AN ACT
relating to the continuation and operation of the workers' compensation system of this state and to the abolition of the Texas Workers' Compensation Commission, the establishment of the office of injured employee counsel, and the transfer of the powers and duties of the Texas Workers' Compensation Commission to the division of workers' compensation of the Texas Department of Insurance and the office of injured employee counsel, and to the provision of workers' compensation benefits to injured employees and the regulation of workers' compensation insurers; providing administrative and criminal penalties.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

ARTICLE 1. ORGANIZATION OF DEPARTMENT

SECTION 1.001. The heading to Chapter 402, Labor Code, is amended to read as follows:

CHAPTER 402. OPERATION AND ADMINISTRATION OF [TEXAS WORKERS'] COMPENSATION SYSTEM [COMMISSION]

SECTION 1.002. The heading to Subchapter A, Chapter 402, Labor Code, is amended to read as follows:

SUBCHAPTER A. GENERAL ADMINISTRATION OF SYSTEM; WORKERS' COMPENSATION DIVISION [ORGANIZATION]

SECTION 1.003. Section 402.001, Labor Code, is amended to read as follows:

Sec. 402.001. ADMINISTRATION OF SYSTEM: TEXAS DEPARTMENT
OF INSURANCE; WORKERS' COMPENSATION DIVISION. (a) Except as
provided by Section 402.002, the Texas Department of Insurance is
the state agency designated to oversee the workers' compensation
system of this state.

(b) The division of workers' compensation is established as
a division within the Texas Department of Insurance to administer
and operate the workers' compensation system of this state as
provided by this title. [MEMBERSHIP REQUIREMENTS. (a) The Texas
Workers' Compensation Commission is composed of six members
appointed by the governor with the advice and consent of the senate.

[(b) Appointments to the commission shall be made without
regard to the race, color, disability, sex, religion, age, or
national origin of the appointee. Section 401.011(16) does not
apply to the use of the term "disability" in this subsection.

[(c) Three members of the commission must be employers of
labor and three members of the commission must be wage earners. A
person is not eligible for appointment as a member of the commission
if the person provides services subject to regulation by the
commission or charges fees that are subject to regulation by the
commission.

[(d) In making appointments to the commission, the governor
shall attempt to reflect the social, geographic, and economic
diversity of the state. To ensure balanced representation, the
governor may consider:

[(1) the geographic location of a prospective
appointee's domicile;

[(2) the prospective appointee's experience as an
employer or wage earner;

(3) the number of employees employed by a prospective member who would represent employers; and

(4) the type of work performed by a prospective member who would represent wage earners.

(e) The governor shall consider the factors listed in Subsection (d) in appointing a member to fill a vacancy on the commission.

(f) In making an appointment to the commission, the governor shall consider recommendations made by groups that represent employers or wage earners.

SECTION 1.004. Subchapter A, Chapter 402, Labor Code, is amended by adding Sections 402.00111-402.00128 to read as follows:

Sec. 402.00111. RELATIONSHIP BETWEEN COMMISSIONER OF INSURANCE AND COMMISSIONER OF WORKERS' COMPENSATION; SEPARATION OF AUTHORITY; RULEMAKING. (a) The division is administered by the commissioner of workers' compensation as provided by this subchapter. Except as otherwise provided by this title, the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority, under this title.

(b) The commissioner of insurance may delegate to the commissioner of workers' compensation or to that person's designee and may redact any delegation, and the commissioner of workers' compensation may delegate to the commissioner of insurance or to that person's designee, any power or duty regarding workers' compensation imposed on the commissioner of insurance or the commissioner of workers' compensation under this title, including
the authority to make final orders or decisions. A delegation made
under this subsection must be made in writing.

(c) The commissioner of insurance shall develop and
implement policies that clearly separate the respective
responsibilities of the department and the division.

(d) The commissioner of insurance may provide advice,
research, and comment regarding the adoption of rules by the
commissioner of workers' compensation under this subtitle.

Sec. 402.00112. INVESTIGATION OF DIVISION. The department
shall investigate the conduct of the work of the division. For that
purpose, the department shall have access at any time to all
division books and records and may require an officer or employee of
the division to furnish written or oral information.

Sec. 402.00113. ADMINISTRATIVE ATTACHMENT TO DEPARTMENT.
(a) The division of workers' compensation is administratively
attached to the department.

(b) The department shall provide the staff and facilities
necessary to enable the division to perform the duties of the
division under this title, including:

(1) administrative assistance and services to the
division, including budget planning and purchasing;

(2) personnel and financial services; and

(3) computer equipment and support.

(c) The commissioner of workers' compensation and the
commissioner of insurance may enter into agreements as necessary to
implement this title.

Sec. 402.00114. DUTIES OF DIVISION; SINGLE POINT OF
CONTACT. (a) In addition to other duties required under this title, the division shall:

(1) regulate and administer the business of workers' compensation in this state; and

(2) ensure that this title and other laws regarding workers' compensation are executed.

(b) To the extent determined feasible by the commissioner, the division shall establish a single point of contact for injured employees receiving services from the division.

Sec. 402.00115. COMPOSITION OF DIVISION. The division is composed of the commissioner of workers' compensation and other officers and employees as required to efficiently implement:

(1) this title;

(2) other workers' compensation laws of this state; and

(3) other laws granting jurisdiction or applicable to the division or the commissioner.

Sec. 402.00116. CHIEF EXECUTIVE. (a) The commissioner of workers' compensation is the division's chief executive and administrative officer. The commissioner shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to the division or the commissioner. Except as otherwise specifically provided by this title, a reference in this title to the "commissioner" means the commissioner of workers' compensation.

(b) The commissioner has the powers and duties vested in the division by this title and other workers' compensation laws of this
Sec. 402.00117. APPOINTMENT; TERM. (a) The governor, with the advice and consent of the senate, shall appoint the commissioner. The commissioner serves a two-year term that expires on February 1 of each odd-numbered year.

(b) The governor shall appoint the commissioner without regard to the race, color, disability, sex, religion, age, or national origin of the appointee.

Sec. 402.00118. QUALIFICATIONS. The commissioner must:

(1) be a competent and experienced administrator;

(2) be well-informed and qualified in the field of workers' compensation; and

(3) have at least five years of experience as an executive in the administration of business or government or as a practicing attorney, physician, or certified public accountant.

Sec. 402.00119. INELIGIBILITY FOR PUBLIC OFFICE. The commissioner is ineligible to be a candidate for a public elective office in this state unless the commissioner has resigned and the governor has accepted the resignation.

Sec. 402.00120. COMPENSATION. The commissioner is entitled to compensation as provided by the General Appropriations Act.

Sec. 402.00121. GROUNDS FOR REMOVAL. (a) It is a ground for removal from office that the commissioner:

(1) does not have at the time of appointment the qualifications required by Section 402.00118;

(2) does not maintain during service as commissioner the qualifications required by Section 402.00118;
(3) violates a prohibition established by Section 402.00122, 402.00124, 402.00125, or 402.00126; or
(4) cannot because of illness or incapacity discharge the commissioner's duties for a substantial part of the commissioner's term.

(b) The validity of an action of the commissioner or the division is not affected by the fact that it is taken when a ground for removal of the commissioner exists.

Sec. 402.00122. PROHIBITED GIFTS; ADMINISTRATIVE VIOLATION. (a) The commissioner or an employee of the division may not accept a gift, a gratuity, or entertainment from a person having an interest in a matter or proceeding pending before the division.

(b) A violation of Subsection (a) is an administrative violation and constitutes a ground for removal from office or termination of employment.

Sec. 402.00123. CIVIL LIABILITY OF COMMISSIONER. The commissioner is not liable in a civil action for an act performed in good faith in the execution of duties as commissioner.

Sec. 402.00124. CONFLICT OF INTEREST. (a) In this section, "Texas trade association" means a cooperative and voluntarily joined statewide association of business or professional competitors in this state designed to assist its members and its industry or profession in dealing with mutual business or professional problems and in promoting their common interest.

(b) A person may not be the commissioner and may not be a division employee employed in a "bona fide executive, administrative, or professional capacity" as that phrase is used...
for purposes of establishing an exemption to the overtime provisions of the federal Fair Labor Standards Act of 1938 (29 U.S.C. Section 201 et seq.) if:

(1) the person is an officer, employee, or paid consultant of a Texas trade association in the field of workers' compensation; or

(2) the person's spouse is an officer, manager, or paid consultant of a Texas trade association in the field of workers' compensation.

Sec. 402.00125. PROHIBITION ON CERTAIN EMPLOYMENT OR REPRESENTATION. (a) A former commissioner or former employee of the division involved in hearing cases under this title may not:

(1) be employed by an insurance carrier that was subject to the scope of the commissioner's or employee's official responsibility while the commissioner or employee was associated with the division; or

(2) represent a person before the division or a court in a matter:

(A) in which the commissioner or employee was personally involved while associated with the division; or

(B) that was within the commissioner's or employee's official responsibilities while the commissioner or employee was associated with the division.

(b) The prohibition under Subsection (a)(1) applies until the:

(1) second anniversary of the date the commissioner ceases to serve as the commissioner; and
(2) first anniversary of the date the employee's employment with the division ceases.

(c) The prohibition under Subsection (a)(2) applies to a current commissioner or employee of the division while the commissioner or employee is involved in hearing cases under this title and at any time thereafter.

(d) A person commits an offense if the person violates this section. An offense under this section is a Class A misdemeanor.

Sec. 402.00126. LOBBYING ACTIVITIES. A person may not serve as commissioner or act as general counsel to the commissioner if the person is required to register as a lobbyist under Chapter 305, Government Code, because of the person's activities for compensation related to the operation of the department or the division.

Sec. 402.00127. TRAINING PROGRAM FOR COMMISSIONER. (a) Not later than the 90th day after the date on which the commissioner takes office, the commissioner shall complete a training program that complies with this section.

(b) The training program must provide the commissioner with information regarding:

(1) the legislation that created the division;
(2) the programs operated by the division;
(3) the role and functions of the division;
(4) the rules of the commissioner of insurance relating to the division, with an emphasis on the rules that relate to disciplinary and investigatory authority;
(5) the current budget for the division;
(6) the results of the most recent formal audit of the division;

(7) the requirements of:

(A) the open meetings law, Chapter 551, Government Code;

(B) the public information law, Chapter 552, Government Code;

(C) the administrative procedure law, Chapter 2001, Government Code; and

(D) other laws relating to public officials, including conflict-of-interest laws; and

(8) any applicable ethics policies adopted by the division or the Texas Ethics Commission.

Sec. 402.0012. GENERAL POWERS AND DUTIES OF COMMISSIONER.
(a) The commissioner shall conduct the daily operations of the division and otherwise implement division policy.

(b) The commissioner or the commissioner's designee may:

(1) investigate misconduct;

(2) hold hearings;

(3) issue subpoenas to compel the attendance of witnesses and the production of documents;

(4) administer oaths;

(5) take testimony directly or by deposition or interrogatory;

(6) assess and enforce penalties established under this title;

(7) enter appropriate orders as authorized by this
(8) institute an action in the division's name to enjoin the violation of this title;
(9) initiate an action under Section 410.254 to intervene in a judicial proceeding;
(10) prescribe the form, manner, and procedure for the transmission of information to the division;
(11) correct clerical errors in the entry of orders;
and
(12) exercise other powers and perform other duties as necessary to implement and enforce this title.

(c) The commissioner is the agent for service of process on out-of-state employers.

SECTION 1.005. Section 402.002, Labor Code, is amended to read as follows:

Sec. 402.002. ADMINISTRATION OF SYSTEM: OFFICE OF INJURED EMPLOYEE COUNSEL. The office of injured employee counsel established under Chapter 404 shall perform the functions regarding the provision of workers' compensation benefits in this state designated by this subtitle as under the authority of that office. [TERMS; VACANCY. (a) Members of the commission hold office for staggered two-year terms, with the terms of three members expiring on February 1 of each year.

[(b) If a vacancy occurs during a term, the governor shall fill the vacancy for the unexpired term. The replacement must be from the group represented by the member being replaced.]

SECTION 1.006. The heading to Subchapter B, Chapter 402,
Labor Code, is amended to read as follows:

SUBCHAPTER B. SYSTEM GOALS; GENERAL ADMINISTRATION OF SYSTEM

SECTION 1.0065. Section 402.021, Labor Code, is amended to read as follows:

Sec. 402.021. GOALS; LEGISLATIVE INTENT; GENERAL WORKERS' COMPENSATION MISSION OF DEPARTMENT. (a) The basic goals of the workers' compensation system of this state are as follows:

(1) each employee shall be treated with dignity and respect when injured on the job;

(2) each injured employee shall have access to a fair and accessible dispute resolution process;

(3) each injured employee shall have access to prompt, high-quality medical care within the framework established by this subtitle; and

(4) each injured employee shall receive services to facilitate the employee's return to employment as soon as it is considered safe and appropriate by the employee's health care provider.

(b) It is the intent of the legislature that, in implementing the goals described by Subsection (a), the workers' compensation system of this state must:

(1) promote safe and healthy workplaces through appropriate incentives, education, and other actions;

(2) encourage the safe and timely return of injured employees to productive roles in the workplace;

(3) provide appropriate income benefits and medical benefits in a manner that is timely and cost-effective;
provide timely, appropriate, and high-quality medical care supporting restoration of the injured employee's physical condition and earning capacity;

(5) minimize the likelihood of disputes and resolve them promptly and fairly when identified;

(6) promote compliance with this subtitle and rules adopted under this subtitle through performance-based incentives;

(7) promptly detect and appropriately address acts or practices of noncompliance with this subtitle and rules adopted under this subtitle;

(8) effectively educate and clearly inform each person who participates in the system as a claimant, employer, insurance carrier, health care provider, or other participant of the person's rights and responsibilities under the system and how to appropriately interact within the system; and

(9) take maximum advantage of technological advances to provide the highest levels of service possible to system participants and to promote communication among system participants.

(c) This section may not be construed as:

(1) creating a cause of action; or

(2) establishing an entitlement to benefits to which a claimant is not otherwise entitled by this subtitle.

(d) As provided by this subtitle, the division shall work to promote and help ensure the safe and timely return of injured employees to productive roles in the workforce.
(1) a division of workers' health and safety;
(2) a division of medical review;
(3) a division of compliance and practices; and
(4) a division of hearings.

(b) In addition to the divisions listed by Subsection (a), the executive director, with the approval of the commission, may establish divisions within the commission for effective administration and performance of commission functions. The executive director may allocate and reallocate functions among the divisions.

(c) The executive director shall appoint the directors of the divisions of the commission. The directors serve at the pleasure of the executive director.

SECTION 1.007. Subchapter C, Chapter 402, Labor Code, is amended to read as follows:

SUBCHAPTER C. [EXECUTIVE DIRECTOR AND PERSONNEL]

Sec. 402.041. APPOINTMENTS. (a) Subject to the General Appropriations Act or other law, the commissioner shall appoint deputies, assistants, and other personnel as necessary to carry out the powers and duties of the commissioner and the division under this title, other workers' compensation laws of this state, and other laws granting jurisdiction or applicable to the division or the commissioner.

(b) A person appointed under this section must have the professional, administrative, and workers' compensation experience necessary to qualify the person for the position to which the person is appointed.
Sec. 402.042. DIVISION OF RESPONSIBILITIES. The commissioner shall develop and implement policies that clearly define the respective responsibilities of the commissioner and the staff of the division. [EXECUTIVE DIRECTOR. (a) The executive director is the executive officer and administrative head of the commission. The executive director exercises all rights, powers, and duties imposed or conferred by law on the commission, except for rulemaking and other rights, powers, and duties specifically reserved under this subtitle to members of the commission. [(b) The executive director shall hire personnel as necessary to administer this subtitle. [(c) The executive director serves at the pleasure of the commission. [(d) The commission shall develop and implement policies that clearly separate the policymaking responsibilities of the commission and the management responsibilities of the executive director and the staff of the commission. [Sec. 402.042. GENERAL POWERS AND DUTIES OF EXECUTIVE DIRECTOR. (a) The executive director shall conduct the day-to-day operations of the commission in accordance with policies established by the commission and otherwise implement commission policy. [(b) The executive director may: [(1) investigate misconduct; [(2) hold hearings; [(3) issue subpoenas to compel the attendance of witnesses and the production of documents;
(4) administer oaths;
(5) take testimony directly or by deposition or interrogatory;
(6) assess and enforce penalties established under this subtitle;
(7) enter appropriate orders as authorized by this subtitle;
(8) correct clerical errors in the entry of orders;
(9) institute an action in the commission's name to enjoin the violation of this subtitle;
(10) initiate an action under Section 410.254 to intervene in a judicial proceeding;
(11) prescribe the form, manner, and procedure for transmission of information to the commission; and
(12) delegate all powers and duties as necessary.

(c) The executive director is the agent for service of process on out-of-state employers.

Sec. 402.043. ADMINISTRATIVE ASSISTANTS. The executive director shall employ and supervise:

(1) one person representing wage earners permanently assigned to act as administrative assistant to the members of the commission who represent wage earners; and
(2) one person representing employers permanently assigned to act as administrative assistant to the members of the commission who represent employers.

Sec. 402.043 [402.044]. CAREER LADDER; ANNUAL PERFORMANCE EVALUATIONS. (a) The commissioner or the commissioner's designee
[executive director] shall develop an intra-agency career ladder program that addresses opportunities for mobility and advancement for employees within the division [commission]. The program shall require intra-agency postings of all positions concurrently with any public posting.

(b) The commissioner or the commissioner's designee [executive director] shall develop a system of annual performance evaluations that are based on documented employee performance. All merit pay for division [commission] employees must be based on the system established under this subsection.

Sec. 402.044 [402.045]. EQUAL EMPLOYMENT OPPORTUNITY POLICY STATEMENT. (a) The commissioner or the commissioner's designee [executive director] shall prepare and maintain a written policy statement to ensure implementation of a program of equal employment opportunity under which all personnel transactions are made without regard to race, color, disability, sex, religion, age, or national origin. The policy statement must include:

(1) personnel policies, including policies related to recruitment, evaluation, selection, appointment, training, and promotion of personnel that are in compliance with the requirements of Chapter 21;

(2) a comprehensive analysis of the division [commission] work force that meets federal and state guidelines;

(3) procedures by which a determination can be made of significant underuse in the division [commission] work force of all persons for whom federal or state guidelines encourage a more equitable balance; and
(4) reasonable methods to appropriately address those
areas of underuse.

(b) A policy statement prepared under this section must:
(1) cover an annual period;
(2) be updated annually;
(3) be reviewed by the civil rights division of the
Texas Workforce Commission [on Human Rights] for compliance with
Subsection (a)(1); and
(4) be filed with the Texas Workforce Commission
[governor's office].

(c) The Texas Workforce Commission [governor's office]
shall deliver a biennial report to the legislature based on the
information received under Subsection (b). The report may be made
separately or as part of other biennial reports made to the
legislature.

ARTICLE 2. CONFORMING AMENDMENTS WITHIN CHAPTER 402, LABOR CODE;
GENERAL POWERS AND DUTIES OF WORKERS' COMPENSATION DIVISION
SECTION 2.001. Subchapter B, Chapter 402, Labor Code, is
amended by adding Section 402.0215 to read as follows:
Sec. 402.0215. REFERENCE TO COMMISSION DIVISIONS. A
reference in this title or any other law to the division of workers'
health and safety, the division of medical review, the division of
compliance and practices, the division of hearings, and the
division of self-insurance regulation of the former Texas Workers'
Compensation Commission means the division of workers'
compensation of the Texas Department of Insurance.

SECTION 2.002. Section 402.022, Labor Code, is amended to
read as follows:

Sec. 402.022. PUBLIC INTEREST INFORMATION. (a) The commissioner [executive director] shall prepare information of public interest describing the functions of the division [commission] and the procedures by which complaints are filed with and resolved by the division [commission].

(b) The commissioner [executive director] shall make the information available to the public and appropriate state agencies.

(c) The commissioner by rule shall ensure that each division form, standard letter, and brochure under this subtitle:

(1) is written in plain language;

(2) is in a readable and understandable format; and

(3) complies with all applicable requirements relating to minimum readability requirements.

(d) The division shall make informational materials described by this section available in English and Spanish.

SECTION 2.003. Subchapter B, Chapter 402, Labor Code, is amended by amending Section 402.023 and adding Section 402.0235 to read as follows:

Sec. 402.023. COMPLAINT INFORMATION. (a) The commissioner shall:

(1) adopt rules regarding the filing of a complaint under this subtitle against an individual or entity subject to regulation under this subtitle; and

(2) ensure that information regarding the complaint process is available on the division's Internet website.

(b) The rules adopted under this section must, at a minimum:
(1) ensuring that the division clearly defines in rule the method for filing a complaint; and

(2) defining what constitutes a frivolous complaint under this subtitle.

(c) The division shall develop and post on the division's Internet website:

(1) a simple standardized form for filing complaints under this subtitle; and

(2) information regarding the complaint filing process.

(d) The division [executive director] shall keep an information file about each written complaint filed with the division under this subtitle [commission] that is unrelated to a specific workers' compensation claim, including a complaint regarding the administration of the workers' compensation system. The information must include:

(1) the date the complaint is received;

(2) the name of the complainant;

(3) the subject matter of the complaint;

(4) a record of all persons contacted in relation to the complaint;

(5) a summary of the results of the review or investigation of the complaint; and

(6) for complaints for which the division [commission] took no action, an explanation of the reason the complaint was closed without action.

(e) [.] For each written complaint that is unrelated to a
specific workers' compensation claim that the division has authority to resolve, the division shall provide to the person filing the complaint and the person about whom the complaint is made information about the division's policies and procedures under this subtitle relating to complaint investigation and resolution. The division, at least quarterly and until final disposition of the complaint, shall notify those persons about the status of the complaint unless the notice would jeopardize an undercover investigation.

Sec. 402.0235. PRIORITIES FOR COMPLAINT INVESTIGATIONS. (a) The division shall assign priorities to complaint investigations under this subtitle based on risk. In developing priorities under this section, the division shall develop a formal, risk-based complaint investigation system that considers:

(1) the severity of the alleged violation;
(2) whether the alleged violator showed continued or wilful noncompliance; and
(3) whether a commissioner order has been violated.

(b) The commissioner may develop additional risk-based criteria as determined necessary.

SECTION 2.004. Section 402.024, Labor Code, is amended to read as follows:

Sec. 402.024. PUBLIC PARTICIPATION. (a) The commissioner shall develop and implement policies that provide the public with a reasonable opportunity to appear before the division and to speak on issues under the general jurisdiction.
of the division [commission].

(b) The division [commission] shall comply with federal and state laws related to program and facility accessibility.

(c) In addition to compliance with Subsection (a), the commissioner [executive director] shall prepare and maintain a written plan that describes how a person who does not speak English may be provided reasonable access to the division's [commission's] programs and services.

SECTION 2.005. The heading to Subchapter D, Chapter 402, Labor Code, is amended to read as follows:

SUBCHAPTER D. GENERAL POWERS AND DUTIES OF DIVISION AND COMMISSIONER [COMMISSION]

SECTION 2.006. Section 402.061, Labor Code, is amended to read as follows:

Sec. 402.061. ADOPTION OF RULES. The commissioner [commission] shall adopt rules as necessary for the implementation and enforcement of this subtitle.

SECTION 2.007. Subsection (a), Section 402.062, Labor Code, is amended to read as follows:

(a) The division [commission] may accept gifts, grants, or donations as provided by rules adopted by the commissioner [commission].

SECTION 2.008. Section 402.064, Labor Code, is amended to read as follows:

Sec. 402.064. FEES. In addition to fees established by this subtitle, the commissioner [commission] shall set reasonable fees for services provided to persons requesting services from the
division [commission], including services provided under
Subchapter E.

SECTION 2.009. Section 402.065, Labor Code, is amended to
read as follows:

Sec. 402.065. EMPLOYMENT OF COUNSEL. Notwithstanding
Article 1.09-1, Insurance Code, or any other law, the commissioner
[The commission] may employ counsel to represent the division
[commission] in any legal action the division [commission] is
authorized to initiate.

SECTION 2.010. Section 402.066, Labor Code, is amended to
read as follows:

Sec. 402.066. RECOMMENDATIONS TO LEGISLATURE. (a) The
commissioner [commission] shall consider and recommend to the
legislature changes to this subtitle, including any statutory
changes required by an evaluation conducted under Section 402.074.

(b) The commissioner [commission] shall forward the
recommended changes to the legislature not later than December 1 of
each even-numbered year.

SECTION 2.011. Section 402.0665, Labor Code, is amended to
read as follows:

Sec. 402.0665. LEGISLATIVE OVERSIGHT. The legislature may
adopt requirements relating to legislative oversight of the
division [commission] and the workers' compensation system of this
state. The division [commission] shall comply with any
requirements adopted by the legislature under this section.

SECTION 2.012. Section 402.067, Labor Code, is amended to
read as follows:
Sec. 402.067. ADVISORY COMMITTEES. The commissioner may appoint advisory committees as the commissioner considers necessary.

SECTION 2.013. Section 402.068, Labor Code, is amended to read as follows:

Sec. 402.068. DELEGATION OF RIGHTS AND DUTIES. Except as expressly provided by this subtitle [subchapter], the division [commission] may not delegate rights and duties imposed on it by this subchapter.

SECTION 2.014. Section 402.069, Labor Code, is amended to read as follows:

Sec. 402.069. QUALIFICATIONS AND STANDARDS OF CONDUCT INFORMATION. The commissioner or the commissioner's designee [executive director] shall provide to division [members of the commission and commission] employees, as often as necessary, information regarding their:

(1) qualifications for office or employment under this subtitle; and

(2) responsibilities under applicable law relating to standards of conduct for state officers or employees.

SECTION 2.015. Subsection (a), Section 402.071, Labor Code, is amended to read as follows:

(a) The commissioner [commission] shall establish qualifications for a representative and shall adopt rules establishing procedures for authorization of representatives.

SECTION 2.016. Section 402.072, Labor Code, is amended to read as follows:
Sec. 402.072. SANCTIONS. (a) The division may impose sanctions against any person regulated by the division under this subtitle.

(b) Only the commissioner [commission] may impose:

(1) a sanction that deprives a person of the right to practice before the division [commission] or of the right to receive remuneration under this subtitle for a period exceeding 30 days; or

(2) another sanction suspending for more than 30 days or revoking a license, certification, or permit required for practice in the field of workers' compensation.

(c) A sanction imposed by the division is binding pending appeal.

SECTION 2.017. Section 402.073, Labor Code, is amended to read as follows:

Sec. 402.073. COOPERATION WITH STATE OFFICE OF ADMINISTRATIVE HEARINGS. (a) The commissioner [commission] and the chief administrative law judge of the State Office of Administrative Hearings by rule shall adopt a memorandum of understanding governing administrative procedure law hearings under this subtitle conducted by the State Office of Administrative Hearings in the manner provided for a contested case hearing under Chapter 2001, Government Code [the administrative procedure law].

(b) In a case in which a hearing is conducted by the State Office of Administrative Hearings under Section [411.049, 413.031, 413.055, 415.034, 413.055(7) or 415.034, the administrative law judge who
conducts the hearing for the State Office of Administrative
Hearings shall enter the final decision in the case after
completion of the hearing.

(c) In a case in which a hearing is conducted in conjunction
with Section 402.072, 407.046, or 408.023, and in other cases under
this subtitle that are not subject to Subsection (b), the
administrative law judge who conducts the hearing for the State
Office of Administrative Hearings shall propose a decision to the
commissioner for final consideration and decision by
the commissioner.

SECTION 2.018. Subchapter D, Chapter 402, Labor Code, is
amended by adding Sections 402.074, 402.075, 402.076, 402.077, and
402.078 to read as follows:

Sec. 402.074. STRATEGIC MANAGEMENT; EVALUATION. The
commissioner shall implement a strategic management plan that:

(1) requires the division to evaluate and analyze the
effectiveness of the division in implementing:

(A) the statutory goals adopted under Section
402.021, particularly goals established to encourage the safe and
timely return of injured employees to productive work roles; and

(B) the other standards and requirements adopted
under this code, the Insurance Code, and other applicable laws of
this state; and

(2) modifies the organizational structure and
programs of the division as necessary to address shortfalls in the
performance of the workers' compensation system of this state.

Sec. 402.075. INCENTIVES; PERFORMANCE-BASED OVERSIGHT.
(a) The commissioner by rule shall adopt requirements that:

(1) provide incentives for overall compliance in the workers' compensation system of this state; and

(2) emphasize performance-based oversight linked to regulatory outcomes.

(b) The commissioner shall develop key regulatory goals to be used in assessing the performance of insurance carriers and health care providers. The goals adopted under this subsection must align with the general regulatory goals of the division under this subtitle, such as improving workplace safety and return-to-work outcomes, in addition to goals that support timely payment of benefits and increased communication.

(c) At least biennially, the division shall assess the performance of insurance carriers and health care providers in meeting the key regulatory goals. The division shall examine overall compliance records and dispute resolution and complaint resolution practices to identify insurance carriers and health care providers who adversely impact the workers' compensation system and who may require enhanced regulatory oversight. The division shall conduct the assessment through analysis of data maintained by the division and through self-reporting by insurance carriers and health care providers.

(d) Based on the performance assessment, the division shall develop regulatory tiers that distinguish among insurance carriers and health care providers who are poor performers, who generally are average performers, and who are consistently high performers. The division shall focus its regulatory oversight on insurance carriers and health care providers who have been identified through the assessment as poor performers.
carriers and health care providers identified as poor performers.

(e) The commissioner by rule shall develop incentives within each tier under Subsection (d) that promote greater overall compliance and performance. The regulatory incentives may include modified penalties, self-audits, or flexibility based on performance.

(f) The division shall:

(1) ensure that high-performing entities are publicly recognized; and

(2) allow those entities to use that designation as a marketing tool.

(g) In conjunction with the division's accident prevention services under Subchapter E, Chapter 411, the division shall conduct audits of accident prevention services offered by insurance carriers based on the comprehensive risk assessment. The division shall periodically review those services, but may provide incentives for less regulation of carriers based on performance.

Sec. 402.076. GENERAL DUTIES; FUNDING. (a) The division shall perform the workforce education and safety functions of the workers' compensation system of this state.

(b) The operations of the division under this section are funded through the maintenance tax assessed under Section 403.002.

Sec. 402.077. EDUCATIONAL PROGRAMS. (a) The division shall provide education on best practices for return-to-work programs and workplace safety.

(b) The division shall evaluate and develop the most efficient, cost-effective procedures for implementing this
section.

Sec. 402.078. REGIONAL OFFICES. The department shall operate regional offices throughout this state as necessary to implement the duties of the division and the department under this subtitle.

SECTION 2.019. Section 402.081, Labor Code, is amended to read as follows:

Sec. 402.081. DIVISION [COMMISSION] RECORDS. (a) The commissioner [executive director] is the custodian of the division's [commission's] records and shall perform the duties of a custodian required by law, including providing copies and the certification of records.

(b) The division shall comply with records retention schedules as provided by Chapter 441.185, Government Code [executive director may destroy a record maintained by the commission pertaining to an injury after the 50th anniversary of the date of the injury to which the record refers unless benefits are being paid on the claim on that date].

(c) A record maintained by the division [commission] may be preserved in any format permitted by Chapter 441, Government Code, and rules adopted by the Texas State Library and Archives Commission under that chapter.

(d) The division [commission] may charge a reasonable fee for making available for inspection any of its information that contains confidential information that must be redacted before the information is made available. However, when a request for information is for the inspection of 10 or fewer pages, and a copy
of the information is not requested, the division [commission] may charge only the cost of making a copy of the page from which confidential information must be redacted. The fee for access to information under Chapter 552, Government Code, shall be in accord with the rules of the Texas Building and Procurement [General Services] Commission that prescribe the method for computing the charge for copies under that chapter.

SECTION 2.020. Section 402.082, Labor Code, is amended to read as follows:

Sec. 402.082. INJURY INFORMATION MAINTAINED BY DIVISION [COMMISSION]. (a) The division [commission] shall maintain information on every compensable injury as to the:

(1) race, ethnicity, and sex of the claimant;
(2) classification of the injury;
(3) identification of whether the claimant is receiving medical care through a workers’ compensation health care network certified under Chapter 1305, Insurance Code;
(4) amount of wages earned by the claimant before the injury; and
(5) amount of compensation received by the claimant.

(b) The division shall provide information maintained under Subsection (a) to the office of injured employee counsel. The confidentiality requirements imposed under Section 402.083 apply to injury information maintained by the division.

SECTION 2.021. Subsection (a), Section 402.083, Labor Code, is amended to read as follows:
(a) Information in or derived from a claim file regarding an employee is confidential and may not be disclosed by the division except as provided by this subtitle or other law.

SECTION 2.022. Subsections (a), (b), and (d), Section 402.084, Labor Code, are amended to read as follows:

(a) The division shall perform and release a record check on an employee, including current or prior injury information, to the parties listed in Subsection (b) if:

(1) the claim is:

(A) open or pending before the division;

(B) on appeal to a court of competent jurisdiction; or

(C) the subject of a subsequent suit in which the insurance carrier or the subsequent injury fund is subrogated to the rights of the named claimant; and

(2) the requesting party requests the release on a form prescribed by the division for this purpose and provides all required information.

(b) Information on a claim may be released as provided by Subsection (a) to:

(1) the employee or the employee's legal beneficiary;

(2) the employee's or the legal beneficiary's representative;

(3) the employer at the time of injury;

(4) the insurance carrier;

(5) the Texas Certified Self-Insurer Guaranty...
Association established under Subchapter G, Chapter 407, if that
association has assumed the obligations of an impaired employer;

(6) the Texas Property and Casualty Insurance Guaranty
Association, if that association has assumed the obligations of an
impaired insurance company;

(7) a third-party litigant in a lawsuit in which the
cause of action arises from the incident that gave rise to the
injury; or

(8) a subclaimant under Section 409.009 that is an
insurance carrier that has adopted an antifraud plan under
Subchapter B, Chapter 704 [Article 3.97-3], Insurance Code, or the
authorized representative of such a subclaimant.

(d) Information on a claim relating to a subclaimant under
Subsection (b)(8) may include information, in an electronic data
format, on all workers' compensation claims necessary to determine
if a subclaim exists. The information on a claim remains subject to
confidentiality requirements while in the possession of a
subclaimant or representative. The commissioner [commission] by
rule may establish a reasonable fee for all information requested
under this subsection in an electronic data format by subclaimants
or authorized representatives of subclaimants. The commissioner
[commission] shall adopt rules under Section 401.024(d) to
establish:

(1) reasonable security parameters for all transfers
of information requested under this subsection in electronic data
format; and

(2) requirements regarding the maintenance of
electronic data in the possession of a subclaimant or the subclaimant's representative.

SECTION 2.023. Section 402.085, Labor Code, is amended to read as follows:

Sec. 402.085. EXCEPTIONS TO CONFIDENTIALITY. (a) The division [commission] shall release information on a claim to:

(1) the Texas Department of Insurance for any statutory or regulatory purpose, including a research purpose under Chapter 405;

(2) a legislative committee for legislative purposes;

(3) a state or federal elected official requested in writing to provide assistance by a constituent who qualifies to obtain injury information under Section 402.084(b), if the request for assistance is provided to the division [commission];

(4) [the Research and Oversight Council on Workers' Compensation for research purposes; or

[451] the attorney general or another entity that provides child support services under Part D, Title IV, Social Security Act (42 U.S.C. Section 651 et seq.), relating to:

(A) establishing, modifying, or enforcing a child support or medical support obligation; or

(B) locating an absent parent; or

(5) the office of injured employee counsel for any statutory or regulatory purpose that relates to a duty of that office.

(b) The division [commission] may release information on a claim to a governmental agency, political subdivision, or
regulatory body to use to:

(1) investigate an allegation of a criminal offense or licensing or regulatory violation;

(2) provide:
   (A) unemployment compensation benefits;
   (B) crime victims compensation benefits;
   (C) vocational rehabilitation services; or
   (D) health care benefits;

(3) investigate occupational safety or health violations;

(4) verify income on an application for benefits under an income-based state or federal assistance program; or

(5) assess financial resources in an action, including an administrative action, to:
   (A) establish, modify, or enforce a child support or medical support obligation;
   (B) establish paternity;
   (C) locate an absent parent; or
   (D) cooperate with another state in an action authorized under Part D, Title IV, Social Security Act (42 U.S.C. Section 651 et seq.), or Chapter 231, Family H.R. 42 U.S.C. Section 651 et seq.), or Chapter 231, Family Code.

SECTION 2.024. Subsections (a), (b), and (d), Section 402.088, Labor Code, are amended to read as follows:

(a) On receipt of a valid request made under and complying with Section 402.087, the division shall review its records.
(b) If the division [commission] finds that the applicant has made two or more general injury claims in the preceding five years, the division [commission] shall release the date and description of each injury to the employer.

(d) If the employer requests information on three or more applicants at the same time, the division [commission] may refuse to release information until it receives the written authorization from each applicant.

SECTION 2.025. Section 402.089, Labor Code, is amended to read as follows:

Sec. 402.089. FAILURE TO FILE AUTHORIZATION[; ADMINISTRATIVE VIOLATION]. [(a)] An employer who receives information by telephone from the division [commission] under Section 402.088 and who fails to file the necessary authorization in accordance with Section 402.087 commits an [a Class C] administrative violation.

[(b) Each failure to file an authorization is a separate violation.]

SECTION 2.026. Section 402.090, Labor Code, is amended to read as follows:

Sec. 402.090. STATISTICAL INFORMATION. The division [commission], the Texas Department of Insurance [research center], or any other governmental agency may prepare and release statistical information if the identity of an employee is not explicitly or implicitly disclosed.

SECTION 2.027. Subsection (a), Section 402.091, Labor Code, is amended to read as follows:
A person commits an offense if the person knowingly, intentionally, or recklessly publishes, discloses, or distributes information that is confidential under this subchapter to a person not authorized to receive the information directly from the division [commission].

SECTION 2.028. Section 402.092, Labor Code, is amended to read as follows:

Sec. 402.092. INVESTIGATION FILES CONFIDENTIAL; DISCLOSURE OF CERTAIN INFORMATION. (a) In this section, "investigation file" means any information compiled or maintained by the division with respect to a division investigation authorized under this subtitle or other workers' compensation law. The term does not include information or material acquired by the division that is relevant to an investigation by the insurance fraud unit and subject to Section 701.151, Insurance Code.

(b) Information maintained in the investigation files of the division [commission] is confidential and may not be disclosed except:

(1) in a criminal proceeding;

(2) in a hearing conducted by the division [commission];

(3) on a judicial determination of good cause; [or]

(4) to a governmental agency, political subdivision, or regulatory body if the disclosure is necessary or proper for the enforcement of the laws of this or another state or of the United States; or

(5) to an insurance carrier if the investigation file
relates directly to a felony regarding workers' compensation or to a claim in which restitution is required to be paid to the insurance carrier.

(c) Division [Commission] investigation files are not open records for purposes of Chapter 552, Government Code.

(d) Information in an investigation file that is information in or derived from a claim file, or an employer injury report or occupational disease report, is governed by the confidentiality provisions relating to that information.

[(d) For purposes of this section, "investigation file" means any information compiled or maintained by the commission with respect to a commission investigation authorized by law.]

(e) The division [Commission], upon request, shall disclose the identity of a complainant under this section if the division [Commission] finds:

(1) the complaint was groundless or made in bad faith;

[or]

(2) the complaint lacks any basis in fact or evidence;

[or]

(3) the complaint is frivolous; or

(4) the complaint is done specifically for competitive or economic advantage.

(f) Upon completion of an investigation in which [where] the division [Commission] determines a complaint is described by Subsection (e), [groundless, frivolous, made in bad faith, or is not supported by evidence or is done specifically for competitive or economic advantage] the division [Commission] shall notify the
person who was the subject of the complaint of its finding and the
identity of the complainant.

SECTION 2.029. Chapter 402, Labor Code, is amended by
adding Subchapter F to read as follows:

SUBCHAPTER F. COOPERATION WITH OFFICE OF INJURED EMPLOYEE COUNSEL

Sec. 402.251. COOPERATION; FACILITIES. (a) The department
and the division shall cooperate with the office of injured
employee counsel in providing services to claimants under this
subtitle.

(b) The department shall provide facilities to the office of
injured employee counsel in each regional office operated to
administer the duties of the division under this subtitle.

ARTICLE 3. GENERAL OPERATION OF WORKERS' COMPENSATION SYSTEM;
CONFORMING AMENDMENTS WITHIN LABOR CODE

SECTION 3.001. Subsection (b), Section 91.003, Labor Code,
is amended to read as follows:

(b) In particular, the Texas Workforce Commission, the
division of workers' compensation of the Texas Department of
Insurance, the Department of Assistive and Rehabilitative
Services, [the Texas Workers' Compensation Commission,] and the
attorney general's office shall assist in the implementation of
this chapter and shall provide information to the department on
request.

SECTION 3.002. Subsection (a), Section 401.003, Labor Code,
is amended to read as follows:

(a) The division [commission] is subject to audit by the
state auditor in accordance with Chapter 321, Government Code. The
state auditor may audit [the commission's]:

(1) the structure and internal controls of the division;

(2) the level and quality of service provided by the division to employers, injured employees, insurance carriers, self-insured governmental entities, and other participants;

(3) the implementation of statutory mandates by the division;

(4) employee turnover;

(5) information management systems, including public access to nonconfidential information;

(6) the adoption and implementation of administrative rules by the commissioner; and

(7) assessment of administrative violations and the penalties for those violations.

SECTION 3.003. Section 401.011, Labor Code, is amended by amending Subdivisions (1), (2), (8), (15), (37), (38), and (39) and adding Subdivisions (5-a), (13-a), (16-a), (18-a), (22-a), (31-a), and (42-a) to read as follows:


(2) "Administrative violation" means a violation of this subtitle, or a rule adopted under this subtitle, or an order or decision of the commissioner that is subject to penalties and sanctions as provided by this subtitle.

(5-a) "Case management" means a collaborative process
of assessment, planning, facilitation, and advocacy for options and
services to meet an individual's health needs through communication
and application of available resources to promote quality, 
cost-effective outcomes.

(8) "Commissioner" means the commissioner of workers' 
compensation ["Commission" means the Texas Workers' Compensation 
Commission].

(13-a) "Department" means the Texas Department of 
Insurance.

(15) "Designated doctor" means a doctor appointed by 
mutual agreement of the parties or by the division [commission] to 
recommend a resolution of a dispute as to the medical condition of 
an injured employee.

(16-a) "Division" means the division of workers' 
compensation of the department.

(18-a) "Evidence-based medicine" means the use of 
current best quality scientific and medical evidence formulated 
from credible scientific studies, including peer-reviewed medical 
literature and other current scientifically based texts, and 
treatment and practice guidelines in making decisions about the 
care of individual patients.

(22-a) "Health care reasonably required" means health 
care that is clinically appropriate and considered effective for 
the injured employee's injury and provided in accordance with best 
practices consistent with:

(A) evidence-based medicine; or

(B) if that evidence is not available, generally
accepted standards of medical practice recognized in the medical community.

(31-a) "Network" or "workers' compensation health care network" means an organization that is:

(A) formed as a health care provider network to provide health care services to injured employees;

(B) certified in accordance with Chapter 1305, Insurance Code, and rules of the commissioner of insurance; and

(C) established by, or operates under contract with, an insurance carrier.

(37) "Representative" means a person, including an attorney, authorized by the commissioner to assist or represent an employee, a person claiming a death benefit, or an insurance carrier in a matter arising under this subtitle that relates to the payment of compensation.

(38) "Research center" means the research functions of the Texas Department of Insurance required under Chapter 405.

(39) "Sanction" means a penalty or other punitive action or remedy imposed by the commissioner on an insurance carrier, representative, employee, employer, or health care provider for an act or omission in violation of this subtitle or a rule, order, or decision of the commissioner.

(42-a) "Violation" means an administrative violation subject to penalties and sanctions as provided by this subtitle.

SECTION 3.004. Section 401.013, Labor Code, is amended by
adding Subsection (c) to read as follows:

   (c) On the voluntary introduction into the body of any
substance listed under Subsection (a)(2)(B), based on a blood test
or urinalysis, it is a rebuttable presumption that a person is
intoxicated and does not have the normal use of mental or physical
faculties.

SECTION 3.005. Section 401.021, Labor Code, is amended to
read as follows:

Sec. 401.021. APPLICATION OF OTHER ACTS. Except as
otherwise provided by this subtitle:

   (1) a proceeding, hearing, judicial review, or
enforcement of a commissioner order, decision, or rule
is governed by the following subchapters and sections of Chapter
2001, Government Code:

   (A) Subchapters A, B, D, E, G, and H, excluding
Sections 2001.004(3) and 2001.005;
   (C) Sections 2001.056 through 2001.062; and
   (D) Section 2001.141(c);

   (2) a proceeding, hearing, judicial review, or
enforcement of a commissioner order, decision, or rule
is governed by Subchapters A and B, Chapter 2002, Government Code,
excluding Sections 2002.001(3) and 2002.023;

   (3) Chapter 551, Government Code, applies to a
proceeding under this subtitle, other than:

   (A) a benefit review conference;
   (B) a contested case hearing;
(C) a proceeding of the appeals panel;

(D) arbitration; or

(E) another proceeding involving a determination

on a workers' compensation claim; and

(4) Chapter 552, Government Code, applies to a

workers' compensation record of the division, the department,

[commission] or the office of injured employee counsel [the

research center].

SECTION 3.006. Subsection (b), Section 401.023, Labor Code,

is amended to read as follows:

(b) The division [commission] shall compute and publish the

interest and discount rate quarterly, using the treasury constant

maturity rate for one-year treasury bills issued by the United

States government, as published by the Federal Reserve Board on the

15th day preceding the first day of the calendar quarter for which

the rate is to be effective, plus 3.5 percent. For this purpose,

calendar quarters begin January 1, April 1, July 1, and October 1.

SECTION 3.007. Subsections (b), (c), and (d), Section

401.024, Labor Code, are amended to read as follows:

(b) Notwithstanding another provision of this subtitle that

specifies the form, manner, or procedure for the transmission of

specified information, the commissioner [commission] by rule may

permit or require the use of an electronic transmission instead of

the specified form, manner, or procedure. If the electronic

transmission of information is not authorized or permitted by

[commission] rule, the transmission of that information is governed
by any applicable statute or rule that prescribes the form, manner, or procedure for the transmission, including standards adopted by the Department of Information Resources.

(c) The commissioner may designate and contract with a data collection agent to fulfill the data collection requirements of this subtitle.

(d) The commissioner may prescribe the form, manner, and procedure for transmitting any authorized or required electronic transmission, including requirements related to security, confidentiality, accuracy, and accountability.

SECTION 3.008. Subchapter C, Chapter 401, Labor Code, is amended by adding Section 401.025 to read as follows:

Sec. 401.025. REFERENCES TO COMMISSION AND EXECUTIVE DIRECTOR. (a) A reference in this code or other law to the Texas Workers' Compensation Commission or the executive director of that commission means the division or the commissioner as consistent with the respective duties of the commissioner and the division under this code and other workers' compensation laws of this state.

(b) A reference in this code or other law to the executive director of the Texas Workers' Compensation Commission means the commissioner.

SECTION 3.009. The heading to Chapter 403, Labor Code, is amended to read as follows:

CHAPTER 403. DIVISION FINANCING

SECTION 3.010. Section 403.001, Labor Code, is amended to read as follows:

Sec. 403.001. FUNDS. (a) Except as provided
by Sections 403.006 and 403.007 or as otherwise provided by law, money collected under this subtitle, including administrative penalties and advance deposits for purchase of services, shall be deposited in the general revenue fund of the state treasury to the credit of the Texas Department of Insurance operating account [commission].

(b) The money may be spent as authorized by legislative appropriation on warrants issued by the comptroller under requisitions made by the commissioner of insurance [commission].

(c) Money deposited in the general revenue fund under this section may be used to satisfy the requirements of Section 201.052 [Article 4.19], Insurance Code.

SECTION 3.011. Section 403.003, Labor Code, is amended to read as follows:

Sec. 403.003. RATE OF ASSESSMENT. (a) The commissioner of insurance [commission] shall set and certify to the comptroller the rate of maintenance tax assessment [not later than October 31 of each year] taking into account:

(1) any expenditure projected as necessary for the division and the office of injured employee counsel [commission] to:

(A) administer this subtitle during the fiscal year for which the rate of assessment is set; and

(B) reimburse the general revenue fund as provided by Section 201.052 [Article 4.19], Insurance Code;

(2) projected employee benefits paid from general revenues;
(3) a surplus or deficit produced by the tax in the preceding year;
(4) revenue recovered from other sources, including reappropriated receipts, grants, payments, fees, gifts, and penalties recovered under this subtitle; and
(5) expenditures projected as necessary to support the prosecution of workers' compensation insurance fraud.

(b) In setting the rate of assessment, the commissioner of insurance may not consider revenue or expenditures related to:

(1) the State Office of Risk Management;
(2) the workers' compensation research functions of the department under Chapter 405 [and oversight council on workers' compensation]; or
(3) any other revenue or expenditure excluded from consideration by law.

SECTION 3.012. Section 403.004, Labor Code, is amended to read as follows:

Sec. 403.004. COLLECTION OF TAX AFTER WITHDRAWAL FROM BUSINESS. The commissioner of insurance [commissioner of insurance or the executive director of the commission] immediately shall proceed to collect taxes due under this chapter from an insurance carrier that withdraws from business in this state, using legal process as necessary.

SECTION 3.013. Section 403.005, Labor Code, is amended to read as follows:

Sec. 403.005. TAX RATE [SURPLUS OR DEFICIT]. The
commissioner of insurance shall annually adjust the rate of
assessment of the maintenance tax imposed under Section 403.003 so
that the tax imposed that year, together with any unexpended funds
produced by the tax, produces the amount the commissioner of
insurance determines is necessary to pay the expenses of
administering this subtitle. [(a) If the tax rate set by the
commission for a year does not produce sufficient revenue to make
all expenditures authorized by legislative appropriation, the
deficit shall be paid from the general revenue fund.

[(b) If the tax rate set by the commission for a year
produces revenue that exceeds the amount required to make all
expenditures authorized by the legislature, the excess shall be
deposited in the general revenue fund to the credit of the
commission.]

