide information beyond that required by prescribed medical reports and/or records. A narrative report should be single spaced on letter-size paper or

equivalent electronic document format. Clinical or progress notes do not constitute a narrative report.

Source Note: The provisions of this §134.120 adopted to be effective May 2, 2006, 31 TexReg 3561

RULE §134.130 Interest for Late Payment on Medical Bills and Refunds

(a) Insurance carriers shall pay interest on medical bills paid on or after the 60th day after the insurance carrier originally received the complete medical bill, in accordance with §133.340 of this title (relating to Medical Payments and Denials).

(b) Health care providers shall pay interest to insurance carriers on requests for refunds paid later than the 60th day after the date the health care provider received the request for refund, in accordance with §133.260 of this title (relating to Refunds).

(c) The rate of interest to be paid shall be the rate calculated in accordance with Labor Code §401.023 and in effect on the date the payment was made.

(d) Interest shall be calculated as follows:
(1) multiply the rate of interest by the amount on which interest is due (to determine the annual amount of interest);
(2) divide the annual amount of interest by 365 (to determine the daily interest amount); then
(3) multiply the daily interest amount by the number of days of interest to which the recipient is entitled under subsection (a) or (b) of this section.
(e) The percentage of interest for each quarter may be obtained by accessing the Texas Department of Insurance's website, www.tdi.state.tx.us.

(f) This section shall apply to all dates of service on or after May 2, 2006.

Source Note: The provisions of this §134.130 adopted to be effective May 2, 2006, 31 TexReg 3561

RULE §134.150 Reimbursement of Services Provided by a Federal Military Treatment Facility

(a) This section applies, regardless of the date of injury, to medical services provided on or after January 1, 2020, in a federal military treatment facility (FMTF) as defined in Labor Code §413.0112(a) (relating to Reimbursement of Federal Military Treatment Facility).

(b) Reimbursement for medical services provided to an injured employee shall be the amount of the FMTF's charges as determined under Title 32, Code of Federal Regulations, Part 220 (concerning Collection of Reasonable Charges for Healthcare Services). Additionally, charges may include interest, administrative penalties, or collection fees related to medical benefits.

(c) An FMTF is not required to comply with health care provider billing or preauthorization requirements in Chapters 133 (concerning General Medical Provisions) and 134 (concerning Benefits--Guidelines for Medical Services, Charges, and Payments) of this title. An insurance carrier shall process a medical bill from an FMTF and make payment in accordance with Chapters 133 and 134, except as provided in Labor Code §413.0112. The insurance carrier shall contact the FMTF to obtain any information necessary to process a medical bill and document the name and telephone number of the person who supplied the information.

(d) Notwithstanding the requirements of Chapter 133, an insurance carrier shall process professional and institutional medical services submitted on a single bill by an FMTF. An insurance carrier shall identify reimbursement for professional and institutional services separately on the explanation of benefits form.

(e) The insurance carrier may only deny payment of medical services provided by an FMTF for reasons of medical necessity, compensability, extent of injury, or liability.

(f) An insurance carrier shall forward to the division, within 14 calendar days of receipt, in the form and manner prescribed by the division, the first medical bill for an injured employee that it receives from an FMTF.

(g) An insurance carrier shall report FMTF medical bills in accordance with Chapter 134, Subchapter I, of this title. FMTF medical bills are subject to §102.9 of this title (concerning Submission of Information Requested by the Commission) including medical bills not reported in accordance with §134.806(a)(3) (concerning Records Excluded from Reporting).

Source Note: The provisions of this §134.150 adopted to be effective December 11, 2019, 44 TexReg 7549

RULE §134.155 Federal Military Treatment Facility Disputes

(a) Disputes over charges billed by a federal military treatment facility (FMTF):

(1) If an insurance carrier denies payment of a medical bill based on medical necessity, the medical necessity dispute shall be initiated under §133.308 of this title (concerning MDR of Medical Necessity Disputes):

(A) Notwithstanding Chapter 133, Subchapter D, of this title (concerning Dispute of Medical Bills), an injured employee is not required to request reconsideration prior to requesting medical dispute resolution;

(B) Notwithstanding §133.308(f)(2)(B), an injured employee may be a requestor in a medical necessity dispute, and

(C) Notwithstanding §133.308(q), the insurance carrier shall pay all independent review organization fees.

(2) For all other disputes, a party may request a benefit review conference as described under Chapter 141 of this title (concerning Dispute Resolution--Benefit Review Conference).

(b) Except as provided in this section, an FMTF dispute will be conducted in accordance with the division's rules for dispute resolution in §133.308 or Chapters 140 - 147 of this title.

(c) In accordance with Labor Code §504.055 (relating to Expedited Provision of Medical Benefits for Certain Injuries Sustained by First Responders in Course and Scope of Employment) a request for an FMTF dispute that involves a first responder's request for payment of medical expenses will be accelerated by the division and given priority. A first responder shall provide notice to the division that the request involves a first responder.

Source Note: The provisions of this §134.155 adopted to be effective December 11, 2019, 44 TexReg 7549

SUBCHAPTER C MEDICAL FEE GUIDELINES

RULE §134.201 Medical Fee Guideline for Medical Treatments and Services Provided under the Texas Workers' Compensation Act

(a) The commission adopts by reference herein, the Texas Workers' Compensation Commission Medical Fee Guideline 1996. The Guideline shall be effective for all medical treatments, services, durable medical equipment and pharmaceuticals provided on or after April 1, 1996. Medical treatments, services, and durable medical equipment provided prior to April 1, 1996, shall be subject to the 1991 Texas Workers' Compensation Commission Medical Fee Guideline (December 1991 Version). Pharmaceuticals provided prior to April 1, 1996, shall be subject to §134.501 of this title

(relating to the Pharmaceutical Fee Guideline). Copies of both guidelines may be obtained from the Publication Department of the Texas Workers' Compensation Commission, 4000 South IH-35, Southfield Building, Austin, Texas 78704.

(b) An insurance carrier or health care provider which willfully or intentionally violates the provisions of this rule commits an administrative violation under Texas Labor Code, §415.002 or §415.003, and may be assessed a penalty. In addition, an insurance carrier or health care provider which repeatedly violates these statutory provisions may be assessed a penalty not to exceed $10,000 under the Texas Labor Code, §415.021, and may be subject to the sanctions specified in the Texas Labor Code, §415.023, including, but not limited to, restriction or revocation of the right to receive reimbursement under the Texas Workers' Compensation Act.

Source Note: The provisions of this §134.201 adopted to be effective April 1, 1996, 21 TexReg 2361

RULE §134.203 Medical Fee Guideline for Professional Services

(a) Applicability of this rule is as follows:
(1) This section applies to professional medical services provided in the Texas workers' compensation system, other than:
(A) workers' compensation specific codes, services, and programs described in §134.204 of this title (relating to Medical Fee Guideline for Workers' Compensation Specific Services);
(B) prescription drugs or medicine;
(C) dental services;
(D) the facility services of a hospital or other health care facility; and
(E) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.
(2) This section applies to professional medical services provided on or after March 1, 2008.
(3) For professional services provided between August 1, 2003 and March 1, 2008, §134.202 of this title (relating to Medical Fee Guideline) applies.
(4) For professional services provided prior to August 1, 2003, §134.201 of this title (relating to Medical Fee Guideline for Medical Treatments and Services Provided under the Texas Workers' Compensation Act) and §134.302 of this title (relating to Dental Fee Guideline) apply.
(5) "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and

reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

(6) Notwithstanding Medicare payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act.

(7) Specific provisions contained in 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. Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

(8) Whenever a component of the Medicare program is revised, use of the revised component shall be required for compliance with Division rules, decisions, and orders for professional services rendered on or after the effective date, or after the effective date or the adoption date of the revised component, whichever is later.

(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

(2) A 10 percent incentive payment shall be added to the maximum allowable reimbursement (MAR) for services outlined in subsections (c) - (f) and (h) of this section that are performed in designated workers' compensation underserved areas in accordance with §134.2 of this title (relating to Incentive Payments for Workers' Compensation Underserved Areas).

(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st

of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007.

(d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
(1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;
(2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or
(3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

(e) The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:
(1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and,
(2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.

(f) For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

(g) When there is a negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the negotiated or contracted amount that applies to the billed services.

(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the:
(1) 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.

(i) Health care providers (HCPs) shall bill their usual and customary charges using the most current Level I (CPT codes) and Level II HCPCS codes. HCPs shall submit medical bills in accordance with the Labor Code and Division rules.

(j) Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Division-specific modifiers are identified and shall be applied in accordance with §134.204(n) of this title (relating to Medical Fee Guideline for Workers' Compensation Specific Services). When two or more modifiers are applicable to a single CPT code, indicate each modifier on the bill.

Source Note: The provisions of this §134.203 adopted to be effective March 1, 2008, 33 TexReg 364

RULE §134.204 Medical Fee Guideline for Workers' Compensation Specific Services

(a) Applicability of this rule is as follows:
(1) This section applies to workers' compensation specific codes, services and programs provided in the Texas workers' compensation system, other than:
(A) professional medical services described in §134.203 of this title (relating to Medical Fee Guideline for Professional Services);
(B) prescription drugs or medicine;
(C) dental services;
(D) the facility services of a hospital or other health care facility; and
(E) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in §134.1 of this title and Insurance Code Chapter 1305.
(2) This section applies to workers' compensation specific codes, services and programs provided from March 1, 2008 until September 1, 2016.
(3) For workers' compensation specific codes, services and programs provided between August 1, 2003 and March 1, 2008, §134.202 of this title (relating to Medical Fee Guideline) applies.
(4) For workers' compensation specific codes, services and programs provided prior to August 1, 2003, §134.201 of this title (relating to Medical Fee Guideline for Medical Treatments and Services Provided under the Texas Workers' Compensation Act) and §134.302 of this title (relating to Dental Fee Guideline) apply.
(5) Specific provisions contained in the 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 the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program.

Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

(b) Payment Policies Relating to coding, billing, and reporting for workers' compensation specific codes, services, and programs are as follows:
(1) Billing. Health care providers (HCPs) shall bill their usual and customary charges using the most current Level I (CPT codes) and Level II Healthcare Common Procedure Coding System (HCPCS) codes. HCPs shall submit medical bills in accordance with the Labor Code and Division rules.
(2) Modifiers. Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Where HCPCS modifiers apply, carriers shall treat them in accordance with Medicare and Texas Medicaid rules. Additionally, Division-specific modifiers are identified in subsection (n) of this section. When two or more modifiers are applicable to a single HCPCS code, indicate each modifier on the bill.
(3) Incentive Payments. A 10 percent incentive payment shall be added to the maximum allowable reimbursement (MAR) for services outlined in subsections (d), (e), (g), (i), (j), and (k) of this section that are performed in designated workers' compensation underserved areas in accordance with §134.2 of this title (relating to Incentive Payments for Workers' Compensation Underserved Areas).

(c) When there is a negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the negotiated or contracted amount that applies to the billed services.

(d) 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) 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).

(e) Case Management Responsibilities by the Treating Doctor is as follows:
(1) Team conferences and telephone calls shall include coordination with an interdisciplinary team.
(A) Team members shall not be employees of the treating doctor.

(B) Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call.

(2) Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee.

(3) Contact with one or more members of the interdisciplinary team more often than once every 30 days shall be limited to the following:

(A) coordinating with the employer, employee, or an assigned medical or vocational case manager to determine return to work options;

(B) developing or revising a treatment plan, including any treatment plans required by Division rules;

(C) altering or clarifying previous instructions; or

(D) coordinating the care of employees with catastrophic or multiple injuries requiring multiple specialties.

(4) Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows:

(A) CPT Code 99361.

(i) Reimbursement to the treating doctor shall be $113. Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP shall be $28 when a HCP contributes to the case management activity.

(B) CPT Code 99362.

(i) Reimbursement to the treating doctor shall be $198. Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP shall be $50 when a HCP contributes to the case management activity.

(C) CPT Code 99371.

(i) Reimbursement to the treating doctor shall be $18. Modifier "W1" shall be added.

(ii) Reimbursement to a referral HCP contributing to this case management activity shall be $5.

(D) CPT Code 99372.

(i) Reimbursement to the treating doctor shall be $46. Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP contributing to this case management activity shall be $12.

(E) CPT Code 99373.

(i) Reimbursement to the treating doctor shall be $90. Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP contributing to this case management action shall be $23.

(f) To determine the MAR amount for home health services provided through a licensed home health agency, the MAR shall be 125 percent of the published Texas Medicaid fee schedule for home health agencies.

(g) The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements:

(1) A physical examination and neurological evaluation, which include the following:
(A) appearance (observational and palpation);
(B) flexibility of the extremity joint or spinal region (usually observational);
(C) posture and deformities;
(D) vascular integrity;
(E) neurological tests to detect sensory deficit;
(F) myotomal strength to detect gross motor deficit; and
(G) reflexes to detect neurological reflex symmetry.

(2) A physical capacity evaluation of the injured area, which includes the following:
(A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and
(B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.

(3) Functional abilities tests, which include the following:
(A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);
(B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;
(C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and
(D) static positional tolerance (observational determination of tolerance for sitting or standing).

(h) The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier.

(1) Accreditation by the CARF is recommended, but not required.

(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR.

(B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR.

(2) For Division purposes, General Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Conditioning.

(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WC." Each additional hour shall be billed using CPT Code 97546 with modifier "WC." CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $36 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(3) For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.

(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes.

(4) The following shall be applied for billing and reimbursement of Outpatient Medical Rehabilitation Programs.

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "MR" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $90 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(5) The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs.

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(i) The following shall apply to Designated Doctor Examinations.

(1) Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows:

(A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor;

(B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor;

(C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W6";

(D) Whether the injured employee's disability is a direct result of the work-related injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W7";

(E) Ability of the employee to return to work shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W8"; and

(F) Issues similar to those described in subparagraphs (A) - (E) of this paragraph shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W9."

(2) When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection:

(A) the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section;

(B) the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section; and

(C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in subsection (k) of this section.

(j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:

(1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:

(A) the examination;

(B) consultation with the injured employee;

(C) review of the records and films;

(D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and,

(E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Act and Division rules in Chapter 130 of this title (relating to Impairment and Supplemental Income Benefits).

(2) An HCP shall only bill and be reimbursed for an MMI/IR examination if the doctor performing the evaluation (i.e., the examining doctor) is an authorized doctor in accordance with the Act and Division rules in Chapter 130 of this title.

(A) If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added.

(B) If the examining doctor determines MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and only the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection.

(C) If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this subsection.

(3) The following applies for billing and reimbursement of an MMI evaluation.

(A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier.

(i) Reimbursement shall be the applicable established patient office visit level associated with the examination.

(ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit.

(B) If the treating doctor refers the injured employee to another doctor for the examination and certification of MMI (and IR); and, the referral examining doctor has:

(i) previously been treating the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(A) of this subsection; or,

(ii) not previously treated the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(C) of this subsection.

(C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350.

(4) The following applies for billing and reimbursement of an IR evaluation.

(A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form.

(B) When multiple IRs are required as a component of a designated doctor examination under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier "MI" shall be added to the MMI evaluation CPT code.

(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

(i) Musculoskeletal body areas are defined as follows:

(I) spine and pelvis;

(II) upper extremities and hands; and,

(III) lower extremities (including feet).

(ii) The MAR for musculoskeletal body areas shall be as follows.

(I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.

(II) If full physical evaluation, with range of motion, is performed:

(-a-) $300 for the first musculoskeletal body area; and

(-b-) $150 for each additional musculoskeletal body area.

(iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR.

(iv) If, in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment), the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier "26." Reimbursement shall be 80 percent of the total MAR.

(v) If a HCP, other than the examining doctor, performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the HCP shall bill

using the appropriate MMI CPT code with modifier "TC." In accordance with §130.1 of this title, the HCP must be certified. Reimbursement shall be 20 percent of the total MAR.

(D) Non-musculoskeletal body areas shall be billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR.

(i) Non-musculoskeletal body areas are defined as follows:

(I) body systems;

(II) body structures (including skin); and,

(III) mental and behavioral disorders.

(ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides.

(iii) When the examining doctor refers testing for non-musculoskeletal body area(s) to a specialist, then the following shall apply:

(I) The examining doctor (e.g., the referring doctor) shall bill using the appropriate MMI CPT code with modifier "SP" and indicate one unit in the units column of the billing form. Reimbursement shall be $50 for incorporating one or more specialists' report(s) information into the final assignment of IR. This reimbursement shall be allowed only once per examination.

(II) The referral specialist shall bill and be reimbursed for the appropriate CPT code(s) for the tests required for the assignment of IR. Documentation is required.

(iv) When there is no test to determine an IR for a non-musculoskeletal condition:

(I) The IR is based on the charts in the AMA Guides. These charts generally show a category of impairment and a range of percentage ratings that fall within that category.

(II) The impairment rating doctor must determine and assign a finite whole percentage number rating from the range of percentage ratings.

(III) Use of these charts to assign an IR is equivalent to assigning an IR by the DRE method as referenced in subparagraph (C)(ii)(I) of this paragraph.

(v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150.

(5) If the examination for the determination of MMI and/or the assignment of IR requires testing that is not outlined in the AMA Guides, the appropriate CPT code(s) shall be billed and reimbursed in addition to the fees outlined in paragraphs (3) and (4) of this subsection.

(6) The treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor, as stated in the Act and Division Rules, Chapter 130 of this title. The treating doctor shall bill using CPT Code 99455 with modifier "VR" to indicate a review of the report only, and shall be reimbursed $50.

(k) The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested

RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

(l) The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports).

(m) The following shall apply to Treating Doctor Examination to Define the Compensable Injury. When billing for this type of examination, refer to §126.14 of this title (relating to Treating Doctor Examination to Define Compensable Injury).

(n) The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes.

(1) CA, Commission on Accreditation of Rehabilitation Facilities (CARF) Accredited programs--This modifier shall be used when a HCP bills for a Return To Work Rehabilitation Program that is CARF accredited.

(2) CP, Chronic Pain Management Program--This modifier shall be added to CPT Code 97799 to indicate Chronic Pain Management Program services were performed.

(3) FC, Functional Capacity--This modifier shall be added to CPT Code 97750 when a functional capacity evaluation is performed.

(4) MR, Outpatient Medical Rehabilitation Program--This modifier shall be added to CPT Code 97799 to indicate Outpatient Medical Rehabilitation Program services were performed.

(5) MI, Multiple Impairment Ratings--This modifier shall be added to CPT Code 99455 when the designated doctor is required to complete multiple impairment ratings calculations.

(6) NM, Not at Maximum Medical Improvement (MMI)--This modifier shall be added to the appropriate MMI CPT code to indicate that the injured employee has not reached MMI when the purpose of the examination was to determine MMI.

(7) RE, Return to Work (RTW) and/or Evaluation of Medical Care (EMC)--This modifier shall be added to CPT Code 99456 when a RTW or EMC examination is performed.

(8) SP, Specialty Area--This modifier shall be added to the appropriate MMI CPT code when a specialty area is incorporated into the MMI report.

(9) TC, Technical Component--This modifier shall be added to the CPT code when the technical component of a procedure is billed separately.

(10) VR, Review report--This modifier shall be added to CPT Code 99455 to indicate that the service was the treating doctor's review of report(s) only.

(11) V1, Level of MMI for Treating Doctor--This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to a "minimal" level.

(12) V2, Level of MMI for Treating Doctor--This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to "self limited or minor" level.

(13) V3, Level of MMI for Treating Doctor--This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to "low to moderate" level.

(14) V4, Level of MMI for Treating Doctor--This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to "moderate to high severity" level and of at least 25 minutes duration.

(15) V5, Level of MMI for Treating Doctor--This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to "moderate to high severity" level and of at least 45 minutes duration.

(16) WC, Work Conditioning--This modifier shall be added to CPT Code 97545 to indicate work conditioning was performed.

(17) WH, Work Hardening--This modifier shall be added to CPT Code 97545 to indicate work hardening was performed.

(18) WP, Whole Procedure--This modifier shall be added to the CPT code when both the professional and technical components of a procedure are performed by a single HCP.

(19) W1, Case Management for Treating Doctor--This modifier shall be added to the appropriate case management billing code activities when performed by the treating doctor.

(20) W5, Designated Doctor Examination for Impairment or Attainment of Maximum Medical Improvement--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining impairment caused by the compensable injury and in attainment of maximum medical improvement.

(21) W6, Designated Doctor Examination for Extent--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining extent of the employee's compensable injury.

(22) W7, Designated Doctor Examination for Disability--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining whether the injured employee's disability is a direct result of the work-related injury.

(23) W8, Designated Doctor Examination for Return to Work--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining the ability of employee to return to work.

(24) W9, Designated Doctor Examination for Other Similar Issues--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining other similar issues.

Source Note: The provisions of this §134.204 adopted to be effective March 1, 2008, 33 TexReg 364; amended to be effective July 7, 2016, 41 TexReg 4839

RULE §134.209 Applicability

(a) Sections 134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, 134.250, and 134.260 of this title apply to workers' compensation specific codes, services, and programs provided in the Texas workers' compensation system, other than:

(1) professional medical services described in §134.203 of this title;

(2) prescription drugs or medicine;

(3) dental services;

(4) the facility services of a hospital or other health care facility; and

(5) medical services provided through a workers' compensation health care network certified under Insurance Code Chapter 1305, except as provided in §134.1 of this title and Insurance Code Chapter 1305.

(b) Sections 134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, 134.250, and 134.260 of this title apply to workers' compensation specific codes, services, and programs provided on or after June 1, 2024.

(c) If a court of competent jurisdiction holds that any provision of §§134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, 134.250, and 134.260 of this title or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications that can be given effect without the invalid provision or application and the provisions of §§134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, 134.250, and 134.260 of this title are severable.

(d) When billing for a treating doctor examination to define the compensable injury, refer to §126.14 of this title.

Source Note: The provisions of this §134.209 adopted to be effective July 7, 2016, 41 TexReg 4839; amended to be effective June 1, 2024, 49 TexReg 1489

RULE §134.210 Medical Fee Guideline for Workers' Compensation Specific Services

(a) Specific provisions contained in the Labor Code or division rules, including this chapter, take precedence over any conflicting provision adopted or used by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program. Independent review organization decisions on medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title, which are made on a case-by-case basis, take precedence, in that case only, over any division rules and Medicare payment policies.

(b) Payment policies relating to coding, billing, and reporting for workers' compensation specific codes, services, and programs are as follows:

(1) Health care providers must bill their usual and customary charges using the most current Level I Current Procedural Terminology (CPT) and Level II Healthcare Common Procedure Coding System (HCPCS) codes. Health care providers must submit medical bills in accordance with the Labor Code and division rules.

(2) Modifying circumstance must be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Where HCPCS modifiers apply, insurance carriers must treat them in accordance with Medicare and Texas Medicaid rules. In addition, division-specific modifiers are identified in subsection (f) of this section. When two or more modifiers apply to a single HCPCS code, indicate each modifier on the bill.

(3) A 10% incentive payment must be added to the maximum allowable reimbursement (MAR) for services outlined in §§134.220, 134.225, 134.235, 134.240, 134.250, and 134.260 of this title and subsection (d) of this section that are performed in designated workers' compensation underserved areas in accordance with §134.2 of this title. However, reimbursement for a missed appointment under §134.240 does not qualify for the 10% incentive payment.

(4) Fees established in §§134.235, 134.240, 134.250, and 134.260 of this title will be:

(A) adjusted once by applying the Medicare Economic Index (MEI) percentage adjustment factor for the period 2009 - 2024.

(B) adjusted annually by applying the MEI percentage adjustment factor identified in §134.203(c)(2).

(C) rounded to whole dollars by dropping amounts under 50 cents and increasing amounts from 50 to 99 cents to the next dollar. For example, $1.39 becomes $1 and $2.50 becomes $3.

(D) effective on January 1 of each new calendar year.

(c) When there is a negotiated or contracted amount that complies with Labor Code §413.011, reimbursement must be the negotiated or contracted amount that applies to the billed services.

(d) When billing for services in §§134.215, 134.220, 134.225, or 134.230, and there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement must be the least of the:
(1) MAR amount;
(2) health care provider's usual and customary charge; or
(3) fair and reasonable amount consistent with the standards of §134.1 of this title.

(e) For services provided under §§134.235, 134.240, 134.250, or 134.260, health care providers must bill and be reimbursed the MAR.

(f) The following division modifiers must be used by health care providers billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes.
(1) 25--This modifier must be added to CPT code 99456 when the division ordered the designated doctor to perform an examination of an injured employee with one or more of the diagnoses listed in §127.130(b)(9)(B) - (I) of this title.
(2) 52--This modifier must be added to CPT code 99456 when the division ordered the designated doctor to perform an examination of an injured employee, and the injured employee failed to attend the examination.
(3) CA, Commission on Accreditation of Rehabilitation Facilities (CARF) accredited programs--This modifier must be used when a health care provider bills for a return-to-work rehabilitation program that is CARF accredited.
(4) CP, chronic pain management program--This modifier must be added to CPT code 97799 to indicate chronic pain management program services were performed.
(5) FC, functional capacity--This modifier must be added to CPT code 97750 when a functional capacity evaluation is performed.
(6) MR, outpatient medical rehabilitation program--This modifier must be added to CPT code 97799 to indicate outpatient medical rehabilitation program services were performed.
(7) MI, multiple impairment ratings--This modifier must be added to CPT code 99456 when the designated doctor is required to complete multiple impairment ratings calculations.
(8) NM, not at maximum medical improvement (MMI)--This modifier must be added to the appropriate MMI CPT code to indicate that the injured employee has not reached MMI when the purpose of the examination was to determine MMI.

(9) VR, review report--This modifier must be added to CPT code 99455 to indicate that the service was the treating doctor's review of reports only.
(10) V3, treating doctor evaluation of MMI--This modifier must be added to CPT code 99455 when the office visit level of service is equal to CPT code 99213.
(11) V4, treating doctor evaluation of MMI--This modifier must be added to CPT code 99455 when the office visit level of service is equal to CPT code 99214.
(12) V5, treating doctor evaluation of MMI--This modifier must be added to CPT code 99455 when the office visit level of service is equal to CPT code 99215.
(13) WC, work conditioning--This modifier must be added to CPT codes 97545 and 97546 to indicate work conditioning was performed.
(14) WH, work hardening--This modifier must be added to CPT codes 97545 and 97546 to indicate work hardening was performed.
(15) W1, case management for treating doctor--This modifier must be added to the appropriate case management billing code activities when performed by the treating doctor.
(16) W5, designated doctor examination for impairment or attainment of MMI--This modifier must be added to the appropriate examination code performed by a designated doctor when determining impairment caused by the compensable injury and in attainment of MMI.
(17) W6, designated doctor examination for extent--This modifier must be added to the appropriate examination code performed by a designated doctor when determining extent of the injured employee's compensable injury.
(18) W7, designated doctor examination for disability--This modifier must be added to the appropriate examination code performed by a designated doctor when determining whether the injured employee's disability is a direct result of the work-related injury.
(19) W8, designated doctor examination for return to work--This modifier must be added to the appropriate examination code performed by a designated doctor when determining the ability of the injured employee to return to work.
(20) W9, designated doctor examination for other similar issues--This modifier must be added to the appropriate examination code performed by a designated doctor when determining other similar issues.

Source Note: The provisions of this §134.210 adopted to be effective July 7, 2016, 41 TexReg 4839; amended to be effective June 1, 2024, 49 TexReg 1489

RULE §134.215 Home Health Services

The maximum allowable reimbursement (MAR) amount for home health services provided through a licensed home health agency shall be 125 percent of the published Texas Medicaid fee schedule for home health agencies.

Source Note: The provisions of this §134.215 adopted to be July 7, 2016, 41 TexReg 4839

RULE §134.220 Case Management Services

Case management responsibilities by the treating doctor are as follows:

(1) Team conferences and telephone calls shall include coordination with an interdisciplinary team.
(A) Team members shall not be employees of the treating doctor.
(B) Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call.

(2) Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee.

(3) Contact with one or more members of the interdisciplinary team more often than once every 30 days shall be limited to the following:
(A) coordinating with the employer, employee, or an assigned medical or vocational case manager to determine return to work options;
(B) developing or revising a treatment plan, including any treatment plans required by division rules;
(C) altering or clarifying previous instructions; or
(D) coordinating the care of employees with catastrophic or multiple injuries requiring multiple specialties.

(4) Case management services require the treating doctor to submit documentation that identifies any health care provider that contributes to the case management activity. Case management services shall be billed and reimbursed as follows:
(A) CPT code 99361.
(i) Reimbursement to the treating doctor shall be $113. Modifier "W1" shall be added.
(ii) Reimbursement to the referral health care provider shall be $28 when a health care provider contributes to the case management activity.
(B) CPT code 99362.

(i) Reimbursement to the treating doctor shall be $198. Modifier "W1" shall be added.

(ii) Reimbursement to the referral health care provider shall be $50 when a health care provider contributes to the case management activity.

(C) CPT code 99371.

(i) Reimbursement to the treating doctor shall be $18. Modifier "W1" shall be added.

(ii) Reimbursement to a referral health care provider contributing to this case management activity shall be $5.

(D) CPT code 99372.

(i) Reimbursement to the treating doctor shall be $46. Modifier "W1" shall be added.

(ii) Reimbursement to the referral health care provider contributing to this case management activity shall be $12.

(E) CPT code 99373.

(i) Reimbursement to the treating doctor shall be $90. Modifier "W1" shall be added.

(ii) Reimbursement to the referral health care provider contributing to this case management action shall be $23.

Source Note: The provisions of this §134.220 adopted to be July 7, 2016, 41 TexReg 4839

RULE §134.225 Functional Capacity Evaluations

The following applies to functional capacity evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a division ordered test; a maximum of two hours for an interim test; and a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements:

(1) A physical examination and neurological evaluation, which include the following:

(A) appearance (observational and palpation);

(B) flexibility of the extremity joint or spinal region (usually observational);

(C) posture and deformities;

(D) vascular integrity;

(E) neurological tests to detect sensory deficit;

(F) myotomal strength to detect gross motor deficit; and

(G) reflexes to detect neurological reflex symmetry.

(2) A physical capacity evaluation of the injured area, which includes the following:
(A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and
(B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.

(3) Functional abilities tests, which include the following:
(A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);
(B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;
(C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and
(D) static positional tolerance (observational determination of tolerance for sitting or standing).

Source Note: The provisions of this §134.225 adopted to be July 7, 2016, 41 TexReg 4839

RULE §134.230 Return to Work Rehabilitation Programs

The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or insurance carrier.

(1) Accreditation by the CARF is recommended, but not required.
(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the maximum allowable reimbursement (MAR).

(B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR.

(2) For division purposes, General Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Conditioning.

(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT code 97545 with modifier "WC." Each additional hour shall be billed using CPT code 97546 with modifier "WC." CARF accredited programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $36 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(3) For division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.

(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT code 97545 with modifier "WH." Each additional hour shall be billed using CPT code 97546 with modifier "WH." CARF accredited programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(4) The following shall be applied for billing and reimbursement of Outpatient Medical Rehabilitation Programs.

(A) Program shall be billed and reimbursed using CPT code 97799 with modifier "MR" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $90 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(5) The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs.

(A) Program shall be billed and reimbursed using CPT code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

Source Note: The provisions of this §134.230 adopted to be July 7, 2016, 41 TexReg 4839

RULE §134.235 Return to Work/Evaluation of Medical Care

(a) Required medical examination doctors (RME doctors) must perform examinations in accordance with Labor Code §§408.004, 408.0041, 408.0043, and 408.0045 and division rules.

(b) Each examination and its individual billable components will be billed and reimbursed separately.

(c) When conducting an insurance carrier-requested examination to determine impairment or attainment of maximum medical improvement (MMI), the RME doctor must bill, and the insurance carrier must reimburse, using CPT code 99456, with the modifiers and at the rates specified in paragraphs (c)(2) - (3).

(1) The total maximum allowable reimbursement (MAR) for a MMI or impairment rating (IR) examination is equal to the MMI evaluation reimbursement plus the reimbursement for the body area or areas evaluated for the assignment of an IR. The MMI or IR examination must include:

(A) the examination;

(B) consultation with the injured employee;

(C) review of the records and films;

(D) the preparation and submission of reports (including the narrative report and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and

(E) tests used to assign the IR, as outlined in the American Medical Association Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Labor Code and Chapter 130 of this title.

(2) RME doctors must only bill and be reimbursed for an MMI or IR examination if they are an authorized doctor in accordance with the Labor Code and Chapter 130 and §180.23 of this title.

(A) If the RME doctor determines that MMI has not been reached, the RME doctor must bill, and the insurance carrier must reimburse, the MMI evaluation portion of the examination in accordance with subsections (c)(1) and (c)(3) of this section. The RME doctor must add modifier "NM."

(B) If the RME doctor determines that MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, and an IR evaluation was not warranted, the RME doctor must only bill, and the insurance carrier must only reimburse, the MMI evaluation portion of the examination in accordance with subsections (c)(1) and (c)(3) of this section.

(C) If the RME doctor determines MMI has been reached and an IR evaluation is performed, the RME doctor must bill, and the insurance carrier must reimburse, both the MMI evaluation and the IR evaluation portions of the examination in accordance with this subsection.

(3) MMI. MMI evaluations will be reimbursed at $449 adjusted per §134.210(b)(4).

(4) IR. For IR examinations, the RME doctor must bill, and the insurance carrier must reimburse, the components of the IR evaluation. Indicate the number of body areas rated in the units column of the billing form.

(A) For musculoskeletal body areas, the RME doctor may bill for a maximum of three body areas.

(i) Musculoskeletal body areas are:

(I) spine and pelvis;

(II) upper extremities and hands; and

(III) lower extremities (including feet).

(ii) For musculoskeletal body areas:

(I) the reimbursement for the first musculoskeletal body area is $385 adjusted per §134.210(b)(4); and

(II) the reimbursement for each additional musculoskeletal body area is $192 adjusted per §134.210(b)(4).

(B) For non-musculoskeletal body areas, the RME doctor may bill, and the insurance carrier must reimburse, for each non-musculoskeletal body area examined.

(i) Non-musculoskeletal body areas are:

(I) body systems;

(II) body structures (including skin); and

(III) mental and behavioral disorders.

(ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides.

(iii) The reimbursement for the assignment of an IR in a non-musculoskeletal body area is $192 adjusted per §134.210(b)(4).

(C) If the examination for the determination of MMI or the assignment of IR requires testing that is not outlined in the AMA Guides, the RME doctor must bill, and the insurance carrier must reimburse, the appropriate testing CPT code or codes according to the applicable fee guideline in addition to the fees for the examination by the RME doctor outlined in subsection (c) of this section.

(d) When conducting an insurance carrier-requested examination to determine the extent of the employee's compensable injury, whether the injured employee's disability is a direct result of the compensable injury, the ability of the injured employee to return to work, other similar issues, or appropriateness of medical care, the RME doctor must bill, and the insurance carrier must reimburse, using CPT code 99456 and at the rates specified in paragraphs (d)(1) - (5).

(1) Extent of injury. The reimbursement rate for determining the extent of the injured employee's compensable injury is $642 adjusted per §134.210(b)(4).

(2) Disability. The reimbursement rate for determining whether the injured employee's disability is a direct result of the work-related injury is $642 adjusted per §134.210(b)(4).

(3) Return to work. The reimbursement rate for determining the ability of the injured employee to return to work is $642 adjusted per §134.210(b)(4).

(4) Other similar issues. The reimbursement rate for determining other similar issues is $642 adjusted per §134.210(b)(4).

(5) Appropriateness of health care. The reimbursement rate for appropriateness of health care as defined in §126.6 (concerning Required Medical Examination) and Labor Code §408.004 is $642 adjusted per §134.210(b)(4).

(e) When the RME doctor refers testing to a specialist, the referral health care provider must bill, and the insurance carrier must reimburse, the appropriate CPT code or codes for the tests required for the assignment of IR, according to the applicable division fee guideline. Documentation of the referral is required.

Source Note: The provisions of this §134.235 adopted to be effective June 1, 2024, 49 TexReg 1489

RULE §134.239 Billing for Work Status Reports

Work status reports described by §129.5 of this title may not be billed or reimbursed separately when completed as a component of an ordered examination.

Source Note: The provisions of this §134.239 adopted to be effective June 1, 2024, 49 TexReg 1489

RULE §134.240 Designated Doctor Examinations

(a) Designated doctors must perform examinations in accordance with Labor Code §§408.004, 408.0041, and 408.151 and division rules.

(b) The designated doctor must bill, and the insurance carrier must reimburse, for a missed appointment when the injured employee does not attend a properly scheduled or rescheduled examination under 28 TAC §127.5(h) - (j).

(1) The designated doctor may bill for the missed appointment fee when:

(A) the injured employee does not attend a scheduled appointment; and

(B) the designated doctor waits at the examination location for at least 30 minutes after the scheduled appointment time.

(2) When billing for the missed appointment, the designated doctor must bill CPT code 99456 with modifier "52."

(3) Reimbursement for a missed appointment is $100 adjusted per §134.210(b)(4).

(4) Reimbursement for a missed appointment under this section does not qualify for the 10% incentive payment under §134.2 of this chapter.

(c) Each examination and its individual billable components will be billed and reimbursed separately.

(d) When conducting a designated doctor examination, the designated doctor must bill, and the insurance carrier must reimburse, using CPT code 99456 and with the modifiers and rates specified in subsections (d)(1) - (7).

(1) The total maximum allowable reimbursement (MAR) for a maximum medical improvement (MMI) or impairment rating (IR) examination is equal to the MMI evaluation reimbursement plus the reimbursement for the body area or areas evaluated for the assignment of an IR. The MMI or IR examination must include:

(A) the examination;

(B) consultation with the injured employee;

(C) review of the records and films;

(D) the preparation and submission of reports (including the narrative report and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and

(E) tests used to assign the IR, as outlined in the American Medical Association Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Labor Code and Chapter 130 of this title.

(2) A designated doctor must only bill and be reimbursed for an MMI or IR examination if they are an authorized doctor in accordance with the Labor Code and Chapter 130 and §180.23 of this title.

(A) If the designated doctor determines that MMI has not been reached, the MMI evaluation portion of the examination must be billed and reimbursed in accordance with subsection (d) of this section. The designated doctor must add modifier "NM."

(B) If the designated doctor determines that MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and only the MMI evaluation portion of the examination must be billed and reimbursed in accordance with subsection (d) of this section.

(C) If the designated doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination must be billed and reimbursed in accordance with subsection (d) of this section.

(3) MMI. MMI evaluations will be reimbursed at $449 adjusted per §134.210(b)(4), and the designated doctor must apply the additional modifier "W5."

(4) IR. For IR examinations, the designated doctor must bill, and the insurance carrier must reimburse, the components of the IR evaluation. The designated doctor must apply the additional modifier "W5." Indicate the number of body areas rated in the units column of the billing form.

(A) For musculoskeletal body areas, the designated doctor may bill for a maximum of three body areas.

(i) Musculoskeletal body areas are:

(I) spine and pelvis;

(II) upper extremities and hands; and

(III) lower extremities (including feet).

(ii) For musculoskeletal body areas:

(I) the reimbursement for the first musculoskeletal body area is $385 adjusted per §134.210(b)(4); and

(II) the reimbursement for each additional musculoskeletal body area is $192 adjusted per §134.210(b)(4).

(B) For non-musculoskeletal body areas, the designated doctor must bill, and the insurance carrier must reimburse, for each non-musculoskeletal body area examined.

(i) Non-musculoskeletal body areas are defined as follows:

(I) body systems;

(II) body structures (including skin); and

(III) mental and behavioral disorders.

(ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides.

(iii) The reimbursement for the assignment of an IR in a non-musculoskeletal body area is $192 adjusted per §134.210(b)(4).

(iv) The test or tests required by Chapter 127 of this title for the assignment of IR, as outlined in the AMA Guides, must be billed using the appropriate CPT code or codes and reimbursed under the applicable division fee guideline in addition to the fees outlined in subsection (b) and (d)(1) - (3) of this section.

(C) If the examination for the determination of MMI or the assignment of IR requires testing authorized by Chapter 127 of this title that is not outlined in the AMA Guides, the appropriate CPT code or codes must be billed, and the insurance carrier must reimburse, according to the applicable division fee guideline, in addition to the fees outlined in subsections (d)(1) - (3) and (d)(4)(A) - (B) of this section.

(D) When multiple IRs are required as a component of a designated doctor examination under this title, the designated doctor must bill for the number of body areas rated, and the insurance carrier must reimburse, $64 adjusted per §134.210(b)(4) for each additional IR calculation.

(E) When the division requires the designated doctor to complete multiple IR calculations, the designated doctor must apply the additional modifier "MI."

(5) Extent of injury. The reimbursement rate for determining the extent of the employee's compensable injury is $642 adjusted per §134.210(b)(4), and the designated doctor must apply the additional modifier "W6."

(6) Disability. The reimbursement rate for determining whether the injured employee's disability is a direct result of the work-related injury is $642 adjusted per §134.210(b)(4), and the designated doctor must apply the additional modifier "W7."

(7) Return to work. The reimbursement rate for determining the ability of the injured employee to return to work is $642 adjusted per §134.210(b)(4), and the designated doctor must apply the additional modifier "W8."

(8) Other similar issues. The reimbursement rate for determining other similar issues is $642 adjusted per §134.210(b)(4), and the designated doctor must apply the additional modifier "W9" when examining issues similar to those described in subsection (d)(1) - (6).

(e) Required testing or evaluation under §127.10 of this title must be billed using the appropriate CPT codes. Reimbursement will be according to §134.203 or other applicable division fee guideline in addition to the examination fee. If a designated doctor refers an injured employee for additional testing or evaluation under §127.10 of this title:

(1) The 95-day period for timely submission of the designated doctor bill for the examination begins on the date of service of the additional testing or evaluation.

(2) The dates of service (CMS-1500/field 24A) are as follows: the "From" date is the date of the designated doctor examination, and the "To" date is the date of service of the additional testing or evaluation.

(3) The designated doctor and any referral health care providers must include the DWC-provided assignment number in the prior authorization field (CMS-1500/field 23) in accordance with §133.10(f)(1)(N).

(f) When the designated doctor refers an injured employee to a specialist for additional testing or evaluation under §127.10 of this title, the referral health care provider must bill:

(1) using the appropriate CPT codes, and the insurance carrier must reimburse, according to §134.203 or other applicable division fee guideline in addition to the examination fee;

(2) using the assignment number provided by the designated doctor; and

(3) attaching the required documentation.

(g) When the division orders the designated doctor to perform an examination of an injured employee with one or more of the diagnoses listed in §127.130(b)(9)(B) - (I) of this title:
(1) The designated doctor must add modifier "25" to the appropriate examination code.
(2) The designated doctor must add modifier "25" once per bill when addressing issues on the same day, regardless of the number of diagnoses or the number of issues the division ordered the designated doctor to examine.
(3) The designated doctor must bill, and the insurance carrier must reimburse, $300 adjusted per §134.210(b)(4) in addition to the examination fee.

Source Note: The provisions of this §134.240 adopted to be effective June 1, 2024, 49 TexReg 1489

RULE §134.250 Maximum Medical Improvement Evaluations and Impairment Rating Examinations

(a) The total maximum allowable reimbursement (MAR) for a maximum medical improvement (MMI) or impairment rating (IR) examination is equal to the MMI evaluation reimbursement plus the reimbursement for the body area or areas evaluated for the assignment of an IR. The MMI or IR examination must include:
(1) the examination;
(2) consultation with the injured employee;
(3) review of the records and films;
(4) the preparation and submission of reports (including the narrative report and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and
(5) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Labor Code and Chapter 130 of this title.

(b) Treating doctors must only bill and be reimbursed for an MMI and IR examination if they are an authorized doctor in accordance with the Labor Code and Chapter 130 and §180.23 of this title.
(1) If the treating doctor determines that MMI has not been reached, the treating doctor must bill, and the insurance carrier must reimburse, the MMI evaluation portion of the examination in accordance with subsections (c)(1) and (c)(2) of this section.
(2) If the treating doctor determines MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and the treating doctor must bill, and the insurance carrier must reimburse, only the

MMI evaluation portion of the examination in accordance with subsections (c)(1) and (c)(2) of this section.

(3) If the treating doctor determines MMI has been reached and an IR evaluation is performed, the treating doctor must bill, and the insurance carrier must reimburse, both the MMI evaluation and the IR evaluation portions of the examination in accordance with subsection (c) of this section.

(4) If the treating doctor is not authorized to assign an IR, the treating doctor may refer the injured employee to an authorized doctor for the examination and certification of MMI and IR. The referred doctor must bill under §134.260 of this chapter.

(c) The following applies for billing and reimbursement of an MMI or IR evaluation by a treating doctor.

(1) CPT code. The treating doctor must bill using CPT code 99455 with the appropriate modifier. Modifiers "V3," "V4," or "V5" must be added to CPT code 99455 to correspond with the last digit of the applicable office visit.

(2) MMI. MMI evaluations must be reimbursed based on the applicable established patient office visit level associated with the examination under §134.203 of this chapter.

(3) IR. For IR examinations, the treating doctor must bill, and the insurance carrier must reimburse, the components of the IR evaluation. Indicate the number of body areas rated in the units column of the billing form.

(A) For musculoskeletal body areas, the treating doctor may bill for a maximum of three body areas.

(i) Musculoskeletal body areas are:

(I) spine and pelvis;

(II) upper extremities and hands; and

(III) lower extremities (including feet).

(ii) For musculoskeletal body areas:

(I) the reimbursement for the first musculoskeletal body area is $385 adjusted per §134.210(b)(4); and

(II) the reimbursement for each additional musculoskeletal body area is $192 adjusted per §134.210(b)(4).

(B) For non-musculoskeletal body areas, the treating doctor must bill, and the insurance carrier must reimburse, for each non-musculoskeletal body area examined.

(i) Non-musculoskeletal body areas are defined as follows:

(I) body systems;

(II) body structures (including skin); and

(III) mental and behavioral disorders.

(ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides.

(iii) The reimbursement for the assignment of an IR in a non-musculoskeletal body area is $192 adjusted per §134.210(b)(4).

(d) If the examination for the determination of MMI or the assignment of IR requires testing that is not outlined in the AMA Guides, the treating doctor must bill, and the insurance carrier must reimburse, the appropriate testing CPT code or codes according to the applicable fee guideline in addition to the fees for the examination by the treating doctor outlined in subsection (c) of this section.

(e) The treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor, as stated in the Labor Code and Chapter 130 of this title. The treating doctor must bill using CPT code 99455 with modifier "VR" to indicate a review of the report only, and the insurance carrier must reimburse $64 adjusted per §134.210(b)(4).

Source Note: The provisions of this §134.250 adopted to be effective July 7, 2016, 41 TexReg 4839; amended to be effective June 1, 2024, 49 TexReg 1489

RULE §134.260 Maximum Medical Improvement Evaluations and Impairment Rating Examinations by Referred Doctors

(a) The total maximum allowable reimbursement (MAR) for a maximum medical improvement (MMI) or impairment rating (IR) examination is equal to the MMI evaluation reimbursement plus the reimbursement for the body area or areas evaluated for the assignment of an IR. The MMI or IR examination must include:
(1) the examination;
(2) consultation with the injured employee;
(3) review of the records and films;
(4) the preparation and submission of reports (including the narrative report and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and
(5) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Labor Code and Chapter 130 of this title.

(b) Referred doctors must only bill and be reimbursed for an MMI or IR examination if they are an authorized doctor in accordance with the Labor Code and Chapter 130 and §180.23 of this title.
(1) If the referred doctor determines that MMI has not been reached, the referred doctor must bill, and the insurance carrier must reimburse, the MMI evaluation portion

of the examination in accordance with subsections (c)(1) and (c)(2) of this section. The referred doctor must add modifier "NM."

