MEDICAL DISPUTE RESOLUTION RULES DRAW CRITICISM

The Division of Workers’ Compensation received an earful from industry stakeholders at a public hearing over its proposed medical dispute resolution rules. The Division conducted a public hearing on the rules in Austin on July 26, 2006.

Steve Tipton of our office offered public comment regarding troubling aspects of the rules. Mr. Tipton noted that several provisions in the rules would prevent carriers from raising defenses to deny or reduce medical bills in the dispute process if those defenses were not raised during initial medical review with the provider. Observing that health care providers are not similarly restricted, Mr. Tipton said “The proposed rule improperly limits dispute resolution to issues raised in the prerequisite informal mediation process.” Unfortunately, one consequence of this problem is that may be an increase, rather than decrease, of appeals going to district court.

Health care providers also offered critical comments, claiming that the proposed dispute resolution deadlines are confusing and difficult for doctors to meet. The Insurance Council of Texas argued the lack of an administrative hearing that would deprive disputing parties an opportunity to create a record including presentation of evidence and witnesses for appeals to district court. The omission of such a hearing is already the subject of a challenge in District Court in Travis County. That challenge may be resolved at the trial court level in August.

The proposed changes to agency rules are reflected in the following provisions:

- Rule 133.305 Medical Dispute Resolution - General (Repeal)
- Rule 133.305 Medical Dispute Resolution - General (New)
- Rule 133.307 Medical Dispute Resolution of a Medical Fee Dispute (Repeal)
- Rule 133.307 Medical Dispute Resolution of Fee Disputes (New)
- Rule 133.308 Medical Dispute Resolution by Independent Review Organizations (Repeal)
- Rule 133.308 Medical Dispute Resolution by Independent Review Organizations (New)

The proposed rules incorporate specific changes to the medical dispute resolution process that were made under House Bill 7. That legislation removed the statutory provision for a hearing before the State Office of Administrative Hearings when the medical dispute resolution decision is appealed by one or more of the parties. The bill also authorized pharmacy processing agents to act on behalf of pharmacies under the terms and conditions agreed on by pharmacies, established the binding effect of independent review organization decisions, and specified the elements that are required of an IRO decision.

Continued on p. 12
Flahive, Ogden & Latson, a 26 lawyer firm, defends contested workers’ compensation cases statewide every day. The firm has represented insurance companies and employers before the Texas Workers’ Compensation agency for more than 50 years. For general questions concerning the newsletter call: (512) 435-2234.

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An electronic copy of FOLIO, our monthly client newsletter, is now available for clients. If you are interested in receiving FOLIO by email, please let us know. FOLIO is prepared for the exclusive use of Flahive, Ogden & Latson clients only. It contains privileged communications and further sharing of this newsletter (in either hard copy or electronic format) outside your company without the express written consent of Flahive, Ogden & Latson is not permitted.

Our regular office hours are 8:15 a.m. to 4:45 p.m. If you need to call after 4:45, please call Patsy Shelton at (512) 435-2234. She will be on duty until 6:00 p.m. daily.

**FO&L Office Hours**

Don’t wait until the last hour of the day for deadline filing. Any faxes with information due must be received by 3:30 p.m. for any deadline handling for same day delivery to the Commission, and faxed according to the fax directory listed on the last page of FOLIO. Furthermore, if you have a last minute deadline, call our office by 3:00 p.m. and speak with Tillie Aguirre or Patsy Shelton to advise that a last minute filing is necessary to meet a deadline. We will be watching and waiting for the fax. Otherwise, last minute faxes could delay receipt. Our last daily run to the Commission will be at 4:00 p.m., in order to get across town to meet their 5:00 closing time.

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**TDI Addresses Network Certification Questions**

Texas Department of Insurance Associate Commissioner Jennifer Ahrens, recently instructed her staff to clarify two issues of concern regarding certification of health care networks for workers' compensation cases. Those issues relate to the hospital requirement in non-rural counties and the role of third party administrators (TPAs) in contracting for carriers.

The following comments reflect the Department’s position on each issue.

**Hospital Requirement in Non-Rural Counties**

It has come to the Department’s attention that some network applicants are having a difficult time contracting with hospitals in some non-rural counties. Non-rural counties are those not defined as “rural” under Texas Insurance Code 1305.004 (22). Some applicants have proposed that the Department find these non-rural counties to be in compliance with certification requirements by using hospitals in surrounding counties and adding an access plan for any portion of county that is not covered.

Although House Bill 7 prescribes mileage standards for access to care within a service area, when read in concert with the larger system goals laid out in the Labor Code regarding access to quality care, we concluded that having a large metropolitan area without network access to hospitals would not only cause employees to be diverted to other cities for hospital care, but would also cause the network specialist physicians who perform procedures requiring inpatient hospital care to be without a network facility in which to practice. Therefore, the network in these non-rural counties would not only be deficient in hospitals, but would effectively be deficient in specialty care. Thus, the deficiency is larger than just the lack of hospitals. This situation can be distinguished from a deficiency of a particular type of physician, which is the usual case when access plans are utilized.

After reviewing these proposals, re-examining the goals for the workers’ compensation system and the access requirements for networks as defined by House Bill 7 and in consultation with the Legislature and the Governor’s Office, we have determined
that the Department cannot approve a network certification in a non-rural county without a network hospital.

We at the Department understand the difficulty some applicants are experiencing in contracting with hospital providers, and hope that these applicants will discover a means to be successful in obtaining contracted hospitals. Our goal is to certify as many high-quality networks as possible that will meet the goals of the Legislature and provide accessible quality care to injured employees.

**Role of TPA**

We have reviewed the statute and rules and conferred with House Bill 7’s House and Senate authors about the question of whether TPAs can contract with certified networks on behalf of a carrier, either an insurance carrier or a certified self-insured. Because Texas Insurance Code 1305.154(a) states that a network can only provide services under a contract with a carrier, and TPAs are not identified or described in this subsection, we find no authority to permit TPAs to contract with certified networks on behalf of the carrier. If the carrier wants the TPA to manage its claims functions, there may be other contracting arrangements that can be utilized, such as management contracts or third party delegation contracts, but the network/carrier contract must be direct.

If you have questions or comments about this information, please e-mail to wcnet@tdi.state.tx.us.

The Department’s statements on these two issues are not currently the subject of any rule making efforts. However, these positions appear to have been given significant thought and we anticipate that Ms. Ahrens’ staff statement will be enforced as Department policy in future cases.

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**MEDICAL CASE MANAGEMENT RULES STALL**

The Division has yet to propose rules supporting new requirements for medical case management under the Workers’ Compensation Act. As a result, case management remains one area in which little guidance has been given the industry by the agency.

When the Legislature abolished the TWCC, created the DWC, and revamped the worker’s compensation law last year, it contemplated major improvement in the areas of return to work and medical cost containment. One way to facilitate an injured worker’s return to work (prospectively, not retroactively). Carriers that use unbundled business will be expected to obtain the call data from their TPAs. Carriers that use peer review companies should be able to secure the information for the call from their peer review companies.

This Data Call will affect insurance carrier and third party administrator operations. The data is going to be used in conjunction with the development of new peer review rules. It is not being developed in preparation for any currently planned audit. Of course, the Division may see something in the call that causes them to consider enforcement activities, but that is not the purpose of the call.

Commissioner Albert Betts has stated that the Division will publish the identity of those insurance carriers cooperating with the Division in furnishing information responsive to the Data Call. The Division will also publish the identity of those insurance carriers who do not cooperate with the Data Call. Those insurance carriers who do not cooperate with the Data Call should expect increased scrutiny of their claims operations as a result of any lack of cooperation.

The Data Call will consist of an Excel Spread Sheet with data elements to be completed by the insurance carriers. Insurance carriers may furnish their data to the Division by filing CD ROMs.

In a related issue, the Division is preparing to suspend the quarterly preauthorization data call in lieu of the annual data call that is directed to Utilization Review Agents.

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**PEER REVIEW DATA CALL ANNOUNCED**

The Division of Workers’ Compensation has issued a “Data Call” on the use by insurance carriers and third party administrators of peer reviews. The call will solicit 60 to 90 days of data (prospectively, not retroactively). Carriers that use unbundled business will be expected to obtain the call data from their TPAs. Carriers that use peer review companies should be able to secure the information for the call from their peer review companies.