SECTION 3.014. Section 403.006, Labor Code, as amended by
Chapters 211 and 1296, Acts of the 78th Legislature, Regular
Session, 2003, is reenacted and amended to read as follows:

Sec. 403.006. SUBSEQUENT INJURY FUND. (a) The subsequent
injury fund is a dedicated [an] account in the general revenue fund
[in the state treasury]. Money in the account may be appropriated
only for the purposes of this section or as provided by other law.
Section 403.095, Government Code, does not apply to the subsequent
injury fund.

(b) The subsequent injury fund is liable for:

(1) the payment of compensation as provided by Section
408.162;

(2) reimbursement of insurance carrier claims of
overpayment of benefits made under an interlocutory order or
decision of the commissioner as provided by this
subtitle, consistent with the priorities established by rule by the
commissioner; and

(3) reimbursement of insurance carrier claims as
provided by Sections 408.042 and 413.0141, consistent with the
priorities established by rule by the commissioner; and

(4) the payment of an assessment of feasibility and
the development of regional networks established under Section
408.0221.

(c) The commissioner shall appoint an
administrator for the subsequent injury fund.

(d) Based on an actuarial assessment of the funding
available under Section 403.007(e), the commissioner may make partial payment of insurance carrier claims under
Subsection (b)(3).

SECTION 3.015. Section 403.007, Labor Code, is amended to
read as follows:

Sec. 403.007. FUNDING OF SUBSEQUENT INJURY FUND. (a) If a
compensable death occurs and no legal beneficiary survives or a
claim for death benefits is not timely made, the insurance carrier
shall pay to the division for deposit to the credit of
the subsequent injury fund an amount equal to 364 weeks of the death
benefits otherwise payable.

(b) The insurance carrier may elect or the commissioner
may order that death benefits payable to the fund be
commuted on written approval of the commissioner.
director]. The commutation may be discounted for present payment at the rate established in Section 401.023, compounded annually.

(c) If a claim for death benefits is not filed with the division [commission] by a legal beneficiary on or before the first anniversary of the date of the death of the employee, it is presumed, for purposes of this section only, that no legal beneficiary survived the deceased employee. The presumption does not apply against a minor beneficiary or an incompetent beneficiary for whom a guardian has not been appointed.

(d) If the insurance carrier makes payment to the subsequent injury fund and it is later determined by a final award of the commissioner [commission] or the final judgment of a court of competent jurisdiction that a legal beneficiary is entitled to the death benefits, the commissioner [commission] shall order the fund to reimburse the insurance carrier for the amount overpaid to the fund.

(e) If the commissioner [commission] determines that the funding under Subsection (a) is not adequate to meet the expected obligations of the subsequent injury fund established under Section 403.006, the fund shall be supplemented by the collection of a maintenance tax paid by insurance carriers, other than a governmental entity, as provided by Sections 403.002 and 403.003. The rate of assessment must be adequate to provide 120 percent of the projected unfunded liabilities of the fund for the next biennium as certified by an independent actuary or financial advisor.

(f) The commissioner's [commissioner's] actuary or financial
advisor shall report biannually to the department on the financial condition and projected assets and liabilities of the subsequent injury fund. The commissioner shall make the reports available to members of the legislature and the public. The division may purchase annuities to provide for payments due to claimants under this subtitle if the commissioner determines that the purchase of annuities is financially prudent for the administration of the fund.

SECTION 3.016. Subtitle A, Title 5, Labor Code, is amended by adding Chapter 404 to read as follows:

CHAPTER 404. OFFICE OF INJURED EMPLOYEE COUNSEL

SUBCHAPTER A. OFFICE; GENERAL PROVISIONS

Sec. 404.001. DEFINITIONS. In this chapter:

(1) "Office" means the office of injured employee counsel.

(2) "Public counsel" means the injured employee public counsel.

Sec. 404.002. ESTABLISHMENT OF OFFICE; ADMINISTRATIVE ATTACHMENT TO TEXAS DEPARTMENT OF WORKERS' COMPENSATION. (a) The office of injured employee counsel is established to represent the interests of workers' compensation claimants in this state.

(b) The office is administratively attached to the department but is independent of direction by the commissioner, the commissioner of insurance, and the department.

(c) The department shall provide the staff and facilities necessary to enable the office to perform the duties of the office
under this subtitle, including:

(1) administrative assistance and services to the office, including budget planning and purchasing;

(2) personnel services; and

(3) computer equipment and support.

(d) The public counsel may enter into interagency contracts and other agreements with the commissioner of workers' compensation and the commissioner of insurance as necessary to implement this chapter.

Sec. 404.003. SUNSET PROVISION. The office of injured employee counsel is subject to Chapter 325, Government Code (Texas Sunset Act). Unless continued in existence as provided by that chapter, the office is abolished and this chapter expires September 1, 2009.

Sec. 404.004. PUBLIC INTEREST INFORMATION. (a) The office shall prepare information of public interest describing the functions of the office.

(b) The office shall make the information available to the public and appropriate state agencies.

Sec. 404.005. ACCESS TO PROGRAMS AND FACILITIES. (a) The office shall prepare and maintain a written plan that describes how a person who does not speak English can be provided reasonable access to the office's programs.

(b) The office shall comply with federal and state laws for program and facility accessibility.

Sec. 404.006. RULEMAKING. (a) The public counsel shall adopt rules as necessary to implement this chapter.
AARulemaking under this section is subject to Chapter 2001, Government Code.

[Sections 404.007-404.050 reserved for expansion]

SUBCHAPTER B. INJURED EMPLOYEE PUBLIC COUNSEL

Sec. 404.051. APPOINTMENT; TERM. (a) The governor, with the advice and consent of the senate, shall appoint the injured employee public counsel. The public counsel serves a two-year term that expires on February 1 of each odd-numbered year.

(b) The governor shall appoint the public counsel without regard to the race, color, disability, sex, religion, age, or national origin of the appointee. Section 401.011(16) does not apply to the use of the term "disability" in this subchapter.

(c) If a vacancy occurs during a term, the governor shall fill the vacancy for the unexpired term.

(d) In appointing the public counsel, the governor may consider recommendations made by groups that represent wage earners.

Sec. 404.052. QUALIFICATIONS. To be eligible to serve as public counsel, a person must:

(1) be a resident of Texas;

(2) be licensed to practice law in this state;

(3) have demonstrated a strong commitment to and involvement in efforts to safeguard the rights of the working public;

(4) have management experience;

(5) possess knowledge and experience with the workers' compensation system; and
(6) have experience with legislative procedures and administrative law.

Sec. 404.053. BUSINESS INTEREST; SERVICE AS PUBLIC COUNSEL.
A person is not eligible for appointment as public counsel if the person or the person's spouse:

(1) is employed by or participates in the management of a business entity or other organization that holds a license, certificate of authority, or other authorization from the department or division or that receives funds from the department or division;

(2) owns or controls, directly or indirectly, more than a 10 percent interest in a business entity or other organization receiving funds from the department, division, or the office; or

(3) uses or receives a substantial amount of tangible goods or funds from the department, division, or the office, other than compensation or reimbursement authorized by law.

Sec. 404.054. LOBBYING ACTIVITIES. A person may not serve as public counsel if the person is required to register as a lobbyist under Chapter 305, Government Code, because of the person's activities for compensation related to the operation of the department, the division, or the office.

Sec. 404.055. GROUNDS FOR REMOVAL. (a) It is a ground for removal from office that the public counsel:

(1) does not have at the time of appointment or maintain during service as public counsel the qualifications required by Section 404.052;
(2) violates a prohibition established by Section 404.053, 404.054, 404.056, or 404.057; or

(3) cannot, because of illness or disability, discharge the public counsel’s duties for a substantial part of the public counsel’s term.

(b) The validity of an action of the public counsel or the office is not affected by the fact that the action is taken when a ground for removal of the public counsel exists.

Sec. 404.056. PROHIBITED REPRESENTATION OR EMPLOYMENT.

(a) A former public counsel may not make any communication to or appearance before the division, the department, the commissioner, the commissioner of insurance, or an employee of the division or the department before the second anniversary of the date the person ceases to serve as public counsel if the communication or appearance is made:

(1) on behalf of another person in connection with any matter on which the person seeks official action; or

(2) with the intent to influence a commissioner or commissioner of insurance decision or action, unless the person is acting on the person’s own behalf and without remuneration.

(b) A former public counsel may not represent any person or receive compensation for services rendered on behalf of any person regarding a matter before the division or the department before the second anniversary of the date the person ceases to serve as public counsel.

(c) A person commits an offense if the person violates this section. An offense under this section is a Class A misdemeanor.
(d) A former employee of the office may not:

(1) be employed by an insurance carrier regarding a matter that was in the scope of the employee's official responsibility while the employee was associated with the office; or

(2) represent a person before the division or the department or a court in a matter:

(A) in which the employee was personally involved while associated with the office; or

(B) that was within the employee's official responsibility while the employee was associated with the office.

(e) The prohibition of Subsection (d)(1) applies until the first anniversary of the date the employee's employment with the office ceases.

(f) The prohibition of Subsection (d)(2) applies to a current employee of the office while the employee is associated with the office and at any time after.

Sec. 404.057. TRADE ASSOCIATIONS. (a) In this section, "trade association" means a nonprofit, cooperative, and voluntarily joined association of business or professional competitors designed to assist its members and its industry or profession in dealing with mutual business or professional problems and in promoting their common interest.

(b) A person may not serve as public counsel if the person has been, within the previous two years:

(1) an officer, employee, or paid consultant of a trade association in the field of workers' compensation; or
the spouse of an officer, manager, or paid consultant of a trade association in the field of workers' compensation.

[Sections 404.058-404.100 reserved for expansion]

SUBCHAPTER C. GENERAL POWERS AND DUTIES OF OFFICE

Sec. 404.101. GENERAL DUTIES. (a) The office shall, as provided by this subtitle:

(1) provide assistance to workers' compensation claimants;

(2) advocate on behalf of injured employees as a class regarding rulemaking by the commissioner and commissioner of insurance relating to workers' compensation;

(3) assist injured employees with contacting appropriate licensing boards for complaints against a health care provider; and

(4) assist injured employees with referral to local, state, and federal financial assistance, rehabilitation, and work placement programs, as well as other social services that the office considers appropriate.

(b) The office:

(1) may assess the impact of workers' compensation laws, rules, procedures, and forms on injured employees in this state; and

(2) shall, as provided by this subtitle:

(A) monitor the performance and operation of the workers' compensation system, with a focus on the system's effect on the return to work of injured employees;
H.B. No. 7

(B) assist injured employees, through the ombudsman program, with the resolution of complaints pending at the division or department;

(C) assist injured employees, through the ombudsman program, in the division's administrative dispute resolution system; and

(D) advocate in the office's own name positions determined by the public counsel to be most advantageous to a substantial number of injured employees.

(c) The office may not appear or intervene, as a party or otherwise, before the commissioner, commissioner of insurance, division, or department on behalf of an individual injured employee, except through the ombudsman program.

Sec. 404.102. GENERAL POWERS AND DUTIES OF PUBLIC COUNSEL. The public counsel shall administer and enforce this chapter, including preparing and submitting to the legislature a budget for the office and approving expenditures for professional services, travel, per diem, and other actual and necessary expenses incurred in administering the office.

Sec. 404.103. OPERATION OF OMBUDSMAN PROGRAM. (a) The office shall operate the ombudsman program under Subchapter D.

(b) The public counsel shall assign staff attorneys, as the public counsel considers appropriate, to supervise the work of the ombudsman program and advise ombudsmen in providing assistance to claimants and preparing for informal and formal hearings.

(c) The office shall coordinate services provided by the ombudsman program with services provided by the Department of

57
Assistive and Rehabilitative Services.

Sec. 404.104. AUTHORITY TO APPEAR OR INTERVENE. The public counsel:

(1) may appear or intervene, as a party or otherwise, as a matter of right before the commissioner, commissioner of insurance, division, or department on behalf of injured employees as a class in matters involving rules, agency policies, and forms affecting the workers' compensation system that the commissioner or the commissioner of insurance adopts or approves;

(2) may intervene as a matter of right or otherwise appear in a judicial proceeding involving or arising from an action taken by an administrative agency in a proceeding in which the public counsel previously appeared under the authority granted by this chapter;

(3) may appear or intervene, as a party or otherwise, as a matter of right on behalf of injured employees as a class in any proceeding in which the public counsel determines that the interests of injured employees as a class are in need of representation, except that the public counsel may not intervene in an enforcement or parens patriae proceeding brought by the attorney general; and

(4) may appear or intervene before the commissioner, commissioner of insurance, division, or department, as a party or otherwise, on behalf of injured employees as a class in a matter involving rates, rules, agency policies, or forms affecting injured employees as a class in any proceeding in which the public counsel determines that injured employees are in need of representation.
Sec. A404.105. AUTHORITY TO ASSIST INDIVIDUAL INJURED EMPLOYEES IN ADMINISTRATIVE PROCEDURES. The office, through the ombudsman program, may appear before the commissioner or division on behalf of an individual injured employee during an administrative dispute resolution process. This chapter may not be construed as requiring or allowing legal representation for an individual injured employee by an office attorney or ombudsman in any proceeding.

Sec. A404.106. LEGISLATIVE REPORT. (a) The office shall report to the governor, lieutenant governor, speaker of the house of representatives, and the chairs of the legislative committees with appropriate jurisdiction not later than December 1 of each even-numbered year. The report must include:

(1) a description of the activities of the office;
(2) identification of any problems in the workers' compensation system from the perspective of injured employees as a class, as considered by the public counsel, with recommendations for regulatory and legislative action; and
(3) an analysis of the ability of the workers' compensation system to provide adequate, equitable, and timely benefits to injured employees at a reasonable cost to employers.

(b) The office shall coordinate with the workers' compensation research and evaluation group to obtain needed information and data to make the evaluations required for the report.

(c) The office shall publish and disseminate the legislative report to interested persons, and may charge a fee for
the publication as necessary to achieve optimal dissemination.

Sec. 404.107. ACCESS TO INFORMATION BY PUBLIC COUNSEL. The public counsel:

(1) is entitled to the same access as a party, other than division staff or department staff, to division or department records available in a proceeding before the commissioner, commissioner of insurance, division, or department under the authority granted to the public counsel by this chapter; and

(2) is entitled to obtain discovery under Chapter 2001, Government Code, of any nonprivileged matter that is relevant to the subject matter involved in a proceeding or submission before the commissioner, commissioner of insurance, division, or department as authorized by this chapter.

Sec. 404.108. LEGISLATIVE RECOMMENDATIONS. The public counsel may recommend proposed legislation to the legislature that the public counsel determines would positively affect the interests of injured employees as a class.

Sec. 404.109. INJURED EMPLOYEE RIGHTS; NOTICE. The public counsel shall submit to the division and the department for adoption by the commissioners a notice of injured employee rights and responsibilities to be distributed as provided by commissioner and commissioner of insurance rules.

Sec. 404.110. APPLICABILITY OF CONFIDENTIALITY REQUIREMENTS. Confidentiality requirements applicable to examination reports under Article 1.18, Insurance Code, and to the commissioner of insurance under Section 3A, Article 21.28-A, Insurance Code, apply to the public counsel.
Sec. 404.111. ACCESS TO INFORMATION. (a) The office may access information from an executive agency that is otherwise confidential under a law of this state if that information is necessary for the performance of the duties of the office, including information made confidential under:

(1) Section 843.006, Insurance Code;
(2) Chapter 108, Health and Safety Code;
(3) Chapter 552, Government Code; and
(4) Sections 402.083, 402.091, and 402.092 of this code.

(b) On request by the public counsel, the division or the department shall provide any information or data requested by the office in furtherance of the duties of the office under this chapter.

(c) The office may not make public any confidential information provided to the office under this chapter but may disclose a summary of the information that does not directly or indirectly identify the individual or entity that is the subject of the information. The office may not release, and an individual or entity may not gain access to, any information that:

(1) could reasonably be expected to reveal the identity of a health care provider or an injured employee;
(2) reveals the zip code of an injured employee's primary residence;
(3) discloses a health care provider discount or a differential between a payment and a billed charge; or
(4) relates to an actual payment made by a payer to an
identified health care provider.

(d) Information collected or used by the office under this chapter is subject to the confidentiality provisions and criminal penalties of:

(1) Section 81.103, Health and Safety Code;
(2) Section 311.037, Health and Safety Code;
(3) Chapter 159, Occupations Code; and
(4) Section 402.091 of this code.

(e) Information on health care providers and injured employees that is in the possession of the office, and any compilation, report, or analysis produced from the information that identifies providers and injured employees is not:

(1) subject to discovery, subpoena, or other means of legal compulsion for release to any individual or entity; or
(2) admissible in any civil, administrative, or criminal proceeding.

(f) Notwithstanding Subsection (c)(2), the office may use zip code information to analyze information on a geographical basis.

SECTION 3.017. Subchapter C, Chapter 409, Labor Code, is redesignated as Subchapter D, Chapter 404, Labor Code, and Sections 409.041 through 409.044, Labor Code, are renumbered as Sections 404.151 through 404.154, Labor Code, and amended to read as follows:

SUBCHAPTER D [6]. OMBUDSMAN PROGRAM

Sec. 404.151 [409.041]. OMBUDSMAN PROGRAM. (a) The office [commission] shall maintain an ombudsman program as provided
by this subchapter to assist injured employees and persons claiming death benefits in obtaining benefits under this subtitle.

(b) An ombudsman shall:

(1) meet with or otherwise provide information to injured employees;

(2) investigate complaints;

(3) communicate with employers, insurance carriers, and health care providers on behalf of injured employees;

(4) assist unrepresented claimants, employers, and other parties to enable those persons to protect their rights in the workers' compensation system; and

(5) meet with an unrepresented claimant privately for a minimum of 15 minutes prior to any informal or formal hearing.

Sec. 404.152. DESIGNATION AS OMBUDSMAN; ELIGIBILITY AND TRAINING REQUIREMENTS; CONTINUING EDUCATION REQUIREMENTS. (a) At least one specially qualified employee in each division office shall be an ombudsman designated by the office of injured employee counsel, who shall perform the duties under this subchapter as the person's primary responsibility.

(b) To be eligible for designation as an ombudsman, a person must:

(1) demonstrate satisfactory knowledge of the requirements of:

(A) this subtitle and the provisions of Subtitle C that relate to claims management;
(B) other laws relating to workers' compensation; and

(C) rules adopted under this subtitle and the laws described under Subdivision (1)(B);

(2) have demonstrated experience in handling and resolving problems for the general public;

(3) possess strong interpersonal skills; and

(4) have at least one year of demonstrated experience in the field of workers' compensation.

(c) The public counsel shall [commission] by rule [shall]
adopt training guidelines and continuing education requirements for ombudsmen. Training provided under this subsection must:

(1) include education regarding this subtitle, rules adopted under this subtitle, and [appeals panel] decisions of the appeals panel, with emphasis on benefits and the dispute resolution process; [and]

(2) require an ombudsman undergoing training to be observed and monitored by an experienced ombudsman during daily activities conducted under this subchapter; and

(3) incorporate the requirements of Section 404.103(b).

Sec. 404.153 [409.043]. EMPLOYER NOTIFICATION; ADMINISTRATIVE VIOLATION. (a) Each employer shall notify its employees of the ombudsman program in the [a] manner prescribed by the office [commission].

(b) An employer commits an administrative [a] violation if the employer fails to comply with this section. [A violation under
Sec. 404.154. PUBLIC INFORMATION. The office of the commission shall widely disseminate information about the ombudsman program.

SECTION 3.018. Section 405.001, Labor Code, is amended to read as follows:

Sec. 405.001. DEFINITION. In this chapter, "group" means the workers' compensation research and evaluation group [Texas Department of Insurance].

SECTION 3.019. Subsection (a), Section 405.002, Labor Code, is amended to read as follows:

(a) The workers' compensation research and evaluation group is located within the department and serves as a resource for the commissioner of insurance on workers' compensation issues [department shall conduct professional studies and research related to:

[(1) the delivery of benefits;
[(2) litigation and controversy related to workers' compensation;
[(3) insurance rates and rate-making procedures;
[(4) rehabilitation and reemployment of injured workers;
[(5) workplace health and safety issues;
[(6) the quality and cost of medical benefits; and
[(7) other matters relevant to the cost, quality, and operational effectiveness of the workers' compensation system].

SECTION 3.020. Chapter 405, Labor Code, is amended by
adding Sections 405.0025 and 405.0026 to read as follows:

Sec. 405.0025. RESEARCH DUTIES OF GROUP. (a) The group shall conduct professional studies and research related to:

(1) the delivery of benefits;
(2) litigation and controversy related to workers' compensation;
(3) insurance rates and ratemaking procedures;
(4) rehabilitation and reemployment of injured employees;
(5) the quality and cost of medical benefits;
(6) employer participation in the workers' compensation system;
(7) employment health and safety issues; and
(8) other matters relevant to the cost, quality, and operational effectiveness of the workers' compensation system.

(b) The group shall:

(1) objectively evaluate the impact of the workers' compensation health care networks certified under Chapter 1305, Insurance Code, on the cost and quality of medical care provided to injured employees; and

(2) report the group's findings to the governor, the lieutenant governor, the speaker of the house of representatives, and the members of the legislature not later than December 1 of each even-numbered year.

(c) At a minimum, the report required under Subsection (b) must evaluate the impact of workers' compensation health care networks on:
Sec. A405.0026. AARESEARCH AGENDA. (a) The group shall prepare and publish annually in the Texas Register a proposed workers’ compensation research agenda for the commissioner of insurance review and approval.

(b) The commissioner of insurance shall:

(1) accept public comments on the research agenda; and

(2) hold a public hearing on the proposed research agenda if a hearing is requested by interested persons.

SECTION 3.021. Subsections (a) and (e), Section 405.003, Labor Code, are amended to read as follows:

(a) The group’s duties under this chapter are funded through the assessment of a maintenance tax collected annually from all insurance carriers, and self-insurance groups that hold certificates of approval under Chapter 407A, except governmental entities.

(e) Amounts received under this section shall be deposited in the general revenue fund in accordance with
Section 251.004 [Article 5.68(e), Insurance Code, to be used:
(1) for the operation of the group's [department's]
duties under this chapter; and
(2) to reimburse the general revenue fund in
accordance with Section 201.052 [Article 4.19], Insurance Code.

SECTION 3.022. Section 405.004, Labor Code, is amended by
amending Subsections (a), (b), and (d) and adding Subsections (e),
(f), and (g) to read as follows:
(a) As required to fulfill the group's [department's]
objectives under this chapter, the group [department] is entitled
to access to the files and records of:
(1) the division [commission];
(2) the Texas Workforce Commission;
(3) the [Texas] Department of Assistive and
Rehabilitative [Human] Services;
(4) the office of injured employee counsel;
(5) [44] the State Office of Risk Management; and
(6) [45] other appropriate state agencies.
(b) A state agency shall assist and cooperate in providing
information to the group [department].
(d) Except as provided by this subsection, the [The]
identity of an individual or entity selected to participate in a
[department] survey conducted by the group or who participates in
such a survey is confidential and is not subject to public
disclosure under Chapter 552, Government Code. This subsection
does not prohibit the identification of a workers' compensation
health care network in a report card issued under Section 1305.502,
Insurance Code, provided that the report card may not identify any
injured employee or other individual.

(e) A working paper, including all documentary or other
information, prepared or maintained by the group in performing the
group's duties under this chapter or other law to conduct an
evaluation and prepare a report is excepted from the public
disclosure requirements of Section 552.021, Government Code.

(f) A record held by another entity that is considered to be
confidential by law and that the group receives in connection with
the performance of the group's functions under this chapter or
another law remains confidential and is excepted from the public
disclosure requirements of Section 552.021, Government Code.

(g) The commissioner of insurance shall adopt rules as
necessary to establish data reporting requirements to support the
research duties under this chapter. This section may not be
construed as requiring additional reporting requirements on
nonsubscribing employers.

SECTION 3.023. Section 406.004, Labor Code, is amended to
read as follows:

Sec. 406.004. EMPLOYER NOTICE TO DIVISION [COMMISSION; ADMINISTRATIVE VIOLATION]. (a) An employer who does not obtain
workers' compensation insurance coverage shall notify the division
[commission] in writing, in the time and as prescribed by
commissioner [commission] rule, that the employer elects not to
obtain coverage.

(b) The commissioner [commission] shall prescribe forms to
be used for the employer notification and shall require the
employer to provide reasonable information to the division about the employer's business.

(c) The division may contract with the Texas Workforce Commission or the comptroller for assistance in collecting the notification required under this section. Those agencies shall cooperate with the division in enforcing this section.

(d) The employer notification filing required under this section shall be filed with the division in accordance with Section 406.009.

(e) An employer commits an administrative violation if the employer fails to comply with this section. A violation under this subsection is a Class D administrative violation. Each day of noncompliance constitutes a separate violation.

SECTION 3.024. Subsections (c) and (e), Section 406.005, Labor Code, are amended to read as follows:

(c) Each employer shall post a notice of whether the employer has workers' compensation insurance coverage at conspicuous locations at the employer's place of business as necessary to provide reasonable notice to the employees. The commissioner may adopt rules relating to the form and content of the notice. The employer shall revise the notice when the information contained in the notice is changed.

(e) An employer commits an administrative violation if the employer fails to comply with this section. A violation under this subsection is a Class D administrative violation.

SECTION 3.025. Subsections (a), (b), and (c), Section
H.B. No. 7

406.006, Labor Code, are amended to read as follows:

(a) An insurance company from which an employer has obtained workers' compensation insurance coverage, a certified self-insurer, a workers' compensation self-insurance group under Chapter 407A, and a political subdivision shall file notice of the coverage and claim administration contact information with the division [commission] not later than the 10th day after the date on which the coverage or claim administration agreement takes effect, unless the commissioner [commission] adopts a rule establishing a later date for filing. Coverage takes effect on the date on which a binder is issued, a later date and time agreed to by the parties, on the date provided by the certificate of self-insurance, or on the date provided in an interlocal agreement that provides for self-insurance. The commissioner [commission] may adopt rules that establish the coverage and claim administration contact information required under this subsection.

(b) The notice required under this section shall be filed with the division [commission] in accordance with Section 406.009.

(c) An insurance company, a certified self-insurer, a workers' compensation self-insurance group under Chapter 407A, or a political subdivision commits an administrative [a] violation if the person fails to file notice with the division [commission] as provided by this section. [A violation under this subsection is a Class C administrative violation. Each day of noncompliance constitutes a separate violation.]

SECTION 3.026. Subsections (a), (b), and (c), Section 406.007, Labor Code, are amended to read as follows:
H.B. No. 7

(a) An employer who terminates workers' compensation insurance coverage obtained under this subtitle shall file a written notice with the division [commission] by certified mail not later than the 10th day after the date on which the employer notified the insurance carrier to terminate the coverage. The notice must include a statement certifying the date that notice was provided or will be provided to affected employees under Section 406.005.

(b) The notice required under this section shall be filed with the division [commission] in accordance with Section 406.009.

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

(1) the 30th day after the date of filing of notice with the division [commission] under Subsection (a); or

(2) the cancellation date of the policy.

SECTION 3.027. Section 406.008, Labor Code, is amended to read as follows:

Sec. 406.008. CANCELLATION OR NONRENEWAL OF COVERAGE BY INSURANCE COMPANY; NOTICE. (a) An insurance company that cancels a policy of workers' compensation insurance or that does not renew the policy by the anniversary date of the policy shall deliver notice of the cancellation or nonrenewal by certified mail or in person to the employer and the division [commission] not later than:

(1) the 30th day before the date on which the cancellation or nonrenewal takes effect; or

(2) the 10th day before the date on which the cancellation or nonrenewal takes effect if the insurance company
cancels or does not renew because of:

(A) fraud in obtaining coverage;

(B) misrepresentation of the amount of payroll for purposes of premium calculation;

(C) failure to pay a premium when due;

(D) an increase in the hazard for which the employer seeks coverage that results from an act or omission of the employer and that would produce an increase in the rate, including an increase because of a failure to comply with:

   (i) reasonable recommendations for loss control; or

   (ii) recommendations designed to reduce a hazard under the employer's control within a reasonable period; or

(E) a determination made by the commissioner of insurance that the continuation of the policy would place the insurer in violation of the law or would be hazardous to the interest of subscribers, creditors, or the general public.

(b) The notice required under this section shall be filed with the division [commission].

(c) Failure of the insurance company to give notice as required by this section extends the policy until the date on which the required notice is provided to the employer and the division [commission].

SECTION 3.028. Section 406.009, Labor Code, is amended to read as follows:

Sec. 406.009. COLLECTING AND MAINTAINING INFORMATION; MONITORING AND ENFORCING COMPLIANCE. (a) The division
The commissioner may adopt rules as necessary to enforce this subchapter. The commissioner may designate a data collection agent, implement an electronic reporting and public information access program, and adopt rules as necessary to implement the data collection requirements of this subchapter. The commissioner may establish the form, manner, and procedure for the transmission of information to the division.

(d) The division may require an employer or insurance carrier subject to this subtitle to identify or confirm an employer's coverage status and claim administration contact information as necessary to achieve the purposes of this subtitle.

(e) An employer or insurance carrier commits an administrative violation if that person fails to comply with Subsection (d). [A violation under this subsection is a Class C administrative violation.]

SECTION 3.029. Subsections (c) and (d), Section 406.010, Labor Code, is amended to read as follows:

(c) The commissioner by rule shall further specify the requirements of this section.

(d) A person commits an administrative violation if the person violates a rule adopted under this section. [A violation under this subsection is a Class C administrative violation. Each
day of noncompliance constitutes a separate violation.

SECTION 3.030. Section 406.011, Labor Code, is amended to read as follows:

Sec. 406.011. AUSTIN REPRESENTATIVE; ADMINISTRATIVE VIOLATION. (a) The commissioner by rule may require an insurance carrier to designate a representative in Austin to act as the insurance carrier's agent before the division in Austin. Notice to the designated agent constitutes notice to the insurance carrier.

(b) A person commits an administrative violation if the person violates a rule adopted under this section. A violation under this subsection is a Class C administrative violation. Each day of noncompliance constitutes a separate violation.

SECTION 3.031. Section 406.033, Labor Code, is amended by adding Subsections (f) and (g) to read as follows:

(f) A cause of action described by Subsection (a) may not be waived by an employee after the employee's injury unless:

(1) the employee voluntarily enters into the waiver with knowledge of the waiver's effect;

(2) the waiver is entered into not earlier than the 10th business day after the date of the initial report of injury;

(3) the employee, before signing the waiver, has received a medical evaluation from a nonemergency care doctor; and

(4) the waiver is in a writing under which the true intent of the parties is specifically stated in the document.

(g) The waiver provisions required under Subsection (f) must be conspicuous and appear on the face of the agreement. To be
conspicuous, the waiver provisions must appear in a type larger than the type contained in the body of the agreement or in contrasting colors.

SECTION 3.032. Subsection (c), Section 406.051, Labor Code, is amended to read as follows:

(c) The employer may not transfer:

(1) the obligation to accept a report of injury under Section 409.001;

(2) the obligation to maintain records of injuries under Section 409.006;

(3) the obligation to report injuries to the insurance carrier under Section 409.005;

(4) liability for a violation of Section 415.006 or 415.008 or of Chapter 451; or

(5) the obligation to comply with a commissioner [commission] order.

SECTION 3.033. Subsections (b) and (c), Section 406.073, Labor Code, are amended to read as follows:

(b) The employer shall file the agreement with the division [executive director] on request.

(c) A person commits an administrative [a] violation if the person violates Subsection (b). [A violation under this subsection is a Class D administrative violation.]

SECTION 3.034. Subsections (a) and (b), Section 406.074, Labor Code, are amended to read as follows:

(a) The commissioner [executive director] may enter into an agreement with an appropriate agency of another jurisdiction with
1 respect to:
2
3  (1) conflicts of jurisdiction;
4  (2) assumption of jurisdiction in a case in which the
5  contract of employment arises in one state and the injury is
6  incurred in another;
7  (3) procedures for proceeding against a foreign
8  employer who fails to comply with this subtitle; and
9  (4) procedures for the appropriate agency to use to
10  proceed against an employer of this state who fails to comply with
11   the workers’ compensation laws of the other jurisdiction.
12
13 (b) An executed agreement that has been adopted as a rule by
14   the commissioner [commission] binds all subject employers and
15   employees.
16
17 SECTION 3.035. Subsection (b), Section 406.093, Labor Code,
18 is amended to read as follows:
19
20   (b) The commissioner [commission] by rule shall adopt
21   procedures relating to the method of payment of benefits to legally
22   incompetent employees.
23
24 SECTION 3.036. Subsection (b), Section 406.095, Labor Code,
25 is amended to read as follows:
26
27   (b) The commissioner [commission] by rule shall establish
28   the procedures and requirements for an election under this section.
29
30 SECTION 3.037. Subsection (c), Section 406.098, Labor Code,
31 is amended to read as follows:
32
33   (c) The commissioner of insurance [Texas Department of
34   Insurance] shall adopt rules governing the method of calculating
35   premiums for workers' compensation insurance coverage for
volunteer members who are covered pursuant to this section.

SECTION 3.038. Subsections (f) and (g), Section 406.123, Labor Code, are amended to read as follows:

(f) A general contractor shall file a copy of an agreement entered into under this section with the general contractor's workers' compensation insurance carrier not later than the 10th day after the date on which the contract is executed. If the general contractor is a certified self-insurer, the copy must be filed with the division [division of self-insurance regulation].

(g) A general contractor who enters into an agreement with a subcontractor under this section commits an administrative [a] violation if the contractor fails to file a copy of the agreement as required by Subsection (f). [A violation under this subsection is a Class B administrative violation.]

SECTION 3.039. Subsections (c) and (d), Section 406.144, Labor Code, are amended to read as follows:

(c) An agreement under this section shall be filed with the division [commission] either by personal delivery or by registered or certified mail and is considered filed on receipt by the division [commission].

(d) The hiring contractor shall send a copy of an agreement under this section to the hiring contractor's workers' compensation insurance carrier on filing of the agreement with the division [commission].

SECTION 3.040. Subsections (a) through (d) and (f), Section 406.145, Labor Code, are amended to read as follows:

(a) A hiring contractor and an independent subcontractor
may make a joint agreement declaring that the subcontractor is an independent contractor as defined in Section 406.141(2) and that the subcontractor is not the employee of the hiring contractor. If the joint agreement is signed by both the hiring contractor and the subcontractor and filed with the division [commission], the subcontractor, as a matter of law, is an independent contractor and not an employee, and is not entitled to workers' compensation insurance coverage through the hiring contractor unless an agreement is entered into under Section 406.144 to provide workers' compensation insurance coverage. The commissioner [commission] shall prescribe forms for the joint agreement.

(b) A joint agreement shall be delivered to the division [commission] by personal delivery or registered or certified mail and is considered filed on receipt by the division [commission].

(c) The hiring contractor shall send a copy of a joint agreement signed under this section to the hiring contractor's workers' compensation insurance carrier on filing of the joint agreement with the division [commission].

(d) The division [commission] shall maintain a system for accepting and maintaining the joint agreements.

(f) If a subsequent hiring agreement is made to which the joint agreement does not apply, the hiring contractor and independent contractor shall notify the division [commission] and the hiring contractor's workers' compensation insurance carrier in writing.

SECTION 3.041. Subsection (b), Section 406.162, Labor Code, is amended to read as follows:
(b) The comptroller shall prepare a consumer price index for this state and shall certify the applicable index factor to the division before October 1 of each year. The division shall adjust the gross annual payroll requirement under Subsection (a)(2)(B) accordingly.

SECTION 3.042. Subdivision (3), Section 407.001, Labor Code, is amended to read as follows:

(3) "Impaired employer" means a certified self-insurer:

(A) who has suspended payment of compensation as determined by the division;

(B) who has filed for relief under bankruptcy laws;

(C) against whom bankruptcy proceedings have been filed; or

(D) for whom a receiver has been appointed by a court of this state.

SECTION 3.0421. Section 407.023, Labor Code, is amended to read as follows:

Sec. 407.023. EXCLUSIVE POWERS AND DUTIES OF [COMMISSIONER]. [(a) The [commission, by majority vote,] shall:

(1) approve or deny [a recommendation by the director concerning] the issuance or revocation of a certificate of authority to self-insure; and

(2) certify that a certified self-insurer has suspended payment of compensation or has otherwise become an...
impaired employer.

[(b) The commission may not delegate the powers and duties imposed by this section.)

SECTION 3.0422. Subsection (b), Section 407.024, Labor Code, is amended to read as follows:

(b) The commissioner [director] is the agent for service of process for a claim or suit brought by a workers' compensation claimant against the qualified claims servicing contractor of a certified self-insurer.

SECTION 3.043. Subsections (a), (b), and (c), Section 407.041, Labor Code, are amended to read as follows:

(a) An employer who desires to self-insure under this chapter must submit an application to the division [commission] for a certificate of authority to self-insure.

(b) The application must be:

(1) submitted on a form adopted by the commissioner [commission]; and

(2) accompanied by a nonrefundable $1,000 application fee.

(c) Not later than the 60th day after the date on which the application is received, the commissioner [director] shall approve or deny [recommend approval or denial of] the application [to the commission].

SECTION 3.044. Section 407.042, Labor Code, is amended to read as follows:

Sec. 407.042. ISSUANCE OF CERTIFICATE. With the approval of the Texas Certified Self-Insurer Guaranty Association, [and by
majority vote,] the commissioner [commission] shall issue a certificate of authority to self-insure to an applicant who meets the certification requirements under this chapter and pays the required fee.

SECTION 3.045. Section 407.043, Labor Code, is amended to read as follows:

Sec. 407.043. PROCEDURES ON DENIAL OF APPLICATION. (a) If the commissioner [commission] determines that an applicant for a certificate of authority to self-insure does not meet the certification requirements, the division [commission] shall notify the applicant in writing of the commissioner's [its] determination, stating the specific reasons for the denial and the conditions to be met before approval may be granted.

(b) The applicant is entitled to a reasonable period, as determined by the commissioner [commission], to meet the conditions for approval before the application is considered rejected for purposes of appeal.

SECTION 3.046. Section 407.044, Labor Code, is amended to read as follows:

Sec. 407.044. TERM OF CERTIFICATE OF AUTHORITY; RENEWAL. (a) A certificate of authority to self-insure is valid for one year after the date of issuance and may be renewed under procedures prescribed by the commissioner [commission].

(b) The commissioner [director] may stagger the renewal dates of certificates of authority to self-insure to facilitate the work load of the division.

SECTION 3.047. Section 407.045, Labor Code, is amended to
Sec. 407.045. WITHDRAWAL FROM SELF-INSURANCE. (a) A certified self-insurer may withdraw from self-insurance at any time with the approval of the commissioner. The commissioner shall approve the withdrawal if the certified self-insurer shows to the satisfaction of the commissioner that the certified self-insurer has established an adequate program to pay all incurred losses, including unreported losses, that arise out of accidents or occupational diseases first distinctly manifested during the period of operation as a certified self-insurer.

(b) A certified self-insurer who withdraws from self-insurance shall surrender to the division the certificate of authority to self-insure.

SECTION 3.048. Subsections (a), (b), and (d), Section 407.046, Labor Code, are amended to read as follows:

(a) The commissioner may revoke the certificate of authority to self-insure of a certified self-insurer who fails to comply with requirements or conditions established by this chapter or a rule adopted by the commissioner under this chapter.

(b) If the commissioner believes that a ground exists to revoke a certificate of authority to self-insure, the commissioner shall refer the matter to the State Office of Administrative Hearings. That office shall hold a hearing to determine if the certificate should be revoked. The hearing shall be conducted in the manner provided for a contested
case hearing under Chapter 2001, Government Code [(the
administrative procedure law)].

(d) If the certified self-insurer fails to show cause why
the certificate should not be revoked, the commissioner
[commission] immediately shall revoke the certificate.

SECTION 3.049. Subsection (b), Section 407.047, Labor Code,
is amended to read as follows:

(b) The security required under Sections 407.064 and
407.065 shall be maintained with the division [commission] or under
the division's [commission's] control until each claim for workers'
compensation benefits is paid, is settled, or lapses under this
subtitle.

SECTION 3.050. Subsections (a), (c), (e), and (f), Section
407.061, Labor Code, are amended to read as follows:

(a) To be eligible for a certificate of authority to
self-insure, an applicant for an initial or renewal certificate
must present evidence satisfactory to the commissioner
[commission] and the association of sufficient financial strength
and liquidity, under standards adopted by the commissioner
[commission], to ensure that all workers' compensation obligations
incurred by the applicant under this chapter are met promptly.

(c) The applicant must present a plan for claims
administration that is acceptable to the commissioner [commission]
and that designates a qualified claims servicing contractor.

(e) The applicant must provide to the commissioner
[commission] a copy of each contract entered into with a person that
provides claims services, underwriting services, or accident
prevention services if the provider of those services is not an employee of the applicant. The contract must be acceptable to the commissioner and must be submitted in a standard form adopted by the commissioner, if the commissioner adopts such a form.

(f) The commissioner shall adopt rules for the requirements for the financial statements required by Subsection (b)(2).

SECTION 3.051. Section 407.062, Labor Code, is amended to read as follows:

Sec. 407.062. FINANCIAL STRENGTH AND LIQUIDITY REQUIREMENTS. In assessing the financial strength and liquidity of an applicant, the commissioner shall consider:

(1) the applicant's organizational structure and management background;

(2) the applicant's profit and loss history;

(3) the applicant's compensation loss history;

(4) the source and reliability of the financial information submitted by the applicant;

(5) the number of employees affected by self-insurance;

(6) the applicant's access to excess insurance markets;

(7) financial ratios, indexes, or other financial measures that the commissioner finds appropriate; and

(8) any other information considered appropriate by the commissioner.
SECTION 3.052. Subsection (a), Section 407.063, Labor Code, is amended to read as follows:

(a) In addition to meeting the other certification requirements imposed under this chapter, an applicant for an initial certificate of authority to self-insure must present evidence satisfactory to the commissioner of a total unmodified workers' compensation insurance premium in this state in the calendar year of application of at least $500,000.

SECTION 3.053. Subsections (a), (b), and (e), Section 407.064, Labor Code, are amended to read as follows:

(a) Each applicant shall provide security for incurred liabilities for compensation through a deposit with the division, in a combination and from institutions approved by the commissioner, of the following security:

1. cash or negotiable securities of the United States or of this state;
2. a surety bond that names the commissioner as payee; or
3. an irrevocable letter of credit that names the commissioner as payee.

(b) If an applicant who has provided a letter of credit as all or part of the security required under this section desires to cancel the existing letter of credit and substitute a different letter of credit or another form of security, the applicant shall notify the division in writing not later than the 60th day before the effective date of the cancellation of the original letter of credit.
(e) If an applicant is granted a certificate of authority to self-insure, any interest or other income that accrues from cash or negotiable securities deposited by the applicant as security under this section while the cash or securities are on deposit with the division [director] shall be paid to the applicant quarterly.

SECTION 3.054. Subsections (b)-(f), Section 407.065, Labor Code, are amended to read as follows:

(b) A surety bond, irrevocable letter of credit, or document indicating issuance of an irrevocable letter of credit must be in a form approved by the commissioner [director] and must be issued by an institution acceptable to the commissioner [director]. The instrument may be released only according to its terms but may not be released by the deposit of additional security.

(c) The certified self-insurer shall deposit the security with the comptroller on behalf of the division [director]. The comptroller may accept securities for deposit or withdrawal only on the written order of the commissioner [director].

(d) On receipt by the division [director] of a request to renew, submit, or increase or decrease a security deposit, a perfected security interest is created in the certified self-insurer's assets in favor of the commissioner [director] to the extent of any then unsecured portion of the self-insurer's incurred liabilities for compensation. That perfected security interest transfers to cash or securities deposited by the self-insurer with the division [director] after the date of the request and may be released only on:

(1) the acceptance by the commissioner [director] of a
surety bond or irrevocable letter of credit for the full amount of
the incurred liabilities for compensation; or

(2) the return of cash or securities by the division [director].

(e) The certified self-insurer loses all right to, title to,
interest in, and control of the assets or obligations submitted or
deposited as security. The commissioner [director] may liquidate
the deposit and apply it to the certified self-insurer's incurred
liabilities for compensation either directly or through the
association.

(f) If the commissioner [director] determines that a
security deposit is not immediately available for the payment of
compensation, the commissioner [director] shall determine the
appropriate method of payment and claims administration, which may
include payment by the surety that issued the bond or by the issuer
of an irrevocable letter of credit, and administration by a surety,
an adjusting agency, the association, or through any combination of
those entities approved by the commissioner [director].

SECTION 3.055. Subsections (a) and (b), Section 407.066,
Labor Code, are amended to read as follows:

(a) The commissioner [director], after notice to the
concerned parties and an opportunity for a hearing, shall resolve a
dispute concerning the deposit, renewal, termination, release, or
return of all or part of the security, liability arising out of the
submission or failure to submit security, or the adequacy of the
security or reasonableness of the administrative costs, including
legal fees, that arises among:
H.B. No. 7

1 (1) a surety;
2 (2) an issuer of an agreement of assumption and guarantee of workers' compensation liabilities;
3 (3) an issuer of a letter of credit;
4 (4) a custodian of the security deposit;
5 (5) a certified self-insurer; or
6 (6) the association.
7
8 (b) A party aggrieved by a decision of the commissioner [director] is entitled to judicial review. Venue for an appeal is in Travis County.
9
10 SECTION 3.056. Section 407.067, Labor Code, is amended to read as follows:
11
12 Sec. 407.067. EXCESS INSURANCE; REINSURANCE; ADMINISTRATIVE VIOLATION. (a) Each applicant shall obtain excess insurance or reinsurance to cover liability for losses not paid by the self-insurer in an amount not less than the amount required by the commissioner [director].
13 (b) The commissioner [director] shall require excess insurance or reinsurance in at least the amount of $5 million per occurrence.
14 (c) A certified self-insurer shall notify the division [director] not later than the 10th day after the date on which the certified self-insurer has notice of the cancellation or termination of excess insurance or reinsurance coverage required under this section.
15 (d) A person commits an administrative [a] violation if the person violates Subsection (c). [A violation under this subsection
is a Class B administrative violation. Each day of noncompliance
constitutes a separate violation.

SECTION 3.057. Subsections (a) through (d), (f), and (g), Section 407.081, Labor Code, are amended to read as follows:

(a) Each certified self-insurer shall file an annual report with the division. The commissioner shall prescribe the form of the report and shall furnish blank forms for the preparation of the report to each certified self-insurer.

(b) The report must:

(1) include payroll information, in the form prescribed by this chapter and the commissioner;

(2) state the number of injuries sustained in the three preceding calendar years; and

(3) indicate separately the amount paid during each year for income benefits, medical benefits, death benefits, burial benefits, and other proper expenses related to worker injuries.

(c) Each certified self-insurer shall file with the division as part of the annual report annual independent financial statements that reflect the financial condition of the self-insurer. The division shall make a financial statement filed under this subsection available for public review.

(d) The division may require that the report include additional financial and statistical information.

(f) The report must include an estimate of future liability for compensation. The estimate must be signed and sworn to by a certified casualty actuary every third year, or more frequently if...
required by the commissioner [commission].

(g) If the commissioner [commission] considers it necessary, the commissioner [it] may order a certified self-insurer whose financial condition or claims record warrants closer supervision to report as provided by this section more often than annually.

SECTION 3.058. Subsections (a), (c), (d), and (e), Section 407.082, Labor Code, are amended to read as follows:

(a) Each certified self-insurer shall maintain the books, records, and payroll information necessary to compile the annual report required under Section 407.081 and any other information reasonably required by the commissioner [commission].

(c) The material maintained by the certified self-insurer shall be open to examination by an authorized agent or representative of the division [commission] at reasonable times to ascertain the correctness of the information.

(d) The examination may be conducted at any location, including the division's [commission's] Austin offices, or, at the certified self-insurer's option, in the offices of the certified self-insurer. The certified self-insurer shall pay the reasonable expenses, including travel expenses, of an inspector who conducts an inspection at its offices.

(e) An unreasonable refusal on the part of a certified self-insurer to make available for inspection the books, records, payroll information, or other required information constitutes grounds for the revocation of the certificate of authority to self-insure and is an [a Class A] administrative violation. [Each
day of noncompliance constitutes a separate violation.

SECTION 3.059. Subsection (b), Section 407.101, Labor Code, is amended to read as follows:

(b) The department [commission] shall deposit the application fee for a certificate of authority to self-insure in the Texas Department of Insurance operating account [state treasury] to the credit of the division [workers' compensation self-insurance fund].

SECTION 3.060. Section 407.102, Labor Code, is amended to read as follows:

Sec. 407.102. REGULATORY FEE. (a) Each certified self-insurer shall pay an annual fee to cover the administrative costs incurred by the division [commission] in implementing this chapter.

(b) The division [commission] shall base the fee on the total amount of income benefit payments made in the preceding calendar year. The division [commission] shall assess each certified self-insurer a pro rata share based on the ratio that the total amount of income benefit payments made by that certified self-insurer bears to the total amount of income benefit payments made by all certified self-insurers.

SECTION 3.061. Subsections (a), (b), and (d), Section 407.103, Labor Code, are amended to read as follows:

(a) Each certified self-insurer shall pay a self-insurer maintenance tax for the administration of the division and the office of injured employee counsel [commission] and to support the prosecution of workers' compensation insurance fraud in this state.
Not more than two percent of the total tax base of all certified
self-insurers, as computed under Subsection (b), may be assessed
for a maintenance tax under this section.

(b) To determine the tax base of a certified self-insurer
for purposes of this chapter, the department shall
multiply the amount of the certified self-insurer's liabilities for
workers' compensation claims incurred in the previous year,
including claims incurred but not reported, plus the amount of
expense incurred by the certified self-insurer in the previous year
for administration of self-insurance, including legal costs, by

1.02.

(d) In setting the rate of maintenance tax assessment for
insurance companies, the commissioner of insurance may not consider revenue or expenditures related to the operation
of the self-insurer program under this chapter.

SECTION 3.062. Subsections (b) through (e), Section
407.104, Labor Code, are amended to read as follows:

(b) The department shall compute the fee and
taxes of a certified self-insurer and notify the certified
self-insurer of the amounts due. The taxes and fees shall be
remitted to the division.

(c) The regulatory fee imposed under Section 407.102 shall
be deposited in the Texas Department of Insurance operating account
[state treasury] to the credit of the division [workers' compensation self-insurance fund]. The self-insurer maintenance
tax shall be deposited in the Texas Department of Insurance
operating account [state treasury] to the credit of the division
(d) A certified self-insurer commits an administrative violation if the self-insurer does not pay the taxes and fee imposed under Sections 407.102 and 407.103 in a timely manner. [A violation under this subsection is a Class B administrative violation. Each day of noncompliance constitutes a separate violation.]

