By: Staples, Nelson S.B. No. 5

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COMMITTEE SUBSTITUTE FOR S.B. No. 5 By: Williams

A BILL TO BE ENTITLED
AN ACT

relating to the continuation and operation of the workers' compensation system of this state, including changing the name of the Texas Workers' Compensation Commission to the Texas Department of Workers' Compensation, the powers and duties of the governing authority of that department, the provision of workers' compensation benefits to injured employees, and the regulation of workers' compensation insurers; providing administrative penalties.

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

ARTICLE 1. ORGANIZATION OF DEPARTMENT

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

SUBCHAPTER A. ORGANIZATION

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

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

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

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

(1) this title;

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

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

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

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

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

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

Sec. 402.005. QUALIFICATIONS. The commissioner must:

(1) be a competent and experienced administrator;

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

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

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

governor has accepted the resignation.

Sec. 402.007. COMPENSATION. The commissioner is entitled to compensation as provided by the General Appropriations Act.

[~~MEMBERSHIP REQUIREMENTS. (a) The Texas Workers' Compensation Commission is composed of six members appointed by the governor with the advice and consent of the senate.~~

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

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

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

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

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

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

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

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

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

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

[~~(b) A training program established under this section must provide information to the member regarding:~~

[~~(1) the enabling legislation that created the commission;~~

[~~(2) the programs operated by the commission;~~

[~~(3) the role and functions of the commission;~~

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

[~~(5) the current budget for the commission;~~

[~~(6) the results of the most recent formal audit of the commission;~~

[~~(7) the requirements of:~~

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

[~~(B) the open records law, Chapter 552, Government Code; and~~

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

[~~(8) the requirements of the conflict of interest laws and other laws relating to public officials; and~~

[~~(9) any applicable ethics policies adopted by the commission or the Texas Ethics Commission.~~

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

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

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

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

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

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

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

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

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

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

(4) cannot because of illness or incapacity discharge the commissioner's [~~member's~~] duties for a substantial part of the commissioner's term [~~for which the member is appointed; or~~

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

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

[~~(c) If the executive director of the commission knows that a potential ground for removal exists, the executive director shall notify the chairman of the commission of the potential ground. The chairman shall then notify the governor and the attorney general that a potential ground for removal exists. If the potential ground for removal involves the chairman, the executive director shall notify the next highest officer of the commission, who shall notify the governor and the attorney general that a potential ground for removal exists.~~]

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

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

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

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

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

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

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

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

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

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

[~~(1) attendance at commission meetings and hearings;~~

[~~(2) preparation for a commission meeting, not to exceed two days in each calendar quarter;~~

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

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

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

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

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

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

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

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

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

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

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

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

(1) the legislation that created the department;

(2) the programs operated by the department;

(3) the role and functions of the department;

(4) the rules of the department, with an emphasis on the rules that relate to disciplinary and investigatory authority;

(5) the current budget for the department;

(6) the results of the most recent formal audit of the department;

(7) the requirements of:

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

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

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

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

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

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

(b) The commissioner may:

(1) investigate misconduct;

(2) hold hearings;

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

(4) administer oaths;

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

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

(7) enter appropriate orders as authorized by this title;

(8) institute an action in the department's name to enjoin the violation of this subtitle;

(9) initiate an action under Section 410.254 to intervene in a judicial proceeding;

(10) prescribe the form, manner, and procedure for the transmission of information to the department; and

(11) exercise other powers and perform other duties as necessary to implement and enforce this title.

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

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

SUBCHAPTER C. DEPARTMENT [~~EXECUTIVE DIRECTOR AND~~] PERSONNEL

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

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

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

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

[~~(b) The executive director shall hire personnel as necessary to administer this subtitle.~~

[~~(c) The executive director serves at the pleasure of the commission.~~

[~~(d) The commission shall develop and implement policies that clearly separate the policymaking responsibilities of the~~

~~commission and the management responsibilities of the executive director and the staff of the commission.~~

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

[~~(b) The executive director may:~~

[~~(1) investigate misconduct;~~

[~~(2) hold hearings;~~

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

[~~(4) administer oaths;~~

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

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

[~~(7) enter appropriate orders as authorized by this subtitle;~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) reasonable methods to appropriately address those areas of underuse.

(b) A policy statement prepared under this section must:

(1) cover an annual period;

(2) be updated annually;

(3) be reviewed by the civil rights division of the Texas Workforce Commission [~~on Human Rights~~] for compliance with Subsection (a)(1); and

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

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

ARTICLE 2. CONFORMING AMENDMENTS WITHIN CHAPTER 402, LABOR CODE

SECTION 2.001. The heading to Chapter 402, Labor Code, is amended to read as follows:

CHAPTER 402. TEXAS DEPARTMENT OF WORKERS' COMPENSATION [~~COMMISSION~~]

SECTION 2.002. Section 402.021, Labor Code, is amended to read as follows:

Sec. 402.021. DEPARTMENT [~~COMMISSION~~] DIVISIONS. (a) The commissioner [~~commission shall have:~~

[~~(1) a division of workers' health and safety;~~

[~~(2) a division of medical review;~~

[~~(3) a division of compliance and practices; and~~

[~~(4) a division of hearings.~~

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

(b) [~~(c)~~] The commissioner [~~executive director~~] shall appoint the directors of the divisions of the department [~~commission~~]. The directors serve at the pleasure of the commissioner [~~executive director~~].

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

SECTION 2.003. Section 402.022, Labor Code, is amended to read as follows:

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

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

SECTION 2.004. Section 402.023, Labor Code, is amended to read as follows:

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

(1) the date the complaint is received;

(2) the name of the complainant;

(3) the subject matter of the complaint;

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

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

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

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

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

SECTION 2.005. Section 402.024, Labor Code, is amended to read as follows:

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

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

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

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

SUBCHAPTER D. GENERAL POWERS AND DUTIES OF DEPARTMENT [~~COMMISSION~~]

SECTION 2.007. Section 402.061, Labor Code, is amended to read as follows:

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

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

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

SECTION 2.009. Section 402.064, Labor Code, is amended to read as follows:

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

SECTION 2.010. Section 402.065, Labor Code, is amended to read as follows:

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

SECTION 2.011. Section 402.066, Labor Code, is amended to read as follows:

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

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

SECTION 2.012. Section 402.0665, Labor Code, is amended to read as follows:

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

SECTION 2.013. Section 402.067, Labor Code, is amended to read as follows:

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

SECTION 2.014. Section 402.068, Labor Code, is amended to read as follows:

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

SECTION 2.015. Section 402.069, Labor Code, is amended to read as follows:

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

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

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

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

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

SECTION 2.017. Section 402.072, Labor Code, is amended to read as follows:

Sec. 402.072. SANCTIONS. Only the commissioner [~~commission~~] may impose:

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) race, ethnicity, and sex of the claimant;

(2) classification of the injury;

(3) amount of wages earned by the claimant before the injury; and

(4) amount of compensation received by the claimant.

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

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

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

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

(1) the claim is:

(A) open or pending before the department [~~commission~~];

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

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

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

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

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

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

(3) the employer at the time of injury;

(4) the insurance carrier;

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

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

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

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

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

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

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

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

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

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

(2) a legislative committee for legislative purposes;

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

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

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

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

(B) locating an absent parent.

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

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

(2) provide:

(A) unemployment compensation benefits;

(B) crime victims compensation benefits;

(C) vocational rehabilitation services; or

(D) health care benefits;

(3) investigate occupational safety or health violations;

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

(5) assess financial resources in an action, including an administrative action, to:

(A) establish, modify, or enforce a child support or medical support obligation;

(B) establish paternity;

(C) locate an absent parent; or

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

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

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

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

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

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

Sec. 402.089. FAILURE TO FILE AUTHORIZATION[~~; ADMINISTRATIVE VIOLATION~~]. [~~(a)~~] An employer who receives information by telephone from the department [~~commission~~] under Section 402.088 and who fails to file the necessary authorization

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

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

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

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

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

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

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

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

(1) in a criminal proceeding;

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

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

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

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

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

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

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

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

(3) the complaint is frivolous; or

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

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

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

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

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

SECTION 3.002. Section 401.002, Labor Code, is amended to read as follows:

Sec. 401.002. APPLICATION OF SUNSET ACT. The Texas Department of Workers' Compensation [~~Commission~~] is subject to Chapter 325, Government Code (Texas Sunset Act). Unless continued 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.

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

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

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

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

(B) Sections 2001.051, 2001.052, and 2001.053;

(C) Sections 2001.056 through 2001.062; and

(D) Section 2001.141(c);

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

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

(A) a benefit review conference;

(B) a contested case hearing;

(C) an appeals panel proceeding;

(D) arbitration; or

(E) another proceeding involving a determination on a workers' compensation claim; and

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

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

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

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

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

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

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

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

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

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

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

CHAPTER 403. DEPARTMENT [~~COMMISSION~~] FINANCING

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

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

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

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

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

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

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

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

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

(2) projected employee benefits paid from general revenues;

(3) a surplus or deficit produced by the tax in the preceding year;

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

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

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

(1) the State Office of Risk Management;

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

(3) any other revenue or expenditure excluded from consideration by law.

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

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

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

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

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

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

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

(b) The subsequent injury fund is liable for:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 3.016. Section 405.001, Labor Code, is amended to read as follows:

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

(1) "Commissioner" means the commissioner of insurance.

(2) "Department"[~~, "department"~~] means the Texas Department of Insurance.

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

(a) The department shall conduct professional studies and research related to:

(1) the delivery of benefits;

(2) litigation and controversy related to workers' compensation;

(3) insurance rates and rate-making procedures;

(4) rehabilitation and reemployment of injured workers;

(5) workplace health and safety issues;

(6) the quality and cost of medical benefits; [~~and~~]

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

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

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

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

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

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

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

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

(b) The commissioner shall:

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

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

SECTION 3.019. Section 406.004, Labor Code, is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) the cancellation date of the policy.

SECTION 3.023. Section 406.008, Labor Code, is amended to read as follows:

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

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

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

(A) fraud in obtaining coverage;

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

(C) failure to pay a premium when due;

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

(i) reasonable recommendations for loss control; or

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

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

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

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

SECTION 3.024. Section 406.009, Labor Code, is amended to read as follows:

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

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

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

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

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

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

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

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

SECTION 3.026. Section 406.011, Labor Code, is amended to read as follows:

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

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

~~noncompliance constitutes a separate violation.~~]

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

(c) The employer may not transfer:

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

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

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

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

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

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

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

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

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

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

(1) conflicts of jurisdiction;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 3.037. Section 407.021, Labor Code, is amended to read as follows:

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

SECTION 3.038. Section 407.022, Labor Code, is amended to read as follows:

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

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

SECTION 3.039. Section 407.023, Labor Code, is amended to read as follows:

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

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

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

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

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

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

(b) The application must be:

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

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

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

SECTION 3.041. Section 407.042, Labor Code, is amended to read as follows:

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

SECTION 3.042. Section 407.043, Labor Code, is amended to read as follows:

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

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

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

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

SECTION 3.044. Section 407.045, Labor Code, is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 3.048. Section 407.062, Labor Code, is amended to read as follows:

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

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

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

(3) the applicant's compensation loss history;

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

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

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

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

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

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

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

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

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

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

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

~~separate violation.~~]

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

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

(b) The report must:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 3.055. Section 407.102, Labor Code, is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) three certified self-insurers;

(2) one member designated by the commissioner [~~one commission member representing wage earners;~~

[~~(3) one commission member representing employers~~]; and

(3) [~~(4)~~] the public counsel of the office of public insurance counsel.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) obtained workers' compensation insurance coverage;

(2) become a certified self-insurer; or

(3) become a member of another group.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[~~(1)~~] the appropriateness of the health care received by the employee[~~; or~~

[~~(2) similar issues~~].

