The enforcement efforts of the Texas Department of Insurance are changing in response to a report released by the Texas State Auditor’s Office last month, according to a senior Insurance Department staffer. The auditor’s report, released July 16, 2010, criticized recent enforcement practices developed by the Division of Workers’ Compensation.

Catherine Reyer, Senior Associate Commissioner for the Department’s Enforcement Division, said the agency has taken the auditor’s report to heart by replacing key staff members and by instituting more stringent oversight processes of its staff. Addressing a specific allegation in the report, Ms. Reyer says that the agency is also requiring more documentation to support its enforcement decisions.

The auditor’s report focused primarily on the agency’s handling of disciplinary cases against insurance carriers. The report said that as of April 2010, 661 pending insurance carrier cases had been open for an average of 467 calendar days.

A separate report is expected to address the method by which the Division has enforced violations of the act allegedly committed by health care providers. That report is scheduled to be published later this year. The agency defended itself against allegations of enforcement favoritism during sunset commission hearings conducted this past spring. A House committee has scheduled a hearing on September 13, 2010 to explore the allegations in greater depth.

In its report, the state auditor also found that Division staff did not consistently conduct supervisory reviews of staff’s work related to workers’ compensation enforcement cases, the audit said.

Last month, Commissioner of Workers’ Compensation, Rod Bordelon, announced that attorney Leah Gillum had been appointed as the new enforcement team leader, and that two additional attorneys had joined the enforcement team: The new enforcement staff attorneys are Cecily Martinez, a former prosecutor from San Antonio, and Emily Sitton, formerly
Flahive, Ogden & Latson, a 22 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.

Flahive, Ogden & Latson
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FO&L OFFICE HOURS
Monday—Friday
8:15 a.m.—4:45 p.m.

If you need to call after 4:45 p.m. please call Patsy Shelton at (512) 435-2234. She will be on duty until 6:00 p.m. daily.

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 Division, 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 Sally Matthews 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 Division will be at 4:00 p.m., in order to get across town to meet their 5:00 p.m. closing time.

The Division of Workers’ Compensation has notified 2010 Carrier participants of their preliminary PBO scores.

The Division is assessing the same carrier measures in 2010 that it assessed in 2009: timely payment of TIBs (40%); timely medical bill processing (40%); timely EDI submission of initial payment data (10%); and timely EDI submission of medical bill processing data (10%).

Carriers are entitled to prepare a management response with supporting documentation to refute the Division’s findings on the agency’s initial payment data. These responses are due to be filed with the Division no later than September 10, 2010.

The Division will review carrier management responses and prepare a summary of changes with the Texas Attorney General’s Office.

One change recently made by the Division has been the agency’s practice of announcing pending enforcement actions through the process of “omnibus consent orders” where cases with similar violations are grouped and negotiated against a single underwriting company.
for distribution to the carriers. The final results will be published on the Division website after the results have been shared with each carrier respectively. The Division anticipates the publication of final PBO results for carriers in late December 2010.

Just as in past years, the Division will place carriers into three regulatory tiers that distinguish among poor, average and high performers in the system. The tiers will be based on pre-determined performance standards as follows:

- **High Tier:** 95 or greater
- **Average Tier:** 80.00 through 94.99
- **Poor Tier:** 79.99 or less

The Division’s full explanation of the 2010 carrier requirements has been posted on the agency’s website at http://www.tdi.state.tx.us/wc/pbo/index.html.

The Sunset Commission made specific recommendations in seven key areas: benefit dispute resolution, medical quality review, enforcement procedures, designated doctors, Division oversight and adjudication duties, nonsubscriber data collection, and whether the Division should be continued beyond 2011.

In the most controversial subject area, issue number two, the Commission modified all of the recommendations of the staff report dealing with the Division’s Medical Quality Review process. These modifications were designed to allow system stakeholder input before the Division adopts a formal set of procedures for reviewing doctors; to leave the oversight role of the Division's medical advisor unchanged; and to leave intact the Quality Assurance Panel (one of two panels that investigates physician fraud).

The Sunset Commission also made recommendations with respect to six other issues.

### Benefit Dispute Resolution

In response to issue number one, the Sunset Commission considered certain suggested changes to the Division’s dispute resolution process. The Sunset Commission adopted staff’s recommendation to require parties to a dispute to prove preparedness as a prerequisite to a BRC and to require parties to a non-network medical fee dispute to attempt a low-level mediation, through a BRC, before appealing to the CCH level. The Commission also adopted staff’s recommendation to establish an administrative appeal mechanism for network medical necessity disputes.
The Commission adopted staff’s recommendation to extend the timeframe allowed for appeals of DWC decisions regarding medical necessity and non-network medical fee disputes to district court and to clarify the venue for district court appeals of agency decisions regarding medical disputes. Finally the Commission adopted staff’s recommendation to require a review by the Division of all Contested Case Hearing decisions to ensure consistency amongst field office staff.

**Enforcement Procedures**

In response to issue number three, the Commission adopted recommendations related to the Division’s enforcement authority. These included the adoption without modification of the following staff recommendations: 1) to clarify that the Division can conduct announced and unannounced inspections; 2) to authorize DWC to refuse to renew Designated Doctor certifications; 3) to authorize the Commissioner to issue emergency cease-and-desist orders; 4) to specify that the judicial review standard for appeals of DWC enforcement cases is substantial evidence review; 5) to authorize the Commissioner to make final decisions on enforcement cases involving monetary penalties; and to remove outdated and confusing enforcement provisions in the Labor Code.

**Designated Doctors**

In response to issue number four, the commission sought to ensure the use of meaningful expert medical opinions through the designated doctor process. In this regard, the commission adopted the following staff recommendations: 1) Require the Commissioner to develop qualification requirements for Designated Doctors; and 2) direct the Commissioner to adopt rules requiring

Commission staff had recommended that the process for resolving non-network medical disputes, be streamlined by removing SOAH’s involvement in conducting Contested Case Hearings. The Commission ultimately adopted a modification designed to improve the process for resolving medical disputes by holding all medical necessity hearings before the Division and all fee dispute hearings before SOAH. The modification also: 1) retains the staff recommendation to remove the statutory provisions requiring spinal surgery cases to go through the DWC Appeals Panel, and instead treats these cases like all other medical necessity disputes; 2) eliminates SOAH costs paid by DWC for fee disputes by requiring the losing party to pay SOAH hearing costs; 3) authorizes the Division to intervene in SOAH hearings that involve significant issues of fee guideline interpretation; and 4) only affects appeals of IRO medical necessity decisions and staff-level medical fee decisions issued on or after the effective date of the Sunset bill.

The Commission adopted staff’s recommendation to authorize the Division’s Appeals Panel to issue written affirmations in limited circumstances, with a modification to apply only to the following types of cases: 1) cases of first impression; 2) cases that are impacted by a recent change in law; and 3) cases involving errors which require correction but which do not affect the outcome of the dispute, including: findings of fact for which there is insufficient evidence; incorrect conclusions of law; findings of fact or conclusions of law which were not properly before the hearing officer; or other legal errors.
Designated Doctors remain with case assignments, unless otherwise authorized.

The Commission expressly declined to adopt staff recommendations to authorize the Commissioner to establish a certification fee in rule for Designated Doctors or remove the Designated Doctor scheduling data from its website.

**Division Oversight and Adjudication Duties**

In response to issue number five, the Commission voted to adopt staff recommendations to transfer the responsibility for certain claims decisions from DWC to insurance carriers and to direct DWC to require insurance carriers to make decisions on certain individual claims. These include certain initial decisions relating to the acceleration or advancement of IIBs; the initial determination of SIBs; change of treating doctor decisions; and extension of MMI after spinal surgery. They also include certain claim specific decisions related to distribution of death benefits; LIBs annuities; and commutation of IIBs.

**Nonsubscription**

In response to issue number six, the Division adopted a staff recommendation that the Division closely coordinate with other state agencies to include nonsubscription reporting requirements in their print and electronic publications.

**Continued Existence**

Finally, in response to issue number seven, the Division adopted the staff recommendation that the Division of Workers’ Compensation’s existence be extended. It did, however, cut the time for the next sunset review period to six years, bringing the agency back up for Sunset review in 2017.

It is important to remember that none of the recommendations described herein have become law. The recommendations, as adopted, will be drafted into a bill for consideration by the next Legislature.

**Closed Pharmacy Formulary Continues to Vex the Agency**

The Division of Workers’ Compensation continues to struggle to pass a closed formulary. The Division still wants to pass the rules with a January 1, 2011, effective date for the formulary for new claims, and a January 1, 2013 effective date for legacy claims. Many system observers wonder whether that is going to be possible.

The formulary, which was mandated by the legislature in 2005 reforms, is the last item left on a rulemaking exodus taking more than 5 years to complete. And it is one of the most difficult challenges the agency has faced.

Earlier this month, system stakeholders urged the Division to modify several provisions in its proposed closed drug formulary rules, including delaying the effective date for the formulary to September 1, 2011 and controlling the cost of compounded drugs. Testimony at the hearing also challenged the Division’s proposal to deal with legacy claims.
The Division proposes to utilize Appendix A from the ODG (Official Disability Guidelines) as a cornerstone of the closed formulary since Appendix A is a reflection of the evidence-based recommendations detailed in the Division’s adopted treatment guidelines. Using this concept, health care providers would be able to prescribe drugs that are recommended under the guidelines without prior approval. Drugs on the "N" (not recommended or preferred) list would need preauthorization.