(2) If the referred doctor determines that MMI has been reached and there is no permanent impairment because the injury was sufficiently minor and IR evaluation is not warranted, the referred doctor must bill, and the insurance carrier must reimburse, only the MMI evaluation portion of the examination in accordance with subsections (c)(1) and (c)(2) of this section.

(3) If the referred doctor determines MMI has been reached and an IR evaluation is performed, the referred doctor must bill, and the insurance carrier must reimburse, both the MMI evaluation and the IR examination portions of the examination in accordance with subsection (c) of this section.

(c) The following applies for billing and reimbursement of an MMI or IR evaluation by a referred doctor.

(1) CPT code. The referred doctor must bill using CPT code 99456 with the appropriate modifier.

(2) MMI. MMI evaluations will be reimbursed at $449 adjusted per §134.210(b)(4).

(3) IR. For IR examinations, the referred doctor must bill, and the insurance carrier must reimburse, the components of the IR evaluation. Indicate the number of body areas rated in the units column of the billing form.

(A) For musculoskeletal body areas, the referred doctor may bill for a maximum of three body areas.

(i) Musculoskeletal body areas are:

(I) spine and pelvis;

(II) upper extremities and hands; and

(III) lower extremities (including feet).

(ii) For musculoskeletal body areas:

(I) the reimbursement for the first musculoskeletal body area is $385 adjusted per §134.210(b)(4); and

(II) the reimbursement for each additional musculoskeletal body area is $192 adjusted per §134.210(b)(4).

(B) For non-musculoskeletal body areas, the referred doctor must bill, and the insurance carrier must reimburse, for each non-musculoskeletal body area examined.

(i) Non-musculoskeletal body areas are:

(I) body systems;

(II) body structures (including skin); and

(III) mental and behavioral disorders.

(ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides.

(iii) The reimbursement for the assignment of an IR in a non-musculoskeletal body area is $192 adjusted per §134.210(b)(4).

(d) If the examination for the determination of MMI or the assignment of IR requires testing that is not outlined in the AMA Guides, the referred doctor must bill, and the insurance carrier must reimburse, the appropriate testing CPT code or codes according to the applicable fee guideline in addition to the fees for the examination by the referred doctor outlined in subsection (c) of this section.

Source Note: The provisions of this §134.240 adopted to be effective June 1, 2024, 49 TexReg 1489

RULE §134.303 2005 Dental Fee Guideline

(a) Applicability of this rule is as follows:
(1) This section applies to professional dental services provided in the Texas Workers' Compensation system.
(2) This section shall be applicable to professional dental services provided on or after June 15, 2005. For professional dental services provided August 1, 2003 through June 14, 2005, §134.202 of this title (relating to Medical Fee Guideline) shall be applicable. For professional dental services provided December 1, 1996 through July 31, 2003, §134.302 of this title (relating to Dental Fee Guideline) shall be applicable.
(3) Specific provisions contained in the Texas Workers' Compensation Act (the Act), or Texas Workers' Compensation Commission (commission) rules, including this rule, shall take precedence over any provision adopted by or utilized by Texas Medicaid in administering the Texas Medicaid Dental Fee Schedule. Independent Review Organization (IRO) decisions regarding medical necessity are made on a case-by-case basis. The commission will monitor IRO decisions to determine whether commission rulemaking action would be appropriate.
(4) Whenever a component of the Texas Medicaid Dental Fee Schedule is revised and effective, use of the revised component shall be required for compliance with commission rules, decisions and orders for services rendered on or after the effective date of the revised component.

(b) For coding, billing, reporting, and reimbursement of dental treatments and services, Texas Workers' Compensation system participants shall apply the Texas Medicaid Dental Fee Schedule in effect on the date a service is provided with any additions or exceptions in this section.

(c) To determine the maximum allowable reimbursements (MARs), the following apply:

(1) The fees listed for the procedure codes in the Texas Medicaid Dental Fee Schedule shall be multiplied by 200%.
(2) For products and services for which the Texas Medicaid Dental Fee Schedule does not establish a value, the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments.

(d) Reimbursement for dental laboratory procedures is bundled with the maximum fees for the associated dental procedures. No additional reimbursement shall be due.

(e) In all cases, reimbursement shall be the lesser of the:
(1) MAR amount;
(2) health care provider's usual and customary charge; or
(3) workers' compensation negotiated and/or contracted amount that applies to the billed service(s).

Source Note: The provisions of this §134.303 adopted to be effective June 9, 2005, 30 TexReg 3232

SUBCHAPTER E HEALTH FACILITY FEES

RULE §134.402 Ambulatory Surgical Center Fee Guideline

(a) Applicability of this rule is as follows:
(1) This section applies to facility services provided on or after September 1, 2008 by an ambulatory surgical center (ASC), other than professional medical services.
(2) This section does not apply to:
(A) professional medical services billed by a health care provider not employed by the ASC, except for a surgical implant provider as described in this section; or
(B) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.

(b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise.
(1) "Ambulatory Surgical Center" means a health care facility appropriately licensed by the Texas Department of State Health Services.
(2) "ASC device portion" means the portion of the ASC payment rate that represents the cost of the implantable device, and is calculated by applying the Centers for

Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS) device offset percentage to the OPPS payment rate.

(3) "ASC service portion" means the Medicare ASC payment rate less the device portion.

(4) "Device intensive procedure" means an ASC covered surgical procedure that has been designated by CMS as device intensive in TABLE 56 - ASC COVERED SURGICAL PROCEDURES DESIGNATED AS DEVICE INTENSIVE FOR CY 2008 or its successor.

(5) "Implantable" means an object or device that is surgically:

(A) implanted,

(B) embedded,

(C) inserted,

(D) or otherwise applied, and

(E) related equipment necessary to operate, program, and recharge the implantable.

(6) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

(7) "Surgical implant provider" means a person that arranges for the provision of implantable devices to a health care facility and that then seeks reimbursement for the implantable devices provided directly from an insurance carrier.

(c) A surgical implant provider is subject to Chapter 133 of this title and is considered a health care provider for purposes of this section and the sections in Chapter 133.

(d) For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

(1) Specific provisions contained in the 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 the CMS in administering the Medicare program.

(2) Independent Review Organization decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

(3) Whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions, and orders for services rendered on and after the effective date, or after the effective date or the adoption date of the revised Medicare component, whichever is later.

(e) Regardless of billed amount, reimbursement shall be:

(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any reimbursement for implantables.

(3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

(f) The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the Federal Register, or its successor. The following minimal modifications apply:

(1) Reimbursement for non-device intensive procedures shall be:

(A) The Medicare ASC facility reimbursement amount multiplied by 235 percent; or

(B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of:

(i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and

(ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent.

(2) Reimbursement for device intensive procedures shall be:

(A) the sum of:

(i) the ASC device portion; and

(ii) the ASC service portion multiplied by 235 percent; or

(B) If an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the device intensive procedure shall be the sum of:

(i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and

(ii) the ASC service portion multiplied by 235 percent.

(g) A facility, or surgical implant provider with written agreement of the facility, may request separate reimbursement for an implantable.

(1) The facility or surgical implant provider requesting reimbursement for the implantable shall:

(A) bill for the implantable on the Medicare-specific billing form for ASCs;

(B) include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge," and shall be signed by an authorized representative of the facility or surgical implant provider who has personal knowledge of the cost of the implantable and any rebates or discounts to which the facility or surgical implant provider may be entitled.

(2) An insurance carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding §133.307(d)(2)(B) of this title.

(3) Nothing in this rule precludes an ASC or insurance carrier from utilizing a surgical implant provider to arrange for the provision of implantable devices. Implantables provided by a surgical implant provider shall be reimbursed according to this subsection.

(h) For medical services provided in an ASC, but not addressed in the Medicare payment policies as outlined in subsection (f) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

(i) If Medicare prohibits a service from being performed in an ASC setting, the insurance carrier, health care provider, and ASC may agree, on a voluntary basis, to an ASC setting as follows:

(1) The agreement may occur before, or during, preauthorization.

(2) A preauthorization request may be submitted for an ASC facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request.

(3) The agreement between the insurance carrier and the ASC must be in writing, in clearly stated terms, and include:

(A) the reimbursement amount;

(B) any other provisions of the agreement; and

(C) names, titles and signatures of both parties with dates.

(4) Copies of the agreement are to be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1).
(5) Upon request of the Division, the agreement information shall be submitted in the form and manner prescribed by the Division.

(j) Where any terms or parts of this section or its application to any person or circumstance are determined by a court of competent jurisdiction to be invalid, the invalidity does not affect other provisions or applications of this section that can be given effect without the invalidated provision or application.

Source Note: The provisions of this §134.402 adopted to be effective May 9, 2004, 29 TexReg 4191; amended to be effective March 10, 2005, 30 TexReg 1290; amended to be effective December 30, 2007, 32 TexReg 9696; amended to be effective August 31, 2008, 33 TexReg 6830

RULE §134.403 Hospital Facility Fee Guideline—Outpatient

(a) Applicability of this section is as follows.
(1) This section applies to medical services provided in an outpatient acute care hospital on or after March 1, 2008.
(2) This section does not apply to:
(A) professional medical services billed by a provider not employed by the hospital, except for a surgical implant provider as described in this section; or
(B) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.

(b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise.
(1) "Acute care hospital" means a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma.
(2) "Implantable" means an object or device that is surgically:
(A) implanted,
(B) embedded,
(C) inserted,
(D) or otherwise applied, and
(E) related equipment necessary to operate, program and recharge the implantable.

(3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

(4) "Outpatient" means the patient is not admitted for inpatient or residential care. Outpatient medical services includes observation in an outpatient status provided the observation period complies with Medicare policies.

(5) "Surgical implant provider" means a person that arranges for the provision of implantable devices to a health care facility and that then seeks reimbursement for the implantable devices provided directly from an insurance carrier.

(c) A surgical implant provider is subject to Chapter 133 of this title and is considered a health care provider for purposes of this section and the sections in Chapter 133 of this title (relating to Benefits--Medical Benefits).

(d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

(1) Specific provisions contained in 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 the CMS in administering the Medicare program.

(2) Independent Review Organization decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

(3) Whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions, and orders for services rendered on and after the effective date, or after the effective date or the adoption date of the revised Medicare component, whichever is later.

(e) Regardless of billed amount, reimbursement shall be:

(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.

(3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as

outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

(f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

(2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

(1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

(2) A carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding 133.307(d)(2)(B) of this title.

(3) Nothing in this rule precludes a health care facility or insurance carrier from utilizing a surgical implant provider to arrange for the provision of implantable devices. Implantables provided by a surgical implant provider shall be reimbursed according to this subsection.

(h) For medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

(i) Notwithstanding Medicare payment policies, whenever Medicare requires a specific setting for a service, that restriction shall apply, unless an alternative setting and payment has been approved through the Division's preauthorization, concurrent review, or voluntary certification of health care process.

(j) A preauthorization request may be submitted for an alternative facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request. Copies of the agreement shall be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1).

(1) The agreement between the insurance carrier and the party that requested the alternative facility setting must be in writing, in clearly stated terms, and include:

(A) the reimbursement amount;

(B) a description of the services to be performed under the agreement;

(C) any other provisions of the agreement; and

(D) names of the entities, titles, and signatures of both parties, and names, titles, signatures with dates of the persons signing the agreement.

(2) An agreement for an alternative facility setting may be revised during or after preauthorization by written agreement of the insurance carrier and the party that requested the alternative facility setting.

(3) Upon request of the Division, all agreement information shall be submitted in the form and manner prescribed by the Division.

(k) If a court of competent jurisdiction holds that any provision of this section is inconsistent with any statutes of this state, are unconstitutional, or are invalid for any reason, the remaining provisions of this section shall remain in full effect.

Source Note: The provisions of this §134.403 adopted to be effective March 1, 2008, 33 TexReg 400

RULE §134.404 Hospital Facility Fee Guideline—Inpatient

(a) Applicability of this section is as follows.

(1) This section applies to medical services provided in an inpatient acute care hospital with an admission date on or after March 1, 2008.
(2) For admission dates prior to March 1, 2008, the law and Division of Workers' Compensation (Division) rules in effect for those dates of service shall apply.
(3) This section does not apply to:
(A) professional medical services billed by a provider not employed by the hospital, except for a surgical implant provider as described in this section; or
(B) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.

(b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise.
(1) "Acute care hospital" means a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma.
(2) "Implantable" means an object or device that is surgically:
(A) implanted,
(B) embedded,
(C) inserted,
(D) or otherwise applied, and
(E) related equipment necessary to operate, program and recharge the implantable.
(3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.
(4) "Outlier payment amount" means the amount determined through use of the calculations described in subsection (f) of this section.
(5) "Surgical implant provider" means a person that arranges for the provision of implantable devices to a health care facility and that then seeks reimbursement for the implantable devices provided directly from an insurance carrier.

(c) A surgical implant provider is subject to Chapter 133 of this title and is considered a health care provider for purposes of this section and the sections in Chapter 133 of this title (relating to Benefits--Medical Benefits).

(d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

(1) Specific provisions contained in 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 the CMS in administering the Medicare program.

(2) Independent Review Organization decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

(3) Whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions, and orders for services rendered on and after the effective date, or after the effective date or the adoption date of the revised Medicare component, whichever is later.

(e) Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:

(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.

(3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

(f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 143 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.

(2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

(1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

(2) A carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding §133.307(d)(2)(B) of this title.

(3) Nothing in this rule precludes a health care facility or insurance carrier from utilizing a surgical implant provider to arrange for the provision of implantable devices. Implantables provided by a surgical implant provider shall be reimbursed according to this subsection.

(h) A hospital that is classified by Medicare as a Sole Community Hospital, a Medicare Dependent Hospital, or a Rural Referral Center Hospital, shall initially be paid the amount calculated for such hospital in accordance with subsections (e) through (g) of this section. If the initial payment is less than the cost of the services in question, the hospital may request reconsideration in accordance with §133.250 of this title (relating to Reconsideration for Payment of Medical Bills) and present documentation of any amount it would have been paid under the Medicare regulations in effect when the services were performed. If such a showing is made, the hospital shall be paid the difference between the amount initially paid and the amount Medicare would have paid for the services as adjusted by the appropriate multiplier.

(i) Notwithstanding Medicare payment policies, whenever Medicare requires a specific setting for a service, that restriction shall apply, unless an alternative setting and payment has been approved through the Division's preauthorization, concurrent review, or voluntary certification of health care process.

(j) A preauthorization request may be submitted for an alternative facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as

a part of the preauthorization request. Copies of the agreement shall be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1).

(1) The agreement between the insurance carrier and the party that requested the alternative facility setting must be in writing, in clearly stated terms, and include:

(A) the reimbursement amount;

(B) a description of the services to be performed under the agreement;

(C) any other provisions of the agreement; and

(D) names of the entities, titles and signatures of both parties, and names, titles, signatures with dates of the persons signing the agreement.

(2) An agreement for an alternative facility setting may be revised during or after preauthorization by written agreement of the insurance carrier and the party that requested the alternative facility setting.

(3) Upon request of the Division, the agreement information shall be submitted in the form and manner prescribed by the Division.

(k) If a court of competent jurisdiction holds that any provision of this section is inconsistent with any statutes of this state, are unconstitutional, or are invalid for any reason, the remaining provisions of this section shall remain in full effect.

Source Note: The provisions of this §134.404 adopted to be effective March 1, 2008, 33 TexReg 400

SUBCHAPTER F PHARMACEUTICAL BENEFITS

RULE §134.500 Definitions

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

(1) Brand-name drug--A drug marketed under a proprietary, trademark-protected name.

(2) Certified workers' compensation health care network (certified network)--An organization that is certified under Insurance Code Chapter 1305 and department rules.

(3) Closed formulary--All available Food and Drug Administration (FDA) approved prescription and nonprescription drugs prescribed and dispensed for outpatient use, but excludes:

(A) drugs identified with a status of "N" in the current edition of the Official Disability Guidelines Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;

(B) any prescription drug created through compounding prescribed before July 1, 2018, that contains a drug identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;

(C) any prescription drug created through compounding prescribed and dispensed on or after July 1, 2018; and

(D) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

(4) Compounding--As defined under Occupations Code §551.003(9), the preparation, mixing, assembling, packaging, or labeling of a drug or device:

(A) as the result of a practitioner's prescription drug order based on the practitioner-patient-pharmacist relationship in the course of professional practice;

(B) for administration to a patient by a practitioner as the result of a practitioner's initiative based on the practitioner-patient-pharmacist relationship in the course of professional practice;

(C) in anticipation of a prescription drug order based on a routine, regularly observed prescribing pattern; or

(D) for or as an incident to research, teaching, or chemical analysis and not for selling or dispensing, except as allowed under Occupations Code §562.154 or Occupations Code Chapter 563.

(5) Generic--See generically equivalent in definition of paragraph (6) of this section.

(6) Generically equivalent--As defined under Occupations Code §562.001, a drug that, when compared to the prescribed drug, is:

(A) pharmaceutically equivalent--Drug products that have identical amounts of the same active chemical ingredients in the same dosage form and that meet the identical compendia or other applicable standards of strength, quality, and purity according to the United States Pharmacopoeia or another nationally recognized compendium; and

(B) therapeutically equivalent--Pharmaceutically equivalent drug products that, if administered in the same amounts, will provide the same therapeutic effect, identical in duration and intensity.

(7) Medical emergency--The sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain that, in the absence of immediate medical attention, could reasonably be expected to result in:

(A) placing the patient's health or bodily functions in serious jeopardy; or

(B) serious dysfunction of any body organ or part.

(8) Nonprescription drug or over-the-counter medication--A non-narcotic drug that may be sold without a prescription and that is labeled and packaged in compliance with state or federal law.

(9) Prescribing doctor--A physician or dentist who prescribes prescription drugs or over-the-counter medications in accordance with the physician's or dentist's license and state and federal laws and rules. For purposes of this chapter, prescribing doctor includes an advanced practice nurse or physician assistant to whom a physician has delegated the authority to carry out or sign prescription drug orders, under Occupations Code Chapter 157, who prescribes prescription drugs or over-the-counter medication under the physician's supervision and in accordance with the health care practitioner's license and state and federal laws and rules.

(10) Prescription--An order for a prescription or nonprescription drug to be dispensed.

(11) Prescription drug--

(A) A substance for which federal or state law requires a prescription before the substance may be legally dispensed to the public;

(B) A drug that under federal law is required, before being dispensed or delivered, to be labeled with the statement: "Caution: federal law prohibits dispensing without prescription;" "Rx only;" or another legend that complies with federal law; or

(C) A drug that is required by federal or state statute or regulation to be dispensed on prescription or that is restricted to use by a prescribing doctor only.

(12) Statement of medical necessity--A written statement from the prescribing doctor to establish the need for treatments or services, or prescriptions, including the need for a brand-name drug where applicable. A statement of medical necessity must include:

(A) the injured employee's full name;

(B) the date of injury;

(C) the last four digits of the injured employee's Social Security number;

(D) the diagnosis code or codes;

(E) whether the drug has previously been prescribed and dispensed, if known, and whether the inability to obtain the drug poses an unreasonable risk of a medical emergency; and

(F) how the prescription treats the diagnosis, promotes recovery, or enhances the ability of the injured employee to return to or retain employment.

(13) Substitution--As defined under Occupations Code §551.003(41), the dispensing of a drug or a brand of drug other than the drug or brand of drug ordered or prescribed.

Source Note: The provisions of this §134.500 adopted to be effective January 3, 2002, 26 TexReg 10970; amended to be effective January 17, 2011, 35 TexReg 11344; amended to be effective April 22, 2018, 43 TexReg 2275; amended to be effective November 28, 2024, 49 TexReg 9758

RULE §134.501 Initial Pharmaceutical Coverage

(a) For injuries that occur on or after December 1, 2002, the insurance carrier must pay for specified pharmaceutical services sufficient for the first seven days following the date of injury, regardless of issues of liability for or compensability of the injury that the insurance carrier may have, if, before providing the pharmaceutical services, the health care provider obtains both a verification of insurance coverage and an oral or written confirmation that an injury has been reported.

(1) For purposes of this rule, specified pharmaceutical services are prescription drugs and over-the-counter medications prescribed by a doctor that cure or relieve the effects naturally resulting from the compensable injury, promote recovery, or enhance the ability of the injured employee to return to or retain employment.

(2) In determining the first seven days following the injury, the date of the injury is not counted. The first day after the date of injury is "day one." The last day of the seven-day period is "day seven."

(3) If the pharmaceutical services are provided after day one, the insurance carrier's reimbursement under this section is limited to the date the pharmaceutical services were actually provided through day seven. (Example: The pharmaceutical services were provided on day four. The insurance carrier's liability for payment under this section would be for pharmaceutical services in an amount prescribed that would be the quantity sufficient for days four, five, six, and seven.)

(4) Payment for the specified pharmaceutical services for the first seven days following the date of injury must comply with §134.503 of this title (Pharmacy Fee Guideline). The insurance carrier must not deny, prorate, or reduce the dispensing fee for the initial prescription even if the health care provider provided pharmaceutical services beyond the first seven days following the date of injury, and the insurance carrier disputes or denies the pharmaceutical services beyond the first seven days following the date of injury.

(b) The insurance carrier may be eligible for reimbursement from the subsequent injury fund (SIF) for payments made under subsection (a) as provided in Chapter 116 of this title.

(c) The health care provider can verify insurance coverage and confirm the existence of a report of an injury by calling the employer or the insurance carrier. On request, the employer or the insurance carrier must verify coverage and confirm any report of an injury. For verifying insurance coverage, the health care provider can also review the division's internet-based coverage verification system.
  (1) The health care provider must document verifications and confirmations not obtained in writing by indicating how the verification or confirmation was obtained (date obtained, from whom, etc.).
  (2) The health care provider must affirm on the bill for the pharmaceutical services, in the form and manner prescribed by the division, that the health care provider verified that there is insurance coverage and confirmed that an injury has been reported.

(d) Notwithstanding any other provision of this section, the health care provider may dispense prescription or nonprescription medications in the amount ordered by the prescribing doctor under applicable state and federal law (not to exceed the limits imposed by §134.502 of this title (Pharmaceutical Services)).

(e) The health care provider and insurance carrier may voluntarily discuss approval of pharmaceutical services beyond the seven days following the date of injury as provided in Texas Labor Code §413.014(e) and §134.600 of this title (Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care).

(f) Communication is important to ensure prompt delivery of pharmaceutical services.
  (1) Injured employees are encouraged to immediately report their injury to their employer.
  (2) Injured employees are encouraged to ask for, and employers to provide, a written statement that confirms an injury was reported to the employer and identifies the date of injury (as reported by the injured employee) and the employer's insurance carrier. Verifying that there is insurance coverage or confirming that an injury was reported does not waive the employer's right to contest compensability under Texas Labor Code §409.011 should the insurance carrier accept liability for the payment of benefits.
  (3) The insurance carrier's verification of coverage or confirmation of a reported injury does not waive the insurance carrier's right to further review the claim under Texas Labor Code §409.021 and §124.3 of this title (Investigation of an Injury and Notice of Denial or Dispute).

Source Note: The provisions of this §134.501 adopted to be effective November 7, 2002, 27 TexReg 10391; amended to be effective November 28, 2024, 49 TexReg 9758

RULE §134.502 Pharmaceutical Services

(a) A doctor providing care to an injured employee must prescribe for the employee medically necessary prescription drugs and over-the-counter medication alternatives as clinically appropriate and applicable in accordance with applicable state law and as provided by this section.

(1) The doctor must indicate on the prescription that the prescription is related to a workers' compensation claim.

(2) When prescribing an over-the-counter medication alternative to a prescription drug, the doctor must indicate on the prescription the appropriate strength of the medication and the approximate quantity of the over-the-counter medication that is reasonably required by the nature of the compensable injury.

(3) The doctor must prescribe generic prescription drugs when available and clinically appropriate. If in the medical judgment of the prescribing doctor a brand-name drug is necessary, the doctor must specify on the prescription that brand-name drugs be dispensed in accordance with applicable state and federal law, and must maintain documentation justifying the use of the brand-name drug, in the patient's medical record.

(4) The doctor must prescribe over-the-counter medications instead of a prescription drug when clinically appropriate.

(b) When prescribing, the doctor must prescribe in accordance with §134.530 and §134.540 of this title (Closed Formulary for Claims Not Subject to Certified Networks and Closed Formulary for Claims Subject to Certified Networks, respectively).

(c) The pharmacist must dispense no more than a 90-day supply of a prescription drug.

(d) Pharmacies and pharmacy processing agents must submit bills for pharmacy services in accordance with Chapter 133 (General Medical Provisions) and Chapter 134 (Benefits--Guidelines for Medical Services, Charges, and Payments).

(1) Health care providers must bill using national drug codes (NDC) when billing for prescription drugs.

(2) Compound drugs must be billed by listing each drug included in the compound and calculating the charge for each drug separately.

(3) A pharmacy may contract with a separate person or entity to process bills and payments for a medical service. However, these entities are subject to the direction of

the pharmacy, and the pharmacy is responsible for the acts and omissions of the person or entity.
(4) Except as allowed by Labor Code §413.042, the injured employee must not be billed for pharmacy services.

(e) The insurance carrier, injured employee, or pharmacist may request a statement of medical necessity from the prescribing doctor.
(1) If an insurance carrier requests a statement of medical necessity, the insurance carrier must provide the sender of the bill a copy of the request at the time the request is made.
(2) An insurance carrier must not request a statement of medical necessity unless in the absence of such a statement the insurance carrier could reasonably support a denial based on extent of, or relatedness to, the compensable injury or based on an adverse determination.

(f) The prescribing doctor must provide a statement of medical necessity to the requesting party no later than the 14th day after receiving the request. The prescribing doctor must not bill for, and the insurance carrier must not reimburse for, the statement of medical necessity.

(g) In addition to the requirements of §133.240 of this title (Medical Payments and Denials) regarding explanation of benefits (EOB), at the time an insurance carrier denies payment for medications for any reason related to compensability of, liability for, extent of, or relatedness to the compensable injury, or for reasons related to an adverse determination, the insurance carrier must also send the EOB to the injured employee and the prescribing doctor.

Source Note: The provisions of this §134.502 adopted to be effective January 3, 2002, 26 TexReg 10970; amended to be effective January 1, 2003, 27 TexReg 12353; amended to be effective March 30, 2014, 39 TexReg 2102; amended to be effective November 28, 2024, 49 TexReg 9758

RULE §134.503 Pharmacy Fee Guideline

(a) Applicability of this section is as follows:
(1) This section applies to the reimbursement of prescription drugs and nonprescription drugs or over-the-counter medications as those terms are defined in §134.500 of this title (Definitions) for outpatient use in the Texas workers' compensation system, which includes claims:

(A) subject to a certified workers' compensation health care network as defined in §134.500 of this title;

(B) not subject to a certified workers' compensation health care network; and

(C) subject to Labor Code §504.053(b)(2).

(2) This section does not apply to parenteral drugs.

(b) For coding, billing, reporting, and reimbursement of prescription drugs and nonprescription drugs or over-the-counter medications, Texas workers' compensation system participants must comply with Chapters 133 and 134 of this title (General Medical Provisions and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively).

(c) The insurance carrier must reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:

(1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:

(A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;

(B) Brand-name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;

(C) When compounding, a single compounding fee of $15 per prescription must be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or

(2) notwithstanding §133.20(e)(1) of this title (Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:

(A) health care provider; or

(B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug, and the pharmacy processing agent is billing on behalf of the health care provider.

(d) Reimbursement for nonprescription drugs or over-the-counter medications must be the retail price of the lowest package quantity reasonably available that will fill the prescription.

(e) Except as provided by subsection (f) of this section, if an amount cannot be determined under subsections (c)(1) or (d) of this section, reimbursement must be an amount that is consistent with the criteria listed in Labor Code §408.028(f), including providing for reimbursement rates that are fair and reasonable. The insurance carrier must:

(1) develop one or more reimbursement methodologies for determining reimbursement under this subsection;
(2) maintain in reproducible format documentation of the insurance carrier's methodologies for establishing an amount;
(3) apply the reimbursement methodologies consistently among health care providers in determining reimbursements under this subsection; and
(4) on the division's request, provide to the division copies of such documentation.

(f) Notwithstanding the provisions of this section, the insurance carrier may reimburse prescription medication or services, as defined by Labor Code §401.011(19)(E), at a contract rate that is inconsistent with the fee guideline as long as the contract complies with the provisions of Labor Code §408.0281 and applicable division rules.

(g) When the prescribing doctor has written a prescription for a generic drug or a prescription that does not require the use of a brand-name drug under §134.502(a)(3) of this title (Pharmaceutical Services), reimbursement must be as follows:
(1) the health care provider must dispense the generic drug as prescribed, and the insurance carrier must reimburse the fee established for the generic drug, under subsection (c) or (f) of this section; or
(2) when an injured employee chooses to receive a brand-name drug instead of the prescribed generic drug, the health care provider must dispense the brand-name drug as requested and must be reimbursed:
(A) by the insurance carrier, the fee established for the prescribed generic drug under subsection (c) or (f) of this section; and
(B) by the injured employee, the cost difference between the fee established for the generic drug in subsection (c) or (f) of this section and the fee established for the brand-name drug under subsection (c) or (f) of this section.

(h) When the prescribing doctor has written a prescription for a brand-name drug under §134.502(a)(3) of this title, reimbursement must be under subsection (c) or (f) of this section.

(i) On request by the health care provider or the division, the insurance carrier must disclose the source of the nationally recognized pricing reference used to calculate the reimbursement.

(j) Where any provision of this section is determined by a court of competent jurisdiction to be inconsistent with any statutes of this state, or to be unconstitutional, the remaining provisions of this section remain in effect.

Source Note: The provisions of this §134.503 adopted to be effective January 3, 2002, 26 TexReg 10970; amended to be effective March 14, 2004, 29 TexReg 2346; amended to be effective October 23, 2011, 36 TexReg 6949; amended to be effective November 28, 2024, 49 TexReg 9758

RULE §134.504 Pharmaceutical Expenses Incurred by the Injured Employee

(a) If an injured employee needs to purchase prescription drugs or over-the-counter alternatives to prescription drugs prescribed or ordered by the treating doctor or referral health care provider, the injured employee may request reimbursement from the insurance carrier as follows:

(1) The injured employee must submit to the insurance carrier a letter requesting reimbursement along with a receipt indicating the amount paid and documentation concerning the prescription.

(A) The letter should include information to clearly identify the claimant such as the claimant's name, address, date of injury, and Social Security number.

(B) Documentation for prescription drugs submitted with the letter from the employee must include the prescribing health care provider's name, the date the prescription was filled, the name of the drug, employee's name, and dollar amount paid by the employee. As examples, this information may be on an information sheet provided by the pharmacy, or the employee can ask the pharmacist for a printout of work-related prescriptions for a particular time period. Cash register receipts alone are not acceptable.

(2) The insurance carrier must pay the injured employee under §134.503 of this title (Pharmacy Fee Guideline), or notify the injured employee of a reduction or denial of the payment within 45 days of receiving the request for reimbursement from the injured employee.

(A) If the insurance carrier does not reimburse the full amount requested or denies payment, the insurance carrier must include a full and complete explanation of the reasons the insurance carrier reduced or denied the payment and must inform the injured employee of his or her right to request medical dispute resolution under §133.305 of this title (MDR--General).

(B) The statement must include sufficient claim-specific substantive information to enable the employee to understand the insurance carrier's position or action on the claim. A general statement that simply states the insurance carrier's position with a phrase such as, "not entitled to reimbursement" or a similar phrase with no further description of the factual basis does not satisfy the requirements of this section.

(b) An injured employee may choose to receive a brand-name drug rather than a generic drug or over-the-counter alternative to a prescription medication that is

prescribed by a health care provider. In such instances, the injured employee must pay the difference in cost between the generic drug and the brand-name drug. The transaction between the employee and the pharmacist is considered final and is not subject to medical dispute resolution by the division. In addition, the employee is not entitled to reimbursement from the insurance carrier for the difference in cost between generic and brand-name drugs.

(1) The injured employee must notify the pharmacist of their choice to pay the cost difference between the generic and brand-name drugs. An employee's payment of the cost difference is an acceptance of the responsibility for the cost difference and an agreement not to seek reimbursement from the insurance carrier for the cost difference.

(2) The pharmacist must:

(A) determine the costs of both the brand-name and generic drugs under §134.503 of this title, and notify the injured employee of the cost difference amount;

(B) collect the cost difference amount from the injured employee in a form and manner that is acceptable to both parties;

(C) submit a bill to the insurance carrier for the generic drug that was prescribed by the doctor; and

(D) not bill the injured employee for the cost of the generic drug if the insurance carrier reduces or denies the bill.

(3) The insurance carrier must review and process the bill from the pharmacist under Chapters 133 and 134 (General Medical Provisions and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively).

Source Note: The provisions of this §134.504 adopted to be effective January 3, 2002, 26 TexReg 10970; amended to be effective March 14, 2004, 29 TexReg 2346; amended to be effective October 23, 2011, 36 TexReg 6949; amended to be effective November 28, 2024, 49 TexReg 9758

RULE §134.520 Outpatient Closed Formulary

The commissioner of workers' compensation adopts a closed formulary as defined in §134.500(3) of this title (Definitions). The closed formulary applies to all drugs that are prescribed and dispensed for outpatient use.

Source Note: The provisions of this §134.520 adopted to be effective January 17, 2011, 35 TexReg 11344; amended to be effective November 28, 2024, 49 TexReg 9758

RULE §134.530 Closed Formulary for Claims Not Subject to Certified Networks

(a) Applicability. The closed formulary applies to all drugs that are prescribed and dispensed for outpatient use for claims not subject to a certified network.

(b) Preauthorization for claims subject to the division's closed formulary.
(1) Preauthorization is only required for:
(A) drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;
(B) any prescription drug created through compounding; and
(C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but that is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).
(2) When §134.600(p)(12) of this title (Preauthorization, Concurrent Utilization Review, and Voluntary Certification of Health Care) conflicts with this section, this section prevails.

(c) Preauthorization of intrathecal drug delivery systems.
(1) An intrathecal drug delivery system requires preauthorization under §134.600 of this title, and the preauthorization request must include the prescribing doctor's drug regimen plan of care and the anticipated dosage or range of dosages for the administration of pain medication.
(2) Refills of an intrathecal drug delivery system with drugs excluded from the closed formulary, which are billed using Healthcare Common Procedure Coding System (HCPCS) Level II J codes, and submitted on a CMS-1500 or UB-04 billing form, require preauthorization on an annual basis. Preauthorization for these refills is also required whenever:
(A) the medications, dosage or range of dosages, or the drug regimen proposed by the prescribing doctor differs from the medications, dosage or range of dosages, or drug regimen previously preauthorized by that prescribing doctor; or
(B) there is a change in prescribing doctor.

(d) Treatment guidelines. Except as provided by this subsection, the prescribing of drugs must be in accordance with §137.100 of this title (Treatment Guidelines), the division's adopted treatment guidelines.
(1) Prescription and nonprescription drugs included in the division's closed formulary and recommended by the division's adopted treatment guidelines may be prescribed and dispensed without preauthorization.

(2) Prescription and nonprescription drugs included in the division's closed formulary that exceed or are not addressed by the division's adopted treatment guidelines may be prescribed and dispensed without preauthorization.

(3) Drugs included in the closed formulary that are prescribed and dispensed without preauthorization are subject to retrospective review of medical necessity and reasonableness of health care by the insurance carrier under subsection (g) of this section.

(e) Appeals process for drugs excluded from the closed formulary.

(1) When the prescribing doctor determines and documents that a drug excluded from the closed formulary is necessary to treat an injured employee's compensable injury and has prescribed the drug, the prescribing doctor, other requester, or injured employee must request approval of the drug by requesting preauthorization, including reconsideration, under §134.600 of this title and applicable provisions of Chapter 19 of this title (Licensing and Regulation of Insurance Professionals).

(2) If an injured employee or a requester other than the prescribing doctor requests preauthorization and a statement of medical necessity, the prescribing doctor must provide a statement of medical necessity to facilitate the preauthorization submission under §134.502 of this title (Pharmaceutical Services).

(3) If preauthorization for a drug excluded from the closed formulary is denied, the requester may submit a request for medical dispute resolution under §133.308 of this title (MDR of Medical Necessity Disputes).

(4) In the event of an unreasonable risk of a medical emergency, an interlocutory order may be obtained in accordance with §133.306 of this title (Interlocutory Orders for Medical Benefits) or §134.550 of this title (Medical Interlocutory Order).

(f) Initial pharmaceutical coverage.

(1) Drugs included in the closed formulary that are prescribed for initial pharmaceutical coverage under Labor Code §413.0141 may be dispensed without preauthorization and are not subject to retrospective review of medical necessity.

(2) Drugs excluded from the closed formulary that are prescribed for initial pharmaceutical coverage under Labor Code §413.0141 may be dispensed without preauthorization and are subject to retrospective review of medical necessity.

(g) Retrospective review. Except as provided in subsection (f)(1) of this section, drugs that do not require preauthorization are subject to retrospective review for medical necessity under §133.230 of this title (Insurance Carrier Audit of a Medical Bill) and §133.240 of this title (Medical Payments and Denials), and applicable provisions of Chapter 19 of this title.

(1) Health care, including a prescription for a drug, provided under §137.100 of this title is presumed reasonable as Labor Code §413.017 specifies, and is also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).
(2) For an insurance carrier to deny payment subject to a retrospective review for pharmaceutical services that are recommended by the division's adopted treatment guidelines in §137.100 of this title, the denial must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established under Labor Code §413.017.
(3) A prescribing doctor who prescribes pharmaceutical services that exceed, are not recommended, or are not addressed by §137.100 of this title must provide documentation on request under §134.500(13) of this title (Definitions) and §134.502(e) and (f) of this title.

Source Note: The provisions of this §134.530 adopted to be effective January 17, 2011, 35 TexReg 11344; amended to be effective April 22, 2018, 43 TexReg 2275; amended to be effective November 28, 2024, 49 TexReg 9758

RULE §134.540 Closed Formulary for Claims Subject to Certified Networks

(a) Applicability. The closed formulary applies to all drugs that are prescribed and dispensed for outpatient use for claims subject to a certified network.

(b) Preauthorization for claims subject to the division's closed formulary. Preauthorization is only required for:
(1) drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;
(2) any prescription drug created through compounding; and
(3) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but that is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

(c) Preauthorization of intrathecal drug delivery systems.
(1) An intrathecal drug delivery system requires preauthorization under the certified network's treatment guidelines and preauthorization requirements in Insurance Code Chapter 1305 and Chapter 10 of this title (Workers' Compensation Health Care Networks).
(2) Refills of an intrathecal drug delivery system with drugs excluded from the closed formulary, which are billed using Healthcare Common Procedure Coding System

(HCPCS) Level II J codes, and submitted on a CMS-1500 or UB-04 billing form, require preauthorization on an annual basis. Preauthorization for these refills is also required whenever:

(A) the medications, dosage or range of dosages, or the drug regimen proposed by the prescribing doctor differs from the medications, dosage or range of dosages, or drug regimen previously preauthorized by that prescribing doctor; or

(B) there is a change in prescribing doctor.

(d) Treatment guidelines. The prescribing of drugs must be under the certified network's treatment guidelines and preauthorization requirements in Insurance Code Chapter 1305 and Chapter 10 of this title. Drugs included in the closed formulary that are prescribed and dispensed without preauthorization are subject to retrospective review of medical necessity and reasonableness of health care by the insurance carrier under subsection (g) of this section.

(e) Appeals process for drugs excluded from the closed formulary.

(1) When the prescribing doctor determines and documents that a drug excluded from the closed formulary is necessary to treat an injured employee's compensable injury and has prescribed the drug, the prescribing doctor, other requester, or injured employee must request approval of the drug in a specific instance by requesting preauthorization under the certified network's preauthorization process established in Chapter 10, Subchapter F of this title (Utilization Review and Retrospective Review) and applicable provisions of Chapter 19 of this title (Licensing and Regulation of Insurance Professionals).

(2) If an injured employee or a requester other than the prescribing doctor requests preauthorization and a statement of medical necessity, the prescribing doctor must provide a statement of medical necessity to facilitate the preauthorization submission under §134.502 of this title (Pharmaceutical Services).

(3) If preauthorization for a drug excluded from the closed formulary is denied, the requester may submit a request for medical dispute resolution under §133.308 of this title (MDR of Medical Necessity Disputes).

(4) In the event of an unreasonable risk of a medical emergency, an interlocutory order may be obtained in accordance with §133.306 of this title (Interlocutory Orders for Medical Benefits) or §134.550 of this title (Medical Interlocutory Order).

(f) Initial pharmaceutical coverage.

(1) Drugs included in the closed formulary that are prescribed for initial pharmaceutical coverage under Labor Code §413.0141 may be dispensed without preauthorization and are not subject to retrospective review of medical necessity.

(2) Drugs excluded from the closed formulary that are prescribed for initial pharmaceutical coverage under Labor Code §413.0141 may be dispensed without preauthorization and are subject to retrospective review of medical necessity.

(g) Retrospective review. Except as provided in subsection (f)(1) of this section, drugs that do not require preauthorization are subject to retrospective review for medical necessity under §133.230 of this title (Insurance Carrier Audit of a Medical Bill), §133.240 of this title (Medical Payments and Denials), Insurance Code Chapter 1305, and applicable provisions of Chapters 10 and 19 of this title.

(1) For an insurance carrier to deny payment subject to a retrospective review for pharmaceutical services that fall within the treatment parameters of the certified network's treatment guidelines, the denial must be supported by documentation of evidence-based medicine that outweighs the evidence-basis of the certified network's treatment guidelines.

(2) A prescribing doctor who prescribes pharmaceutical services that exceed, are not recommended, or are not addressed by the certified network's treatment guidelines is required to provide documentation on request under §134.500(13) of this title (Definitions) and §134.502(e) and (f) of this title.

Source Note: The provisions of this §134.540 adopted to be effective January 17, 2011, 35 TexReg 11344; amended to be effective April 22, 2018, 43 TexReg 2275; amended to be effective November 28, 2024, 49 TexReg 9758

RULE §134.550 Medical Interlocutory Order

(a) The purpose of this section is to provide a prescribing doctor or pharmacy an ability to obtain a medical interlocutory order when preauthorization denials of previously prescribed and dispensed drugs excluded from the closed formulary pose an unreasonable risk of a medical emergency as defined in §134.500(7) of this title (Definitions) and Insurance Code §1305.004(a)(13).

(b) A request for an interlocutory order that does not meet the criteria described by this section may still be submitted under §133.306 of this title (Interlocutory Orders for Medical Benefits).

(c) A request for a medical interlocutory order must contain the following information:

(1) injured employee name;

(2) date of birth of injured employee;

(3) prescribing doctor's name;

(4) name of drug and dosage;

(5) requester's name (pharmacy or prescribing doctor);
(6) requester's contact information;
(7) a statement that a preauthorization request for a previously prescribed and dispensed drug, which is excluded from the closed formulary, has been denied by the insurance carrier;
(8) a statement that an independent review request has already been submitted to the insurance carrier or the insurance carrier's utilization review agent under §133.308 of this title (MDR of Medical Necessity Disputes);
(9) a statement that the preauthorization denial poses an unreasonable risk of a medical emergency as defined in §134.500(7) of this title;
(10) a statement that the potential medical emergency has been documented in the preauthorization process;
(11) a statement that the insurance carrier has been notified that a request for a medical interlocutory order is being submitted to the division; and
(12) a signature and the following certification by the medical interlocutory order requester for paragraphs (7) - (12) of this subsection, "I hereby certify under penalty of law that the previously listed conditions have been met."

(d) The division will process and approve a complete request for a medical interlocutory order under this section. At its discretion, the division may consider an incomplete request for a medical interlocutory order.

(e) The request for a medical interlocutory order must be in writing and must contain the information in subsection (c) of this section. A convenient form that contains the required information is on the division's website at https://www.tdi.texas.gov/forms/form20numeric.html.

(f) The requester must provide a copy of the request to the insurance carrier, prescribing doctor, injured employee, and dispensing pharmacy, if known, on the date the requester submits the request to the division.

(g) An approved medical interlocutory order is effective retroactively to the date the division received the complete request for the medical interlocutory order.

(h) Notwithstanding §133.308 of this title:
(1) A request for reconsideration of a preauthorization denial is not required prior to a request for independent review when pursuing a medical interlocutory order under this section. If a request for reconsideration or a medical interlocutory order request is not initiated within 15 days from the initial preauthorization denial, then the opportunity to request a medical interlocutory order under this section does not apply.

(2) If pursuing a medical interlocutory order after denial of a reconsideration request, a complete medical interlocutory order must be submitted within five working days of the reconsideration denial.

(i) An appeal of the independent review organization (IRO) decision relating to the medical necessity and reasonableness of the drugs contained in the medical interlocutory order must be submitted under §133.308(t) of this title.

(j) The medical interlocutory order continues in effect until the later of:
(1) final adjudication of a medical dispute about the medical necessity and reasonableness of the drug contained in the medical interlocutory order;
(2) expiration of the period for a timely appeal; or
(3) agreement of the parties.

(k) If a requester withdraws a request for medical necessity dispute resolution, the requester accepts the preauthorization denial.

(l) A party must comply with a medical interlocutory order entered under this section, and the insurance carrier must reimburse the pharmacy for prescriptions dispensed under a medical interlocutory order.

(m) The insurance carrier must notify the prescribing doctor, injured employee, and the dispensing pharmacy once reimbursement is no longer required under subsection (j) of this section.

(n) Payments made by insurance carriers under this section may be eligible for reimbursement from the subsequent injury fund under Labor Code §§410.209 and 413.055 and applicable rules.

(o) A decision issued by an IRO is not an agency or commissioner decision.

(p) A party may seek to reverse or modify a medical interlocutory order issued under this section if:
(1) a final determination of medical necessity has been rendered; and
(2) the party requests a benefit contested case hearing (CCH) from the division's chief clerk no later than 20 days after the date the IRO decision is sent to the party. A benefit review conference is not a prerequisite to a division CCH under this subsection. Except as provided by this subsection, a division CCH must be conducted under Chapters 140 and 142 of this title (Dispute Resolution--General Provisions and Dispute Resolution--Benefit Contested Case Hearing).

(q) The insurance carrier may dispute an interlocutory order entered under this title by filing a written request for a hearing under Labor Code §413.055 and §148.3 of this title (Requesting a Hearing).

Source Note: The provisions of this §134.550 adopted to be effective January 17, 2011, 35 TexReg 11344; amended to be effective November 28, 2024, 49 TexReg 9758

SUBCHAPTER G PROSPECTIVE AND CONCURRENT REVIEW OF HEALTH CARE

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

(a) The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:
(1) Adverse determination: A determination by a utilization review agent made on behalf of a payor that the health care services provided or proposed to be provided to an injured employee are not medically necessary or appropriate. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review. An adverse determination does not include a determination that health care services are experimental or investigational.
(2) Ambulatory surgical services: surgical services provided in a facility that operates primarily to provide surgical services to patients who do not require overnight hospital care.
(3) Concurrent utilization review: a form of utilization review for on-going health care listed in subsection (q) of this section for an extension of treatment beyond previously approved health care listed in subsection (p) of this section.
(4) Diagnostic study: any test used to help establish or exclude the presence of disease/injury in symptomatic individuals. The test may help determine the diagnosis, screen for specific disease/injury, guide the management of an established disease/injury, and formulate a prognosis.
(5) Final adjudication: the commissioner has issued a final decision or order that is no longer subject to appeal by either party.
(6) Outpatient surgical services: surgical services provided in a freestanding surgical center or a hospital outpatient department to patients who do not require overnight hospital care.
(7) Preauthorization: a form of prospective utilization review by a payor or a payor's utilization review agent of health care services proposed to be provided to an injured employee.