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

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

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

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

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

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

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

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

(g) An insurance carrier who unreasonably requests a medical examination under Subsection (b) commits a violation. [~~A violation under this subsection is a Class B administrative violation.~~]

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

SECTION 3.072. Section 408.0041, Labor Code, is amended to read as follows:

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

(1) the impairment caused by the compensable injury; [~~or~~]

(2) the attainment of maximum medical improvement;

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

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

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

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

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

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

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

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

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

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

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

(h) The insurance carrier shall pay for:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) the professional reputation of the doctor;

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

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

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

SECTION 3.075. Section 408.023, Labor Code, is amended to read as follows:

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

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

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

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

(1) provide health care services as treating doctors;

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

(3) perform medical peer review under this subtitle;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) employees have access to health care; and

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

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

(1) return-to-work outcomes;

(2) patient satisfaction; and

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

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

SECTION 3.076. Section 408.0231, Labor Code, is amended to read as follows:

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

(1) who fails to register with the department [~~commission~~] as provided by this chapter and commissioner [~~commission~~] rules;

(2) who is deceased;

(3) whose license to practice in this state is

revoked, suspended, or not renewed by the appropriate licensing authority; or

(4) who requests to be removed from the list.

(b) The commissioner [~~commission~~] by rule shall establish criteria for:

(1) deleting or suspending a doctor from the list of approved doctors;

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

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

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

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

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

(2) a sanction by the Medicare or Medicaid program for:

(A) substandard medical care;

(B) overcharging;

(C) overutilization of medical services; or

(D) any other substantive noncompliance with requirements of those programs regarding professional practice or billing;

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

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

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

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

(7) a criminal conviction.

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

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

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

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

(1) compliance with applicable regulations; and

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

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

(1) reduction of allowable reimbursement;

(2) mandatory preauthorization of all or certain health care services;

(3) required peer review monitoring, reporting, and audit;

(4) deletion or suspension from the approved doctor list and the designated doctor list;

(5) restrictions on appointment under this chapter;

(6) conditions or restrictions on an insurance carrier regarding actions by insurance carriers under this subtitle in accordance with the memorandum of understanding adopted between the department [~~commission~~] and the Texas Department of Insurance regarding Article 21.58A, Insurance Code; and

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

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

SECTION 3.077. Section 408.024, Labor Code, is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

SECTION 3.080. Section 408.026, Labor Code, is amended to read as follows:

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

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

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

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

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

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

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

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

SECTION 3.083. Section 408.030, Labor Code, is amended to read as follows:

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

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

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

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

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

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

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

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

(d) The commissioner [~~commission~~] shall:

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

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

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

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

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

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

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

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

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

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

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

necessary to implement this section.

SECTION 3.090. Section 408.045, Labor Code, is amended to read as follows:

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

SECTION 3.091. Section 408.047, Labor Code, is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

(1) on the request of the employee and the agreement of the employee and the insurance carrier; and

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

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

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

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

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

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

SECTION 3.098. Section 408.085, Labor Code, is amended to

read as follows:

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

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

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

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

SECTION 3.099. Section 408.086, Labor Code, is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) restrict the participation of a designated doctor; or

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

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

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

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

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

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

(1) the department [~~commission~~];

(2) the employee; and

(3) the insurance carrier.

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

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

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

(1) compelling medical evidence exists of:

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

(B) a clearly mistaken diagnosis or a previously undiagnosed medical condition; or

(C) improper or inadequate treatment of the injury before the date of the certification or assignment that would render the certification or assignment invalid; or

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

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

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

SECTION 3.105. Section 408.124, Labor Code, is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) required to relieve hardship; and

(2) in the overall best interest of the employee.

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

SECTION 3.109. Section 408.141, Labor Code, is amended to read as follows:

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

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

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

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

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

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

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

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

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

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

SECTION 3.112. Section 408.148, Labor Code, is amended to read as follows:

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

SECTION 3.113. Section 408.149, Labor Code, is amended to read as follows:

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

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

SECTION 3.114. Section 408.150, Labor Code, is amended to read as follows:

Sec. 408.150. VOCATIONAL REHABILITATION. (a) The department [~~commission~~] shall refer an employee to the Department of Assistive and Rehabilitative Services [~~Texas Rehabilitation Commission~~] with a recommendation for appropriate services if the department [~~commission~~] determines that an employee [~~entitled to supplemental income benefits~~] could be materially assisted by vocational rehabilitation or training in returning to employment or returning to employment more nearly approximating the employee's preinjury employment. The department [~~commission~~] shall also notify insurance carriers of the need for vocational rehabilitation or training services. The insurance carrier may provide services through a private provider of vocational rehabilitation services under Section 409.012.

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

SECTION 3.115. Section 408.151, Labor Code, is amended to read as follows:

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

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

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

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

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

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

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

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

(1) on the request of the legal beneficiary and the agreement of the legal beneficiary and the insurance carrier; and

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

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

SECTION 3.118. Subsection (f), Section 408.182, Labor Code, is amended to read as follows:

(f) In this section:

(1) "Eligible child" means a child of a deceased employee if the child is:

(A) a minor;

(B) enrolled as a full-time student in an accredited educational institution and is less than 25 years of age; or

(C) a dependent of the deceased employee at the time of the employee's death.

(2) "Eligible grandchild" means a grandchild of a deceased employee who is a dependent of the deceased employee and whose parent is not an eligible child.

(3) "Eligible spouse" means the surviving spouse of a deceased employee unless the spouse abandoned the employee for longer than the year immediately preceding the death without good cause, as determined by the department [~~commission~~].

SECTION 3.119. Subsection (b), Section 408.183, Labor Code, is amended to read as follows:

(b) An eligible spouse is entitled to receive death benefits for life or until remarriage. On remarriage, the eligible spouse is entitled to receive 104 weeks of death benefits, commuted as provided by commissioner [~~commission~~] rule.

SECTION 3.120. Subsection (c), Section 408.187, Labor Code, is amended to read as follows:

(c) The commissioner [~~commission~~] shall require the insurance carrier to pay the costs of a procedure ordered under this section.

SECTION 3.121. Section 408.202, Labor Code, is amended to read as follows:

Sec. 408.202. ASSIGNABILITY OF BENEFITS. Benefits are not assignable, except a legal beneficiary may, with the commissioner's [~~commission~~] approval, assign the right to death benefits.

SECTION 3.122. Subsections (a) through (g), Section 408.221, Labor Code, are amended to read as follows:

(a) An attorney's fee, including a contingency fee, for

representing a claimant before the department [~~commission~~] or court under this subtitle must be approved by the commissioner [~~commission~~] or court.

(b) Except as otherwise provided, an attorney's fee under this section is based on the attorney's time and expenses according to written evidence presented to the department [~~commission~~] or court. Except as provided by Subsection (c) or Section 408.147(c), the attorney's fee shall be paid from the claimant's recovery.

(c) An insurance carrier that seeks judicial review under Subchapter G, Chapter 410, of a final decision of a department [~~commission~~] appeals panel regarding compensability or eligibility for, or the amount of, income or death benefits is liable for reasonable and necessary attorney's fees as provided by Subsection (d) incurred by the claimant as a result of the insurance carrier's appeal if the claimant prevails on an issue on which judicial review is sought by the insurance carrier in accordance with the limitation of issues contained in Section 410.302. If the carrier appeals multiple issues and the claimant prevails on some, but not all, of the issues appealed, the court shall apportion and award fees to the claimant's attorney only for the issues on which the claimant prevails. In making that apportionment, the court shall consider the factors prescribed by Subsection (d). This subsection does not apply to attorney's fees for which an insurance carrier may be liable under Section 408.147. An award of attorney's fees under this subsection is not subject to commissioner [~~commission~~] rules adopted under Subsection (f). [~~This subsection expires September 1, 2005.~~]

(d) In approving an attorney's fee under this section, the commissioner [~~commission~~] or court shall consider:

(1) the time and labor required;

(2) the novelty and difficulty of the questions involved;

(3) the skill required to perform the legal services properly;

(4) the fee customarily charged in the locality for similar legal services;

(5) the amount involved in the controversy;

(6) the benefits to the claimant that the attorney is responsible for securing; and

(7) the experience and ability of the attorney performing the services.

(e) The commissioner [~~commission~~] by rule or the court may provide for the commutation of an attorney's fee, except that the attorney's fee shall be paid in periodic payments in a claim involving death benefits if the only dispute is as to the proper beneficiary or beneficiaries.

(f) The commissioner [~~commission~~] by rule shall provide guidelines for maximum attorney's fees for specific services in accordance with this section.

(g) An attorney's fee may not be allowed in a case involving a fatal injury or lifetime income benefit if the insurance carrier admits liability on all issues and tenders payment of maximum benefits in writing under this subtitle while the claim is pending before the department [~~commission~~].

SECTION 3.123. Section 408.222, Labor Code, is amended to read as follows:

Sec. 408.222. ATTORNEY'S FEES PAID TO DEFENSE COUNSEL. (a) The amount of an attorney's fee for defending an insurance carrier in a workers' compensation action brought under this subtitle must be approved by the commissioner [~~commission~~] or court and determined by the commissioner [~~commission~~] or court to be reasonable and necessary.

(b) In determining whether a fee is reasonable under this section, the commissioner [~~commission~~] or court shall consider issues analogous to those listed under Section 408.221(d). The defense counsel shall present written evidence to the commissioner [~~commission~~] or court relating to:

(1) the time spent and expenses incurred in defending the case; and

(2) other evidence considered necessary by the commissioner [~~commission~~] or court in making a determination under this section.

SECTION 3.124. Section 409.002, Labor Code, is amended to read as follows:

Sec. 409.002. FAILURE TO FILE NOTICE OF INJURY. Failure to notify an employer as required by Section 409.001(a) relieves the employer and the employer's insurance carrier of liability under this subtitle unless:

(1) the employer, a person eligible to receive notice under Section 409.001(b), or the employer's insurance carrier has actual knowledge of the employee's injury;

(2) the commissioner [~~commission~~] determines that good cause exists for failure to provide notice in a timely manner; or

(3) the employer or the employer's insurance carrier does not contest the claim.

SECTION 3.125. Section 409.003, Labor Code, is amended to read as follows:

Sec. 409.003. CLAIM FOR COMPENSATION. An employee or a person acting on the employee's behalf shall file with the department [~~commission~~] a claim for compensation for an injury not later than one year after the date on which:

(1) the injury occurred; or

(2) if the injury is an occupational disease, the employee knew or should have known that the disease was related to the employee's employment.

