

1-1 By: Staples, Nelson S.B. No. 5
1-2 (In the Senate - Filed January 13, 2005; February 1, 2005,
1-3 read first time and referred to Committee on State Affairs;
1-4 March 9, 2005, reported adversely, with favorable Committee
1-5 Substitute by the following vote: Yeas 9, Nays 0; March 9, 2005,
1-6 sent to printer.)

1-7 COMMITTEE SUBSTITUTE FOR S.B. No. 5 By: Williams

1-8 A BILL TO BE ENTITLED
1-9 AN ACT

1-10 relating to the continuation and operation of the workers'
1-11 compensation system of this state, including changing the name of
1-12 the Texas Workers' Compensation Commission to the Texas Department
1-13 of Workers' Compensation, the powers and duties of the governing
1-14 authority of that department, the provision of workers'
1-15 compensation benefits to injured employees, and the regulation of
1-16 workers' compensation insurers; providing administrative
1-17 penalties.

1-18 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

1-19 ARTICLE 1. ORGANIZATION OF DEPARTMENT

1-20 SECTION 1.001. Subchapter A, Chapter 402, Labor Code, is
1-21 amended to read as follows:

1-22 SUBCHAPTER A. ORGANIZATION

1-23 Sec. 402.001. DUTIES OF DEPARTMENT. In addition to the
1-24 other duties required of the Texas Department of Workers'
1-25 Compensation, the department shall:

1-26 (1) regulate the business of workers' compensation in
1-27 this state; and

1-28 (2) ensure that this title and other laws regarding
1-29 workers' compensation are executed.

1-30 Sec. 402.002. COMPOSITION OF DEPARTMENT. The department is
1-31 composed of the commissioner and other officers and employees as
1-32 required to efficiently implement:

1-33 (1) this title;
1-34 (2) other workers' compensation laws of this state;

1-35 and
1-36 (3) other laws granting jurisdiction or applicable to
1-37 the department or the commissioner.

1-38 Sec. 402.003. CHIEF EXECUTIVE. (a) The commissioner is
1-39 the department's chief executive and administrative officer. The
1-40 commissioner shall administer and enforce this title, other
1-41 workers' compensation laws of this state, and other laws granting
1-42 jurisdiction to or applicable to the department or the
1-43 commissioner.

1-44 (b) The commissioner has the powers and duties vested in the
1-45 department by this title and other workers' compensation laws of
1-46 this state.

1-47 Sec. 402.004. APPOINTMENT; TERM. (a) The governor, with
1-48 the advice and consent of the senate, shall appoint the
1-49 commissioner. The commissioner serves a two-year term that expires
1-50 on February 1 of each odd-numbered year.

1-51 (b) The governor shall appoint the commissioner without
1-52 regard to the race, color, disability, sex, religion, age, or
1-53 national origin of the appointee.

1-54 Sec. 402.005. QUALIFICATIONS. The commissioner must:

1-55 (1) be a competent and experienced administrator;

1-56 (2) be well informed and qualified in the field of
1-57 workers' compensation; and

1-58 (3) have at least five years of experience as an
1-59 executive in the administration of business or government or as a
1-60 practicing attorney, physician, or certified public accountant.

1-61 Sec. 402.006. INELIGIBILITY FOR PUBLIC OFFICE. The
1-62 commissioner is ineligible to be a candidate for a public elective
1-63 office in this state unless the commissioner has resigned and the

2-1 governor has accepted the resignation.

2-2 Sec. 402.007. COMPENSATION. The commissioner is entitled
 2-3 to compensation as provided by the General Appropriations Act.
 2-4 [MEMBERSHIP REQUIREMENTS. (a) The Texas Workers' Compensation
 2-5 Commission is composed of six members appointed by the governor
 2-6 with the advice and consent of the senate.

2-7 [(b) Appointments to the commission shall be made without
 2-8 regard to the race, color, disability, sex, religion, age, or
 2-9 national origin of the appointee. Section 401.011(16) does not
 2-10 apply to the use of the term "disability" in this subsection.

2-11 [(c) Three members of the commission must be employers of
 2-12 labor and three members of the commission must be wage earners. A
 2-13 person is not eligible for appointment as a member of the commission
 2-14 if the person provides services subject to regulation by the
 2-15 commission or charges fees that are subject to regulation by the
 2-16 commission.

2-17 [(d) In making appointments to the commission, the governor
 2-18 shall attempt to reflect the social, geographic, and economic
 2-19 diversity of the state. To ensure balanced representation, the
 2-20 governor may consider:

2-21 [(1) the geographic location of a prospective
 2-22 appointee's domicile;

2-23 [(2) the prospective appointee's experience as an
 2-24 employer or wage earner;

2-25 [(3) the number of employees employed by a prospective
 2-26 member who would represent employers; and

2-27 [(4) the type of work performed by a prospective
 2-28 member who would represent wage earners.

2-29 [(e) The governor shall consider the factors listed in
 2-30 Subsection (d) in appointing a member to fill a vacancy on the
 2-31 commission.

2-32 [(f) In making an appointment to the commission, the
 2-33 governor shall consider recommendations made by groups that
 2-34 represent employers or wage earners.

2-35 [Sec. 402.0015. TRAINING PROGRAM FOR COMMISSION MEMBERS.
 2-36 (a) Before a member of the commission may assume the member's
 2-37 duties, the member must complete the training program established
 2-38 under this section.

2-39 [(b) A training program established under this section must
 2-40 provide information to the member regarding:

2-41 [(1) the enabling legislation that created the
 2-42 commission;

2-43 [(2) the programs operated by the commission;

2-44 [(3) the role and functions of the commission;

2-45 [(4) the rules of the commission, with an emphasis on
 2-46 the rules that relate to disciplinary and investigatory authority;

2-47 [(5) the current budget for the commission;

2-48 [(6) the results of the most recent formal audit of the
 2-49 commission;

2-50 [(7) the requirements of:

2-51 [(A) the open meetings law, Chapter 551,
 2-52 Government Code;

2-53 [(B) the open records law, Chapter 552,
 2-54 Government Code; and

2-55 [(C) the administrative procedure law, Chapter
 2-56 2001, Government Code;

2-57 [(8) the requirements of the conflict of interest laws
 2-58 and other laws relating to public officials; and

2-59 [(9) any applicable ethics policies adopted by the
 2-60 commission or the Texas Ethics Commission.

2-61 [Sec. 402.002. TERMS, VACANCY. (a) Members of the
 2-62 commission hold office for staggered two-year terms, with the terms
 2-63 of three members expiring on February 1 of each year.

2-64 [(b) If a vacancy occurs during a term, the governor shall
 2-65 fill the vacancy for the unexpired term. The replacement must be
 2-66 from the group represented by the member being replaced.]

2-67 Sec. 402.008 [402.003]. EFFECT OF LOBBYING ACTIVITY. A
 2-68 person may not serve as commissioner [a member of the commission] or
 2-69 act as the general counsel to the department [commission] if the

3-1 person is required to register as a lobbyist under Chapter 305,
 3-2 Government Code, because of the person's activities for
 3-3 compensation on behalf of a profession that is regulated by or that
 3-4 has fees regulated by the department [~~commission~~].

3-5 [~~Sec. 402.004. VOTING REQUIREMENTS. (a) The commission~~
 3-6 ~~may take action only by a majority vote of its membership.~~

3-7 [~~(b) Decisions regarding the employment of an executive~~
 3-8 ~~director require the affirmative vote of at least two commissioners~~
 3-9 ~~representing employers and two commissioners representing wage~~
 3-10 ~~earners.]~~

3-11 Sec. 402.009. GROUNDS FOR REMOVAL. [~~402.005. REMOVAL OF~~
 3-12 ~~COMMISSION MEMBERS.]~~ (a) It is a ground for removal from office if
 3-13 the commissioner [~~the commission if a member~~]:

3-14 (1) does not have at the time of appointment the
 3-15 qualifications required by Section 402.005 [~~for appointment to the~~
 3-16 ~~commission~~];

3-17 (2) does not maintain during service as commissioner
 3-18 [~~on the commission~~] the qualifications required by Section 402.005
 3-19 [~~for appointment to the commission~~];

3-20 (3) violates a prohibition established by Section
 3-21 402.008 [~~402.003~~] or 402.012; or

3-22 (4) cannot because of illness or incapacity discharge
 3-23 the commissioner's [~~member's~~] duties for a substantial part of the
 3-24 commissioner's term [~~for which the member is appointed, or~~

3-25 [~~(5) is absent from more than half of the regularly~~
 3-26 ~~scheduled commission meetings that the member is eligible to attend~~
 3-27 ~~during a calendar year].~~

3-28 (b) The validity of an action of the commissioner or the
 3-29 department [~~commission~~] is not affected by the fact that it is taken
 3-30 when a ground for removal of the commissioner [~~a commission member~~]
 3-31 exists.

3-32 [~~(c) If the executive director of the commission knows that~~
 3-33 ~~a potential ground for removal exists, the executive director shall~~
 3-34 ~~notify the chairman of the commission of the potential ground. The~~
 3-35 ~~chairman shall then notify the governor and the attorney general~~
 3-36 ~~that a potential ground for removal exists. If the potential ground~~
 3-37 ~~for removal involves the chairman, the executive director shall~~
 3-38 ~~notify the next highest officer of the commission, who shall notify~~
 3-39 ~~the governor and the attorney general that a potential ground for~~
 3-40 ~~removal exists.]~~

3-41 Sec. 402.010 [~~402.006~~]. PROHIBITED GIFTS; ADMINISTRATIVE
 3-42 VIOLATION. [~~(a)~~] The commissioner [~~A member~~] or an employee of
 3-43 the department [~~commission~~] may not accept a gift, gratuity, or
 3-44 entertainment from a person having an interest in a matter or
 3-45 proceeding pending before the department [~~commission~~].

3-46 [~~(b) A violation of Subsection (a) is a Class A~~
 3-47 ~~administrative violation and constitutes a ground for removal from~~
 3-48 ~~office or termination of employment.~~

3-49 [~~Sec. 402.007. MEETINGS. The commission shall meet at~~
 3-50 ~~least once in each calendar quarter and may meet at other times at~~
 3-51 ~~the call of the chairman or as provided by the rules of the~~
 3-52 ~~commission.~~

3-53 [~~Sec. 402.008. CHAIRMAN. (a) The governor shall designate~~
 3-54 ~~a member of the commission as the chairman of the commission to~~
 3-55 ~~serve in that capacity for a two-year term expiring February 1 of~~
 3-56 ~~each odd-numbered year. The governor shall alternate the~~
 3-57 ~~chairmanship between the members who are employers and the members~~
 3-58 ~~who are wage earners.~~

3-59 [~~(b) The chairman may vote on all matters before the~~
 3-60 ~~commission.~~

3-61 [~~Sec. 402.009. LEAVE OF ABSENCE. (a) An employer may not~~
 3-62 ~~terminate the employment of an employee who is appointed as a member~~
 3-63 ~~of the commission because of the exercise by the employee of duties~~
 3-64 ~~required as a commission member.~~

3-65 [~~(b) A member of the commission is entitled to a leave of~~
 3-66 ~~absence from employment for the time required to perform commission~~
 3-67 ~~duties. During the leave of absence, the member may not be~~
 3-68 ~~subjected to loss of time, vacation time, or other benefits of~~
 3-69 ~~employment, other than salary.]~~

4-1 Sec. ~~402.011~~ [402.010]. CIVIL LIABILITY OF THE
 4-2 COMMISSIONER [MEMBER]. The commissioner [A member of the
 4-3 ~~commission~~] is not liable in a civil action for an act performed in
 4-4 good faith in the execution of duties as commissioner [~~a commission~~
 4-5 ~~member~~].

4-6 ~~[Sec. 402.011. REIMBURSEMENT. (a) A member of the~~
 4-7 ~~commission is entitled to reimbursement for actual and necessary~~
 4-8 ~~expenses incurred in performing functions as a member of the~~
 4-9 ~~commission. Reimbursement under this subsection may not exceed a~~
 4-10 ~~limit established in the General Appropriations Act.~~

4-11 ~~[(b) A member is entitled to reimbursement for actual lost~~
 4-12 ~~wages or use of leave benefits, if any, for:~~

4-13 ~~[(1) attendance at commission meetings and hearings;~~
 4-14 ~~[(2) preparation for a commission meeting, not to~~
 4-15 ~~exceed two days in each calendar quarter;~~

4-16 ~~[(3) attendance at a subcommittee meeting, not to~~
 4-17 ~~exceed one day each month;~~

4-18 ~~[(4) attendance by the chair or vice chair of the~~
 4-19 ~~commission at a legislative committee meeting if attendance is~~
 4-20 ~~requested by the committee chair; and~~

4-21 ~~[(5) attendance at a meeting by a member appointed to~~
 4-22 ~~the Research and Oversight Council on Workers' Compensation or the~~
 4-23 ~~Texas Certified Self-Insured Guaranty Association.~~

4-24 ~~[(c) Reimbursement under Subsection (b) may not exceed \$100~~
 4-25 ~~a day and \$5,000 a year.~~

4-26 ~~[(d) A member of the commission is entitled to reimbursement~~
 4-27 ~~for actual and necessary expenses for attendance at not more than~~
 4-28 ~~five seminars in a calendar year if:~~

4-29 ~~[(1) the member is invited as a representative of the~~
 4-30 ~~commission to participate in a program offered at the seminar; and~~

4-31 ~~[(2) the member's participation is approved by the~~
 4-32 ~~chair of the commission.]~~

4-33 Sec. 402.012. CONFLICT OF INTEREST. (a) An officer,
 4-34 employee, or paid consultant of a Texas trade association whose
 4-35 members provide services subject to regulation by the department
 4-36 [~~commission~~] or provide services whose fees are subject to
 4-37 regulation by the department [~~commission~~] may not be the
 4-38 commissioner [~~a member of the commission~~] or an employee of the
 4-39 department [~~commission~~] who is exempt from the state's position
 4-40 classification plan or is compensated at or above the amount
 4-41 prescribed by the General Appropriations Act for step 1, salary
 4-42 group A17 [17], of the position classification salary schedule.

4-43 (b) On acceptance of appointment as commissioner [~~to the~~
 4-44 ~~commission~~], a commissioner [~~an appointee~~] who is an officer,
 4-45 employee, or paid consultant of a Texas trade association described
 4-46 by Subsection (a) must resign the position or terminate the
 4-47 contract with the trade association.

4-48 (c) For the purposes of this section, "Texas trade
 4-49 association" means a nonprofit, cooperative, and voluntarily
 4-50 joined association of business or professional competitors in this
 4-51 state designed to assist its members and its industry or profession
 4-52 in dealing with mutual business or professional problems and in
 4-53 promoting their common interest. The term does not include a labor
 4-54 union or an employees' association.

4-55 Sec. 402.013. TRAINING PROGRAM FOR COMMISSIONER. (a) Not
 4-56 later than the 90th day after the date on which the commissioner
 4-57 takes office, the commissioner shall complete a training program
 4-58 that complies with this section.

4-59 (b) The training program must provide the commissioner with
 4-60 information regarding:

4-61 (1) the legislation that created the department;
 4-62 (2) the programs operated by the department;
 4-63 (3) the role and functions of the department;
 4-64 (4) the rules of the department, with an emphasis on
 4-65 the rules that relate to disciplinary and investigatory authority;

4-66 (5) the current budget for the department;

4-67 (6) the results of the most recent formal audit of the
 4-68 department;

4-69 (7) the requirements of:

5-1 (A) the open meetings law, Chapter 551,
 5-2 Government Code;
 5-3 (B) the public information law, Chapter 552,
 5-4 Government Code;
 5-5 (C) the administrative procedure law, Chapter
 5-6 2001, Government Code; and
 5-7 (D) other laws relating to public officials,
 5-8 including conflict-of-interest laws; and
 5-9 (8) any applicable ethics policies adopted by the
 5-10 department or the Texas Ethics Commission.

5-11 Sec. 402.014. GENERAL POWERS AND DUTIES OF COMMISSIONER.
 5-12 (a) The commissioner shall conduct the day-to-day operations of
 5-13 the department and otherwise implement department policy.

5-14 (b) The commissioner may:
 5-15 (1) investigate misconduct;
 5-16 (2) hold hearings;
 5-17 (3) issue subpoenas to compel the attendance of
 5-18 witnesses and the production of documents;
 5-19 (4) administer oaths;
 5-20 (5) take testimony directly or by deposition or
 5-21 interrogatory;
 5-22 (6) assess and enforce penalties established under
 5-23 this title;
 5-24 (7) enter appropriate orders as authorized by this
 5-25 title;
 5-26 (8) institute an action in the department's name to
 5-27 enjoin the violation of this subtitle;
 5-28 (9) initiate an action under Section 410.254 to
 5-29 intervene in a judicial proceeding;
 5-30 (10) prescribe the form, manner, and procedure for the
 5-31 transmission of information to the department; and
 5-32 (11) exercise other powers and perform other duties as
 5-33 necessary to implement and enforce this title.

5-34 (c) The commissioner is the agent for service of process on
 5-35 out-of-state employers.

5-36 SECTION 1.002. Subchapter C, Chapter 402, Labor Code, is
 5-37 amended to read as follows:

5-38 SUBCHAPTER C. DEPARTMENT [~~EXECUTIVE DIRECTOR AND~~] PERSONNEL

5-39 Sec. 402.041. APPOINTMENTS. (a) Subject to the General
 5-40 Appropriations Act or other law, the commissioner shall appoint
 5-41 deputies, assistants, division directors, and other personnel as
 5-42 necessary to carry out the powers and duties of the commissioner and
 5-43 the department under this title, other workers' compensation laws
 5-44 of this state, and other laws granting jurisdiction or applicable
 5-45 to the department or the commissioner.

5-46 (b) A person appointed under this section must have the
 5-47 professional, administrative, and workers' compensation experience
 5-48 necessary to qualify the person for the position to which the person
 5-49 is appointed.

5-50 (c) A person appointed as an associate or deputy
 5-51 commissioner or to hold an equivalent position must have at least
 5-52 five years of the experience required for appointment as
 5-53 commissioner under Section 402.005. At least two years of that
 5-54 experience must be in work related to the position to be held.

5-55 Sec. 402.042. DIVISION OF RESPONSIBILITIES. The
 5-56 commissioner shall develop and implement policies that clearly
 5-57 define the respective responsibilities of the commissioner and the
 5-58 staff of the department. [~~EXECUTIVE DIRECTOR. (a) The executive~~
 5-59 director is the executive officer and administrative head of the
 5-60 commission. The executive director exercises all rights, powers,
 5-61 and duties imposed or conferred by law on the commission, except for
 5-62 rulemaking and other rights, powers, and duties specifically
 5-63 reserved under this subtitle to members of the commission.

5-64 [(b) The executive director shall hire personnel as
 5-65 necessary to administer this subtitle.

5-66 [(c) The executive director serves at the pleasure of the
 5-67 commission.

5-68 [(d) The commission shall develop and implement policies
 5-69 that clearly separate the policymaking responsibilities of the

6-1 ~~commission and the management responsibilities of the executive~~
 6-2 ~~director and the staff of the commission.~~

6-3 ~~[Sec. 402.042. GENERAL POWERS AND DUTIES OF EXECUTIVE~~
 6-4 ~~DIRECTOR. (a) The executive director shall conduct the day-to-day~~
 6-5 ~~operations of the commission in accordance with policies~~
 6-6 ~~established by the commission and otherwise implement commission~~
 6-7 ~~policy.~~

6-8 ~~[(b) The executive director may:~~

6-9 ~~[(1) investigate misconduct;~~

6-10 ~~[(2) hold hearings;~~

6-11 ~~[(3) issue subpoenas to compel the attendance of~~
 6-12 ~~witnesses and the production of documents;~~

6-13 ~~[(4) administer oaths;~~

6-14 ~~[(5) take testimony directly or by deposition or~~
 6-15 ~~interrogatory;~~

6-16 ~~[(6) assess and enforce penalties established under~~
 6-17 ~~this subtitle;~~

6-18 ~~[(7) enter appropriate orders as authorized by this~~
 6-19 ~~subtitle;~~

6-20 ~~[(8) correct clerical errors in the entry of orders;~~

6-21 ~~[(9) institute an action in the commission's name to~~
 6-22 ~~enjoin the violation of this subtitle;~~

6-23 ~~[(10) initiate an action under Section 410.254 to~~
 6-24 ~~intervene in a judicial proceeding;~~

6-25 ~~[(11) prescribe the form, manner, and procedure for~~
 6-26 ~~transmission of information to the commission; and~~

6-27 ~~[(12) delegate all powers and duties as necessary.~~

6-28 ~~[(c) The executive director is the agent for service of~~
 6-29 ~~process on out-of-state employers.~~

6-30 ~~[Sec. 402.043. ADMINISTRATIVE ASSISTANTS. The executive~~
 6-31 ~~director shall employ and supervise:~~

6-32 ~~[(1) one person representing wage earners permanently~~
 6-33 ~~assigned to act as administrative assistant to the members of the~~
 6-34 ~~commission who represent wage earners; and~~

6-35 ~~[(2) one person representing employers permanently~~
 6-36 ~~assigned to act as administrative assistant to the members of the~~
 6-37 ~~commission who represent employers.]~~

6-38 ~~Sec. 402.043 [402.044]. CAREER LADDER; ANNUAL PERFORMANCE~~
 6-39 ~~EVALUATIONS. (a) The commissioner or the commissioner's designee~~
 6-40 ~~[executive director] shall develop an intra-agency career ladder~~
 6-41 ~~program that addresses opportunities for mobility and advancement~~
 6-42 ~~for employees within the department [commission]. The program~~
 6-43 ~~shall require intra-agency postings of all positions concurrently~~
 6-44 ~~with any public posting.~~

6-45 ~~(b) The commissioner or the commissioner's designee~~
 6-46 ~~[executive director] shall develop a system of annual performance~~
 6-47 ~~evaluations that are based on documented employee performance. All~~
 6-48 ~~merit pay for department [commission] employees must be based on~~
 6-49 ~~the system established under this subsection.~~

6-50 ~~Sec. 402.044 [402.045]. EQUAL EMPLOYMENT OPPORTUNITY~~
 6-51 ~~POLICY STATEMENT. (a) The commissioner or the commissioner's~~
 6-52 ~~designee [executive director] shall prepare and maintain a written~~
 6-53 ~~policy statement to ensure implementation of a program of equal~~
 6-54 ~~employment opportunity under which all personnel transactions are~~
 6-55 ~~made without regard to race, color, disability, sex, religion, age,~~
 6-56 ~~or national origin. The policy statement must include:~~

6-57 ~~(1) personnel policies, including policies related to~~
 6-58 ~~recruitment, evaluation, selection, appointment, training, and~~
 6-59 ~~promotion of personnel that are in compliance with the requirements~~
 6-60 ~~of Chapter 21;~~

6-61 ~~(2) a comprehensive analysis of the department~~
 6-62 ~~[commission] work force that meets federal and state guidelines;~~

6-63 ~~(3) procedures by which a determination can be made of~~
 6-64 ~~significant underuse in the department [commission] work force of~~
 6-65 ~~all persons for whom federal or state guidelines encourage a more~~
 6-66 ~~equitable balance; and~~

6-67 ~~(4) reasonable methods to appropriately address those~~
 6-68 ~~areas of underuse.~~

6-69 ~~(b) A policy statement prepared under this section must:~~

7-1 (1) cover an annual period;
 7-2 (2) be updated annually;
 7-3 (3) be reviewed by the civil rights division of the
 7-4 Texas Workforce Commission [~~on Human Rights~~] for compliance with
 7-5 Subsection (a)(1); and

7-6 (4) be filed with the Texas Workforce Commission
 7-7 [~~governor's office~~].

7-8 (c) The governor's office shall deliver a biennial report to
 7-9 the legislature based on the information received under Subsection
 7-10 (b). The report may be made separately or as part of other biennial
 7-11 reports made to the legislature.

7-12 ARTICLE 2. CONFORMING AMENDMENTS WITHIN CHAPTER 402, LABOR CODE
 7-13 SECTION 2.001. The heading to Chapter 402, Labor Code, is
 7-14 amended to read as follows:

7-15 CHAPTER 402. TEXAS DEPARTMENT OF WORKERS' COMPENSATION
 7-16 [~~COMMISSION~~]

7-17 SECTION 2.002. Section 402.021, Labor Code, is amended to
 7-18 read as follows:

7-19 Sec. 402.021. DEPARTMENT [~~COMMISSION~~] DIVISIONS. (a) The
 7-20 commissioner [~~commissioner shall have:~~

- 7-21 [~~(1) a division of workers' health and safety;~~
- 7-22 [~~(2) a division of medical review;~~
- 7-23 [~~(3) a division of compliance and practices; and~~
- 7-24 [~~(4) a division of hearings.~~

7-25 [~~(b) In addition to the divisions listed by Subsection (a),~~
 7-26 ~~the executive director, with the approval of the commission,~~] may
 7-27 establish divisions within the department [~~commission~~] for
 7-28 effective administration and performance of department
 7-29 [~~commission~~] functions. The commissioner [~~executive director~~] may
 7-30 allocate and reallocate functions among the divisions.

7-31 (b) [~~(c)~~] The commissioner [~~executive director~~] shall
 7-32 appoint the directors of the divisions of the department
 7-33 [~~commission~~]. The directors serve at the pleasure of the
 7-34 commissioner [~~executive director~~].

7-35 (c) A reference in this title or any other law to the
 7-36 division of workers' health and safety, the division of medical
 7-37 review, the division of compliance and practices, the division of
 7-38 hearings, and the division of self-insurance regulation of the
 7-39 former Texas Workers' Compensation Commission means the
 7-40 department.

7-41 SECTION 2.003. Section 402.022, Labor Code, is amended to
 7-42 read as follows:

7-43 Sec. 402.022. PUBLIC INTEREST INFORMATION. (a) The
 7-44 commissioner [~~executive director~~] shall prepare information of
 7-45 public interest describing the functions of the department
 7-46 [~~commission~~] and the procedures by which complaints are filed with
 7-47 and resolved by the department [~~commission~~].

7-48 (b) The commissioner [~~executive director~~] shall make the
 7-49 information available to the public and appropriate state agencies.

7-50 SECTION 2.004. Section 402.023, Labor Code, is amended to
 7-51 read as follows:

7-52 Sec. 402.023. COMPLAINT INFORMATION. (a) The
 7-53 commissioner [~~executive director~~] shall keep an information file
 7-54 about each written complaint filed with the department [~~commission~~]
 7-55 that is unrelated to a specific workers' compensation claim. The
 7-56 information must include:

- 7-57 (1) the date the complaint is received;
- 7-58 (2) the name of the complainant;
- 7-59 (3) the subject matter of the complaint;
- 7-60 (4) a record of all persons contacted in relation to
 7-61 the complaint;
- 7-62 (5) a summary of the results of the review or
 7-63 investigation of the complaint; and
- 7-64 (6) for complaints for which the department
 7-65 [~~commission~~] took no action, an explanation of the reason the
 7-66 complaint was closed without action.

7-67 (b) For each written complaint that is unrelated to a
 7-68 specific workers' compensation claim that the department
 7-69 [~~commission~~] has authority to resolve, the commissioner [~~executive~~

8-1 ~~director~~] shall provide to the person filing the complaint and the
 8-2 person about whom the complaint is made information about the
 8-3 department's [~~commission's~~] policies and procedures relating to
 8-4 complaint investigation and resolution. The commissioner
 8-5 [~~commission~~], at least quarterly and until final disposition of the
 8-6 complaint, shall notify those persons about the status of the
 8-7 complaint unless the notice would jeopardize an undercover
 8-8 investigation.

8-9 SECTION 2.005. Section 402.024, Labor Code, is amended to
 8-10 read as follows:

8-11 Sec. 402.024. PUBLIC PARTICIPATION. (a) The commissioner
 8-12 [~~commission~~] shall develop and implement policies that provide the
 8-13 public with a reasonable opportunity to appear before the
 8-14 department [~~commission~~] and to speak on issues under the general
 8-15 jurisdiction of the department [~~commission~~].

8-16 (b) The department [~~commission~~] shall comply with federal
 8-17 and state laws related to program and facility accessibility.

8-18 (c) In addition to compliance with Subsection (a), the
 8-19 commissioner [~~executive director~~] shall prepare and maintain a
 8-20 written plan that describes how a person who does not speak English
 8-21 may be provided reasonable access to the department's
 8-22 [~~commission's~~] programs and services.

8-23 SECTION 2.006. The heading to Subchapter D, Chapter 402,
 8-24 Labor Code, is amended to read as follows:

8-25 SUBCHAPTER D. GENERAL POWERS AND DUTIES OF DEPARTMENT
 8-26 [~~COMMISSION~~]

8-27 SECTION 2.007. Section 402.061, Labor Code, is amended to
 8-28 read as follows:

8-29 Sec. 402.061. ADOPTION OF RULES. The commissioner
 8-30 [~~commission~~] shall adopt rules as necessary for the implementation
 8-31 and enforcement of this subtitle.

8-32 SECTION 2.008. Subsection (a), Section 402.062, Labor Code,
 8-33 is amended to read as follows:

8-34 (a) The department [~~commission~~] may accept gifts, grants,
 8-35 or donations as provided by rules adopted by the commissioner
 8-36 [~~commission~~].

8-37 SECTION 2.009. Section 402.064, Labor Code, is amended to
 8-38 read as follows:

8-39 Sec. 402.064. FEES. In addition to fees established by this
 8-40 subtitle, the commissioner [~~commission~~] shall set reasonable fees
 8-41 for services provided to persons requesting services from the
 8-42 department [~~commission~~], including services provided under
 8-43 Subchapter E.

8-44 SECTION 2.010. Section 402.065, Labor Code, is amended to
 8-45 read as follows:

8-46 Sec. 402.065. EMPLOYMENT OF COUNSEL. The commissioner
 8-47 [~~commission~~] may employ counsel to represent the department
 8-48 [~~commission~~] in any legal action the department [~~commission~~] is
 8-49 authorized to initiate.

8-50 SECTION 2.011. Section 402.066, Labor Code, is amended to
 8-51 read as follows:

8-52 Sec. 402.066. RECOMMENDATIONS TO LEGISLATURE. (a) The
 8-53 commissioner [~~commission~~] shall consider and recommend to the
 8-54 legislature changes to this subtitle.

8-55 (b) The commissioner [~~commission~~] shall forward the
 8-56 recommended changes to the legislature not later than December 1 of
 8-57 each even-numbered year.

8-58 SECTION 2.012. Section 402.0665, Labor Code, is amended to
 8-59 read as follows:

8-60 Sec. 402.0665. LEGISLATIVE OVERSIGHT. The legislature may
 8-61 adopt requirements relating to legislative oversight of the
 8-62 department [~~commission~~] and the workers' compensation system of
 8-63 this state. The department [~~commission~~] shall comply with any
 8-64 requirements adopted by the legislature under this section.

8-65 SECTION 2.013. Section 402.067, Labor Code, is amended to
 8-66 read as follows:

8-67 Sec. 402.067. ADVISORY COMMITTEES. The commissioner
 8-68 [~~commission~~] may appoint advisory committees as the commissioner
 8-69 [~~it~~] considers necessary.

9-1 SECTION 2.014. Section 402.068, Labor Code, is amended to
9-2 read as follows:

9-3 Sec. 402.068. DELEGATION OF RIGHTS AND DUTIES. Except as
9-4 expressly provided by this subchapter, the department [~~commission~~]
9-5 may not delegate rights and duties imposed on it by this subchapter.

9-6 SECTION 2.015. Section 402.069, Labor Code, is amended to
9-7 read as follows:

9-8 Sec. 402.069. QUALIFICATIONS AND STANDARDS OF CONDUCT
9-9 INFORMATION. The commissioner or the commissioner's designee
9-10 [~~executive director~~] shall provide to department [~~members of the~~
9-11 ~~commission and commission~~] employees, as often as necessary,
9-12 information regarding their:

9-13 (1) qualifications for office or employment under this
9-14 subtitle; and

9-15 (2) responsibilities under applicable law relating to
9-16 standards of conduct for state officers or employees.

9-17 SECTION 2.016. Subsection (a), Section 402.071, Labor Code,
9-18 is amended to read as follows:

9-19 (a) The commissioner [~~commission~~] shall establish
9-20 qualifications for a representative and shall adopt rules
9-21 establishing procedures for authorization of representatives.

9-22 SECTION 2.017. Section 402.072, Labor Code, is amended to
9-23 read as follows:

9-24 Sec. 402.072. SANCTIONS. Only the commissioner
9-25 [~~commission~~] may impose:

9-26 (1) a sanction that deprives a person of the right to
9-27 practice before the department [~~commission~~] or of the right to
9-28 receive remuneration under this subtitle for a period exceeding 30
9-29 days; or

9-30 (2) another sanction suspending for more than 30 days
9-31 or revoking a license, certification, or permit required for
9-32 practice in the field of workers' compensation.

9-33 SECTION 2.018. Subsections (a) and (c), Section 402.073,
9-34 Labor Code, are amended to read as follows:

9-35 (a) The commissioner [~~commission~~] and the chief
9-36 administrative law judge of the State Office of Administrative
9-37 Hearings by rule shall adopt a memorandum of understanding
9-38 governing administrative procedure law hearings under this
9-39 subtitle conducted by the State Office of Administrative Hearings
9-40 in the manner provided for a contested case hearing under Chapter
9-41 2001, Government Code [~~(the administrative procedure law)~~].

9-42 (c) In a case in which a hearing is conducted in conjunction
9-43 with Section 402.072, 407.046, or 408.023, and in other cases under
9-44 this subtitle that are not subject to Subsection (b), the
9-45 administrative law judge who conducts the hearing for the State
9-46 Office of Administrative Hearings shall propose a decision to the
9-47 commissioner [~~commission~~] for final consideration and decision by
9-48 the commissioner [~~commission~~].

9-49 SECTION 2.019. Section 402.081, Labor Code, is amended to
9-50 read as follows:

9-51 Sec. 402.081. DEPARTMENT [~~COMMISSION~~] RECORDS. (a) The
9-52 commissioner [~~executive director~~] is the custodian of the
9-53 department's [~~commission's~~] records and shall perform the duties of
9-54 a custodian required by law, including providing copies and the
9-55 certification of records.

9-56 (b) The commissioner [~~executive director~~] may destroy a
9-57 record maintained by the department [~~commission~~] pertaining to an
9-58 injury after the 50th anniversary of the date of the injury to which
9-59 the record refers unless benefits are being paid on the claim on
9-60 that date.

9-61 (c) A record maintained by the department [~~commission~~] may
9-62 be preserved in any format permitted by Chapter 441, Government
9-63 Code, and rules adopted by the Texas State Library and Archives
9-64 Commission under that chapter.

9-65 (d) The department [~~commission~~] may charge a reasonable fee
9-66 for making available for inspection any of its information that
9-67 contains confidential information that must be redacted before the
9-68 information is made available. However, when a request for
9-69 information is for the inspection of 10 or fewer pages, and a copy

10-1 of the information is not requested, the department [~~commission~~]
 10-2 may charge only the cost of making a copy of the page from which
 10-3 confidential information must be redacted. The fee for access to
 10-4 information under Chapter 552, Government Code, shall be in accord
 10-5 with the rules of the Texas Building and Procurement [~~General~~
 10-6 ~~Services~~] Commission that prescribe the method for computing the
 10-7 charge for copies under that chapter.

10-8 SECTION 2.020. Section 402.082, Labor Code, is amended to
 10-9 read as follows:

10-10 Sec. 402.082. INJURY INFORMATION MAINTAINED BY DEPARTMENT
 10-11 [~~COMMISSION~~]. The department [~~commission~~] shall maintain
 10-12 information on every compensable injury as to the:

- 10-13 (1) race, ethnicity, and sex of the claimant;
- 10-14 (2) classification of the injury;
- 10-15 (3) amount of wages earned by the claimant before the
 10-16 injury; and
- 10-17 (4) amount of compensation received by the claimant.

10-18 SECTION 2.021. Subsection (a), Section 402.083, Labor Code,
 10-19 is amended to read as follows:

10-20 (a) Information in or derived from a claim file regarding an
 10-21 employee is confidential and may not be disclosed by the department
 10-22 [~~commission~~] except as provided by this subtitle or other law.

10-23 SECTION 2.022. Subsections (a), (b), and (d), Section
 10-24 402.084, Labor Code, are amended to read as follows:

10-25 (a) The department [~~commission~~] shall perform and release a
 10-26 record check on an employee, including current or prior injury
 10-27 information, to the parties listed in Subsection (b) if:

- 10-28 (1) the claim is:
 - 10-29 (A) open or pending before the department
 - 10-30 [~~commission~~];
 - 10-31 (B) on appeal to a court of competent
 - 10-32 jurisdiction; or
 - 10-33 (C) the subject of a subsequent suit in which the
 - 10-34 insurance carrier or the subsequent injury fund is subrogated to
 - 10-35 the rights of the named claimant; and

10-36 (2) the requesting party requests the release on a
 10-37 form prescribed by the department [~~commission~~] for this purpose and
 10-38 provides all required information.

10-39 (b) Information on a claim may be released as provided by
 10-40 Subsection (a) to:

- 10-41 (1) the employee or the employee's legal beneficiary;
- 10-42 (2) the employee's or the legal beneficiary's
 10-43 representative;
- 10-44 (3) the employer at the time of injury;
- 10-45 (4) the insurance carrier;
- 10-46 (5) the Texas Certified Self-Insurer Guaranty
 10-47 Association established under Subchapter G, Chapter 407, if that
 10-48 association has assumed the obligations of an impaired employer;
- 10-49 (6) the Texas Property and Casualty Insurance Guaranty
 10-50 Association, if that association has assumed the obligations of an
 10-51 impaired insurance company;
- 10-52 (7) a third-party litigant in a lawsuit in which the
 10-53 cause of action arises from the incident that gave rise to the
 10-54 injury; or

10-55 (8) a subclaimant under Section 409.009 that is an
 10-56 insurance carrier that has adopted an antifraud plan under
 10-57 Subchapter B, Chapter 704 [~~Article 3.97-3~~], Insurance Code, or the
 10-58 authorized representative of such a subclaimant.

10-59 (d) Information on a claim relating to a subclaimant under
 10-60 Subsection (b)(8) may include information, in an electronic data
 10-61 format, on all workers' compensation claims necessary to determine
 10-62 if a subclaim exists. The information on a claim remains subject to
 10-63 confidentiality requirements while in the possession of a
 10-64 subclaimant or representative. The commissioner [~~commission~~] by
 10-65 rule may establish a reasonable fee for all information requested
 10-66 under this subsection in an electronic data format by subclaimants
 10-67 or authorized representatives of subclaimants. The commissioner
 10-68 [~~commission~~] shall adopt rules under Section 401.024(d) to
 10-69 establish:

11-1 (1) reasonable security parameters for all transfers
11-2 of information requested under this subsection in electronic data
11-3 format; and

11-4 (2) requirements regarding the maintenance of
11-5 electronic data in the possession of a subclaimant or the
11-6 subclaimant's representative.

11-7 SECTION 2.023. Section 402.085, Labor Code, is amended to
11-8 read as follows:

11-9 Sec. 402.085. EXCEPTIONS TO CONFIDENTIALITY. (a) The
11-10 department [~~commission~~] shall release information on a claim to:

11-11 (1) the Texas Department of Insurance for any
11-12 statutory or regulatory purpose, including a research purpose under
11-13 Chapter 405;

11-14 (2) a legislative committee for legislative purposes;

11-15 (3) a state or federal elected official requested in
11-16 writing to provide assistance by a constituent who qualifies to
11-17 obtain injury information under Section 402.084(b), if the request
11-18 for assistance is provided to the department [~~commission~~]; or

11-19 (4) [~~the Research and Oversight Council on Workers'~~
11-20 ~~Compensation for research purposes; or~~

11-21 [~~5~~] the attorney general or another entity that
11-22 provides child support services under Part D, Title IV, Social
11-23 Security Act (42 U.S.C. Section 651 et seq.), relating to:

11-24 (A) establishing, modifying, or enforcing a
11-25 child support or medical support obligation; or

11-26 (B) locating an absent parent.

11-27 (b) The department [~~commission~~] may release information on
11-28 a claim to a governmental agency, political subdivision, or
11-29 regulatory body to use to:

11-30 (1) investigate an allegation of a criminal offense or
11-31 licensing or regulatory violation;

11-32 (2) provide:

11-33 (A) unemployment compensation benefits;

11-34 (B) crime victims compensation benefits;

11-35 (C) vocational rehabilitation services; or

11-36 (D) health care benefits;

11-37 (3) investigate occupational safety or health
11-38 violations;

11-39 (4) verify income on an application for benefits under
11-40 an income-based state or federal assistance program; or

11-41 (5) assess financial resources in an action, including
11-42 an administrative action, to:

11-43 (A) establish, modify, or enforce a child support
11-44 or medical support obligation;

11-45 (B) establish paternity;

11-46 (C) locate an absent parent; or

11-47 (D) cooperate with another state in an action
11-48 authorized under Part D, Title IV, Social Security Act (42 U.S.C.
11-49 Section 651 et seq.), or Chapter 231, Family [~~76, Human Resources~~]
11-50 Code.

11-51 SECTION 2.024. Subsections (a), (b), and (d), Section
11-52 402.088, Labor Code, are amended to read as follows:

11-53 (a) On receipt of a valid request made under and complying
11-54 with Section 402.087, the department [~~commission~~] shall review its
11-55 records.

11-56 (b) If the department [~~commission~~] finds that the applicant
11-57 has made two or more general injury claims in the preceding five
11-58 years, the department [~~commission~~] shall release the date and
11-59 description of each injury to the employer.

11-60 (d) If the employer requests information on three or more
11-61 applicants at the same time, the department [~~commission~~] may refuse
11-62 to release information until it receives the written authorization
11-63 from each applicant.

11-64 SECTION 2.025. Section 402.089, Labor Code, is amended to
11-65 read as follows:

11-66 Sec. 402.089. FAILURE TO FILE AUTHORIZATION[~~+~~
11-67 ~~ADMINISTRATIVE VIOLATION~~]. [~~a~~] An employer who receives
11-68 information by telephone from the department [~~commission~~] under
11-69 Section 402.088 and who fails to file the necessary authorization

12-1 in accordance with Section 402.087 commits an [~~a Class C~~]
12-2 administrative violation.

12-3 [~~(b) Each failure to file an authorization is a separate~~
12-4 ~~violation.~~]

12-5 SECTION 2.026. Section 402.090, Labor Code, is amended to
12-6 read as follows:

12-7 Sec. 402.090. STATISTICAL INFORMATION. The department
12-8 [~~commission~~], the Texas Department of Insurance [~~research center~~],
12-9 or any other governmental agency may prepare and release
12-10 statistical information if the identity of an employee is not
12-11 explicitly or implicitly disclosed.

12-12 SECTION 2.027. Subsection (a), Section 402.091, Labor Code,
12-13 is amended to read as follows:

12-14 (a) A person commits an offense if the person knowingly,
12-15 intentionally, or recklessly publishes, discloses, or distributes
12-16 information that is confidential under this subchapter to a person
12-17 not authorized to receive the information directly from the
12-18 department [~~commission~~].

12-19 SECTION 2.028. Subsections (a), (b), (d), (e), and (f),
12-20 Section 402.092, Labor Code, are amended to read as follows:

12-21 (a) Information maintained in the investigation files of
12-22 the department [~~commission~~] is confidential and may not be
12-23 disclosed except:

- 12-24 (1) in a criminal proceeding;
12-25 (2) in a hearing conducted by the department
12-26 [~~commission~~];
12-27 (3) on a judicial determination of good cause; or
12-28 (4) to a governmental agency, political subdivision,
12-29 or regulatory body if the disclosure is necessary or proper for the
12-30 enforcement of the laws of this or another state or of the United
12-31 States.

12-32 (b) Department [~~Commission~~] investigation files are not
12-33 open records for purposes of Chapter 552, Government Code.

12-34 (d) For purposes of this section, "investigation file"
12-35 means any information compiled or maintained by the department
12-36 [~~commission~~] with respect to a department [~~commission~~]
12-37 investigation authorized by law.

12-38 (e) The department [~~commission~~], upon request, shall
12-39 disclose the identity of a complainant under this section if the
12-40 department [~~commission~~] finds:

- 12-41 (1) the complaint was groundless or made in bad faith;
12-42 or
12-43 (2) the complaint lacks any basis in fact or evidence;
12-44 or
12-45 (3) the complaint is frivolous; or
12-46 (4) the complaint is done specifically for competitive
12-47 or economic advantage.

12-48 (f) Upon completion of an investigation where the
12-49 department [~~commission~~] determines a complaint is groundless,
12-50 frivolous, made in bad faith, or is not supported by evidence or is
12-51 done specifically for competitive or economic advantage the
12-52 department [~~commission~~] shall notify the person who was the subject
12-53 of the complaint of its finding and the identity of the complainant.

12-54 ARTICLE 3. GENERAL OPERATION OF WORKERS' COMPENSATION SYSTEM;
12-55 CONFORMING AMENDMENTS WITHIN LABOR CODE

12-56 SECTION 3.001. Subsection (b), Section 91.003, Labor Code,
12-57 is amended to read as follows:

12-58 (b) In particular, the Texas Workforce Commission, the
12-59 Texas Department of Insurance, the Texas Department of Workers'
12-60 Compensation [~~Commission~~], the Department of Assistive and
12-61 Rehabilitative Services, and the attorney general's office shall
12-62 assist in the implementation of this chapter and shall provide
12-63 information to the department on request.

12-64 SECTION 3.002. Section 401.002, Labor Code, is amended to
12-65 read as follows:

12-66 Sec. 401.002. APPLICATION OF SUNSET ACT. The Texas
12-67 Department of Workers' Compensation [~~Commission~~] is subject to
12-68 Chapter 325, Government Code (Texas Sunset Act). Unless continued
12-69 in existence as provided by that chapter, the department

[~~commission~~] is abolished September 1, 2017 [~~2005~~].

SECTION 3.003. Subsection (a), Section 401.003, Labor Code, is amended to read as follows:

(a) The department [~~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 department;

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

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

(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 3.004. Section 401.011, Labor Code, is amended by amending Subdivisions (2), (8), (15), (37), (38), and (39) and by adding Subdivisions (18-a), (22-a), (45), and (46) 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 department that is subject to penalties and sanctions as provided by this subtitle.

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

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

(18-a) "Evidence-based medicine" means the use of current best quality scientific and medical evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating best available clinical scientific evidence with individual clinical expertise.

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

(A) evidence-based medicine, formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts, and treatment and practice guidelines; or

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

(37) "Representative" means a person, including an attorney, authorized by the commissioner [~~commission~~] 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 [~~Texas Workers' Compensation Research Center established~~] under Chapter 405 [~~404~~].

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

(45) "Department" means the Texas Department of Workers' Compensation.

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

14-1 SECTION 3.005. Section 401.021, Labor Code, is amended to
14-2 read as follows:

14-3 Sec. 401.021. APPLICATION OF OTHER ACTS. Except as
14-4 otherwise provided by this subtitle:

14-5 (1) a proceeding, hearing, judicial review, or
14-6 enforcement of a commissioner [~~commission~~] order, decision, or rule
14-7 is governed by the following subchapters and sections of Chapter
14-8 2001, Government Code:

14-9 (A) Subchapters A, B, D, E, G, and H, excluding
14-10 Sections 2001.004(3) and 2001.005;

14-11 (B) Sections 2001.051, 2001.052, and 2001.053;

14-12 (C) Sections 2001.056 through 2001.062; and

14-13 (D) Section 2001.141(c);

14-14 (2) a proceeding, hearing, judicial review, or
14-15 enforcement of a commissioner [~~commission~~] order, decision, or rule
14-16 is governed by Subchapters A and B, Chapter 2002, Government Code,
14-17 excluding Sections 2002.001(2) and 2002.023;

14-18 (3) Chapter 551, Government Code, applies to a
14-19 proceeding under this subtitle, other than:

14-20 (A) a benefit review conference;

14-21 (B) a contested case hearing;

14-22 (C) an appeals panel proceeding;

14-23 (D) arbitration; or

14-24 (E) another proceeding involving a determination
14-25 on a workers' compensation claim; and

14-26 (4) Chapter 552, Government Code, applies to a record
14-27 of the department [~~commission~~] or a record of the Texas Department
14-28 of Insurance regarding workers' compensation [~~the~~] research
14-29 [~~center~~].

14-30 SECTION 3.006. Subsection (b), Section 401.023, Labor Code,
14-31 is amended to read as follows:

14-32 (b) The department [~~commission~~] shall compute and publish
14-33 the interest and discount rate quarterly, using the treasury
14-34 constant maturity rate for one-year treasury bills issued by the
14-35 United States government, as published by the Federal Reserve Board
14-36 on the 15th day preceding the first day of the calendar quarter for
14-37 which the rate is to be effective, plus 3.5 percent. For this
14-38 purpose, calendar quarters begin January 1, April 1, July 1, and
14-39 October 1.

14-40 SECTION 3.007. Subsections (b), (c), and (d), Section
14-41 401.024, Labor Code, are amended to read as follows:

14-42 (b) Notwithstanding another provision of this subtitle that
14-43 specifies the form, manner, or procedure for the transmission of
14-44 specified information, the commissioner [~~commission~~] by rule may
14-45 permit or require the use of an electronic transmission instead of
14-46 the specified form, manner, or procedure. If the electronic
14-47 transmission of information is not authorized or permitted by
14-48 [~~commission~~] rule, the transmission of that information is governed
14-49 by any applicable statute or rule that prescribes the form, manner,
14-50 or procedure for the transmission, including standards adopted by
14-51 the Department of Information Resources.

14-52 (c) The commissioner [~~commission~~] may designate and
14-53 contract with a data collection agent to fulfill the data
14-54 collection requirements of this subtitle.

14-55 (d) The commissioner [~~executive director~~] may prescribe the
14-56 form, manner, and procedure for transmitting any authorized or
14-57 required electronic transmission, including requirements related
14-58 to security, confidentiality, accuracy, and accountability.

14-59 SECTION 3.008. Subchapter C, Chapter 401, Labor Code, is
14-60 amended by adding Section 401.025 to read as follows:

14-61 Sec. 401.025. REFERENCES TO COMMISSION AND EXECUTIVE
14-62 DIRECTOR. (a) A reference in this code or other law to the Texas
14-63 Workers' Compensation Commission or the executive director of that
14-64 commission means the department or the commissioner as consistent
14-65 with the respective duties of the commissioner and the department
14-66 under this code and other workers' compensation laws of this state.