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is the use of case managers. In fact, this aspect of claims management is so important that it is mandatory in some provisions. For example, § 413.021 of the Texas Labor Code mandates that insurance carriers “shall, with the agreement of a participating employer, provide the employer with return to work coordination services as necessary to ease employees’ return to work.”

To do this, a workers’ compensation carrier must evaluate every compensable injury that could result in lost time as early as practical to determine if skilled case management is necessary to address return to work issues. Case managers who are appropriately licensed to practice in this state must be used to perform these evaluations. A claims adjuster may not be used as a case manager per § 413.021.

What is case management, then? The Worker’s Compensation Act now defines this term. Section 411.011(5-a) states that “case management” is “a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual’s health needs through communication and application of available resources to promote quality, cost-effective outcomes.” The point of this, then, is to achieve a return to health for the injured worker. Certified case managers will also be used within the network. (See Folio, May 2006, page 4.) It would appear, then, that based on the definition, case management is to be used to deal with health needs. But based on the statutory provisions, case management is also geared toward the return to work of injured workers.

Unfortunately, we still await the adoption of rules to implement the statutes discussing case management to clarify exactly what it is. In the May 2006 issue of the TDI DWC’s Workers’ Comp Update, an article regarding disability management noted the following:

Case management is a component of disability management. The Division will consider rules related to case management when other priority rules have been adopted.

There are, however, new Chapter 137 rules related to Disability Management that became effective on February 22, 2006. They specifically discuss the small employer return-to-work pilot program. While there is not a specific mention of case management, it is evident that a case manager would be key in facilitating the injured worker’s return to work. A case manager will likely be seen as a liaison among the carrier, the health care provider, and the injured worker.

There are at least 15 separate sections within the Act that reference case management, so we do anticipate new rules discussing case management. Not all of these provisions are new; there is simply more emphasis on this now. Those provisions are summarized below.

Texas Labor Code:

§ 402.021(a) notes that the basic goals of workers’ compensation in this state include “each injured employee shall receive services to facilitate the employee’s return to employment as soon as it is considered safe and appropriate by the employee’s health care provider.”

§ 401.021(b) to implement goals, must encourage safe and timely return to work.

§ 402.075 provides incentives to carriers by recognizing high performing organizations.

§ 404.101 requires the OIEC to monitor the performance and operation of the system, with focus on return to work.

§ 405.0025 provides for research and evaluation group to study and evaluate, among other things, return-to-work outcomes.

§ 409.005(j) notes that upon request, an employer must provide information regarding return to work opportunities and assist the carrier in assessing modified duty and return-to-work options.

§ 413.021(a) states that a carrier must offer return-to-work coordination services.

§ 413.021(b) states that return-to-work coordination services may include (among other items) medical or vocational case management to coordinate the efforts of the employer, treating doctor and the injured employee to achieve timely return to work.

§ 1305.103(f) notes that the treating doctor shall participate in medical case management as required by the network, including return to work planning.
§ 413.021(e) and (f) requires the DWC to collect data on return-to-work outcomes and include it in the Report Card.
§ 413.022 creates a RTW pilot program for small employers. (This is the provision implemented in Rules 137.42-137.48.)
§§ 413.023 and 413.024 provides that assistance and information regarding return-to-work option, access to high-quality medical care, etc. to be provided to employers and employees

Texas Insurance Code:
§ 1305.303(a) indicates that the Quality Improvement Program must include return to work and medical case management programs.
§ 1305.303(j) notes that the healthcare network shall have a medical case management program with certified case managers. Case managers shall work with treating doctors, referral providers, and employers to facilitate cost-effective care and employee return to work.
§ 1305.502 notes that a consumer report card will include information on return to work and medical outcomes.

Of course, Flahive, Ogden and Latson will update you with the new rules implementing these provisions that reference case management. Hopefully, these rules will give carriers the necessary information to determine the necessity and depth of case management that is required under the Act.

**WORKERS’ COMPENSATION WORKING GROUP (WCWG)**
**JULY 12, 2006,**
**MEETING NOTES**

Audrey Selden reviewed the antitrust statement and members introduced themselves.

Update on networks: Jennifer Ahrens announced there are now three WC networks, TDI certified Memorial Hermann, a network primarily for Harris County, at the end of June. Additional networks will likely be certified by the end of July. No applications have been withdrawn. She reported that the weekly conference calls with network applicants and interested parties, as well as conference calls with individual applicants, are working well. TDI’s HWCN staff are also developing a newsletter about WC networks. Please continue to send suggestions about how to improve the network process to Jennifer at jennifer.ahrens@tdi.state.tx.us or Margaret Lazaretti at margaret.lazaretti@tdi.state.tx.us. Jennifer reviewed the WC networks complaint summary: 17 have been received and 11 are closed. “Accessibility/availability” indicates that the complaints involved incomplete directories provided via websites, not access to care issues. HWCN staff is also revising the report to make it more informative for WCWG.

Regarding outreach efforts, Audrey announced that a special web resource page for injured employees is available at http://www.tdi.state.tx.us/consumer/wcnetie.html. The page includes a “virtual workshop” on WC networks and links to OIEC’s web page and the Rights and Responsibilities for Injured Employees; TDI is having the Rights and Responsibilities translated into Chinese, Korean, and Vietnamese. Next TDI will develop a web resource page for providers. All suggestions for the page are welcome; please send ideas to wcwg@tdi.state.tx.us. When the page is “live,” TDI will partner with TMA to distribute the web link to providers. Members reviewed the list of outreach events. Audrey noted that audiences are very receptive and there continues to be a need for information about WC networks and other changes resulting from HB 7. Please continue to invite TDI to events.

Lindsay Johnson asked, could the resource pages include information about how an employee or a provider determines whether the employee or patient is in a WC network? As required by HB 7, when employers choose to be in a WC network they are required to notify employees about the new WC network. If an employee is in a WC network, then the employee should have received such a notice. If an employee is not sure, the employee should contact the company’s HR department. TDI will verify this is explained clearly on the web resource pages.

Continued on p. 8
Q: The employee was in the breakroom and drank what he thought was a glass of tea. When he drank it, he noted that it tasted awful. He later found out that there was cleaner in the container that he drank from. Is this an injury in the course and scope of employment? Clearly, the injured worker was not furthering the affairs of the employer, but would it fall under the personal comfort and convenience doctrine?

A: An injury in the course and scope of employment requires proof of two elements. First, the injury occurred in the furtherance of the employer's work, and second, the injury arose out of the claimant's employment. The personal comfort and convenience doctrine satisfies the first element, but does not satisfy the second one. Thus, the question is whether the injury (assuming that there is an injury because there is nothing in your question to suggest that he suffered damage or harm to the physical structure of his body), was from an activity that arose from his employment. If the employee did sustain an injury, then it is likely a compensable injury because the cleaner was on the employer's premises which posed a risk to the claimant.

Q: The injured worker was taken off work on June 14, 2006 and given a return to work light duty on June 28, 2006. Prior to June 14, 2006, the injured worker had no lost time. Is the injured worker owed temporary income benefits for the waiting period?

A: When the waiting period was changed in House Bill 7 which became effective on September 1, 2005, the statutory language did not change except for the previous phrase of four weeks was changed to two weeks. The statute states that if disability continues for two weeks or longer after the date it begins, then the waiting period is payable. The key words are “continue” and “after.” Thus, the rule is that the waiting period is not due until the 15th day of disability. In this case, the injured worker had disability from June 14 through June 27, 2006 which is 14 days of disability. The injured worker did not have disability on the 15th day since she was returned to work modified duty beginning June 28, 2006. The waiting period would not be owed under these facts.

Q: The employee was injured on January 21, 2006. On January 23, 2006, he sought treatment at a regional clinic which is his regular family doctor. The clinic does not accept workers’ compensation claims but chose to treat the injured worker anyway. The clinic indicated that if the injured worker needed follow up care, they would direct him to another facility which did accept workers’ compensation patients. Carrier denied the bill on the basis that the doctor was not on the Approved Doctors List. Carrier received a request for reconsideration where the clinic quoted Section 408.023(f) and Rule 180.1(11) stating that they are entitled to reimbursement because the treatment provided to the injured worker qualifies as immediate care after the date of injury. Does the carrier owe for this treatment?