SECTION 3.126. Section 409.004, Labor Code, is amended to read as follows:

Sec. 409.004. FAILURE TO FILE CLAIM FOR COMPENSATION. Failure to file a claim for compensation with the department [~~commission~~] as required under Section 409.003 relieves the employer and the employer's insurance carrier of liability under this subtitle unless:

(1) good cause exists for failure to file a claim in a timely manner; or

(2) the employer or the employer's insurance carrier does not contest the claim.

SECTION 3.127. Subsections (d), (e), (f), and (h) through (l), Section 409.005, Labor Code, are amended to read as follows:

(d) The insurance carrier shall file the report of the injury on behalf of the policyholder. Except as provided by Subsection (e), the insurance carrier must electronically file the report with the department [~~commission~~] not later than the seventh day after the date on which the carrier receives the report from the employer.

(e) The commissioner [~~executive director~~] may waive the electronic filing requirement under Subsection (d) and allow an insurance carrier to mail or deliver the report to the department [~~commission~~] not later than the seventh day after the date on which the carrier receives the report from the employer.

(f) A report required under this section may not be considered to be an admission by or evidence against an employer or an insurance carrier in a proceeding before the department [~~commission~~] or a court in which the facts set out in the report are contradicted by the employer or insurance carrier.

(h) The commissioner [~~commission~~] may adopt rules relating to:

(1) the information that must be contained in a report required under this section, including the summary of rights and responsibilities required under Subsection (g); and

(2) the development and implementation of an electronic filing system for injury reports under this section.

(i) An employer and insurance carrier shall file subsequent reports as required by commissioner [~~commission~~] rule.

(j) The employer shall, on the written request of the employee, a doctor, the insurance carrier, or the commissioner [~~commission~~], notify the employee, the employee's treating doctor if known to the employer, and the insurance carrier of the existence

or absence of opportunities for modified duty or a modified duty return-to-work program available through the employer. If those opportunities or that program exists, the employer shall identify the employer's contact person and provide other information to assist the doctor, the employee, and the insurance carrier to assess modified duty or return-to-work options.

(k) This section does not prohibit the commissioner [~~commission~~] from imposing requirements relating to return-to-work under other authority granted to the department [~~commission~~] in this subtitle.

(l) A person commits a violation if the person fails to comply with this section unless good cause exists. [~~A violation under this subsection is a Class D administrative violation.~~]

SECTION 3.128. Subsections (b), (c), and (e), Section 409.006, Labor Code, are amended to read as follows:

(b) The record shall be available to the department [~~commission~~] at reasonable times and under conditions prescribed by the commissioner [~~commission~~].

(c) The commissioner [~~commission~~] may adopt rules relating to the information that must be contained in an employer record under this section.

(e) A person commits a violation if the person fails to comply with this section. [~~A violation under this subsection is a Class D administrative violation.~~]

SECTION 3.129. Subsection (a), Section 409.007, Labor Code, is amended to read as follows:

(a) A person must file a claim for death benefits with the department [~~commission~~] not later than the first anniversary of the date of the employee's death.

SECTION 3.130. Section 409.009, Labor Code, is amended to read as follows:

Sec. 409.009. SUBCLAIMS. A person may file a written claim with the department [~~commission~~] as a subclaimant if the person has:

(1) provided compensation, including health care provided by a health care insurer, directly or indirectly, to or for an employee or legal beneficiary; and

(2) sought and been refused reimbursement from the insurance carrier.

SECTION 3.131. Section 409.010, Labor Code, is amended to read as follows:

Sec. 409.010. INFORMATION PROVIDED TO EMPLOYEE OR LEGAL BENEFICIARY. Immediately on receiving notice of an injury or death from any person, the department [~~commission~~] shall mail to the employee or legal beneficiary a clear and concise description of:

(1) the services provided by the department [~~commission~~], including the services of the ombudsman program;

(2) the department's [~~commission's~~] procedures; and

(3) the person's rights and responsibilities under this subtitle.

SECTION 3.132. Subsections (a) and (c), Section 409.011, Labor Code, are amended to read as follows:

(a) Immediately on receiving notice of an injury or death from any person, the department [~~commission~~] shall mail to the employer a description of:

(1) the services provided by the department [~~commission~~];

(2) the department's [~~commission's~~] procedures; and

(3) the employer's rights and responsibilities under this subtitle.

(c) The department [~~commission~~] is not required to provide the information to an employer more than once during a calendar year.

SECTION 3.133. Section 409.012, Labor Code, is amended to read as follows:

Sec. 409.012. VOCATIONAL REHABILITATION INFORMATION. (a) The commissioner [~~commission~~] shall analyze each report of injury received from an employer under this chapter to determine whether the injured employee would be assisted by vocational

rehabilitation.

(b) If the commissioner [~~commission~~] determines that an injured employee would be assisted by vocational rehabilitation, the department [~~commission~~] shall notify the injured employee in writing of the services and facilities available through the Department of Assistive and Rehabilitative Services [~~Texas Rehabilitation Commission~~] and private providers of vocational rehabilitation. The department [~~commission~~] shall notify the Department of Assistive and Rehabilitative Services [~~Texas Rehabilitation Commission~~] and the affected insurance carrier that the injured employee has been identified as one who could be assisted by vocational rehabilitation.

(c) The department [~~commission~~] shall cooperate with the Department of Assistive and Rehabilitative Services [~~Texas Rehabilitation Commission~~] and private providers of vocational rehabilitation in the provision of services and facilities to employees by the Department of Assistive and Rehabilitative Services [~~Texas Rehabilitation Commission~~].

(d) A private provider of vocational rehabilitation services may register with the department [~~commission~~].

(e) The commissioner [~~commission~~] by rule may require that a private provider of vocational rehabilitation services maintain certain credentials and qualifications in order to provide services in connection with a workers' compensation insurance claim.

(f) The department and the Department of Assistive and Rehabilitative Services shall report to the legislature not later than August 1, 2006, on their actions to improve access to and the effectiveness of vocational rehabilitation programs for injured employees. The report must include:

(1) a description of the actions each agency has taken to improve communication regarding and coordination of vocational rehabilitation programs;

(2) an analysis identifying the population of injured employees that have the poorest return-to-work outcomes and are in the greatest need for vocational rehabilitation services;

(3) any changes recommended to improve the access to and effectiveness of vocational rehabilitation programs for the populations identified in Subdivision (2); and

(4) a plan to implement these changes.

SECTION 3.134. Section 409.013, Labor Code, is amended to read as follows:

Sec. 409.013. PLAIN LANGUAGE INFORMATION; NOTIFICATION OF INJURED WORKER. (a) The department [~~commission~~] shall develop information for public dissemination about the benefit process and the compensation procedures established under this chapter. The information must be written in plain language and must be available in English and Spanish.

(b) On receipt of a report under Section 409.005, the department [~~commission~~] shall contact the affected employee by mail or by telephone and shall provide the information required under Subsection (a) to that employee, together with any other information that may be prepared by the department [~~commission~~] for public dissemination that relates to the employee's situation, such as information relating to back injuries or occupational diseases.

SECTION 3.135. Subsections (a) and (b), Section 409.021, Labor Code, are amended to read as follows:

(a) An insurance carrier shall initiate compensation under this subtitle promptly. Not later than the 15th day after the date on which an insurance carrier receives written notice of an injury, the insurance carrier shall:

(1) begin the payment of benefits as required by this subtitle; or

(2) notify the department [~~commission~~] and the employee in writing of its refusal to pay and advise the employee of:

(A) the right to request a benefit review conference; and

(B) the means to obtain additional information from the department [~~commission~~].

(b) An insurance carrier shall notify the department [~~commission~~] in writing of the initiation of income or death benefit payments in the manner prescribed by commissioner [~~commission~~] rules.

SECTION 3.136. Subsection (c), Section 409.022, Labor Code, is amended to read as follows:

(c) An insurance carrier commits a violation if the insurance carrier does not have reasonable grounds for a refusal to pay benefits, as determined by the commissioner [~~commission. A violation under this subsection is a Class B administrative violation~~].

SECTION 3.137. Subsections (a), (c), and (d), Section 409.023, Labor Code, are amended to read as follows:

(a) An insurance carrier shall continue to pay benefits promptly as and when the benefits accrue without a final decision, order, or other action of the commissioner [~~commission~~], except as otherwise provided.

(c) An insurance carrier commits a violation if the insurance carrier fails to comply with this section. [~~A violation under this subsection is a Class B administrative violation. Each day of noncompliance constitutes a separate violation.~~]

(d) An insurance carrier that commits multiple violations of this section commits an additional [~~a Class A~~] administrative violation and is subject to:

(1) the sanctions provided under Section 415.023; and

(2) revocation of the right to do business under the workers' compensation laws of this state.

SECTION 3.138. Subsection (b), Section 409.0231, Labor Code, is amended to read as follows:

(b) The commissioner [~~commission~~] shall adopt rules in consultation with the Texas Department of Information Resources as necessary to implement this section, including rules prescribing a period of benefits that is of sufficient duration to allow payment by electronic funds transfer.

SECTION 3.139. Section 409.024, Labor Code, is amended to read as follows:

Sec. 409.024. TERMINATION OR REDUCTION OF BENEFITS; NOTICE; ADMINISTRATIVE VIOLATION. (a) An insurance carrier shall file with the department [~~commission~~] a notice of termination or reduction of benefits, including the reasons for the termination or reduction, not later than the 10th day after the date on which benefits are terminated or reduced.

(b) An insurance carrier commits a violation if the insurance carrier does not have reasonable grounds to terminate or reduce benefits, as determined by the commissioner [~~commission. A violation under this subsection is a Class B administrative violation~~].

SECTION 3.140. Subsection (a), Section 409.041, Labor Code, is amended to read as follows:

(a) The department [~~commission~~] shall maintain an ombudsman program as provided by this subchapter to assist injured workers and persons claiming death benefits in obtaining benefits under this subtitle.

SECTION 3.141. Subsections (a) and (c), Section 409.042, Labor Code, are amended to read as follows:

(a) At least one specially qualified employee in each department [~~commission~~] office shall be designated an ombudsman who shall perform the duties under this section as the person's primary responsibility.

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

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

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

SECTION 3.142. Section 409.043, Labor Code, is amended to

read as follows:

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

(b) An employer commits a violation if the employer fails to comply with this section. [~~A violation under this section is a Class C administrative violation.~~]

SECTION 3.143. Section 409.044, Labor Code, is amended to read as follows:

Sec. 409.044. PUBLIC INFORMATION. The department [~~commission~~] shall widely disseminate information about the ombudsman program.

SECTION 3.144. Section 410.002, Labor Code, is amended to read as follows:

Sec. 410.002. LAW GOVERNING LIABILITY PROCEEDINGS. A proceeding before the department [~~commission~~] to determine the liability of an insurance carrier for compensation for an injury or death under this subtitle is governed by this chapter.