Some speakers at the public hearing complained about the interrelationship between the preauthorization process and the process of retrospective review under the proposed rules.

Prompt payment to pharmacists is a priority to the all system participants, who are currently faced with the possible loss of the ability of pharmacy benefits managers to navigate the pharmacy transaction after January 1, 2011. That’s the date that informal or voluntary networks must become certified as health care networks in order to vary payments from the agency fee guidelines.

The question whether pharmacy benefits managers may take such discounts after the first of the year is currently pending before the Texas Attorney General’s office on an opinion request. Pharmacy benefits managers are not permitted to deliver pharmacy services under the HCN statute.

The proposed closed formulary rules can be found in PDF format at:


The Division’s rule making initiative to revise Pharmacy Fee Guidelines is in queue behind the proposed pharmaceutical formulary rules.

Texas Labor Code §408.028 provides that the Commissioner of Workers’ Compensation by rule shall adopt a fee schedule for pharmacy and pharmaceutical services that will: – provide reimbursement rates that are fair and reasonable; – assure adequate access to medications and services for injured employees; and – minimize costs to employees and insurance carriers.

Earlier this year the Division conducted a system stakeholder meeting to gather input on the development of a Pharmacy Reimbursement Guideline rule. Agency staff are continuing to work on an informal working draft of a revision to 28 Texas Administrative Code §134.503–Reimbursement Methodology.

The revision will follow the requirements of the Texas Labor Code. The process for developing this rule is complicated by ongoing changes in the benchmarks used to develop pharmaceutical reimbursement methodologies in both public and private systems.

Division staff continues to insist that the agency will establish the appropriate benchmark upon which to build the Texas workers’ compensation

Continued on pg. 8
NCCI Submits its First Workers Compensation Loss Cost Filing in Texas

On August 12, 2010, the National Council on Compensation Insurance (NCCI) submitted its first Texas workers’ compensation loss cost filing to the Texas Department of Insurance (TDI). The proposed effective date of the filing is May 1, 2011.

NCCI has long served as a statistical agent for TDI collecting workers compensation premium and loss data from all workers compensation insurers writing in Texas. Since 1999, NCCI has also been licensed in Texas as an advisory organization. Under Texas law, advisory organizations are permitted to file loss costs, supplementary rating information and forms. NCCI has not previously submitted any such filings since obtaining its advisory organization license. NCCI currently files workers compensation loss costs in 33 other states.

TDI currently promulgates relativities which are a type of rate base used by workers compensation insurers to develop their final workers compensation rates. Each carrier adjusts the relativities to reflect its own loss experience, expenses, and profits. Loss costs are another type of rate base commonly used by insurers in other states to develop final workers compensation rates. A carrier using loss costs adjusts them to reflect its’ own expenses and profit. Loss costs are also a rate base commonly used by insurers in Texas in develop final rates in other lines of insurance. For example, the Insurance Services Office (ISO) is an advisory organization that files Texas loss costs in auto and many other property/casualty lines.

Until now, carriers have had the choice of using TDI relativities or their own specific relativities in the development of their final workers compensation rates. Nearly all carriers have used the TDI relativities. Now, carriers will have a third option of using NCCI loss costs in the development of their final workers compensation rates.

1 For example, the 5/1/09 relativity for the fairly non-hazardous clerical classification code 8810 is 34 cents per $100 payroll. The 5/1/09 relativity for the much more hazardous roofing classification code 5551 is $19.42 per $100 payroll. In other words, the roofing relativity is approximately 57 times the clerical relativity. When a carrier adjusts the relativities based on its own experience, expenses and profits, the final rates may vary significantly from the relativities; however, the relationship of one being approximately 57 times the other will be maintained.

2 Other states are adjusted to same payroll distribution as Texas. The region includes AR, LA, NM, and OK. Countrywide is defined as NCCI states.

If a carrier switches from using relativities to loss costs, the impact on an employer’s premiums depends on its carrier’s adjustments to its selected rate base. There could be minimal impact on employer premiums if a carrier’s goal is to achieve the same final rate regardless of the selected rate base. This is best demonstrated by example. Assume for the purpose of this example that the carrier is using either 5/1/11 TDI relativities or 5/1/11 NCCI loss costs as its rate base. Also assume that all other factors utilized by the carrier to increase or decrease the employer’s premium remain the same. If a relativity is set at 80 cents per $100 payroll and the carrier adjusts the relativity to reflect its experience, expenses, and profit, by adding a deviation of 20 cents per $100 payroll, the final rate is $1.00 per $100 payroll. If the carrier decides to use loss costs
and the loss cost is set at 70 cents per $100 payroll, the carrier could adjust the loss cost by adding expenses and profit of 30 cents per $100 payroll to achieve the same final rate of $1.00. In this example, the choice of rate base will not impact the employer’s premium.

In summary, please note:

1. TDI will continue to produce relativities. NCCI is offering loss costs as another option. Carriers can use their own data or choose either the TDI or NCCI rate base to develop their final rates.

2. TDI relativities and NCCI loss costs are not comparable. They represent different types of rate bases. Texas loss costs are comparable to loss costs in other states. The average Texas loss cost proposed in NCCI’s loss cost filing is $0.72 per $100 payroll compared to $1.03 in the region and $0.96 countrywide.2

3. Whether a carrier uses its own data, relativities, or loss costs as their rate base, final rates are dependent on carrier adjustments. An employer’s premium is based on the carrier’s final rates plus other factors a carrier uses to increase or decrease the premium (schedule rating, experience modification factors, etc.).

More information on the pharmacy reimbursement guideline rule including materials provided to stakeholders at the February 2, 2010 stakeholder meeting is available on the agency website at: http://www.tdi.state.tx.us/webcast/audio10.html.
The Division, through its Complaint Resolution Intake Unit, has recently begun issuing Requests for Documentation to monitor the system participant’s compliance with the BRC exchange rules. This presents a good opportunity to reiterate the rules regarding these exchanges, which have been in effect since 1991.

Unless the Benefit Review Conference is set on an expedited basis, the parties must exchange all pertinent information with the other side no later than 14 days before the hearing. Failure to do so is an administrative violation with a potential penalty of up to $25,000 per day for non-compliance. See Rule 14134(b) and §415.021(a) of the Texas Labor Code.

Unless our office is specifically requested to make the exchange, or unless we have a standing agreement to do so, the responsibility will remain with the carrier or its TPA to make the exchange.

The Division has given every indication that it intends to step up enforcement actions regarding this issue.

If our office is provided the file material prior to the exchange deadline, we would be pleased to make the exchange on behalf of the carrier. You may make the request with Cindi Friedel by email (caf@fol.com) or by phone (512-435-2244).
Reminder: DWC has Adopted New Rules for RTW Program

The Division of Workers’ Compensation has adopted 28 TAC §§137.41-137.51—Regarding the Return-To-Work Reimbursement Program for Employers. The new rules were adopted April 1, 2010 and were published in Texas Register April 61, 2010.

The new rules implement statutory amendments to Texas Labor Code §413.022 under Senate Bill 1814, enacted by the 81st Legislature, Regular Session, effective September 1, 2009. These amended and new rules make permanent the former Return-to-Work Reimbursement Pilot Program for Small Employers, increase the amount an employer may receive from the program from $2,500 to $5,000, and they add an optional advance of funds plan to the program.

The amended and new rules also provide further clarification about the eligibility, administration, and TDI’s Division of Workers’ Compensation (TDI-DWC) supervision of the Return-to-Work Reimbursement Program.

Reminder: DWC Has Adopted New Death Benefits Rules

Earlier this year the Division adopted 28 TAC §§122.100, 132.6 and 132.11—Regarding a Non-Dependent Parent’s Eligibility for Death Benefits in the Texas Workers’ Compensation System. The new rules were adopted February 26, 2010 and were published in the Texas Register March 12, 2010.

The new rules incorporated recent legislative amendments in House Bill 1058 into existing rules governing death benefits. The rules affect a surviving non-dependent parent’s right to receive death benefits under the Texas Workers’ Compensation Act.

House Bill 1058 took effect September 1, 2009. The legislation amended the definition of “eligible parent” and provides that an eligible parent’s failure to file a claim for death benefits in the time required will not bar the claim if good cause exists for the failure to file the claim timely. HB 1058 also provides that payment of death benefits to eligible parents may not exceed 104 weeks “regardless of the number of surviving eligible parents.”

Reminder: DWC Has Adopted Employee Rights and Responsibilities Rules

The Division adopted 28 TAC §120.2, Regarding the Notice of Injured Employers Rights and Responsibilities earlier this year. The new rules were adopted February 26, 2010 and were published in the Texas Register March 12, 2010.

The new rules implement statutory amendments to TEXAS LAB. CODE ANN. § 404.109 which were passed by the 81st Legislature under House Bill 673. The statutory amendments became effective September 1, 2009.

The Division’s amended rule clarifies that the Public Counsel of the Office of Injured Employee Counsel, after consulting with the Commissioner of Workers’ Compensation, shall adopt the Notice in the Texas Workers’ Compensation System.

A copy of the notice is available on the OIEC website at http://www.tdi.state.tx.us/pubs/factsheets/ierrenglish.pdf.
Reminder: DWC has adopted SIF rules

The Division of Workers’ Compensation adopted 28 TAC §116.11 and §116.12 earlier this year. Both rules relate to reimbursement from the Subsequent Injury Fund. The rules were adopted December 17, 2009 and were published in the Texas Register on January 1, 2010.