14-67 (b) A reference in this code or other law to the executive
14-68 director of the Texas Workers' Compensation Commission means the
14-69 commissioner.

15-1 SECTION 3.009. The heading to Chapter 403, Labor Code, is
15-2 amended to read as follows:

15-3 CHAPTER 403. DEPARTMENT [~~COMMISSION~~] FINANCING

15-4 SECTION 3.010. Section 403.001, Labor Code, is amended to
15-5 read as follows:

15-6 Sec. 403.001. DEPARTMENT [~~COMMISSION~~] FUNDS. (a) Except
15-7 as provided by Sections 403.006 and 403.007 or as otherwise
15-8 provided by law, money collected under this subtitle, including
15-9 administrative penalties and advance deposits for purchase of
15-10 services, shall be deposited in the general revenue fund of the
15-11 state treasury to the credit of the department [~~commission~~].

15-12 (b) The money may be spent as authorized by legislative
15-13 appropriation on warrants issued by the comptroller under
15-14 requisitions made by the department [~~commission~~].

15-15 (c) Money deposited in the general revenue fund under this
15-16 section may be used to satisfy the requirements of Section 201.052
15-17 [~~Article 4.19~~], Insurance Code.

15-18 SECTION 3.011. Section 403.003, Labor Code, is amended to
15-19 read as follows:

15-20 Sec. 403.003. RATE OF ASSESSMENT. (a) The commissioner
15-21 [~~commission~~] shall set and certify to the comptroller the rate of
15-22 maintenance tax assessment not later than October 31 of each year,
15-23 taking into account:

15-24 (1) any expenditure projected as necessary for the
15-25 department [~~commission~~] to:

15-26 (A) administer this subtitle during the fiscal
15-27 year for which the rate of assessment is set; and

15-28 (B) reimburse the general revenue fund as
15-29 provided by Section 201.052 [~~Article 4.19~~], Insurance Code;

15-30 (2) projected employee benefits paid from general
15-31 revenues;

15-32 (3) a surplus or deficit produced by the tax in the
15-33 preceding year;

15-34 (4) revenue recovered from other sources, including
15-35 reappropriated receipts, grants, payments, fees, gifts, and
15-36 penalties recovered under this subtitle; and

15-37 (5) expenditures projected as necessary to support the
15-38 prosecution of workers' compensation insurance fraud.

15-39 (b) In setting the rate of assessment, the commissioner
15-40 [~~commission~~] may not consider revenue or expenditures related to:

15-41 (1) the State Office of Risk Management;

15-42 (2) the workers' compensation research functions of
15-43 the Texas Department of Insurance under Chapter 405 [~~and oversight~~
15-44 ~~council on workers' compensation~~]; or

15-45 (3) any other revenue or expenditure excluded from
15-46 consideration by law.

15-47 SECTION 3.012. Section 403.004, Labor Code, is amended to
15-48 read as follows:

15-49 Sec. 403.004. COLLECTION OF TAX AFTER WITHDRAWAL FROM
15-50 BUSINESS. The insurance commissioner or the commissioner
15-51 [~~executive director of the commission~~] immediately shall proceed to
15-52 collect taxes due under this chapter from an insurance carrier that
15-53 withdraws from business in this state, using legal process as
15-54 necessary.

15-55 SECTION 3.013. Section 403.005, Labor Code, is amended to
15-56 read as follows:

15-57 Sec. 403.005. TAX RATE SURPLUS OR DEFICIT. (a) If the tax
15-58 rate set by the commissioner [~~commission~~] for a year does not
15-59 produce sufficient revenue to make all expenditures authorized by
15-60 legislative appropriation, the deficit shall be paid from the
15-61 general revenue fund.

15-62 (b) If the tax rate set by the commissioner [~~commission~~] for
15-63 a year produces revenue that exceeds the amount required to make all
15-64 expenditures authorized by the legislature, the excess shall be
15-65 deposited in the general revenue fund to the credit of the
15-66 department [~~commission~~].

15-67 SECTION 3.014. Section 403.006, Labor Code, as amended by
15-68 Chapters 211 and 1296, Acts of the 78th Legislature, Regular
15-69 Session, 2003, is reenacted and amended to read as follows:

16-1 Sec. 403.006. SUBSEQUENT INJURY FUND. (a) The subsequent
 16-2 injury fund is a dedicated ~~[an]~~ account in the general revenue fund.
 16-3 Money in the account may be appropriated only for the purposes of
 16-4 this section or as provided by other law. ~~[Section 403.095,~~
 16-5 ~~Government Code, does not apply to the subsequent injury fund.]~~

16-6 (b) The subsequent injury fund is liable for:

16-7 (1) the payment of compensation as provided by Section
 16-8 408.162;

16-9 (2) reimbursement of insurance carrier claims of
 16-10 overpayment of benefits made under an interlocutory order or
 16-11 decision of the commissioner ~~[commission]~~ as provided by this
 16-12 subtitle, consistent with the priorities established by rule by the
 16-13 commissioner ~~[commission]~~; and

16-14 (3) reimbursement of insurance carrier claims as
 16-15 provided by Sections 408.042 and 413.0141, consistent with the
 16-16 priorities established by rule by the commissioner ~~[commission]~~; and

16-17 ~~[(4) the payment of an assessment of feasibility and~~
 16-18 ~~the development of regional networks established under Section~~
 16-19 ~~408.0221].~~

16-20 (c) The commissioner ~~[executive director]~~ shall appoint an
 16-21 administrator for the subsequent injury fund.

16-22 (d) Based on an actuarial assessment of the funding
 16-23 available under Section 403.007(e), the commissioner ~~[commission]~~
 16-24 may make partial payment of insurance carrier claims under
 16-25 Subsection (b)(3).

16-26 SECTION 3.015. Section 403.007, Labor Code, is amended to
 16-27 read as follows:

16-28 Sec. 403.007. FUNDING OF SUBSEQUENT INJURY FUND. (a) If a
 16-29 compensable death occurs and no legal beneficiary survives or a
 16-30 claim for death benefits is not timely made, the insurance carrier
 16-31 shall pay to the department ~~[commission]~~ for deposit to the credit
 16-32 of the subsequent injury fund an amount equal to 364 weeks of the
 16-33 death benefits otherwise payable.

16-34 (b) The insurance carrier may elect or the commissioner
 16-35 ~~[commission]~~ may order that death benefits payable to the fund be
 16-36 commuted on written approval of the commissioner ~~[executive~~
 16-37 ~~director]~~. The commutation may be discounted for present payment
 16-38 at the rate established in Section 401.023, compounded annually.

16-39 (c) If a claim for death benefits is not filed with the
 16-40 department ~~[commission]~~ by a legal beneficiary on or before the
 16-41 first anniversary of the date of the death of the employee, it is
 16-42 presumed, for purposes of this section only, that no legal
 16-43 beneficiary survived the deceased employee. The presumption does
 16-44 not apply against a minor beneficiary or an incompetent beneficiary
 16-45 for whom a guardian has not been appointed.

16-46 (d) If the insurance carrier makes payment to the subsequent
 16-47 injury fund and it is later determined by a final award of the
 16-48 commissioner ~~[commission]~~ or the final judgment of a court of
 16-49 competent jurisdiction that a legal beneficiary is entitled to the
 16-50 death benefits, the commissioner ~~[commission]~~ shall order the fund
 16-51 to reimburse the insurance carrier for the amount overpaid to the
 16-52 fund.

16-53 (e) If the commissioner ~~[commission]~~ determines that the
 16-54 funding under Subsection (a) is not adequate to meet the expected
 16-55 obligations of the subsequent injury fund established under Section
 16-56 403.006, the fund shall be supplemented by the collection of a
 16-57 maintenance tax paid by insurance carriers, other than a
 16-58 governmental entity, as provided by Sections 403.002 and 403.003.
 16-59 The rate of assessment must be adequate to provide 120 percent of
 16-60 the projected unfunded liabilities of the fund for the next
 16-61 biennium as certified by an independent actuary or financial
 16-62 advisor.

16-63 (f) The commissioner's ~~[commission's]~~ actuary or financial
 16-64 advisor shall report biannually to the Texas Department of
 16-65 Insurance ~~[Research and Oversight Council on Workers'~~
 16-66 ~~Compensation]~~ on the financial condition and projected assets and
 16-67 liabilities of the subsequent injury fund. The commissioner
 16-68 ~~[commission]~~ shall make the reports available to members of the
 16-69 legislature and the public. The department ~~[commission]~~ may

17-1 purchase annuities to provide for payments due to claimants under
 17-2 this subtitle if the commissioner [~~commission~~] determines that the
 17-3 purchase of annuities is financially prudent for the administration
 17-4 of the fund.

17-5 SECTION 3.016. Section 405.001, Labor Code, is amended to
 17-6 read as follows:

17-7 Sec. 405.001. DEFINITIONS [~~DEFINITION~~]. In this chapter:

17-8 (1) "Commissioner" means the commissioner of
 17-9 insurance.

17-10 (2) "Department" [~~"department"~~] means the Texas
 17-11 Department of Insurance.

17-12 SECTION 3.017. Section 405.002, Labor Code, is amended by
 17-13 amending Subsection (a) and adding Subsections (d) and (e) to read
 17-14 as follows:

17-15 (a) The department shall conduct professional studies and
 17-16 research related to:

17-17 (1) the delivery of benefits;
 17-18 (2) litigation and controversy related to workers'
 17-19 compensation;

17-20 (3) insurance rates and rate-making procedures;
 17-21 (4) rehabilitation and reemployment of injured
 17-22 workers;

17-23 (5) workplace health and safety issues;
 17-24 (6) the quality and cost of medical benefits; [~~and~~]

17-25 (7) the impact of workers' compensation health care
 17-26 networks certified under Chapter 1305, Insurance Code, on claims
 17-27 costs and injured employee outcomes; and

17-28 (8) other matters relevant to the cost, quality, and
 17-29 operational effectiveness of the workers' compensation system.

17-30 (d) In accordance with Subchapter K, Chapter 1305,
 17-31 Insurance Code, the department shall:

17-32 (1) biennially evaluate the cost and quality of health
 17-33 care provided by workers' compensation health care networks; and

17-34 (2) issue annual consumer report cards comparing
 17-35 workers' compensation health care networks certified by the
 17-36 department under Chapter 1305, Insurance Code.

17-37 (e) The commissioner of insurance shall adopt rules as
 17-38 necessary to establish data reporting requirements to support the
 17-39 research duties of the department under this chapter.

17-40 SECTION 3.018. Chapter 405, Labor Code, is amended by
 17-41 adding Section 405.0021 to read as follows:

17-42 Sec. 405.0021. RESEARCH AGENDA. (a) The department shall
 17-43 prepare and publish annually in the Texas Register a proposed
 17-44 workers' compensation research agenda for commissioner review and
 17-45 approval.

17-46 (b) The commissioner shall:

17-47 (1) accept public comments on the research agenda; and
 17-48 (2) hold a public hearing on the proposed research
 17-49 agenda if a hearing is requested by interested persons.

17-50 SECTION 3.019. Section 406.004, Labor Code, is amended to
 17-51 read as follows:

17-52 Sec. 406.004. EMPLOYER NOTICE TO DEPARTMENT [~~COMMISSION,~~
 17-53 ~~ADMINISTRATIVE VIOLATION~~]. (a) An employer who does not obtain
 17-54 workers' compensation insurance coverage shall notify the
 17-55 department [~~commission~~] in writing, in the time and as prescribed
 17-56 by commissioner [~~commission~~] rule, that the employer elects not to
 17-57 obtain coverage.

17-58 (b) The commissioner [~~commission~~] shall prescribe forms to
 17-59 be used for the employer notification and shall require the
 17-60 employer to provide reasonable information to the department
 17-61 [~~commission~~] about the employer's business.

17-62 (c) The department [~~commission~~] may contract with the Texas
 17-63 Workforce [~~Employment~~] Commission or the comptroller for
 17-64 assistance in collecting the notification required under this
 17-65 section. Those agencies shall cooperate with the department
 17-66 [~~commission~~] in enforcing this section.

17-67 (d) The employer notification filing required under this
 17-68 section shall be filed with the department [~~commission~~] in
 17-69 accordance with Section 406.009.

18-1 (e) An employer commits a violation if the employer fails to
 18-2 comply with this section. [~~A violation under this subsection is a~~
 18-3 ~~Class D administrative violation. Each day of noncompliance~~
 18-4 ~~constitutes a separate violation.~~]

18-5 SECTION 3.020. Subsections (c) and (e), Section 406.005,
 18-6 Labor Code, are amended to read as follows:

18-7 (c) Each employer shall post a notice of whether the
 18-8 employer has workers' compensation insurance coverage at
 18-9 conspicuous locations at the employer's place of business as
 18-10 necessary to provide reasonable notice to the employees. The
 18-11 commissioner [~~commission~~] may adopt rules relating to the form and
 18-12 content of the notice. The employer shall revise the notice when
 18-13 the information contained in the notice is changed.

18-14 (e) An employer commits a violation if the employer fails to
 18-15 comply with this section. [~~A violation under this subsection is a~~
 18-16 ~~Class D administrative violation.~~]

18-17 SECTION 3.021. Subsections (a), (b), and (c), Section
 18-18 406.006, Labor Code, are amended to read as follows:

18-19 (a) An insurance company from which an employer has obtained
 18-20 workers' compensation insurance coverage, a certified
 18-21 self-insurer, a workers' compensation self-insurance group under
 18-22 Chapter 407A, and a political subdivision shall file notice of the
 18-23 coverage and claim administration contact information with the
 18-24 department [~~commission~~] not later than the 10th day after the date
 18-25 on which the coverage or claim administration agreement takes
 18-26 effect, unless the commissioner [~~commission~~] adopts a rule
 18-27 establishing a later date for filing. Coverage takes effect on the
 18-28 date on which a binder is issued, a later date and time agreed to by
 18-29 the parties, on the date provided by the certificate of
 18-30 self-insurance, or on the date provided in an interlocal agreement
 18-31 that provides for self-insurance. The commissioner [~~commission~~]
 18-32 may adopt rules that establish the coverage and claim
 18-33 administration contact information required under this subsection.

18-34 (b) The notice required under this section shall be filed
 18-35 with the department [~~commission~~] in accordance with Section
 18-36 406.009.

18-37 (c) An insurance company, a certified self-insurer, a
 18-38 workers' compensation self-insurance group under Chapter 407A, or a
 18-39 political subdivision commits a violation if the person fails to
 18-40 file notice with the department [~~commission~~] as provided by this
 18-41 section. [~~A violation under this subsection is a Class C~~
 18-42 ~~administrative violation. Each day of noncompliance constitutes a~~
 18-43 ~~separate violation.~~]

18-44 SECTION 3.022. Subsections (a), (b), and (c), Section
 18-45 406.007, Labor Code, are amended to read as follows:

18-46 (a) An employer who terminates workers' compensation
 18-47 insurance coverage obtained under this subtitle shall file a
 18-48 written notice with the department [~~commission~~] by certified mail
 18-49 not later than the 10th day after the date on which the employer
 18-50 notified the insurance carrier to terminate the coverage. The
 18-51 notice must include a statement certifying the date that notice was
 18-52 provided or will be provided to affected employees under Section
 18-53 406.005.

18-54 (b) The notice required under this section shall be filed
 18-55 with the department [~~commission~~] in accordance with Section
 18-56 406.009.

18-57 (c) Termination of coverage takes effect on the later of:
 18-58 (1) the 30th day after the date of filing of notice
 18-59 with the department [~~commission~~] under Subsection (a); or
 18-60 (2) the cancellation date of the policy.

18-61 SECTION 3.023. Section 406.008, Labor Code, is amended to
 18-62 read as follows:

18-63 Sec. 406.008. CANCELLATION OR NONRENEWAL OF COVERAGE BY
 18-64 INSURANCE COMPANY; NOTICE. (a) An insurance company that cancels
 18-65 a policy of workers' compensation insurance or that does not renew
 18-66 the policy by the anniversary date of the policy shall deliver
 18-67 notice of the cancellation or nonrenewal by certified mail or in
 18-68 person to the employer and the department [~~commission~~] not later
 18-69 than:

19-1 (1) the 30th day before the date on which the
19-2 cancellation or nonrenewal takes effect; or

19-3 (2) the 10th day before the date on which the
19-4 cancellation or nonrenewal takes effect if the insurance company
19-5 cancels or does not renew because of:

19-6 (A) fraud in obtaining coverage;
19-7 (B) misrepresentation of the amount of payroll
19-8 for purposes of premium calculation;

19-9 (C) failure to pay a premium when due;
19-10 (D) an increase in the hazard for which the
19-11 employer seeks coverage that results from an act or omission of the
19-12 employer and that would produce an increase in the rate, including
19-13 an increase because of a failure to comply with:

19-14 (i) reasonable recommendations for loss
19-15 control; or

19-16 (ii) recommendations designed to reduce a
19-17 hazard under the employer's control within a reasonable period; or

19-18 (E) a determination made by the commissioner of
19-19 insurance that the continuation of the policy would place the
19-20 insurer in violation of the law or would be hazardous to the
19-21 interest of subscribers, creditors, or the general public.

19-22 (b) The notice required under this section shall be filed
19-23 with the department [~~commission~~].

19-24 (c) Failure of the insurance company to give notice as
19-25 required by this section extends the policy until the date on which
19-26 the required notice is provided to the employer and the department
19-27 [~~commission~~].

19-28 SECTION 3.024. Section 406.009, Labor Code, is amended to
19-29 read as follows:

19-30 Sec. 406.009. COLLECTING AND MAINTAINING INFORMATION;
19-31 MONITORING AND ENFORCING COMPLIANCE. (a) The department
19-32 [~~commission~~] shall collect and maintain the information required
19-33 under this subchapter and shall monitor compliance with the
19-34 requirements of this subchapter.

19-35 (b) The commissioner [~~commission~~] may adopt rules as
19-36 necessary to enforce this subchapter.

19-37 (c) The commissioner [~~commission~~] may designate a data
19-38 collection agent, implement an electronic reporting and public
19-39 information access program, and adopt rules as necessary to
19-40 implement the data collection requirements of this subchapter. The
19-41 commissioner [~~executive director~~] may establish the form, manner,
19-42 and procedure for the transmission of information to the department
19-43 [~~commission as authorized by Section 402.042(b)(11)~~].

19-44 (d) The department [~~commission~~] may require an employer or
19-45 insurance carrier subject to this subtitle to identify or confirm
19-46 an employer's coverage status and claim administration contact
19-47 information as necessary to achieve the purposes of this subtitle.

19-48 (e) An employer or insurance carrier commits a violation if
19-49 that person fails to comply with Subsection (d). [~~A violation under
19-50 this subsection is a Class C administrative violation.~~]

19-51 SECTION 3.025. Subsections (c) and (d), Section 406.010,
19-52 Labor Code, is amended to read as follows:

19-53 (c) The commissioner [~~commission~~] by rule shall further
19-54 specify the requirements of this section.

19-55 (d) A person commits a violation if the person violates a
19-56 rule adopted under this section. [~~A violation under this
19-57 subsection is a Class C administrative violation. Each day of
19-58 noncompliance constitutes a separate violation.~~]

19-59 SECTION 3.026. Section 406.011, Labor Code, is amended to
19-60 read as follows:

19-61 Sec. 406.011. AUSTIN REPRESENTATIVE; ADMINISTRATIVE
19-62 VIOLATION. (a) The commissioner [~~commission~~] by rule may require
19-63 an insurance carrier to designate a representative in Austin to act
19-64 as the insurance carrier's agent before the department [~~commission~~]
19-65 in Austin. Notice to the designated agent constitutes notice to the
19-66 insurance carrier.

19-67 (b) A person commits a violation if the person violates a
19-68 rule adopted under this section. [~~A violation under this
19-69 subsection is a Class C administrative violation. Each day of~~]

20-1 ~~noncompliance constitutes a separate violation.]~~

20-2 SECTION 3.027. Subsection (c), Section 406.051, Labor Code,
20-3 is amended to read as follows:

20-4 (c) The employer may not transfer:

20-5 (1) the obligation to accept a report of injury under
20-6 Section 409.001;

20-7 (2) the obligation to maintain records of injuries
20-8 under Section 409.006;

20-9 (3) the obligation to report injuries to the insurance
20-10 carrier under Section 409.005;

20-11 (4) liability for a violation of Section 415.006 or
20-12 415.008 or of Chapter 451; or

20-13 (5) the obligation to comply with a commissioner
20-14 [~~commission~~] order.

20-15 SECTION 3.028. Subsections (b) and (c), Section 406.073,
20-16 Labor Code, are amended to read as follows:

20-17 (b) The employer shall file the agreement with the
20-18 department [~~executive director~~] on request.

20-19 (c) A person commits a violation if the person violates
20-20 Subsection (b). [~~A violation under this subsection is a Class D~~
20-21 ~~administrative violation.~~]

20-22 SECTION 3.029. Subsections (a) and (b), Section 406.074,
20-23 Labor Code, are amended to read as follows:

20-24 (a) The commissioner [~~executive director~~] may enter into an
20-25 agreement with an appropriate agency of another jurisdiction with
20-26 respect to:

20-27 (1) conflicts of jurisdiction;

20-28 (2) assumption of jurisdiction in a case in which the
20-29 contract of employment arises in one state and the injury is
20-30 incurred in another;

20-31 (3) procedures for proceeding against a foreign
20-32 employer who fails to comply with this subtitle; and

20-33 (4) procedures for the appropriate agency to use to
20-34 proceed against an employer of this state who fails to comply with
20-35 the workers' compensation laws of the other jurisdiction.

20-36 (b) An executed agreement that has been adopted as a rule by the
20-37 commissioner [~~commission~~] binds all subject employers and employees.

20-38 SECTION 3.030. Subsection (b), Section 406.093, Labor Code,
20-39 is amended to read as follows:

20-40 (b) The commissioner [~~commission~~] by rule shall adopt
20-41 procedures relating to the method of payment of benefits to legally
20-42 incompetent employees.

20-43 SECTION 3.031. Subsection (b), Section 406.095, Labor Code,
20-44 is amended to read as follows:

20-45 (b) The commissioner [~~commission~~] by rule shall establish
20-46 the procedures and requirements for an election under this section.

20-47 SECTION 3.032. Subsection (g), Section 406.123, Labor Code,
20-48 is amended to read as follows:

20-49 (g) A general contractor who enters into an agreement with a
20-50 subcontractor under this section commits a violation if the contractor
20-51 fails to file a copy of the agreement as required by Subsection (f). [~~A~~
20-52 ~~violation under this subsection is a Class B administrative violation.~~]

20-53 SECTION 3.033. Subsections (c) and (d), Section 406.144,
20-54 Labor Code, are amended to read as follows:

20-55 (c) An agreement under this section shall be filed with the
20-56 department [~~commission~~] either by personal delivery or by
20-57 registered or certified mail and is considered filed on receipt by
20-58 the department [~~commission~~].

20-59 (d) The hiring contractor shall send a copy of an agreement
20-60 under this section to the hiring contractor's workers' compensation
20-61 insurance carrier on filing of the agreement with the department
20-62 [~~commission~~].

20-63 SECTION 3.034. Subsections (a) through (d) and (f), Section
20-64 406.145, Labor Code, are amended to read as follows:

20-65 (a) A hiring contractor and an independent subcontractor
20-66 may make a joint agreement declaring that the subcontractor is an
20-67 independent contractor as defined in Section 406.141(2) and that
20-68 the subcontractor is not the employee of the hiring contractor. If
20-69 the joint agreement is signed by both the hiring contractor and the

21-1 subcontractor and filed with the department [~~commission~~], the
 21-2 subcontractor, as a matter of law, is an independent contractor and
 21-3 not an employee, and is not entitled to workers' compensation
 21-4 insurance coverage through the hiring contractor unless an
 21-5 agreement is entered into under Section 406.144 to provide workers'
 21-6 compensation insurance coverage. The commissioner [~~commission~~]
 21-7 shall prescribe forms for the joint agreement.

21-8 (b) A joint agreement shall be delivered to the department
 21-9 [~~commission~~] by personal delivery or registered or certified mail
 21-10 and is considered filed on receipt by the department [~~commission~~].

21-11 (c) The hiring contractor shall send a copy of a joint
 21-12 agreement signed under this section to the hiring contractor's
 21-13 workers' compensation insurance carrier on filing of the joint
 21-14 agreement with the department [~~commission~~].

21-15 (d) The department [~~commission~~] shall maintain a system for
 21-16 accepting and maintaining the joint agreements.

21-17 (f) If a subsequent hiring agreement is made to which the
 21-18 joint agreement does not apply, the hiring contractor and
 21-19 independent contractor shall notify the department [~~commission~~]
 21-20 and the hiring contractor's workers' compensation insurance carrier
 21-21 in writing.

21-22 SECTION 3.035. Subsection (b), Section 406.162, Labor Code,
 21-23 is amended to read as follows:

21-24 (b) The comptroller shall prepare a consumer price index for
 21-25 this state and shall certify the applicable index factor to the
 21-26 department [~~commission~~] before October 1 of each year. The
 21-27 department [~~commission~~] shall adjust the gross annual payroll
 21-28 requirement under Subsection (a)(2)(B) accordingly.

21-29 SECTION 3.036. Subdivision (3), Section 407.001, Labor
 21-30 Code, is amended to read as follows:

21-31 (3) "Impaired employer" means a certified
 21-32 self-insurer:

21-33 (A) who has suspended payment of compensation as
 21-34 determined by the department [~~commission~~];

21-35 (B) who has filed for relief under bankruptcy laws;

21-36 (C) against whom bankruptcy proceedings have
 21-37 been filed; or

21-38 (D) for whom a receiver has been appointed by a
 21-39 court of this state.

21-40 SECTION 3.037. Section 407.021, Labor Code, is amended to
 21-41 read as follows:

21-42 Sec. 407.021. DIVISION. The division of self-insurance
 21-43 regulation is a division of the department [~~commission~~].

21-44 SECTION 3.038. Section 407.022, Labor Code, is amended to
 21-45 read as follows:

21-46 Sec. 407.022. DIRECTOR. (a) The commissioner [~~executive~~
 21-47 ~~director of the commission~~] shall appoint the director of the
 21-48 division.

21-49 (b) The director shall exercise all the rights, powers, and
 21-50 duties imposed or conferred on the department [~~commission~~] by this
 21-51 chapter, other than by Section 407.023.

21-52 SECTION 3.039. Section 407.023, Labor Code, is amended to
 21-53 read as follows:

21-54 Sec. 407.023. EXCLUSIVE POWERS AND DUTIES OF COMMISSIONER
 21-55 [~~COMMISSIONER~~]. (a) The commissioner [~~commission, by majority~~
 21-56 ~~vote,~~] shall:

21-57 (1) approve or deny a recommendation by the director
 21-58 concerning the issuance or revocation of a certificate of authority
 21-59 to self-insure; and

21-60 (2) certify that a certified self-insurer has
 21-61 suspended payment of compensation or has otherwise become an
 21-62 impaired employer.

21-63 (b) The commissioner [~~commission~~] may not delegate the
 21-64 powers and duties imposed by this section.

21-65 SECTION 3.040. Subsections (a), (b), and (c), Section
 21-66 407.041, Labor Code, are amended to read as follows:

21-67 (a) An employer who desires to self-insure under this
 21-68 chapter must submit an application to the department [~~commission~~]
 21-69 for a certificate of authority to self-insure.

22-1 (b) The application must be:

22-2 (1) submitted on a form adopted by the commissioner
22-3 [~~commission~~]; and

22-4 (2) accompanied by a nonrefundable \$1,000 application
22-5 fee.

22-6 (c) Not later than the 60th day after the date on which the
22-7 application is received, the director shall recommend approval or
22-8 denial of the application to the department [~~commission~~].

22-9 SECTION 3.041. Section 407.042, Labor Code, is amended to
22-10 read as follows:

22-11 Sec. 407.042. ISSUANCE OF CERTIFICATE. With the approval
22-12 of the Texas Certified Self-Insurer Guaranty Association, [~~and by~~
22-13 ~~majority vote,~~] the commissioner [~~commission~~] shall issue a
22-14 certificate of authority to self-insure to an applicant who meets
22-15 the certification requirements under this chapter and pays the
22-16 required fee.

22-17 SECTION 3.042. Section 407.043, Labor Code, is amended to
22-18 read as follows:

22-19 Sec. 407.043. PROCEDURES ON DENIAL OF APPLICATION. (a) If
22-20 the commissioner [~~commission~~] determines that an applicant for a
22-21 certificate of authority to self-insure does not meet the
22-22 certification requirements, the commissioner [~~commission~~] shall
22-23 notify the applicant in writing of the commissioner's [~~its~~]
22-24 determination, stating the specific reasons for the denial and the
22-25 conditions to be met before approval may be granted.

22-26 (b) The applicant is entitled to a reasonable period, as
22-27 determined by the commissioner [~~commission~~], to meet the conditions
22-28 for approval before the application is considered rejected for
22-29 purposes of appeal.

22-30 SECTION 3.043. Subsection (a), Section 407.044, Labor Code,
22-31 is amended to read as follows:

22-32 (a) A certificate of authority to self-insure is valid for
22-33 one year after the date of issuance and may be renewed under
22-34 procedures prescribed by the commissioner [~~commission~~].

22-35 SECTION 3.044. Section 407.045, Labor Code, is amended to
22-36 read as follows:

22-37 Sec. 407.045. WITHDRAWAL FROM SELF-INSURANCE. (a) A
22-38 certified self-insurer may withdraw from self-insurance at any time
22-39 with the approval of the commissioner [~~commission~~]. The
22-40 commissioner [~~commission~~] shall approve the withdrawal if the
22-41 certified self-insurer shows to the satisfaction of the
22-42 commissioner [~~commission~~] that the certified self-insurer has
22-43 established an adequate program to pay all incurred losses,
22-44 including unreported losses, that arise out of accidents or
22-45 occupational diseases first distinctly manifested during the
22-46 period of operation as a certified self-insurer.

22-47 (b) A certified self-insurer who withdraws from
22-48 self-insurance shall surrender to the department [~~commission~~] the
22-49 certificate of authority to self-insure.

22-50 SECTION 3.045. Subsections (a), (b), and (d), Section
22-51 407.046, Labor Code, are amended to read as follows:

22-52 (a) The commissioner [~~commission by majority vote~~] may
22-53 revoke the certificate of authority to self-insure of a certified
22-54 self-insurer who fails to comply with requirements or conditions
22-55 established by this chapter or a rule adopted by the commissioner
22-56 [~~commission~~] under this chapter.

22-57 (b) If the commissioner [~~commission~~] believes that a ground
22-58 exists to revoke a certificate of authority to self-insure, the
22-59 commissioner [~~commission~~] shall refer the matter to the State
22-60 Office of Administrative Hearings. That office shall hold a
22-61 hearing to determine if the certificate should be revoked. The
22-62 hearing shall be conducted in the manner provided for a contested
22-63 case hearing under Chapter 2001, Government Code [~~the~~
22-64 ~~administrative procedure law~~].

22-65 (d) If the certified self-insurer fails to show cause why
22-66 the certificate should not be revoked, the commissioner
22-67 [~~commission~~] immediately shall revoke the certificate.

22-68 SECTION 3.046. Subsection (b), Section 407.047, Labor Code,
22-69 is amended to read as follows:

23-1 (b) The security required under Sections 407.064 and
 23-2 407.065 shall be maintained with the department [~~commission~~] or
 23-3 under the department's [~~commission's~~] control until each claim for
 23-4 workers' compensation benefits is paid, is settled, or lapses under
 23-5 this subtitle.

23-6 SECTION 3.047. Subsections (a), (c), (e), and (f), Section
 23-7 407.061, Labor Code, are amended to read as follows:

23-8 (a) To be eligible for a certificate of authority to
 23-9 self-insure, an applicant for an initial or renewal certificate
 23-10 must present evidence satisfactory to the commissioner
 23-11 [~~commission~~] and the association of sufficient financial strength
 23-12 and liquidity, under standards adopted by the commissioner
 23-13 [~~commission~~], to ensure that all workers' compensation obligations
 23-14 incurred by the applicant under this chapter are met promptly.

23-15 (c) The applicant must present a plan for claims
 23-16 administration that is acceptable to the commissioner [~~commission~~]
 23-17 and that designates a qualified claims servicing contractor.

23-18 (e) The applicant must provide to the commissioner
 23-19 [~~commission~~] a copy of each contract entered into with a person that
 23-20 provides claims services, underwriting services, or accident
 23-21 prevention services if the provider of those services is not an
 23-22 employee of the applicant. The contract must be acceptable to the
 23-23 commissioner [~~commission~~] and must be submitted in a standard form
 23-24 adopted by the commissioner [~~commission~~], if the commissioner
 23-25 [~~commission~~] adopts such a form.

23-26 (f) The commissioner [~~commission~~] shall adopt rules for the
 23-27 requirements for the financial statements required by Subsection
 23-28 (b)(2).

23-29 SECTION 3.048. Section 407.062, Labor Code, is amended to
 23-30 read as follows:

23-31 Sec. 407.062. FINANCIAL STRENGTH AND LIQUIDITY
 23-32 REQUIREMENTS. In assessing the financial strength and liquidity of
 23-33 an applicant, the commissioner [~~commission~~] shall consider:

23-34 (1) the applicant's organizational structure and
 23-35 management background;

23-36 (2) the applicant's profit and loss history;

23-37 (3) the applicant's compensation loss history;

23-38 (4) the source and reliability of the financial
 23-39 information submitted by the applicant;

23-40 (5) the number of employees affected by
 23-41 self-insurance;

23-42 (6) the applicant's access to excess insurance
 23-43 markets;

23-44 (7) financial ratios, indexes, or other financial
 23-45 measures that the commissioner [~~commission~~] finds appropriate; and

23-46 (8) any other information considered appropriate by
 23-47 the commissioner [~~commission~~].

23-48 SECTION 3.049. Subsection (a), Section 407.063, Labor Code,
 23-49 is amended to read as follows:

23-50 (a) In addition to meeting the other certification
 23-51 requirements imposed under this chapter, an applicant for an
 23-52 initial certificate of authority to self-insure must present
 23-53 evidence satisfactory to the commissioner [~~commission~~] of a total
 23-54 unmodified workers' compensation insurance premium in this state in
 23-55 the calendar year of application of at least \$500,000.

23-56 SECTION 3.050. Subsection (b), Section 407.064, Labor Code,
 23-57 is amended to read as follows:

23-58 (b) If an applicant who has provided a letter of credit as
 23-59 all or part of the security required under this section desires to
 23-60 cancel the existing letter of credit and substitute a different
 23-61 letter of credit or another form of security, the applicant shall
 23-62 notify the department [~~commission~~] in writing not later than the
 23-63 60th day before the effective date of the cancellation of the
 23-64 original letter of credit.

23-65 SECTION 3.051. Subsection (d), Section 407.067, Labor Code,
 23-66 is amended to read as follows:

23-67 (d) A person commits a violation if the person violates
 23-68 Subsection (c). [~~A violation under this subsection is a Class B~~
 23-69 ~~administrative violation. Each day of noncompliance constitutes a~~

24-1 ~~separate violation.]~~

24-2 SECTION 3.052. Subsections (a) through (d), (f), and (g),
24-3 Section 407.081, Labor Code, are amended to read as follows:

24-4 (a) Each certified self-insurer shall file an annual report
24-5 with the department [~~commission~~]. The commissioner [~~commission~~]
24-6 shall prescribe the form of the report and shall furnish blank forms
24-7 for the preparation of the report to each certified self-insurer.

24-8 (b) The report must:

24-9 (1) include payroll information, in the form
24-10 prescribed by this chapter and the department [~~commission~~];

24-11 (2) state the number of injuries sustained in the
24-12 three preceding calendar years; and

24-13 (3) indicate separately the amount paid during each
24-14 year for income benefits, medical benefits, death benefits, burial
24-15 benefits, and other proper expenses related to worker injuries.

24-16 (c) Each certified self-insurer shall file with the
24-17 department [~~commission~~] as part of the annual report annual
24-18 independent financial statements that reflect the financial
24-19 condition of the self-insurer. The department [~~commission~~] shall
24-20 make a financial statement filed under this subsection available
24-21 for public review.

24-22 (d) The department [~~commission~~] may require that the report
24-23 include additional financial and statistical information.

24-24 (f) The report must include an estimate of future liability
24-25 for compensation. The estimate must be signed and sworn to by a
24-26 certified casualty actuary every third year, or more frequently if
24-27 required by the commissioner [~~commission~~].

24-28 (g) If the commissioner [~~commission~~] considers it
24-29 necessary, the commissioner [~~it~~] may order a certified self-insurer
24-30 whose financial condition or claims record warrants closer
24-31 supervision to report as provided by this section more often than
24-32 annually.

24-33 SECTION 3.053. Subsections (a), (c), (d), and (e), Section
24-34 407.082, Labor Code, are amended to read as follows:

24-35 (a) Each certified self-insurer shall maintain the books,
24-36 records, and payroll information necessary to compile the annual
24-37 report required under Section 407.081 and any other information
24-38 reasonably required by the commissioner [~~commission~~].

24-39 (c) The material maintained by the certified self-insurer
24-40 shall be open to examination by an authorized agent or
24-41 representative of the department [~~commission~~] at reasonable times
24-42 to ascertain the correctness of the information.

24-43 (d) The examination may be conducted at any location,
24-44 including the department's [~~commission's~~] Austin offices, or, at
24-45 the certified self-insurer's option, in the offices of the
24-46 certified self-insurer. The certified self-insurer shall pay the
24-47 reasonable expenses, including travel expenses, of an inspector who
24-48 conducts an inspection at its offices.

24-49 (e) An unreasonable refusal on the part of a certified
24-50 self-insurer to make available for inspection the books, records,
24-51 payroll information, or other required information constitutes
24-52 grounds for the revocation of the certificate of authority to
24-53 self-insure and is an [a Class A] administrative violation. [~~Each~~
24-54 ~~day of noncompliance constitutes a separate violation.]~~

24-55 SECTION 3.054. Subsection (b), Section 407.101, Labor Code,
24-56 is amended to read as follows:

24-57 (b) The department [~~commission~~] shall deposit the
24-58 application fee for a certificate of authority to self-insure in
24-59 the state treasury to the credit of the workers' compensation
24-60 self-insurance fund.

24-61 SECTION 3.055. Section 407.102, Labor Code, is amended to
24-62 read as follows:

24-63 Sec. 407.102. REGULATORY FEE. (a) Each certified
24-64 self-insurer shall pay an annual fee to cover the administrative
24-65 costs incurred by the department [~~commission~~] in implementing this
24-66 chapter.

24-67 (b) The department [~~commission~~] shall base the fee on the
24-68 total amount of income benefit payments made in the preceding
24-69 calendar year. The department [~~commission~~] shall assess each

25-1 certified self-insurer a pro rata share based on the ratio that the
 25-2 total amount of income benefit payments made by that certified
 25-3 self-insurer bears to the total amount of income benefit payments
 25-4 made by all certified self-insurers.

25-5 SECTION 3.056. Subsections (a) and (d), Section 407.103,
 25-6 Labor Code, are amended to read as follows:

25-7 (a) Each certified self-insurer shall pay a self-insurer
 25-8 maintenance tax for the administration of the department
 25-9 [~~commission~~] and to support the prosecution of workers'
 25-10 compensation insurance fraud in this state. Not more than two
 25-11 percent of the total tax base of all certified self-insurers, as
 25-12 computed under Subsection (b), may be assessed for a maintenance
 25-13 tax under this section.

25-14 (d) In setting the rate of maintenance tax assessment for
 25-15 insurance companies, the commissioner [~~commission~~] may not
 25-16 consider revenue or expenditures related to the division.

25-17 SECTION 3.057. Subsections (b) through (e), Section
 25-18 407.104, Labor Code, are amended to read as follows:

25-19 (b) The department [~~commission~~] shall compute the fee and
 25-20 taxes of a certified self-insurer and notify the certified
 25-21 self-insurer of the amounts due. The taxes and fees shall be
 25-22 remitted to the department [~~commission~~].

25-23 (c) The regulatory fee imposed under Section 407.102 shall
 25-24 be deposited in the state treasury to the credit of the workers'
 25-25 compensation self-insurance fund. The self-insurer maintenance
 25-26 tax shall be deposited in the state treasury to the credit of the
 25-27 department [~~commission~~].

25-28 (d) A certified self-insurer commits a violation if the
 25-29 self-insurer does not pay the taxes and fee imposed under Sections
 25-30 407.102 and 407.103 in a timely manner. [~~A violation under this~~
 25-31 ~~subsection is a Class B administrative violation. Each day of~~
 25-32 ~~noncompliance constitutes a separate violation.]~~

25-33 (e) If the certificate of authority to self-insure of a
 25-34 certified self-insurer is terminated, the insurance commissioner
 25-35 or the commissioner [~~executive director of the commission~~] shall
 25-36 proceed immediately to collect taxes due under this subtitle, using
 25-37 legal process as necessary.

25-38 SECTION 3.058. Subsections (b) and (c), Section 407.122,
 25-39 Labor Code, are amended to read as follows:

25-40 (b) The board of directors is composed of the following
 25-41 voting members:

- 25-42 (1) three certified self-insurers;
 25-43 (2) one member designated by the commissioner [~~one~~
 25-44 ~~commission member representing wage earners,~~
 25-45 [~~(3) one commission member representing employers~~];
 25-46 and

25-47 (3) [~~(4)~~] the public counsel of the office of public
 25-48 insurance counsel.

25-49 (c) The [~~executive director of the commission and the~~
 25-50 director of the division of self-insurance regulation serves
 25-51 [~~serve~~] as a nonvoting member [~~members~~] of the board of directors.

25-52 SECTION 3.059. Subsection (b), Section 407.123, Labor Code,
 25-53 is amended to read as follows:

25-54 (b) Rules adopted by the board are subject to the approval
 25-55 of the commissioner [~~commission~~].

25-56 SECTION 3.060. Subsections (a) and (c), Section 407.124,
 25-57 Labor Code, are amended to read as follows:

25-58 (a) On determination by the commissioner [~~commission~~] that
 25-59 a certified self-insurer has become an impaired employer, the
 25-60 director shall secure release of the security deposit required by
 25-61 this chapter and shall promptly estimate:

25-62 (1) the amount of additional funds needed to
 25-63 supplement the security deposit;

25-64 (2) the available assets of the impaired employer for
 25-65 the purpose of making payment of all incurred liabilities for
 25-66 compensation; and

25-67 (3) the funds maintained by the association for the
 25-68 emergency payment of compensation liabilities.

25-69 (c) A certified self-insurer designated as an impaired

26-1 employer is exempt from assessments beginning on the date of the
 26-2 designation until the commissioner [~~commission~~] determines that
 26-3 the employer is no longer impaired.

26-4 SECTION 3.061. Subsection (d), Section 407.126, Labor Code,
 26-5 is amended to read as follows:

26-6 (d) The board of directors shall administer the trust fund
 26-7 in accordance with rules adopted by the commissioner [~~commission~~].

26-8 SECTION 3.062. Subsection (a), Section 407.127, Labor Code,
 26-9 is amended to read as follows:

26-10 (a) If the commissioner [~~commission~~] determines that the
 26-11 payment of benefits and claims administration shall be made through
 26-12 the association, the association assumes the workers' compensation
 26-13 obligations of the impaired employer and shall begin the payment of
 26-14 the obligations for which it is liable not later than the 30th day
 26-15 after the date of notification by the director.

26-16 SECTION 3.063. Subsection (a), Section 407.133, Labor Code,
 26-17 is amended to read as follows:

26-18 (a) The commissioner [~~commission, after notice and hearing~~
 26-19 ~~and by majority vote,~~] may suspend or revoke the certificate of
 26-20 authority to self-insure of a certified self-insurer who fails to
 26-21 pay an assessment. The association promptly shall report such a
 26-22 failure to the director.

26-23 SECTION 3.064. Subsection (d), Section 407A.053, Labor
 26-24 Code, is amended to read as follows:

26-25 (d) Any securities posted must be deposited in the state
 26-26 treasury and must be assigned to and made negotiable by the
 26-27 commissioner of the Texas Department of Workers' Compensation
 26-28 [~~executive director of the commission~~] under a trust document
 26-29 acceptable to the commissioner of insurance. Interest accruing on
 26-30 a negotiable security deposited under this subsection shall be
 26-31 collected and transmitted to the depositor if the depositor is not
 26-32 in default.

26-33 SECTION 3.065. Subsection (c), Section 407A.201, Labor
 26-34 Code, is amended to read as follows:

26-35 (c) The membership of an individual member of a group is
 26-36 subject to cancellation by the group as provided by the bylaws of
 26-37 the group. An individual member may also elect to terminate
 26-38 participation in the group. The group shall notify the
 26-39 commissioner and the Texas Department of Workers' Compensation
 26-40 [~~commission~~] of the cancellation or termination of a membership not
 26-41 later than the 10th day after the date on which the cancellation or
 26-42 termination takes effect and shall maintain coverage of each
 26-43 canceled or terminated member until the 30th day after the date of
 26-44 the notice, at the terminating member's expense, unless before that
 26-45 date the Texas Department of Workers' Compensation [~~commission~~]
 26-46 notifies the group that the canceled or terminated member has:

26-47 (1) obtained workers' compensation insurance
 26-48 coverage;

26-49 (2) become a certified self-insurer; or

26-50 (3) become a member of another group.

26-51 SECTION 3.066. The heading to Section 407A.301, Labor Code,
 26-52 is amended to read as follows:

26-53 Sec. 407A.301. MAINTENANCE TAX FOR DEPARTMENT OF WORKERS'
 26-54 COMPENSATION [~~COMMISSION~~] AND RESEARCH FUNCTIONS OF DEPARTMENT OF
 26-55 INSURANCE [~~AND OVERSIGHT COUNCIL~~].

26-56 SECTION 3.067. Subsection (a), Section 407A.301, Labor
 26-57 Code, is amended to read as follows:

26-58 (a) Each group shall pay a self-insurance group maintenance
 26-59 tax under this section for:

26-60 (1) the administration of the Texas Department of
 26-61 Workers' Compensation [~~commission~~];

26-62 (2) the prosecution of workers' compensation insurance
 26-63 fraud in this state; and

26-64 (3) the research functions of the department under
 26-65 Chapter 405 [~~Research and Oversight Council on Workers'~~
 26-66 ~~Compensation~~].

26-67 SECTION 3.068. Section 407A.303, Labor Code, is amended to
 26-68 read as follows:

26-69 Sec. 407A.303. COLLECTION AND PAYMENT OF TAXES. (a) The

27-1 group shall remit the taxes for deposit in the state treasury to the
 27-2 credit of the Texas Department of Workers' Compensation
 27-3 [~~commission~~].

27-4 (b) A group commits a violation if the group does not pay the
 27-5 taxes imposed under Sections 407A.301 and 407A.302 in a timely
 27-6 manner. [~~A violation under this subsection is a Class B~~
 27-7 ~~administrative violation. Each day of noncompliance constitutes a~~
 27-8 ~~separate violation.~~]

27-9 (c) If the certificate of approval of a group is terminated,
 27-10 the commissioner of insurance or the commissioner [~~executive~~
 27-11 ~~director~~] of the Texas Department of Workers' Compensation
 27-12 [~~commission~~] shall immediately notify the comptroller to collect
 27-13 taxes as directed under Sections 407A.301 and 407A.302.

27-14 SECTION 3.069. Subsection (b), Section 407A.357, Labor
 27-15 Code, is amended to read as follows:

27-16 (b) The guaranty association advisory committee is composed
 27-17 of the following voting members:

27-18 (1) three members who represent different groups under
 27-19 this chapter, subject to Subsection (c);

27-20 (2) one member designated by the commissioner of the
 27-21 Texas Department of Workers' Compensation [~~one commission member~~
 27-22 ~~who represents wage earners~~];

27-23 (3) one member designated by the insurance
 27-24 commissioner; and

27-25 (4) the public counsel of the office of public
 27-26 insurance counsel.

27-27 SECTION 3.070. Subsection (c), Section 408.003, Labor Code,
 27-28 is amended to read as follows:

27-29 (c) The employer shall notify the department [~~commission~~]
 27-30 and the insurance carrier on forms prescribed by the commissioner
 27-31 [~~commission~~] of the initiation of and amount of payments made under
 27-32 this section.

27-33 SECTION 3.071. Section 408.004, Labor Code, is amended by
 27-34 amending Subsections (a), (b), and (d) through (g), and by adding
 27-35 Subsection (h) to read as follows:

27-36 (a) The commissioner [~~commission~~] may require an employee
 27-37 to submit to medical examinations to resolve any question about [+
 27-38 [~~(1)~~] the appropriateness of the health care received
 27-39 by the employee [~~, or~~

27-40 [~~(2)~~ ~~similar issues~~].

27-41 (b) The commissioner [~~commission~~] may require an employee
 27-42 to submit to a medical examination at the request of the insurance
 27-43 carrier, but only after the insurance carrier has attempted and
 27-44 failed to receive the permission and concurrence of the employee
 27-45 for the examination. Except as otherwise provided by this
 27-46 subsection, the insurance carrier is entitled to the examination
 27-47 only once in a 180-day period. The commissioner [~~commission~~] may
 27-48 adopt rules that require an employee to submit to not more than
 27-49 three medical examinations in a 180-day period under specified
 27-50 circumstances, including to determine whether there has been a
 27-51 change in the employee's condition and [~~, and whether treatment should~~
 27-52 ~~be extended to another body part or system~~]. The commissioner
 27-53 [~~commission~~] by rule shall adopt a system for monitoring requests
 27-54 made under this subsection by insurance carriers. That system must
 27-55 ensure that good cause exists for any additional medical
 27-56 examination allowed under this subsection that is not requested by
 27-57 the employee. A subsequent examination must be performed by the
 27-58 same doctor unless otherwise approved by the commissioner
 27-59 [~~commission~~].

27-60 (d) An injured employee is entitled to have a doctor of the
 27-61 employee's choice present at an examination required by the
 27-62 department [~~commission~~] at the request of an insurance carrier.
 27-63 The insurance carrier shall pay a fee set by the commissioner
 27-64 [~~commission~~] to the doctor selected by the employee.