SECTION 3.145. Section 410.004, Labor Code, is amended to read as follows:

Sec. 410.004. DIVISION OF HEARINGS. The division shall conduct benefit review conferences, contested case hearings, arbitration, and appeals within the department [~~commission~~] related to workers' compensation claims.

SECTION 3.146. Subsection (a), Section 410.005, Labor Code, is amended to read as follows:

(a) Unless the commissioner [~~commission~~] determines that good cause exists for the selection of a different location, a benefit review conference or a contested case hearing may not be conducted at a site more than 75 miles from the claimant's residence at the time of the injury.

SECTION 3.147. Section 410.021, Labor Code, is amended to read as follows:

Sec. 410.021. PURPOSE. A benefit review conference is a nonadversarial, informal dispute resolution proceeding designed to:

(1) explain, orally and in writing, the rights of the respective parties to a workers' compensation claim and the procedures necessary to protect those rights;

(2) discuss the facts of the claim, review available information in order to evaluate the claim, and delineate the disputed issues; and

(3) mediate and resolve disputed issues by agreement of the parties in accordance with this subtitle and the policies of the department [~~commission~~].

SECTION 3.148. Subsections (b) and (c), Section 410.022, Labor Code, are amended to read as follows:

(b) A benefit review officer must:

(1) be an employee of the department [~~commission~~]; and

(2) be trained in the principles and procedures of dispute mediation.

(c) The department [~~commission~~] shall institute and maintain an education and training program for benefit review officers and shall consult or contract with the Federal Mediation and Conciliation Service or other appropriate organizations for this purpose.

SECTION 3.149. Section 410.023, Labor Code, is amended to read as follows:

Sec. 410.023. REQUEST FOR BENEFIT REVIEW CONFERENCE. On receipt of a request from a party or on its own motion, the department [~~commission~~] may direct the parties to a disputed workers' compensation claim to meet in a benefit review conference to attempt to reach agreement on disputed issues involved in the claim.

SECTION 3.150. Section 410.024, Labor Code, is amended to read as follows:

Sec. 410.024. BENEFIT REVIEW CONFERENCE AS PREREQUISITE TO FURTHER PROCEEDINGS ON CERTAIN CLAIMS. (a) Except as otherwise

provided by law or commissioner [~~commission~~] rule, the parties to a disputed compensation claim are not entitled to a contested case hearing or arbitration on the claim unless a benefit review conference is conducted as provided by this subchapter.

(b) The commissioner [~~commission~~] by rule shall adopt guidelines relating to claims that do not require a benefit review conference and may proceed directly to a contested case hearing or arbitration.

SECTION 3.151. Section 410.025, Labor Code, is amended to read as follows:

Sec. 410.025. SCHEDULING OF BENEFIT REVIEW CONFERENCE; NOTICE. (a) The commissioner [~~commission~~] by rule shall prescribe the time within which a benefit review conference must be scheduled.

(b) At the time a benefit review conference is scheduled, the department [~~commission~~] shall schedule a contested case hearing to be held not later than the 60th day after the date of the benefit review conference if the disputed issues are not resolved at the benefit review conference.

(c) The department [~~commission~~] shall send written notice of the benefit review conference to the parties to the claim and the employer.

(d) The commissioner [~~commission~~] by rule shall provide for expedited proceedings in cases in which compensability or liability for essential medical treatment is in dispute.

SECTION 3.152. Subsection (a), Section 410.026, Labor Code, is amended to read as follows:

(a) A benefit review officer shall:

(1) mediate disputes between the parties and assist in the adjustment of the claim consistent with this subtitle and the policies of the department [~~commission~~];

(2) thoroughly inform all parties of their rights and responsibilities under this subtitle, especially in a case in which the employee is not represented by an attorney or other representative; and

(3) ensure that all documents and information relating to the employee's wages, medical condition, and any other information pertinent to the resolution of disputed issues are contained in the claim file at the conference, especially in a case in which the employee is not represented by an attorney or other representative.

SECTION 3.153. Subsection (a), Section 410.027, Labor Code, is amended to read as follows:

(a) The commissioner [~~commission~~] shall adopt rules for conducting benefit review conferences.

SECTION 3.154. Subsection (b), Section 410.028, Labor Code, is amended to read as follows:

(b) A party commits a violation if the party fails to attend a benefit review conference without good cause as determined by the benefit review officer. [~~A violation under this subsection is a Class D administrative violation.~~]

SECTION 3.155. Section 410.030, Labor Code, is amended to read as follows:

Sec. 410.030. BINDING EFFECT OF AGREEMENT. (a) An agreement signed in accordance with Section 410.029 is binding on the insurance carrier through the conclusion of all matters relating to the claim, unless the department [~~commission~~] or a court, on a finding of fraud, newly discovered evidence, or other good and sufficient cause, relieves the insurance carrier of the effect of the agreement.

(b) The agreement is binding on the claimant, if represented by an attorney, to the same extent as on the insurance carrier. If the claimant is not represented by an attorney, the agreement is binding on the claimant through the conclusion of all matters relating to the claim while the claim is pending before the department [~~commission~~], unless the commissioner [~~commission~~] for good cause relieves the claimant of the effect of the agreement.

SECTION 3.156. Subsection (b), Section 410.034, Labor Code, is amended to read as follows:

(b) The commissioner [~~commission~~] by rule shall prescribe the times within which the agreement and report must be filed.

SECTION 3.157. Section 410.102, Labor Code, is amended to read as follows:

Sec. 410.102. ARBITRATORS; QUALIFICATIONS. (a) An arbitrator must be an employee of the department [~~commission~~], except that the department [~~commission~~] may contract with qualified arbitrators on a determination of special need.

(b) An arbitrator must:

(1) be a member of the National Academy of Arbitrators;

(2) be on an approved list of the American Arbitration Association or Federal Mediation and Conciliation Service; or

(3) meet qualifications established by the commissioner [~~commission~~] by rule [~~and be approved by an affirmative vote of at least two commission members representing employers of labor and at least two commission members representing wage earners~~].

(c) The department [~~commission~~] shall require that each arbitrator have appropriate training in the workers' compensation laws of this state. The commissioner [~~commission~~] shall establish procedures to carry out this subsection.

SECTION 3.158. Section 410.103, Labor Code, is amended to read as follows:

Sec. 410.103. DUTIES OF ARBITRATOR. An arbitrator shall:

(1) protect the interests of all parties;

(2) ensure that all relevant evidence has been disclosed to the arbitrator and to all parties; and

(3) render an award consistent with this subtitle and the policies of the department [~~commission~~].

SECTION 3.159. Subsections (b) and (c), Section 410.104, Labor Code, are amended to read as follows:

(b) To elect arbitration, the parties must file the election with the department [~~commission~~] not later than the 20th day after the last day of the benefit review conference. The commissioner [~~commission~~] shall prescribe a form for that purpose.

(c) An election to engage in arbitration under this subchapter is irrevocable and binding on all parties for the resolution of all disputes arising out of the claims that are under the jurisdiction of the department [~~commission~~].

SECTION 3.160. Section 410.105, Labor Code, is amended to read as follows:

Sec. 410.105. LISTS OF ARBITRATORS. (a) The department [~~commission~~] shall establish regional lists of arbitrators who meet the qualifications prescribed under Sections 410.102(a) and (b). Each regional list shall be initially prepared in a random name order, and subsequent additions to a list shall be added chronologically.

(b) The commissioner [~~commission~~] shall review the lists of arbitrators annually and determine if each arbitrator is fair and impartial and makes awards that are consistent with and in accordance with this subtitle and the rules of the commissioner [~~commission. The commission shall remove an arbitrator if after review the arbitrator does not receive an affirmative vote of at least two commission members representing employers of labor and at least two commission members representing wage earners~~].

(c) The department's [~~commission's~~] lists are confidential and are not subject to disclosure under Chapter 552, Government Code. The lists may not be revealed by any department [~~commission~~] employee to any person who is not a department [~~commission~~] employee. The lists are exempt from discovery in civil litigation unless the party seeking the discovery establishes reasonable cause to believe that a violation of the requirements of this section or Section 410.106, 410.107, 410.108, or 410.109(b) occurred and that the violation is relevant to the issues in dispute.

SECTION 3.161. Section 410.106, Labor Code, is amended to read as follows:

Sec. 410.106. SELECTION OF ARBITRATOR. The department [~~commission~~] shall assign the arbitrator for a particular case by

selecting the next name after the previous case's selection in consecutive order. The department [~~commission~~] may not change the order of names once the order is established under this subchapter, except that once each arbitrator on the list has been assigned to a case, the names shall be randomly reordered.

SECTION 3.162. Subsection (a), Section 410.107, Labor Code, is amended to read as follows:

(a) The department [~~commission~~] shall assign an arbitrator to a pending case not later than the 30th day after the date on which the election for arbitration is filed with the department [~~commission~~].

SECTION 3.163. Subsection (a), Section 410.108, Labor Code, is amended to read as follows:

(a) Each party is entitled, in its sole discretion, to one rejection of the arbitrator in each case. If a party rejects the arbitrator, the department [~~commission~~] shall assign another arbitrator as provided by Section 410.106.

SECTION 3.164. Section 410.109, Labor Code, is amended to read as follows:

Sec. 410.109. SCHEDULING OF ARBITRATION. (a) The arbitrator shall schedule arbitration to be held not later than the 30th day after the date of the arbitrator's assignment and shall notify the parties and the department [~~commission~~] of the scheduled date.

(b) If an arbitrator is unable to schedule arbitration in accordance with Subsection (a), the department [~~commission~~] shall appoint the next arbitrator on the applicable list. Each party is entitled to reject the arbitrator appointed under this subsection in the manner provided under Section 410.108.

SECTION 3.165. Section 410.111, Labor Code, is amended to read as follows:

Sec. 410.111. RULES. The commissioner [~~commission~~] shall adopt rules for arbitration consistent with generally recognized arbitration principles and procedures.

SECTION 3.166. Subsection (b), Section 410.112, Labor Code, is amended to read as follows:

(b) A party commits a violation if the party, without good cause as determined by the arbitrator, fails to comply with Subsection (a). [~~A violation under this subsection is a Class D administrative violation.~~]

SECTION 3.167. Subsection (b), Section 410.113, Labor Code, is amended to read as follows:

(b) A party commits a violation if the party does not attend the arbitration unless the arbitrator determines that the party had good cause not to attend. [~~A violation under this subsection is a Class D administrative violation.~~]

SECTION 3.168. Subsection (b), Section 410.114, Labor Code, is amended to read as follows:

(b) The department [~~commission~~] shall make an electronic recording of the proceeding.

SECTION 3.169. Subsection (d), Section 410.118, Labor Code, is amended to read as follows:

(d) The arbitrator shall file a copy of the award as part of the permanent claim file at the department [~~commission~~] and shall notify the parties in writing of the decision.

SECTION 3.170. Subsection (b), Section 410.119, Labor Code, is amended to read as follows:

(b) An arbitrator's award is a final order of the department [~~commission~~].