The purpose of adopting amended 28 Texas Administrative Code §116.11 and §116.12 was to implement statutory provisions enacted by Senate Bill 1169, 80th Legislature, Regular Session, effective September 1, 2007, (SB 1169) to TEXAS LAB. CODE ANN. §§403.006, 408.0041, and 408.042.

Section 403.006 provides that the Subsequent Injury Fund is liable for the reimbursement of an insurance carrier as provided for by Labor Code §408.0041(f-1).

Section 408.0041(f-1) requires the SIF to reimburse an insurance carrier for an overpayment of benefits made by the insurance carrier based on the opinion of a designated doctor if that opinion is reversed or modified by a final arbitration or a final order or decision of the Commissioner of Workers’ Compensation or a court. Section 408.042(g) adds the provision that an insurance carrier is entitled to apply for and receive reimbursement from the SIF for the amount of death benefits, in addition to the amount of income benefits, if any, paid to an employee that are based on employment other than the employment during which the compensable injury occurred.
July 21, 2010

TO: All Insurance Companies, Corporations, Exchanges, Mutuals, Reciprocals, Associations, Lloyds, or Other Insurers Writing Workers’ Compensation and Employers’ Liability Insurance in the State of Texas, Their Agents and Representatives, and to the Public Generally

RE: Adoption of the Texas Detailed Claim Information Statistical Plan, 2010 Edition


Currently, insurance companies writing workers’ compensation insurance in Texas must use the Detailed Claim Information (DCI) Statistical Plan adopted effective January 1, 1991, and last amended effective January 1, 1997 (1997 Stat Plan). The updated reporting requirements included in the 2010 Stat Plan shall apply to all claims with a reported-to-insurer date of September 2010 and later. All claims with a reported-to-insurer date prior to September 2010 shall continue to use the reporting requirements in the 1997 Stat Plan and those claims shall continue to be reported up to and including reports due through April 30, 2014.

The 2010 Stat Plan is necessary to provide needed clarification regarding the reporting requirements of certain data fields, eliminate unnecessary and noncritical data elements, and add necessary data elements. Many of the changes in the 2010 Stat Plan were made to align DCI data reporting requirements in Texas with similar requirements made by the National Council on Compensation Insurance (NCCI) for other states. NCCI serves as the Department’s designated statistical agent for the collection of DCI data in Texas.

Further, the 2010 Stat Plan will gather comprehensive data for all indemnity claims with a loss value greater than zero. Under the 1997 Stat Plan, only claims with incurred losses of $5,000 or greater are required to be reported. This change will provide enhanced opportunities for research and monitoring of claims below $5,000, as well as more accurate pricing of statutory and regulatory changes affecting those claims. Details regarding which claims need to be reported may be found in Part 4, Claim Selection and Sampling, of the 2010 Stat Plan.
Complete copies of the 1997 Stat Plan and the 2010 Stat Plan can be found at: "www.tdi.state.tx.us/company/indexpc.html#stat."

Questions relating to this bulletin should be directed to the undersigned at (512) 475-3026 or by e-mail to gary.gola@tdi.state.tx.us.

Gary Gola
Property & Casualty - Data Services

For more information contact: PropertyCasualty@tdi.state.tx.us
Discount Rate and Interest Rate Determined for
July 1, 2010 through September 30, 2010

The Texas Department of Insurance, Division of Workers' Compensation has determined, pursuant to the authority and direction given under the Texas Workers' Compensation Act (Texas Labor Code, Section 401.023), that any interest or discount provided for in the Act shall be at the rate of 3.80%. This rate is computed by using the treasury constant maturity rate for one-year treasury bills (0.30%) issued by the United States Government, as published by the Federal Reserve Board on June 16, 2010 (the 15th day preceding the first day of the calendar quarter for which the rate is to be effective), plus 3.5% as required by Section 401.023. The rate shall be effective July 1, 2010 through September 30, 2010. The rate in effect for the previous period of April 1, 2010 through June 30, 2010 was 3.91%.

For more information regarding calculation of the Discount Rate and Interest Rate, contact Dareld Morris III, Texas Department of Insurance, Financial Services, at 512-305-7274.

Issued in Austin, Texas on the 22nd day of June, 2010.

Rod Bordehn
Commissioner of Workers' Compensation
Letters of Clarification Review and Determination

June 22, 2010

Rule References: Under 28 Texas Administrative Code (TAC) §126.7(u) parties who seek clarification of a report of a designated doctor may file a request with the Texas Department of Insurance, Division of Workers’ Compensation (TDI-DWC). The TDI-DWC may contact the designated doctor, “if it determines that clarification is necessary to resolve an issue” regarding the report.

Review and Determination: The TDI-DWC recently established a mechanism whereby TDI-DWC Claim Services Officers (CSOs) located in the TDI-DWC field offices receive recommendations from a team of TDI-DWC Hearings personnel to facilitate and improve the quality of decisions about whether a Letter of Clarification (LOC) is necessary to resolve an issue.

Benefits: Although it is anticipated that the process may result in additional requests for Benefit Review Conferences (BRCs) and/or Contested Case Hearings (CCHs), the overall effect is expected to provide a number of benefits, including:

(a) shortening time it takes to resolve disputes regarding designated doctor reports by moving issues more quickly to an appropriate venue (BRC or CCH);
(b) establishing statewide consistency in the analysis and decision making process for LOCs to assure adherence to the intent of the rule;
(c) improving the quality of requests for clarification submitted to doctors so they do not spend time responding to repetitive, imprecise or inappropriate questions that will not assist in resolution of an issue in dispute;
(d) resulting in potential cost savings to the Texas workers’ compensation system by avoiding the cost of additional dispute resolution and or litigation;
(e) saving TDI-DWC resources spent issuing and tracking thousands of pro forma LOC communications sent to doctors annually; and
(f) synchronizing the decision making process more closely with similar regulatory processes within TDI-DWC (i.e., Letter of Clarification requests regarding decisions of Independent Review Organizations per 28 TAC §133.308).

The attached Frequently Asked Questions: Letters of Clarification will be made available on the agency website and for distribution to workers’ compensation system participants. For questions regarding Letters of Clarification, contact TDI-DWC Hearings at 512-804-4010.
Frequently Asked Questions: Letter of Clarification

June 22, 2010

What is a Letter of Clarification (LOC)?
A Letter of Clarification (LOC) is a letter drafted by the Texas Department of Insurance, Division of Workers’ Compensation (TDI-DWC) and sent to a designated doctor requesting clarification on certain issues in a report the doctor submitted following the examination of an injured employee.

Under 28 Texas Administrative Code (TAC) §126.7(u) parties to a workers’ compensation claim who want clarification of a report of a designated doctor may file a request with the TDI-DWC for a LOC.

The TDI-DWC may contact the designated doctor requesting a LOC, “if it determines that clarification is necessary to resolve an issue” regarding the report. Under 28 TAC §126.7 (v), disputes regarding a designated doctor’s report shall be resolved through the dispute resolution process.

How does a party request a LOC?
Parties to a workers’ compensation claim can submit a request for a LOC to the TDI-DWC field office handling the claim. For a list of TDI-DWC field offices and their contact information, visit the agency website at http://www.tdi.state.tx.us/wc/dwccontacts.html#offices.

When may a party submit the request of LOC?
Parties may submit a request for a LOC to the TDI-DWC at any point in the dispute resolution process [i.e., prior to a Benefit Review Conference (BRC), during a BRC or during a Contested Case Hearing (CCH)]. Historically, most requests have been submitted prior to a BRC.

Do parties have a right to an LOC?
Parties are allowed by TDI-DWC rule to request an LOC. The ultimate determination of whether a Letter of Clarification is granted rests with the TDI-DWC.

What happens after a request is approved?
Should the TDI-DWC determine clarification is necessary, they send a letter to the designated doctor setting out the questions to be answered. Sometimes additional medical or other information is provided for consideration. The designated doctor has five days to provide a response to the request for clarification.
What happens if the TDI-DWC denies a request for a LOC?
If the TDI-DWC denies a request for a LOC, a denial letter will be sent to the requesting parties specifying the reasons for the denial.

What are the options if a request for LOC is denied?
Parties may:
(a) resubmit the request for an LOC, taking into account the reasons for the previous denial;
(b) request a BRC to dispute the designated doctor’s report to resolve the issue for which the designated doctor was appointed;
(c) consider submitting appropriate issues directly to the doctor by requesting a new designated doctor examination using the established process (filing a DWC Form-032, Request for Designated Doctor); or
(d) request an expedited BRC or CCH to challenge the denial.

Texas Department of Insurance
Division of Workers’ Compensation

FOR IMMEDIATE RELEASE
July 8, 2010
News Release

FOR MORE INFORMATION
(General) Michelle Banks @ (512) 804-4203
(Media) John Greeley @ (512) 463-6425

Commissioner of Workers’ Compensation Appoints New Medical Advisor

AUSTIN, TX – Dr. Donald Patrick will join the Texas Department of Insurance, Division of Workers’ Compensation as the Medical Advisor effective July 12, 2010.

Dr. Patrick served as the Executive Director of the Texas Medical Board until August 2008. Prior to this position, Dr. Patrick practiced neurosurgery in Austin from 1969 to 2001. Currently he is a Diplomate of the American Board of Neurological Surgery and a member of the Austin EMS Advisory Committee, the Texas A&M Kingsville Foundation Board and Board of Managers for Central Health (formerly the Travis County Healthcare District).