A: Section 408.023(f) provides that each doctor who provides health care services must be on the Approved Doctors List except for emergencies or immediate post-injury medical care. Rule 180.1(11) defines immediate post-injury medical care as healthcare provided on the date that the employee first seeks medical attention for the work-related injury. Rule 18.20(h)(1) further provides that all licensed doctors, whether on the Approved Doctors List or not, are entitled to reimbursement in accordance with the statute and rules for providing reasonable and necessary emergency or immediate post-injury medical care. Thus, as long as the claimant did not receive medical care elsewhere, (i.e. at a hospital, after the injury and before the visit to the regional clinic), then that office visit will be considered immediate post-injury medical care and the carrier is liable for that treatment.

Q: The employee suffered a compensable injury. The employer did not notify the injured worker that he had to seek treatment from a doctor on the Approved Doctors List. The injured employee treated with the VA Hospital who then took the injured employee
off of work. Since a non-Approved Doctors List doctor provided an off work slip, does Carrier have to pay temporary income benefits based upon that off work slip?

A: Whether or not the off work slip comes from a “workers’ compensation doctor” is not really relevant to the question of whether the compensable injury prevented the claimant from working. An off work slip from any doctor is some evidence of disability. In fact, a claimant can prove disability without a doctor’s off work slip through his own assertion that his symptoms or injury prevented him from performing some or all of his usual work-related duties. Therefore, you need to consider the facts of the case in connection with the off work slip to determine whether or not you have any reasonable basis to argue that the claimant does not have disability.

Q: The employer is informing the carrier that they have an employee who suffered an injury on June 1, 2005, who may not have a legal United States status. The person at the employer who performed the hiring did not get a copy of the employee’s greencard. The employee’s application noted that he had a greencard, but the employer never obtained a copy of it. If the employee does not have a legal status within the United States, would Carrier be liable for compensation benefits?

A: An injured worker’s legal or illegal status is not a basis upon which a Texas workers’ compensation claim may be denied. The definition of employee includes those who do not have proper documentation. It is generally understood that the legislature did not want employers who knowingly hired illegal workers to avoid liability for workers’ compensation benefits. There are a few exceptions where an injured workers’ illegal status may impact eligibility for benefits. For example, there may be some cases where the carrier can argue that an injured worker is not entitled to temporary income benefits or supplemental income benefits because it is the illegal status of the injured worker that is preventing him from returning to work, not the compensable injury.

Q: Carrier has disputed the claim in its entirety. Carrier recently received the first TWCC-69 certifying the injured worker as reaching maximum medical improvement with an impairment rating. Should the carrier take any steps with regard to the TWCC-69 and narrative report in order to begin the 90-day Rule since this claim has been denied in its entirety?

A: We recommend that the carrier respond to this and other similar issues as though there were no pending compensability dispute. If the compensability dispute is later lost or there is an agreement that the injured worker suffered an injury, then the carrier may have defenses that it can later assert should the claim become compensable.

Q: The injured worker lives and works out of Texas. He suffers a work-related injury while in Oklahoma. Can the claimant choose under which jurisdiction he would like to receive benefits?

A: We do not handle workers’ compensation benefits in Oklahoma and cannot make any comment on whether the injured worker is entitled to benefits under Oklahoma law. If the injured worker does pursue a claim under Oklahoma law, the carrier still needs to make sure to timely file a dispute, if one exists before the Texas Division of Workers’ Compensation in order to ensure that the carrier does not waive any disputes should the claimant later decide to pursue benefits under Texas law. If the claimant elects to receive Oklahoma benefits, Carrier may have an argument under Section 406.075 of the Texas Labor Code that the claimant is barred from recovering Texas benefits. Keep in mind, however, as long as the claimant does not pursue his claim to a final decision in Oklahoma, the injured worker is allowed to change his mind and switch his claim over to Texas without being barred pursuant to Section 406.075. Nonetheless, it is recommended that the Section 406.075 defense be listed among any of the defenses you identify in your dispute.

In order to receive benefits under Texas law, the claimant will have to prove that the Division of Workers’ Compensation has extra territorial jurisdiction over the claim. To prove extra territorial jurisdiction under Section 406.071 of
the Texas Labor Code, the claimant must prove that the injury would be compensable had the injury occurred in Texas and the claimant has significant contacts with Texas or the employer was principally located in Texas. Note that this requires that the claimant prove significant contacts or that the employment was principally located in Texas. To establish contacts with Texas, the employee must be hired or recruited in Texas and must have worked in Texas for 10 days in the proceeding 12 months. Whether an injured worker is hired or recruited in Texas is a factual determination that analyzes the claimant’s contacts with the employer during the hiring and recruitment process. Many of the Appeals Panel decisions addressing extra territorial jurisdiction find a sufficient connection with Texas where the injured worker’s residence is located in Texas and the injured worker was contacted by the employer about employment while located at his Texas residence and the injury was within one year from the date of hire. Keep in mind, however, that this is a factual determination.

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**WCWG Meeting Notes – continued from p. 5**

Regarding a situation in which an organization implied that it was “working with TDI” on education/outreach efforts, Commissioner Albert Betts said that TDI is not aware of any organizations doing this; however, please let TDI know if an organization is charging money for such activities. He added that though TDI’s efforts are successful in getting the word out, TDI still needs to do more, especially regarding provider education. Members can help by inviting TDI to exhibit at events or provide a speaker for a meeting.

Open discussion: Commissioner Betts asked the members about their expectations for the WC system and for TDI, and how they feel the implementation of HB 7 reforms is going. Members’ comments are summarized below.

-- Creg Parks commended TDI, he sees movement and that TDI is getting things done. He would like to see more action regarding access to care and more doctors taking WC patients. He asked if non-network injured employees may access a network physician if they cannot find another doctor. Regarding the suggestion to designate an ombudsman for providers, Jennifer suggested that we use the weekly conference call model and host a separate call for providers. Also TDI can facilitate communication between providers and carriers. Providers may send specific questions to wcwg@tdi.state.tx.us and TDI will add the answers to the providers FAQs web page. Providers who are not currently on the DWC providers e-mail list may wish to join; please contact Chuck Whitacre at chuck.whitacre@tdi.state.tx.us.

-- Regarding issues reported to TMA, Michael Reed said that providers want injured employees to have access to the best care possible. He added that, at the same time, physicians are having to negotiate WC network contracts with the carriers, and the carriers are not offering good rates. Another issue is that administrative burdens remain high for providers to submit WC claims. A recent survey showed that it cost a provider on average about $20 to prepare a paper WC claim, much higher than the $2-$3 cost of a typical electronic health care claim. Also providers often must file a WC claim multiple times. Pam Beachley explained that the paperwork comes from the WC compensability issue and a carrier’s responsibility to verify every claim is related to WC (injury on the job), not group health (pre-existing condition). Jaylene Fayhee noted that the proposed treatment guidelines will help. Creg Parks added that electronic access to an injured worker’s medical record would also help. Commissioner Betts noted the e-billing rule has a 2008 effective date, and that the treatment guidelines will be adopted in early August 2006.

-- Creg Parks said the biggest problem providers have is that their WC claims are “lost” and there is no one designated at the carrier or at DWC who the provider can call for help.

-- Rick Levy observed there is a definite change in the atmosphere. His biggest fear/disappointment is with the WC networks - he feels there is no real doctor choice and the WC networks do not look like group health. If the injured worker goes to the “wrong” doctor and has to pay, then there will be problems. Jennifer explained that TDI is seriously looking into access to care issues. At the same time, WC networks will not always look like group health networks, particularly because the population
served by the WC networks is much smaller than that served by group health networks. TDI has to balance the need to get physicians into WC and the requirement to get WC networks off the ground. She added that some WC network applications remain pending because their proposed networks are not adequate.

-- Michael Reed stated that in-network WC patients are being balance billed now, by providers who are not in the certified WC networks. Such occurrences should be reported as a complaint immediately to Margaret Lazaretti, please send an e-mail to margaret.lazaretti@tdi.state.tx.us. Under no circumstances should a WC patient who is not in a network be balance billed.