27-65 (e) An employee who, without good cause as determined by the
 27-66 commissioner [~~commission~~], fails or refuses to appear at the time
 27-67 scheduled for an examination under Subsection (a) or (b) commits a
 27-68 violation. [~~A violation under this subsection is a Class D~~
 27-69

28-1 ~~administrative violation. An employee is not entitled to temporary~~
 28-2 ~~income benefits, and an insurance carrier may suspend the payment~~
 28-3 ~~of temporary income benefits, during and for a period in which the~~
 28-4 ~~employee fails to submit to an examination under Subsection (a) or~~
 28-5 ~~(b) unless the commission determines that the employee had good~~
 28-6 ~~cause for the failure to submit to the examination. The commission~~
 28-7 ~~may order temporary income benefits to be paid for the period that~~
 28-8 ~~the commission determines the employee had good cause.] The~~
 28-9 ~~commissioner [commission] by rule shall ensure that an employee~~
 28-10 ~~receives reasonable notice of an examination [and of the insurance~~
 28-11 ~~carrier's basis for suspension of payment,] and that the employee~~
 28-12 ~~is provided a reasonable opportunity to reschedule an examination~~
 28-13 ~~missed by the employee for good cause.~~

28-14 (f) This section does not apply to health care provided
 28-15 through a workers' compensation health care network established
 28-16 under Chapter 1305, Insurance Code [If the report of a doctor
 28-17 selected by an insurance carrier indicates that an employee can
 28-18 return to work immediately or has reached maximum medical
 28-19 improvement, the insurance carrier may suspend or reduce the
 28-20 payment of temporary income benefits on the 14th day after the date
 28-21 on which the insurance carrier files a notice of suspension with the
 28-22 commission as provided by this subsection. The commission shall
 28-23 hold an expedited benefit review conference, by personal appearance
 28-24 or by telephone, not later than the 10th day after the date on which
 28-25 the commission receives the insurance carrier's notice of
 28-26 suspension. If a benefit review conference is not held by the 14th
 28-27 day after the date on which the commission receives the insurance
 28-28 carrier's notice of suspension, an interlocutory order, effective
 28-29 from the date of the report certifying maximum medical improvement,
 28-30 is automatically entered for the continuation of temporary income
 28-31 benefits until a benefit review conference is held, and the
 28-32 insurance carrier is eligible for reimbursement for any overpayment
 28-33 of benefits as provided by Chapter 410. The commission is not
 28-34 required to automatically schedule a contested case hearing as
 28-35 required by Section 410.025(b) if a benefit review conference is
 28-36 scheduled under this subsection. If a benefit review conference is
 28-37 held not later than the 14th day, the commission may enter an
 28-38 interlocutory order for the continuation of benefits, and the
 28-39 insurance carrier is eligible for reimbursement for any
 28-40 overpayments of benefits as provided by Chapter 410. The
 28-41 commission shall adopt rules as necessary to implement this
 28-42 subsection under which:

28-43 ~~[(1) an insurance carrier is required to notify the~~
 28-44 ~~employee and the treating doctor of the suspension of benefits~~
 28-45 ~~under this subsection by certified mail or another verifiable~~
 28-46 ~~delivery method;~~

28-47 ~~[(2) the commission makes a reasonable attempt to~~
 28-48 ~~obtain the treating doctor's opinion before the commission makes a~~
 28-49 ~~determination regarding the entry of an interlocutory order; and~~

28-50 ~~[(3) the commission may allow abbreviated contested~~
 28-51 ~~case hearings by personal appearance or telephone to consider~~
 28-52 ~~issues relating to overpayment of benefits under this section].~~

28-53 (g) An insurance carrier who unreasonably requests a
 28-54 medical examination under Subsection (b) commits a violation. [A
 28-55 violation under this subsection is a Class B administrative
 28-56 violation.]

28-57 (h) A person who makes a frivolous request for a medical
 28-58 examination under Subsection (b), as determined by the
 28-59 commissioner, commits a violation. A violation under this
 28-60 subsection is a Class B administrative violation.

28-61 SECTION 3.072. Section 408.0041, Labor Code, is amended to
 28-62 read as follows:

28-63 Sec. 408.0041. DESIGNATED DOCTOR EXAMINATION. (a) At the
 28-64 request of an insurance carrier or an employee, or on the
 28-65 commissioner's own order, the commissioner may [commission shall]
 28-66 order a medical examination to resolve any question about:

- 28-67 (1) the impairment caused by the compensable injury;
 28-68 [~~or~~]
 28-69 (2) the attainment of maximum medical improvement;

29-1 (3) the extent of the employee's compensable injury;
 29-2 (4) whether the injured employee's disability is a
 29-3 direct result of the work-related injury;
 29-4 (5) the ability of the employee to return to work; or
 29-5 (6) issues similar to those described by Subdivisions
 29-6 (1)-(5).

29-7 (b) A medical examination requested under Subsection (a)
 29-8 shall be performed by the next available doctor on the department's
 29-9 ~~[commission's]~~ list of designated doctors whose credentials are
 29-10 appropriate for the issue in question and the injured employee's
 29-11 medical condition as determined by commissioner rule. ~~[The~~
 29-12 ~~designated doctor doing the review must be trained and experienced~~
 29-13 ~~with the treatment and procedures used by the doctor treating the~~
 29-14 ~~patient's medical condition, and the treatment and procedures~~
 29-15 ~~performed must be within the scope of practice of the designated~~
 29-16 ~~doctor.]~~ The department ~~[commission]~~ shall assign a designated
 29-17 doctor not later than the 10th day after the date on which the
 29-18 request under Subsection (a) is received, and the examination must
 29-19 be conducted not later than the 21st day after the date on which the
 29-20 commissioner ~~[commission]~~ issues the order under Subsection (a).
 29-21 An examination under this section may not be conducted more
 29-22 frequently than every 60 days, unless good cause for more frequent
 29-23 examinations exists, as defined by commissioner ~~[commission]~~
 29-24 rules.

29-25 (c) The treating doctor and the insurance carrier are both
 29-26 responsible for sending to the designated doctor all of the injured
 29-27 employee's medical records relating to the issue to be evaluated by
 29-28 the designated doctor that are in their possession. The treating
 29-29 doctor and insurance carrier may send the records without a signed
 29-30 release from the employee. The designated doctor is authorized to
 29-31 receive the employee's confidential medical records to assist in
 29-32 the resolution of disputes. The treating doctor and insurance
 29-33 carrier may also send the designated doctor an analysis of the
 29-34 injured employee's medical condition, functional abilities, and
 29-35 return-to-work opportunities.

29-36 (d) To avoid undue influence on a person selected as a
 29-37 designated doctor under this section, and except as provided by
 29-38 Subsection (c), only the injured employee or an appropriate member
 29-39 of the department's staff ~~[of the commission]~~ may communicate with
 29-40 the designated doctor about the case regarding the injured
 29-41 employee's medical condition or history before the examination of
 29-42 the injured employee by the designated doctor. After that
 29-43 examination is completed, communication with the designated doctor
 29-44 regarding the injured employee's medical condition or history may
 29-45 be made only through appropriate department ~~[commission]~~ staff
 29-46 members. The designated doctor may initiate communication with any
 29-47 doctor who has previously treated or examined the injured employee
 29-48 for the work-related injury or with peer reviewers identified by
 29-49 the insurance carrier.

29-50 (e) The designated doctor shall report to the department
 29-51 ~~[commission]~~. The report of the designated doctor has presumptive
 29-52 weight unless the preponderance ~~[great weight]~~ of the evidence is
 29-53 to the contrary. An employer may make a bona fide offer of
 29-54 employment subject to Sections 408.103(e) and 408.144(c) based on
 29-55 the designated doctor's report.

29-56 (f) Unless otherwise ordered by the department, the
 29-57 insurance carrier shall pay benefits based on the opinion of the
 29-58 designated doctor during the pendency of any dispute. If an
 29-59 insurance carrier is not satisfied with the opinion rendered by a
 29-60 designated doctor under this section, the insurance carrier may
 29-61 request the commissioner ~~[commission]~~ to order an employee to
 29-62 attend an examination by a doctor selected by the insurance
 29-63 carrier. ~~[The commission shall allow the insurance carrier~~
 29-64 ~~reasonable time to obtain and present the opinion of the doctor~~
 29-65 ~~selected under this subsection before the commission makes a~~
 29-66 ~~decision on the merits of the issue in question.]~~

29-67 (g) Except as otherwise provided by this subsection, an
 29-68 injured employee is entitled to have a doctor of the employee's
 29-69 choice present at an examination requested by an insurance carrier

30-1 under Subsection (f). The insurance carrier shall pay a fee set by
 30-2 the commissioner to the doctor selected by the employee. If the
 30-3 injured employee is subject to a workers' compensation health care
 30-4 network under Chapter 1305, Insurance Code, the doctor must be the
 30-5 employee's treating doctor.

30-6 (h) The insurance carrier shall pay for:

30-7 (1) an examination required under Subsection (a) or
 30-8 (f); and

30-9 (2) the reasonable expenses incident to the employee
 30-10 in submitting to the examination.

30-11 (i) ~~[(h)]~~ An employee who, without good cause as determined
 30-12 by the commissioner, fails or refuses to appear at the time
 30-13 scheduled for an examination under Subsection (a) or (f), commits a
 30-14 violation. A violation under this subsection is a Class D
 30-15 administrative violation.

30-16 (j) An employee is not entitled to temporary income benefits
 30-17 ~~[compensation]~~, and an insurance carrier is authorized to suspend
 30-18 the payment of temporary income benefits, during and for a period in
 30-19 which the employee fails to submit to an examination required by
 30-20 Subsection (a) or (f) ~~[this chapter]~~ unless the commissioner
 30-21 ~~[commission]~~ determines that the employee had good cause for the
 30-22 failure to submit to the examination. The commissioner
 30-23 ~~[commission]~~ may order temporary income benefits to be paid for the
 30-24 period for which the commissioner ~~[commission]~~ determined that the
 30-25 employee had good cause. The commissioner ~~[commission]~~ by rule
 30-26 shall ensure that:

30-27 (1) an employee receives reasonable notice of an
 30-28 examination and the insurance carrier's basis for suspension; and

30-29 (2) the employee is provided a reasonable opportunity
 30-30 to reschedule an examination for good cause.

30-31 (k) ~~[(i)]~~ If the report of a designated doctor indicates
 30-32 that an employee has reached maximum medical improvement or is
 30-33 otherwise able to return to work immediately, the insurance carrier
 30-34 may suspend or reduce the payment of temporary income benefits
 30-35 immediately.

30-36 (l) A person who makes a frivolous request for a medical
 30-37 examination under Subsection (a) or (f), as determined by the
 30-38 commissioner, commits a violation. A violation under this
 30-39 subsection is a Class B administrative violation.

30-40 SECTION 3.073. Subsection (e), Section 408.005, Labor Code,
 30-41 is amended to read as follows:

30-42 (e) The director of the division of hearings shall approve a
 30-43 settlement if the director is satisfied that:

30-44 (1) the settlement accurately reflects the agreement
 30-45 between the parties;

30-46 (2) the settlement reflects adherence to all
 30-47 appropriate provisions of law and the policies of the commissioner
 30-48 ~~[commission]~~; and

30-49 (3) under the law and facts, the settlement is in the
 30-50 best interest of the claimant.

30-51 SECTION 3.074. Section 408.022, Labor Code, is amended by
 30-52 amending Subsections (a), (b), and (c) and adding Subsection (f) to
 30-53 read as follows:

30-54 (a) Except in an emergency, the department ~~[commission]~~
 30-55 shall require an employee to receive medical treatment from a
 30-56 doctor chosen from a list of doctors approved by the commissioner
 30-57 ~~[commission]~~. A doctor may perform only those procedures that are
 30-58 within the scope of the practice for which the doctor is licensed.
 30-59 The employee is entitled to the employee's initial choice of a
 30-60 doctor from the department's ~~[commission's]~~ list.

30-61 (b) If an employee is dissatisfied with the initial choice
 30-62 of a doctor from the department's ~~[commission's]~~ list, the employee
 30-63 may notify the department ~~[commission]~~ and request authority to
 30-64 select an alternate doctor. The notification must be in writing
 30-65 stating the reasons for the change, except notification may be by
 30-66 telephone when a medical necessity exists for immediate change.

30-67 (c) The commissioner ~~[commission]~~ shall prescribe criteria
 30-68 to be used by the department ~~[commission]~~ in granting the employee
 30-69 authority to select an alternate doctor. The criteria may include:

31-1 (1) whether treatment by the current doctor is
31-2 medically inappropriate;

31-3 (2) the professional reputation of the doctor;

31-4 (3) whether the employee is receiving appropriate
31-5 medical care to reach maximum medical improvement; and

31-6 (4) whether a conflict exists between the employee and
31-7 the doctor to the extent that the doctor-patient relationship is
31-8 jeopardized or impaired.

31-9 (f) This section does not apply to requirements regarding
31-10 the selection of a doctor under a workers' compensation health care
31-11 network established under Chapter 1305, Insurance Code, except as
31-12 provided by that chapter.

31-13 SECTION 3.075. Section 408.023, Labor Code, is amended to
31-14 read as follows:

31-15 Sec. 408.023. LIST OF APPROVED DOCTORS; DUTIES OF TREATING
31-16 DOCTORS. (a) The department [~~commission~~] shall develop a list of
31-17 doctors licensed in this state who are approved to provide health
31-18 care services under this subtitle. A [~~Each~~] doctor [~~licensed in~~
31-19 ~~this state on September 1, 2001,~~] is eligible to be included on the
31-20 department's [~~commission's~~] list of approved doctors if the doctor:

31-21 (1) registers with the department [~~commission~~] in the
31-22 manner prescribed by commissioner [~~commission~~] rules; and

31-23 (2) complies with the requirements adopted by the
31-24 commissioner [~~commission~~] under this section.

31-25 (b) The commissioner [~~commission~~] by rule shall establish
31-26 reasonable requirements for doctors and health care providers
31-27 financially related to those doctors regarding training,
31-28 impairment rating testing, and disclosure of financial interests as
31-29 required by Section 413.041, and for monitoring of those doctors
31-30 and health care providers as provided by Sections 408.0231 and
31-31 413.0512. The commissioner [~~commission~~] by rule shall provide a
31-32 reasonable period, not to exceed 18 months after the adoption of
31-33 rules under this section, for doctors to comply with the
31-34 registration and training requirements of this subchapter. Except
31-35 as otherwise provided by this section, the requirements under this
31-36 subsection apply to doctors and other health care providers who:

31-37 (1) provide health care services as treating doctors;

31-38 (2) provide health care services as authorized by this
31-39 chapter;

31-40 (3) perform medical peer review under this subtitle;

31-41 (4) perform utilization review of medical benefits
31-42 provided under this subtitle; or

31-43 (5) provide health care services on referral from a
31-44 treating doctor, as provided by commissioner [~~commission~~] rule.

31-45 (c) The department [~~commission~~] shall issue to a doctor who
31-46 is approved by the commissioner [~~commission~~] a certificate of
31-47 registration. In determining whether to issue a certificate of
31-48 registration, the commissioner [~~commission~~] may consider and
31-49 condition [~~its~~] approval on any practice restrictions applicable to
31-50 the applicant that are relevant to services provided under this
31-51 subtitle. The commissioner [~~commission~~] may also consider the
31-52 practice restrictions of an applicant when determining appropriate
31-53 sanctions under Section 408.0231.

31-54 (d) A certificate of registration issued under this section
31-55 is valid, unless revoked, suspended, or revised, for the period
31-56 provided by commissioner [~~commission~~] rule and may be renewed on
31-57 application to the department [~~commission~~]. The department
31-58 [~~commission~~] shall provide notice to each doctor on the approved
31-59 doctor list of the pending expiration of the doctor's certificate
31-60 of registration not later than the 60th day before the date of
31-61 expiration of the certificate.

31-62 (e) Notwithstanding other provisions of this section, a
31-63 doctor not licensed in this state but licensed in another state or
31-64 jurisdiction who treats employees or performs utilization review of
31-65 health care for an insurance carrier may apply for a certificate of
31-66 registration under this section to be included on the department's
31-67 [~~commission's~~] list of approved doctors.

31-68 (f) A doctor who contracts with a workers' compensation
31-69 health care network certified under Chapter 1305, Insurance Code,

32-1 is not subject to the registration requirements of this section for
 32-2 the purpose of treating injured employees who are required to seek
 32-3 medical care from a network. However, a doctor who contracts with a
 32-4 workers' compensation health care network shall:

32-5 (1) comply with the requirements of Section 413.041
 32-6 regarding the disclosure of financial interests; and

32-7 (2) if the doctor intends to provide certifications of
 32-8 maximum medical improvement or assign impairment ratings, comply
 32-9 with the impairment rating training and testing requirements
 32-10 established by commissioner rule.

32-11 (g) A person required to comply with Subsection (f) who does
 32-12 not comply commits a violation. A violation under this subsection
 32-13 is a Class B administrative violation.

32-14 (h) An insurance carrier may not use a certification of
 32-15 maximum medical improvement or an impairment rating assigned by a
 32-16 doctor who fails to comply with Subsection (f)(2) for the purpose of
 32-17 suspending temporary income benefits or computing impairment
 32-18 income benefits.

32-19 (i) Except in an emergency or for immediate post-injury
 32-20 medical care as defined by commissioner [commission] rule, or as
 32-21 provided by Subsection (f), (k), [~~(h)~~] or (l) [~~(i)~~], each doctor who
 32-22 performs functions under this subtitle, including examinations
 32-23 under this chapter, must hold a certificate of registration and be
 32-24 on the department's list of approved doctors in order to perform
 32-25 services or receive payment for those services.

32-26 (j) [~~(g)~~] The commissioner [commission] by rule shall
 32-27 modify registration and training requirements for doctors who
 32-28 infrequently provide health care or [7] who perform utilization
 32-29 review or peer review functions for insurance carriers [7, or who
 32-30 participate in regional networks established under this
 32-31 subchapter,] as necessary to ensure that those doctors are informed
 32-32 of the regulations that affect health care benefit delivery under
 32-33 this subtitle.

32-34 (k) [~~(h)~~] Notwithstanding Section 4(h), Article 21.58A,
 32-35 Insurance Code, a utilization review agent that uses doctors to
 32-36 perform reviews of health care services provided under this
 32-37 subtitle may use doctors licensed by another state to perform the
 32-38 reviews, but the reviews must be performed under the direction of a
 32-39 doctor licensed to practice in this state.

32-40 (l) [~~(i)~~] The commissioner [commission] may grant
 32-41 exceptions to the requirement imposed under Subsection (i) [~~(f)~~] as
 32-42 necessary to ensure that:

32-43 (1) employees have access to health care; and
 32-44 (2) insurance carriers have access to evaluations of
 32-45 an employee's health care and income benefit eligibility as
 32-46 provided by this subtitle.

32-47 (m) [~~(j)~~] The injured employee's treating doctor is
 32-48 responsible for the efficient management of medical care as
 32-49 required by Section 408.025(c) and commissioner [commission]
 32-50 rules. The department [commission] shall collect information
 32-51 regarding:

32-52 (1) return-to-work outcomes;
 32-53 (2) patient satisfaction; and
 32-54 (3) cost and utilization of health care provided or
 32-55 authorized by a treating doctor on the list of approved doctors.

32-56 (n) [~~(k)~~] The commissioner [commission] may adopt rules to
 32-57 define the role of the treating doctor and to specify outcome
 32-58 information to be collected for a treating doctor.

32-59 SECTION 3.076. Section 408.0231, Labor Code, is amended to
 32-60 read as follows:

32-61 Sec. 408.0231. MAINTENANCE OF LIST OF APPROVED DOCTORS;
 32-62 SANCTIONS AND PRIVILEGES RELATING TO HEALTH CARE. (a) The
 32-63 commissioner [executive director] shall delete from the list of
 32-64 approved doctors a doctor:

32-65 (1) who fails to register with the department
 32-66 [commission] as provided by this chapter and commissioner
 32-67 [commission] rules;

32-68 (2) who is deceased;
 32-69 (3) whose license to practice in this state is

33-1 revoked, suspended, or not renewed by the appropriate licensing
33-2 authority; or

33-3 (4) who requests to be removed from the list.
33-4 (b) The commissioner [~~commission~~] by rule shall establish
33-5 criteria for:

33-6 (1) deleting or suspending a doctor from the list of
33-7 approved doctors;

33-8 (2) imposing sanctions on a doctor or an insurance
33-9 carrier as provided by this section;

33-10 (3) monitoring of utilization review agents, as
33-11 provided by a memorandum of understanding between the department
33-12 [~~commission~~] and the Texas Department of Insurance; and

33-13 (4) authorizing increased or reduced utilization
33-14 review and preauthorization controls on a doctor.

33-15 (c) Rules adopted under Subsection (b) are in addition to,
33-16 and do not affect, the rules adopted under Section 415.023(b). The
33-17 criteria for deleting a doctor from the list or for recommending or
33-18 imposing sanctions may include anything the commissioner
33-19 [~~commission~~] considers relevant, including:

33-20 (1) a sanction of the doctor by the commissioner
33-21 [~~commission~~] for a violation of Chapter 413 or Chapter 415;

33-22 (2) a sanction by the Medicare or Medicaid program
33-23 for:

33-24 (A) substandard medical care;

33-25 (B) overcharging;

33-26 (C) overutilization of medical services; or

33-27 (D) any other substantive noncompliance with
33-28 requirements of those programs regarding professional practice or
33-29 billing;

33-30 (3) evidence from the department's [~~commission's~~]
33-31 medical records that the applicable insurance carrier's
33-32 utilization review practices or the doctor's charges, fees,
33-33 diagnoses, treatments, evaluations, or impairment ratings are
33-34 substantially different from those the commissioner [~~commission~~]
33-35 finds to be fair and reasonable based on either a single
33-36 determination or a pattern of practice;

33-37 (4) a suspension or other relevant practice
33-38 restriction of the doctor's license by an appropriate licensing
33-39 authority;

33-40 (5) professional failure to practice medicine or
33-41 provide health care, including chiropractic care, in an acceptable
33-42 manner consistent with the public health, safety, and welfare;

33-43 (6) findings of fact and conclusions of law made by a
33-44 court, an administrative law judge of the State Office of
33-45 Administrative Hearings, or a licensing or regulatory authority; or

33-46 (7) a criminal conviction.

33-47 (d) The commissioner [~~commission~~] by rule shall establish
33-48 procedures under which a doctor may apply for:

33-49 (1) reinstatement to the list of approved doctors; or

33-50 (2) restoration of doctor practice privileges removed
33-51 by the commissioner [~~commission~~] based on sanctions imposed under
33-52 this section.

33-53 (e) The commissioner [~~commission~~] shall act on a
33-54 recommendation by the medical advisor selected under Section
33-55 413.0511 and, after notice and the opportunity for a hearing, may
33-56 impose sanctions under this section on a doctor or an insurance
33-57 carrier or may recommend action regarding a utilization review
33-58 agent. The department [~~commission~~] and the Texas Department of
33-59 Insurance shall enter into a memorandum of understanding to
33-60 coordinate the regulation of insurance carriers and utilization
33-61 review agents as necessary to ensure:

33-62 (1) compliance with applicable regulations; and

33-63 (2) that appropriate health care decisions are reached
33-64 under this subtitle and under Article 21.58A, Insurance Code.

33-65 (f) The sanctions the commissioner [~~commission~~] may
33-66 recommend or impose under this section include:

33-67 (1) reduction of allowable reimbursement;

33-68 (2) mandatory preauthorization of all or certain
33-69 health care services;

34-1 (3) required peer review monitoring, reporting, and
 34-2 audit;
 34-3 (4) deletion or suspension from the approved doctor
 34-4 list and the designated doctor list;
 34-5 (5) restrictions on appointment under this chapter;
 34-6 (6) conditions or restrictions on an insurance carrier
 34-7 regarding actions by insurance carriers under this subtitle in
 34-8 accordance with the memorandum of understanding adopted between the
 34-9 department [~~commission~~] and the Texas Department of Insurance
 34-10 regarding Article 21.58A, Insurance Code; and

34-11 (7) mandatory participation in training classes or
 34-12 other courses as established or certified by the department
 34-13 [~~commission~~].

34-14 (g) The commissioner shall adopt rules regarding doctors
 34-15 who perform peer review functions for insurance carriers. Those
 34-16 rules may include standards for peer review, imposition of
 34-17 sanctions on doctors performing peer review functions, including
 34-18 restriction, suspension, or removal of the doctor's ability to
 34-19 perform peer review on behalf of insurance carriers in the workers'
 34-20 compensation system, and other issues important to the quality of
 34-21 peer review, as determined by the commissioner.

34-22 SECTION 3.077. Section 408.024, Labor Code, is amended to
 34-23 read as follows:

34-24 Sec. 408.024. NONCOMPLIANCE WITH SELECTION REQUIREMENTS.
 34-25 Except as otherwise provided, and after notice and an opportunity
 34-26 for hearing, the commissioner [~~commission~~] may relieve an insurance
 34-27 carrier of liability for health care that is furnished by a health
 34-28 care provider or another person selected in a manner inconsistent
 34-29 with the requirements of this subchapter.

34-30 SECTION 3.078. Subsections (a), (b), and (d), Section
 34-31 408.025, Labor Code, are amended to read as follows:

34-32 (a) The commissioner [~~commission~~] by rule shall adopt
 34-33 requirements for reports and records that are required to be filed
 34-34 with the department [~~commission~~] or provided to the injured
 34-35 employee, the employee's attorney, or the insurance carrier by a
 34-36 health care provider.

34-37 (b) The commissioner [~~commission~~] by rule shall adopt
 34-38 requirements for reports and records that are to be made available
 34-39 by a health care provider to another health care provider to prevent
 34-40 unnecessary duplication of tests and examinations.

34-41 (d) On the request of an injured employee, the employee's
 34-42 attorney, or the insurance carrier, a health care provider shall
 34-43 furnish records relating to treatment or hospitalization for which
 34-44 compensation is being sought. The department [~~commission~~] may
 34-45 regulate the charge for furnishing a report or record, but the
 34-46 charge may not be less than the fair and reasonable charge for
 34-47 furnishing the report or record. A health care provider may
 34-48 disclose to the insurance carrier of an affected employer records
 34-49 relating to the diagnosis or treatment of the injured employee
 34-50 without the authorization of the injured employee to determine the
 34-51 amount of payment or the entitlement to payment.

34-52 SECTION 3.079. Subchapter B, Chapter 408, Labor Code, is
 34-53 amended by adding Section 408.0251 to read as follows:

34-54 Sec. 408.0251. ELECTRONIC BILLING REQUIREMENTS. (a) The
 34-55 commissioner by rule shall establish requirements regarding:

34-56 (1) the electronic submission and processing of
 34-57 medical bills by health care providers to insurance carriers; and

34-58 (2) the electronic payment of medical bills by
 34-59 insurance carriers to health care providers.

34-60 (b) Insurance carriers shall accept medical bills submitted
 34-61 electronically by health care providers in accordance with
 34-62 commissioner rule.

34-63 (c) The commissioner shall by rule establish criteria for
 34-64 granting exceptions to insurance carriers and health care providers
 34-65 who are unable to submit or accept medical bills electronically.

34-66 SECTION 3.080. Section 408.026, Labor Code, is amended to
 34-67 read as follows:

34-68 Sec. 408.026. SPINAL SURGERY. Except in a medical
 34-69 emergency, an insurance carrier is liable for medical costs related

35-1 to spinal surgery only as provided by Section 413.014 and
 35-2 commissioner [~~commission~~] rules.

35-3 SECTION 3.081. Subsection (d), Section 408.027, Labor Code,
 35-4 is amended to read as follows:

35-5 (d) If an insurance carrier disputes the amount of payment
 35-6 or the health care provider's entitlement to payment, the insurance
 35-7 carrier shall send to the department [~~commission~~], the health care
 35-8 provider, and the injured employee a report that sufficiently
 35-9 explains the reasons for the reduction or denial of payment for
 35-10 health care services provided to the employee. The insurance
 35-11 carrier is entitled to a hearing as provided by Section 413.031(d).

35-12 SECTION 3.082. Subsections (b), (d), and (e), Section
 35-13 408.028, Labor Code, are amended to read as follows:

35-14 (b) The commissioner [~~commission~~] by rule shall require
 35-15 [~~develop an open formulary under Section 413.011 that requires~~] the
 35-16 use of generic pharmaceutical medications and clinically
 35-17 appropriate over-the-counter alternatives to prescription
 35-18 medications unless otherwise specified by the prescribing doctor,
 35-19 in accordance with applicable state law. The department by rule may
 35-20 adopt a closed formulary under Section 413.011. Rules adopted by
 35-21 the department shall allow an appeals process for claims in which a
 35-22 treating doctor determines and documents that a drug not included
 35-23 in the formulary is necessary to treat an injured employee's
 35-24 compensable injury.

35-25 (d) The commissioner [~~commission~~] shall adopt rules to
 35-26 allow an employee to purchase over-the-counter alternatives to
 35-27 prescription medications prescribed or ordered under Subsection
 35-28 (a) or (b) and to obtain reimbursement from the insurance carrier
 35-29 for those medications.

35-30 (e) Notwithstanding Subsection (b), the commissioner
 35-31 [~~commission~~] by rule shall allow an employee to purchase a brand
 35-32 name drug rather than a generic pharmaceutical medication or
 35-33 over-the-counter alternative to a prescription medication if a
 35-34 health care provider prescribes a generic pharmaceutical
 35-35 medication or an over-the-counter alternative to a prescription
 35-36 medication. The employee shall be responsible for paying the
 35-37 difference between the cost of the brand name drug and the cost of
 35-38 the generic pharmaceutical medication or of an over-the-counter
 35-39 alternative to a prescription medication. The employee may not
 35-40 seek reimbursement for the difference in cost from an insurance
 35-41 carrier and is not entitled to use the medical dispute resolution
 35-42 provisions of Chapter 413 with regard to the prescription. A
 35-43 payment described by this subsection by an employee to a health care
 35-44 provider does not violate Section 413.042. This subsection does
 35-45 not affect the duty of a health care provider to comply with the
 35-46 requirements of Subsection (b) when prescribing medications or
 35-47 ordering over-the-counter alternatives to prescription
 35-48 medications.

35-49 SECTION 3.083. Section 408.030, Labor Code, is amended to
 35-50 read as follows:

35-51 Sec. 408.030. REPORTS OF PHYSICIAN VIOLATIONS. If the
 35-52 department [~~commission~~] discovers an act or omission by a physician
 35-53 that may constitute a felony, a misdemeanor involving moral
 35-54 turpitude, a violation of a state or federal narcotics or
 35-55 controlled substance law, an offense involving fraud or abuse under
 35-56 the Medicare or Medicaid program, or a violation of this subtitle,
 35-57 the department [~~commission~~] shall immediately report that act or
 35-58 omission to the Texas State Board of Medical Examiners.

35-59 SECTION 3.084. Subchapter B, Chapter 408, Labor Code, is
 35-60 amended by adding Section 408.031 to read as follows:

35-61 Sec. 408.031. WORKERS' COMPENSATION HEALTH CARE NETWORKS.
 35-62 (a) Notwithstanding any other provision of this chapter, an
 35-63 injured employee may receive benefits under a workers' compensation
 35-64 health care network established under Chapter 1305, Insurance Code,
 35-65 in the manner provided by that chapter.

35-66 (b) In the event of a conflict between this title and
 35-67 Chapter 1305, Insurance Code, as to the operation and regulation of
 35-68 workers' compensation health care networks, regulation of the
 35-69 health care providers who contract with those networks, or the

36-1 resolution of disputes regarding medical benefits provided through
 36-2 those networks, Chapter 1305, Insurance Code, prevails.

36-3 SECTION 3.085. Subsection (c), Section 408.041, Labor Code,
 36-4 is amended to read as follows:

36-5 (c) If Subsection (a) or (b) cannot reasonably be applied
 36-6 because the employee's employment has been irregular or because the
 36-7 employee has lost time from work during the 13-week period
 36-8 immediately preceding the injury because of illness, weather, or
 36-9 another cause beyond the control of the employee, the commissioner
 36-10 [~~commission~~] may determine the employee's average weekly wage by
 36-11 any method that the commissioner [~~commission~~] considers fair, just,
 36-12 and reasonable to all parties and consistent with the methods
 36-13 established under this section.

36-14 SECTION 3.086. Subsections (d), (f), and (g), Section
 36-15 408.042, Labor Code, are amended to read as follows:

36-16 (d) The commissioner [~~commission~~] shall:

36-17 (1) prescribe a form to collect information regarding
 36-18 the wages of employees with multiple employment; and

36-19 (2) by rule, determine the manner by which the
 36-20 department [~~commission~~] collects and distributes wage information
 36-21 to implement this section.

36-22 (f) If the commissioner [~~commission~~] determines that
 36-23 computing the average weekly wage for an employee as provided by
 36-24 Subsection (c) is impractical or unreasonable, the commissioner
 36-25 [~~commission~~] shall set the average weekly wage in a manner that more
 36-26 fairly reflects the employee's average weekly wage and that is fair
 36-27 and just to both parties or is in the manner agreed to by the
 36-28 parties. The commissioner [~~commission~~] by rule may define methods
 36-29 to determine a fair and just average weekly wage consistent with
 36-30 this section.

36-31 (g) An insurance carrier is entitled to apply for and
 36-32 receive reimbursement at least annually from the subsequent injury
 36-33 fund for the amount of income benefits paid to a worker under this
 36-34 section that are based on employment other than the employment
 36-35 during which the compensable injury occurred. The commissioner
 36-36 [~~commission~~] may adopt rules that govern the documentation,
 36-37 application process, and other administrative requirements
 36-38 necessary to implement this subsection.

36-39 SECTION 3.087. Subsection (c), Section 408.043, Labor Code,
 36-40 is amended to read as follows:

36-41 (c) If, for good reason, the commissioner [~~commission~~]
 36-42 determines that computing the average weekly wage for a seasonal
 36-43 employee as provided by this section is impractical, the
 36-44 commissioner [~~commission~~] shall compute the average weekly wage as
 36-45 of the time of the injury in a manner that is fair and just to both
 36-46 parties.

36-47 SECTION 3.088. Subsection (b), Section 408.0445, Labor
 36-48 Code, is amended to read as follows:

36-49 (b) For purposes of computing income benefits or death
 36-50 benefits under Section 88.303, Education Code, the average weekly
 36-51 wage of a Texas Task Force 1 member, as defined by Section 88.301,
 36-52 Education Code, who is engaged in authorized training or duty is an
 36-53 amount equal to the sum of the member's regular weekly wage at any
 36-54 employment, including self-employment, that the member holds in
 36-55 addition to serving as a member of Texas Task Force 1, except that
 36-56 the amount may not exceed 100 percent of the state average weekly
 36-57 wage as determined under Section 408.047. A member for whom an
 36-58 average weekly wage cannot be computed shall be paid the minimum
 36-59 weekly benefit established by the commissioner [~~commission~~].

36-60 SECTION 3.089. Subsections (d) and (e), Section 408.0446,
 36-61 Labor Code, are amended to read as follows:

36-62 (d) If the commissioner [~~commission~~] determines that
 36-63 computing the average weekly wage of a school district employee as
 36-64 provided by this section is impractical because the employee did
 36-65 not earn wages during the 12 months immediately preceding the date
 36-66 of the injury, the commissioner [~~commission~~] shall compute the
 36-67 average weekly wage in a manner that is fair and just to both
 36-68 parties.

36-69 (e) The commissioner [~~commission~~] shall adopt rules as

37-1 necessary to implement this section.

37-2 SECTION 3.090. Section 408.045, Labor Code, is amended to
37-3 read as follows:

37-4 Sec. 408.045. NONPECUNIARY WAGES. The commissioner
37-5 [~~commission~~] may not include nonpecuniary wages in computing an
37-6 employee's average weekly wage during a period in which the
37-7 employer continues to provide the nonpecuniary wages.

37-8 SECTION 3.091. Section 408.047, Labor Code, is amended to
37-9 read as follows:

37-10 Sec. 408.047. STATE AVERAGE WEEKLY WAGE. (a) On and after
37-11 October 1, 2006, the state average weekly wage is equal to 85
37-12 percent of the average weekly wage in covered employment computed
37-13 by the Texas Workforce Commission under Section 207.002(c).

37-14 (b) The state average weekly wage for the period [~~fiscal~~
37-15 ~~year~~] beginning September 1, 2005 [2003], and ending September 30,
37-16 2006 [August 31, 2004], is \$540 [~~\$537, and for the fiscal year~~
37-17 ~~beginning September 1, 2004, and ending August 31, 2005, is \$539~~].
37-18 This subsection expires October 1, 2006.

37-19 SECTION 3.092. Subsection (f), Section 408.061, Labor Code,
37-20 is amended to read as follows:

37-21 (f) The commissioner [~~commission~~] shall compute the maximum
37-22 weekly income benefits for each state fiscal year not later than
37-23 October [~~September~~] 1 of each year.

37-24 SECTION 3.093. Subsection (b), Section 408.062, Labor Code,
37-25 is amended to read as follows:

37-26 (b) The commissioner [~~commission~~] shall compute the minimum
37-27 weekly income benefit for each state fiscal year not later than
37-28 October [~~September~~] 1 of each year.

37-29 SECTION 3.094. Subsections (a) and (c), Section 408.063,
37-30 Labor Code, are amended to read as follows:

37-31 (a) To expedite the payment of income benefits, the
37-32 commissioner [~~commission~~] may by rule establish reasonable
37-33 presumptions relating to the wages earned by an employee, including
37-34 the presumption that an employee's last paycheck accurately
37-35 reflects the employee's usual wage.

37-36 (c) An employer who fails to file a wage statement in
37-37 accordance with Subsection (b) commits a violation. [~~A violation~~
37-38 ~~under this subsection is a Class D administrative violation.~~]

37-39 SECTION 3.095. Subsections (b) and (c), Section 408.081,
37-40 Labor Code, are amended to read as follows:

37-41 (b) Except as otherwise provided by this section or this
37-42 subtitle, income benefits shall be paid weekly as and when they
37-43 accrue without order from the commissioner [~~commission~~]. Interest
37-44 on accrued but unpaid benefits shall be paid, without order of the
37-45 commissioner [~~commission~~], at the time the accrued benefits are
37-46 paid.

37-47 (c) The commissioner [~~commission~~] by rule shall establish
37-48 requirements for agreements under which income benefits may be paid
37-49 monthly. Income benefits may be paid monthly only:

37-50 (1) on the request of the employee and the agreement of
37-51 the employee and the insurance carrier; and

37-52 (2) in compliance with the requirements adopted by the
37-53 commissioner [~~commission~~].

37-54 SECTION 3.096. Subsection (c), Section 408.082, Labor Code,
37-55 is amended to read as follows:

37-56 (c) If the disability continues for two [~~four~~] weeks or
37-57 longer after the date it begins, compensation shall be computed
37-58 from the date the disability begins.

37-59 SECTION 3.097. Subsections (a) and (b), Section 408.084,
37-60 Labor Code, are amended to read as follows:

37-61 (a) At the request of the insurance carrier, the
37-62 commissioner [~~commission~~] may order that impairment income
37-63 benefits and supplemental income benefits be reduced in a
37-64 proportion equal to the proportion of a documented impairment that
37-65 resulted from earlier compensable injuries.

37-66 (b) The commissioner [~~commission~~] shall consider the
37-67 cumulative impact of the compensable injuries on the employee's
37-68 overall impairment in determining a reduction under this section.

37-69 SECTION 3.098. Section 408.085, Labor Code, is amended to

38-1 read as follows:

38-2 Sec. 408.085. ADVANCE OF BENEFITS FOR HARDSHIP. (a) If
38-3 there is a likelihood that income benefits will be paid, the
38-4 commissioner [~~commission~~] may grant an employee suffering
38-5 financial hardship advances as provided by this subtitle against
38-6 the amount of income benefits to which the employee may be entitled.
38-7 An advance may be ordered before or after the employee attains
38-8 maximum medical improvement. An insurance carrier shall pay the
38-9 advance ordered.

38-10 (b) An employee must apply to the department [~~commission~~]
38-11 for an advance on a form prescribed by the commissioner
38-12 [~~commission~~]. The application must describe the hardship that is
38-13 the grounds for the advance.

38-14 (c) An advance under this section may not exceed an amount
38-15 equal to four times the maximum weekly benefit for temporary income
38-16 benefits as computed in Section 408.061. The commissioner
38-17 [~~commission~~] may not grant more than three advances to a particular
38-18 employee based on the same injury.

38-19 (d) The commissioner [~~commission~~] may not grant an advance
38-20 to an employee who is receiving, on the date of the application
38-21 under Subsection (b), at least 90 percent of the employee's net
38-22 preinjury wages under Section 408.003 or 408.129.

38-23 SECTION 3.099. Section 408.086, Labor Code, is amended to
38-24 read as follows:

38-25 Sec. 408.086. DEPARTMENT [~~COMMISSION~~] DETERMINATION OF
38-26 EXTENDED UNEMPLOYMENT OR UNDEREMPLOYMENT. (a) During the period
38-27 that impairment income benefits or supplemental income benefits are
38-28 being paid to an employee, the commissioner [~~commission~~] shall
38-29 determine at least annually whether any extended unemployment or
38-30 underemployment is a direct result of the employee's impairment.

38-31 (b) To make this determination, the commissioner
38-32 [~~commission~~] may require periodic reports from the employee and the
38-33 insurance carrier and, at the insurance carrier's expense, may
38-34 require physical or other examinations, vocational assessments, or
38-35 other tests or diagnoses necessary to perform the commissioner's
38-36 [~~its~~] duty under this section and Subchapter H.

38-37 SECTION 3.100. Subsection (b), Section 408.102, Labor Code,
38-38 is amended to read as follows:

38-39 (b) The commissioner [~~commission~~] by rule shall establish a
38-40 presumption that maximum medical improvement has been reached based
38-41 on a lack of medical improvement in the employee's condition.

38-42 SECTION 3.101. Subsection (b), Section 408.103, Labor Code,
38-43 is amended to read as follows:

38-44 (b) A temporary income benefit under Subsection (a)(2) may
38-45 not exceed the employee's actual earnings for the previous year. It
38-46 is presumed that the employee's actual earnings for the previous
38-47 year are equal to:

38-48 (1) the sum of the employee's wages as reported in the
38-49 most recent four quarterly wage reports to the Texas Workforce
38-50 [~~Employment~~] Commission divided by 52;

38-51 (2) the employee's wages in the single quarter of the
38-52 most recent four quarters in which the employee's earnings were
38-53 highest, divided by 13, if the commissioner [~~commission~~] finds that
38-54 the employee's most recent four quarters' earnings reported in the
38-55 Texas Workforce [~~Employment~~] Commission wage reports are not
38-56 representative of the employee's usual earnings; or

38-57 (3) the amount the commissioner [~~commission~~]
38-58 determines from other credible evidence to be the actual earnings
38-59 for the previous year if the Texas Workforce [~~Employment~~]
38-60 Commission does not have a wage report reflecting at least one
38-61 quarter's earnings because the employee worked outside the state
38-62 during the previous year.

38-63 SECTION 3.102. Subsections (a) and (c), Section 408.104,
38-64 Labor Code, are amended to read as follows:

38-65 (a) On application by either the employee or the insurance
38-66 carrier, the commissioner [~~commission~~] by order may extend the
38-67 104-week period described by Section 401.011(30)(B) if the employee
38-68 has had spinal surgery, or has been approved for spinal surgery
38-69 under Section 408.026 and commissioner [~~commission~~] rules, within

39-1 12 weeks before the expiration of the 104-week period. If an order
 39-2 is issued under this section, the order shall extend the statutory
 39-3 period for maximum medical improvement to a date certain, based on
 39-4 medical evidence presented to the commissioner [~~commission~~].

39-5 (c) The commissioner [~~commission~~] shall adopt rules to
 39-6 implement this section, including rules establishing procedures
 39-7 for requesting and disputing an extension.

39-8 SECTION 3.103. Subchapter G, Chapter 408, Labor Code, is
 39-9 amended by amending Section 408.122 and adding Section 408.1225 to
 39-10 read as follows:

39-11 Sec. 408.122. ELIGIBILITY FOR IMPAIRMENT INCOME BENEFITS [~~+~~
 39-12 ~~DESIGNATED DOCTOR~~]. [~~(a)~~] A claimant may not recover impairment
 39-13 income benefits unless evidence of impairment based on an objective
 39-14 clinical or laboratory finding exists. If the finding of
 39-15 impairment is made by a doctor chosen by the claimant and the
 39-16 finding is contested, a designated doctor or a doctor selected by
 39-17 the insurance carrier must be able to confirm the objective
 39-18 clinical or laboratory finding on which the finding of impairment
 39-19 is based.

39-20 Sec. 408.1225. DESIGNATED DOCTOR. (a) [~~(b)~~] To be
 39-21 eligible to serve as a designated doctor, a doctor must meet
 39-22 specific qualifications, including training in the determination
 39-23 of impairment ratings and demonstrated expertise in performing
 39-24 examinations and making evaluations as described by Section
 39-25 408.0041. The commissioner [~~executive director~~] shall develop
 39-26 qualification standards and administrative policies to implement
 39-27 this subsection[~~7~~] and [~~the commission~~] may adopt rules as
 39-28 necessary.

39-29 (b) The commissioner shall ensure the quality of designated
 39-30 doctor decisions and reviews through active monitoring of the
 39-31 decisions and reviews, and may take action as necessary to:

39-32 (1) restrict the participation of a designated doctor;
 39-33 or

39-34 (2) remove a doctor from inclusion on the department's
 39-35 list of designated doctors. [~~The designated doctor doing the~~
 39-36 ~~review must be trained and experienced with the treatment and~~
 39-37 ~~procedures used by the doctor treating the patient's medical~~
 39-38 ~~condition, and the treatment and procedures performed must be~~
 39-39 ~~within the scope of practice of the designated doctor. A designated~~
 39-40 ~~doctor's credentials must be appropriate for the issue in question~~
 39-41 ~~and the injured employee's medical condition.]~~

39-42 (c) The report of the designated doctor has presumptive
 39-43 weight, and the department [~~commission~~] shall base its
 39-44 determination of whether the employee has reached maximum medical
 39-45 improvement on the report unless the preponderance [~~great weight~~]
 39-46 of the other medical evidence is to the contrary.

39-47 (d) The commissioner shall develop rules to ensure that a
 39-48 designated doctor called on to conduct an examination under Section
 39-49 408.0041 has no conflict of interest in serving as a designated
 39-50 doctor in performing any examination.

39-51 SECTION 3.104. Section 408.123, Labor Code, is amended and
 39-52 reenacted to read as follows:

39-53 Sec. 408.123. CERTIFICATION OF MAXIMUM MEDICAL
 39-54 IMPROVEMENT; EVALUATION OF IMPAIRMENT RATING. (a) After an
 39-55 employee has been certified by a doctor as having reached maximum
 39-56 medical improvement, the certifying doctor shall evaluate the
 39-57 condition of the employee and assign an impairment rating using the
 39-58 impairment rating guidelines described by Section 408.124. If the
 39-59 certification and evaluation are performed by a doctor other than
 39-60 the employee's treating doctor, the certification and evaluation
 39-61 shall be submitted to the treating doctor, and the treating doctor
 39-62 shall indicate agreement or disagreement with the certification and
 39-63 evaluation.

39-64 (b) A certifying doctor shall issue a written report
 39-65 certifying that maximum medical improvement has been reached,
 39-66 stating the employee's impairment rating, and providing any other
 39-67 information required by the commissioner [~~commission~~] to:

39-68 (1) the department [~~commission~~];
 39-69 (2) the employee; and

40-1 (3) the insurance carrier.

40-2 (c) If an employee is not certified as having reached
40-3 maximum medical improvement before the expiration of 102 weeks
40-4 after the date income benefits begin to accrue, the department
40-5 [~~commission~~] shall notify the treating doctor of the requirements
40-6 of this subchapter.

40-7 (d) Except as otherwise provided by this section, an
40-8 employee's first valid certification of maximum medical
40-9 improvement and first valid assignment of an impairment rating is
40-10 final if the certification or assignment is not disputed before the
40-11 91st day after the date written notification of the certification
40-12 or assignment is provided to the employee and the carrier by
40-13 verifiable means.

40-14 (e) An employee's first certification of maximum medical
40-15 improvement or assignment of an impairment rating may be disputed
40-16 after the period described by Subsection (d) if:

40-17 (1) compelling medical evidence exists of:

40-18 (A) a significant error by the certifying doctor
40-19 in applying the appropriate American Medical Association
40-20 guidelines or in calculating the impairment rating;

40-21 (B) a clearly mistaken diagnosis or a previously
40-22 undiagnosed medical condition; or

40-23 (C) improper or inadequate treatment of the
40-24 injury before the date of the certification or assignment that
40-25 would render the certification or assignment invalid; or

40-26 (2) other compelling circumstances exist as
40-27 prescribed by commissioner [~~commission~~] rule.

40-28 (f) If an employee has not been certified as having reached
40-29 maximum medical improvement before the expiration of 104 weeks
40-30 after the date income benefits begin to accrue or the expiration
40-31 date of any extension of benefits under Section 408.104, the
40-32 impairment rating assigned after the expiration of either of those
40-33 periods is final if the impairment rating is not disputed before the
40-34 91st day after the date written notification of the certification
40-35 or assignment is provided to the employee and the carrier by
40-36 verifiable means. A certification or assignment may be disputed
40-37 after the 90th day only as provided by Subsection (e).

40-38 (g) If an employee's disputed certification of maximum
40-39 medical improvement or assignment of impairment rating is finally
40-40 modified, overturned, or withdrawn, the first certification or
40-41 assignment made after the date of the modification, overturning, or
40-42 withdrawal becomes final if the certification or assignment is not
40-43 disputed before the 91st day after the date notification of the
40-44 certification or assignment is provided to the employee and the
40-45 carrier by verifiable means. A certification or assignment may be
40-46 disputed after the 90th day only as provided by Subsection (e).

40-47 SECTION 3.105. Section 408.124, Labor Code, is amended to
40-48 read as follows:

40-49 Sec. 408.124. IMPAIRMENT RATING GUIDELINES. (a) An award
40-50 of an impairment income benefit, whether by the commissioner
40-51 [~~commission~~] or a court, shall be made on an impairment rating
40-52 determined using the impairment rating guidelines described in this
40-53 section.

40-54 (b) For determining the existence and degree of an
40-55 employee's impairment, the commissioner [~~commission~~] shall use
40-56 "Guides to the Evaluation of Permanent Impairment," third edition,
40-57 second printing, dated February 1989, published by the American
40-58 Medical Association.