In addition to his distinguished medical career, Dr. Patrick also earned a J.D. from the University of Texas, School of Law in 1996 and is certified to practice law in the State of Texas.

Dr. Patrick’s additional distinctions and honors include: Distinguished Alumnus of Texas A&M University Kingsville; Chief of Staff of Brackenridge Hospital in 1984; President of the Pflugerville Independent School District Board of Trustees, serving from 1985-88; and President of the Texas Association of Neurological Surgeons in 1988-1989.

###
MEMORANDUM

DATE: August 20, 2010

TO: Workers' Compensation Insurance Carriers

FROM: Patricia Gilbert, Executive Deputy Commissioner for Operations

RE: Spanish Translation of Plain Language Notices

The Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) has posted Spanish translations of Plain Language Notices (PLNs) 1 – 11 on its website at http://www.tdi.state.tx.us/forms/form20plain.html.

Workers' compensation insurance carriers using their own in-house translations of the PLNs must use the new TDI-DWC version effective November 1, 2010. When a Spanish PLN is used, the insurance carrier's explanatory comments should be provided in Spanish as well.

For assistance or more information about Spanish PLNs, contact Michelle Banks at 512-804-4203.
Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 • 512-804-4001 fax • www.tdi.state.tx.us

MEMORANDUM

DATE: August 10, 2010

TO: Insurance Carriers and Health Care Providers in the Texas Workers' Compensation System

FROM: Patricia Gilbert, Executive Deputy Commissioner for Operations

RE: Notice included with the DWC Form-069, Report of Medical Evaluation

The Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) has made available in Chinese and Vietnamese the notice included with the DWC Form-069, Report of Medical Evaluation. This is in addition to the English and Spanish versions already available. The notice is required by 28 Texas Administrative Code §130.2(a)(3) to be sent to injured employees by treating doctors with the DWC Form-069 following certification of Maximum Medical Improvement and evaluation of Permanent Impairment.

The sample notices are available for download in PDF and Word formats from the TDI website at http://www.tdi.state.tx.us/forms/form20medical.html#dwc069.
## Division of Workers Compensation - Rule Status Chart*

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<tr>
<td>Pharmacy Closed Formulary (RxF)</td>
<td>Amend §134.500 and §134.506 and new §§134.510, 134.520, 134.530, 134.540, and 134.550 and Amend §133.306 Interlocutory Orders for Medical Benefits</td>
<td>Pursuant to HB 7, these rules are necessary to adopt a pharmacy closed formulary.</td>
<td>Published in the <em>Texas Register</em> and posted to the Division’s website 7/16/2010: comment period ends 8/16/2010. Hearing scheduled for August 16, 2010 at 9:00 a.m. CST in the Tippy Foster Conference Room of the Texas Department of Insurance, Division of Workers’ Compensation, 7551 Metro Center Drive, Austin, Texas 78744-1645. Link: <a href="http://www.tdi.state.tx.us/wc/rules/proposedrules/index.html">http://www.tdi.state.tx.us/wc/rules/proposedrules/index.html</a></td>
</tr>
<tr>
<td>Designated Doctor Requests and General Procedures (DD 126)</td>
<td>§126.7 (Chapter 127 will house this new rule set)</td>
<td>Rule amendments to address revisions to DD requests and procedures.</td>
<td>Published in the <em>Texas Register</em> and posted to the Division’s website 7/16/2010: comment period ends 8/16/2010. Hearing scheduled for August 17, 2010 at 9:00 a.m. CST in the Tippy Foster Conference Room of the Texas Department of Insurance, Division of Workers’ Compensation, 7551 Metro Center Drive, Austin, Texas 78744-1645. Link: <a href="http://www.tdi.state.tx.us/wc/rules/proposedrules/index.html">http://www.tdi.state.tx.us/wc/rules/proposedrules/index.html</a></td>
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<tr>
<td>180 Rules Doctor Certification &amp; Requirements (190s)</td>
<td>Amend: §§180.1-180.3, 180.5, 180.7, 180.8, and 180.24, 180.26, 180.27, and 180.28</td>
<td>Amend and repeal rules to recognize: - HB 7 provisions that delete the Approved Doctors List, specify certain requirements for doctors, expand the sanctions that the DWC may impose or recommend and that require the Commissioner to adopt rules regarding the process to file</td>
<td>ETA on Texas Registry submission: Summer 2010</td>
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Note:
- This list is not inclusive of all rules under development by the Division of Workers’ Compensation (DWC); the list is being provided as a reference tool.
- All dates are tentative and may change based on decisions made by the Commissioner of Workers’ Compensation, in consultation with the Commissioner of Insurance and the Office of Injured Employee Counsel (OIEC).
- For other general non-network Workers’ Compensation rule information see [http://www.tdi.state.tx.us/wc/rules/index.html](http://www.tdi.state.tx.us/wc/rules/index.html).
- For House Bill (HB) and Senate Bill (SB) references please see the legislative bill references at the end of this chart.

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July 2010, updated 07/26/2010
## Division of Workers Compensation - Rule Status Chart

<table>
<thead>
<tr>
<th>Rule Project</th>
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<tr>
<td>Repeal §§180.6, 180.7, 180.10 - 180.18, 180.20, and 180.26</td>
<td>complaints with the DWC. - HB 34 provisions regarding workers' compensation payments and inducements. - HB 1003 requirements regarding independent review doctor licensing requirements. - HB 1006 requirements regarding doctor licensing requirements; and - HB 2004 certification requirements for reviewing doctors.</td>
<td>ETA on Texas Registry submission: Summer 2010</td>
<td></td>
</tr>
<tr>
<td>Case Management (CM)</td>
<td>New §137.5</td>
<td>HB 7 and SB 1814 amendments to this rule sets up criteria for what constitutes &quot;appropriate licensure and/or certification&quot; for case managers dealing with non-network claims.</td>
<td>ETA on Texas Registry submission: Fall 2010</td>
</tr>
<tr>
<td>E-billing / Electronic Formats (E-bill)</td>
<td>Amend §§133.2, 133.10, 133.210, 133.500, 133.501, 133.502, and 134.120</td>
<td>Amend rules to reference adopted HIPAA standards by the Secretary of the Department of Health and Human Services.</td>
<td>ETA on Texas Registry submission: Fall 2010</td>
</tr>
<tr>
<td>Medical State Reporting Rules (MSR)</td>
<td>New §§134.800, 134.801, 134.803 - 134.807 and amend §134.802</td>
<td>Repeal existing rule and add new rules to Chapter 134 to include data element requirements for medical data interchange to the Division.</td>
<td>ETA on Texas Registry submission: Fall 2010</td>
</tr>
</tbody>
</table>

### Informal proposals

- **Designated Doctor Rules (DD requirements for list eligibility)**
  - Amend §180.21
  - Rule amendments to address revisions to the requirements for admission to the Division's designated doctor list.
  - Inclusion of American with Disabilities (ADA) requirements.
  - Informal posting ETA: Fall 2010

- **Designated Doctor Rules (DD Testing)**
  - Amend §180.23
  - Rule amendments to address revisions to doctor training requirements regarding maximum medical improvement (MMI), impairment ratings (IR), and designated doctor training.
  - Informal posting ETA: Fall 2010

### Development

- **Pharmacy Fee Guideline (RxFG)**
  - Amend §134.503
  - Pursuant to HB 7, rule amendments will revise reimbursement rates for pharmaceuticals.
  - Informal posting ETA: TBD


July 2010, updated 07/26/2010
### Division of Workers Compensation - Rule Status Chart*

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<tr>
<td>American Medical Association (AMA)</td>
<td>Amend §130.1</td>
<td>Rule is being reviewed to gather information regarding the impact of the 4th, 5th, and 6th editions of the American Medical Association Guides to the Evaluation of Permanent Impairment on the Texas workers' compensation system.</td>
<td>Under development.</td>
</tr>
</tbody>
</table>