(e) If the certificate of authority to self-insure of a certified self-insurer is terminated, the [insurance] commissioner or the [executive director of the] commissioner of insurance [commissioner] shall proceed immediately to collect taxes due under this subtitle, using legal process as necessary.

SECTION 3.063. Subsection (b), Section 407.122, Labor Code, is amended to read as follows:

(b) The board of directors is composed of the following voting members:

(1) three certified self-insurers;
(2) one member designated by the commissioner [one commission member representing wage earners];
(3) one commission member representing employers; and
(4) the public counsel of the office of public insurance counsel.

SECTION 3.064. Subsection (b), Section 407.123, Labor Code, is amended to read as follows:

(b) Rules adopted by the board are subject to the approval of the commissioner [commission].

SECTION 3.065. Section 407.124, Labor Code, is amended to
Sec. 407.124. IMPAIRED EMPLOYER; ASSESSMENTS. (a) On determination by the division [commission] that a certified self-insurer has become an impaired employer, the commissioner [director] shall secure release of the security deposit required by this chapter and shall promptly estimate:

(1) the amount of additional funds needed to supplement the security deposit;

(2) the available assets of the impaired employer for the purpose of making payment of all incurred liabilities for compensation; and

(3) the funds maintained by the association for the emergency payment of compensation liabilities.

(b) The commissioner [director] shall advise the board of directors of the association of the estimate of necessary additional funds, and the board shall promptly assess each certified self-insurer to collect the required funds. An assessment against a certified self-insurer shall be made in proportion to the ratio that the total paid income benefit payment for the preceding reported calendar year for that self-insurer bears to the total paid income benefit payment by all certified self-insurers, except impaired employers, in this state in that calendar year.

(c) A certified self-insurer designated as an impaired employer is exempt from assessments beginning on the date of the designation until the division [commission] determines that the employer is no longer impaired.
SECTION 3.066. Subsection (d), Section 407.126, Labor Code, is amended to read as follows:

(d) The board of directors shall administer the trust fund in accordance with rules adopted by the commissioner.

SECTION 3.067. Subsection (a), Section 407.127, Labor Code, is amended to read as follows:

(a) If the commissioner determines that the payment of benefits and claims administration shall be made through the association, the association assumes the workers' compensation obligations of the impaired employer and shall begin the payment of the obligations for which it is liable not later than the 30th day after the date of notification by the director.

SECTION 3.068. Section 407.128, Labor Code, is amended to read as follows:

Sec. 407.128. POSSESSION OF SECURITY BY ASSOCIATION. On the assumption of obligations by the association under the commissioner's determination, the association is entitled to immediate possession of any deposited security, and the custodian, surety, or issuer of an irrevocable letter of credit shall deliver the security to the association with any accrued interest.

SECTION 3.069. Section 407.132, Labor Code, is amended to read as follows:

Sec. 407.132. SPECIAL FUND. Funds advanced by the association under this subchapter do not become assets of the impaired employer but are a special fund advanced to the commissioner, trustee in bankruptcy, receiver, or other
lawful conservator only for the payment of compensation
liabilities, including the costs of claims administration and legal
costs.

SECTION 3.070. Subsection (a), Section 407.133, Labor Code, is amended to read as follows:

(a) The commissioner [commission, after notice and hearing and by majority vote,] may suspend or revoke the certificate of authority to self-insure of a certified self-insurer who fails to pay an assessment. The association promptly shall report such a failure to the director.

SECTION 3.071. Subsection (d), Section 407A.053, Labor Code, is amended to read as follows:

(d) Any securities posted must be deposited in the state treasury and must be assigned to and made negotiable by the commissioner of workers' compensation [executive director of the commission] under a trust document acceptable to the commissioner of insurance. Interest accruing on a negotiable security deposited under this subsection shall be collected and transmitted to the depositor if the depositor is not in default.

SECTION 3.072. Subsection (c), Section 407A.201, Labor Code, is amended to read as follows:

(c) The membership of an individual member of a group is subject to cancellation by the group as provided by the bylaws of the group. An individual member may also elect to terminate participation in the group. The group shall notify the commissioner and the commissioner of workers' compensation [commission] of the cancellation or termination of a membership not
later than the 10th day after the date on which the cancellation or
termination takes effect and shall maintain coverage of each
canceled or terminated member until the 30th day after the date of
the notice, at the terminating member's expense, unless before that
date the commissioner of workers' compensation [commission]
notifies the group that the canceled or terminated member has:

(1) obtained workers' compensation insurance

coverage;

(2) become a certified self-insurer; or

(3) become a member of another group.

SECTION 3.073. The heading to Section 407A.301, Labor Code,
is amended to read as follows:

Sec. 407A.301. MAINTENANCE TAX FOR DIVISION [COMMISSION]
AND RESEARCH FUNCTIONS OF DEPARTMENT [AND OVERSIGHT COUNCIL].

SECTION 3.074. Subsections (a) and (c), Section 407A.301,
Labor Code, are amended to read as follows:

(a) Each group shall pay a self-insurance group maintenance
tax under this section for:

(1) the administration of the division of workers' 
compensation of the department [commission];

(2) the prosecution of workers' compensation insurance
fraud in this state; [and]

(3) the research functions of the department under
Chapter 405; and

(4) the administration of the office of injured
employee counsel under Chapter 404 [Research and Oversight Council
on Workers' Compensation].
(c) The tax liability of a group under Subsection (a)(3) is based on gross premium for the group's retention multiplied by the rate assessed insurance carriers under Section 405.003 [404.003].

SECTION 3.075. Section 407A.303, Labor Code, is amended to read as follows:

Sec. 407A.303. COLLECTION AND PAYMENT OF TAXES. (a) The group shall remit the taxes for deposit in the Texas Department of Insurance operating account [state treasury] to the credit of the division [commission].

(b) A group commits an administrative [a] violation if the group does not pay the taxes imposed under Sections 407A.301 and 407A.302 in a timely manner. [A violation under this subsection is a Class B administrative violation. Each day of noncompliance constitutes a separate violation.]

(c) If the certificate of approval of a group is terminated, the commissioner or the commissioner of insurance [executive director of the commission] shall immediately notify the comptroller to collect taxes as directed under Sections 407A.301 and 407A.302.

SECTION 3.076. Subsection (b), Section 407A.357, Labor Code, is amended to read as follows:

(b) The guaranty association advisory committee is composed of the following voting members:

(1) three members who represent different groups under this chapter, subject to Subsection (c);

(2) one member designated by the commissioner of workers' compensation [one commission member who represents wage
earners];

(3) one member designated by the insurance commissioner; and

(4) the public counsel of the office of public insurance counsel.

SECTION 3.077. Section 408.001, Labor Code, is amended by adding Subsection (d) to read as follows:

(d) A determination under Section 406.032, 409.002, or 409.004 that a work-related injury is noncompensable does not adversely affect the exclusive remedy provisions under Subsection (a).

SECTION 3.078. Subsection (c), Section 408.003, Labor Code, is amended to read as follows:

(c) The employer shall notify the division [commission] and the insurance carrier on forms prescribed by the commissioner [commission] of the initiation of and amount of payments made under this section.

SECTION 3.079. Subsections (a), (b), and (d) through (g), Section 408.004, Labor Code, are amended to read as follows:

(a) The commissioner [commission] may require an employee to submit to medical examinations to resolve any question about:

(1) the appropriateness of the health care received by the employee;

(2) similar issues.

(b) The commissioner [commission] may require an employee to submit to a medical examination at the request of the insurance carrier, but only after the insurance carrier has attempted and
failed to receive the permission and concurrence of the employee for the examination. Except as otherwise provided by this subsection, the insurance carrier is entitled to the examination only once in a 180-day period. The commissioner may adopt rules that require an employee to submit to not more than three medical examinations in a 180-day period under specified circumstances, including to determine whether there has been a change in the employee's condition and whether it is necessary to change the employee's diagnosis, and whether treatment should be extended to another body part or system. The commissioner by rule shall adopt a system for monitoring requests made under this subsection by insurance carriers. That system must ensure that good cause exists for any additional medical examination allowed under this subsection that is not requested by the employee. A subsequent examination must be performed by the same doctor unless otherwise approved by the commissioner.

(d) An injured employee is entitled to have a doctor of the employee's choice present at an examination required by the division at the request of an insurance carrier. The insurance carrier shall pay a fee set by the commissioner to the doctor selected by the employee.

(e) An employee who, without good cause as determined by the commissioner, fails or refuses to appear at the time scheduled for an examination under Subsection (a) or (b) commits an administrative violation. A violation under this subsection is a Class D administrative violation. An employee is not entitled
to temporary income benefits, and an insurance carrier may suspend
the payment of temporary income benefits, during and for a period in
which the employee fails to submit to an examination under
Subsection (a) or (b) unless the commission determines that the
employee had good cause for the failure to submit to the
examination. The commission may order temporary income benefits to
be paid for the period that the commission determines the employee
had good cause.] The commissioner [commission] by rule shall
ensure that an employee receives reasonable notice of an
examination [and of the insurance carrier's basis for suspension of
payment,] and that the employee is provided a reasonable
opportunity to reschedule an examination missed by the employee for
good cause.

(f) This section does not apply to health care provided
through a workers' compensation health care network established
under Chapter 1305, Insurance Code [if the report of a doctor
selected by an insurance carrier indicates that an employee can
return to work immediately or has reached maximum medical
improvement, the insurance carrier may suspend or reduce the
payment of temporary income benefits on the 14th day after the date
on which the insurance carrier files a notice of suspension with the
commission as provided by this subsection. The commission shall
hold an expedited benefit review conference, by personal appearance
or by telephone, not later than the 10th day after the date on which
the commission receives the insurance carrier's notice of
suspension. If a benefit review conference is not held by the 14th
day after the date on which the commission receives the insurance
carrier's notice of suspension, an interlocutory order, effective from the date of the report certifying maximum medical improvement, is automatically entered for the continuation of temporary income benefits until a benefit review conference is held, and the insurance carrier is eligible for reimbursement for any overpayment of benefits as provided by Chapter 410. The commission is not required to automatically schedule a contested case hearing as required by Section 410.025(b) if a benefit review conference is scheduled under this subsection. If a benefit review conference is held not later than the 14th day, the commission may enter an interlocutory order for the continuation of benefits, and the insurance carrier is eligible for reimbursement for any overpayments of benefits as provided by Chapter 410. The commission shall adopt rules as necessary to implement this subsection under which:

(1) an insurance carrier is required to notify the employee and the treating doctor of the suspension of benefits under this subsection by certified mail or another verifiable delivery method;

(2) the commission makes a reasonable attempt to obtain the treating doctor's opinion before the commission makes a determination regarding the entry of an interlocutory order; and

(3) the commission may allow abbreviated contested case hearings by personal appearance or telephone to consider issues relating to overpayment of benefits under this section).

(g) An insurance carrier who makes a frivolous request for [unreasonably requests] a medical examination under Subsection
(b), as determined by the commissioner, commits an administrative
[a] violation. [A violation under this subsection is a Class B
administrative violation.]

SECTION 3.080. Section 408.0041, Labor Code, is amended to
read as follows:

Sec. 408.0041. DESIGNATED DOCTOR EXAMINATION. (a) At the
request of an insurance carrier or an employee, or on the
commissioner's own order, the commissioner may [commission shall]
order a medical examination to resolve any question about:

(1) the impairment caused by the compensable injury;

(2) the attainment of maximum medical improvement;

(3) the extent of the employee's compensable injury;

(4) whether the injured employee's disability is a
direct result of the work-related injury;

(5) the ability of the employee to return to work; or

(6) issues similar to those described by Subdivisions
(1)-(5).

(b) A medical examination requested under Subsection (a)
shall be performed by the next available doctor on the division's
[commission's] list of designated doctors whose credentials are
appropriate for the issue in question and the injured employee's
medical condition as determined by commissioner rule. [The
designated doctor doing the review must be trained and experienced
with the treatment and procedures used by the doctor treating the
patient's medical condition, and the treatment and procedures
performed must be within the scope of practice of the designated
The division [commission] shall assign a designated doctor not later than the 10th day after the date on which the request under Subsection (a) is approved [received], and the examination must be conducted not later than the 21st day after the date on which the commissioner [commission] issues the order under Subsection (a). An examination under this section may not be conducted more frequently than every 60 days, unless good cause for more frequent examinations exists, as defined by commissioner [commission] rules.

(c) The treating doctor and the insurance carrier are both responsible for sending to the designated doctor all of the injured employee's medical records relating to the issue to be evaluated by the designated doctor that are in their possession. The treating doctor and insurance carrier may send the records without a signed release from the employee. The designated doctor is authorized to receive the employee's confidential medical records to assist in the resolution of disputes. The treating doctor and insurance carrier may also send the designated doctor an analysis of the injured employee's medical condition, functional abilities, and return-to-work opportunities.

(d) To avoid undue influence on a person selected as a designated doctor under this section, and except as provided by Subsection (c), only the injured employee or an appropriate member of the division's staff [of the commission] may communicate with the designated doctor about the case regarding the injured employee's medical condition or history before the examination of the injured employee by the designated doctor. After that
examination is completed, communication with the designated doctor regarding the injured employee's medical condition or history may be made only through appropriate division [commission] staff members. The designated doctor may initiate communication with any doctor or health care provider who has previously treated or examined the injured employee for the work-related injury or with peer reviewers identified by the insurance carrier.

(e) The designated doctor shall report to the division [commission]. The report of the designated doctor has presumptive weight unless the preponderance [great weight] of the evidence is to the contrary. An employer may make a bona fide offer of employment subject to Sections 408.103(e) and 408.144(c) based on the designated doctor's report.

(f) Unless otherwise ordered by the commissioner, the insurance carrier shall pay benefits based on the opinion of the designated doctor during the pendency of any dispute. If an insurance carrier is not satisfied with the opinion rendered by a designated doctor under this section, the insurance carrier may request the commissioner [commission] to order an employee to attend an examination by a doctor selected by the insurance carrier. [The commission shall allow the insurance carrier reasonable time to obtain and present the opinion of the doctor selected under this subsection before the commission makes a decision on the merits of the issue in question.]

(g) Except as otherwise provided by this subsection, an injured employee is entitled to have a doctor of the employee's choice present at an examination requested by an insurance carrier.
under Subsection (f). The insurance carrier shall pay a fee set by
the commissioner to the doctor selected by the employee. If the
injured employee is subject to a workers' compensation health care
network under Chapter 1305, Insurance Code, the doctor must be the
employee's treating doctor.

(h) The insurance carrier shall pay for:

(1) an examination required under Subsection (a) or
(f); and

(2) the reasonable expenses incident to the employee
in submitting to the examination.

(i) An employee who, without good cause as determined
by the commissioner, fails or refuses to appear at the time
scheduled for an examination under Subsection (a) or (f) commits an
administrative violation. An injured employee may not be fined
more than $10,000 for a violation of this subsection.

(j) An employee is not entitled to temporary income benefits
[compensation], and an insurance carrier is authorized to suspend
the payment of temporary income benefits, during and for a period in
which the employee fails to submit to an examination required by
Subsection (a) or (f) [this chapter] unless the commissioner
[commission] determines that the employee had good cause for the
failure to submit to the examination. The commissioner
[commission] may order temporary income benefits to be paid for the
period for which the commissioner [commission] determined that the
employee had good cause. The commissioner [commission] by rule
shall ensure that:

(1) an employee receives reasonable notice of an
examination and the insurance carrier's basis for suspension; and
(2) the employee is provided a reasonable opportunity
to reschedule an examination for good cause.

(k) If the report of a designated doctor indicates
that an employee has reached maximum medical improvement or is
otherwise able to return to work immediately, the insurance carrier
may suspend or reduce the payment of temporary income benefits
immediately.

(l) A person who makes a frivolous request for a medical
examination under Subsection (a) or (f), as determined by the
commissioner, commits an administrative violation.

SECTION 3.0805. Subchapter A, Chapter 408, Labor Code, is
amended by adding Section 408.0042 to read as follows:

Sec. 408.0042. MEDICAL EXAMINATION BY TREATING DOCTOR TO
DEFINE COMPENSABLE INJURY. (a) The division shall require an
injured employee to submit to a single medical examination to
define the compensable injury on request by the insurance carrier.

(b) A medical examination under this section shall be
performed by the employee's treating doctor. The insurance carrier
shall pay the costs of the examination.

(c) After the medical examination is performed, the
treating doctor shall submit to the insurance carrier a report that
details all injuries and diagnoses related to the compensable
injury, on receipt of which the insurance carrier shall:

(1) accept all injuries and diagnoses as related to
the compensable injury; or

(2) dispute the determination of specific injuries and
diagnoses.

(d) Any treatment for an injury or diagnosis that is not accepted by the insurance carrier under Subsection (c) as compensable at the time of the medical examination under Subsection (a) must be preauthorized before treatment is rendered. If the insurance carrier denies preauthorization because the treatment is for an injury or diagnosis unrelated to the compensable injury, the injured employee or affected health care provider may file an extent of injury dispute.

(e) Any treatment for an injury or diagnosis that is accepted by the insurance carrier under Subsection (c) as compensable at the time of the medical examination under Subsection (a) may not be reviewed for compensability, but may be reviewed for medical necessity.

(f) The commissioner may adopt rules relating to requirements for a report under this section, including requirements regarding the contents of a report.

(g) This section does not limit an injured employee or insurance carrier's ability to request an examination under Section 408.004 or 408.0041, as provided by those sections.

SECTION 3.081. Subsections (d), (e), (f), and (g), Section 408.005, Labor Code, are amended to read as follows:

(d) A settlement must be signed by the commissioner [director of the division of hearings] and all parties to the dispute.

(e) The commissioner [director of the division of hearings] shall approve a settlement if the commissioner [director] is
satisfied that:

(1) the settlement accurately reflects the agreement between the parties;

(2) the settlement reflects adherence to all appropriate provisions of law and the policies of the division [commission]; and

(3) under the law and facts, the settlement is in the best interest of the claimant.

(f) A settlement that is not approved or rejected before the 16th day after the date the settlement is submitted to the commissioner [director of the division of hearings] is considered to be approved by the commissioner [director] on that date.

(g) A settlement takes effect on the date it is approved by the commissioner [director of the division of hearings].

SECTION 3.082. Section 408.022, Labor Code, is amended by amending Subsections (a), (b), and (c) and adding Subsection (f) to read as follows:

(a) Except in an emergency, the division [commission] shall require an employee to receive medical treatment from a doctor chosen from a list of doctors approved by the commissioner [commission]. A doctor may perform only those procedures that are within the scope of the practice for which the doctor is licensed. The employee is entitled to the employee's initial choice of a doctor from the division's [commission's] list.

(b) If an employee is dissatisfied with the initial choice of a doctor from the division's [commission's] list, the employee may notify the division [commission] and request authority to
select an alternate doctor. The notification must be in writing stating the reasons for the change, except notification may be by telephone when a medical necessity exists for immediate change.

   (c) The commissioner [commission] shall prescribe criteria to be used by the division [commission] in granting the employee authority to select an alternate doctor. The criteria may include:
   (1) whether treatment by the current doctor is medically inappropriate;
   (2) the professional reputation of the doctor;
   (3) whether the employee is receiving appropriate medical care to reach maximum medical improvement; and
   (4) whether a conflict exists between the employee and the doctor to the extent that the doctor-patient relationship is jeopardized or impaired.

   (f) This section does not apply to requirements regarding the selection of a doctor under a workers' compensation health care network established under Chapter 1305, Insurance Code, except as provided by that chapter.

SECTION 3.083. Section 408.023, Labor Code, is amended to read as follows:

Sec. 408.023. LIST OF APPROVED DOCTORS; DUTIES OF TREATING DOCTORS. (a) The division [commission] shall develop a list of doctors licensed in this state who are approved to provide health care services under this subtitle. A [Each] doctor [licensed in this state on September 1, 2001,] is eligible to be included on the division's [commission's] list of approved doctors if the doctor:
   (1) registers with the division [commission] in the
manner prescribed by \textit{commissioner} \texttt{[commission]} rules; and

(2) complies with the requirements adopted by the \textit{commissioner} \texttt{[commission]} under this section.

(b) The \textit{commissioner} \texttt{[commission]} by rule shall establish reasonable requirements for training for doctors as a prerequisite for inclusion on the list \texttt{[and health care providers financially related to those doctors regarding training, impairment rating testing, and disclosure of financial interests as required by Section 413.041, and for monitoring of those doctors and health care providers as provided by Sections 408.0231 and 413.0512. The commission by rule shall provide a reasonable period, not to exceed 18 months after the adoption of rules under this section, for doctors to comply with the registration and training requirements of this subchapter].} Except as otherwise provided by this section, the requirements adopted under this subsection apply to doctors and other health care providers who:

(1) provide health care services as treating doctors;

(2) provide health care services as authorized by this chapter;

(3) perform medical peer review under this subtitle;

(4) perform utilization review of medical benefits provided under this subtitle; or

(5) provide health care services on referral from a treating doctor, as provided by \textit{commissioner} \texttt{[commission]} rule.

(c) The \textit{division} \texttt{[commission]} shall issue to a doctor who is approved by the \textit{commissioner} \texttt{[commission]} a certificate of registration. In determining whether to issue a certificate of
registration, the commissioner may consider and condition approval on any practice restrictions applicable to the applicant that are relevant to services provided under this subtitle. The commissioner may also consider the practice restrictions of an applicant when determining appropriate sanctions under Section 408.0231.

(d) A certificate of registration issued under this section is valid, unless revoked, suspended, or revised, for the period provided by commissioner rule and may be renewed on application to the division. The division shall provide notice to each doctor on the approved doctor list of the pending expiration of the doctor's certificate of registration not later than the 60th day before the date of expiration of the certificate.

(e) Notwithstanding other provisions of this section, a doctor not licensed in this state but licensed in another state or jurisdiction who treats employees or performs utilization review of health care for an insurance carrier may apply for a certificate of registration under this section to be included on the division's list of approved doctors.

(f) Except in an emergency or for immediate post-injury medical care as defined by commissioner rule, or as provided by Subsection (h) or (i), each doctor who performs functions under this subtitle, including examinations under this chapter, must hold a certificate of registration and be on the division's list of approved doctors in order to perform services or receive payment for those services.
(g) The commissioner by rule shall modify registration and training requirements for doctors who infrequently provide health care or who perform utilization review or peer review functions for insurance carriers, or who participate in regional networks established under this subchapter, as necessary to ensure that those doctors are informed of the regulations that affect health care benefit delivery under this subtitle.

(h) Notwithstanding Section 4(h), Article 21.58A, Insurance Code, a utilization review agent that uses doctors to perform reviews of health care services provided under this subtitle may use doctors licensed by another state to perform the reviews, but the reviews must be performed under the direction of a doctor licensed to practice in this state.

(i) The commissioner may grant exceptions to the requirement imposed under Subsection (f) as necessary to ensure that:

(1) employees have access to health care; and

(2) insurance carriers have access to evaluations of an employee's health care and income benefit eligibility as provided by this subtitle.

(j) A doctor who contracts with a workers' compensation health care network certified under Chapter 1305, Insurance Code, is not subject to the registration requirements of Subsections (a)-(i) for the purpose of providing health care services under that network contract. The doctor is subject to the requirements of Subsections (l)-(p), and Subsection (q) applies to health care
services and functions provided by a doctor who contracts with a certified workers' compensation health care network.

(k) The requirements of Subsections (a)-(g) and Subsection (i) expire September 1, 2007. Before that date, the commissioner may waive the application of the provisions of Subsections (a)-(g) and Subsection (i) that require doctors to hold a certificate of registration and to be on the list of approved doctors if the commissioner determines that:

(1) injured employees have adequate access to health care providers who are willing to treat injured employees for compensable injuries through workers' compensation health care networks certified under Chapter 1305, Insurance Code; or

(2) injured employees who are not covered by a workers' compensation health care network certified under Chapter 1305, Insurance Code, do not have adequate access to health care providers who are willing to treat injured employees for compensable injuries.

(1) The injured employee's treating doctor is responsible for the efficient management of medical care as required by Section 408.025(c) and commissioner rules. The division shall collect information regarding:

(1) return-to-work outcomes;

(2) patient satisfaction; and

(3) cost and utilization of health care provided or authorized by a treating doctor on the list of approved doctors.

(m) The commissioner may adopt rules to define the role of the treating doctor and to specify outcome

115
(n) The commissioner by rule shall establish reasonable requirements for doctors, and health care providers financially related to those doctors, regarding training, impairment rating testing, and disclosure of financial interests as required by Section 413.041, and for monitoring of those doctors and health care providers as provided by Sections 408.0231, 413.0511, and 413.0512.

(o) A doctor, including a doctor who contracts with a workers' compensation health care network, shall:

1. comply with the requirements established by commissioner rule under Subsections (l) and (m) and with Section 413.041 regarding the disclosure of financial interests; and

2. if the doctor intends to provide certifications of maximum medical improvement or assign impairment ratings, comply with the impairment rating training and testing requirements established by commissioner rule under Subsection (n).

(p) A person required to comply with Subsection (o), including a doctor who contracts with a workers' compensation health care network, who does not comply with that section commits an administrative violation.

(q) An insurance carrier may not use, for the purpose of suspending temporary income benefits or computing impairment income benefits, a certification of maximum medical improvement or an impairment rating assigned by a doctor, including a doctor who contracts with a workers' compensation health care network certified under Chapter 1305, Insurance Code, who fails to comply

H.B. No. 7

116
with Subsection (o)(2).

(r) Notwithstanding the waiver or expiration of Subsections (a)-(g) and (i), there may be no direct or indirect provision of health care under this subtitle and rules adopted under this subtitle, and no direct or indirect receipt of remuneration under this subtitle and rules adopted under this subtitle by a doctor who:

   (1) before September 1, 2007:

       (A) was removed or deleted from the list of approved doctors either by action of the Texas Workers' Compensation Commission or the division or by agreement with the doctor;

       (B) was not admitted to the list of approved doctors either by action of the Texas Workers' Compensation Commission or the division or by agreement with the doctor;

       (C) was suspended from the list of approved doctors either by action of the Texas Workers' Compensation Commission or the division or by agreement with the doctor; or

       (D) had the doctor's license to practice suspended by the appropriate licensing agency, including a suspension that was stayed, deferred, or probated, or voluntarily relinquished the license to practice; and

   (2) was not reinstated or restored by the Texas Workers' Compensation Commission or the division to the list of approved doctors before September 1, 2007.

(s) The waiver or expiration of Subsections (a)-(g) and (i) do not limit the division's ability to impose sanctions as provided by this subtitle and commissioner rules.
SECTION 3.084. Section 408.0231, Labor Code, is amended to read as follows:

Sec. 408.0231. MAINTENANCE OF LIST OF APPROVED DOCTORS; SANCTIONS AND PRIVILEGES RELATING TO HEALTH CARE. (a) The commissioner shall delete from the list of approved doctors a doctor:
(1) who fails to register with the division as provided by this chapter and commissioner rules;
(2) who is deceased;
(3) whose license to practice in this state is revoked, suspended, or not renewed by the appropriate licensing authority; or
(4) who requests to be removed from the list.
(b) The commissioner by rule shall establish criteria for:
(1) deleting or suspending a doctor from the list of approved doctors;
(2) imposing sanctions on a doctor or an insurance carrier as provided by this section;
(3) monitoring of utilization review agents, as provided by a memorandum of understanding between the division and the Texas Department of Insurance; and
(4) authorizing increased or reduced utilization review and preauthorization controls on a doctor.
(c) Rules adopted under Subsection (b) are in addition to, and do not affect, the rules adopted under Section 415.023(b). The
criteria for deleting a doctor from the list or for recommending or imposing sanctions may include anything the commissioner considers relevant, including:

1. a sanction of the doctor by the commissioner for a violation of Chapter 413 or Chapter 415;
2. a sanction by the Medicare or Medicaid program for:
   A. substandard medical care;
   B. overcharging;
   C. overutilization of medical services; or
   D. any other substantive noncompliance with requirements of those programs regarding professional practice or billing;
3. evidence from the division's medical records that the applicable insurance carrier's utilization review practices or the doctor's charges, fees, diagnoses, treatments, evaluations, or impairment ratings are substantially different from those the commissioner finds to be fair and reasonable based on either a single determination or a pattern of practice;
4. a suspension or other relevant practice restriction of the doctor's license by an appropriate licensing authority;
5. professional failure to practice medicine or provide health care, including chiropractic care, in an acceptable manner consistent with the public health, safety, and welfare;
6. findings of fact and conclusions of law made by a
court, an administrative law judge of the State Office of Administrative Hearings, or a licensing or regulatory authority; or

(7) a criminal conviction.

d) The commissioner by rule shall establish procedures under which a doctor may apply for:

(1) reinstatement to the list of approved doctors; or

(2) restoration of doctor practice privileges removed by the commissioner based on sanctions imposed under this section.

e) The commissioner shall act on a recommendation by the medical advisor selected under Section 413.0511 and, after notice and the opportunity for a hearing, may impose sanctions under this section on a doctor or an insurance carrier or may recommend action regarding a utilization review agent. The commissioner and the commissioner of insurance shall enter into a memorandum of understanding to coordinate the regulation of insurance carriers and utilization review agents as necessary to ensure:

(1) compliance with applicable regulations; and

(2) that appropriate health care decisions are reached under this subtitle and under Article 21.58A, Insurance Code.

f) The sanctions the commissioner may recommend or impose under this section include:

(1) reduction of allowable reimbursement;

(2) mandatory preauthorization of all or certain health care services;
required peer review monitoring, reporting, and audit;
(4) deletion or suspension from the approved doctor list and the designated doctor list;
(5) restrictions on appointment under this chapter;
(6) conditions or restrictions on an insurance carrier regarding actions by insurance carriers under this subtitle in accordance with the memorandum of understanding adopted under Subsection (e) [between the commission and the Texas Department of Insurance regarding Article 21.58A, Insurance Code]; and
(7) mandatory participation in training classes or other courses as established or certified by the division.

(g) The commissioner shall adopt rules regarding doctors who perform peer review functions for insurance carriers. Those rules may include standards for peer review, imposition of sanctions on doctors performing peer review functions, including restriction, suspension, or removal of the doctor's ability to perform peer review on behalf of insurance carriers in the workers' compensation system, and other issues important to the quality of peer review, as determined by the commissioner. A doctor who performs peer review under this subtitle must hold the appropriate professional license issued by this state.

SECTION 3.085. Section 408.024, Labor Code, is amended to read as follows:

Sec. 408.024. NONCOMPLIANCE WITH SELECTION REQUIREMENTS. Except as otherwise provided, and after notice and an opportunity
for hearing, the commissioner [commission] may relieve an insurance
carrier of liability for health care that is furnished by a health
care provider or another person selected in a manner inconsistent
with the requirements of this subchapter.

SECTION 3.086. Subsections (a), (b), and (d), Section
408.025, Labor Code, are amended to read as follows:
(a) The commissioner [commission] by rule shall adopt
requirements for reports and records that are required to be filed
with the division [commission] or provided to the injured employee,
the employee's attorney, or the insurance carrier by a health care
provider.
(b) The commissioner [commission] by rule shall adopt
requirements for reports and records that are to be made available
by a health care provider to another health care provider to prevent
unnecessary duplication of tests and examinations.
(d) On the request of an injured employee, the employee's
attorney, or the insurance carrier, a health care provider shall
furnish records relating to treatment or hospitalization for which
compensation is being sought. The division [commission] may
regulate the charge for furnishing a report or record, but the
charge may not be less than the fair and reasonable charge for
furnishing the report or record. A health care provider may
disclose to the insurance carrier of an affected employer records
relating to the diagnosis or treatment of the injured employee
without the authorization of the injured employee to determine the
amount of payment or the entitlement to payment.

SECTION 3.087. Subchapter B, Chapter 408, Labor Code, is
amended by adding Sections 408.0251 and 408.0252 to read as
follows:

Sec. 408.0251. ELECTRONIC BILLING REQUIREMENTS. (a) The
commissioner, by rule and in cooperation with the commissioner of
insurance, shall adopt rules regarding the electronic submission
and processing of medical bills by health care providers to
insurance carriers.

(b) Insurance carriers shall accept medical bills submitted
electronically by health care providers in accordance with
commissioner rule.

(c) The commissioner shall by rule establish criteria for
granting exceptions to insurance carriers and health care providers
who are unable to submit or accept medical bills electronically.

(d) On or after January 1, 2008, the commissioner may adopt
rules regarding the electronic payment of medical bills by
insurance carriers to health care providers.

Sec. 408.0252. UNDERSERVED AREAS. The commissioner by rule
may identify areas of this state in which access to health care
providers is less available and may adopt appropriate standards,
guidelines, and rules regarding the delivery of health care in
those areas.

SECTION 3.088. Section 408.026, Labor Code, is amended to
read as follows:

Sec. 408.026. SPINAL SURGERY. Except in a medical
emergency, an insurance carrier is liable for medical costs related
to spinal surgery only as provided by Section 413.014 and
commissioner [commission] rules.
Section 408.027, Labor Code, is amended to read as follows:

Sec. 408.027. PAYMENT OF HEALTH CARE PROVIDER. (a) A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment. An insurance carrier shall pay the fee allowed under Section 413.011 for a service rendered by a health care provider not later than the 45th day after the date the insurance carrier receives the charge unless the amount of the payment or the entitlement to payment is disputed.

(b) The insurance carrier must pay, reduce, deny, or determine to audit the health care provider's claim not later than the 45th day after the date of receipt by the carrier of the provider's claim. The carrier may request additional documentation necessary to clarify the provider's charges at any time during the 45-day period. If the insurance carrier requests additional documentation under this subsection, the health care provider must provide the requested documentation not later than the 15th day after the date of receipt of the carrier's request. If the insurance carrier elects to audit the claim, the carrier must complete the audit not later than the 160th day after the date of receipt by the carrier of the health care provider's claim, and, not later than the 160th day after the receipt of the claim, must make a determination regarding the relationship of the health care

H.B. No. 7

SECTION 3.089. Section 408.027, Labor Code, is amended to read as follows:

Sec. 408.027. PAYMENT OF HEALTH CARE PROVIDER. (a) A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment. An insurance carrier shall pay the fee allowed under Section 413.011 for a service rendered by a health care provider not later than the 45th day after the date the insurance carrier receives the charge unless the amount of the payment or the entitlement to payment is disputed.

(b) The insurance carrier must pay, reduce, deny, or determine to audit the health care provider's claim not later than the 45th day after the date of receipt by the carrier of the provider's claim. The carrier may request additional documentation necessary to clarify the provider's charges at any time during the 45-day period. If the insurance carrier requests additional documentation under this subsection, the health care provider must provide the requested documentation not later than the 15th day after the date of receipt of the carrier's request. If the insurance carrier elects to audit the claim, the carrier must complete the audit not later than the 160th day after the date of receipt by the carrier of the health care provider's claim, and, not later than the 160th day after the receipt of the claim, must make a determination regarding the relationship of the health care

H.B. No. 7

SECTION 3.089. Section 408.027, Labor Code, is amended to read as follows:

Sec. 408.027. PAYMENT OF HEALTH CARE PROVIDER. (a) A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment. An insurance carrier shall pay the fee allowed under Section 413.011 for a service rendered by a health care provider not later than the 45th day after the date the insurance carrier receives the charge unless the amount of the payment or the entitlement to payment is disputed.

(b) The insurance carrier must pay, reduce, deny, or determine to audit the health care provider's claim not later than the 45th day after the date of receipt by the carrier of the provider's claim. The carrier may request additional documentation necessary to clarify the provider's charges at any time during the 45-day period. If the insurance carrier requests additional documentation under this subsection, the health care provider must provide the requested documentation not later than the 15th day after the date of receipt of the carrier's request. If the insurance carrier elects to audit the claim, the carrier must complete the audit not later than the 160th day after the date of receipt by the carrier of the health care provider's claim, and, not later than the 160th day after the receipt of the claim, must make a determination regarding the relationship of the health care
services provided to the compensable injury, the extent of the
injury, and the medical necessity of the services provided. If the
insurance carrier chooses to audit the claim, the insurance carrier
must pay to the health care provider not later than the 45th day
after the date of receipt by the carrier of the provider's claim 85
percent of:

(1) the amount for the health care service established
under the fee guidelines authorized under this subtitle if the
health care service is not provided through a workers' compensation
health care network under Chapter 1305, Insurance Code; or

(2) the amount of the contracted rate for that health
care service if the health care service is provided through a
workers' compensation health care network under Chapter 1305,
Insurance Code [If an insurance carrier disputes the amount charged
by a health care provider and requests an audit of the services
rendered, the insurance carrier shall pay 50 percent of the amount
charged by the health care provider not later than the 45th day
after the date the insurance carrier receives the statement of
charge].

(c) If the health care services provided are determined to
be appropriate, the insurance carrier shall pay the health care
provider the remaining 15 percent of the claim not later than the
160th day after the date of receipt by the carrier of the health
care provider's documentation of the claim. An insurance carrier
commits an administrative violation if the carrier, in violation of
Subsection (b), fails to:

(1) pay, reduce, deny, or notify the health care
provider of the intent to audit the claim by the 45th day after the
date of receipt by the carrier of the health care provider's claim;
or
(2) pay, reduce, or deny an audited claim by the 160th
day after the date of receipt of the claim.

(d) If an insurance carrier contests the compensability of
an injury and the injury is determined not to be compensable, the
carrier may recover the amounts paid for health care services from
the employee's [denies liability or the health care provider's
entitlement to payment and an] accident or health benefit plan, or
any other person who may be obligated for the cost of the [insurance
company provides benefits to the employee for medical or other]
health care services[, the right to recover that amount may be
assigned by the employee to the accident or health insurance
company]. If an accident or health insurance carrier or other
person obligated for the cost of health care services has paid for
health care services for an employee for an injury for which a
workers' compensation insurance carrier denies compensability, and
the injury is later determined to be compensable, the accident or
health insurance carrier or other person may recover the amounts
paid for such services from the workers' compensation insurance
carrier.

(e) [(d) If an insurance carrier disputes the amount of
payment or the health care provider's entitlement to payment, the
insurance carrier shall send to the division [commission], the
health care provider, and the injured employee a report that
sufficiently explains the reasons for the reduction or denial of
payment for health care services provided to the employee. The
insurance carrier is entitled to a hearing as provided by Section
413.031(d).

(f) Any payment made by an insurance carrier under this
section shall be in accordance with the fee guidelines authorized
under this subtitle if the health care service is not provided
through a workers' compensation health care network under Chapter
1305, Insurance Code, or at a contracted rate for that health care
service if the health care service is provided through a workers' compensation health care network under Chapter 1305, Insurance
Code.

(g) Notwithstanding any other provision in this subtitle or
Chapter 1305, Insurance Code, this section and Section 408.0271
apply to health care provided through a workers' compensation
health care network established under Chapter 1305, Insurance Code.
The commissioner shall adopt rules as necessary to implement the
provisions of this section and Section 408.0271.

SECTION 3.0895. Subchapter B, Chapter 408, Labor Code, is
amended by adding Section 408.0271 to read as follows:

Sec. 408.0271. REIMBURSEMENT BY HEALTH CARE PROVIDER. (a)
If the health care services provided to an injured employee are
determined by the insurance carrier to be inappropriate, the
insurance carrier shall:

(1) notify the health care provider in writing of the
carrier's decision; and

(2) demand a refund by the health care provider of the
portion of payment on the claim that was received by the health care
provider for the inappropriate services.

(b) The health care provider may appeal the insurance
carrier's determination under Subsection (a). The health care
provider must file an appeal under this subsection with the
insurance carrier not later than the 45th day after the date of the
insurance carrier's request for the refund. The insurance carrier
must act on the appeal not later than the 45th day after the date on
which the provider files the appeal.

(c) A health care provider shall reimburse the insurance
carrier for payments received by the provider for inappropriate
charges not later than the 45th day after the date of the carrier's
notice. The failure by the health care provider to timely remit
payment to the carrier constitutes an administrative violation.

SECTION 3.090. Section 408.028, Labor Code, is amended by
amending Subsections (b), (d), and (e) and adding Subsections (f)
and (g) to read as follows:

(b) The commissioner [commission] by rule shall require
[develop an open formulary under Section 413.011 that requires] the
use of generic pharmaceutical medications and clinically
appropriate over-the-counter alternatives to prescription
medications unless otherwise specified by the prescribing doctor,
in accordance with applicable state law. The commissioner by rule
shall adopt a closed formulary under Section 413.011. Rules
adopted by the commissioner shall allow an appeals process for
claims in which a treating doctor determines and documents that a
drug not included in the formulary is necessary to treat an injured
employee's compensable injury.
(d) The commissioner shall adopt rules to allow an employee to purchase over-the-counter alternatives to prescription medications prescribed or ordered under Subsection (a) or (b) and to obtain reimbursement from the insurance carrier for those medications.

(e) Notwithstanding Subsection (b), the commissioner by rule shall allow an employee to purchase a brand name drug rather than a generic pharmaceutical medication or over-the-counter alternative to a prescription medication if a health care provider prescribes a generic pharmaceutical medication or an over-the-counter alternative to a prescription medication. The employee shall be responsible for paying the difference between the cost of the brand name drug and the cost of the generic pharmaceutical medication or of an over-the-counter alternative to a prescription medication. The employee may not seek reimbursement for the difference in cost from an insurance carrier and is not entitled to use the medical dispute resolution provisions of Chapter 413 with regard to the prescription. A payment described by this subsection by an employee to a health care provider does not violate Section 413.042. This subsection does not affect the duty of a health care provider to comply with the requirements of Subsection (b) when prescribing medications or ordering over-the-counter alternatives to prescription medications.

(f) Notwithstanding any other provision of this title, the commissioner by rule shall adopt a fee schedule for pharmacy and pharmaceutical services that will:
(1) provide reimbursement rates that are fair and reasonable;

(2) assure adequate access to medications and services for injured workers; and

(3) minimize costs to employees and insurance carriers.

(g) Insurance carriers must reimburse for pharmacy benefits and services using the fee schedule as developed by this section, or at rates negotiated by contract.

SECTION 3.091. Section 408.030, Labor Code, is amended to read as follows:

Sec. 408.030. REPORTS OF PHYSICIAN VIOLATIONS. If the division [commission] discovers an act or omission by a physician that may constitute a felony, a misdemeanor involving moral turpitude, a violation of a state or federal narcotics or controlled substance law, an offense involving fraud or abuse under the Medicare or Medicaid program, or a violation of this subtitle, the division [commission] shall immediately report that act or omission to the Texas State Board of Medical Examiners.

SECTION 3.092. Subchapter B, Chapter 408, Labor Code, is amended by adding Section 408.031 to read as follows:

Sec. 408.031. WORKERS' COMPENSATION HEALTH CARE NETWORKS. (a) Notwithstanding any other provision of this chapter, an injured employee may receive benefits under a workers' compensation health care network established under Chapter 1305, Insurance Code, in the manner provided by that chapter.

(b) In the event of a conflict between this title and
Chapter 1305, Insurance Code, as to the provision of medical benefits for injured employees, the establishment and regulation of fees for medical treatments and services, the time frames for payment of medical bills, the operation and regulation of workers' compensation health care networks, the regulation of the health care providers who contract with those networks, or the resolution of disputes regarding medical benefits provided through those networks, Chapter 1305, Insurance Code, prevails.

SECTION 3.093. Subchapter B, Chapter 408, Labor Code, is amended by adding Section 408.032 to read as follows:

Sec. 408.032. STUDY ON INTERDISCIPLINARY PAIN REHABILITATION PROGRAM AND FACILITY ACCREDITATION REQUIREMENT. The division shall study the issue of required accreditation of interdisciplinary pain rehabilitation programs or interdisciplinary pain rehabilitation treatment facilities that provide services to injured employees and shall report to the legislature regarding any statutory changes that the division considers necessary to require that accreditation.

SECTION 3.094. Subsection (c), Section 408.041, Labor Code, is amended to read as follows:

(c) If Subsection (a) or (b) cannot reasonably be applied because the employee's employment has been irregular or because the employee has lost time from work during the 13-week period immediately preceding the injury because of illness, weather, or another cause beyond the control of the employee, the commissioner may determine the employee's average weekly wage by any method that the commissioner considers fair, just,

H.B. No. 7

1 Chapter 1305, Insurance Code, as to the provision of medical
2 benefits for injured employees, the establishment and regulation of
3 fees for medical treatments and services, the time frames for
4 payment of medical bills, the operation and regulation of workers'
5 compensation health care networks, the regulation of the health
6 care providers who contract with those networks, or the resolution
7 of disputes regarding medical benefits provided through those
8 networks, Chapter 1305, Insurance Code, prevails.
9
10 SECTION 3.093. Subchapter B, Chapter 408, Labor Code, is
11 amended by adding Section 408.032 to read as follows:
12
13 Sec. 408.032. STUDY ON INTERDISCIPLINARY PAIN
14 REHABILITATION PROGRAM AND FACILITY ACCREDITATION REQUIREMENT. The division shall study the issue of required accreditation of interdisciplinary pain rehabilitation programs or interdisciplinary pain rehabilitation treatment facilities that provide services to injured employees and shall report to the legislature regarding any statutory changes that the division considers necessary to require that accreditation.
15
16 SECTION 3.094. Subsection (c), Section 408.041, Labor Code, is amended to read as follows:
17
18 (c) If Subsection (a) or (b) cannot reasonably be applied because the employee's employment has been irregular or because the employee has lost time from work during the 13-week period immediately preceding the injury because of illness, weather, or another cause beyond the control of the employee, the commissioner may determine the employee's average weekly wage by any method that the commissioner considers fair, just,
and reasonable to all parties and consistent with the methods
established under this section.

SECTION 3.095. Subsections (d), (f), and (g), Section
408.042, Labor Code, are amended to read as follows:

(d) The commissioner shall:

(1) prescribe a form to collect information regarding
the wages of employees with multiple employment; and

(2) by rule, determine the manner by which the
commission collects and distributes wage information to
implement this section.

(f) If the commissioner determines that
computing the average weekly wage for an employee as provided by
Subsection (c) is impractical or unreasonable, the commissioner
shall set the average weekly wage in a manner that more
fairly reflects the employee's average weekly wage and that is fair
and just to both parties or is in the manner agreed to by the
parties. The commissioner by rule may define methods
to determine a fair and just average weekly wage consistent with
this section.

(g) An insurance carrier is entitled to apply for and
receive reimbursement at least annually from the subsequent injury
fund for the amount of income benefits paid to a worker under this
section that are based on employment other than the employment
during which the compensable injury occurred. The commissioner
may adopt rules that govern the documentation,
application process, and other administrative requirements
necessary to implement this subsection.
SECTION 3.096. Subsection (c), Section 408.043, Labor Code, is amended to read as follows:

   (c) If, for good reason, the commissioner determines that computing the average weekly wage for a seasonal employee as provided by this section is impractical, the commissioner shall compute the average weekly wage as of the time of the injury in a manner that is fair and just to both parties.

SECTION 3.097. Subsection (b), Section 408.0445, Labor Code, is amended to read as follows:

   (b) For purposes of computing income benefits or death benefits under Section 88.303, Education Code, the average weekly wage of a Texas Task Force 1 member, as defined by Section 88.301, Education Code, who is engaged in authorized training or duty is an amount equal to the sum of the member's regular weekly wage at any employment, including self-employment, that the member holds in addition to serving as a member of Texas Task Force 1, except that the amount may not exceed 100 percent of the state average weekly wage as determined under Section 408.047. A member for whom an average weekly wage cannot be computed shall be paid the minimum weekly benefit established by the division.

SECTION 3.098. Subsections (d) and (e), Section 408.0446, Labor Code, are amended to read as follows:

   (d) If the commissioner determines that computing the average weekly wage of a school district employee as provided by this section is impractical because the employee did not earn wages during the 12 months immediately preceding the date...
of the injury, the commissioner shall compute the average weekly wage in a manner that is fair and just to both parties.

(e) The commissioner shall adopt rules as necessary to implement this section.

SECTION 3.099. Section 408.045, Labor Code, is amended to read as follows:

Sec. 408.045. NONPECUNIARY WAGES. The division may not include nonpecuniary wages in computing an employee's average weekly wage during a period in which the employer continues to provide the nonpecuniary wages.

SECTION 3.100. Section 408.047, Labor Code, is amended to read as follows:

Sec. 408.047. STATE AVERAGE WEEKLY WAGE. (a) On and after October 1, 2006, the state average weekly wage is equal to 88 percent of the average weekly wage in covered employment computed by the Texas Workforce Commission under Section 207.002(c).

(b) The state average weekly wage for the period beginning September 1, 2005, and ending September 30, 2006, is $540. For the fiscal year beginning September 1, 2004, and ending August 31, 2005, is $539. This subsection expires October 1, 2006.

(c) Notwithstanding Subsection (a), the commissioner by rule may increase the state average weekly wage to an amount not to exceed 100 percent of the average weekly wage in covered employment computed by the Texas Workforce Commission under Section 207.002(c).
SECTION 3.101. Subsection (f), Section 408.061, Labor Code, is amended to read as follows:

(f) The division [commission] shall compute the maximum weekly income benefits for each state fiscal year not later than October [September] 1 of each year.

SECTION 3.102. Subsection (b), Section 408.062, Labor Code, is amended to read as follows:

(b) The division [commission] shall compute the minimum weekly income benefit for each state fiscal year not later than October [September] 1 of each year.

SECTION 3.103. Subsections (a) and (c), Section 408.063, Labor Code, are amended to read as follows:

(a) To expedite the payment of income benefits, the commissioner [commission] may by rule establish reasonable presumptions relating to the wages earned by an employee, including the presumption that an employee's last paycheck accurately reflects the employee's usual wage.

(c) An employer who fails to file a wage statement in accordance with Subsection (b) commits an administrative [a] violation. [A violation under this subsection is a Class D administrative violation.]

SECTION 3.104. Subsections (b) and (c), Section 408.081, Labor Code, are amended to read as follows:

(b) Except as otherwise provided by this section or this subtitle, income benefits shall be paid weekly as and when they accrue without order from the commissioner [commission]. Interest on accrued but unpaid benefits shall be paid, without order of the
commissioner, at the time the accrued benefits are paid.