(8) Reasonable opportunity: At least one documented good faith attempt to contact the provider of record that provides an opportunity for the provider of record to discuss the services under review with the utilization review agent during normal business hours prior to issuing a prospective, concurrent, or retrospective utilization review adverse determination:

(A) no less than one working day prior to issuing a prospective utilization review adverse determination;

(B) no less than five working days prior to issuing a retrospective utilization review adverse determination; or

(C) prior to issuing a concurrent or post-stabilization review adverse determination.

(9) Requestor: the health care provider or designated representative, including office staff or a referral health care provider or health care facility that requests preauthorization, concurrent utilization review, or voluntary certification.

(10) Work conditioning and work hardening: return-to-work rehabilitation programs as defined in this chapter.

(b) When division-adopted treatment guidelines conflict with this section, this section prevails.

(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care:

(1) listed in subsection (p) or (q) of this section only when the following situations occur:

(A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);

(B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;

(C) concurrent utilization review of any health care listed in subsection (q) of this section that was approved prior to providing the health care; or

(D) when ordered by the commissioner;

(2) or per subsection (r) of this section when voluntary certification was requested and payment agreed upon prior to providing the health care for any health care not listed in subsection (p) of this section.

(d) The insurance carrier is not liable under subsection (c)(1)(B) or (C) of this section if there has been a final adjudication that the injury is not compensable or that the health care was provided for a condition unrelated to the compensable injury.

(e) The insurance carrier shall designate accessible direct telephone and facsimile numbers and may designate an electronic transmission address for use by the requestor

or injured employee to request preauthorization or concurrent utilization review during normal business hours. The direct number shall be answered or the facsimile or electronic transmission address responded to within the time limits established in subsection (i) of this section. The insurance carrier shall also comply with any additional requirements of §19.2012 of this title (relating to URA's Telephone Access and Procedures for Certain Drug Requests and Post-Stabilization Care).

(f) The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent utilization review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent utilization review shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission and, include the:

(1) name of the injured employee;

(2) specific health care listed in subsection (p) or (q) of this section;

(3) number of specific health care treatments and the specific period of time requested to complete the treatments;

(4) information to substantiate the medical necessity of the health care requested;

(5) accessible telephone and facsimile numbers and may designate an electronic transmission address for use by the insurance carrier;

(6) name of the requestor and requestor's professional license number or national provider identifier, or injured employee's name if the injured employee is requesting preauthorization;

(7) name, professional license number or national provider identifier of the health care provider who will render the health care if different than paragraph (6) of this subsection and if known;

(8) facility name, and the facility's national provider identifier if the proposed health care is to be rendered in a facility; and

(9) estimated date of proposed health care.

(g) A health care provider may submit a request for health care to treat an injury or diagnosis that is not accepted by the insurance carrier in accordance with Labor Code §408.0042.

(1) The request shall be in the form of a treatment plan for a 60 day timeframe.

(2) The insurance carrier shall review requests submitted in accordance with this subsection for both medical necessity and relatedness.

(3) If denying the request, the insurance carrier shall indicate whether it is issuing an adverse determination, and/or whether the denial is based on an unrelated injury or diagnosis in accordance with subsection (m) of this section.

(4) The requestor or injured employee may file an extent of injury dispute upon receipt of an insurance carrier's response which includes a denial due to an unrelated injury or diagnosis, regardless of whether an adverse determination was also issued.

(5) Requests which include a denial due to an unrelated injury or diagnosis may not proceed to medical dispute resolution based on the denial of unrelatedness. However, requests which include the dispute of an adverse determination may proceed to medical dispute resolution for the issue of medical necessity in accordance with subsection (o) of this section.

(h) Except for requests submitted in accordance with subsection (g) of this section, the insurance carrier shall either approve or issue an adverse determination on each request based solely on the medical necessity of the health care required to treat the injury, regardless of:

(1) unresolved issues of compensability, extent of or relatedness to the compensable injury;

(2) the insurance carrier's liability for the injury; or

(3) the fact that the injured employee has reached maximum medical improvement.

(i) The insurance carrier shall contact the requestor or injured employee within the following timeframes by telephone, facsimile, or electronic transmission with the decision to approve the request; issue an adverse determination on a request; or deny a request under subsection (g) of this section because of an unrelated injury or diagnoses as follows:

(1) three working days of receipt of a request for preauthorization; or

(2) three working days of receipt of a request for concurrent utilization review, except for health care listed in subsection (q)(1) of this section, which is due within one working day of the receipt of the request.

(j) The insurance carrier shall send written notification of the approval of the request, adverse determination on the request, or denial of the request under subsection (g) of this section because of an unrelated injury or diagnosis within one working day of the decision to the:

(1) injured employee;

(2) injured employee's representative; and

(3) requestor, if not previously sent by facsimile or electronic transmission.

(k) The insurance carrier's failure to comply with any timeframe requirements of this section shall result in an administrative violation.

(l) The insurance carrier shall not withdraw a preauthorization or concurrent utilization review approval once issued. The approval shall include:
(1) the specific health care;
(2) the approved number of health care treatments and specific period of time to complete the treatments;
(3) a notice of any unresolved dispute regarding the denial of compensability or liability or an unresolved dispute of extent of or relatedness to the compensable injury; and
(4) the insurance carrier's preauthorization approval number that conforms to the standards described in §19.2009(a)(4) of this title (relating to Notice of Determinations Made in Utilization Review).

(m) In accordance with §19.2010 of this title (relating to Requirements Prior to Issuing Adverse Determination), the insurance carrier shall afford the requestor a reasonable opportunity to discuss the clinical basis for the adverse determination prior to issuing the adverse determination. The notice of adverse determination must comply with the requirements of §19.2009 of this title and if preauthorization is denied under Labor Code §408.0042 because the treatment is for an injury or diagnosis unrelated to the compensable injury the notice must include notification to the injured employee and health care provider of entitlement to file an extent of injury dispute in accordance with Chapter 141 of this title (relating to Dispute Resolution--Benefit Review Conference).

(n) The insurance carrier shall not condition an approval or change any elements of the request as listed in subsection (f) of this section, unless the condition or change is mutually agreed to by the health care provider and insurance carrier and is documented.

(o) If the initial response is an adverse determination of preauthorization or concurrent utilization review, the requestor or injured employee may request reconsideration orally or in writing. A request for reconsideration under this section constitutes an appeal for the purposes of §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determinations).
(1) The requestor or injured employee may within 30 days of receipt of a written adverse determination request the insurance carrier to reconsider the adverse determination and shall document the reconsideration request.
(2) The insurance carrier shall respond to the request for reconsideration of the adverse determination:
(A) as soon as practicable but not later than the 30th day after receiving a request for reconsideration of an adverse determination of preauthorization; or

(B) within three working days of receipt of a request for reconsideration of an adverse determination of concurrent utilization review, except for health care listed in subsection (q)(1) of this section, which is due within one working day of the receipt of the request.

(3) In addition to the requirements in this section and §19.2011 of this title, the insurance carrier's reconsideration procedures shall include a provision that the period during which the reconsideration is to be completed shall be based on the medical or clinical immediacy of the condition, procedure, or treatment.

(4) In any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services prior to the issuance of an adverse determination on the request for reconsideration, the insurance carrier shall comply with the requirements of §19.2010 and §19.2011 of this title, including the requirement that the insurance carrier afford the requestor a reasonable opportunity to discuss the proposed health care with a doctor or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor, respectively.

(5) The requestor or injured employee may appeal the denial of a reconsideration request regarding an adverse determination by filing a dispute in accordance with Labor Code §413.031 and related division rules.

(6) A request for preauthorization for the same health care shall only be resubmitted when the requestor provides objective clinical documentation to support a substantial change in the injured employee's medical condition or that demonstrates that the injured employee has met clinical prerequisites for the requested health care that had not been previously met before submission of the previous request. The insurance carrier shall review the documentation and determine if any substantial change in the injured employee's medical condition has occurred or if all necessary clinical prerequisites have been met. A frivolous resubmission of a preauthorization request for the same health care constitutes an administrative violation.

(p) Non-emergency health care requiring preauthorization includes:

(1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay;

(2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;

(3) spinal surgery;

(4) all work hardening or work conditioning services;

(5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:

(A) Level I code range for Physical Medicine and Rehabilitation, but limited to:

(i) Modalities, both supervised and constant attendance;

(ii) Therapeutic procedures, excluding work hardening and work conditioning;

(iii) Orthotics/Prosthetics Management;

(iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and

(B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;

(C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:

(i) the date of injury; or

(ii) a surgical intervention previously preauthorized by the insurance carrier;

(6) any investigational or experimental service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care;

(7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized return-to-work rehabilitation program;

(8) unless otherwise specified in this subsection, a repeat individual diagnostic study;

(A) with a reimbursement rate of greater than $350 as established in the current Medical Fee Guideline; or

(B) without a reimbursement rate established in the current Medical Fee Guideline;

(9) all durable medical equipment (DME) in excess of $500 billed charges per item (either purchase or expected cumulative rental);

(10) chronic pain management/interdisciplinary pain rehabilitation;

(11) drugs not included in the applicable division formulary;

(12) treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the insurance carrier. This requirement does not apply to drugs prescribed for claims under §§134.506, 134.530 or 134.540 of this title (relating to Pharmaceutical Benefits);

(13) required treatment plans; and

(14) any treatment for an injury or diagnosis that is not accepted by the insurance carrier under Labor Code §408.0042 and §126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury).

(q) The health care requiring concurrent utilization review for an extension for previously approved services includes:

(1) inpatient length of stay;

(2) all work hardening or work conditioning services;

(3) physical and occupational therapy services as referenced in subsection (p)(5) of this section;

(4) investigational or experimental services or use of devices;
(5) chronic pain management/interdisciplinary pain rehabilitation; and
(6) required treatment plans.

(r) The requestor and insurance carrier may voluntarily discuss health care that does not require preauthorization or concurrent utilization review under subsections (p) and (q) of this section respectively.
(1) Denial of a request for voluntary certification is not subject to dispute resolution for prospective review of medical necessity.
(2) The insurance carrier may certify health care requested. The carrier and requestor shall document the agreement. Health care provided as a result of the agreement is not subject to retrospective utilization review of medical necessity.
(3) If there is no agreement between the insurance carrier and requestor, health care provided is subject to retrospective utilization review of medical necessity.

(s) An increase or decrease in review and preauthorization controls may be applied to individual doctors or individual workers' compensation claims by the division in accordance with Labor Code §408.0231(b)(4) and other sections of this title.

(t) The insurance carrier shall maintain accurate records to reflect information regarding requests for preauthorization, or concurrent utilization review approval or adverse determination decisions, and appeals, including requests for reconsideration and requests for medical dispute resolution, if any. The insurance carrier shall also maintain accurate records to reflect information regarding requests for voluntary certification approval/denial decisions. Upon request of the division, the insurance carrier shall submit such information in the form and manner prescribed by the division.

(u) For the purposes of this section, all utilization review must be performed by an insurance carrier that is registered with, or a utilization review agent that is certified by, the Texas Department of Insurance to perform utilization review in accordance with Insurance Code Chapter 4201 and Chapter 19 of this title (relating to Licensing and Regulation of Insurance Professionals).
(1) All utilization review agents or registered insurance carriers who perform utilization review under this section must comply with Labor Code §504.055 and any other provisions of Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided under Workers' Compensation Insurance Coverage) that relate to the expedited provision of medical benefits to first responders employed by political subdivisions who sustain a serious bodily injury in the course and scope of employment.

(2) An insurance carrier must accelerate and give priority to a claim for medical benefits, including all health care required to cure or relieve the effects naturally resulting from a compensable injury, under the following conditions:

(A) In accordance with Labor Code §501.028(b), the claim is by a member of the Texas military forces who, while on state active duty, sustains a serious bodily injury, as defined by Penal Code §1.07.

(B) In accordance with Labor Code §504.057(c), the claim is by a death investigation professional who sustains a serious bodily injury, as defined by Penal Code §1.07, in the course and scope of employment.

Source Note: The provisions of this §134.600 adopted to be effective December 23, 1991, 16 TexReg 7099; amended to be effective April 1, 1997, 22 TexReg 1317; amended to be effective January 1, 2002, 26 TexReg 9874; amended to be effective January 1, 2003, 27 TexReg 12359; amended to be effective March 14, 2004, 29 TexReg 2349; amended to be effective May 2, 2006, 31 TexReg 3566; amended to be effective July 1, 2012, 37 TexReg 2420; amended to be effective March 30, 2014, 39 TexReg 2102; amended to be effective November 1, 2018, 43 TexReg 7174; amended to be effective December 28, 2023, 48 TexReg 8001; amended to be effective January 29, 2026, 51 TexReg 411.

SUBCHAPTER I MEDICAL BILL REPORTING

RULE §134.800 Applicability

(a) This subchapter applies to all insurance carriers as defined in Labor Code §401.011(27), including insurance carriers that have contracted with or established a workers' compensation health care network as defined in Labor Code §401.011(31-a) and insurance carriers that provide medical benefits in a manner authorized by Labor Code §504.053(b)(2). All insurance carriers are required to report information prescribed by the commissioner under Labor Code §413.007 and §413.008 for each medical bill on a workers' compensation claim.

(b) This section is effective September 1, 2011. Insurance carriers and trading partners may submit medical EDI records in accordance with this subchapter prior to this effective date.

Source Note: The provisions of this §134.800 adopted to be effective September 1, 2011, 36 TexReg 4136

RULE §134.801 Purpose

(a) The purpose of this subchapter is to prescribe the reporting requirements for information and data submitted to the division and to adopt by reference the implementation guide and specifications necessary for successful electronic data interchange transaction processing. The reporting of information and data is necessary to maintain a statewide data base of medical charges, actual payments, and treatment protocols pursuant to Labor Code §413.007 and §413.008.

(b) This section is effective September 1, 2011.

Source Note: The provisions of this §134.801 adopted to be effective September 1, 2011, 36 TexReg 4136

RULE §134.802 Definitions

(a) The following words and terms, when used in this subchapter, shall have the following meaning, unless the context clearly indicates otherwise:
(1) Application Acknowledgment Code--A code used to identify the accepted or rejected status of the transaction being acknowledged.
(2) Claim Adjustment Reason Code (CARC)--A code that is used on a medical EDI record and an explanation of benefits to communicate why the amount paid for a medical bill or service line does not equal the amount charged. The term is synonymous with service adjustment reason code in the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.0, dated July 4, 2002.
(3) Claim Administrator Claim Number--An identifier that distinguishes a specific claim within a claim administrator's claim processing system and is used throughout the life of the claim.
(4) Division--The Texas Department of Insurance, Division of Workers' Compensation or its data collection agent.
(5) EDI--Electronic data interchange.
(6) Element Requirement Table--A receiver specific list of requirement codes for each data element depending on the bill submission reason code.
(7) IAIABC--The International Association of Industrial Accident Boards and Commissions.
(8) Medical EDI Record--The accurate data associated with a single medical bill which is being reported in a Medical EDI Transaction obtained from all sources, including the medical bill, explanation of benefits, and insurance carrier's claim file.
(9) Medical EDI Transmission--The data that is contained within the interchange envelope.
(10) Medical EDI Transaction--The data that is contained within the functional group.

(11) Person--An individual, partnership, corporation, hospital district, insurance carrier, organization, business trust, estate trust, association, limited liability company, limited liability partnership or other entity. This term does not include an injured employee.
(12) Trading Partner--A person that has entered into an agreement with the insurance carrier to format electronic data for transmission to the division, transmits electronic data to the division, and responds to any technical issues related to the contents or structure of an EDI file.
(13) W3--A Texas-specific claim adjustment reason code to designate the medical EDI record as a reconsideration or appeal.

(b) This section is effective September 1, 2015.

Source Note: The provisions of this §134.802 adopted to be effective February 20, 1991, 16 TexReg 671; amended to be effective June 1, 1992, 17 TexReg 3250; amended to be effective December 1, 1992, 17 TexReg 7903; amended to be effective July 15, 2000, 25 TexReg 2139; amended to be effective July 11, 2004, 29 TexReg 6303; amended to be effective April 28, 2005, 30 TexReg 2398; amended to be effective May 2, 2006, 31 TexReg 3561; amended to be effective September 1, 2011, 36 TexReg 4136; amended to be effective September 1, 2015, 40 TexReg 595

RULE §134.803 Reporting Standards

(a) Except as provided in this subchapter, the commissioner adopts by reference the IAIABC EDI Implementation Guide for Medical Bill Payment Records, Release 1.0, dated July 4, 2002 (IAIABC Guide) published by the IAIABC.

(b) The commissioner adopts by reference the Texas EDI Medical Data Element Requirement Table, Version 2.0, dated September 2015, the Texas EDI Medical Data Element Edits Table, Version 2.0, dated September 2015, and the Texas EDI Medical Difference Table, Version 3.0, dated September 2015. All tables are published by the division.

(c) The adopted division tables may be found on the division's website: http://www.tdi.texas.gov/wc/edi/index.html.

(d) In the event of a conflict between the IAIABC Guide and the Labor Code or division rules, the Labor Code or division rules shall prevail.

(e) This section is effective September 1, 2015.

Source Note: The provisions of this §134.803 adopted to be effective September 1, 2011, 36 TexReg 4136; amended to be effective February 17, 2013, 38 TexReg 673; amended to be effective September 1, 2015, 40 TexReg 595

RULE §134.804 Reporting Requirements

(a) Insurance carriers shall submit an '00' original medical EDI record for each action (initial processing, request for reconsideration or appeal, or subsequent orders) taken on an individual medical bill. Original medical EDI records shall be reported within 30 days after the date of the action. Each iteration of an '00' original medical EDI record must contain a different unique medical bill identification number. The amount paid on each action related to a medical bill must contain only the amount issued for that event and must not contain a cumulative amount reflecting all events related to an individual medical bill. Original medical EDI records on subsequent actions must contain a Texas-specific claim adjustment reason code of 'W3' to designate the medical EDI record as a reconsideration or appeal. The Texas-specific claim adjustment reason code must be included on the explanation of benefits issued pursuant to §133.250 of this title (relating to Reconsideration for Payment of Medical Bills).

(b) Insurance carriers shall submit an '01' cancel medical EDI record if the '00' original medical EDI record should not have been sent or contained the incorrect insurance carrier identification number. Cancel medical EDI records shall be reported within 30 days after the earliest date the insurance carrier discovered the reporting error. The '01' cancel medical EDI record must contain the same unique bill identification number as the '00' original medical EDI record that was previously submitted and accepted. An '00' original medical EDI record must be accepted by the division before an '01' cancel medical EDI record may be submitted.

(c) Insurance carriers shall submit an '05' replacement medical EDI record when correcting data on a previously submitted medical EDI record. Replacement medical EDI records shall be submitted within 30 days after the earliest date the insurance carrier discovered the reporting error. The '05' replacement medical EDI record must contain the same unique bill identification number as the associated '00' original medical EDI record. An '00' original medical EDI record must be accepted by the division before an '05' replacement medical EDI record may be submitted.

(d) Insurance carriers must submit timely and accurate medical EDI records to the division. For the purpose of this section, a medical EDI record is considered to have been accurately submitted when the record:
(1) received an Application Acknowledgment Code of accepted;

(2) contained accurate medical EDI data; medical EDI data may be obtained from all sources, including the medical bill, explanation of benefits, and insurance carrier's claim file; and
(3) to the extent supported by the format, contained all appropriate modifiers, code qualifiers, and data elements necessary to identify health care services, charges and payments.

(e) Insurance carriers are responsible for correcting and resubmitting rejected medical EDI records within 30 days of the action that triggered the reporting requirement. The insurance carrier's receipt of a rejection does not modify, extend or otherwise change the date the transaction is required to be reported to the division. The resubmitted medical EDI record must contain the same unique bill identification number as the previously rejected medical EDI record.

(f) This section is effective September 1, 2015.

Source Note: The provisions of this §134.804 adopted to be effective September 1, 2011, 36 TexReg 4136; amended to be effective September 1, 2015, 40 TexReg 595

RULE §134.805 Records Required to be Reported

(a) Insurance carriers shall submit medical EDI records when the insurance carrier:
(1) pays a medical bill;
(2) reduces or denies payment for a medical bill, including duplicate bills;
(3) receives a refund for a medical bill;
(4) discovers that a medical EDI record should not have been submitted to the division and the medical EDI record had previously been accepted by the division;
(5) reimburses an injured employee for health care paid in accordance with §133.270; or
(6) reimburses an employer for health care paid in accordance with §133.280.

(b) Regardless of the Application Acknowledgment Code returned in an acknowledgment, medical EDI records are not considered received by the division if the medical EDI record:
(1) contains data which does not accurately reflect the code values used or actions taken when the insurance carrier processed the medical bill; or
(2) fails to contain a conditional data element and the mandatory trigger condition existed at the time the insurance carrier processed the medical bill.

(c) Except in situations where the health care provider included an invalid service or procedure code on the medical bill, rejected medical EDI records are not considered received and shall be corrected and resubmitted to the division as provided in §134.804(e) of this title (relating to Reporting Requirements). Medical EDI records submitted in the test environment are not considered received and do not comply with the reporting requirements of this section.

(d) This section is effective September 1, 2015.

Source Note: The provisions of this §134.805 adopted to be effective September 1, 2011, 36 TexReg 4136; amended to be effective September 1, 2015, 40 TexReg 595

RULE §134.806 Records Excluded from Reporting

(a) Insurance carriers shall not report medical EDI records for health care services:
(1) rendered outside the United States;
(2) related to dates of injury before January 1, 1991;
(3) rendered at a Federal health care facility and the health care facility does not provide the insurance carrier with the data required to be reported;
(4) related to an injured employee's travel reimbursement as provided in §134.110 of this title (relating to Reimbursement of Injured Employee for Travel Expenses Incurred); or
(5) related to a request for reimbursement by a health care insurer in accordance with the provisions of Labor Code §409.0091.

(b) Insurance carriers shall not report interest and penalty payments paid on health care services, medical cost containment expenses, medical bill review expenses or data transmission expenses in medical EDI records.
(c) This section is effective September 1, 2011.

Source Note: The provisions of this §134.806 adopted to be effective September 1, 2011, 36 TexReg 4136

RULE §134.807 State Specific Requirements

(a) A medical EDI transmission shall not exceed a file size of 1.5 megabytes. A transaction set shall not contain more than 100 medical EDI records in a claimant hierarchical loop.

(b) Insurance carriers shall submit medical EDI transactions using Secure File Transfer Protocol (SFTP). All alphabetic characters used in the SFTP file name must be lower case and the file must be compressed/zipped. Files that do not comply with these requirements or the naming convention may be rejected and placed in appropriate failure folders. Insurance carriers must monitor these folders for file failures and make corrections in accordance with §134.804(e) of this title (relating to Reporting Requirements).

(c) SFTP files must comply with the following naming convention:
(1) Two digit alphanumeric state indicator of 'tx';
(2) Nine digit trading partner Federal Employer Identification Number (FEIN);
(3) Nine digit trading partner postal code;
(4) Nine digit insurance carrier FEIN or 'xxxxxxxxx' if the file contains medical EDI transactions from different insurance carriers;
(5) Three digit record type '837';
(6) One character Test/Production indicator ('t' or 'p');
(7) Eight digit date file sent 'CCYYMMDD';
(8) Six digit time file sent 'HHMMSS';
(9) One character standard extension delimiter of '.'; and
(10) Three digit alphanumeric standard file extension of 'zip' or 'txt'.

(d) The transaction types accepted by the division include '00' original, '01' cancel, and '05' replacement.

(e) Insurance carriers are required to use the following delimiters:
(1) Date Element Separator--'*' asterisk;
(2) Sub-element Separator--':' colon; and
(3) Segment Terminator--'~' tilde.

(f) In addition to the requirements adopted under §134.803 of this title (relating to Reporting Standards), state reporting of medical EDI transactions shall comply with the following formatting requirements:
(1) Loop 2400 Service Line Information must not contain more than one type of service. Only one of the following data segments may be contained in an iteration of this loop: SV1 Professional Service, SV2 Institutional Service, SV3 Dental Service or SV4 Pharmacy Service.
(2) When reporting compound medications, Loop 2400 Service Line Information SV4 Pharmacy Drug Service must include a separate line for each reimbursable component of the compound medication. The same prescription number for each reimbursable component of the compound medication, including the compounding fee, must be

reported. The compounding fee must be reported using a default NDC number equal to '99999999999' as a separate service line.

(3) When reporting pharmacy medical EDI records, the following data element definition clarifications apply:

(A) DN501 Total Charge Per Bill is the total amount charged by the pharmacy or pharmacy processing agent;

(B) DN511 Date Insurer Received Bill is the date the insurance carrier received the bill;

(C) DN512 Date Insurer Paid Bill is the date the insurance carrier paid the pharmacy or pharmacy processing agent;

(D) DN638 Rendering Bill Provider Last/Group Name is the name of the dispensing pharmacy;

(E) DN690 Referring Provider Last/Group Name is the last name of the prescribing doctor; and

(F) DN691 Referring Provider First Name is the first name of the prescribing doctor.

(4) When ICD-10-CM and ICD-10-PCS codes are contained on the medical bill, the insurance carrier must report these codes in the associated ICD-9-CM data elements using the ICD-9-CM code qualifiers.

(5) If the injured employee's social security number is unknown, it must be reported in accordance with §102.8(a)(1) of this title (relating to Information Requested on Written Communications to the Division).

(6) The DN53 data element must be reported on all medical EDI records.

(7) The provider agreement code must be reported on all medical EDI records, must not be reported with the value of "Y", and must only contain one of the following values:

(A) "H" for services performed within a Certified Workers' Compensation Health Care Network;

(B) "P" for services performed under a contractual fee arrangement, excluding services performed within a certified network; or

(C) "N" to indicate no contractual fee arrangement for services performed.

(8) When an insurance carrier calculated a reimbursement amount by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) as required in §134.404 of this title (relating to Hospital Facility Fee Guideline--Inpatient), the DN515 (Contract Type Code) must be reported as "01" and the valid Diagnosis Related Group Code for DN518 must be reported.

(9) On a professional medical bill, an insurance carrier shall only report up to four (4) diagnosis codes on each medical EDI record.

(10) On a professional medical bill, an insurance carrier shall only report to the Division up to four diagnosis code pointers and those pointers must be reported numerically. If a professional medical bill containing more than four diagnosis pointers is reported to the insurance carrier, each diagnosis pointer after the first four shall be reported to the Division with the value of "1."

(g) This section is effective September 1, 2015.

Source Note: The provisions of this §134.807 adopted to be effective September 1, 2011, 36 TexReg 4136; amended to be effective February 17, 2013, 38 TexReg 673; amended to be effective September 1, 2015, 40 TexReg 595

RULE §134.808 Insurance Carrier EDI Compliance Coordinator and Trading Partners

(a) Insurance carriers may submit medical EDI records directly to the division or may contract with an external trading partner to submit the records on the insurance carrier's behalf.

(b) Each insurance carrier, including those using external trading partners, must designate one individual to the division as the EDI Compliance Coordinator and provide the individual's name, working title, mailing address, email address, and telephone number in the form and manner prescribed by the division. The EDI Compliance Coordinator must:
(1) be a centrally-located employee of the insurance carrier who has the responsibility for EDI reporting;
(2) receive and appropriately disperse data reporting information received from the division; and
(3) serve as the central compliance control for data reporting under this subchapter.

(c) At least five working days prior to sending its first transaction to the division under this subchapter, the insurance carrier shall send a notice to the division. The notice shall be in the form and manner established by the division. The notice shall include the name of the insurance carrier, the insurance carrier's FEIN, the insurance carrier's TxCOMP customer number, the name of the trading partner(s) authorized to conduct medical EDI transactions on behalf of the insurance carrier, the FEIN of the trading partner(s), and the EDI Compliance Coordinator's signature. The insurance carrier shall report changes within five working days of any amendment to data sharing agreements, including the addition or removal of any trading partners. The failure to timely submit updated information may result in the rejection of medical EDI records.

(d) At least five working days prior to sending its first test transaction to the division under this subchapter, the insurance carrier or trading partner sending the medical EDI transmission shall send a notice to the division. The notice shall be in the form and manner established by the division. The notice shall include the entity's name, FEIN, nine-digit postal code, address, and the technical contact's name, address, phone

number, and email address. The insurance carrier or trading partner shall report changes within five working days of any amendment to the information required to be reported.

(e) Insurance carriers and trading partners must successfully complete testing prior to transmitting any production data. Trading partners must receive approval to submit data for at least one insurance carrier prior to initiating the testing process. Insurance carriers and trading partners must submit each transaction type during the testing process which can be successfully processed by the division. The division will not approve an insurance carrier or trading partner for production submissions until the insurance carrier or trading partner has:
(1) successfully submitted ten percent of its anticipated monthly volume per service type, not to exceed 100 medical EDI records per service type;
(2) received and reviewed the acknowledgments generated by the division; and
(3) correctly resubmitted rejected records identified in the acknowledgments.

(f) Insurance carriers are responsible for the acts or omissions of their trading partners. The insurance carrier commits an administrative violation if the insurance carrier or its trading partner fails to timely or accurately submit medical EDI records.

(g) This section is effective September 1, 2015.

Source Note: The provisions of this §134.808 adopted to be effective September 1, 2011, 36 TexReg 4136; amended to be effective September 1, 2015, 40 TexReg 595

RULE §134.900 Medical Benefit Review and Audit

(a) The division of medical review (the division) shall review and audit medical services, to include, but not be limited to:
(1) treatments administered;
(2) services provided;
(3) fees charged;
(4) payments made for medical treatment or services provided to injured employees; and
(5) compliance with other commission rules regulating health care.

(b) The division may conduct a review or audit at the office of an insurance carrier, third party administrator, audit company, health care provider, or at any other appropriate location as determined by the division.

(c) The division shall notify, in writing, the person or entity whose documents are to be reviewed and audited, stating when the review and audit will be performed and the commission employee to contact.

(d) The division shall be granted access to documents and to information regarding health care treatment; fees charged; or payments made, modified, or denied. Pursuant to law, failure or refusal to comply with a division request or order for any information is an administrative violation subject to penalty as provided by the Act.

(e) The person or entity being reviewed or audited by the division shall furnish division personnel, for the duration of the review and audit, with:
(1) a contact person to answer questions and respond to the needs of division staff;
(2) office space;
(3) access to a copy machine; and
(4) access to a telephone.

(f) The commission shall charge a reasonable administrative fee, set in accordance with Administrative Procedure 5, for the review and audit conducted under this rule.

(g) The intensity of review and audit for compliance with medical policies and fee guidelines shall be increased as necessary to induce compliance by the health care provider who has established practices and patterns in medical charges or treatments inconsistent with medical policies and guidelines established by the commission.

(h) Reports of all probable violations of law and commission rules found during a review and audit shall be forwarded to the division of compliance and practices.

Source Note: The provisions of this §134.900 adopted to be effective October 1, 1992, 17 TexReg 6364

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 136	BENEFITS--VOCATIONAL REHABILITATION

RULE §136.1 Review of Employer Report of Injury

(a) The division shall analyze each employer report of injury, within 30 days of its receipt, for any information indicating that the injured employee had or is likely to have:
(1) an amputation of:
(A) an arm or leg;
(B) three fingers or more; or
(C) the large toe or one-third of the foot or more;
(2) the loss of use of an arm or leg;
(3) a permanent spinal cord injury;
(4) a head injury;
(5) a heart attack or heart disease;
(6) an occupational disease;
(7) blindness or significant vision loss;
(8) severe or extensive burns;
(9) any other condition that indicates an impairment is likely; or
(10) any injury resulting in more than 30 days lost time. Such injury shall be reviewed and a determination made as to the degree of impairment and the appropriateness of vocational rehabilitation services.

(b) Whenever the division finds facts that suggest one or more of the conditions listed in subsection (a) of this section, the division shall notify the injured employee and the Texas Workforce Commission that the division has identified an injured employee who may be assisted by vocational rehabilitation. The notice shall:
(1) be made no later than 60 days after the date the division received the employer report of injury; and
(2) contain the following information:
(A) the workers' compensation claim number assigned by the division;
(B) the address of the local office of the division assigned to manage the claim;
(C) the insurance carrier's name and division assigned identification number (if any);
(D) the name, address, and phone number of the injured employee; and
(E) the condition listed in subsection (a) of this section, that indicates that the injured employee may be assisted by vocational rehabilitation.

(c) In addition to the information required by subsection (b) of this section, the division's notice to the injured employee shall contain the following:

(1) the address and telephone number of the central office of the Texas Workforce Commission; and

(2) a statement that the division notified the Texas Workforce Commission that the injured employee may be assisted by vocational rehabilitation.

Source Note: The provisions of this §136.1 adopted to be effective March 18, 1991, 16 TexReg 1367; amended to be effective February 3, 2011, 36 TexReg 427; amended to be effective April 15, 2018, 43 TexReg 2155

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 137	DISABILITY MANAGEMENT
SUBCHAPTER A	GENERAL PROVISIONS

RULE §137.1 Disability Management Concept

(a) Disability management is a process designed to optimize health care and return to work outcomes for injured employees to avoid delayed recovery in the Texas Workers' Compensation System.

(b) This chapter is designed to provide disability management tools, such as treatment and return to work guidelines, treatment protocols, treatment planning, and case management to benchmark, manage, and achieve improved outcomes. The Division may use these tools for the following purposes, including, but not limited to:

(1) resolving income benefit disputes;
(2) resolving medical benefit disputes;
(3) establishing performance-based tiers;
(4) defining performance-based incentives;
(5) determining sanctions or penalties;
(6) performing medical quality reviews; or
(7) assessing other matters deemed appropriate by the Commissioner of Workers' Compensation.

(c) The Division will utilize this chapter to implement and interpret specific provisions contained in Labor Code §413.011(a) and (e), and this chapter takes precedence over any conflicting payment policy provisions adopted or utilized by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program.

(d) 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 Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over adopted treatment guidelines, treatment protocols, treatment planning and Medicare payment policies.

Source Note: The provisions of this §137.1 adopted to be effective January 18, 2007, 32 TexReg 163

RULE §137.5 Case Manager Certification

(a) This section applies to all case 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 September 1, 2011.

(b) This section does not apply to case management services:
(1) subject to Insurance Code Chapter 1305;
(2) subject to Labor Code §504.053(b)(2); or
(3) of a health care provider subject to §134.204 of this title (relating to Medical Fee Guideline for Workers' Compensation Specific Services).

(c) Case managers who are certified must be certified by an established accredited organization including the National Commission for Certifying Agencies, the American Board of Nursing Specialties, or other national accrediting agencies with similar standards for case management certification. Case managers must be certified in one or more of the following areas:
(1) case management;
(2) case management administration;
(3) continuity of care;
(4) disability management;
(5) occupational health; or
(6) rehabilitation case management.

(d) When conducting evaluations to determine if case management services are required, insurance carriers shall utilize case managers who are certified in accordance with subsection (c) of this section.

(e) When providing case management services other than those specified in subsection (d) of this section, an insurance carrier shall utilize case managers who are:
(1) appropriately certified in accordance with subsection (c) of this section; or
(2) skilled, non-certified case managers as specified in subsection (f) of this section.

(f) Skilled, non-certified case managers are eligible to provide services other than those identified in subsection (d) of this section if:
(1) they meet all of the requirements of subsection (c) to sit for a case management certification examination, with the exception of work experience; and
(2) they are working under the direct supervision of an identified case manager that is certified in accordance with subsection (c) of this section in order to meet the experience requirements to sit for a case management certification examination.

(g) Individuals may only be employed or contracted as skilled, non-certified case managers as specified in subsection (f) of this section for an aggregate total of 24 months, beginning with the first month in which the individual first performs case management related services that occurs after the effective date outlined in subsection (a) of this section. After accrual of the 24 months, these individuals shall not conduct case management services until a certification is obtained in accordance with subsection (c) of this section.

(h) Insurance carriers shall be responsible for verifying and documenting in writing compliance with the requirements of subsections (d), (e) and (f) of this section. Insurance carriers shall provide this verification and documentation information to the division upon request.

(i) Claims adjusters shall not be used as case managers. This does not prohibit claims adjusters from performing claims services that are within the scope of licensure in accordance with the Insurance Code Chapter 4101.

(j) Reimbursement policies and maximum allowable reimbursement rates set forth in the adopted fee guidelines under §134.204 of this title between the treating doctor and other health care providers does not apply to the reimbursement of case managers employed or contracted by insurance carriers under this section.

(k) If the requirements of this section are not met, the insurance carrier may be held liable for administrative violations in accordance with Labor Code provisions and division rules.

Source Note: The provisions of this §137.5 adopted to be effective September 1, 2011, 35 TexReg 11378

SUBCHAPTER B RETURN TO WORK

RULE §137.10 Return to Work Guidelines

(a) Insurance carriers, health care providers, and employers shall use the disability duration values in the current edition of The Medical Disability Advisor, Workplace Guidelines for Disability Duration, excluding all sections and tables relating to rehabilitation, (MDA), published by the Reed Group, Ltd. (Division return to work guidelines), as guidelines for the evaluation of expected or average return to work time frames.

(b) Information on how to obtain or inspect copies of the Division return to work guidelines may be found on the Division's website: www.tdi.state.tx.us.

(c) The Division return to work guidelines provide disability duration expectancies. The Division return to work guidelines shall be presumed to be a reasonable length of disability duration and shall be used by:

(1) health care providers to establish return to work goals or a return to work plan for safely returning injured employees to medically appropriate work environments;

(2) insurance carriers as a basis for requesting a designated doctor examination to resolve an issue regarding an injured employee's ability to return to work as well as a basis to initiate case management and to refer an injured employee to vocational rehabilitation providers; and

(3) employers, insurance carriers, health care providers, and injured employees to facilitate and improve communications among the parties regarding the return to work goals or plans established by health care providers.

(d) The health care provider, insurance carrier, employer, and Division may consider co-morbid conditions, medical complications, or other factors that may influence medical recoveries and disability durations as mitigating circumstances when setting return to work goals or revising expected return to work durations and goals.

(e) Disability duration values in the guidelines are not absolute values and do not represent specific lengths or periods of time at which an injured employee must return to work; the values represent points in time at which additional evaluation may take place if full medical recovery and return to work have not occurred. System participants may, however, determine additional evaluation is appropriate at any time during a claim. The disability duration values depict a continuum from the minimum time to the maximum time for most individuals to return to work following a particular injury. An insurance carrier may request additional return to work information from a health care provider at any time. An insurance carrier may not use the Division return to work guidelines as the sole justification or the only reasonable grounds for reducing, denying, suspending or terminating income benefits to an injured employee.

(f) For all diagnoses or injuries that are not addressed by the Division return to work guidelines, system participants shall establish disability duration parameters and return to work goals in accordance with the principles of evidence-based medicine as defined by Labor Code §401.011(18-a).

(g) This section is effective on or after May 1, 2007.

Source Note: The provisions of this §137.10 adopted to be effective January 18, 2007, 32 TexReg 163

RULE §137.41 Purpose

The purpose of §§137.41 - 137.51 of this title (relating to Disability Management) is to set forth the terms, conditions, and requirements for the return-to-work reimbursement program for employers.

Source Note: The provisions of this §137.41 adopted to be effective February 22, 2006, 31 TexReg 1037; amended to be effective February 7, 2008, 33 TexReg 930; amended to be effective April 25, 2010, 35 TexReg 3061

RULE §137.42 Definitions

The following words and terms shall have the following meanings only for the purposes of the return-to-work reimbursement program for employers:

(1) Allowable expense--An expenditure of funds, costs incurred, or costs that will be incurred by an eligible employer for workplace modifications or other costs that are necessary to reasonably assist an injured employee's doctor-identified restrictions that are intended to facilitate the early and sustained return to work of an employee who has a compensable injury. An indemnity benefit, medical benefit, or health care for which an insurance carrier is liable is not an allowable expense under the program.

(2) Applicant--The employer requesting funds from the return-to-work reimbursement program.

(3) Application--The return-to-work reimbursement program application provided by the division for reimbursement, preauthorization, or advancement of funds used or proposed to be used by employers for workplace modifications.

(4) Alternative duty--Job duties that are different from the injured employee's normal or regular pre-injury job duties and that are assigned specifically to facilitate the injured employee's doctor-identified work restrictions or limitations.

(5) Eligible employer--Any employer that:
(A) is not a state agency or political subdivision of the state;
(B) employed at least two but not more than 50 employees on each business day during the preceding calendar year; and

(C) has workers' compensation insurance coverage in Texas.

(6) Division--The Texas Department of Insurance, Division of Workers' Compensation.

(7) Modified duty--The injured employee's normal or regular pre-injury job with workplace modifications to facilitate doctor-identified work restrictions or limitations.

(8) Return-to-work reimbursement program (program)--The division's program for the reimbursement, preauthorization, or advancement of funds to eligible employers for allowable expenses which facilitate the early and sustained return to work of an employee who has a compensable injury.

(9) Return-to-work reimbursement program administrator (administrator)--The administrator of the Texas Department of Insurance, Division of Workers' Compensation return-to-work reimbursement program for employers.

(10) Single employer--An employer operating one or more businesses under the same federal employer identification number. In the absence of a federal employer identification number, a single employer is established by the employer's social security number.

(11) State appropriation year--The State of Texas' fiscal accounting year that begins September 1 and ends August 31 of the following year.

(12) Workplace modification--Physical modifications to the worksite; equipment, devices, furniture, or tools; or other reasonable costs necessary to facilitate an employee's return to restricted, modified or alternative duty.

Source Note: The provisions of this §137.42 adopted to be effective February 22, 2006, 31 TexReg 1037; amended to be effective April 25, 2010, 35 TexReg 3061

RULE §137.43 Return-to-Work Reimbursement Program Administrator

The Commissioner of Workers' Compensation shall appoint a qualified employee of the Texas Department of Insurance, Division of Workers' Compensation to serve as the return-to-work reimbursement program administrator to implement the provisions of this subchapter.

Source Note: The provisions of this §137.43 adopted to be effective February 22, 2006, 31 TexReg 1037; amended to be effective April 25, 2010, 35 TexReg 3061

RULE §137.44 Return-to-Work Reimbursement Program for Employers

(a) Disbursements of funds for the program are dependent on the availability of funds identified by the division.

(b) The disbursement that any single employer may receive from the program may not exceed $5,000 for all workplace modification expenditures made during the state appropriation year for all injured employees.

(c) Disbursements from the program to approved eligible employers shall be made on a reimbursement basis, or at the discretion of the commissioner or the commissioner's designee on an advancement basis, subject to verification of employer eligibility, receipts and expenditures, workplace modifications, the employee's return to work, approval of the employer's application, and any other requirements listed in §§137.45 - 137.50 of this title (relating to the Return-to-Work Reimbursement Program).

(d) Applications shall be processed in the order that completed applications are received by the division.

(e) Approved applications shall be funded from the program as funds become available.

(f) Applications may be denied in whole or in part due to the lack of available funds for the program or if the division determines that all or part of the application does not meet the requirements listed in §§137.45 - 137.50 of this title.

Source Note: The provisions of this §137.44 adopted to be effective February 22, 2006, 31 TexReg 1037; amended to be effective April 25, 2010, 35 TexReg 3061

RULE §137.45 Employer Eligibility for Disbursements from the Return-to-Work Reimbursement Program

(a) In order to be eligible to receive a disbursement from the program, an employer must:
(1) be an eligible employer that has incurred or will incur an allowable expense;
(2) have Texas workers' compensation insurance coverage in effect on the date the employee is injured and be able to provide proof of coverage;
(3) submit an application for funds from the program;
(4) timely provide any additional or supplemental information to the administrator that may be deemed necessary by the division; and
(5) the application must be approved by the division.

(b) In order for an expense to be eligible for a disbursement from the program, the expense must not have been incurred by the employer beyond one year prior to submitting the application to the division. For good cause, the division or the administrator may extend this one year requirement.

(c) After approval of an application by the division, release of funds are contingent upon the approval of the Texas Comptroller of Public Accounts. Approval of an application by the division is not a guarantee of release of funds from the Texas Comptroller of Public Accounts.

Source Note: The provisions of this §137.45 adopted to be effective February 22, 2006, 31 TexReg 1037; amended to be effective April 25, 2010, 35 TexReg 3061

RULE §137.46 Application for Funds from the Return-to-Work Reimbursement Program

(a) An eligible employer seeking funds from the program shall submit to the division an application as defined in §137.42 of this title (relating to Definitions).

(b) Applications shall be available on the division's website (www.tdi.state.tx.us/wc) and through the division. Upon request, the division shall provide an application form to an employer.

(c) Applications shall be submitted to the division in the form prescribed by the division and must meet the minimum requirements provided in §137.47 of this title (relating to the Criteria for Return-to-Work Reimbursement Program Applications).

(d) The date the completed application is received by the division shall be the official date for purposes of processing the application. An application shall not be processed for approval until all required or requested documentation has been received by the division and any other applicable requirements listed on the application have been met.

(e) An application that has information missing or that does not include the information described in §137.47 of this title, receipts, or other documentation necessary to support the application and to justify the workplace modification may be returned to the employer for completion, documentation supplementation, or the application may be denied.

Source Note: The provisions of this §137.46 adopted to be effective February 22, 2006, 31 TexReg 1037; amended to be effective April 25, 2010, 35 TexReg 3061

RULE §137.47 Criteria for Return-to-Work Reimbursement Program Applications

In order to be processed and approved by the division an application must contain at a minimum:

(1) The date the employee returned to work or will return to work, and the injured employee's name, date of injury, and Texas Department of Insurance, Division of Workers' Compensation claim number.

(2) An employer's statement or certification that the injured employee returned to work or will return to work in either a modified or alternative duty capacity.

(3) An employer's statement or certification that the employer was able or will be able to sustain the employment of the injured employee as a result of the workplace modification.

(4) A copy of the division's "Work Status Report" as provided by §129.5 of this title (relating to Work Status Reports) from the injured employee's doctor that specifies the injured employee's physical restrictions or limitations, which necessitated the provision of a workplace modification in order for the employee to return to work in a modified or alternative duty capacity and additional documentation, if any.

(5) A detailed description of the workplace modification, including any supporting information such as receipts, photos or diagrams of the modification, and how the modification facilitates the doctor-identified physical restrictions or limitations.

(6) Documentation of the expenses, including receipts, that provided the workplace modification or other costs necessary to facilitate the injured employee's return to work or the estimated costs in making those proposed workplace modifications.

(7) A signature by the employer or the employer's authorized representative.

Source Note: The provisions of this §137.47 adopted to be effective February 22, 2006, 31 TexReg 1037; amended to be effective April 25, 2010, 35 TexReg 3061

RULE §137.48 Return-to-Work Reimbursement Program Administrator Determinations

(a) The administrator shall make determinations regarding the following:
(1) the employer's eligibility to participate in the program;

(2) the appropriateness of the workplace modification in facilitating the injured employee's return to work based on doctor-identified restrictions;
(3) the effectiveness of the workplace modification in facilitating the injured employee's early and sustained return to work;
(4) the cost of the workplace modification in relation to usual and customary costs of the same or similar modification; and
(5) the appropriateness of other costs incurred or to be incurred by the employer to return the injured employee to work in a modified or alternative duty capacity.

(b) The administrator or designee may make an on-site evaluation or request information from the employer or providers of a workplace modification in order to verify that:
(1) the workplace modification was or will be provided;
(2) the workplace modification was or will be a reasonable modification and expenditure; and
(3) the injured employee returned to work as a result of the workplace modification.

(c) The administrator may utilize the National Institute of Health's "Searchable Online Accommodation Resource," U.S. Department of Labor resources, Texas Department of Assistive and Rehabilitative Services resources, or similar resources in evaluating and verifying workplace modifications and associated costs. The administrator may consult with a rehabilitation counselor or specialist when verifying the appropriateness of workplace modifications and costs.