-- Lindsay Johnson observed that WC networks will never look like group health because of the indemnity concern. He would like to see more emphasis on return-to-work outcomes.

Commissioner Betts introduced Stan Strickland, the new DWC Deputy Commissioner for Legal & Compliance. Stan is the former Chief of the Financial section of TDI Legal & Compliance, and brings more than 12 years of TDI experience to his new job. Stan will oversee rule development as well as violation referrals.

WC rule updates:

-- Peer review rule and data call: Allen McDonald said the designated doctor/required medical exam/peer review rules will be adopted by the end of July 2006. DWC is working with the WCWG sub-group to finalize the data elements for the peer review data call. It will be in the form of an Excel spreadsheet sent to the carriers who will get the data from their TPAs, if applicable. DWC will request two or three months of data starting with August 2006. Carriers may wish to contact their TPAs to begin preparations now. Allen said that the pre-authorization data call will be suspended, and this will be announced soon. Commissioner Betts said that if a carrier refuses to provide the peer review data he will contact the carrier, and an enforcement action will follow if necessary.

-- Hospital fee guidelines: Allen explained that the hospital fee guidelines are based on Medicare. He urged members to take time to understand Medicare - it is based on prospective payment followed by adjustments and reconciliation, and is complex. DWC will modify the Medicare model to make it work for WC.

-- HB 251: Patricia Gilbert explained the proposed rule will govern the release of data to carriers that will allow them to settle subrogated claims. DWC will receive data from carriers, match it to WC claim information, and return it to the carriers. The proposed rule is on a fast track and will likely be adopted in September/October 2006. The rule includes a notice requirement to injured employees, as well as a fraud check.

Status report on performance-based oversight: Teresa Carney reviewed the discussion paper provided to the WCWG (see copy attached). The scope of this sub-group has been expanded to include placement of carriers and providers into tiers, and incentives. Bonnie Bruce urged WCWG members to participate in this sub-group; meetings are scheduled every Wednesday morning from 9 a.m. to noon in the Tippy Foster room at Metro. Teresa will arrange for members to participate via conference call. Audrey suggested members adopt the “three-deep” concept and send an alternate to represent them at the meetings. Also, members will continue to review and discuss the draft PBO concept paper at future WCWG meetings. Members are welcome to submit their written comments and suggestions for PBO to wcwg@tdi.state.tx.us. In particular, Teresa asked the members to consider the following questions and send responses to TDI.

1. Does Section 402.075 of the Texas Labor Code envision three simple tiers for all participants, or something more complex?
2. Should the placement of system participants into a tier be done relative to a performance standard, relative to each other (bell curve), or via a combination of these?
   * What should the performance standards be?
   * If the bell curve is used, what percentage of participants should be on each tier?
   * If the entire curve of participants falls well below any reasonable standard of acceptable performance, is it really appropriate to call any of them high performers?
* If a high percentage of participants have performance above 95%, or some other pre-determined number, is it appropriate to call any of them average or poor performers?

3. Should participants with a data volume in the review period that is insufficient for statistical analysis be placed in the Average Tier? Placed into a Default Tier? Not be tiered at all? Performance assessed and placed into sub-tiers?

4. Should participants be able to appeal their placement in a tier, and if so, how do you envision the appeals process would work?

5. Should each new performance assessment and tier placement be done without regard for the previous one (i.e., “clean slate”)?

6. For participants with a data volume in the review period that is sufficient for statistical analysis, is it necessary to distinguish between larger volume participants and smaller volume participants if everyone’s performance is expressed as a percentage? (Example: A carrier processes medical bills timely X% of the time, where the numerator is the number of timely processed bills in the review period and the denominator is the total number of bills received in the review period.)

7. How should a participant’s performance assessments relative to multiple KRGs be combined to achieve a final tier placement?

Should individual KRGs or Measures be weighted, and if so, how?

At the July 19 meeting, the sub-group will focus on the remaining two key regulatory goals:
- Ensure each injured employee shall have access to prompt, high-quality, cost-effective medical care and
- Limit disputes to those appropriate and necessary.

TDI has set up a special PBO sub-group conference call dial-in number with passcode. The PBO sub-group meetings are on Wednesdays and begin at 9 a.m. Central Daylight Time. To participate in the sub-group meetings via conference call, please follow the instructions below.

1. Dial in: 1-888-391-2102
2. Enter the passcode: 9063381#

Review WCWG topics list: Members discussed the topics suggested at prior meetings; please see list below - those in bold indicate priority topics.
- Access to care
- Complaint trends
- Conversion of legacy claims to network
- Credentialing
- Criteria TDI uses to look at access issues
- Disability management model and its components: treatment guidelines, treatment planning, the role of the designated doctor, and return to work
- Employee acknowledgment forms - challenges and best practices
- How a physician determines if a patient is in or out of a network
- Independent review organization (IRO) guidelines
- Leased and “ghost” networks and “silent” PPOs
- Physician credentialing
- Preauthorization
- Referral procedures - does the network control where the physician refers a patient?
- Report card content and development process
- Reports from other working groups about related topics
- Survey of physicians
- Updates on rules
- Utilization review agent/IRO process - overview

Additional topics to indicate as priorities include return-to-work guidelines, balance billing of WC patients, and the disability management model. Members also would like a report on the results of the peer review data call. In addition, members suggested that TDI alert the certified WC networks to the fact that interested persons are checking the “doctor lookup” features on their web pages, and the lookup lists should be complete and up to date.
The Division has adopted Rule 126.14 to address the provision added by the Legislature in 2005 allowing a carrier to request an examination from the treating doctor to define the compensable injury. This rule was published in the July 7, 2006, edition of the Texas Register and became effective on July 10, 2006. It is posted on the Division’s web site. As the statutory provision (Section 408.0042 of the Labor Code) has been effective since September 1, 2005, for all practical purposes the procedure outlined in the rule is already effective.

Rule 126.14 was first proposed on February 3, 2006. This firm and other interested parties raised several objections to the rule as proposed. As a result of those comments, the rule has been materially modified. These changes will make it more likely a carrier would invoke the procedure, and therefore, satisfy legislative intent.

Labor Code Section 408.0042 creates an entirely voluntary process. The Act has several apparent purposes:

1. to define the scope of the nature of the compensable injury so as to avoid situations, even years later, where the claimant asserts that certain injuries have been present since the beginning but were ignored;

2. to allow diagnostic testing (at the carrier’s expense) to obtain an early concrete diagnosis and ensure that proper medical treatment is provided;

3. to allow carriers the opportunity to know the nature of the claimant injury so as to set appropriate reserves;

4. to ensure the provider receives payment for services rendered for injuries during the pending dispute of those injuries (much like the provisions contained in Section 409.021 that the carrier is liable for accrued benefits until the liability dispute is filed);

5. to allow a claimant and providers the opportunity to pursue dispute resolution of disputed conditions early in the claim.

Note that this process is not designed to resolve extent of injury disputes. Extent issues will still be resolved through the designated doctor, PRME and dispute resolution processes. The result of invoking this rule in the interim is to provide for payment for accepted treatment and require preauthorization for all treatment for unaccepted conditions or body parts.

To this end, the carrier is liable for accrued medical benefits during the period of “acceptance” of the extent issues as determined by the treating doctor. The legislature did not include a waiver provision with a deadline for dispute. Rather, it simply provides that the carrier is liable for medical treatment for the condition until such time that it subsequently disputes the extent. The section provides that the carrier is only liable for medical benefits and not indemnity benefits for the conditions.

The rule as originally proposed, however, created a permanent waiver provision. That is, if the carrier “accepted” a condition, then the carrier was forever liable for the condition. This proposal generated substantial opposition to the rule.

In response, the Division removed all references to waiver and expressly states in the preamble to the adopted rule that “[n]either §408.0042 nor this section creates a waiver.” The rule as adopted stresses that it cannot be used to “diminish” an injury previously found compensable through the true waiver provision of Section 409.021 of the Labor Code, but does not otherwise create waiver.