### Adoptions

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<tr>
<td>BRC Resolution Rule (BRC)</td>
<td>Amend §§141.1, 141.2, 141.4, and 141.7</td>
<td>Address HB 7 provisions by providing guidelines regarding the type of information a requesting party needs to provide to DWC and the documented efforts the parties need to make to resolve the disputed issues before a BRC request is submitted to DWC.</td>
<td>Adoption ETA: August 2010&lt;br&gt;Effective date ETA: Fall 2010</td>
</tr>
<tr>
<td>Return to Work Reimbursement (RTW)</td>
<td>Amend §§137.42, 137.44, 137.46, and 137.49</td>
<td>The Return to Work &quot;Pilot&quot; Program is amended by becoming a permanent program pursuant SB 1814, 81st Legislature.</td>
<td>Adoption: 04/05/2010&lt;br&gt;- Published in Texas Register: 04/05/2010&lt;br&gt;- Effective: 04/25/2010</td>
</tr>
<tr>
<td>Injured Employee Rights and Responsibilities (IERR)</td>
<td>Amend §120.2</td>
<td>- Amend rule to address statutory amendments enacted by House Bill (HB) 673.&lt;br&gt;- Clarifies the notice of injured employee rights and responsibilities is adopted by the Office of the Injured Employee Counsel (OIEC).</td>
<td>Adoption: 02/26/2010&lt;br&gt;- Published in Texas Register: 03/12/2010&lt;br&gt;- Effective: 03/22/2010</td>
</tr>
<tr>
<td>Death Benefits (DBs)</td>
<td>Amend §§122.100, 132.6, and 132.11</td>
<td>Amend rule to address statutory amendments to Labor Code §408.182 enacted by House Bill (HB) 1058.&lt;br&gt;- Changes the definition of &quot;eligible parent&quot;.&lt;br&gt;- Provides a &quot;good cause&quot; standard for an eligible parent's failure to timely file a claim.&lt;br&gt;- Provides that total payment of death benefits to all eligible parents may not exceed 104 weeks.</td>
<td>Adoption: 02/26/2010&lt;br&gt;- Published in Texas Register: 03/12/2010&lt;br&gt;- Effective: 03/22/2010</td>
</tr>
<tr>
<td>Subsequent Injury Fund (SIF)</td>
<td>Amend §116.11 &amp; §116.12</td>
<td>Amend rule to address SB 1169 requirements regarding carriers' ability to be reimbursed from the SIF after an overturn of a designated doctor's opinion.</td>
<td>Adoption: 12/17/2009&lt;br&gt;- Published in Texas Register: 01/01/2010&lt;br&gt;- Effective: 01/07/2010</td>
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*July 2010, updated 07/26/2010*
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| Appeals Panel (AP) | Amend §§143.2 - 143.5 | Amend rules to address HB 7 requirements regarding appeal panel decisions. Also amend rules to address new HB 4545 requirement regarding the time for filing a petition for judicial review. | - Adoption: 11/19/2009  
- Published in Texas Register: 12/04/2009  
- Effective: 12/24/2009 |
| Drug-Free Workplace program & Hazardous Employer Program | Repeal Chapters 164 and 168 | HB 7 repealed labor Code Chapter 411, Subchapters D (Hazardous Employer Program) and G (Policy for Elimination of Drugs in the Workplace) which eliminates the statutory authority for rules related to these subchapters. | - Adoption: 10/01/2009  
- Published in Texas Register: 10/30/2009  
- Effective: 11/20/2009 |

**Legislative bill references:**
- **House Bills (HB):**
  - 2009: enacted by 81st Legislature, Regular Session, effective September 1, 2009
    - HB 673
    - HB 1058
    - HB 4545
  - 2007: enacted by the 80th Legislature, Regular Session, effective September 1, 2007
    - HB 34
    - HB 724
    - HB 1003
    - HB 1005
    - HB 1006
    - HB 2004
  - 2005: enacted by the 79th Legislature, Regular Session, effective September 1, 2005
    - HB 7
- **Senate Bills (SB):**
  - 2009: enacted by 81st Legislature, Regular Session, effective September 1, 2009
    - SB 1814
  - 2007: enacted by the 80th Legislature, Regular Session, effective September 1, 2007
    - SB 1169
Q: The claimant was taken off work and was receiving 70% of his average weekly wage calculated from the DWC-1. The claimant returned to light duty and is receiving the minimum temporary income benefit (“TIB”) rate of $116. The carrier received a wage statement from the employer and the average weekly wage calculation is now actually lower than the calculation that was made based upon the DWC-1 information. For unrepresented claimants, Rule 128.1 allows the carrier to recoup the overpayment up to 25% without the claimant’s agreement. Is the carrier able to reduce the claimant’s TIB rate up to 25% of the weekly benefit amount to recoup the overpayment even though the claimant will be getting less than the minimum $116 weekly amount?

A: A claimant who has returned to work is generally not entitled to the minimum compensation rate. Rule 129.3(g) provides that the minimum compensation rate is only due when the claimant’s PIE plus the standard TIB rate calculation is less than the minimum rate. Once the correct TIB rate is determined, Rule 128.1(e) permits the carrier to take a portion of that weekly amount as reimbursement for a previous overpayment due to the receipt of a wage statement. Nothing in the statutes or rules states that the net amount received by the claimant per week must be the minimum compensation rate under these circumstances.

Q: The carrier pre-authorizes spinal injection. The carrier receives the medical bill for the spinal injection, but at the time the carrier received the medical bill, it had not filed any PLN-11 with the Division limiting the compensable injury to a lumbar sprain/strain. The carrier wants to dispute the medical bill because the spinal injection is treatment for a non-compensable injury or condition. Can the carrier deny the medical bill on the basis that it was treatment for a non-compensable injury even though it did not have a PLN-11 on file at the time the healthcare services were pre-authorized?

A: Yes. Note, however, that a spinal injection under certain circumstances might be related to a sprain/strain. To the extent that the injection was obtained for diagnostic purposes, it would not be appropriate to deny the injection on the basis of compensability grounds. Assuming, however, that the injection was approved for treatment purposes, preauthorization does not mandate liability for a noncompensable condition. Recently, the Texas Supreme Court rendered a decision in Zenith Ins. Co. v. Ayala confirming that preauthorization decisions are entirely based upon medical necessity of the treatment. When the carrier approves a preauthorization request, it is not liable for payment for noncompensable conditions. Once the carrier gives a pre-authorization approval, the medical necessity issue is resolved, but the compensability issue is not. To deny a medical bill based upon questions of relatedness, a carrier must have already filed a PLN-11 disputing the condition, or it must simultaneously file the PLN-11. As the carrier is denying the bill based upon an extent of injury dispute, the carrier should file an explanation of benefit (“EOB”) asserting that the bill is denied using ANSI Code W12 (extent of injury).
**Q:** The claimant was working modified duty at wages that were less than his average weekly wage. The claimant was then terminated due to a reduction in force. The claimant received a severance package valued at $10,000. Can the carrier count the value of the severance package as post injury earnings thereby relieving it of the obligation to pay temporary income benefits?

**A:** Not under Appeals Panel authority. Rule 129.2 defines post injury earnings. Certain things are defined as PIE and certain things are defined as not PIE. A severance package does not fall within either definition. However the language of the rule with respect to what does not constitute PIE is exclusive. The language of the rule with respect to what does constitute PIE is specifically not exclusive. Thus, it would seem that a severance package should constitute PIE. Nevertheless, and without any analysis, the Appeals Panel has simply declare that it is not.

**Q:** The claimant is receiving temporary income benefits (“TIBs”), social security disability, and retirement funds from his pension. Does the carrier owe the claimant TIBs since he has retired and is receiving his pension funds?

**A:** It is important to recognize that entitlement to TIBs is a two-part question. First, the claimant must be disabled. Second, AWW must be greater than PIE. The question as proposed does not address the disability issue. A retired claimant may or may not be disabled depending upon the particular facts and circumstances of the case. Assuming that the claimant is disabled, the question becomes whether the identified sources of income constitute PIE.

Anything that constitutes AWW constitutes PIE. The employer’s share of social security contributions does not constitute AWW and therefore social security payments cannot constitute PIE. The Appeals Panel, however, has held that an employer’s contribution to a pension fund, to the extent to which the employee has vested in said fund, do constitute AWW. Thus, payments from the fund would constitute PIE, in a proportion equal to the employer’s contribution. You will, of course, have to ensure that his AWW has been properly calculated to include such contributions. If PIE is greater than or equal to AWW, then no TIBs are due.

**Q:** The claimant returned to light duty work for two days. The employer did not provide the claimant with a written bona fide offer of light duty employment. The employer terminated the claimant at the end of the second day for failure to follow his supervisor’s instructions. Does the carrier owe temporary income benefits (“TIBs”)?

**A:** It depends. If the claimant had post-injury earnings from his light duty work equivalent to or more than his average weekly wage, then the carrier will have an argument that the claimant’s lost wages were due solely to the just cause termination. If, on the other hand, the claimant’s post-injury earnings were
less than his average weekly wage, then the claimant was still disabled at the time of the termination and the carrier will owe TIBs at the full rate as PIE will be $0.00. Under the Appeals Panel’s interpretation of the relevant rules, A carrier may only continue to utilize offered wages as PIE to the extent that these were memorialized in a bona fide offer of employment. A claimant’s failure to comply with his supervisor’s post-RTW instructions is tantamount to a rejection of a bona fide offer of employment.

Q: A healthcare provider submits a medical bill to the carrier in the amount of $22,000 for surgery that was performed. The bill review audit company states that the maximum allowable reimbursement (MAR) value is actually $30,000. Is the carrier allowed to reimburse the provider $22,000 because it billed a lower amount that allowed for under the Medical Fee Guidelines?

A: Unless the carrier and the provider had a written contractual agreement for the lower amount, the carrier is required to pay the MAR value. Rule 134.1 provides that MAR is the maximum amount payable to a healthcare provider in the absence of a contractual fee arrangement that is consistent with section 413.011 of the Labor Code and the Division rules. Moreover, “fair and reasonable reimbursement” shall be consistent with the criteria of section 413.011, ensure that similar procedures provided in similar circumstances receive similar reimbursement, and be based on nationally recognized published studies, published Division medical dispute decisions, and or values assigned for services involving similar work and resource commitments, if available. Prior to May 2, 2006, the carrier would have been able to pay the lesser amount because the medical bill rules allowed for payment of the billed amount if it was lower than the MAR value.

Q: The Division appointed a designated doctor to address ability to return to work and he issued a work status report indicating that the injured worker could return to work modified duty beginning 5/1/10. The designated doctor did not, however, provide how long the injured worker should be at modified duty. Then the treating doctor provided a work status report indicating that the injured worker could return to work full duty on 6/1/10. Can the carrier stop temporary income benefits upon receipt of the treating doctor’s full duty release?