(d) The administrator may approve or deny in whole or in part the employer's request for funds from the program pursuant to §137.44 of this title (relating to the Return-to-Work Reimbursement Program for Employers), §137.45 of this title (relating to Employer Eligibility for Disbursements from the Return-to-Work Reimbursement Program), §137.46 of this title (relating to the Application for Funds from the Return-to-Work Reimbursement Program), and §137.47 of this title (relating to the Criteria for Return-to-Work Reimbursement Program Applications).

(e) Decisions regarding approval or denial of applications, the reason for approval or denial of an application, and the amount to be disbursed from the program are final, may not be appealed, and are the discretion of the administrator.

(f) Upon completion of the application evaluation, the employer will be notified in writing of the approval or denial of the application by the administrator.

Source Note: The provisions of this §137.48 adopted to be effective February 22, 2006, 31 TexReg 1037; amended to be effective April 25, 2010, 35 TexReg 3061

RULE §137.49 Optional Preauthorization Plan

(a) An eligible employer, as provided by §137.45 of this title (relating to Employer Eligibility for Disbursements from the Return-to-Work Reimbursement Program), who participates in the return-to-work reimbursement program for employers may apply to the division for a preauthorized reimbursement of allowable expenses from the program prior to making workplace modifications designed to accommodate an injured employee's return to work.

(b) To apply for a preauthorized reimbursement of allowable expenses, an eligible employer must submit to the division a properly completed application as provided in §137.47 of this title (relating to the Criteria for Return-to-Work Reimbursement Program Applications). The application may be obtained from the division as provided by §137.46 of this title (relating to the Application for Funds from the Return-to-Work Reimbursement Program).

(c) Applications will be reviewed in accordance with §137.48 of this title (relating to Return-to-Work Reimbursement Program Administrator Determinations).

(d) Upon receipt of division approval of the application, the employer may begin all approved workplace modifications set out in the approved application. Upon completion of the approved workplace modifications, the employer may obtain reimbursement from the program by submitting to the division sufficient documentation and receipts to show that the approved workplace modification has been completed.

(e) Upon receipt of the information described in subsection (d) of this section and subject to §137.44 of this title (relating to the Return-to-Work Reimbursement Program for Employers), the division shall reimburse the employer the costs incurred by the employer in making the approved workplace modifications unless the division determines that the modifications differ materially from the employer's application.

(f) Release of funds are subject to §137.45(c) of this title.

Source Note: The provisions of this §137.49 adopted to be effective February 7, 2008, 33 TexReg 930; amended to be effective April 25, 2010, 35 TexReg 3061

RULE §137.50 Optional Advance of Funds Plan

(a) An eligible employer, as provided by §137.45 of this title (relating to Employer Eligibility for Disbursements from the Return-to-Work Reimbursement Program), who participates in the return-to-work reimbursement program for employers may apply to the division for an advance of funds for allowable expenses from the program prior to making workplace modifications designed to accommodate an injured employee's return to work.

(b) To apply for an advance of funds for allowable expenses, an eligible employer must submit to the division a properly completed application as provided in §137.47 of this title (relating to the Criteria for Return-to-Work Reimbursement Program Applications). The application may be obtained from the division as provided by §137.46 of this title (relating to the Application for Funds from the Return-to-Work Reimbursement Program).

(c) Applications will be reviewed in accordance with §137.48 of this title (relating to Return-to-Work Reimbursement Program Administrator Determinations).

(d) Upon receipt of a completed application and subject to §137.44 of this title (relating to the Return-to-Work Reimbursement Program for Employers), the division may advance funds to the employer to make approved workplace modifications. The employer shall not make workplace modifications that materially differ from the employer's approved application unless the employer receives written approval from the division for the materially different modifications.

(e) Upon the receipt of the advanced funds from the division, the employer shall complete all approved workplace modifications set out in the approved application within six months of receiving funds from the division. For good cause, the division or the administrator may extend this six-month requirement. Any extension of time for completing workplace modifications must be granted by the division in writing and for a determinable period of time.

(f) Upon completion of the approved workplace modifications, the employer shall submit to the division all receipts for the payments made by the employer for the approved modifications. Any funds not spent after the six-month time frame must be immediately returned to the division.

(g) Release of funds are subject to §137.45(c) of this title.

Source Note: The provisions of this §137.50 adopted to be effective April 25, 2010, 35 TexReg 3061

RULE §137.51 Monitoring and Enforcement

(a) Once an application is submitted, the commissioner or the commissioner's designated representative(s), including the administrator, may inspect the applicant's business to insure that the funds have been or will be spent according to what was or could be authorized. The commissioner or the commissioner's designated representative(s), including the administrator, are authorized to make a complete on-site review of the operations of each applicant at the place of business where the workplace modification has been or will be made, as often as is deemed necessary.

(b) At a minimum, notice of an on-site inspection shall be in writing and be presented by the commissioner or the commissioner's designated representative(s), including the administrator, upon arrival. On-site inspections shall not be conducted during legal holidays as defined in the Government Code §662.003(a).

(c) During an on-site review or upon written request of the commissioner or the commissioner's designated representative(s), including the administrator, the applicant shall make available all records relating to the requested or spent funds. Employers must maintain all relevant records for at least one year from the date of disbursement from the division.

(d) An employer commits an administrative violation if any part of the reimbursed or advanced funds are not used for the purpose or in the manner that the division previously approved in writing. Any unused funds must be returned to the division within six months of disbursement and any funds that are used not in accordance with the plan approved by the division must be immediately returned to the division.

Source Note: The provisions of this §137.51 adopted to be effective April 25, 2010, 35 TexReg 3061

SUBCHAPTER C TREATMENT GUIDELINES

RULE §137.100 Treatment Guidelines

(a) Health care providers shall provide treatment in accordance with the current edition of the Official Disability Guidelines - Treatment in Workers' Comp, excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment

guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) or §137.300 of this title (relating to Required Treatment Planning).

(b) Information on how to obtain or inspect copies of the Division treatment guidelines may be found on the Division's website: www.tdi.state.tx.us.

(c) Health care provided in accordance with the Division treatment guidelines is presumed reasonable as specified in Labor Code §413.017, and is also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).

(d) The insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines unless:
(1) the treatment(s) or service(s) were provided in a medical emergency; or
(2) the treatment(s) or service(s) were preauthorized in accordance with §134.600 or §137.300 of this title.

(e) An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017.

(f) A health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title, or may be required to submit a treatment plan in accordance with §137.300 of this title.

(g) The insurance carrier shall not deny treatment solely because the diagnosis or treatment is not specifically addressed by the Division treatment guidelines or Division treatment protocols.

(h) This section applies to health care provided on or after May 1, 2007.

Source Note: The provisions of this §137.100 adopted to be effective January 18, 2007, 32 TexReg 163

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 140	DISPUTE RESOLUTION--GENERAL PROVISIONS

RULE §140.1 Definitions

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

(1) Benefit dispute--A disputed issue arising under the Texas Workers' Compensation Act (Act) in a workers' compensation claim regarding compensability or eligibility for, or the amount of, income or death benefits.

(2) Benefit proceeding--A proceeding pursuant to the Act, Chapter 410, conducted by a presiding officer to resolve one or more benefit disputes. Benefit proceedings include benefit review conferences, benefit contested case hearings, appeals, and, after January 1, 1992, arbitration.

(3) Party to a proceeding--A person entitled to take part in a proceeding because of a direct legal interest in the outcome.

(4) Presiding officer--The division employee, or independent arbitrator, assigned to conduct a proceeding. Presiding officers include benefit review officers, administrative law judges, appeals panel judges, and arbitrators.

(5) Special accommodations--Individuals and equipment necessary to allow an individual who does not speak English or who has a physical, mental, or developmental handicap to participate in a proceeding. The term includes spoken language translators and sign language translators.

(6) Stipulation--A voluntary accord between parties to a benefit contested case hearing regarding any matter relating to the hearing that does not constitute an agreement, as defined by the Act, §401.011(3), or a settlement, as defined by the Act, §401.011(40).

Source Note: The provisions of this §140.1 adopted to be effective May 24, 1991, 16 TexReg 2607; amended to be effective June 9, 2005, 30 TexReg 3236; amended to be effective January 7, 2019, 44 TexReg 104

RULE §140.2 Special Accommodations

(a) The commission, on its own motion or upon request, will provide special accommodations to an individual who intends to participate in a proceeding and who does not speak English, or who has a physical, mental, or developmental handicap.

(b) A request for special accommodations may be made by the individual desiring them, the carrier, or anyone knowing of the need.

(c) The request:
(1) may be made in any manner;
(2) should describe the special accommodations needed; and
(3) should be sent to the commission no later than 10 days before the date of the proceeding.

Source Note: The provisions of this §140.2 adopted to be effective May 24, 1991, 16 TexReg 2607

RULE §140.3 Expedited Proceedings

In addition to expedited proceedings provided by any other commission rule, the commission may provide expedited benefit review conferences and benefit contested case hearings for resolution of disputes involving compensability, liability for essential medical treatment, or any type of issue as defined by commission policy for which the executive director or delegate determines an expedited proceeding will serve the best interests of the workers' compensation system or its participants.

Source Note: The provisions of this §140.3 adopted to be effective May 24, 1991, 16 TexReg 2607; amended to be effective September 1, 1993, 18 TexReg 5214

RULE §140.4 Conduct and Decorum

(a) The presiding officer may at the beginning of any proceeding and during the course of that proceeding establish rules of decorum to be followed during the proceeding. The presiding officer may also establish times for beginning the proceeding, for recesses, and for ending the proceeding.

(b) Parties and participants in a proceeding shall conduct themselves with dignity, shall show courtesy and respect for one another and for the presiding officer, shall follow the decorum prescribed by the presiding officer at the proceeding, and shall adhere to the

beginning times of the proceeding, and to the times established for each recess and for ending the proceeding.

(c) To maintain and enforce proper conduct and decorum at a proceeding, and to enforce promptness at a proceeding, the presiding officer may take appropriate action, including, but not limited to:
(1) issuing a warning;
(2) excluding any person from the proceeding;
(3) recessing the proceeding; and
(4) referring an action for possible enforcement as an administrative violation.

Source Note: The provisions of this §140.4 adopted to be effective May 24, 1991, 16 TexReg 2607; amended to be effective June 9, 2005, 30 TexReg 3236

RULE §140.5 Correction of Clerical Error

(a) The executive director or the executive director's designee may at any time revise an order or decision to correct clerical error:
(1) at the joint written request of the parties;
(2) at the request of a party affected by the order or decision; or
(3) on his or her own motion.

(b) When a party requests correction of clerical error, the request must:
(1) include a copy of the order or decision marked to indicate the alleged error;
(2) state the requested correction, and the reasons for making it;
(3) be filed with the hearings division; and
(4) be sent to all other parties affected by the order or decision.

(c) A party affected by the order or decision may file a response to the request no later than 10 days after receipt of the request.

(d) No later than 30 days after the request was filed, the hearings division shall either:
(1) issue and deliver to the parties a corrected order or decision; or
(2) advise the parties in writing that the order or decision was correct as originally entered.

(e) When clerical error is corrected on the motion of the executive director or designee, a copy of the corrected order or decision will be delivered to all affected parties.

Source Note: The provisions of this §140.5 adopted to be effective May 24, 1991, 16 TexReg 2607; amended to be effective May 1, 1996, 21 TexReg 3436

RULE §140.6 Subclaimant Status: Establishment, Rights, and Procedures

(a) Applicability. This section is applicable to a subclaim pursued under Labor Code §409.009, including a subclaim pursued by a health care insurer.

(b) Party status. A subclaimant as described in §409.009 is a party to a claim concerning workers' compensation benefits.

(c) Rights in Relation to the Injured Employee.
(1) A subclaimant may file and pursue a claim for reimbursement of a benefit that has been provided to an injured employee, and is entitled to appropriate dispute resolution in accordance with the Texas Workers' Compensation Act (Act) and Division of Workers' Compensation (Division) rules.
(2) A subclaimant may pursue a claim for reimbursement of a benefit that has been provided to an injured employee and participate in the dispute resolution process without the participation of the injured employee if:
(A) there is no prior written agreement between the injured employee and the workers' compensation insurance carrier or no final decision by the Division on the issue in dispute;
(B) the workers' compensation insurance carrier has denied the entitlement to benefits under the Act and Division rules;
(C) the injured employee is not pursuing dispute resolution to establish the injured employee's entitlement to benefits with reasonable diligence; and
(D) the subclaimant has provided the injured employee with written notice of:
(i) subclaimant's intent to pursue a claim for reimbursement of a benefit;
(ii) warning that a decision rendered may be binding against the injured employee; and
(iii) contact information for the Office of the Injured Employee Counsel.
(3) At a contested case hearing without the participation of the injured employee, the subclaimant must show, in addition to other facts:
(A) subclaimant provided written notice to the injured employee as specified in paragraph (2)(D) of this subsection;
(B) it has contacted the injured employee and the injured employee is not pursuing the dispute with reasonable diligence; or
(C) it has been unable to contact the injured employee through the exercise of reasonable diligence.

(d) Claims for Reimbursement of Medical Benefits.
(1) Subclaimants, other than subclaimants described in §409.0091, must pursue a claim for reimbursement of medical benefits and participate in medical dispute resolution in the same manner as an injured employee or in the same manner as a health care provider, as appropriate, under Chapters 133 and 134 of this title (relating to General Medical Provisions and Benefits--Guidelines for Medical Services, Charges, and Payments).
(2) A health care insurer subclaimant must submit a reimbursement request in the form/format and manner prescribed by the Division and must contain all the required elements listed on the form.
(3) Workers' compensation insurance carriers must process reimbursement requests from subclaimants pursuant to Chapters 133 and 134 of this title.

(e) Contested Case Hearing. A subclaimant may pursue a contested case hearing under the provisions of Chapters 140 - 143 of this title (relating to Dispute Resolution).

Source Note: The provisions of this §140.6 adopted to be effective September 23, 2008, 33 TexReg 8002

RULE §140.7 Health Care Insurer Reimbursement under Labor Code §409.0091

(a) Applicability. This section applies only to subclaims by a health care insurer based on information received under Labor Code §402.084(c-3).

(b) Health care insurer. "Health care insurer" means an insurance carrier and an authorized representative of an insurance carrier, as described by Labor Code §402.084(c-1).

(c) Reimbursement of Health Care Insurers. A health care insurer may be reimbursed for medical benefits provided to or paid on behalf of an injured employee with a compensable workers' compensation claim in accordance with Labor Code §409.0091, the procedures of §140.8 of this title (relating to Procedures for Health Care Insurers to Pursue Reimbursement of Medical Benefits under Labor Code §409.0091), and this section.

(d) Certain Defenses Not Allowed. A workers' compensation insurance carrier shall not deny a reimbursement request under Labor Code §409.0091 from a health care insurer because:
(1) the health care insurer has not sought reimbursement from the health care provider or the health care insurer's insured;

(2) the health care insurer or the health care provider did not request preauthorization under §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) or Labor Code §413.014; or
(3) the health care provider did not bill the workers' compensation insurance carrier, as provided by Labor Code §408.027, before the 95th day after the date the health care for which the health care insurer paid was provided.

Source Note: The provisions of this §140.7 adopted to be effective September 23, 2008, 33 TexReg 8002

RULE §140.8 Procedures for Health Care Insurers to Pursue Reimbursement of Medical Benefits under Labor Code §409.0091

(a) Applicability. This section applies only to subclaims by a health care insurer based on information received under Labor Code §402.084(c-3).

(b) Health care insurer. "Health care insurer" means an insurance carrier and an authorized representative of an insurance carrier, as described by Labor Code §402.084(c-1).

(c) Request to Workers' Compensation Insurance Carrier. A health care insurer seeking reimbursement must first file a reimbursement request with the workers' compensation insurance carrier.
(1) Form. The request must be in the form/format and manner prescribed by the Division of Workers' Compensation (Division) and must contain all the required elements listed on the form.
(2) Notice. The health care insurer must give notice of the request to the injured employee and the health care provider that performed the services that are the subject of the reimbursement request. The notice shall include a copy of the reimbursement request and an explanation that the health care insurer is seeking reimbursement for medical care costs.

(d) Deadlines for Response to Reimbursement Request to the Workers' Compensation Insurance Carrier.
(1) 90 Day Response Deadline. The workers' compensation insurance carrier must respond to a reimbursement request under this section by either paying, reducing, or denying payment in writing not later than the 90th day after the date the reimbursement request was first received, unless additional information is requested, pursuant to paragraph (2) of this subsection.

(2) Request for Additional Information. The workers' compensation insurance carrier may request additional information from the health care insurer if there is not sufficient information to substantiate the claim. The health care insurer has 30 days after receiving the request for more information to provide the information requested to the workers' compensation insurance carrier. Any request for additional information shall be in writing, be relevant and necessary for the resolution of the request. A workers' compensation insurance carrier shall not be penalized, including not being held responsible for costs of obtaining the additional information, if the workers' compensation insurance carrier denies payment in order to move to dispute resolution to obtain additional information to process the request. It is the health care insurer's obligation to furnish its authorized representatives with any information necessary for the resolution of a reimbursement request. The Division considers any medical billing information or documentation possessed by the health care insurer or one of its authorized representatives to be simultaneously possessed by the health care insurer and all of its authorized representatives.

(3) 120 Day Response Deadline. If the workers' compensation insurance carrier has requested additional information from the health care insurer pursuant to paragraph (2) of this subsection, the workers' compensation insurance carrier must respond in writing to the health care insurer's reimbursement request not later than the 120th day after the date the reimbursement request was first received, unless otherwise provided by mutual agreement.

(e) Response to a Reimbursement Request. The workers' compensation insurance carrier must respond to a reimbursement request by either paying, reducing or denying payment.

(1) Paying or Reducing Payment.

(A) The workers' compensation insurance carrier shall pay the health care insurer the lesser of:

(i) the amount payable under the applicable Division fee guideline as of the date of service; or

(ii) the actual amount paid by the health care insurer.

(B) If No Fee Guideline. In the absence of a Division fee guideline for a specific service paid, the amount per service paid by the health care insurer shall be considered in determining a fair and reasonable payment pursuant to §134.1 of this title (relating to Medical Reimbursement).

(C) Interest. The health care insurer may not recover interest as a part of the payable amount.

(D) Previous Payments. The workers' compensation insurance carrier shall reduce any reimbursable amount by any payments the workers' compensation insurance carrier previously made to the same health care provider for the provision of the same health

care on the same dates of service. In making such a reduction in reimbursement, the workers' compensation insurance carrier shall provide evidence of the previous payments made to the health care provider.

(E) Notice to Injured Employee and Health Care Provider. The workers' compensation insurance carrier must give notice of its response to the reimbursement request to the injured employee and the health care provider that performed the services that are the subject of the reimbursement request. If the claim is compensable, the notice shall include an explanation that the claim is compensable and that the health care provider must reimburse the injured employee for any amounts paid to the health care provider by the injured employee.

(F) The health care provider may submit a reimbursement request to the workers' compensation insurance carrier for any money owed under Division fee guidelines for the medical services rendered on a compensable claim and is entitled to dispute resolution under §133.307 of this title (relating to MDR of Fee Disputes). The workers' compensation insurance carrier is liable for full payment in accordance with Division fee guidelines and applicable rules for the medical services rendered on a compensable claim.

(2) Explanation of Benefits. The workers' compensation insurance carrier must provide the health care insurer, all health care providers, and the injured employee an explanation of benefits (EOB) in the form and manner prescribed by the Division. The EOB must provide sufficient explanation regarding the basis for a denial of the reimbursement request.

(f) Reimbursement of Injured Employee. If the injured employee's medical care costs are reimbursable under Title 5 of the Labor Code, a health care provider must refund to the injured employee any payments made by the injured employee to the health care provider, including but not limited to, copays and deductibles. Reimbursement must be made within 45 days of receipt of the notice that the claim is compensable.

(g) Filing Notice of Subclaimant Status.

(1) 120 Day Deadline. A health care insurer must file a written notice of subclaimant status with the Division not later than the 120th day after a workers' compensation insurance carrier fails to respond to a health care insurer's reimbursement request or reduces or denies the requested reimbursement amount.

(2) Location for Filing Notice. The notice may be filed with the Division of Workers' Compensation at any local Division field office or at the Division's central office in Austin, Texas.

(3) One Injured Employee Per Notice. A health care insurer must file separate notices for each individual injured employee in which the health care insurer seeks subclaimant status.

(4) One Notice Per Injured Employee Date of Injury. If an individual injured employee has multiple claims based on different dates of injury, the health care insurer must file a separate notice for each date of injury for which medical benefits were provided.

(5) Form. The notice of subclaimant status must be in the form and manner prescribed by the Division.

(h) Request for Dispute Resolution. The rules applicable to dispute resolution vary according to the reason for denial of reimbursement. Disputes regarding extent of injury, liability, or medical necessity must be resolved prior to pursuing a medical fee dispute. A request for medical dispute resolution may be filed in lieu of a request for subclaimant status, and shall be considered a request for subclaimant status for purposes of this section.

(1) Claim or Treatment Not Compensable.

(A) A health care insurer must file a request for a benefit review conference pursuant to §141.1 of this title (relating to Requesting and Setting a Benefit Review Conference) with the Division not later than the 120th day after a workers' compensation insurance carrier reduces or denies the requested reimbursement amount based on compensability or extent of injury issues.

(B) The health care insurer may pursue dispute resolution to obtain an order from an administrative law judge regarding compensability or eligibility for benefits in accordance with Labor Code Chapter 410 and applicable Division rules.

(C) A subclaim dispute based on a denial of reimbursement due to compensability or extent of injury is subject to dispute resolution pursuant to Chapters 140 - 143 of this title (relating to Dispute Resolution).

(2) Lack of Medical Necessity.

(A) A health care insurer must file a request for medical dispute resolution with the workers' compensation insurance carrier or the insurance carrier's utilization review agent not later than the 120th day after a workers' compensation insurance carrier reduces or denies the requested reimbursement amount due to lack of medical necessity.

(B) A medical dispute based on the workers' compensation insurance carrier's denial of a health care insurer's reimbursement request due to lack of medical necessity is subject to dispute resolution pursuant to §133.308 of this title (relating to MDR of Medical Necessity Disputes).

(C) A subclaimant shall follow the independent review process allowed for a non-network health care provider seeking retrospective review of a service under that section, with any modifications specified by this subsection.

(D) A request for reconsideration is not required prior to a request for independent review, notwithstanding the requirements for requesting independent review under §133.308 of this title.

(E) A request for independent review may be filed, notwithstanding the timeliness requirements for filing a request for independent review under §133.308 of this title.

(F) Notwithstanding the provisions of §133.308 of this title, regarding independent review organization requests for additional information, if a health care provider is requested to submit records, the health care insurer shall reimburse the health care provider copy expenses for the requested records.

(3) Reduction, Denial or Failure to Respond.

(A) A health care insurer must file a request for medical dispute resolution with the Division not later than:

(i) the 120th day after a workers' compensation insurance carrier fails to respond to a health care insurer's reimbursement request or reduces or denies the requested reimbursement amount for reasons other than lack of medical necessity; or

(ii) 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability or extent of injury issues raised in accordance with this subsection.

(B) A medical dispute based on the workers' compensation insurance carrier's failure to respond to a health care insurer's reimbursement request or the result of a reduction or denial of the requested reimbursement amount for reasons other than those listed in paragraph (1) or (2) of this subsection is subject to medical dispute resolution pursuant to §133.307 of this title, notwithstanding the definition of medical fee dispute in §133.305 of this title (relating to MDR--General), and the health care insurer must follow the medical fee dispute resolution process allowed for a health care provider under that section, with any modifications specified by this subsection.

(C) Notwithstanding the requirements of §133.307(c)(2) of this title, a health care insurer shall only be required to include with a request for medical fee dispute resolution, a copy of the health care insurer reimbursement request as originally submitted to the workers' compensation insurance carrier, a copy of the EOB relevant to the fee dispute received from the workers' compensation insurance carrier, and sufficient information to substantiate the claim.

(D) A request for reconsideration is not required prior to a request for medical fee dispute resolution, notwithstanding the requirements for requesting medical fee dispute resolution under §133.307 of this title.

(E) A request for medical fee dispute resolution may be filed, notwithstanding the timeliness requirements for filing a request for medical fee dispute resolution under §133.307 of this title.

(i) Multiple Entities Seeking Reimbursement for Same Services. If there are multiple entities seeking reimbursement for the same services and dates of services for the same health care insurer for the same injured employee, the following apply:

(1) When the workers' compensation insurance carrier obtains a release from the health care insurer indicating that those specific services have been paid in full, no other entity may collect for those specific services.
(2) If a dispute remains over the fees to be paid for those specific services, the first in time to file a dispute with the Division is the only subclaimant that has a right to dispute resolution, and reimbursement, for that injured employee's claim and those specific services rendered unless that subclaimant abandons the dispute resolution process prior to a final adjudication of the issues.

Source Note: The provisions of this §140.8 adopted to be effective September 23, 2008, 33 TexReg 8002; amended to be effective January 7, 2019, 44 TexReg 104

RULE §140.9 Requests by Parties

(a) This subsection applies to carriers, carrier representatives, claimants represented by an attorney, and claimants assisted by the Office of Injured Employee Counsel (OIEC). The parties shall work collaboratively to reach any agreement reasonably necessary for the efficient disposition of a case. Unless presented during a proceeding, all requests to presiding officers, including rescheduling and continuance requests, discovery requests, and other requests, must be in writing and include a signed statement that the requester made reasonable efforts to confer with the other party or parties about the request. If the requester was unable to confer with the other party or parties, the statement must summarize the efforts made to confer. If the parties conferred, the statement must:
(1) include whether the other party or parties oppose the request; and
(2) for a request to reschedule or continue a proceeding, propose a date and time the parties are available for the rescheduled proceeding that has been coordinated with the division's docketing section.

(b) Requests must be sent to the division and to the opposing party or parties. For claimants represented by an attorney, requests must be sent to the claimant and the claimant's representative. For claimants assisted by OIEC, requests must be sent to the claimant and to OIEC.

(c) Unless otherwise directed or allowed by a presiding officer, any responses to requests for rescheduling and continuance must be filed, in writing, with the division and delivered to all parties within three days of receipt of the request and any responses to other requests must be filed, in writing, with the division and delivered to all parties within five days of receipt.

(d) Unless precluded by other law, a presiding officer may, in the interest of justice, consider a request or response that is not timely filed or which otherwise fails to comply with the requirements of this section. The presiding officer may reconsider previous rulings made in the absence of this information.

(e) Requests to reschedule or cancel a benefit review conference must meet the requirements of §141.2 of this title (relating to Canceling or Rescheduling a Benefit Review Conference).

(f) Claimants who are neither represented by an attorney nor assisted by OIEC may request a continuance by contacting the division in any manner.

Source Note: The provisions of this §140.9 adopted to be effective January 7, 2019, 44 TexReg 104

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 141	DISPUTE RESOLUTION--BENEFIT REVIEW CONFERENCE

RULE §141.1 Requesting and Setting a Benefit Review Conference

(a) Prior Notification. Before requesting a benefit review conference, a disputing party must notify the other parties of the nature of the dispute and attempt to resolve the dispute.

(b) Who May Request. A request for a benefit review conference may be made by an injured employee, a subclaimant, or an insurance carrier. An employer may request a benefit review conference to contest compensability when the insurance carrier has accepted the claim as compensable.

(c) Subclaimant. A request for a benefit review conference made by a subclaimant under Labor Code §409.009 must also comply with the requirements of §140.6 of this title (relating to Subclaimant Status: Establishment, Rights, and Procedures).

(d) Request for Benefit Review Conference. A request for a benefit review conference must be made in the form and manner required by the division. The request must:
(1) identify and describe the disputed issues;
(2) provide details and supporting documentation of efforts made by the requesting party to resolve the disputed issues, including, but not limited to, copies of the notification provided in accordance with subsection (a) of this section, correspondence, emails, faxes, records of telephone contacts, or summaries of meetings or telephone conversations. For the purposes of this subsection, copies of the notification provided under subsection (a) of this section, correspondence, emails, faxes, records of telephone contacts, or summaries of meetings or telephone conversations should not include all attachments of pertinent information exchanged with the opposing parties as required by §141.4 of this title (relating to Sending and Exchanging Pertinent Information);
(3) contain the requesting party's signature to show that the party made reasonable efforts to resolve the disputed issues before requesting a benefit review conference, and provide any pertinent information in their possession to the other parties as required by §141.4(c) of this title; and
(4) send the request to the division and opposing parties.

(e) Complete Request. A request that meets the requirements of subsection (d) of this section is a complete request for a benefit review conference. The division will schedule

a benefit review conference if the request is complete and otherwise appropriate for a benefit review conference.

(f) Incomplete Request. A request for a benefit review conference that does not meet the requirements of subsection (d) of this section is an incomplete request. The division will deny an incomplete request.
(1) A denied request for a benefit review conference does not constitute a dispute proceeding, except as provided by subsection (g) of this section.
(2) If the division denies a request, it will provide notice to the parties and state the reasons for the denial.
(3) On notice from the division, the requesting party may submit a new request for a benefit review conference that meets the requirements of this section.

(g) Incomplete Request Denials. If a party disagrees with the division's determination that the request was incomplete, or if a party has good cause for failing to meet the requirements of subsection (d) of this section, the party may pursue an administrative appeal of the division's determination under Chapter 142 of this title (relating to Dispute Resolution--Benefit Contested Case Hearing). The party may also request an expedited contested case hearing under §140.3 of this title (relating to Expedited Proceedings).

(h) Setting. If a request meets the standards of subsection (e) of this section, the division will schedule a benefit review conference:
(1) within 40 days after the division received the request; and
(2) within 20 days after the division received the request, if the division determines that an expedited setting is needed.

(i) Notice. After setting the benefit review conference, the division must provide, by first class mail, electronic transmission, or personal delivery, written notice of the date, time, and location to the parties and the employer.

(j) Method for Conducting. The benefit review conference will be conducted by telephone or videoconference, unless the division determines that good cause exists for conducting the benefit review conference in person. Unless the division determines that good cause exists for the selection of a different location, an in-person benefit review conference will be conducted at a site no more than 75 miles from the injured employee's residence at the time of injury.

Source Note: The provisions of this §141.1 adopted to be effective June 7, 1991, 16 TexReg 2876; amended to be effective October 1, 2010, 35 TexReg 7430; amended to be effective December 9, 2021, 46 TexReg 8258

RULE §141.2 Canceling or Rescheduling a Benefit Review Conference

(a) In this subsection, "good cause" will be determined at the discretion of the benefit review officer on a case-by-case basis, including consideration of prejudice to parties, and means:
(1) objective facts beyond the control of a party, which reasonably:
(A) prevent a party from attending the benefit review conference; or
(B) would prevent the benefit review conference from accomplishing its purpose, such as the need for a reasonable amount of additional time to secure necessary evidence for the dispute; or
(2) objective facts which make the benefit review conference unnecessary.

(b) The division may cancel a benefit review conference at any time before the benefit review conference:
(1) on its own motion;
(2) at the request of the party who requested the conference; or
(3) at the mutual request of the parties.

(c) The division may reschedule a benefit review conference at any time before the benefit review conference:
(1) on its own motion, or
(2) at the request of a party.

(d) A request for cancellation or rescheduling under subsection (b) or (c) of this section shall be made by notifying the division in writing, with a copy to all parties, within 10 days of the date the notice of setting is received.
(1) The first request to reschedule a benefit review conference under subsection (d) of this section does not have to demonstrate good cause for the request but must comply with §140.9 of this title (relating to Requests by Parties).
(2) A request to reschedule or cancel a benefit review conference made outside of the 10-day period, as well as all subsequent rescheduling requests under subsection (c) of this section by any party, must:
(A) be in writing and in the form prescribed by the division;
(B) demonstrate good cause for canceling or rescheduling, as defined by subsection (a) of this section;
(C) be sent to the division and opposing party or parties no later than five days before the scheduled benefit review conference unless good cause is demonstrated for filing later; and
(D) comply with the requirements of §140.9 of this title.

(3) A claimant who is neither represented by an attorney nor assisted by OIEC may request that a benefit review conference be rescheduled or cancelled by contacting the division in any manner.

(4) A cancellation of a benefit review conference without simultaneous rescheduling constitutes a withdrawal of the dispute on the issue. A request to cancel a benefit review conference subject to §130.12 of this title (relating to Finality of the First Certification of Maximum Medical Improvement and/or First Assignment of Impairment Rating) must comply with the provisions of §130.12(b)(3) of this title.

(5) Unless otherwise directed by a presiding officer, a party opposing the rescheduling or cancellation of a benefit review conference must file any written opposition with the division within three days of receiving the cancellation or rescheduling request.

(6) The division will notify the parties of a cancellation or rescheduling of a benefit review conference in a timely manner.

(7) If the benefit review officer denies a request to cancel or reschedule a benefit review conference under this section, the benefit review officer will notify the parties in writing and state the reasons for the denial.

Source Note: The provisions of this §141.2 adopted to be effective June 7, 1991, 16 TexReg 2876; amended to be effective October 1, 2010, 35 TexReg 7430; amended to be effective November 20, 2011, 36 TexReg 7867; amended to be effective January 7, 2019, 44 TexReg 107

RULE §141.3 Failure to Attend a Benefit Review Conference

(a) Applicability. This subsection applies to a benefit review conference that is requested before December 1, 2011.

(1) When a party fails to attend a benefit review conference without good cause, as determined by the benefit review officer, the benefit review officer:

(A) shall hold the conference as scheduled; and

(B) may recommend the issuance of an administrative violation.

(2) A representative who fails to attend a benefit review conference without good cause commits an administrative violation.

(b) Applicability. This subsection applies to a benefit review conference that is requested on or after December 1, 2011.

(1) In this subsection, "good cause" will be determined at the discretion of the benefit review officer on a case-by-case basis and means objective facts beyond the control of a party, which reasonably:

(A) prevented the party from attending the benefit review conference;

(B) prevented the party from requesting the division to cancel or reschedule in advance of the benefit review conference; and

(C) if applicable, prevented the party from filing a request to reschedule within the third business day after failing to attend the scheduled benefit review conference and justifies the subsequent delay in filing the request to reschedule.

(2) When a party fails to attend a benefit review conference without good cause, as determined by the benefit review officer, the benefit review officer shall hold the conference as scheduled.

(3) A party who fails to attend a scheduled benefit review conference may request to reschedule the benefit review conference under the provisions of this subsection. The request to reschedule must:

(A) be filed with the division as soon as practicable, but no later than the close of the third business day after the scheduled benefit review conference, unless good cause exists for further delay;

(B) be in writing and in the form prescribed by the division;

(C) establish good cause in accordance with paragraph (1) of this subsection; and

(D) be sent to opposing party or parties.

(4) Except as provided by paragraph (5) of this subsection, if a party fails to attend a benefit review conference without good cause, the party forfeits the party's entitlement to attend a benefit review conference on the issue in dispute. If a party forfeits this entitlement, the division will not reschedule the benefit review conference on the issue in dispute.

(5) A party will not be considered to have forfeited the party's entitlement to attend a benefit review conference on the issue in dispute under paragraph (4) of this subsection if a benefit review officer is authorized to schedule an additional benefit review conference under Labor Code §410.026(b).

(6) A party who forfeits the party's entitlement to attend a benefit review conference on the issue in dispute does not forfeit the party's right, as provided by the Workers' Compensation Act and division rules, to a contested case hearing on the issue in dispute.

(7) Notwithstanding paragraph (3) of this subsection, the division may refuse to reschedule a benefit review conference under this section and may direct the parties to proceed to a contested case hearing, if authorized under §142.5(b) of this title (relating to Sequence of Proceedings to Resolve Benefit Disputes).

(8) A party who fails to attend a benefit review conference without good cause commits an administrative violation.

(9) If the benefit review officer denies a request to reschedule a benefit review conference under this section, the benefit review officer will notify the parties in writing and state the reasons for the denial.

Source Note: The provisions of this §141.3 adopted to be effective June 7, 1991, 16 TexReg 2876; amended to be effective May 10, 2000, 25 TexReg 3988; amended to be effective November 20, 2011, 36 TexReg 7867

RULE §141.4 Sending and Exchanging Pertinent Information

(a) As used in this chapter "pertinent information" means all information relevant to the resolution of the disputed issue or issues to be addressed at the benefit review conference, including but not limited to:
(1) reports regarding the compensable injury;
(2) the injured employee's wage records; and
(3) the injured employee's medical records.

(b) Examples of "pertinent information" are listed on the division's website.

(c) All pertinent information, as described in subsections (a) and (b) of this section, not previously exchanged, in the possession of the party requesting a benefit review conference must be sent to the opposing party or parties before the time the request for a benefit review conference is sent to the division.

(d) The opposing party must send all pertinent information in its possession, not previously exchanged, to the requesting party and other parties within 10 working days after receiving a copy of the request for a benefit review conference.

(e) Not later than 14 days before the benefit review conference, or not later than five days before an expedited conference set under §141.1(d)(2) of this title (relating to Requesting and Setting a Benefit Review Conference):
(1) all pertinent information in the parties' possession not previously sent to the division shall be sent to the division; and
(2) all pertinent information in the parties' possession not previously exchanged must be sent to the other parties.

(f) Additional pertinent information that becomes available thereafter shall be brought to the conference in sufficient copies for the division and opposing party or parties.

(g) The benefit review officer may schedule a second conference upon a determination that pertinent information necessary to resolve the dispute has not been submitted or exchanged. No more than two benefit review conferences may be scheduled for each disputed issue.

(h) The division will not retain the pertinent information received for the BRC after the parties:
(1) reach an agreement on the issues;
(2) set unresolved issues for a contested case hearing; or
(3) fail to reschedule a second benefit review conference within at least 90 days after the first benefit review conference.

(i) Effective date. The effective date of this section is October 1, 2010.

Source Note: The provisions of this §141.4 adopted to be effective June 7, 1991, 16 TexReg 2876; amended to be effective October 1, 2010, 35 TexReg 7430

RULE §141.5 Description of the Benefit Review Conference

(a) Definitions. As used in this section, "participant" means an individual entitled or permitted to attend and take part in a benefit review conference. Participants include:
(1) the parties;
(2) the parties' representatives;
(3) the employer exercising the right to present evidence relevant to the disputed issue or issues; and
(4) any other individual, at the discretion of the benefit review officer.

(b) Overview of the benefit review conference. The benefit review conference consists of three parts: opening, mediation, and closing.

(c) Opening. The benefit review officer shall:
(1) identify the case and introduce the parties and other participants;
(2) thoroughly inform the parties and participants of their rights and responsibilities under the Texas Workers' Compensation Act;
(3) explain the purpose of the conference and the procedures and time frame to be observed;
(4) identify and describe the disputed issues to be mediated; and
(5) elicit each party's statement of position regarding each disputed issue.

(d) Mediation. The benefit review officer shall:
(1) ask and answer questions of the parties and other participants;
(2) encourage the parties to discuss the disputed issues and ask and answer questions;
(3) permit the employer to present evidence relevant to the disputed issues;
(4) permit other participants to discuss the disputed issues and ask and answer questions, to the extent the benefit review officer deems appropriate;

(5) if necessary, caucus individually with each party;
(6) assist the parties to agree on specific options for resolution; and
(7) assist the parties in resolving disputed issues by agreement or settlement.

(e) Closing. The benefit review officer shall:
(1) assist the parties in reducing agreements or settlements to writing;
(2) identify any issues left unresolved; and
(3) if available information pertinent to the resolution of the disputed issue(s) was not produced at the benefit review conference, require a second benefit review conference to be scheduled if a second one has not already been conducted.

Source Note: The provisions of this §141.5 adopted to be effective June 7, 1991, 16 TexReg 2876; amended to be effective September 4, 2006, 31 TexReg 7127

RULE §141.7 Division Actions After a Benefit Review Conference

(a) All Issues Resolved. Division actions if all issues are resolved at the benefit review conference.
(1) If all issues in dispute are resolved at the benefit review conference by agreement or settlement, the agreement or settlement must be reduced to writing and signed by each party and their designated representative, if any, and the benefit review officer.
(2) The benefit review officer shall make the agreement part of the claim file. If all issues in dispute are resolved at the benefit review conference by settlement, the benefit review officer shall submit the signed settlement to the commissioner or commissioner's designee for handling as provided by Chapter 147 of this title (relating to Dispute Resolution--Agreements, Settlements, Commutations). If the commissioner or commissioner's designee rejects the settlement, the parties may request:
(A) a second benefit review conference, if a second benefit review conference has not already been held; or
(B) a contested case hearing.

(b) Issues Not Resolved. Division actions if issues are not resolved at the benefit review conference.
(1) After First Benefit Review Conference. If all issues in dispute are not resolved at the first benefit review conference, the benefit review officer may set a second benefit review conference or a contested case hearing.
(2) After Second Benefit Review Conference. If all issues in dispute are not resolved at the second benefit review conference, a contested case hearing will be scheduled by the benefit review officer.

(c) Written Report. Within five days after the benefit review conference is closed, the benefit review officer shall submit the written report and any signed agreements to the division's central office in Austin in accordance with Labor Code §410.031 and §410.034.

(d) Copies of Report and Hearing Notice. The division shall send to the injured employee; injured employee's representative, if any; the insurance carrier; subclaimants; and the employer the following:
(1) a file-stamped copy of the report; and
(2) notice of the date, time, and location of the contested case hearing.

(e) Effective date. The effective date of this section is October 1, 2010.

Source Note: The provisions of this §141.7 adopted to be effective June 7, 1991, 16 TexReg 2876; amended to be effective May 10, 2000, 25 TexReg 3988; amended to be effective September 4, 2006, 31 TexReg 7127; amended to be effective October 1, 2010, 35 TexReg 7430

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 142	DISPUTE RESOLUTION--BENEFIT CONTESTED CASE HEARING

RULE §142.1 Application of the Administrative Procedure Act

The following sections of the Government Code, apply to benefit contested case hearings: §2001.201, relating to enforcement of subpoenas.

Source Note: The provisions of this §142.1 adopted to be effective February 12, 1991, 16 TexReg 463; amended to be effective May 10, 2000, 25 TexReg 3990

RULE §142.2 Authority of the Administrative Law Judge

The administrative law judge is authorized to:

(1) issue subpoenas;

(2) rule on requests;

(3) issue orders, including interlocutory orders;

(4) use summary procedures as provided by §142.8 of this chapter (relating to Summary Procedures);

(5) direct parties to appear at a prehearing conference to resolve evidentiary and procedural issues;

(6) establish time limits for conducting a hearing;

(7) administer oaths;

(8) rule on the admissibility of evidence;

(9) determine the relevancy, materiality, weight, and credibility of evidence;

(10) request additional evidence;

(11) take official notice of the law of Texas and other jurisdictions, Texas city and county ordinances, the contents of the Texas Register, the rule of state agencies, facts that are judicially cognizable, and generally recognized facts within the division's specialized knowledge;

(12) examine parties and witnesses, and permit examination and cross-examination of parties and witnesses;

(13) recess, postpone, or dismiss a hearing; and

(14) take any other action as authorized by law, or as may facilitate the orderly conduct and disposition of the hearing.

Source Note: The provisions of this §142.2 adopted to be effective February 12, 1991, 16 TexReg 463; amended to be effective May 10, 2000, 25 TexReg 3990; amended to be effective January 7, 2019, 44 TexReg 108

RULE §142.3 Ex Parte Communications

(a) No person, except as otherwise provided in subsection (c) of this section, may communicate, either directly or indirectly, with the administrative law judge regarding any facts, issues, law or rules relating to the benefit contested case hearing after the hearing has been set, and until all administrative and judicial remedies have been exhausted, unless all parties to the hearing are present, except where the communication is:
(1) written; and
(2) delivered to all parties, as provided by §142.4 of this title (relating to Delivery of Copies to All Parties).

(b) Notwithstanding subsection (a) of this section, any of the individuals named in subsection (a) may communicate with the administrative law judge in any manner regarding procedural issues.

(c) An administrative law judge assigned to render a decision in a benefit contested case hearing, may communicate ex parte with other division employees for the purpose of utilizing their special skills or knowledge in evaluating the evidence.

Source Note: The provisions of this §142.3 adopted to be effective February 12, 1991, 16 TexReg 463; amended to be effective May 10, 2000, 25 TexReg 3990; amended to be effective January 7, 2019, 44 TexReg 108

RULE §142.4 Delivery of Copies to All Parties

A party who sends a document relating to a benefit contested case hearing to the division shall also deliver copies of the document to all other parties as provided in §140.9 of this title (Requests by Parties). Delivery shall be accomplished by presenting in person, mailing by first class mail, facsimile, or electronic transmission. The document sent to the division shall contain a statement certifying delivery. The following statement of certification shall be used: "I hereby certify that I have on this _____ day of _____, _____, delivered a copy of the attached document to (state the names of all parties to whom a copy was delivered) by (state the manner of delivery)."

Source Note: The provisions of this §142.4 adopted to be effective February 12, 1991, 16 TexReg 463; amended to be effective May 10, 2000, 25 TexReg 3990; amended to be effective January 7, 2019, 44 TexReg 108

RULE §142.5 Sequence of Proceedings to Resolve Benefit Disputes

(a) Usual sequence. Except as provided in this section, parties to a benefit dispute are required to attempt to resolve the dispute by mediation at a benefit review conference before proceeding to a contested case hearing or to arbitration by mutual election.

(b) Guidelines for proceeding directly to a benefit contested case hearing. Parties may proceed directly to a contested case hearing without attending a benefit review conference if the division determines that:
(1) mediation would not prove effective to resolve the dispute;
(2) necessary evidence cannot be obtained without subpoena; or
(3) the situation of the parties or the nature of the facts or law of the case is such that the overall policy of the Act would be advanced by proceeding directly to a contested case hearing.

(c) Requesting a hearing. A party may request that the division set a benefit contested case hearing. The request shall be made in the following manner:
(1) If the requester is a carrier, carrier representative, claimant represented by an attorney, or claimant assisted by OIEC, the request shall:
(A) be made in writing and signed by the requestor;
(B) identify and describe the disputed issue or issues;
(C) state the reason for requesting the hearing;
(D) be sent to the division; and

(E) be delivered to all the other parties, as provided by §142.4 of this chapter (relating to Delivery of Copies to All Parties).

(2) A claimant who is neither represented by an attorney nor assisted by OIEC may request a hearing by contacting the division in any manner.

(d) Division action on a request for hearing. The division will rule on the request and notify the parties. A ruling granting the request will include a notice of hearing, as provided in §142.6 of this chapter (relating to Setting a Benefit Contested Case Hearing). A ruling denying the request may include a notice of benefit review conference.

(e) Response. If a hearing is set upon request, the other party or parties may submit a response. The response shall:

(1) be made in writing and signed;

(2) describe and explain the party's position on the dispute or disputes;

(3) be sent to the division no later than five days before the hearing; and

(4) be delivered to all other parties, as provided by §142.4 of this title (relating to Delivery of Copies to All Parties).

(f) A claimant who is neither represented by an attorney nor assisted by OIEC may respond by contacting the division in any manner.

Source Note: The provisions of this §142.5 adopted to be effective February 12, 1991, 16 TexReg 463; amended to be effective May 10, 2000, 25 TexReg 3990; amended to be effective January 7, 2019, 44 TexReg 108

RULE §142.6 Setting a Benefit Contested Case Hearing

(a) Setting with prior benefit review conference. The commission shall set a benefit contested case hearing to be held:

(1) no later than 60 days from the date of the benefit review conference; or

(2) if the commission determines that an expedited setting is appropriate, as provided by §140.3 of this title (relating to Expedited Hearings), no later than 30 days from the date of the benefit review conference.