Two provisions of the adopted rule support the assertion that while a carrier is liable for medical treatment during its period of “acceptance,” it need not remain liable upon the filing of a later dispute. The first of these is subsection (n), which provides: “Once the treating doctor has defined the compensable injury and the insurance carrier has accepted injuries or diagnoses as related, the insurance carrier shall not review treatment of the accepted injuries and diagnoses for compensability.” The focus of this provision is on “treatment” not the injuries or diagnoses itself. In other words, during the period of acceptance, the treatment may not be denied on the basis that the injury or diagnosis is not compensable. That the carrier may subsequently dispute the compensability of the injury or diagnosis (while remaining liable for incurred treatment) seems to be guaranteed.
by subsection (j)(2), which provides that “[t]he 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 prior to filing a denial as required by §124.2 of this title.” As there is no time limit on the filing of an extent of injury dispute under Rule 124.2 (although the dispute should be filed within the time to audit and pay the bill), it appears that a carrier may subsequently deny the injuries or diagnoses previously accepted. However, the carrier would remain liable for medical treatment incurred prior to its denial. Subsection (l) provides that the denial is effective on the date it is received by the doctor.

We cannot guarantee the Appeals Panel will interpret the preamble and rule in the same manner. Until such time the Division or the Appeals Panel clearly states that a carrier's “acceptance” of a condition is not permanent, and is subject to subsequent dispute, we cannot wholeheartedly endorse a carrier's use of this provision. Upon such a declaration, however, this procedure may offer a powerful tool in the management of claims.

The Rule as adopted explains the procedure for requesting the examination and the carrier’s obligations upon receiving the treating doctor’s report. The carrier must individually “accept” or “deny” the injuries or diagnoses. For those accepted, the carrier is liable for medical treatment during the period of acceptance. For those denied, the doctor must receive preauthorization for each service to treat the condition. The carrier, as outlined in the recent amendments to Rule 134.600, may deny preauthorization on the basis of compensability until such time that the injury is ultimately determined compensable through the dispute resolution process.

Because of the continued uncertainty of the ultimate application of this rule to waivers of extent of injury, FOLIO gives a qualified endorsement of the rule as adopted. Perhaps our separate recommendation of filing a PLN 11 within 60 days in every case will solve or diminish the problems sought to be solved by this rule. (See “AP Decisions Re: Waiver of Extent of Injury” in the upcoming June 2006 FOLIO). Carrier’s that choose to invoke this treating doctor exam process should do so with a full understanding that any “acceptance” of injuries or diagnoses following the examination may be determined to be permanent without the ability to revisit the issue. Therefore, upon receipt of the report, a carrier should carefully scrutinize it (with perhaps assistance from a peer reviewer, RME or designated doctor) before simply accepting injuries or diagnoses.

Before invoking this process, we invite you to call us and explore further the advantages and potential disadvantages in your circumstance.

Medical Dispute Rules – continued from p. 1

The proposed rules consolidate the IRO processes of the DWC with those of the Texas Department of Insurance (TDI) and create a single process for submitting and processing workers’ compensation health care network and non-network requests for IRO review with TDI’s Health and Workers’ Compensation Network Certification and Quality Assurance Division.

Proposed Rule 133.305 outlines the general requirements of the medical dispute resolution process. Proposed Rule 133.307 establishes the new medical dispute resolution process for resolving payment disputes. Subsection (f) of Rule 133.307 provides that a medical fee dispute decision of the Division of Workers’ Compensation may be appealed by filing a petition seeking judicial review with the Travis County District Court.

Proposed Rule 133.308 establishes the new medical dispute resolution for resolving network and non-network preauthorization, concurrent, and retrospective medical necessity disputes. Subsection (r) of proposed Rule 133.308 provides that the decision of an IRO is not a decision of the DWC or TDI. This subsection provides that neither the DWC or TDI shall be considered a party to an appeal. The rule does not provide for a contested case hearing. Subsections (r) and (t) of Rule 133.308 set out the process for appealing a network and non-network medical necessity dispute resolution decision of an IRO to district court. Subsection (s) of the rule provides that an IRO decision regarding the medical necessity of a spinal surgery may be appealed by requesting a contested case hearing.

Our firm continues to monitor the development of these rules as well as the district court proceedings concerning medical dispute resolution.
(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.

Effective Date: July 10, 2006 (31 Tex. Reg.)

DIVISION OFFERS SPECIFIC GUIDANCE FOR SETTLEMENT OF CASES

Settlements are generally not permitted in Texas workers’ compensation cases. They are, however, allowed in some types of claims. Many carriers and claimants are unaware of the requirements to obtain approval of a settlement in a Texas workers’ compensation case. The Division recently published a helpful set of guidelines for securing approval of a settlement in a Texas claim.

For approval a settlement must meet the requirements of the Texas Workers’ Compensation Act and the Rules of the Division of Workers’ Compensation of the Texas Department of Insurance. For your convenience, the most important sections of the act and rules are listed below.

An unusual and significant aspect of the settlement process is that a settlement may only be approved if it “is in the best interest of the claimant”. (Section 408.005(e)(3) of the Act).

The provisions of a DWC-25 (Benefit Dispute Settlement) should:

1) State the weekly/monthly rate to be paid and the dates of the period(s) for the payments for all income benefits payable. Also, the settlement should have a provision that payment will be made in a lump sum for all accrued income benefits with interest if the payable date is past. For example: “The claimant is entitled to and will be paid supplemental income benefits at a monthly rate of $$ for the 13th, 14th and 15th quarters (6/1/06 – 2/28/07). Accrued but unpaid benefits will be paid in a lump sum with interest paid at the rate provided by the Act, Section 401.023. Unaccrued benefits will be paid as they accrue and are payable.”

2) The settlement should also have provisions that address payment for all past and future income benefits. (i.e. “all other income benefits have been paid and the claimant is not entitled to any further or future income benefits”).

3) It is important that the settlement define the compensable injury. The injury is defined based on any agreements of the parties, the MMI/IR report establishing the claimant’s IR, Section 408.0042, and any waivers under Sections 409.021 and 409.022 of the Act. In addition, the injury is defined by the exclusion of any other injuries based on the claimant’s condition as of the date of the settlement. The settlement definition of the compensable injury may not exclude an injury or diagnosis that has already been finally established as part of the compensable injury.

4) The settlement should state the date of maximum medical improvement and the
improvement rating based on a final decision or a doctor’s certification.

5) The settlement should state that the settlement is a final resolution of all issues related to liability for and entitlement to income benefits and the parties waive their right to future Division proceedings related to liability for and entitlement to income benefits.

6) It is important that any settlement state that the settlement does not limit or terminate the claimant’s right to medical benefits. The parties do not waive the right to future Division proceedings related to liability for and entitlement to medical benefits, which may include extent of injury (EOI) disputes over injuries with a specific diagnosis that arose after the date of the settlement agreement. The parties do not waive the right to future Division proceedings necessary to enforce the terms of this agreement. The parties may request a Benefit Review Conference to address EOI disputes or the enforcement of the terms of this agreement through the indemnity dispute resolution process.

7) A settlement may include a provision for payment of attorney fees; however, the parties may only agree that the claimant’s attorney will limit the fee request to a specified amount for approval the Division. Parties cannot agree to the specific amount of attorney fees that the carrier will be liable for and have to pay. That is because the Division, through a separate attorney fee request process, must approve the amount of attorney fees to be paid.

8) If there have been prior agreements on the claim, the settlement should have all prior agreements of the parties incorporated by reference and attached. Any prior oral agreements should be incorporated by reference, put in writing, and attached.

In addition to the DWC-25, the parties shall provide: A joint explanation or separate explanations from each party stating why the parties believe settlement is in the best interest of the claimant. The joint explanation or separate explanations must have supporting information that may or may not be incorporated into the settlement at the discretion of the parties. That supporting information should address:

• The total amount of income benefits that would be payable to the claimant under the terms of the settlement without adjustments for expected wages and any other deductions such as for Social Security Disability Indemnity payments.
• The claimants expected wages, if any, and the reduction, if any, of income benefits payable under the settlement based on those expected wages.
• Deductions for Social Security Disability Indemnity payments, if any, for the period of the income benefits payable under the settlement.
• Other sources of future income or financial support for the claimant.
• An agreed prospective medical treatment plan from a doctor, in accordance with §413.014(f).