(c) The commissioner by rule shall establish requirements for agreements under which income benefits may be paid monthly. Income benefits may be paid monthly only:

(1) on the request of the employee and the agreement of the employee and the insurance carrier; and

(2) in compliance with the requirements adopted by the commissioner.

SECTION 3.105. Subsection (c), Section 408.082, Labor Code, is amended to read as follows:

(c) If the disability continues for two weeks or longer after the date it begins, compensation shall be computed from the date the disability begins.

SECTION 3.106. Subsections (a) and (b), Section 408.084, Labor Code, are amended to read as follows:

(a) At the request of the insurance carrier, the commissioner may order that impairment income benefits and supplemental income benefits be reduced in a proportion equal to the proportion of a documented impairment that resulted from earlier compensable injuries.

(b) The commissioner shall consider the cumulative impact of the compensable injuries on the employee's overall impairment in determining a reduction under this section.

SECTION 3.107. Section 408.085, Labor Code, is amended to read as follows:

Sec. 408.085. ADVANCE OF BENEFITS FOR HARDSHIP. (a) If
there is a likelihood that income benefits will be paid, the commissioner [commission] may grant an employee suffering financial hardship advances as provided by this subtitle against the amount of income benefits to which the employee may be entitled. An advance may be ordered before or after the employee attains maximum medical improvement. An insurance carrier shall pay the advance ordered.

(b) An employee must apply to the division [commission] for an advance on a form prescribed by the commissioner [commission]. The application must describe the hardship that is the grounds for the advance.

(c) An advance under this section may not exceed an amount equal to four times the maximum weekly benefit for temporary income benefits as computed in Section 408.061. The commissioner [commission] may not grant more than three advances to a particular employee based on the same injury.

(d) The commissioner [commission] may not grant an advance to an employee who is receiving, on the date of the application under Subsection (b), at least 90 percent of the employee's net preinjury wages under Section 408.003 or 408.129.

SECTION 3.108. Section 408.086, Labor Code, is amended to read as follows:

Sec. 408.086. DIVISION [COMMISSION] DETERMINATION OF EXTENDED UNEMPLOYMENT OR UNDEREMPLOYMENT. (a) During the period that impairment income benefits or supplemental income benefits are being paid to an employee, the commissioner [commission] shall determine at least annually whether any extended unemployment or
underemployment is a direct result of the employee's impairment.

(b) To make this determination, the commissioner [commission] may require periodic reports from the employee and the insurance carrier and, at the insurance carrier's expense, may require physical or other examinations, vocational assessments, or other tests or diagnoses necessary to perform the commissioner's [its] duty under this section and Subchapter H.

SECTION 3.109. Subsection (b), Section 408.102, Labor Code, is amended to read as follows:

(b) The commissioner [commission] by rule shall establish a presumption that maximum medical improvement has been reached based on a lack of medical improvement in the employee's condition.

SECTION 3.110. Subsection (b), Section 408.103, Labor Code, is amended to read as follows:

(b) A temporary income benefit under Subsection (a)(2) may not exceed the employee's actual earnings for the previous year. It is presumed that the employee's actual earnings for the previous year are equal to:

(1) the sum of the employee's wages as reported in the most recent four quarterly wage reports to the Texas Workforce [Employment] Commission divided by 52;

(2) the employee's wages in the single quarter of the most recent four quarters in which the employee's earnings were highest, divided by 13, if the commissioner [commission] finds that the employee's most recent four quarters' earnings reported in the Texas Workforce [Employment] Commission wage reports are not representative of the employee's usual earnings; or
(3) the amount the commissioner [commission] determines from other credible evidence to be the actual earnings for the previous year if the Texas Workforce [Employment] Commission does not have a wage report reflecting at least one quarter's earnings because the employee worked outside the state during the previous year.

SECTION 3.111. Subsections (a) and (c), Section 408.104, Labor Code, are amended to read as follows:

(a) On application by either the employee or the insurance carrier, the commissioner [commission] by order may extend the 104-week period described by Section 401.011(30)(B) if the employee has had spinal surgery, or has been approved for spinal surgery under Section 408.026 and commissioner [commission] rules, within 12 weeks before the expiration of the 104-week period. If an order is issued under this section, the order shall extend the statutory period for maximum medical improvement to a date certain, based on medical evidence presented to the commissioner [commission].

(c) The commissioner [commission] shall adopt rules to implement this section, including rules establishing procedures for requesting and disputing an extension.

SECTION 3.112. Subchapter G, Chapter 408, Labor Code, is amended by amending Section 408.122 and adding Section 408.1225 to read as follows:

Sec. 408.122. ELIGIBILITY FOR IMPAIRMENT INCOME BENEFITS[DESIGNATED DOCTOR]. [(a)] A claimant may not recover impairment income benefits unless evidence of impairment based on an objective clinical or laboratory finding exists. If the finding of
impairment is made by a doctor chosen by the claimant and the
finding is contested, a designated doctor or a doctor selected by
the insurance carrier must be able to confirm the objective
clinical or laboratory finding on which the finding of impairment
is based.

Sec. 408.1225. DESIGNATED DOCTOR. (a) To be
eligible to serve as a designated doctor, a doctor must meet
specific qualifications, including training in the determination
of impairment ratings and demonstrated expertise in performing
examinations and making evaluations as described by Section
408.0041. The commissioner shall develop qualification standards and administrative policies to implement
this subsection and may adopt rules as necessary.

(b) The commissioner shall ensure the quality of designated
doctor decisions and reviews through active monitoring of the
decisions and reviews, and may take action as necessary to:

(1) restrict the participation of a designated doctor;
or

(2) remove a doctor from inclusion on the department's
list of designated doctors. [The designated doctor doing the
review must be trained and experienced with the treatment and
procedures used by the doctor treating the patient's medical
condition, and the treatment and procedures performed must be
within the scope of practice of the designated doctor. A designated
doctor's credentials must be appropriate for the issue in question
and the injured employee's medical condition.]

140
(c) The report of the designated doctor has presumptive weight, and the division shall base its determination of whether the employee has reached maximum medical improvement on the report unless the preponderance [great weight] of the other medical evidence is to the contrary.

(d) The commissioner shall develop rules to ensure that a designated doctor called on to conduct an examination under Section 408.0041 has no conflict of interest in serving as a designated doctor in performing any examination.

SECTION 3.113. Section 408.123, Labor Code, is amended and reenacted to read as follows:

Sec. 408.123. CERTIFICATION OF MAXIMUM MEDICAL IMPROVEMENT; EVALUATION OF IMPAIRMENT RATING. (a) After an employee has been certified by a doctor as having reached maximum medical improvement, the certifying doctor shall evaluate the condition of the employee and assign an impairment rating using the impairment rating guidelines described by Section 408.124. If the certification and evaluation are performed by a doctor other than the employee's treating doctor, the certification and evaluation shall be submitted to the treating doctor, and the treating doctor shall indicate agreement or disagreement with the certification and evaluation.

(b) A certifying doctor shall issue a written report certifying that maximum medical improvement has been reached, stating the employee's impairment rating, and providing any other information required by the commissioner to:

(1) the division;
(2) the employee; and

(3) the insurance carrier.

(c) The commissioner shall adopt a rule that provides that, at the conclusion of any examination in which maximum medical improvement is certified and any impairment rating is assigned by the treating doctor, written notice shall be given to the employee that the employee may dispute the certification of maximum medical improvement and assigned impairment rating. The notice to the employee must state how to dispute the certification of maximum medical improvement and impairment rating.

(d) If an employee is not certified as having reached maximum medical improvement before the expiration of 102 weeks after the date income benefits begin to accrue, the division shall notify the treating doctor of the requirements of this subchapter.

(e) [Repealed]

(f) [Repealed] An employee's first certification of maximum medical improvement or assignment of an impairment rating may be disputed after the period described by Subsection (e) [Repealed] if:

(1) compelling medical evidence exists of:

(A) a significant error by the certifying doctor
in applying the appropriate American Medical Association
guidelines or in calculating the impairment rating;

(B) a clearly mistaken diagnosis or a previously
undiagnosed medical condition; or

(C) improper or inadequate treatment of the
injury before the date of the certification or assignment that
would render the certification or assignment invalid; or

(2) other compelling circumstances exist as
prescribed by commissioner [commission] rule.

(g) [Repealed by Acts 93-985, § 7.012] If an employee has not been certified as having
reached maximum medical improvement before the expiration of 104
weeks after the date income benefits begin to accrue or the
expiration date of any extension of benefits under Section 408.104,
the impairment rating assigned after the expiration of either of
those periods is final if the impairment rating is not disputed
before the 91st day after the date written notification of the
certification or assignment is provided to the employee and the
carrier by verifiable means. A certification or assignment may be
disputed after the 90th day only as provided by Subsection (f)
[(e)].

(h) [Repealed by Acts 93-985, § 7.012] If an employee's disputed certification of
maximum medical improvement or assignment of impairment rating is
finally modified, overturned, or withdrawn, the first
certification or assignment made after the date of the
modification, overturning, or withdrawal becomes final if the
certification or assignment is not disputed before the 91st day
after the date notification of the certification or assignment is
provided to the employee and the carrier by verifiable means. A

certification or assignment may be disputed after the 90th day only

as provided by Subsection \(\text{(f)}\) [(e)].

SECTION 3.114. Section 408.124, Labor Code, is amended to
read as follows:

Sec. 408.124. IMPAIRMENT RATING GUIDELINES. (a) An award
of an impairment income benefit, whether by the commissioner
[commission] or a court, must be based [shall be made] on an
impairment rating determined using the impairment rating
guidelines described by [in] this section.

(b) For determining the existence and degree of an
employee's impairment, the division [commission] shall use "Guides
to the Evaluation of Permanent Impairment," third edition, second
printing, dated February 1989, published by the American Medical
Association.

(c) Notwithstanding Subsection (b), the commissioner
[commission] by rule may adopt the fourth edition of the "Guides to
the Evaluation of Permanent Impairment," published by the American
Medical Association, or a subsequent edition of those guides, for
determining the existence and degree of an employee's impairment.

SECTION 3.115. Subsections (a) through (d) and (f), Section
408.125, Labor Code, are amended to read as follows:

(a) If an impairment rating is disputed, the commissioner
[commission] shall direct the employee to the next available doctor
on the division's [commission's] list of designated doctors, as
provided by Section 408.0041.

(b) The designated doctor shall report in writing to the
division [commission].

(c) The report of the designated doctor shall have presumptive weight, and the division [commission] shall base the impairment rating on that report unless the preponderance [great weight] of the other medical evidence is to the contrary. If the preponderance [great weight] of the medical evidence contradicts the impairment rating contained in the report of the designated doctor chosen by the division [commission], the division [commission] shall adopt the impairment rating of one of the other doctors.

(d) To avoid undue influence on a person selected as a designated doctor under this section, only the injured employee or an appropriate member of the staff of the division [commission] may communicate with the designated doctor about the case regarding the injured employee's medical condition or history before the examination of the injured employee by the designated doctor. After that examination is completed, communication with the designated doctor regarding the injured employee's medical condition or history may be made only through appropriate division [commission] staff members. The designated doctor may initiate communication with any doctor who has previously treated or examined the injured employee for the work-related injury.

(f) A violation of Subsection (d) is an [a Class C] administrative violation.

SECTION 3.116. Subsection (c), Section 408.127, Labor Code, is amended to read as follows:

(c) The commissioner [commission] shall adopt rules and
forms to ensure the full reporting and the accuracy of reductions and reimbursements made under this section.

SECTION 3.117. Subsections (a), (b), and (d), Section 408.129, Labor Code, are amended to read as follows:

(a) On approval by the commissioner of a written request received from an employee, an insurance carrier shall accelerate the payment of impairment income benefits to the employee. The accelerated payment may not exceed a rate of payment equal to that of the employee's net preinjury wage.

(b) The commissioner shall approve the request and order the acceleration of the benefits if the commissioner determines that the acceleration is:

(1) required to relieve hardship; and

(2) in the overall best interest of the employee.

(d) The commissioner may prescribe forms necessary to implement this section.

SECTION 3.118. Section 408.141, Labor Code, is amended to read as follows:

Sec. 408.141. AWARD OF SUPPLEMENTAL INCOME BENEFITS. An award of a supplemental income benefit, whether by the commissioner or a court, shall be made in accordance with this subchapter.

SECTION 3.119. Subchapter H, Chapter 408, Labor Code, is amended by adding Section 408.1415 to read as follows:

Sec. 408.1415. WORK SEARCH COMPLIANCE STANDARDS. (a) The commissioner by rule shall adopt compliance standards for supplemental income benefit recipients that require each recipient
to demonstrate an active effort to obtain employment. To be
eligible to receive supplemental income benefits under this
chapter, a recipient must provide evidence satisfactory to the
division of:

(1) active participation in a vocational
rehabilitation program conducted by the Department of Assistive and
Rehabilitative Services or a private vocational rehabilitation
provider;

(2) active participation in work search efforts
conducted through the Texas Workforce Commission; or

(3) active work search efforts documented by job
applications submitted by the recipient.

(b) In adopting rules under this section, the commissioner
shall:

(1) establish the level of activity that a recipient
should have with the Texas Workforce Commission and the Department
of Assistive and Rehabilitative Services;

(2) define the number of job applications required to
be submitted by a recipient to satisfy the work search
requirements; and

(3) consider factors affecting the availability of
employment, including recognition of access to employment in rural
areas, economic conditions, and other appropriate employment
availability factors.

(c) The commissioner may consult with the Texas Workforce
Commission, the Department of Assistive and Rehabilitative
Services, and other appropriate entities in adopting rules under
this section.

SECTION 3.1195. Subsection (a), Section 408.142, Labor Code, is amended to read as follows:

(a) An employee is entitled to supplemental income benefits if on the expiration of the impairment income benefit period computed under Section 408.121(a)(1) the employee:

(1) has an impairment rating of 15 percent or more as determined by this subtitle from the compensable injury;

(2) has not returned to work or has returned to work earning less than 80 percent of the employee's average weekly wage as a direct result of the employee's impairment;

(3) has not elected to commute a portion of the impairment income benefit under Section 408.128; and

(4) has complied with the requirements adopted under Section 408.1415 [attempted in good faith to obtain employment commensurate with the employee's ability to work].

SECTION 3.120. Subsections (a) and (b), Section 408.143, Labor Code, are amended to read as follows:

(a) After the commissioner's [commission's] initial determination of supplemental income benefits, the employee must file a statement with the insurance carrier stating:

(1) that the employee has earned less than 80 percent of the employee's average weekly wage as a direct result of the employee's impairment;

(2) the amount of wages the employee earned in the filing period provided by Subsection (b); and

(3) that the employee has complied with the
requirements adopted under Section 408.1415 [in good faith sought employment commensurate with the employee's ability to work].

(b) The statement required under this section must be filed quarterly on a form and in the manner provided by the commissioner. The commissioner may modify the filing period as appropriate to an individual case.

SECTION 3.1205. Subsection (b), Section 408.144, Labor Code, is amended to read as follows:

(b) Subject to Section 408.061, the amount of a supplemental income benefit for a week is equal to 80 percent of the amount computed by subtracting the weekly wage the employee earned during the reporting period provided by Section 408.143(b) from 80 percent of the employee's average weekly wage determined under Section 408.041, 408.042, 408.043,[or] 408.044, 408.0445, or 408.0446.

SECTION 3.121. Subsection (c), Section 408.147, Labor Code, is amended to read as follows:

(c) If an insurance carrier disputes the commissioner's determination that an employee is entitled to supplemental income benefits or the amount of supplemental income benefits due and the employee prevails on any disputed issue, the insurance carrier is liable for reasonable and necessary attorney's fees incurred by the employee as a result of the insurance carrier's dispute and for supplemental income benefits accrued but not paid and interest on that amount, according to Section 408.064. Attorney's fees awarded under this subsection are not subject to Sections 408.221(b), (f), and (i).

SECTION 3.122. Section 408.148, Labor Code, is amended to
Sec. 408.148. EMPLOYEE DISCHARGE AFTER TERMINATION. The commissioner may reinstate supplemental income benefits to an employee who is discharged within 12 months of the date of losing entitlement to supplemental income benefits under Section 408.146(c) if the commissioner finds that the employee was discharged at that time with the intent to deprive the employee of supplemental income benefits.

SECTION 3.123. Section 408.149, Labor Code, is amended to read as follows:

Sec. 408.149. STATUS REVIEW; BENEFIT REVIEW CONFERENCE. (a) Not more than once in each period of 12 calendar months, an employee and an insurance carrier each may request the commissioner to review the status of the employee and determine whether the employee's unemployment or underemployment is a direct result of impairment from the compensable injury.

(b) Either party may request a benefit review conference to contest a determination of the commissioner at any time, subject only to the limits placed on the insurance carrier by Section 408.147.

SECTION 3.124. Section 408.150, Labor Code, is amended to read as follows:

Sec. 408.150. VOCATIONAL REHABILITATION. (a) The division shall refer an employee to the Department of Assistive and Rehabilitative Services with a recommendation for appropriate services if the division determines that an employee [entitled to...
supplemental income benefits] could be materially assisted by vocational rehabilitation or training in returning to employment or returning to employment more nearly approximating the employee's preinjury employment. The division [commission] shall also notify insurance carriers of the need for vocational rehabilitation or training services. The insurance carrier may provide services through a private provider of vocational rehabilitation services under Section 409.012.

(b) An employee who refuses services or refuses to cooperate with services provided under this section by the Department of Assistive and Rehabilitative Services [Texas Rehabilitation Commission] or a private provider loses entitlement to supplemental income benefits.

SECTION 3.125. Section 408.151, Labor Code, is amended to read as follows:

Sec. 408.151. MEDICAL EXAMINATIONS FOR SUPPLEMENTAL INCOME BENEFITS. (a) On or after the second anniversary of the date the commissioner [commission] makes the initial award of supplemental income benefits, an insurance carrier may not require an employee who is receiving supplemental income benefits to submit to a medical examination more than annually if, in the preceding year, the employee's medical condition resulting from the compensable injury has not improved sufficiently to allow the employee to return to work.

(b) If a dispute exists as to whether the employee's medical condition has improved sufficiently to allow the employee to return to work, the commissioner [commission] shall direct the employee to
be examined by a designated doctor chosen by the division [commission]. The designated doctor shall report to the division [commission]. The report of the designated doctor has presumptive weight, and the division [commission] shall base its determination of whether the employee's medical condition has improved sufficiently to allow the employee to return to work on that report unless the preponderance [great weight] of the other medical evidence is to the contrary.

[(c) The commission may require an employee to whom Subsection (a) applies to submit to a medical examination under Section 408.004 only to determine whether the employee's medical condition is a direct result of impairment from a compensable injury.]}

SECTION 3.126. Subsection (d), Section 408.161, Labor Code, is amended to read as follows:

(d) An insurance carrier may pay lifetime income benefits through an annuity if the annuity agreement meets the terms and conditions for annuity agreements adopted by the commissioner [commission] by rule. The establishment of an annuity under this subsection does not relieve the insurance carrier of the liability under this title for ensuring that the lifetime income benefits are paid.

SECTION 3.127. Subsections (c) and (d), Section 408.181, Labor Code, are amended to read as follows:

(c) The commissioner [commission] by rule shall establish requirements for agreements under which death benefits may be paid monthly. Death benefits may be paid monthly only:
(1) on the request of the legal beneficiary and the agreement of the legal beneficiary and the insurance carrier; and

(2) in compliance with the requirements adopted by the commissioner [commission].

(d) An insurance carrier may pay death benefits through an annuity if the annuity agreement meets the terms and conditions for annuity agreements adopted by the commissioner [commission] by rule. The establishment of an annuity under this subsection does not relieve the insurance carrier of the liability under this title for ensuring that the death benefits are paid.

SECTION 3.128. Subsection (f), Section 408.182, Labor Code, is amended to read as follows:

(f) In this section:

(1) "Eligible child" means a child of a deceased employee if the child is:

(A) a minor;

(B) enrolled as a full-time student in an accredited educational institution and is less than 25 years of age; or

(C) a dependent of the deceased employee at the time of the employee's death.

(2) "Eligible grandchild" means a grandchild of a deceased employee who is a dependent of the deceased employee and whose parent is not an eligible child.

(3) "Eligible spouse" means the surviving spouse of a deceased employee unless the spouse abandoned the employee for longer than the year immediately preceding the death without good
cause, as determined by the division [commission].

SECTION 3.129. Subsection (b), Section 408.183, Labor Code, is amended to read as follows:

(b) An eligible spouse is entitled to receive death benefits for life or until remarriage. On remarriage, the eligible spouse is entitled to receive 104 weeks of death benefits, commuted as provided by commissioner [commission] rule.

SECTION 3.130. Subsection (c), Section 408.187, Labor Code, is amended to read as follows:

(c) The commissioner [commission] shall require the insurance carrier to pay the costs of a procedure ordered under this section.

SECTION 3.131. Section 408.202, Labor Code, is amended to read as follows:

Sec. 408.202. ASSIGNABILITY OF BENEFITS. Benefits are not assignable, except a legal beneficiary may, with the commissioner's [commission] approval, assign the right to death benefits.

SECTION 3.132. Subsections (a) through (g), Section 408.221, Labor Code, are amended to read as follows:

(a) An attorney's fee, including a contingency fee, for representing a claimant before the division [commission] or court under this subtitle must be approved by the commissioner [commission] or court.

(b) Except as otherwise provided, an attorney's fee under this section is based on the attorney's time and expenses according to written evidence presented to the division [commission] or court. Except as provided by Subsection (c) or Section 408.147(c),
the attorney's fee shall be paid from the claimant's recovery.

(c) An insurance carrier that seeks judicial review under Subchapter G, Chapter 410, of a final decision of the appeals panel regarding compensability or eligibility for, or the amount of, income or death benefits is liable for reasonable and necessary attorney's fees as provided by Subsection (d) incurred by the claimant as a result of the insurance carrier's appeal if the claimant prevails on an issue on which judicial review is sought by the insurance carrier in accordance with the limitation of issues contained in Section 410.302. If the carrier appeals multiple issues and the claimant prevails on some, but not all, of the issues appealed, the court shall apportion and award fees to the claimant's attorney only for the issues on which the claimant prevails. In making that apportionment, the court shall consider the factors prescribed by Subsection (d). This subsection does not apply to attorney's fees for which an insurance carrier may be liable under Section 408.147. An award of attorney's fees under this subsection is not subject to commissioner rules adopted under Subsection (f). [This subsection expires September 1, 2005.]

(d) In approving an attorney's fee under this section, the commissioner or court shall consider:

(1) the time and labor required;
(2) the novelty and difficulty of the questions involved;
(3) the skill required to perform the legal services properly;
(4) the fee customarily charged in the locality for
similar legal services;
(5) the amount involved in the controversy;
(6) the benefits to the claimant that the attorney is
responsible for securing; and
(7) the experience and ability of the attorney
performing the services.
(e) The commissioner [commission] by rule or the court may
provide for the commutation of an attorney's fee, except that the
attorney's fee shall be paid in periodic payments in a claim
involving death benefits if the only dispute is as to the proper
beneficiary or beneficiaries.
(f) The commissioner [commission] by rule shall provide
guidelines for maximum attorney's fees for specific services in
accordance with this section.
(g) An attorney's fee may not be allowed in a case involving
a fatal injury or lifetime income benefit if the insurance carrier
admits liability on all issues and tenders payment of maximum
benefits in writing under this subtitle while the claim is pending
before the division [commission].

SECTION 3.133. Section 408.222, Labor Code, is amended to
read as follows:
Sec. 408.222. ATTORNEY'S FEES PAID TO DEFENSE COUNSEL.
(a) The amount of an attorney's fee for defending an insurance
carrier in a workers' compensation action brought under this
subtitle must be approved by the division [commission] or court and
determined by the division [commission] or court to be reasonable
and necessary.

(b) In determining whether a fee is reasonable under this section, the division [commission] or court shall consider issues analogous to those listed under Section 408.221(d). The defense counsel shall present written evidence to the division [commission] or court relating to:

1. the time spent and expenses incurred in defending the case; and
2. other evidence considered necessary by the division [commission] or court in making a determination under this section.

SECTION 3.134. Section 409.002, Labor Code, is amended to read as follows:

Sec. 409.002. FAILURE TO FILE NOTICE OF INJURY. Failure to notify an employer as required by Section 409.001(a) relieves the employer and the employer's insurance carrier of liability under this subtitle unless:

1. the employer, a person eligible to receive notice under Section 409.001(b), or the employer's insurance carrier has actual knowledge of the employee's injury;
2. the division [commission] determines that good cause exists for failure to provide notice in a timely manner; or
3. the employer or the employer's insurance carrier does not contest the claim.

SECTION 3.135. Section 409.003, Labor Code, is amended to read as follows:

Sec. 409.003. CLAIM FOR COMPENSATION. An employee or a
person acting on the employee's behalf shall file with the division [commission] a claim for compensation for an injury not later than one year after the date on which:

(1) the injury occurred; or

(2) if the injury is an occupational disease, the employee knew or should have known that the disease was related to the employee's employment.

SECTION 3.136. Section 409.004, Labor Code, is amended to read as follows:

Sec. 409.004. EFFECT OF FAILURE TO FILE CLAIM FOR COMPENSATION. Failure to file a claim for compensation with the division [commission] as required under Section 409.003 relieves the employer and the employer's insurance carrier of liability under this subtitle unless:

(1) good cause exists for failure to file a claim in a timely manner; or

(2) the employer or the employer's insurance carrier does not contest the claim.

SECTION 3.137. Subsections (d), (e), (f), and (h) through (l), Section 409.005, Labor Code, are amended to read as follows:

(d) The insurance carrier shall file the report of the injury on behalf of the policyholder. Except as provided by Subsection (e), the insurance carrier must electronically file the report with the division [commission] not later than the seventh day after the date on which the carrier receives the report from the employer.

(e) The commissioner [executive director] may waive the
electronic filing requirement under Subsection (d) and allow an
insurance carrier to mail or deliver the report to the division
not later than the seventh day after the date on which
the carrier receives the report from the employer.

(f) A report required under this section may not be
considered to be an admission by or evidence against an employer or
an insurance carrier in a proceeding before the division
or a court in which the facts set out in the report are
contradicted by the employer or insurance carrier.

(h) The commissioner may adopt rules relating
to:

(1) the information that must be contained in a report
required under this section, including the summary of rights and
responsibilities required under Subsection (g); and

(2) the development and implementation of an
electronic filing system for injury reports under this section.

(i) An employer and insurance carrier shall file subsequent
reports as required by commissioner rule.

(j) The employer shall, on the written request of the
employee, a doctor, the insurance carrier, or the division
notify the employee, the employee's treating doctor
if known to the employer, and the insurance carrier of the existence
or absence of opportunities for modified duty or a modified duty
return-to-work program available through the employer. If those
opportunities or that program exists, the employer shall identify
the employer's contact person and provide other information to
assist the doctor, the employee, and the insurance carrier to
assess modified duty or return-to-work options.

(k) This section does not prohibit the commissioner [commission] from imposing requirements relating to return-to-work under other authority granted to the division [commission] in this subtitle.

(1) A person commits an administrative [a] violation if the person fails to comply with this section unless good cause exists. [A violation under this subsection is a Class D administrative violation.]

SECTION 3.138. Subsections (b), (c), and (e), Section 409.006, Labor Code, are amended to read as follows:

(b) The record shall be available to the division [commission] at reasonable times and under conditions prescribed by the commissioner [commission].

(c) The commissioner [commission] may adopt rules relating to the information that must be contained in an employer record under this section.

(e) A person commits an administrative [a] violation if the person fails to comply with this section. [A violation under this subsection is a Class D administrative violation.]

SECTION 3.139. Subsection (a), Section 409.007, Labor Code, is amended to read as follows:

(a) A person must file a claim for death benefits with the division [commission] not later than the first anniversary of the date of the employee's death.

SECTION 3.140. Section 409.009, Labor Code, is amended to read as follows:
Sec. 409.009. SUBCLAIMS. A person may file a written claim with the division [commission] as a subclaimant if the person has:

(1) provided compensation, including health care provided by a health care insurer, directly or indirectly, to or for an employee or legal beneficiary; and

(2) sought and been refused reimbursement from the insurance carrier.

SECTION 3.141. Section 409.010, Labor Code, is amended to read as follows:

Sec. 409.010. INFORMATION PROVIDED TO EMPLOYEE OR LEGAL BENEFICIARY. Immediately on receiving notice of an injury or death from any person, the division [commission] shall mail to the employee or legal beneficiary a clear and concise description of:

(1) the services provided by:

(A) the division; and

(B) the office of injured employee counsel [commission], including the services of the ombudsman program;

(2) the division's [commission's] procedures; and

(3) the person's rights and responsibilities under this subtitle.

SECTION 3.142. Subsections (a) and (c), Section 409.011, Labor Code, are amended to read as follows:

(a) Immediately on receiving notice of an injury or death from any person, the division [commission] shall mail to the employer a description of:

(1) the services provided by the division and the office of injured employee counsel [commission];
(2) the division's [commission's] procedures; and
(3) the employer's rights and responsibilities under this subtitle.

(c) The division [commission] is not required to provide the information to an employer more than once during a calendar year.

SECTION 3.143. Section 409.012, Labor Code, is amended to read as follows:

Sec. 409.012. VOCATIONAL REHABILITATION INFORMATION.

(a) The division [commission] shall analyze each report of injury received from an employer under this chapter to determine whether the injured employee would be assisted by vocational rehabilitation.

(b) If the division [commission] determines that an injured employee would be assisted by vocational rehabilitation, the division [commission] shall notify:

(1) the injured employee in writing of the services and facilities available through the Department of Assistive and Rehabilitative Services [Texas Rehabilitation Commission] and private providers of vocational rehabilitation; and

(2) [The commission shall notify] the Department of Assistive and Rehabilitative Services [Texas Rehabilitation Commission] and the affected insurance carrier that the injured employee has been identified as one who could be assisted by vocational rehabilitation.

(c) The division [commission] shall cooperate with the office of injured employee counsel, the Department of Assistive and Rehabilitative Services, [Texas Rehabilitation Commission] and
private providers of vocational rehabilitation in the provision of services and facilities to employees by the Department of Assistive and Rehabilitative Services [Texas Rehabilitation Commission].

(d) A private provider of vocational rehabilitation services may register with the division [commission].

(e) The commissioner [commission] by rule may require that a private provider of vocational rehabilitation services maintain certain credentials and qualifications in order to provide services in connection with a workers' compensation insurance claim.

(f) The division and the Department of Assistive and Rehabilitative Services shall report to the legislature not later than August 1, 2006, on their actions to improve access to and the effectiveness of vocational rehabilitation programs for injured employees. The report must include:

(1) a description of the actions each agency has taken to improve communication regarding and coordination of vocational rehabilitation programs;

(2) an analysis identifying the population of injured employees that have the poorest return-to-work outcomes and are in the greatest need for vocational rehabilitation services;

(3) any changes recommended to improve the access to and effectiveness of vocational rehabilitation programs for the populations identified in Subdivision (2); and

(4) a plan to implement these changes.

SECTION 3.144. Section 409.013, Labor Code, is amended to read as follows:

Sec. 409.013. PLAIN LANGUAGE INFORMATION; NOTIFICATION OF
INJURED EMPLOYEE [WORKER]. (a) The division [commission] shall develop information for public dissemination about the benefit process and the compensation procedures established under this chapter. The information must be written in plain language and must be available in English and Spanish.

(b) On receipt of a report under Section 409.005, the division [commission] shall contact the affected employee by mail or by telephone and shall provide the information required under Subsection (a) to that employee, together with any other information that may be prepared by the office of injured employee counsel or the division [commission] for public dissemination that relates to the employee's situation, such as information relating to back injuries or occupational diseases.

SECTION 3.145. Section 409.021, Labor Code, is amended by amending Subsections (a) and (b) and adding Subsection (j) to read as follows:

(a) An insurance carrier shall initiate compensation under this subtitle promptly. Not later than the 15th day after the date on which an insurance carrier receives written notice of an injury, the insurance carrier shall:

(1) begin the payment of benefits as required by this subtitle; or

(2) notify the division [commission] and the employee in writing of its refusal to pay and advise the employee of:

(A) the right to request a benefit review conference; and

(B) the means to obtain additional information
from the division [commission].

(b) An insurance carrier shall notify the division [commission] in writing of the initiation of income or death benefit payments in the manner prescribed by commissioner [commission] rules.

(j) Each insurance carrier shall establish a single point of contact in the carrier’s office for an injured employee for whom the carrier receives a notice of injury.

SECTION 3.146. Subsection (c), Section 409.022, Labor Code, is amended to read as follows:

(c) An insurance carrier commits an administrative [a] violation if the insurance carrier does not have reasonable grounds for a refusal to pay benefits, as determined by the commissioner [commission]. A violation under this subsection is a Class B administrative violation.

SECTION 3.147. Subsections (a), (c), and (d), Section 409.023, Labor Code, are amended to read as follows:

(a) An insurance carrier shall continue to pay benefits promptly as and when the benefits accrue without a final decision, order, or other action of the commissioner [commission], except as otherwise provided.

(c) An insurance carrier commits an administrative [a] violation if the insurance carrier fails to comply with this section. [A violation under this subsection is a Class B administrative violation. Each day of noncompliance constitutes a separate violation.]

(d) An insurance carrier that commits multiple violations
of this section commits an additional [a Class A] administrative violation and is subject to:

(1) the sanctions provided under Section 415.023; and

(2) revocation of the right to do business under the workers' compensation laws of this state.

SECTION 3.148. Subsection (b), Section 409.0231, Labor Code, is amended to read as follows:

(b) The commissioner [commission] shall adopt rules in consultation with the Texas Department of Information Resources as necessary to implement this section, including rules prescribing a period of benefits that is of sufficient duration to allow payment by electronic funds transfer.

SECTION 3.149. Section 409.024, Labor Code, is amended to read as follows:

Sec. 409.024. TERMINATION OR REDUCTION OF BENEFITS; NOTICE; ADMINISTRATIVE VIOLATION. (a) An insurance carrier shall file with the division [commission] a notice of termination or reduction of benefits, including the reasons for the termination or reduction, not later than the 10th day after the date on which benefits are terminated or reduced.

(b) An insurance carrier commits an administrative [a] violation if the insurance carrier does not have reasonable grounds to terminate or reduce benefits, as determined by the commissioner [commission]. A violation under this subsection is a Class B administrative violation.

SECTION 3.150. Section 410.002, Labor Code, is amended to read as follows:
H.B. No. 7

Sec. 410.002. LAW GOVERNING LIABILITY PROCEEDINGS. A proceeding before the division [commission] to determine the liability of an insurance carrier for compensation for an injury or death under this subtitle is governed by this chapter.

SECTION 3.151. Section 410.005, Labor Code, is amended by amending Subsection (a) and adding Subsection (d) to read as follows:

(a) Unless the division [commission] determines that good cause exists for the selection of a different location, a benefit review conference or a contested case hearing may not be conducted at a site more than 75 miles from the claimant's residence at the time of the injury.

(d) Notwithstanding Subsection (a), the division may conduct a benefit review conference telephonically on agreement by the injured employee.

SECTION 3.152. Subchapter A, Chapter 410, Labor Code, is amended by adding Section 410.007 to read as follows:

Sec. 410.007. INFORMATION LIST. (a) The division shall determine the type of information that is most useful to parties to help resolve disputes regarding income benefits. That information may include:

(1) reports regarding the compensable injury;

(2) medical information regarding the injured employee; and

(3) wage records.

(b) The division shall publish a list developed from the information described under Subsection (a) in appropriate media,
including the division's Internet website, to provide guidance to a
party to a dispute regarding the type of information the party
should have available at a benefit review conference or a contested
case hearing.
(c) At the time a benefit review conference or contested
case hearing is scheduled, the division shall make available a copy
of the list developed under Subsection (b) to each party to the
dispute.
SECTION 3.153. Section 410.021, Labor Code, is amended to
read as follows:
Sec. 410.021. PURPOSE. A benefit review conference is a
nonadversarial, informal dispute resolution proceeding designed
to:
(1) explain, orally and in writing, the rights of the
respective parties to a workers' compensation claim and the
procedures necessary to protect those rights;
(2) discuss the facts of the claim, review available
information in order to evaluate the claim, and delineate the
disputed issues; and
(3) mediate and resolve disputed issues by agreement
of the parties in accordance with this subtitle and the policies of
the division [commission].
SECTION 3.154. Subsections (b) and (c), Section 410.022,
Labor Code, are amended to read as follows:
(b) A benefit review officer must:
(1) be an employee of the division [commission];[and]
(2) be trained in the principles and procedures of
dispute mediation; and

(3) have documentation satisfactory to the commissioner that evidences the completion by the officer of at least 40 classroom hours of training in dispute resolution techniques from an alternative dispute resolution organization recognized by the commissioner.

(c) The division [commission] shall institute and maintain an education and training program for benefit review officers and shall consult or contract with the Federal Mediation and Conciliation Service or other appropriate organizations for this purpose.

SECTION 3.155. Section 410.023, Labor Code, is amended to read as follows:

Sec. 410.023. REQUEST FOR BENEFIT REVIEW CONFERENCE. (a) On receipt of a request from a party or on its own motion, the division [commission] may direct the parties to a disputed workers' compensation claim to meet in a benefit review conference to attempt to reach agreement on disputed issues involved in the claim.

(b) The division shall require the party requesting the benefit review conference to provide documentation of efforts made to resolve the disputed issues before the request was submitted. The commissioner by rule shall adopt guidelines regarding the type of information necessary to satisfy this requirement.

SECTION 3.156. Section 410.024, Labor Code, is amended to read as follows:

Sec. 410.024. BENEFIT REVIEW CONFERENCE AS PREREQUISITE TO
FURTHER PROCEEDINGS ON CERTAIN CLAIMS. (a) Except as otherwise provided by law or commissioner [commission] rule, the parties to a disputed compensation claim are not entitled to a contested case hearing or arbitration on the claim unless a benefit review conference is conducted as provided by this subchapter.

(b) The commissioner [commission] by rule shall adopt guidelines relating to claims that do not require a benefit review conference and may proceed directly to a contested case hearing or arbitration.

SECTION 3.157. Section 410.025, Labor Code, is amended to read as follows:

Sec. 410.025. SCHEDULING OF BENEFIT REVIEW CONFERENCE; NOTICE. (a) The commissioner [commission] by rule shall prescribe the time within which a benefit review conference must be scheduled.

(b) The division [At the time a benefit review conference is scheduled, the commission] shall schedule a contested case hearing to be held not later than the 60th day after the date of the benefit review conference if the disputed issues are not resolved at the benefit review conference.

(c) The division [commission] shall send written notice of the benefit review conference to the parties to the claim and the employer.

(d) The commissioner [commission] by rule shall provide for expedited proceedings in cases in which compensability or liability for essential medical treatment is in dispute.

SECTION 3.158. Subsections (a) and (b), Section 410.026,
Labor Code, are amended to read as follows:

(a) A benefit review officer shall:

1. mediate disputes between the parties and assist in the adjustment of the claim consistent with this subtitle and the policies of the division [commission];

2. thoroughly inform all parties of their rights and responsibilities under this subtitle, especially in a case in which the employee is not represented by an attorney or other representative; and

3. ensure that all documents and information relating to the employee’s wages, medical condition, and any other information pertinent to the resolution of disputed issues are contained in the claim file at the conference, especially in a case in which the employee is not represented by an attorney or other representative; and

4. prepare a written report that details each issue that is not resolved at the benefit review conference, as required under Section 410.031, including any issue raised for the first time at the conclusion of an additional benefit review conference conducted under Subsection (b).

(b) A benefit review officer may schedule an additional benefit review conference if:

1. the benefit review officer determines that any available information pertinent to the resolution of disputed issues was not produced at the initial benefit review conference; and

2. a second benefit review conference has not already
been conducted.

SECTION 3.159. Subsection (a), Section 410.027, Labor Code, is amended to read as follows:

(a) The commissioner shall adopt rules for conducting benefit review conferences.

SECTION 3.160. Subsection (b), Section 410.028, Labor Code, is amended to read as follows:

(b) A party commits an administrative violation if the party fails to attend a benefit review conference without good cause as determined by the benefit review officer. [A violation under this subsection is a Class D administrative violation.]

SECTION 3.161. Section 410.030, Labor Code, is amended to read as follows:

Sec. 410.030. BINDING EFFECT OF AGREEMENT. (a) An agreement signed in accordance with Section 410.029 is binding on the insurance carrier through the conclusion of all matters relating to the claim, unless the division or a court, on a finding of fraud, newly discovered evidence, or other good and sufficient cause, relieves the insurance carrier of the effect of the agreement.

(b) The agreement is binding on the claimant, if represented by an attorney, to the same extent as on the insurance carrier. If the claimant is not represented by an attorney, the agreement is binding on the claimant through the conclusion of all matters relating to the claim while the claim is pending before the division, unless the commissioner for good cause relieves the claimant of the effect of the agreement.
SECTION 3.162. Sections 410.031 and 410.032, Labor Code, are amended to read as follows:

Sec. 410.031. INCOMPLETE RESOLUTION; REPORT. (a) If a dispute is not entirely resolved at a benefit review conference, the benefit review officer shall prepare a written report that details each issue that is not resolved at the conference.

(b) The report must also include:

(1) a statement of each resolved issue;
(2) a statement of each issue raised but not resolved;
(3) a statement of the position of the parties regarding each unresolved issue;
(4) the officer's recommendation regarding each unresolved issue;
(5) the officer's recommendations regarding the payment or denial of benefits;
(6) a statement of any interlocutory orders entered under Sections 410.032 and 410.033(a); and
(7) a statement of the procedures required to request a contested case hearing or arbitration and a complete explanation of the differences in those proceedings and the rights of the parties to subsequent review of the determinations made in those proceedings; and

(5) the date of the contested case hearing scheduled in accordance with Section 410.025(b).

Sec. 410.032. PAYMENT OF BENEFITS UNDER INTERLOCUTORY ORDER. As designated by the commissioner, division staff, other
than the benefit review officer who presided or will preside at the
benefit review conference, shall consider a request for an
interlocutory order and shall issue an interlocutory order if
determined to be appropriate. [If a benefit review officer
recommends that benefits be paid or not paid, the benefit review
officer may issue an interlocutory order for the payment of all or
part of medical benefits or income benefits.] The order may address
accrued benefits, future benefits, or both accrued benefits and
future benefits.

SECTION 3.163. Subsection (a), Section 410.033, Labor Code,
is amended to read as follows:

(a) If there is a dispute as to which of two or more
insurance carriers is liable for compensation for one or more
compensable injuries, the commissioner [benefit review officer]
may issue an interlocutory order directing each insurance carrier
to pay a proportionate share of benefits due pending a final
decision on liability. The proportionate share is computed by
dividing the compensation due by the number of insurance carriers
involved.

SECTION 3.164. Section 410.034, Labor Code, is amended to
read as follows:

Sec. 410.034. FILING OF AGREEMENT AND REPORT. (a) The
benefit review officer shall file the signed agreement and the
report with the division [director].

(b) The commissioner [commission] by rule shall prescribe
the times within which the agreement and report must be filed.

(c) The division [director] shall furnish a copy of the
file-stamped report to:

(1) the claimant;
(2) the employer; and
(3) the insurance carrier.

SECTION 3.165. Section 410.102, Labor Code, is amended to read as follows:

Sec. 410.102. ARBITRATORS; QUALIFICATIONS. (a) An arbitrator must be an employee of the division [commission], except that the division [commission] may contract with qualified arbitrators on a determination of special need.

(b) An arbitrator must:

(1) be a member of the National Academy of Arbitrators;
(2) be on an approved list of the American Arbitration Association or Federal Mediation and Conciliation Service; or
(3) meet qualifications established by the commissioner [commission] by rule [and be approved by an affirmative vote of at least two commission members representing employers of labor and at least two commission members representing wage earners].

(c) The division [commission] shall require that each arbitrator have appropriate training in the workers' compensation laws of this state. The commissioner [commission] shall establish procedures to carry out this subsection.

SECTION 3.166. Section 410.103, Labor Code, is amended to read as follows:

Sec. 410.103. DUTIES OF ARBITRATOR. An arbitrator shall:
(1) protect the interests of all parties;
(2) ensure that all relevant evidence has been disclosed to the arbitrator and to all parties; and
(3) render an award consistent with this subtitle and the policies of the division [commission].

SECTION 3.167. Subsections (b) and (c), Section 410.104, Labor Code, are amended to read as follows:

(b) To elect arbitration, the parties must file the election with the division [commission] not later than the 20th day after the last day of the benefit review conference. The commissioner [commission] shall prescribe a form for that purpose.

(c) An election to engage in arbitration under this subchapter is irrevocable and binding on all parties for the resolution of all disputes arising out of the claims that are under the jurisdiction of the division [commission].

SECTION 3.168. Section 410.105, Labor Code, is amended to read as follows:

Sec. 410.105. LISTS OF ARBITRATORS. (a) The division [commission] shall establish regional lists of arbitrators who meet the qualifications prescribed under Sections 410.102(a) and (b). Each regional list shall be initially prepared in a random name order, and subsequent additions to a list shall be added chronologically.

(b) The commissioner [commission] shall review the lists of arbitrators annually and determine if each arbitrator is fair and impartial and makes awards that are consistent with and in accordance with this subtitle and the rules of the commissioner.
[commission]. The commissioner [commission] shall remove an arbitrator if, after the review, the commissioner determines that the arbitrator is not fair and impartial or does not make awards consistent with this subtitle and commissioner rules [arbitrator does not receive an affirmative vote of at least two commission members representing employers of labor and at least two commission members representing wage earners].

(c) The division's [commission's] lists are confidential and are not subject to disclosure under Chapter 552, Government Code. The lists may not be revealed by any division [commission] employee to any person who is not a division [commission] employee. The lists are exempt from discovery in civil litigation unless the party seeking the discovery establishes reasonable cause to believe that a violation of the requirements of this section or Section 410.106, 410.107, 410.108, or 410.109(b) occurred and that the violation is relevant to the issues in dispute.

SECTION 3.169. Section 410.106, Labor Code, is amended to read as follows:

Sec. 410.106. SELECTION OF ARBITRATOR. The division [commission] shall assign the arbitrator for a particular case by selecting the next name after the previous case's selection in consecutive order. The division [commission] may not change the order of names once the order is established under this subchapter, except that once each arbitrator on the list has been assigned to a case, the names shall be randomly reordered.

SECTION 3.170. Subsection (a), Section 410.107, Labor Code, is amended to read as follows:
(a) The division [commission] shall assign an arbitrator to a pending case not later than the 30th day after the date on which the election for arbitration is filed with the division [commission].

SECTION 3.171. Subsection (a), Section 410.108, Labor Code, is amended to read as follows:

(a) Each party is entitled, in its sole discretion, to one rejection of the arbitrator in each case. If a party rejects the arbitrator, the division [commission] shall assign another arbitrator as provided by Section 410.106.

SECTION 3.172. Section 410.109, Labor Code, is amended to read as follows:

Sec. 410.109. SCHEDULING OF ARBITRATION. (a) The arbitrator shall schedule arbitration to be held not later than the 30th day after the date of the arbitrator’s assignment and shall notify the parties and the division [commission] of the scheduled date.

(b) If an arbitrator is unable to schedule arbitration in accordance with Subsection (a), the division [commission] shall appoint the next arbitrator on the applicable list. Each party is entitled to reject the arbitrator appointed under this subsection in the manner provided under Section 410.108.

SECTION 3.173. Section 410.111, Labor Code, is amended to read as follows:

Sec. 410.111. RULES. The commissioner [commission] shall adopt rules for arbitration consistent with generally recognized arbitration principles and procedures.
SECTION 3.174. Subsection (b), Section 410.112, Labor Code, is amended to read as follows:

(b) A party commits an administrative [a] violation if the party, without good cause as determined by the arbitrator, fails to comply with Subsection (a). [A violation under this subsection is a Class D administrative violation.]

SECTION 3.175. Subsection (b), Section 410.113, Labor Code, is amended to read as follows:

(b) A party commits an administrative [a] violation if the party does not attend the arbitration unless the arbitrator determines that the party had good cause not to attend. [A violation under this subsection is a Class D administrative violation.]

SECTION 3.176. Subsection (b), Section 410.114, Labor Code, is amended to read as follows:

(b) The division [commission] shall make an electronic recording of the proceeding.

SECTION 3.177. Subsection (d), Section 410.118, Labor Code, is amended to read as follows:

(d) The arbitrator shall file a copy of the award as part of the permanent claim file at the division [commission] and shall notify the parties in writing of the decision.

SECTION 3.178. Subsection (b), Section 410.119, Labor Code, is amended to read as follows:

(b) An arbitrator’s award is a final order of the division [commission].

SECTION 3.179. Subsections (a) and (b), Section 410.121,
Labor Code, are amended to read as follows:

(a) On application of an aggrieved party, a court of competent jurisdiction shall vacate an arbitrator's award on a finding that:

(1) the award was procured by corruption, fraud, or misrepresentation;
(2) the decision of the arbitrator was arbitrary and capricious; or
(3) the award was outside the jurisdiction of the division.

(b) If an award is vacated, the case shall be remanded to the division for another arbitration proceeding.

SECTION 3.180. Subsection (b), Section 410.151, Labor Code, is amended to read as follows:

(b) An issue that was not raised at a benefit review conference or that was resolved at a benefit review conference may not be considered unless:

(1) the parties consent; or
(2) if the issue was not raised, the commissioner determines that good cause existed for not raising the issue at the conference.

SECTION 3.181. Section 410.153, Labor Code, is amended to read as follows:

Sec. 410.153. APPLICATION OF ADMINISTRATIVE PROCEDURE ACT. Chapter 2001, Government Code, applies to a contested case hearing to the extent that the commissioner finds appropriate, except that the following do not apply:
SECTION 3.182. Section 410.154, Labor Code, is amended to read as follows:

Sec. 410.154. SCHEDULING OF HEARING. The division [commission] shall schedule a contested case hearing in accordance with Section 410.024 or 410.025(b).

SECTION 3.183. Section 410.155, Labor Code, is amended to read as follows:

Sec. 410.155. CONTINUANCE. (a) A written request by a party for a continuance of a contested case hearing to another date must be directed to the division [commission].

(b) The division [commission] may grant a continuance only if the division [commission] determines that there is good cause for the continuance.

SECTION 3.184. Subsection (b), Section 410.156, Labor Code, is amended to read as follows:

(b) A party commits an administrative [a] violation if the party, without good cause as determined by the hearing officer, does not attend a contested case hearing. [A violation under this subsection is a Class C administrative violation.]