(b) Setting without prior benefit review conference. For those disputes determined not to require a benefit review conference, as defined in §142.5 of this title (relating to Sequence of Proceedings To Resolve Benefit Disputes), the commission may set a benefit contested case hearing on its own motion, or at the request of a party. When requested, the hearing shall be set on a date:

(1) no later than 60 days from receipt of the request; or

(2) if the commission determines that an expedited setting is appropriate, no later than 30 days from the commission's receipt of the request.

(c) Notice of hearing. After setting a hearing, the commission shall furnish to the parties, by first class mail or personal delivery, written notice of the date, time, duration, and location of the hearing. The notice shall be furnished:
(1) at the same time that the notice of the benefit review conference is given;
(2) not later than 45 days before a hearing set under subsection (b)(1) of this section; or
(3) not later than 10 days before a hearing set under subsection (b)(2) of this section.

Source Note: The provisions of this §142.6 adopted to be effective February 12, 1991, 16 TexReg 463

RULE §142.7 Statement of Disputes

(a) Statement of disputes. The statement of disputes is a written description of the benefit dispute or disputes to be considered by the administrative law judge. A dispute not expressly included in the statement of disputes will not be considered by the administrative law judge.

(b) Statement of disputes after a benefit review conference. The statement of disputes for a hearing held after a benefit review conference includes:
(1) the benefit review officer's report, identifying the disputes remaining unresolved at the close of the benefit review conference;
(2) the parties' responses, if any;
(3) additional disputes by unanimous consent, as provided by subsection (c) of this section; and
(4) additional disputes presented by a party, as provided by subsections (d) and (e) of this section, if the administrative law judge determines that the party has good cause.

(c) Party response to the benefit review officer's report. A party may submit a response to the disputes identified as unresolved in the benefit review officer's report. The response shall:
(1) be in writing;
(2) describe and explain the party's position on the unresolved dispute or disputes;
(3) be sent to the division no later than 20 days after receiving the benefit review officer's report; and
(4) be delivered to all other parties, as provided by §142.4 of this title (relating to Delivery of Copies to All Parties).

(d) Additional disputes by unanimous consent. Parties may, by unanimous consent, submit for inclusion in the statement of disputes one or more disputes not identified as unresolved in the benefit review officer's report. Additional disputes submitted by consent shall:

(1) be made in writing;

(2) identify the dispute and explain the party's position on it;

(3) be signed by all parties;

(4) be sent to the division no later than 10 days before the hearing; and

(5) explain why the issue was not raised earlier.

(e) Additional disputes by permission of the administrative law judge. A party may request the administrative law judge to include in the statement of disputes one or more disputes not identified as unresolved in the benefit review officer's report. The administrative law judge will allow such amendment only on a determination of good cause.

(1) If the requester is a carrier, carrier representative, claimant represented by an attorney, or claimant assisted by OIEC, the request shall:

(A) be made in writing;

(B) identify and describe the dispute or disputes;

(C) state the reason for the request;

(D) be sent to the division no later than 15 days before the hearing; and

(E) be delivered to all other parties, as provided by §142.4 of this title (relating to Delivery of Copies to All Parties).

(2) A claimant who is neither represented by an attorney nor assisted by OIEC may request additional disputes to be included in the statement of disputes by contacting the division in any manner no later than 15 days before the hearing.

(3) The administrative law judge will rule on the request, and notify the parties of the ruling.

(f) Statement of disputes without prior benefit review conference. The statement of disputes for a hearing held without a prior benefit review conference includes:

(1) the request for hearing, as described in §142.5(c) of this title (relating to Sequence of Proceedings To Resolve Benefit Disputes); and

(2) the other party's response, as described in §142.5(e) of this title (relating to Sequence of Proceedings To Resolve Benefit Disputes), if any.

Source Note: The provisions of this §142.7 adopted to be effective February 12, 1991, 16 TexReg 463; amended to be effective January 7, 2019, 44 TexReg 108

RULE §142.8 Summary Procedures

(a) In order to expedite the presentation of a case, the administrative law judge may allow summary procedures, including, but not limited to, the use of:
(1) sworn witness statements;
(2) summaries of evidence;
(3) medical reports;
(4) agreements; and
(5) stipulations.

(b) The administrative law judge may allow the use of summary procedures:
(1) on its own motion; or
(2) at the request of a party.

(c) A party may request the use of summary procedures in any manner and at any time before the hearing.

Source Note: The provisions of this §142.8 adopted to be effective February 12, 1991, 16 TexReg 463; amended to be effective January 7, 2019, 44 TexReg 108

RULE §142.9 Stipulations, Agreements, and Settlements

(a) At any time before or during the hearing, parties may:
(1) enter into stipulations, as provided by §140.1 of this title (relating to Definitions);
(2) resolve one or more benefit disputes by agreement; or
(3) resolve all benefit disputes by settlement.

(b) Stipulations shall be made as follows:
(1) Stipulations made before the hearing shall be:
(A) made in writing;
(B) signed by all parties to the stipulation, or their representative; and
(C) sent to the Commission no later than the day before the hearing.
(2) Stipulations may be made orally at a hearing and preserved in the record.

(c) Agreements and Settlements shall be made as provided by Chapter 147 of this title (relating to Dispute Resolution by Agreement or Settlement).

Source Note: The provisions of this §142.9 adopted to be effective February 12, 1991, 16 TexReg 463; amended to be effective May 10, 2000, 25 TexReg 3990

RULE §142.10 Continuance

(a) As used in this chapter, continuance means postponing a hearing from the time or date set, and rescheduling it on a later time or date.

(b) The division may continue a hearing:
(1) on its own motion; or
(2) at the request of a party, if the administrative law judge determines the party has good cause.

(c) A request for continuance may be made before or during a hearing.
(1) A request made before a hearing by a carrier, carrier representative, claimant represented by an attorney, or claimant assisted by OIEC shall:
(A) be in writing;
(B) state the reason for continuing the hearing;
(C) be sent to the division no later than five days before the hearing; and
(D) be delivered to all parties, as provided by §142.4 of this title (relating to Delivery of Copies to All Parties).
(2) A claimant who is neither represented by an attorney nor assisted by OIEC may request a continuance before a hearing by contacting the division in any manner.
(3) A party may orally request a continuance during a hearing. In addition to showing good cause, the party must show that a continuance will not prejudice the rights of the other parties.

(d) The administrative law judge will rule on the request and notify all parties of the ruling. A ruling granting the continuance will include notice of the date, time, and location of the rescheduled hearing.

Source Note: The provisions of this §142.10 adopted to be effective February 12, 1991, 16 TexReg 463; amended to be effective January 7, 2019, 44 TexReg 108

RULE §142.11 Failure To Attend a Benefit Contested Case Hearing

(a) When a party fails to attend a scheduled contested case hearing for which proper notice was provided, the administrative law judge shall proceed with the scheduled hearing. Following the close of evidence, the administrative law judge shall send written notice that the non-attending party has 10 days from the date of receipt of the notice to respond in writing and show good cause for the party's failure to attend.

(b) Other parties to the proceeding may reply, in writing, to the non-attending party's response within three days of receipt of the response.

(c) The administrative law judge shall issue a written ruling based on the filings allowed under subsections (a) and (b) of this section. If the administrative law judge determines that good cause exists for the failure to attend, the hearing will be rescheduled. If good cause is not found, or if the non-attending party does not respond to the notice, the administrative law judge shall issue a decision based on the evidence presented at the hearing and may recommend the issuance of an administrative violation.

Source Note: The provisions of this §142.11 adopted to be effective February 12, 1991, 16 TexReg 463; amended to be effective January 7, 2019, 44 TexReg 108

RULE §142.12 Subpoena

(a) Definitions. The following words and terms, as used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:
(1) Evidence - Testimony or documents, including books, papers, and tangible things.
(2) Service - Delivery of a subpoena by an authorized individual to the person to whom it is addressed.
(3) Subpoena - A division order issued by the administrative law judge requiring a person to attend or to produce evidence at a deposition (deposition subpoena) or at a hearing (hearing subpoena).

(b) How issued. The division may issue a subpoena:
(1) on its own motion; or
(2) at the request of a party, if the administrative law judge determines the party has a good cause.

(c) Request for subpoena. A party may request a subpoena in the following manner:
(1) If the requester is a carrier, carrier representative, claimant represented by an attorney, or claimant assisted by OIEC, the request shall:
(A) be in writing;
(B) identify the evidence to be produced, and explain why it is relevant to a disputed issue;
(C) state whether the subpoena is for a deposition or a hearing;
(D) be sent to the division; and
(E) be delivered to all parties, as provided by §142.4 of this chapter (relating to Delivery of Copies to All Parties).

(2) A claimant who is neither represented by an attorney nor assisted by OIEC may request a subpoena by contacting the division in any manner, and may also request the division to arrange for service, if service will be at no cost to the division.

(d) Special provisions for hearing subpoenas. A request for a hearing subpoena shall be sent to the division and delivered to the parties, as provided by §142.4 of this chapter (relating to Delivery of Copies to All Parties), no later than 10 days before the hearing. The administrative law judge may deny a request for a hearing subpoena upon a determination that the testimony may be adequately obtained by deposition or written affidavit.

(e) Service. Upon granting a request and issuing a subpoena, the administrative law judge shall:
(1) return it to the requester for service, according to §176.5, Texas Rules of Civil Procedure; or
(2) send it to the appropriate sheriff or constable, or any person who is not a party and is 18 years of age or older for service, if a claimant who is neither represented by an attorney nor assisted by OIEC has requested the division to arrange for service, as provided by subsection (c)(2) of this section.

(f) Costs.
(1) Except as provided by subsection (c)(2) of this section, the party requesting the subpoena is responsible for all costs associated with the subpoena, including service, witness fees, and mileage.
(2) A witness or deponent who is not a party and who is subpoenaed or otherwise compelled to attend a hearing or deposition to give testimony or produce documents is entitled to receive from the party requesting the subpoena:
(A) a fee of $30 a day for each day or part of a day the person is necessarily present as a witness or deponent;
(B) mileage at the rate set for state employees in the General Appropriations Act, for going to and returning from the place of the hearing or the place of the deposition, if the place is more than 25 miles from the person's place of residence; and
(C) fees for providing expert testimony relating to medical issues shall be paid according to guidelines established by the division pursuant to the Texas Labor Code, Chapter 413.

(g) A subpoena may be enforced in the manner provided by the Government Code §2001.201 and the Texas Labor Code.

Source Note: The provisions of this §142.12 adopted to be effective February 12, 1991, 16 TexReg 463; amended to be effective May 10, 2000, 25 TexReg 3990; amended to be effective January 7, 2019, 44 TexReg 108

RULE §142.13 Discovery

(a) Description of discovery. As used in this chapter, discovery is the process by which a party may, before the hearing, obtain evidence relating to the disputed issue or issues from the other parties and witnesses. If the evidence is not produced voluntarily, the party may request a subpoena, as provided in §142.12 of this title (relating to Subpoena). Discovery includes:

(1) parties' exchange of documentary evidence;

(2) interrogatories, as prescribed by §142.19 of this title (relating to Interrogatories); and

(3) witness depositions, as follows:

(A) a health care provider may be deposed only on written questions; and

(B) other witnesses may be deposed within their county of residence or employment, orally or on written questions, if the administrative law judge determines the party has good cause to request such testimony.

(b) Sequence of discovery. Parties shall exchange documentary evidence in their possession not previously exchanged, as described in subsection (c) of this section, before requesting additional discovery by interrogatory, as described in subsection (d) of this section, or deposition, as described in subsection (e) of this section. Additional discovery shall be limited to evidence not exchanged, or not readily derived from evidence exchanged.

(c) Parties' exchange of documentary evidence.

(1) Except as provided in subsection (g) of this section, no later than 15 days after the benefit review conference, parties shall exchange with one another the following information:

(A) all medical reports and reports of expert witnesses who will testify at the hearing;

(B) all medical records;

(C) any witness statements;

(D) the identity and location of any witness known to have knowledge of relevant facts; and

(E) all photographs or other documents which a party intends to offer into evidence at the hearing.

(2) Thereafter, parties shall exchange additional documentary evidence as it becomes available.

(3) Parties shall bring all documentary evidence not previously exchanged to the hearing in sufficient copies for exchange. The administrative law judge shall make a determination whether good cause exists for a party not having previously exchanged such information or documents to introduce such evidence at the hearing.

(d) Interrogatories.
(1) Interrogatories, as prescribed by §142.19 of this title (concerning Interrogatories), may be used by all parties, including subclaimants, to obtain information from any other party.
(2) Except as provided in subsection (g) of this section, interrogatories must be presented no later than 25 days before the hearing, unless otherwise agreed.
(3) Answers to interrogatories must be exchanged no later than 10 days after receipt of the interrogatories.
(4) Answers to interrogatories must be made under oath.

(e) Witness deposition. A party wishing to depose a witness shall request permission for deposition from the administrative law judge. The request shall:
(1) be made in writing;
(2) identify the witness to be deposed;
(3) state why the testimony is needed;
(4) propose a date, time, and place for taking the deposition;
(5) include a copy of the questions to be asked, if the deposition is to be on written questions;
(6) if needed, include a request for subpoena, as provided by §142.12 of this title (relating to Subpoena);
(7) be filed with the division no later than 10 days before the hearing; and
(8) be delivered to all parties, as provided by §142.4 of this title (relating to Delivery of Copies to All Parties).

(f) Additional discovery. The administrative law judge may grant a party permission to conduct discovery beyond that described previously upon a showing of good cause at a hearing held for this purpose.

(g) Time for discovery when the hearing is expedited or held without a prior benefit review conference. The notice setting an expedited hearing, or a hearing held without a prior benefit review conference, shall include time limits for completion of discovery.

Source Note: The provisions of this §142.13 adopted to be effective February 12, 1991, 16 TexReg 463; amended to be effective February 18, 1992, 17 TexReg 949; amended to

be effective January 7, 2019, 44 TexReg 108; amended to be effective February 18, 2021, 46 TexReg 1068

RULE §142.14 Permission To Use Court Reporter

(a) A party may request permission to have the hearing recorded by a court reporter provided by the party. The party may select, and must bear the cost of, the court reporter.

(b) A request for permission to use a court reporter may be made in any manner and at any time before the hearing. The administrative law judge will rule on the request, and notify the parties only if the request is denied.

(c) A copy of the court reporter's audiotape, or transcript, if produced, shall be furnished to the division at no charge.

Source Note: The provisions of this §142.14 adopted to be effective February 12, 1991, 16 TexReg 463; amended to be effective January 7, 2019, 44 TexReg 108

RULE §142.16 Decision

(a) After the record closes, the administrative law judge shall issue a decision on benefits. The decision shall:
(1) be in writing;
(2) include findings of fact and conclusions of law; a determination of whether benefits are due; and, if so, an award of benefits due; and
(3) be signed by the administrative law judge.

(b) On a form prescribed by the division the administrative law judge shall issue a separate written decision regarding attorney's fees and any matter related to attorney fees. A decision on income or medical benefits may include an interlocutory order at the discretion of the administrative law judge.

(c) No later than the tenth day after the close of the hearing, the administrative law judge shall file all decisions with the division.

(d) No later than seven days after filing the decision, the division shall furnish to the parties, by first class mail or personal delivery:
(1) a file-stamped copy of the decision; and

(2) a statement specifying the place, manner, and time period within which an appeal must be filed.

(e) A decision issued under this section shall be effective and binding on the date signed by the administrative law judge unless superceded by an interlocutory order contained in the decision, if any.

(f) A decision regarding benefits not appealed to the appeals panel, as provided by the Texas Labor Code, §410.202 and Chapter 143 of this title, becomes final on the sixteenth day after the date received from the division of hearings. Parties shall comply with a final decision or order within 20 days of the date it becomes final as provided by the Texas Labor Code, §410.208.

(g) A decision regarding benefits appealed to the appeals panel as provided by the Texas Labor Code, §410.202 and Chapter 143 of this title, is binding on the parties and payable during an appeal to the appeals panel unless superceded by an interlocutory order contained in the decision, if any.

(h) Parties shall comply with a decision regarding benefits appealed to the appeals panel that does not contain an interlocutory order by issuing and delivering payment of accrued and unpaid income benefits no later than the fifth day after filing a written request for appeal with the appeals panel as provided by the Texas Labor Code, §410.202, and Chapter 143 of this title.

(i) Payment of accrued and unpaid income benefits paid in accordance with a decision shall include interest pursuant to the Texas Labor Code, §408.064 and §408.081.

(j) Payment of medical benefits pursuant to a decision shall be made in accordance with Chapters 408 and 413 of the Texas Labor Code.

Source Note: The provisions of this §142.16 adopted to be effective February 12, 1991, 16 TexReg 467; amended to be effective May 10, 2000, 25 TexReg 3990; amended to be effective January 7, 2019, 44 TexReg 108

RULE §142.17 Transcript or Duplicate of the Hearing Audiotape

(a) A party or the employer may submit a request to the commission for a transcript of the hearing audiotape. The requester shall pay the cost of the transcript, as established by the commission.

(b) A party or the employer may submit a request to the commission for a duplicate of the hearing audiotape. The requester shall pay the cost of the duplication, as established by the commission.

Source Note: The provisions of this §142.17 adopted to be effective February 12, 1991, 16 TexReg 467

RULE §142.18 Special Provisions for Cases on Remand from the Appeals Panel

(a) Priority setting for case on remand from appeals panel. When the appeals panel reverses an administrative law judge's decision and remands the case for further consideration, the division shall set the hearing to be held within 30 days of the date of the appeals panel's decision.

(b) Notice of hearing. After setting a hearing under this section, the division shall furnish, by first class mail or personal delivery, written notice of the date, time, and location to the parties. The notice shall be furnished at least 20 days before the hearing.

(c) Statement of issues. For cases on remand from the appeals panel, the statement of issues includes:
(1) the decision of the appeals panel; and
(2) the parties' responses, if any.

Source Note: The provisions of this §142.18 adopted to be effective February 12, 1991, 16 TexReg 467; amended to be effective January 7, 2019, 44 TexReg 108

RULE §142.19 Form Interrogatories

(a) The division has developed standard interrogatories for parties to exchange the following information:
(1) the name and contact information of the person answering the interrogatories;
(2) the issues in dispute;
(3) any certification of maximum medical improvement and impairment rating;
(4) any statement obtained from any person on the issues in dispute;
(5) the name and contact information for each health care provider the claimant has seen since the date of injury, and the conditions the health care provider treated;
(6) any recordings, photographs, videotapes, or similar material showing the claimant since the date of injury;
(7) for each health care provider the claimant has seen during the five years before the date of injury for treatment of a body part the claimant believes to be part of the claim:

(A) the health care provider's name and contact information;
(B) the dates the health care provider treated the claimant; and
(C) the conditions the health care provider treated; and
(8) for each expert witness expected to testify:
(A) the expert witness' name and contact information;
(B) the subject matter the expert witness may or will testify on; and
(C) the general substance of the expert witness' opinions and a brief summary of the basis for them.

(b) In addition to these standard interrogatories, a party may add up to five additional questions. The parties should write the questions in plain language and present them in a readable and understandable format.

(c) Parties to a dispute must use the standard form interrogatories developed and published by the division in a form and manner consistent with this rule:
(1) Claimant's Interrogatories to Carrier; and
(2) Carrier's Interrogatories to Claimant.

Source Note: The provisions of this §142.19 adopted to be effective July 9, 1991, 16 TexReg 3397; amended to be effective February 18, 2021, 46 TexReg 1068

RULE §142.20 Interlocutory Orders

(a) The administrative law judge may enter an interlocutory order to pay all or part of income benefits or medical benefits.

(b) An interlocutory order contained in a decision supercedes the decision as it pertains to the payment of income benefits or medical benefits and remains in effect until:
(1) the decision becomes final in accordance with §142.16(f) of this title (relating to the Decision);
(2) the decision of the appeals panel is issued pursuant to the Texas Labor Code, §410.204, and Chapter 143 of this title, if appealed to the appeals panel as provided by the Texas Labor Code, §410.202, and Chapter 143 of this title and the decision and order are affirmed or an appeals panel decision reverses the administrative law judge's decision and renders a decision;
(3) reversed or modified by an agreement or settlement, as provided by §147.7 of this title (relating to Effect on Previously-Entered Decisions and Orders); or
(4) reversed or modified by a subsequent interlocutory order or decision issued after remand from the appeals panel pursuant to the Texas Labor Code, §410.203, and Chapter 143 of this title.

(c) An interlocutory order for payment of income benefits or medical benefits shall be effective on the date signed by the administrative law judge.

(d) A party shall comply with an interlocutory order by issuing and delivering payment of accrued and unpaid income benefits no later than the fifth day after receiving the interlocutory order to pay accrued and unpaid benefits, and shall pay benefits in accordance with the interlocutory order as and when they accrue.

(e) Payment of accrued and unpaid income benefits paid in accordance with an interlocutory order shall include interest pursuant to the Texas Labor Code, §408.064 and §408.081.

(f) Payment of medical benefits pursuant to an interlocutory order shall be made in accordance with Chapters 408 and 413 of the Texas Labor Code.

(g) An interlocutory order contained in a decision will be distributed to the parties as provided by §142.16 of this title (relating to the Decision).

Source Note: The provisions of this §142.20 adopted to be effective May 10, 2000, 25 TexReg 3990; amended to be effective January 7, 2019, 44 TexReg 108

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 143	DISPUTE RESOLUTION REVIEW BY THE APPEALS PANEL

RULE §143.1 Definitions

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

(1) Appellant--A party to a benefit contested case hearing who is dissatisfied with the decision of the administrative law judge, and files a request for review of that decision by the appeals panel.

(2) Request--The appellant's written appeal for review of the decision of an administrative law judge.

(3) Respondent--The other party to a benefit contested case hearing who must file a response to the appellant's request.

(4) Response--The respondent's written answer to the appellant's request.

Source Note: The provisions of this §143.1 adopted to be effective March 7, 1991, 16 TexReg 1195; amended to be effective May 9, 2004, 29 TexReg 4223; amended to be effective January 7, 2019, 44 TexReg 111

RULE §143.2 Description of the Appeal Proceeding

(a) To review the decision of the administrative law judge, the appeals panel considers the appellant's request, the respondent's response, and the record of the benefit contested case hearing. The parties do not appear in person before the panel.

(b) The appeals panel may:
(1) reverse the decision of the administrative law judge and render a new decision;
(2) reverse the decision of the administrative law judge and remand to the administrative law judge for a second benefit contested case hearing, which shall be set as provided by §142.18 of this title (relating to Special Provisions for Cases on Remand from the Appeals Panel). The appeals panel may not remand a case more than once; or
(3) affirm the decision of an administrative law judge in a case as described by Labor Code §410.204(a-1).

Source Note: The provisions of this §143.2 adopted to be effective March 7, 1991, 16 TexReg 1195; amended to be effective December 13, 2009, 34 TexReg 8739; amended to be effective November 20, 2011, 36 TexReg 7876; amended to be effective January 7, 2019, 44 TexReg 111

RULE §143.3 Requesting the Appeals Panel to Review the Decision of the Administrative Law Judge

(a) A party to a benefit contested case hearing who is dissatisfied with the decision of the administrative law judge may request the appeals panel to review that decision. The request shall:

(1) be in writing;

(2) clearly and concisely rebut each issue in the administrative law judge's decision that the appellant wants reviewed, and state the relief the appellant wants granted;

(3) be filed with the Chief Clerk of Proceedings in the division's central office in Austin not later than the 15th day after receipt of the administrative law judge's decision. The administrative law judge's decision is deemed to have been received by the parties in accordance with §102.5 (relating to General Rules for Written Communications To and From the Commission) and §102.3 (relating to Computation of Time) of this title. Requests that are timely submitted to a division location other than the Chief Clerk of Proceedings, such as a local field office of the division, will be considered timely filed and forwarded to the division's appeals panel for consideration, but this may result in delay in the processing of the request. Untimely requests, regardless of whether they are filed with the Chief Clerk of Proceedings in the division's central office or in a different division field office, do not invoke the jurisdiction of the appeals panel and will not be reviewed by the appeals panel;

(4) be served on the other party or parties on the same day filed with the division; and

(5) contain a statement certifying that a copy has been served on the other party or parties in person, mailed by certified mail, return receipt requested, or transmitted by verifiable means. A certificate in substantially the following form shall be used: "I hereby certify that I have on this ____ day of _____, _____, served a copy of the attached request for appeal on _____ (state the name of the other party or parties on whom a copy was served) by _____ (state the manner of service)." _____ Signature

(b) If it is not clear from the request for review that the party has properly served a copy of the request on the other party or parties, the division will provide a copy of the request expeditiously.

(c) A party may make a conditional request for review by the appeals panel even if the overall contested case hearing decision is favorable. A timely request that indicates that the filing party seeks consideration only if the opposing party files a request for review will not be treated as a request for review unless an opposing party timely files a request. If an opposing party does file a timely request, the conditional request will be treated as a cross-appeal.

(d) A request for review by the appeals panel shall be filed not later than the 15th day after the appealing party is deemed to have received the administrative law judge's decision. Saturdays and Sundays and holidays listed in Government Code §662.003 are not included in the computation of this 15-day period. A request made under this section shall be presumed to be timely filed or timely served with the division if it is:
(1) mailed on or before the 15th day after the date of deemed receipt of the administrative law judge's decision, as provided in subsection (a) of this section; and
(2) received by the division not later than the 20th day after the date of deemed receipt of the administrative law judge's decision.

Source Note: The provisions of this §143.3 adopted to be effective March 7, 1991, 16 TexReg 1195; amended to be effective December 31, 1991, 16 TexReg 7358; amended to be effective March 14, 2001, 26 TexReg 2032; amended to be effective May 9, 2004, 29 TexReg 4223; amended to be effective December 13, 2009, 34 TexReg 8739; amended to be effective January 7, 2019, 44 TexReg 111

RULE §143.4 Responding to a Request for Review by the Appeals Panel

(a) The other party shall respond to the appellant's request. The response shall:
(1) be in writing;
(2) clearly and concisely support each issue in the administrative law judge's decision that the appellant has rebutted in the request, and state why the appellant's relief should not be granted;
(3) be filed with the Chief Clerk of Proceedings in the division's central office in Austin not later than the 15th day after receipt of the appellant's appeal. The appellant's appeal is deemed received in accordance with §102.5 (relating to General Rules for Written Communications To and From the Commission, §102.4 (relating to General Rules for Non-Commission Communications) and §102.3 (relating to Computation of Time) of this title. Responses that are timely submitted to a division location other than the Chief Clerk of Proceedings, such as a local field office of the division, will be considered filed timely and forwarded to the division's appeals panel for consideration, but this may result in delay in the processing of the response. Untimely responses, regardless of

whether they are filed with the Chief Clerk of Proceedings or in a different division office, will not be reviewed by the appeals panel;

(4) be served on the other party or parties on the same day filed with the division; and

(5) contain a statement certifying that a copy has been served on the other party or parties in person, mailed by certified mail, return receipt requested, or transmitted by verifiable means. A certificate in substantially the following form shall be used: "I hereby certify that I have on this ____ day of _____, _____, served a copy of the attached response to a request for appeal on _____ (state the name of the other party or parties on whom a copy was served) by _____ (state the manner of service)." _____ Signature

(b) If it is not clear from the response that the party has properly served a copy of the response on the other party or parties, the division shall provide a copy of the response expeditiously.

(c) A response to the appellant's request with the division shall be filed not later than the 15th day after the responding party is deemed to have received the appellant's request. Saturdays and Sundays and holidays listed in §662.003, Government Code, are not included in the computation of this 15-day period. A response made under this section shall be presumed to be timely filed with the division if it is:

(1) mailed on or before the 15th day after the date of deemed receipt of the appellant's request, as provided in subsection (a) of this section; and

(2) received by the division not later than the 20th day after the date of deemed receipt of the appellant's request.

Source Note: The provisions of this §143.4 adopted to be effective March 7, 1991, 16 TexReg 1195; amended to be effective March 31, 1992, 17 TexReg 2009; amended to be effective March 14, 2001, 26 TexReg 2032; amended to be effective May 9, 2004, 29 TexReg 4223; amended to be effective December 13, 2009, 34 TexReg 8739; amended to be effective January 7, 2019, 44 TexReg 111

RULE §143.5 Decision of the Appeals Panel

(a) Not later than the 45th day after the date the response was filed with the division, the appeals panel will issue its written decision, concluding with a separate paragraph stating words to the effect: "The true corporate name of the insurance carrier is (NAME IN BOLD PRINT) and the name and address of its registered agent for service of process is (NAME AND ADDRESS IN BOLD PRINT)", and file a copy with the division.

(b) If the appeals panel does not issue a written decision by the 45th day after the date the response was filed with the division, the administrative law judge's decision becomes final, constitutes the decision of the appeals panel, and, for the purpose of establishing the time for seeking judicial review, is deemed filed with the division on that day.

(c) Not later than the seventh day after the appeals panel files its decision with the division, or a decision is deemed filed, as provided in subsection (b) of this section, the division shall send to each party a copy of the decision, or a notice that the administrative law judge's decision has become final and constitutes the decision of the appeals panel.

(d) A decision of the appeals panel that is not appealed for judicial review, as provided by the Texas Labor Code §410.252, et seq., becomes final on the 46th day after the division mailed the party the decision of the appeals panel. For purposes of this section the mailing date is considered to be the fifth day after the date the decision of the appeals panel was filed by the division.

(e) A decision of the appeals panel that is appealed for judicial review is binding on the parties for the duration of the judicial review.

Source Note: The provisions of this §143.5 adopted to be effective March 7, 1991, 16 TexReg 1195; amended to be effective May 9, 2004, 29 TexReg 4223; amended to be effective December 13, 2009, 34 TexReg 8739; amended to be effective January 7, 2019, 44 TexReg 111

TITLE 28 **INSURANCE**
PART 2 **TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION**
CHAPTER 144 **DISPUTE RESOLUTION**

SUBCHAPTER A ARBITRATION

RULE §144.1 Authority and Duties of Arbitrators

(a) The arbitrator is authorized but not limited to:
(1) set the time and location of the arbitration proceeding pursuant to the applicable provisions of Labor Code §410.005 and §410.109;
(2) compel the parties to exchange all pertinent medical reports and other documentary evidence, and proposals for resolving the issues in dispute;
(3) conduct, at the arbitrator's discretion, preliminary conferences to identify issues to resolve questions concerning evidence and witnesses, and to otherwise expedite the arbitration proceeding;
(4) exclude individuals other than the parties and the employer from the arbitration proceeding;
(5) administer oaths;
(6) take official notice of the law of Texas and other jurisdictions, Texas city and county ordinances, the content of the Texas Register, the rules of state agencies, facts that are judicially cognizable, and generally recognized facts within the division's specialized knowledge;
(7) determine the relevancy and materiality of the evidence offered, without a requirement to conform to legal rules of evidence; and
(8) accept stipulations by the parties on uncontested issues.

(b) The arbitrator has a duty to:
(1) disclose to all parties and the division's chief clerk of proceedings any potential conflicts of interest prior to and during the arbitration, including any pecuniary, personal or business related interest. Further, to disclose any circumstances that may affect or reasonably raise a question as to the impartiality of the arbitrator, including any past or present relationships with the parties;
(2) protect the interests of all parties, including the advisement of the injured employee's rights if not represented;
(3) maintain the confidentiality of the arbitration proceeding;
(4) encourage brevity, consistent with completeness, at all stages of the arbitration proceeding;

(5) ensure that all relevant evidence has been disclosed to the arbitrator and to all parties;
(6) render an award based upon the evidence and consistent with the terms of the Act, and the rules and policies of the division;
(7) ensure an electronic recording is made of the proceedings;
(8) arrange for the provision of interpreter services if necessary; and
(9) comply with standards of conduct and ethical principles of the arbitrator's professional group, those set forth in the Act, division rules, and the codes of professional responsibility and conduct promulgated by the arbitrator's professional association.

Source Note: The provisions of this §144.1 adopted to be effective December 31, 1991, 16 TexReg 7358; amended to be effective May 31, 2012, 37 TexReg 3856

RULE §144.2 Ex Parte Communications

(a) On any substantive matter regarding facts, issues, law, or rules, an arbitrator may not communicate with any party outside the arbitration unless the communication is:
(1) in writing; and
(2) a copy is delivered to all parties to the arbitration.

(b) Notwithstanding subsection (a) of this section, any party may communicate with the arbitrator concerning any procedural matter.

RULE §144.3 Delivery of Copies of Documents

A party who sends a document relating to the arbitration proceeding to the division's chief clerk of proceedings or the arbitrator shall also deliver copies of the document to all other parties, or their representatives or attorneys. Delivery shall be accomplished by presenting in person, mailing by certified mail, or electronic transmission. The document sent to the division's chief clerk of proceedings or the arbitrator shall contain a statement certifying delivery using the following format: "I hereby certify that I have on the ____ day of _____, _____, delivered a copy of the attached document to _____ by _____ (state manner of delivery)."

RULE §144.4 Election to Engage in Arbitration

(a) Following a benefit review conference where disputed benefit issue(s) remain unresolved, the parties may mutually agree to engage in arbitration on those issues.

(b) Parties agreeing to engage in arbitration must complete and sign a form prescribed by the division and file it with the division's chief clerk of proceedings not later than the 20th day after the last day of the benefit review conference.

(c) A party may submit a response to the disputes identified as unresolved in the benefit review officer's report. The response shall:
(1) be in writing;
(2) describe and explain the party's position on the unresolved dispute or disputes;
(3) be sent to the division's chief clerk of proceedings no later than 20 days after receiving the benefit review officer's report; and
(4) be delivered to all other parties, as provided by §144.3 of this title (relating to Delivery of Copies of Documents).

(d) Except as provided by §144.10 of this title (relating to Stipulations, Agreements, and Settlements), the decision to proceed with arbitration in place of a division contested case hearing, once filed with the division's chief clerk of proceedings, is binding and irrevocable for the resolution of all disputes arising out of the claims that are under the jurisdiction of the division. For medical fee disputes arising from Labor Code §413.0312, except as provided by §144.10 of this title, the decision to proceed with arbitration in place of a contested case hearing at the State Office of Administrative Hearings is binding and irrevocable for the resolution of that dispute.

Source Note: The provisions of this §144.4 adopted to be effective December 31, 1991, 16 TexReg 7358; amended to be effective May 31, 2012, 37 TexReg 3856

RULE §144.5 Statement of Disputes

(a) Statement of disputes. The statement of disputes is a written description of the dispute(s) to be considered by the arbitrator. A dispute not expressly included in the statement of disputes will not be considered by the arbitrator.

(b) Statement of disputes after a benefit review conference. The statement of disputes for an arbitration proceeding conducted after a benefit review conference includes:
(1) the benefit review officer's report, identifying the disputes remaining unresolved at the close of the benefit review conference;

(2) the parties' responses to the benefit review officer's report, if any; and
(3) additional disputes by unanimous consent, as provided by subsections (c) and (d) of this section.

(c) Additional disputes by unanimous consent. Parties may, by unanimous consent, submit for inclusion in the statement of disputes one or more disputes not identified as unresolved in the benefit review officer's report. Additional disputes submitted by consent shall:
(1) be made in writing;
(2) identify the dispute and explain each party's position on it;
(3) be signed by all parties;
(4) be sent to the division's chief clerk of proceedings no later than 10 days before the arbitration proceeding; and
(5) explain why the issue was not raised earlier.

(d) The statement of dispute in the arbitration of a medical fee dispute may not include a dispute regarding compensability, extent of injury, liability, or medical necessity for the same service for which there is a medical fee dispute. Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills) requires parties to resolve such disputes prior to requesting medical fee dispute resolution by the division. If a party provides the arbitrator with documentation listed in §133.307(d)(2)(H) or (I) of this title (relating to MDR of Fee Disputes) that shows unresolved issues regarding compensability, extent of injury, liability, or medical necessity for the same service subject to the fee dispute, then the arbitrator shall abate the arbitration proceedings until those issues have been resolved.

Source Note: The provisions of this §144.5 adopted to be effective December 31, 1991, 16 TexReg 7358; amended to be effective May 31, 2012, 37 TexReg 3856

RULE §144.6 Assignment of Arbitrator

(a) The division will maintain, in random name order, lists of qualified arbitrators established by the division. Not later than the 30th day after an election to engage in arbitration is filed, an arbitrator will be assigned from the appropriate list. Each party will be notified immediately either personally or by certified mail.

(b) Assignment from the list of arbitrators shall be from the top of the list. When the list has been exhausted by assignment of each arbitrator to a case, the list will be randomly reordered.

(c) Each party to the arbitration proceeding is entitled to one rejection of an assigned arbitrator and must exercise such rejection not later than the third day following receipt of notification of an arbitrator's assignment. Once a rejection is exercised, the next arbitrator from the top of the list will be assigned.

(d) A rejection exercised by a party must be:
(1) in writing;
(2) signed by the party or authorized representative;
(3) personally delivered, sent by certified mail or electronic transmission, not later than the third day following receipt of notice of an arbitrator's assignment, to the division's chief clerk of proceedings with a copy to all parties.

Source Note: The provisions of this §144.6 adopted to be effective December 31, 1991, 16 TexReg 7358; amended to be effective May 31, 2012, 37 TexReg 3856

RULE §144.7 Setting the Arbitration Proceeding

(a) Following any rejections as set forth in §144.6 of this title (relating to Assignment of Arbitrator), the arbitrator shall schedule arbitration to be held not later than the 30th day following the assignment of the arbitrator.

(b) The arbitrator shall notify, in writing, all parties and the employer of the time and place scheduled for the arbitration. The notification shall be by personal delivery or certified mail.

(c) Unless the assigned arbitrator determines that good cause exists for the selection of a different location, arbitration proceedings may not be conducted at a site more than 75 miles from the injured employee's residence at the time of injury.

Source Note: The provisions of this §144.7 adopted to be effective December 31, 1991, 16 TexReg 7358; amended to be effective May 31, 2012, 37 TexReg 3856

RULE §144.8 Expediting Procedures

(a) In addition to the use of affidavits, medical reports, stipulations, and agreements, the arbitrator may allow, to the maximum extent possible and with due consideration to completeness and fairness, expediting procedures, including, but not limited to, the use of:
(1) unsworn witness statements; and
(2) summaries of evidence.

(b) The arbitrator may allow use of expediting procedures unless objected to by a party, and the arbitrator determines that there is good cause for sustaining the objection.

Source Note: The provisions of this §144.8 adopted to be effective December 31, 1991, 16 TexReg 7358

RULE §144.9 Exchange of Evidence and Proposed Resolution

(a) Not later than the seventh day preceding the arbitration proceeding, each party is required to exchange with the other party, and file with the arbitrator:
(1) all pertinent medical reports and other documentary evidence in the party's possession not previously exchanged or filed; and
(2) written proposals for resolving the issues in dispute.

(b) A party failing to comply with this requirement without good cause, as determined by the arbitrator, commits an administrative violation.

Source Note: The provisions of this §144.9 adopted to be effective December 31, 1991, 16 TexReg 7358; amended to be effective May 31, 2012, 37 TexReg 3856

RULE §144.10 Stipulations, Agreements, and Settlements

(a) Except as provided by subsections (d) and (e) of this section, at any time before or during the arbitration proceeding, parties may:
(1) enter into stipulations, defined as a voluntary accord between parties to an arbitration regarding any matter relating to the arbitration that does not constitute an agreement or a settlement, as defined by Labor Code §401.011;
(2) resolve one or more benefit disputes by agreement; or
(3) resolve all benefit disputes by settlement.

(b) Stipulations shall be made as follows:
(1) in writing; and
(2) signed by all parties to the stipulation, or their representatives.

(c) Agreements and settlements shall be made as provided by Chapter 147 of this title (relating to Dispute Resolution--Agreements, Settlements, Commutations).

(d) Parties to a medical fee dispute may not enter into a:
(1) settlement; or

(2) a stipulation or agreement on a dispute regarding compensability, extent of injury, liability, or medical necessity for the same service for which there is a medical fee dispute.

(e) Parties to a medical fee dispute may not resolve the dispute by negotiating fees that are inconsistent with any applicable fee guidelines adopted by the commissioner of workers' compensation.

Source Note: The provisions of this §144.10 adopted to be effective December 31, 1991, 16 TexReg 7358; amended to be effective May 31, 2012, 37 TexReg 3856

RULE §144.11 Continuance

(a) Any request for a continuance by a party must be directed to the division's chief clerk of proceedings and served personally by certified mail, or by electronic transmission, on all other parties.

(b) A continuance may be granted for up to 30 days only upon a determination of good cause. Notwithstanding the existence of good cause, not more than one continuance will be granted to each party.

Source Note: The provisions of this §144.11 adopted to be effective December 31, 1991, 16 TexReg 7358; amended to be effective May 31, 2012, 37 TexReg 3856

RULE §144.12 Failure to Attend Arbitration

A party who fails to attend any session of the arbitration proceeding after electing arbitration commits an administrative violation unless the arbitrator determines that the party had good cause not to attend.

Source Note: The provisions of this §144.12 adopted to be effective December 31, 1991, 16 TexReg 7358; amended to be effective May 31, 2012, 37 TexReg 3856

RULE §144.13 Rights of Parties

(a) Each party to the arbitration proceeding is entitled to be present, to have a full, fair, and impartial hearing of all relevant evidence, and to present the party's respective position on the issue(s) in dispute.

(b) Parties to the arbitration are entitled to be represented by counsel or other representative authorized under and in accordance with the Texas Workers' Compensation Act and division rules.

(c) Each party, and the arbitrator, is permitted to call witnesses who have relevant information to testify (under oath if required by the arbitrator or requested by a party) and to ask questions of any witnesses called.

(d) A party desiring to have a record made of the arbitration proceeding by stenographic means may do so and is responsible for arranging for and the expense of making a record by such means. A copy of the stenographic report shall be provided to the division's chief clerk of proceedings at no charge and may be made available to the other parties.

Source Note: The provisions of this §144.13 adopted to be effective December 31, 1991, 16 TexReg 7358; amended to be effective May 31, 2012, 37 TexReg 3856

RULE §144.14 Usual Order of Proceedings

(a) The arbitration proceeding will begin with pre
liminary matters including the introduction of copies of the election of arbitration and the assignment of the arbitrator, the introduction of all parties and representatives, statements for the record of the date, time, and place of the proceedings, and a concise statement of the disputed issue(s).

(b) An electronic recording of the proceeding will be made by the arbitrator.

(c) The arbitrator will allow and may assist each party to make a brief opening statement setting forth its position on unresolved issues and the issues with respect to which it is prepared to stipulate.

(d) The requestor shall be the first party to present all relevant evidence desired in support of the claim including the testimony of witnesses.

(e) Following the requestor's presentation of evidence, the other party to the proceeding may present evidence desired to be considered by the arbitrator, including the calling of witnesses.

(f) After each party has presented the evidence desired, the arbitrator may call for additional evidence that the arbitrator considers necessary for a proper understanding and determination of the issues.

(g) Each party may present closing statements as desired, but the record may not remain open for written briefs unless requested by the arbitrator.

Source Note: The provisions of this §144.14 adopted to be effective December 31, 1991, 16 TexReg 7358; amended to be effective May 31, 2012, 37 TexReg 3856

RULE §144.15 Award of the Arbitrator

(a) Not later than the seventh day after the last day of arbitration, the arbitrator shall enter the final award which must:
(1) be in writing;
(2) be signed and dated by the arbitrator;
(3) include a statement of the arbitrator's decision on the contested issues and the parties' stipulations on uncontested issues;
(4) be sent to the division and all parties by certified mail, or personal delivery; and
(5) be filed as a part of the permanent claim file.

(b) The award entered is final and binding on all parties. Except as provided by Labor Code §410.121 there is no right of appeal or judicial review.

(c) The arbitrator's award is a final order of the division.

(d) For the purposes of correcting a clerical error, an arbitrator retains jurisdiction of the award for 20 days after the date of the award.

Source Note: The provisions of this §144.15 adopted to be effective December 31, 1991, 16 TexReg 7358; amended to be effective May 31, 2012, 37 TexReg 3856

RULE §144.16 Requesting a Copy of the Record

A party or the employer may request a copy of the electronic recording of the arbitration proceeding from the division. The requestor shall pay the cost of the duplication, as established by the division.

Source Note: The provisions of this §144.16 adopted to be effective December 31, 1991, 16 TexReg 7358; amended to be effective May 31, 2012, 37 TexReg 3856

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 147	DISPUTE RESOLUTION--AGREEMENTS, SETTLEMENTS, COMMUTATIONS

RULE §147.1 Form and Execution

(a) A settlement or a written agreement must be on a form prescribed by the division.

(b) In addition to the parties, the employee's representative, if any, must sign the written agreement or settlement.

(c) Unless the division finds that an extraordinary circumstance applies, an employee's representative must not sign a written agreement or settlement on behalf of the employee.

(d) The insurance carrier's representative must sign a written agreement or settlement as the agent of the insurance carrier, and the insurance carrier will be bound by the written agreement or settlement.

Source Note: The provisions of this §147.1 adopted to be effective July 8, 2024, 49 TexReg 4921

RULE §147.4 Agreements; Filing and Effective Dates

(a) An agreement may be reduced to writing and sent to the division. The agreement is effective and binding on the date the division approves it.

(b) An oral agreement reached during a benefit contested case hearing and preserved in the record is effective and binding on the date made.

(c) A signed written agreement, or one made orally, as provided by subsection (b) of this section, is binding on:
(1) an insurance carrier and a claimant represented by an attorney through the final conclusion of all matters relating to the claim, whether before the division or in court, unless set aside by the division or court on a finding of fraud, newly discovered evidence, or other good and sufficient cause; and

(2) a claimant not represented by an attorney through the final conclusion of all matters relating to the claim while the claim is pending before the division, unless set aside by the division for good cause.

Source Note: The provisions of this §147.4 adopted to be effective April 25, 1991, 16 TexReg 2097; amended to be effective July 8, 2024, 49 TexReg 4921

RULE §147.5 Settlements: Requirements, Effective Dates, and Informal Settlement Conferences

(a) A settlement must be sent to the division.

(b) The division may approve or reject it before the 16th day after the date the settlement is submitted to the division.

(c) A settlement must:
(1) establish that the insurance carrier is liable for the claim;
(2) establish that the claim is compensable;
(3) establish that the employee is entitled to benefits;
(4) incorporate by reference all prior oral and written agreements between the parties; and
(5) state that a final resolution has been reached on all issues in the claim, and that the parties waive their rights to subsequent division proceedings, other than those necessary to resolve medical benefit disputes or to enforce compliance with the terms of the settlement.

Source Note: The provisions of this §147.5 adopted to be effective April 25, 1991, 16 TexReg 2097; amended to be effective July 8, 2024, 49 TexReg 4921

RULE §147.7 Agreements and Settlements: Effect on Previously Entered Decisions and Orders

(a) A written agreement on one or more disputed issues addressed in a presiding officer's decision or order, including an interlocutory order, sets aside the decision or order, as it relates to the agreement, on the date the agreement is approved by the presiding officer.

(b) A settlement filed before a presiding officer's decision becomes final sets aside a presiding officer's decision or order, except for an interlocutory order, on the date

received by the division. If the division rejects the settlement, the decision or order will be immediately reentered.
(c) A settlement sets aside an interlocutory order on the date the settlement becomes effective.

Source Note: The provisions of this §147.7 adopted to be effective April 25, 1991, 16 TexReg 2097; amended to be effective July 8, 2024, 49 TexReg 4921

RULE §147.10 Commutation of Impairment Income Benefits

(a) A request to commute impairment income benefits must:
(1) be in writing on a form prescribed by the division;
(2) state the date the employee reached maximum medical improvement, the impairment rating, and the employee's weekly impairment income benefit;
(3) be sent to the insurance carrier; and
(4) be filed with the division.