We are pleased to assist you in drafting settlement agreements and in working with you and the Division in attempting to secure approval for settlement agreements that you may have negotiated with the claimant directly.

NEW EMPLOYEE “NOTICE LETTER” RAISES QUESTION

The Public Counsel for the Office of Injured Employee Counsel recently developed and published a new notice of injured employee rights and responsibilities to the Texas Department of Insurance and the Texas Department of Insurance, Division of Workers Compensation. The Texas Labor Code §404.109 requires the notice to be adopted by the Commissioner of Workers’ Compensation and Commissioner of Insurance and the distribution of the notice is to be provided by rule.

The Notice of Injured Employee Rights and Responsibilities as submitted by the Public Counsel is now approved for use. The Division is now providing the new notice to injured employees. The new notice may be found on the Division’s website at http://www.tdi.state.tx.us/wc/information/workerrights.html.

Some questions have arisen regarding the purpose of the new notice as well as how it will affect carrier’s responsibilities.

The new notice is designed to replace the notice required in DWC Rule 120.2 (c). That rule provides:
(c) The employer shall also provide the employee a summary of rights and responsibilities at the time the report required in subsection (c) of this section is filed with the insurance carrier. The text for the summary shall be in English and Spanish, or in English and any other language common to the employee. This does not preclude the employer or carrier from providing the employee with additional information but such information must be separate from and in addition to the text contained in this subsection and may not infer that the additional information is being provided or required by the Commission. The following English text and the Spanish text provided by the commission must be used without any additional words or changes.

This is the summary of rights and responsibilities that the employer is supposed to provide to the employee at the time that it prepares and files the DWC 1. The new notice is subject to Division rulemaking and that rulemaking may require carriers to provide the notice to employees and claimants at some point in the future. But, at present, there are not any rules that require the carrier to provide this notice. Only the employer is affected.

At this time, it would be prudent for Carriers to notify their policyholders of the existence of this new notice and to suggest that they go ahead and begin using it in lieu of the existing notice of rights and responsibilities.

DIVISION PUBLISHES NEW TRAVEL REIMBURSEMENT FORM

Division Rule 134.110 permits an employee to request reimbursement for travel expenses in order to obtain reasonable and necessary medical care if the treatment is not reasonably available within 30 miles of the injured employee's residence. The distance traveled to secure medical treatment must be greater than 30 miles one way and the injured employee must submit the request to the insurance carrier on a newly created form within one year of the date the injured employee incurred the expenses.

The new form, a DWC048, (Request for Travel Reimbursement) is available to injured employees on the Division's website.

Insurance carriers are instructed to make appropriate payment to the injured employee or notify the injured employee the reason for reduction or denial of the payment within 45 days of receipt of the request for reimbursement.

Injured employees can visit the Comptroller of Public Accounts website http://www.window.state.tx.us/ under “Mileage Guide” to calculate their mileage travel reimbursement, or they may contact the Division for the current rate for mileage travel reimbursement.

The Division has advised claimants to attach any receipts for food and lodging when submitted. In addition, the employee must sign and date the form and mail it to the insurance carrier. Finally, the Division advises employees to keep a copy of their submission for record purposes.

AUDITORS: TXCOMP PROJECT PERFORMING POORLY

The Department of Insurance (TDI) became responsible for the development of, and contracts related to, the automated Texas Workers’ Compensation System (TxCOMP) in September 2005. The project had been initiated six years earlier by the Texas Workers’ Compensation Commission (TWCC), but after the 79th Legislature abolished TWCC effective September 1, 2005, its functions were transferred to TDI. The original mission of TxCOMP was threefold:

1. Provide improved services to workers’ compensation customers by combining streamlined business processes with up-to-date technology.
2. Facilitate efficient and effective communication of information between all workers’ compensation system participants.
3. Capture and provide access to comprehensive, accurate, and reliable workers’ compensation information.

A recent audit by the State Auditor's Office found poor contract management, project delays, and cost increases during the initial six years of the project. As of March 2006, the project was only thirty percent (30%) complete, yet at least seventy-four percent (74%) of the funds appropriated for the project had been spent.

As a means of improving the management of the project, TDI restructured the project to allow for better accountability and decision-making. In addition, an employee with the requisite experience to be the project manager was assigned to the project. Further, a contractor was hired to assess the current status of the project and determine what is necessary to stabilize the current technical environment. A March 2006 report determined that users experienced significant downtime and unacceptable performance from TxCOMP. Stabilization was recommended before the implementation of further applications. To date, work has been completed on 398 of the 474 known defects and enhancements.

The TxCOMP contractors were selected using a fair and competitive process. However, there was not a formal process in place to monitor, manage, and execute contracts to ensure that state funds were spent appropriately. As a result, there were contract payments in excess of $150,000 for work performed by contract employees who were known to have performance problems. In addition, statistics show that only fifteen percent (15%) of contract employees who were required to submit periodic status reports actually submitted all required reports. Of the reports that were submitted, some were very detailed regarding tasks completed and tasks for the next period, and others were not. Auditors could not verify whether there was sufficient support for payments made to contractors. Some invoices did not have corresponding timesheets or could not be reconciled to the hours billed on the invoice.

TDI believes the applications that comprise TxCOMP will still be delivered by the project deadline (August 2007). This requires a change to the project’s scope significantly, and has led TDI to contract with a vendor to identify software and infrastructure modifications that will be necessary before further implementation occurs. Changes to the project’s organization have been made to increase accountability, and no less than four additional roles have been created.

The State Auditor’s Officer made several recommendations for the TDI, which agreed with said recommendations. These recommendations include a review of prior expenditures to verify they were coded correctly to reflect accurate costs for the project and tighter monitoring on the creation and execution of future contracts.

REMEMBER: DON’T DENY FUTURE MEDICAL CARE

House Bill 7 contains a specific provision that prohibits a carrier from denying all future medical care for a compensable injury. Some guidance on how to apply this legislation can be found in Question Resolution Log question 06-02. That document provides:

From QRL 06-02:

**Question:**

Section 415.002(a) of the Act states, “An insurance carrier or its representative commits an administrative violation if that person: (21) makes a statement denying ALL future medical care for a compensable injury; or…”

Please define “ALL” medical care. Does this section allow a carrier to deny medical care for a particular body part or condition without being in violation of this section of the Act?

Example: An injured worker injures his back and arm. The carrier denies additional medical care for the arm only. Is the denial of additional medical care for the arm only, not the back, considered a denial of ALL medical treatment under this section?

**Answer:**

Section 408.021 of the Act provides that an injured employee is entitled to all health care reasonably required by the nature of the injury as and when needed.

Once the carrier has accepted compensability of an injury, the carrier may not prospectively deny ALL future medical care for that injury.
The denial of ALL future medical care for any individual compensable body part or condition or the denial of ALL future medical care for all of the compensable body parts or conditions would not be in compliance with Section 415.002(a) of the Act.

PEER REVIEW PANEL APPOINTED

Texas Lt. Gov. David Dewhurst (R) and Speaker Tom Craddick, R-Midland, have released the names of Senate and House of Representatives appointees to the Joint Select Committee to Study the Medical Peer Review Process.

This panel will not be examining the peer review process in workers’ compensation settings. Immediately after the panel was announced rumors circulated that the panel would be examining the use of peer reviews in workers compensation cases. One reason this speculation occurred is because of the placement of Rep. Burt Solomons on the panel. Rep. Solomons is the author and sponsor of HB7 and he has a heavy involvement in the oversight of the development of this legislation.

The panel will examine the process used in health-care settings.

“This issue came up during discussions of Senate Bill 419 and the sunset review of the former Board of Medical Examiners,” Craddick said.

“I thought it was key to involve persons from both the House Public Health Committee which dealt with the legislation as well as the Committee on Civil Practices due to its connection to malpractice lawsuits.”

SB 419 reorganized the Board of Medical Examiners as the Texas Medical Board.

Senate appointees are Sens. Kyle Janek, R-Houston; Robert Deuell, R-Greenville, and Royce West, D-Dallas.

House appointees are Reps. Glenda Dawson, R-Pearland; Burt Solomons, R-Carrollton, and Patrick Rose, D-Dripping Springs.