40-59 (c) Notwithstanding Subsection (b), the commissioner
40-60 [~~commission~~] by rule may adopt the fourth edition of the "Guides to
40-61 the Evaluation of Permanent Impairment," published by the American
40-62 Medical Association, for determining the existence and degree of an
40-63 employee's impairment.

40-64 SECTION 3.106. Subsections (a) through (d) and (f), Section
40-65 408.125, Labor Code, are amended to read as follows:

40-66 (a) If an impairment rating is disputed, the commissioner
40-67 [~~commission~~] shall direct the employee to the next available doctor
40-68 on the department's [~~commission's~~] list of designated doctors, as
40-69 provided by Section 408.0041.

41-1 (b) The designated doctor shall report in writing to the
41-2 department [~~commission~~].

41-3 (c) The report of the designated doctor shall have
41-4 presumptive weight, and the department [~~commission~~] shall base the
41-5 impairment rating on that report unless the preponderance [~~great~~
41-6 ~~weight~~] of the other medical evidence is to the contrary. If the
41-7 preponderance [~~great weight~~] of the medical evidence contradicts
41-8 the impairment rating contained in the report of the designated
41-9 doctor chosen by the department [~~commission~~], the department
41-10 [~~commission~~] shall adopt the impairment rating of one of the other
41-11 doctors.

41-12 (d) To avoid undue influence on a person selected as a
41-13 designated doctor under this section, only the injured employee or
41-14 an appropriate member of the staff of the department [~~commission~~]
41-15 may communicate with the designated doctor about the case regarding
41-16 the injured employee's medical condition or history before the
41-17 examination of the injured employee by the designated doctor.
41-18 After that examination is completed, communication with the
41-19 designated doctor regarding the injured employee's medical
41-20 condition or history may be made only through appropriate
41-21 department [~~commission~~] staff members. The designated doctor may
41-22 initiate communication with any doctor who has previously treated
41-23 or examined the injured employee for the work-related injury.

41-24 (f) A violation of Subsection (d) is an [~~a Class C~~]
41-25 administrative violation.

41-26 SECTION 3.107. Subsection (c), Section 408.127, Labor Code,
41-27 is amended to read as follows:

41-28 (c) The commissioner [~~commission~~] shall adopt rules and
41-29 forms to ensure the full reporting and the accuracy of reductions
41-30 and reimbursements made under this section.

41-31 SECTION 3.108. Subsections (a), (b), and (d), Section
41-32 408.129, Labor Code, are amended to read as follows:

41-33 (a) On approval by the commissioner [~~commission~~] of a
41-34 written request received from an employee, an insurance carrier
41-35 shall accelerate the payment of impairment income benefits to the
41-36 employee. The accelerated payment may not exceed a rate of payment
41-37 equal to that of the employee's net preinjury wage.

41-38 (b) The commissioner [~~commission~~] shall approve the request
41-39 and order the acceleration of the benefits if the commissioner
41-40 [~~commission~~] determines that the acceleration is:

- 41-41 (1) required to relieve hardship; and
41-42 (2) in the overall best interest of the employee.

41-43 (d) The commissioner [~~commission~~] may prescribe forms
41-44 necessary to implement this section.

41-45 SECTION 3.109. Section 408.141, Labor Code, is amended to
41-46 read as follows:

41-47 Sec. 408.141. AWARD OF SUPPLEMENTAL INCOME BENEFITS. An
41-48 award of a supplemental income benefit, whether by the commissioner
41-49 [~~commission~~] or a court, shall be made in accordance with this
41-50 subchapter.

41-51 SECTION 3.110. Subsections (a) and (b), Section 408.143,
41-52 Labor Code, are amended to read as follows:

41-53 (a) After the commissioner's [~~commission's~~] initial
41-54 determination of supplemental income benefits, the employee must
41-55 file a statement with the insurance carrier stating:

41-56 (1) that the employee has earned less than 80 percent
41-57 of the employee's average weekly wage as a direct result of the
41-58 employee's impairment;

41-59 (2) the amount of wages the employee earned in the
41-60 filing period provided by Subsection (b); and

41-61 (3) that the employee has in good faith sought
41-62 employment commensurate with the employee's ability to work.

41-63 (b) The statement required under this section must be filed
41-64 quarterly on a form and in the manner provided by the commissioner
41-65 [~~commission~~]. The commissioner [~~commission~~] may modify the filing
41-66 period as appropriate to an individual case.

41-67 SECTION 3.111. Subsection (c), Section 408.147, Labor Code,
41-68 is amended to read as follows:

41-69 (c) If an insurance carrier disputes the commissioner's [~~a~~

42-1 ~~commissioner~~] determination that an employee is entitled to
 42-2 supplemental income benefits or the amount of supplemental income
 42-3 benefits due and the employee prevails on any disputed issue, the
 42-4 insurance carrier is liable for reasonable and necessary attorney's
 42-5 fees incurred by the employee as a result of the insurance carrier's
 42-6 dispute and for supplemental income benefits accrued but not paid
 42-7 and interest on that amount, according to Section 408.064.
 42-8 Attorney's fees awarded under this subsection are not subject to
 42-9 Sections 408.221(b), (f), and (i).

42-10 SECTION 3.112. Section 408.148, Labor Code, is amended to
 42-11 read as follows:

42-12 Sec. 408.148. EMPLOYEE DISCHARGE AFTER TERMINATION. The
 42-13 commissioner [~~commissioner~~] may reinstate supplemental income
 42-14 benefits to an employee who is discharged within 12 months of the
 42-15 date of losing entitlement to supplemental income benefits under
 42-16 Section 408.146(c) if the commissioner [~~commissioner~~] finds that the
 42-17 employee was discharged at that time with the intent to deprive the
 42-18 employee of supplemental income benefits.

42-19 SECTION 3.113. Section 408.149, Labor Code, is amended to
 42-20 read as follows:

42-21 Sec. 408.149. STATUS REVIEW; BENEFIT REVIEW CONFERENCE.
 42-22 (a) Not more than once in each period of 12 calendar months, an
 42-23 employee and an insurance carrier each may request the commissioner
 42-24 [~~commissioner~~] to review the status of the employee and determine
 42-25 whether the employee's unemployment or underemployment is a direct
 42-26 result of impairment from the compensable injury.

42-27 (b) Either party may request a benefit review conference to
 42-28 contest a determination of the commissioner [~~commissioner~~] at any
 42-29 time, subject only to the limits placed on the insurance carrier by
 42-30 Section 408.147.

42-31 SECTION 3.114. Section 408.150, Labor Code, is amended to
 42-32 read as follows:

42-33 Sec. 408.150. VOCATIONAL REHABILITATION. (a) The
 42-34 department [~~commissioner~~] shall refer an employee to the Department
 42-35 of Assistive and Rehabilitative Services [~~Texas Rehabilitation~~
 42-36 ~~Commissioner~~] with a recommendation for appropriate services if the
 42-37 department [~~commissioner~~] determines that an employee [~~entitled to~~
 42-38 ~~supplemental income benefits~~] could be materially assisted by
 42-39 vocational rehabilitation or training in returning to employment or
 42-40 returning to employment more nearly approximating the employee's
 42-41 preinjury employment. The department [~~commissioner~~] shall also
 42-42 notify insurance carriers of the need for vocational rehabilitation
 42-43 or training services. The insurance carrier may provide services
 42-44 through a private provider of vocational rehabilitation services
 42-45 under Section 409.012.

42-46 (b) An employee who refuses services or refuses to cooperate
 42-47 with services provided under this section by the Department of
 42-48 Assistive and Rehabilitative Services [~~Texas Rehabilitation~~
 42-49 ~~Commissioner~~] or a private provider loses entitlement to supplemental
 42-50 income benefits.

42-51 SECTION 3.115. Section 408.151, Labor Code, is amended to
 42-52 read as follows:

42-53 Sec. 408.151. MEDICAL EXAMINATIONS FOR SUPPLEMENTAL INCOME
 42-54 BENEFITS. (a) On or after the second anniversary of the date the
 42-55 commissioner [~~commissioner~~] makes the initial award of supplemental
 42-56 income benefits, an insurance carrier may not require an employee
 42-57 who is receiving supplemental income benefits to submit to a
 42-58 medical examination more than annually if, in the preceding year,
 42-59 the employee's medical condition resulting from the compensable
 42-60 injury has not improved sufficiently to allow the employee to
 42-61 return to work.

42-62 (b) If a dispute exists as to whether the employee's medical
 42-63 condition has improved sufficiently to allow the employee to return
 42-64 to work, the commissioner [~~commissioner~~] shall direct the employee to
 42-65 be examined by a designated doctor chosen by the department
 42-66 [~~commissioner~~]. The designated doctor shall report to the department
 42-67 [~~commissioner~~]. The report of the designated doctor has presumptive
 42-68 weight, and the department [~~commissioner~~] shall base its
 42-69 determination of whether the employee's medical condition has

43-1 improved sufficiently to allow the employee to return to work on
 43-2 that report unless the preponderance [~~great weight~~] of the other
 43-3 medical evidence is to the contrary.

43-4 [~~(c) The commission may require an employee to whom
 43-5 Subsection (a) applies to submit to a medical examination under
 43-6 Section 408.004 only to determine whether the employee's medical
 43-7 condition is a direct result of impairment from a compensable
 43-8 injury.~~]

43-9 SECTION 3.116. Subsection (d), Section 408.161, Labor Code,
 43-10 is amended to read as follows:

43-11 (d) An insurance carrier may pay lifetime income benefits
 43-12 through an annuity if the annuity agreement meets the terms and
 43-13 conditions for annuity agreements adopted by the commissioner
 43-14 [~~commission~~] by rule. The establishment of an annuity under this
 43-15 subsection does not relieve the insurance carrier of the liability
 43-16 under this title for ensuring that the lifetime income benefits are
 43-17 paid.

43-18 SECTION 3.117. Subsections (c) and (d), Section 408.181,
 43-19 Labor Code, are amended to read as follows:

43-20 (c) The commissioner [~~commission~~] by rule shall establish
 43-21 requirements for agreements under which death benefits may be paid
 43-22 monthly. Death benefits may be paid monthly only:

43-23 (1) on the request of the legal beneficiary and the
 43-24 agreement of the legal beneficiary and the insurance carrier; and

43-25 (2) in compliance with the requirements adopted by the
 43-26 commissioner [~~commission~~].

43-27 (d) An insurance carrier may pay death benefits through an
 43-28 annuity if the annuity agreement meets the terms and conditions for
 43-29 annuity agreements adopted by the commissioner [~~commission~~] by
 43-30 rule. The establishment of an annuity under this subsection does
 43-31 not relieve the insurance carrier of the liability under this title
 43-32 for ensuring that the death benefits are paid.

43-33 SECTION 3.118. Subsection (f), Section 408.182, Labor Code,
 43-34 is amended to read as follows:

43-35 (f) In this section:

43-36 (1) "Eligible child" means a child of a deceased
 43-37 employee if the child is:

43-38 (A) a minor;

43-39 (B) enrolled as a full-time student in an
 43-40 accredited educational institution and is less than 25 years of
 43-41 age; or

43-42 (C) a dependent of the deceased employee at the
 43-43 time of the employee's death.

43-44 (2) "Eligible grandchild" means a grandchild of a
 43-45 deceased employee who is a dependent of the deceased employee and
 43-46 whose parent is not an eligible child.

43-47 (3) "Eligible spouse" means the surviving spouse of a
 43-48 deceased employee unless the spouse abandoned the employee for
 43-49 longer than the year immediately preceding the death without good
 43-50 cause, as determined by the department [~~commission~~].

43-51 SECTION 3.119. Subsection (b), Section 408.183, Labor Code,
 43-52 is amended to read as follows:

43-53 (b) An eligible spouse is entitled to receive death benefits
 43-54 for life or until remarriage. On remarriage, the eligible spouse is
 43-55 entitled to receive 104 weeks of death benefits, commuted as
 43-56 provided by commissioner [~~commission~~] rule.

43-57 SECTION 3.120. Subsection (c), Section 408.187, Labor Code,
 43-58 is amended to read as follows:

43-59 (c) The commissioner [~~commission~~] shall require the
 43-60 insurance carrier to pay the costs of a procedure ordered under this
 43-61 section.

43-62 SECTION 3.121. Section 408.202, Labor Code, is amended to
 43-63 read as follows:

43-64 Sec. 408.202. ASSIGNABILITY OF BENEFITS. Benefits are not
 43-65 assignable, except a legal beneficiary may, with the commissioner's
 43-66 [~~commission~~] approval, assign the right to death benefits.

43-67 SECTION 3.122. Subsections (a) through (g), Section
 43-68 408.221, Labor Code, are amended to read as follows:

43-69 (a) An attorney's fee, including a contingency fee, for

44-1 representing a claimant before the department [~~commission~~] or court
 44-2 under this subtitle must be approved by the commissioner
 44-3 [~~commission~~] or court.

44-4 (b) Except as otherwise provided, an attorney's fee under
 44-5 this section is based on the attorney's time and expenses according
 44-6 to written evidence presented to the department [~~commission~~] or
 44-7 court. Except as provided by Subsection (c) or Section 408.147(c),
 44-8 the attorney's fee shall be paid from the claimant's recovery.

44-9 (c) An insurance carrier that seeks judicial review under
 44-10 Subchapter G, Chapter 410, of a final decision of a department
 44-11 [~~commission~~] appeals panel regarding compensability or eligibility
 44-12 for, or the amount of, income or death benefits is liable for
 44-13 reasonable and necessary attorney's fees as provided by Subsection
 44-14 (d) incurred by the claimant as a result of the insurance carrier's
 44-15 appeal if the claimant prevails on an issue on which judicial review
 44-16 is sought by the insurance carrier in accordance with the
 44-17 limitation of issues contained in Section 410.302. If the carrier
 44-18 appeals multiple issues and the claimant prevails on some, but not
 44-19 all, of the issues appealed, the court shall apportion and award
 44-20 fees to the claimant's attorney only for the issues on which the
 44-21 claimant prevails. In making that apportionment, the court shall
 44-22 consider the factors prescribed by Subsection (d). This subsection
 44-23 does not apply to attorney's fees for which an insurance carrier may
 44-24 be liable under Section 408.147. An award of attorney's fees under
 44-25 this subsection is not subject to commissioner [~~commission~~] rules
 44-26 adopted under Subsection (f). [~~This subsection expires September~~
 44-27 ~~1, 2005.~~]

44-28 (d) In approving an attorney's fee under this section, the
 44-29 commissioner [~~commission~~] or court shall consider:

- 44-30 (1) the time and labor required;
 44-31 (2) the novelty and difficulty of the questions
 44-32 involved;
 44-33 (3) the skill required to perform the legal services
 44-34 properly;
 44-35 (4) the fee customarily charged in the locality for
 44-36 similar legal services;
 44-37 (5) the amount involved in the controversy;
 44-38 (6) the benefits to the claimant that the attorney is
 44-39 responsible for securing; and
 44-40 (7) the experience and ability of the attorney
 44-41 performing the services.

44-42 (e) The commissioner [~~commission~~] by rule or the court may
 44-43 provide for the commutation of an attorney's fee, except that the
 44-44 attorney's fee shall be paid in periodic payments in a claim
 44-45 involving death benefits if the only dispute is as to the proper
 44-46 beneficiary or beneficiaries.

44-47 (f) The commissioner [~~commission~~] by rule shall provide
 44-48 guidelines for maximum attorney's fees for specific services in
 44-49 accordance with this section.

44-50 (g) An attorney's fee may not be allowed in a case involving
 44-51 a fatal injury or lifetime income benefit if the insurance carrier
 44-52 admits liability on all issues and tenders payment of maximum
 44-53 benefits in writing under this subtitle while the claim is pending
 44-54 before the department [~~commission~~].

44-55 SECTION 3.123. Section 408.222, Labor Code, is amended to
 44-56 read as follows:

44-57 Sec. 408.222. ATTORNEY'S FEES PAID TO DEFENSE COUNSEL.

44-58 (a) The amount of an attorney's fee for defending an insurance
 44-59 carrier in a workers' compensation action brought under this
 44-60 subtitle must be approved by the commissioner [~~commission~~] or court
 44-61 and determined by the commissioner [~~commission~~] or court to be
 44-62 reasonable and necessary.

44-63 (b) In determining whether a fee is reasonable under this
 44-64 section, the commissioner [~~commission~~] or court shall consider
 44-65 issues analogous to those listed under Section 408.221(d). The
 44-66 defense counsel shall present written evidence to the commissioner
 44-67 [~~commission~~] or court relating to:

- 44-68 (1) the time spent and expenses incurred in defending
 44-69 the case; and

45-1 (2) other evidence considered necessary by the
 45-2 commissioner [~~commission~~] or court in making a determination under
 45-3 this section.

45-4 SECTION 3.124. Section 409.002, Labor Code, is amended to
 45-5 read as follows:

45-6 Sec. 409.002. FAILURE TO FILE NOTICE OF INJURY. Failure to
 45-7 notify an employer as required by Section 409.001(a) relieves the
 45-8 employer and the employer's insurance carrier of liability under
 45-9 this subtitle unless:

45-10 (1) the employer, a person eligible to receive notice
 45-11 under Section 409.001(b), or the employer's insurance carrier has
 45-12 actual knowledge of the employee's injury;

45-13 (2) the commissioner [~~commission~~] determines that
 45-14 good cause exists for failure to provide notice in a timely manner;
 45-15 or

45-16 (3) the employer or the employer's insurance carrier
 45-17 does not contest the claim.

45-18 SECTION 3.125. Section 409.003, Labor Code, is amended to
 45-19 read as follows:

45-20 Sec. 409.003. CLAIM FOR COMPENSATION. An employee or a
 45-21 person acting on the employee's behalf shall file with the
 45-22 department [~~commission~~] a claim for compensation for an injury not
 45-23 later than one year after the date on which:

45-24 (1) the injury occurred; or

45-25 (2) if the injury is an occupational disease, the
 45-26 employee knew or should have known that the disease was related to
 45-27 the employee's employment.

45-28 SECTION 3.126. Section 409.004, Labor Code, is amended to
 45-29 read as follows:

45-30 Sec. 409.004. FAILURE TO FILE CLAIM FOR COMPENSATION.
 45-31 Failure to file a claim for compensation with the department
 45-32 [~~commission~~] as required under Section 409.003 relieves the
 45-33 employer and the employer's insurance carrier of liability under
 45-34 this subtitle unless:

45-35 (1) good cause exists for failure to file a claim in a
 45-36 timely manner; or

45-37 (2) the employer or the employer's insurance carrier
 45-38 does not contest the claim.

45-39 SECTION 3.127. Subsections (d), (e), (f), and (h) through
 45-40 (l), Section 409.005, Labor Code, are amended to read as follows:

45-41 (d) The insurance carrier shall file the report of the
 45-42 injury on behalf of the policyholder. Except as provided by
 45-43 Subsection (e), the insurance carrier must electronically file the
 45-44 report with the department [~~commission~~] not later than the seventh
 45-45 day after the date on which the carrier receives the report from the
 45-46 employer.

45-47 (e) The commissioner [~~executive director~~] may waive the
 45-48 electronic filing requirement under Subsection (d) and allow an
 45-49 insurance carrier to mail or deliver the report to the department
 45-50 [~~commission~~] not later than the seventh day after the date on which
 45-51 the carrier receives the report from the employer.

45-52 (f) A report required under this section may not be
 45-53 considered to be an admission by or evidence against an employer or
 45-54 an insurance carrier in a proceeding before the department
 45-55 [~~commission~~] or a court in which the facts set out in the report are
 45-56 contradicted by the employer or insurance carrier.

45-57 (h) The commissioner [~~commission~~] may adopt rules relating
 45-58 to:

45-59 (1) the information that must be contained in a report
 45-60 required under this section, including the summary of rights and
 45-61 responsibilities required under Subsection (g); and

45-62 (2) the development and implementation of an
 45-63 electronic filing system for injury reports under this section.

45-64 (i) An employer and insurance carrier shall file subsequent
 45-65 reports as required by commissioner [~~commission~~] rule.

45-66 (j) The employer shall, on the written request of the
 45-67 employee, a doctor, the insurance carrier, or the commissioner
 45-68 [~~commission~~], notify the employee, the employee's treating doctor
 45-69 if known to the employer, and the insurance carrier of the existence

46-1 or absence of opportunities for modified duty or a modified duty
 46-2 return-to-work program available through the employer. If those
 46-3 opportunities or that program exists, the employer shall identify
 46-4 the employer's contact person and provide other information to
 46-5 assist the doctor, the employee, and the insurance carrier to
 46-6 assess modified duty or return-to-work options.

46-7 (k) This section does not prohibit the commissioner
 46-8 [~~commission~~] from imposing requirements relating to return-to-work
 46-9 under other authority granted to the department [~~commission~~] in
 46-10 this subtitle.

46-11 (l) A person commits a violation if the person fails to
 46-12 comply with this section unless good cause exists. [~~A violation~~
 46-13 ~~under this subsection is a Class D administrative violation.~~]

46-14 SECTION 3.128. Subsections (b), (c), and (e), Section
 46-15 409.006, Labor Code, are amended to read as follows:

46-16 (b) The record shall be available to the department
 46-17 [~~commission~~] at reasonable times and under conditions prescribed by
 46-18 the commissioner [~~commission~~].

46-19 (c) The commissioner [~~commission~~] may adopt rules relating
 46-20 to the information that must be contained in an employer record
 46-21 under this section.

46-22 (e) A person commits a violation if the person fails to
 46-23 comply with this section. [~~A violation under this subsection is a~~
 46-24 ~~Class D administrative violation.~~]

46-25 SECTION 3.129. Subsection (a), Section 409.007, Labor Code,
 46-26 is amended to read as follows:

46-27 (a) A person must file a claim for death benefits with the
 46-28 department [~~commission~~] not later than the first anniversary of the
 46-29 date of the employee's death.

46-30 SECTION 3.130. Section 409.009, Labor Code, is amended to
 46-31 read as follows:

46-32 Sec. 409.009. SUBCLAIMS. A person may file a written claim
 46-33 with the department [~~commission~~] as a subclaimant if the person
 46-34 has:

46-35 (1) provided compensation, including health care
 46-36 provided by a health care insurer, directly or indirectly, to or for
 46-37 an employee or legal beneficiary; and

46-38 (2) sought and been refused reimbursement from the
 46-39 insurance carrier.

46-40 SECTION 3.131. Section 409.010, Labor Code, is amended to
 46-41 read as follows:

46-42 Sec. 409.010. INFORMATION PROVIDED TO EMPLOYEE OR LEGAL
 46-43 BENEFICIARY. Immediately on receiving notice of an injury or death
 46-44 from any person, the department [~~commission~~] shall mail to the
 46-45 employee or legal beneficiary a clear and concise description of:

46-46 (1) the services provided by the department
 46-47 [~~commission~~], including the services of the ombudsman program;

46-48 (2) the department's [~~commission's~~] procedures; and

46-49 (3) the person's rights and responsibilities under
 46-50 this subtitle.

46-51 SECTION 3.132. Subsections (a) and (c), Section 409.011,
 46-52 Labor Code, are amended to read as follows:

46-53 (a) Immediately on receiving notice of an injury or death
 46-54 from any person, the department [~~commission~~] shall mail to the
 46-55 employer a description of:

46-56 (1) the services provided by the department
 46-57 [~~commission~~];

46-58 (2) the department's [~~commission's~~] procedures; and

46-59 (3) the employer's rights and responsibilities under
 46-60 this subtitle.

46-61 (c) The department [~~commission~~] is not required to provide
 46-62 the information to an employer more than once during a calendar
 46-63 year.

46-64 SECTION 3.133. Section 409.012, Labor Code, is amended to
 46-65 read as follows:

46-66 Sec. 409.012. VOCATIONAL REHABILITATION INFORMATION.

46-67 (a) The commissioner [~~commission~~] shall analyze each report of
 46-68 injury received from an employer under this chapter to determine
 46-69 whether the injured employee would be assisted by vocational

47-1 rehabilitation.

47-2 (b) If the commissioner [~~commission~~] determines that an
 47-3 injured employee would be assisted by vocational rehabilitation,
 47-4 the department [~~commission~~] shall notify the injured employee in
 47-5 writing of the services and facilities available through the
 47-6 Department of Assistive and Rehabilitative Services [~~Texas~~
 47-7 ~~Rehabilitation Commission~~] and private providers of vocational
 47-8 rehabilitation. The department [~~commission~~] shall notify the
 47-9 Department of Assistive and Rehabilitative Services [~~Texas~~
 47-10 ~~Rehabilitation Commission~~] and the affected insurance carrier that
 47-11 the injured employee has been identified as one who could be
 47-12 assisted by vocational rehabilitation.

47-13 (c) The department [~~commission~~] shall cooperate with the
 47-14 Department of Assistive and Rehabilitative Services [~~Texas~~
 47-15 ~~Rehabilitation Commission~~] and private providers of vocational
 47-16 rehabilitation in the provision of services and facilities to
 47-17 employees by the Department of Assistive and Rehabilitative
 47-18 Services [~~Texas Rehabilitation Commission~~].

47-19 (d) A private provider of vocational rehabilitation
 47-20 services may register with the department [~~commission~~].

47-21 (e) The commissioner [~~commission~~] by rule may require that a
 47-22 private provider of vocational rehabilitation services maintain
 47-23 certain credentials and qualifications in order to provide services
 47-24 in connection with a workers' compensation insurance claim.

47-25 (f) The department and the Department of Assistive and
 47-26 Rehabilitative Services shall report to the legislature not later
 47-27 than August 1, 2006, on their actions to improve access to and the
 47-28 effectiveness of vocational rehabilitation programs for injured
 47-29 employees. The report must include:

47-30 (1) a description of the actions each agency has taken
 47-31 to improve communication regarding and coordination of vocational
 47-32 rehabilitation programs;

47-33 (2) an analysis identifying the population of injured
 47-34 employees that have the poorest return-to-work outcomes and are in
 47-35 the greatest need for vocational rehabilitation services;

47-36 (3) any changes recommended to improve the access to
 47-37 and effectiveness of vocational rehabilitation programs for the
 47-38 populations identified in Subdivision (2); and

47-39 (4) a plan to implement these changes.

47-40 SECTION 3.134. Section 409.013, Labor Code, is amended to
 47-41 read as follows:

47-42 Sec. 409.013. PLAIN LANGUAGE INFORMATION; NOTIFICATION OF
 47-43 INJURED WORKER. (a) The department [~~commission~~] shall develop
 47-44 information for public dissemination about the benefit process and
 47-45 the compensation procedures established under this chapter. The
 47-46 information must be written in plain language and must be available
 47-47 in English and Spanish.

47-48 (b) On receipt of a report under Section 409.005, the
 47-49 department [~~commission~~] shall contact the affected employee by mail
 47-50 or by telephone and shall provide the information required under
 47-51 Subsection (a) to that employee, together with any other
 47-52 information that may be prepared by the department [~~commission~~] for
 47-53 public dissemination that relates to the employee's situation, such
 47-54 as information relating to back injuries or occupational diseases.

47-55 SECTION 3.135. Subsections (a) and (b), Section 409.021,
 47-56 Labor Code, are amended to read as follows:

47-57 (a) An insurance carrier shall initiate compensation under
 47-58 this subtitle promptly. Not later than the 15th day after the date
 47-59 on which an insurance carrier receives written notice of an injury,
 47-60 the insurance carrier shall:

47-61 (1) begin the payment of benefits as required by this
 47-62 subtitle; or

47-63 (2) notify the department [~~commission~~] and the
 47-64 employee in writing of its refusal to pay and advise the employee
 47-65 of:

47-66 (A) the right to request a benefit review
 47-67 conference; and

47-68 (B) the means to obtain additional information
 47-69 from the department [~~commission~~].

48-1 (b) An insurance carrier shall notify the department
 48-2 [~~commission~~] in writing of the initiation of income or death
 48-3 benefit payments in the manner prescribed by commissioner
 48-4 [~~commission~~] rules.

48-5 SECTION 3.136. Subsection (c), Section 409.022, Labor Code,
 48-6 is amended to read as follows:

48-7 (c) An insurance carrier commits a violation if the
 48-8 insurance carrier does not have reasonable grounds for a refusal to
 48-9 pay benefits, as determined by the commissioner [~~commission~~]. ~~A~~
 48-10 ~~violation under this subsection is a Class B administrative~~
 48-11 ~~violation].~~

48-12 SECTION 3.137. Subsections (a), (c), and (d), Section
 48-13 409.023, Labor Code, are amended to read as follows:

48-14 (a) An insurance carrier shall continue to pay benefits
 48-15 promptly as and when the benefits accrue without a final decision,
 48-16 order, or other action of the commissioner [~~commission~~], except as
 48-17 otherwise provided.

48-18 (c) An insurance carrier commits a violation if the
 48-19 insurance carrier fails to comply with this section. [~~A violation~~
 48-20 ~~under this subsection is a Class B administrative violation. Each~~
 48-21 ~~day of noncompliance constitutes a separate violation.]~~

48-22 (d) An insurance carrier that commits multiple violations
 48-23 of this section commits an additional [~~a Class A~~] administrative
 48-24 violation and is subject to:

48-25 (1) the sanctions provided under Section 415.023; and

48-26 (2) revocation of the right to do business under the
 48-27 workers' compensation laws of this state.

48-28 SECTION 3.138. Subsection (b), Section 409.0231, Labor
 48-29 Code, is amended to read as follows:

48-30 (b) The commissioner [~~commission~~] shall adopt rules in
 48-31 consultation with the Texas Department of Information Resources as
 48-32 necessary to implement this section, including rules prescribing a
 48-33 period of benefits that is of sufficient duration to allow payment
 48-34 by electronic funds transfer.

48-35 SECTION 3.139. Section 409.024, Labor Code, is amended to
 48-36 read as follows:

48-37 Sec. 409.024. TERMINATION OR REDUCTION OF BENEFITS; NOTICE;
 48-38 ADMINISTRATIVE VIOLATION. (a) An insurance carrier shall file
 48-39 with the department [~~commission~~] a notice of termination or
 48-40 reduction of benefits, including the reasons for the termination or
 48-41 reduction, not later than the 10th day after the date on which
 48-42 benefits are terminated or reduced.

48-43 (b) An insurance carrier commits a violation if the
 48-44 insurance carrier does not have reasonable grounds to terminate or
 48-45 reduce benefits, as determined by the commissioner [~~commission~~]. ~~A~~
 48-46 ~~violation under this subsection is a Class B administrative~~
 48-47 ~~violation].~~

48-48 SECTION 3.140. Subsection (a), Section 409.041, Labor Code,
 48-49 is amended to read as follows:

48-50 (a) The department [~~commission~~] shall maintain an ombudsman
 48-51 program as provided by this subchapter to assist injured workers
 48-52 and persons claiming death benefits in obtaining benefits under
 48-53 this subtitle.

48-54 SECTION 3.141. Subsections (a) and (c), Section 409.042,
 48-55 Labor Code, are amended to read as follows:

48-56 (a) At least one specially qualified employee in each
 48-57 department [~~commission~~] office shall be designated an ombudsman who
 48-58 shall perform the duties under this section as the person's primary
 48-59 responsibility.

48-60 (c) The commissioner [~~commission~~] by rule shall adopt
 48-61 training guidelines and continuing education requirements for
 48-62 ombudsmen. Training provided under this subsection must:

48-63 (1) include education regarding this subtitle, rules
 48-64 adopted under this subtitle, and appeals panel decisions, with
 48-65 emphasis on benefits and the dispute resolution process; and

48-66 (2) require an ombudsman undergoing training to be
 48-67 observed and monitored by an experienced ombudsman during daily
 48-68 activities conducted under this subchapter.

48-69 SECTION 3.142. Section 409.043, Labor Code, is amended to

49-1 read as follows:

49-2 Sec. 409.043. EMPLOYER NOTIFICATION; ADMINISTRATIVE
49-3 VIOLATION. (a) Each employer shall notify its employees of the
49-4 ombudsman program in a manner prescribed by the commissioner
49-5 [~~commission~~].

49-6 (b) An employer commits a violation if the employer fails to
49-7 comply with this section. [~~A violation under this section is a~~
49-8 ~~Class C administrative violation.~~]

49-9 SECTION 3.143. Section 409.044, Labor Code, is amended to
49-10 read as follows:

49-11 Sec. 409.044. PUBLIC INFORMATION. The department
49-12 [~~commission~~] shall widely disseminate information about the
49-13 ombudsman program.

49-14 SECTION 3.144. Section 410.002, Labor Code, is amended to
49-15 read as follows:

49-16 Sec. 410.002. LAW GOVERNING LIABILITY PROCEEDINGS. A
49-17 proceeding before the department [~~commission~~] to determine the
49-18 liability of an insurance carrier for compensation for an injury or
49-19 death under this subtitle is governed by this chapter.

49-20 SECTION 3.145. Section 410.004, Labor Code, is amended to
49-21 read as follows:

49-22 Sec. 410.004. DIVISION OF HEARINGS. The division shall
49-23 conduct benefit review conferences, contested case hearings,
49-24 arbitration, and appeals within the department [~~commission~~]
49-25 related to workers' compensation claims.

49-26 SECTION 3.146. Subsection (a), Section 410.005, Labor Code,
49-27 is amended to read as follows:

49-28 (a) Unless the commissioner [~~commission~~] determines that
49-29 good cause exists for the selection of a different location, a
49-30 benefit review conference or a contested case hearing may not be
49-31 conducted at a site more than 75 miles from the claimant's residence
49-32 at the time of the injury.

49-33 SECTION 3.147. Section 410.021, Labor Code, is amended to
49-34 read as follows:

49-35 Sec. 410.021. PURPOSE. A benefit review conference is a
49-36 nonadversarial, informal dispute resolution proceeding designed
49-37 to:

49-38 (1) explain, orally and in writing, the rights of the
49-39 respective parties to a workers' compensation claim and the
49-40 procedures necessary to protect those rights;

49-41 (2) discuss the facts of the claim, review available
49-42 information in order to evaluate the claim, and delineate the
49-43 disputed issues; and

49-44 (3) mediate and resolve disputed issues by agreement
49-45 of the parties in accordance with this subtitle and the policies of
49-46 the department [~~commission~~].

49-47 SECTION 3.148. Subsections (b) and (c), Section 410.022,
49-48 Labor Code, are amended to read as follows:

49-49 (b) A benefit review officer must:

49-50 (1) be an employee of the department [~~commission~~]; and

49-51 (2) be trained in the principles and procedures of
49-52 dispute mediation.

49-53 (c) The department [~~commission~~] shall institute and
49-54 maintain an education and training program for benefit review
49-55 officers and shall consult or contract with the Federal Mediation
49-56 and Conciliation Service or other appropriate organizations for
49-57 this purpose.

49-58 SECTION 3.149. Section 410.023, Labor Code, is amended to
49-59 read as follows:

49-60 Sec. 410.023. REQUEST FOR BENEFIT REVIEW CONFERENCE. On
49-61 receipt of a request from a party or on its own motion, the
49-62 department [~~commission~~] may direct the parties to a disputed
49-63 workers' compensation claim to meet in a benefit review conference
49-64 to attempt to reach agreement on disputed issues involved in the
49-65 claim.

49-66 SECTION 3.150. Section 410.024, Labor Code, is amended to
49-67 read as follows:

49-68 Sec. 410.024. BENEFIT REVIEW CONFERENCE AS PREREQUISITE TO
49-69 FURTHER PROCEEDINGS ON CERTAIN CLAIMS. (a) Except as otherwise

50-1 provided by law or commissioner [~~commission~~] rule, the parties to a
 50-2 disputed compensation claim are not entitled to a contested case
 50-3 hearing or arbitration on the claim unless a benefit review
 50-4 conference is conducted as provided by this subchapter.

50-5 (b) The commissioner [~~commission~~] by rule shall adopt
 50-6 guidelines relating to claims that do not require a benefit review
 50-7 conference and may proceed directly to a contested case hearing or
 50-8 arbitration.

50-9 SECTION 3.151. Section 410.025, Labor Code, is amended to
 50-10 read as follows:

50-11 Sec. 410.025. SCHEDULING OF BENEFIT REVIEW CONFERENCE;
 50-12 NOTICE. (a) The commissioner [~~commission~~] by rule shall prescribe
 50-13 the time within which a benefit review conference must be
 50-14 scheduled.

50-15 (b) At the time a benefit review conference is scheduled,
 50-16 the department [~~commission~~] shall schedule a contested case hearing
 50-17 to be held not later than the 60th day after the date of the benefit
 50-18 review conference if the disputed issues are not resolved at the
 50-19 benefit review conference.

50-20 (c) The department [~~commission~~] shall send written notice
 50-21 of the benefit review conference to the parties to the claim and the
 50-22 employer.

50-23 (d) The commissioner [~~commission~~] by rule shall provide for
 50-24 expedited proceedings in cases in which compensability or liability
 50-25 for essential medical treatment is in dispute.

50-26 SECTION 3.152. Subsection (a), Section 410.026, Labor Code,
 50-27 is amended to read as follows:

50-28 (a) A benefit review officer shall:

50-29 (1) mediate disputes between the parties and assist in
 50-30 the adjustment of the claim consistent with this subtitle and the
 50-31 policies of the department [~~commission~~];

50-32 (2) thoroughly inform all parties of their rights and
 50-33 responsibilities under this subtitle, especially in a case in which
 50-34 the employee is not represented by an attorney or other
 50-35 representative; and

50-36 (3) ensure that all documents and information relating
 50-37 to the employee's wages, medical condition, and any other
 50-38 information pertinent to the resolution of disputed issues are
 50-39 contained in the claim file at the conference, especially in a case
 50-40 in which the employee is not represented by an attorney or other
 50-41 representative.

50-42 SECTION 3.153. Subsection (a), Section 410.027, Labor Code,
 50-43 is amended to read as follows:

50-44 (a) The commissioner [~~commission~~] shall adopt rules for
 50-45 conducting benefit review conferences.

50-46 SECTION 3.154. Subsection (b), Section 410.028, Labor Code,
 50-47 is amended to read as follows:

50-48 (b) A party commits a violation if the party fails to attend
 50-49 a benefit review conference without good cause as determined by the
 50-50 benefit review officer. [~~A violation under this subsection is a~~
 50-51 ~~Class D administrative violation.~~]

50-52 SECTION 3.155. Section 410.030, Labor Code, is amended to
 50-53 read as follows:

50-54 Sec. 410.030. BINDING EFFECT OF AGREEMENT. (a) An
 50-55 agreement signed in accordance with Section 410.029 is binding on
 50-56 the insurance carrier through the conclusion of all matters
 50-57 relating to the claim, unless the department [~~commission~~] or a
 50-58 court, on a finding of fraud, newly discovered evidence, or other
 50-59 good and sufficient cause, relieves the insurance carrier of the
 50-60 effect of the agreement.

50-61 (b) The agreement is binding on the claimant, if represented
 50-62 by an attorney, to the same extent as on the insurance carrier. If
 50-63 the claimant is not represented by an attorney, the agreement is
 50-64 binding on the claimant through the conclusion of all matters
 50-65 relating to the claim while the claim is pending before the
 50-66 department [~~commission~~], unless the commissioner [~~commission~~] for
 50-67 good cause relieves the claimant of the effect of the agreement.

50-68 SECTION 3.156. Subsection (b), Section 410.034, Labor Code,
 50-69 is amended to read as follows:

51-1 (b) The commissioner [~~commission~~] by rule shall prescribe
51-2 the times within which the agreement and report must be filed.

51-3 SECTION 3.157. Section 410.102, Labor Code, is amended to
51-4 read as follows:

51-5 Sec. 410.102. ARBITRATORS; QUALIFICATIONS. (a) An
51-6 arbitrator must be an employee of the department [~~commission~~],
51-7 except that the department [~~commission~~] may contract with qualified
51-8 arbitrators on a determination of special need.

51-9 (b) An arbitrator must:

51-10 (1) be a member of the National Academy of
51-11 Arbitrators;

51-12 (2) be on an approved list of the American Arbitration
51-13 Association or Federal Mediation and Conciliation Service; or

51-14 (3) meet qualifications established by the
51-15 commissioner [~~commission~~] by rule [~~and be approved by an~~
51-16 ~~affirmative vote of at least two commission members representing~~
51-17 ~~employers of labor and at least two commission members representing~~
51-18 ~~wage earners~~].

51-19 (c) The department [~~commission~~] shall require that each
51-20 arbitrator have appropriate training in the workers' compensation
51-21 laws of this state. The commissioner [~~commission~~] shall establish
51-22 procedures to carry out this subsection.

51-23 SECTION 3.158. Section 410.103, Labor Code, is amended to
51-24 read as follows:

51-25 Sec. 410.103. DUTIES OF ARBITRATOR. An arbitrator shall:

51-26 (1) protect the interests of all parties;

51-27 (2) ensure that all relevant evidence has been
51-28 disclosed to the arbitrator and to all parties; and

51-29 (3) render an award consistent with this subtitle and
51-30 the policies of the department [~~commission~~].

51-31 SECTION 3.159. Subsections (b) and (c), Section 410.104,
51-32 Labor Code, are amended to read as follows:

51-33 (b) To elect arbitration, the parties must file the election
51-34 with the department [~~commission~~] not later than the 20th day after
51-35 the last day of the benefit review conference. The commissioner
51-36 [~~commission~~] shall prescribe a form for that purpose.

51-37 (c) An election to engage in arbitration under this
51-38 subchapter is irrevocable and binding on all parties for the
51-39 resolution of all disputes arising out of the claims that are under
51-40 the jurisdiction of the department [~~commission~~].

51-41 SECTION 3.160. Section 410.105, Labor Code, is amended to
51-42 read as follows:

51-43 Sec. 410.105. LISTS OF ARBITRATORS. (a) The department
51-44 [~~commission~~] shall establish regional lists of arbitrators who meet
51-45 the qualifications prescribed under Sections 410.102(a) and (b).
51-46 Each regional list shall be initially prepared in a random name
51-47 order, and subsequent additions to a list shall be added
51-48 chronologically.

51-49 (b) The commissioner [~~commission~~] shall review the lists of
51-50 arbitrators annually and determine if each arbitrator is fair and
51-51 impartial and makes awards that are consistent with and in
51-52 accordance with this subtitle and the rules of the commissioner
51-53 [~~commission~~]. ~~The commission shall remove an arbitrator if after~~
51-54 ~~review the arbitrator does not receive an affirmative vote of at~~
51-55 ~~least two commission members representing employers of labor and at~~
51-56 ~~least two commission members representing wage earners~~].

51-57 (c) The department's [~~commission's~~] lists are confidential
51-58 and are not subject to disclosure under Chapter 552, Government
51-59 Code. The lists may not be revealed by any department [~~commission~~]
51-60 employee to any person who is not a department [~~commission~~]
51-61 employee. The lists are exempt from discovery in civil litigation
51-62 unless the party seeking the discovery establishes reasonable cause
51-63 to believe that a violation of the requirements of this section or
51-64 Section 410.106, 410.107, 410.108, or 410.109(b) occurred and that
51-65 the violation is relevant to the issues in dispute.

51-66 SECTION 3.161. Section 410.106, Labor Code, is amended to
51-67 read as follows:

51-68 Sec. 410.106. SELECTION OF ARBITRATOR. The department
51-69 [~~commission~~] shall assign the arbitrator for a particular case by

52-1 selecting the next name after the previous case's selection in
 52-2 consecutive order. The department [~~commission~~] may not change the
 52-3 order of names once the order is established under this subchapter,
 52-4 except that once each arbitrator on the list has been assigned to a
 52-5 case, the names shall be randomly reordered.

52-6 SECTION 3.162. Subsection (a), Section 410.107, Labor Code,
 52-7 is amended to read as follows:

52-8 (a) The department [~~commission~~] shall assign an arbitrator
 52-9 to a pending case not later than the 30th day after the date on which
 52-10 the election for arbitration is filed with the department
 52-11 [~~commission~~].

52-12 SECTION 3.163. Subsection (a), Section 410.108, Labor Code,
 52-13 is amended to read as follows:

52-14 (a) Each party is entitled, in its sole discretion, to one
 52-15 rejection of the arbitrator in each case. If a party rejects the
 52-16 arbitrator, the department [~~commission~~] shall assign another
 52-17 arbitrator as provided by Section 410.106.

52-18 SECTION 3.164. Section 410.109, Labor Code, is amended to
 52-19 read as follows:

52-20 Sec. 410.109. SCHEDULING OF ARBITRATION. (a) The
 52-21 arbitrator shall schedule arbitration to be held not later than the
 52-22 30th day after the date of the arbitrator's assignment and shall
 52-23 notify the parties and the department [~~commission~~] of the scheduled
 52-24 date.

52-25 (b) If an arbitrator is unable to schedule arbitration in
 52-26 accordance with Subsection (a), the department [~~commission~~] shall
 52-27 appoint the next arbitrator on the applicable list. Each party is
 52-28 entitled to reject the arbitrator appointed under this subsection
 52-29 in the manner provided under Section 410.108.

52-30 SECTION 3.165. Section 410.111, Labor Code, is amended to
 52-31 read as follows:

52-32 Sec. 410.111. RULES. The commissioner [~~commission~~] shall
 52-33 adopt rules for arbitration consistent with generally recognized
 52-34 arbitration principles and procedures.

52-35 SECTION 3.166. Subsection (b), Section 410.112, Labor Code,
 52-36 is amended to read as follows:

52-37 (b) A party commits a violation if the party, without good
 52-38 cause as determined by the arbitrator, fails to comply with
 52-39 Subsection (a). [~~A violation under this subsection is a Class D~~
 52-40 ~~administrative violation.~~]

52-41 SECTION 3.167. Subsection (b), Section 410.113, Labor Code,
 52-42 is amended to read as follows:

52-43 (b) A party commits a violation if the party does not attend
 52-44 the arbitration unless the arbitrator determines that the party had
 52-45 good cause not to attend. [~~A violation under this subsection is a~~
 52-46 ~~Class D administrative violation.~~]

52-47 SECTION 3.168. Subsection (b), Section 410.114, Labor Code,
 52-48 is amended to read as follows:

52-49 (b) The department [~~commission~~] shall make an electronic
 52-50 recording of the proceeding.

52-51 SECTION 3.169. Subsection (d), Section 410.118, Labor Code,
 52-52 is amended to read as follows:

52-53 (d) The arbitrator shall file a copy of the award as part of
 52-54 the permanent claim file at the department [~~commission~~] and shall
 52-55 notify the parties in writing of the decision.

52-56 SECTION 3.170. Subsection (b), Section 410.119, Labor Code,
 52-57 is amended to read as follows:

52-58 (b) An arbitrator's award is a final order of the department
 52-59 [~~commission~~].

52-60 SECTION 3.171. Subsections (a) and (b), Section 410.121,
 52-61 Labor Code, are amended to read as follows:

52-62 (a) On application of an aggrieved party, a court of
 52-63 competent jurisdiction shall vacate an arbitrator's award on a
 52-64 finding that:

52-65 (1) the award was procured by corruption, fraud, or
 52-66 misrepresentation;

52-67 (2) the decision of the arbitrator was arbitrary and
 52-68 capricious; or

52-69 (3) the award was outside the jurisdiction of the

53-1 department [commissioner].

53-2 (b) If an award is vacated, the case shall be remanded to the
53-3 department [commissioner] for another arbitration proceeding.

53-4 SECTION 3.172. Subsection (b), Section 410.151, Labor Code,
53-5 is amended to read as follows:

53-6 (b) An issue that was not raised at a benefit review
53-7 conference or that was resolved at a benefit review conference may
53-8 not be considered unless:

53-9 (1) the parties consent; or

53-10 (2) if the issue was not raised, the commissioner
53-11 [commissioner] determines that good cause existed for not raising the
53-12 issue at the conference.

53-13 SECTION 3.173. Section 410.153, Labor Code, is amended to
53-14 read as follows:

53-15 Sec. 410.153. APPLICATION OF ADMINISTRATIVE PROCEDURE ACT.
53-16 Chapter 2001, Government Code, applies to a contested case hearing
53-17 to the extent that the commissioner [commissioner] finds appropriate,
53-18 except that the following do not apply:

53-19 (1) Section 2001.054;

53-20 (2) Sections 2001.061 and 2001.062;

53-21 (3) Section 2001.202; and

53-22 (4) Subchapters F, G, I, and Z, except for Section
53-23 2001.141(c).

53-24 SECTION 3.174. Section 410.154, Labor Code, is amended to
53-25 read as follows:

53-26 Sec. 410.154. SCHEDULING OF HEARING. The department
53-27 [commissioner] shall schedule a contested case hearing in accordance
53-28 with Section 410.024 or 410.025(b).

53-29 SECTION 3.175. Section 410.155, Labor Code, is amended to
53-30 read as follows:

53-31 Sec. 410.155. CONTINUANCE. (a) A written request by a
53-32 party for a continuance of a contested case hearing to another date
53-33 must be directed to the commissioner [commissioner].

53-34 (b) The commissioner [commissioner] may grant a continuance
53-35 only if the commissioner [commissioner] determines that there is good
53-36 cause for the continuance.

53-37 SECTION 3.176. Subsection (b), Section 410.156, Labor Code,
53-38 is amended to read as follows:

53-39 (b) A party commits a violation if the party, without good
53-40 cause as determined by the hearing officer, does not attend a
53-41 contested case hearing. ~~[A violation under this subsection is a~~
53-42 ~~Class C administrative violation.]~~

53-43 SECTION 3.177. Section 410.157, Labor Code, is amended to
53-44 read as follows:

53-45 Sec. 410.157. RULES. The commissioner [commissioner] shall
53-46 adopt rules governing procedures under which contested case
53-47 hearings are conducted.

53-48 SECTION 3.178. Subsection (a), Section 410.158, Labor Code,
53-49 is amended to read as follows:

53-50 (a) Except as provided by Section 410.162, discovery is
53-51 limited to:

53-52 (1) depositions on written questions to any health
53-53 care provider;

53-54 (2) depositions of other witnesses as permitted by the
53-55 hearing officer for good cause shown; and

53-56 (3) interrogatories as prescribed by the commissioner
53-57 [commissioner].

53-58 SECTION 3.179. Section 410.159, Labor Code, is amended to
53-59 read as follows:

53-60 Sec. 410.159. STANDARD INTERROGATORIES. (a) The
53-61 commissioner [commissioner] by rule shall prescribe standard form
53-62 sets of interrogatories to elicit information from claimants and
53-63 insurance carriers.

53-64 (b) Standard interrogatories shall be answered by each
53-65 party and served on the opposing party within the time prescribed by
53-66 commissioner [commissioner] rule, unless the parties agree
53-67 otherwise.