SECTION 3.185. Section 410.157, Labor Code, is amended to read as follows:

Sec. 410.157. RULES. The commissioner [commission] shall
adopt rules governing procedures under which contested case
hearings are conducted.

SECTION 3.186. Subsection (a), Section 410.158, Labor Code,
is amended to read as follows:

(a) Except as provided by Section 410.162, discovery is
limited to:

(1) depositions on written questions to any health
care provider;
(2) depositions of other witnesses as permitted by the
hearing officer for good cause shown; and
(3) interrogatories as prescribed by the commissioner
[commission].

SECTION 3.187. Section 410.159, Labor Code, is amended to
read as follows:

Sec. 410.159. STANDARD INTERROGATORIES. (a) The
commissioner [commission] by rule shall prescribe standard form
sets of interrogatories to elicit information from claimants and
insurance carriers.

(b) Standard interrogatories shall be answered by each
party and served on the opposing party within the time prescribed by
commissioner [commission] rule, unless the parties agree
otherwise.

SECTION 3.188. Section 410.160, Labor Code, is amended to
read as follows:

Sec. 410.160. EXCHANGE OF INFORMATION. Within the time
prescribed by commissioner [commission] rule, the parties shall
exchange:
all medical reports and reports of expert witnesses who will be called to testify at the hearing;

(2) all medical records;

(3) any witness statements;

(4) the identity and location of any witness known to the parties to have knowledge of relevant facts; and

(5) all photographs or other documents that a party intends to offer into evidence at the hearing.

SECTION 3.189. Section 410.161, Labor Code, is amended to read as follows:

Sec. 410.161. FAILURE TO DISCLOSE INFORMATION. A party who fails to disclose information known to the party or documents that are in the party's possession, custody, or control at the time disclosure is required by Sections 410.158-410.160 may not introduce the evidence at any subsequent proceeding before the division [commission] or in court on the claim unless good cause is shown for not having disclosed the information or documents under those sections.

SECTION 3.190. Subsections (d) and (e), Section 410.168, Labor Code, are amended to read as follows:

(d) On a form that the commissioner [commission] by rule prescribes, the hearing officer shall issue a separate written decision regarding attorney's fees and any matter related to attorney's fees. The decision regarding attorney's fees and the form may not be made known to a jury in a judicial review of an award, including an appeal.

(e) The commissioner [commission] by rule shall prescribe
the times within which the hearing officer must file the decisions
with the division.

SECTION 3.191. Subsection (a), Section 410.201, Labor Code, is amended to read as follows:

(a) Appeals judges, in a three-member panel [panels of three], shall conduct administrative appeals proceedings.

SECTION 3.192. Section 410.203, Labor Code, is amended to read as follows:

Sec. 410.203. POWERS AND DUTIES OF APPEALS PANEL; PRIORITY OF HEARING ON REMAND. (a) The appeals panel shall consider:

(1) the record developed at the contested case hearing; and

(2) the written request for appeal and response filed with the appeals panel.

(b) The appeals panel may:

(1) [affirm the decision of the hearing officer;]

(2) reverse the [that] decision of the hearing officer; or

(2) reverse the [that] decision of the hearings officer and remand the case to the hearing officer for further consideration and development of evidence.

(c) The appeals panel may not remand a case under Subsection (b)(2) [of (b)(3)] more than once.

(d) A hearing on remand shall be accelerated and the commissioner [commission] shall adopt rules to give priority to the hearing over other proceedings.

(e) The appeals panel shall issue and maintain a precedent
manual. The precedent manual shall be composed of precedent-establishing decisions and may include other information as identified by the appeals panel.

SECTION 3.193. Subsections (a), (b), and (c), Section 410.204, Labor Code, are amended to read as follows:

(a) The appeals panel shall review each request and issue a written decision on each reversed or remanded case that determines each issue on which review was requested. The decision must be in writing and shall be issued not later than the 45th (30th) day after the date on which the written response to the request for appeal is filed. The appeals panel shall file a copy of the decision with the commissioner.

(b) A copy of the decision of the appeals panel shall be sent to each party not later than the seventh day after the date the decision is filed with the division.

(c) If the appeals panel does not issue a decision in accordance with this section, the decision of the hearing officer becomes final and is the final decision of the appeals panel.

SECTION 3.194. Subsection (a), Section 410.205, Labor Code, is amended to read as follows:

(a) A decision of the appeals panel regarding benefits is final in the absence of a timely appeal for judicial review.

SECTION 3.195. Section 410.206, Labor Code, is amended to read as follows:

Sec. 410.206. CLERICAL ERROR. The division [executive director] may revise a decision in a contested case hearing on a
finding of clerical error.

SECTION 3.196. Section 410.207, Labor Code, is amended to read as follows:

Sec. 410.207. CONTINUATION OF DIVISION [COMMISSION] JURISDICTION. During judicial review of the [an] appeals panel decision on any disputed issue relating to a workers' compensation claim, the division [commission] retains jurisdiction of all other issues related to the claim.

SECTION 3.197. Section 410.208, Labor Code, is amended to read as follows:

Sec. 410.208. JUDICIAL ENFORCEMENT OF ORDER OR DECISION; ADMINISTRATIVE VIOLATION. (a) If a person refuses or fails to comply with an interlocutory order, final order, or decision of the commissioner [commission], the division [commission] may bring suit in Travis County to enforce the order or decision.

(b) If an insurance carrier refuses or fails to comply with an interlocutory order, a final order, or a decision of the commissioner [commission], the claimant may bring suit in the county of the claimant's residence at the time of the injury, or death if the employee is deceased, or, in the case of an occupational disease, in [or] the county in which the employee resided on the date disability began or any county agreed to by the parties [injury occurred to enforce the order or decision].

(c) If the division [commission] brings suit to enforce an interlocutory order, final order, or decision of the commissioner [commission], the division [commission] is entitled to reasonable attorney's fees and costs for the prosecution and collection of the
claim, in addition to a judgment enforcing the order or decision and any other remedy provided by law.

(d) A claimant who brings suit to enforce an interlocutory order, final order, or decision of the commissioner [commission] is entitled to a penalty equal to 12 percent of the amount of benefits recovered in the judgment, interest, and reasonable attorney's fees for the prosecution and collection of the claim, in addition to a judgment enforcing the order or decision.

(e) A person commits an administrative [a] violation if the person fails or refuses to comply with an interlocutory order, final order, or decision of the commissioner [commission] within 20 days after the date the order or decision becomes final. [A violation under this subsection is a Class A administrative violation.]

SECTION 3.198. Section 410.209, Labor Code, is amended to read as follows:

Sec. 410.209. REIMBURSEMENT FOR OVERPAYMENT. The subsequent injury fund shall reimburse an insurance carrier for any overpayments of benefits made under an interlocutory order or decision if that order or decision is reversed or modified by final arbitration, order, or decision of the commissioner [commission] or a court. The commissioner [commission] shall adopt rules to provide for a periodic reimbursement schedule, providing for reimbursement at least annually.

SECTION 3.199. Section 410.253, Labor Code, is amended to read as follows:

Sec. 410.253. SERVICE; NOTICE. (a) A party seeking
judicial review shall simultaneously:

(1) file a copy of the party's petition with the court;
(2) serve any opposing party to the suit; and
(3) provide written notice of the suit or notice of appeal to the division [commission].

(b) A party may not seek judicial review under Section 410.251 unless the party has provided written notice of the suit to the division [commission] as required by this section.

SECTION 3.200. Section 410.254, Labor Code, is amended to read as follows:

Sec. 410.254. [COMMISSION] INTERVENTION. On timely motion initiated by the commissioner [executive director], the division [commission] shall be permitted to intervene in any judicial proceeding under this subchapter or Subchapter G.

SECTION 3.2001. Subsection (a), Section 410.256, Labor Code, is amended to read as follows:

(a) A claim or issue may not be settled contrary to the provisions of the [an] appeals panel decision issued on the claim or issue unless a party to the proceeding has filed for judicial review under this subchapter or Subchapter G. The trial court must approve a settlement made by the parties after judicial review of an award is sought and before the court enters judgment.

SECTION 3.2002. Subsection (a), Section 410.257, Labor Code, is amended to read as follows:

(a) A judgment entered by a court on judicial review of the [an] appeals panel decision under this subchapter or Subchapter G must comply with all appropriate provisions of the law.
SECTION 3.201. The heading to Section 410.258, Labor Code, is amended to read as follows:

Sec. 410.258. NOTIFICATION OF DIVISION [COMMISSION] OF PROPOSED JUDGMENTS AND SETTLEMENTS; RIGHT TO INTERVENE.

SECTION 3.202. Subsections (a) through (e), Section 410.258, Labor Code, are amended to read as follows:

(a) The party who initiated a proceeding under this subchapter or Subchapter G must file any proposed judgment or settlement made by the parties to the proceeding, including a proposed default judgment, with the division [executive director of the commission] not later than the 30th day before the date on which the court is scheduled to enter the judgment or approve the settlement. The proposed judgment or settlement must be mailed to the division [executive director] by certified mail, return receipt requested.

(b) The division [commission] may intervene in a proceeding under Subsection (a) not later than the 30th day after the date of receipt of the proposed judgment or settlement.

(c) The commissioner [commission] shall review the proposed judgment or settlement to determine compliance with all appropriate provisions of the law. If the commissioner [commission] determines that the proposal is not in compliance with the law, the division [commission] may intervene as a matter of right in the proceeding not later than the 30th day after the date of receipt of the proposed judgment or settlement. The court may limit the extent of the division's [commission's] intervention to providing the information described by Subsection (e).
(d) If the division [commission] does not intervene before the 31st day after the date of receipt of the proposed judgment or settlement, the court shall enter the judgment or approve the settlement if the court determines that the proposed judgment or settlement is in compliance with all appropriate provisions of the law.

(e) If the division [commission] intervenes in the proceeding, the commissioner [commission] shall inform the court of each reason the commissioner [commission] believes the proposed judgment or settlement is not in compliance with the law. The court shall give full consideration to the information provided by the commissioner [commission] before entering a judgment or approving a settlement.

SECTION 3.203. Subsection (a), Section 410.301, Labor Code, is amended to read as follows:

(a) Judicial review of a final decision of the [commission] appeals panel regarding compensability or eligibility for or the amount of income or death benefits shall be conducted as provided by this subchapter.

SECTION 3.204. Section 410.302, Labor Code, is amended to read as follows:

Sec. 410.302. ADMISSIBILITY OF RECORDS; LIMITATION OF ISSUES. (a) The records of a contested case hearing conducted under this chapter are admissible in a trial under this subchapter in accordance with the Texas Rules of Evidence.

(b) A trial under this subchapter is limited to issues decided by the [commission] appeals panel and on which judicial
review is sought. The pleadings must specifically set forth the
determinations of the appeals panel by which the party is
aggrieved.

SECTION 3.205. Section 410.304, Labor Code, is amended to
read as follows:

Sec. 410.304. CONSIDERATION OF APPEALS PANEL DECISION.
(a) In a jury trial, the court, before submitting the case to the
jury, shall inform the jury in the court’s instructions, charge, or
questions to the jury of the appeals panel decision on
each disputed issue described by Section 410.301(a) that is
submitted to the jury.

(b) In a trial to the court without a jury, the court in
rendering its judgment on an issue described by Section 410.301(a)
shall consider the decision of the appeals panel.

SECTION 3.206. Subsections (b) and (c), Section 410.306,
Labor Code, are amended to read as follows:

(b) The division on payment of a reasonable fee
shall make available to the parties a certified copy of the
division's record. All facts and evidence the
record contains are admissible to the extent allowed under the
Texas Rules of Civil Evidence.

(c) Except as provided by Section 410.307, evidence of
extent of impairment shall be limited to that presented to the
division. The court or jury, in its determination of
the extent of impairment, shall adopt one of the impairment ratings
under Subchapter G, Chapter 408.

SECTION 3.207. Subsections (a) and (d), Section 410.307,
Labor Code, are amended to read as follows:

(a) Evidence of the extent of impairment is not limited to that presented to the division [commission] if the court, after a hearing, finds that there is a substantial change of condition. The court's finding of a substantial change of condition may be based only on:

(1) medical evidence from the same doctor or doctors whose testimony or opinion was presented to the division [commission];

(2) evidence that has come to the party's knowledge since the contested case hearing;

(3) evidence that could not have been discovered earlier with due diligence by the party; and

(4) evidence that would probably produce a different result if it is admitted into evidence at the trial.

(d) If the court finds a substantial change of condition under this section, new medical evidence of the extent of impairment must be from and is limited to the same doctor or doctors who made impairment ratings before the division [commission] under Section 408.123.

SECTION 3.208. Subsection (a), Section 410.308, Labor Code, is amended to read as follows:

(a) The division [commission or the Texas Department of Insurance] shall furnish any interested party in the claim with a certified copy of the notice of the employer securing compensation with the insurance carrier, filed with the division [commission].

SECTION 3.2085. Subsection (a), Section 411.003, Labor
Code, is amended to read as follows:

(a) An insurance company, the agent, servant, or employee of the insurance company, or a safety consultant who performs a safety consultation under this chapter [Subchapter D or E] has no liability for an accident, injury, or occupational disease based on an allegation that the accident, injury, or occupational disease was caused or could have been prevented by a program, inspection, or other activity or service undertaken by the insurance company for the prevention of accidents in connection with operations of the employer.

SECTION 3.209. Section 411.013, Labor Code, is amended to read as follows:

Sec. 411.013. FEDERAL CONTRACTS AND PROGRAMS. The [With the approval of the commission, the] division may:

(1) enter into contracts with the federal government to perform occupational safety projects; and

(2) apply for federal funds through any federal program relating to occupational safety.

SECTION 3.2095. Subsection (a), Section 411.014, Labor Code, is amended to read as follows:

(a) The division shall promote workers' health and safety through educational and other innovative programs developed by the department, the division, or other state agencies [division].

SECTION 3.210. Subsections (b) and (c), Section 411.031, Labor Code, are amended to read as follows:

(b) The division shall obtain from any appropriate state agency, including the Texas Workforce Commission [Department of
Insurance], the [Texas] Department of State Health Services, and
the Department of Assistive and Rehabilitative Services [Texas
Employment Commission], data and statistics, including data and
statistics compiled for rate-making purposes.

(c) The division shall consult with the Texas Workforce
[Department of Insurance and the Texas Employment] Commission in
the design of data information and retrieval systems to accomplish
the mutual purposes of the division [those agencies] and [of] the
Texas Workforce Commission [division].

SECTION 3.211. Section 411.032, Labor Code, is amended to
read as follows:

Sec. 411.032. EMPLOYER INJURY AND OCCUPATIONAL DISEASE
REPORT; ADMINISTRATIVE VIOLATION. (a) An employer shall file with
the division [commission] a report of each:

(1) on-the-job injury that results in the employee's
absence from work for more than one day; and

(2) occupational disease of which the employer has
knowledge.

(b) The commissioner [commission] shall adopt rules and
prescribe the form and manner of reports filed under this section.

(c) An employer commits an administrative violation if the
employer fails to report to the division [commission] as required
under Subsection (a) unless good cause exists, as determined by the
commissioner [commission], for the failure. [A violation under
this subsection is a Class D administrative violation.]

SECTION 3.212. Section 411.035, Labor Code, is amended to
read as follows:

194
Sec. 411.035. USE OF INJURY REPORT. A report made under Section 411.032 may not be considered to be an admission by or evidence against an employer or an insurance carrier in a proceeding before the division [commission] or a court in which the facts set out in the report are contradicted by the employer or insurance carrier.

SECTION 3.213. Subsections (a) and (c), Section 411.064, Labor Code, are amended to read as follows:

(a) The division may [shall] conduct inspections [an inspection at least every two years] to determine the adequacy of the accident prevention services required by Section 411.061 for each insurance company writing workers' compensation insurance in this state.

(c) The insurance company shall reimburse the division [commission] for the reasonable cost of the reinspection, including a reasonable allocation of the division's [commission's] administrative costs incurred in conducting the inspections.

SECTION 3.214. Subsection (b), Section 411.065, Labor Code, is amended to read as follows:

(b) The information must include:

(1) the amount of money spent by the insurance company on accident prevention services;

(2) the number and qualifications of field safety representatives employed by the insurance company;

(3) the number of site inspections performed;

(4) accident prevention services for which the insurance company contracts;
H.B. No. 7

(4) [4] a breakdown of the premium size of the risks
to which services were provided;

(5) [5] evidence of the effectiveness of and
accomplishments in accident prevention; and

(6) [6] any additional information required by the

commissioner [commission].

SECTION 3.215. The heading to Section 411.067, Labor Code,
is amended to read as follows:

Sec. 411.067. DIVISION [COMMISSION] PERSONNEL.

SECTION 3.216. Subsection (a), Section 411.067, Labor Code,
is amended to read as follows:

(a) The division [commission] shall employ the personnel
necessary to enforce this subchapter, including at least 10 safety
inspectors to perform inspections at a job site and at an insurance
company to determine the adequacy of the accident prevention
services provided by the insurance company.

SECTION 3.217. Subsection (b), Section 411.068, Labor Code,
is amended to read as follows:

(b) A violation under Subsection (a) is an [a Class B]
administrative violation. [Each day of noncompliance constitutes a
separate violation.]

SECTION 3.218. The heading to Subchapter F, Chapter 411,
Labor Code, is amended to read as follows:

SUBCHAPTER F. EMPLOYEE REPORTS OF SAFETY VIOLATIONS; EDUCATIONAL
MATERIALS

SECTION 3.219. Section 411.081, Labor Code, is amended to
read as follows:
Sec. 411.081. TELEPHONE HOTLINE. (a) The division shall maintain a 24-hour toll-free telephone service in English and Spanish for reports of violations of occupational health or safety law.

(b) Each employer shall notify its employees of this service in a manner prescribed by the commissioner. The commissioner shall, by rule, require the notice to be posted in English and Spanish, as appropriate.

(c) The commissioner shall adopt rules requiring that the notice required by Subsection (b) be posted:

(1) in a conspicuous place in the employer's place of business; and

(2) in sufficient locations to be convenient to all employees.

SECTION 3.220. Subchapter F, Chapter 411, Labor Code, is amended by adding Section 411.084 to read as follows:

Sec. 411.084. EDUCATIONAL PUBLICATIONS. (a) The division shall provide to employers and employees educational material, including books, pamphlets, brochures, films, videotapes, or other informational material.

(b) Educational material shall be provided to employees in English and Spanish.

(c) The department shall adopt minimum content requirements for the educational material required under this section, including:

(1) information on an employee's right to report an unsafe working environment;
(2) instructions on how to report unsafe working
conditions and safety violations; and

(3) information on state laws regarding retaliation by
employers.

SECTION 3.221. Section 411.105, Labor Code, is amended to
read as follows:

Sec. 411.105. CONFIDENTIAL INFORMATION; PENALTY. (a) The
division [commission] and its employees may not disclose at a
public hearing or otherwise information relating to secret
processes, methods of manufacture, or products.

(b) The commissioner [a member] or an employee of the
division [commission] commits an offense if the commissioner
[member] or employee wilfully discloses or conspires to disclose
information made confidential under this section. An offense under
this subsection is a misdemeanor punishable by a fine not to exceed
$1,000 and by forfeiture of the person's appointment as
commissioner [a member] or as an employee of the division
[commission].

SECTION 3.222. Section 411.106, Labor Code, is amended to
read as follows:

Sec. 411.106. SAFETY CLASSIFICATION. (a) To establish a
safety classification for employers, the division [commission]
shall:

(1) obtain medical and compensation cost information
regularly compiled by the department [Texas Department of
Insurance] in performing [that agency's] rate-making duties and
functions regarding employer liability and workers' compensation
insurance; and

(2) collect and compile information relating to:

(A) the frequency rate of accidents;

(B) the existence and implementation of private safety programs;

(C) the number of work-hour losses because of injuries; and

(D) other facts showing accident experience.

(b) From the information obtained under Subsection (a), the division [commission] shall classify employers as appropriate to implement this subchapter.

SECTION 3.223. Section 411.107, Labor Code, is amended to read as follows:

Sec. 411.107. ELIMINATION OF SAFETY IMPEDIMENTS. The division [commission] may endeavor to eliminate an impediment to occupational or industrial safety that is reported to the division [commission] by an affected employer. In attempting to eliminate an impediment the division [commission] may advise and consult with an employer, or a representative of an employer, who is directly involved.

SECTION 3.224. Section 411.108, Labor Code, is amended to read as follows:

Sec. 411.108. ACCIDENT REPORTS. The division [commission] may require an employer and any other appropriate person to report accidents, personal injuries, fatalities, or other statistics and information relating to accidents on forms prescribed by and covering periods designated by the commissioner [commission].
SECTION 3.225. Subsections (g), (i), and (l), Section 412.041, Labor Code, are amended to read as follows:

(g) The director shall act as an adversary before the division and courts and present the legal defenses and positions of the state as an employer and insurer, as appropriate.

(i) In administering Chapter 501, the director is subject to the rules, orders, and decisions of the commissioner in the same manner as a private employer, insurer, or association.

(l) The director shall furnish copies of all rules to:

1. The commissioner of insurance;
2. The commissioner of the Texas Department of Insurance; and
3. The administrative heads of all state agencies affected by this chapter and Chapter 501.

SECTION 3.226. The heading to Subchapter A, Chapter 413, Labor Code, is amended to read as follows:

SUBCHAPTER A. GENERAL PROVISIONS

SECTION 3.227. Section 413.002, Labor Code, is amended to read as follows:

Sec. 413.002. [DIVISION OF] MEDICAL REVIEW. (a) [The commission shall maintain a division of medical review to ensure compliance with the rules and to implement this chapter under the policies adopted by the commission.

(b) The division shall monitor health care providers, insurance carriers, independent review organizations, and workers' compensation claimants who receive medical services to ensure the compliance of those persons with rules adopted by the commissioner.
(b) [ ] In monitoring health care providers who serve as designated doctors under Chapter 408 and independent review organizations who provide services described by this chapter, the division shall evaluate:

(1) [the] compliance with this subtitle and with rules adopted by the commissioner relating to medical policies, fee guidelines, treatment guidelines, return-to-work guidelines, and impairment ratings; and

(2) the quality and timeliness of decisions made under Section 408.0041, 408.122, 408.151, or 413.031.

(c) The division shall report the results of the monitoring of independent review organizations under Subsection (b) to the department on at least a quarterly basis.

(d) If the commissioner determines that an independent review organization is in violation of this chapter, rules adopted by the commissioner under this chapter, applicable provisions of this code or rules adopted under this code, or applicable provisions of the Insurance Code or rules adopted under that code, the commissioner or a designated representative shall notify the independent review organization of the alleged violation and may compel the production of any documents or other information as necessary to determine whether the violation occurred.

SECTION 3.228. Section 413.003, Labor Code, is amended to read as follows:

Sec. 413.003. AUTHORITY TO CONTRACT. The division
[commission] may contract with a private or public entity to perform a duty or function of the division.

SECTION 3.229. Section 413.004, Labor Code, is amended to read as follows:

Sec. 413.004. COORDINATION WITH PROVIDERS. The division shall coordinate its activities with health care providers as necessary to perform its duties under this chapter. The coordination may include:

(1) conducting educational seminars on [commission] rules and procedures; or

(2) providing information to and requesting assistance from professional peer review organizations.

SECTION 3.230. Section 413.006, Labor Code, is amended to read as follows:

Sec. 413.006. ADVISORY COMMITTEES. The [commission] may appoint advisory committees [in addition to the medical advisory committee] as the [commission] considers necessary.

SECTION 3.231. Subsections (a) and (c), Section 413.007, Labor Code, are amended to read as follows:

(a) The division shall maintain a statewide data base of medical charges, actual payments, and treatment protocols that may be used by:

(1) the [commission] in adopting the medical policies and fee guidelines; and

(2) the division in administering the medical policies, fee guidelines, or rules.
(c) The division shall ensure that the data base is available for public access for a reasonable fee established by the commissioner. The identities of injured workers and beneficiaries may not be disclosed.

SECTION 3.232. Section 413.008, Labor Code, is amended to read as follows:

Sec. 413.008. INFORMATION FROM INSURANCE CARRIERS; ADMINISTRATIVE VIOLATION. (a) On request from the division for specific information, an insurance carrier shall provide to the division any information in the carrier's possession, custody, or control that reasonably relates to the duties under this subtitle and to health care:

(1) treatment;
(2) services;
(3) fees; and
(4) charges.

(b) The division shall keep confidential information that is confidential by law.

(c) An insurance carrier commits an administrative violation if the insurance carrier fails or refuses to comply with a request or violates a rule adopted to implement this section. Each day of noncompliance constitutes a separate violation.

SECTION 3.233. Section 413.011, Labor Code, is amended to read as follows:
Sec. 413.011. REIMBURSEMENT POLICIES AND GUIDELINES; TREATMENT GUIDELINES AND PROTOCOLS. (a) The commissioner shall adopt health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems with minimal modifications to those reimbursement methodologies as necessary to meet occupational injury requirements. To achieve standardization, the commissioner shall adopt the most current reimbursement methodologies, models, and values or weights used by the federal Centers for Medicare and Medicaid Services, including applicable payment policies relating to coding, billing, and reporting, and may modify documentation requirements as necessary to meet the requirements of Section 413.053.

(b) In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d). The commissioner shall also provide for reasonable fees for the evaluation and management of care as required by Section 408.025(c) and commissioner rules. This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services.

(c) This section may not be interpreted in a manner that
would discriminate in the amount or method of payment or reimbursement for services in a manner prohibited by Section 1451.104 (d), Article 21.52, Insurance Code, or as restricting the ability of chiropractors to serve as treating doctors as authorized by this subtitle. The commissioner shall also develop guidelines relating to fees charged or paid for providing expert testimony relating to an issue arising under this subtitle.

(d) Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines. Notwithstanding Section 413.016 or any other provision of this title, an insurance carrier may pay fees to a health care provider that are inconsistent with the fee guidelines adopted by the division if the insurance carrier or a network under Chapter 1305, Insurance Code, has a contract with the health care provider and that contract includes a specific fee schedule.

(e) The commissioner by rule shall adopt treatment guidelines and, including return-to-work guidelines, and may adopt individual treatment protocols. Treatment guidelines
and protocols must be evidence-based [nationally recognized], scientifically valid, and outcome-focused [outcome-based] and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. Treatment may not be denied solely on the basis that the treatment for the compensable injury in question is not specifically addressed by the treatment guidelines. [If a nationally recognized treatment guideline or protocol is not available for adoption by the commission, the commission may adopt another treatment guideline or protocol as long as it is scientifically valid and outcome-based].

(f) In addition to complying with the requirements of Subsection (e), [The commission by rule may establish medical policies or treatment guidelines or protocols relating to necessary treatments for injuries.]

[(g) Any] medical policies or guidelines adopted by the commissioner [commission] must be:

(1) designed to ensure the quality of medical care and to achieve effective medical cost control;
(2) designed to enhance a timely and appropriate return to work; and
(3) consistent with Sections 413.013, 413.020, 413.052, and 413.053.

(g) The commissioner may adopt rules relating to disability management that are designed to promote appropriate health care at the earliest opportunity after the injury to maximize injury healing and improve stay-at-work and return-to-work outcomes through appropriate management of work-related injuries or
conditions. The commissioner by rule may identify claims in which
application of disability management activities is required and
prescribe at what point in the claim process a treatment plan is
required. The determination may be based on any factor considered
relevant by the commissioner. Rules adopted under this subsection
do not apply to claims subject to workers' compensation health care
networks under Chapter 1305, Insurance Code.

(h) A dispute involving a treatment plan required under
Subsection (g) may be appealed to an independent review
organization in the manner described by Section 413.031.

(i) The division shall examine whether injured employees
have reasonable access to surgically implanted, inserted, or
otherwise applied devices or tissues and investigate whether
reimbursement rates or any other barriers exist that reduce the
ability of an injured employee to access those medical needs. The
division shall recommend to the legislature any statutory changes
necessary to ensure appropriate access to those medical needs.

SECTION 3.234. Subchapter B, Chapter 413, Labor Code, is
amended by adding Section 413.0111 to read as follows:

Sec. 413.0111. PROCESSING AGENTS. The rules adopted by the
commissioner for the reimbursement of prescription medications and
services must authorize pharmacies to use agents or assignees to
process claims and act on the behalf of the pharmacies under terms
and conditions agreed on by the pharmacies.

SECTION 3.235. Section 413.013, Labor Code, is amended to
read as follows:

Sec. 413.013. PROGRAMS. The commissioner [commission] by
rule shall establish:

(1) a program for prospective, concurrent, and retrospective review and resolution of a dispute regarding health care treatments and services;

(2) a program for the systematic monitoring of the necessity of treatments administered and fees charged and paid for medical treatments or services, including the authorization of prospective, concurrent, or retrospective review under the medical policies of the division [commission] to ensure that the medical policies or guidelines are not exceeded;

(3) a program to detect practices and patterns by insurance carriers in unreasonably denying authorization of payment for medical services requested or performed if authorization is required by the medical policies of the division [commission]; and

(4) a program to increase the intensity of review for compliance with the medical policies or fee guidelines for any health care provider that has established a practice or pattern in charges and treatments inconsistent with the medical policies and fee guidelines.

SECTION 3.236. Section 413.014, Labor Code, is amended by amending Subsections (b)-(e) and adding Subsection (f) to read as follows:

(b) The commissioner [commission] by rule shall specify which health care treatments and services require express preauthorization or concurrent review by the insurance carrier. Treatments and services for a medical emergency do not require
express preauthorization.

(c) The commissioner's rules adopted under this section must provide that preauthorization and concurrent review are required at a minimum for:

1 (1) spinal surgery, as provided by Section 408.026;
2 (2) work-hardening or work-conditioning services provided by a health care facility that is not credentialed by an organization recognized by commissioner rules;
3 (3) inpatient hospitalization, including any procedure and length of stay;
4 (4) physical and occupational therapy;
5 (5) outpatient or ambulatory surgical services, as defined by commissioner rule; and
6 (6) any investigational or experimental services or devices.

(d) The insurance carrier is not liable for those specified treatments and services requiring preauthorization unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or ordered by the commissioner.

(e) If a specified health care treatment or service is preauthorized as provided by this section, that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service.

(f) The division may not prohibit an insurance carrier and a health care provider from voluntarily discussing health care treatment and treatment plans and pharmaceutical
services, either prospectively or concurrently, and may not 
prohibit an insurance carrier from certifying or agreeing to pay 
for health care consistent with those agreements. The insurance 
carrier is liable for health care treatment and treatment plans and 
pharmaceutical services that are voluntarily preauthorized and may 
not dispute the certified or agreed-on preauthorized health care 
treatment and treatment plans and pharmaceutical services at a 
later date.

SECTION 3.237. Section 413.0141, Labor Code, is amended to 
read as follows:

Sec. 413.0141. INITIAL PHARMACEUTICAL COVERAGE. The 
commissioner may by rule provide that an insurance 
carrier shall provide for payment of specified pharmaceutical 
services sufficient for the first seven days following the date of 
injury if the health care provider requests and receives 
verification of insurance coverage and a verbal confirmation of an 
injury from the employer or from the insurance carrier as provided 
by Section 413.014. The rules adopted by the commissioner 
shall provide that an insurance carrier is eligible 
for reimbursement for pharmaceutical services paid under this 
section from the subsequent injury fund in the event the injury is 
determined not to be compensable.

SECTION 3.238. Subsection (b), Section 413.015, Labor Code, 
is amended to read as follows:

(b) The commissioner shall provide by rule for 
the review and audit of the payment by insurance carriers of charges 
for medical services provided under this subtitle to ensure
compliance of health care providers and insurance carriers with the medical policies and fee guidelines adopted by the commissioner.

SECTION 3.239. Subsection (b), Section 413.016, Labor Code, is amended to read as follows:

(b) If the division determines that an insurance carrier has paid medical charges that are inconsistent with the medical policies or fee guidelines adopted by the commissioner, the division shall investigate the potential violation [refer the insurance carrier alleged to have violated this subtitle to the division of compliance and practices]. If the insurance carrier reduced a charge of a health care provider that was within the guidelines, the insurance carrier shall be directed to submit the difference to the provider unless the reduction is in accordance with an agreement between the health care provider and the insurance carrier.

SECTION 3.240. Section 413.017, Labor Code, is amended to read as follows:

Sec. 413.017. PRESUMPTION OF REASONABLENESS. The following medical services are presumed reasonable:

(1) medical services consistent with the medical policies and fee guidelines adopted by the commissioner; and

(2) medical services that are provided subject to prospective, concurrent, or retrospective review as required by the medical policies of the division and that are authorized by an insurance carrier.
SECTION 3.241. Subsections (a), (c), (d), and (e), Section 413.018, Labor Code, are amended to read as follows:

(a) The commissioner by rule shall provide for the periodic review of medical care provided in claims in which guidelines for expected or average return to work time frames are exceeded.

(c) The division shall implement a program to encourage employers and treating doctors to discuss the availability of modified duty to encourage the safe and more timely return to work of injured employees. The division may require a treating or examining doctor, on the request of the employer, insurance carrier, or division, to provide a functional capacity evaluation of an injured employee and to determine the employee's ability to engage in physical activities found in the workplace or in activities that are required in a modified duty setting.

(d) The division shall provide through the division's health and safety information and medical review outreach programs information to employers regarding effective return to work programs. This section does not require an employer to provide modified duty or an employee to accept a modified duty assignment. An employee who does not accept an employer's offer of modified duty determined by the division to be a bona fide job offer is subject to Section 408.103(e).

(e) The commissioner may adopt rules and forms as necessary to implement this section.
SEC. 3.242. Section 413.020, Labor Code, is amended to read as follows:

Sec. 413.020. DIVISION [COMMISSION] CHARGES. The commissioner [commission] by rule shall establish procedures to enable the division [commission] to charge:

(1) an insurance carrier a reasonable fee for access to or evaluation of health care treatment, fees, or charges under this subtitle; and

(2) a health care provider who exceeds a fee or utilization guideline established under this subtitle or an insurance carrier who unreasonably disputes charges that are consistent with a fee or utilization guideline established under this subtitle a reasonable fee for review of health care treatment, fees, or charges under this subtitle.

SEC. 3.243. Subsections (a), (d), and (e), Section 413.021, Labor Code, are amended to read as follows:

(a) An insurance carrier shall, with the agreement of a participating employer, provide the employer with return-to-work coordination services as necessary to facilitate an employee's return to employment. The insurance carrier shall notify the employer of the availability of return-to-work coordination services. In offering the services, insurance carriers and the division [commission] shall target employers without return-to-work programs and shall focus return-to-work efforts on workers who begin to receive temporary income benefits. The insurance carrier shall evaluate a compensable injury in which the injured employee sustains an injury that could potentially result
in lost time from employment as early as practicable to determine if skilled case management is necessary for the injured employee's case. As necessary, case managers who are appropriately licensed to practice in this state shall be used to perform these evaluations. A claims adjuster may not be used as a case manager. These services may be offered by insurance carriers in conjunction with the accident prevention services provided under Section 411.061. Nothing in this section supersedes the provisions of a collective bargaining agreement between an employer and the employer's employees, and nothing in this section authorizes an employer to engage in conduct that would otherwise be a violation of the employer's obligations under the National Labor Relations Act (29 U.S.C. Section 151 et seq.)[, and its subsequent amendments].

(d) The division [commission] shall use certified rehabilitation counselors or other appropriately trained or credentialed specialists to provide training to division [commission] staff regarding the coordination of return-to-work services under this section.

(e) The commissioner [commission] shall adopt rules necessary to collect data on return-to-work outcomes to allow full evaluations of successes and of barriers to achieving timely return to work after an injury.

SECTION 3.244. Subchapter B, Chapter 413, Labor Code, is amended by adding Sections 413.022-413.025 to read as follows:

Sec. 413.022. RETURN-TO-WORK PILOT PROGRAM FOR SMALL EMPLOYERS; FUND. (a) In this section:

(1) "Account" means the workers' compensation
return-to-work account.

(2) "Eligible employer" means any employer, other than this state or a political subdivision subject to Subtitle C, who employs at least two but not more than 50 employees on each business day during the preceding calendar year and who has workers' compensation insurance coverage.

(b) The commissioner shall establish by rule a return-to-work pilot program designed to promote the early and sustained return to work of an injured employee who sustains a compensable injury.

(c) The pilot program shall reimburse from the account an eligible employer for expenses incurred by the employer to make workplace modifications necessary to accommodate an injured employee's return to modified or alternative work. Reimbursement under this section to an eligible employer may not exceed $2,500. The expenses must be incurred to allow the employee to perform modified or alternative work within doctor-imposed work restrictions. Allowable expenses may include:

(1) physical modifications to the worksite;
(2) equipment, devices, furniture, or tools; and
(3) other costs necessary for reasonable accommodation of the employee's restrictions.

(d) The account is established as a special account in the general revenue fund. From administrative penalties received by the division under this subtitle, the commissioner shall deposit in the account an amount not to exceed $100,000 annually. Money in the account may be spent by the division, on appropriation by the
legislature, only for the purposes of implementing this section.

(e) An employer who wilfully applies for or receives reimbursement from the account under this section knowing that the employer is not an eligible employer commits a violation.

(f) Notwithstanding Subsections (a)-(e), this section may be implemented only to the extent funds are available.

(g) This section expires September 1, 2009.

Sec. 413.023. INFORMATION TO EMPLOYERS. (a) The division shall provide employers with information on methods to enhance the ability of an injured employee to return to work. The information may include access to available research and best practice information regarding return-to-work programs for employers.

(b) The division shall augment return-to-work program information provided to employers to include information regarding methods for an employer to appropriately assist an injured employee to obtain access to doctors who:

(1) provide high-quality care; and

(2) use effective occupational medicine treatment practices that lead to returning employees to productive work.

(c) The information provided to employers under this section must help to foster:

(1) effective working relationships with local doctors and with insurance carriers or workers' compensation health care networks certified under Chapter 1305, Insurance Code, to improve return-to-work communication; and

(2) access to return-to-work coordination services provided by insurance carriers.
(d) The division shall develop and make available the
information described by this section.

Sec. 413.024. INFORMATION TO EMPLOYEES. The division shall
provide injured employees with information regarding the benefits
of early return to work. The information must include information
on how to receive assistance in accessing high-quality medical care
through the workers' compensation system.

Sec. 413.025. RETURN-TO-WORK GOALS AND ASSISTANCE. (a)
The division shall assist recipients of income benefits to return
to the workforce. The division shall develop improved data
sharing, within the standards of federal privacy requirements, with
all appropriate state agencies and workforce programs to inform the
division of changes needed to assist income benefit recipients to
successfully reenter the workforce.

(b) The division shall train staff dealing with income
benefits to respond to questions and assist injured employees in
their effort to return to the workforce. If the division determines
that an injured employee is unable to ever return to the workforce,
the division shall inform the employee of possible eligibility for
other forms of benefits, such as social security disability income
benefits.

(c) As necessary to implement the requirements of this
section, the division shall:

(1) attempt to remove any barriers to successful
employment that are identified at the division, the Texas Workforce
Commission, the Department of Assistive and Rehabilitative
Services, and private vocational rehabilitation programs;
(2) ensure that data is tracked among the division, the Texas Workforce Commission, the Department of Assistive and Rehabilitative Services, and insurance carriers, including outcome data;

(3) establish a mechanism to refer income benefit recipients to the Texas Workforce Commission and local workforce development centers for employment opportunities; and

(4) develop a mechanism to promote employment success that includes post-referral contacts by the division with income benefit recipients.

SECTION 3.245. Section 413.031, Labor Code, is amended by amending Subsections (a) through (d), (e-1), (f), (g), (h), (k), and (m) and adding Subsection (n) to read as follows:

(a) A party, including a health care provider, is entitled to a review of a medical service provided or for which authorization of payment is sought if a health care provider is:

(1) denied payment or paid a reduced amount for the medical service rendered;

(2) denied authorization for the payment for the service requested or performed if authorization is required or allowed by this subtitle or commissioner [commission] rules;

(3) ordered by the commissioner [commission] to refund a payment received; or

(4) ordered to make a payment that was refused or reduced for a medical service rendered.

(b) A health care provider who submits a charge in excess of the fee guidelines or treatment policies is entitled to a review of
the medical service to determine if reasonable medical justification exists for the deviation. A claimant is entitled to a review of a medical service for which preauthorization is sought by the health care provider and denied by the insurance carrier. The commissioner [commission] shall adopt rules to notify claimants of their rights under this subsection.

(c) In resolving disputes over the amount of payment due for services determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division [commission] is to adjudicate the payment given the relevant statutory provisions and commissioner [commission] rules. The division [commission] shall publish on its Internet website the division's [its] medical dispute decisions, including decisions of independent review organizations, and any subsequent decisions by the State Office of Administrative Hearings. Before publication, the division [commission] shall redact only that information necessary to prevent identification of the injured worker.

(d) A review of the medical necessity of a health care service requiring preauthorization under Section 413.014 or commissioner [commission] rules under that section or Section 413.011(g) shall be conducted by an independent review organization under Article 21.58C, Insurance Code, in the same manner as reviews of utilization review decisions by health maintenance organizations. It is a defense for the insurance carrier if the carrier timely complies with the decision of the independent review organization.

(e-1) In performing a review of medical necessity under
Subsection (d) or (e), the independent review organization shall consider the division's [commission's] health care reimbursement policies and guidelines adopted under Section 413.011 [if those policies and guidelines are raised by one of the parties to the dispute]. If the independent review organization's decision is contrary to the division's [commission's] policies or guidelines adopted under Section 413.011, the independent review organization must indicate in the decision the specific basis for its divergence in the review of medical necessity. [This subsection does not prohibit an independent review organization from considering the payment policies adopted under Section 413.011 in any dispute, regardless of whether those policies are raised by a party to the dispute.]

(f) The commissioner [commission] by rule shall specify the appropriate dispute resolution process for disputes in which a claimant has paid for medical services and seeks reimbursement.

(g) In performing a review of medical necessity under Subsection (d) or (e), an independent review organization may request that the commissioner [commission] order an examination by a designated doctor under Chapter 408.

(h) The insurance carrier shall pay the cost of the review if the dispute arises in connection with:

(1) a request for health care services that require preauthorization under Section 413.014 or commissioner [commission] rules under that section; or

(2) a treatment plan under Section 413.011(g) or commissioner rules under that section.
(k) Except as provided by Subsection (1), a party to a medical dispute that remains unresolved after a review of the medical service under this section is entitled to a hearing. The hearing shall be conducted by the State Office of Administrative Hearings within 90 days of receipt of a request for a hearing in the manner provided for a contested case under Chapter 2001, Government Code (the administrative procedure law). A party who has exhausted the party’s administrative remedies under this subtitle and who is aggrieved by a final decision of the State Office of Administrative Hearings may seek judicial review of the decision. The division and the department are not considered to be parties to the medical dispute for purposes of this subsection. Judicial review under this subsection shall be conducted in the manner provided for judicial review of contested cases under Subchapter G, Chapter 2001, Government Code.

(m) The decision of an independent review organization under Subsection (d) is binding during the pendency of a dispute.

(n) The commissioner by rule may prescribe an alternate dispute resolution process to resolve disputes regarding medical services costing less than the cost of a review of the medical necessity of a health care service by an independent review organization. The cost of a review under the alternate dispute resolution process shall be paid by the nonprevailing party.

SECTION 3.246. Subsections (a), (b), and (d), Section 413.041, Labor Code, are amended to read as follows:

(a) Each health care practitioner shall disclose to the division the identity of any health care provider in

221
which the health care practitioner, or the health care provider that employs the health care practitioner, has a financial interest. The health care practitioner shall make the disclosure in the manner provided by commissioner [commission] rule.

(b) The commissioner [commission] shall require by rule that a doctor disclose financial interests in other health care providers as a condition of registration for the approved doctor list established under Section 408.023 and shall define "financial interest" for purposes of this section [subsection] as provided by analogous federal regulations. The commissioner [commission] by rule shall adopt the federal standards that prohibit the payment or acceptance of payment in exchange for health care referrals relating to fraud, abuse, and antikickbacks.

(d) The division [commission] shall publish all final disclosure enforcement orders issued under this section on the division's [commission's] Internet website.

SECTION 3.247. Subchapter C, Chapter 413, Labor Code, is amended by adding Section 413.032 to read as follows:

Sec. 413.032. INDEPENDENT REVIEW ORGANIZATION DECISION; APPEAL. (a) An independent review organization that conducts a review under this chapter shall specify the elements on which the decision of the organization is based. At a minimum, the decision must include:

(1) a list of all medical records and other documents reviewed by the organization;

(2) a description and the source of the screening criteria or clinical basis used in making the decision;
(3) an analysis of and explanation for the decision, including the findings and conclusions used to support the decision; and

(4) a description of the qualifications of each physician or other health care provider who reviews the decision.

(b) The independent review organization shall certify that each physician or other health care provider who reviews the decision certifies that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, the injured employee's insurance carrier, the utilization review agent, or any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the independent review organization.

SECTION 3.248. Subsection (b), Section 413.042, Labor Code, is amended to read as follows:

(b) A health care provider commits an administrative violation if the provider violates Subsection (a). [A violation under this subsection is a Class B administrative violation.]

SECTION 3.249. Section 413.044, Labor Code, is amended to read as follows:

Sec. 413.044. SANCTIONS ON DESIGNATED DOCTOR. (a) In addition to or in lieu of an administrative penalty under Section 415.021 or a sanction imposed under Section 415.023, the commissioner [commission] may impose sanctions against a person who serves as a designated doctor under Chapter 408 who, after an evaluation conducted under Section 413.002(b) [413.002(c)], is determined by the division to be out of compliance with this
subtitle or with rules adopted by the commissioner [commission] relating to:

(1) medical policies, fee guidelines, and impairment ratings; or

(2) the quality of decisions made under Section 408.0041 or Section 408.122.

(b) Sanctions imposed under Subsection (a) may include:

(1) removal or suspension from the division list of designated doctors; or

(2) restrictions on the reviews made by the person as a designated doctor.

SECTION 3.250. Section 413.051, Labor Code, is amended to read as follows:

Sec. 413.051. CONTRACTS WITH REVIEW ORGANIZATIONS AND HEALTH CARE PROVIDERS. (a) In this section, "health care provider professional review organization" includes an independent review organization.

(b) The division [commission] may contract with a health care provider, health care provider professional review organization, or other entity to develop, maintain, or review medical policies or fee guidelines or to review compliance with the medical policies or fee guidelines.

(c) [4(b)] For purposes of review or resolution of a dispute as to compliance with the medical policies or fee guidelines, the division [commission] may contract with a health care provider, health care provider professional review organization, or other entity that includes in the review process health care
practitioners who are licensed in the category under review and are
of the same field or specialty as the category under review.

(d) The division may contract with a
health care provider, health care provider professional review
organization, or other entity for medical consultant services,
including:

(1) independent medical examinations;
(2) medical case reviews; or
(3) establishment of medical policies and fee
guidelines.

(e) The commissioner shall establish
standards for contracts under this section.

[(e) For purposes of this section, "health care provider
professional review organization" includes an independent review
organization.]

SECTION 3.251. Section 413.0511, Labor Code, is amended to
read as follows:

Sec. 413.0511. MEDICAL ADVISOR. (a) The division
shall employ or contract with a medical advisor, who
must be a doctor as that term is defined by Section 401.011.

(b) The medical advisor shall make recommendations
regarding the adoption of rules and policies to:

(1) develop, maintain, and review guidelines as
provided by Section 413.011, including rules regarding impairment
ratings;

(2) review compliance with those guidelines;

(3) regulate or perform other acts related to medical
benefits as required by the commissioner;

(4) impose sanctions or delete doctors from the division's list of approved doctors under Section 408.023 for:

(A) any reason described by Section 408.0231; or

(B) noncompliance with commissioner rules;

(5) impose conditions or restrictions as authorized by Section 408.0231(f);

(6) receive, and share with the medical quality review panel established under Section 413.0512, confidential information, and other information to which access is otherwise restricted by law, as provided by Sections 413.0512, 413.0513, and 413.0514 from the Texas State Board of Medical Examiners, the Texas Board of Chiropractic Examiners, or other occupational licensing boards regarding a physician, chiropractor, or other type of doctor who applies for registration or is registered with the division on the list of approved doctors; and

(7) determine minimal modifications to the reimbursement methodology and model used by the Medicare system as necessary to meet occupational injury requirements; and

(8) monitor the quality and timeliness of decisions made by designated doctors and independent review organizations, and the imposition of sanctions regarding those decisions.

SECTION 3.252. Subsections (a) and (c), Section 413.0512, Labor Code, are amended to read as follows:

(a) The medical advisor shall establish a medical quality
review panel of health care providers to assist the medical advisor
in performing the duties required under Section 413.0511. The
panel is [independent of the medical advisory committee created
under Section 413.005 and is] not subject to Chapter 2110,
Government Code.

(c) The medical quality review panel shall recommend to the
medical advisor:

(1) appropriate action regarding doctors, other
health care providers, insurance carriers, [and] utilization
review agents, and independent review organizations; and

(2) the addition or deletion of doctors from the list
of approved doctors under Section 408.023 or the list of designated
doctors established under Section 408.1225 [408.122].

SECTION 3.253. Section 413.0513, Labor Code, is amended to
read as follows:

Sec. 413.0513. CONFIDENTIALITY REQUIREMENTS. (a) Information
collected, assembled, or maintained by or on behalf of the division
[commission] under Section 413.0511 or 413.0512 constitutes an
investigation file for purposes of Section 402.092 and may not be
disclosed under Section 413.0511 or 413.0512 except as provided by
that section.

(b) Confidential information, and other information to
which access is restricted by law, developed by or on behalf of the
division [commission] under Section 413.0511 or 413.0512 is not
subject to discovery or court subpoena in any action other than:

(1) an action to enforce this subtitle brought by the
agency, or an appropriate enforcement authority; or

(2) a criminal proceeding.

SECTION 3.254. Section 413.0514, Labor Code, is amended to read as follows:

Sec. 413.0514. INFORMATION SHARING WITH OCCUPATIONAL LICENSING BOARDS. (a) This section applies only to information held by or for the division [commission], the Texas State Board of Medical Examiners, and Texas Board of Chiropractic Examiners that relates to a person who is licensed or otherwise regulated by any of those state agencies.