SECTION 3.171. Subsections (a) and (b), Section 410.121, Labor Code, are amended to read as follows:

(a) On application of an aggrieved party, a court of competent jurisdiction shall vacate an arbitrator's award on a finding that:

(1) the award was procured by corruption, fraud, or misrepresentation;

(2) the decision of the arbitrator was arbitrary and capricious; or

(3) the award was outside the jurisdiction of the

department [~~commission~~].

(b) If an award is vacated, the case shall be remanded to the department [~~commission~~] for another arbitration proceeding.

SECTION 3.172. Subsection (b), Section 410.151, Labor Code, is amended to read as follows:

(b) An issue that was not raised at a benefit review conference or that was resolved at a benefit review conference may not be considered unless:

(1) the parties consent; or

(2) if the issue was not raised, the commissioner [~~commission~~] determines that good cause existed for not raising the issue at the conference.

SECTION 3.173. Section 410.153, Labor Code, is amended to read as follows:

Sec. 410.153. APPLICATION OF ADMINISTRATIVE PROCEDURE ACT. Chapter 2001, Government Code, applies to a contested case hearing to the extent that the commissioner [~~commission~~] finds appropriate, except that the following do not apply:

(1) Section 2001.054;

(2) Sections 2001.061 and 2001.062;

(3) Section 2001.202; and

(4) Subchapters F, G, I, and Z, except for Section 2001.141(c).

SECTION 3.174. Section 410.154, Labor Code, is amended to read as follows:

Sec. 410.154. SCHEDULING OF HEARING. The department [~~commission~~] shall schedule a contested case hearing in accordance with Section 410.024 or 410.025(b).

SECTION 3.175. Section 410.155, Labor Code, is amended to read as follows:

Sec. 410.155. CONTINUANCE. (a) A written request by a party for a continuance of a contested case hearing to another date must be directed to the commissioner [~~commission~~].

(b) The commissioner [~~commission~~] may grant a continuance only if the commissioner [~~commission~~] determines that there is good cause for the continuance.

SECTION 3.176. Subsection (b), Section 410.156, Labor Code, is amended to read as follows:

(b) A party commits a violation if the party, without good cause as determined by the hearing officer, does not attend a contested case hearing. [~~A violation under this subsection is a Class C administrative violation.~~]

SECTION 3.177. Section 410.157, Labor Code, is amended to read as follows:

Sec. 410.157. RULES. The commissioner [~~commission~~] shall adopt rules governing procedures under which contested case hearings are conducted.

SECTION 3.178. Subsection (a), Section 410.158, Labor Code, is amended to read as follows:

(a) Except as provided by Section 410.162, discovery is limited to:

(1) depositions on written questions to any health care provider;

(2) depositions of other witnesses as permitted by the hearing officer for good cause shown; and

(3) interrogatories as prescribed by the commissioner [~~commission~~].

SECTION 3.179. Section 410.159, Labor Code, is amended to read as follows:

Sec. 410.159. STANDARD INTERROGATORIES. (a) The commissioner [~~commission~~] by rule shall prescribe standard form sets of interrogatories to elicit information from claimants and insurance carriers.

(b) Standard interrogatories shall be answered by each party and served on the opposing party within the time prescribed by commissioner [~~commission~~] rule, unless the parties agree otherwise.

SECTION 3.180. Section 410.160, Labor Code, is amended to read as follows:

Sec. 410.160. EXCHANGE OF INFORMATION. Within the time prescribed by commissioner [~~commission~~] rule, the parties shall exchange:

(1) all medical reports and reports of expert witnesses who will be called to testify at the hearing;

(2) all medical records;

(3) any witness statements;

(4) the identity and location of any witness known to the parties to have knowledge of relevant facts; and

(5) all photographs or other documents that a party intends to offer into evidence at the hearing.

SECTION 3.181. Section 410.161, Labor Code, is amended to read as follows:

Sec. 410.161. FAILURE TO DISCLOSE INFORMATION. A party who fails to disclose information known to the party or documents that are in the party's possession, custody, or control at the time disclosure is required by Sections 410.158-410.160 may not introduce the evidence at any subsequent proceeding before the department [~~commission~~] or in court on the claim unless good cause is shown for not having disclosed the information or documents under those sections.

SECTION 3.182. Subsections (d) and (e), Section 410.168, Labor Code, are amended to read as follows:

(d) On a form that the commissioner [~~commission~~] by rule prescribes, the hearing officer shall issue a separate written decision regarding attorney's fees and any matter related to attorney's fees. The decision regarding attorney's fees and the form may not be made known to a jury in a judicial review of an award, including an appeal.

(e) The commissioner [~~commission~~] by rule shall prescribe the times within which the hearing officer must file the decisions with the division.

SECTION 3.183. Subsection (d), Section 410.203, Labor Code, is amended to read as follows:

(d) A hearing on remand shall be accelerated and the commissioner [~~commission~~] shall adopt rules to give priority to the hearing over other proceedings.

SECTION 3.184. Subsection (b), Section 410.204, Labor Code, is amended to read as follows:

(b) A copy of the decision of the appeals panel shall be sent to each party not later than the seventh day after the date the decision is filed with the department [~~commission~~].

SECTION 3.185. Section 410.206, Labor Code, is amended to read as follows:

Sec. 410.206. CLERICAL ERROR. The commissioner [~~executive director~~] may revise a decision in a contested case hearing on a finding of clerical error.

SECTION 3.186. Section 410.207, Labor Code, is amended to read as follows:

Sec. 410.207. CONTINUATION OF DEPARTMENT [~~COMMISSION~~] JURISDICTION. During judicial review of an appeals panel decision on any disputed issue relating to a workers' compensation claim, the department [~~commission~~] retains jurisdiction of all other issues related to the claim.

SECTION 3.187. Section 410.208, Labor Code, is amended to read as follows:

Sec. 410.208. JUDICIAL ENFORCEMENT OF ORDER OR DECISION; ADMINISTRATIVE VIOLATION. (a) If a person refuses or fails to comply with an interlocutory order, final order, or decision of the commissioner [~~commission~~], the department [~~commission~~] may bring suit in Travis County to enforce the order or decision.

(b) If an insurance carrier refuses or fails to comply with an interlocutory order, a final order, or a decision of the commissioner [~~commission~~], the claimant may bring suit in the county of the claimant's residence or the county in which the injury occurred to enforce the order or decision.

(c) If the department [~~commission~~] brings suit to enforce an interlocutory order, final order, or decision of the commissioner [~~commission~~], the department [~~commission~~] is entitled to

reasonable attorney's fees and costs for the prosecution and collection of the claim, in addition to a judgment enforcing the order or decision and any other remedy provided by law.

(d) A claimant who brings suit to enforce an interlocutory order, final order, or decision of the commissioner [~~commission~~] is entitled to a penalty equal to 12 percent of the amount of benefits recovered in the judgment, interest, and reasonable attorney's fees for the prosecution and collection of the claim, in addition to a judgment enforcing the order or decision.

(e) A person commits a violation if the person fails or refuses to comply with an interlocutory order, final order, or decision of the commissioner [~~commission~~] within 20 days after the date the order or decision becomes final. [~~A violation under this subsection is a Class A administrative violation.~~]

SECTION 3.188. Section 410.209, Labor Code, is amended to read as follows:

Sec. 410.209. REIMBURSEMENT FOR OVERPAYMENT. The subsequent injury fund shall reimburse an insurance carrier for any overpayments of benefits made under an interlocutory order or decision if that order or decision is reversed or modified by final arbitration, order, or decision of the commissioner [~~commission~~] or a court. The commissioner [~~commission~~] shall adopt rules to provide for a periodic reimbursement schedule, providing for reimbursement at least annually.

SECTION 3.189. Section 410.253, Labor Code, is amended to read as follows:

Sec. 410.253. SERVICE; NOTICE. (a) A party seeking judicial review shall simultaneously:

(1) file a copy of the party's petition with the court;

(2) serve any opposing party to the suit; and

(3) provide written notice of the suit or notice of appeal to the department [~~commission~~].

(b) A party may not seek judicial review under Section 410.251 unless the party has provided written notice of the suit to the department [~~commission~~] as required by this section.

SECTION 3.190. Section 410.254, Labor Code, is amended to read as follows:

Sec. 410.254. [~~COMMISSION~~] INTERVENTION. On timely motion initiated by the commissioner [~~executive director~~], the department [~~commission~~] shall be permitted to intervene in any judicial proceeding under this subchapter or Subchapter G.

SECTION 3.191. The heading to Section 410.258, Labor Code, is amended to read as follows:

Sec. 410.258. NOTIFICATION OF DEPARTMENT [~~COMMISSION~~] OF PROPOSED JUDGMENTS AND SETTLEMENTS; RIGHT TO INTERVENE.

SECTION 3.192. Subsections (a) through (e), Section 410.258, Labor Code, are amended to read as follows:

(a) The party who initiated a proceeding under this subchapter or Subchapter G must file any proposed judgment or settlement made by the parties to the proceeding, including a proposed default judgment, with the commissioner [~~executive director of the commission~~] not later than the 30th day before the date on which the court is scheduled to enter the judgment or approve the settlement. The proposed judgment or settlement must be mailed to the department [~~executive director~~] by certified mail, return receipt requested.

(b) The department [~~commission~~] may intervene in a proceeding under Subsection (a) not later than the 30th day after the date of receipt of the proposed judgment or settlement.

(c) The commissioner [~~commission~~] shall review the proposed judgment or settlement to determine compliance with all appropriate provisions of the law. If the commissioner [~~commission~~] determines that the proposal is not in compliance with the law, the department [~~commission~~] may intervene as a matter of right in the proceeding not later than the 30th day after the date of receipt of the proposed judgment or settlement. The court may limit the extent of the department's [~~commission's~~] intervention to providing the information described by Subsection (e).

(d) If the department [~~commission~~] does not intervene

before the 31st day after the date of receipt of the proposed judgment or settlement, the court shall enter the judgment or approve the settlement if the court determines that the proposed judgment or settlement is in compliance with all appropriate provisions of the law.

(e) If the department [~~commission~~] intervenes in the proceeding, the commissioner [~~commission~~] shall inform the court of each reason the commissioner [~~commission~~] believes the proposed judgment or settlement is not in compliance with the law. The court shall give full consideration to the information provided by the commissioner [~~commission~~] before entering a judgment or approving a settlement.

SECTION 3.193. Subsection (a), Section 410.301, Labor Code, is amended to read as follows:

(a) Judicial review of a final decision of a department [~~commission~~] appeals panel regarding compensability or eligibility for or the amount of income or death benefits shall be conducted as provided by this subchapter.

SECTION 3.194. Section 410.302, Labor Code, is amended to read as follows:

Sec. 410.302. LIMITATION OF ISSUES. A trial under this subchapter is limited to issues decided by the department [~~commission~~] appeals panel and on which judicial review is sought. The pleadings must specifically set forth the determinations of the appeals panel by which the party is aggrieved.

SECTION 3.195. Section 410.304, Labor Code, is amended to read as follows:

Sec. 410.304. CONSIDERATION OF APPEALS PANEL DECISION. (a) In a jury trial, the court, before submitting the case to the jury, shall inform the jury in the court's instructions, charge, or questions to the jury of the department [~~commission~~] appeals panel decision on each disputed issue described by Section 410.301(a) that is submitted to the jury.