53-68 SECTION 3.180. Section 410.160, Labor Code, is amended to
53-69 read as follows:

54-1 Sec. 410.160. EXCHANGE OF INFORMATION. Within the time
54-2 prescribed by commissioner [~~commission~~] rule, the parties shall
54-3 exchange:

54-4 (1) all medical reports and reports of expert
54-5 witnesses who will be called to testify at the hearing;

54-6 (2) all medical records;

54-7 (3) any witness statements;

54-8 (4) the identity and location of any witness known to
54-9 the parties to have knowledge of relevant facts; and

54-10 (5) all photographs or other documents that a party
54-11 intends to offer into evidence at the hearing.

54-12 SECTION 3.181. Section 410.161, Labor Code, is amended to
54-13 read as follows:

54-14 Sec. 410.161. FAILURE TO DISCLOSE INFORMATION. A party who
54-15 fails to disclose information known to the party or documents that
54-16 are in the party's possession, custody, or control at the time
54-17 disclosure is required by Sections 410.158-410.160 may not
54-18 introduce the evidence at any subsequent proceeding before the
54-19 department [~~commission~~] or in court on the claim unless good cause
54-20 is shown for not having disclosed the information or documents
54-21 under those sections.

54-22 SECTION 3.182. Subsections (d) and (e), Section 410.168,
54-23 Labor Code, are amended to read as follows:

54-24 (d) On a form that the commissioner [~~commission~~] by rule
54-25 prescribes, the hearing officer shall issue a separate written
54-26 decision regarding attorney's fees and any matter related to
54-27 attorney's fees. The decision regarding attorney's fees and the
54-28 form may not be made known to a jury in a judicial review of an
54-29 award, including an appeal.

54-30 (e) The commissioner [~~commission~~] by rule shall prescribe
54-31 the times within which the hearing officer must file the decisions
54-32 with the division.

54-33 SECTION 3.183. Subsection (d), Section 410.203, Labor Code,
54-34 is amended to read as follows:

54-35 (d) A hearing on remand shall be accelerated and the
54-36 commissioner [~~commission~~] shall adopt rules to give priority to the
54-37 hearing over other proceedings.

54-38 SECTION 3.184. Subsection (b), Section 410.204, Labor Code,
54-39 is amended to read as follows:

54-40 (b) A copy of the decision of the appeals panel shall be sent
54-41 to each party not later than the seventh day after the date the
54-42 decision is filed with the department [~~commission~~].

54-43 SECTION 3.185. Section 410.206, Labor Code, is amended to
54-44 read as follows:

54-45 Sec. 410.206. CLERICAL ERROR. The commissioner [~~executive~~
54-46 ~~director~~] may revise a decision in a contested case hearing on a
54-47 finding of clerical error.

54-48 SECTION 3.186. Section 410.207, Labor Code, is amended to
54-49 read as follows:

54-50 Sec. 410.207. CONTINUATION OF DEPARTMENT [~~COMMISSION~~]
54-51 JURISDICTION. During judicial review of an appeals panel decision
54-52 on any disputed issue relating to a workers' compensation claim,
54-53 the department [~~commission~~] retains jurisdiction of all other
54-54 issues related to the claim.

54-55 SECTION 3.187. Section 410.208, Labor Code, is amended to
54-56 read as follows:

54-57 Sec. 410.208. JUDICIAL ENFORCEMENT OF ORDER OR DECISION;
54-58 ADMINISTRATIVE VIOLATION. (a) If a person refuses or fails to
54-59 comply with an interlocutory order, final order, or decision of the
54-60 commissioner [~~commission~~], the department [~~commission~~] may bring
54-61 suit in Travis County to enforce the order or decision.

54-62 (b) If an insurance carrier refuses or fails to comply with
54-63 an interlocutory order, a final order, or a decision of the
54-64 commissioner [~~commission~~], the claimant may bring suit in the
54-65 county of the claimant's residence or the county in which the injury
54-66 occurred to enforce the order or decision.

54-67 (c) If the department [~~commission~~] brings suit to enforce an
54-68 interlocutory order, final order, or decision of the commissioner
54-69 [~~commission~~], the department [~~commission~~] is entitled to

55-1 reasonable attorney's fees and costs for the prosecution and
55-2 collection of the claim, in addition to a judgment enforcing the
55-3 order or decision and any other remedy provided by law.

55-4 (d) A claimant who brings suit to enforce an interlocutory
55-5 order, final order, or decision of the commissioner [~~commission~~] is
55-6 entitled to a penalty equal to 12 percent of the amount of benefits
55-7 recovered in the judgment, interest, and reasonable attorney's fees
55-8 for the prosecution and collection of the claim, in addition to a
55-9 judgment enforcing the order or decision.

55-10 (e) A person commits a violation if the person fails or
55-11 refuses to comply with an interlocutory order, final order, or
55-12 decision of the commissioner [~~commission~~] within 20 days after the
55-13 date the order or decision becomes final. [~~A violation under this~~
55-14 ~~subsection is a Class A administrative violation.~~]

55-15 SECTION 3.188. Section 410.209, Labor Code, is amended to
55-16 read as follows:

55-17 Sec. 410.209. REIMBURSEMENT FOR OVERPAYMENT. The
55-18 subsequent injury fund shall reimburse an insurance carrier for any
55-19 overpayments of benefits made under an interlocutory order or
55-20 decision if that order or decision is reversed or modified by final
55-21 arbitration, order, or decision of the commissioner [~~commission~~] or
55-22 a court. The commissioner [~~commission~~] shall adopt rules to
55-23 provide for a periodic reimbursement schedule, providing for
55-24 reimbursement at least annually.

55-25 SECTION 3.189. Section 410.253, Labor Code, is amended to
55-26 read as follows:

55-27 Sec. 410.253. SERVICE; NOTICE. (a) A party seeking
55-28 judicial review shall simultaneously:

- 55-29 (1) file a copy of the party's petition with the court;
55-30 (2) serve any opposing party to the suit; and
55-31 (3) provide written notice of the suit or notice of
55-32 appeal to the department [~~commission~~].

55-33 (b) A party may not seek judicial review under Section
55-34 410.251 unless the party has provided written notice of the suit to
55-35 the department [~~commission~~] as required by this section.

55-36 SECTION 3.190. Section 410.254, Labor Code, is amended to
55-37 read as follows:

55-38 Sec. 410.254. [~~COMMISSION~~] INTERVENTION. On timely motion
55-39 initiated by the commissioner [~~executive director~~], the department
55-40 [~~commission~~] shall be permitted to intervene in any judicial
55-41 proceeding under this subchapter or Subchapter G.

55-42 SECTION 3.191. The heading to Section 410.258, Labor Code,
55-43 is amended to read as follows:

55-44 Sec. 410.258. NOTIFICATION OF DEPARTMENT [~~COMMISSION~~] OF
55-45 PROPOSED JUDGMENTS AND SETTLEMENTS; RIGHT TO INTERVENE.

55-46 SECTION 3.192. Subsections (a) through (e), Section
55-47 410.258, Labor Code, are amended to read as follows:

55-48 (a) The party who initiated a proceeding under this
55-49 subchapter or Subchapter G must file any proposed judgment or
55-50 settlement made by the parties to the proceeding, including a
55-51 proposed default judgment, with the commissioner [~~executive~~
55-52 ~~director of the commission~~] not later than the 30th day before the
55-53 date on which the court is scheduled to enter the judgment or
55-54 approve the settlement. The proposed judgment or settlement must
55-55 be mailed to the department [~~executive director~~] by certified mail,
55-56 return receipt requested.

55-57 (b) The department [~~commission~~] may intervene in a
55-58 proceeding under Subsection (a) not later than the 30th day after
55-59 the date of receipt of the proposed judgment or settlement.

55-60 (c) The commissioner [~~commission~~] shall review the proposed
55-61 judgment or settlement to determine compliance with all appropriate
55-62 provisions of the law. If the commissioner [~~commission~~] determines
55-63 that the proposal is not in compliance with the law, the department
55-64 [~~commission~~] may intervene as a matter of right in the proceeding
55-65 not later than the 30th day after the date of receipt of the
55-66 proposed judgment or settlement. The court may limit the extent of
55-67 the department's [~~commission's~~] intervention to providing the
55-68 information described by Subsection (e).

55-69 (d) If the department [~~commission~~] does not intervene

56-1 before the 31st day after the date of receipt of the proposed
 56-2 judgment or settlement, the court shall enter the judgment or
 56-3 approve the settlement if the court determines that the proposed
 56-4 judgment or settlement is in compliance with all appropriate
 56-5 provisions of the law.

56-6 (e) If the department [~~commission~~] intervenes in the
 56-7 proceeding, the commissioner [~~commission~~] shall inform the court of
 56-8 each reason the commissioner [~~commission~~] believes the proposed
 56-9 judgment or settlement is not in compliance with the law. The court
 56-10 shall give full consideration to the information provided by the
 56-11 commissioner [~~commission~~] before entering a judgment or approving a
 56-12 settlement.

56-13 SECTION 3.193. Subsection (a), Section 410.301, Labor Code,
 56-14 is amended to read as follows:

56-15 (a) Judicial review of a final decision of a department
 56-16 [~~commission~~] appeals panel regarding compensability or eligibility
 56-17 for or the amount of income or death benefits shall be conducted as
 56-18 provided by this subchapter.

56-19 SECTION 3.194. Section 410.302, Labor Code, is amended to
 56-20 read as follows:

56-21 Sec. 410.302. LIMITATION OF ISSUES. A trial under this
 56-22 subchapter is limited to issues decided by the department
 56-23 [~~commission~~] appeals panel and on which judicial review is sought.
 56-24 The pleadings must specifically set forth the determinations of the
 56-25 appeals panel by which the party is aggrieved.

56-26 SECTION 3.195. Section 410.304, Labor Code, is amended to
 56-27 read as follows:

56-28 Sec. 410.304. CONSIDERATION OF APPEALS PANEL DECISION.
 56-29 (a) In a jury trial, the court, before submitting the case to the
 56-30 jury, shall inform the jury in the court's instructions, charge, or
 56-31 questions to the jury of the department [~~commission~~] appeals panel
 56-32 decision on each disputed issue described by Section 410.301(a)
 56-33 that is submitted to the jury.

56-34 (b) In a trial to the court without a jury, the court in
 56-35 rendering its judgment on an issue described by Section 410.301(a)
 56-36 shall consider the decision of the department [~~commission~~] appeals
 56-37 panel.

56-38 SECTION 3.196. Subsections (b) and (c), Section 410.306,
 56-39 Labor Code, are amended to read as follows:

56-40 (b) The department [~~commission~~] on payment of a reasonable
 56-41 fee shall make available to the parties a certified copy of the
 56-42 department's [~~commission's~~] record. All facts and evidence the
 56-43 record contains are admissible to the extent allowed under the
 56-44 Texas Rules of [~~Civil~~] Evidence.

56-45 (c) Except as provided by Section 410.307, evidence of
 56-46 extent of impairment shall be limited to that presented to the
 56-47 department [~~commission~~]. The court or jury, in its determination
 56-48 of the extent of impairment, shall adopt one of the impairment
 56-49 ratings under Subchapter G, Chapter 408.

56-50 SECTION 3.197. Subsections (a) and (d), Section 410.307,
 56-51 Labor Code, are amended to read as follows:

56-52 (a) Evidence of the extent of impairment is not limited to
 56-53 that presented to the department [~~commission~~] if the court, after a
 56-54 hearing, finds that there is a substantial change of condition. The
 56-55 court's finding of a substantial change of condition may be based
 56-56 only on:

56-57 (1) medical evidence from the same doctor or doctors
 56-58 whose testimony or opinion was presented to the department
 56-59 [~~commission~~];

56-60 (2) evidence that has come to the party's knowledge
 56-61 since the contested case hearing;

56-62 (3) evidence that could not have been discovered
 56-63 earlier with due diligence by the party; and

56-64 (4) evidence that would probably produce a different
 56-65 result if it is admitted into evidence at the trial.

56-66 (d) If the court finds a substantial change of condition
 56-67 under this section, new medical evidence of the extent of
 56-68 impairment must be from and is limited to the same doctor or doctors
 56-69 who made impairment ratings before the department [~~commission~~]

57-1 under Section 408.123.

57-2 SECTION 3.198. Subsection (a), Section 410.308, Labor Code,
57-3 is amended to read as follows:

57-4 (a) The department [~~commission or the Texas Department of~~
57-5 ~~Insurance~~] shall furnish any interested party in the claim with a
57-6 certified copy of the notice of the employer securing compensation
57-7 with the insurance carrier, filed with the department [~~commission~~].

57-8 SECTION 3.199. Subdivision (1), Section 411.001, Labor
57-9 Code, is amended to read as follows:

57-10 (1) "Division" means the division of workers' health
57-11 and safety of the department [~~commission~~].

57-12 SECTION 3.200. Section 411.013, Labor Code, is amended to
57-13 read as follows:

57-14 Sec. 411.013. FEDERAL CONTRACTS AND PROGRAMS. With the
57-15 approval of the commissioner [~~commission~~], the division may:

57-16 (1) enter into contracts with the federal government
57-17 to perform occupational safety projects; and

57-18 (2) apply for federal funds through any federal
57-19 program relating to occupational safety.

57-20 SECTION 3.201. Section 411.032, Labor Code, is amended to
57-21 read as follows:

57-22 Sec. 411.032. EMPLOYER INJURY AND OCCUPATIONAL DISEASE
57-23 REPORT; ADMINISTRATIVE VIOLATION. (a) An employer shall file with
57-24 the department [~~commission~~] a report of each:

57-25 (1) on-the-job injury that results in the employee's
57-26 absence from work for more than one day; and

57-27 (2) occupational disease of which the employer has
57-28 knowledge.

57-29 (b) The commissioner [~~commission~~] shall adopt rules and
57-30 prescribe the form and manner of reports filed under this section.

57-31 (c) An employer commits an administrative violation if the
57-32 employer fails to report to the department [~~commission~~] as required
57-33 under Subsection (a) unless good cause exists, as determined by the
57-34 commissioner [~~commission~~], for the failure. [~~A violation under~~
57-35 ~~this subsection is a Class D administrative violation.~~]

57-36 SECTION 3.202. Section 411.035, Labor Code, is amended to
57-37 read as follows:

57-38 Sec. 411.035. USE OF INJURY REPORT. A report made under
57-39 Section 411.032 may not be considered to be an admission by or
57-40 evidence against an employer or an insurance carrier in a
57-41 proceeding before the department [~~commission~~] or a court in which
57-42 the facts set out in the report are contradicted by the employer or
57-43 insurance carrier.

57-44 SECTION 3.203. Section 411.0415, Labor Code, is amended to
57-45 read as follows:

57-46 Sec. 411.0415. EXEMPTION FOR CERTAIN EMPLOYERS; HEARING.

57-47 (a) The commissioner [~~executive director~~] may exclude from
57-48 identification as a hazardous employer an employer who presents
57-49 evidence satisfactory to the commissioner [~~commission~~] that the
57-50 injury frequencies of the employer substantially exceed those that
57-51 may reasonably be expected in that employer's business or industry
57-52 only because of a fatality that:

57-53 (1) occurred because of factors beyond the employer's
57-54 control; or

57-55 (2) was outside the course and scope of the deceased
57-56 individual's employment.

57-57 (b) The commissioner [~~commission~~] by rule shall analyze and
57-58 list fatalities that may not be related to the work environment,
57-59 including:

- 57-60 (1) heart attacks;
- 57-61 (2) common diseases of life;
- 57-62 (3) homicides;
- 57-63 (4) suicides;
- 57-64 (5) vehicle accidents involving a third party;
- 57-65 (6) common carrier accidents; and
- 57-66 (7) natural events.

57-67 (c) If the commissioner [~~commission~~] determines that the
57-68 case history of the employee's fatality indicates that the employer
57-69 or the work environment was a proximate cause of the fatality, the

58-1 commissioner [~~commission~~] may request a hearing under Section
 58-2 411.049. If the hearing establishes that a proximate cause of the
 58-3 fatality was a factor or factors within the employer's control and
 58-4 was within the course and scope of the employment, the commissioner
 58-5 [~~commission~~] may identify the employer for the hazardous employer
 58-6 program if that fatality causes the employer to be designated as a
 58-7 hazardous employer.

58-8 SECTION 3.204. Subsection (b), Section 411.042, Labor Code,
 58-9 is amended to read as follows:

58-10 (b) The commissioner [~~commission~~] by rule shall require a
 58-11 minimum interval of at least six months before a subsequent audit to
 58-12 identify an employer who was previously identified as a hazardous
 58-13 employer.

58-14 SECTION 3.205. Subsection (b), Section 411.043, Labor Code,
 58-15 is amended to read as follows:

58-16 (b) The safety consultant shall file a written report with
 58-17 the department [~~commission~~] and the employer setting out any
 58-18 hazardous conditions or practices identified by the safety
 58-19 consultation.

58-20 SECTION 3.206. Subsection (a), Section 411.045, Labor Code,
 58-21 is amended to read as follows:

58-22 (a) Not earlier than six months or later than nine months
 58-23 after the formulation of an accident prevention plan under Section
 58-24 411.043, the division shall conduct a follow-up inspection of the
 58-25 employer's premises. The department [~~commission~~] may require the
 58-26 participation of the safety consultant who performed the initial
 58-27 consultation and formulated the safety plan.

58-28 SECTION 3.207. Subsection (b), Section 411.046, Labor Code,
 58-29 is amended to read as follows:

58-30 (b) A violation under Subsection (a) is an an [~~a Class B~~]
 58-31 administrative violation. [~~Each day of noncompliance constitutes a~~
 58-32 ~~separate violation.~~]

58-33 SECTION 3.208. Section 411.048, Labor Code, is amended to
 58-34 read as follows:

58-35 Sec. 411.048. COSTS CHARGED TO EMPLOYER. (a) The
 58-36 department [~~commission~~] shall charge an employer that is a
 58-37 political subdivision for reimbursement of the reasonable cost of
 58-38 services provided by the division, including a reasonable
 58-39 allocation of the department's [~~commission's~~] administrative
 58-40 costs, in formulating and monitoring the implementation of a plan
 58-41 under Section 411.043 or 411.047, investigating an accident under
 58-42 Section 411.044, or in conducting a follow-up inspection under
 58-43 Section 411.045.

58-44 (b) The department [~~commission~~] shall charge a private
 58-45 employer for reimbursement of the reasonable cost of services
 58-46 provided by the division, including a reasonable allocation of the
 58-47 department's [~~commission's~~] administrative costs, in providing
 58-48 safety and health services under this program at the request of the
 58-49 private employer. This subsection does not apply to services
 58-50 provided to the employer under Section 411.018.

58-51 SECTION 3.209. Subsection (a), Section 411.049, Labor Code,
 58-52 is amended to read as follows:

58-53 (a) An employer may request a hearing to contest findings
 58-54 made by the department [~~commission~~] under this subchapter.

58-55 SECTION 3.210. Section 411.050, Labor Code, is amended to
 58-56 read as follows:

58-57 Sec. 411.050. ADMISSIBILITY OF IDENTIFICATION AS HAZARDOUS
 58-58 EMPLOYER. The identification of an employer as a hazardous
 58-59 employer under this subchapter is not admissible in any judicial
 58-60 proceeding unless:

58-61 (1) the department [~~commission~~] has determined that
 58-62 the employer is not in compliance with this subchapter; and

58-63 (2) that determination has not been reversed or
 58-64 superseded at the time of the event giving rise to the judicial
 58-65 proceeding.

58-66 SECTION 3.211. Section 411.062, Labor Code, is amended to
 58-67 read as follows:

58-68 Sec. 411.062. FIELD SAFETY REPRESENTATIVE; QUALIFICATIONS.
 58-69 (a) The commissioner [~~commission~~] by rule shall establish

59-1 qualifications for field safety representatives. The rules must
59-2 include education and experience requirements for those
59-3 representatives.

59-4 (b) Each field safety representative must meet the
59-5 qualifications established by the commissioner [~~commission~~].

59-6 SECTION 3.212. Subsection (c), Section 411.064, Labor Code,
59-7 is amended to read as follows:

59-8 (c) The insurance company shall reimburse the department
59-9 [~~commission~~] for the reasonable cost of the reinspection, including
59-10 a reasonable allocation of the department's [~~commission's~~]
59-11 administrative costs incurred in conducting the inspections.

59-12 SECTION 3.213. Subsection (b), Section 411.065, Labor Code,
59-13 is amended to read as follows:

59-14 (b) The information must include:

59-15 (1) the amount of money spent by the insurance company
59-16 on accident prevention services;

59-17 (2) the number and qualifications of field safety
59-18 representatives employed by the insurance company;

59-19 (3) the number of site inspections performed;

59-20 (4) accident prevention services for which the
59-21 insurance company contracts;

59-22 (5) a breakdown of the premium size of the risks to
59-23 which services were provided;

59-24 (6) evidence of the effectiveness of and
59-25 accomplishments in accident prevention; and

59-26 (7) any additional information required by the
59-27 department [~~commission~~].

59-28 SECTION 3.214. The heading to Section 411.067, Labor Code,
59-29 is amended to read as follows:

59-30 Sec. 411.067. DEPARTMENT [~~COMMISSION~~] PERSONNEL.

59-31 SECTION 3.215. Subsection (a), Section 411.067, Labor Code,
59-32 is amended to read as follows:

59-33 (a) The department [~~commission~~] shall employ the personnel
59-34 necessary to enforce this subchapter, including at least 10 safety
59-35 inspectors to perform inspections at a job site and at an insurance
59-36 company to determine the adequacy of the accident prevention
59-37 services provided by the insurance company.

59-38 SECTION 3.216. Subsection (b), Section 411.068, Labor Code,
59-39 is amended to read as follows:

59-40 (b) A violation under Subsection (a) is an [~~a Class B~~]
59-41 administrative violation. [~~Each day of noncompliance constitutes a~~
59-42 ~~separate violation.~~]

59-43 SECTION 3.217. Subsection (b), Section 411.081, Labor Code,
59-44 is amended to read as follows:

59-45 (b) Each employer shall notify its employees of this service
59-46 in a manner prescribed by the department [~~commission~~].

59-47 SECTION 3.218. Section 411.092, Labor Code, is amended to
59-48 read as follows:

59-49 Sec. 411.092. ENFORCEMENT; RULES. The commissioner
59-50 [~~commission~~] shall enforce Section 411.091 and may adopt rules for
59-51 that purpose.

59-52 SECTION 3.219. Subsection (b), Section 411.104, Labor Code,
59-53 is amended to read as follows:

59-54 (b) In addition to the duties specified in this chapter, the
59-55 division shall perform other duties as required by the department
59-56 [~~commission~~].

59-57 SECTION 3.220. Section 411.105, Labor Code, is amended to
59-58 read as follows:

59-59 Sec. 411.105. CONFIDENTIAL INFORMATION; PENALTY. (a) The
59-60 department [~~commission~~] and its employees may not disclose at a
59-61 public hearing or otherwise information relating to secret
59-62 processes, methods of manufacture, or products.

59-63 (b) The commissioner [~~A member~~] or an employee of the
59-64 department [~~commission~~] commits an offense if the commissioner
59-65 [~~member~~] or employee wilfully discloses or conspires to disclose
59-66 information made confidential under this section. An offense under
59-67 this subsection is a misdemeanor punishable by a fine not to exceed
59-68 \$1,000 and by forfeiture of the person's appointment as
59-69 commissioner [~~a member~~] or as an employee of the department

60-1 [~~commission~~].

60-2 SECTION 3.221. Section 411.106, Labor Code, is amended to
60-3 read as follows:

60-4 Sec. 411.106. SAFETY CLASSIFICATION. (a) To establish a
60-5 safety classification for employers, the department [~~commission~~]
60-6 shall:

60-7 (1) obtain medical and compensation cost information
60-8 regularly compiled by the Texas Department of Insurance in
60-9 performing that agency's rate-making duties and functions
60-10 regarding employer liability and workers' compensation insurance;
60-11 and

60-12 (2) collect and compile information relating to:

60-13 (A) the frequency rate of accidents;

60-14 (B) the existence and implementation of private
60-15 safety programs;

60-16 (C) the number of work-hour losses because of
60-17 injuries; and

60-18 (D) other facts showing accident experience.

60-19 (b) From the information obtained under Subsection (a), the
60-20 department [~~commission~~] shall classify employers as appropriate to
60-21 implement this subchapter.

60-22 SECTION 3.222. Section 411.107, Labor Code, is amended to
60-23 read as follows:

60-24 Sec. 411.107. ELIMINATION OF SAFETY IMPEDIMENTS. The
60-25 department [~~commission~~] may endeavor to eliminate an impediment to
60-26 occupational or industrial safety that is reported to the
60-27 department [~~commission~~] by an affected employer. In attempting to
60-28 eliminate an impediment the department [~~commission~~] may advise and
60-29 consult with an employer, or a representative of an employer, who is
60-30 directly involved.

60-31 SECTION 3.223. Section 411.108, Labor Code, is amended to
60-32 read as follows:

60-33 Sec. 411.108. ACCIDENT REPORTS. The department
60-34 [~~commission~~] may require an employer and any other appropriate
60-35 person to report accidents, personal injuries, fatalities, or other
60-36 statistics and information relating to accidents on forms
60-37 prescribed by and covering periods designated by the department
60-38 [~~commission~~].

60-39 SECTION 3.224. Subsections (g), (i), and (l), Section
60-40 412.041, Labor Code, are amended to read as follows:

60-41 (g) The director shall act as an adversary before the
60-42 department [~~commission~~] and courts and present the legal defenses
60-43 and positions of the state as an employer and insurer, as
60-44 appropriate.

60-45 (i) In administering Chapter 501, the director is subject to
60-46 the rules, orders, and decisions of the commissioner [~~commission~~]
60-47 in the same manner as a private employer, insurer, or association.

60-48 (l) The director shall furnish copies of all rules to:

60-49 (1) the department [~~commission~~];

60-50 (2) the commissioner of the Texas Department of
60-51 Insurance; and

60-52 (3) the administrative heads of all state agencies
60-53 affected by this chapter and Chapter 501.

60-54 SECTION 3.225. Section 413.001, Labor Code, is amended to
60-55 read as follows:

60-56 Sec. 413.001. DEFINITION. In this chapter, "division"
60-57 means the division of medical review of the department
60-58 [~~commission~~].

60-59 SECTION 3.226. Section 413.002, Labor Code, is amended to
60-60 read as follows:

60-61 Sec. 413.002. DIVISION OF MEDICAL REVIEW. (a) The
60-62 department [~~commission~~] shall maintain a division of medical review
60-63 to ensure compliance with the rules and to implement this chapter
60-64 under the policies adopted by the department [~~commission~~].

60-65 (b) The division shall monitor health care providers,
60-66 insurance carriers, [~~and~~] workers' compensation claimants who
60-67 receive medical services, and independent review organizations to
60-68 ensure the compliance of those persons with rules adopted by the
60-69 commissioner [~~commission~~] relating to health care, including

61-1 medical policies and fee guidelines.

61-2 (c) In monitoring health care providers who serve as
61-3 designated doctors under Chapter 408 and independent review
61-4 organizations who provide services described by this chapter, the
61-5 division shall evaluate:

61-6 (1) ~~the~~ compliance ~~[of those providers]~~ with this
61-7 subtitle and with rules adopted by the commissioner ~~[commission]~~
61-8 relating to medical policies, fee guidelines, treatment
61-9 guidelines, return-to-work guidelines, and impairment ratings; and

61-10 (2) the quality and timeliness of decisions made under
61-11 Section 408.0041, 408.122, 408.151, or 413.031.

61-12 (d) The division shall report the results of the monitoring
61-13 of independent review organizations under Subsection (c) to the
61-14 Texas Department of Insurance on at least a quarterly basis.

61-15 (e) If the commissioner of the Texas Department of Insurance
61-16 determines that an independent review organization is in violation
61-17 of this chapter, rules adopted by the commissioner under this
61-18 chapter, or applicable provisions of this code, or rules adopted
61-19 under this code, or applicable provisions of the Insurance Code or
61-20 rules adopted under that code, the commissioner of the Texas
61-21 Department of Insurance or a designated representative shall notify
61-22 the independent review organization of the alleged violation and
61-23 may compel the production of any documents or other information as
61-24 necessary to determine whether the violation occurred.

61-25 SECTION 3.227. Section 413.003, Labor Code, is amended to
61-26 read as follows:

61-27 Sec. 413.003. AUTHORITY TO CONTRACT. The department
61-28 ~~[commission]~~ may contract with a private or public entity to
61-29 perform a duty or function of the division.

61-30 SECTION 3.228. Section 413.004, Labor Code, is amended to
61-31 read as follows:

61-32 Sec. 413.004. COORDINATION WITH PROVIDERS. The division
61-33 shall coordinate its activities with health care providers as
61-34 necessary to perform its duties under this chapter. The
61-35 coordination may include:

61-36 (1) conducting educational seminars on commissioner
61-37 ~~[commission]~~ rules and procedures; or

61-38 (2) providing information to and requesting
61-39 assistance from professional peer review organizations.

61-40 SECTION 3.229. Section 413.006, Labor Code, is amended to
61-41 read as follows:

61-42 Sec. 413.006. ADVISORY COMMITTEES. The commissioner
61-43 ~~[commission]~~ may appoint advisory committees ~~[in addition to the~~
61-44 ~~medical advisory committee]~~ as the commissioner [it] considers
61-45 necessary.

61-46 SECTION 3.230. Subsections (a) and (c), Section 413.007,
61-47 Labor Code, are amended to read as follows:

61-48 (a) The division shall maintain a statewide data base of
61-49 medical charges, actual payments, and treatment protocols that may
61-50 be used by:

61-51 (1) the department [commission] in adopting the
61-52 medical policies and fee guidelines; and

61-53 (2) the division in administering the medical
61-54 policies, fee guidelines, or rules.

61-55 (c) The division shall ensure that the data base is
61-56 available for public access for a reasonable fee established by the
61-57 commissioner [commission]. The identities of injured workers and
61-58 beneficiaries may not be disclosed.

61-59 SECTION 3.231. Section 413.008, Labor Code, is amended to
61-60 read as follows:

61-61 Sec. 413.008. INFORMATION FROM INSURANCE CARRIERS;
61-62 ADMINISTRATIVE VIOLATION. (a) On request from the department
61-63 ~~[commission]~~ for specific information, an insurance carrier shall
61-64 provide to the division any information in its possession, custody,
61-65 or control that reasonably relates to the department's
61-66 ~~[commission's]~~ duties under this subtitle and to health care:

61-67 (1) treatment;

61-68 (2) services;

61-69 (3) fees; and

62-1 (4) charges.

62-2 (b) The department [~~commission~~] shall keep confidential
62-3 information that is confidential by law.

62-4 (c) An insurance carrier commits a violation if the
62-5 insurance carrier fails or refuses to comply with a request or
62-6 violates a rule adopted to implement this section. [~~A violation~~
62-7 ~~under this subsection is a Class C administrative violation. Each~~
62-8 ~~day of noncompliance constitutes a separate violation.~~]

62-9 SECTION 3.232. Section 413.011, Labor Code, is amended to
62-10 read as follows:

62-11 Sec. 413.011. REIMBURSEMENT POLICIES AND GUIDELINES;
62-12 TREATMENT GUIDELINES AND PROTOCOLS. (a) The department
62-13 [~~commission~~] shall use health care reimbursement policies and
62-14 guidelines that reflect the standardized reimbursement structures
62-15 found in other health care delivery systems with minimal
62-16 modifications to those reimbursement methodologies as necessary to
62-17 meet occupational injury requirements. To achieve
62-18 standardization, the department [~~commission~~] shall adopt the most
62-19 current reimbursement methodologies, models, and values or weights
62-20 used by the federal Centers for Medicare and Medicaid Services
62-21 [~~Health Care Financing Administration~~], including applicable
62-22 payment policies relating to coding, billing, and reporting, and
62-23 may modify documentation requirements as necessary to meet the
62-24 requirements of Section 413.053.

62-25 (b) In determining the appropriate fees, the commissioner
62-26 [~~commission~~] shall also develop conversion factors or other payment
62-27 adjustment factors taking into account economic indicators in
62-28 health care and the requirements of Subsection (d). The
62-29 commissioner [~~commission~~] shall also provide for reasonable fees
62-30 for the evaluation and management of care as required by Section
62-31 408.025(c) and commissioner [~~commission~~] rules. This section does
62-32 not adopt the Medicare fee schedule, and the commissioner may
62-33 [~~commission shall~~] not adopt conversion factors or other payment
62-34 adjustment factors based solely on those factors as developed by
62-35 the federal Centers for Medicare and Medicaid Services [~~Health Care~~
62-36 ~~Financing Administration~~].

62-37 (c) This section may not be interpreted in a manner that
62-38 would discriminate in the amount or method of payment or
62-39 reimbursement for services in a manner prohibited by Section
62-40 1451.104 [~~3(d), Article 21.52~~], Insurance Code, or as restricting
62-41 the ability of chiropractors to serve as treating doctors as
62-42 authorized by this subtitle. The commissioner [~~commission~~] shall
62-43 also develop guidelines relating to fees charged or paid for
62-44 providing expert testimony relating to an issue arising under this
62-45 subtitle.

62-46 (d) Guidelines for medical services fees must be fair and
62-47 reasonable and designed to ensure the quality of medical care and to
62-48 achieve effective medical cost control. The guidelines may not
62-49 provide for payment of a fee in excess of the fee charged for
62-50 similar treatment of an injured individual of an equivalent
62-51 standard of living and paid by that individual or by someone acting
62-52 on that individual's behalf. The commissioner [~~commission~~] shall
62-53 consider the increased security of payment afforded by this
62-54 subtitle in establishing the fee guidelines.

62-55 (e) The commissioner [~~commission~~] by rule shall [~~may~~] adopt
62-56 treatment guidelines and [~~, including~~] return-to-work guidelines,
62-57 and may adopt individual treatment protocols. Treatment [~~Except as~~
62-58 ~~otherwise provided by this subsection, the treatment~~] guidelines
62-59 and protocols must be evidence-based [~~nationally recognized~~],
62-60 scientifically valid, and outcome-focused [~~outcome-based~~] and
62-61 designed to reduce excessive or inappropriate medical care while
62-62 safeguarding necessary medical care [~~If a nationally recognized~~
62-63 ~~treatment guideline or protocol is not available for adoption by~~
62-64 ~~the commission, the commission may adopt another treatment~~
62-65 ~~guideline or protocol as long as it is scientifically valid and~~
62-66 ~~outcome-based~~].

62-67 (f) In addition to complying with the requirements of
62-68 Subsection (e), [~~The commission by rule may establish medical~~
62-69 ~~policies or treatment guidelines or protocols relating to necessary~~

63-1 ~~treatments for injuries.~~

63-2 [~~(g) Any~~] medical policies or guidelines adopted by the
63-3 commissioner [~~commission~~] must be:

63-4 (1) designed to ensure the quality of medical care and
63-5 to achieve effective medical cost control;

63-6 (2) designed to enhance a timely and appropriate
63-7 return to work; and

63-8 (3) consistent with Sections 413.013, 413.020,
63-9 413.052, and 413.053.

63-10 (g) The commissioner may adopt rules relating to disability
63-11 management that are designed to promote appropriate health care at
63-12 the earliest opportunity after the injury to maximize injury
63-13 healing and improve stay-at-work and return-to-work outcomes
63-14 through appropriate management of work-related injuries or
63-15 conditions. The commissioner by rule may identify claims in which
63-16 application of disability management activities is required and
63-17 prescribe at what point in the claim process a treatment plan is
63-18 required. The determination may be based on any factor considered
63-19 relevant by the commissioner. Rules adopted under this subsection
63-20 do not apply to claims subject to workers' compensation health care
63-21 networks under Chapter 1305, Insurance Code.

63-22 (h) A dispute involving a treatment plan required under
63-23 Subsection (g) may be appealed to an independent review
63-24 organization in the manner described by Section 413.031.

63-25 SECTION 3.233. Section 413.013, Labor Code, is amended to
63-26 read as follows:

63-27 Sec. 413.013. PROGRAMS. The commissioner [~~commission~~] by
63-28 rule shall establish:

63-29 (1) a program for prospective, concurrent, and
63-30 retrospective review and resolution of a dispute regarding health
63-31 care treatments and services;

63-32 (2) a program for the systematic monitoring of the
63-33 necessity of treatments administered and fees charged and paid for
63-34 medical treatments or services, including the authorization of
63-35 prospective, concurrent, or retrospective review under the medical
63-36 policies of the department [~~commission~~] to ensure that the medical
63-37 policies or guidelines are not exceeded;

63-38 (3) a program to detect practices and patterns by
63-39 insurance carriers in unreasonably denying authorization of
63-40 payment for medical services requested or performed if
63-41 authorization is required by the medical policies of the department
63-42 [~~commission~~]; and

63-43 (4) a program to increase the intensity of review for
63-44 compliance with the medical policies or fee guidelines for any
63-45 health care provider that has established a practice or pattern in
63-46 charges and treatments inconsistent with the medical policies and
63-47 fee guidelines.

63-48 SECTION 3.234. Subsections (b) through (e), Section
63-49 413.014, Labor Code, are amended to read as follows:

63-50 (b) The commissioner [~~commission~~] by rule shall specify
63-51 which health care treatments and services require express
63-52 preauthorization or concurrent review by the insurance carrier.
63-53 Treatments and services for a medical emergency do not require
63-54 express preauthorization.

63-55 (c) The commissioner's [~~commission~~] rules adopted under
63-56 this section must provide that preauthorization and concurrent
63-57 review are required at a minimum for:

63-58 (1) spinal surgery, as provided by Section 408.026;

63-59 (2) work-hardening or work-conditioning services
63-60 provided by a health care facility that is not credentialed by an
63-61 organization recognized by commissioner [~~commission~~] rules;

63-62 (3) inpatient hospitalization, including any
63-63 procedure and length of stay;

63-64 (4) outpatient or ambulatory surgical services, as
63-65 defined by commissioner [~~commission~~] rule; and

63-66 (5) any investigational or experimental services or
63-67 devices.

63-68 (d) The insurance carrier is not liable for those specified
63-69 treatments and services requiring preauthorization unless

64-1 preauthorization is sought by the claimant or health care provider
 64-2 and either obtained from the insurance carrier or ordered by the
 64-3 commissioner [~~commission~~].

64-4 (e) The commissioner [~~commission~~] may not prohibit an
 64-5 insurance carrier and a health care provider from voluntarily
 64-6 discussing health care treatment and treatment plans and
 64-7 pharmaceutical services, either prospectively or concurrently, and
 64-8 may not prohibit an insurance carrier from certifying or agreeing
 64-9 to pay for health care consistent with those agreements. The
 64-10 insurance carrier is liable for health care treatment and treatment
 64-11 plans and pharmaceutical services that are voluntarily
 64-12 preauthorized and may not dispute the certified or agreed-on
 64-13 preauthorized health care treatment and treatment plans and
 64-14 pharmaceutical services at a later date.

64-15 SECTION 3.235. Section 413.0141, Labor Code, is amended to
 64-16 read as follows:

64-17 Sec. 413.0141. INITIAL PHARMACEUTICAL COVERAGE. The
 64-18 commissioner [~~commission~~] may by rule provide that an insurance
 64-19 carrier shall provide for payment of specified pharmaceutical
 64-20 services sufficient for the first seven days following the date of
 64-21 injury if the health care provider requests and receives
 64-22 verification of insurance coverage and a verbal confirmation of an
 64-23 injury from the employer or from the insurance carrier as provided
 64-24 by Section 413.014. The rules adopted by the commissioner
 64-25 [~~commission~~] shall provide that an insurance carrier is eligible
 64-26 for reimbursement for pharmaceutical services paid under this
 64-27 section from the subsequent injury fund in the event the injury is
 64-28 determined not to be compensable.

64-29 SECTION 3.236. Subsection (b), Section 413.015, Labor Code,
 64-30 is amended to read as follows:

64-31 (b) The commissioner [~~commission~~] shall provide by rule for
 64-32 the review and audit of the payment by insurance carriers of charges
 64-33 for medical services provided under this subtitle to ensure
 64-34 compliance of health care providers and insurance carriers with the
 64-35 medical policies and fee guidelines adopted by the commissioner
 64-36 [~~commission~~].

64-37 SECTION 3.237. Subsection (b), Section 413.016, Labor Code,
 64-38 is amended to read as follows:

64-39 (b) If the division determines that an insurance carrier has
 64-40 paid medical charges that are inconsistent with the medical
 64-41 policies or fee guidelines adopted by the commissioner
 64-42 [~~commission~~], the division shall refer the insurance carrier
 64-43 alleged to have violated this subtitle to the division of
 64-44 compliance and practices. If the insurance carrier reduced a
 64-45 charge of a health care provider that was within the guidelines, the
 64-46 insurance carrier shall be directed to submit the difference to the
 64-47 provider unless the reduction is in accordance with an agreement
 64-48 between the health care provider and the insurance carrier.

64-49 SECTION 3.238. Section 413.017, Labor Code, is amended to
 64-50 read as follows:

64-51 Sec. 413.017. PRESUMPTION OF REASONABLENESS. The following
 64-52 medical services are presumed reasonable:

64-53 (1) medical services consistent with the medical
 64-54 policies and fee guidelines adopted by the commissioner
 64-55 [~~commission~~]; and

64-56 (2) medical services that are provided subject to
 64-57 prospective, concurrent, or retrospective review as required by the
 64-58 medical policies of the department [~~commission~~] and that are
 64-59 authorized by an insurance carrier.

64-60 SECTION 3.239. Subsections (a), (c), (d), and (e), Section
 64-61 413.018, Labor Code, are amended to read as follows:

64-62 (a) The commissioner [~~commission~~] by rule shall provide for
 64-63 the periodic review of medical care provided in claims in which
 64-64 guidelines for expected or average return to work time frames are
 64-65 exceeded.

64-66 (c) The department [~~commission~~] shall implement a program
 64-67 to encourage employers and treating doctors to discuss the
 64-68 availability of modified duty to encourage the safe and more timely
 64-69 return to work of injured employees. The department [~~commission~~]

65-1 may require a treating or examining doctor, on the request of the
65-2 employer, insurance carrier, or department [~~commission~~], to
65-3 provide a functional capacity evaluation of an injured employee and
65-4 to determine the employee's ability to engage in physical
65-5 activities found in the workplace or in activities that are
65-6 required in a modified duty setting.

65-7 (d) The department [~~commission~~] shall provide through the
65-8 department's [~~commission's~~] health and safety information and
65-9 medical review outreach programs information to employers
65-10 regarding effective return to work programs. This section does not
65-11 require an employer to provide modified duty or an employee to
65-12 accept a modified duty assignment. An employee who does not accept
65-13 an employer's offer of modified duty determined by the department
65-14 [~~commission~~] to be a bona fide job offer is subject to Section
65-15 408.103(e).

65-16 (e) The commissioner [~~commission~~] may adopt rules and forms
65-17 as necessary to implement this section.

65-18 SECTION 3.240. Section 413.020, Labor Code, is amended to
65-19 read as follows:

65-20 Sec. 413.020. DEPARTMENT [~~COMMISSION~~] CHARGES. The
65-21 commissioner [~~commission~~] by rule shall establish procedures to
65-22 enable the department [~~commission~~] to charge:

65-23 (1) an insurance carrier a reasonable fee for access
65-24 to or evaluation of health care treatment, fees, or charges under
65-25 this subtitle; and

65-26 (2) a health care provider who exceeds a fee or
65-27 utilization guideline established under this subtitle or an
65-28 insurance carrier who unreasonably disputes charges that are
65-29 consistent with a fee or utilization guideline established under
65-30 this subtitle a reasonable fee for review of health care treatment,
65-31 fees, or charges under this subtitle.

65-32 SECTION 3.241. Subsections (a), (d), and (e), Section
65-33 413.021, Labor Code, are amended to read as follows:

65-34 (a) An insurance carrier shall, with the agreement of a
65-35 participating employer, provide the employer with return-to-work
65-36 coordination services as necessary to facilitate an employee's
65-37 return to employment. The insurance carrier shall notify the
65-38 employer of the availability of return-to-work coordination
65-39 services. In offering the services, insurance carriers and the
65-40 department [~~commission~~] shall target employers without
65-41 return-to-work programs and shall focus return-to-work efforts on
65-42 workers who begin to receive temporary income benefits. These
65-43 services may be offered by insurance carriers in conjunction with
65-44 the accident prevention services provided under Section 411.061.
65-45 Nothing in this section supersedes the provisions of a collective
65-46 bargaining agreement between an employer and the employer's
65-47 employees, and nothing in this section authorizes or requires an
65-48 employer to engage in conduct that would otherwise be a violation of
65-49 the employer's obligations under the National Labor Relations Act
65-50 (29 U.S.C. Section 151 et seq.) [~~, and its subsequent amendments~~].

65-51 (d) The department [~~commission~~] shall use certified
65-52 rehabilitation counselors or other appropriately trained or
65-53 credentialed specialists to provide training to department
65-54 [~~commission~~] staff regarding the coordination of return-to-work
65-55 services under this section.

65-56 (e) The commissioner [~~commission~~] shall adopt rules
65-57 necessary to collect data on return-to-work outcomes to allow full
65-58 evaluations of successes and of barriers to achieving timely return
65-59 to work after an injury.

65-60 SECTION 3.242. Subchapter B, Chapter 413, Labor Code, is
65-61 amended by adding Section 413.022 to read as follows:

65-62 Sec. 413.022. RETURN-TO-WORK PILOT PROGRAM FOR SMALL
65-63 EMPLOYERS; FUND. (a) In this section:

65-64 (1) "Account" means the workers' compensation
65-65 return-to-work account.

65-66 (2) "Eligible employer" means any employer, other than
65-67 this state or a political subdivision subject to Subtitle C, who
65-68 employs at least two but not more than 50 employees on each business
65-69 day during the preceding calendar year and who has workers'

66-1 compensation insurance coverage.

66-2 (b) The commissioner shall establish by rule a
 66-3 return-to-work pilot program designed to promote the early and
 66-4 sustained return to work of an injured employee who sustains a
 66-5 compensable injury.

66-6 (c) The pilot program shall reimburse from the account an
 66-7 eligible employer for expenses incurred by the employer to make
 66-8 workplace modifications necessary to accommodate an injured
 66-9 employee's return to modified or alternative work. Reimbursement
 66-10 under this section to an eligible employer may not exceed \$2,500.
 66-11 The expenses must be incurred to allow the employee to perform
 66-12 modified or alternative work within doctor-imposed work
 66-13 restrictions. Allowable expenses may include:

66-14 (1) physical modifications to the worksite;

66-15 (2) equipment, devices, furniture, or tools; and

66-16 (3) other costs necessary for reasonable
 66-17 accommodation of the employee's restrictions.

66-18 (d) The account is established as a special account in the
 66-19 general revenue fund. From administrative penalties received by
 66-20 the department under this subtitle, the commissioner shall deposit
 66-21 in the account an amount not to exceed \$100,000 annually. Money in
 66-22 the account may be spent by the department, on appropriation by the
 66-23 legislature, only for the purposes of implementing this section.

66-24 (e) An employer who wilfully applies for or receives
 66-25 reimbursement from the account under this section knowing that the
 66-26 employer is not an eligible employer commits a violation. A
 66-27 violation under this subsection is a Class B administrative
 66-28 violation.

66-29 (f) Notwithstanding Subsections (a)-(e), this section may
 66-30 be implemented only to the extent funds are available.

66-31 (g) This section expires September 1, 2009.

66-32 SECTION 3.243. Section 413.031, Labor Code, is amended by
 66-33 amending Subsections (a) through (d), (e-1), (f), (g), (h), (k),
 66-34 and (m) and by adding Subsection (n) to read as follows:

66-35 (a) A party, including a health care provider, is entitled
 66-36 to a review of a medical service provided or for which authorization
 66-37 of payment is sought if a health care provider is:

66-38 (1) denied payment or paid a reduced amount for the
 66-39 medical service rendered;

66-40 (2) denied authorization for the payment for the
 66-41 service requested or performed if authorization is required or
 66-42 allowed by this subtitle or commissioner [~~commission~~] rules;

66-43 (3) ordered by the commissioner [~~commission~~] to refund
 66-44 a payment received; or

66-45 (4) ordered to make a payment that was refused or
 66-46 reduced for a medical service rendered.

66-47 (b) A health care provider who submits a charge in excess of
 66-48 the fee guidelines or treatment policies is entitled to a review of
 66-49 the medical service to determine if reasonable medical
 66-50 justification exists for the deviation. A claimant is entitled to a
 66-51 review of a medical service for which preauthorization is sought by
 66-52 the health care provider and denied by the insurance carrier. The
 66-53 commissioner [~~commission~~] shall adopt rules to notify claimants of
 66-54 their rights under this subsection.

66-55 (c) In resolving disputes over the amount of payment due for
 66-56 services determined to be medically necessary and appropriate for
 66-57 treatment of a compensable injury, the role of the department
 66-58 [~~commission~~] is to adjudicate the payment given the relevant
 66-59 statutory provisions and commissioner [~~commission~~] rules. The
 66-60 department [~~commission~~] shall publish on its Internet website its
 66-61 medical dispute decisions, including decisions of independent
 66-62 review organizations, and any subsequent decisions by the State
 66-63 Office of Administrative Hearings. Before publication, the
 66-64 department [~~commission~~] shall redact only that information
 66-65 necessary to prevent identification of the injured worker.

66-66 (d) A review of the medical necessity of a health care
 66-67 service requiring preauthorization under Section 413.014 or
 66-68 commissioner [~~commission~~] rules under that section or Section
 66-69 413.011(g) shall be conducted by an independent review organization

67-1 under Article 21.58C, Insurance Code, in the same manner as reviews
 67-2 of utilization review decisions by health maintenance
 67-3 organizations. It is a defense for the insurance carrier if the
 67-4 carrier timely complies with the decision of the independent review
 67-5 organization.

67-6 (e-1) In performing a review of medical necessity under
 67-7 Subsection (d) or (e), the independent review organization shall
 67-8 consider the department's [commission's] health care reimbursement
 67-9 policies and guidelines adopted under Section 413.011 [~~if those~~
 67-10 ~~policies and guidelines are raised by one of the parties to the~~
 67-11 ~~dispute~~]. If the independent review organization's decision is
 67-12 contrary to the department's [commission's] policies or guidelines
 67-13 adopted under Section 413.011, the independent review organization
 67-14 must indicate in the decision the specific basis for its divergence
 67-15 in the review of medical necessity. [~~This subsection does not~~
 67-16 ~~prohibit an independent review organization from considering the~~
 67-17 ~~payment policies adopted under Section 413.011 in any dispute,~~
 67-18 ~~regardless of whether those policies are raised by a party to the~~
 67-19 ~~dispute.~~]

67-20 (f) The commissioner [commission] by rule shall specify the
 67-21 appropriate dispute resolution process for disputes in which a
 67-22 claimant has paid for medical services and seeks reimbursement.