(b) The division [commission] and the Texas State Board of Medical Examiners on request or on its own initiative, may share with each other confidential information or information to which access is otherwise restricted by law. The division [commission] and the Texas State Board of Medical Examiners shall cooperate with and assist each other when either agency is conducting an investigation by providing information to each other that the sending agency determines is relevant to the investigation. Except as provided by this section, confidential information that is shared under this section remains confidential under law and legal restrictions on access to the information remain in effect. Furnishing information by the Texas State Board of Medical Examiners to the division [commission] or by the division [commission] to the Texas State Board of Medical Examiners under this subsection does not constitute a waiver of privilege or confidentiality as established by law.

(c) Information that is received by the division
(d) The division [commission] and the Texas Board of Chiropractic Examiners on request or on its own initiative, may share with each other confidential information or information to which access is otherwise restricted by law. The division [commission] and the Texas Board of Chiropractic Examiners shall cooperate with and assist each other when either agency is conducting an investigation by providing information to each other that is relevant to the investigation. Except as provided by this section, confidential information that is shared under this section remains confidential under law and legal restrictions on access to the information remain in effect unless the agency sharing the information approves use of the information by the receiving agency for enforcement purposes. Furnishing information by the Texas Board of Chiropractic Examiners to the division [commission] or by the division [commission] to the Texas Board of Chiropractic Examiners under this subsection does not constitute a waiver of privilege or confidentiality as established by law.

(e) Information that is received by the division [commission] from the Texas Board of Chiropractic Examiners or by the Texas Board of Chiropractic Examiners from the division [commission] remains confidential and may not be disclosed by the division [commission]
except as necessary to further the investigation unless the agency
sharing the information and the agency receiving the information
agree to use of the information by the receiving agency for
enforcement purposes.

(f) The division [commission] and the Texas State Board of
Medical Examiners shall provide information to each other on all
disciplinary actions taken.

(g) The division [commission] and the Texas Board of
Chiropractic Examiners shall provide information to each other on
all disciplinary actions taken.

SECTION 3.255. Section 413.0515, Labor Code, is amended to
read as follows:

Sec. 413.0515. REPORTS OF PHYSICIAN AND CHIROPRACTOR
VIOLATIONS. (a) If the division [commission] or the Texas State
Board of Medical Examiners discovers an act or omission by a
physician that may constitute a felony, a misdemeanor involving
moral turpitude, a violation of state or federal narcotics or
controlled substance law, an offense involving fraud or abuse under
the Medicare or Medicaid program, or a violation of this subtitle,
the agency shall report that act or omission to the other agency.

(b) If the division [commission] or the Texas Board of
Chiropractic Examiners discovers an act or omission by a
chiropractor that may constitute a felony, a misdemeanor involving
moral turpitude, a violation of state or federal narcotics or
controlled substance law, an offense involving fraud or abuse under
the Medicare or Medicaid program, or a violation of this subtitle,
the agency shall report that act or omission to the other agency.
SECTION 3.256. Section 413.052, Labor Code, is amended to read as follows:

Sec. 413.052. PRODUCTION OF DOCUMENTS. The commissioner by rule shall establish procedures to enable the division to compel the production of documents.

SECTION 3.257. Section 413.053, Labor Code, is amended to read as follows:

Sec. 413.053. STANDARDS OF REPORTING AND BILLING. The commissioner by rule shall establish standards of reporting and billing governing both form and content.

SECTION 3.258. Subsection (a), Section 413.054, Labor Code, is amended to read as follows:

(a) A person who performs services for the division as a designated doctor, an independent medical examiner, a doctor performing a medical case review, or a member of a peer review panel has the same immunity from liability as the commissioner under Section 402.0024.

SECTION 3.259. Subsections (a) and (b), Section 413.055, Labor Code, are amended to read as follows:

(a) The commissioner may enter an interlocutory order for the payment of all or part of medical benefits. The order may address accrued benefits, future benefits, or both accrued benefits and future benefits.

(b) The subsequent injury fund shall reimburse an insurance carrier for any overpayments of benefits made under an order.
entered under Subsection (a) if the order is reversed or modified by
final arbitration, order, or decision of the commissioner
or a court. The commissioner shall adopt
rules to provide for a periodic reimbursement schedule, providing
for reimbursement at least annually.

SECTION 3.2595. The heading to Chapter 414, Labor Code, is
amended to read as follows:

CHAPTER 414. ENFORCEMENT OF COMPLIANCE
AND PRACTICE REQUIREMENTS

SECTION 3.260. Subsection (a), Section 414.002, Labor Code,
is amended to read as follows:

(a) The division shall monitor for compliance with
commissioner rules, this subtitle, and other laws
relating to workers' compensation the conduct of persons subject to
this subtitle[other than persons monitored by the division of
medical review]. Persons to be monitored include:

(1) persons claiming benefits under this subtitle;
(2) employers;
(3) insurance carriers; [and]
(4) attorneys and other representatives of parties;

and

(5) health care providers.

SECTION 3.261. Section 414.003, Labor Code, is amended to
read as follows:

Sec. 414.003. COMPILATION AND USE OF INFORMATION. (a) The
division shall compile and maintain statistical and other
information as necessary to detect practices or patterns of conduct

232
by persons subject to monitoring under this chapter that:

(1) violate this subtitle, commissioner rules, or a commissioner order or decision; or

(2) otherwise adversely affect the workers' compensation system of this state.

(b) The commissioner shall use the information compiled under this section to impose appropriate penalties and other sanctions under Chapters 415 and 416.

SECTION 3.262. Section 414.005, Labor Code, is amended to read as follows:

Sec. 414.005. INVESTIGATION UNIT. The division shall maintain an investigation unit to conduct investigations relating to alleged violations of this subtitle, commissioner rules, or a commissioner order or decision, with particular emphasis on violations of Chapters 415 and 416.

SECTION 3.263. Section 414.006, Labor Code, is amended to read as follows:

Sec. 414.006. REFERRAL TO OTHER AUTHORITIES. For further investigation or the institution of appropriate proceedings, the division may refer the persons involved in a case subject to an investigation to:

(1) the division of hearings; or

(2) other appropriate authorities, including licensing agencies, district and county attorneys, or the attorney general.

SECTION 3.264. Section 414.007, Labor Code, is amended to read as follows:
Sec. 414.007. [REVIEW OF REFERRALS FROM DIVISION OF MEDICAL REVIEW. The division shall review information [and referrals received from the division of medical review] concerning alleged violations of this subtitle regarding the provision of medical benefits, commissioner rules, or a commissioner order or decision, and, under Sections 414.005 and 414.006 and Chapters 415 and 416, may conduct investigations, make referrals to other authorities, and initiate administrative violation proceedings.

SECTION 3.265. Section 415.001, Labor Code, is amended to read as follows:

Sec. 415.001. ADMINISTRATIVE VIOLATION BY REPRESENTATIVE OF EMPLOYEE OR LEGAL BENEFICIARY. A representative of an employee or legal beneficiary commits an administrative violation if the person [wilfully or intentionally]:

(1) fails without good cause to attend a dispute resolution proceeding within the division [commission];

(2) attends a dispute resolution proceeding within the division [commission] without complete authority or fails to exercise authority to effectuate an agreement or settlement;

(3) commits an act of barratry under Section 38.12, Penal Code;

(4) withholds from the employee's or legal beneficiary's weekly benefits or from advances amounts not authorized to be withheld by the division [commission];

(5) enters into a settlement or agreement without the knowledge, consent, and signature of the employee or legal beneficiary;
(6) takes a fee or withholds expenses in excess of the amounts authorized by the division [commission];

(7) refuses or fails to make prompt delivery to the employee or legal beneficiary of funds belonging to the employee or legal beneficiary as a result of a settlement, agreement, order, or award;

(8) violates the Texas Disciplinary Rules of Professional Conduct of the State Bar of Texas;

(9) misrepresents the provisions of this subtitle to an employee, an employer, a health care provider, or a legal beneficiary;

(10) violates a commissioner [commission] rule; or

(11) fails to comply with this subtitle.

SECTION 3.266. Section 415.002, Labor Code, is amended to read as follows:

Sec. 415.002. ADMINISTRATIVE VIOLATION BY AN INSURANCE CARRIER. (a) An insurance carrier or its representative commits an administrative violation if that person [wilfully or intentionally]:

(1) misrepresents a provision of this subtitle to an employee, an employer, a health care provider, or a legal beneficiary;

(2) terminates or reduces benefits without substantiating evidence that the action is reasonable and authorized by law;

(3) instructs an employer not to file a document required to be filed with the division [commission];
instructs or encourages an employer to violate a
claimant's right to medical benefits under this subtitle;

(5) fails to tender promptly full death benefits if a
legitimate dispute does not exist as to the liability of the
insurance carrier;

(6) allows an employer, other than a self-insured
employer, to dictate the methods by which and the terms on which a
claim is handled and settled;

(7) fails to confirm medical benefits coverage to a
person or facility providing medical treatment to a claimant if a
legitimate dispute does not exist as to the liability of the
insurance carrier;

(8) fails, without good cause, to attend a dispute
resolution proceeding within the division [commission];

(9) attends a dispute resolution proceeding within the
division [commission] without complete authority or fails to
exercise authority to effectuate agreement or settlement;

(10) adjusts a workers' compensation claim in a manner
contrary to license requirements for an insurance adjuster,
including the requirements of Chapter 4101, Insurance Code [407,
Acts of the 63rd Legislature, Regular Session, 1973 (Article
21.07-4, Vernon's Texas Insurance Code)], or the rules of the
commissioner [State Board] of insurance [Insurance];

(11) fails to process claims promptly in a reasonable
and prudent manner;

(12) fails to initiate or reinstate benefits when due
if a legitimate dispute does not exist as to the liability of the
insurance carrier;

(13) misrepresents the reason for not paying benefits or terminating or reducing the payment of benefits;

(14) dates documents to misrepresent the actual date of the initiation of benefits;

(15) makes a notation on a draft or other instrument indicating that the draft or instrument represents a final settlement of a claim if the claim is still open and pending before the division [commission];

(16) fails or refuses to pay benefits from week to week as and when due directly to the person entitled to the benefits;

(17) fails to pay an order awarding benefits;

(18) controverts a claim if the evidence clearly indicates liability;

(19) unreasonably disputes the reasonableness and necessity of health care;

(20) violates a commissioner [commission] rule; or

(21) makes a statement denying all future medical care for a compensable injury; or

(22) fails to comply with a provision of this subtitle.

(b) An insurance carrier or its representative does not commit an administrative violation under Subsection (a)(6) by allowing an employer to:

(1) freely discuss a claim;

(2) assist in the investigation and evaluation of a claim; or
H.B. No. 7

(3) attend a proceeding of the division [commission] and participate at the proceeding in accordance with this subtitle.

SECTION 3.267. Section 415.003, Labor Code, is amended to read as follows:

Sec. 415.003. ADMINISTRATIVE VIOLATION BY HEALTH CARE PROVIDER. A health care provider commits an administrative violation if the person [wilfully or intentionally]:

(1) submits a charge for health care that was not furnished;

(2) administers improper, unreasonable, or medically unnecessary treatment or services;

(3) makes an unnecessary referral;

(4) violates the division's [commission's] fee and treatment guidelines;

(5) violates a commissioner [commission] rule; or

(6) fails to comply with a provision of this subtitle.

SECTION 3.268. Subsections (a), (b), (e), and (f), Section 415.0035, Labor Code, are amended to read as follows:

(a) An insurance carrier or its representative commits an administrative violation if that person:

(1) fails to submit to the division [commission] a settlement or agreement of the parties;

(2) fails to timely notify the division [commission] of the termination or reduction of benefits and the reason for that action; or

(3) denies preauthorization in a manner that is not in accordance with rules adopted by the commissioner [commission]
under Section 413.014.

(b) A health care provider commits an administrative violation if that person:

(1) fails or refuses to timely file required reports or records; or

(2) fails to file with the division [commission] the annual disclosure statement required by Section 413.041.

(e) An insurance carrier or health care provider commits an administrative violation if that person violates this subtitle or a rule, order, or decision of the commissioner [commission].

(f) A subsequent administrative violation under this section, after prior notice to the insurance carrier or health care provider of noncompliance, is subject to penalties as provided by Section 415.021. Prior notice under this subsection is not required [if the violation was committed wilfully or intentionally, or if the violation was of a decision or order of the commissioner] [commission].

SECTION 3.269. Subsection (b), Section 415.005, Labor Code, is amended to read as follows:

(b) A violation under this section is an [Class B] administrative violation. A health care provider may be liable for an administrative penalty regardless of whether a criminal action is initiated under Section 413.043.

SECTION 3.270. Subsection (c), Section 415.006, Labor Code, is amended to read as follows:

(c) A person commits an administrative [a] violation if the person violates Subsection (a). [A violation under this subsection... ]
is a Class C administrative violation.]

SECTION 3.271. Subsection (a), Section 415.007, Labor Code, is amended to read as follows:

(a) An attorney who represents a claimant before the division [commission] may not lend money to the claimant during the pendency of the workers' compensation claim.

SECTION 3.272. Subsection (e), Section 415.008, Labor Code, is amended to read as follows:

(e) If an administrative violation proceeding is pending under this section against an employee or person claiming death benefits, the division [commission] may not take final action on the person's benefits.

SECTION 3.273. Subsection (a), Section 415.009, Labor Code, is amended to read as follows:

(a) A person commits a violation if the person [knowingly] brings, prosecutes, or defends an action for benefits under this subtitle or requests initiation of an administrative violation proceeding that does not have a basis in fact or is not warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law.

SECTION 3.274. Subsection (a), Section 415.010, Labor Code, is amended to read as follows:

(a) A party to an agreement approved by the division [commission] commits a violation if the person [knowingly] breaches a provision of the agreement.

SECTION 3.275. Section 415.021, Labor Code, is amended to read as follows:
Sec. 415.021. ASSESSMENT OF ADMINISTRATIVE PENALTIES.
(a) In addition to any other provisions in this subtitle relating to violations, a person commits an administrative violation if the person violates, fails to comply with, or refuses to comply with this subtitle or a rule, order, or decision of the commissioner. In addition to any sanctions, administrative penalty, or other remedy authorized by this subtitle, the commissioner [The commission] may assess an administrative penalty against a person who commits an administrative violation. The administrative penalty shall not exceed $25,000 per day per occurrence. Each day of noncompliance constitutes a separate violation. The commissioner's authority under this chapter is in addition to any other authority to enforce a sanction, penalty, fine, forfeiture, denial, suspension, or revocation otherwise authorized by law [Notwithstanding Subsection (c), the commission by rule shall adopt a schedule of specific monetary administrative penalties for specific violations under this subtitle].
(b) The commissioner [commission] may assess an administrative penalty not to exceed $10,000 and may enter a cease and desist order against a person who:
(1) commits repeated administrative violations;
(2) allows, as a business practice, the commission of repeated administrative violations; or
(3) violates an order or decision of the commissioner [commission].
(c) In assessing an administrative penalty:
(1) [1] the commissioner [commission] shall consider:
the seriousness of the violation, including the nature, circumstances, consequences, extent, and
gravity of the prohibited act;
(B) the history and extent of previous administrative violations;
(C) the demonstrated good faith of the violator, including actions taken to rectify the consequences of
the prohibited act;
(D) the economic benefit resulting from the prohibited act;
(E) other matters that justice may require; and
(2) the commissioner shall, to the extent reasonable,
consider the economic benefit resulting from the prohibited act.
(d) A penalty may be assessed only after the person charged with an administrative violation has been given an opportunity for
a hearing under Subchapter C.
SECTION 3.276. Subsection (b), Section 415.023, Labor Code,
is amended to read as follows:
(b) The commissioner may adopt rules providing
for:
(1) a reduction or denial of fees;
(2) public or private reprimand by the commissioner;
(3) suspension from practice before the division.
(4) restriction, suspension, or revocation of the right to receive reimbursement under this subtitle; or

(5) referral and petition to the appropriate licensing authority for appropriate disciplinary action, including the restriction, suspension, or revocation of the person's license.

SECTION 3.277. Section 415.024, Labor Code, is amended to read as follows:

Sec. 415.024. BREACH OF SETTLEMENT AGREEMENT; ADMINISTRATIVE VIOLATION. A material and substantial breach of a settlement agreement that establishes a compliance plan is an [Class A] administrative violation. In determining the amount of the penalty, the commissioner [commission] shall consider the total volume of claims handled by the insurance carrier.

SECTION 3.278. Subchapter B, Chapter 415, Labor Code, is amended by adding Section 415.025 to read as follows:

Sec. 415.025. REFERENCES TO A CLASS OF VIOLATION OR PENALTY. A reference in this code or other law, or in rules of the former Texas Workers' Compensation Commission or the commissioner, to a particular class of violation, administrative violation, or penalty shall be construed as a reference to an administrative penalty. Except as otherwise provided by this subtitle, an administrative penalty may not exceed $25,000 per day per occurrence. Each day of noncompliance constitutes a separate violation.

SECTION 3.279. Section 415.031, Labor Code, is amended to read as follows:
Sec. 415.031. INITIATION OF ADMINISTRATIVE VIOLATION PROCEEDINGS. Any person may request the initiation of administrative violation proceedings by filing a written allegation with the division of compliance and practices.

SECTION 3.280. Section 415.032, Labor Code, is amended to read as follows:

Sec. 415.032. NOTICE OF POSSIBLE ADMINISTRATIVE VIOLATION; RESPONSE. (a) If investigation by the division indicates that an administrative violation has occurred, the division shall notify the person alleged to have committed the violation in writing of:

(1) the charge;
(2) the proposed penalty;
(3) the right to consent to the charge and the penalty; and
(4) the right to request a hearing.

(b) Not later than the 20th day after the date on which notice is received, the charged party shall:

(1) remit the amount of the penalty to the division; or
(2) submit to the division a written request for a hearing.

SECTION 3.281. Section 415.033, Labor Code, is amended to read as follows:

Sec. 415.033. FAILURE TO RESPOND. If, without good cause, a charged party fails to respond as required under Section 415.032,
the penalty is due and the division [commission] shall initiate
enforcement proceedings.

SECTION 3.282. Subsection (a), Section 415.034, Labor Code,
is amended to read as follows:

(a) On the request of the charged party or the commissioner
[executive director], the State Office of Administrative Hearings
shall set a hearing. The hearing shall be conducted in the manner
provided for a contested case under Chapter 2001, Government Code
(the administrative procedure law).

SECTION 3.283. Subsections (b) and (d), Section 415.035,
Labor Code, are amended to read as follows:

(b) If an administrative penalty is assessed, the person
charged shall:

(1) forward the amount of the penalty to the division
[executive director] for deposit in an escrow account; or

(2) post with the division [executive director] a bond
for the amount of the penalty, effective until all judicial review
of the determination is final.

(d) If the court determines that the penalty should not have
been assessed or reduces the amount of the penalty, the division
[executive director] shall:

(1) remit the appropriate amount, plus accrued
interest, if the administrative penalty was paid; or

(2) release the bond.

SECTION 3.284. Section 416.001, Labor Code, is amended to
read as follows:

Sec. 416.001. CERTAIN CAUSES OF ACTION PRECLUDED. An
action taken by an insurance carrier under an order of the
commissioner or recommendations of a benefit review
officer under Section 410.031, 410.032, or 410.033 may not be the
basis of a cause of action against the insurance carrier for a
breach of the duty of good faith and fair dealing.

SECTION 3.285. Subsections (c) and (d), Section 417.001, Labor Code, are amended to read as follows:

(c) If a claimant receives benefits from the subsequent injury fund, the division is:

1. considered to be the insurance carrier under this section for purposes of those benefits;
2. subrogated to the rights of the claimant; and
3. entitled to reimbursement in the same manner as the insurance carrier.

(d) The division shall remit money recovered under this section to the comptroller for deposit to the credit of the subsequent injury fund.

SECTION 3.286. Subsection (b), Section 417.003, Labor Code, is amended to read as follows:

(b) An attorney who represents the claimant and is also to represent the subrogated insurance carrier shall make a full written disclosure to the claimant before employment as an attorney by the insurance carrier. The claimant must acknowledge the disclosure and consent to the representation. A signed copy of the disclosure shall be furnished to all concerned parties and made a part of the division file. A copy of the disclosure with the claimant's consent shall be filed with the claimant's
pleading before a judgment is entered and approved by the court. The claimant's attorney may not receive a fee under this section to which the attorney is otherwise entitled under an agreement with the insurance carrier unless the attorney complies with the requirements of this subsection.

SECTION 3.287. Subtitle A, Title 5, Labor Code, is amended by adding Chapter 419 to read as follows:

CHAPTER 419. MISUSE OF DIVISION NAME

Sec. 419.001. DEFINITIONS. (a) In this chapter:

(1) "Representation of the division's logo" includes a nonexact representation that is deceptively similar to the logo used by the division.

(2) "Representation of the state seal" has the meaning assigned by Section 17.08(a)(2), Business & Commerce Code.

(b) A term or representation is "deceptively similar" for purposes of this chapter if:

(1) a reasonable person would believe that the term or representation is in any manner approved, endorsed, sponsored, authorized by, the same as, or associated with the division, the department, this state, or an agency of this state; or

(2) the circumstances under which the term is used could mislead a reasonable person as to its identity.

Sec. 419.002. MISUSE OF DIVISION'S NAME OR SYMBOLS PROHIBITED. (a) Except as authorized by law, a person, in connection with any impersonation, advertisement, solicitation, business name, business activity, document, product, or service made or offered by the person regarding workers' compensation
coverage or benefits, may not knowingly use or cause to be used:

(1) the words "Texas Department of Insurance,"
"Department of Insurance," "Texas Workers' Compensation," or
"division of workers' compensation";

(2) any term using both "Texas" and "Workers' Compensation" or any term using both "Texas" and "Workers' Comp";

(3) the initials "T.D.I."; or

(4) any combination or variation of the words or initials, or any term deceptively similar to the words or initials,
described by Subdivisions (1)-(3).

(b) A person subject to Subsection (a) may not knowingly use
or cause to be used a word, term, or initials described by
Subsection (a) alone or in conjunction with:

(1) the state seal or a representation of the state seal;

(2) a picture or map of this state; or

(3) the official logo of the department or the division or a representation of the department's or division's logo.

Sec. 419.003. RULES. The commissioner may adopt rules
relating to the regulation of the use of the division's name and
other rules as necessary to implement this chapter.

Sec. 419.004. CIVIL PENALTY. (a) A person who violates
Section 419.002 or a rule adopted under this chapter is liable for a
civil penalty not to exceed $5,000 for each violation.

(b) The attorney general, at the request of the commissioner, shall bring an action to collect a civil penalty
under this section in a district court in Travis County.

Sec. 419.005. ADMINISTRATIVE PENALTY. (a) The division may assess an administrative penalty against a person who violates Section 419.002 or a rule adopted under this chapter.

(b) An administrative penalty imposed under this section is subject to the procedural requirements adopted for administrative penalties imposed under Section 415.021.

Sec. 419.006. INJUNCTIVE RELIEF. (a) At the request of the commissioner, the attorney general or a district attorney may bring an action in district court in Travis County to enjoin or restrain a violation or threatened violation of this chapter on a showing that a violation has occurred or is likely to occur.

(b) The division may recover the costs of investigating an alleged violation of this chapter if an injunction is issued.

Sec. 419.007. REMEDIES NOT EXCLUSIVE. The remedies provided by this chapter are not exclusive and may be sought in any combination determined by the commissioner as necessary to enforce this chapter.

SECTION 3.288. Subdivisions (1) and (5), Section 501.001, Labor Code, are amended to read as follows:

(1) "Division" ["Commission"] means the division of workers' compensation of the Texas Department of Insurance [Workers' Compensation Commission].

(5) "Employee" means a person who is:

(A) in the service of the state pursuant to an election, appointment, or express oral or written contract of hire;

(B) paid from state funds but whose duties
require that the person work and frequently receive supervision in
a political subdivision of the state;
(C) a peace officer employed by a political
subdivision, while the peace officer is exercising authority
granted under:
   (i) Article 2.12, Code of Criminal
    Procedure; or
   (ii) Articles 14.03(d) and (g), Code of
    Criminal Procedure;
(D) a member of the state military forces, as
defined by Section 431.001, Government Code, who is engaged in
authorized training or duty; or
(E) a Texas Task Force 1 member, as defined by
Section 88.301, Education Code, who is activated by the governor's
division of emergency management or is injured during any training
session sponsored or sanctioned by Texas Task Force 1.

SECTION 3.289. Subsection (a), Section 501.002, Labor Code,
is amended to read as follows:
(a) The following provisions of Subtitles A and B apply to
and are included in this chapter except to the extent that they are
inconsistent with this chapter:
   (1) Chapter 401, other than Section 401.012 defining
    "employee";
   (2) Chapter 402;
   (3) Chapter 403, other than Sections 403.001-403.005;
   (4) Chapters 404 and [Chapter] 405;
   (5) Subchapters B and D through H, Chapter 406, other
than Sections 406.071(a), 406.073, and 406.075;
(6) Chapter 408, other than Sections 408.001(b) and (c);
(7) Chapters 409 and 410;
(8) Subchapters A and G, Chapter 411, other than Sections 411.003 and 411.004;
(9) Chapters 412-417; and
(10) Chapter 451.

SECTION 3.290. Subsection (d), Section 501.026, Labor Code, is amended to read as follows:
(d) A person entitled to benefits under this section may receive the benefits only if the person seeks medical attention from a doctor for the injury not later than 48 hours after the occurrence of the injury or after the date the person knew or should have known the injury occurred. The person shall comply with the requirements of Section 409.001 by providing notice of the injury to the division [commission] or the state agency with which the officer or employee under Subsection (b) is associated.

SECTION 3.291. Subsection (a), Section 501.050, Labor Code, is amended to read as follows:
(a) In each case appealed from the division [commission] to a county or district court:
(1) the clerk of the court shall mail to the division [commission]:
(A) not later than the 20th day after the date the case is filed, a notice containing the style, number, and date of filing of the case; and
(B) not later than the 20th day after the date the
judgment is rendered, a certified copy of the judgment; and
(2) the attorney preparing the judgment shall file the
original and a copy of the judgment with the clerk.

SECTION 3.292. The heading to Chapter 502, Labor Code, is
amended to read as follows:

CHAPTER 502. WORKERS' COMPENSATION INSURANCE COVERAGE FOR
EMPLOYEES OF THE TEXAS A&M UNIVERSITY SYSTEM

AND EMPLOYEES OF INSTITUTIONS OF THE TEXAS A&M UNIVERSITY SYSTEM

SECTION 3.293. Subdivision (1), Section 502.001, Labor
Code, is amended to read as follows:

(1) "Division" means the division of workers'
compensation of the Texas Department of Insurance ["Commission"
means the Texas Workers' Compensation Commission].

SECTION 3.294. Subsections (a) and (b), Section 502.002,
Labor Code, are amended to read as follows:

(a) The following provisions of Subtitle A apply to and are
included in this chapter except to the extent that they are
inconsistent with this chapter:

(1) Chapter 401, other than Section 401.012 defining
"employee";

(2) Chapter 402;

(3) Chapter 403, other than Sections 403.001-403.005;

(4) Chapters 404 and [Chapter] 405;

(5) Sections 406.031-406.033; Subchapter D, Chapter
406; Sections 406.092 and 406.093;

(6) Chapter 408, other than Sections 408.001(b) and
Chapters 409 and 410;
(8) Subchapters A and G, Chapter 411, other than Sections 411.003 and 411.004; and
(9) Chapters 412-417.

(b) For the purpose of applying the provisions listed by Subsection (a) to this chapter, "employer" means "the institution," and "system" means the insurance carrier under Section 502.022. [""

SECTION 3.295. Subsection (a), Section 502.021, Labor Code, is amended to read as follows:
(a) The system [institution] shall pay benefits as provided by this chapter to an employee with a compensable injury.

SECTION 3.296. Section 502.041, Labor Code, is amended to read as follows:
Sec. 502.041. EXHAUSTION OF ANNUAL AND SICK LEAVE. (a) An employee may elect to use accrued sick leave before receiving income benefits. If an employee elects to use sick leave, the employee is not entitled to income benefits under this chapter until the employee has exhausted the employee's accrued sick leave [institution may provide that an injured employee may remain on the payroll until the employee's earned annual and sick leave is exhausted].

(b) An employee may elect to use all or any number of weeks of accrued annual leave after the employee's accrued sick leave is exhausted. If an employee elects to use annual leave, the employee is not entitled to income benefits under this chapter until the elected number of weeks of leave have been exhausted [While an
injured employee remains on the payroll under Subsection (a), medical services remain available to the employee, but workers' compensation benefits do not accrue or become payable to the injured employee).

SECTION 3.297. Subsections (a) and (c), Section 502.061, Labor Code, are amended to read as follows: (a) The system [Each institution] shall administer this chapter.

(c) The system [institution] may:

(1) adopt and publish rules and prescribe and furnish forms necessary for the administration of this chapter; and

(2) adopt and enforce rules necessary for the prevention of accidents and injuries.

SECTION 3.298. Section 502.063, Labor Code, is amended to read as follows:

Sec. 502.063. CERTIFIED COPIES OF DIVISION [COMMISSION] DOCUMENTS. (a) The division [commission] shall furnish a certified copy of an order, award, decision, or paper on file in the division's [commission's] office to a person entitled to the copy on written request and payment of the fee for the copy. The fee is the same as that charged for similar services by the secretary of state's office.

(b) The system or an [An] institution may obtain certified copies under this section without charge.

(c) A fee or salary may not be paid to an [a member or] employee of the division [commission] for making a copy under Subsection (a) that exceeds the fee charged for the copy.
SECTION 3.299. Subsection (a), Section 502.065, Labor Code, is amended to read as follows:

(a) In addition to a report of an injury filed with the division [commission] under Section 409.005(a), an institution shall file a supplemental report that contains:

(1) the name, age, sex, and occupation of the injured employee;
(2) the character of work in which the employee was engaged at the time of the injury;
(3) the place, date, and hour of the injury; and
(4) the nature and cause of the injury.

SECTION 3.300. Subsections (a), (b), (d), and (e), Section 502.066, Labor Code, are amended to read as follows:

(a) The division [commission] may require an employee who claims to have been injured to submit to an examination by the division [commission] or a person acting under the division's [commission's] authority at a reasonable time and place in this state.

(b) On the request of an employee or the system [institution], the employee, [or] the institution, or the system is entitled to have a physician or chiropractor selected by the employee, [or] the institution, or the system, as appropriate, present to participate in an examination under Subsection (a) or Section 408.004.

(d) The system or the institution may have an injured employee examined at a reasonable time and at a place suitable to the employee's condition and convenient and accessible to the
employee by a physician or chiropractor selected by the system or the institution. The system or the institution shall pay for an examination under this subsection and for the employee's reasonable expenses incident to the examination. The employee is entitled to have a physician or chiropractor selected by the employee present to participate in an examination under this subsection.

(e) The system or the institution shall pay the fee set by the division for the services of a physician or chiropractor selected by the employee under Subsection (b) or (d).

SECTION 3.301. Subsection (a), Section 502.067, Labor Code, is amended to read as follows:

(a) The commissioner of workers' compensation may order or direct the system or the institution to reduce or suspend the compensation of an injured employee who:

(1) persists in insanitary or injurious practices that tend to imperil or retard the employee's recovery; or

(2) refuses to submit to medical, surgical, chiropractic, or other remedial treatment recognized by the state that is reasonably essential to promote the employee's recovery.

SECTION 3.302. Section 502.068, Labor Code, is amended to read as follows:

Sec. 502.068. POSTPONEMENT OF HEARING. If an injured employee is receiving benefits under this chapter and the system or the institution is providing hospitalization, medical treatment, or chiropractic care to the employee, the division may postpone the hearing on the employee's claim. An appeal may not be taken from a division order under this section.
SECTION 3.303. Subsection (a), Section 502.069, Labor Code, is amended to read as follows:

(a) In each case appealed from the division [commission] to a county or district court:

(1) the clerk of the court shall mail to the division [commission]:

(A) not later than the 20th day after the date the case is filed, a notice containing the style, number, and date of filing of the case; and

(B) not later than the 20th day after the date the judgment is rendered, a certified copy of the judgment; and

(2) the attorney preparing the judgment shall file the original and a copy of the judgment with the clerk.

SECTION 3.304. The heading to Chapter 503, Labor Code, is amended to read as follows:

CHAPTER 503. WORKERS' COMPENSATION INSURANCE COVERAGE FOR EMPLOYEES OF THE UNIVERSITY OF TEXAS SYSTEM AND EMPLOYEES OF INSTITUTIONS OF THE UNIVERSITY OF TEXAS SYSTEM

SECTION 3.305. Section 503.001, Labor Code, is amended by amending Subdivision (1) and by adding Subdivision (1-a) to read as follows:

(1) "Commissioner" means the commissioner of workers' compensation ["Commission" means the Texas Workers' Compensation Commission].

(1-a) "Division" means the division of workers' compensation of the Texas Department of Insurance.

SECTION 3.306. Subsections (a) and (b), Section 503.002,
Labor Code, are amended to read as follows:

(a) The following provisions of Subtitle A apply to and are included in this chapter except to the extent that they are inconsistent with this chapter:

(1) Chapter 401, other than Section 401.012 defining "employee";
(2) Chapter 402;
(3) Chapter 403, other than Sections 403.001-403.005;
(4) Chapters 404 and 405;
(5) Sections 406.031-406.033; Subchapter D, Chapter 406; Sections 406.092 and 406.093;
(6) Chapter 408, other than Sections 408.001(b) and (c);
(7) Chapters 409 and 410;
(8) Subchapters A and G, Chapter 411, other than Sections 411.003 and 411.004; and
(9) Chapters 412-417.

(b) For the purpose of applying the provisions listed by Subsection (a) to this chapter, "employer" means "the institution," and "system" means the insurance carrier under Section 503.022.[""

SECTION 3.307. Subsection (a), Section 503.021, Labor Code, is amended to read as follows:

(a) The system [institution] shall pay benefits as provided by this chapter to an employee with a compensable injury.

SECTION 3.308. Section 503.022, Labor Code, is amended to read as follows:

Sec. 503.022. AUTHORITY TO SELF-INSURE. An institution may
self-insure as part of a system insurance plan.

SECTION 3.309. Section 503.041, Labor Code, is amended to read as follows:

Sec. 503.041. EXHAUSTION OF ANNUAL AND SICK LEAVE. (a) An employee may elect to use accrued sick leave before receiving income benefits. If an employee elects to use sick leave, the employee is not entitled to income benefits under this chapter until the employee has exhausted the employee's accrued sick leave [An institution may provide that an injured employee may remain on the payroll until the employee's earned annual and sick leave is exhausted].

(b) An employee may elect to use all or any number of weeks of accrued annual leave after the employee's accrued sick leave is exhausted. If an employee elects to use annual leave, the employee is not entitled to income benefits under this chapter until the elected number of weeks of leave have been exhausted [While an injured employee remains on the payroll under Subsection (a), the employee is entitled to medical benefits but income benefits do not accrue].

SECTION 3.310. Subsections (a) and (c), Section 503.061, Labor Code, are amended to read as follows:

(a) The system [Each institution] shall administer this chapter.

(c) The system [institution] may:

(1) adopt and publish rules and prescribe and furnish forms necessary for the administration of this chapter; and

(2) adopt and enforce rules necessary for the
prevention of accidents and injuries.

SECTION 3.311. Section 503.063, Labor Code, is amended to read as follows:

Sec. 503.063. CERTIFIED COPIES OF DIVISION [COMMISSION] DOCUMENTS. (a) The division [commission] shall furnish a certified copy of an order, award, decision, or paper on file in the division's [commission's] office to a person entitled to the copy on written request and payment of the fee for the copy. The fee is the same as that charged for similar services by the secretary of state's office.

(b) The system or the institution may obtain certified copies under this section without charge.

(c) A fee or salary may not be paid to an [a member or] employee of the division [commission] for making a copy under Subsection (a) that exceeds the fee charged for the copy.

SECTION 3.312. Subsection (a), Section 503.065, Labor Code, is amended to read as follows:

(a) In addition to a report of an injury filed with the division [commission] under Section 409.005(a), an institution shall file a supplemental report that contains:

(1) the name, age, sex, and occupation of the injured employee;

(2) the character of work in which the employee was engaged at the time of the injury;

(3) the place, date, and hour of the injury; and

(4) the nature and cause of the injury.

SECTION 3.313. Subsections (a), (b), (d), and (e), Section
503.066, Labor Code, are amended to read as follows:

(a) The division [commission] may require an employee who claims to have been injured to submit to an examination by the division [commission] or a person acting under the division's [commission's] authority at a reasonable time and place in this state.

(b) On the request of an employee, the system, or the institution, the employee, the system, or the institution is entitled to have a physician selected by the employee, the system, or the institution, as appropriate, present to participate in an examination under Subsection (a) or Section 408.004.

(d) The system or the institution may have an injured employee examined at a reasonable time and at a place suitable to the employee's condition and convenient and accessible to the employee by a physician selected by the system or the institution. The system or the institution shall pay for an examination under this subsection and for the employee's reasonable expenses incident to the examination. The employee is entitled to have a physician selected by the employee present to participate in an examination under this subsection.

(e) The system or the institution shall pay the fee, as set by the division [commission], of a physician selected by the employee under Subsection (b) or (d).

SECTION 3.314. Subsection (a), Section 503.067, Labor Code, is amended to read as follows:

(a) The commissioner [commission] may order or direct the system or the institution to reduce or suspend the compensation of
an injured employee who:

(1) persists in insanitary or injurious practices that
tend to imperil or retard the employee's recovery; or

(2) refuses to submit to medical, surgical, or other
remedial treatment recognized by the state that is reasonably
essential to promote the employee's recovery.

SECTION 3.315. Section 503.068, Labor Code, is amended to
read as follows:

Sec. 503.068. POSTPONEMENT OF HEARING. If an injured
employee is receiving benefits under this chapter and the system or
the institution is providing hospitalization or medical treatment
to the employee, the division [commission] may postpone the hearing
on the employee’s claim. An appeal may not be taken from a
commissioner [commission] order under this section.

SECTION 3.316. Subsection (a), Section 503.069, Labor Code,
is amended to read as follows:

(a) In each case appealed from the division [commission] to
a county or district court:

(1) the clerk of the court shall mail to the division
[commission]:

(A) not later than the 20th day after the date the
case is filed, a notice containing the style, number, and date of
filing of the case; and

(B) not later than the 20th day after the date the
judgment is rendered, a certified copy of the judgment; and

(2) the attorney preparing the judgment shall file the
original and a copy of the judgment with the clerk.
SECTION 3.317. Subsection (a), Section 503.070, Labor Code, is amended to read as follows:

(a) A party who does not consent to abide by the final decision of the commissioner shall file notice with the division as required by Section 410.253 and bring suit in the county in which the injury occurred to set aside the final decision of the commissioner.

SECTION 3.318. Section 504.001, Labor Code, is amended by amending Subdivision (1) and adding Subdivision (4) to read as follows:

(1) "Division" means the division of workers' compensation of the Texas Department of Insurance ["Commission" means the Texas Workers' Compensation Commission].

(4) "Pool" means two or more political subdivisions collectively self-insuring under an interlocal contract under Chapter 791, Government Code.

SECTION 3.319. Subsection (a), Section 504.002, Labor Code, is amended to read as follows:

(a) The following provisions of Subtitles A and B apply to and are included in this chapter except to the extent that they are inconsistent with this chapter:

(1) Chapter 401, other than Section 401.011(18) defining "employer" and Section 401.012 defining "employee";

(2) Chapter 402;

(3) Chapter 403, other than Sections 403.001-403.005;

(4) Chapters 404 and 405;

(5) Sections 406.006-406.009 and Subchapters B and
D-G, Chapter 406, other than Sections 406.033, 406.034, 406.035, 406.091, and 406.096;

(6) Chapter 408, other than Sections 408.001(b) and (c);

(7) Chapters 409-412; and

(8) Chapter 413, except as provided by Section 504.053;

(9) Chapters 414-417; and

(10) Chapter 451.

SECTION 3.320. The heading to Section 504.018, Labor Code, is amended to read as follows:

Sec. 504.018. NOTICE TO DIVISION [COMMISSION] AND EMPLOYEES; EFFECT ON COMMON-LAW OR STATUTORY LIABILITY.

SECTION 3.321. Subsection (a), Section 504.018, Labor Code, is amended to read as follows:

(a) A political subdivision shall notify the division [commission] of the method by which its employees will receive benefits, the approximate number of employees covered, and the estimated amount of payroll.

SECTION 3.322. Subchapter C, Chapter 504, Labor Code, is amended by adding Section 504.053 to read as follows:

Sec. 504.053. ELECTION. (a) A political subdivision that self-insures either individually or collectively shall provide workers' compensation medical benefits to the injured employees of the political subdivision through a workers' compensation health care network certified under Chapter 1305, Insurance Code, if the governing body of the political subdivision determines that
provision of those benefits through a network is available to the employees and practical for the political subdivision. A political subdivision may enter into interlocal agreements and other agreements with other political subdivisions to establish or contract with networks under this section.

(b) If a political subdivision or a pool determines that a workers' compensation health care network certified under Chapter 1305, Insurance Code, is not available or practical for the political subdivision or pool, the political subdivision or pool may provide medical benefits to its injured employees or to the injured employees of the members of the pool:

(1) in the manner provided by Chapter 408, other than Sections 408.001(b) and (c) and Section 408.002, and by Subchapters B and C, Chapter 413; or

(2) by directly contracting with health care providers or by contracting through a health benefits pool established under Chapter 172, Local Government Code.

(c) If the political subdivision or pool provides medical benefits in the manner authorized under Subsection (b)(2), the following do not apply:

(1) Sections 408.004 and 408.0041, unless use of a required medical examination or designated doctor is necessary to resolve an issue relating to the entitlement to or amount of income benefits under this title;

(2) Subchapter B, Chapter 408, except for Section 408.021;

(3) Chapter 413, except for Section 413.042; and

(d) If the political subdivision or pool provides medical benefits in the manner authorized under Subsection (b)(2), the following standards apply:

(1) the political subdivision or pool must ensure that workers' compensation medical benefits are reasonably available to all injured workers of the political subdivision or the injured workers of the members of the pool within a designed service area;

(2) the political subdivision or pool must ensure that all necessary health care services are provided in a manner that will ensure the availability of and accessibility to adequate health care providers, specialty care, and facilities;

(3) the political subdivision or pool must have an internal review process for resolving complaints relating to the manner of providing medical benefits, including an appeal to the governing body or its designee and appeal to an independent review organization;

(4) the political subdivision or pool must establish reasonable procedures for the transition of injured workers to contract providers and for the continuity of treatment, including notice of impending termination of providers and a current list of contract providers;

(5) the political subdivision or pool shall provide for emergency care if an injured worker cannot reasonably reach a contract provider and the care is for medical screening or other evaluation that is necessary to determine whether a medical
emergency condition exists, necessary emergency care services
including treatment and stabilization, and services originating in
a hospital emergency facility following treatment or stabilization
of an emergency medical condition;

(6) prospective or concurrent review of the medical
necessity and appropriateness of health care services must comply
with Article 21.58A, Insurance Code;

(7) the political subdivision or pool shall continue
to report data to the appropriate agency as required by Title 5 of
this code and Chapter 1305, Insurance Code; and

(8) a political subdivision or pool is subject to the
requirements under Sections 1305.501, 1305.502, and 1305.503,
Insurance Code.

(e) Nothing in this chapter waives sovereign immunity or
creates a new cause of action.

SECTION 3.323. Subsection (a), Section 505.002, Labor Code,
is amended to read as follows:

(a) The following provisions of Subtitles A and B apply to
and are included in this chapter except to the extent that they are
inconsistent with this chapter:

(1) Chapter 401, other than Section 401.012, defining
"employee";

(2) Chapter 402;

(3) Chapter 403, other than Sections 403.001-403.005;

(4) Chapters 404 and [Chapter] 405;

(5) Subchapters B, D, E, and H, Chapter 406, other than
Sections 406.071-406.073, and 406.075;
(6) Chapter 408, other than Sections 408.001(b) and (c);
(7) Chapters 409 and 410;
(8) Subchapters A and G, Chapter 411, other than Sections 411.003 and 411.004;
(9) Chapters 412-417; and
(10) Chapter 451.

SECTION 3.324. The heading to Section 505.053, Labor Code, is amended to read as follows:

Sec. 505.053. CERTIFIED COPIES OF DOCUMENTS.

SECTION 3.325. Subsections (a) and (c), Section 505.053, Labor Code, are amended to read as follows:

(a) The division of workers' compensation shall furnish a certified copy of an order, award, decision, or paper on file with the division to a person entitled to the copy on written request and payment of the fee for the copy. The fee shall be the same as that charged for similar services by the secretary of state's office.

(c) A fee or salary may not be paid to an employee of the division for making the copies that exceeds the fee charged for the copies.

SECTION 3.326. Subsection (d), Section 505.054, Labor Code, is amended to read as follows:

(d) A physician designated under Subsection (c) who conducts an examination shall file with the department a complete transcript of the examination on a form furnished by the
The department shall maintain all reports under this subsection as part of the department's permanent records. A report under this subsection is admissible in evidence before the division of workers' compensation and in an appeal from a final award or ruling of the commissioner of workers' compensation in which the individual named in the examination is a claimant for compensation under this chapter. A report under this subsection that is admitted is prima facie evidence of the facts stated in the report.

SECTION 3.327. Section 505.055, Labor Code, is amended to read as follows:

Sec. 505.055. REPORTS OF INJURIES. (a) A report of an injury filed with the division of workers' compensation under Section 409.005, in addition to the information required by the commissioner of workers' compensation rules, must contain:

(1) the name, age, sex, and occupation of the injured employee;

(2) the character of work in which the employee was engaged at the time of the injury;

(3) the place, date, and hour of the injury; and

(4) the nature and cause of the injury.

(b) In addition to subsequent reports of an injury filed with the division of workers' compensation under Section 409.005(e), the department shall file a subsequent report on a form obtained for that purpose:

(1) on the termination of incapacity of the injured employee;
employee; or

(2) if the incapacity extends beyond 60 days.

SECTION 3.328. Subsections (a) and (d), Section 505.056, Labor Code, are amended to read as follows:

(a) The division of workers' compensation [commission] may require an employee who claims to have been injured to submit to an examination by the division [commission] or a person acting under the division's [commission's] authority at a reasonable time and place in this state.

(d) On the request of an employee or the department, the employee or the department is entitled to have a physician selected by the employee or the department present to participate in an examination under Subsection (a) or Section 408.004. The employee is entitled to have a physician selected by the employee present to participate in an examination under Subsection (c). The department shall pay the fee set by the commissioner of workers' compensation [commission] of a physician selected by the employee under this subsection.

SECTION 3.329. Subsection (a), Section 505.057, Labor Code, is amended to read as follows:

(a) The commissioner of workers' compensation [commission] may order or direct the department to reduce or suspend the compensation of an injured employee if the employee:

(1) persists in insanitary or injurious practices that tend to imperil or retard the employee's recovery; or

(2) refuses to submit to medical, surgical, or other remedial treatment recognized by the state that is reasonably
essential to promote the employee's recovery.

SECTION 3.330. Section 505.058, Labor Code, is amended to read as follows:

Sec. 505.058. POSTPONEMENT OF HEARING. If an injured employee is receiving benefits under this chapter and the department is providing hospitalization or medical treatment to the employee, the division of workers' compensation [commission] may postpone the hearing of the employee's claim. An appeal may not be taken from an [a commission] order of the commissioner of workers' compensation under this section.

SECTION 3.331. Subsection (a), Section 505.059, Labor Code, is amended to read as follows:

(a) In each case appealed from the division of workers' compensation [commission] to a county or district court:

(1) the clerk of the court shall mail to the division [commission]:

(A) not later than the 20th day after the date the case is filed, a notice containing the style, number, and date of filing of the case; and

(B) not later than the 20th day after the date the judgment is rendered, a certified copy of the judgment; and

(2) the attorney preparing the judgment shall file the original and a copy of the judgment with the clerk.

ARTICLE 4. PROVISION OF WORKERS' COMPENSATION MEDICAL BENEFITS THROUGH WORKERS' COMPENSATION HEALTH CARE NETWORKS

SECTION 4.01. The heading to Subtitle D, Title 8, Insurance Code, is amended to read as follows:
SUBTITLE D. [PREFERRED] PROVIDER [BENEFIT] PLANS

SECTION 4.02. Subtitle D, Title 8, Insurance Code, is amended by adding Chapter 1305 to read as follows:

CHAPTER 1305. WORKERS' COMPENSATION HEALTH CARE NETWORKS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1305.001. SHORT TITLE. This chapter may be cited as the Workers' Compensation Health Care Network Act.

Sec. 1305.002. PURPOSE. The purpose of this chapter is to:

(1) authorize the establishment of workers' compensation health care networks for the provision of workers' compensation medical benefits; and

(2) provide standards for the certification, administration, evaluation, and enforcement of the delivery of health care services to injured employees by networks contracting with or established by:

(A) workers' compensation insurance carriers;

(B) employers certified to self-insure under Chapter 407, Labor Code;

(C) groups of employers certified to self-insure under Chapter 407A, Labor Code; and

(D) governmental entities that self-insure, either individually or collectively.

Sec. 1305.003. LIMITATIONS ON APPLICABILITY. (a) This chapter does not affect the authority of the division of workers' compensation of the department to exercise the powers granted to the division under Title 5, Labor Code, that do not conflict with this chapter.

272
In the event of a conflict between Title 5, Labor Code, and this chapter as to the provision of medical benefits for injured employees, the establishment and regulation of fees for medical treatments and services, the time frames for payment of medical bills, the operation and regulation of workers' compensation health care networks, the regulation of health care providers who contract with those networks, or the resolution of disputes regarding medical benefits provided through those networks, this chapter prevails.

Sec. 1305.004. DEFINITIONS. (a) In this chapter, unless the context clearly indicates otherwise:

(1) "Adverse determination" means a determination, made through utilization review or retrospective review, that the health care services furnished or proposed to be furnished to an employee are not medically necessary or appropriate.

(2) "Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls or is controlled by, or is under common control with, the person specified.

(3) "Capitation" means a method of compensation for arranging for or providing health care services to employees for a specified period that is based on a predetermined payment for each employee for the specified period, without regard to the quantity of services provided for the compensable injury.

(4) "Complainant" means a person who files a complaint under this chapter. The term includes:

(A) an employee;
(B) an employer;
(C) a health care provider; and
(D) another person designated to act on behalf of an employee.