(b) The insurance carrier must send a notice of approval or denial of the request to the employee no later than 14 days after receiving the request. A notice of approval must include payment of the commuted impairment income benefits. A notice of denial must include the insurance carrier's reasons for denial. A copy of the notice must be filed with the division.

(c) If the insurance carrier denies the request, the employee may request the division to schedule a benefit review conference to resolve the issue, as provided by §141.1 of this title (relating to Form and Execution).

Source Note: The provisions of this §147.10 adopted to be effective December 16, 1991, 16 TexReg 7018; amended to be effective July 8, 2024, 49 TexReg 4921

RULE §147.11 Notification to Division of Proposed Judgments and Settlements

The insurance carrier or its representative must file a copy of a final judgment or settlement with the division no later than the 10th day after a court approves the agreement or settlement.

Source Note: The provisions of this §147.11 adopted to be effective February 2, 1996, 21 TexReg 514; amended to be effective December 2, 1997, 22 TexReg 11714; amended to be effective July 8, 2024, 49 TexReg 4921

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 148	HEARINGS CONDUCTED BY THE STATE OFFICE OF ADMINISTRATIVE HEARINGS

RULE §148.1 Definitions

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

(1) Act--The Texas Workers' Compensation Act, Labor Code, §§401.001 et seq.
(2) ALJ--The administrative law judge designated by the State Office of Administrative Hearings to preside over the hearing.
(3) APA--The Administrative Procedure Act, as specified in the Government Code, Chapter 2001.
(4) Chief Clerk of Proceedings--The Chief Clerk of Proceedings within the hearings section in the central office of the Texas Department of Insurance, Division of Workers' Compensation.
(5) Contested Case--A proceeding held by the State Office of Administrative Hearings in which the legal rights, duties, or privileges of a party are to be determined by an agency after an opportunity for adjudicative hearing as defined in Government Code, §2001.003.
(6) Division Representative--The attorney or any representative that may be designated by the commissioner or his designee to represent the division.
(7) Party--A person or state agency named or admitted as a party.
(8) Person--An individual, partnership, corporation, association, governmental subdivision, or public or private organization that is not a state agency as defined in the APA.
(9) Petitioner--
(A) The division is the petitioner in a contested case in which the division seeks to impose a sanction or has issued an emergency cease and desist order.
(B) In all other cases, the petitioner is the person who has filed a written request for a hearing in accordance with these procedures.
(10) Respondent--
(A) The respondent is the opposing party to the division in a contested case in which the division seeks to impose a sanction or has issued an emergency cease and desist order.
(B) In all other cases, the respondent is the person responding to the petitioner's request for a hearing.

(11) SOAH--The State Office of Administrative Hearings.

Source Note: The provisions of this §148.1 adopted to be effective June 9, 2005, 30 TexReg 3237; amended to be effective July 27, 2014, 39 TexReg 5608

RULE §148.2 Scope and Applicability

(a) Scope. This chapter governs contested case hearings, which adjudicate disputes before SOAH as authorized under the Act.

(b) Coordination with SOAH's Procedural Rules. This chapter governs the following procedural matters and also provides related policies of the division on the following:
(1) matters arising before a case is transferred by the division to SOAH;
(2) matters arising after a proposal for decision or after the entire case is received from SOAH;
(3) requests for the issuance of a subpoena and related matters; and
(4) requests for issuance of a commission requiring deposition and related matters.

(c) Applicability of the APA.
(1) The entire APA applies to contested case hearings under Labor Code §§407.046, 407A.007, 413.031, 413.0312, 413.055, 415.0211, and 415.034.
(2) The sections of the APA enumerated in Labor Code §401.021(1) apply to all other contested case hearings governed by this chapter.
(3) The ALJ renders the final decision in hearings conducted pursuant to Labor Code §§413.031, 413.0312, and 413.055.
(4) The commissioner renders the final decision in all other cases not specified in paragraph (3) of this subsection pursuant to Government Code §2001.062.

Source Note: The provisions of this §148.2 adopted to be effective June 9, 2005, 30 TexReg 3237; amended to be effective July 27, 2014, 39 TexReg 5608

RULE §148.3 Requesting a Hearing

(a) Hearings Requested by the Division. The division may request a hearing before SOAH as permitted by the APA, the Act, and division rules.

(b) Requests for Hearing by Other Parties. Other Parties may file requests for hearings before SOAH as permitted by the APA, the Act, and division rules. The request for hearing must be in writing. The request for hearing must be filed with the Chief Clerk of Proceedings.

(c) Date Deemed Filed or Received. When a request for a hearing is addressed to the Chief Clerk of Proceedings but is sent to an office other than the Chief Clerk of Proceedings, the date filed or received shall be the date the request is received by the division. The request for hearing will be forwarded to the division's Chief Clerk of Proceedings, but this may result in delay of processing the request. When a request for a hearing is not addressed to the Chief Clerk of Proceedings, it will not be considered filed or received by the division unless it is actually received by the Chief Clerk of Proceedings. Otherwise, a request for a hearing is deemed filed as of the date of the division date stamp placed on the document or other evidence of receipt.

(d) Deadlines for Filing. A request for hearing before SOAH must be filed with the Chief Clerk of Proceedings within the following time periods:
(1) medical fee dispute under Labor Code §413.031 and §413.0312: 20 days after the conclusion of the benefit review conference under Chapter 141 of this title (concerning Dispute Resolution--Benefit Review Conference);
(2) administrative violation: 20 days after receipt of a notice of possible administrative violation under Labor Code §415.032 and §180.8 of this title (concerning Notices of Violation; Notices of Hearing; Default Judgments);
(3) interlocutory order: 20 days after receipt of an interlocutory order for payment under Labor Code §413.055;
(4) emergency cease and desist order: not later than the 30th day after the date the affected person receives the order;
(5) division audit or review: 20 days after receipt of a division refund order issued pursuant to a division audit or review; or
(6) requests for hearing not specified in this subsection: the time for filing a request for hearing before SOAH is 20 days after receipt of a notice of the action that the party is requesting a hearing on, unless specified in other law.

(e) Requests for Hearing Under Labor Code §413.031 and §413.0312. If the request for hearing is based on Labor Code §413.031 and §413.0312, the request must be in the form and manner specified by the division and must:
(1) contain a statement indicating that it is a request for hearing;
(2) include a copy of the findings and decision on which a hearing is being requested;
(3) include verification of the date of the conclusion of the Benefit Review Conference;
(4) be signed by a requestor or respondent as defined by §133.305 of this title (concerning MDR--General), or its representative; and
(5) include a certificate of service demonstrating that the request has been sent to the other party in accordance with the requirements of §133.307 of this title (concerning MDR of Fee Disputes), in substance as follows: "I hereby certify that I have on this ___

day of _____, 20 __, served a copy of the attached instrument on (state the name of the other parties on whom a copy was served) by (state the manner of service.)"

(f) Notice of Violation.

(1) If a person receives a notice of violation, the person charged must file an answer not later than the 20th day after the date of receipt of the notice. The answer must either:

(A) remit the amount of the sanction to the division or otherwise consent to the imposed sanction; or

(B) request a hearing.

(2) If the person charged does not file an answer to the notice of violation, the division shall schedule a hearing at SOAH, pursuant to §180.8(c) of this title (concerning Notices of Violation; Notices of Hearing; Default Judgments).

(g) Dismissal of Late Filings. The division, or the ALJ pursuant to paragraph (3) of this subsection, shall dismiss a request for hearing filed later than the deadline date. This subsection does not apply to requests for hearing submitted in response to a Notice of Violation pursuant to §180.8 of this title.

(1) The division shall send a letter to the requestor informing the requestor that the untimely request will be dismissed unless the requestor provides information about timely filing or good cause for untimely filing within 10 working days of the date of the letter.

(2) If the requestor responds with information about timely filing or good cause, the Chief Clerk of Proceedings will send the request for hearing and the additional filing or good cause information to SOAH.

(3) The SOAH ALJ will dismiss a request for hearing that the ALJ determines to be filed later than the deadline date without good cause.

(h) Division Delivery of Request for Hearing to SOAH. The Chief Clerk of Proceedings shall send the request for a hearing to SOAH within 20 working days of receipt, unless:

(1) the decision has been withdrawn under the provisions contained in §148.8 of this title (concerning Withdrawal of Hearing Request);

(2) the request for hearing has been dismissed under subsection (g) of this section;

(3) the division has notified the parties of a proposed clerical correction to the order or decision; or

(4) a party has requested a correction of clerical error with the division.

Source Note: The provisions of this §148.3 adopted to be effective July 27, 2014, 39 TexReg 5608

RULE §148.4 Correction of Clerical Error

(a) Correction of Clerical Error Discovered by the Division. The division may at any time revise an order or decision to correct a clerical error. The division may enter a nunc pro tunc order after an order or decision has become final. To initiate the correction, the division will notify the parties to the order or decision of the proposed correction. If a party objects to the proposed clerical correction, it must do so by the date and time specified by the division. The date and time specified by the division may not exceed the point at which the order or decision becomes final.

(b) Request for Correction of Clerical Error Discovered by a Party.
(1) A party to an order or decision may request the correction of a clerical error from the division prior to the point at which the order or decision becomes final.
(2) To initiate the correction, the division will notify the parties of the proposed correction. If a party objects to the proposed clerical correction, it must do so by the date and time specified by the division. The date and time specified by the division may not exceed the point at which the order or decision becomes final.

(c) Notification. The division will notify the parties to an order or decision that a clerical correction was made by issuing a letter that includes the:
(1) date of the original order or decision;
(2) erroneous portion as originally stated;
(3) corrected portion as it reads; and
(4) signature of the authorized division personnel.

RULE §148.5 Notice of Hearing

(a) Notice of Hearing. The Chief Clerk of Proceedings shall notify the parties in writing, by verifiable means, of the date, time, place, and nature of the hearing no later than 10 days before the hearing date. SOAH shall notify the parties of a hearing no later than 30 days before the hearing date for a hearing under Labor Code §407.046(b).

(b) Contents. The notice of hearing must include:
(1) a statement of the time, place, and nature of the hearing;
(2) the docket number;
(3) the legal authority and jurisdiction under which the hearing will be held;
(4) a reference to the particular sections of the statutes and any rules involved;
(5) a notice regarding failure to appear and default judgments; and
(6) a short, plain statement of the matters asserted.

(c) Alternative Submission. In lieu of the Chief Clerk of Proceedings, the division's representative may provide the reference to the statutes and any rules involved, nature of the hearing, and the short, plain statement of the matters asserted.

(d) Administrative Violation Notice of Hearing; Default.
(1) A person who receives a notice of hearing under §180.8(c) of this title (relating to Notices of Violation; Notices of Hearing; Default Judgments) must file a written answer or other responsive pleading with the Chief Clerk of Proceedings within 20 days of receipt of the notice as required by §180.8(c) of this title.
(2) Failure to file the required answer or pleading constitutes a default, and the division may seek informal disposition by default under §180.8(f) and (g) of this title.

(e) Notice of Hearing under Labor Code §407.046(b) from SOAH.
(1) SOAH shall notify, in writing, a certified self-insurer and the Chief Clerk of Proceedings of the date, time, place, and nature of a hearing concerning the intent of the division to revoke a certificate of self-insurance under Labor Code §407.046.
(2) The notice must be sent no later than 30 days before the hearing date.
(3) The notice must include:
(A) the notice required under Government Code §2001.052, and
(B) a notice regarding failure to appear and default judgment.

Source Note: The provisions of this §148.5 adopted to be effective July 27, 2014, 39 TexReg 5608

RULE §148.6 Venue

Hearings under this chapter are held in Austin, Travis County, Texas.

Source Note: The provisions of this §148.6 adopted to be effective June 9, 2005, 30 TexReg 3237; amended to be effective July 27, 2014, 39 TexReg 5608

RULE §148.7 Representation

(a) Representation of Injured Employees or Insurance Carriers. Pursuant to Labor Code §402.071 and §150.3 of this title (relating to Representatives: Written Authorization Required), a person representing an injured employee or insurance carrier in a contested case hearing shall not receive a fee for providing representation under this subtitle unless the person is an adjuster representing an insurance carrier or licensed to practice law.

(b) Fee Defined. For the purposes of this section, "fee" means any remuneration received directly or indirectly, in cash or in kind. It includes voluntary contributions. The provision of representation before SOAH as an extension of, or in addition to, other services for which a fee was paid shall be considered receipt of a fee for providing representation as specified in Labor Code §401.011(37) and §402.071 and §150.3 of this title.

(c) Representation by Employee. The prohibitions in subsections (a) and (b) of this section do not preclude representation by a person who receives a salary as an employee of the person represented to perform services in the usual course and scope of the employer's business.

(1) For the purposes of this subsection, "employee" means a person in the service of another under a contract of hire, whether express or implied, or oral or written.

(2) The term "employee" does not include:

(A) an independent contractor or the employee of an independent contractor; or

(B) a person whose employment is not in the usual course and scope of the employer's business.

(d) Ombudsman Program. Nothing in this subsection shall be construed to limit assistance pursuant to Labor Code §404.105.

(e) Administrative violation. A person commits an administrative violation if that person receives a fee for providing representation under circumstances prohibited by this section.

Source Note: The provisions of this §148.7 adopted to be effective June 9, 2005, 30 TexReg 3237; amended to be effective July 27, 2014, 39 TexReg 5608

RULE §148.8 Withdrawal of Hearing Request

(a) The petitioner may, at any time before the decision or order is signed, submit a written request to withdraw the request for a hearing. The request must be sent to the Chief Clerk of Proceedings and to SOAH in accordance with its procedural rules in Title 1 TAC Chapter 155 (relating to Rules of Procedure).

(b) Notwithstanding the provisions of subsection (a) of this section, a decision of the division's medical fee dispute resolution section in a review of a medical fee under the Act may be withdrawn by the division within 15 working days after the division receives the request for hearing before SOAH if the request has not yet been delivered to SOAH.

Source Note: The provisions of this §148.8 adopted to be effective June 9, 2005, 30 TexReg 3237; amended to be effective July 27, 2014, 39 TexReg 5608

RULE §148.10 Hearings Subpoenas to Compel Attendance and Subpoenas Duces Tecum

(a) Issuance of Subpoena. A request for issuance of a subpoena shall be directed to the Chief Clerk of Proceedings in the division's central office. On the written request of any party in compliance with the requirements set forth below and upon a showing of good cause, the division shall issue a subpoena addressed to the sheriff or any constable to require the attendance of a witness and production of books, records, paper, or other objects that may be necessary and proper for the purpose of the proceedings. The determination of good cause under this section shall include consideration of whether the issuance of the subpoena would cause undue burden or expense to the person served.

(b) Request for Subpoena. A request for issuance of a subpoena must be in writing, addressed to the Chief Clerk of Proceedings, contain a showing of good cause, and comply with the following:

(1) The request must include the subpoena sought to be issued and be prepared for the signature of the Chief Clerk of Proceedings.

(2) The subpoena must be addressed to a sheriff or constable for service in accordance with Government Code §2001.089. The request must contain the name and address of the applicable sheriff or constable.

(3) The request must include a good faith, itemized estimate of the amount likely to accrue under §148.20 of this title (relating to Reimbursement, Travel Expenses, and Fees for Witnesses and Deponents) and include a deposit of the same amount as required by Government Code §2001.089(2) (relating to Issuance of Subpoena). The deposit must be made by certified check, money order, or other negotiable instrument satisfactory to the division.

(4) If the subpoena is for the attendance of a witness, the written request and accompanying subpoena must contain:

(A) the name, address, and title, if any, of the witness;

(B) the date, time and place where the person is to appear and give testimony;

(C) the docket number of the SOAH proceeding; and

(D) a statement showing date of execution and return of the subpoena to the Chief Clerk of Proceedings.

(5) If the subpoena is for the production of books, records, writings, or other tangible items, the written request and accompanying subpoena sought must contain:

(A) a specific, detailed description of the items sought to be produced;

(B) the date, time, and place where the person is to appear and give testimony and produce the requested items;

(C) the docket number of the proceeding; and

(D) a statement showing date of execution and return of the subpoena duces tecum to the Chief Clerk of Proceedings.

(6) The request must contain a description of the reasonable steps taken to avoid imposing undue burden or expense on the person served.

(c) Failure to Comply with Subpoena. If a person fails to comply with a subpoena, the division, acting through the attorney general, or the party requesting the subpoena, may bring suit to enforce the subpoena in a district court in Travis County. This remedy is not exclusive. The division may enforce the subpoena in any manner permitted by the Act, the APA, or division rules.

Source Note: The provisions of this §148.10 adopted to be effective June 9, 2005, 30 TexReg 3237; amended to be effective July 27, 2014, 39 TexReg 5608

RULE §148.11 Commissions to Compel Attendance for Deposition

(a) Issuance of Commission Requiring Deposition. A request for issuance of a commission requiring deposition must be directed to the Chief Clerk of Proceedings in the division's central office. On the written request of any party in compliance with the requirements set forth below, the division must issue a commission addressed to the several officers authorized by statute to take depositions in accordance with the requirements of Government Code §2001.094. On the written request of any party in compliance with the requirements set forth below the Chief Clerk of Proceedings shall issue a commission to require that the witness appear and produce, at the time the deposition is taken, books, records, papers, or other objects that may be necessary and proper for the purpose of the proceeding.

(b) Commission Not Required for a Party. The issuance of a commission requiring deposition is not required if the witness is a party or is retained by, employed by, or otherwise subject to the control of a party. Service of the notice of oral deposition upon the party or the party's representative is sufficient.

(c) Deposition of a Member of an Agency, Board, or Division. A member of an agency, board, or division shall not be deposed after a hearing date has been set.

(d) Requests for Commissions Requiring Deposition. A request for a commission requiring deposition must be in writing addressed to the Chief Clerk of Proceedings and comply with the following:

(1) The request must include the commission requiring deposition sought to be issued prepared for the signature of the Chief Clerk of Proceedings.

(2) The commission requiring deposition must be addressed to an officer authorized by statute to take a deposition in accordance with Government Code §2001.094. The request must contain the name and address of the applicable officer authorized to take the deposition, the date, time and place where either the witness is to appear and give testimony or where the written deposition responses are to be sent, a detailed description of any items the witness will be required to produce, and a statement showing date of execution and return of the commission requiring deposition to the Chief Clerk of Proceedings.

(3) The request must include a good faith itemized estimate of the amount likely to accrue under §148.20 of this title (relating to Reimbursement, Travel Expenses, and Fees for Witnesses and Deponents) and include a deposit of the same amount as required by Government Code §2001.094(a). The deposit must be made by certified check, money order, or other negotiable instrument satisfactory to the division.

(4) The party seeking the commission requiring deposition shall coordinate with the other party or parties and with the witness to determine a mutually agreeable location and time for the attendance of the witness. The request for commission requiring deposition must state whether such coordination has been made and whether the proposed location and time is by mutual agreement of the parties and witness.

(5) The party seeking the commission requiring deposition that includes a requirement for production should coordinate with the other party or parties, and with the person from whom production is sought, to determine a mutually agreeable location and time for the requested production. The request for the commission requiring deposition must state whether such coordination has been made and whether the proposed location and time is by mutual agreement with the parties and the person from whom production is sought.

(e) Application of the APA. Matters related to deposition conduct, use, opening, and any other matters relating to depositions not covered by these rules shall be in accordance with the requirements of the APA.

(f) Failure to Comply with Commission Requiring Deposition. If a person fails to comply with a commission requiring deposition, the division acting through the attorney general, or the party requesting the subpoena or commission, may bring suit to enforce the subpoena or commission in a district court in Travis County. This remedy is not

exclusive. The division may enforce the subpoena or commission requiring deposition in any manner permitted by the Act, the APA, or division rules.

Source Note: The provisions of this §148.11 adopted to be effective June 9, 2005, 30 TexReg 3237; amended to be effective July 27, 2014, 39 TexReg 5608

RULE §148.13 Recording the Hearing

(a) Arrangement for Court Reporter and Costs. In cases in which a court reporter is required, on the division's initiative, at the request of a party, or when required by SOAH rules or the ALJ of a case, the division will arrange for a court reporter. The Petitioner is responsible for all associated costs including the costs of the court reporter at the hearing and the costs associated with preparation of a verbatim record if one is required. In cases in which more than one party is seeking affirmative relief, the costs will be assessed equally. Nothing in this section precludes the parties from entering into their own agreement regarding arrangements for a court reporter or allocation of associated costs.

(b) Recording by a Party. A party electing to use a means of making a record that is in addition to the means specified in SOAH's rules or by the ALJ is responsible for all associated costs. If a verbatim record is made, the party shall provide the division and SOAH with a copy of the audiotape or videotape free of charge. If a transcript is made, the party shall provide the division with the original of the transcript free of charge.

Source Note: The provisions of this §148.13 adopted to be effective June 9, 2005, 30 TexReg 3237; amended to be effective July 27, 2014, 39 TexReg 5608

RULE §148.14 Burden of Proof

(a) Burden of Proof on the Division. The division has the burden of proof in a contested case in which the division seeks to impose a sanction or has issued an emergency cease and desist order.

(b) Burden of Proof on Party Seeking Relief. The burden of proof rests with the party seeking relief in hearings conducted pursuant to Labor Code §§408.024, 413.031, 413.0312, and 413.055.

(c) Burden of Proof on the Certified Self-Insurer. The burden of proof rests with the certified self-insurer in hearings conducted pursuant to the following sections of the Labor Code:

(1) Section 407.043;
(2) Section 407.046;
(3) Section 407.133; and
(4) Section 407.066. The certified self-insurer has the burden of proof if they request the hearing to challenge the position of the division.

(d) Burden of Proof on the Employer. The burden of proof of showing timely filing or good cause when an allegation of untimely filing has been made rests with the employer in issues under §120.2 of this title (relating to Employer's First Report of Injury).

(e) Standard of Proof. The standard of proof in a contested case is preponderance of the evidence.

Source Note: The provisions of this §148.14 adopted to be effective June 9, 2005, 30 TexReg 3237; amended to be effective July 27, 2014, 39 TexReg 5608

RULE §148.15 Final Decision by the ALJ

(a) Decision or Order. The ALJ shall adjourn the hearing after all evidence has been received in contested cases held under Labor Code §§413.031, 413.0312, and 413.055.

(b) Decision or Order that May Become Final. The ALJ shall issue a decision or order that may become final.

(c) Contents of Decision or Order that May Become Final. The decision or order that may become final must include orders that are necessary to implement the decision or order. When the decision or order requires any action or compliance, it must contain a period of time for such action to be completed, normally not to exceed 30 days from the date the decision or order is received, for such action or compliance to be completed.

(d) Furnishing the Decision or Order that May Become Final.
(1) The decision or order that may become final will be sent immediately to the parties or their representatives by verifiable means that shall be documented in the hearing file.
(2) If the decision or order that may become final is furnished by personal delivery, a receipt verifying personal delivery and containing the date of delivery and the person, any business title, and person's business address that received the delivery shall be made by the person who makes the personal delivery, and shall be date-stamped and placed in the hearing file.

(e) Procedures for Motion for Rehearing. The decision or order that may become final will become final if a motion for rehearing is not filed with SOAH within 20 days after receipt of the decision or order. The procedures for a motion for rehearing are governed by the Government Code, Chapter 2001, Subchapter F, and a motion for rehearing is a prerequisite for appealing a decision or order under this section.

(f) Finality of Decision or Order. The finality of the ALJ's decision or order is determined by Government Code §2001.144, except as provided by Labor Code §413.031 and §133.307 of this title (relating to MDR of Fee Disputes).

(g) Exhaustion of Administrative Remedies. The notification to a party of the ALJ's decision or order that has become final under Government Code §2001.144 constitutes exhaustion of all administrative remedies, except as provided by Labor Code §413.031 and §133.307 of this title.

(h) Judicial Review. A party dissatisfied with a final decision or order of the ALJ may seek judicial review as provided by the Act in accordance with the Government Code, Chapter 2001, Subchapter G, Labor Code §413.031 and §133.307 of this title.

Source Note: The provisions of this §148.15 adopted to be effective June 9, 2005, 30 TexReg 3237; amended to be effective July 27, 2014, 39 TexReg 5608

RULE §148.16 Proposal for Decision or Order by the ALJ

(a) Proposal for Decision or Order. The ALJ shall adjourn the hearing after all evidence has been received in contested cases held under the Act not governed by §148.15 of this title (relating to Final Decision by ALJ).

(b) Description of Proposal for Decision or Order. The proposal for decision or order must be based solely upon the record of the individual case. It must be in writing and include:

(1) a statement of the reasons upon which the decision is based;

(2) findings of fact based on the evidence presented and matters officially noticed. If there is evidence presented regarding the ability of a party to pay the amount of a proposed sanction or bonding amount in a hearing involving assessment of sanctions under Labor Code §415.021, the ALJ shall make findings of fact on those issues;

(3) conclusions of law based on the findings of fact and other legal requirements of the law;

(4) the sanction or order recommended by the ALJ;

(5) a conclusion of whether the division is authorized by the Act or division rules to take disciplinary or sanction action against the petitioner; and

(6) the proposal for decision or order may also contain:

(A) a summary of the evidence presented by each party; and

(B) a list of all mitigating circumstances and a list of all aggravating circumstances, separately stated, which are necessary for the commissioner to have a complete understanding of the case.

(c) Furnishing Proposal for Decision or Order. SOAH shall furnish the proposal for decision or order to:

(1) the Chief Clerk of Proceedings; and

(2) the parties of the hearing. SOAH shall furnish the proposal for decision or order by verifiable means and retain information on the date, address, person or entity served, and the means of service

(d) Filing of Briefs and Exceptions. If a party files a brief or exception to the proposal for decision or order or replies to the exceptions or brief with SOAH, it must also file a copy with the Chief Clerk of Proceedings.

(e) Commissioner's Hearing on the Proposal for Decision or Order.

(1) A party may submit a request for a commissioner's hearing to consider arguments with the Chief Clerk of Proceedings within 10 days after SOAH issues the proposal for decision or order.

(2) The commissioner may determine if a hearing is necessary to consider arguments, whether or not a request for a hearing has been filed. If such a determination is made, the commissioner shall consider the case at a posted hearing of the division, no later than 120 days after:

(A) SOAH provides the division with the proposal for decision or order;

(B) the date of the ALJ's comments or response to any exceptions or briefs and any replies to such exceptions or briefs; or

(C) the expiration of the ALJ's deadline for such response in accordance with Title 1 TAC §155.507 (relating to Proposal for Decision).

(3) If the commissioner determines that a hearing is not necessary, the division will notify any requestors and the commissioner shall consider the case after the later of:

(A) the issuance of the proposal for decision or order;

(B) the date of the expiration of the ALJ's comments or response to any exceptions or briefs and any replies to such exceptions or briefs; or

(C) the expiration of the ALJ's deadline for such response in accordance with Title 1 TAC §155.507.

(f) Issuance of Decision or Order That May Become Final. The commissioner shall issue a decision or order that may become final in contested cases under this section pursuant to Labor Code §§407.046, 407A.007, 415.0211, and 415.034. A decision or order that may become final will become final in accordance with Government Code §2001.144. In all other cases, the commissioner shall issue a final decision or order and no motion for rehearing will be considered.

(g) Motion for Rehearing. A motion for rehearing may be filed in contested cases under this section pursuant to Labor Code §§407.046, 407A.007, 415.0211, and 415.034. The procedures of the Government Code, Chapter 2001, Subchapter F govern a motion for rehearing under this section. A motion for rehearing is a prerequisite for filing an appeal of a decision or order under Labor Code §§407.046, 407A.007, 415.0211, or 415.034.

(h) Notification. The Chief Clerk of Proceedings shall notify the parties to a contested case of the final decision or order of the commissioner by verifiable means.

(i) Exhaustion of Administrative Remedies. The notification to a party of the commissioner's final decision or order constitutes exhaustion of all administrative remedies.

(j) Judicial Review. A party dissatisfied with a decision or order of the commissioner may seek judicial review as provided in the Act in accordance with the APA. Judicial review will be in accordance with the Act and the Government Code §§2001.171, 2001.172, and 2001.174.

Source Note: The provisions of this §148.16 adopted to be effective June 9, 2005, 30 TexReg 3237; amended to be effective July 27, 2014, 39 TexReg 5608

RULE §148.17 Special Provisions for Sanctions

(a) Unless otherwise stated in a final, unappealable order from the commissioner or a court, a charged party must comply with a sanction no later than 30 days after the order becomes final and unappealable.

(b) If an order imposing a sanction assesses a penalty against the charged party, the charged party must file the amount of the penalty with the Chief Clerk of Proceedings in the form of a cashier's check, a certified check, a certified draft, or other form of payment authorized by the division.

Source Note: The provisions of this §148.17 adopted to be effective June 9, 2005, 30 TexReg 3237; amended to be effective July 27, 2014, 39 TexReg 5608; amended to be effective January 9, 2019, 44 TexReg 263

RULE §148.19 Transcript or Duplicate of the Hearing Audiotape or Videotape

(a) A party may submit a request to the division for a transcript of the hearing audiotape or videotape. The requestor shall pay the cost of the transcript, as established by the division.

(b) A party may submit a request to the division for a duplicate of the hearing audiotape or videotape. The requestor shall pay the cost of the duplication, as established by the division.

Source Note: The provisions of this §148.19 adopted to be effective June 9, 2005, 30 TexReg 3237; amended to be effective July 27, 2014, 39 TexReg 5608

RULE §148.20 Reimbursement, Travel Expenses, and Fees for Witnesses and Deponents

(a) Reimbursement of Witness or Deponent. A witness or deponent who is not a party and who is served with a subpoena or otherwise compelled to attend any hearing or proceeding to give a deposition or to produce books, records, papers, or other objects that are necessary for the proceeding is entitled to receive reimbursement for travel, meals, lodging, and other amounts as specified and limited in the Government Code §2001.103.

(b) Reasonable and Necessary Expenses and Service. The party requesting the subpoena or commission or otherwise compelling the attendance of a witness at any hearing or proceeding to give a deposition or produce books, records, papers, or other objects shall be responsible for the payment, of any expense, incurred in serving the subpoena, as well as reasonable and necessary expenses incurred by a nonparty witness who appears in response to the subpoena.

(c) Failure to Pay Expenses. The party requesting the subpoena or commission or otherwise compelling the attendance of a witness at any hearing or proceeding to give a deposition or produce books, records, papers, or other objects shall pay the witness the amount accrued under this section. Failure to pay the witness the amount accrued when sought is an administrative violation.

(d) Return of Deposit. After the Chief Clerk of Proceedings has received, from the party requesting the subpoena or commission to take deposition, sufficient documentation of all requests by the witness for payment of witness expenses and sufficient proof of payment of all amounts due to the non-party witness or deponent, the division will return the amount of any deposit required under §148.10(b)(3) and §148.11(d)(3) of this title (relating to Hearings Subpoenas To Compel Attendance and Subpoenas Duces Tecum and Commissions To Compel Attendance For Deposition), respectively.

Source Note: The provisions of this §148.20 adopted to be effective June 9, 2005, 30 TexReg 3237; amended to be effective July 27, 2014, 39 TexReg 5608

RULE §148.21 Expenses to be Paid by Party Seeking Judicial Review

(a) Upon receiving a copy of a petition filed in district court which seeks judicial review of a final decision in a contested case decided under this chapter, the division shall prepare a certified copy of the entire record of the proceeding under review, including a transcript of the hearing audiotape, and transmit it to the reviewing court.

(b) The division shall assess to the party seeking judicial review, expenses incurred by the division in preparing this copy, including transcription costs, in accordance with the Government Code §2001.177. Upon request, the division shall consider the financial ability of the party to pay the costs or any other factor that is relevant to a just and reasonable assessment of costs. If the party seeking judicial review is an injured employee, the division shall not charge for duplicating the record.

Source Note: The provisions of this §148.21 adopted to be effective June 9, 2005, 30 TexReg 3237; amended to be effective July 27, 2014, 39 TexReg 5608

RULE §148.22 Failure to Appear or Comply with Order or Decision, Administrative Violation

A person commits an administrative violation if that person in the status of a party, or otherwise within the jurisdiction of SOAH (for example, a witness), in a contested case hearing or proceeding before SOAH, fails to comply with an order of the ALJ to include any final decisions issued.

Source Note: The provisions of this §148.22 adopted to be effective June 9, 2005, 30 TexReg 3237; amended to be effective July 27, 2014, 39 TexReg 5608

RULE §148.23 Division Enforcement of Orders

Any final order of SOAH is a final order of the division and may be enforced by the division in any manner permitted by the Act, the APA, or division rules. After conclusion of the administrative process, any SOAH order which survives the entry of a final order, the sending of a proposal for decision to the division, or the dismissal or withdrawal of the case from the SOAH docket, regardless of upon whose motion the dismissal or withdrawal was granted, is an order of the commissioner and may be enforced by the division in any manner permitted by the Act, the APA, or division rules. Examples of enforceable orders include, but are not limited to, orders to reimburse, orders to pay reasonable and necessary medical costs, orders to pay administrative fines, orders to refund, orders assessing attorney fees, orders assessing costs, and orders imposing discovery sanctions.

RULE §148.24 Confidentiality of Records

(a) SOAH shall ensure that the confidentiality provisions of Labor Code, §§402.082 - 402.092, 411.034, 413.0513, and 413.0514 and the Code of Federal Regulations, Title 20, §603.6 and §603.7 (for information obtained from the Texas Workforce Commission or its successor agencies) will be followed, including requests for release of documents or information made confidential under the Act or other applicable law.

(b) Unless authorized by law, SOAH will not identify the name of a claimant for workers' compensation coverage under the Act or other information contained in or derived from the division's claim file for such a claimant in listings of docketed cases or in other documents distributed to persons other than to the division and the parties to a contested case involving that claimant.

(c) If a party or a member of the public files a written request with the Chief Clerk of Proceedings and with SOAH that a hearing be conducted as a hearing open to the public, the ALJ shall consider that request and issue a ruling prior to the opening of the hearing to the public.

(d) Any request for a hearing open to the public shall be filed with the Chief Clerk of Proceedings and with SOAH at least seven days prior to the first day of the hearing unless the ALJ allows a shorter filing period upon a showing of good cause.

(e) When considering a request that a hearing be open to the public, the ALJ's considerations shall include, but are not limited to, whether the hearing would contain information made confidential under the Act or other applicable laws. If confidential

information would be included, then the ALJ may consider whether any procedure could be devised and utilized which would allow a hearing to be open to the public without violating the confidentiality provisions of the Act, other applicable laws, other applicable regulations, and agreements required by those laws or regulations or without causing an undue burden on the division or the parties to the hearing.

(f) While SOAH will have temporary custody of the hearing records, the commissioner retains statutory authority as custodian of records and is ultimately responsible, as the originating agency, for the release or non-release of the information. Therefore, should any information, which may be confidential under the Act, division rules, or other law, be requested from SOAH by any person or entity, SOAH shall follow all legal requirements necessary to ensure that the confidential information or document is not released, unless specifically required by law, and shall provide such request to the commissioner immediately upon receipt.

(g) Pursuant to Labor Code §413.031(c), the division shall be responsible for publishing any SOAH decisions required to be published by that section on the department's website. SOAH shall as soon as practicable deliver to the division a version of the decision in an electronic format.

(h) SOAH and the division have responsibilities for compliance with the Texas Public Information Act, Government Code, Chapter 552. Each agency maintains information that may be considered confidential or exempt from disclosure under laws administered by that agency. To the extent required by law, each agency is responsible for replying to all public information requests for information maintained by that agency. Each agency will promptly notify the other agency of the receipt of a Texas Public Information Act request relating to confidential or exempt records obtained from the other agency and will coordinate responses as necessary.

Source Note: The provisions of this §148.24 adopted to be effective July 27, 2014, 39 TexReg 5608

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 150	REPRESENTATION OF PARTIES BEFORE THE AGENCY--QUALIFICATIONS FOR REPRESENTATIVES

RULE §150.1 Minimum Standards of Practice for an Attorney

(a) An attorney, in practice before the commission, shall observe:
(1) these rules;
(2) the Texas Disciplinary Rules of Professional Conduct; and
(3) the Texas Lawyer's Creed, promulgated by the Supreme Court of Texas on November 7, 1989.

(b) An attorney who undertakes representation of a claimant on a valid compensation claim and a third party liability action shall not abandon the compensation claim for the purpose of avoiding the maximum attorney fee established under the Texas Workers' Compensation Act (the Act), §4.09.

(c) An attorney who fails to comply with this rule may be assessed an administrative penalty under the Act, §10.07(a)(11).

Source Note: The provisions of this §150.1 adopted to be effective March 7, 1991, 16 TexReg 1196

RULE §150.2 Qualification and Authorization of Attorney To Practice before the Commission

(a) An attorney who represents any party before the commission shall be licensed to practice law by the State Bar of Texas in order to receive an attorney's fee.

(b) An attorney who represents a claimant for benefits shall notify the commission in writing within 10 days of undertaking the representation of the party. The written notice shall identify the attorney and the claimant and the injured employee (if different from the claimant).

(c) An attorney may be disqualified, after a hearing under the Texas Workers' Compensation Act (the Act), §10.33, from representing any party before the commission for the following activities:
(1) knowingly charging a claimant a fee in excess of that allowed by the commission;

(2) knowingly assisting any person in making a false or misleading statement, misrepresenting or concealing a material fact, and/or fabricating, altering, concealing, or destroying a document, in order to claim benefits;
(3) knowingly assisting any person in making a false or misleading statement, misrepresenting or concealing a material fact, and/or fabricating, altering, concealing, or destroying a document, in order to defeat a claim for benefits;
(4) for engaging in conduct described in the Act, §10.07(a)(1)-(10) or (b)(1)-(23), whether or not an administrative violation is assessed; or
(5) being suspended or disbarred by the State Bar of Texas.

(d) An attorney who is disqualified may apply to the commission for reinstatement, no sooner than the expiration of the term of disqualification. However, an attorney who has been disbarred by the State Bar of Texas cannot apply for reinstatement to practice before the commission unless the State Bar of Texas certifies that the attorney has had the license to practice law reinstated.

Source Note: The provisions of this §150.2 adopted to be effective March 7, 1991, 16 TexReg 1197

RULE §150.3 Representatives: Written Authorization Required

(a) A representative, as that term is defined in the Texas Workers' Compensation Act (the Act), §1.03(40), is authorized under the Act, §2.09(e), to provide services in workers' compensation matters if:
(1) the person is an insurance adjuster holding a State Board of Insurance license to adjust workers' compensation claims, if the adjuster provides, to the commission, a written authorization from an insurance carrier to adjust claims. Written authorization is not required from an adjuster who is an employee of the insurance carrier;
(2) the person is an attorney and complies with the requirements of §150.2(a) of this title (relating to Qualification and Authorization of Attorney To Practice before the Commission); or
(3) the person who is not either an adjuster or attorney files with the commission 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.

(b) A representative that fails to comply with the Act, or violates a rule of the commission, may be subject to sanctions, including suspension, as provided by the Act, §2.09(f) and §10.07(d).

Source Note: The provisions of this §150.3 adopted to be effective July 8, 1991, 16 TexReg 3399

TITLE 28 **INSURANCE**
PART 2 **TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION**
CHAPTER 152 **ATTORNEY FEES**

RULE §152.1 Attorney Fees: General Provisions

(a) To be eligible to earn a fee, an attorney representing any party shall hold an active license to practice law in Texas and not be currently under suspension for any reason.

(b) An attorney may receive a fee for representation of any party before the commission only after the commission approves the amount of the fee. An attorney shall not receive an amount greater than the fee approved by the commission, notwithstanding any agreements between the parties, including retainer fee agreements.

(c) The fee approved by the commission shall be limited to 25% of each weekly income benefit payment to the employee, up to 25% of the total income benefits allowed and shall also be based on the attorney's time and expenses, subject to the guidelines and standards set forth in the Texas Workers' Compensation Act (the Act) and commission rules. An attorney's fee for representing an injured employee becomes a lien against any unpaid income benefits due the injured employee once the carrier receives the commission order approving the fee. The carrier must begin payment out of the approved income benefits by mailing a check to the attorney within seven days after receiving the commission order and thereafter whenever income benefits are paid until the fee has been paid or income benefits cease.

(d) An attorney's fee for representing a claimant may upon request by the attorney or carrier and approval by the commission be commuted to a lump sum only out of a sum certain award or order to pay benefits. This commuted fee may be discounted for present payment at the rate provided under the Act, §401.023, and shall not exceed 25% of the unpaid sum certain. A commuted fee shall be recouped by the carrier out of the future income benefits paid to the represented claimant, not to exceed more than 25% out of any single payment. The fee for representing a claimant for death benefits cannot be commuted where the only dispute involves identification of the proper beneficiaries.

(e) A client who discharges an attorney does not, by that action, defeat the attorney's right to claim a fee for services performed by that attorney prior to discharge.

(f) An attorney for an employee who prevails when a carrier contests a commission determination of eligibility for supplemental income benefits shall be eligible to receive

a reasonable and necessary attorney's fee, including expenses. This fee is payable by the carrier, not out of the employee's benefits, and the fee shall not be limited to a maximum of 25% of the employee's recovery. All provisions of these rules, except §152.4 of this title (relating to Guidelines for Legal Services Provided to Claimants and Carriers), apply.

Source Note: The provisions of this §152.1 adopted to be effective February 22, 1991, 16 TexReg 774; amended to be effective April 20, 1994, 19 TexReg 2547

RULE §152.2 Attorney Fees: Representation of Claimants

(a) An attorney who represents a claimant shall notify the commission in writing within 10 days of undertaking representation, and shall provide a copy of the contract of employment if requested by the commission.

(b) For purposes of computing the maximum amount of a fee that may be fixed and approved for a claimant's attorney, "claimant's recovery" shall not include:
(1) the amount of benefits paid to the claimant prior to hiring the attorney;
(2) benefits initiated or offered by an insurance carrier when the initiation or offer is based upon documentation in a claimant's file, and has not been the subject of a dispute with the carrier;
(3) any undisputed portion of impairment benefits paid or offered to the claimant based upon an impairment rating that is assessed by the carrier, under the Texas Workers' Compensation Act (the Act), §4.26(f);
(4) the value of medical and hospital benefits provided to the claimant; or
(5) lifetime income or death benefits when the carrier admits liability on all issues involved, and when the maximum benefit is tendered in writing by a carrier, no later than the date on which the carrier is required to contest the claim.

(c) An attorney shall not represent multiple legal beneficiaries on a claim for death benefits if it is reasonably foreseeable that a judgment favorable to one legal beneficiary would impact unfavorably on another legal beneficiary.

(d) The total amount that the commission approves for the attorney's time and expenses constitute the fee, and shall not exceed 25% of the claimant's recovery, except as provided in the Act, §4.28(l)(2), and §152.1(f) of this title (relating to Attorney Fees: General Provisions).

Source Note: The provisions of this §152.2 adopted to be effective February 22, 1991, 16 TexReg 774

RULE §152.3 Approval or Denial of Fee by the Division

(a) To claim a fee, an attorney representing any party must submit to the division a complete and accurate application for attorney fees in the form and manner prescribed by the division.

(b) An application for attorney fees must include:
(1) each attorney's name and bar card number;
(2) the law firm name, phone number, and mailing address;
(3) the injured employee's name, date of injury, and DWC claim number;
(4) the beneficiary's name, type, contact information, and social security number, if applicable;
(5) the dates of legal service;
(6) the hourly rate and number of hours for each attorney and legal assistant providing legal services;
(7) an itemized list of each legal service performed and expense incurred representing the claimant or insurance carrier that identifies the attorney or legal assistant who provided the service, the date the service was provided, and the hours or amount requested;
(8) a certification that every statement, numerical figure, and calculation in the application for attorney fees submitted to the division is within the attorney's personal knowledge, is true and correct, and represents services, charges, and expenses provided by the attorney or a legal assistant under the attorney's supervision; and
(9) additional case-specific justification for any fee that exceeds the guidelines for legal services.

(c) The division may approve, partially approve, or deny an application for attorney fees based on the division's determination of whether the requested time and expenses are reasonable according to the guidelines for legal services and maximum hourly rate established in §152.4 of this title, Labor Code §408.221 and §408.222, and written evidence presented to the division. The division will issue an order approving, partially approving, or denying an application for attorney fees. Submission of an application requesting fees for the same services or expenses addressed in any previous application is prohibited. Attorneys are subject to review for compliance with commissioner rules, the Act, and other laws under Labor Code Chapter 414. An order approving, partially approving, or denying an application for attorney fees does not limit the commissioner's authority to enforce a sanction, administrative penalty, or other remedy authorized by the Act. At any time an attorney whose application is found to contain false or inaccurate information may be referred to enforcement or other authorities, including

licensing agencies, district and county attorneys, or the attorney general for investigation and appropriate proceedings.

(d) To contest a division order approving, partially approving, or denying an application for attorney fees, an attorney, claimant, or insurance carrier must request a contested case hearing through the dispute resolution process outlined in Chapters 140 - 144 of this title. A request must be submitted by personal delivery, first class mail, or facsimile to the division no later than the 20th day after receipt of the division's order. A claimant may request a hearing by contacting the division in any manner no later than the 20th day after receipt of the division's order. A contesting party other than a claimant must send a copy of the request by personal delivery, first class mail, or electronic transmission to the insurance carrier and the other parties, including the claimant and attorney, on the same day the request is submitted to the division.

(e) After a contested case hearing under subsection (d) of this section, an attorney, claimant, or insurance carrier must request review by the appeals panel pursuant to the provisions of §143.3 of this title (Requesting the Appeals Panel To Review the Decision of the Administrative Law Judge) to contest the division order approving, partially approving, or denying an application for attorney fees.

(f) The division's order approving, partially approving, or denying an application for attorney fees is binding during the pendency of a contest or an appeal of the order. Notice of a contest or an appeal does not relieve the insurance carrier of the obligation to pay attorney fees according to the division order.

(g) Following a contested case hearing or appeals panel review of an order approving, partially approving, or denying an application for attorney fees under subsection (d) or subsection (e) of this section, the division will issue a final order or decision. If the final order or decision of the division requires an attorney to reimburse funds, the reimbursement must be made no later than the 15th day after receipt of the final order or decision.

(h) This section is effective January 30, 2017.

Source Note: The provisions of this §152.3 adopted to be effective January 30, 2017, 41 TexReg 10624; amended to be effective January 7, 2019, 44 TexReg 111

RULE §152.4 Guidelines for Legal Services Provided to Claimants and Insurance Carriers

(a) The division will consider the guidelines for legal services outlined in subsection (c), the maximum hourly rate for legal services in subsection (d), Labor Code, §408.221 and §408.222, and written evidence presented to the division, when approving, partially approving, or denying an application for attorney fees.

(b) An attorney may request, and the division may approve, a number of hours greater than those allowed by the guidelines for legal services if the attorney demonstrates to the satisfaction of the division that the higher fee was justified based on the circumstances of the specific claim and Labor Code, §408.221 and §408.222.

(c) The guidelines for legal services provided to claimants and insurance carriers are as follows:
Attached Graphic

(d) The maximum hourly rate for legal services shall be as follows. Hourly rate:
(1) attorney--$200; and
(2) legal assistant (not to include hours for general office staff)--$65.

(e) Each attorney must bill for hours using that attorney's state bar card number.

(f) This section is effective January 30, 2017.

Source Note: The provisions of this §152.4 adopted to be effective January 30, 2017, 41 TexReg 10624

RULE §152.5 Allowable Expenses

(a) As part of the application for attorney fees, an attorney shall submit an itemized list of expenses incurred for the preparation and presentation of the client's case. The date, nature, and amount of the expense shall be clearly identified.