A: Section 408.0041(f) of the Texas Labor Code provides that the carrier shall pay benefits based upon the opinion of the designated doctor during the pendency of any dispute. Rule 126.7(r) provides that the carrier shall begin or continue to pay weekly income benefits, in accordance with the designated doctor’s report for the issue in dispute. If the designated doctor’s opinion as to ability to work is not inconsistent with the treating doctor’s, then you may suspend benefits. If it is, then you should request a letter of clarification.
Q: The employee is being treated through a healthcare network. The employee has to travel 35 miles one-way from his home to the doctor’s office for some of his exam visits. Do the healthcare network rules allow for travel reimbursement?

A: There are no specific healthcare network provisions that provide for travel reimbursement. Based upon legislative history and intent, we believe that Rule 134.110, the travel reimbursement rule, would apply to those employees who obtain healthcare services through a healthcare network. Therefore, where an employee lives within the network service area and it is reasonably necessary for him to treat with a network (or approved out-of-network) doctor whose office is more than 30 miles from the place where the employee lives, the employee is entitled to mileage reimbursement for the round trip to the doctor.

Q: The carrier disputed the claim and lost at the CCH. The decision and order requires the carrier to pay temporary income benefits for a disability period from the day after the date of injury through the CCH date. Does the carrier have to pay interest on the temporary income benefits from the date of the decision and order, or some other date?

A: Pursuant to Sections 408.064 and 408.081(b) of the Texas Labor Code, the carrier is required to pay interest on accrued income benefits from the date that the benefits accrued through the date that the benefits are paid. In this case, the benefits first accrued on the 15th day after the date the carrier first received written notice of injury. See Rule 124.3(a)(1). As such, interest would be owed for those benefits due on the 15th day after receiving the first written notice of injury and for those benefits owed weekly thereafter.

Q: The employee submitted a SIBs application for the first quarter to the Division. The Division sent notice to the employee that he is entitled to the first quarter. Is the Division or the carrier required to send the employee the application for the second quarter?

A: Under these facts, both the Division and the carrier are actually required to send the second quarter application to the employee. Rule 130.104(b) provides that with the first monthly payment of SIBs for any eligible quarter and with any carrier determination of non-entitlement, the carrier shall send the employee a copy of the SIBs application. This language is broad enough to cover the situation where the carrier agrees to pay for the first quarter or where the carrier files a DWC-45 to dispute the entitlement determination. At the same time, Rule 130.103(b)(5) provides that if the Division determines the employee is entitled to the first quarter of SIBs, then it shall include with its notice of entitlement a SIBs application.
Under the evidence standard of City of Laredo v. Garza, 293 S.W.3d 625 (Tex. App-San Antonio 2009, no pet.), the cause and existence of medical conditions that are matters beyond common experience require medical evidence to establish a causal connection as a matter of reasonable medical probability.

Medical evidence is required to establish how sitting in the truck, with crossed legs or stepping out of the truck would cause left foot drop, peroneal nerve dysfunction across the left knee, lumbar strain and lumbar radiculopathy.

Facts: A CCH was held on the issues of whether claimant sustained a compensable injury; whether the compensable injury includes left foot drop, peroneal nerve dysfunction across the left knee, lumbar strain, and lumbar radiculopathy; and whether the claimant sustained disability. The claimant testified that on the date of injury, he was sitting in his truck for an extended period of time waiting on his next load assignment when he noticed his left toe and left foot going numb. The evidence supports that the claimant stepped out of his truck and his left foot twisted when he placed it on the pavement. The claimant testified that he is a diabetic and that he does not know how he injured himself. The claimant first sought medical attention at a hospital ER on August 14, 2009, and the ER records include a history that claimant noticed numbness in his left big toe and foot. The clinical impression was peripheral nerve entrapment or left foot drop. The ER report notes that the injury to the left foot was not caused by a direct blow or crush injury. Hospital discharge instructions stated that the claimant had been evaluated for neuropathy and included information on foot drop. The medical evidence showed that claimant returned to Texas and began treating with Dr. B, and his records also recite the history of the claimant sitting in the truck with his legs crossed for a long period of time, with complaints of numbness of the left toe. Dr. B diagnosed lumbar radiculopathy and lumbar strain. In evidence was a lumbar MRI report that showed minimal to mild disc bulge at L4-5 with mild, left greater than right, neural foraminal narrowing. The MRI also noted a lipoma (a benign tumor usually composed of mature fat cells) from mid L2 down to the L4-5 disc level. Dr. F, a referral physician, also noted a history of “sudden onset after sitting in his truck, leaning his leg.” Dr. F’s assessment is injury of the peroneal nerve “likely compressive, by history and likely mechanism.” An EMG was also in evidence that showed an abnormal study with “evidence for peroneal nerve dysfunction across the knee on the left.” The claimant filed an Employee’s Claim for Compensation for a Work-Related Injury or Occupational Disease (DWC-41) describing the cause of the injury as “numbness in foot, pain in lower back, due to sitting too long waiting on freight.” Carrier evidence included the opinion of Dr. C, a carrier peer review doctor, who opined that sitting in a truck could not result in radiculopathy or neuropathy that would cause foot drop, and offered other causes for the conditions in issue.

The hearing officer concluded that a fair reading of the medical records, diagnostic studies and the claimant’s testimony show the claimant sustained a compensable injury, that includes the claimed conditions of left foot drop, peroneal nerve dysfunction across the left knee, lumbar strain and lumbar radiculopathy. The hearing officer also found claimant entitled to all disability sought. The carrier appealed all issues asserting there was no, or insufficient evidence of causation of the injury and no, or insufficient medical evidence to support the hearing officer’s decision. The claimant responded, urging affirmance.

Holding: Reversed and rendered. Citing to City of Laredo v. Garza, 293 S.W.3d 625 (Tex. App-San Antonio 2009, no pet.) citing Guevara v. Ferrer, 247 S.W.3d 662 (Tex. 2007), the Appeals Panel noted that the cause and existence of foot drop, peroneal nerve dysfunction across the left knee, lumbar strain and lumbar radiculopathy in this situation, are matters beyond common experience and medical evidence should be submitted
which establishes the causal connection as a matter of reasonable medical probability. Reviewing the evidence, the Appeals Panel found that there was no medical report or evidence to establish how sitting in the truck, with crossed legs or stepping out of the truck would cause left foot drop, peroneal nerve dysfunction across the left knee, lumbar strain and lumbar radiculopathy. The Appeals Panel observed that the fact that the proof of causation may be difficult does not relieve the claimant of the burden of proof. In this case, although doctors diagnosed the various conditions, no doctor had given an opinion how sitting in a truck, with legs crossed, can cause peroneal nerve dysfunction or foot drop. The Appeals Panel noted that the carrier’s peer review doctor opined the cause of the conditions at issue was something other than sitting in the truck or stepping out on the pavement.

Because the Appeals Panel found that there was no medical (or testimonial) evidence regarding how and whether the conditions were caused by sitting in the truck, with or without legs crossed, or stepping out of the truck, the Appeals Panel reversed the hearing officer’s decision that the claimant sustained a compensable injury, and that the compensable injury included left foot drop, peroneal nerve dysfunction across the left knee, lumbar strain and lumbar radiculopathy as so against the great weight and preponderance of the evidence as to be clearly wrong and unjust. The Appeals Panel rendered a new decision that the claimant did not sustain a compensable injury. Accordingly, the Appeal Panel also reversed the hearing officer’s determination that the claimant sustained disability and rendered a new decision finding no disability.

TEXAS DIVISION OF WORKERS’ COMPENSATION APPEAL NO. 100467-s

Under Rule 130.102(f), to meet the requirements of active participation in work search efforts, an injured employee must provide credible documentation sufficient to establish that he has, each week during the qualifying period, made the minimum number of job applications and/or work search contacts consistent with the work search contacts established by the Texas Workforce Commission (TWC).

Facts: A CCH was held on whether claimant was entitled to supplemental income benefits (SIBs) for the 1st quarter. The claimant’s theory of entitlement was based on an active work search effort, by making a minimum number of 3 work search contacts every week of the qualifying period. The claimant’s county of residence on the first day of the qualifying period was in County A in Texas, which requires a minimum of 3 work searches per week. The claimant testified that he moved to another state during the qualifying period in dispute. The minimum work search each week in the new out-of-state location was also 3 per week. According to the Application for SIBs in evidence, the claimant made a minimum of three work searches each week, for the qualifying period in dispute, and attached a detailed job search listing that shows the employer’s name and contact information for each of the work searches for the qualifying period in dispute. In the background information, the hearing officer states that “apart from notations in his contact log, claimant failed to offer any evidence of the job applications or resumes other than those scattered confirmations.” The hearing officer found that the claimant did not submit any job applications to document an active job search during each week of the qualifying period. The hearing officer found that the claimant was not entitled to SIBs for the 1st quarter. The claimant appealed.

Holding: Reversed and rendered. Because claimant’s qualifying period occurred after July 1, 2009, eligibility for SIBs entitlement is governed by Rules 130.100-130.109. Under Section 408.1415(a)(3), to be eligible to receive SIBs, a recipient must provide evidence satisfactory to the Division of active work search efforts documented by job applications submitted by the recipient. Under Rule 130.102(d)(1)(D), an claimant demonstrates an active effort to obtain employment by performing work search efforts documented by job applications. Under Rule 130.102(f), regarding active participation in work search efforts and active work search efforts, an
injured employee shall provide documentation sufficient to establish that he has, each week during the qualifying period, made the minimum number of job applications and/or work search contacts consistent with the work search contacts established by the Texas Workforce Commission (TWC).