Joint presiding officers of the committee will be Janek and Dawson.

“Medical peer review” is defined as the “means of evaluation of medical and health care services, including evaluation of the qualifications of and patient care by professional health care practitioners,” the announcement noted.

Evaluation includes merits of a complaint, accuracy of a diagnosis, and quality of the care.

Medical peer review occurs in hospitals, physician organizations and is required within health plans.

The committee will report its findings and recommendations to the governor, lieutenant governor and speaker no later than Jan. 1.

Its mandate expires Sept. 1, 2007

INJURED EMPLOYEE COUNSEL ASSESSES OIEC PROGRESS

Norman Darwin, Public Counsel for the Office of Injured Employee Counsel recently expressed his view of the progress that his new branch of TDI has made in implementing House Bill 7. We reprint Mr. Darwin’s comments in full below.

As we approach the close of our second quarter as a functioning agency, I am very pleased to report that we have made amazing progress. Many of our accomplishments will be discussed in greater detail at other places in this Quarterly Report, but because of the dedication and commitment of our staff, I think some special recognition is justified.

- We have hired our first three regional staff attorneys. They come to us with exceptional qualifications and are progressing quickly through our training program. These employees will provide the foundation for adding additional attorneys and give us valuable insight for future attorney training. Our ombudsmen will have legal resources that have never before been available and we eagerly anticipate enhanced performance of our ombudsmen services.

- Our Injured Employee’s Rights and Responsibilities publication has been approved and adopted and is now posted on our website. Texas Mutual

Continued on p. 26
When a claimant prevails at a CCH on the issue of contribution, the claimant has not invoked a carrier's liability for payment of attorney's fees under Section 408.147(c) and Rule 152.1(f) regarding a dispute of determination of entitlement to SIBs.

FACTS: The claimant was found to be entitled to the first quarter of supplemental income benefits (SIBs) in March 2005. This decision was not appealed. In April 2005, the carrier requested a Reduction of Income Benefits Due to Contribution (TWCC-73). The Division ordered the carrier to reduce IIBs and SIBs by 80%. The claimant requested a benefit review conference to challenge the order on contribution. The BRC was held in November 2005 and a Contested Case Hearing was held in January 2006 to determine whether the carrier was entitled to a reduction in impairment income benefits (IIBs) and supplemental income benefits (SIBs) based upon contribution from an earlier compensable injury. The hearing officer determined that the carrier was not entitled to a reduction based upon contribution. The claimant's attorney initially characterized services such that attorney fees were directly taken out the claimant's benefits. Then, the attorney's fee orders were rescinded and new orders entered wherein the claimant's attorney characterized services for the contribution BRC and CCH as involving entitlement to and amount of SIBs. As such, attorney’s fees were paid directly to the attorney. Subsequently, the hearing officer ordered attorney fees for dates of service in November 2005 (Sequence 36) and ordered attorney's fee to be paid for dates of service in January 2006 (Sequence 38).

The carrier appealed the attorney's fees ordered in Sequences 36 and 38. The carrier contended that it was improper to order the carrier, under Section 408.147(c) and Rule 152.1(f), to directly pay attorney fees to the claimant's attorney because the CCH did not address entitlement to SIBs, but instead involved the issue of contribution. The claimant objected to the jurisdiction of the Appeals Panel, on the basis that no benefit CCH had taken place to invoke review by the Appeals Panel. The claimant also contended that Section 408.147(c) applies to both the November 2005 BRC and the January 2006 CCH because by seeking contribution, the carrier was disputing both entitlement and the amount of SIBs.

HOLDING: Reversed and rendered a decision vacating the attorney’s fees orders. The Appeals Panel has jurisdiction. The attorney’s fees orders for the BRC and CCH were ordered after the CCH, and the proper way to appeal the orders was to timely appeal to the Appeals Panel. The Appeals Panel also held that the contribution dispute under Section 408.084 did not make the carrier liable for the claimant's attorney's fees, even if the claimant prevails. Under Section 408.147(c), if a carrier disputes a commissioner's determination of entitlement to SIBs or the amount of SIBs and the employee prevails, the carrier is liable for reasonable and necessary attorney’s fees incurred as a result of the dispute. Under Rule 152.1, an attorney for an employee who prevails when a carrier contests a commissioner's determination of eligibility for SIBs shall be eligible to receive attorney's fees. Section 408.084 is the authority by which a carrier may request that the commissioner take into account a documented prior impairment. When a carrier requests an order for reduction of SIBs and IIBs on the basis of contribution, the carrier is not disputing the commissioner's determination on entitlement to SIBs or the amount of SIBs. Therefore, when a claimant prevails at a CCH on the issue of contribution, the claimant has not invoked a carrier's liability for payment of attorney's fees under Section 408.147(c) or Rule 152.1(f).
Under Rule 128.1(c), nonpecuniary wages shall be included in the AWW if the employer discontinues providing nonpecuniary wages. The reason for discontinuation is irrelevant to the determination of whether or not to include the nonpecuniary wages.

FACTS: Claimant was enrolled in the self-insured employer’s health and dental insurance program before and after his compensable injury until August 2004. While he was enrolled, the self-insured paid its portion of the claimant’s premiums. In August 2004, the self-insured notified its employees that they were required to enroll with a new health insurer. Claimant was off work when notice was given and was not aware of this change. The claimant’s insurance was terminated due to his failure to resubmit enrollment. Therefore, as of September 2004, the self-insured stopped paying its portion of the claimant’s premiums.

The claimant and self-insured disagreed on whether premiums paid for health and dental insurance should be included in the claimant’s average weekly wage (AWW) and also disagreed on the amount of the insurance premium. At the CCH, the issue was the claimant’s correct AWW after September 1, 2004. The hearing officer found that the AWW after September 2004 should not increase and did not include premiums paid by the self-insured. The Hearing Officer stated that the premiums were fringe benefits that the claimant elected not to receive. The Hearing Officer found that the premiums constitute nonpecuniary wages and the wages were not discontinued by the employer, under Rule 126.1(2). The claimant appealed, contending that his AWW after September 2004 should include discontinued nonpecuniary wages.

HOLDING: Reversed and remanded for calculation of the amount of the discontinued nonpecuniary wage. The hearing officer used an irrelevant factor (the claimant’s failure to re-enroll) as the basis for not including the value in the AWW. Under Section 401.011(43), “wages” includes all forms of remuneration payable for a given period to an employee for personal services, and that the term includes the market value of [any] advantage that can be estimated in money that the employee receives. Nonpecuniary wages are defined by Rule 126.1(2) as wages paid to an employee in a form other than money, and one of the examples is health insurance premiums. Rule 128.1(c) states that nonpecuniary wages shall be included in the AWW if the employer discontinues providing nonpecuniary wages. Because this rule does not provide for an analysis of the reasons that the employer discontinues the wages, the reason for discontinuation is irrelevant.
Under Section 409.022(a), a carrier's notice of refusal to pay benefits must specify the grounds for refusal and those stated grounds constitute the only basis for the carrier's defense unless a defense is based upon newly discovered evidence. When waiver is contained in a party's position statement, but is not certified as a distinct issue, it may be actually litigated by the parties at a hearing.

FACTS: Claimant was employed as a custodian. She was injured on the job. Claimant reported a claim to her employer. Over a year after the work accident, claimant sought help at a Division field office and filed a claim. After the carrier received notice, it filed its denial in August 2005. In its pertinent part, the PLN-1 stated that benefits were denied because employee failed to timely report injury as mandated by the TWCC. There was no denial on the basis that the claimant had failed to file a claim within one year.

The claimant requested a BRC, and issues raised were 1) whether claimant sustained a compensable injury; 2) whether claimant had disability; 3) whether the carrier is relieved from liability under Section 409.002 because of claimant's failure to timely notify his employer pursuant to Section 409.001; and 4) whether carrier is relieved from liability under Section 409.004 because the claimant failed to timely file a claim for compensation with the [Division] within one year of the date of injury as required under Section 409.003. The claimant's position in the BRC report regarding the failure to file a claim defense was that the carrier never raised this as an issue on the PLN-1, and that because the issue was not raised within the first 60 days of the claim, the carrier had waived its right to raise the late filing issue. At the CCH, the ombudsman raised waiver by the carrier in both the opening and closing.