67-23 (g) In performing a review of medical necessity under
 67-24 Subsection (d) or (e), an independent review organization may
 67-25 request that the commissioner [commission] order an examination by
 67-26 a designated doctor under Chapter 408.

67-27 (h) The insurance carrier shall pay the cost of the review
 67-28 if the dispute arises in connection with:

67-29 (1) a request for health care services that require
 67-30 preauthorization under Section 413.014 or commissioner
 67-31 [commission] rules under that section; or

67-32 (2) a treatment plan under Section 413.011(g) or
 67-33 commissioner rules under that section.

67-34 (k) Except as provided by Subsection (l), a party to a
 67-35 medical dispute that remains unresolved after a review of the
 67-36 medical service under this section [~~is entitled to a hearing. The~~
 67-37 ~~hearing shall be conducted by the State Office of Administrative~~
 67-38 ~~Hearings within 90 days of receipt of a request for a hearing in the~~
 67-39 ~~manner provided for a contested case under Chapter 2001, Government~~
 67-40 ~~Code (the administrative procedure law). A party who has exhausted~~
 67-41 ~~the party's administrative remedies under this subtitle and who is~~
 67-42 ~~aggrieved by a final decision of the State Office of Administrative~~
 67-43 ~~Hearings] may seek judicial review of the decision. The department
 67-44 is not considered to be a party to the medical dispute for purposes
 67-45 of this subsection. Judicial review under this subsection shall be
 67-46 conducted in the manner provided for judicial review of contested
 67-47 cases under Subchapter G, Chapter 2001, Government Code.~~

67-48 (m) The decision of an independent review organization
 67-49 under Subsection (d) is binding during the pendency of a dispute.

67-50 (n) The commissioner [commission] by rule may prescribe an
 67-51 alternate dispute resolution process to resolve disputes regarding
 67-52 medical services costing less than the cost of a review of the
 67-53 medical necessity of a health care service by an independent review
 67-54 organization. The cost of a review under the alternate dispute
 67-55 resolution process shall be paid by the nonprevailing party.

67-56 SECTION 3.244. Subsections (a), (b), and (d), Section
 67-57 413.041, Labor Code, are amended to read as follows:

67-58 (a) Each health care practitioner shall disclose to the
 67-59 department [commission] the identity of any health care provider in
 67-60 which the health care practitioner, or the health care provider
 67-61 that employs the health care practitioner, has a financial
 67-62 interest. The health care practitioner shall make the disclosure
 67-63 in the manner provided by commissioner [commission] rule.

67-64 (b) The commissioner [commission] shall require by rule
 67-65 that a doctor disclose financial interests in other health care
 67-66 providers as a condition of registration for the approved doctor
 67-67 list established under Section 408.023 and shall define "financial
 67-68 interest" for purposes of this subsection as provided by analogous
 67-69 federal regulations. The commissioner [commission] by rule shall

68-1 adopt the federal standards that prohibit the payment or acceptance
68-2 of payment in exchange for health care referrals relating to fraud,
68-3 abuse, and antikickbacks.

68-4 (d) The department [~~commission~~] shall publish all final
68-5 disclosure enforcement orders issued under this section on the
68-6 department's [~~commission's~~] Internet website.

68-7 SECTION 3.245. Subsection (b), Section 413.042, Labor Code,
68-8 is amended to read as follows:

68-9 (b) A health care provider commits a violation if the
68-10 provider violates Subsection (a). [~~A violation under this~~
68-11 ~~subsection is a Class B administrative violation.~~]

68-12 SECTION 3.246. Section 413.044, Labor Code, is amended to
68-13 read as follows:

68-14 Sec. 413.044. SANCTIONS ON DESIGNATED DOCTOR. (a) In
68-15 addition to or in lieu of an administrative penalty under Section
68-16 415.021 or a sanction imposed under Section 415.023, the
68-17 commissioner [~~commission~~] may impose sanctions against a person who
68-18 serves as a designated doctor under Chapter 408 who, after an
68-19 evaluation conducted under Section 413.002(c), is determined by the
68-20 division to be out of compliance with this subtitle or with rules
68-21 adopted by the commissioner [~~commission~~] relating to:

68-22 (1) medical policies, fee guidelines, and impairment
68-23 ratings; or

68-24 (2) the quality of decisions made under Section
68-25 408.0041 or Section 408.122.

68-26 (b) Sanctions imposed under Subsection (a) may include:

68-27 (1) removal or suspension from the department list of
68-28 designated doctors; or

68-29 (2) restrictions on the reviews made by the person as a
68-30 designated doctor.

68-31 SECTION 3.247. Subsections (a) through (d), Section
68-32 413.051, Labor Code, are amended to read as follows:

68-33 (a) The department [~~commission~~] may contract with a health
68-34 care provider, health care provider professional review
68-35 organization, or other entity to develop, maintain, or review
68-36 medical policies or fee guidelines or to review compliance with the
68-37 medical policies or fee guidelines.

68-38 (b) For purposes of review or resolution of a dispute as to
68-39 compliance with the medical policies or fee guidelines, the
68-40 department [~~commission~~] may contract with a health care provider,
68-41 health care provider professional review organization, or other
68-42 entity that includes in the review process health care
68-43 practitioners who are licensed in the category under review and are
68-44 of the same field or specialty as the category under review.

68-45 (c) The department [~~commission~~] may contract with a health
68-46 care provider, health care provider professional review
68-47 organization, or other entity for medical consultant services,
68-48 including:

68-49 (1) independent medical examinations;

68-50 (2) medical case reviews; or

68-51 (3) establishment of medical policies and fee
68-52 guidelines.

68-53 (d) The commissioner [~~commission~~] shall establish standards
68-54 for contracts under this section.

68-55 SECTION 3.248. Section 413.0511, Labor Code, is amended to
68-56 read as follows:

68-57 Sec. 413.0511. MEDICAL ADVISOR. (a) The department
68-58 [~~commission~~] shall employ or contract with a medical advisor, who
68-59 must be a doctor as that term is defined by Section 401.011.

68-60 (b) The medical advisor shall make recommendations
68-61 regarding the adoption of rules and policies to:

68-62 (1) develop, maintain, and review guidelines as
68-63 provided by Section 413.011, including rules regarding impairment
68-64 ratings;

68-65 (2) review compliance with those guidelines;

68-66 (3) regulate or perform other acts related to medical
68-67 benefits as required by the commissioner [~~commission~~];

68-68 (4) impose sanctions or delete doctors from the
68-69 department's [~~commission's~~] list of approved doctors under Section

408.023 for:

- (A) any reason described by Section 408.0231; or
- (B) noncompliance with commissioner [~~commission~~]

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 department [~~commission~~] 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 3.249. Subsection (c), Section 413.0512, Labor Code, is amended to read as follows:

(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 3.250. 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 department [~~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 department [~~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 department [~~commission~~], an appropriate licensing or regulatory agency, or an appropriate enforcement authority; or

(2) a criminal proceeding.

SECTION 3.251. 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 department [~~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 department [~~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 department [~~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 department [~~commission~~] or by the department [~~commission~~] to the Texas State Board of Medical Examiners under

70-1 this subsection does not constitute a waiver of privilege or
70-2 confidentiality as established by law.

70-3 (c) Information that is received by the department
70-4 [~~commission~~] from the Texas State Board of Medical Examiners or by
70-5 the Texas State Board of Medical Examiners from the department
70-6 [~~commission~~] remains confidential, may not be disclosed by the
70-7 department [~~commission~~] except as necessary to further the
70-8 investigation, and shall be exempt from disclosure under Sections
70-9 402.092 and 413.0513.

70-10 (d) The department [~~commission~~] and the Texas Board of
70-11 Chiropractic Examiners on request or on its own initiative, may
70-12 share with each other confidential information or information to
70-13 which access is otherwise restricted by law. The department
70-14 [~~commission~~] and the Texas Board of Chiropractic Examiners shall
70-15 cooperate with and assist each other when either agency is
70-16 conducting an investigation by providing information to each other
70-17 that is relevant to the investigation. Except as provided by this
70-18 section, confidential information that is shared under this section
70-19 remains confidential under law and legal restrictions on access to
70-20 the information remain in effect unless the agency sharing the
70-21 information approves use of the information by the receiving agency
70-22 for enforcement purposes. Furnishing information by the Texas
70-23 Board of Chiropractic Examiners to the department [~~commission~~] or
70-24 by the department [~~commission~~] to the Texas Board of Chiropractic
70-25 Examiners under this subsection does not constitute a waiver of
70-26 privilege or confidentiality as established by law.

70-27 (e) Information that is received by the department
70-28 [~~commission~~] from the Texas Board of Chiropractic Examiners or by
70-29 the Texas Board of Chiropractic Examiners remains confidential and
70-30 may not be disclosed by the department [~~commission~~] except as
70-31 necessary to further the investigation unless the agency sharing
70-32 the information and the agency receiving the information agree to
70-33 use of the information by the receiving agency for enforcement
70-34 purposes.

70-35 (f) The department [~~commission~~] and the Texas State Board of
70-36 Medical Examiners shall provide information to each other on all
70-37 disciplinary actions taken.

70-38 (g) The department [~~commission~~] and the Texas Board of
70-39 Chiropractic Examiners shall provide information to each other on
70-40 all disciplinary actions taken.

70-41 SECTION 3.252. Section 413.0515, Labor Code, is amended to
70-42 read as follows:

70-43 Sec. 413.0515. REPORTS OF PHYSICIAN AND CHIROPRACTOR
70-44 VIOLATIONS. (a) If the department [~~commission~~] or the Texas State
70-45 Board of Medical Examiners discovers an act or omission by a
70-46 physician that may constitute a felony, a misdemeanor involving
70-47 moral turpitude, a violation of state or federal narcotics or
70-48 controlled substance law, an offense involving fraud or abuse under
70-49 the Medicare or Medicaid program, or a violation of this subtitle,
70-50 the agency shall report that act or omission to the other agency.

70-51 (b) If the department [~~commission~~] or the Texas Board of
70-52 Chiropractic Examiners discovers an act or omission by a
70-53 chiropractor that may constitute a felony, a misdemeanor involving
70-54 moral turpitude, a violation of state or federal narcotics or
70-55 controlled substance law, an offense involving fraud or abuse under
70-56 the Medicare or Medicaid program, or a violation of this subtitle,
70-57 the agency shall report that act or omission to the other agency.

70-58 SECTION 3.253. Section 413.052, Labor Code, is amended to
70-59 read as follows:

70-60 Sec. 413.052. PRODUCTION OF DOCUMENTS. The commissioner
70-61 [~~commission~~] by rule shall establish procedures to enable the
70-62 department [~~commission~~] to compel the production of documents.

70-63 SECTION 3.254. Section 413.053, Labor Code, is amended to
70-64 read as follows:

70-65 Sec. 413.053. STANDARDS OF REPORTING AND BILLING. The
70-66 commissioner [~~commission~~] by rule shall establish standards of
70-67 reporting and billing governing both form and content.

70-68 SECTION 3.255. Subsection (a), Section 413.054, Labor Code,
70-69 is amended to read as follows:

71-1 (a) A person who performs services for the department
 71-2 [~~commission~~] as a designated doctor, an independent medical
 71-3 examiner, a doctor performing a medical case review, or a member of
 71-4 a peer review panel has the same immunity from liability as the
 71-5 commissioner [~~a commission member~~] under Section 402.011
 71-6 [~~402.010~~].

71-7 SECTION 3.256. Subsections (a) and (b), Section 413.055,
 71-8 Labor Code, are amended to read as follows:

71-9 (a) The department [~~executive director~~], as provided by
 71-10 commissioner [~~commission~~] rule, may enter an interlocutory order
 71-11 for the payment of all or part of medical benefits. The order may
 71-12 address accrued benefits, future benefits, or both accrued benefits
 71-13 and future benefits.

71-14 (b) The subsequent injury fund shall reimburse an insurance
 71-15 carrier for any overpayments of benefits made under an order
 71-16 entered under Subsection (a) if the order is reversed or modified by
 71-17 final arbitration, order, or decision of the commissioner
 71-18 [~~commission~~] or a court. The commissioner [~~commission~~] shall adopt
 71-19 rules to provide for a periodic reimbursement schedule, providing
 71-20 for reimbursement at least annually.

71-21 SECTION 3.257. Subsection (a), Section 414.002, Labor Code,
 71-22 is amended to read as follows:

71-23 (a) The division shall monitor for compliance with
 71-24 commissioner [~~commission~~] rules, this subtitle, and other laws
 71-25 relating to workers' compensation the conduct of persons subject to
 71-26 this subtitle, other than persons monitored by the division of
 71-27 medical review. Persons to be monitored include:

- 71-28 (1) persons claiming benefits under this subtitle;
 71-29 (2) employers;
 71-30 (3) insurance carriers; and
 71-31 (4) attorneys and other representatives of parties.

71-32 SECTION 3.258. Section 414.003, Labor Code, is amended to
 71-33 read as follows:

71-34 Sec. 414.003. COMPILATION AND USE OF INFORMATION. (a) The
 71-35 division shall compile and maintain statistical and other
 71-36 information as necessary to detect practices or patterns of conduct
 71-37 by persons subject to monitoring under this chapter that:

- 71-38 (1) violate this subtitle, commissioner [or
 71-39 ~~commission~~] rules, or a commissioner order or decision; or
 71-40 (2) otherwise adversely affect the workers'
 71-41 compensation system of this state.

71-42 (b) The department [~~commission~~] shall use the information
 71-43 compiled under this section to impose appropriate penalties and
 71-44 other sanctions under Chapters 415 and 416.

71-45 SECTION 3.259. Section 414.005, Labor Code, is amended to
 71-46 read as follows:

71-47 Sec. 414.005. INVESTIGATION UNIT. The division shall
 71-48 maintain an investigation unit to conduct investigations relating
 71-49 to alleged violations of this subtitle, commissioner [~~or~~
 71-50 ~~commission~~] rules, or a commissioner order or decision, with
 71-51 particular emphasis on violations of Chapters 415 and 416.

71-52 SECTION 3.260. Section 414.007, Labor Code, is amended to
 71-53 read as follows:

71-54 Sec. 414.007. REVIEW OF REFERRALS FROM DIVISION OF MEDICAL
 71-55 REVIEW. The division shall review information and referrals
 71-56 received from the division of medical review concerning alleged
 71-57 violations of this subtitle, commissioner rules, or a commissioner
 71-58 order or decision, and, under Sections 414.005 and 414.006 and
 71-59 Chapters 415 and 416, may conduct investigations, make referrals to
 71-60 other authorities, and initiate administrative violation
 71-61 proceedings.

71-62 SECTION 3.261. Section 415.001, Labor Code, is amended to
 71-63 read as follows:

71-64 Sec. 415.001. ADMINISTRATIVE VIOLATION BY REPRESENTATIVE
 71-65 OF EMPLOYEE OR LEGAL BENEFICIARY. A representative of an employee
 71-66 or legal beneficiary commits an administrative violation if,
 71-67 regardless of the person's mental state, the person [~~wilfully or~~
 71-68 ~~intentionally~~]:

- 71-69 (1) fails without good cause to attend a dispute

72-1 resolution proceeding within the department [~~commission~~];

72-2 (2) attends a dispute resolution proceeding within the

72-3 department [~~commission~~] without complete authority or fails to

72-4 exercise authority to effectuate an agreement or settlement;

72-5 (3) commits an act of barratry under Section 38.12,

72-6 Penal Code;

72-7 (4) withholds from the employee's or legal

72-8 beneficiary's weekly benefits or from advances amounts not

72-9 authorized to be withheld by the department [~~commission~~];

72-10 (5) enters into a settlement or agreement without the

72-11 knowledge, consent, and signature of the employee or legal

72-12 beneficiary;

72-13 (6) takes a fee or withholds expenses in excess of the

72-14 amounts authorized by the department [~~commission~~];

72-15 (7) refuses or fails to make prompt delivery to the

72-16 employee or legal beneficiary of funds belonging to the employee or

72-17 legal beneficiary as a result of a settlement, agreement, order, or

72-18 award;

72-19 (8) violates the Texas Disciplinary Rules of

72-20 Professional Conduct of the State Bar of Texas;

72-21 (9) misrepresents the provisions of this subtitle to

72-22 an employee, an employer, a health care provider, or a legal

72-23 beneficiary;

72-24 (10) violates a commissioner [~~commission~~] rule; or

72-25 (11) fails to comply with this subtitle.

72-26 SECTION 3.262. Section 415.002, Labor Code, is amended to

72-27 read as follows:

72-28 Sec. 415.002. ADMINISTRATIVE VIOLATION BY AN INSURANCE

72-29 CARRIER. (a) An insurance carrier or its representative commits

72-30 an administrative violation if, regardless of the person's mental

72-31 state, that person [~~wilfully or intentionally~~]:

72-32 (1) misrepresents a provision of this subtitle to an

72-33 employee, an employer, a health care provider, or a legal

72-34 beneficiary;

72-35 (2) terminates or reduces benefits without

72-36 substantiating evidence that the action is reasonable and

72-37 authorized by law;

72-38 (3) instructs an employer not to file a document

72-39 required to be filed with the department [~~commission~~];

72-40 (4) instructs or encourages an employer to violate a

72-41 claimant's right to medical benefits under this subtitle;

72-42 (5) fails to tender promptly full death benefits if a

72-43 legitimate dispute does not exist as to the liability of the

72-44 insurance carrier;

72-45 (6) allows an employer, other than a self-insured

72-46 employer, to dictate the methods by which and the terms on which a

72-47 claim is handled and settled;

72-48 (7) fails to confirm medical benefits coverage to a

72-49 person or facility providing medical treatment to a claimant if a

72-50 legitimate dispute does not exist as to the liability of the

72-51 insurance carrier;

72-52 (8) fails, without good cause, to attend a dispute

72-53 resolution proceeding within the department [~~commission~~];

72-54 (9) attends a dispute resolution proceeding within the

72-55 department [~~commission~~] without complete authority or fails to

72-56 exercise authority to effectuate agreement or settlement;

72-57 (10) adjusts a workers' compensation claim in a manner

72-58 contrary to license requirements for an insurance adjuster,

72-59 including the requirements of Chapter 4101, Insurance Code [407,

72-60 ~~Acts of the 63rd Legislature, Regular Session, 1973 (Article~~

72-61 ~~21.07-4, Vernon's Texas Insurance Code)], or the rules of the~~

72-62 commissioner [~~State Board~~] of insurance [~~Insurance~~];

72-63 (11) fails to process claims promptly in a reasonable

72-64 and prudent manner;

72-65 (12) fails to initiate or reinstate benefits when due

72-66 if a legitimate dispute does not exist as to the liability of the

72-67 insurance carrier;

72-68 (13) misrepresents the reason for not paying benefits

72-69 or terminating or reducing the payment of benefits;

73-1 (14) dates documents to misrepresent the actual date
73-2 of the initiation of benefits;

73-3 (15) makes a notation on a draft or other instrument
73-4 indicating that the draft or instrument represents a final
73-5 settlement of a claim if the claim is still open and pending before
73-6 the department [~~commission~~];

73-7 (16) fails or refuses to pay benefits from week to week
73-8 as and when due directly to the person entitled to the benefits;

73-9 (17) fails to pay an order awarding benefits;

73-10 (18) controverts a claim if the evidence clearly
73-11 indicates liability;

73-12 (19) unreasonably disputes the reasonableness and
73-13 necessity of health care;

73-14 (20) violates a commissioner [~~commission~~] rule; ~~or~~

73-15 (21) makes a statement denying all future medical care
73-16 for a compensable injury; or

73-17 (22) fails to comply with a provision of this
73-18 subtitle.

73-19 (b) An insurance carrier or its representative does not
73-20 commit an administrative violation under Subsection (a)(6) by
73-21 allowing an employer to:

73-22 (1) freely discuss a claim;

73-23 (2) assist in the investigation and evaluation of a
73-24 claim; or

73-25 (3) attend a proceeding of the department [~~commission~~]
73-26 and participate at the proceeding in accordance with this subtitle.

73-27 SECTION 3.263. Section 415.003, Labor Code, is amended to
73-28 read as follows:

73-29 Sec. 415.003. ADMINISTRATIVE VIOLATION BY HEALTH CARE
73-30 PROVIDER. A health care provider commits an administrative
73-31 violation if, regardless of the person's mental state, the person
73-32 [~~wilfully or intentionally~~]:

73-33 (1) submits a charge for health care that was not
73-34 furnished;

73-35 (2) administers improper, unreasonable, or medically
73-36 unnecessary treatment or services;

73-37 (3) makes an unnecessary referral;

73-38 (4) violates the department's [~~commission's~~] fee and
73-39 treatment guidelines;

73-40 (5) violates a commissioner [~~commission~~] rule; or

73-41 (6) fails to comply with a provision of this subtitle.

73-42 SECTION 3.264. Subsections (a), (b), (e), and (f), Section
73-43 415.0035, Labor Code, are amended to read as follows:

73-44 (a) An insurance carrier or its representative commits an
73-45 administrative violation if, regardless of the person's mental
73-46 state, that person:

73-47 (1) fails to submit to the department [~~commission~~] a
73-48 settlement or agreement of the parties;

73-49 (2) fails to timely notify the department [~~commission~~]
73-50 of the termination or reduction of benefits and the reason for that
73-51 action; or

73-52 (3) denies preauthorization in a manner that is not in
73-53 accordance with rules adopted by the commissioner [~~commission~~]
73-54 under Section 413.014.

73-55 (b) A health care provider commits an administrative
73-56 violation if, regardless of the person's mental state, that person:

73-57 (1) fails or refuses to timely file required reports
73-58 or records; or

73-59 (2) fails to file with the department [~~commission~~] the
73-60 annual disclosure statement required by Section 413.041.

73-61 (e) An insurance carrier or health care provider commits an
73-62 administrative violation if that person violates this subtitle or a
73-63 rule, order, or decision of the commissioner [~~commission~~].

73-64 (f) A subsequent administrative violation under this
73-65 section, after prior notice to the insurance carrier or health care
73-66 provider of noncompliance, is subject to penalties as provided by
73-67 Section 415.021. Prior notice under this subsection is not
73-68 required [~~if the violation was committed wilfully or intentionally,~~
73-69 ~~or~~] if the violation was of a decision or order of the commissioner

74-1 [~~commission~~].

74-2 SECTION 3.265. The heading to Section 415.005, Labor Code,
74-3 is amended to read as follows:

74-4 Sec. 415.005. OVERCHARGING BY HEALTH CARE PROVIDERS
74-5 PROHIBITED[~~, ADMINISTRATIVE VIOLATION~~].

74-6 SECTION 3.266. Subsection (b), Section 415.005, Labor Code,
74-7 is amended to read as follows:

74-8 (b) A violation under this section is an [~~a Class B~~]
74-9 administrative violation. A health care provider may be liable for
74-10 an administrative penalty regardless of whether a criminal action
74-11 is initiated under Section 413.043.

74-12 SECTION 3.267. The heading to Section 415.006, Labor Code,
74-13 is amended to read as follows:

74-14 Sec. 415.006. EMPLOYER CHARGEBACKS PROHIBITED[~~+~~
74-15 ADMINISTRATIVE VIOLATION].

74-16 SECTION 3.268. Subsection (c), Section 415.006, Labor Code,
74-17 is amended to read as follows:

74-18 (c) A person commits a violation if the person violates
74-19 Subsection (a). [~~A violation under this subsection is a Class C~~
74-20 ~~administrative violation.~~]

74-21 SECTION 3.269. Subsection (a), Section 415.007, Labor Code,
74-22 is amended to read as follows:

74-23 (a) An attorney who represents a claimant before the
74-24 department [~~commission~~] may not lend money to the claimant during
74-25 the pendency of the workers' compensation claim.

74-26 SECTION 3.270. Subsection (e), Section 415.008, Labor Code,
74-27 is amended to read as follows:

74-28 (e) If an administrative violation proceeding is pending
74-29 under this section against an employee or person claiming death
74-30 benefits, the department [~~commission~~] may not take final action on
74-31 the person's benefits.

74-32 SECTION 3.271. Subsection (a), Section 415.009, Labor Code,
74-33 is amended to read as follows:

74-34 (a) A person commits a violation if, regardless of the
74-35 person's mental state, the person [~~knowingly~~] brings, prosecutes,
74-36 or defends an action for benefits under this subtitle or requests
74-37 initiation of an administrative violation proceeding that does not
74-38 have a basis in fact or is not warranted by existing law or a good
74-39 faith argument for the extension, modification, or reversal of
74-40 existing law.

74-41 SECTION 3.272. Subsection (a), Section 415.010, Labor Code,
74-42 is amended to read as follows:

74-43 (a) A party to an agreement approved by the department
74-44 [~~commission~~] commits a violation if, regardless of the person's
74-45 mental state, the person [~~knowingly~~] breaches a provision of the
74-46 agreement.

74-47 SECTION 3.273. Section 415.021, Labor Code, is amended to
74-48 read as follows:

74-49 Sec. 415.021. ASSESSMENT OF ADMINISTRATIVE PENALTIES.
74-50 (a) In addition to any other provisions in this subtitle relating
74-51 to violations, a person commits an administrative violation if the
74-52 person violates, fails to comply with, or refuses to comply with
74-53 this subtitle or a rule, order, or decision of the department. In
74-54 addition to any sanctions, administrative penalty, or other remedy
74-55 authorized by this subtitle, the commissioner [~~The commission~~] may
74-56 assess an administrative penalty against a person who commits an
74-57 administrative violation. The administrative penalty shall not
74-58 exceed \$25,000 per day per occurrence. Each day of noncompliance
74-59 constitutes a separate violation. The commissioner's authority
74-60 under this chapter is in addition to any other authority to enforce
74-61 a sanction, penalty, fine, forfeiture, denial, suspension, or
74-62 revocation otherwise authorized by law [~~Notwithstanding Subsection~~
74-63 ~~(c), the commission by rule shall adopt a schedule of specific~~
74-64 ~~monetary administrative penalties for specific violations under~~
74-65 ~~this subtitle~~].

74-66 (b) The commissioner [~~commission~~ ~~may assess an~~
74-67 ~~administrative penalty not to exceed \$10,000 and~~] may enter a cease
74-68 and desist order against a person who:

74-69 (1) commits repeated administrative violations;

75-1 (2) allows, as a business practice, the commission of
75-2 repeated administrative violations; or

75-3 (3) violates an order or decision of the commissioner
75-4 [~~commissioner~~].

75-5 (c) In assessing an administrative penalty:

75-6 (1) [~~7~~] the commissioner [~~commissioner~~] shall consider:
75-7 (A) [~~1~~] the seriousness of the violation,
75-8 including the nature, circumstances, consequences, extent, and
75-9 gravity of the prohibited act;

75-10 (B) [~~2~~] the history and extent of previous
75-11 administrative violations;

75-12 (C) [~~3~~] the demonstrated good faith of the
75-13 violator, including actions taken to rectify the consequences of
75-14 the prohibited act;

75-15 (D) [~~4~~] ~~the economic benefit resulting from the~~
75-16 ~~prohibited act;~~

75-17 [~~5~~] the penalty necessary to deter future
75-18 violations; and

75-19 (E) [~~6~~] other matters that justice may
75-20 require; and

75-21 (2) the commissioner shall, to the extent reasonable,
75-22 consider the economic benefit resulting from the prohibited act.

75-23 (d) A penalty may be assessed only after the person charged
75-24 with an administrative violation has been given an opportunity for
75-25 a hearing under Subchapter C.

75-26 SECTION 3.274. Subsection (b), Section 415.023, Labor Code,
75-27 is amended to read as follows:

75-28 (b) The commissioner [~~commissioner~~] may adopt rules providing
75-29 for:

75-30 (1) a reduction or denial of fees;
75-31 (2) public or private reprimand by the commissioner

75-32 [~~commissioner~~];
75-33 (3) suspension from practice before the commissioner

75-34 [~~commissioner~~];
75-35 (4) restriction, suspension, or revocation of the
75-36 right to receive reimbursement under this subtitle; or

75-37 (5) referral and petition to the appropriate licensing
75-38 authority for appropriate disciplinary action, including the
75-39 restriction, suspension, or revocation of the person's license.

75-40 SECTION 3.275. Section 415.024, Labor Code, is amended to
75-41 read as follows:

75-42 Sec. 415.024. BREACH OF SETTLEMENT AGREEMENT;
75-43 ADMINISTRATIVE VIOLATION. A material and substantial breach of a
75-44 settlement agreement that establishes a compliance plan is an an [~~a~~
75-45 ~~Class A~~] administrative violation. In determining the amount of
75-46 the penalty, the commissioner [~~commissioner~~] shall consider the total
75-47 volume of claims handled by the insurance carrier.

75-48 SECTION 3.276. Subsection (b), Section 415.032, Labor Code,
75-49 is amended to read as follows:

75-50 (b) Not later than the 20th day after the date on which
75-51 notice is received, the charged party shall:

75-52 (1) remit the amount of the penalty to the department
75-53 [~~commissioner~~]; or

75-54 (2) submit to the department [~~commissioner~~] a written
75-55 request for a hearing.

75-56 SECTION 3.277. Section 415.033, Labor Code, is amended to
75-57 read as follows:

75-58 Sec. 415.033. FAILURE TO RESPOND. If, without good cause, a
75-59 charged party fails to respond as required under Section 415.032,
75-60 the penalty is due and the department [~~commissioner~~] shall initiate
75-61 enforcement proceedings.

75-62 SECTION 3.278. Subsection (a), Section 415.034, Labor Code,
75-63 is amended to read as follows:

75-64 (a) On the request of the charged party or the commissioner
75-65 [~~executive director~~], the State Office of Administrative Hearings
75-66 shall set a hearing. The hearing shall be conducted in the manner
75-67 provided for a contested case under Chapter 2001, Government Code
75-68 (the administrative procedure law).

75-69 SECTION 3.279. Subsections (b) and (d), Section 415.035,

76-1 Labor Code, are amended to read as follows:

76-2 (b) If an administrative penalty is assessed, the person
76-3 charged shall:

76-4 (1) forward the amount of the penalty to the
76-5 commissioner [~~executive director~~] for deposit in an escrow account;
76-6 or

76-7 (2) post with the commissioner [~~executive director~~] a
76-8 bond for the amount of the penalty, effective until all judicial
76-9 review of the determination is final.

76-10 (d) If the court determines that the penalty should not have
76-11 been assessed or reduces the amount of the penalty, the
76-12 commissioner [~~executive director~~] shall:

76-13 (1) remit the appropriate amount, plus accrued
76-14 interest, if the administrative penalty was paid; or

76-15 (2) release the bond.

76-16 SECTION 3.280. Section 416.001, Labor Code, is amended to
76-17 read as follows:

76-18 Sec. 416.001. CERTAIN CAUSES OF ACTION PRECLUDED. An
76-19 action taken by an insurance carrier under an order of the
76-20 commissioner [~~commission~~] or recommendations of a benefit review
76-21 officer under Section 410.031, 410.032, or 410.033 may not be the
76-22 basis of a cause of action against the insurance carrier for a
76-23 breach of the duty of good faith and fair dealing.

76-24 SECTION 3.281. Subsections (c) and (d), Section 417.001,
76-25 Labor Code, are amended to read as follows:

76-26 (c) If a claimant receives benefits from the subsequent
76-27 injury fund, the department [~~commission~~] is:

76-28 (1) considered to be the insurance carrier under this
76-29 section for purposes of those benefits;

76-30 (2) subrogated to the rights of the claimant; and

76-31 (3) entitled to reimbursement in the same manner as
76-32 the insurance carrier.

76-33 (d) The department [~~commission~~] shall remit money recovered
76-34 under this section to the comptroller for deposit to the credit of
76-35 the subsequent injury fund.

76-36 SECTION 3.282. Subsection (b), Section 417.003, Labor Code,
76-37 is amended to read as follows:

76-38 (b) An attorney who represents the claimant and is also to
76-39 represent the subrogated insurance carrier shall make a full
76-40 written disclosure to the claimant before employment as an attorney
76-41 by the insurance carrier. The claimant must acknowledge the
76-42 disclosure and consent to the representation. A signed copy of the
76-43 disclosure shall be furnished to all concerned parties and made a
76-44 part of the department [~~commission~~] file. A copy of the disclosure
76-45 with the claimant's consent shall be filed with the claimant's
76-46 pleading before a judgment is entered and approved by the court.
76-47 The claimant's attorney may not receive a fee under this section to
76-48 which the attorney is otherwise entitled under an agreement with
76-49 the insurance carrier unless the attorney complies with the
76-50 requirements of this subsection.

76-51 SECTION 3.283. Subdivisions (1) and (5), Section 501.001,
76-52 Labor Code, are amended to read as follows:

76-53 (1) "Department" [~~"Commission"~~] means the Texas
76-54 Department of Workers' Compensation [~~Commission~~].

76-55 (5) "Employee" means a person who is:

76-56 (A) in the service of the state pursuant to an
76-57 election, appointment, or express oral or written contract of hire;

76-58 (B) paid from state funds but whose duties
76-59 require that the person work and frequently receive supervision in
76-60 a political subdivision of the state;

76-61 (C) a peace officer employed by a political
76-62 subdivision, while the peace officer is exercising authority
76-63 granted under:

76-64 (i) Article 2.12 [~~12~~], Code of Criminal
76-65 Procedure; or

76-66 (ii) Articles 14.03(d) and (g), Code of
76-67 Criminal Procedure;

76-68 (D) a member of the state military forces, as
76-69 defined by Section 431.001, Government Code, who is engaged in

77-1 authorized training or duty; or

77-2 (E) a Texas Task Force 1 member, as defined by
77-3 Section 88.301, Education Code, who is activated by the governor's
77-4 division of emergency management or is injured during any training
77-5 session sponsored or sanctioned by Texas Task Force 1.

77-6 SECTION 3.284. Subsection (d), Section 501.026, Labor Code,
77-7 is amended to read as follows:

77-8 (d) A person entitled to benefits under this section may
77-9 receive the benefits only if the person seeks medical attention
77-10 from a doctor for the injury not later than 48 hours after the
77-11 occurrence of the injury or after the date the person knew or should
77-12 have known the injury occurred. The person shall comply with the
77-13 requirements of Section 409.001 by providing notice of the injury
77-14 to the department [~~commission~~] or the state agency with which the
77-15 officer or employee under Subsection (b) is associated.

77-16 SECTION 3.285. Subsection (a), Section 501.050, Labor Code,
77-17 is amended to read as follows:

77-18 (a) In each case appealed from the department [~~commission~~]
77-19 to a county or district court:

77-20 (1) the clerk of the court shall mail to the department
77-21 [~~commission~~]:

77-22 (A) not later than the 20th day after the date the
77-23 case is filed, a notice containing the style, number, and date of
77-24 filing of the case; and

77-25 (B) not later than the 20th day after the date the
77-26 judgment is rendered, a certified copy of the judgment; and

77-27 (2) the attorney preparing the judgment shall file the
77-28 original and a copy of the judgment with the clerk.

77-29 SECTION 3.286. The heading to Chapter 502, Labor Code, is
77-30 amended to read as follows:

77-31 CHAPTER 502. WORKERS' COMPENSATION INSURANCE COVERAGE FOR
77-32 EMPLOYEES OF THE TEXAS A&M UNIVERSITY SYSTEM

77-33 AND EMPLOYEES OF INSTITUTIONS OF THE TEXAS A&M UNIVERSITY SYSTEM

77-34 SECTION 3.287. Subdivision (1), Section 502.001, Labor
77-35 Code, is amended to read as follows:

77-36 (1) "Department" means the Texas Department of
77-37 Workers' Compensation [~~"Commission" means the Texas Workers'~~
77-38 ~~Compensation Commission~~].

77-39 SECTION 3.288. Subsection (b), Section 502.002, Labor Code,
77-40 is amended to read as follows:

77-41 (b) For the purpose of applying the provisions listed by
77-42 Subsection (a) to this chapter, "employer" means "the institution,"
77-43 and "system" means the insurance carrier under Section 502.022.

77-44 SECTION 3.289. Subsection (a), Section 502.021, Labor Code,
77-45 is amended to read as follows:

77-46 (a) The system [~~institution~~] shall pay benefits as provided
77-47 by this chapter to an employee with a compensable injury.

77-48 SECTION 3.290. Section 502.041, Labor Code, is amended to
77-49 read as follows:

77-50 Sec. 502.041. EXHAUSTION OF ANNUAL AND SICK LEAVE. (a) An
77-51 employee may elect to use accrued sick leave before receiving
77-52 income benefits. If an employee elects to use sick leave, the
77-53 employee is not entitled to income benefits under this chapter
77-54 until the employee has exhausted the employee's accrued sick leave
77-55 [institution may provide that an injured employee may remain on the
77-56 payroll until the employee's earned annual and sick leave is
77-57 exhausted].

77-58 (b) An employee may elect to use all or any number of weeks
77-59 of accrued annual leave after the employee's accrued sick leave is
77-60 exhausted. If an employee elects to use annual leave, the employee
77-61 is not entitled to income benefits under this chapter until the
77-62 elected number of weeks of leave have been exhausted [While an
77-63 injured employee remains on the payroll under Subsection (a),
77-64 medical services remain available to the employee, but workers'
77-65 compensation benefits do not accrue or become payable to the
77-66 injured employee].

77-67 SECTION 3.291. Subsections (a) and (c), Section 502.061,
77-68 Labor Code, are amended to read as follows:

77-69 (a) The system [~~Each institution~~] shall administer this

78-1 chapter.

78-2 (c) The system [~~institution~~] may:

78-3 (1) adopt and publish rules and prescribe and furnish
78-4 forms necessary for the administration of this chapter; and

78-5 (2) adopt and enforce rules necessary for the
78-6 prevention of accidents and injuries.

78-7 SECTION 3.292. Section 502.063, Labor Code, is amended to
78-8 read as follows:

78-9 Sec. 502.063. CERTIFIED COPIES OF DEPARTMENT [~~COMMISSION~~]
78-10 DOCUMENTS. (a) The department [~~commission~~] shall furnish a
78-11 certified copy of an order, award, decision, or paper on file in the
78-12 department's [~~commission's~~] office to a person entitled to the copy
78-13 on written request and payment of the fee for the copy. The fee is
78-14 the same as that charged for similar services by the secretary of
78-15 state's office.

78-16 (b) The system or an [~~An~~] institution may obtain certified
78-17 copies under this section without charge.

78-18 (c) A fee or salary may not be paid to an [~~a member or~~]
78-19 employee of the department [~~commission~~] for making a copy under
78-20 Subsection (a) that exceeds the fee charged for the copy.

78-21 SECTION 3.293. Subsection (a), Section 502.065, Labor Code,
78-22 is amended to read as follows:

78-23 (a) In addition to a report of an injury filed with the
78-24 department [~~commission~~] under Section 409.005(a), an institution
78-25 shall file a supplemental report that contains:

78-26 (1) the name, age, sex, and occupation of the injured
78-27 employee;

78-28 (2) the character of work in which the employee was
78-29 engaged at the time of the injury;

78-30 (3) the place, date, and hour of the injury; and

78-31 (4) the nature and cause of the injury.

78-32 SECTION 3.294. Subsections (a), (b), (d), and (e), Section
78-33 502.066, Labor Code, are amended to read as follows:

78-34 (a) The department [~~commission~~] may require an employee who
78-35 claims to have been injured to submit to an examination by the
78-36 department [~~commission~~] or a person acting under the department's
78-37 [~~commission's~~] authority at a reasonable time and place in this
78-38 state.

78-39 (b) On the request of an employee or the system
78-40 [~~institution~~], the employee, [~~or~~] the institution, or the system is
78-41 entitled to have a physician or chiropractor selected by the
78-42 employee, [~~or~~] the institution, or the system, as appropriate,
78-43 present to participate in an examination under Subsection (a) or
78-44 Section 408.004.

78-45 (d) The system or the institution may have an injured
78-46 employee examined at a reasonable time and at a place suitable to
78-47 the employee's condition and convenient and accessible to the
78-48 employee by a physician or chiropractor selected by the system or
78-49 the institution. The system or the institution shall pay for an
78-50 examination under this subsection and for the employee's reasonable
78-51 expenses incident to the examination. The employee is entitled to
78-52 have a physician or chiropractor selected by the employee present
78-53 to participate in an examination under this subsection.

78-54 (e) The system or the institution shall pay the fee set by
78-55 the department [~~commission~~] of a physician or chiropractor selected
78-56 by the employee under Subsection (b) or (d).

78-57 SECTION 3.295. Subsection (a), Section 502.067, Labor Code,
78-58 is amended to read as follows:

78-59 (a) The commissioner of the Texas Department of Workers'
78-60 Compensation [~~commission~~] may order or direct the system or the
78-61 institution to reduce or suspend the compensation of an injured
78-62 employee who:

78-63 (1) persists in insanitary or injurious practices that
78-64 tend to imperil or retard the employee's recovery; or

78-65 (2) refuses to submit to medical, surgical,
78-66 chiropractic, or other remedial treatment recognized by the state
78-67 that is reasonably essential to promote the employee's recovery.

78-68 SECTION 3.296. Section 502.068, Labor Code, is amended to
78-69 read as follows:

79-1 Sec. 502.068. POSTPONEMENT OF HEARING. If an injured
79-2 employee is receiving benefits under this chapter and the system or
79-3 the institution is providing hospitalization, medical treatment,
79-4 or chiropractic care to the employee, the department [~~commission~~]
79-5 may postpone the hearing on the employee's claim. An appeal may not
79-6 be taken from a department [~~commission~~] order under this section.

79-7 SECTION 3.297. Subsection (a), Section 502.069, Labor Code,
79-8 is amended to read as follows:

79-9 (a) In each case appealed from the department [~~commission~~]
79-10 to a county or district court:

79-11 (1) the clerk of the court shall mail to the department
79-12 [~~commission~~]:

79-13 (A) not later than the 20th day after the date the
79-14 case is filed, a notice containing the style, number, and date of
79-15 filing of the case; and

79-16 (B) not later than the 20th day after the date the
79-17 judgment is rendered, a certified copy of the judgment; and

79-18 (2) the attorney preparing the judgment shall file the
79-19 original and a copy of the judgment with the clerk.

79-20 SECTION 3.298. The heading to Chapter 503, Labor Code, is
79-21 amended to read as follows:

79-22 CHAPTER 503. WORKERS' COMPENSATION INSURANCE COVERAGE FOR
79-23 EMPLOYEES OF THE UNIVERSITY OF TEXAS SYSTEM AND
79-24 EMPLOYEES OF INSTITUTIONS OF THE UNIVERSITY OF TEXAS SYSTEM

79-25 SECTION 3.299. Section 503.001, Labor Code, is amended by
79-26 amending Subdivision (1) and by adding Subdivision (1-a) to read as
79-27 follows:

79-28 (1) "Commissioner" means the commissioner of the Texas
79-29 Department of Workers' Compensation [~~"Commission" means the Texas~~
79-30 ~~Workers' Compensation Commission~~].

79-31 (1-a) "Department" means the Texas Department of
79-32 Workers' Compensation.

79-33 SECTION 3.300. Subsection (b), Section 503.002, Labor Code,
79-34 is amended to read as follows:

79-35 (b) For the purpose of applying the provisions listed by
79-36 Subsection (a) to this chapter, "employer" means "the institution,"
79-37 and "system" means the insurance carrier under Section 503.022.

79-38 SECTION 3.301. Subsection (a), Section 503.021, Labor Code,
79-39 is amended to read as follows:

79-40 (a) The system [~~institution~~] shall pay benefits as provided
79-41 by this chapter to an employee with a compensable injury.

79-42 SECTION 3.302. Section 503.022, Labor Code, is amended to
79-43 read as follows:

79-44 Sec. 503.022. AUTHORITY TO SELF-INSURE. An institution may
79-45 self-insure as part of a system insurance plan.

79-46 SECTION 3.303. Section 503.041, Labor Code, is amended to
79-47 read as follows:

79-48 Sec. 503.041. EXHAUSTION OF ANNUAL AND SICK LEAVE. (a) An
79-49 employee may elect to use accrued sick leave before receiving
79-50 income benefits. If an employee elects to use sick leave, the
79-51 employee is not entitled to income benefits under this chapter
79-52 until the employee has exhausted the employee's accrued sick leave
79-53 [An institution may provide that an injured employee may remain on
79-54 the payroll until the employee's earned annual and sick leave is
79-55 exhausted].

79-56 (b) An employee may elect to use all or any number of weeks
79-57 of accrued annual leave after the employee's accrued sick leave is
79-58 exhausted. If an employee elects to use annual leave, the employee
79-59 is not entitled to income benefits under this chapter until the
79-60 elected number of weeks of leave have been exhausted [While an
79-61 injured employee remains on the payroll under Subsection (a), the
79-62 employee is entitled to medical benefits but income benefits do not
79-63 accrue].

79-64 SECTION 3.304. Subsections (a) and (c), Section 503.061,
79-65 Labor Code, are amended to read as follows:

79-66 (a) The system [~~Each institution~~] shall administer this
79-67 chapter.

79-68 (c) The system [~~institution~~] may:

79-69 (1) adopt and publish rules and prescribe and furnish

80-1 forms necessary for the administration of this chapter; and

80-2 (2) adopt and enforce rules necessary for the
80-3 prevention of accidents and injuries.

80-4 SECTION 3.305. Section 503.063, Labor Code, is amended to
80-5 read as follows:

80-6 Sec. 503.063. CERTIFIED COPIES OF DEPARTMENT [COMMISSION]
80-7 DOCUMENTS. (a) The department [~~commission~~] shall furnish a
80-8 certified copy of an order, award, decision, or paper on file in the
80-9 department's [~~commission's~~] office to a person entitled to the copy
80-10 on written request and payment of the fee for the copy. The fee is
80-11 the same as that charged for similar services by the secretary of
80-12 state's office.

80-13 (b) The system or the institution may obtain certified
80-14 copies under this section without charge.

80-15 (c) A fee or salary may not be paid to an [~~a member or~~]
80-16 employee of the department [~~commission~~] for making a copy under
80-17 Subsection (a) that exceeds the fee charged for the copy.

80-18 SECTION 3.306. Subsection (a), Section 503.065, Labor Code,
80-19 is amended to read as follows:

80-20 (a) In addition to a report of an injury filed with the
80-21 department [~~commission~~] under Section 409.005(a), an institution
80-22 shall file a supplemental report that contains:

80-23 (1) the name, age, sex, and occupation of the injured
80-24 employee;

80-25 (2) the character of work in which the employee was
80-26 engaged at the time of the injury;

80-27 (3) the place, date, and hour of the injury; and

80-28 (4) the nature and cause of the injury.

80-29 SECTION 3.307. Subsections (a), (b), (d), and (e), Section
80-30 503.066, Labor Code, are amended to read as follows:

80-31 (a) The department [~~commission~~] may require an employee who
80-32 claims to have been injured to submit to an examination by the
80-33 department [~~commission~~] or a person acting under the department's
80-34 [~~commission's~~] authority at a reasonable time and place in this
80-35 state.

80-36 (b) On the request of an employee, the system, or the
80-37 institution, the employee, the system, or the institution is
80-38 entitled to have a physician selected by the employee, the system,
80-39 or the institution, as appropriate, present to participate in an
80-40 examination under Subsection (a) or Section 408.004.

80-41 (d) The system or the institution may have an injured
80-42 employee examined at a reasonable time and at a place suitable to
80-43 the employee's condition and convenient and accessible to the
80-44 employee by a physician selected by the system or the institution.
80-45 The system or the institution shall pay for an examination under
80-46 this subsection and for the employee's reasonable expenses incident
80-47 to the examination. The employee is entitled to have a physician
80-48 selected by the employee present to participate in an examination
80-49 under this subsection.

80-50 (e) The system or the institution shall pay the fee, as set
80-51 by the department [~~commission~~], of a physician selected by the
80-52 employee under Subsection (b) or (d).

80-53 SECTION 3.308. Subsection (a), Section 503.067, Labor Code,
80-54 is amended to read as follows:

80-55 (a) The commissioner [~~commission~~] may order or direct the
80-56 system or the institution to reduce or suspend the compensation of
80-57 an injured employee who:

80-58 (1) persists in insanitary or injurious practices that
80-59 tend to imperil or retard the employee's recovery; or

80-60 (2) refuses to submit to medical, surgical, or other
80-61 remedial treatment recognized by the state that is reasonably
80-62 essential to promote the employee's recovery.

80-63 SECTION 3.309. Section 503.068, Labor Code, is amended to
80-64 read as follows:

80-65 Sec. 503.068. POSTPONEMENT OF HEARING. If an injured
80-66 employee is receiving benefits under this chapter and the system or
80-67 the institution is providing hospitalization or medical treatment
80-68 to the employee, the department [~~commission~~] may postpone the
80-69 hearing on the employee's claim. An appeal may not be taken from a

81-1 commissioner [~~commission~~] order under this section.

81-2 SECTION 3.310. Subsection (a), Section 503.069, Labor Code,
81-3 is amended to read as follows:

81-4 (a) In each case appealed from the department [~~commission~~]
81-5 to a county or district court:

81-6 (1) the clerk of the court shall mail to the department
81-7 [~~commission~~]:

81-8 (A) not later than the 20th day after the date the
81-9 case is filed, a notice containing the style, number, and date of
81-10 filing of the case; and

81-11 (B) not later than the 20th day after the date the
81-12 judgment is rendered, a certified copy of the judgment; and

81-13 (2) the attorney preparing the judgment shall file the
81-14 original and a copy of the judgment with the clerk.

81-15 SECTION 3.311. Subsection (a), Section 503.070, Labor Code,
81-16 is amended to read as follows:

81-17 (a) A party who does not consent to abide by the final
81-18 decision of the commissioner [~~commission~~] shall file notice with
81-19 the department [~~commission~~] as required by Section 410.253 and
81-20 bring suit in the county in which the injury occurred to set aside
81-21 the final decision of the commissioner [~~commission~~].

81-22 SECTION 3.312. Section 504.001, Labor Code, is amended by
81-23 amending Subdivision (1) and adding Subdivision (4) to read as
81-24 follows:

81-25 (1) "Department" means the Texas Department of
81-26 Workers' Compensation [~~"Commission" means the Texas Workers'~~
81-27 ~~Compensation Commission~~].