(b) In a trial to the court without a jury, the court in rendering its judgment on an issue described by Section 410.301(a) shall consider the decision of the department [~~commission~~] appeals panel.

SECTION 3.196. Subsections (b) and (c), Section 410.306, Labor Code, are amended to read as follows:

(b) The department [~~commission~~] on payment of a reasonable fee shall make available to the parties a certified copy of the department's [~~commission's~~] record. All facts and evidence the record contains are admissible to the extent allowed under the Texas Rules of [~~Civil~~] Evidence.

(c) Except as provided by Section 410.307, evidence of extent of impairment shall be limited to that presented to the department [~~commission~~]. The court or jury, in its determination of the extent of impairment, shall adopt one of the impairment ratings under Subchapter G, Chapter 408.

SECTION 3.197. Subsections (a) and (d), Section 410.307, Labor Code, are amended to read as follows:

(a) Evidence of the extent of impairment is not limited to that presented to the department [~~commission~~] if the court, after a hearing, finds that there is a substantial change of condition. The court's finding of a substantial change of condition may be based only on:

(1) medical evidence from the same doctor or doctors whose testimony or opinion was presented to the department [~~commission~~];

(2) evidence that has come to the party's knowledge since the contested case hearing;

(3) evidence that could not have been discovered earlier with due diligence by the party; and

(4) evidence that would probably produce a different result if it is admitted into evidence at the trial.

(d) If the court finds a substantial change of condition under this section, new medical evidence of the extent of impairment must be from and is limited to the same doctor or doctors who made impairment ratings before the department [~~commission~~]

under Section 408.123.

SECTION 3.198. Subsection (a), Section 410.308, Labor Code, is amended to read as follows:

(a) The department [~~commission or the Texas Department of Insurance~~] shall furnish any interested party in the claim with a certified copy of the notice of the employer securing compensation with the insurance carrier, filed with the department [~~commission~~].

SECTION 3.199. Subdivision (1), Section 411.001, Labor Code, is amended to read as follows:

(1) "Division" means the division of workers' health and safety of the department [~~commission~~].

SECTION 3.200. Section 411.013, Labor Code, is amended to read as follows:

Sec. 411.013. FEDERAL CONTRACTS AND PROGRAMS. With the approval of the commissioner [~~commission~~], the division may:

(1) enter into contracts with the federal government to perform occupational safety projects; and

(2) apply for federal funds through any federal program relating to occupational safety.

SECTION 3.201. Section 411.032, Labor Code, is amended to read as follows:

Sec. 411.032. EMPLOYER INJURY AND OCCUPATIONAL DISEASE REPORT; ADMINISTRATIVE VIOLATION. (a) An employer shall file with the department [~~commission~~] a report of each:

(1) on-the-job injury that results in the employee's absence from work for more than one day; and

(2) occupational disease of which the employer has knowledge.

(b) The commissioner [~~commission~~] shall adopt rules and prescribe the form and manner of reports filed under this section.

(c) An employer commits an administrative violation if the employer fails to report to the department [~~commission~~] as required under Subsection (a) unless good cause exists, as determined by the commissioner [~~commission~~], for the failure. [~~A violation under this subsection is a Class D administrative violation.~~]

SECTION 3.202. Section 411.035, Labor Code, is amended to read as follows:

Sec. 411.035. USE OF INJURY REPORT. A report made under Section 411.032 may not be considered to be an admission by or evidence against an employer or an insurance carrier in a proceeding before the department [~~commission~~] or a court in which the facts set out in the report are contradicted by the employer or insurance carrier.

SECTION 3.203. Section 411.0415, Labor Code, is amended to read as follows:

Sec. 411.0415. EXEMPTION FOR CERTAIN EMPLOYERS; HEARING. (a) The commissioner [~~executive director~~] may exclude from identification as a hazardous employer an employer who presents evidence satisfactory to the commissioner [~~commission~~] that the injury frequencies of the employer substantially exceed those that may reasonably be expected in that employer's business or industry only because of a fatality that:

(1) occurred because of factors beyond the employer's control; or

(2) was outside the course and scope of the deceased individual's employment.

(b) The commissioner [~~commission~~] by rule shall analyze and list fatalities that may not be related to the work environment, including:

(1) heart attacks;

(2) common diseases of life;

(3) homicides;

(4) suicides;

(5) vehicle accidents involving a third party;

(6) common carrier accidents; and

(7) natural events.

(c) If the commissioner [~~commission~~] determines that the case history of the employee's fatality indicates that the employer or the work environment was a proximate cause of the fatality, the

commissioner [~~commission~~] may request a hearing under Section 411.049. If the hearing establishes that a proximate cause of the fatality was a factor or factors within the employer's control and was within the course and scope of the employment, the commissioner [~~commission~~] may identify the employer for the hazardous employer program if that fatality causes the employer to be designated as a hazardous employer.

SECTION 3.204. Subsection (b), Section 411.042, Labor Code, is amended to read as follows:

(b) The commissioner [~~commission~~] by rule shall require a minimum interval of at least six months before a subsequent audit to identify an employer who was previously identified as a hazardous employer.

SECTION 3.205. Subsection (b), Section 411.043, Labor Code, is amended to read as follows:

(b) The safety consultant shall file a written report with the department [~~commission~~] and the employer setting out any hazardous conditions or practices identified by the safety consultation.

SECTION 3.206. Subsection (a), Section 411.045, Labor Code, is amended to read as follows:

(a) Not earlier than six months or later than nine months after the formulation of an accident prevention plan under Section 411.043, the division shall conduct a follow-up inspection of the employer's premises. The department [~~commission~~] may require the participation of the safety consultant who performed the initial consultation and formulated the safety plan.

SECTION 3.207. Subsection (b), Section 411.046, Labor Code, is amended to read as follows:

(b) A violation under Subsection (a) is an [~~a Class B~~] administrative violation. [~~Each day of noncompliance constitutes a separate violation.~~]

SECTION 3.208. Section 411.048, Labor Code, is amended to read as follows:

Sec. 411.048. COSTS CHARGED TO EMPLOYER. (a) The department [~~commission~~] shall charge an employer that is a political subdivision for reimbursement of the reasonable cost of services provided by the division, including a reasonable allocation of the department's [~~commission's~~] administrative costs, in formulating and monitoring the implementation of a plan under Section 411.043 or 411.047, investigating an accident under Section 411.044, or in conducting a follow-up inspection under Section 411.045.

(b) The department [~~commission~~] shall charge a private employer for reimbursement of the reasonable cost of services provided by the division, including a reasonable allocation of the department's [~~commission's~~] administrative costs, in providing safety and health services under this program at the request of the private employer. This subsection does not apply to services provided to the employer under Section 411.018.

SECTION 3.209. Subsection (a), Section 411.049, Labor Code, is amended to read as follows:

(a) An employer may request a hearing to contest findings made by the department [~~commission~~] under this subchapter.

SECTION 3.210. Section 411.050, Labor Code, is amended to read as follows:

Sec. 411.050. ADMISSIBILITY OF IDENTIFICATION AS HAZARDOUS EMPLOYER. The identification of an employer as a hazardous employer under this subchapter is not admissible in any judicial proceeding unless:

(1) the department [~~commission~~] has determined that the employer is not in compliance with this subchapter; and

(2) that determination has not been reversed or superseded at the time of the event giving rise to the judicial proceeding.

SECTION 3.211. Section 411.062, Labor Code, is amended to read as follows:

Sec. 411.062. FIELD SAFETY REPRESENTATIVE; QUALIFICATIONS. (a) The commissioner [~~commission~~] by rule shall establish

qualifications for field safety representatives. The rules must include education and experience requirements for those representatives.

(b) Each field safety representative must meet the qualifications established by the commissioner [~~commission~~].

SECTION 3.212. Subsection (c), Section 411.064, Labor Code, is amended to read as follows:

(c) The insurance company shall reimburse the department [~~commission~~] for the reasonable cost of the reinspection, including a reasonable allocation of the department's [~~commission's~~] administrative costs incurred in conducting the inspections.

SECTION 3.213. Subsection (b), Section 411.065, Labor Code, is amended to read as follows:

(b) The information must include:

(1) the amount of money spent by the insurance company on accident prevention services;

(2) the number and qualifications of field safety representatives employed by the insurance company;

(3) the number of site inspections performed;

(4) accident prevention services for which the insurance company contracts;

(5) a breakdown of the premium size of the risks to which services were provided;

(6) evidence of the effectiveness of and accomplishments in accident prevention; and

(7) any additional information required by the department [~~commission~~].

SECTION 3.214. The heading to Section 411.067, Labor Code, is amended to read as follows:

Sec. 411.067. DEPARTMENT [~~COMMISSION~~] PERSONNEL.

SECTION 3.215. Subsection (a), Section 411.067, Labor Code, is amended to read as follows:

(a) The department [~~commission~~] shall employ the personnel necessary to enforce this subchapter, including at least 10 safety inspectors to perform inspections at a job site and at an insurance company to determine the adequacy of the accident prevention services provided by the insurance company.

SECTION 3.216. Subsection (b), Section 411.068, Labor Code, is amended to read as follows:

(b) A violation under Subsection (a) is an [~~a Class B~~] administrative violation. [~~Each day of noncompliance constitutes a separate violation.~~]

SECTION 3.217. Subsection (b), Section 411.081, Labor Code, is amended to read as follows:

(b) Each employer shall notify its employees of this service in a manner prescribed by the department [~~commission~~].

SECTION 3.218. Section 411.092, Labor Code, is amended to read as follows:

Sec. 411.092. ENFORCEMENT; RULES. The commissioner [~~commission~~] shall enforce Section 411.091 and may adopt rules for that purpose.

SECTION 3.219. Subsection (b), Section 411.104, Labor Code, is amended to read as follows:

(b) In addition to the duties specified in this chapter, the division shall perform other duties as required by the department [~~commission~~].

SECTION 3.220. Section 411.105, Labor Code, is amended to read as follows:

Sec. 411.105. CONFIDENTIAL INFORMATION; PENALTY. (a) The department [~~commission~~] and its employees may not disclose at a public hearing or otherwise information relating to secret processes, methods of manufacture, or products.

(b) The commissioner [~~A member~~] or an employee of the department [~~commission~~] commits an offense if the commissioner [~~member~~] or employee wilfully discloses or conspires to disclose information made confidential under this section. An offense under this subsection is a misdemeanor punishable by a fine not to exceed $1,000 and by forfeiture of the person's appointment as commissioner [~~a member~~] or as an employee of the department

[~~commission~~].

SECTION 3.221. Section 411.106, Labor Code, is amended to read as follows:

Sec. 411.106. SAFETY CLASSIFICATION. (a) To establish a safety classification for employers, the department [~~commission~~] shall:

(1) obtain medical and compensation cost information regularly compiled by the Texas Department of Insurance in performing that agency's rate-making duties and functions regarding employer liability and workers' compensation insurance; and

(2) collect and compile information relating to:

(A) the frequency rate of accidents;

(B) the existence and implementation of private safety programs;

(C) the number of work-hour losses because of injuries; and

(D) other facts showing accident experience.