The hearing officer found in favor of the claimant on issues 1, 2 and 3. On the fourth issue, the hearing officer found in favor of the carrier, finding that the claimant had failed to timely file a claim within one year. The hearing officer stated that carrier waiver due to failing to raise the one-year filing defense in its PLN-1 was not an issue contained in the BRC report, was not added at the CCH, and was not litigated by both parties. The carrier did not appeal issues 1, 2, and 3. The claimant appealed the determination regarding the failure to file a claim within one year contending that the hearing officer erred by failing to add an issue that the carrier did not timely raise the one year filing defense or that the carrier's failure to raise the one year defense was subsumed in the failure to file a claim issue. Carrier responded stating that the timely notice requirement could not be waived.

HOLDING: Reversed and rendered a new decision that the claimant had raised the issue of waiver at the BRC and that the issue was actually litigated. The Appeals Panel found that the determination was not supported by the evidence and was against the great weight of the evidence because the issue was raised in the claimant's position in the BRC report, and in both the claimant's opening and closing at the CCH. It held that an issue may be actually litigated by the parties at a hearing notwithstanding that it was not in the statement of disputes. Section 409.022(a) states that a carrier's notice of refusal to pay benefits must specify the grounds for refusal and those stated grounds constitute the only basis for the carrier's defense unless a new defense is based upon newly discovered evidence. The Appeals Panel therefore rejected the carrier's contention that the defense could not be waived.
When there is a determination that the carrier has waived its right to deny the compensability of a condition, then that condition becomes part of the compensable injury as a matter of law, despite the quality of evidence offered by the claimant to overcome the extent of injury denial.

FACTS:

Claimant sustained a compensable injury. Claimant reported that she felt pain in her back while moving a bag. Carrier received notice of the injury on August 30, 2005. Carrier filed a PLN-11 on September 15, 2005, disputing compensability for claimant’s cervical and thoracic areas. In this PLN-11, the carrier acknowledged that it was “accepting a strain/sprain of claimant’s lumbar area.”

Claimant underwent a lumbar spine MRI on September 19, 2005 that showed disc dessication at L5-S1 and a disc protrusion at L5-S1. On October 10, 2005, an orthopedic surgeon addressed her injury and provided the diagnosis of disc displacement, spondylosis without myelopathy, and sprain in the lumbar region. An EMG was performed in February 2006, which showed S1 radiculopathy. The EMG was performed outside of the waiver period.

The claimant sought to have the diagnosed lumbar spine conditions included in the claim—desiccation at L5-S1, disc protrusion at L5-S1, lumbar radiculopathy, and lumbar spondylosis. At the Contested Case Hearing, the issues were 1) whether the compensable injury extended to include the findings from the September 19, 2005 lumbar spine MRI, lumbar radiculopathy, and lumbar spondylosis; 2) whether the carrier had waived its right to contest compensability of the claimed injury by not timely contesting the injury in accordance with Section 409.021, and 3) whether claimant was entitled to disability.

The hearing officer found that the carrier had not waived its right to contest compensability of any of the lumbar spine conditions. The hearing officer also found that the claimant had failed to prove that the comp injury included any of the lumbar spine conditions, and that claimant failed to prove disability. The claimant appealed.
HOLDING: Affirmed in part, reversed and rendered in part, and reversed and remanded in part. When a carrier does not timely dispute the compensability of a claim, the compensable injury is defined by the information that could have been reasonably discovered by the carrier’s investigation prior to the expiration of the waiver period. The Appeals Panel held that the carrier through a reasonable investigation could have discovered that the MRI findings and spondylosis were claimed to be part of the compensable injury. The PLN-11 filed by the carrier did not deny any injury to the lumbar spine, either specifically or by limiting the lumbar conditions that it accepted. The carrier only stated that it had accepted a lumbar sprain/strain. Because the EMG was not performed until after 60-day waiver period, the Appeals Panel affirmed the findings regarding lumbar radiculopathy. The appeals panel reversed the determination that carrier had not waived its right to dispute the MRI findings and spondylosis, and rendered a new determination that the carrier had waived its right to deny these conditions.

With respect to the issue of extent of injury, the Appeals Panel held that the MRI findings and spondylosis became compensable as a matter of law. Also, because the MRI findings and spondylosis became part of the compensable injury, as a matter of law, the issue of disability was reversed and remanded to reexamine the evidence based upon the compensable injury.

This AP Decision reiterates the recommendation that a carrier, in an extent of injury dispute, use wording that not only addresses the accepted diagnosis or body part, but also limits the accepted injury, such as “lumbar strain/sprain only” to prevent the outcome in 060701-s. See Appeal No. 000119, where the carrier filed the following dispute: “Carrier disputes that the compensable injury extends to both shoulders or any other body part. The compensable [ ] injury is limited to the lumbar area only.” There, the AP reversed and rendered a finding of waiver, stating that the language disputed everything except the lumbar injury.
INTEREST CALCULATOR

Interest Rate Effective from 07/1/2006 through 09/30/2006: **8.68%**

1. Determine number of weeks of continuous payment owed. Find corresponding “X” value on chart.
2. Multiply “X” by weekly compensation rate. This is the approximate amount of interest owed on the
   ending date of benefits.
3. Determine number of weeks between ending date of payments and date benefits are to be paid. Find
   corresponding “Y” value on chart.
4. Multiply “Y” by the total benefits owed (not including interest determined in steps 1 and 2 above).
   This is the approximate amount of interest owed from benefit ending date to payment date.
5. Determine total benefits plus interest owed by adding interest from steps 2 and 4, and adding total
   benefits to be paid.

**TIBs:** Calculate interest from the 7th day after first day benefits began, or the 7th day after the first
   notice, whichever is LATER.

**IIBs:** Calculate interest from the 5th day after notice of the certification of MMI and impairment, or the
date of a CARRIER dispute of MMI or impairment, whichever is EARLIER.

**NOTE:** For partial weeks, round up to next week (8 2/7ths weeks = 9 weeks).

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Insurance Company has agreed to send it to their legacy claimants that have previously been moved into their network and they will send it to future legacy claimants as they progress into their medical network program. I would like to express my appreciation to Russ Oliver, CEO of Texas Mutual Insurance Company, for his cooperation in making this happen. I would also like to express my appreciation to Commissioner Albert Betts and Commissioner Mike Geeslin for their cooperation and efforts to adopt this publication so that injured employees will know that we are here and eager to help them through the complexity of the workers’ compensation process.

- I have personally visited OIEC staff in the field offices in Denton, Dallas, and Ft. Worth to discuss issues that affect them. The Deputy Public Counsel and/or the Director of Injured Employee Services have visited several field offices this quarter, including Abilene, Corpus Christi, Dallas, El Paso, Houston, Midland, and Victoria. All three of us are in the process of scheduling more visits to field offices in the near future. These visits are particularly important for me so that I can become better acquainted with the ombudsmen and ombudsmen a better understanding of the kind of support that they require.
- Our ombudsmen have produced remarkable results since the first of the year. They had a win rate of 44.5% for 2005. Between January and April 1st that had increased to 47% and for the period between January and June 1st it had increased to a 50.9% win rate. That amazing success was accomplished without the assistance of the regional staff attorneys that are soon to be available to them. All of our ombudsmen get a heartfelt “Way to go!”
- We have finalized the agenda for the ombudsmen conference scheduled for the week of July 10th. Because of our confidence in the skills and commitment of our staff, challenging exercises will be presented and highly qualified and interesting speakers are scheduled to present lectures on advanced concepts.
- I would also like to commend our Counsel for Policy Development regarding his input on proposed rules and his involvement in several key TDI workgroups on behalf of OIEC. He is doing an excellent job in ensuring that injured employees have a voice on several important issues.

Even though the next legislative session is not scheduled to begin until January, 2007 we are making plans and beginning preparations for a full participation in the discussions that will pertain to our mission and our progress.
## FLAHIVE, OGDEN & LATSON DIRECTORY

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*Attorney’s direct dial fax no. is directed to his/her paralegal.

**Alternative e-mail address: first initial+last name@fol.com (Example: rstokes@fol.com)
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