The Appeals Panel cited its recent Decision Appeal No. 100229-s, wherein its references the preamble to Rule 130.102(d)(1)(D), and clarifies that “work search efforts” encompass both job applications and work search contacts as described by TWC rules. The Appeals Panel noted that in the instant case, the DWC-52 reflects that the claimant met the work search efforts requirement by making at least three job applications and work search contacts for each week during the entire qualifying period in dispute. The Appeals Panel therefore reversed the hearing officer’s decision that the claimant was not entitled to SIBs for the 1st quarter and rendered a new decision that the claimant is entitled to SIBs for the 1st quarter.

TEXAS DIVISION OF WORKERS’ COMPENSATION Appeal No. 100429-s

Under the new SIBs Rule 130.102(d)(1), the injured employee is required to make an active effort to meet the work search requirements each week during the entire qualifying period by making use of any one or more of the criteria in Rule 130.102(d)(1)(A)-(E)(Under the old SIBs rules, if the injured employee returned to work in a position which was relatively equal to the injured employee’s ability during any portion of the qualifying period that would satisfy the good faith requirement for SIBs entitlement).

Under Rule 130.102(d)(1) and Rule 130.101(8), to demonstrate an active effort to obtain employment by active participation in a Vocational Rehabilitation Plan (VRP), including an IPE with DARS, the claimant must also show at a minimum: an employment goal, any intermediate goals, a description of the services to be provided or arranged, the start and end dates of the described services, and the injured employee’s responsibilities for the successful completion of the plan.

Under Rule 130.102(d)(1)(B), active participation in a vocational rehab program means the injured employee is making a reasonable effort to fulfill her obligations in accordance with the terms of his or her VRP or IPE.

Under Rule 130.102(f), the claimant must provide documentation sufficient to establish that she has, each week during the qualifying period, made the minimum number of job applications and or work search contacts consistent with the work search contacts established by the Texas Workforce Commission (TWC).

Facts: The disputed issue before the hearing officer whether the claimant was entitled to supplemental income benefits (SIBs) for the 23rd quarter. The claimant’s theory of entitlement to SIBs was based on a combination of: 1) return to work in a position that is commensurate with her ability to work; 2) active participation in a vocational rehabilitation program (VRP); and 3) active work search efforts documented by job applications every week of the qualifying period. Claimant’s Application for SIBs showed that she was employed only during the 3rd, 7th and 10th weeks of the qualifying period. Also in evidence is a letter from DARS dated November 5, 2009, which states that the claimant “has been actively involved with vocational rehabilitation service from Division for Rehabilitation Services. She is currently in plan and seeking full time employment.” The letter included neither an employment goal, a description of the services to be provided or arranged, the start and end dates of the described services, nor the injured employee’s responsibilities for the successful
completion of the plan. The DARS letter did not indicate that the claimant was making a reasonable effort to fulfill her obligations in accordance with the terms of a vocational rehabilitation plan (VRP) or IPE. There was no IPE in evidence. There was no other evidence that the claimant was actively participating in a VRP during the qualifying period in dispute.

The minimum number of weekly work search efforts for claimant’s county of residence is three. The claimant attached to her DWC-52 a Detailed Job Search/Employer Contact Log for each week of the qualifying period documenting her work searches. For the 12th week of the qualifying period she documented only 2 work searches, but also wrote thank you letters. The hearing officer found that claimant demonstrated an active effort to obtain employment each week during the entire qualifying period by returning to work in a position commensurate with her ability to work; by performing active work search efforts; and by actively participating in a VRP. The carrier appealed, arguing that the claimant did not meet her burden of proof in demonstrating an active effort to obtain employment each week during the qualifying period in dispute. The claimant responded, urging affirmance.

**Holding:** Reversed and rendered. Claimant’s qualifying period began after July 2009; therefore the eligibility criteria for SIBs entitlement is guided by §§ 408.142 and 408.1415, and Rule 130.102(d)(1)(A-E), regarding work search compliance standards. Under Rule 130.102(d)(1), an injured employee demonstrates an active effort to obtain employment by meeting at least one or any combination of the following work search requirements each week during the entire qualifying period. The preamble to Rule 130.102(d)(1) clarifies that “the injured employee is required to make an active effort to meet the work search requirements each week during the entire qualifying period by making use of any one or more of the criteria in Rule 130.102(d)(1)(A)-(E) rather than being restricted to only one of the criteria during a qualifying period.”

Rule 130.102(d)(1) provides that an injured employee demonstrates an active effort to obtain employment by meeting at least one or any combination of the work search requirements each week during the entire qualifying period. The Appeals Panel noted that in the instant case, the claimant need not be employed every week of the qualifying period, because she may combine any one or more of the criteria in Rule 130.102(d)(1)(A)-(E) during the qualifying period to establish entitlement to SIBs.

The Appeals Panel noted that under the old SIBs rules, if the injured employee returned to work in a position which was relatively equal to the injured employee’s ability to work during any portion of the qualifying period, that would satisfy the good faith requirement for SIBs entitlement. However, under the new SIBs rules, Rule 130.102(d)(1), an injured employee is required to make an active effort to meet the work search requirements each week during the entire qualifying period by making use of any one or more of the criteria in Rule 130.102(d)(1)(A)-(E). By citing to the preamble to Rule 130.102(d)(1), the Appeals Panel notes that amendments were made to clarify that the injured employee’s work search efforts were to continue each week during the entire qualifying period.

The Appeals Panel found that the claimant complied with Rule 130.102(d)(1)(A), for the 3rd, 7th and 10th weeks of the qualifying period. That portion of the hearing officer’s finding that the claimant demonstrated an active effort to obtain employment by “returning to work in a position commensurate with her ability to work” during the 3rd, 7th and 10th weeks of the qualifying period, is supported by sufficient evidence.

The Appeals Panel noted that under Rule 130.102(d)(1), an injured employee can demonstrate an active effort to obtain employment by actively participated in a VRP as defined in Rule 130.101. A VRP, also known as an IPE at DARS, includes, at a minimum, an employment goal, any intermediate goals, a description of the services to be provided or arranged, the start and end dates of the described services, and the injured employee’s responsibilities for the successful completion of the plan. The Appeals Panel concluded that the DARS letter in evidence did not constitute an IPE because it did not include the information under Rule 130.101(8). The Ap-
peals Panel concluded that the hearing officer’s finding that the claimant demonstrated an active effort to obtain employment each week during the entire qualifying period by actively participating in a VRP as defined by Rule 130.101 is against the great weight and preponderance of the evidence.

The Appeals Panel further commented that the preamble to Rule 130.102(d)(1)(B) included public comments and responses from the Division that comment upon “active participation” in a vocational rehab program. Active participation means the injured employee is making a reasonable effort to fulfill her obligations in accordance with the terms of his or her VRP or IPE. Evidence from DARS regarding the injured employee’s participation level will be considered equally along with all other evidence.

With respect to the number of job applications required to be submitted by a recipient to satisfy the work search requirements, the Appeals Panel noted that under Rule 130.102(f), an injured employee shall provide documentation sufficient to establish that she has, each week during the qualifying period, made the minimum number of job applications and or work search contacts consistent with the work search contacts established by the Texas Workforce Commission (TWC). The Appeals Panel notes that the preamble to Rule 130.102 discusses new emphasis on required documentation that an injured employee must provide to sufficiently establish active participation in work search efforts and active work search efforts. The preamble notes that “work search efforts” would be consistent with job applications or the work search contacts established by TWC.

The Appeals Panel concluded that in the instant case, the claimant did not provide documentation sufficient to establish that she has, each week during the qualifying period, made the minimum number of job applications and or work search contacts consistent with the work search contacts established by TWC. The evidence shows that the claimant did not provide documentation to establish that she has made three job applications or work search contacts for the 12th week of the qualifying period. That portion of the hearing officer’s finding that the claimant demonstrated an active effort to obtain employment each week during the entire qualifying period by performing active work search efforts documented by job applications is against the great weight and preponderance of the evidence.

The evidence reflects that the claimant demonstrated an active effort to obtain employment by returning to work in a position commensurate with her ability to work for the 3rd, 7th and 10th weeks of the qualifying period, and by performing active work search efforts documented by job applications for the 1st through 11th and 13th weeks of the qualifying period. Because the evidence did not establish that the claimant met any of the requirements under to Rule 130.102(d)(1)(A)-(E) for active work search efforts during the 12th week of the qualifying period, the hearing officer’s determination that the claimant is entitled to SIBs for the 23rd quarter of SIBs is against the great weight and preponderance of the evidence. Accordingly, the Appeals Panel reversed the hearing officer’s decision that the claimant is entitled to SIBs for the 23rd quarter and rendered a new decision that the claimant was not entitled to SIBs for the 23rd quarter.
For spinal surgery CCH, under Rule 142.13(g), the notice setting an expedited hearing, or a hearing without a prior BRC, shall include time limits for completion of discovery. If there is no good cause for failure to exchange, when there were scheduled time limits for completion of discovery, the hearing officer’s admission of the claimant’s untimely-exchanged evidence may be reversible error.

Under Rules 133.308(l) and (m), an IRO Decision and any determination whether a surgery request currently meets appropriate ODG criteria must be based on current medical records at the time of the IRO decision, rather than records that were created after the IRO request.