(b) The commission shall allow those expenses necessary for the preparation and presentation of a person's claim or a carrier's defense before the commission, including:
(1) travel expenses, at the rate set for state employees by the legislature for state employees in the General Appropriation Act, if the attorney is required to attend a benefit review conference or hearing more than 25 miles from the attorney's office nearest to the location of the conference or hearing;

(2) expenses necessary to present a case at a hearing including subpoena costs, court reporter's fee, per diem witness fees incurred, and translator's fee;
(3) the costs of records necessary to prepare or present a claim or defense including copies of commission files, a record check performed by the commission, medical reports (except medical reports required to be provided by commission rule), and copies of certificates, licenses, and decrees necessary for perfecting a claim for death benefits;
(4) costs of long distance telephone calls to: the client, an attorney or other representative of the other party, health care providers, or others necessary to prepare the claim or defense;
(5) costs of collect long distance telephone calls from the client; and
(6) investigative services necessary to establish or dispute a claim.

(c) The commission shall not allow as attorney expenses those expenses that are not necessary for the preparation and presentation of a party's individual claim or defense before the commission, including:
(1) attorney travel, except as permitted in subsection (b)(1) of this section;
(2) overhead costs of operating a law office including: rent, utilities, copies, fax, telecopier, postage, shipping, local telephone calls, long distance calls to the commission, and salaries for general office staff; and
(3) medical reports and hospital records that commission rules require to be sent to the claimant and carrier.

(d) An attorney's payment of out-of-pocket expenses for items listed in subsection (b) of this section does not constitute a loan to the client as prohibited by the Texas Workers' Compensation Act, §10.03.

RULE §152.6 Attorney Withdrawal

(a) An attorney withdrawing representation must submit a notice of withdrawal under subsection (b) of this section or a motion to withdraw under subsection (d) of this section and comply with the Texas Disciplinary Rules of Professional Conduct of the State Bar of Texas, including surrendering papers and property to the client as required.

(b) An attorney must submit a notice of withdrawal in the form and manner prescribed by the division when:
(1) the attorney withdraws representation and a motion to withdraw under subsection (d) of this section is not required; or
(2) the attorney's representation is terminated by the attorney's client.

(c) An attorney must submit a notice of withdrawal under subsection (b) of this section to the division by personal delivery, first class mail, or facsimile no later than the 10th day following withdrawal. An attorney must provide a copy of the notice to the attorney's client and the opposing party by personal delivery, first class mail, or electronic transmission on the same day the notice is submitted to the division. The notice of withdrawal must include:

(1) the attorney's name, bar card number, and contact information;

(2) the law firm name, if applicable;

(3) the injured employee's name, contact information, date of injury, and DWC claim number;

(4) the beneficiary's name, contact information, and social security number, if applicable;

(5) the insurance carrier name;

(6) the effective date of the attorney's withdrawal of representation under paragraph (1) or (2) of subsection (b); and

(7) the attorney's signature.

(d) Except when the attorney's representation is terminated by the attorney's client, an attorney withdrawing representation must submit a motion to withdraw to the division, and receive a division order granting the motion to withdraw, after notice of a scheduled benefit review conference or contested case hearing has been received and until resolution of the disputed issues through the division's dispute resolution process provided in Labor Code Chapter 410, Subchapters A - E.

(e) The motion to withdraw must provide good cause for withdrawing from the case and a certification that states:

(1) the attorney's client has knowledge of and has approved or refused to approve the withdrawal; or

(2) the attorney made a good faith effort to notify the attorney's client and the attorney's client cannot be located.

(f) An attorney must submit the motion to withdraw to the division by personal delivery, first class mail, or facsimile. An attorney must also provide a copy of the motion to the attorney's client and the opposing party by personal delivery, first class mail, or electronic transmission on the same day the motion is submitted to the division.

(g) The administrative law judge will determine whether good cause exists for the attorney's withdrawal based on Rule 1.15 of the Texas Disciplinary Rules of Professional Conduct and other factors, including:

(1) how close in time the attorney withdrawal is to a scheduled benefit review conference or contested case hearing;
(2) the amount of attorney fees that have been requested and approved by the division;
(3) whether the attorney is willing to waive payment of any portion of the approved fees;
(4) the attorney's reason for the withdrawal; and
(5) whether the attorney's client refused to approve the withdrawal, if applicable.

(h) If the administrative law judge determines good cause does not exist for the attorney's withdrawal, the attorney must continue to represent the party until resolution of the disputed issues through the division's dispute resolution process provided in Labor Code Chapter 410, Subchapters A - E.

(i) This section does not prevent the attorney's client from terminating the attorney-client relationship or notifying the division of the termination of the attorney-client relationship. If the attorney's client notifies the division of a termination, the attorney is not relieved of the duty to submit to the division a notice of withdrawal under subsection (b) of this section.

(j) This section is effective January 30, 2017.

Source Note: The provisions of this §152.6 adopted to be effective January 30, 2017, 41 TexReg 10624; amended to be effective January 7, 2019, 44 TexReg 111

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 156	REPRESENTATION OF PARTIES BEFORE THE AGENCY--CARRIER'S AUSTIN REPRESENTATIVE

RULE §156.1 Carrier's Austin Representative

(a) Each insurance carrier shall designate a person in Austin, Travis County, Texas as its representative to the Commission, to act as agent for receiving notice from the Commission.

(b) The designation required by this section shall be made in the form and manner prescribed by the Commission and contain the representative's name, address, telephone number, facsimile number and e- mail address.

(c) Any notice from the Commission, sent to the designated representative's Austin address, is notice from the Commission to the insurance carrier.

(d) A person designated under this rule continues as agent for the insurance carrier until 30 days after the Commission receives notice that the insurance carrier designates another representative.

Source Note: The provisions of this §156.1 adopted to be effective January 1, 1991, 15 TexReg 7029; amended to be effective March 13, 2000, 25 TexReg 2147

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 160	REPORTS OF INJURY AND OCCUPATIONAL DISEASE--GENERAL PROVISIONS

RULE §160.1 Applicability

(a) This chapter applies to an employer as defined by Labor Code §411.001(2) and that is subject to Labor Code Chapter 411, Subchapter C.

(b) This section is effective January 1, 2013.

Source Note: The provisions of this §160.1 adopted to be effective January 1, 2013, 37 TexReg 5592

RULE §160.2 Non-Subscribing Employer's Report of Injury

(a) An employer that does not have workers' compensation insurance coverage (non-subscriber) and employs five or more employees not exempt from workers' compensation insurance coverage shall file with the division a report of each:
(1) death;
(2) on-the-job injury that results in more than one day's absence from work for the injured employee; and
(3) occupational disease of which the employer has knowledge.

(b) An employer shall file a report required by subsection (a) of this section with the division not later than the seventh day of the month following the month in which:
(1) the death occurred;
(2) the employee was absent from work for more than one day as a result of the on-the-job injury; or
(3) the employer acquired knowledge of the occupational disease.

(c) A report shall be filed in writing or electronically and shall be in the form and manner prescribed by the division. A report must include:
(1) the employer's business name;
(2) the employer's North American Industry Classification System (NAICS) codes;
(3) the employer's business mailing address;
(4) the employer's physical address (if different from mailing address);
(5) the employer's telephone number;

(6) the employer's federal employer identification number (FEIN);
(7) the name, title, telephone number, signature, and date of signature of the person completing the report for the employer;
(8) the reporting period;
(9) the injured employee's name;
(10) the employee's social security number;
(11) the employee's date of birth;
(12) the employee's date of hire;
(13) the employee's sex;
(14) the employee's occupation;
(15) the employee's hourly wage;
(16) the employee's NAICS code;
(17) the employee's race/ethnic identification;
(18) the address where injury or occupational disease occurred;
(19) the type of location of where injury or occupational disease occurred;
(20) the date of injury or occupational disease;
(21) the date reported by employee;
(22) the return-to-work date or expected date;
(23) the reported cause of injury;
(24) the nature of injury or occupational disease;
(25) any equipment involved in the injury;
(26) body part(s) affected;
(27) the first day of absence from work;
(28) the number of days absent from work;
(29) whether the injury is an occupational disease;
(30) whether the injury resulted in death; and
(31) a description of incident.

(d) Employers are responsible for timely and accurate filing of reports under this section. A report required by this section is considered filed with the division only when it accurately contains all of the data elements specified under subsection (c) of this section and is received by the division.

(e) This section is effective January 1, 2013.

Source Note: The provisions of this §160.2 adopted to be effective June 1, 1992, 17 TexReg 3252; amended to be effective February 2, 1996, 21 TexReg 515; amended to be effective March 13, 2000, 25 TexReg 2148; amended to be effective January 1, 2013, 37 TexReg 5592

RULE §160.3 Subscribing Employer's Report of Injury

(a) An employer that has workers' compensation insurance coverage (subscriber) shall file a report of injury with the division pursuant to Labor Code §411.032. A subscribing employer's report of injury filed in accordance with Labor Code §409.005 and applicable division rules satisfies that employer's requirement to file a report of injury under Labor Code §411.032, unless the division requests that the employer file a report with the division for a specific injury.

(b) For an employee who has waived workers' compensation insurance coverage in accordance with Labor Code §406.034, an employer covered by workers' compensation insurance, whether by commercial insurance or through self-insurance as provided by the Texas Workers' Compensation Act, shall file with the division a report of each:
(1) death;
(2) on-the-job injury that results in more than one day's absence from work for the injured employee; and
(3) occupational disease of which the employer has knowledge.

(c) The report of injury required by subsection (b) of this section shall be filed in the form, manner, and timeframes prescribed by the division in §160.2(b) and (c) of this title (relating to Non-Subscribing Employer's Report of Injury) and shall include a statement that the injured employee has waived workers' compensation coverage in accordance with Labor Code §406.034.

(d) Employers are responsible for timely and accurate filing of reports under this section. A report required by this section is considered filed with the division only when it accurately contains all of the data elements specified under subsection (c) of this section and is received by the division.

(e) This section is effective January 1, 2013.

Source Note: The provisions of this §160.3 adopted to be effective February 2, 1996, 21 TexReg 515; amended to be effective January 1, 2013, 37 TexReg 5592

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 165	REJECTED RISK: INJURY PREVENTION SERVICES

RULE §165.1 Identification and Notification of Certain Policyholders Insured by the Texas Mutual Insurance Company Acting as the Insurer of Last Resort

(a) The Texas Mutual Insurance Company must provide the division a list of the policyholders requiring accident prevention services (rejected risk employers). This list must include rejected risk employers that meet the criteria in Texas Insurance Code Chapter 2054, Subchapters H and K.

(b) A policyholder subject to Texas Insurance Code §2054.504, whose corporate office is located outside of Texas must, on receipt of notification by the Texas Mutual Insurance Company of the requirement to get a safety consultation as a condition of insurance, provide the Texas Mutual Insurance Company the following information:
(1) the name and title of the senior official in Texas with the authority to commit funds and to establish policy, procedures, and actions required to implement the accident prevention plan and address the exposures identified in the hazard exposure survey;
(2) the official's mailing address; and
(3) the official's business telephone number.

(c) Information required by subsection (b) of this section must be mailed to the Texas Mutual Insurance Company at 2200 Aldrich Street, Austin, Texas 78723-3474.

Source Note: The provisions of this §165.1 adopted to be effective April 25, 1999, 24 TexReg 3092; amended to be effective March 14, 2001, 26 TexReg 2034; amended to be effective September 12, 2004, 29 TexReg 8610; amended to be effective March 26, 2023, 48 TexReg 1637

RULE §165.2 Safety Consultation

(a) Policyholders who have not had an accident prevention plan developed and implemented in the last six months prior to notification shall, not later than 30 days following the effective date of the policy, or receipt of notice of identification as a Rejected Risk employer, whichever occurs later, complete a safety consultation using a source approved by the division pursuant to §164.9 and §164.10 of this title (relating to

Approval of Professional Sources for Safety Consultations; and Removal From the List of Approved Sources). The consultation may be provided by:
(1) the Texas Workers' Compensation Commission's Division of Workers' Health and Safety (the division);
(2) the Texas Mutual Insurance Company; or
(3) another professional source.

(b) Policyholders who have had an accident prevention plan developed and implemented within the six months prior to notification of their identification as a Rejected Risk employer must obtain division review of the plan for adequacy, to include an on-site visit.

(c) The division shall provide the Texas Mutual Insurance Company with a list of approved professional sources. If the Texas Mutual Insurance Company elects not to provide the policyholder with safety consultation and accident prevention plan development services, the Texas Mutual Insurance Company shall include a copy of the list with the notification letter to the policyholder. If the Texas Mutual Insurance Company elects to provide such services, the list will be provided to the policyholder by the Texas Mutual Insurance Company at the request of the policyholder.

(d) The safety consultant, identified in subsection (a) of this section, shall visit the policyholder's work place, review existing safety programs, conduct a walk through at each appropriate job site to include a hazard exposure survey, and prepare a program review report. The report shall be in a written format prescribed by the commission.

(e) The initial program review report must be delivered to the division of Workers' Health and Safety no later than 30 days after the policyholder receives the notice of identification. An extension of 30 days may be obtained from the division for good cause.

(f) The safety consultants identified in subsection (a) of this section may charge the employer for consultations provided under this section.

Source Note: The provisions of this §165.2 adopted to be effective April 25, 1999, 24 TexReg 3092; amended to be effective September 12, 2004, 29 TexReg 8610

RULE §165.3 Formulation and Components of Accident Prevention Plan

(a) Policyholders who have not had an accident prevention plan developed in the last six months prior to notification will, within 30 days of the date of the safety consultant's

initial report, develop an accident prevention plan. This plan will be consistent with established state safety and health codes and with accepted industry practices. The accident prevention plan shall be developed with the assistance of an Approved Professional Source as defined in §164.9 of this title (relating to Approval of Professional Sources for Safety Consultations), and shall be in the format prescribed by the commission. The policyholder shall submit the completed accident prevention plan, developed and signed by the policyholder and the Approved Professional Source, to the division. The Approved Professional Source's signature on the accident prevention plan cover sheet certifies that the accident prevention plan meets the format prescribed by the commission. The format shall include the following components and specify the individual responsible for each, by position or title:

(1) a management component with a written safety policy statement and assignment of responsibilities and authority;

(2) analysis component which includes a review of safety program documentation, existing operations, and injury trends. The analysis will be used to evaluate the effectiveness of the existing programs and to detect existing or potential trends. The analysis component will contain a statement as to the interval between the accomplishment of the analyses;

(3) a safety program recordkeeping system component;

(4) a safety and health education and training component with a statement as to the interval between training sessions;

(5) a safety audit/inspection component with a statement as to the interval between safety audits/inspections;

(6) an accident investigation component to identify the cause factors of injuries, and plan and record corrective actions; and

(7) a component to ensure review and revision of the safety program when changes in operations, equipment, or employee activities are determined or anticipated, to ensure continued effectiveness of the program requirements. This component also includes the periodic review and revisions of the safety program including a statement as to the interval (minimum of annually) between reviews.

(b) Policyholders who have had an accident prevention plan developed and implemented within the six months prior to notification as a Rejected Risk Employer and verified and approved by the Texas Mutual Insurance Company or the Texas Workers' Compensation Commission's Division of Workers' Health and Safety (the division) will continue implementation of the plan and obtain an inspection by the division as provided in §165.6 of this title (relating to Follow-up Inspection by the Division).

(c) Reference material for the development of an accident prevention plan may be obtained from the division.

(d) An implementation time line, not to exceed three months after the formulation of the plan, shall be developed and included with the plan.

(e) If the policyholder disagrees with any or all of the plan, the policyholder shall sign the accident prevention plan cover sheet and attach a statement containing the specific reasons for disagreement to the plan and what alternative measures the policyholder proposes to meet the objectives of the program. The division will review the areas of disagreement and notify the policyholder and the safety consultant of the decision on each area of the disagreement.

(f) The policyholder's signature is understood to exclude those areas of the plan for which a disagreement has been attached to the plan, pending review by the division or a formal appeal.

(g) If the division finds it is practical to do so, the division may direct the policyholder to begin implementation of any or all parts of the plan that are not subject to the policyholder's disagreement. The time lines specified in the plan shall remain in effect for those parts of the plan the policyholder is directed to implement.

(h) The policyholder shall be responsible for filing the accident prevention plan that has been reviewed by the Approved Professional Source and signed as meeting the criteria in subsection (a) of this section with the division no later than 30 days after completion of the safety consultation and no later than 90 days after the policyholder received notification of identification as a Rejected Risk employer. Delays requested for good cause may be granted by the division.

Source Note: The provisions of this §165.3 adopted to be effective April 25, 1999, 24 TexReg 3092; amended to be effective September 12, 2004, 29 TexReg 8610

RULE §165.4 Request for Safety Consultation From the Division

(a) A policyholder notified as a Rejected Risk employer may request that the division perform the safety consultation.

(b) The request shall be in writing on the form prescribed by the commission and may be delivered to the Texas Workers' Compensation Commission's Division of Workers' Health and Safety (the division) by mail, in person, by facsimile, or by electronic transmission. The form shall include:
(1) the policyholder's name, address, and telephone number;

(2) the name of the contact person at the policyholder's place of business; and
(3) the date the policyholder received notice of identification as a Rejected Risk employer.

(c) The division shall notify each policyholder who requests services whether the division has accepted or rejected the request. The notice shall be in writing and shall be made within three working days of the date the commission received the request.

Source Note: The provisions of this §165.4 adopted to be effective April 25, 1999, 24 TexReg 3092

RULE §165.5 Reimbursement of Division for Services Provided to Rejected Risk Employers

(a) A policyholder shall be required to reimburse the Texas Workers' Compensation Commission's Division of Workers' Health and Safety (the division) for the services the division renders when:
(1) the policyholder requested services under §165.4 of this title (relating to Request for Safety Consultation from the Division) and the division provides the consultation and formulates an accident prevention plan for the policyholder;
(2) the division conducts a follow-up inspection of the policyholder's premises under §165.6 of this title (relating to Follow-up Inspection by the Division); or
(3) the division investigates accidents at the policyholder's worksite(s) while the policyholder is in the rejected risk program.

(b) The commission shall bill the policyholder as listed in the commission's approved fee schedule.

(c) The commission shall provide the policyholder with an itemized statement each month. The payment is due 30 days after the billing date.

Source Note: The provisions of this §165.5 adopted to be effective April 25, 1999, 24 TexReg 3092

RULE §165.6 Follow-up Inspection of the Policyholder's Premises by the Division

(a) The Texas Workers' Compensation Commission's Division of Workers' Health and Safety (the division) shall conduct a follow-up inspection to ensure compliance with, and effectiveness of, the accident prevention plan developed in response to a safety consultation required by the Texas Insurance Code, Article 5.76-3, §8(c). This inspection

shall be conducted at the policyholder's premises. The inspection shall be conducted not earlier than 90 days or later than six months after the date the accident prevention plan is submitted to the division.

(b) The inspection shall be conducted and completed during normal work hours.

(c) The policyholder shall allow the division access to the policyholder's premises, including remote job sites, and employees during normal work hours to conduct the follow-up inspection. A policyholder who without good cause refuses to allow the division access to the policyholder's premises may be served with an order of the commission demanding such access. Failure to comply with the commission order will subject the policyholder to penalties and sanctions as provided in the Texas Insurance Code and the Texas Labor Code.

(d) The division may require the presence of the professional source consultant that conducted the hazard survey or assisted with the accident prevention plan development during the follow-up inspection. If the professional source is required during the inspection, the division will coordinate that requirement with the policyholder and the professional source, at the policyholder's expense.

(e) At the time of the inspection, the division may consider as evidence of compliance information which includes, but is not limited to, visual verification, written policies and procedures, attendance rosters for training programs, employee interviews, and purchase orders or receipts for equipment or services necessary to support the accident prevention plan.

Source Note: The provisions of this §165.6 adopted to be effective April 25, 1999, 24 TexReg 3092; amended to be effective June 5, 2003, 28 TexReg 4294

RULE §165.7 Report of Follow-Up Inspection

(a) As soon as practical, but not later than 30 days from the date of the follow-up inspection, the policyholder, the safety consultant, and the Texas Mutual Insurance Company, shall be provided copies of the follow-up inspection report by the division.

(b) The report shall be in writing and shall specify whether the policyholder has, or has not, implemented the accident prevention plan or other acceptable corrective measures approved by the division.

(c) If the policyholder is found not to have implemented the accident prevention plan, the report shall also contain a list of the specific areas of the accident prevention plan which have not been implemented.

(d) Failure or refusal to implement the accident prevention plan is an administrative violation with penalty not to exceed $5,000 for each day of non-compliance. The Texas Workers' Compensation Commission's Division of Workers' Health and Safety (the division) shall refer the matter to the Commission's Division of Compliance and Practices to pursue the administrative violation if:

(1) the policyholder fails or refuses to implement the accident prevention plan or approved alternative measures;

(2) the policyholder does not cancel coverage within 30 days after the date of the division's determination of such failure or refusal; and

(3) the Texas Mutual Insurance Company notifies the division that it will not cancel the coverage.

Source Note: The provisions of this §165.7 adopted to be effective April 25, 1999, 24 TexReg 3092; amended to be effective September 12, 2004, 29 TexReg 8610

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 166	ACCIDENT PREVENTION SERVICES

RULE §166.1 Definitions of Terms

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

(1) Accident prevention facilities--All personnel, procedures, equipment, materials, documents, buildings, programs, and information necessary to maintain or provide accident prevention services to the policyholder.

(2) Nature of the policyholders' operations--Type of business or industry with specific reference to potential for accident, injury, or disease determined by the standard hazards associated with the most hazardous industrial operations in which the policyholder is engaged.

(3) Premium--The amount charged for a workers' compensation insurance policy, including any endorsements, after the application of individual risk variations based on loss or expense considerations as defined by Insurance Code §2053.001(2-a).

(4) Survey--An on-site visit to a policyholder's worksite in Texas where the risk exists or the loss occurred and during which the insurance company's accident prevention personnel performs a hazard assessment of the worksite, reviews safety and health programs, and makes recommendations to assist in mitigating risks and preventing injuries and illnesses.

(b) This section is effective July 1, 2024.

Source Note: The provisions of this §166.1 adopted to be effective September 1, 1995, 20 TexReg 5248; amended to be effective December 2, 1997, 22 TexReg 11715; amended to be effective October 1, 2013, 38 TexReg 2000; amended to be effective July 1, 2024, 49 TexReg 2546

RULE §166.2 Adequacy of Accident Prevention Services

(a) Under Labor Code §§411.061, 411.063, and 411.068(a)(1), an insurance company writing workers' compensation insurance in Texas must maintain or provide accident prevention facilities that are adequate to provide accident prevention services required by the nature of its policyholders' operations, and must include:

(1) surveys;

(2) recommendations;

(3) training programs;
(4) consultations;
(5) analyses of accident causes;
(6) industrial hygiene;
(7) industrial health services;
(8) qualified accident prevention personnel. To provide qualified accident prevention personnel and services, an insurance company may:
(A) employ qualified personnel;
(B) retain qualified independent contractors;
(C) contract with the policyholder to provide personnel and services; or
(D) use a combination of the methods provided in this paragraph; and
(9) written records, reports, and evidence of all accident prevention services provided to each policyholder.

(b) Under Labor Code §411.068(a)(2), an insurance company must use accident prevention services to prevent injuries to employees of its policyholders in a reasonable manner, which at a minimum, include:
(1) Notice of availability of accident prevention services and return-to-work coordination services. Under Labor Code §411.066, an insurance company must include a notice on the information page or on the front of the policy containing text identical to the following in at least 10-point bold type for each workers' compensation insurance policy delivered or issued for delivery in Texas: Pursuant to Texas Labor Code §411.066, (name of company) is required to notify its policyholders that accident prevention services are available from (name of company) at no additional charge. These services may include surveys, recommendations, training programs, consultations, analyses of accident causes, industrial hygiene, and industrial health services. (Name of company) is also required to provide return-to-work coordination services as required by Texas Labor Code §413.021 and to notify you of the availability of the return-to-work reimbursement program for employers under Texas Labor Code §413.022. If you would like more information, contact (name of company) at (telephone number) and (email address) for accident prevention services or (telephone number) and (email address) for return-to-work coordination services. For information about these requirements, call the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) at 1-800-687-7080 or for information about the return-to-work reimbursement program for employers, call the TDI-DWC at (512) 804-5000. If (name of company) fails to respond to your request for accident prevention services or return-to-work coordination services, you may file a complaint with the TDI-DWC in writing at http://www.tdi.texas.gov or by mail to Texas Department of Insurance, Division of Workers' Compensation, P.O. Box 12050, HS-WS, Austin, Texas 78711-2050;

(2) Contact and surveys following fatalities. An insurance company must contact the policyholder within seven working days of knowledge of a work-related fatality and offer a survey. Survey offers accepted by the policyholder must be initiated by the insurance company within 60 days of policyholder acceptance of the survey offer. No offer of a survey is required if the fatality occurred outside of Texas or was the result of an accident on a common carrier, unless the fatality involves an employee of the common carrier during the course and scope of normal job duties; and

(3) Services requested by a policyholder. An insurance company must provide to each policyholder accident prevention services required by the nature of their policyholders' operations within 15 days from the date of a policyholder request for services, if appropriate services can be provided without conducting a survey; and within 60 days from the date of a policyholder request, if a survey is required regardless of any provision of this section. Services can be provided at a later date if circumstances require, and the policyholder agrees to the later date.

(c) The division may determine adequacy of an insurance company's accident prevention services in accordance with the requirements of this chapter and generally accepted tools and guidelines of loss control provision and through:

(1) review of reports of annual information, as required by §166.3 of this title; and

(2) inspections, as specified in §166.5 of this title (relating to Inspections of Adequacy of Accident Prevention Facilities and Services).

(d) Accident prevention services must be provided to policyholders at no additional charge.

(e) An insurance company must not solicit or obtain from its policyholders a prospective waiver declining all accident prevention services. Under Labor Code §411.063(a)(3), if an insurance company contracts with a policyholder to provide accident prevention personnel or services, this contract does not limit in any way the insurance company's authority or responsibility to comply with any statutory or regulatory requirement contained in this chapter. Insurance companies are responsible for maintaining or providing all services, including contracted services, in accordance with this chapter.

(f) This section is effective July 1, 2024.

Source Note: The provisions of this §166.2 adopted to be effective October 1, 2013, 38 TexReg 2000; amended to be effective July 1, 2024, 49 TexReg 2546

RULE §166.3 Annual Information Submitted by Insurance Companies

(a) An insurance company writing workers' compensation insurance in Texas must file with the division an annual report on its accident prevention services no later than April 1 of each calendar year.

(b) An annual report required by this section must be filed with the division in the format and manner prescribed by the division.

(c) The annual reports must not include the expenses or the costs of underwriting visits to a policyholder's premises unless accident prevention services are provided during the visit. In that case, the proportionate costs of the accident prevention services may be included in the report.

(d) Insurance companies are responsible for timely and accurate reporting under this section. A report required by this section is considered filed with the division only when it accurately contains all of the required data elements and is received by the division.

(e) This section is effective July 1, 2024.

Source Note: The provisions of this §166.3 adopted to be effective September 1, 1995, 20 TexReg 5248; amended to be effective October 1, 2013, 38 TexReg 2000; amended to be effective July 1, 2024, 49 TexReg 2546

RULE §166.5 Inspections of Adequacy of Accident Prevention Facilities and Services

(a) Inspections. The division may conduct inspections to determine the adequacy of an insurance company's accident prevention services.
  (1) Affiliated companies of an insurer may be inspected together if the same facilities, programs, and personnel are used by each of the companies.
  (2) At least 90 days before an inspection, the division must notify the insurance company in writing of the inspection. The notice must specify the location and date of the inspection.
  (3) The division may conduct unannounced on-site visits to determine compliance with the Labor Code and division rules in accordance with the procedures governing on-site visits in Chapter 180 of this title (relating to Monitoring and Enforcement) regardless of the provisions of this section.

(b) Site of inspection. The inspection of the insurance company's accident prevention services must take place as determined by the division:
(1) at the insurance company's office in Texas;
(2) at the division; or
(3) electronically.

(c) Pre-inspection exchange of information.
(1) At least 60 days before the date set for inspection, in the format and manner specified by the division, the insurance company must provide to the division a list of policyholders.
(A) For the period of time determined by the division, the list must be organized by:
(i) policyholder name;
(ii) policy number;
(iii) effective date or expiration date of the policy;
(iv) premium;
(v) number of fatalities;
(vi) principal Texas location;
(vii) indication of whether the insurance company has contracted with the policyholder for accident prevention services; and
(viii) indication of whether that policyholder has requested accident prevention services.
(B) The list must also:
(i) be taken from the insurance company's most current records;
(ii) be separated by affiliated companies;
(iii) be arranged in descending order by premium; and
(iv) include all policies.
(2) Within 10 days of receipt of the policyholder list, the division must select the specific policyholder files to be evaluated and notify the insurance company of those selected files.
(3) For each policy selected by the division, the insurance company must prepare an accident prevention services worksheet in the format and manner prescribed by the division. The worksheet must include the:
(A) policyholder name;
(B) policy number;
(C) number of employees;
(D) principal Texas office address or principal corporate office address if there is no principal Texas office address;
(E) policyholder contact person's name, phone number, and email address;
(F) insurance company name;
(G) effective date of the policy; and

(H) name of person completing the form and date completed.

(4) At least 10 days before the date of the inspection, the insurance company must file the completed worksheets with the division.

(d) Information to be made available at or before the inspection. The insurance company must make available for the time frame specified by the division:

(1) the loss control files corresponding to the requested worksheets;

(2) a sample policy declaratory page as evidence that each policyholder has been provided the notice required by §166.2(b)(1) of this title;

(3) a copy of all documentation of accident prevention services provided in accordance with this title;

(4) samples of policyholder training materials, audiovisual aids, and training programs; and

(5) other information requested by the division necessary to complete the inspection. Information requested may include, but is not limited to:

(A) records of surveys;

(B) consultations;

(C) recommendations;

(D) training provided;

(E) loss analyses;

(F) industrial health and hygiene services;

(G) return-to-work coordination services information; and

(H) the name, location, status (whether employee or contractor), and qualifications of each person that provided accident prevention services in the loss control files being reviewed during the inspection.

(e) Insurance company policyholder visits and contacts. The division may conduct scheduled visits of the jobsite of an insurance company's policyholder and make other off-site contacts with a policyholder to obtain information about the insurance company's accident prevention facilities and use of services.

(f) Written report of inspection.

(1) The division must prepare a written report of the inspection and must provide a copy to the insurance company's executive management and to the Texas Department of Insurance, Loss Control Regulation Division.

(2) The inspection report must contain the division's determination of adequacy in accordance with Labor Code §411.061 and §166.2 of this title, and include specific findings and required corrective actions. The inspection report will indicate whether the division has issued a final determination of adequacy, a final determination of

inadequacy, or an initial determination of inadequacy with regard to an insurance company's accident prevention services.

(3) The division will provide written notification to the insurance company of specific deficiencies and recommendations for corrective action if it assigns an initial determination of inadequacy. Not later than the 60th day after the date of the initial inspection report, the insurance company must provide written documentation evidencing its compliance with the division's recommendations contained in the initial inspection report. The written documentation must detail the corrective actions taken to address each specific finding. If the insurance company believes that it will take more than 60 days to implement the recommendations listed in the initial inspection report, it must request an extension from the division. After the end of the correction period, a final determination of adequacy or inadequacy will be assigned. The division must provide the insurance company with notification of this final determination.

(g) Reinspection.

(1) After an inspection and a final determination of inadequacy of an insurance company's accident prevention services, the division will reinspect the accident prevention services of the insurance company not earlier than the 180th day or later than the 270th day after the date the accident prevention services were determined by the division to be inadequate.

(2) Information required under this section to be provided at the time of initial inspection is required to again be provided at the time of reinspection in accordance with the time frames established within this section.

(h) This section is effective July 1, 2024.

Source Note: The provisions of this §166.5 adopted to be effective September 1, 1995, 20 TexReg 5248; amended to be effective October 1, 2013, 38 TexReg 2000; amended to be effective July 1, 2024, 49 TexReg 2546

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 180	MONITORING AND ENFORCEMENT
SUBCHAPTER A	GENERAL RULES FOR ENFORCEMENT

RULE §180.1 Definitions

The following words and terms, when used in this chapter, will have the following meanings:

(1) Act--The Texas Workers' Compensation Act, Labor Code, Title 5, Subtitle A.

(2) Administrative violation--A violation, failure to comply with, or refusal to comply with the Act, or a rule, order, or decision of the commissioner. This term is synonymous with the terms "violation" or "violate."

(3) Agent--A person who a system participant uses or contracts with for the purpose of providing claims service or fulfilling duties under the Labor Code, Title 5 and rules. The system participant who uses or contracts with the agent may also be responsible for the administrative violations of that agent.

(4) Appropriate credentials--The certifications, education, training, and experience to provide the health care that an injured employee is receiving or is requesting to receive. Under Texas Labor Code §408.0043, a physician who performs a peer review, utilization review, or independent review of health care services requested, ordered, provided, or to be provided by a physician must be of the same or similar specialty as the physician who requested, ordered, provided, or will provide the health care service. A dentist must meet the requirements of Texas Labor Code §408.0044. A chiropractor must meet the requirements of Texas Labor Code §408.0045.

(5) Commissioner--The commissioner of workers' compensation.

(6) Complaint--A written submission to the division alleging a violation of the Act or rules by a system participant.

(7) Compliance Audit (also Performance Review)--An official examination of compliance with one or more duties under the Act and rules. A compliance audit does not include monitoring or review activities involving the Medical Advisor or the Medical Quality Review Panel.

(8) Conviction or convicted--

(A) A system participant is considered to have been convicted when:

(i) a judgment of conviction has been entered against the system participant in a federal, state, or local court;

(ii) the system participant has been found guilty in a federal, state, or local court;

(iii) the system participant has entered a plea of guilty or nolo contendere (no contest) that has been accepted by a federal, state, or local court;

(iv) the system participant has entered a first offender or other program and judgment of conviction has been withheld; or

(v) the system participant has received probation or community supervision, including deferred adjudication.

(B) A conviction is still a conviction until and unless overturned on appeal even if:

(i) it is stayed, deferred, or probated;

(ii) an appeal is pending; or

(iii) the system participant has been discharged from probation or community supervision, including deferred adjudication.

(9) Department--Texas Department of Insurance.

(10) Division--Texas Department of Insurance, Division of Workers' Compensation.

(11) Emergency--As defined in §133.2 of this title (relating to Definitions). This definition does not apply to "emergency" as used in the term "ex parte emergency cease and desist orders."

(12) Frivolous--That which does not have a basis in fact or is not warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law.

(13) Frivolous complaint--A complaint that does not have a basis in fact or is not warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law.

(14) Immediate post-injury medical care--That health care provided on the date that the injured employee first seeks medical attention for the workers' compensation injury.

(15) Notice of Violation (NOV)--A notice issued to a system participant by the division when the division has found that the system participant has committed an administrative violation and the division seeks to impose a sanction in accordance with Labor Code, Title 5 or division rules.

(16) Peer Review--An administrative review by a health care provider performed at the insurance carrier's request without a physical examination of the injured employee.

(17) Remuneration--Any payment or other benefit made directly or indirectly, overtly or covertly, in cash or in kind, including, but not limited to, forgiveness of debt.

(18) Rules--The division's rules adopted under Labor Code, Title 5.

(19) Sanction--A penalty or other punitive action or remedy imposed by the commissioner on an insurance carrier, representative, injured employee, employer, or health care provider, or any other person regulated by the division under the Act, for an administrative violation.

(20) SOAH--The State Office of Administrative Hearings.

(21) System Participant--A person or their agent subject to the Act or a rule, order, or decision of the commissioner.

Source Note: The provisions of this §180.1 adopted to be effective July 29, 1991, 16 TexReg 3940; amended to be effective March 14, 2002, 27 TexReg 1817; amended to be effective September 14, 2003, 28 TexReg 7711; amended to be effective January 9, 2011, 35 TexReg 11873; amended to be effective February 14, 2012, 37 TexReg 691; amended to be effective February 10, 2021, 46 TexReg 928

RULE §180.2 Filing a Complaint

(a) Any person may submit a complaint to the division for alleged administrative violations, except as provided in subsection (b) of this section.

(b) A health care provider cannot submit a complaint about a medical billing issue if the date of service for the medical billing issue was more than 12 months before the date of the complaint, unless the issue qualifies for an exception to the filing deadline under §133.307(c)(1)(B) of this title, concerning medical fee dispute resolution. If the issue qualifies for an exception to the medical fee dispute resolution filing deadline under §133.307(c)(1)(B), then a health care provider cannot submit a complaint about that issue if the medical fee dispute resolution filing deadline in §133.307(c)(1)(B) has passed. This subsection does not apply to a health care provider submitting a complaint under Insurance Code Chapter 1305.

(c) A person may submit a complaint to the division:
(1) through the division's website;
(2) by email;
(3) through written correspondence;
(4) by fax; or
(5) in person. The division will help a person submitting an in-person complaint reduce the complaint to writing.

(d) A complaint submitted on the form provided by the division or in any other written format must contain the following information as applicable:
(1) complainant's name and contact information;
(2) name and contact information of the subject or parties of the complaint, if known;
(3) name and contact information of witnesses, if known;
(4) claim file information, including, but not limited to, the name, address, and date of injury of the injured employee, if known;
(5) the statement of the facts about the alleged violation, including the dates or time period the alleged violation occurred;
(6) the nature of the alleged violation, including the specific sections of the Act and division rules alleged to have been violated, if known;
(7) supporting documentation relevant to the allegation that may include, but is not limited to, medical bills, Explanation of Benefits statements, copies of payment invoices or checks, and medical reports, as applicable;
(8) supporting documentation for alleged fraud that may include photographs, video, audio, and surveillance recordings, and reports; and
(9) other sources of pertinent information, if known.

(e) Contact information may include, but is not limited to, name, address, telephone number, fax number, email address, business name, business address, business telephone number, and websites.

(f) A complaint must contain sufficient information for the division to investigate the complaint.

(g) On receipt of a complaint, the division will review, monitor, and may investigate the allegation against a person or entity who may have violated the Act or division rules.

(h) The division will assign priorities to complaints being investigated based on a risk-based complaint investigation system that considers:
(1) the severity of the alleged violation;
(2) whether the noncompliance or alleged violation is ongoing;

(3) whether a commissioner order has been violated; or
(4) other risk-based criteria the division determines necessary.

(i) A person commits an administrative violation if the person submits a complaint to the division that is:
(1) frivolous, as defined in §180.1 of this title (relating to Definitions);
(2) groundless or made in bad faith; or
(3) done specifically for competitive or economic advantage.

Source Note: The provisions of this §180.2 adopted to be effective March 14, 2002, 27 TexReg 1817; amended to be effective January 9, 2011, 35 TexReg 11873; amended to be effective May 27, 2024, 49 TexReg 3805

RULE §180.3 Compliance Audits

(a) The division shall conduct Compliance Audits of the workers' compensation records of system participants and their agents for compliance with the Act and division rules.

(b) The division may conduct a compliance audit at the offices of a system participant or at any location the division deems appropriate. During a compliance audit, the division may, at its discretion, utilize persons in addition to division staff to provide additional expertise.

(c) The division shall provide reasonable notice in advance of a compliance audit. That notice shall:
(1) be in writing;
(2) be sent at least 10 days before the compliance audit is to be performed;
(3) specify the information that must be made available;
(4) list the name and telephone number of the audit coordinator; and
(5) specify the date, time, location, and conditions of the compliance audit.

(d) The system participant being audited (auditee) shall designate a general contact person and a contact person at each relevant location to coordinate the compliance audit. That contact person shall:
(1) provide reasonable access to requested personnel and information;
(2) respond to reasonable needs of auditors on-site or to inquiries by auditors; and
(3) be familiar with the system participant's procedures and recordkeeping systems related to the scope of the compliance audit.

(e) System participants (which may include those who are not being audited but whose records are necessary to conduct an audit of another system participant), upon request, shall make available for review claim files and other workers' compensation records in the format and manner specified by the division.

(f) Initial findings of the compliance audit will be provided in writing to the auditee.

(g) The auditee may prepare and file with the division a management response to the initial findings. The response may include proposed corrective actions. If such a response is provided, the division shall review the response and shall adjust its findings if deemed appropriate.

(h) Final compliance audit reports may be published on the division's Internet website and shall be redacted to not include any confidential claim file information.

(i) The division, should it deem it appropriate or upon request of a licensing or certification authority, shall provide the appropriate licensing or certification authority with a copy of all final compliance audit reports (redacted in accordance with subsection (h) of this section) and the auditee's response to the final compliance audit report, if any.

(j) To the extent permitted by the Act and division rules, the division shall submit a bill to the auditee for the actual expenses associated with the compliance audit, including audit staff time, additional expertise, travel and per diem expenses, and copying costs.

(k) The auditee shall submit payment by check, made payable to the order of the Texas Department of Insurance, for the expenses within 25 days after receipt of the bill.

Source Note: The provisions of this §180.3 adopted to be effective July 29, 1991, 16 TexReg 3940; amended to be effective September 14, 2003, 28 TexReg 7711; amended to be effective January 9, 2011, 35 TexReg 11873; amended to be effective February 14, 2012, 37 TexReg 691

RULE §180.4 On-Site Visits

(a) As often as it considers necessary, the division may review the operations of a system participant to determine compliance with the Act or division rules.

(b) When reviewing the operations of a system participant to determine compliance with the Act or division rules, the division may conduct on-site visits to the system participant's premises. On-site visits may be announced or unannounced.

(c) The on-site visit will occur during the system participant's normal business hours.

(d) An on-site visit must not disturb a health care provider's actual provision of health care to a patient.

(e) The division shall provide written notice of each announced and unannounced on-site visit. This notice shall:
(1) be sent at least 10 days before the on-site visit unless the on-site visit is unannounced in which case the notice will be provided at the time of the on-site visit;
(2) specify the alleged violation(s) that is the subject of the on-site visit;
(3) specify the types of records that must be made available during the on-site visit;
(4) list the name and telephone number of the division staff representative; and
(5) specify the date, time, location, and conditions of the on-site visit.

(f) The person who is the subject of the on-site visit shall designate a general contact person at the premises. During the on-site visit the contact person shall:
(1) provide access to requested personnel and information;
(2) respond to the needs of division staff and to inquiries by division staff; and
(3) be familiar with the system participant's procedures and recordkeeping systems that are related to the records and information requested during the on-site visit.

(g) The person subject to an on-site visit shall make available to the division in the format and manner specified by the division all records specified in the written notice provided under subsection (e) of this section. A written notice may specify for inspection any records related to the person's participation in the workers' compensation system, including:
(1) claim files;
(2) medical records and reports;
(3) payment records;
(4) billing records;
(5) electronic records;
(6) communications;
(7) adjustor notes;
(8) accident reports;
(9) notifications of lost time;
(10) notifications of injuries;
(11) payroll data and wage statements;
(12) investigative reports;
(13) filed division forms; and

(14) contracts.

Source Note: The provisions of this §180.4 adopted to be effective February 14, 2012, 37 TexReg 691

RULE §180.5 Access to Workers' Compensation Related Records and Information

(a) Upon written request from the division any system participant shall provide copies of or access to all records and information held by that system participant related to issues being reviewed or investigated in the format and manner specified by the division.
(b) The request will identify the records and information to be produced and will provide a specific, reasonable date to produce the information.

Source Note: The provisions of this §180.5 adopted to be effective July 29, 1991, 16 TexReg 3941; amended to be effective February 14, 2012, 37 TexReg 691

RULE §180.8 Notices of Violation; Notices of Hearing; Default Judgments

(a) A notice of violation (NOV) is a notice issued to a system participant when the division finds that the system participant has committed an administrative violation and the division seeks to impose a sanction under the Act or division rules. An NOV is not required to be issued before or after the issuance of an ex parte emergency cease and desist order.

(b) An NOV shall be in writing and include:
(1) the provision(s) of the Act, rule, order, or decision of the commissioner that the system participant violated;
(2) a summary of the facts that establish that the violation(s) occurred;
(3) a description of the proposed sanction that the division intends to impose;
(4) a statement of the basis for the proposed sanction including:
(A) a description of the underlying facts considered by the division for each of the factors listed in Labor Code §415.021(c) and (c-2), if applicable, (relating to Assessment of Administrative Penalties) and §180.26 of this title (relating to Criteria for Proposing, Recommending and Determining Sanctions; Other Remedies) in determining the appropriateness of the division's proposed sanction;
(B) a description of which factors under Labor Code §415.021(c) and (c-2), if applicable, and §180.26 of this title had a mitigating or aggravating effect on the division's proposed sanctions; and
(C) a description of the division's proposed sanction for each violation or violation type in the case of repeated administrative violations. This requirement does not

prohibit the division from considering the aggregate impact of all administrative violations described in the NOV when proposing a sanction if justice requires such consideration;
(5) the right to consent to the charge and the proposed sanction(s);
(6) the right to request a hearing; and
(7) other information about the rights, obligations, and procedures for requesting a hearing.

(c) The charged party shall file a written answer to the NOV not later than the twentieth day after the notice is received. The answer shall either consent to the proposed sanction, and remit the amount of the penalty, if any, or request a hearing by being filed with the division's chief clerk of proceedings. If the charged party fails to respond to the NOV within 20 days of receipt of the notice, the division shall schedule a hearing at the State Office of Administrative Hearings (SOAH) and provide notice of hearing to the charged party that meets the requirements of §148.5 of this title (relating to Notice of Hearing) and must include the information in subsection (b)(3) and (4) of this section.

(d) A charged party that receives a notice of hearing under subsection (c) of this section shall, within 20 days of the date on which the notice of hearing is provided to the party, file a written answer or other responsive pleading. Such response shall be filed in accordance with 1 TAC §155.101 of this title (relating to Filing Documents) and §155.103 of this title (relating to Service of Documents on Parties).

(e) For purposes of this section, events described in paragraphs (1) or (2) of this subsection constitute a default on the part of a charged party who receives a notice of hearing under subsection (c) of this section:
(1) failure of the charged party to file a written response as provided by subsection (d) of this section; or
(2) failure of the charged party to appear in person or by legal representative on the day and at the time set for hearing in a contested case at SOAH, regardless of whether a written response has been filed.

(f) In the event that a charged party defaults as described by subsection (e) of this section, the division may seek informal disposition by default by the commissioner as permitted by Government Code §2001.056.

(g) For purposes of this subchapter, "disposition by default" shall mean the issuance of an order against the charged party in which the allegations against the party in the notice of hearing are deemed admitted as true, upon the offer of proof to the commissioner that proper notice was provided to the defaulting party. For purposes of

this section, proper notice means notice sufficient to meet the provisions of the Government Code §2001.051 and §2001.052 and §148.5 of this title (relating to Notice of Hearing).

(h) After informal disposition of a contested case by default, a charged party may file a written motion to set aside the default order and reopen the record. A motion by the charged party to set aside the default order and reopen the record shall be granted by the commissioner if the charged party establishes that the failure to file a written response or to attend the hearing was neither intentional nor the result of conscious indifference, and that such failure was due to a mistake or accident. A motion to set aside the default order and reopen the record shall be filed by the charged party with the division's chief clerk of proceedings prior to the time that the order of the commissioner becomes final pursuant to the applicable provisions of Government Code, Chapter 2001, Subchapter F.

(i) A motion to set aside the default order and reopen the record is not a motion for rehearing and is not to be considered a substitute for a motion for rehearing. A motion for rehearing is required in order to exhaust administrative remedies. The filing of a motion to set aside the default order and reopen the record has no effect on either the statutory time periods for the filing of a motion for rehearing or on the time period for ruling on a motion for rehearing, as provided in applicable provisions of the Government Code, Chapter 2001, Subchapter F.