81-28 (4) "Pool" means two or more political subdivisions
81-29 collectively self-insuring under an interlocal contract under
81-30 Chapter 791, Government Code.

81-31 SECTION 3.313. Subsection (a), Section 504.002, Labor Code,
81-32 is amended to read as follows:

81-33 (a) The following provisions of Subtitles A and B apply to
81-34 and are included in this chapter except to the extent that they are
81-35 inconsistent with this chapter:

81-36 (1) Chapter 401, other than Section 401.011(18)
81-37 defining "employer" and Section 401.012 defining "employee";

81-38 (2) Chapter 402;

81-39 (3) Chapter 403, other than Sections 403.001-403.005;

81-40 (4) Sections 406.006-406.009 and Subchapters B and
81-41 D-G, Chapter 406, other than Sections 406.033, 406.034, 406.035,
81-42 406.091, and 406.096;

81-43 (5) Chapter 408, other than Sections 408.001(b) and
81-44 (c);

81-45 (6) Chapters 409-412 [~~409-417~~]; [~~and~~]

81-46 (7) Chapter 413, except as provided by Section
81-47 504.053;

81-48 (8) Chapters 414-417; and

81-49 (9) Chapter 451.

81-50 SECTION 3.314. The heading to Section 504.018, Labor Code,
81-51 is amended to read as follows:

81-52 Sec. 504.018. NOTICE TO DEPARTMENT [~~COMMISSION~~] AND
81-53 EMPLOYEES; EFFECT ON COMMON-LAW OR STATUTORY LIABILITY.

81-54 SECTION 3.315. Subsection (a), Section 504.018, Labor Code,
81-55 is amended to read as follows:

81-56 (a) A political subdivision shall notify the department
81-57 [~~commission~~] of the method by which its employees will receive
81-58 benefits, the approximate number of employees covered, and the
81-59 estimated amount of payroll.

81-60 SECTION 3.316. Subchapter C, Chapter 504, Labor Code, is
81-61 amended by adding Section 504.053 to read as follows:

81-62 Sec. 504.053. ELECTION. (a) A political subdivision that
81-63 self-insures either individually or collectively shall provide
81-64 workers' compensation medical benefits to the injured employees of
81-65 the political subdivision or the injured employees of the members
81-66 of a pool:

81-67 (1) in the manner provided by Chapter 1305, Insurance
81-68 Code;

81-69 (2) in the manner provided by Chapter 408, other than

82-1 Sections 408.001(b) and (c) and Section 408.002, and by Subchapters
82-2 B and C, Chapter 413; or

82-3 (3) by direct contracting with health care providers
82-4 or by contracting through a health benefits pool established under
82-5 Chapter 172, Local Government Code.

82-6 (b) Chapter 1305, Insurance Code, and the provisions of
82-7 Chapter 408 relating to medical benefits and Chapter 413 of this
82-8 code, do not apply if the political subdivision or pool provides
82-9 medical benefits in the manner authorized under Subsection (a)(3).

82-10 (c) If the political subdivision or pool provides medical
82-11 benefits in the manner authorized under Subsection (a)(3), the
82-12 following standards apply:

82-13 (1) the political subdivision or pool must ensure that
82-14 workers' compensation medical benefits are reasonably available to
82-15 all injured workers of the political subdivision or the injured
82-16 workers of the members of the pool within a designed service area;

82-17 (2) the political subdivision or pool must ensure that
82-18 all necessary health care services are provided in a manner that
82-19 will ensure the availability of and accessibility to adequate
82-20 health care providers, specialty care, and facilities;

82-21 (3) the political subdivision or pool must have an
82-22 internal review process for resolving complaints relating to the
82-23 manner of providing medical benefits, including an appeal to the
82-24 governing body or its designee and appeal to an independent review
82-25 organization;

82-26 (4) the political subdivision or pool must establish
82-27 reasonable procedures for the transition of injured workers to
82-28 contract providers and for the continuity of treatment, including
82-29 notice of impending termination of providers and a current list of
82-30 contract providers;

82-31 (5) the political subdivision or pool shall provide
82-32 for emergency care if an injured worker cannot reasonably reach a
82-33 contact provider and the care is for medical screening or other
82-34 evaluation that is necessary to determine whether a medical
82-35 emergency condition exists, necessary emergency care services
82-36 including treatment and stabilization, and services originating in
82-37 a hospital emergency facility following treatment or stabilization
82-38 of an emergency medical condition;

82-39 (6) prospective or concurrent review of the medical
82-40 necessity and appropriateness of health care services must comply
82-41 with Article 21.58A, Insurance Code;

82-42 (7) the political subdivision or pool shall continue
82-43 to report data to the appropriate agency as required by Title 5 of
82-44 this code and Chapter 1305, Insurance Code; and

82-45 (8) a political subdivision or pool is subject to the
82-46 requirements under Sections 1305.501, 1305.502, and 1305.503,
82-47 Insurance Code.

82-48 (d) Nothing in this chapter waives sovereign immunity or
82-49 creates a new cause of action.

82-50 SECTION 3.317. The heading to Section 505.053, Labor Code,
82-51 is amended to read as follows:

82-52 Sec. 505.053. CERTIFIED COPIES OF TEXAS DEPARTMENT OF
82-53 WORKERS' COMPENSATION [~~COMMISSION~~] DOCUMENTS.

82-54 SECTION 3.318. Subsections (a) and (c), Section 505.053,
82-55 Labor Code, are amended to read as follows:

82-56 (a) The Texas Department of Workers' Compensation
82-57 [~~commission~~] shall furnish a certified copy of an order, award,
82-58 decision, or paper on file in that department's [~~the commission's~~]
82-59 office to a person entitled to the copy on written request and
82-60 payment of the fee for the copy. The fee shall be the same as that
82-61 charged for similar services by the secretary of state's office.

82-62 (c) A fee or salary may not be paid to a person in the Texas
82-63 Department of Workers' Compensation [~~commission~~] for making the
82-64 copies that exceeds the fee charged for the copies.

82-65 SECTION 3.319. Subsection (d), Section 505.054, Labor Code,
82-66 is amended to read as follows:

82-67 (d) A physician designated under Subsection (c) who
82-68 conducts an examination shall file with the department a complete
82-69 transcript of the examination on a form furnished by the

83-1 department. The department shall maintain all reports under this
 83-2 subsection as part of the department's permanent records. A report
 83-3 under this subsection is admissible in evidence before the Texas
 83-4 Department of Workers' Compensation [~~commission~~] and in an appeal
 83-5 from a final award or ruling of that department [~~the commission~~] in
 83-6 which the individual named in the examination is a claimant for
 83-7 compensation under this chapter. A report under this subsection
 83-8 that is admitted is prima facie evidence of the facts stated in the
 83-9 report.

83-10 SECTION 3.320. Section 505.055, Labor Code, is amended to
 83-11 read as follows:

83-12 Sec. 505.055. REPORTS OF INJURIES. (a) A report of an
 83-13 injury filed with the Texas Department of Workers' Compensation
 83-14 [~~commission~~] under Section 409.005, in addition to the information
 83-15 required by commissioner of workers' compensation [~~commission~~]
 83-16 rules, must contain:

83-17 (1) the name, age, sex, and occupation of the injured
 83-18 employee;

83-19 (2) the character of work in which the employee was
 83-20 engaged at the time of the injury;

83-21 (3) the place, date, and hour of the injury; and

83-22 (4) the nature and cause of the injury.

83-23 (b) In addition to subsequent reports of an injury filed
 83-24 with the Texas Department of Workers' Compensation [~~commission~~]
 83-25 under Section 409.005(e), the department shall file a subsequent
 83-26 report on a form obtained for that purpose:

83-27 (1) on the termination of incapacity of the injured
 83-28 employee; or

83-29 (2) if the incapacity extends beyond 60 days.

83-30 SECTION 3.321. Subsections (a) and (d), Section 505.056,
 83-31 Labor Code, are amended to read as follows:

83-32 (a) The Texas Department of Workers' Compensation
 83-33 [~~commission~~] may require an employee who claims to have been
 83-34 injured to submit to an examination by that department [~~the~~
 83-35 ~~commission~~] or a person acting under the [~~commission's~~] authority
 83-36 of that department at a reasonable time and place in this state.

83-37 (d) On the request of an employee or the department, the
 83-38 employee or the department is entitled to have a physician selected
 83-39 by the employee or the department present to participate in an
 83-40 examination under Subsection (a) or Section 408.004. The employee
 83-41 is entitled to have a physician selected by the employee present to
 83-42 participate in an examination under Subsection (c). The department
 83-43 shall pay the fee set by the commissioner of the Texas Department of
 83-44 Workers' Compensation [~~commission~~] of a physician selected by the
 83-45 employee under this subsection.

83-46 SECTION 3.322. Subsection (a), Section 505.057, Labor Code,
 83-47 is amended to read as follows:

83-48 (a) The commissioner of the Texas Department of Workers'
 83-49 Compensation [~~commission~~] may order or direct the department to
 83-50 reduce or suspend the compensation of an injured employee if the
 83-51 employee:

83-52 (1) persists in insanitary or injurious practices that
 83-53 tend to imperil or retard the employee's recovery; or

83-54 (2) refuses to submit to medical, surgical, or other
 83-55 remedial treatment recognized by the state that is reasonably
 83-56 essential to promote the employee's recovery.

83-57 SECTION 3.323. Section 505.058, Labor Code, is amended to
 83-58 read as follows:

83-59 Sec. 505.058. POSTPONEMENT OF HEARING. If an injured
 83-60 employee is receiving benefits under this chapter and the
 83-61 department is providing hospitalization or medical treatment to the
 83-62 employee, the Texas Department of Workers' Compensation
 83-63 [~~commission~~] may postpone the hearing of the employee's claim. An
 83-64 appeal may not be taken from an [~~a commission~~] order of the
 83-65 commissioner of the Texas Department of Workers' Compensation under
 83-66 this section.

83-67 SECTION 3.324. Subsection (a), Section 505.059, Labor Code,
 83-68 is amended to read as follows:

83-69 (a) In each case appealed from the Texas Department of

Workers' Compensation [~~commission~~] to a county or district court:
(1) the clerk of the court shall mail to the Texas Department of Workers' Compensation [~~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 PROVIDER NETWORKS

SECTION 4.01. The heading to Subtitle D, Title 8, Insurance Code, as effective April 1, 2005, is amended to read as follows:

SUBTITLE D. [~~PREFERRED~~] PROVIDER [~~BENEFIT~~] PLANS

SECTION 4.02. Subtitle D, Title 8, Insurance Code, as effective April 1, 2005, 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 Texas Department of Workers' Compensation to exercise the powers granted to that agency under Title 5, Labor Code, that do not conflict with this chapter.

(b) In the event of a conflict between Title 5, Labor Code, and this chapter as to the operation and regulation of health care networks that provide workers' compensation medical benefits or the provision of health care to injured employees who are subject to workers' compensation health care 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

85-1 orally or in writing by a complainant to a network regarding any
 85-2 aspect of the network's operation. The term includes
 85-3 dissatisfaction relating to medical fee disputes and the network's
 85-4 administration and the manner in which a service is provided. The
 85-5 term does not include:

85-6 (A) a misunderstanding or a problem of
 85-7 misinformation that is resolved promptly by clearing up the
 85-8 misunderstanding or supplying the appropriate information to the
 85-9 satisfaction of the complainant; or

85-10 (B) an oral or written expression of
 85-11 dissatisfaction or disagreement with an adverse determination.

85-12 (6) "Credentialing" means the review, under
 85-13 nationally recognized standards to the extent that those standards
 85-14 do not conflict with other laws of this state, of qualifications and
 85-15 other relevant information relating to a health care provider who
 85-16 seeks a contract with a network.

85-17 (7) "Emergency" means either a medical or mental
 85-18 health emergency.

85-19 (8) "Employee" has the meaning assigned by Section
 85-20 401.012, Labor Code.

85-21 (9) "Fee dispute" means a dispute over the amount of
 85-22 payment due for health care services determined to be medically
 85-23 necessary and appropriate for treatment of a compensable injury.

85-24 (10) "Health care facility" means a general or
 85-25 specialty hospital, emergency clinic, outpatient clinic, or other
 85-26 facility providing health care.

85-27 (11) "Health care provider" or "provider" means:

85-28 (A) a doctor or other person licensed to practice
 85-29 one or more of the healing arts within the scope of the license of
 85-30 the license holder;

85-31 (B) a health care facility; or

85-32 (C) an entity providing health care that is
 85-33 covered under this chapter.

85-34 (12) "Independent review" means a system for final
 85-35 administrative review by an independent review organization of the
 85-36 medical necessity and appropriateness of health care services being
 85-37 provided, proposed to be provided, or that have been provided to an
 85-38 employee.

85-39 (13) "Independent review organization" means an
 85-40 entity that is certified by the commissioner to conduct independent
 85-41 review under Article 21.58C and rules adopted by the commissioner.

85-42 (14) "Life-threatening" has the meaning assigned by
 85-43 Section 2, Article 21.58A.

85-44 (15) "Medical emergency" means the sudden onset of a
 85-45 medical condition manifested by acute symptoms of sufficient
 85-46 severity, including severe pain, that the absence of immediate
 85-47 medical attention could reasonably be expected to result in:

85-48 (A) placing the patient's health or bodily
 85-49 functions in serious jeopardy; or

85-50 (B) serious dysfunction of any body organ or
 85-51 part.

85-52 (16) "Medical records" means the history of diagnosis
 85-53 and treatment for an injury, including medical, dental, and other
 85-54 health care records from each health care practitioner who provides
 85-55 care to an injured employee.

85-56 (17) "Mental health emergency" means a condition that
 85-57 could reasonably be expected to present danger to the person
 85-58 experiencing the mental health condition or another person.

85-59 (18) "Network" or "workers' compensation health care
 85-60 network" means an organization that is:

85-61 (A) formed as a health care provider network to
 85-62 provide health care services to injured employees;

85-63 (B) certified in accordance with this chapter and
 85-64 commissioner rules; and

85-65 (C) established by, or operates under contract
 85-66 with, an insurance carrier.

85-67 (19) "Nurse" has the meaning assigned by Section 2,
 85-68 Article 21.58A.

85-69 (20) "Person" means any natural or artificial person,

86-1 including an individual, partnership, association, corporation,
 86-2 organization, trust, hospital district, community mental health
 86-3 center, mental retardation center, mental health and mental
 86-4 retardation center, limited liability company, or limited
 86-5 liability partnership.

86-6 (21) "Preauthorization" means the process required to
 86-7 request approval from the network to provide a specific treatment
 86-8 or service before the treatment or service is provided.

86-9 (22) "Quality improvement program" means a system
 86-10 designed to continuously examine, monitor, and revise processes and
 86-11 systems that support and improve administrative and clinical
 86-12 functions.

86-13 (23) "Retrospective review" means the process of
 86-14 reviewing the medical necessity and reasonableness of health care
 86-15 that has been provided to an injured employee.

86-16 (24) "Rural area" means:
 86-17 (A) a county with a population of 50,000 or less;
 86-18 (B) an area that is not designated as an
 86-19 urbanized area by the United States Census Bureau; or

86-20 (C) any other area designated as rural under
 86-21 rules adopted by the commissioner.

86-22 (25) "Screening criteria" means the written policies,
 86-23 decision rules, medical protocols, and treatment guidelines used by
 86-24 a network as part of utilization review or retrospective review.

86-25 (26) "Service area" means a geographic area within
 86-26 which health care services from network providers are available and
 86-27 accessible to employees who live within that geographic area.

86-28 (27) "Texas Workers' Compensation Act" means Subtitle
 86-29 A, Title 5, Labor Code.

86-30 (28) "Transfer of risk" means, for purposes of this
 86-31 chapter only, an insurance carrier's transfer of financial risk for
 86-32 the provision of health care services to a network through
 86-33 capitation or other means.

86-34 (29) "Utilization review" has the meaning assigned by
 86-35 Section 2, Article 21.58A.

86-36 (30) "Utilization review agent" has the meaning
 86-37 assigned by Article 21.58A.

86-38 (31) "Utilization review plan" means the screening
 86-39 criteria and utilization review procedures of a workers'
 86-40 compensation health care network or utilization review agent.

86-41 (b) In this chapter, the following terms have the meanings
 86-42 assigned by Section 401.011, Labor Code:

- 86-43 (1) "compensable injury";
- 86-44 (2) "doctor";
- 86-45 (3) "employer";
- 86-46 (4) "health care";
- 86-47 (5) "injury";
- 86-48 (6) "insurance carrier"; and
- 86-49 (7) "treating doctor."

86-50 Sec. 1305.005. PARTICIPATION IN NETWORK; NOTICE OF NETWORK
 86-51 REQUIREMENTS. (a) An employer that elects to provide workers'
 86-52 compensation insurance coverage under the Texas Workers'
 86-53 Compensation Act may receive workers' compensation health care
 86-54 services for the employer's injured employees through a workers'
 86-55 compensation health care network.

86-56 (b) An insurance carrier may establish or contract with
 86-57 networks certified under this chapter to provide health care
 86-58 services under the Texas Workers' Compensation Act. If an employer
 86-59 elects to contract with an insurance company for the provision of
 86-60 health care services through a network, or if a self-insured
 86-61 employer under Chapter 407, Labor Code, a group of employers
 86-62 certified to self-insure under Chapter 407A, Labor Code, or a
 86-63 public employer under Subtitle C, Title 5, Labor Code, elects to
 86-64 establish or contract with a network, the employer's employees who
 86-65 live within the network's service area are required to obtain
 86-66 medical treatment for a compensable injury within the network,
 86-67 except as provided by Section 1305.006(a)(1) and (3).

86-68 (c) The insurance carrier shall provide to the employer, and
 86-69 shall ensure that the employer provides to the employer's

87-1 employees, notice of network requirements, including all
 87-2 information required by Section 1305.451. The carrier shall
 87-3 require the employer to:

87-4 (1) obtain a signed acknowledgment from each employee,
 87-5 written in English, Spanish, and any other language common to the
 87-6 employer's employees, that the employee has received information
 87-7 concerning the network and the network's requirements; and

87-8 (2) post notice of the network requirements at each
 87-9 place of employment.

87-10 (d) The insurance carrier shall ensure that an employer
 87-11 provides to each employee hired after the notice is given under
 87-12 Subsection (c) the notice and information required under that
 87-13 subsection not later than the third day after the date of hire.

87-14 (e) An injured employee who has received notice of network
 87-15 requirements but refuses to sign the acknowledgment form required
 87-16 under Subsection (c) remains subject to the network requirements
 87-17 established under this chapter.

87-18 (f) The insurance carrier shall require the employer to
 87-19 notify an injured employee of the network requirements at the time
 87-20 the employer receives actual or constructive notice of an injury.

87-21 (g) An injured employee is not required to comply with the
 87-22 network requirements until the employee receives the notice under
 87-23 Subsection (c) or (d).

87-24 (h) The commissioner may adopt rules as necessary to
 87-25 implement this section.

87-26 Sec. 1305.006. INSURANCE CARRIER LIABILITY FOR
 87-27 OUT-OF-NETWORK HEALTH CARE. (a) An insurance carrier that
 87-28 establishes or contracts with a network is liable for the following
 87-29 out-of-network health care that is provided to an injured employee:

87-30 (1) emergency care;

87-31 (2) health care provided to an injured employee who
 87-32 does not live within the service area of any network established by
 87-33 the insurance carrier or with which the insurance carrier has a
 87-34 contract; and

87-35 (3) health care provided by an out-of-network provider
 87-36 pursuant to a referral from the injured employee's treating doctor
 87-37 that has been approved by the network pursuant to Section 1305.103.

87-38 (b) If an accident or health insurance carrier or other
 87-39 person obligated for the cost of health care services has paid for
 87-40 health care services for an employee for an injury for which a
 87-41 workers' compensation insurance carrier denies compensability, and
 87-42 the injury is later determined to be compensable, the accident or
 87-43 health insurance carrier or other person may recover the amounts
 87-44 paid for such services from the workers' compensation insurance
 87-45 carrier.

87-46 Sec. 1305.007. RULES. The commissioner may adopt rules as
 87-47 necessary to implement this chapter.

87-48 [Sections 1305.008-1305.050 reserved for expansion]

87-49 SUBCHAPTER B. CERTIFICATION

87-50 Sec. 1305.051. CERTIFICATION REQUIRED. (a) A person may
 87-51 not operate a workers' compensation health care network in this
 87-52 state unless the person holds a certificate issued under this
 87-53 chapter and rules adopted by the commissioner.

87-54 (b) A person may not perform any act of a workers'
 87-55 compensation health care network except in accordance with the
 87-56 specific authorization of this chapter or rules adopted by the
 87-57 commissioner.

87-58 (c) A health maintenance organization regulated under
 87-59 Chapter 843 or an organization of physicians and providers that
 87-60 operates as a preferred provider benefit plan, as defined by
 87-61 Chapter 1301, may obtain a certification as a workers' compensation
 87-62 health care network in the same manner as any other person if that
 87-63 entity meets the requirements of this chapter and rules adopted by
 87-64 the commissioner under this chapter.

87-65 Sec. 1305.052. CERTIFICATE APPLICATION. (a) A person who
 87-66 seeks to operate as a workers' compensation health care network
 87-67 shall apply to the department for a certificate to organize and
 87-68 operate as a network.

87-69 (b) A certificate application must be:

88-1 (1) filed with the department in the form prescribed
 88-2 by the commissioner;

88-3 (2) verified by the applicant or an officer or other
 88-4 authorized representative of the applicant; and

88-5 (3) accompanied by a nonrefundable fee set by
 88-6 commissioner rule.

88-7 Sec. 1305.053. CONTENTS OF APPLICATION. Each certificate
 88-8 application must include:

88-9 (1) a description or a copy of the applicant's basic
 88-10 organizational structure documents and other related documents,
 88-11 including organizational charts or lists that show:

88-12 (A) the relationships and contracts between the
 88-13 applicant and any affiliates of the applicant; and

88-14 (B) the internal organizational structure of the
 88-15 applicant's management and administrative staff;

88-16 (2) biographical information regarding each person
 88-17 who governs or manages the affairs of the applicant, accompanied by
 88-18 information sufficient to allow the commissioner to determine the
 88-19 competence, fitness, and reputation of each officer or director of
 88-20 the applicant or other person having control of the applicant;

88-21 (3) a copy of the form of any contract between the
 88-22 applicant and any provider or group of providers, and with any third
 88-23 party performing services on behalf of the applicant under
 88-24 Subchapter D;

88-25 (4) a copy of the form of each contract with an
 88-26 insurance carrier, as described by Section 1305.154;

88-27 (5) a financial statement, current as of the date of
 88-28 the application, that is prepared using generally accepted
 88-29 accounting practices and includes:

88-30 (A) a balance sheet that reflects a solvent
 88-31 financial position;

88-32 (B) an income statement;

88-33 (C) a cash flow statement; and

88-34 (D) the sources and uses of all funds;

88-35 (6) a statement acknowledging that lawful process in a
 88-36 legal action or proceeding against the network on a cause of action
 88-37 arising in this state is valid if served in the manner provided by
 88-38 Chapter 804 for a domestic company;

88-39 (7) a description and a map of the applicant's service
 88-40 area or areas, with key and scale, that identifies each county or
 88-41 part of a county to be served;

88-42 (8) a description of programs and procedures to be
 88-43 utilized, including:

88-44 (A) a complaint system, as required under
 88-45 Subchapter I;

88-46 (B) a quality improvement program, as required
 88-47 under Subchapter G; and

88-48 (C) the utilization review and retrospective
 88-49 review programs described in Subchapter H;

88-50 (9) a list of all contracted network providers that
 88-51 demonstrates the adequacy of the network to provide comprehensive
 88-52 health care services sufficient to serve the population of injured
 88-53 employees within the service area and maps that demonstrate that
 88-54 the access and availability standards under Subchapter G are met;
 88-55 and

88-56 (10) any other information that the commissioner
 88-57 requires by rule to implement this chapter.

88-58 Sec. 1305.054. ACTION ON APPLICATION; RENEWAL OF
 88-59 CERTIFICATION. (a) The commissioner shall approve or disapprove
 88-60 an application for certification as a network not later than the
 88-61 60th day after the date the completed application is received by the
 88-62 department. An application is considered complete on receipt of
 88-63 all information required by this chapter and any commissioner
 88-64 rules, including receipt of any additional information requested by
 88-65 the commissioner as needed to make the determination.

88-66 (b) Additional information requested by the commissioner
 88-67 under Subsection (a) may include information derived from an
 88-68 on-site quality-of-care examination.

88-69 (c) The department shall notify the applicant of any

89-1 deficiencies in the application and may allow the applicant to
 89-2 request additional time to revise the application, in which case
 89-3 the 60-day period for approval or disapproval is tolled. The
 89-4 commissioner may grant or deny requests for additional time at the
 89-5 commissioner's discretion.

89-6 (d) An order issued by the commissioner disapproving an
 89-7 application must specify in what respects the application does not
 89-8 comply with applicable statutes and rules. An applicant whose
 89-9 application is disapproved may request a hearing not later than the
 89-10 30th day after the date of the commissioner's disapproval order.
 89-11 The hearing is a contested case hearing under Chapter 2001,
 89-12 Government Code.

89-13 (e) A certificate issued under this subchapter is valid
 89-14 until revoked or suspended.

89-15 Sec. 1305.055. USE OF CERTAIN INSURANCE TERMS BY NETWORK
 89-16 PROHIBITED. A network is not an insurer and may not use in the
 89-17 network's name or informational literature the word "insurance,"
 89-18 "casualty," "surety," or "mutual" or any other word that is:

89-19 (1) descriptive of the insurance, casualty, or surety
 89-20 business; or

89-21 (2) deceptively similar to the name or description of
 89-22 an insurer or surety corporation engaging in the business of
 89-23 insurance in this state.

89-24 Sec. 1305.056. RESTRAINT OF TRADE; APPLICATION OF CERTAIN
 89-25 LAWS. (a) A network that contracts with a provider or providers
 89-26 practicing individually or as a group is not, because of the
 89-27 contract or arrangement, considered to have entered into a
 89-28 conspiracy in restraint of trade in violation of Chapter 15,
 89-29 Business & Commerce Code.

89-30 (b) Notwithstanding any other law, a person who contracts
 89-31 under this chapter with one or more providers in the process of
 89-32 conducting activities that are permitted by law but that do not
 89-33 require a certificate of authority or other authorization under
 89-34 this code is not, because of the contract, considered to have
 89-35 entered into a conspiracy in restraint of trade in violation of
 89-36 Chapter 15, Business & Commerce Code.

89-37 (c) A network is subject to Articles 21.28 and 21.28-A and
 89-38 is considered an insurer or insurance company, as applicable, for
 89-39 purposes of those laws.

89-40 [Sections 1305.057-1305.100 reserved for expansion]

89-41 SUBCHAPTER C. GENERAL POWERS AND DUTIES OF WORKERS' COMPENSATION
 89-42 HEALTH CARE NETWORKS

89-43 Sec. 1305.101. PROVIDING OR ARRANGING FOR HEALTH CARE.

89-44 (a) Except for emergencies and out-of-network referrals, a
 89-45 network shall provide or arrange for health care services only
 89-46 through providers or provider groups that are under contract with
 89-47 or are employed by the network.

89-48 (b) A network doctor may not serve as a designated doctor or
 89-49 perform a required medical examination, as those terms are used
 89-50 under the Texas Workers' Compensation Act, for an employee
 89-51 receiving medical care through a network with which the doctor
 89-52 contracts or is employed.

89-53 (c) Notwithstanding any other provision of this chapter,
 89-54 prescription medication or services, as defined by Section
 89-55 401.011(19)(E), Labor Code, may not be delivered through a workers'
 89-56 compensation health care network. Prescription medication and
 89-57 services shall be reimbursed as provided by the Texas Workers'
 89-58 Compensation Act and applicable rules of the commissioner of the
 89-59 Texas Department of Workers' Compensation.

89-60 Sec. 1305.102. MANAGEMENT CONTRACTS. (a) A network may
 89-61 not enter into a contract with another entity for management
 89-62 services unless the proposed contract is first filed with the
 89-63 department and approved by the commissioner.

89-64 (b) The commissioner shall approve or disapprove the
 89-65 contract not later than the 30th day after the date the contract is
 89-66 filed, or within a reasonable extended period that the commissioner
 89-67 specifies by notice given within the 30-day period.

89-68 (c) The contract must state that:

89-69 (1) the contract may not be canceled without cause

90-1 without at least 90 days' prior written notice;

90-2 (2) notice of any cancellation must be sent
90-3 simultaneously to the commissioner by certified mail; and

90-4 (3) the network is responsible for ensuring that all
90-5 functions delegated by the contract are performed in accordance
90-6 with applicable statutes and rules, subject to the carrier's
90-7 oversight and monitoring of the network's performance.

90-8 (d) The management contractor proposing to contract shall
90-9 provide to the commissioner information sufficient to allow the
90-10 commissioner to determine the competence, fitness, or reputation of
90-11 each of the contractor's officers and directors or other person
90-12 having control of the contractor, including criminal history
90-13 information demonstrating that none of those individuals has been
90-14 convicted of a felony involving moral turpitude or breach of
90-15 fiduciary duty.

90-16 (e) The commissioner shall disapprove the proposed contract
90-17 if the commissioner determines that the contract authorizes a
90-18 person who is not sufficiently trustworthy, competent,
90-19 experienced, and free from conflict of interest to manage the
90-20 network with due regard for the interests of employers, employees,
90-21 creditors, or the public.

90-22 (f) The commissioner may not approve a proposed management
90-23 contract unless the management contractor has in force in the
90-24 management contractor's own name a fidelity bond on the
90-25 contractor's officers and employees in the amount of \$250,000 or a
90-26 greater amount prescribed by the commissioner.

90-27 (g) The fidelity bond must be issued by an insurer
90-28 authorized to engage in business in this state and must be filed
90-29 with the department. If the commissioner determines that a
90-30 fidelity bond is not available from an insurer authorized to engage
90-31 in business in this state, the management contractor may obtain a
90-32 fidelity bond procured by a surplus lines agent under Chapter 981.

90-33 (h) The fidelity bond must obligate the surety to pay any
90-34 loss of money or other property or damage that the network sustains
90-35 because of an act of fraud or dishonesty by an employee or officer
90-36 of the management contractor during the period that the management
90-37 contract is in effect.

90-38 (i) In lieu of a fidelity bond, and at the commissioner's
90-39 discretion, the management contractor may deposit with the
90-40 comptroller cash or readily marketable liquid securities
90-41 acceptable to the commissioner. The deposit must be maintained in
90-42 the amount of, and is subject to the same conditions required for, a
90-43 fidelity bond under this section.

90-44 (j) A management contract approved by the commissioner
90-45 under this section may not be assigned to any other entity.

90-46 (k) A management contract filed with the department under
90-47 this section is confidential and is not subject to disclosure as
90-48 public information under Chapter 552, Government Code.

90-49 Sec. 1305.103. TREATING DOCTOR; REFERRALS. (a) A network
90-50 shall determine the specialty or specialties of doctors who may
90-51 serve as treating doctors.

90-52 (b) For each injury, an injured employee shall select a
90-53 treating doctor from the list of all treating doctors under
90-54 contract with the network in that service area.

90-55 (c) An employee being treated by a non-network provider for
90-56 an injury that occurred before the employer's insurance carrier
90-57 contracted with the network shall select a network treating doctor
90-58 on notification by the carrier that health care services are being
90-59 provided through the network. The carrier shall provide to the
90-60 employee all information required by Section 1305.451. If the
90-61 employee fails to select a treating doctor on or before the 14th day
90-62 after the date of receipt of the information required by Section
90-63 1305.451, the network may assign the employee a network treating
90-64 doctor.

90-65 (d) Each network shall, by contract, require treating
90-66 doctors to provide, at a minimum, the functions and services for
90-67 injured employees described by this section.

90-68 (e) A treating doctor shall provide health care to the
90-69 employee for the employee's compensable injury and shall make

91-1 referrals to other network providers, or request referrals to
 91-2 out-of-network providers if medically necessary services are not
 91-3 available within the network. Referrals to out-of-network
 91-4 providers must be approved by the network. The network shall
 91-5 approve a referral to an out-of-network provider not later than the
 91-6 seventh day after the date on which the referral is requested, or
 91-7 sooner if circumstances and the condition of the employee require
 91-8 expedited approval. If the network denies the referral request,
 91-9 the employee may appeal the decision through the network's
 91-10 complaint process under Subchapter I.

91-11 (f) The treating doctor shall participate in the medical
 91-12 case management process as required by the network, including
 91-13 participation in return-to-work planning.

91-14 Sec. 1305.104. SELECTION OF TREATING DOCTOR. (a) An
 91-15 injured employee is entitled to the employee's initial choice of a
 91-16 treating doctor from the list provided by the network of all
 91-17 treating doctors under contract with the network who provide
 91-18 services within the service area in which the injured employee
 91-19 lives. The following does not constitute an initial choice of
 91-20 treating doctor:

91-21 (1) a doctor salaried by the employer;

91-22 (2) a doctor providing emergency care; or

91-23 (3) any doctor who provides care before the employee
 91-24 is enrolled in the network, except for a doctor selected under
 91-25 Section 1305.105.

91-26 (b) An employee who is dissatisfied with the initial choice
 91-27 of a treating doctor is entitled to select an alternate treating
 91-28 doctor from the network's list of treating doctors who provide
 91-29 services within the service area in which the injured employee
 91-30 lives by notifying the network in the manner prescribed by the
 91-31 network. The network may not deny a selection of an alternate
 91-32 treating doctor.

91-33 (c) An employee who is dissatisfied with an alternate
 91-34 treating doctor must obtain authorization from the network to
 91-35 select any subsequent treating doctor. The network shall establish
 91-36 procedures and criteria to be used in authorizing an employee to
 91-37 select subsequent treating doctors. The criteria must include, at
 91-38 a minimum, whether:

91-39 (1) treatment by the current treating doctor is
 91-40 medically inappropriate;

91-41 (2) the employee is receiving appropriate medical care
 91-42 to reach maximum medical improvement or medical care in compliance
 91-43 with the network's treatment guidelines; and

91-44 (3) a conflict exists between the employee and the
 91-45 current treating doctor to the extent that the doctor-patient
 91-46 relationship is jeopardized or impaired.

91-47 (d) Denial of a request for any subsequent treating doctor
 91-48 is subject to the appeal process for a complaint filed under
 91-49 Subchapter I.

91-50 (e) For purposes of this section, the following do not
 91-51 constitute the selection of an alternate or any subsequent treating
 91-52 doctor:

91-53 (1) a referral made by the treating doctor, including
 91-54 a referral for a second or subsequent opinion;

91-55 (2) the selection of a treating doctor because the
 91-56 original treating doctor:

91-57 (A) dies;

91-58 (B) retires; or

91-59 (C) leaves the network; or

91-60 (3) a change of treating doctor required because of a
 91-61 change of residence by the employee to a location outside the
 91-62 service area distance requirements, as described by Section
 91-63 1305.302(g).

91-64 (f) A network shall provide that an injured employee with a
 91-65 chronic, life-threatening injury or chronic pain related to a
 91-66 compensable injury may apply to the network's medical director to
 91-67 use a nonprimary care physician specialist that is in the network as
 91-68 the injured employee's treating doctor.

91-69 (g) An application under Subsection (f) must:

92-1 (1) include information specified by the network,
 92-2 including certification of the medical need provided by the
 92-3 nonprimary care physician specialist; and

92-4 (2) be signed by the injured employee and the
 92-5 nonprimary care physician specialist interested in serving as the
 92-6 injured employee's treating doctor.

92-7 (h) To be eligible to serve as the injured employee's
 92-8 treating doctor, a physician specialist must agree to accept the
 92-9 responsibility to coordinate all of the injured employee's health
 92-10 care needs.

92-11 (i) If a network denies a request under Subsection (f), the
 92-12 injured employee may appeal the decision through the network's
 92-13 established complaint resolution process under Subchapter I.

92-14 Sec. 1305.105. TREATMENT BY A PRIMARY CARE PROVIDER UNDER
 92-15 CHAPTER 843. (a) Notwithstanding any other provision of this
 92-16 chapter, an injured employee required to receive health care
 92-17 services within a network may select as the employee's treating
 92-18 doctor a doctor who the employee selected, prior to injury, as the
 92-19 employee's primary care provider under Chapter 843.

92-20 (b) A doctor serving as an employee's treating doctor under
 92-21 Subsection (a) must agree to abide by the terms of the network's
 92-22 contract and comply with the provisions of this subchapter and
 92-23 Subchapters D and G. Services provided by such a doctor are
 92-24 considered to be network services and are subject to Subchapters H
 92-25 and I.

92-26 (c) Any change of doctor requested by an employee being
 92-27 treated by a doctor under Subsection (a) must be to a network doctor
 92-28 and is subject to the requirements of this chapter.

92-29 Sec. 1305.106. PAYMENT OF HEALTH CARE PROVIDER. (a) A
 92-30 health care provider shall submit a charge to an insurance carrier
 92-31 not later than the 95th day after the date the provider provides the
 92-32 service for which the charge relates. In the case of a workers'
 92-33 compensation health care network, the parties may agree by contract
 92-34 to extend the 95-day period.

92-35 (b) Not later than 45th day after the date on which an
 92-36 insurance carrier receives a charge for services rendered by a
 92-37 health care provider, the carrier shall:

92-38 (1) pay the fee allowed under Section 413.011, Labor
 92-39 Code, or, in the case of a provider contracted with a workers'
 92-40 compensation health care network, the amount agreed to by contract;

92-41 (2) if the carrier disputes the amount charged by the
 92-42 health care provider and intends to audit the services or the
 92-43 charge, notify the provider and pay 85 percent of the amount or, in
 92-44 the case of a provider contracted with a workers' compensation
 92-45 health care network, 85 percent of the contracted rate;

92-46 (3) if the carrier determines that a portion of the
 92-47 charge is payable, pay the portion that is not in dispute and notify
 92-48 the health care provider why the remaining amount will not be paid;
 92-49 or

92-50 (4) if the carrier determines that the charge is not
 92-51 payable, notify the provider in writing why the claim will not be
 92-52 paid.

92-53 (c) If the insurance carrier denies liability for a claim,
 92-54 the carrier may not deny payment for health care services on the
 92-55 grounds that the injury was not compensable until the carrier
 92-56 notifies the health care provider in writing that the carrier has
 92-57 contested compensability.

92-58 (d) If the insurance carrier denies liability or the health
 92-59 care provider's entitlement to payment and an accident or health
 92-60 insurance company provides benefits to the employee for medical or
 92-61 other health care services, the right to recover that amount may be
 92-62 assigned by the employee to the accident or health insurance
 92-63 company.

92-64 (e) If an insurance carrier disputes the amount of the
 92-65 charge or the health care provider's entitlement to payment, the
 92-66 carrier shall send to the health care provider and the injured
 92-67 employee a report that sufficiently explains the reasons for the
 92-68 reduction or denial of payment for health care services provided to
 92-69 the employee. The insurance carrier is entitled to a hearing as

93-1 provided by Section 413.031(d), Labor Code.

93-2 (f) An insurance carrier shall complete the audit under
 93-3 Subsection (b)(2) not later than the 180th day after the date it
 93-4 receives the charge. Following completion of an audit, any
 93-5 additional payment due a health care provider or any refund due the
 93-6 carrier shall be made not later than the 30th day after the date the
 93-7 health care provider receives notice of the audit results.

93-8 (g) An insurance carrier that does not comply with
 93-9 Subsection (b) is liable to the health care provider for the fee
 93-10 allowed under Section 413.011, Labor Code, or, if the provider is
 93-11 contracted with a workers' compensation health care network, for
 93-12 the contracted amount, plus a penalty in the amount of 18 percent a
 93-13 year.

93-14 Sec. 1305.107. TELEPHONE ACCESS. (a) Each network shall
 93-15 have appropriate personnel reasonably available through a
 93-16 toll-free telephone service at least 40 hours per week during
 93-17 normal business hours, in both time zones in this state if
 93-18 applicable, to discuss an employee's care and to allow response to
 93-19 requests for information, including information regarding adverse
 93-20 determinations.

93-21 (b) A network must have a telephone system capable of
 93-22 accepting or recording or providing instructions to incoming calls
 93-23 during other than normal business hours. The network shall respond
 93-24 to those calls not later than two business days after the date:

93-25 (1) the call was received by the network; or

93-26 (2) the details necessary to respond were received by
 93-27 the network from the caller.

93-28 [Sections 1305.108-1305.150 reserved for expansion]

93-29 SUBCHAPTER D. CONTRACTING PROVISIONS

93-30 Sec. 1305.151. TRANSFER OF RISK. A contract under this
 93-31 subchapter may not involve a transfer of risk.

93-32 Sec. 1305.152. NETWORK CONTRACTS WITH PROVIDERS. (a) A
 93-33 network shall enter into a written contract with each provider or
 93-34 group of providers that participates in the network. A provider
 93-35 contract under this section is confidential and is not subject to
 93-36 disclosure as public information under Chapter 552, Government
 93-37 Code.

93-38 (b) A network is not required to accept an application for
 93-39 participation in the network from a health care provider who
 93-40 otherwise meets the requirements specified in this chapter for
 93-41 participation if the network determines that the network has
 93-42 contracted with a sufficient number of qualified health care
 93-43 providers.

93-44 (c) Provider contracts and subcontracts must include, at a
 93-45 minimum, the following provisions:

93-46 (1) a hold-harmless clause stating that the network
 93-47 and the network's contracted providers are prohibited from billing
 93-48 or attempting to collect any amounts from employees for health care
 93-49 services under any circumstances, including the insolvency of the
 93-50 insurance carrier or the network, except as provided by Section
 93-51 1305.451(b)(6);

93-52 (2) a statement that the provider agrees to follow
 93-53 treatment guidelines adopted by the network under Section 1305.304,
 93-54 as applicable to an employee's injury;

93-55 (3) a continuity of treatment clause that states that
 93-56 if a provider leaves the network, the insurance carrier or network
 93-57 is obligated to continue to reimburse the provider for a period not
 93-58 to exceed 90 days at the contracted rate for care of an employee
 93-59 with a life-threatening condition or an acute condition for which
 93-60 disruption of care would harm the employee;

93-61 (4) a clause regarding appeal by the provider of
 93-62 termination of provider status and applicable written notification
 93-63 to employees regarding such a termination, including provisions
 93-64 determined by the commissioner; and

93-65 (5) any other provisions required by the commissioner
 93-66 by rule.

93-67 (d) Continued care as described by Subsection (c)(3) must be
 93-68 requested by a provider. A dispute involving continuity of care is
 93-69 subject to the dispute resolution process under Subchapter I.

94-1 (e) An insurance carrier and a network may not use any
 94-2 financial incentive or make a payment to a health care provider that
 94-3 acts directly or indirectly as an inducement to limit medically
 94-4 necessary services.

94-5 Sec. 1305.153. PROVIDER REIMBURSEMENT. (a) The amount of
 94-6 reimbursement for services provided by a network provider is
 94-7 determined by the contract between the network and the provider or
 94-8 group of providers.

94-9 (b) If a network has preauthorized a health care service,
 94-10 the insurance carrier or network or the network's agent or other
 94-11 representative may not deny payment to a provider except for
 94-12 reasons other than medical necessity.

94-13 (c) Out-of-network providers who provide care as described
 94-14 by Section 1305.006(a) shall be reimbursed as provided by the Texas
 94-15 Workers' Compensation Act and applicable rules of the commissioner
 94-16 of the Texas Department of Workers' Compensation.

94-17 (d) Subject to Subsection (a), billing by, and
 94-18 reimbursement to, contracted and out-of-network providers is
 94-19 subject to standard reimbursement requirements as provided by the
 94-20 Texas Workers' Compensation Act and applicable rules of the
 94-21 commissioner of the Texas Department of Workers' Compensation, as
 94-22 consistent with this chapter. This subsection may not be construed
 94-23 to require application of rules of the commissioner of the Texas
 94-24 Department of Workers' Compensation regarding reimbursement if
 94-25 application of those rules would negate reimbursement amounts
 94-26 negotiated by the network.

94-27 (e) An insurance carrier shall notify in writing a network
 94-28 provider if the carrier contests the compensability of the injury
 94-29 for which the provider provides health care services. A carrier may
 94-30 not deny payment for health care services provided by a network
 94-31 provider before that notification on the grounds that the injury
 94-32 was not compensable.

94-33 (f) If an insurance carrier contests the compensability of
 94-34 an injury and the injury is determined not to be compensable, the
 94-35 carrier may recover the amounts paid for health care services from
 94-36 the employee's accident or health insurance carrier or any other
 94-37 person who may be obligated for the cost of the health care
 94-38 services.

94-39 Sec. 1305.154. NETWORK-CARRIER CONTRACTS. (a) Except for
 94-40 emergencies and out-of-network referrals, a network may provide
 94-41 services to employees only through a written contract with an
 94-42 insurance carrier. A network-carrier contract under this section
 94-43 is confidential and is not subject to disclosure as public
 94-44 information under Chapter 552, Government Code.

94-45 (b) A carrier and a network may negotiate the functions to
 94-46 be provided by the network, except that the network shall contract
 94-47 with providers for the provision of health care functions related
 94-48 to the operation of a quality improvement program, and
 94-49 credentialing in accordance with the requirements of this chapter.

94-50 (c) A network's contract with a carrier must include:

94-51 (1) a description of the functions that the carrier
 94-52 delegates to the network, consistent with the requirements of
 94-53 Subsection (b), and the reporting requirements for each function;

94-54 (2) a statement that the network and any management
 94-55 contractor or third party to which the network delegates a function
 94-56 will perform all delegated functions in full compliance with all
 94-57 requirements of this chapter, the Texas Workers' Compensation Act,
 94-58 and rules of the commissioner of insurance or the commissioner of
 94-59 the Texas Department of Workers' Compensation;

94-60 (3) a provision that the contract:

94-61 (A) may not be terminated without cause by either
 94-62 party without 90 days' prior written notice; and

94-63 (B) must be terminated immediately if cause
 94-64 exists;

94-65 (4) a hold-harmless provision stating that the
 94-66 network, a management contractor, a third party to which the
 94-67 network delegates a function, and the network's contracted
 94-68 providers are prohibited from billing or attempting to collect any
 94-69 amounts from employees for health care services under any

95-1 circumstances, including the insolvency of the carrier or the
 95-2 network, except as provided by Section 1305.451(b)(6);

95-3 (5) a statement that the carrier retains ultimate
 95-4 responsibility for ensuring that all delegated functions and all
 95-5 management contractor functions are performed in accordance with
 95-6 applicable statutes and rules and that the contract may not be
 95-7 construed to limit in any way the carrier's responsibility,
 95-8 including financial responsibility, to comply with all statutory
 95-9 and regulatory requirements;

95-10 (6) a statement that the network's role is to provide
 95-11 the services described under Subsection (b) as well as any other
 95-12 services or functions delegated by the carrier, including functions
 95-13 delegated to a management contractor, subject to the carrier's
 95-14 oversight and monitoring of the network's performance;

95-15 (7) a requirement that the network provide the
 95-16 carrier, at least monthly and in a form usable for audit purposes,
 95-17 the data necessary for the carrier to comply with reporting
 95-18 requirements of the department and the Texas Department of Workers'
 95-19 Compensation with respect to any services provided under the
 95-20 contract, as determined by commissioner rules;

95-21 (8) a requirement that the carrier, the network, any
 95-22 management contractor, and any third party to which the network
 95-23 delegates a function comply with the data reporting requirements of
 95-24 the Texas Workers' Compensation Act and rules of the commissioner
 95-25 of the Texas Department of Workers' Compensation;

95-26 (9) a contingency plan under which the carrier would,
 95-27 in the event of termination of the contract or a failure to perform,
 95-28 reassume one or more functions of the network under the contract,
 95-29 including functions related to:

95-30 (A) payments to providers and notification to
 95-31 employees;

95-32 (B) quality of care;

95-33 (C) utilization review;

95-34 (D) retrospective review; and

95-35 (E) continuity of care, including a plan for
 95-36 identifying and transitioning employees to new providers;

95-37 (10) a provision that requires that any agreement by
 95-38 which the network delegates any function to a management contractor
 95-39 or any third party be in writing, and that such an agreement require
 95-40 the delegated third party or management contractor to be subject to
 95-41 all the requirements of this subchapter;

95-42 (11) a provision that requires the network to provide
 95-43 to the department the license number of a management contractor or
 95-44 any delegated third party who performs a function that requires a
 95-45 license as a utilization review agent under Article 21.58A or any
 95-46 other license under this code or another insurance law of this
 95-47 state;

95-48 (12) an acknowledgment that:

95-49 (A) any management contractor or third party to
 95-50 whom the network delegates a function must perform in compliance
 95-51 with this chapter and other applicable statutes and rules, and that
 95-52 the management contractor or third party is subject to the
 95-53 carrier's and the network's oversight and monitoring of its
 95-54 performance; and

95-55 (B) if the management contractor or the third
 95-56 party fails to meet monitoring standards established to ensure that
 95-57 functions delegated to the management contractor or the third party
 95-58 under the delegation contract are in full compliance with all
 95-59 statutory and regulatory requirements, the carrier or the network
 95-60 may cancel the delegation of one or more delegated functions;

95-61 (13) a requirement that the network and any management
 95-62 contractor or third party to which the network delegates a function
 95-63 provide all necessary information to allow the carrier to provide
 95-64 information to employees as required by Section 1305.451; and

95-65 (14) a provision that requires the network, in
 95-66 contracting with a third party directly or through another third
 95-67 party, to require the third party to permit the commissioner to
 95-68 examine at any time any information the commissioner believes is
 95-69 relevant to the third party's financial condition or the ability of

96-1 the network to meet the network's responsibilities in connection
 96-2 with any function the third party performs or has been delegated.

96-3 (d) An insurance carrier, a network, and any management
 96-4 contractor or third party to which the network delegates a function
 96-5 may not use any financial incentive or make a payment to a health
 96-6 care provider that acts directly or indirectly as an inducement to
 96-7 limit medically necessary services.