(b) From the information obtained under Subsection (a), the department [~~commission~~] shall classify employers as appropriate to implement this subchapter.

SECTION 3.222. Section 411.107, Labor Code, is amended to read as follows:

Sec. 411.107. ELIMINATION OF SAFETY IMPEDIMENTS. The department [~~commission~~] may endeavor to eliminate an impediment to occupational or industrial safety that is reported to the department [~~commission~~] by an affected employer. In attempting to eliminate an impediment the department [~~commission~~] may advise and consult with an employer, or a representative of an employer, who is directly involved.

SECTION 3.223. Section 411.108, Labor Code, is amended to read as follows:

Sec. 411.108. ACCIDENT REPORTS. The department [~~commission~~] may require an employer and any other appropriate person to report accidents, personal injuries, fatalities, or other statistics and information relating to accidents on forms prescribed by and covering periods designated by the department [~~commission~~].

SECTION 3.224. Subsections (g), (i), and (l), Section 412.041, Labor Code, are amended to read as follows:

(g) The director shall act as an adversary before the department [~~commission~~] and courts and present the legal defenses and positions of the state as an employer and insurer, as appropriate.

(i) In administering Chapter 501, the director is subject to the rules, orders, and decisions of the commissioner [~~commission~~] in the same manner as a private employer, insurer, or association.

(l) The director shall furnish copies of all rules to:

(1) the department [~~commission~~];

(2) the commissioner of the Texas Department of Insurance; and

(3) the administrative heads of all state agencies affected by this chapter and Chapter 501.

SECTION 3.225. Section 413.001, Labor Code, is amended to read as follows:

Sec. 413.001. DEFINITION. In this chapter, "division" means the division of medical review of the department [~~commission~~].

SECTION 3.226. Section 413.002, Labor Code, is amended to read as follows:

Sec. 413.002. DIVISION OF MEDICAL REVIEW. (a) The department [~~commission~~] shall maintain a division of medical review to ensure compliance with the rules and to implement this chapter under the policies adopted by the department [~~commission~~].

(b) The division shall monitor health care providers, insurance carriers, [~~and~~] workers' compensation claimants who receive medical services, and independent review organizations to ensure the compliance of those persons with rules adopted by the commissioner [~~commission~~] relating to health care, including

medical policies and fee guidelines.

(c) In monitoring health care providers who serve as designated doctors under Chapter 408 and independent review organizations who provide services described by this chapter, the division shall evaluate:

(1) [~~the~~] compliance [~~of those providers~~] with this subtitle and with rules adopted by the commissioner [~~commission~~] relating to medical policies, fee guidelines, treatment guidelines, return-to-work guidelines, and impairment ratings; and

(2) the quality and timeliness of decisions made under Section 408.0041, 408.122, 408.151, or 413.031.

(d) The division shall report the results of the monitoring of independent review organizations under Subsection (c) to the Texas Department of Insurance on at least a quarterly basis.

(e) If the commissioner of the Texas Department of Insurance determines that an independent review organization is in violation of this chapter, rules adopted by the commissioner under this chapter, or applicable provisions of this code, or rules adopted under this code, or applicable provisions of the Insurance Code or rules adopted under that code, the commissioner of the Texas Department of Insurance or a designated representative shall notify the independent review organization of the alleged violation and may compel the production of any documents or other information as necessary to determine whether the violation occurred.

SECTION 3.227. Section 413.003, Labor Code, is amended to read as follows:

Sec. 413.003. AUTHORITY TO CONTRACT. The department [~~commission~~] may contract with a private or public entity to perform a duty or function of the division.

SECTION 3.228. Section 413.004, Labor Code, is amended to read as follows:

Sec. 413.004. COORDINATION WITH PROVIDERS. The division shall coordinate its activities with health care providers as necessary to perform its duties under this chapter. The coordination may include:

(1) conducting educational seminars on commissioner [~~commission~~] rules and procedures; or

(2) providing information to and requesting assistance from professional peer review organizations.

SECTION 3.229. Section 413.006, Labor Code, is amended to read as follows:

Sec. 413.006. ADVISORY COMMITTEES. The commissioner [~~commission~~] may appoint advisory committees [~~in addition to the medical advisory committee~~] as the commissioner [~~it~~] considers necessary.

SECTION 3.230. Subsections (a) and (c), Section 413.007, Labor Code, are amended to read as follows:

(a) The division shall maintain a statewide data base of medical charges, actual payments, and treatment protocols that may be used by:

(1) the department [~~commission~~] in adopting the medical policies and fee guidelines; and

(2) the division in administering the medical policies, fee guidelines, or rules.

(c) The division shall ensure that the data base is available for public access for a reasonable fee established by the commissioner [~~commission~~]. The identities of injured workers and beneficiaries may not be disclosed.

SECTION 3.231. Section 413.008, Labor Code, is amended to read as follows:

Sec. 413.008. INFORMATION FROM INSURANCE CARRIERS; ADMINISTRATIVE VIOLATION. (a) On request from the department [~~commission~~] for specific information, an insurance carrier shall provide to the division any information in its possession, custody, or control that reasonably relates to the department's [~~commission's~~] duties under this subtitle and to health care:

(1) treatment;

(2) services;

(3) fees; and

(4) charges.

(b) The department [~~commission~~] shall keep confidential information that is confidential by law.

(c) An insurance carrier commits a violation if the insurance carrier fails or refuses to comply with a request or violates a rule adopted to implement this section. [~~A violation under this subsection is a Class C administrative violation. Each day of noncompliance constitutes a separate violation.~~]

SECTION 3.232. Section 413.011, Labor Code, is amended to read as follows:

Sec. 413.011. REIMBURSEMENT POLICIES AND GUIDELINES; TREATMENT GUIDELINES AND PROTOCOLS. (a) The department [~~commission~~] shall use health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems with minimal modifications to those reimbursement methodologies as necessary to meet occupational injury requirements. To achieve standardization, the department [~~commission~~] shall adopt the most current reimbursement methodologies, models, and values or weights used by the federal Centers for Medicare and Medicaid Services [~~Health Care Financing Administration~~], including applicable payment policies relating to coding, billing, and reporting, and may modify documentation requirements as necessary to meet the requirements of Section 413.053.

(b) In determining the appropriate fees, the commissioner [~~commission~~] shall also develop conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d). The commissioner [~~commission~~] shall also provide for reasonable fees for the evaluation and management of care as required by Section 408.025(c) and commissioner [~~commission~~] rules. This section does not adopt the Medicare fee schedule, and the commissioner may [~~commission shall~~] not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services [~~Health Care Financing Administration~~].

(c) This section may not be interpreted in a manner that would discriminate in the amount or method of payment or reimbursement for services in a manner prohibited by Section 1451.104 [~~3(d), Article 21.52~~], Insurance Code, or as restricting the ability of chiropractors to serve as treating doctors as authorized by this subtitle. The commissioner [~~commission~~] shall also develop guidelines relating to fees charged or paid for providing expert testimony relating to an issue arising under this subtitle.

(d) Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commissioner [~~commission~~] shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.

(e) The commissioner [~~commission~~] by rule shall [~~may~~] adopt treatment guidelines and [~~, including~~] return-to-work guidelines, and may adopt individual treatment protocols. Treatment [~~Except as otherwise provided by this subsection, the treatment~~] guidelines and protocols must be evidence-based [~~nationally recognized~~], scientifically valid, and outcome-focused [~~outcome-based~~] and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care [~~If a nationally recognized treatment guideline or protocol is not available for adoption by the commission, the commission may adopt another treatment guideline or protocol as long as it is scientifically valid and outcome-based~~].

(f) In addition to complying with the requirements of Subsection (e), [~~The commission by rule may establish medical policies or treatment guidelines or protocols relating to necessary~~

~~treatments for injuries.~~

[~~(g) Any~~] medical policies or guidelines adopted by the commissioner [~~commission~~] must be:

(1) designed to ensure the quality of medical care and to achieve effective medical cost control;

(2) designed to enhance a timely and appropriate return to work; and

(3) consistent with Sections 413.013, 413.020, 413.052, and 413.053.

(g) The commissioner may adopt rules relating to disability management that are designed to promote appropriate health care at the earliest opportunity after the injury to maximize injury healing and improve stay-at-work and return-to-work outcomes through appropriate management of work-related injuries or conditions. The commissioner by rule may identify claims in which application of disability management activities is required and prescribe at what point in the claim process a treatment plan is required. The determination may be based on any factor considered relevant by the commissioner. Rules adopted under this subsection do not apply to claims subject to workers' compensation health care networks under Chapter 1305, Insurance Code.

(h) A dispute involving a treatment plan required under Subsection (g) may be appealed to an independent review organization in the manner described by Section 413.031.

SECTION 3.233. Section 413.013, Labor Code, is amended to read as follows:

Sec. 413.013. PROGRAMS. The commissioner [~~commission~~] by rule shall establish:

(1) a program for prospective, concurrent, and retrospective review and resolution of a dispute regarding health care treatments and services;

(2) a program for the systematic monitoring of the necessity of treatments administered and fees charged and paid for medical treatments or services, including the authorization of prospective, concurrent, or retrospective review under the medical policies of the department [~~commission~~] to ensure that the medical policies or guidelines are not exceeded;

(3) a program to detect practices and patterns by insurance carriers in unreasonably denying authorization of payment for medical services requested or performed if authorization is required by the medical policies of the department [~~commission~~]; and

(4) a program to increase the intensity of review for compliance with the medical policies or fee guidelines for any health care provider that has established a practice or pattern in charges and treatments inconsistent with the medical policies and fee guidelines.

SECTION 3.234. Subsections (b) through (e), Section 413.014, Labor Code, are amended to read as follows:

(b) The commissioner [~~commission~~] by rule shall specify which health care treatments and services require express preauthorization or concurrent review by the insurance carrier. Treatments and services for a medical emergency do not require express preauthorization.

(c) The commissioner's [~~commission~~] rules adopted under this section must provide that preauthorization and concurrent review are required at a minimum for:

(1) spinal surgery, as provided by Section 408.026;

(2) work-hardening or work-conditioning services provided by a health care facility that is not credentialed by an organization recognized by commissioner [~~commission~~] rules;

(3) inpatient hospitalization, including any procedure and length of stay;

(4) outpatient or ambulatory surgical services, as defined by commissioner [~~commission~~] rule; and

(5) any investigational or experimental services or devices.

(d) The insurance carrier is not liable for those specified treatments and services requiring preauthorization unless

preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or ordered by the commissioner [~~commission~~].

(e) The commissioner [~~commission~~] may not prohibit an insurance carrier and a health care provider from voluntarily discussing health care treatment and treatment plans and pharmaceutical services, either prospectively or concurrently, and may not prohibit an insurance carrier from certifying or agreeing to pay for health care consistent with those agreements. The insurance carrier is liable for health care treatment and treatment plans and pharmaceutical services that are voluntarily preauthorized and may not dispute the certified or agreed-on preauthorized health care treatment and treatment plans and pharmaceutical services at a later date.