Source Note: The provisions of this §180.8 adopted to be effective July 29, 1991, 16 TexReg 3941; amended to be effective December 4, 1995, 20 TexReg 9717; amended to be effective September 14, 2003, 28 TexReg 7711; amended to be effective January 9, 2011, 35 TexReg 11873; amended to be effective February 14, 2012, 37 TexReg 691; amended to be effective January 16, 2019, 44 TexReg 264; amended to be effective January 12, 2020, 45 TexReg 359

RULE §180.9 Proposals for Decision

(a) If a hearing was conducted in conjunction with Labor Code §§407.046, 408.023, 415.0215, or 415.034, or in another case under the Act that is not subject to Labor Code §402.073(b), the commissioner shall review the proposed decision of the administrative law judge. If the commissioner modifies, amends, or changes a recommended finding of fact or conclusion of law, or order of the administrative law judge, the commissioner's final order shall state the legal basis and the specific reasons for the change.

(b) The division shall notify the person by issuing an order that describes the effects of the sanction. This order shall be delivered by verifiable means with a copy to the appropriate licensing or certification authority.

(c) Failure to comply with the sanction may result in additional administrative violations.

Source Note: The provisions of this §180.9 adopted to be effective February 14, 2012, 37 TexReg 691

RULE §180.10 Ex Parte Emergency Cease and Desist Orders

(a) The commissioner ex parte may issue an emergency cease and desist order upon application by division staff if:
(1) the commissioner believes a person regulated by the division under Labor Code, Title 5 is engaging in conduct violating a law, rule or order; and
(2) the commissioner believes that the alleged conduct under paragraph (1) of this subsection will result in harm to the health, safety, or welfare of another person.

(b) The order must contain the following information:
(1) the name and last known address of the person against whom the order is entered;
(2) the alleged conduct that the commissioner believes the person regulated by the division under Labor Code, Title 5 is engaging in that is a violation of a law, rule, or order and that the commissioner believes will result in harm to the health, safety, or welfare of another person;
(3) a statement that the person is to immediately cease and desist from the acts, methods, or practices stated in the order;
(4) the rights of the person against whom the order is entered with regard to requesting a hearing to contest the order. (This statement must include a reference to the specific statute, rule, or order found to have been violated, a statement of the legal authority and jurisdiction under which the order is issued, specific reference to the time limit for requesting a hearing to contest the order, and reference to the statute or statutes in which the time limit is contained. This statement must include the fact that the burden of requesting the hearing is on the person against whom the order was entered);
(5) a statement that the order is final on the 31st day after the date the affected person receives the order unless the affected person requests a hearing; and
(6) a statement regarding the actions that may be taken or sanctions that may be imposed against the person against whom the order was entered in the event of violation of the order.

(c) A request for a hearing to contest the order must be requested not later than the 30th day after the date the affected person receives the order and must:
(1) be in writing;
(2) be directed to the commissioner and filed with the division's chief clerk of proceedings; and
(3) state the grounds for the request to set aside or modify the order.

(d) On receiving a request for a hearing the division shall serve notice of the time and place of the hearing at the State Office of Administrative Hearings (SOAH). The hearing shall be held not later than the 10th day after the date the commissioner receives the request for a hearing unless the parties mutually agree to a later hearing date. At the hearing, the person requesting the hearing is entitled to show cause why the order should not be affirmed and the burden of proof is on the division to show why the order should be affirmed.

(e) Agreements to hold the hearing at a later date must be in writing. The person who is adversely affected by the issuance of the ex parte emergency cease and desist order and who desires a hearing regarding such order must file any such agreement with the division's chief clerk of proceedings before the expiration of the 10th day after the date the request for hearing is received.

(f) Following receipt of the proposal for decision from SOAH regarding the hearing the commissioner shall review the proposed decision of the administrative law judge and wholly or partly affirm, modify, or set aside the order. If the commissioner modifies, amends, or changes a recommended finding of fact or conclusion of law, or order of the administrative law judge, the commissioner's final order shall state the legal basis and the specific reasons for the change.

(g) Pending a hearing, the order continues in effect unless the order is stayed by the commissioner.

(h) If the person against whom the order was entered submits a motion for stay of the ex parte emergency cease and desist order, the motion may be granted by the commissioner before the date of the show cause hearing. If the parties agree to a later show cause hearing date pursuant to subsection (d) of this section, the motion for stay may be granted by the commissioner before the date of the show cause hearing upon written motion by any party to the hearing. If the motion for stay is granted, notice shall be sent to the requesting party that the order has been stayed in whole or in part and what part of the order continues to be in effect. If the motion is not granted before the

date of the show cause hearing the motion is denied and notice is not required of the denial.

Source Note: The provisions of this §180.10 adopted to be effective February 14, 2012, 37 TexReg 691

RULE §180.19 Incentives

(a) The purpose of this section is to develop incentives and emphasize performance-based oversight to regulatory outcomes. Regulatory outcomes are assessed for the following key regulatory goals:
(1) provide timely and accurate income and medical benefits;
(2) increase timely and accurate communications among system participants;
(3) encourage safe and timely return of injured employees to productive roles;
(4) promote safe and healthy workplaces;
(5) ensure each injured employee shall have access to prompt, high-quality, cost-effective medical care; and
(6) limit disputes to those appropriate and necessary.

(b) At least once every biennium, the Division shall assess the performance of insurance carriers and health care providers based on the key regulatory goals stated in subsection (a)(1) - (6) of this section.

(c) Insurance carriers and health care providers who are assessed will be placed into one of the following regulatory tiers based upon their level of compliance with the Labor Code and related rules and their performance in meeting the key regulatory goals in §180.19(a) relative to the performance of all other assessed insurance carriers and health care providers:
(1) high performers;
(2) average performers; or
(3) poor performers.

(d) Incentives will be based on the regulatory tier into which the insurance carrier or health care provider was placed after being assessed on the key regulatory goals.

(e) In granting incentives, the Commissioner may also consider any other factors that the Commissioner finds relevant which leads to overall compliance or which may adversely impact the workers' compensation system.

(f) Incentives for insurance carriers and health care providers placed into the high performer regulatory tier are:
(1) public recognition, and
(2) use of that designation as a marketing tool.

(g) Other incentives for insurance carriers and health care providers placed into a regulatory tier may include:
(1) limited audit exemption for insurance carriers and health care providers placed in the average and high performers regulatory tiers, while reserving the Division's discretion to audit an average or high performer if deemed necessary;
(2) penalties which may be lower than normally assessed for insurance carriers and health care providers who have been placed in the high performer regulatory tier;
(3) penalties which may be reduced for insurance carriers and health care providers in any regulatory tier who self-disclose non-compliance;
(4) flexibility for audits and inspections based on performance and placement in any regulatory tier; and
(5) any other incentive the Commissioner may deem appropriate.

Source Note: The provisions of this §180.19 adopted to be effective January 16, 2008, 33 TexReg 428

SUBCHAPTER B MEDICAL BENEFIT REGULATION

RULE §180.22 Health Care Provider Roles and Responsibilities

(a) Health care providers as defined in subsections (c) - (e) of this section shall provide all health care reasonably required by the nature of the injury as and when needed to:
(1) cure or relieve the effects naturally resulting from the compensable injury;
(2) promote recovery; or
(3) enhance the ability of the injured employee to return to or retain employment.

(b) In addition to the general requirements of this section, health care providers shall timely and appropriately comply with all applicable requirements under the Act and department and division rules, including, but not limited to:
(1) reporting required information;
(2) disclosing financial interests;
(3) impartially evaluating an injured employee's condition;
(4) correctly billing for health care provided;
(5) examine an injured employee to determine a date of maximum medical improvement and design impairment ratings as and when appropriate; and

(6) complying with all applicable provisions of the Americans with Disabilities Act.

(c) The treating doctor is the doctor primarily responsible for the efficient management of health care and for coordinating the health care for an injured employee's compensable injury. The treating doctor shall:

(1) except in the case of an emergency, approve or recommend all health care reasonably required that is to be rendered to the injured employee including, but not limited to, treatment or evaluation provided through referrals to consulting and referral doctors or other health care providers, as defined in this section;

(2) maintain efficient utilization of health care;

(3) communicate with the injured employee, injured employee's representative, if any, employer, and insurance carrier about the injured employee's ability to work or any work restrictions on the injured employee;

(4) make available, upon request, in the form and manner prescribed by the division:

(A) work release data;

(B) cost and utilization data; and/or

(C) patient satisfaction data, including comorbidity, patient outcomes, return-to-work outcomes, functional health outcomes, and recovery expectations; and

(5) examine an injured employee to determine a date of maximum medical improvement and assign impairment ratings when appropriate.

(d) The consulting doctor is a doctor who examines an injured employee or the injured employee's medical record in response to a request from the treating doctor, the designated doctor, or the division. The consulting doctor shall:

(1) perform unbiased evaluations of the injured employee as directed by the requestor including, but not limited to, evaluations of:

(A) the accuracy of the diagnosis and appropriateness of the treatment of the injured employee;

(B) the injured employee's work status, ability to work, and work restrictions;

(C) the injured employee's medical condition; and

(D) other similar issues;

(2) submit a narrative report to the treating doctor, the injured employee, the injured employee's representative (if any), the insurance carrier, and the division (if the requestor was the division);

(3) not make referrals without the approval of the treating doctor and when such approval is obtained, ensure that the health care provider to whom the consulting doctor is making an approved referral knows the identity and contact information of the treating doctor;

(4) initiate or provide treatment only if the treating doctor approves or recommends the treatment; and

(5) become a referral doctor if the doctor begins to prescribe or provide health care to an injured employee.

(e) The referral doctor is a doctor who examines and treats an injured employee in response to a request from the treating doctor. The referral doctor shall:
(1) supplement the treating doctor's care;
(2) timely report the injured employee's status to the treating doctor and the insurance carrier as required by applicable division rules; and
(3) not make referrals without the approval of the treating doctor and when such approval is obtained, ensure that the health care provider to whom the referral doctor is making an approved referral knows the identity and contact information of the treating doctor.

(f) The Required Medical Examination (RME) doctor is a doctor who examines the injured employee's medical condition in response to a request from the insurance carrier or the division pursuant to Labor Code §§408.004, 408.0041, or 408.151. The RME doctor shall:
(1) perform unbiased evaluations of the injured employee as directed by the RME notice issued by the division;
(2) not make referrals without the approval of the treating doctor and when such approval is obtained, ensure that the health care provider to whom the RME doctor is making an approved referral knows the identity and contact information of the treating doctor;
(3) initiate or provide treatment only if the treating doctor approves or recommends the treatment; and
(4) not evaluate, except following an examination by a designated doctor:
(A) the impairment caused by the injured employee's compensable injury;
(B) the attainment of maximum medical improvement;
(C) the extent of the injured employee's compensable injury;
(D) whether the injured employee's disability is a direct result of the work related injury;
(E) the ability of the injured employee to return to work; or
(F) issues similar to those described by subparagraphs (A) - (E) of this paragraph; and
(5) be a doctor licensed to practice medicine in Texas that holds the appropriate credentials as defined in §180.1 of this title (relating to Definitions);
(A) a dentist that performs dental services under the Act may review dental services that may lawfully be performed within the scope of the dentist's license to practice dentistry; or

(B) a chiropractor that performs chiropractic services under the Act may review chiropractic services that may lawfully be performed within the scope of the chiropractor's license to engage in the practice of chiropractic.

(g) A peer reviewer is a health care provider who performs an administrative review at the insurance carrier's request without a physical examination of the injured employee. The peer reviewer must not have any known conflicts of interest with the injured employee or the health care provider who has proposed or rendered any health care being reviewed.

(1) A peer reviewer who performs a prospective, concurrent, or retrospective review of the medical necessity or reasonableness of health care services (utilization review) is subject to the applicable provisions of the Labor Code; Insurance Code, Chapters 1305 and 4201; and department and division rules. A peer reviewer who performs utilization review must:

(A) be certified or registered as a utilization review agent (URA) by the department or be employed by or under contract with a certified or registered URA to perform utilization review;

(B) hold the appropriate professional license issued by this state; and

(C) hold the appropriate credentials as defined in §180.1 of this title.

(2) A peer reviewer who performs a review for any issue other than medical necessity, such as compensability or an injured employee's ability to return to work, must:

(A) hold the appropriate professional license issued by this state; and

(B) hold the appropriate credentials as defined in §180.1 of this title.

(h) The designated doctor is a doctor assigned by the division to recommend a resolution of a dispute as to the medical condition of an injured employee. At the request of an insurance carrier or an injured employee, or on the commissioner's own order, the commissioner may order a medical examination by a designated doctor in accordance with Labor Code §408.0041 and §408.1225. The credentials, qualifications, and responsibilities of a designated doctor are governed by §180.21 of this title (relating to Division Designated Doctor List), §180.1 of this title that defines "appropriate credentials", applicable provisions of the Act, and other rules providing for use of a designated doctor.

(i) A member of the MQRP is a health care provider chosen by the division's Medical Advisor under Labor Code §413.0512. All eligibilities, terms, responsibilities, and prohibitions shall be prescribed by contract, and the MQRP members shall serve on the MQRP as prescribed by contract. A health care provider must meet the performance standards specified in the contract to be eligible for selection by the Medical Advisor to serve on the MQRP. A member of the medical quality review panel, other than a

chiropractor or dentist, who reviews a specific workers' compensation case is subject to Labor Code §408.0043. Doctors seeking membership on the MQRP must hold appropriate credentials as defined in §180.1 of this title. A chiropractor who serves on the MQRP and that reviews a chiropractic service under the Act must be licensed to engage in the practice of chiropractic pursuant to Labor Code §408.0045. A health care provider that serves on the MQRP may only review health care services or treatment that may lawfully be performed within the scope of the health care provider's license.

(j) Independent review organizations (IROs) must comply with the applicable provisions of Insurance Code, Chapter 4201; Labor Code, Title 5; and Chapters 12, 133 and 180 of this title (relating to Independent Review Organizations; General Medical Provisions; and Monitoring and Enforcement, respectively). The division or the department may initiate appropriate proceedings under applicable provisions of the Insurance Code, Chapter 4201; Labor Code, Title 5; and Chapters 12, 133 and 180 of this title.

Source Note: The provisions of this §180.22 adopted to be effective March 14, 2002, 27 TexReg 1817; amended to be effective August 16, 2006, 31 TexReg 6370; amended to be effective January 9, 2011, 35 TexReg 11873

RULE §180.23 Division Required Training for Doctors

(a) Applicability. This section governs authorization relating to certification of maximum medical improvement (MMI), determination of permanent impairment, and assignment of impairment ratings in the event that a doctor finds permanent impairment exists.

(b) Authorization. Full authorization to assign an impairment rating and certify MMI in an instance where the injured employee is found to have permanent impairment requires a doctor to obtain division certification by completing the division-prescribed impairment rating training and passing the test or meeting the training and testing requirements for designated doctor certification under §127.100 of this title (relating to Designated Doctor Certification). To remain certified, a doctor is required to complete follow-up training at least every two years.

(c) Training. A doctor who has not completed the required training under subsection (b) of this section but who has had similar training in the American Medical Association Guides from a division-approved vendor within the prior two years may submit the syllabus and training materials from that course to the division for review. If the division determines that the training is substantially the same as the division-required training and the doctor passes the division-required test, the doctor is fully authorized under this section. The ability to substitute training only applies to the initial training requirement.

(d) Exceptions. Notwithstanding any other provision of this section, a doctor who has not successfully completed training and testing required by this section for authorization to assign impairment ratings and certify MMI when there is permanent impairment may receive permission by exception to do so from the division on a specific case-by-case basis.

Source Note: The provisions of this §180.23 adopted to be effective March 14, 2002, 27 TexReg 1817; amended to be effective June 5, 2003, 28 TexReg 4294; amended to be effective September 1, 2012, 37 TexReg 5476; amended to be effective April 30, 2023, 48 TexReg 2133

RULE §180.24 Financial Disclosure

(a) Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise.
(1) Compensation arrangement--Any arrangement involving any remuneration between a health care practitioner (or a member of a health care practitioner's immediate family) and a health care provider.
(2) Financial interest means:
(A) an interest of a health care practitioner, including an interest of the health care provider who employs the health care practitioner, or an interest of an immediate family member of the health care practitioner, which constitutes a direct or indirect ownership or investment interest in a health care provider; or
(B) a direct or indirect compensation arrangement between the health care practitioner, the health care provider who employs the referring health care practitioner, or an immediate family member of the health care practitioner and a health care provider.
(3) Immediate family member--Immediate family member or member of a doctor's immediate family means husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

(b) Submission of Financial Disclosure Information to the division.
(1) If a health care practitioner refers an injured employee to another health care provider in which the health care practitioner, or the health care provider that employs the health care practitioner, has a financial interest, the health care practitioner shall file

a disclosure with the division within 30 days of the date the first referral is made unless the disclosure was previously made. This annual disclosure shall be filed for each health care provider to whom an injured employee is referred and shall include the information in paragraph (2) of this subsection.

(2) The health care practitioner's disclosures in paragraph (1) of this subsection shall at a minimum include:

(A) the disclosing health care practitioner's name, business address, federal tax identification number, professional license number, and any other unique identification number;

(B) the name(s), business address(es), federal tax identification number(s), professional license number(s), and any other unique identification number of the health care provider(s) in which the disclosing health care practitioner has a financial interest as defined in subsection (a)(2) of this section; and

(C) the nature of the financial interest including, but not limited to, percentage of ownership, type of ownership (e.g., direct or indirect, equity, mortgage), type of compensation arrangement (e.g., salary, contractual arrangement, stock as part of a salary payment) and the entity with the ownership (disclosing health care practitioner, the health care provider who employs the health care practitioner, or an immediate family member of the health care practitioner).

(c) Failure to disclose. In addition to any sanctions provided by the Act and rules, failure to disclose a financial interest by a health care provider is an administrative violation and is subject to a penalty of forfeiture of the right to reimbursement for any services rendered on the claim during the period of noncompliance, regardless of whether the circumstances of the services themselves were subject to disclosure, and regardless of whether the services were medically necessary.

(1) Limitations on billing. A health care practitioner who rendered services on a claim during a period in which the practitioner was out of compliance with the disclosure requirements under this section for that claim, regardless of whether the circumstances of the services themselves were subject to disclosure, shall not present or cause to be presented a claim or bill to any individual, third party payer, or other entity for those services (regardless of whether the services were medically necessary).

(2) Refunds. If a health care practitioner collects any amounts that were billed for services on a claim provided during a period in which the practitioner was in noncompliance with the disclosure requirements of this section for that claim, regardless of whether the circumstances of the services themselves were subject to disclosure, the practitioner shall be liable to the individual or entity for, and shall timely refund, any amounts collected (regardless of whether the services were medically necessary).

(3) Rebuttable Presumption. A referral for services to a health care provider by a health care practitioner under circumstances which required a disclosure under this section, but

which was not timely disclosed as required, creates a rebuttable presumption that the services were not medically necessary unless one of the statutory and regulatory exceptions that apply to referrals in Title 42, United States Code §1395nn(b)-(e) applies to the referral in question. Whenever one of these exceptions is revised and effective, the revised exception shall be effective for referrals made on or after the effective date of the revision.

Source Note: The provisions of this §180.24 adopted to be effective March 14, 2002, 27 TexReg 1817; amended to be effective January 9, 2011, 35 TexReg 11873

RULE §180.25 Improper Inducements, Influence and Threats

(a) Pursuant to Labor Code §415.0036, offering, paying, soliciting, or receiving an improper inducement relating to the delivery of benefits to an injured employee is prohibited. Improper attempts to influence the delivery of benefits to an injured employee, including the making of improper threats. This section applies to all system participants in the workers' compensation system who have authority under Labor Code, Title 5 to request the performance of a service affecting the delivery of benefits to an injured employee or who actually performs such a service, including peer reviews, performance of designated doctor examinations, performance of required medical examinations, or case management.

(b) The following specific acts will be deemed to be an improper inducement, attempt to influence or threat:
(1) Soliciting or receiving any remuneration (including, but not limited to, any kickback, bribe, or rebate) in return for referring an injured employee to a person (either the person soliciting or receiving the inducement or another person):
(A) for the furnishing or arranging for the furnishing of any item, treatment, or service constituting a medical benefit for which payment may be made in whole or in part under Labor Code, Title 5 or rules; or
(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, treatment or item constituting a medical benefit for which payment may be made in whole or in part under Labor Code, Title 5 or rules.
(2) Offering or paying any remuneration (including, but not limited to, any kickback, bribe, or rebate) in return for referring an injured employee to a person (either the person offering or paying the inducement or another person):

(A) for the furnishing or arranging for the furnishing of any item, treatment or service constituting a medical benefit for which payment may be made in whole or in part under the Labor Code, Title 5 or rules; or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, treatment, or item constituting a medical benefit for which payment may be made in whole or in part under Labor Code, Title 5 or rules.

(3) Providing any financial incentive or promising or threatening to provide injured employee evaluation reports or other medical opinions that could enhance or reduce the injured employee's income benefits or affect the injured employee's work release status as an inducement to have the injured employee treat with or be evaluated by the health care provider or comply with the health care provider's proposed treatment.

(4) Offering or soliciting an inducement in return for selecting a particular health care provider for the furnishing or arranging for the furnishing of any item, treatment, or service (including purchasing or leasing) for which payment may be made in whole or in part under Labor Code, Title 5 or rules; or offering or soliciting an inducement which may reasonably tend to cause a particular health care provider to be selected (excluding a convenience necessary to allow for the provision of health care, such as transportation to and from the health care provider's facility, translator services related to evaluation and treatment, providing claim filing forms or information on rights and responsibilities under the Labor Code, Title 5 and rules, if generally available to all patients). Such inducement is improper whether offered directly or indirectly, overtly or covertly, in cash or in kind.

(5) Making, presenting, filing, or threatening to make, present, or file any frivolous claim or assertion against a system participant, medical peer reviewer, or any other person performing duties arising under Labor Code, Title 5 or rules, with the division or any licensing, certifying, regulatory, or investigatory body.

(6) Making or causing to be made a threat against life, safety, or property directed to a system participant related to their performance of duties arising under Labor Code, Title 5 or rules.

(c) The exceptions that apply to subsection (b)(1) and (2) of this section are those that apply to analogous provisions in Title 42, United States Code §1320a-7b(3). The exceptions shall apply to subsection (b)(1) and (2) of this section.

(d) A violation of applicable federal standards that prohibit the payment or acceptance of payment in exchange for health care referrals relating to fraud, abuse, and antikickbacks is an administrative violation.

Source Note: The provisions of this §180.25 adopted to be effective March 14, 2002, 27 TexReg 1817; amended to be effective January 9, 2011, 35 TexReg 11873

RULE §180.26 Criteria for Imposing, Recommending and Determining Sanctions; Other Remedies

(a) The division may impose sanctions on any system participant if that system participant commits an administrative violation.

(b) The division may impose the following sanctions against a doctor or insurance carrier for any reason listed in Labor Code §408.0231(c) or any other criteria the commissioner considers relevant.

(c) In addition to a penalty or the other sanctions that may be imposed in accordance with other applicable provisions of the Act, the division may also impose the following sanctions pursuant to Labor Code §415.023(b) against an insurance carrier or its representative, a health care provider, or a representative of an injured employee or legal beneficiary if any of those parties commit an administrative violation as a matter of practice, meaning a repeated violation of the Act or a rule, order, or decision of the commissioner:
(1) a reduction or denial of fees;
(2) public or private reprimand by the commissioner;
(3) suspension from practice before the division;
(4) restriction, suspension, or revocation of the right to receive reimbursement under the Act; and
(5) referral and petition to the appropriate licensing authority for appropriate disciplinary action, including the restriction, suspension, or revocation of the person's license.

(d) In addition to, or in lieu of, the sanctions in subsections (b) and (c) of this section, the division may impose any other sanction or remedy allowed under the Act or division rules, including but not limited to assessing an administrative penalty of up to $25,000 per violation against a person who commits an administrative violation.

(e) When determining which sanction to impose against a system participant and the severity of that sanction, the division shall consider the factors listed in Labor Code §415.021(c) and other matters that justice may require, including but not limited to:
(1) Performance Based Oversight (PBO) assessment;
(2) the promptness and earnestness of actions to prevent future violations;
(3) self-report of the violation;
(4) the size of the company or practice;
(5) the effect of a sanction on the availability of health care; and

(6) evidence of heightened awareness of the legal duty to comply with the Act and division rules.

(f) When determining which sanction to impose against a system participant and the severity of that sanction in claims where the insurance carrier provided notice under Labor Code §409.021(a-3), (Notice of Continuing Investigation), the division shall consider the factors listed in Labor Code §415.021(c-2).

(g) In an investigation where both an administrative violation and a criminal prosecution are possible, the division may, at its discretion, postpone action on the administrative violation until the related criminal prosecution is completed.

(h) As an alternative to imposing a sanction such as an administrative penalty on a charged system participant, the division may, at its discretion, provide formal notice of the violation through a Warning Letter. A Warning Letter shall:

(1) include a summary of the duty that the division believes that the charged system participant failed to fulfill or timely fulfill;

(2) identify the facts that establish that a violation occurred; and

(3) inform the charged system participant that subsequent noncompliance of the same sort may be deemed to be a repeated administrative violation or matter of practice, any of which will be subject to sanction.

(i) The division may enter into a consent order with the system participant if the division and the system participant have communicated regarding:

(1) the relevant statute or rule violated;

(2) the facts establishing that the administrative violation occurred; and

(3) the appropriateness of the proposed sanction, including how the division considered the factors under Labor Code §415.021(c) and (c-2) and subsection (e) of this section in determining the proposed sanction.

(j) A consent order may be entered into before or after issuance of an NOV under §180.8 of this title (relating to Notices of Violation; Notices of Hearing; Default Judgments). Consent orders must include:

(1) a description of which factors under Labor Code §415.021(c) and (c-2) and subsection (e) of this section the division considered aggravating or mitigating when determining the proposed sanctions; and

(2) a statement that the system participant acknowledges:

(A) the division and the system participant communicated regarding the information listed in subsection (h)(1)-(3) of this section; and

(B) the division considered the factors under Labor Code §415.021(c) and (c-2) and subsection (e) of this section.

Source Note: The provisions of this §180.26 adopted to be effective January 9, 2011, 35 TexReg 11873; amended to be effective January 16, 2019, 44 TexReg 264; amended to be effective January 12, 2020, 45 TexReg 359

RULE §180.27 Restoration

(a) In accordance with Labor Code §408.0231(d)(2) a doctor, other than a doctor to which Labor Code §408.023(r) applies, may apply for the restoration of a doctor privilege removed under Labor Code §408.0231 by sending a letter of consideration to the Medical Advisor.
(b) The request shall be evaluated by the Medical Advisor and /or members of the Medical Quality Review Panel. The requestor shall be liable for the cost of the review, which may include an audit of the records of the requestor.
(1) If, in the Medical Advisor's opinion, the doctor:
(A) has all the appropriate unrestricted licenses/certifications;
(B) has overcome the conditions that resulted in the sanction;
(C) meets all the division's qualification standards and conditions for restoration of some or all of the practice privileges removed; and
(D) is not out of compliance with the Labor Code, Insurance Code, a department rule, or a rule, order, or decision of the commissioner the Medical Advisor may recommend that the commissioner lift the sanction(s) or restore some or all of the privileges removed or restricted by the sanction(s).
(2) If in the Medical Advisor's opinion, the doctor has not met all the requirements for restoration of privileges, the Medical Advisor shall notify the doctor by verifiable means of the intent to recommend to the commissioner that the sanctions not be lifted or that the privileges removed or restricted by the sanction(s) not be restored in whole or in part and the reasons for that recommendation. Within 15 days after receiving the notice, a doctor may file a response that addresses the reasons given in the recommendation to deny lifting the sanction(s) or restoration of some or all of the privileges removed or restricted by the sanction(s). The Medical Advisor shall review the response and make a final recommendation to the commissioner. A copy of the requestor's response to the division shall be provided to the commissioner for consideration.

(c) The commissioner shall consider the matter and shall notify the requestor of the final decision by verifiable means, and may send a copy to the appropriate licensing or certification authority. If the commissioner does not lift the sanction, the commissioner may include in the final decision the conditions that the doctor must meet before the division will reconsider lifting the sanctions including, but not limited to, the amount of

time that the doctor must wait prior to re-requesting lifting the sanction(s) or restoration of some or all of the privileges removed or restricted by the sanction(s).

RULE §180.28 Peer Review Requirements, Reporting, and Sanctions

(a) A peer reviewer's report, including a report used to deny preauthorization, shall document the objective medical findings and evidence-based medicine that supports the opinion and include:
(1) the peer reviewer's name and professional Texas license number;
(2) certification that the peer reviewer holds the appropriate credentials as defined in §180.1 of this title (relating to Definitions);
(3) a summary of the reviewer's qualifications;
(4) a list of all medical records and other documents reviewed by the peer reviewer, including dates of those documents;
(5) a summary of the clinical history; and
(6) an analysis and explanation for the peer review recommendation, including the findings and conclusions used to support the recommendations.

(b) The insurance carrier shall not request subsequent peer reviews regarding the medical necessity of health care for dates of services for which a peer review report has already been issued unless:
(1) the review is for a different health care service requiring review by a different peer review specialty;
(2) the insurance carrier needs clarification of the peer review opinion based on new medical evidence that has not been presented to the peer reviewer;
(3) the peer reviewer failed to fully address the questions submitted by the insurance carrier; or
(4) for purposes other than determining medical necessity of the health care.

(c) 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 injured employee's representative, if any, when the insurance carrier uses the report to deny the compensability or extent of the compensable injury or reduce or deny income or medical benefits of an injured employee.

(d) A peer reviewer and insurance carrier shall maintain accurate records to reflect information regarding requests, reports, and results for peer reviews. The insurance carrier and peer reviewer shall submit such information at the request of the division in the form and manner proscribed by the division. The division will monitor peer review

use, activity, and decisions which may result in the initiation of a medical quality review or other division action.

(e) The commissioner may impose sanctions on health care providers performing peer reviews pursuant to §180.26 and §180.27 of this title (relating to Criteria for Imposing, Recommending and Determining Sanctions; Other Remedies; and Sanctions Process/Appeals/Restoration, respectively) and other applicable provisions of the Labor Code and division rules. The commissioner may prohibit a doctor from conducting peer reviews for any of the following:

(1) non-compliance with the provisions of §180.22 of this title (relating to Health Care Provider Roles and Responsibilities), this section, or applicable provisions of the Act, or a rule, order, or decision of the commissioner;

(2) failure to consider all records provided for review;

(3) a history of improper or unjustified decisions regarding the medical necessity of health care reviewed;

(4) failure to hold the appropriate professional license issued by this state;

(5) review of health care without holding the appropriate credentials, as defined in §180.1 of this title, in a health care specialty appropriate to the type of health care reviewed; or

(6) any other violation of the Labor Code or division rules.

(f) In accordance with Labor Code §408.0046, an entity requesting a peer review must obtain and provide to the doctor providing peer review services all relevant and updated medical records.

Source Note: The provisions of this §180.28 adopted to be effective August 16, 2006, 31 TexReg 6370; amended to be effective January 9, 2011, 35 TexReg 11873

RULE §180.50 Severability

Where any provisions of this chapter are determined by a court of competent jurisdiction to be inconsistent with any statutes of this state, or to be unconstitutional, the remaining provisions of this chapter shall remain in effect.

Source Note: The provisions of this §180.50 adopted to be effective January 9, 2011, 35 TexReg 11873

SUBCHAPTER C MEDICAL QUALITY REVIEW PANEL

RULE §180.60 Definitions

The following terms, when used in this subchapter, shall have the following meanings:

(1) Doctor--As defined by Labor Code §401.011(17), a doctor of medicine, osteopathic medicine, optometry, dentistry, podiatry, or chiropractic who is licensed and authorized to practice.

(2) Medical Case Review--A review of a particular case by a Medical Quality Review Panel (MQRP) member regarding professional medical services, delivery of health care, or the quality of a health care practitioner's opinion, recommendation or report. Medical case review includes but it is not limited to review of a treating doctor, peer review doctor, designated doctor, another health care practitioner, an independent review organization, an insurance carrier, or a utilization review agent.

Source Note: The provisions of this §180.60 adopted to be effective January 1, 2013, 37 TexReg 8839

RULE §180.62 Medical Quality Review Panel

(a) Purpose. The purpose of the Medical Quality Review Panel (MQRP) is to assist the medical advisor in the performance of the medical advisor's duties under Labor Code §413.0511 in accordance with the provisions of Labor Code §§413.0512, 413.05121, and 413.05122.

(b) Experts. Members of the MQRP who prepare reports for medical case review will be known as MQRP Experts.

(c) Composition. Applicants may be selected and appointed to the MQRP at the discretion of the medical advisor and the commissioner of workers' compensation (commissioner) in accordance with this section. The MQRP must be composed of health care practitioners appointed by the medical advisor and the commissioner in accordance with this section.

(1) The MQRP must have at least 25 members.

(2) The MQRP must, at a minimum, have members in the following health care specialty fields:

(A) Orthopedic Surgery--A medical doctor (MD) or a doctor of osteopathy (DO) with board certification in orthopedic surgery.

(B) Neurosurgery--An MD or DO with board certification in neurological surgery.

(C) Chiropractic--A licensed doctor of chiropractic.

(D) Occupational Medicine--An MD or DO with board certification in occupational medicine.

(E) Pain Medicine--An MD or DO with a board certification in a subspecialty of anesthesiology, neurology, or physical medicine.

(3) The MQRP may have members that include other types of health care practitioners determined to be necessary by the medical advisor and the commissioner.

(d) Eligibility. To be eligible to serve on the MQRP, a health care practitioner must meet the following criteria, as applicable:

(1) Possess an unrestricted license to practice in Texas with the appropriate credentials, as defined by §180.1 of this title (relating to Definitions);

(2) Be board-certified in a specialty or subspecialty. An MD or DO is board-certified in a specialty or subspecialty if the MD or DO holds:

(A) a general certificate in the specialty or a subspecialty certificate from one of the member boards of the American Board of Medical Specialties (ABMS); or

(B) a primary certificate in the specialty and:

(i) a certificate of special qualifications from the American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS); or

(ii) a certificate of added qualifications in the subspecialty from the AOABOS.

(3) Be in active practice in Texas. "Active practice" means, within either of the last two calendar years, at the time of appointment to the MQRP, the applicant has:

(A) actively diagnosed or treated persons at least 20 hours per week for 40 weeks duration during a given calendar year; or

(B) performed administrative, leadership, or advisory roles in the practice of medicine.

(4) The medical advisor and the commissioner may waive the requirements of paragraphs (2) and (3) of this subsection if needed to adequately perform medical case review.

(e) Term; Resignation; Removal.

(1) MQRP members will be appointed for a maximum term of 10 years. They will serve until the expiration of their term, until their resignation, or until their removal from the MQRP. The division will review MQRP members periodically during their term to ensure their continued eligibility.

(2) An MQRP member may submit a new application for membership in the MQRP after the term expires.

(3) An MQRP member may resign from the MQRP at any time.

(4) An MQRP member may be removed from the MQRP for cause at any time. The notice of removal will state the date of removal, which may be immediately after the member receives the notice or on a specified future date. Causes for removal include, but are not limited to:

(A) Failure to maintain eligibility under this subchapter.
(B) Failure to timely inform the division of conflicts of interest.
(C) Repeated failure to timely review medical case review assignments or timely submit reports to the division.
(D) Repeated failure to prepare the reports in the prescribed format.
(E) Other issues deemed sufficient by the medical advisor or commissioner.

(f) Prohibition. An MQRP member must not use his or her position to influence an insurance carrier, agent, or other person or entity in connection with a personal or other insurance-related matter beyond referring to their position to demonstrate qualifications.
(g) Quality Assurance Panel.
(1) The medical advisor will establish the Quality Assurance Panel (QAP) within the MQRP. All members of the QAP are members of the MQRP. They perform all the duties of an MQRP member under Labor Code §413.0512, as well as the duties of a QAP member under Labor Code §413.05121.
(2) A member of the QAP will also be known as an Arbiter.
(3) QAP members may provide any services to the medical advisor provided by Labor Code §§413.0512, 413.05121, and 413.05122, including, but not limited to:
(A) Serving as the chair to the quality assurance committee.
(B) Serving as expert witnesses in enforcement actions as appropriate.
(C) Providing an additional level of medical expertise and quality assurance to assist the medical advisor in the medical advisor's duties under Labor Code §413.0511.
(D) Performing medical case review if no other MQRP member is available in a specific area of expertise. In this case, the Arbiter would be ineligible from participating in the informal settlement process for the subject the Arbiter reviewed.

Source Note: The provisions of this §180.62 adopted to be effective January 1, 2013, 37 TexReg 8839; amended to be effective October 6, 2022, 47 TexReg 6436

RULE §180.64 MQRP Application Process

(a) To apply to the MQRP, a person must submit an application in the form and manner required by the division demonstrating compliance with the required qualifications. The application must contain complete information as provided by subsection (b) of this section. The medical advisor and the Commissioner may select and appoint only qualified applicants to the division's MQRP but are not required to accept all applicants who meet the requirements specified in this subchapter.

(b) The division's required application form for the MQRP, at a minimum, shall include:

(1) contact information for the health care practitioner;
(2) information about the health care practitioner's education;
(3) a description of the health care practitioner's license(s), certifications, and professional specialty, if any;
(4) a description of the health care practitioner's work history and hospital or other health care practitioner affiliations;
(5) a description of any affiliations the health care practitioner has with a workers' compensation health care network certified under Chapter 1305 of the Insurance Code or a political subdivision as described in Labor Code §504.053(b)(2);
(6) identification of and a description of all current and past medical review affiliations, including but not limited to an independent review organization (IRO), utilization review agent (URA), licensing board, and insurance carrier;
(7) information regarding the health care practitioner's current practice locations;
(8) disclosure regarding the health care practitioner's professional background, education, training, and fitness to perform the duties of an MQRP member, including disclosure of any disciplinary actions or other sanctions taken against the health care practitioner by any state licensing board, state or federal agency, and hospital or other health care institution, as well as disclosure of any voluntary relinquishments, drug and alcohol misuse, malpractice claims history and criminal history;
(9) a description of all ownership interests or other financial arrangements, such as salaried or contract employment, involving a person or their agent subject to the Act or a rule, order, or decision of the commissioner;
(10) an authorization for third parties to release information relevant to the verification of the information provided on the application to the division;
(11) an affirmation that all information provided in the application is accurate and complete to the best of the health care practitioner's knowledge; and
(12) an affirmation of understanding of the legal requirements, including confidentiality provisions, for MQRP members.

(c) A credentialing application for hospital credentialing may substitute for some items under subsection (b) of this section.

(d) The health care practitioner must inform the medical advisor of any changes to this information within 30 days after the change.

(e) The application shall be reviewed by the medical advisor.

(f) The medical advisor and the commissioner have the discretion to select, appoint and remove an applicant to the MQRP.

(g) Membership in the MQRP is for a term of 10 years. The acceptance letter will include the effective date and expiration date.

(h) Membership in the MQRP is not a guarantee of any number of assignments.

(i) MQRP members shall be entitled to compensation for work assigned by the medical advisor at the following hourly rates:
(1) Doctors - Medical case reviews, ad hoc work groups, or special projects: $150 per hour.
(2) Non-Doctors - Medical case reviews, ad hoc work groups or special projects: $100 per hour.
(3) Limits on hours. A member shall not be paid for more than:
(A) five hours for a medical case review of a single case;
(B) five hours for ad hoc work group or special project service; or
(C) 20 hours in a given calendar month.
(4) The medical advisor may approve additional hours in writing upon review of a submitted narrative report or a report of an ad hoc work group.
(5) Hearings or trial preparation.
(A) Doctors - Payment for time spent in hearing or in trial preparation, in providing testimony in deposition, hearing or trial: $350 per hour.
(B) Non-doctors - Payment for time spent in hearing or in trial preparation, in providing testimony in deposition, hearing or trial: $175 per hour.
(C) An MQRP member shall not be paid for more than eight hours per day for a deposition, a hearing, trial preparation or court testimony. If travel is required, the division will pay the member for travel, lodging and per diem expenses in accordance with the Texas State Travel Management Program, 34 TAC §20.301 et seq.
(6) The division may vary the above reimbursement provisions if deemed by the division to be in the best interests of the division or the State of Texas.

(j) In accordance with Labor Code §§402.083 - 402.086, 402.091, 402.092, and 413.0513, an MQRP member may not disclose confidential information, including a report or other documentation prepared by the MQRP member for the division.

(k) All reports and related documents, including electronic and non-electronic data, prepared by or furnished to the member for the MQRP, are the sole property of the division.

Source Note: The provisions of this §180.64 adopted to be effective January 1, 2013, 37 TexReg 8839; amended to be effective August 22, 2023, 48 TexReg 4484

RULE §180.66 Medical Case Review

The MQRP may perform medical case review for the medical advisor. Medical case review may be performed for the purposes of the medical quality review process, designated doctor certification and recertification, performance based oversight, or any other medical case review necessary to assist the medical advisor in performing the medical advisor's duties under the Labor Code.

Source Note: The provisions of this §180.66 adopted to be effective January 1, 2013, 37 TexReg 8839

RULE §180.68 Medical Quality Review Process

(a) The medical quality review process is medical case review initiated on the basis of complaints, plan-based audits, or monitoring as a result of a consent order and performed in accordance with criteria adopted under Labor Code §413.05115. The medical quality review process does not include medical case review performed for the purpose of:

(1) certification and renewal of designated doctors;
(2) performance-based oversight;
(3) administrative violations that do not require an expert medical opinion; or
(4) complaints about professionalism that do not require an expert medical opinion.

(b) A complaint must be documented in accordance with the provisions of §180.2 of this title (relating to Filing a Complaint).

(c) Nothing in this subchapter prevents referrals of complaints to another licensing or law enforcement authority.

Source Note: The provisions of this §180.68 adopted to be effective January 1, 2013, 37 TexReg 8839; amended to be effective August 22, 2023, 48 TexReg 4484

RULE §180.70 MQRP Training

An MQRP member must receive training by the division prior to any assignments and at least every two years thereafter on the following topics:

(1) The requirements of this subchapter concerning the medical quality review process under §180.68 of this title (relating to Medical Quality Review Process);
(2) The division's goals regarding the medical quality review process;
(3) Administrative violations that affect the delivery of appropriate medical care;
(4) Confidentiality requirements of Labor Code §§402.083, 402.091, 402.092 and 413.0513;
(5) Immunity from liability under Labor Code §413.054;
(6) The medical quality review criteria adopted under Labor Code §413.05115;
(7) The current division adopted edition of the American Medical Association Guides to the Evaluation of Permanent Impairment and the division's adopted treatment and return-to-work guidelines; and
(8) Other topics as determined by the medical advisor and commissioner.

Source Note: The provisions of this §180.70 adopted to be effective January 1, 2013, 37 TexReg 8839

RULE §180.72 Conflict of Interest

(a) If the selected MQRP member has a conflict of interest in a case under medical review, that member may not review the case or serve as an arbiter. If all MQRP members in a particular health care specialty field as the subject of a medical case review have conflicts of interest in a case under medical case review, and the division is unable to enter into an interagency agreement pursuant to subsection (e) of this section, then the division may refer the case to the appropriate licensing authority.

(b) A conflict of interest exists if the selected MQRP member:
(1) has a familial relationship within the third degree of affinity with any party or witness related to the case;
(2) has a relationship with the subject beyond a mere acquaintance;
(3) has ever treated the injured employee whose records are being reviewed;
(4) in regard to a particular injured employee's claim, has served as a:
(A) peer review doctor;
(B) designated doctor; or
(C) required medical examination doctor.
(5) has a financial interest in a matter as set forth in §180.24 of this title (relating to Financial Disclosure);
(6) is a medical director for an Insurance Carrier, Utilization Review Agent, or a workers' compensation health care network certified under Chapter 1305 of the Insurance Code or a political subdivision as described in Labor Code §504.053(b)(2). Medical directors

can perform all functions of the MQRP and the QAP except performing individual medical case reviews or serving as Arbiters in a informal settlement conference (ISC); or
(7) has other issues deemed to be a conflict of interest by the medical advisor.

(c) If an MQRP member selected for a medical case review has a conflict of interest, the member must notify the medical advisor of the conflict before taking any further action on the case.
(d) If the medical advisor has a conflict of interest in a case, the medical advisor must recuse himself from the case. If the medical advisor recuses himself, the commissioner will delegate the duties of the medical advisor, including enforcement decisions and recommendations, for that particular case, to an arbiter.

(e) The division may enter into agreements with other state agencies to access, as necessary, expertise in health care specialty fields as determined by the medical advisor.

Source Note: The provisions of this §180.72 adopted to be effective January 1, 2013, 37 TexReg 8839; amended to be effective August 22, 2023, 48 TexReg 4484

RULE §180.74 MQRP Notification of Case Status

The division shall notify MQRP panel members in writing at least quarterly of the status of and enforcement outcomes resulting from cases in the medical quality review process. A MQRP panel member shall comply with all confidentiality laws that apply to information provided under this section including Labor Code §§402.083 - 402.086, 402.091, 402.092 and 413.0513.

Source Note: The provisions of this §180.74 adopted to be effective January 1, 2013, 37 TexReg 8839

RULE §180.76 Rights and Responsibilities of Persons Involved in the Medical Quality Review Process

(a) The person subject to the medical quality review process has the right:
(1) to be notified that the person has been selected for the medical quality review process;
(2) to be notified of the disposition of the medical quality review process;
(3) to communicate with the office of the medical advisor at any time during the medical quality review process;
(4) to be represented by legal counsel, including legal counsel at the informal settlement conference (ISC);

(5) to receive written notice of an ISC at least 45 days before the ISC, including the time and place of the ISC and the nature of the allegations; and

(6) to an ISC in accordance with the provisions of this section. The ISC provides persons subject to the medical quality review process an opportunity to discuss and resolve their medical case review with arbiters. The division may, at its discretion, conduct an ISC remotely or in person. An ISC is available under the following conditions:

(A) The case has been referred to enforcement.

(B) The request for an ISC must be in writing.

(C) The division will notify the requester of the scheduled date of the ISC.

(D) The requester has the right to receive copies of all documents that pertain to the substance of the case and that were given to the arbiters for review for that particular case.

(E) All information the requester wishes the arbiters to consider at the ISC must be received by the division no later than 15 days before the ISC. The arbiters may refuse to consider any information not timely received by the division.

(F) The requester may request to reschedule the scheduled date of the ISC for good cause shown, in writing, as determined by the division's presiding attorney. Good cause means circumstances beyond the requester's control that reasonably prevent the requester from attending the ISC and requesting that the ISC be rescheduled any sooner.

(G) If a requester fails to attend an ISC as scheduled, the requester loses the right to an ISC. But failure to attend the ISC does not affect the requester's rights to:

(i) communicate with the office of the medical advisor as paragraph (3) of this subsection provides;

(ii) enter into a consent order with the division; or

(iii) defend an enforcement case at the State Office of Administrative Hearings.

(b) A person subject to a medical case review must:

(1) provide records and information requested from the office of the medical advisor in the format and manner specified by the division;

(2) provide the records and information within the time period specified in the request; and

(3) attach an accurate and completed business records affidavit to the request for records and information.

Source Note: The provisions of this §180.76 adopted to be effective January 1, 2013, 37 TexReg 8839; amended to be effective August 22, 2023, 48 TexReg 4484

RULE §180.78 Effective Date

This subchapter is effective on January 1, 2013. Existing members of the MQRP on that date shall continue to serve through the terms of their contracts. New terms of membership after January 1, 2013 shall be established through the process in this subchapter.

Source Note: The provisions of this §180.78 adopted to be effective January 1, 2013, 37 TexReg 8839