96-8 Sec. 1305.155. COMPLIANCE REQUIREMENTS. (a) An insurance
 96-9 carrier that becomes aware of any information that indicates that
 96-10 the network, any management contractor, or any third party to which
 96-11 the network delegates a function is not operating in accordance
 96-12 with the contract or is operating in a condition that renders the
 96-13 continuance of the network's business hazardous to employees shall:

96-14 (1) notify the network in writing of those findings;
 96-15 (2) request in writing a written explanation, with
 96-16 documentation supporting the explanation, of:

96-17 (A) the network's apparent noncompliance with
 96-18 the contract; or

96-19 (B) the existence of the condition that
 96-20 apparently renders the continuance of the network's business
 96-21 hazardous to employees; and

96-22 (3) notify the commissioner and provide the department
 96-23 with copies of all notices and requests submitted to the network and
 96-24 the responses and other documentation the carrier generates or
 96-25 receives in response to the notices and requests.

96-26 (b) A network shall respond to a request from a carrier
 96-27 under Subsection (a) in writing not later than the 30th day after
 96-28 the date the request is received.

96-29 (c) The carrier shall cooperate with the network to correct
 96-30 any failure by the network to comply with any regulatory
 96-31 requirement of the department.

96-32 (d) On receipt of a notice under Subsection (a), or if a
 96-33 complaint is filed with the department, on receipt of that
 96-34 complaint, the commissioner or the commissioner's designated
 96-35 representative shall examine the matters contained in the notice or
 96-36 complaint as well as any other matter relating to the financial
 96-37 solvency of the network or the network's ability to meet its
 96-38 responsibilities in connection with any function performed by the
 96-39 network or delegated to the network by the carrier.

96-40 (e) Except as provided by this subsection, on completion of
 96-41 the examination, the department shall report to the network and the
 96-42 carrier the results of the examination and any action the
 96-43 department determines is necessary to ensure that the carrier meets
 96-44 its responsibilities under this chapter, this code, and rules
 96-45 adopted by the commissioner, and that the network can meet the
 96-46 network's responsibilities in connection with any function
 96-47 delegated by the carrier or performed by the network, any
 96-48 management contractor, or any third party to which the network
 96-49 delegates a function. The department may not report to the carrier
 96-50 any information regarding fee schedules, prices, cost of care, or
 96-51 other information not relevant to the monitoring plan.

96-52 (f) The network and the carrier shall respond to the
 96-53 department's report and submit a corrective plan to the department
 96-54 not later than the 30th day after the date of receipt of the report.

96-55 (g) The commissioner may order a carrier to take any action
 96-56 the commissioner determines is necessary to ensure that the carrier
 96-57 can provide all health care services under the Texas Workers'
 96-58 Compensation Act, including:

96-59 (1) reassuming the functions performed by or delegated
 96-60 to the network, including claims payments for services previously
 96-61 provided to injured employees;

96-62 (2) temporarily or permanently ceasing coverage of
 96-63 employees through the network;

96-64 (3) complying with the contingency plan required by
 96-65 Section 1305.154(c)(9), including permitting an injured employee
 96-66 to select a treating doctor in the manner provided by Section
 96-67 408.022, Labor Code; or

96-68 (4) terminating the carrier's contract with the
 96-69 network.

97-1 (h) The carrier retains ultimate responsibility for
97-2 ensuring that all delegated functions and all management contractor
97-3 functions are performed in accordance with applicable statutes and
97-4 rules and nothing in this section may be construed to limit in any
97-5 way the carrier's responsibility, including financial
97-6 responsibility, to comply with all statutory and regulatory
97-7 requirements.

97-8 [Sections 1305.156-1305.200 reserved for expansion]

97-9 SUBCHAPTER E. FINANCIAL REQUIREMENTS

97-10 Sec. 1305.201. NETWORK FINANCIAL REQUIREMENTS. (a) Each
97-11 network shall prepare financial statements in accordance with
97-12 generally accepted accounting standards, which must include
97-13 adequate provisions for liabilities, including incurred but not
97-14 reported obligations relating to providing benefits or services.

97-15 (b) Each network shall file the financial statement under
97-16 Subsection (a) with the department in the manner prescribed by
97-17 commissioner rule.

97-18 [Sections 1305.202-1305.250 reserved for expansion]

97-19 SUBCHAPTER F. EXAMINATIONS

97-20 Sec. 1305.251. EXAMINATION OF NETWORK. (a) As often as
97-21 the commissioner considers necessary, the commissioner or the
97-22 commissioner's designated representative may review the operations
97-23 of a network to determine compliance with this chapter. The review
97-24 may include on-site visits to the network's premises.

97-25 (b) During on-site visits, the network must make available
97-26 to the department all records relating to the network's operations.

97-27 Sec. 1305.252. EXAMINATION OF PROVIDER OR THIRD PARTY. If
97-28 requested by the commissioner or the commissioner's
97-29 representative, each provider, provider group, or third party with
97-30 which the network has contracted to provide health care services or
97-31 any other services delegated to the network by an insurance carrier
97-32 shall make available for examination by the department that portion
97-33 of the books and records of the provider, provider group, or third
97-34 party that is relevant to the relationship with the network of the
97-35 provider, provider group, or third party.

97-36 [Sections 1305.253-1305.300 reserved for expansion]

97-37 SUBCHAPTER G. PROVISION OF SERVICES BY NETWORK; QUALITY
97-38 IMPROVEMENT PROGRAM

97-39 Sec. 1305.301. NETWORK ORGANIZATION; SERVICE AREAS.
97-40 (a) The chief executive officer, operations officer, or governing
97-41 body of a network is responsible for:

97-42 (1) the development, approval, implementation, and
97-43 enforcement of:

97-44 (A) administrative, operational, personnel, and
97-45 patient care policies; and

97-46 (B) network procedures; and

97-47 (2) the development of any documents necessary for the
97-48 operation of the network.

97-49 (b) Each network shall have a chief executive officer or
97-50 operations officer who:

97-51 (1) is accountable for the day-to-day administration
97-52 of the network; and

97-53 (2) shall ensure compliance with all applicable
97-54 statutes and rules pertaining to the operation of the network.

97-55 (c) Each network shall have a medical director, who must be
97-56 an occupational medicine specialist or employ or contract with an
97-57 occupational medicine specialist, and who must be licensed to
97-58 practice medicine in the United States. The medical director
97-59 shall:

97-60 (1) be available at all times to address complaints,
97-61 clinical issues, and any quality improvement issues on behalf of
97-62 the network;

97-63 (2) be actively involved in all quality improvement
97-64 activities; and

97-65 (3) comply with the network's credentialing
97-66 requirements.

97-67 (d) The network shall establish one or more service areas
97-68 within this state. For each defined service area, the network must:

97-69 (1) demonstrate to the satisfaction of the department

98-1 the ability to provide continuity, accessibility, availability,
 98-2 and quality of services;

98-3 (2) specify the counties and zip code areas, or any
 98-4 parts of a county or zip code area, included in the service area;
 98-5 and

98-6 (3) provide a complete provider directory to all
 98-7 employers in the service area.

98-8 Sec. 1305.302. ACCESSIBILITY AND AVAILABILITY
 98-9 REQUIREMENTS. (a) All services specified by this section must be
 98-10 provided by a provider who holds an appropriate license, unless the
 98-11 provider is exempt from license requirements.

98-12 (b) The network shall ensure that the network's provider
 98-13 panel includes an adequate number of treating doctors and
 98-14 specialists, who must be available and accessible to employees 24
 98-15 hours a day, seven days a week, within the network's service area.
 98-16 An adequate number of the treating doctors and specialists must
 98-17 have admitting privileges at one or more network hospitals located
 98-18 within the network's service area to ensure that any necessary
 98-19 hospital admissions are made.

98-20 (c) Hospital services must be available and accessible 24
 98-21 hours a day, seven days a week, within the network's service area.
 98-22 The network shall provide for the necessary hospital services by
 98-23 contracting with general, special, and psychiatric hospitals.

98-24 (d) Physical and occupational therapy services and
 98-25 chiropractic services must be available and accessible within the
 98-26 network's service area.

98-27 (e) Emergency care must be available and accessible 24 hours
 98-28 a day, seven days a week, without restrictions as to where the
 98-29 services are rendered.

98-30 (f) Except for emergencies, a network shall arrange for
 98-31 services, including referrals to specialists, to be accessible to
 98-32 employees on a timely basis on request, but not later than the last
 98-33 day of the third week after the date of the request.

98-34 (g) Each network shall provide that network services are
 98-35 sufficiently accessible and available as necessary to ensure that
 98-36 the distance from any point in the network's service area to a point
 98-37 of service by a treating doctor or general hospital is not greater
 98-38 than 30 miles in nonrural areas and 60 miles in rural areas and that
 98-39 the distance from any point in the network's service area to a point
 98-40 of service by a specialist or specialty hospital is not greater than
 98-41 75 miles in nonrural areas and 75 miles in rural areas. For
 98-42 portions of the service area in which the network identifies
 98-43 noncompliance with this subsection, the network must file an access
 98-44 plan with the department in accordance with Subsection (h).

98-45 (h) The network shall submit an access plan, as required by
 98-46 commissioner rules, to the department for approval at least 30 days
 98-47 before implementation of the plan if any health care service or a
 98-48 network provider is not available to an employee within the
 98-49 distance specified by Subsection (g) because:

98-50 (1) providers are not located within that distance;
 98-51 (2) the network is unable to obtain provider contracts
 98-52 after good faith attempts; or

98-53 (3) providers meeting the network's minimum quality of
 98-54 care and credentialing requirements are not located within that
 98-55 distance.

98-56 (i) The network may make arrangements with providers
 98-57 outside the service area to enable employees to receive a skill or
 98-58 specialty not available within the network service area.

98-59 (j) The network may not be required to expand services
 98-60 outside the network's service area to accommodate employees who
 98-61 live outside the service area.

98-62 Sec. 1305.303. QUALITY OF CARE REQUIREMENTS. (a) A
 98-63 network shall develop and maintain an ongoing quality improvement
 98-64 program designed to objectively and systematically monitor and
 98-65 evaluate the quality and appropriateness of care and services and
 98-66 to pursue opportunities for improvement. The quality improvement
 98-67 program must include return-to-work and medical case management
 98-68 programs.

98-69 (b) The network's governing body is ultimately responsible

99-1 for the quality improvement program. The governing body shall:

99-2 (1) appoint a quality improvement committee that
 99-3 includes network providers;

99-4 (2) approve the quality improvement program;

99-5 (3) approve an annual quality improvement plan;

99-6 (4) meet at least annually to receive and review
 99-7 reports of the quality improvement committee or group of
 99-8 committees, and take action as appropriate; and

99-9 (5) review the annual written report on the quality
 99-10 improvement program.

99-11 (c) The quality improvement committee or committees shall
 99-12 evaluate the overall effectiveness of the quality improvement
 99-13 program as determined by commissioner rules.

99-14 (d) The quality improvement program must be continuous and
 99-15 comprehensive and must address both the quality of clinical care
 99-16 and the quality of services. The network shall dedicate adequate
 99-17 resources, including adequate personnel and information systems,
 99-18 to the quality improvement program.

99-19 (e) The network shall develop a written description of the
 99-20 quality improvement program that outlines the organizational
 99-21 structure of the program, the functional responsibilities of the
 99-22 program, and the frequency of committee meetings.

99-23 (f) The network shall develop an annual quality improvement
 99-24 work plan designed to reflect the type of services and the
 99-25 populations served by the network in terms of age groups, disease or
 99-26 injury categories, and special risk status, such as type of
 99-27 industry.

99-28 (g) The network shall prepare an annual written report to
 99-29 the department on the quality improvement program. The report must
 99-30 include:

99-31 (1) completed activities;

99-32 (2) the trending of clinical and service goals;

99-33 (3) an analysis of program performance; and

99-34 (4) conclusions regarding the effectiveness of the
 99-35 program.

99-36 (h) Each network shall implement a documented process for
 99-37 the selection and retention of contracted providers, in accordance
 99-38 with rules adopted by the commissioner.

99-39 (i) The quality improvement program must provide for a peer
 99-40 review action procedure for providers, as described by Section
 99-41 151.002, Occupations Code.

99-42 (j) The network shall have a medical case management program
 99-43 with certified case managers. Case managers shall work with
 99-44 treating doctors, referral providers, and employers to facilitate
 99-45 cost-effective care and employee return-to-work.

99-46 Sec. 1305.304. GUIDELINES AND PROTOCOLS. Each network
 99-47 shall adopt treatment guidelines, return-to-work guidelines, and
 99-48 individual treatment protocols. The treatment guidelines and
 99-49 individual treatment protocols must be evidence-based,
 99-50 scientifically valid, and outcome-focused and be designed to reduce
 99-51 inappropriate or unnecessary health care while safeguarding
 99-52 necessary care.

99-53 [Sections 1305.305-1305.350 reserved for expansion]

99-54 SUBCHAPTER H. UTILIZATION REVIEW; RETROSPECTIVE REVIEW

99-55 Sec. 1305.351. UTILIZATION REVIEW AND RETROSPECTIVE REVIEW
 99-56 IN NETWORK. (a) The requirements of Article 21.58A apply to
 99-57 utilization review conducted in relation to claims in a workers'
 99-58 compensation health care network. In the event of a conflict
 99-59 between Article 21.58A and this chapter, this chapter controls.

99-60 (b) Any screening criteria used for utilization review or
 99-61 retrospective review related to a workers' compensation health care
 99-62 network must be consistent with the network's treatment guidelines.

99-63 Sec. 1305.352. GENERAL STANDARDS FOR RETROSPECTIVE REVIEW.

99-64 (a) Retrospective review of a health care service shall be based
 99-65 on written screening criteria established and periodically updated
 99-66 with appropriate involvement from doctors, including actively
 99-67 practicing doctors, and other health care providers.

99-68 (b) Retrospective review must be performed under the
 99-69 direction of a physician.

100-1 Sec. 1305.353. NOTICE OF CERTAIN UTILIZATION REVIEW
 100-2 DETERMINATIONS; PREAUTHORIZATION REQUIREMENTS. (a) The entity
 100-3 performing utilization review or retrospective review shall notify
 100-4 the employee or the employee's representative, if any, and the
 100-5 requesting provider of a determination made in a utilization review
 100-6 or retrospective review.

100-7 (b) Notification of an adverse determination must include:
 100-8 (1) the principal reasons for the adverse
 100-9 determination;

100-10 (2) the clinical basis for the adverse determination;

100-11 (3) a description of or the source of the screening
 100-12 criteria that were used as guidelines in making the determination;

100-13 (4) a description of the procedure for the
 100-14 reconsideration process; and

100-15 (5) notification of the availability of independent
 100-16 review in the form prescribed by the commissioner.

100-17 (c) On receipt of a preauthorization request from a provider
 100-18 for proposed services that require preauthorization, the
 100-19 utilization review agent shall issue and transmit a determination
 100-20 indicating whether the proposed health care services are
 100-21 preauthorized. The utilization review agent shall respond to
 100-22 requests for preauthorization within the periods prescribed by this
 100-23 section.

100-24 (d) For services not described under Subsection (e) or (f),
 100-25 the determination under Subsection (c) must be issued and
 100-26 transmitted not later than the third calendar day after the date the
 100-27 request is received.

100-28 (e) If the proposed services are for concurrent
 100-29 hospitalization care, the utilization review agent shall, within 24
 100-30 hours of receipt of the request, transmit a determination
 100-31 indicating whether the proposed services are preauthorized.

100-32 (f) If the proposed health care services involve
 100-33 poststabilization treatment or a life-threatening condition, the
 100-34 utilization review agent shall transmit to the requesting provider
 100-35 a determination indicating whether the proposed services are
 100-36 preauthorized within the time appropriate to the circumstances
 100-37 relating to the delivery of the services and the condition of the
 100-38 patient, not to exceed one hour from receipt of the request. If the
 100-39 utilization review agent issues an adverse determination in
 100-40 response to a request for poststabilization treatment or a request
 100-41 for treatment involving a life-threatening condition, the
 100-42 utilization review agent shall provide to the employee or the
 100-43 employee's representative, if any, and the employee's treating
 100-44 provider the notification required under Subsection (a).

100-45 (g) For life-threatening conditions, the notification of
 100-46 adverse determination must include notification of the
 100-47 availability of independent review in the form prescribed by the
 100-48 commissioner.

100-49 Sec. 1305.354. RECONSIDERATION OF ADVERSE DETERMINATION.

100-50 (a) A utilization review agent shall maintain and make available a
 100-51 written description of the reconsideration procedures involving an
 100-52 adverse determination. The reconsideration procedures must be
 100-53 reasonable and must include:

100-54 (1) a provision stating that reconsideration must be
 100-55 performed by a provider other than the provider who made the
 100-56 original adverse determination;

100-57 (2) a provision that an employee, a person acting on
 100-58 behalf of the employee, or the employee's requesting provider may,
 100-59 not later than the 30th day after the date of issuance of written
 100-60 notification of an adverse determination, request reconsideration
 100-61 of the adverse determination either orally or in writing;

100-62 (3) a provision that, not later than the fifth
 100-63 calendar day after the date of receipt of the request, the network
 100-64 shall send to the requesting party a letter acknowledging the date
 100-65 of the receipt of the request that includes a reasonable list of
 100-66 documents the requesting party is required to submit;

100-67 (4) a provision that, after completion of the review
 100-68 of the request for reconsideration of the adverse determination,
 100-69 the utilization review agent shall issue a response letter to the

101-1 employee or person acting on behalf of the employee, and the
 101-2 employee's requesting provider, that:

101-3 (A) explains the resolution of the
 101-4 reconsideration; and

101-5 (B) includes:
 101-6 (i) a statement of the specific medical or
 101-7 clinical reasons for the resolution;

101-8 (ii) the medical or clinical basis for the
 101-9 decision;

101-10 (iii) the professional specialty of any
 101-11 provider consulted; and

101-12 (iv) notice of the requesting party's right
 101-13 to seek review of the denial by an independent review organization
 101-14 and the procedures for obtaining that review; and

101-15 (5) written notification to the requesting party of
 101-16 the determination of the request for reconsideration as soon as
 101-17 practicable, but not later than the 30th day after the date the
 101-18 utilization review agent received the request.

101-19 (b) In addition to the written request for reconsideration,
 101-20 the reconsideration procedures must include a method for expedited
 101-21 reconsideration procedures for denials of proposed health care
 101-22 services involving poststabilization treatment or life-threatening
 101-23 conditions, and for denials of continued stays for hospitalized
 101-24 employees. The procedures must include a review by a provider who
 101-25 has not previously reviewed the case and who is of the same or a
 101-26 similar specialty as a provider who typically manages the
 101-27 condition, procedure, or treatment under review. The period during
 101-28 which that reconsideration must be completed shall be based on the
 101-29 medical or clinical immediacy of the condition, procedure, or
 101-30 treatment, but may not exceed one calendar day from the date of
 101-31 receipt of all information necessary to complete the
 101-32 reconsideration.

101-33 (c) Notwithstanding Subsection (a) or (b), an employee with
 101-34 a life-threatening condition is entitled to an immediate review by
 101-35 an independent review organization and is not required to comply
 101-36 with the procedures for a reconsideration of an adverse
 101-37 determination.

101-38 Sec. 1305.355. INDEPENDENT REVIEW OF ADVERSE
 101-39 DETERMINATION. (a) The utilization review agent shall:

101-40 (1) permit the employee or person acting on behalf of
 101-41 the employee and the employee's requesting provider whose
 101-42 reconsideration of an adverse determination is denied to seek
 101-43 review of that determination within the period prescribed by
 101-44 Subsection (b) by an independent review organization assigned in
 101-45 accordance with Article 21.58C and commissioner rules; and

101-46 (2) provide to the appropriate independent review
 101-47 organization, not later than the third business day after the date
 101-48 the utilization review agent receives notification of the
 101-49 assignment of the request to an independent review organization:

101-50 (A) any medical records of the employee that are
 101-51 relevant to the review;

101-52 (B) any documents used by the utilization review
 101-53 agent in making the determination;

101-54 (C) the response letter described by Section
 101-55 1305.354(a)(4);

101-56 (D) any documentation and written information
 101-57 submitted in support of the request for reconsideration; and

101-58 (E) a list of the providers who provided care to
 101-59 the employee and who may have medical records relevant to the
 101-60 review.

101-61 (b) A request for independent review under Subsection (a)
 101-62 must be timely filed by the requestor as follows:

101-63 (1) for a request for preauthorization or concurrent
 101-64 review by an independent review organization, not later than the
 101-65 45th day after the date of denial of a reconsideration for health
 101-66 care requiring preauthorization or concurrent review; or

101-67 (2) for a request for retrospective medical necessity
 101-68 review, not later than the 45th day after the denial of
 101-69 reconsideration.

102-1 (c) The insurance carrier shall pay for the independent
 102-2 review provided under this subchapter.

102-3 (d) The department shall assign the review request to an
 102-4 independent review organization.

102-5 (e) A party to a medical dispute that remains unresolved
 102-6 after a review under this section may seek judicial review of the
 102-7 decision. The department is not considered a party to the medical
 102-8 dispute.

102-9 (f) A determination of an independent review organization
 102-10 related to a request for preauthorization or concurrent review is
 102-11 binding during the pendency of any appeal, and the carrier and
 102-12 network shall comply with the determination.

102-13 (g) If judicial review is not sought under this section, the
 102-14 carrier and network shall comply with the independent review
 102-15 organization's determination.

102-16 [Sections 1305.356-1305.400 reserved for expansion]

102-17 SUBCHAPTER I. COMPLAINT RESOLUTION

102-18 Sec. 1305.401. COMPLAINT SYSTEM REQUIRED. (a) Each
 102-19 network shall implement and maintain a complaint system that
 102-20 provides reasonable procedures to resolve an oral or written
 102-21 complaint.

102-22 (b) The network may require a complainant to file the
 102-23 complaint not later than the 90th day after the date of the event or
 102-24 occurrence that is the basis for the complaint.

102-25 (c) The complaint system must include a process for the
 102-26 notice and appeal of a complaint.

102-27 (d) The commissioner may adopt rules as necessary to
 102-28 implement this section.

102-29 Sec. 1305.402. COMPLAINT INITIATION AND INITIAL RESPONSE;
 102-30 DEADLINES FOR RESPONSE AND RESOLUTION. (a) If a complainant
 102-31 notifies a network of a complaint, the network, not later than the
 102-32 seventh calendar day after the date the network receives the
 102-33 complaint, shall respond to the complainant, acknowledging the date
 102-34 of receipt of the complaint and providing a description of the
 102-35 network's complaint procedures and deadlines.

102-36 (b) The network shall investigate and resolve a complaint
 102-37 not later than the 30th calendar day after the date the network
 102-38 receives the complaint.

102-39 Sec. 1305.403. RECORD OF COMPLAINTS. (a) Each network
 102-40 shall maintain a complaint and appeal log regarding each complaint.
 102-41 The commissioner shall adopt rules designating the classification
 102-42 of network complaints under this section.

102-43 (b) Each network shall maintain a record of and
 102-44 documentation on each complaint, complaint proceeding, and action
 102-45 taken on the complaint until the third anniversary of the date the
 102-46 complaint was received.

102-47 (c) A complainant is entitled to a copy of the network's
 102-48 record regarding the complaint and any proceeding relating to that
 102-49 complaint.

102-50 (d) The department, during any investigation or examination
 102-51 of a network, may review documentation maintained under this
 102-52 subchapter, including original documentation, regarding a
 102-53 complaint and action taken on the complaint.

102-54 Sec. 1305.404. RETALIATORY ACTION PROHIBITED. A network
 102-55 may not engage in any retaliatory action against an employer or
 102-56 employee because the employer or employee or a person acting on
 102-57 behalf of the employer or employee has filed a complaint against the
 102-58 network.

102-59 Sec. 1305.405. POSTING OF INFORMATION ON COMPLAINT PROCESS
 102-60 REQUIRED. (a) A contract between a network and a provider must
 102-61 require the provider to post, in the provider's office, a notice to
 102-62 injured employees on the process for resolving complaints with the
 102-63 network.

102-64 (b) The notice required under Subsection (a) must include
 102-65 the department's toll-free telephone number for filing a complaint.

102-66 [Sections 1305.406-1305.450 reserved for expansion]

102-67 SUBCHAPTER J. EMPLOYEE INFORMATION AND RESPONSIBILITIES

102-68 Sec. 1305.451. EMPLOYEE INFORMATION; RESPONSIBILITIES OF
 102-69 EMPLOYEE. (a) An insurance carrier that establishes or contracts

103-1 with a network shall provide to employers, and ensure that the
 103-2 employer provides to its employees, an accurate written description
 103-3 of the terms and conditions for obtaining health care within the
 103-4 network's service area.

103-5 (b) The written description required under Subsection (a)
 103-6 must be in English, Spanish, and any additional language common to
 103-7 an employer's employees, must be in plain language and in a readable
 103-8 and understandable format, and must include, in a clear, complete,
 103-9 and accurate format:

103-10 (1) a statement that the entity providing health care
 103-11 to employees is a workers' compensation health care network;

103-12 (2) the network's toll-free number and address for
 103-13 obtaining additional information about the network, including
 103-14 information about network providers;

103-15 (3) a statement that in the event of an injury, the
 103-16 employee must select a treating doctor:

103-17 (A) from a list of all the network's treating
 103-18 doctors who have contracts with the network in that service area; or

103-19 (B) as described by Section 1305.105;

103-20 (4) a statement that, except for emergency services,
 103-21 the employee shall obtain all health care and specialist referrals
 103-22 through the employee's treating doctor;

103-23 (5) an explanation that network providers have agreed
 103-24 to look only to the network or insurance carrier and not to
 103-25 employees for payment of providing health care, except as provided
 103-26 by Subdivision (6);

103-27 (6) a statement that if the employee obtains health care
 103-28 from non-network providers without network approval or as provided by
 103-29 Section 1305.006(a), the insurance carrier may not be liable, and the
 103-30 employee may be liable, for payment for that health care;

103-31 (7) information about how to obtain emergency care
 103-32 services, including emergency care outside the service area, and
 103-33 after-hours care;

103-34 (8) a list of the health care services for which the
 103-35 network requires preauthorization;

103-36 (9) an explanation regarding continuity of treatment
 103-37 in the event of the termination from the network of a treating
 103-38 doctor;

103-39 (10) a description of the network's complaint system,
 103-40 including a statement that the network is prohibited from
 103-41 retaliating against:

103-42 (A) an employee if the employee files a complaint
 103-43 against the network or appeals a decision of the network; or

103-44 (B) a provider if the provider, on behalf of an
 103-45 employee, reasonably files a complaint against the network or
 103-46 appeals a decision of the network;

103-47 (11) a summary of the network's procedures relating to
 103-48 adverse determinations and the availability of the independent
 103-49 review process;

103-50 (12) a list of network providers updated at least
 103-51 quarterly, including:

103-52 (A) the names and addresses of the providers;

103-53 (B) a statement of limitations of accessibility
 103-54 and referrals to specialists; and

103-55 (C) a disclosure of which providers are accepting
 103-56 new patients; and

103-57 (13) a description of the network's service area.

103-58 (c) The network and the network's representatives and
 103-59 agents may not cause or knowingly permit the use or distribution to
 103-60 employees of information that is untrue or misleading.

103-61 (d) A network that contracts with an insurance carrier shall
 103-62 provide all the information necessary to allow the carrier to
 103-63 comply with this section.

103-64 [Sections 1305.452-1305.500 reserved for expansion]

103-65 SUBCHAPTER K. EVALUATION OF NETWORKS; CONSUMER REPORT CARD

103-66 Sec. 1305.501. EVALUATION OF NETWORKS. (a) In accordance
 103-67 with the research duties assigned to the department under Chapter
 103-68 405, Labor Code, the department shall:

103-69 (1) objectively evaluate the cost and the quality of

104-1 medical care provided by networks certified under this chapter; and
 104-2 (2) report the department's findings to the governor,
 104-3 the lieutenant governor, the speaker of the house of
 104-4 representatives, and the members of the legislature not later than
 104-5 September 1 of each even-numbered year.

104-6 (b) At the minimum, the report required under Subsection (a)
 104-7 must evaluate:

104-8 (1) the average medical and indemnity cost per claim
 104-9 for health care services provided through networks;

104-10 (2) the access to care and utilization by injured
 104-11 employees of health care provided through networks;

104-12 (3) injured employee return-to-work outcomes;

104-13 (4) injured employee satisfaction and health-related
 104-14 functional outcomes; and

104-15 (5) the frequency, duration, and outcome of disputes
 104-16 regarding medical benefits.

104-17 (c) The department shall include in the report a comparison
 104-18 of the administrative burdens incurred by health care providers who
 104-19 provide workers' compensation medical benefits through networks
 104-20 with those incurred by providers who provide analogous medical
 104-21 benefits outside the network structure.

104-22 Sec. 1305.502. CONSUMER REPORT CARDS. (a) The department
 104-23 shall annually issue consumer report cards that identify and
 104-24 compare, on an objective basis, the networks certified by the
 104-25 department under this chapter.

104-26 (b) The department shall ensure that consumer report cards
 104-27 issued by the department under this section are accessible to the
 104-28 public on the department's Internet website and available to any
 104-29 person on request. The commissioner, by rule, may set a reasonable
 104-30 fee to obtain a paper copy of consumer report cards.

104-31 Sec. 1305.503. CONFIDENTIALITY REQUIREMENTS. (a) As
 104-32 necessary to implement this subchapter, the department is entitled
 104-33 to information that is otherwise confidential under any law of this
 104-34 state, including the Texas Workers' Compensation Act.

104-35 (b) Confidential information provided to or obtained by the
 104-36 department under this section remains confidential and is not
 104-37 subject to disclosure under Chapter 552, Government Code. The
 104-38 department may not release, and a person may not gain access to, any
 104-39 information that:

104-40 (1) could reasonably be expected to reveal the
 104-41 identity of an injured employee; or

104-42 (2) discloses provider discounts or differentials
 104-43 between payments and billed charges for individual providers or
 104-44 networks.

104-45 (c) Information that is in the possession of the department
 104-46 and that relates to an individual injured employee, and any
 104-47 compilation, report, or analysis produced from the information that
 104-48 identifies an individual injured employee, are not:

104-49 (1) subject to discovery, subpoena, or other means of
 104-50 legal compulsion for release to any person; or

104-51 (2) admissible in any civil, administrative, or
 104-52 criminal proceeding.

104-53 [Sections 1305.504-1305.550 reserved for expansion]

104-54 SUBCHAPTER L. DISCIPLINARY ACTIONS

104-55 Sec. 1305.551. DETERMINATION OF VIOLATION; NOTICE. (a) If
 104-56 the commissioner determines that a network, insurance carrier, or
 104-57 any other person or third party operating under this chapter,
 104-58 including a third party to which a network delegates a function, or
 104-59 any third party with which a network contracts for management
 104-60 services, is in violation of this chapter, rules adopted by the
 104-61 commissioner under this chapter, or applicable provisions of the
 104-62 Labor Code or rules adopted under that code, the commissioner or a
 104-63 designated representative may notify the network, insurance
 104-64 carrier, person, or third party of the alleged violation and may
 104-65 compel the production of any documents or other information as
 104-66 necessary to determine whether the violation occurred.

104-67 (b) The commissioner's designated representative may
 104-68 initiate the proceedings under this section.

104-69 (c) A proceeding under this section is a contested case

105-1 under Chapter 2001, Government Code.

105-2 Sec. 1305.552. DISCIPLINARY ACTIONS. If under Section
 105-3 1305.551 the commissioner determines that a network, insurance
 105-4 carrier, or other person or third party described under Section
 105-5 1305.551 has violated or is violating this chapter, rules adopted
 105-6 by the commissioner under this chapter, or the Labor Code or rules
 105-7 adopted under that code, the commissioner may:

105-8 (1) suspend or revoke a certificate issued under this
 105-9 code;

105-10 (2) impose sanctions under Chapter 82;

105-11 (3) issue a cease and desist order under Chapter 83;

105-12 (4) impose administrative penalties under Chapter 84;

105-13 or

105-14 (5) take any combination of these actions.

105-15 ARTICLE 5. RATES AND UNDERWRITING REQUIREMENTS

105-16 SECTION 5.01. Section 1, Article 5.55, Insurance Code, is
 105-17 amended by amending Subdivision (2) and adding Subdivision (2-a) to
 105-18 read as follows:

105-19 (2) "Insurer" means a person authorized and admitted
 105-20 by the department [~~Texas Department of Insurance~~] to engage in the
 105-21 [~~do insurance~~] business of insurance in this state under a
 105-22 certificate of authority that includes authorization to write
 105-23 workers' compensation insurance. The term includes:

105-24 (A) the Texas Mutual Insurance Company;

105-25 (B) a Lloyd's plan under Chapter 941 of this

105-26 code;

105-27 (C) a reciprocal and interinsurance exchange
 105-28 under Chapter 942 of this code; and

105-29 (D) a workers' compensation self-insurance group
 105-30 required to file rates under Chapter 407A, Labor Code.

105-31 (2-a) "Premium" means the amount charged for a
 105-32 workers' compensation insurance policy, including any
 105-33 endorsements, after the application of individual risk variations
 105-34 based on loss or expense considerations.

105-35 SECTION 5.02. Subsections (b) and (d), Section 2, Article
 105-36 5.55, Insurance Code, are amended to read as follows:

105-37 (b) In setting rates, an insurer shall consider:

105-38 (1) past and prospective loss cost experience;

105-39 (2) operation expenses;

105-40 (3) investment income;

105-41 (4) a reasonable margin for profit and contingencies;

105-42 [and]

105-43 (5) the effect on premiums of individual risk
 105-44 variations based on loss or expense considerations; and

105-45 (6) any other relevant factors.

105-46 (d) Rates and premiums established under this article may
 105-47 not be excessive, inadequate, or unfairly discriminatory.

105-48 SECTION 5.03. Section 3, Article 5.55, Insurance Code, is
 105-49 amended by adding Subsections (e) through (h) to read as follows:

105-50 (e) Not later than December 1 of each even-numbered year,
 105-51 the commissioner shall report to the governor, lieutenant governor,
 105-52 and speaker of the house of representatives regarding the impact
 105-53 that legislation enacted during the regular session of the 79th
 105-54 Legislature reforming the workers' compensation system of this
 105-55 state has had on the affordability and availability of workers'
 105-56 compensation insurance for the employers of this state. The report
 105-57 must include an analysis of:

105-58 (1) the projected workers' compensation premium
 105-59 savings realized by employers as a result of the reforms;

105-60 (2) the impact of the reforms on:

105-61 (A) the percentage of employers who provide
 105-62 workers' compensation insurance coverage for their employees; and

105-63 (B) to the extent possible, economic development
 105-64 and job creation;

105-65 (3) the effects of the reforms on market competition
 105-66 and carrier financial solvency, including an analysis of how
 105-67 carrier loss ratios, combined ratios, and use of individual risk
 105-68 variations have changed since implementation of the reforms; and

105-69 (4) the extent of participation in workers'

106-1 compensation health care networks by small and medium-sized
 106-2 employers.

106-3 (f) If the commissioner determines that workers'
 106-4 compensation rate filings or premium levels analyzed by the
 106-5 department do not appropriately reflect the savings associated with
 106-6 the reforms described by Subsection (e) of this section, the
 106-7 commissioner shall include in the report required under Subsection
 106-8 (e) of this section any recommendations, including any recommended
 106-9 legislative changes, necessary to identify the tools needed by the
 106-10 department to more effectively regulate workers' compensation
 106-11 rates.

106-12 (g) At the request of the department, each insurer shall
 106-13 submit to the department all data and other information considered
 106-14 necessary by the commissioner to generate the report required under
 106-15 Subsection (e) of this section. Failure by an insurer to submit the
 106-16 data and information in a timely fashion, as determined by
 106-17 commissioner rule, constitutes grounds for sanctions under Chapter
 106-18 82 of this code.

106-19 (h) In reviewing rates under this article, the commissioner
 106-20 shall consider any state or federal legislation that has been
 106-21 enacted and that may impact rates and premiums for workers'
 106-22 compensation insurance coverage in this state.

106-23 SECTION 5.04. Subsection (b), Section 6, Article 5.55,
 106-24 Insurance Code, is amended to read as follows:

106-25 (b) The disapproval order must be issued not later than the
 106-26 15th day after the close of a hearing and must specify how the rate
 106-27 fails to meet the requirements of this article. The disapproval
 106-28 order must state the date on which the further use of that rate is
 106-29 prohibited. [A disapproval order does not affect a policy made or
 106-30 issued in accordance with this code before the expiration of the
 106-31 period established in the order.]

106-32 SECTION 5.05. Section 7, Article 5.55, Insurance Code, is
 106-33 amended to read as follows:

106-34 Sec. 7. EFFECT OF DISAPPROVAL; PENALTY. (a) If a policy is
 106-35 issued and the commissioner [board] subsequently disapproves the
 106-36 rate or filing that governs the premium charged on the policy:

106-37 (1) the policyholder may continue the policy at the
 106-38 original rate;

106-39 (2) the policyholder may cancel the policy without
 106-40 penalty; or

106-41 (3) the policyholder and the insurer may agree to
 106-42 amend the policy to reflect the premium that would have been charged
 106-43 based on the insurer's most recently approved rate; the amendment
 106-44 may not take effect before the date on which further use of the rate
 106-45 is prohibited under the disapproval order.

106-46 (b) If a policy is issued and the commissioner subsequently
 106-47 disapproves the rate or filing on which the premium is based, the
 106-48 commissioner, after notice and the opportunity for a hearing, may:

106-49 (1) impose sanctions under Chapter 82 of this code;

106-50 (2) issue a cease and desist order under Chapter 83 of
 106-51 this code;

106-52 (3) impose administrative penalties under Chapter 84
 106-53 of this code; or

106-54 (4) take any combination of these actions [If the
 106-55 board determines, based on a pattern of charges for premiums, that
 106-56 an insurer is consistently overcharging or undercharging, the board
 106-57 may assess an administrative penalty. The penalty shall be
 106-58 assessed in accordance with Article 10, Texas Workers' Compensation
 106-59 Act (Article 8308-10.01 et seq., Vernon's Texas Civil Statutes),
 106-60 and set by the board in an amount reasonable and necessary to deter
 106-61 the overcharging or undercharging of policyholders].

106-62 SECTION 5.06. Subchapter D, Chapter 5, Insurance Code, is
 106-63 amended by adding Article 5.55A to read as follows:

106-64 Art. 5.55A. UNDERWRITING GUIDELINES

106-65 Sec. 1. DEFINITIONS. In this article:

106-66 (1) "Insurer" has the meaning assigned by Section
 106-67 1(2), Article 5.55, of this code.

106-68 (2) "Underwriting guideline" means a rule, standard,
 106-69 guideline, or practice, whether written, oral, or electronic, that

107-1 is used by an insurer or its agent to decide whether to accept or
 107-2 reject an application for coverage under a workers' compensation
 107-3 insurance policy or to determine how to classify those risks that
 107-4 are accepted for the purpose of determining a rate.

107-5 Sec. 2. UNDERWRITING GUIDELINES. Each underwriting
 107-6 guideline used by an insurer in writing workers' compensation
 107-7 insurance must be sound, actuarially justified, or otherwise
 107-8 substantially commensurate with the contemplated risk. An
 107-9 underwriting guideline may not be unfairly discriminatory.

107-10 Sec. 3. ENFORCEMENT. This article may be enforced in the
 107-11 manner provided by Section 38.003(g) of this code.

107-12 Sec. 4. FILING REQUIREMENTS. Each insurer shall file with
 107-13 the department a copy of the insurer's underwriting guidelines.
 107-14 The insurer shall update its filing each time the underwriting
 107-15 guidelines are changed. If a group of insurers files one set of
 107-16 underwriting guidelines for the group, the group shall identify
 107-17 which underwriting guidelines apply to each insurer in the group.

107-18 Sec. 5. APPLICABILITY OF SECTION 38.003. Section 38.003 of
 107-19 this code applies to this article to the extent consistent with this
 107-20 article.

107-21 SECTION 5.07. Subsection (b), Article 5.58, Insurance Code,
 107-22 is amended to read as follows:

107-23 (b) Standards and Procedures. For purposes of Subsection
 107-24 (c) of this article, the commissioner shall establish standards and
 107-25 procedures for categorizing insurance and medical benefits
 107-26 reported on each workers' compensation claim. The commissioner
 107-27 shall consult with the Texas Department of Workers' Compensation
 107-28 [~~Commission and the Research and Oversight Council on Workers'~~
 107-29 ~~Compensation~~] in establishing these standards to ensure that the
 107-30 data collection methodology will also yield data necessary for
 107-31 research and medical cost containment efforts.

107-32 ARTICLE 6. REPEALER

107-33 SECTION 6.001. The following provisions of the Labor Code
 107-34 are repealed:

- 107-35 (1) Section 402.025;
- 107-36 (2) Subsection (b), Section 402.062;
- 107-37 (3) Sections 402.063 and 402.070;
- 107-38 (4) Subsection (c), Section 402.091;
- 107-39 (5) Section 406.012;
- 107-40 (6) Subsection (g), Section 408.004;
- 107-41 (7) Sections 408.0221, 408.0222, and 408.0223;
- 107-42 (8) Subsection (d), Section 411.034;
- 107-43 (9) Section 413.005;
- 107-44 (10) Subsection (b), Section 413.043;
- 107-45 (11) Subsections (c) and (d), Section 415.0035;
- 107-46 (12) Section 415.004;
- 107-47 (13) Subsection (b), Section 415.008;
- 107-48 (14) Subsection (b), Section 415.009;
- 107-49 (15) Subsection (b), Section 415.010;
- 107-50 (16) Section 415.022; and
- 107-51 (17) Subdivision (1), Section 505.001.

107-52 ARTICLE 7. TRANSITION; EFFECTIVE DATE

107-53 SECTION 7.001. EFFECT OF CHANGE IN DESIGNATION. The change
 107-54 in designation of the Texas Workers' Compensation Commission to the
 107-55 Texas Department of Workers' Compensation does not affect or impair
 107-56 any act done or taken, any rule, standard, or rate adopted, any
 107-57 order or certificate issued, or any form approved by the Texas
 107-58 Workers' Compensation Commission as a state agency, or any penalty
 107-59 assessed by the Texas Workers' Compensation Commission as a state
 107-60 agency before the change in designation made by this Act.

107-61 SECTION 7.002. ABOLITION OF TEXAS WORKERS' COMPENSATION
 107-62 COMMISSION. (a) The Texas Workers' Compensation Commission is
 107-63 abolished on the effective date of this Act. The term of a person
 107-64 who is serving on the Texas Workers' Compensation Commission on the
 107-65 effective date of this Act expires on the date the commissioner of
 107-66 workers' compensation is appointed.

107-67 (b) All appropriations made by the legislature for the use
 107-68 and benefit of the Texas Workers' Compensation Commission are
 107-69 available for the use and benefit of the Texas Department of

108-1 Workers' Compensation.

108-2 (c) The divisions of the Texas Workers' Compensation
108-3 Commission established under Section 402.021, Labor Code, as that
108-4 section existed prior to amendment by this Act, are abolished on the
108-5 effective date of this Act.

108-6 SECTION 7.003. COMMISSIONER. The governor shall appoint
108-7 the commissioner of workers' compensation not later than September
108-8 30, 2005.

108-9 SECTION 7.004. RULES REGARDING MEDICAL EXAMINATIONS. The
108-10 commissioner of workers' compensation shall adopt rules to
108-11 implement the changes in law made to Sections 408.004 and 408.0041,
108-12 Labor Code, as amended by this Act, on or before February 1, 2006.
108-13 The changes in law made to Sections 408.004 and 408.0041, Labor
108-14 Code, are effective on the date provided by commissioner rule.

108-15 SECTION 7.005. ELECTRONIC BILLING RULES. The commissioner
108-16 of workers' compensation shall adopt rules under Section 408.0251,
108-17 Labor Code, as added by this Act, not later than January 1, 2006.

108-18 SECTION 7.006. ACCRUAL OF RIGHT TO INCOME BENEFITS.
108-19 Subsection (c), Section 408.082, Labor Code, as amended by this
108-20 Act, applies only to a claim for workers' compensation benefits
108-21 based on a compensable injury that occurs on or after the effective
108-22 date of this Act. A claim based on a compensable injury that occurs
108-23 before that date is governed by the law in effect on the date that
108-24 the compensable injury occurred, and the former law is continued in
108-25 effect for that purpose.

108-26 SECTION 7.007. ELIGIBILITY FOR PILOT PROGRAM. The pilot
108-27 program established under Section 413.022, Labor Code, as added by
108-28 this Act, takes effect January 1, 2006.

108-29 SECTION 7.008. REPORTS. (a) Not later than October 1,
108-30 2006, the commissioner of workers' compensation shall report to the
108-31 governor, the lieutenant governor, the speaker of the house of
108-32 representatives, and the members of the 79th Legislature regarding
108-33 the implementation of Section 408.1225, Labor Code, as added by
108-34 this Act.

108-35 (b) Not later than October 1, 2008, the commissioner of
108-36 workers' compensation shall report to the governor, the lieutenant
108-37 governor, the speaker of the house of representatives, and the
108-38 members of the legislature regarding the implementation of the
108-39 pilot program established by Section 413.022, Labor Code, as added
108-40 by this Act, and the results of the pilot program. The report must
108-41 include any recommendations regarding the continuation of the pilot
108-42 program, including any changes required to enhance the
108-43 effectiveness of the program.

108-44 (c) The commissioner of insurance shall submit the initial
108-45 report required under Subsection (e), Section 3, Article 5.55,
108-46 Insurance Code, as added by this Act, not later than December 1,
108-47 2006.

108-48 (d) The commissioner of insurance shall submit to the
108-49 governor, the lieutenant governor, the speaker of the house of
108-50 representatives, and the members of the legislature the first
108-51 report under Subsection (a), Section 1305.501, Insurance Code, as
108-52 added by this Act, not later than December 1, 2008.

108-53 SECTION 7.009. ABOLITION OF MEDICAL ADVISORY COMMITTEE.
108-54 The medical advisory committee established under Section 413.005,
108-55 Labor Code, as that section existed prior to repeal by this Act, is
108-56 abolished on the effective date of this Act.

108-57 SECTION 7.010. STATE OFFICE OF ADMINISTRATIVE HEARINGS
108-58 REVIEW. (a) This section applies to a hearing conducted by the
108-59 State Office of Administrative Hearings under Subsection (k),
108-60 Section 413.031, Labor Code, as that subsection existed prior to
108-61 amendment by this Act.

108-62 (b) The State Office of Administrative Hearings shall
108-63 conclude on or before December 31, 2005, any hearings pending
108-64 before that office regarding medical disputes that remain
108-65 unresolved after a review by an independent review organization.

108-66 (c) Effective September 1, 2005, the State Office of
108-67 Administrative Hearings may not accept for hearing a medical
108-68 dispute that remains unresolved after a review by an independent
108-69 review organization. A medical dispute that is not pending for a

109-1 hearing by the State Office of Administrative Hearings on or before
 109-2 August 31, 2005, is subject to Subsection (k), Section 413.031,
 109-3 Labor Code, as amended by this Act, and is not subject to a hearing
 109-4 before the State Office of Administrative Hearings.

109-5 SECTION 7.011. IMPLEMENTATION OF PROVIDER NETWORKS.

109-6 (a) The commissioner of insurance and the commissioner of workers'
 109-7 compensation shall adopt rules as necessary to implement Chapter
 109-8 1305, Insurance Code, as added by this Act, not later than December
 109-9 1, 2005. The Texas Department of Insurance shall accept
 109-10 applications from a network seeking certification under Chapter
 109-11 1305, Insurance Code, as added by this Act, beginning December 15,
 109-12 2005.

109-13 (b) An insurance carrier may begin to offer workers'
 109-14 compensation medical benefits through a network under Chapter 1305,
 109-15 Insurance Code, as added by this Act, on certification of the
 109-16 network by the commissioner of insurance.

109-17 SECTION 7.012. CONSUMER REPORT CARD. The Texas Department
 109-18 of Insurance shall issue the first annual workers' compensation
 109-19 consumer report card under Section 1305.502, Insurance Code, as
 109-20 added by this Act, not later than 18 months after the date on which
 109-21 that department certifies the first workers' compensation health
 109-22 care network under Chapter 1305, Insurance Code, as added by this
 109-23 Act.

109-24 SECTION 7.013. APPLICATION TO MEDICAL BENEFITS.

109-25 (a) Article 4 of this Act applies to a claim for workers'
 109-26 compensation medical benefits based on a compensable injury
 109-27 incurred by an employee whose employer elects to provide workers'
 109-28 compensation insurance coverage if the insurance carrier of the
 109-29 employer enters into a contract to provide workers' compensation
 109-30 medical benefits through a network certified under Chapter 1305,
 109-31 Insurance Code, as added by this Act.

109-32 (b) A claim for workers' compensation medical benefits
 109-33 based on a compensable injury that occurs on or after the effective
 109-34 date of a contract described by Subsection (a) of this section is
 109-35 subject to the provisions of Chapter 1305, Insurance Code, as added
 109-36 by this Act.

109-37 (c) Notwithstanding Subsection (a) of this section, an
 109-38 injured employee who receives workers' compensation medical
 109-39 benefits based on a compensable injury that occurs before the
 109-40 effective date of this Act is subject to the provisions of Chapter
 109-41 1305, Insurance Code, as added by this Act, and must receive
 109-42 treatment through a network health care provider if the insurer
 109-43 liable for the payment of benefits on that claim elects to use a
 109-44 workers' compensation health care network to provide medical
 109-45 benefits and the claimant lives in a network service area. The
 109-46 insurer shall notify affected injured employees in writing of the
 109-47 election.

109-48 SECTION 7.014. APPLICATION TO SANCTIONS AND VIOLATIONS.

109-49 (a) The changes in law made by this Act apply only to a penalty or
 109-50 sanction for an offense or violation committed on or after the
 109-51 effective date of this Act.

109-52 (b) For purposes of this section, an offense or violation is
 109-53 committed before the effective date of this Act if any element of
 109-54 the offense occurs before that date.

109-55 (c) An offense committed before the effective date of this
 109-56 Act is governed by the law in effect when the offense was committed,
 109-57 and the former law is continued in effect for that purpose.

109-58 SECTION 7.015. EFFECT OF UPDATE ACT. To the extent of any
 109-59 conflict, this Act prevails over another Act of the 79th
 109-60 Legislature, Regular Session, 2005, relating to nonsubstantive
 109-61 additions to and corrections in enacted codes (the General Code
 109-62 Update bill).

109-63 SECTION 7.016. EFFECTIVE DATE. This Act takes effect
 109-64 September 1, 2005.

109-65 * * * * *