(5) "Complaint" means any dissatisfaction expressed orally or in writing by a complainant to a network regarding any aspect of the network's operation. The term includes dissatisfaction relating to medical fee disputes and the network's administration and the manner in which a service is provided. The term does not include:
   (A) a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the complainant; or
   (B) an oral or written expression of dissatisfaction or disagreement with an adverse determination.

(6) "Credentialing" means the review, under nationally recognized standards to the extent that those standards do not conflict with other laws of this state, of qualifications and other relevant information relating to a health care provider who seeks a contract with a network.

(7) "Emergency" means either a medical or mental health emergency.

(8) "Employee" has the meaning assigned by Section 401.012, Labor Code.

(9) "Fee dispute" means a dispute over the amount of payment due for health care services determined to be medically
necessary and appropriate for treatment of a compensable injury.

(10) "Independent review" means a system for final
administrative review by an independent review organization of the
medical necessity and appropriateness of health care services being
provided, proposed to be provided, or that have been provided to an
employee.

(11) "Independent review organization" means an
entity that is certified by the commissioner to conduct independent
review under Article 21.58C and rules adopted by the commissioner.

(12) "Life-threatening" has the meaning assigned by
Section 2, Article 21.58A.

(13) "Medical emergency" means the sudden onset of a
medical condition manifested by acute symptoms of sufficient
severity, including severe pain, that the absence of immediate
medical attention could reasonably be expected to result in:

(A) placing the patient's health or bodily
functions in serious jeopardy; or

(B) serious dysfunction of any body organ or
part.

(14) "Medical records" means the history of diagnosis
and treatment for an injury, including medical, dental, and other
health care records from each health care practitioner who provides
care to an injured employee.

(15) "Mental health emergency" means a condition that
could reasonably be expected to present danger to the person
experiencing the mental health condition or another person.

(16) "Network" or "workers' compensation health care
network" means an organization that is:

(A) formed as a health care provider network to
provide health care services to injured employees;

(B) certified in accordance with this chapter and
commissioner rules; and

(C) established by, or operates under contract
with, an insurance carrier.

(17) "Nurse" has the meaning assigned by Section 2,
Article 21.58A.

(18) "Person" means any natural or artificial person,
including an individual, partnership, association, corporation,
organization, trust, hospital district, community mental health
center, mental retardation center, mental health and mental
retardation center, limited liability company, or limited
liability partnership.

(19) "Preauthorization" means the process required to
request approval from the insurance carrier or the network to
provide a specific treatment or service before the treatment or
service is provided.

(20) "Quality improvement program" means a system
designed to continuously examine, monitor, and revise processes and
systems that support and improve administrative and clinical
functions.

(21) "Retrospective review" means the process of
reviewing the medical necessity and reasonableness of health care
that has been provided to an injured employee.

(22) "Rural area" means:
(A) a county with a population of 50,000 or less;
(B) an area that is not designated as an urbanized area by the United States Census Bureau; or
(C) any other area designated as rural under rules adopted by the commissioner.

(23) "Screening criteria" means the written policies, medical protocols, and treatment guidelines used by an insurance carrier or a network as part of utilization review or retrospective review.

(24) "Service area" means a geographic area within which health care services from network providers are available and accessible to employees who live within that geographic area.

(25) "Texas Workers' Compensation Act" means Subtitle A, Title 5, Labor Code.

(26) "Transfer of risk" means, for purposes of this chapter only, an insurance carrier's transfer of financial risk for the provision of health care services to a network through capitation or other means.

(27) "Utilization review" has the meaning assigned by Section 2, Article 21.58A.

(28) "Utilization review agent" has the meaning assigned by Article 21.58A.

(29) "Utilization review plan" means the screening criteria and utilization review procedures of an insurance carrier, a workers' compensation health care network, or a utilization review agent.

(b) In this chapter, the following terms have the meanings
assigned by Section 401.011, Labor Code:

(1) "compensable injury";

(2) "doctor";

(3) "employer";

(4) "health care";

(5) "health care facility";

(6) "health care practitioner";

(7) "health care provider";

(8) "injury";

(9) "insurance carrier"; and

(10) "treating doctor."

Sec. 1305.005. PARTICIPATION IN NETWORK; NOTICE OF NETWORK REQUIREMENTS. (a) An employer that elects to provide workers' compensation insurance coverage under the Texas Workers' Compensation Act may receive workers' compensation health care services for the employer's injured employees through a workers' compensation health care network.

(b) An insurance carrier may establish or contract with networks certified under this chapter to provide health care services under the Texas Workers' Compensation Act. If an employer elects to contract with an insurance company for the provision of health care services through a network, or if a self-insured employer under Chapter 407, Labor Code, a group of employers certified to self-insure under Chapter 407A, Labor Code, or a public employer under Subtitle C, Title 5, Labor Code, elects to establish or contract with a network, the employer's employees who live within the network's service area are required to obtain
medical treatment for a compensable injury within the network, except as provided by Sections 1305.006(1) and (3).

(c) Notwithstanding Subsection (b), the State Office of Risk Management shall have exclusive authority to establish or contract with networks certified under this chapter to provide health care services under Chapter 501, Labor Code.

(d) The insurance carrier shall provide to the employer, and the employer shall provide to the employer's employees, notice of network requirements, including all information required by Section 1305.451. The employer shall:

(1) obtain a signed acknowledgment from each employee, written in English, Spanish, and any other language common to the employer's employees, that the employee has received information concerning the network and the network's requirements; and

(2) post notice of the network requirements at each place of employment.

(e) The employer shall provide to each employee hired after the notice is given under Subsection (d) the notice and information required under that subsection not later than the third day after the date of hire.

(f) An injured employee who has received notice of network requirements but refuses to sign the acknowledgment form required under Subsection (d) remains subject to the network requirements established under this chapter.

(g) The employer shall notify an injured employee of the network requirements at the time the employer receives actual or constructive notice of an injury.
(h) An injured employee is not required to comply with the network requirements until the employee receives the notice under Subsection (d), (e), or (g). An insurance carrier that establishes or contracts with a network is liable for the payment of medical care under the requirements of Title 5, Labor Code, for an injured employee who does not receive notice until the employee receives notice of network requirements under this section.

(i) The commissioner may adopt rules as necessary to implement this section.

Sec. 1305.006. INSURANCE CARRIER LIABILITY FOR OUT-OF-NETWORK HEALTH CARE. An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:

(1) emergency care;

(2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and

(3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103.

Sec. 1305.007. RULES. The commissioner may adopt rules as necessary to implement this chapter.

[Sections 1305.008-1305.050 reserved for expansion]

SUBCHAPTER B. CERTIFICATION

Sec. 1305.051. CERTIFICATION REQUIRED. (a) A person may not operate a workers' compensation health care network in this
state unless the person holds a certificate issued under this chapter and rules adopted by the commissioner.

(b) A person may not perform any act of a workers' compensation health care network except in accordance with the specific authorization of this chapter or rules adopted by the commissioner.

(c) A health maintenance organization regulated under Chapter 843 or an organization of physicians and providers that operates as a preferred provider benefit plan, as defined by Chapter 1301, may obtain a certification as a workers' compensation health care network in the same manner as any other person if that entity meets the requirements of this chapter and rules adopted by the commissioner under this chapter.

Sec. 1305.052. CERTIFICATE APPLICATION. (a) A person who seeks to operate as a workers' compensation health care network shall apply to the department for a certificate to organize and operate as a network.

(b) A certificate application must be:

(1) filed with the department in the form prescribed by the commissioner;

(2) verified by the applicant or an officer or other authorized representative of the applicant; and

(3) accompanied by a nonrefundable fee set by commissioner rule.

Sec. 1305.053. CONTENTS OF APPLICATION. Each certificate application must include:

(1) a description or a copy of the applicant's basic
organizational structure documents and other related documents, including organizational charts or lists that show:

(A) the relationships and contracts between the applicant and any affiliates of the applicant; and

(B) the internal organizational structure of the applicant's management and administrative staff;

(2) biographical information regarding each person who governs or manages the affairs of the applicant, accompanied by information sufficient to allow the commissioner to determine the competence, fitness, and reputation of each officer or director of the applicant or other person having control of the applicant;

(3) a copy of the form of any contract between the applicant and any provider or group of providers, and with any third party performing services on behalf of the applicant under Subchapter D;

(4) a copy of the form of each contract with an insurance carrier, as described by Section 1305.154;

(5) a financial statement, current as of the date of the application, that is prepared using generally accepted accounting practices and includes:

(A) a balance sheet that reflects a solvent financial position;

(B) an income statement;

(C) a cash flow statement; and

(D) the sources and uses of all funds;

(6) a statement acknowledging that lawful process in a legal action or proceeding against the network on a cause of action
arising in this state is valid if served in the manner provided by
Chapter 804 for a domestic company;

(7) a description and a map of the applicant's service
area or areas, with key and scale, that identifies each county or
part of a county to be served;

(8) a description of programs and procedures to be
utilized, including:
  (A) a complaint system, as required under
  Subchapter I;
  (B) a quality improvement program, as required
  under Subchapter G; and
  (C) the utilization review and retrospective
  review programs described in Subchapter H;

(9) a list of all contracted network providers that
demonstrates the adequacy of the network to provide comprehensive
health care services sufficient to serve the population of injured
employees within the service area and maps that demonstrate that
the access and availability standards under Subchapter G are met;
and

(10) any other information that the commissioner
requires by rule to implement this chapter.

Sec. 1305.054. ACTION ON APPLICATION; RENEWAL OF
CERTIFICATION. (a) The commissioner shall approve or disapprove
an application for certification as a network not later than the
60th day after the date the completed application is received by the
department. An application is considered complete on receipt of
all information required by this chapter and any commissioner
rules, including receipt of any additional information requested by
the commissioner as needed to make the determination.

(b) Additional information requested by the commissioner
under Subsection (a) may include information derived from an
on-site quality-of-care examination.

(c) The department shall notify the applicant of any
deficiencies in the application and may allow the applicant to
request additional time to revise the application, in which case
the 60-day period for approval or disapproval is tolled. The
commissioner may grant or deny requests for additional time at the
commissioner's discretion.

(d) An order issued by the commissioner disapproving an
application must specify in what respects the application does not
comply with applicable statutes and rules. An applicant whose
application is disapproved may request a hearing not later than the
30th day after the date of the commissioner's disapproval order.
The hearing is a contested case hearing under Chapter 2001,
Government Code.

(e) A certificate issued under this subchapter is valid
until revoked or suspended.

Sec. 1305.055. USE OF CERTAIN INSURANCE TERMS BY NETWORK
PROHIBITED. A network is not an insurer and may not use in the
network's name or informational literature the word "insurance,"
"casualty," "surety," or "mutual" or any other word that is:

(1) descriptive of the insurance, casualty, or surety
business; or

(2) deceptively similar to the name or description of
an insurer or surety corporation engaging in the business of
insurance in this state.

Sec. 1305.056. RESTRAINT OF TRADE; APPLICATION OF CERTAIN
LAWS. (a) A network that contracts with a provider or providers
practicing individually or as a group is not, because of the
contract or arrangement, considered to have entered into a
conspiracy in restraint of trade in violation of Chapter 15,
Business & Commerce Code.

(b) Notwithstanding any other law, a person who contracts
under this chapter with one or more providers in the process of
conducting activities that are permitted by law but that do not
require a certificate of authority or other authorization under
this code is not, because of the contract, considered to have
entered into a conspiracy in restraint of trade in violation of
Chapter 15, Business & Commerce Code.

(c) A network is subject to Articles 21.28 and 21.28-A and
is considered an insurer or insurance company, as applicable, for
purposes of those laws.

[Sections 1305.057-1305.100 reserved for expansion]

SUBCHAPTER C. GENERAL POWERS AND DUTIES OF WORKERS' COMPENSATION

HEALTH CARE NETWORKS

Sec. 1305.101. PROVIDING OR ARRANGING FOR HEALTH CARE.

(a) Except for emergencies and out-of-network referrals, a
network shall provide or arrange for health care services only
through providers or provider groups that are under contract with
or are employed by the network.

(b) A network doctor may not serve as a designated doctor or
perform a required medical examination, as those terms are used
der the Texas Workers' Compensation Act, for an employee
receiving medical care through a network with which the doctor
contracts or is employed.

(c) Notwithstanding any other provision of this chapter,
prescription medication or services, as defined by Section
401.011(19)(E), Labor Code, may not be delivered through a workers'
compensation health care network. Prescription medication and
services shall be reimbursed as provided by the Texas Workers'
Compensation Act and applicable rules of the commissioner of
workers' compensation.

Sec. 1305.102. MANAGEMENT CONTRACTS. (a) A network may
not enter into a contract with another entity for management
services unless the proposed contract is first filed with the
department and approved by the commissioner.

(b) The commissioner shall approve or disapprove the
contract not later than the 30th day after the date the contract is
filed, or within a reasonable extended period that the commissioner
specifies by notice given within the 30-day period.

(c) The contract must state that:

(1) the contract may not be canceled without cause
without at least 90 days' prior written notice;

(2) notice of any cancellation must be sent
simultaneously to the commissioner by certified mail; and

(3) the network is responsible for ensuring that all
functions delegated by the contract are performed in accordance
with applicable statutes and rules, subject to the carrier's
oversight and monitoring of the network's performance.

(d) The management contractor proposing to contract shall provide to the commissioner information sufficient to allow the commissioner to determine the competence, fitness, or reputation of each of the contractor's officers and directors or other person having control of the contractor, including criminal history information demonstrating that none of those individuals has been convicted of a felony involving moral turpitude or breach of fiduciary duty.

(e) The commissioner shall disapprove the proposed contract if the commissioner determines that the contract authorizes a person who is not sufficiently trustworthy, competent, experienced, and free from conflict of interest to manage the network with due regard for the interests of employers, employees, creditors, or the public.

(f) The commissioner may not approve a proposed management contract unless the management contractor has in force in the contractor's own name a fidelity bond on the contractor's officers and employees in the amount of $250,000 or a greater amount prescribed by the commissioner.

(g) The fidelity bond must be issued by an insurer authorized to engage in business in this state and must be filed with the department. If the commissioner determines that a fidelity bond is not available from an insurer authorized to engage in business in this state, the management contractor may obtain a fidelity bond procured by a surplus lines agent under Chapter 981.

(h) The fidelity bond must obligate the surety to pay any
loss of money or other property or damage that the network sustains because of an act of fraud or dishonesty by an employee or officer of the management contractor during the period that the management contract is in effect.

(i) In lieu of a fidelity bond, and at the commissioner's discretion, the management contractor may deposit with the comptroller cash or readily marketable liquid securities acceptable to the commissioner. The deposit must be maintained in the amount of, and is subject to the same conditions required for, a fidelity bond under this section.

(j) A management contract approved by the commissioner under this section may not be assigned to any other entity.

(k) A management contract filed with the department under this section is confidential and is not subject to disclosure as public information under Chapter 552, Government Code.

Sec. 1305.103. TREATING DOCTOR; REFERRALS. (a) A network shall determine the specialty or specialties of doctors who may serve as treating doctors.

(b) For each injury, an injured employee shall select a treating doctor from the list of all treating doctors under contract with the network in that service area.

(c) An employee who lives within the service area of a network and who is being treated by a non-network provider for an injury that occurred before the employer's insurance carrier established or contracted with the network, shall select a network treating doctor on notification by the carrier that health care services are being provided through the network. The carrier shall
provide to the employee all information required by Section 1305.451. If the employee fails to select a treating doctor on or before the 14th day after the date of receipt of the information required by Section 1305.451, the network may assign the employee a network treating doctor.

(d) Each network shall, by contract, require treating doctors to provide, at a minimum, the functions and services for injured employees described by this section.

(e) A treating doctor shall provide health care to the employee for the employee's compensable injury and shall make referrals to other network providers, or request referrals to out-of-network providers if medically necessary services are not available within the network. Referrals to out-of-network providers must be approved by the network. The network shall approve a referral to an out-of-network provider not later than the seventh day after the date on which the referral is requested, or sooner if circumstances and the condition of the employee require expedited approval. If the network denies the referral request, the employee may appeal the decision through the network's complaint process under Subchapter I.

(f) The treating doctor shall participate in the medical case management process as required by the network, including participation in return-to-work planning.

Sec. 1305.104. SELECTION OF TREATING DOCTOR. (a) An injured employee is entitled to the employee's initial choice of a treating doctor from the list provided by the network of all treating doctors under contract with the network who provide
services within the service area in which the injured employee
lives. The following does not constitute an initial choice of
treating doctor:

(1) a doctor salaried by the employer;
(2) a doctor providing emergency care; or
(3) any doctor who provides care before the employee
is enrolled in the network, except for a doctor selected under
Section 1305.105.

(b) An employee who is dissatisfied with the initial choice
of a treating doctor is entitled to select an alternate treating
doctor from the network's list of treating doctors who provide
services within the service area in which the injured employee
lives by notifying the network in the manner prescribed by the
network. The network may not deny a selection of an alternate
treating doctor.

(c) An employee who is dissatisfied with an alternate
treating doctor must obtain authorization from the network to
select any subsequent treating doctor. The network shall establish
procedures and criteria to be used in authorizing an employee to
select subsequent treating doctors. The criteria must include, at
a minimum, whether:

(1) treatment by the current treating doctor is
medically inappropriate;
(2) the employee is receiving appropriate medical care
to reach maximum medical improvement or medical care in compliance
with the network's treatment guidelines; and
(3) a conflict exists between the employee and the
current treating doctor to the extent that the doctor-patient relationship is jeopardized or impaired.

(d) Denial of a request for any subsequent treating doctor is subject to the appeal process for a complaint filed under Subchapter I.

(e) For purposes of this section, the following do not constitute the selection of an alternate or any subsequent treating doctor:

(1) a referral made by the treating doctor, including a referral for a second or subsequent opinion;

(2) the selection of a treating doctor because the original treating doctor:

(A) dies;

(B) retires; or

(C) leaves the network; or

(3) a change of treating doctor required because of a change of address by the employee to a location outside the service area distance requirements, as described by Section 1305.302(g).

(f) A network shall provide that an injured employee with a chronic, life-threatening injury or chronic pain related to a compensable injury may apply to the network's medical director to use a nonprimary care physician specialist that is in the network as the injured employee's treating doctor.

(g) An application under Subsection (f) must:

(1) include information specified by the network, including certification of the medical need provided by the nonprimary care physician specialist; and
(2) be signed by the injured employee and the
nonprimary care physician specialist interested in serving as the
injured employee's treating doctor.

(h) To be eligible to serve as the injured employee's
treating doctor, a physician specialist must agree to accept the
responsibility to coordinate all of the injured employee's health
care needs.

(i) If a network denies a request under Subsection (f), the
injured employee may appeal the decision through the network's
established complaint resolution process under Subchapter I.

Sec. 1305.105. TREATMENT BY A PRIMARY CARE PHYSICIAN OR
PROVIDER UNDER CHAPTER 843; RECOMMENDATIONS REGARDING USE OF
PREFERRED PROVIDER PLAN. (a) Notwithstanding any other provision
of this chapter, an injured employee required to receive health
care services within a network may select as the employee's
treating doctor a doctor who the employee selected, prior to
injury, as the employee's primary care physician or provider under
Chapter 843, as the terms "physician" and "provider" are defined in
that chapter.

(b) A doctor serving as an employee's treating doctor under
Subsection (a) must agree to abide by the terms of the network's
contract and comply with the provisions of this subchapter and
Subchapters D and G. Services provided by such a doctor are
considered to be network services and are subject to Subchapters H
and I.

(c) Any change of doctor requested by an employee being
treated by a doctor under Subsection (a) must be to a network doctor
and is subject to the requirements of this chapter.

(d) In studying the adequacy of networks under this chapter, the department shall offer recommendations to the 80th Legislature regarding whether to make statutory changes to allow treatment by non-network providers through a preferred provider benefit plan, as defined by Chapter 1301.

Sec. 1305.106. PAYMENT OF HEALTH CARE PROVIDER. Notwithstanding any other provision of this chapter, an insurance carrier shall pay, reduce, deny, or determine to audit, a claim for services provided through a workers' compensation health care network only in accordance with Section 408.027, Labor Code.

Sec. 1305.107. TELEPHONE ACCESS. (a) Each network shall have appropriate personnel reasonably available through a toll-free telephone service at least 40 hours per week during normal business hours, in both time zones in this state if applicable, to discuss an employee's care and to allow response to requests for information, including information regarding adverse determinations.

(b) A network must have a telephone system capable of accepting or recording or providing instructions to incoming calls during other than normal business hours. The network shall respond to those calls not later than two business days after the date:

(1) the call was received by the network; or
(2) the details necessary to respond were received by the network from the caller.

[Sections 1305.108-1305.150 reserved for expansion]
SUBCHAPTER D. CONTRACTING PROVISIONS

Sec. 1305.151. TRANSFER OF RISK. A contract under this subchapter may not involve a transfer of risk.

Sec. 1305.152. NETWORK CONTRACTS WITH PROVIDERS. (a) A network shall enter into a written contract with each provider or group of providers that participates in the network. A provider contract under this section is confidential and is not subject to disclosure as public information under Chapter 552, Government Code.

(b) A network is not required to accept an application for participation in the network from a health care provider who otherwise meets the requirements specified in this chapter for participation if the network determines that the network has contracted with a sufficient number of qualified health care providers.

(c) Provider contracts and subcontracts must include, at a minimum, the following provisions:

(1) a hold-harmless clause stating that the network and the network's contracted providers are prohibited from billing or attempting to collect any amounts from employees for health care services under any circumstances, including the insolvency of the insurance carrier or the network, except as provided by Section 1305.451(b)(6);

(2) a statement that the provider agrees to follow treatment guidelines adopted by the network under Section 1305.304, as applicable to an employee's injury;

(3) a continuity of treatment clause that states that
if a provider leaves the network, the insurance carrier or network
is obligated to continue to reimburse the provider for a period not
to exceed 90 days at the contracted rate for care of an employee
with a life-threatening condition or an acute condition for which
disruption of care would harm the employee;

(4) a clause regarding appeal by the provider of
termination of provider status and applicable written notification
to employees regarding such a termination, including provisions
determined by the commissioner; and

(5) any other provisions required by the commissioner
by rule.

(d) Continued care as described by Subsection (c)(3) must be
requested by a provider. A dispute involving continuity of care is
subject to the dispute resolution process under Subchapter I.

(e) An insurance carrier and a network may not use any
financial incentive or make a payment to a health care provider that
acts directly or indirectly as an inducement to limit medically
necessary services.

Sec. 1305.153. PROVIDER REIMBURSEMENT. (a) The amount of
reimbursement for services provided by a network provider is
determined by the contract between the network and the provider or
group of providers.

(b) If an insurance carrier or network has preauthorized a
health care service, the insurance carrier or network or the
network's agent or other representative may not deny payment to a
provider except for reasons other than medical necessity.

(c) Out-of-network providers who provide care as described
by Section 1305.006 shall be reimbursed as provided by the Texas
Workers' Compensation Act and applicable rules of the commissioner
of workers' compensation.

(d) Subject to Subsection (a), billing by, and
reimbursement to, contracted and out-of-network providers is
subject to the requirements of the Texas Workers' Compensation Act
and applicable rules of the commissioner of workers' compensation,
as consistent with this chapter. This subsection may not be
construed to require application of rules of the commissioner of
workers' compensation regarding reimbursement if application of
those rules would negate reimbursement amounts negotiated by the
network.

(e) An insurance carrier shall notify in writing a network
provider if the carrier contests the compensability of the injury
for which the provider provides health care services. A carrier may
not deny payment for health care services provided by a network
provider before that notification on the grounds that the injury
was not compensable. Payment for medically necessary health care
services provided prior to written notification of a compensability
denial is not subject to denial, recoupment, or refund from a
network provider based on compensability. If the insurance carrier
successfully contests compensability, the carrier is liable for
health care provided before issuance of the notification required
by this subsection, up to a maximum of $7,000.

Sec. 1305.154. NETWORK-CARRIER CONTRACTS. (a) Except for
emergencies and out-of-network referrals, a network may provide
health care services to employees only through a written contract
with an insurance carrier. A network-carrier contract under this
section is confidential and is not subject to disclosure as public
information under Chapter 552, Government Code.

(b) A carrier and a network may negotiate the functions to
be provided by the network, except that the network shall contract
with providers for the provision of health care, and shall perform
functions related to the operation of a quality improvement program
and credentialing in accordance with the requirements of this
chapter.

(c) A network's contract with a carrier must include:

(1) a description of the functions that the carrier
delegates to the network, consistent with the requirements of
Subsection (b), and the reporting requirements for each function;

(2) a statement that the network and any management
contractor or third party to which the network delegates a function
will perform all delegated functions in full compliance with all
requirements of this chapter, the Texas Workers' Compensation Act,
and rules of the commissioner or the commissioner of workers'
compensation;

(3) a provision that the contract:

(A) may not be terminated without cause by either
party without 90 days' prior written notice; and

(B) must be terminated immediately if cause
exists;

(4) a hold-harmless provision stating that the
network, a management contractor, a third party to which the
network delegates a function, and the network's contracted
providers are prohibited from billing or attempting to collect any amounts from employees for health care services under any circumstances, including the insolvency of the carrier or the network, except as provided by Section 1305.451(b)(6);

(5) a statement that the carrier retains ultimate responsibility for ensuring that all delegated functions and all management contractor functions are performed in accordance with applicable statutes and rules and that the contract may not be construed to limit in any way the carrier's responsibility, including financial responsibility, to comply with all statutory and regulatory requirements;

(6) a statement that the network's role is to provide the services described under Subsection (b) as well as any other services or functions delegated by the carrier, including functions delegated to a management contractor, subject to the carrier's oversight and monitoring of the network's performance;

(7) a requirement that the network provide the carrier, at least monthly and in a form usable for audit purposes, the data necessary for the carrier to comply with reporting requirements of the department and the division of workers' compensation with respect to any services provided under the contract, as determined by commissioner rules;

(8) a requirement that the carrier, the network, any management contractor, and any third party to which the network delegates a function comply with the data reporting requirements of the Texas Workers' Compensation Act and rules of the commissioner of workers' compensation;
(9) a contingency plan under which the carrier would, in the event of termination of the contract or a failure to perform, reassume one or more functions of the network under the contract, including functions related to:

(A) payments to providers and notification to employees;
(B) quality of care;
(C) utilization review;
(D) retrospective review; and
(E) continuity of care, including a plan for identifying and transitioning employees to new providers;

(10) a provision that requires that any agreement by which the network delegates any function to a management contractor or any third party be in writing, and that such an agreement require the delegated third party or management contractor to be subject to all the requirements of this subchapter;

(11) a provision that requires the network to provide to the department the license number of a management contractor or any delegated third party who performs a function that requires a license as a utilization review agent under Article 21.58A or any other license under this code or another insurance law of this state;

(12) an acknowledgment that:

(A) any management contractor or third party to whom the network delegates a function must perform in compliance with this chapter and other applicable statutes and rules, and that the management contractor or third party is subject to the
carrier's and the network's oversight and monitoring of its performance; and

(B) if the management contractor or the third party fails to meet monitoring standards established to ensure that functions delegated to the management contractor or the third party under the delegation contract are in full compliance with all statutory and regulatory requirements, the carrier or the network may cancel the delegation of one or more delegated functions;

(13) a requirement that the network and any management contractor or third party to which the network delegates a function provide all necessary information to allow the carrier to provide information to employees as required by Section 1305.451; and

(14) a provision that requires the network, in contracting with a third party directly or through another third party, to require the third party to permit the commissioner to examine at any time any information the commissioner believes is relevant to the third party's financial condition or the ability of the network to meet the network's responsibilities in connection with any function the third party performs or has been delegated.

Sec. 1305.1545. RESTRICTIONS ON PAYMENT AND REIMBURSEMENT.

(a) An insurance carrier or third-party administrator may not reimburse a doctor or other health care provider, an institutional provider, or an organization of doctors and health care providers on a discounted fee basis for services that are provided to an injured employee unless:

(1) the carrier or third-party administrator has contracted with either:
(A) the doctor or other health care provider, institutional provider, or organization of doctors and health care providers; or

(B) a network that has contracted with the doctor or other health care provider, institutional provider, or organization of doctors and health care providers; and

(2) the doctor or other health care provider, institutional provider, or organization of doctors and health care providers has agreed to the contract and has agreed to provide health care services under the terms of the contract.

(b) A party to a carrier-network contract may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority of and prior adequate notification to the other contracting parties. This subsection does not affect the authority of the commissioner under this code to request and obtain information.

(c) An insurance carrier or third-party administrator who violates this section:

(1) commits an unfair claim settlement practice in violation of Subchapter A, Chapter 542, Insurance Code; and

(2) is subject to administrative penalties under Chapters 82 and 84, Insurance Code.
continuance of the network's business hazardous to employees shall:

(1) notify the network in writing of those findings;

(2) request in writing a written explanation, with documentation supporting the explanation, of:

(A) the network's apparent noncompliance with the contract; or

(B) the existence of the condition that apparently renders the continuance of the network's business hazardous to employees; and

(3) notify the commissioner and provide the department with copies of all notices and requests submitted to the network and the responses and other documentation the carrier generates or receives in response to the notices and requests.

(b) A network shall respond to a request from a carrier under Subsection (a) in writing not later than the 30th day after the date the request is received.

(c) The carrier shall cooperate with the network to correct any failure by the network to comply with any regulatory requirement of the department.

(d) On receipt of a notice under Subsection (a), or if a complaint is filed with the department, on receipt of that complaint, the commissioner or the commissioner's designated representative shall examine the matters contained in the notice or complaint as well as any other matter relating to the financial solvency of the network or the network's ability to meet its responsibilities in connection with any function performed by the network or delegated to the network by the carrier.
(e) Except as provided by this subsection, on completion of the examination, the department shall report to the network and the carrier the results of the examination and any action the department determines is necessary to ensure that the carrier meets its responsibilities under this chapter, this code, and rules adopted by the commissioner, and that the network can meet the network's responsibilities in connection with any function delegated by the carrier or performed by the network, any management contractor, or any third party to which the network delegates a function. The department may not report to the carrier any information regarding fee schedules, prices, cost of care, or other information not relevant to the monitoring plan.

(f) The network and the carrier shall respond to the department's report and submit a corrective plan to the department not later than the 30th day after the date of receipt of the report.

(g) The commissioner may order a carrier to take any action the commissioner determines is necessary to ensure that the carrier can provide all health care services under the Texas Workers' Compensation Act, including:

1. reassuming the functions performed by or delegated to the network, including claims payments for services previously provided to injured employees;
2. temporarily or permanently ceasing coverage of employees through the network;
3. complying with the contingency plan required by Section 1305.154(c)(9), including permitting an injured employee to select a treating doctor in the manner provided by Section
(4) terminating the carrier's contract with the network.

(h) The carrier retains ultimate responsibility for ensuring that all delegated functions and all management contractor functions are performed in accordance with applicable statutes and rules and nothing in this section may be construed to limit in any way the carrier's responsibility, including financial responsibility, to comply with all statutory and regulatory requirements.

[Sections 1305.156-1305.200 reserved for expansion]

SUBCHAPTER E. FINANCIAL REQUIREMENTS

Sec. 1305.201. NETWORK FINANCIAL REQUIREMENTS. (a) Each network shall prepare financial statements in accordance with generally accepted accounting standards, which must include adequate provisions for liabilities, including incurred but not reported obligations relating to providing benefits or services.

(b) Each network shall file the financial statement under Subsection (a) with the department in the manner prescribed by commissioner rule.

[Sections 1305.202-1305.250 reserved for expansion]

SUBCHAPTER F. EXAMINATIONS

Sec. 1305.251. EXAMINATION OF NETWORK. (a) As often as the commissioner considers necessary, the commissioner or the commissioner's designated representative may review the operations of a network to determine compliance with this chapter. The review may include on-site visits to the network's premises.
(b) During on-site visits, the network must make available to the department all records relating to the network's operations.

Sec. 1305.252. EXAMINATION OF PROVIDER OR THIRD PARTY. If requested by the commissioner or the commissioner's representative, each provider, provider group, or third party with which the network has contracted to provide health care services or any other services delegated to the network by an insurance carrier shall make available for examination by the department that portion of the books and records of the provider, provider group, or third party that is relevant to the relationship with the network of the provider, provider group, or third party.

[Sections 1305.253-1305.300 reserved for expansion]

SUBCHAPTER G. PROVISION OF SERVICES BY NETWORK; QUALITY IMPROVEMENT PROGRAM

Sec. 1305.301. NETWORK ORGANIZATION; SERVICE AREAS. (a) The chief executive officer, operations officer, or governing body of a network is responsible for:

(1) the development, approval, implementation, and enforcement of:

(A) administrative, operational, personnel, and patient care policies; and

(B) network procedures; and

(2) the development of any documents necessary for the operation of the network.

(b) Each network shall have a chief executive officer or operations officer who:

(1) is accountable for the day-to-day administration
of the network; and

(2) shall ensure compliance with all applicable statutes and rules pertaining to the operation of the network.

(c) Each network shall have a medical director, who must be an occupational medicine specialist or employ or contract with an occupational medicine specialist, and who must be licensed to practice medicine in the United States. The medical director shall:

(1) be available at all times to address complaints, clinical issues, and any quality improvement issues on behalf of the network;

(2) be actively involved in all quality improvement activities; and

(3) comply with the network's credentialing requirements.

(d) The network shall establish one or more service areas within this state. For each defined service area, the network must:

(1) demonstrate to the satisfaction of the department the ability to provide continuity, accessibility, availability, and quality of services;

(2) specify the counties and zip code areas, or any parts of a county or zip code area, included in the service area; and

(3) provide a complete provider directory to all policyholders who have selected a network in the service area.

Sec. 1305.302. ACCESSIBILITY AND AVAILABILITY REQUIREMENTS. (a) All services specified by this section must be
provided by a provider who holds an appropriate license, unless the
provider is exempt from license requirements.

(b) The network shall ensure that the network's provider
panel includes an adequate number of treating doctors and
specialists, who must be available and accessible to employees 24
hours a day, seven days a week, within the network's service area.
A network must include sufficient numbers and types of health care
providers to ensure choice, access, and quality of care to injured
employees. An adequate number of the treating doctors and
specialists must have admitting privileges at one or more network
hospitals located within the network's service area to ensure that
any necessary hospital admissions are made.

(c) Hospital services must be available and accessible 24
hours a day, seven days a week, within the network's service area.
The network shall provide for the necessary hospital services by
contracting with general, special, and psychiatric hospitals.

(d) Physical and occupational therapy services and
chiropractic services must be available and accessible within the
network's service area.

(e) Emergency care must be available and accessible 24 hours
a day, seven days a week, without restrictions as to where the
services are rendered.

(f) Except for emergencies, a network shall arrange for
services, including referrals to specialists, to be accessible to
employees on a timely basis on request, but not later than the last
day of the third week after the date of the request.

(g) Each network shall provide that network services are
sufficiently accessible and available as necessary to ensure that
the distance from any point in the network's service area to a point
of service by a treating doctor or general hospital is not greater
than 30 miles in nonrural areas and 60 miles in rural areas and that
the distance from any point in the network's service area to a point
of service by a specialist or specialty hospital is not greater than
75 miles in nonrural areas and 75 miles in rural areas. For
portions of the service area in which the network identifies
noncompliance with this subsection, the network must file an access
plan with the department in accordance with Subsection (h).

(h) The network shall submit an access plan, as required by
commissioner rules, to the department for approval at least 30 days
before implementation of the plan if any health care service or a
network provider is not available to an employee within the
distance specified by Subsection (g) because:

(1) providers are not located within that distance;

(2) the network is unable to obtain provider contracts
after good faith attempts; or

(3) providers meeting the network's minimum quality of
care and credentialing requirements are not located within that
distance.

(i) The network may make arrangements with providers
outside the service area to enable employees to receive a skill or
specialty not available within the network service area.

(j) The network may not be required to expand services
outside the network's service area to accommodate employees who
live outside the service area.
Sec. 1305.303. QUALITY OF CARE REQUIREMENTS. (a) A

network shall develop and maintain an ongoing quality improvement
program designed to objectively and systematically monitor and
evaluate the quality and appropriateness of care and services and
to pursue opportunities for improvement. The quality improvement
program must include return-to-work and medical case management
programs.

(b) The network's governing body is ultimately responsible

for the quality improvement program. The governing body shall:

(1) appoint a quality improvement committee that

includes network providers;

(2) approve the quality improvement program;

(3) approve an annual quality improvement plan;

(4) meet at least annually to receive and review

reports of the quality improvement committee or group of

committees, and take action as appropriate; and

(5) review the annual written report on the quality

improvement program.

(c) The quality improvement committee or committees shall

evaluate the overall effectiveness of the quality improvement
program as determined by commissioner rules.

(d) The quality improvement program must be continuous and

comprehensive and must address both the quality of clinical care
and the quality of services. The network shall dedicate adequate
resources, including adequate personnel and information systems,
to the quality improvement program.

(e) The network shall develop a written description of the
quality improvement program that outlines the organizational structure of the program, the functional responsibilities of the program, and the frequency of committee meetings.

(f) The network shall develop an annual quality improvement work plan designed to reflect the type of services and the populations served by the network in terms of age groups, disease or injury categories, and special risk status, such as type of industry.

(g) The network shall prepare an annual written report to the department on the quality improvement program. The report must include:

(1) completed activities;
(2) the trending of clinical and service goals;
(3) an analysis of program performance; and
(4) conclusions regarding the effectiveness of the program.

(h) Each network shall implement a documented process for the selection and retention of contracted providers, in accordance with rules adopted by the commissioner.

(i) The quality improvement program must provide for a peer review action procedure for providers, as described by Section 151.002, Occupations Code.

(j) The network shall have a medical case management program with certified case managers. Case managers shall work with treating doctors, referral providers, and employers to facilitate cost-effective care and employee return-to-work.

Sec. 1305.304. GUIDELINES AND PROTOCOLS. Each network
shall adopt treatment guidelines, return-to-work guidelines, and individual treatment protocols. The treatment guidelines and individual treatment protocols must be evidence-based, scientifically valid, and outcome-focused and be designed to reduce inappropriate or unnecessary health care while safeguarding necessary care. Treatment may not be denied solely on the basis that the treatment for the compensable injury in question is not specifically addressed by the treatment guidelines used by the insurance carrier or network.

[Sections 1305.305-1305.350 reserved for expansion]

SUBCHAPTER H. UTILIZATION REVIEW; RETROSPECTIVE REVIEW

Sec. 1305.351. UTILIZATION REVIEW AND RETROSPECTIVE REVIEW IN NETWORK. (a) The requirements of Article 21.58A apply to utilization review conducted in relation to claims in a workers' compensation health care network. In the event of a conflict between Article 21.58A and this chapter, this chapter controls.

(b) Any screening criteria used for utilization review or retrospective review related to a workers' compensation health care network must be consistent with the network's treatment guidelines.

(c) The preauthorization requirements of Section 413.014, Labor Code, and commissioner of workers' compensation rules adopted under that section, do not apply to health care provided through a workers' compensation network. If a network or carrier uses a preauthorization process within a network, the requirements of this subchapter and commissioner rules apply. A network or an insurance carrier may not require preauthorization of treatments and services for a medical emergency.
Sec. 1305.352. GENERAL STANDARDS FOR RETROSPECTIVE REVIEW.

(a) Retrospective review of a health care service shall be based on written screening criteria established and periodically updated with appropriate involvement from doctors, including actively practicing doctors, and other health care providers.

(b) Retrospective review must be performed under the direction of a physician.

Sec. 1305.353. NOTICE OF CERTAIN UTILIZATION REVIEW DETERMINATIONS; PREAUTHORIZATION REQUIREMENTS. (a) The entity performing utilization review or retrospective review shall notify the employee or the employee's representative, if any, and the requesting provider of a determination made in a utilization review or retrospective review.

(b) Notification of an adverse determination must include:

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

(3) a description of or the source of the screening criteria that were used as guidelines in making the determination;

(4) a description of the procedure for the reconsideration process; and

(5) notification of the availability of independent review in the form prescribed by the commissioner.

(c) On receipt of a preauthorization request from a provider for proposed services that require preauthorization, the utilization review agent shall issue and transmit a determination indicating whether the proposed health care services are
preauthorized. The utilization review agent shall respond to requests for preauthorization within the periods prescribed by this section.

(d) For services not described under Subsection (e) or (f), the determination under Subsection (c) must be issued and transmitted not later than the third calendar day after the date the request is received.

(e) If the proposed services are for concurrent hospitalization care, the utilization review agent shall, within 24 hours of receipt of the request, transmit a determination indicating whether the proposed services are preauthorized.

(f) If the proposed health care services involve poststabilization treatment or a life-threatening condition, the utilization review agent shall transmit to the requesting provider a determination indicating whether the proposed services are preauthorized within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, not to exceed one hour from receipt of the request. If the utilization review agent issues an adverse determination in response to a request for poststabilization treatment or a request for treatment involving a life-threatening condition, the utilization review agent shall provide to the employee or the employee's representative, if any, and the employee's treating provider the notification required under Subsection (a).

(g) For life-threatening conditions, the notification of adverse determination must include notification of the availability of independent review in the form prescribed by the
(h) Treatments and services for an emergency do not require preauthorization.

Sec. 1305.354. RECONSIDERATION OF ADVERSE DETERMINATION.

(a) A utilization review agent shall maintain and make available a written description of the reconsideration procedures involving an adverse determination. The reconsideration procedures must be reasonable and must include:

(1) a provision stating that reconsideration must be performed by a provider other than the provider who made the original adverse determination;

(2) a provision that an employee, a person acting on behalf of the employee, or the employee's requesting provider may, not later than the 30th day after the date of issuance of written notification of an adverse determination, request reconsideration of the adverse determination either orally or in writing;

(3) a provision that, not later than the fifth calendar day after the date of receipt of the request, the network shall send to the requesting party a letter acknowledging the date of receipt of the request that includes a reasonable list of documents the requesting party is required to submit;

(4) a provision that, after completion of the review of the request for reconsideration of the adverse determination, the utilization review agent shall issue a response letter to the employee or person acting on behalf of the employee, and the employee's requesting provider, that:

(A) explains the resolution of the
reconsideration; and

(B) includes:

(i) a statement of the specific medical or clinical reasons for the resolution;

(ii) the medical or clinical basis for the decision;

(iii) the professional specialty of any provider consulted; and

(iv) notice of the requesting party's right to seek review of the denial by an independent review organization and the procedures for obtaining that review; and

(5) written notification to the requesting party of the determination of the request for reconsideration as soon as practicable, but not later than the 30th day after the date the utilization review agent received the request.

(b) In addition to the written request for reconsideration, the reconsideration procedures must include a method for expedited reconsideration procedures for denials of proposed health care services involving poststabilization treatment or life-threatening conditions, and for denials of continued stays for hospitalized employees. The procedures must include a review by a provider who has not previously reviewed the case and who is of the same or a similar specialty as a provider who typically manages the condition, procedure, or treatment under review. The period during which that reconsideration must be completed shall be based on the medical or clinical immediacy of the condition, procedure, or treatment, but may not exceed one calendar day from the date of
receipt of all information necessary to complete the reconsideration.

(c) Notwithstanding Subsection (a) or (b), an employee with a life-threatening condition is entitled to an immediate review by an independent review organization and is not required to comply with the procedures for a reconsideration of an adverse determination.

Sec. 1305.355. INDEPENDENT REVIEW OF ADVERSE DETERMINATION. (a) The utilization review agent shall:

(1) permit the employee or person acting on behalf of the employee and the employee's requesting provider whose reconsideration of an adverse determination is denied to seek review of that determination within the period prescribed by Subsection (b) by an independent review organization assigned in accordance with Article 21.58C and commissioner rules; and

(2) provide to the appropriate independent review organization, not later than the third business day after the date the utilization review agent receives notification of the assignment of the request to an independent review organization:

(A) any medical records of the employee that are relevant to the review;

(B) any documents used by the utilization review agent in making the determination;

(C) the response letter described by Section 1305.354(a)(4);

(D) any documentation and written information submitted in support of the request for reconsideration; and
(E) a list of the providers who provided care to
the employee and who may have medical records relevant to the
review.

(b) A request for independent review under Subsection (a)
must be timely filed by the requestor as follows:

(1) for a request for preauthorization or concurrent
review by an independent review organization, not later than the
45th day after the date of denial of a reconsideration for health
care requiring preauthorization or concurrent review; or

(2) for a request for retrospective medical necessity
review, not later than the 45th day after the denial of
reconsideration.

(c) The insurance carrier shall pay for the independent
review provided under this subchapter.

(d) The department shall assign the review request to an
independent review organization.

(e) A party to a medical dispute that remains unresolved
after a review under this section may seek judicial review of the
decision. The division of workers' compensation and the department
are not considered to be parties to the medical dispute.

(f) A determination of an independent review organization
related to a request for preauthorization or concurrent review is
binding during the pendency of any appeal, and the carrier and
network shall comply with the determination.

(g) If judicial review is not sought under this section, the
carrier and network shall comply with the independent review
organization's determination.
[Sections 1305.356-1305.400 reserved for expansion]

SUBCHAPTER I. COMPLAINT RESOLUTION

Sec. 1305.401. COMPLAINT SYSTEM REQUIRED. (a) Each network shall implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint.

(b) The network may require a complainant to file the complaint not later than the 90th day after the date of the event or occurrence that is the basis for the complaint.

(c) The complaint system must include a process for the notice and appeal of a complaint.

(d) The commissioner may adopt rules as necessary to implement this section.

Sec. 1305.402. COMPLAINT INITIATION AND INITIAL RESPONSE; DEADLINES FOR RESPONSE AND RESOLUTION. (a) If a complainant notifies a network of a complaint, the network, not later than the seventh calendar day after the date the network receives the complaint, shall respond to the complainant, acknowledging the date of receipt of the complaint and providing a description of the network's complaint procedures and deadlines.

(b) The network shall investigate and resolve a complaint not later than the 30th calendar day after the date the network receives the complaint.

Sec. 1305.403. RECORD OF COMPLAINTS. (a) Each network shall maintain a complaint and appeal log regarding each complaint. The commissioner shall adopt rules designating the classification of network complaints under this section.
(b) Each network shall maintain a record of and documentation on each complaint, complaint proceeding, and action taken on the complaint until the third anniversary of the date the complaint was received.

(c) A complainant is entitled to a copy of the network's record regarding the complaint and any proceeding relating to that complaint.

(d) The department, during any investigation or examination of a network, may review documentation maintained under this subchapter, including original documentation, regarding a complaint and action taken on the complaint.

Sec. 1305.404. RETALIATORY ACTION PROHIBITED. A network may not engage in any retaliatory action against an employer or employee because the employer or employee or a person acting on behalf of the employer or employee has filed a complaint against the network.

Sec. 1305.405. POSTING OF INFORMATION ON COMPLAINT PROCESS REQUIRED. (a) A contract between a network and a provider must require the provider to post, in the provider's office, a notice to injured employees on the process for resolving complaints with the network.

(b) The notice required under Subsection (a) must include the department's toll-free telephone number for filing a complaint.

[Sections 1305.406-1305.450 reserved for expansion]

SUBCHAPTER J. EMPLOYEE INFORMATION AND RESPONSIBILITIES

Sec. 1305.451. EMPLOYEE INFORMATION; RESPONSIBILITIES OF EMPLOYEE. (a) An insurance carrier that establishes or contracts
with a network shall provide to employers, and the employer shall
provide to its employees, an accurate written description of the
terms and conditions for obtaining health care within the network's
service area.

(b) The written description required under Subsection (a)
 must be in English, Spanish, and any additional language common to
an employer's employees, must be in plain language and in a readable
and understandable format, and must include, in a clear, complete,
and accurate format:

(1) a statement that the entity providing health care
to employees is a workers' compensation health care network;

(2) the network's toll-free number and address for
obtaining additional information about the network, including
information about network providers;

(3) a statement that in the event of an injury, the
employee must select a treating doctor:

   (A) from a list of all the network's treating
doctors who have contracts with the network in that service area; or
   (B) as described by Section 1305.105;

(4) a statement that, except for emergency services,
the employee shall obtain all health care and specialist referrals
through the employee's treating doctor;

(5) an explanation that network providers have agreed
to look only to the network or insurance carrier and not to
employees for payment of providing health care, except as provided
by Subdivision (6);

(6) a statement that if the employee obtains health
care from non-network providers without network approval, except as
provided by Section 1305.006, the insurance carrier may not be
liable, and the employee may be liable, for payment for that health
care;

(7) information about how to obtain emergency care
services, including emergency care outside the service area, and
after-hours care;

(8) a list of the health care services for which the
insurance carrier or network requires preauthorization or
concurrent review;

(9) an explanation regarding continuity of treatment
in the event of the termination from the network of a treating
doctor;

(10) a description of the network's complaint system,
including a statement that the network is prohibited from
retaliating against:

(A) an employee if the employee files a complaint
against the network or appeals a decision of the network; or

(B) a provider if the provider, on behalf of an
employee, reasonably files a complaint against the network or
appeals a decision of the network;

(11) a summary of the insurance carrier's or network's
procedures relating to adverse determinations and the availability
of the independent review process;

(12) a list of network providers updated at least
quarterly, including:

(A) the names and addresses of the providers;
(B) a statement of limitations of accessibility and referrals to specialists; and

(C) a disclosure of which providers are accepting new patients; and

(13) a description of the network’s service area.

(c) The network and the network’s representatives and agents may not cause or knowingly permit the use or distribution to employees of information that is untrue or misleading.

(d) A network that contracts with an insurance carrier shall provide all the information necessary to allow the carrier to comply with this section.

[Sections 1305.452-1305.500 reserved for expansion]

SUBCHAPTER K. EVALUATION OF NETWORKS; CONSUMER REPORT CARD

Sec. 1305.501. EVALUATION OF NETWORKS. In accordance with the research duties assigned to the group under Chapter 405, Labor Code, the group shall, in accordance with the requirements adopted under Section 405.0025, Labor Code:

(1) objectively evaluate the impact of the workers’ compensation health care networks certified under this chapter on the cost and quality of medical care provided to injured employees; and

(2) report the group’s findings to the governor, the lieutenant governor, the speaker of the house of representatives, and the members of the legislature not later than December 1 of each even-numbered year.

Sec. 1305.502. CONSUMER REPORT CARDS. (a) The group shall develop and issue an annual informational report card that
identifies and compares, on an objective basis, the quality, costs, health care provider availability, and other analogous factors of workers' compensation health care networks operating under the workers' compensation system of this state with each other and with medical care provided outside of networks.