Facts: The claimant sustained a compensable lumbar spine injury. An August 2009 IRO decision determined that the claimant should not have spinal surgery. The IRO decision upheld the self-insured’s denial of the requested procedure, which included a revision laminectomy, discectomy, and fusion. The screening criteria or other clinical basis used by the IRO included the Official Disability Guidelines-Treatment in Workers’ Comp (ODG) for this procedure. The IRO decision stated that the requested surgery cannot be justified for reasons including that records do not indicate that a psychological evaluation had been performed, among other reasons. Further, the IRO stated that the request did not meet appropriate ODG criteria for the requested surgery.

A Contested Case Hearing occurred on the issue of whether the preponderance of the evidence is contrary to the Independent Review Organization’s (IRO) decision.

In addition to the August 2009 IRO Decision, the hearing officer admitted a March 2010 medical report from Dr. Z, the treating surgeon, in which he references medical records that were not in existence at the time of the IRO decision. Dr. Z stated that the claimant underwent a pre-surgery psychological evaluation in October 2009 (after the IRO decision). The Dr. Z report was not exchanged prior to the hearing, and the carrier objected to its admission. The hearing officer commented that the claimant’s failure to exchange the report was attributed to the ombudsman and the report was crucial to the determination of the issue in dispute, and therefore the claimant showed good cause for the untimely exchange of documentation. Also in evidence was an “Order Setting CCH on an IRO” dated September 9, 2009, which states the date, time and location of the CCH, however, it did not state the time limits for completion of discovery, pursuant to Rule 142.13(g).

The hearing officer found that the claimant met the ODG criteria as a candidate for a revision surgery and concluded that the preponderance of the evidence was contrary to the decision of the IRO. The self-insured appealed the hearing officer’s IRO decision, and asserted that the hearing officer abused her discretion in admitting the claimant’s evidence that was not timely exchanged. The self-insured states that the hearing officer’s evidentiary ruling resulted in an improper judgment. The claimant responded, urging affirmance.

Holding: Reversed and rendered. On the issue of the hearing officer’s abuse of discretion in the admission or exclusion of evidence, the Appeals Panel noted that an appellant must first show that the admission or exclusion was in fact an abuse of discretion, and also that the error was reasonably calculated to cause and probably did cause the rendition of an improper judgment. Hernandez v. Hernandez, 611 S.W.2d 732 (Tex. Civ. App.-San Antonio 1981, no writ). In determining whether there has been an abuse of discretion, the Appeals Panel looks to see whether the hearing officer acted without reference to any guiding rules or principles. Appeals Panel Decision 043000, decided January 12, 2005; Morrow v. H.E.B., Inc., 714 S.W.2d 297 (Tex. 1986).
In a spinal surgery case, an expedited CCH is set pursuant to Labor Code Section 413.031(l) and Rule 133.308(u). Under Rule 142.13(g), the notice setting an expedited hearing, or a hearing held without a prior BRC, shall include time limits for completion of discovery. The Appeals Panel noted that under the preamble, the new subsection (g) was necessary to inform parties of an exception to the usual time limits for prehearing discovery. The Appeals Panel looked at the Hearing Officer’s reason for admitting the unexchanged report of Dr. Z, and concluded that the hearing officer’s reasoning was not good cause for untimely exchange. However, because the order setting an expedited CCH did not include time limits for completion of discovery, the hearing officer’s admission of the claimant’s evidence was not reversible error.

Looking more at the IRO Decision and other evidence, the Appeals Panel noted that under Rule 133.308(l), the carrier or the carrier URA shall submit the required documentation required in paragraphs (1)-(6) of Rule 133.308 to the IRO not later than the 3rd working day after the date the carrier reviews the notice of the IRO assignment. Based upon Rules 133.308(l) and (m), denials need to be based on current medical records.

The Appeals Panel noted that in the instant case, the pre-surgery psychological evaluation was performed on October 7, 2009, after the IRO decision. The IRO determined that the spinal surgery request did not currently meet appropriate ODG criteria for the requested surgery. Specifically, the IRO determined, in part, that the spinal surgery request did not include the pre-operative clinical psychosocial screen. Therefore, at the time of the IRO decision on August 20, 2009, the medical records reviewed by the IRO did not meet the ODG criteria for spinal surgery.

The Appeals Panel concluded that the claimant failed to present evidence to establish that the preponderance of the evidence was contrary to the decision of the IRO dated August 20, 2009. The Appeals Panel therefore reversed the hearing officer’s decision that the preponderance of the evidence is contrary to the decision of the IRO and rendered a new decision that the preponderance of the evidence is not contrary to the decision of the IRO.

TEXAS DIVISION OF WORKERS’ COMPENSATION Appeal No. 100636-s

Under §408.123, a certification of MMI and impairment rating can become final if it is valid, which means that the certification of MMI and/or IR must be on a DWC-69, and the certification meets the requirements of Rule 130.12(c): 1) there is an MMI date that is not prospective; 2) there is an IR determination of either no impairment or a percentage IR assigned; and 3) there is the signature of the certifying doctor who is authorized by the Division to make the assigned IR determination.

A certification of MMI that is after the date of statutory MMI stipulated by the parties, is neither invalid nor prospective if the MMI date is not projected to occur at some time after the certification of MMI, but rather is made by Dr. L on the date of certification.

Facts: Claimant sustained a compensable injury, for which the statutory date of MMI is June 5, 2007. Claimant’s first certification of maximum medical improvement and impairment rating was by Dr. L, who certified
A contested case hearing was held on the issues of whether the compensable injury extends to include a disc extrusion at L5-S1; and whether the first certification of MMI and IR from Dr. L on June 20, 2007, became final under Rule 130.12. The hearing officer determined that the injury did not extend to include a disc extrusion at L5-S1, and the first certification of MMI/IR from Dr. L on June 20, 2007, did not become final under §408.123 and Rule 130.12. Claimant appealed the hearing officer’s extent-of-injury determination, and the self-insured responded, urging affirmance of the extent-of-injury determination. The self-insured cross-appealed the finality determination, and claimant responded, urging affirmance.

**Holding:** Affirmed in part on the extent of injury, and reversed and rendered in part regarding finality. The Appeals Panel found that the extent-of-injury determination was supported by sufficient evidence and was affirmed. On the issue of the finality of the first valid certification of MMI and impairment, the Appeals Panel noted that under §408.123(e), an employee’s first valid certification of MMI and the first valid assignment of an IR is final if the certification or assignment is not disputed before the 91st day after the date written notification of the certification is provided to the parties by verifiable means. The Appeals Panel noted that a hearing officer should initially determine whether there is a *first valid certification* of MMI/IR before determining whether that first valid certification of MMI/IR has or has not become final. (See generally APD 061569-s, which held that a finality determination is contingent on there being a first *valid* certification of MMI and first *valid* assignment of IR under §408.123 and Rule 130.12.)

Under Rule 130.12(c), a certification of MMI and/or IR must be on a DWC-69, and it is valid if: 1) there is an MMI date that is not prospective; 2) there is an IR determination of either no impairment or a percentage IR assigned; and 3) there is the signature of the certifying doctor who is authorized by the Division to make the assigned IR determination.

The Appeals Panel noted that a date of MMI becomes prospective if it is *projected* to occur at some time after the certification of MMI is made. In this case, the Appeals Panel noted that the key consideration is that the date of MMI was not after the date of certification, that is, the signature of the certifying doctor, on the DWC-69. Under Rule 130.12(c)(1), a certification of MMI is invalid if it is prospective, however, in this case, the date of MMI was not prospective. The DWC-69 in evidence reflects that on his DWC-69, Dr. L certified on June 20, 2009, that the claimant reached MMI on that same date. Although the MMI date certified by Dr. L is not after the date of MMI stipulated by the parties, the MMI date of June 20, 2007, is not prospective because it is not projected to occur at some time after the certification of MMI was made by Dr. L on June 20, 2007. The Appeals Panel concluded that the DWC-69 in evidence was the first valid certification of MMI/IR because: 1) the DWC-69 reflects that the MMI date is June 20, 2007, which is not a prospective MMI date; 2) an impairment rating was assigned; and 3) Dr. L, as the certifying doctor authorized by the Division, signed the DWC-69.

The Appeals Panel then concluded that because Dr. L’s first certification of MMI/IR was the first valid certification, but the claimant did not dispute the certification within 90 days after receipt of written notice, Dr. L’s first certification of MMI/IR on June 20, 2007, became final pursuant to Section 408.123 and Rule 130.12.

The Appeals Panel noted that there was no argument at the hearing that an exception to finality should be considered. Accordingly, the Appeals Panel reversed the hearing officer’s determination that the first certification of MMI and assigned IR by Dr. L on June 20, 2007, did not become final and rendered a new decision that the first certification of MMI and assigned IR by Dr. L on June 20, 2007, did become final under Section 408.123 and Rule 130.12.
**Interest Calculation Per Rule 126.12**

**Third Quarter 2010**

Interest Rate Effective from 07/01/2010 through 09/30/2010: **3.80%**

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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<td>Tricia Blackshear</td>
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# KEY TASK DIRECTORY

To help expedite your email or faxed information to the correct area within FO&L and get it to the responsible person at the earliest time, use the following fax directory. Please remember the 3:30 p.m. receipt deadline for material required to be date stamped at the Division. Material received after 4:00 p.m. does not permit time to deliver it across town prior to the DWC close.

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<td>479-5319</td>
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