(b) The group may procure services as necessary to produce the report card. The report card must include a risk-adjusted evaluation of:

(1) employee access to care;
(2) return-to-work outcomes;
(3) health-related outcomes;
(4) employee satisfaction with care; and
(5) health care costs and utilization of health care.

(c) The report cards may be based on information or data from any person, agency, organization, or governmental entity that the group considers reliable. The group may not endorse or recommend a specific workers' compensation health care network or plan, or subjectively rate or rank networks or plans, other than through comparison and evaluation of objective criteria.

(d) The commissioner shall ensure that consumer report cards issued by the group under this section are accessible to the public on the department's Internet website and available to any person on request. The commissioner by rule may set a reasonable fee for obtaining a paper copy of report cards.

Sec. 1305.503. CONFIDENTIALITY REQUIREMENTS. (a) As necessary to implement this subchapter, the department may access information from an executive agency that is otherwise confidential
under any law of this state, including the Texas Workers’ Compensation Act.

(b) Confidential information provided to or obtained by the department under this section remains confidential and is not subject to disclosure under Chapter 552, Government Code. The department may not release, and a person may not gain access to, any information that:

(1) could reasonably be expected to reveal the identity of an injured employee; or

(2) discloses provider discounts or differentials between payments and billed charges for individual providers or networks.

(c) Information that is in the possession of the department and that relates to an individual injured employee, and any compilation, report, or analysis produced from the information that identifies an individual injured employee, are not:

(1) subject to discovery, subpoena, or other means of legal compulsion for release to any person; or

(2) admissible in any civil, administrative, or criminal proceeding.

[Sections 1305.504-1305.550 reserved for expansion]

SUBCHAPTER L. DISCIPLINARY ACTIONS

Sec. 1305.551. DETERMINATION OF VIOLATION; NOTICE. (a) If the commissioner determines that a network, insurance carrier, or any other person or third party operating under this chapter, including a third party to which a network delegates a function, or any third party with which a network contracts for management
services, is in violation of this chapter, rules adopted by the
commissioner under this chapter, or applicable provisions of the
Labor Code or rules adopted under that code, the commissioner or a
designated representative may notify the network, insurance
carrier, person, or third party of the alleged violation and may
compel the production of any documents or other information as
necessary to determine whether the violation occurred.

(b) The commissioner's designated representative may
initiate the proceedings under this section.

(c) A proceeding under this section is a contested case

Sec. 1305.552. DISCIPLINARY ACTIONS. If under Section
1305.551 the commissioner determines that a network, insurance
carrier, or other person or third party described under Section
1305.551 has violated or is violating this chapter, rules adopted
by the commissioner under this chapter, or the Labor Code or rules
adopted under that code, the commissioner may:

(1) suspend or revoke a certificate issued under this
code;

(2) impose sanctions under Chapter 82;

(3) issue a cease and desist order under Chapter 83;

(4) impose administrative penalties under Chapter 84;

or

(5) take any combination of these actions.

ARTICLE 5. RATES AND UNDERWRITING REQUIREMENTS;

CONFORMING AMENDMENTS

SECTION 5.01. Section 1, Article 5.55, Insurance Code, is
amended by amending Subdivision (2) and adding Subdivision (2-a) to
read as follows:

(2) "Insurer" means a person authorized and admitted
by the department [Texas Department of Insurance] to engage in the
[do insurance] business of insurance in this state under a
certificate of authority that includes authorization to write
workers' compensation insurance. The term includes:

(A) the Texas Mutual Insurance Company;

(B) a Lloyd's plan under Chapter 941 of this
code; and

(C) a reciprocal and interinsurance exchange
under Chapter 942 of this code.

(2-a) "Premium" means the amount charged for a
workers' compensation insurance policy, including any
endorsements, after the application of individual risk variations
based on loss or expense considerations.

SECTION 5.02. Subsections (b) and (d), Section 2, Article
5.55, Insurance Code, are amended to read as follows:

(b) In setting rates, an insurer shall consider:

(1) past and prospective loss cost experience;

(2) operation expenses;

(3) investment income;

(4) a reasonable margin for profit and contingencies;

(5) the effect on premiums of individual risk
variations based on loss or expense considerations; and

(6) any other relevant factors.
H.B. No. 7

(d) Rates and premiums established under this article may not be excessive, inadequate, or unfairly discriminatory.

SECTION 5.03. Section 3, Article 5.55, Insurance Code, is amended by adding Subsections (e) through (h) to read as follows:

(e) Not later than December 1 of each even-numbered year, the commissioner shall report to the governor, lieutenant governor, and speaker of the house of representatives regarding the impact that legislation enacted during the regular session of the 79th Legislature reforming the workers' compensation system of this state has had on the affordability and availability of workers' compensation insurance for the employers of this state. The report must include an analysis of:

   (1) the projected workers' compensation premium savings realized by employers as a result of the reforms;

   (2) the impact of the reforms on:

       (A) the percentage of employers who provide workers' compensation insurance coverage for their employees; and

       (B) to the extent possible, economic development and job creation;

   (3) the effects of the reforms on market competition and carrier financial solvency, including an analysis of how carrier loss ratios, combined ratios, and use of individual risk variations have changed since implementation of the reforms; and

   (4) the extent of participation in workers' compensation health care networks by small and medium-sized employers.

(f) If the commissioner determines that workers'
compensation rate filings or premium levels analyzed by the department do not appropriately reflect the savings associated with the reforms described by Subsection (e) of this section, the commissioner shall include in the report required under Subsection (e) of this section any recommendations, including any recommended legislative changes, necessary to identify the tools needed by the department to more effectively regulate workers' compensation rates.

(g) At the request of the department, each insurer shall submit to the department all data and other information considered necessary by the commissioner to generate the report required under Subsection (e) of this section. Failure by an insurer to submit the data and information in a timely fashion, as determined by commissioner rule, constitutes grounds for sanctions under Chapter 82 of this code.

(h) In reviewing rates under this article, the commissioner shall consider any state or federal legislation that has been enacted and that may impact rates and premiums for workers' compensation insurance coverage in this state.

SECTION 5.04. Subsection (b), Section 6, Article 5.55, Insurance Code, is amended to read as follows:

(b) The disapproval order must be issued not later than the 15th day after the close of a hearing and must specify how the rate fails to meet the requirements of this article. The disapproval order must state the date on which the further use of that rate is prohibited. [A disapproval order does not affect a policy made or issued in accordance with this code before the expiration of the

328
SECTION 5.05. Section 7, Article 5.55, Insurance Code, is amended to read as follows:

Sec. 7. EFFECT OF DISAPPROVAL; PENALTY. (a) If a policy is issued and the commissioner subsequently disapproves the rate or filing that governs the premium charged on the policy:

(1) the policyholder may continue the policy at the original rate;
(2) the policyholder may cancel the policy without penalty; or
(3) the policyholder and the insurer may agree to amend the policy to reflect the premium that would have been charged based on the insurer's most recently approved rate; the amendment may not take effect before the date on which further use of the rate is prohibited under the disapproval order.

(b) If a policy is issued and the commissioner subsequently disapproves the rate or filing on which the premium is based, the commissioner, after notice and the opportunity for a hearing, may:

(1) impose sanctions under Chapter 82 of this code;
(2) issue a cease and desist order under Chapter 83 of this code;
(3) impose administrative penalties under Chapter 84 of this code; or
(4) take any combination of these actions. If the board determines, based on a pattern of charges for premiums, that an insurer is consistently overcharging or undercharging, the board may assess an administrative penalty. The penalty shall be

329
assessed in accordance with Article 10, Texas Workers' Compensation Act (Article 8308-10.01 et seq., Vernon's Texas Civil Statutes), and set by the board in an amount reasonable and necessary to deter the overcharging or undercharging of policyholders).

SECTION 5.055. Article 5.55, Insurance Code, is amended by adding Section 8 to read as follows:

Sec. 8. EXCLUSIVE JURISDICTION. The department has exclusive jurisdiction over all rates and premiums subject to this article.

SECTION 5.06. Subchapter D, Chapter 5, Insurance Code, is amended by adding Article 5.55A to read as follows:

Art. 5.55A. UNDERWRITING GUIDELINES

Sec. 1. DEFINITIONS. In this article:

(1) "Insurer" has the meaning assigned by Section 1(2), Article 5.55, of this code.

(2) "Underwriting guideline" means a rule, standard, guideline, or practice, whether written, oral, or electronic, that is used by an insurer or its agent to decide whether to accept or reject an application for coverage under a workers' compensation insurance policy or to determine how to classify those risks that are accepted for the purpose of determining a rate.

Sec. 2. UNDERWRITING GUIDELINES. Each underwriting guideline used by an insurer in writing workers' compensation insurance must be sound, actuarially justified, or otherwise substantially commensurate with the contemplated risk. An underwriting guideline may not be unfairly discriminatory.

Sec. 3. ENFORCEMENT. This article may be enforced in the
manner provided by Section 38.003(g) of this code.

Sec. 4. FILING REQUIREMENTS. Each insurer shall file with
the department a copy of the insurer's underwriting guidelines.
The insurer shall update its filing each time the underwriting
guidelines are changed. If a group of insurers files one set of
underwriting guidelines for the group, the group shall identify
which underwriting guidelines apply to each insurer in the group.

Sec. 5. APPLICABILITY OF SECTION 38.003. Section 38.003 of
this code applies to this article to the extent consistent with this
article.

SECTION 5.07. Subsection (b), Article 5.58, Insurance Code,
is amended to read as follows:

(b) Standards and Procedures. For purposes of Subsection
(c) of this article, the commissioner shall establish standards and
procedures for categorizing insurance and medical benefits
reported on each workers' compensation claim. The commissioner
shall consult with the commissioner of workers' compensation [Texas
Workers' Compensation Commission and the Research and Oversight
Council on Workers' Compensation] in establishing these standards
to ensure that the data collection methodology will also yield data
necessary for research and medical cost containment efforts.

SECTION 5.08. Article 5.60A, Insurance Code, is amended to
read as follows:

Art. 5.60A. RATE HEARINGS. (a) The commissioner [Board]
shall conduct a public [an annual] hearing each biennium, beginning
not later than December 1, 2008, to review rates to be charged for
workers' compensation insurance written in this state [under this
A public hearing under this article is not a contested case as defined by Section 2001.003, Government Code. The hearing shall be conducted under the contested case provisions of the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes).

(b) Not later than the 30th day before the date of the public hearing required under Subsection (a) of this article, each insurer subject to this subchapter shall file the insurer's rates, supporting information, and supplementary rating information with the commissioner. The Board shall conduct a hearing six months prior to the annual hearing to revise rates to establish the methodology and sources of data to be used in reviewing rates. The hearing shall be conducted under the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes).

(c) The commissioner shall review the information submitted under Subsection (b) of this article to determine the positive or negative impact of the enactment of workers' compensation reform legislation enacted by the 79th Legislature, Regular Session, 2005, on workers' compensation rates and premiums. The commissioner may consider other factors, including relativities under Article 5.60 of this code, in determining whether a change in rates has impacted the premium charged to policyholders. To assist the Board in making rates and to provide additional information on certain trends that may affect the costs of workers' compensation insurance, the executive director of the Texas Workers' Compensation Commission or a person designated by that officer shall testify at any rate.
hearing conducted under this article. The testimony shall relate

to trends in:

[(1) claims resolution of workers' compensation cases;]

and

[(2) cost components in workers' compensation cases].

(d) The commissioner shall implement rules as necessary to

mandate rate reductions or to modify the use of individual risk

variations if the commissioner determines that the rates or

premiums charged by insurers do not meet the rating standards as

defined in this code [The testimony of the executive director or

designee is subject to cross-examination by the Board and any party

to the hearing].

(e) The commissioner shall adopt rules as necessary to

mandate rate or premium reductions by insurers for the use of

cost-containment strategies that result in savings to the workers'

compensation system, including use of a workers' compensation

health care network health care delivery system, as described by

Chapter 1305 of this code [The Board shall consider changes in the

workers' compensation laws when setting workers' compensation

insurance rates].

ARTICLE 6. GENERAL CONFORMING AMENDMENTS

PART 1. CONFORMING AMENDMENTS--GOVERNMENT CODE

SECTION 6.001. Subsection (a), Section 23.101, Government

Code, is amended to read as follows:

(a) The trial courts of this state shall regularly and

frequently set hearings and trials of pending matters, giving

preference to hearings and trials of the following:
(1) temporary injunctions;
(2) criminal actions, with the following actions given
preference over other criminal actions:
   (A) criminal actions against defendants who are
detained in jail pending trial;
   (B) criminal actions involving a charge that a
person committed an act of family violence, as defined by Section
71.004, Family Code; and
   (C) an offense under:
      (i) Section 21.11, Penal Code;
      (ii) Chapter 22, Penal Code, if the victim
of the alleged offense is younger than 17 years of age;
      (iii) Section 25.02, Penal Code, if the
victim of the alleged offense is younger than 17 years of age; or
      (iv) Section 25.06, Penal Code;
(3) election contests and suits under the Election
Code;
(4) orders for the protection of the family under
Subtitle B, Title 4, Family Code;
(5) appeals of final rulings and decisions of the
division of workers' compensation of the Texas Department of
Insurance regarding workers' compensation claims [Workers' Compensation Commission] and claims under the Federal Employers'
Liability Act and the Jones Act; and
(6) appeals of final orders of the commissioner of the
General Land Office under Section 51.3021, Natural Resources Code.

SECTION 6.002. Subsection (c), Section 25.0003, Government
Code, is amended to read as follows:

(c) In addition to other jurisdiction provided by law, a statutory county court exercising civil jurisdiction concurrent with the constitutional jurisdiction of the county court has concurrent jurisdiction with the district court in:

(1) civil cases in which the matter in controversy exceeds $500 but does not exceed $100,000, excluding interest, statutory or punitive damages and penalties, and attorney's fees and costs, as alleged on the face of the petition; and

(2) appeals of final rulings and decisions of the division of workers' compensation of the Texas Department of Insurance regarding workers' compensation claims [Workers' Compensation Commission], regardless of the amount in controversy.

SECTION 6.003. Subsection (a), Section 25.0222, Government Code, is amended to read as follows:

(a) In addition to the jurisdiction provided by Section 25.0003 and other law, a statutory county court in Brazoria County has concurrent jurisdiction with the district court in:

(1) civil cases in which the matter in controversy exceeds $500 but does not exceed $100,000, excluding interest, statutory damages and penalties, and attorney's fees and costs, as alleged on the face of the petition; and

(2) appeals of final rulings and decisions of the division of workers' compensation of the Texas Department of Insurance regarding workers' compensation claims [Workers' Compensation Commission], regardless of the amount in controversy; and
(3) family law cases and proceedings and juvenile jurisdiction under Section 23.001.

SECTION 6.004. Subsection (i), Section 25.0862, Government Code, is amended to read as follows:

(i) The clerk of the statutory county courts and statutory probate court shall keep a separate docket for each court. The clerk shall tax the official court reporter's fees as costs in civil actions in the same manner as the fee is taxed in civil cases in the district courts. The district clerk serves as clerk of the county courts in a cause of action arising under the Family Code and an appeal of a final ruling or decision of the division of workers' compensation of the Texas Department of Insurance regarding workers' compensation claims [Workers' Compensation Commission], and the county clerk serves as clerk of the court in all other cases.

SECTION 6.005. Subsection (b), Section 25.2222, Government Code, as amended by Chapter 22, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(b) A county court at law has concurrent jurisdiction with the district court in:

(1) civil cases in which the matter in controversy exceeds $500 and does not exceed $100,000, excluding mandatory damages and penalties, attorney's fees, interest, and costs;

(2) nonjury family law cases and proceedings;

(3) final rulings and decisions of the division of workers' compensation of the Texas Department of Insurance regarding workers' compensation claims [Workers' Compensation
Commission], regardless of the amount in controversy;
(4) eminent domain proceedings, both statutory and inverse, regardless of the amount in controversy;
(5) suits to decide the issue of title to real or personal property;
(6) suits to recover damages for slander or defamation of character;
(7) suits for the enforcement of a lien on real property;
(8) suits for the forfeiture of a corporate charter;
(9) suits for the trial of the right to property valued at $200 or more that has been levied on under a writ of execution, sequestration, or attachment; and
(10) suits for the recovery of real property.

SECTION 6.006. Subsection (b), Section 551.044, Government Code, is amended to read as follows:
(b) Subsection (a) does not apply to:
(1) the Texas Department of Insurance, as regards proceedings and activities under Title 5, Labor Code, of the department, the commissioner of insurance, or the commissioner of workers' compensation [Workers' Compensation Commission]; or
(2) the governing board of an institution of higher education.

SECTION 6.007. Subdivision (7), Section 2001.003, Government Code, is amended to read as follows:
(7) "State agency" means a state officer, board, commission, or department with statewide jurisdiction that makes
rules or determines contested cases. The term includes the State Office of Administrative Hearings for the purpose of determining contested cases. The term does not include:

(A) a state agency wholly financed by federal money;
(B) the legislature;
(C) the courts;
(D) the Texas Department of Insurance, as regards proceedings and activities under Title 5, Labor Code, of the department, the commissioner of insurance, or the commissioner of workers' compensation [Workers' Compensation Commission]; or
(E) an institution of higher education.

SECTION 6.008. Subdivision (3), Section 2002.001, Government Code, is amended to read as follows:

(3) "State agency" means a state officer, board, commission, or department with statewide jurisdiction that makes rules or determines contested cases other than:

(A) an agency wholly financed by federal money;
(B) the legislature;
(C) the courts;
(D) the Texas Department of Insurance, as regards proceedings and activities under Title 5, Labor Code, of the department, the commissioner of insurance, or the commissioner of workers' compensation [Workers' Compensation Commission]; or
(E) an institution of higher education.

SECTION 6.009. Subdivision (4), Section 2003.001, Government Code, is amended to read as follows:
(4) "State agency" means:

(A) a state board, commission, department, or other agency that is subject to Chapter 2001; and

(B) to the extent provided by Title 5, Labor Code, the Texas Department of Insurance, as regards proceedings and activities under Title 5, Labor Code, of the department, the commissioner of insurance, or the commissioner of workers' compensation.

SECTION 6.010. Subsection (c), Section 2003.021, Government Code, is amended to read as follows:

(c) The office shall conduct hearings under Title 5, Labor Code, as provided by that title. In conducting hearings under Title 5, Labor Code, the office shall consider the applicable substantive rules and policies of the division of workers' compensation of the Texas Department of Insurance regarding workers' compensation claims. The office and the Texas Department of Insurance shall enter into an interagency contract under Chapter 771 to pay the costs incurred by the office in implementing this subsection.

SECTION 6.011. Subsection (c), Section 2054.021, Government Code, is amended to read as follows:

(c) Two groups each composed of three ex officio members serve on the board on a rotating basis. The ex officio members serve as nonvoting members of the board. Only one group serves at a time. The first group is composed of the commissioner of workers' compensation, the executive director of the Texas Workers' Compensation Commission, the executive commissioner of the Health

H.B. No. 7

339
and Human Services Commission [health and human services], and the executive director of the Texas Department of Transportation. Members of the first group serve for two-year terms that begin February 1 of every other odd-numbered year and that expire on February 1 of the next odd-numbered year. The second group is composed of the commissioner of education, the executive director of the Texas Department of Criminal Justice, and the executive director of the Parks and Wildlife Department. Members of the second group serve for two-year terms that begin February 1 of the odd-numbered years in which the terms of members of the first group expire and that expire on February 1 of the next odd-numbered year.

PART 2. CONFORMING AMENDMENTS--INSURANCE CODE

SECTION 6.051. Section 31.002, Insurance Code, is amended to read as follows:

Sec. 31.002. DUTIES OF DEPARTMENT. In addition to the other duties required of the Texas Department of Insurance, the department shall:

(1) regulate the business of insurance in this state; and

(2) administer the workers' compensation system of this state as provided by Title 5, Labor Code; and

(3) ensure that this code and other laws regarding insurance and insurance companies are executed.

SECTION 6.052. Section 31.004, Insurance Code, is amended to read as follows:

Sec. 31.004. SUNSET PROVISION. (a) The Texas Department of Insurance is subject to Chapter 325, Government Code (Texas Sunset
Act). Unless continued in existence as provided by that chapter, the department is abolished September 1, 2009. (b) Unless continued as provided by Chapter 325, Government Code, the duties of the division of workers' compensation of the Texas Department of Insurance under Title 5, Labor Code, expire September 1, 2009, or another date designated by the legislature.

SECTION 6.053. Subsection (b), Section 31.021, Insurance Code, is amended to read as follows:

(b) The commissioner has the powers and duties vested in the department by:

(1) this code and other insurance laws of this state; and

(2) Title 5, Labor Code, and other workers' compensation insurance laws of this state.

SECTION 6.054. Subsection (a), Section 33.007, Insurance Code, is amended to read as follows:

(a) A person who served as the commissioner, the general counsel to the commissioner, or the public insurance counsel, or as an employee of the State Office of Administrative Hearings who was involved in hearing cases under this code, or another insurance law of this state, or Title 5, Labor Code, commits an offense if the person represents another person in a matter before the department or receives compensation for services performed on behalf of another person regarding a matter pending before the department during the one-year period after the date the person ceased to be the commissioner, the general counsel to the commissioner, the public insurance counsel, or an employee of the State Office of
Administrative Hearings.

SECTION 6.055. Section 36.104, Insurance Code, is amended to read as follows:

Sec. 36.104. INFORMAL DISPOSITION OF CERTAIN CONTESTED CASES [CASE]. (a) The commissioner may, on written agreement or stipulation of each party and any intervenor, informally dispose of a contested case in accordance with Section 2001.056, Government Code, notwithstanding any provision of this code that requires a hearing before the commissioner.

(b) This section does not apply to a contested case under Title 5, Labor Code.

SECTION 6.056. Subchapter D, Chapter 36, Insurance Code, is amended by adding Section 36.2015 to read as follows:

Sec. 36.2015. ACTIONS UNDER TITLE 5, LABOR CODE. Notwithstanding Section 36.201, a decision, order, form, or administrative or other rule of the commissioner of workers' compensation under Title 5, Labor Code, or a rule adopted by the commissioner of insurance under Title 5, Labor Code, is subject to judicial review as provided by Title 5, Labor Code.

SECTION 6.057. Subsection (c), Section 40.003, Insurance Code, is amended to read as follows:

(c) This chapter does not apply to a proceeding conducted under Chapter 201 [Article 1.04D] or to a proceeding relating to:

(1) approving or reviewing rates or rating manuals filed by an individual company, unless the rates or manuals are contested;

(2) adopting a rule;
(3) adopting or approving a policy form or policy form
endorsement;

(4) adopting or approving a plan of operation for an
organization subject to the jurisdiction of the department; [or]

(5) adopting a presumptive rate under Chapter 1153; or

(6) a workers' compensation claim brought under Title
5, Labor Code [Article 3.53].

SECTION 6.058. Subsection (c), Section 81.001, Insurance
Code, is amended to read as follows:

(c) This section does not apply to conduct that is:

(1) a violation that is ongoing at the time the
department seeks to impose the sanction, penalty, or fine; [or]

(2) a violation of Subchapter A, Chapter 544 [Article
21.21-6 of this code, as added by Chapter 415, Acts of the 74th
Legislature, Regular Session, 1995], or Section 541.057 [4(7)(a),
Article 21.21 of this code], as those provisions relate to
discrimination on the basis of race or color, regardless of the time
the conduct occurs; or

(3) a violation of Title 5, Labor Code.

SECTION 6.059. Section 84.002, Insurance Code, is amended
by adding Subsection (c) to read as follows:

(c) This chapter applies to a monetary penalty the
department or the commissioner of workers' compensation imposes
under Title 5, Labor Code, only as provided by that title.

SECTION 6.060. Section 843.101, Insurance Code, is amended
by adding Subsection (e) to read as follows:

(e) A health maintenance organization may serve as a
workers' compensation health care network, as defined by Section 1305.004, in accordance with Chapter 1305.

SECTION 6.061. Subsection (b), Section 1301.056, Insurance Code, as effective April 1, 2005, is amended to read as follows:

(b) A party to a preferred provider contract, including a contract with a preferred provider organization, may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority of and prior adequate notification to the other contracting parties. This subsection does not affect the authority of the commissioner of insurance or the commissioner of workers' compensation [or the Texas Workers' Compensation Commission] under this code or Title 5, Labor Code, to request and obtain information.

SECTION 6.062. Section (a), Article 5.65A, Insurance Code, is amended to read as follows:

(a) A company or association that writes workers' compensation insurance in this state shall notify each policyholder of any claim that is filed against the policy. Thereafter a company shall notify the policyholder of any proposal to settle a claim or, on receipt of a written request from the policyholder, of any administrative or judicial proceeding relating to the resolution of a claim[. including a benefit review conference conducted by the Texas Workers' Compensation Commission].

SECTION 6.063. Subsections (a), (e), (g)-(i), (k), and (l), Section 8, Article 5.76-3, Insurance Code, are amended to read as follows:

(a) The company may make and enforce requirements for the
prevention of injuries to employees of its policyholders or applicants for insurance under this article. For this purpose, representatives of the company[, representatives of the commission,] or representatives of the department on reasonable notice shall be granted free access to the premises of each policyholder or applicant during regular working hours.

(e) The policyholder shall obtain the safety consultation not later than the 30th day after the effective date of the policy and shall obtain the safety consultation from the division of workers' compensation [health and safety] of the department [commission], the company, or another professional source approved for that purpose by the division of workers' compensation [health and safety]. The safety consultant shall file a written report with the division [commission] and the policyholder setting out any hazardous conditions or practices identified by the safety consultation.

(g) The division of workers' compensation [health and safety] of the department [commission] may investigate accidents occurring at the work sites of a policyholder for whom a plan has been developed under Subsection (f) of this section, and the division may otherwise monitor the implementation of the accident prevention plan as it finds necessary.

(h) In accordance with rules adopted by the commissioner of workers' compensation [commission], not earlier than 90 days or later than six months after the development of an accident prevention plan under Subsection (f) of this section, the division of workers' compensation [health and safety] of the department
[commission] shall conduct a follow-up inspection of the policyholder's premises. The division [commission] may require the participation of the safety consultant who performed the initial consultation and developed the safety plan. If the commissioner of workers' compensation [division] determines that the policyholder has complied with the terms of the accident prevention plan or has implemented other accepted corrective measures, the commissioner of workers' compensation [division] shall so certify. If a policyholder fails or refuses to implement the accident prevention plan or other suitable hazard abatement measures, the policyholder may elect to cancel coverage not later than the 30th day after the date of the [division] determination. If the policyholder does not elect to cancel, the company may cancel the coverage or the commissioner of workers' compensation [commission] may assess an administrative penalty not to exceed $5,000. Each day of noncompliance constitutes a separate violation. Penalties collected under this section shall be deposited in the general revenue fund and may be appropriated [to the credit of the commission or reappropriated] to the division of workers' compensation of the department [commission] to offset the costs of implementing and administering this section.

(i) In assessing an administrative penalty, the commissioner of workers' compensation [commission] may consider any matter that justice may require and shall consider:

(1) the seriousness of the violation, including the nature, circumstances, consequences, extent, and gravity of the prohibited act;
(2) the history and extent of previous administrative violations;

(3) the demonstrated good faith of the violator, including actions taken to rectify the consequences of the prohibited act;

(4) any economic benefit resulting from the prohibited act; and

(5) the penalty necessary to deter future violations.

(k) The division of workers' compensation of the department shall charge the policyholder for the reasonable cost of services provided under Subsections (e), (f), and (h) of this section. The fees for those services shall be set at a cost-reimbursement level including a reasonable allocation of the division's administrative costs.

(l) The division of workers' compensation of the department shall enforce compliance with this section through the administrative violation proceedings under Chapter 415, Labor Code.

SECTION 6.064. Subsections (a), (b), and (e), Section 9, Article 5.76-3, Insurance Code, are amended to read as follows:

(a) The company shall develop and implement a program to identify and investigate fraud and violations of this code relating to workers' compensation insurance by an applicant, policyholder, claimant, agent, insurer, health care provider, or other person. The company shall cooperate with the division of workers' compensation of the department to compile and maintain information necessary to detect practices or patterns of conduct
that violate this code relating to the workers' compensation insurance or Subtitle A, Title 5, Labor Code (the Texas Workers' Compensation Act).

(b) The company may conduct investigations of cases of suspected fraud and violations of this code relating to workers' compensation insurance. The company may:

(1) coordinate its investigations with those conducted by the division of workers' compensation of the department [commission] to avoid duplication of efforts; and

(2) refer cases that are not otherwise resolved by the company to the division of workers' compensation of the department [commission] to:

(A) perform any further investigations that are necessary under the circumstances;

(B) conduct administrative violation proceedings; and

(C) assess and collect penalties and restitution.

(e) Penalties collected under Subsection (b) of this section shall be deposited in the Texas Department of Insurance operating account [general revenue fund to the credit of the commission] and shall be appropriated to the division of workers' compensation of the department [commission] to offset the costs of this program.

SECTION 6.065. Subsection (a), Section 10, Article 5.76-3, Insurance Code, is amended to read as follows:

(a) Information maintained in the investigation files of
the company is confidential and may not be disclosed except:

(1) in a criminal proceeding;
(2) in a hearing conducted by the division of workers' compensation of the department [commission];
(3) on a judicial determination of good cause; or
(4) to a governmental agency, political subdivision, or regulatory body if the disclosure is necessary or proper for the enforcement of the laws of this or another state or of the United States.

SECTION 6.066. Subsection (e), Section 12, Article 5.76-3, Insurance Code, is amended to read as follows:

(e) The company shall file annual statements with the department [and the commission] in the same manner as required of other workers' compensation insurance carriers, and the commissioner shall include a report on the company's condition in the commissioner's annual report under Section 32.021 of this code.

SECTION 6.067. Subsection (b), Section 16, Article 5.76-3, Insurance Code, is amended to read as follows:

(b) The company shall file with the department [and the commission] all reports required of other workers' compensation insurers.

SECTION 6.068. Subsections (a) and (c), Section 10, Article 5.76-5, Insurance Code, are amended to read as follows:

(a) A maintenance tax surcharge is assessed against:
(1) each insurance company writing workers' compensation insurance in this state;
(2) each certified self-insurer under Chapter 407,
Labor Code [as provided in Chapter D, Article 3, Texas Workers' Compensation Act (Article 8308-3.51 et seq., Vernon's Texas Civil Statutes)]; and

(3) the fund.

(c) On determining [receiving notice of] the rate of assessment [set by the Texas Workers' Compensation Commission] under Section 403.003, Labor Code [2.23, Texas Workers' Compensation Act (Article 8308-2.23, Vernon's Texas Civil Statutes)], the commissioner [State Board of Insurance] shall increase the tax rate to a rate sufficient to pay all debt service on the bonds subject to the maximum tax rate established by Section 403.002, Labor Code [2.22, Texas Workers' Compensation Act (Article 8308-2.22, Vernon's Texas Civil Statutes)]. If the resulting tax rate is insufficient to pay all costs for the department under this article [Texas Workers' Compensation Commission] and all debt service on the bonds, the commissioner [State Board of Insurance] may assess an additional surcharge not to exceed one percent of gross workers' compensation premiums to cover all debt service on the bonds. In this code, the maintenance tax surcharge includes the additional maintenance tax assessed under this subsection and the surcharge assessed under this subsection to pay all debt service of the bonds.

SECTION 6.069. Section 3A, Article 21.28, Insurance Code, is amended to read as follows:

Sec. 3A. WORKERS' COMPENSATION CARRIER: NOTIFICATION [OF TEXAS WORKERS' COMPENSATION COMMISSION]. (a) The liquidator shall notify the department [Texas Workers' Compensation Commission]
immediately upon a finding of insolvency or impairment upon any
insurance company which has in force any workers' compensation
coverage in Texas.

(b) The department [Texas Workers' Compensation Commission]
shall, upon said notice, submit to the liquidator a list of active
cases pending before the division of workers' compensation of the
department [Texas Workers' Compensation Commission] in which there
has been an acceptance of liability by the carrier, where it appears
that no bona fide dispute exists and where payments were commenced
prior to the finding of insolvency or impairment and where future or
past indemnity or medical payments are due.

(c) Notwithstanding the provisions of Section 3 of this
Article, the liquidator is authorized to commence or continue the
payment of claims based upon the list submitted in Subsection (b)
above.

(d) In order to avoid undue delay in the payment of covered
workers' compensation claims, the liquidator shall contract with
the Texas Workers' Compensation Pool or any [other] qualified
organization for claims adjusting. Files and information delivered
by the department [Texas Workers' Compensation Commission] to the
liquidator may be delivered to the [Texas Workers' Compensation
Pool or any] organization with which the liquidator has contracted
for claims adjusting services.

(e) The Texas Workers' Compensation Commission shall report
to the State Board of Insurance any occasion when a workers'
compensation insurer has committed acts that may indicate insurer
financial impairment, delinquency or insolvency.]
SECTION 6.070. Subsection (d), Section 8, Article 21.28-C, Insurance Code, is amended to read as follows:
(d) The association shall investigate and adjust, compromise, settle, and pay covered claims to the extent of the association's obligation and deny all other claims. The association may review settlements, releases, and judgments to which the impaired insurer or its insureds were parties to determine the extent to which those settlements, releases, and judgments may be properly contested. Any judgment taken before the designation of impairment in which an insured under a liability policy or the insurer failed to exhaust all appeals, any judgment taken by default or consent against an insured or the impaired insurer, and any settlement, release, or judgment entered into by the insured or the impaired insurer, is not binding on the association, and may not be considered as evidence of liability or of damages in connection with any claim brought against the association or any other party under this Act. Notwithstanding any other provision of this Act, a covered claim shall not include any claim filed with the guaranty association on a date that is later than eighteen months after the date of the order of liquidation, except that a claim for workers' compensation benefits is governed by Title 5, Labor Code, and the applicable rules of the commissioner of workers' compensation [Texas Workers' Compensation Commission].

SECTION 6.071. Subsection (l), Section 4, Article 21.58A, Insurance Code, is amended to read as follows:
(l) Unless precluded or modified by contract, a utilization review agent shall reimburse health care providers for the...
reasonable costs for providing medical information in writing, including copying and transmitting any requested patient records or other documents. A health care provider's charges for providing medical information to a utilization review agent shall not exceed the cost of copying set by rule of the commissioner of workers' compensation [Texas Workers' Compensation Commission] for records regarding a workers' compensation claim and may not include any costs that are otherwise recouped as a part of the charge for health care.

SECTION 6.072. Subsection (c), Section 14, Article 21.58A, Insurance Code, is amended to read as follows:

(c) Except as otherwise provided by this subsection, this article applies to utilization review of health care services provided to persons eligible for workers' compensation medical benefits under Title 5, Labor Code. The commissioner of workers' compensation shall regulate in the manner provided by this article a person who performs review of a medical benefit provided under Title 5 [Chapter 408], Labor Code. [This subsection does not affect the authority of the Texas Workers' Compensation Commission to exercise the powers granted to that commission under Title 5, Labor Code.] In the event of a conflict between this article and Title 5, Labor Code, Title 5, Labor Code, prevails. The commissioner of workers' compensation [and the Texas Workers' Compensation Commission] may adopt rules [and enter into memoranda of understanding] as necessary to implement this subsection.

PART 3. CONFORMING AMENDMENTS--OTHER CODES

SECTION 6.101. Section 92.009, Health and Safety Code, is
amended to read as follows:

Sec. 92.009. COORDINATION WITH TEXAS DEPARTMENT OF INSURANCE [WORKERS’ COMPENSATION COMMISSION]. The department and the Texas Department of Insurance [Workers’ Compensation Commission] shall enter into a memorandum of understanding which shall include the following:

(1) the department and the Texas Department of Insurance [commission] shall exchange relevant injury data on an ongoing basis notwithstanding Section 92.006;

(2) confidentiality of injury data provided to the department by the Texas Department of Insurance [commission] is governed by Subtitle A, Title 5, Labor Code;

(3) confidentiality of injury data provided to the Texas Department of Insurance [commission] by the department is governed by Section 92.006; and

(4) cooperation in conducting investigations of work-related injuries.

SECTION 6.102. Subsection (a), Section 160.006, Occupations Code, is amended to read as follows:

(a) A record, report, or other information received and maintained by the board under this subchapter or Subchapter B, including any material received or developed by the board during an investigation or hearing and the identity of, and reports made by, a physician performing or supervising compliance monitoring for the board, is confidential. The board may disclose this information only:

(1) in a disciplinary hearing before the board or in a
subsequent trial or appeal of a board action or order;

(2) to the physician licensing or disciplinary
authority of another jurisdiction, to a local, state, or national
professional medical society or association, or to a medical peer
review committee located inside or outside this state that is
concerned with granting, limiting, or denying a physician hospital
privileges;

(3) under a court order;

(4) to qualified personnel for bona fide research or
educational purposes, if personally identifiable information
relating to any physician or other individual is first deleted; or

(5) to the division of workers' compensation of the
Texas Department of Insurance [Workers' Compensation Commission]
as provided by Section 413.0514, Labor Code.

ARTICLE 7. REPEALER

SECTION 7.01. The following laws are repealed:

(1) Subdivision (2), Section 1, Article 5.76-3, 
Insurance Code;

(2) Section 401.002, Labor Code;

(3) Section 402.0015, Labor Code;

(4) Section 402.003, Labor Code;

(5) Section 402.004, Labor Code;

(6) Section 402.005, Labor Code;

(7) Section 402.006, Labor Code;

(8) Section 402.007, Labor Code;

(9) Section 402.008, Labor Code;

(10) Section 402.009, Labor Code;
ARTICLE 8. TRANSITION; EFFECTIVE DATE

SECTION 8.001. ABOLITION OF TEXAS WORKERS’ COMPENSATION COMMISSION; GENERAL TRANSFER OF AUTHORITY TO TEXAS DEPARTMENT OF
INSURANCE; DIVISION OF WORKERS' COMPENSATION. (a) The Texas Workers' Compensation Commission is abolished on the effective date of this Act.

(b) Except as otherwise provided by this article, all powers, duties, obligations, rights, contracts, funds, unspent appropriations, records, real or personal property, and personnel of the Texas Workers' Compensation Commission shall be transferred to the division of workers' compensation of the Texas Department of Insurance not later than February 28, 2006.

(c) The division of workers' compensation of the Texas Department of Insurance created under Chapter 402, Labor Code, as amended by this Act, is established September 1, 2005.

(d) The governor shall appoint the commissioner of workers' compensation under Section 402.0018, Labor Code, as added by this Act, not later than October 1, 2005.

SECTION 8.002. OFFICE OF INJURED EMPLOYEE COUNSEL. (a) The office of injured employee counsel created under Chapter 404, Labor Code, as added by this Act, is established September 1, 2005.

(b) The governor shall appoint the injured employee public counsel of the office of injured employee counsel not later than October 1, 2005.

(c) The injured employee public counsel of the office of injured employee counsel shall adopt initial rules for the office under Section 404.006, Labor Code, as added by this Act, not later than March 1, 2006.

(d) The Texas Department of Insurance shall provide, in Austin and in each regional office operated by the division of
workers' compensation of the department to administer Subtitle A, Title 5, Labor Code, as amended by this Act, suitable office space, personnel services, computer support, and other administrative support to the office of injured employee counsel as required by Chapter 404, Labor Code, as added by this Act. The department shall provide the facilities and support not later than October 1, 2005.

(e) All powers, duties, obligations, rights, contracts, funds, unspent appropriations, records, real or personal property, and personnel of the Texas Workers' Compensation Commission relating to the operation of the workers' compensation ombudsman program under Subchapter C, Chapter 409, Labor Code, as that subchapter existed before amendment by this Act, shall be transferred to the office of injured employee counsel not later than March 1, 2006. An ombudsman transferred to the office of injured employee counsel under this section shall begin providing services under Chapter 404, Labor Code, as added by this Act, not later than March 1, 2006.

SECTION 8.003. INITIAL REPORT OF WORKERS' COMPENSATION RESEARCH AND EVALUATION GROUP. The workers' compensation research and evaluation group shall submit the initial report required under Section 405.0025, Labor Code, as added by this Act, not later than December 1, 2008.

SECTION 8.004. CONTINUATION OF CERTAIN POLICIES, PROCEDURES, OR DECISIONS. (a) A policy, procedure, or decision of the Texas Workers' Compensation Commission relating to a duty of that commission that is transferred to the authority of the Texas Department of Insurance under Subtitle A, Title 5, Labor Code, as
amended by this Act, continues in effect as a policy, procedure, or
decision of the commissioner of insurance or the commissioner of
workers' compensation until superseded by an act of the
commissioner of insurance or the commissioner of workers' compensation.

(b) A policy, procedure, or decision of the Texas Workers' Compensation Commission relating to a duty of that commission that is transferred to the authority of the office of injured employee counsel established under Chapter 404, Labor Code, as added by this Act, continues in effect as a policy, procedure, or decision of the office of injured employee counsel until superseded by an act of the injured employee public counsel.

(c) Except as otherwise provided by this article, the validity of a plan or procedure adopted, contract or acquisition made, proceeding begun, grant or loan awarded, obligation incurred, right accrued, or other action taken by or in connection with the authority of the Texas Workers' Compensation Commission before that commission is abolished under Section 8.001 of this article is not affected by the abolishment.

SECTION 8.005. RULES. (a) The commissioner of insurance and the commissioner of workers' compensation shall adopt rules relating to the transfer of the workers' compensation programs assigned to the Texas Department of Insurance under Subtitle A, Title 5, Labor Code, as amended by this Act, not later than December 1, 2005.

(b) The injured employee public counsel of the office of injured employee counsel established under Chapter 404, Labor Code,
as added by this Act, shall adopt rules relating to the transfer of
the programs assigned to the office of injured employee counsel
under Subtitle A, Title 5, Labor Code, as amended by this Act, not
later than March 1, 2006.

(c) A rule of the Texas Workers' Compensation Commission
relating to a duty of that commission that is transferred to the
authority of the division of workers' compensation of the Texas
Department of Insurance under Subtitle A, Title 5, Labor Code, as
amended by this Act, continues in effect as a rule of the
commissioner of workers' compensation until the date on which the
rule is superseded by a rule adopted by the commissioner of workers'
compensation.

(d) A rule of the Texas Workers' Compensation Commission
relating to a duty of that commission that is transferred to the
authority of the office of injured employee counsel under Subtitle
A, Title 5, Labor Code, as amended by this Act, continues in effect
as a rule of the injured employee public counsel of the office of
injured employee counsel until the date on which the rule is
superseded by a rule adopted by the injured employee public
counsel.

(e) The commissioner of insurance and the commissioner of
workers' compensation may identify rules required by the passage of
this Act that require adoption on an emergency basis, and may use
the procedures established under Section 2001.034, Government
Code, for adopting those rules. The commissioner of insurance and
the commissioner of workers' compensation are not required to make
the finding described by Subsection (a), Section 2001.034,
Government Code, to adopt emergency rules under this subsection.

SECTION 8.006. BUDGET EXECUTION AUTHORITY.

Notwithstanding Subsection (e), Section 317.005, Government Code, the Legislative Budget Board may adopt an order under Section 317.005, Government Code, affecting any portion of the total appropriation of the Texas Department of Insurance or office of injured employee counsel if necessary to implement the provisions of this Act. This section expires March 31, 2006.

SECTION 8.007. RULES REGARDING MEDICAL EXAMINATIONS. The commissioner of workers' compensation shall adopt rules to implement the changes in law made to Sections 408.004 and 408.0041, Labor Code, as amended by this Act, on or before February 1, 2006. The changes in law made to Sections 408.004 and 408.0041, Labor Code, are effective on the date provided by commissioner rule.

SECTION 8.008. ELECTRONIC BILLING RULES. The commissioner of workers' compensation shall adopt rules under Section 408.0251, Labor Code, as added by this Act, not later than January 1, 2006.

SECTION 8.009. ACCRUAL OF RIGHT TO INCOME BENEFITS. Sections 408.047 and 408.082, Labor Code, as amended by this Act, apply only to a claim for workers' compensation benefits based on a compensable injury that occurs on or after the effective date of this Act. A claim based on a compensable injury that occurs before that date is governed by the law in effect on the date that the compensable injury occurred, and the former law is continued in effect for that purpose.

SECTION 8.010. ELIGIBILITY FOR PILOT PROGRAM. The pilot program established under Section 413.022, Labor Code, as added by
this Act, takes effect January 1, 2006.

SECTION 8.011. REPORTS. (a) Not later than October 1, 2006, the commissioner of workers' compensation shall report to the governor, the lieutenant governor, the speaker of the house of representatives, and the members of the 79th Legislature regarding the implementation of Section 408.1225, Labor Code, as added by this Act.

(b) Not later than October 1, 2008, the commissioner of workers' compensation shall report to the governor, the lieutenant governor, the speaker of the house of representatives, and the members of the legislature regarding the implementation of the pilot program established by Section 413.022, Labor Code, as added by this Act, and the results of the pilot program. The report must include any recommendations regarding the continuation of the pilot program, including any changes required to enhance the effectiveness of the program.

(c) The commissioner of insurance shall submit the initial report required under Subsection (e), Section 3, Article 5.55, Insurance Code, as added by this Act, not later than December 1, 2006.

(d) The commissioner of insurance shall submit to the governor, the lieutenant governor, the speaker of the house of representatives, and the members of the legislature the first report under Section 1305.501, Insurance Code, as added by this Act, not later than December 1, 2008.

SECTION 8.012. ABOLITION OF MEDICAL ADVISORY COMMITTEE. The medical advisory committee established under Section 413.005,
Labor Code, as that section existed prior to repeal by this Act, is abolished on the effective date of this Act.

SECTION 8.013. STATE OFFICE OF ADMINISTRATIVE HEARINGS REVIEW. (a) This section applies to a hearing conducted by the State Office of Administrative Hearings under Subsection (k), Section 413.031, Labor Code, as that subsection existed prior to amendment by this Act.

(b) Effective September 1, 2005, the State Office of Administrative Hearings may not accept for hearing a medical dispute that remains unresolved pursuant to Section 413.031, Labor Code. A medical dispute that is not pending for a hearing by the State Office of Administrative Hearings on or before August 31, 2005, is subject to Subsection (k), Section 413.031, Labor Code, as amended by this Act, and is not subject to a hearing before the State Office of Administrative Hearings.

SECTION 8.014. IMPLEMENTATION OF WORKERS' COMPENSATION HEALTH CARE NETWORKS. (a) The commissioner of insurance shall adopt rules as necessary to implement Chapter 1305, Insurance Code, as added by this Act, not later than December 1, 2005. The Texas Department of Insurance shall accept applications from a network seeking certification under Chapter 1305, Insurance Code, as added by this Act, beginning January 1, 2006.

(b) An insurance carrier may begin to offer workers' compensation medical benefits through a network under Chapter 1305, Insurance Code, as added by this Act, on certification of the network by the commissioner of insurance.

SECTION 8.015. CONSUMER REPORT CARD. The Texas Department
of Insurance shall issue the first annual workers' compensation consumer report card under Section 1305.502, Insurance Code, as added by this Act, not later than 18 months after the date on which that department certifies the first workers' compensation health care network under Chapter 1305, Insurance Code, as added by this Act.

SECTION 8.016. APPLICATION TO MEDICAL BENEFITS.
(a) Article 4 of this Act applies to a claim for workers' compensation medical benefits based on a compensable injury incurred by an employee whose employer elects to provide workers' compensation insurance coverage if the insurance carrier of the employer enters into a contract to provide workers' compensation medical benefits through a network certified under Chapter 1305, Insurance Code, as added by this Act.

(b) A claim for workers' compensation medical benefits based on a compensable injury that occurs on or after the effective date of a contract described by Subsection (a) of this section is subject to the provisions of Chapter 1305, Insurance Code, as added by this Act.

(c) Notwithstanding Subsection (a) of this section, an injured employee who receives workers' compensation medical benefits based on a compensable injury that occurs before the effective date of this Act is subject to the provisions of Chapter 1305, Insurance Code, as added by this Act, and must receive treatment through a network health care provider if the insurer liable for the payment of benefits on that claim elects to use a workers' compensation health care network to provide medical
benefits and the claimant lives in a network service area. The insurer shall notify affected injured employees in writing of the election.

SECTION 8.017. APPLICATION TO SANCTIONS AND VIOLATIONS.
(a) The changes in law made by this Act apply only to a penalty or sanction for an offense or violation committed on or after the effective date of this Act.
(b) For purposes of this section, an offense or violation is committed before the effective date of this Act if any element of the offense occurs before that date.
(c) An offense committed before the effective date of this Act is governed by the law in effect when the offense was committed, and the former law is continued in effect for that purpose.

SECTION 8.018. EFFECT OF UPDATE ACT. To the extent of any conflict, this Act prevails over another Act of the 79th Legislature, Regular Session, 2005, relating to nonsubstantive additions to and corrections in enacted codes (the General Code Update bill).

SECTION 8.019. REFERENCES IN LAW. (a) A reference in law to the Texas Workers' Compensation Commission means the division of workers' compensation of the Texas Department of Insurance or the office of injured employee counsel as consistent with the respective duties of those state governmental entities under the Labor Code, the Insurance Code, and other laws of this state, as amended by this Act.
(b) A reference in Title 5, Labor Code, or any other law to the division of workers' health and safety, the division of medical

365
review, the division of compliance and practices, the division of
hearings, and the division of self-insurance regulation of the
former Texas Workers' Compensation Commission means the division of
workers' compensation of the Texas Department of Insurance.

SECTION 8.020. EFFECTIVE DATE. Except as otherwise
provided by this article, this Act takes effect September 1, 2005.
H.B. No. 7

President of the Senate

I certify that H.B. No. 7 was passed by the House on March 31, 2005, by a non-record vote; that the House refused to concur in Senate amendments to H.B. No. 7 on May 19, 2005, and requested the appointment of a conference committee to consider the differences between the two houses; and that the House adopted the conference committee report on H.B. No. 7 on May 28, 2005, by a non-record vote.

Speaker of the House

Chief Clerk of the House
H.B. No. 7

I certify that H.B. No. 7 was passed by the Senate, with amendments, on May 13, 2005, by the following vote: Yeas 30, Nays 0; at the request of the House, the Senate appointed a conference committee to consider the differences between the two houses; and that the Senate adopted the conference committee report on H.B. No. 7 on May 29, 2005, by the following vote: Yeas 31, Nays 0.

____________________________
Secretary of the Senate

APPROVED: __________________
Date

__________________________
Governor