SECTION 3.235. Section 413.0141, Labor Code, is amended to read as follows:

Sec. 413.0141. INITIAL PHARMACEUTICAL COVERAGE. The commissioner [~~commission~~] may by rule provide that an insurance carrier shall provide for payment of specified pharmaceutical services sufficient for the first seven days following the date of injury if the health care provider requests and receives verification of insurance coverage and a verbal confirmation of an injury from the employer or from the insurance carrier as provided by Section 413.014. The rules adopted by the commissioner [~~commission~~] shall provide that an insurance carrier is eligible for reimbursement for pharmaceutical services paid under this section from the subsequent injury fund in the event the injury is determined not to be compensable.

SECTION 3.236. Subsection (b), Section 413.015, Labor Code, is amended to read as follows:

(b) The commissioner [~~commission~~] shall provide by rule for the review and audit of the payment by insurance carriers of charges for medical services provided under this subtitle to ensure compliance of health care providers and insurance carriers with the medical policies and fee guidelines adopted by the commissioner [~~commission~~].

SECTION 3.237. Subsection (b), Section 413.016, Labor Code, is amended to read as follows:

(b) If the division determines that an insurance carrier has paid medical charges that are inconsistent with the medical policies or fee guidelines adopted by the commissioner [~~commission~~], the division shall refer the insurance carrier alleged to have violated this subtitle to the division of compliance and practices. If the insurance carrier reduced a charge of a health care provider that was within the guidelines, the insurance carrier shall be directed to submit the difference to the provider unless the reduction is in accordance with an agreement between the health care provider and the insurance carrier.

SECTION 3.238. Section 413.017, Labor Code, is amended to read as follows:

Sec. 413.017. PRESUMPTION OF REASONABLENESS. The following medical services are presumed reasonable:

(1) medical services consistent with the medical policies and fee guidelines adopted by the commissioner [~~commission~~]; and

(2) medical services that are provided subject to prospective, concurrent, or retrospective review as required by the medical policies of the department [~~commission~~] and that are authorized by an insurance carrier.

SECTION 3.239. Subsections (a), (c), (d), and (e), Section 413.018, Labor Code, are amended to read as follows:

(a) The commissioner [~~commission~~] by rule shall provide for the periodic review of medical care provided in claims in which guidelines for expected or average return to work time frames are exceeded.

(c) The department [~~commission~~] shall implement a program to encourage employers and treating doctors to discuss the availability of modified duty to encourage the safe and more timely return to work of injured employees. The department [~~commission~~]

may require a treating or examining doctor, on the request of the employer, insurance carrier, or department [~~commission~~], to provide a functional capacity evaluation of an injured employee and to determine the employee's ability to engage in physical activities found in the workplace or in activities that are required in a modified duty setting.

(d) The department [~~commission~~] shall provide through the department's [~~commission's~~] health and safety information and medical review outreach programs information to employers regarding effective return to work programs. This section does not require an employer to provide modified duty or an employee to accept a modified duty assignment. An employee who does not accept an employer's offer of modified duty determined by the department [~~commission~~] to be a bona fide job offer is subject to Section 408.103(e).

(e) The commissioner [~~commission~~] may adopt rules and forms as necessary to implement this section.

SECTION 3.240. Section 413.020, Labor Code, is amended to read as follows:

Sec. 413.020. DEPARTMENT [~~COMMISSION~~] CHARGES. The commissioner [~~commission~~] by rule shall establish procedures to enable the department [~~commission~~] to charge:

(1) an insurance carrier a reasonable fee for access to or evaluation of health care treatment, fees, or charges under this subtitle; and

(2) a health care provider who exceeds a fee or utilization guideline established under this subtitle or an insurance carrier who unreasonably disputes charges that are consistent with a fee or utilization guideline established under this subtitle a reasonable fee for review of health care treatment, fees, or charges under this subtitle.

SECTION 3.241. Subsections (a), (d), and (e), Section 413.021, Labor Code, are amended to read as follows:

(a) An insurance carrier shall, with the agreement of a participating employer, provide the employer with return-to-work coordination services as necessary to facilitate an employee's return to employment. The insurance carrier shall notify the employer of the availability of return-to-work coordination services. In offering the services, insurance carriers and the department [~~commission~~] shall target employers without return-to-work programs and shall focus return-to-work efforts on workers who begin to receive temporary income benefits. These services may be offered by insurance carriers in conjunction with the accident prevention services provided under Section 411.061. Nothing in this section supersedes the provisions of a collective bargaining agreement between an employer and the employer's employees, and nothing in this section authorizes or requires an employer to engage in conduct that would otherwise be a violation of the employer's obligations under the National Labor Relations Act (29 U.S.C. Section 151 et seq.) [~~, and its subsequent amendments~~].

(d) The department [~~commission~~] shall use certified rehabilitation counselors or other appropriately trained or credentialed specialists to provide training to department [~~commission~~] staff regarding the coordination of return-to-work services under this section.

(e) The commissioner [~~commission~~] shall adopt rules necessary to collect data on return-to-work outcomes to allow full evaluations of successes and of barriers to achieving timely return to work after an injury.

SECTION 3.242. Subchapter B, Chapter 413, Labor Code, is amended by adding Section 413.022 to read as follows:

Sec. 413.022. RETURN-TO-WORK PILOT PROGRAM FOR SMALL EMPLOYERS; FUND. (a) In this section:

(1) "Account" means the workers' compensation return-to-work account.

(2) "Eligible employer" means any employer, other than this state or a political subdivision subject to Subtitle C, who employs at least two but not more than 50 employees on each business day during the preceding calendar year and who has workers'

compensation insurance coverage.

(b) The commissioner shall establish by rule a return-to-work pilot program designed to promote the early and sustained return to work of an injured employee who sustains a compensable injury.

(c) The pilot program shall reimburse from the account an eligible employer for expenses incurred by the employer to make workplace modifications necessary to accommodate an injured employee's return to modified or alternative work. Reimbursement under this section to an eligible employer may not exceed $2,500. The expenses must be incurred to allow the employee to perform modified or alternative work within doctor-imposed work restrictions. Allowable expenses may include:

(1) physical modifications to the worksite;

(2) equipment, devices, furniture, or tools; and

(3) other costs necessary for reasonable accommodation of the employee's restrictions.

(d) The account is established as a special account in the general revenue fund. From administrative penalties received by the department under this subtitle, the commissioner shall deposit in the account an amount not to exceed $100,000 annually. Money in the account may be spent by the department, on appropriation by the legislature, only for the purposes of implementing this section.

(e) An employer who wilfully applies for or receives reimbursement from the account under this section knowing that the employer is not an eligible employer commits a violation. A violation under this subsection is a Class B administrative violation.

(f) Notwithstanding Subsections (a)-(e), this section may be implemented only to the extent funds are available.

(g) This section expires September 1, 2009.

SECTION 3.243. Section 413.031, Labor Code, is amended by amending Subsections (a) through (d), (e-1), (f), (g), (h), (k), and (m) and by adding Subsection (n) to read as follows:

(a) A party, including a health care provider, is entitled to a review of a medical service provided or for which authorization of payment is sought if a health care provider is:

(1) denied payment or paid a reduced amount for the medical service rendered;

(2) denied authorization for the payment for the service requested or performed if authorization is required or allowed by this subtitle or commissioner [~~commission~~] rules;

(3) ordered by the commissioner [~~commission~~] to refund a payment received; or

(4) ordered to make a payment that was refused or reduced for a medical service rendered.

(b) A health care provider who submits a charge in excess of the fee guidelines or treatment policies is entitled to a review of the medical service to determine if reasonable medical justification exists for the deviation. A claimant is entitled to a review of a medical service for which preauthorization is sought by the health care provider and denied by the insurance carrier. The commissioner [~~commission~~] shall adopt rules to notify claimants of their rights under this subsection.

(c) In resolving disputes over the amount of payment due for services determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the department [~~commission~~] is to adjudicate the payment given the relevant statutory provisions and commissioner [~~commission~~] rules. The department [~~commission~~] shall publish on its Internet website its medical dispute decisions, including decisions of independent review organizations, and any subsequent decisions by the State Office of Administrative Hearings. Before publication, the department [~~commission~~] shall redact only that information necessary to prevent identification of the injured worker.

(d) A review of the medical necessity of a health care service requiring preauthorization under Section 413.014 or commissioner [~~commission~~] rules under that section or Section 413.011(g) shall be conducted by an independent review organization

under Article 21.58C, Insurance Code, in the same manner as reviews of utilization review decisions by health maintenance organizations. It is a defense for the insurance carrier if the carrier timely complies with the decision of the independent review organization.

(e-1) In performing a review of medical necessity under Subsection (d) or (e), the independent review organization shall consider the department's [~~commission's~~] health care reimbursement policies and guidelines adopted under Section 413.011 [~~if those policies and guidelines are raised by one of the parties to the dispute~~]. If the independent review organization's decision is contrary to the department's [~~commission's~~] policies or guidelines adopted under Section 413.011, the independent review organization must indicate in the decision the specific basis for its divergence in the review of medical necessity. [~~This subsection does not prohibit an independent review organization from considering the payment policies adopted under Section 413.011 in any dispute, regardless of whether those policies are raised by a party to the dispute.~~]

(f) The commissioner [~~commission~~] by rule shall specify the appropriate dispute resolution process for disputes in which a claimant has paid for medical services and seeks reimbursement.

(g) In performing a review of medical necessity under Subsection (d) or (e), an independent review organization may request that the commissioner [~~commission~~] order an examination by a designated doctor under Chapter 408.

(h) The insurance carrier shall pay the cost of the review if the dispute arises in connection with:

(1) a request for health care services that require preauthorization under Section 413.014 or commissioner [~~commission~~] rules under that section; or

(2) a treatment plan under Section 413.011(g) or commissioner rules under that section.

(k) Except as provided by Subsection (l), a party to a medical dispute that remains unresolved after a review of the medical service under this section [~~is entitled to a hearing. The hearing shall be conducted by the State Office of Administrative Hearings within 90 days of receipt of a request for a hearing in the manner provided for a contested case under Chapter 2001, Government Code (the administrative procedure law). A party who has exhausted the party's administrative remedies under this subtitle and who is aggrieved by a final decision of the State Office of Administrative Hearings~~] may seek judicial review of the decision. The department is not considered to be a party to the medical dispute for purposes of this subsection. Judicial review under this subsection shall be conducted in the manner provided for judicial review of contested cases under Subchapter G, Chapter 2001, Government Code.

(m) The decision of an independent review organization under Subsection (d) is binding during the pendency of a dispute.

(n) The commissioner [~~commission~~] by rule may prescribe an alternate dispute resolution process to resolve disputes regarding medical services costing less than the cost of a review of the medical necessity of a health care service by an independent review organization. The cost of a review under the alternate dispute resolution process shall be paid by the nonprevailing party.

SECTION 3.244. Subsections (a), (b), and (d), Section 413.041, Labor Code, are amended to read as follows:

(a) Each health care practitioner shall disclose to the department [~~commission~~] the identity of any health care provider in which the health care practitioner, or the health care provider that employs the health care practitioner, has a financial interest. The health care practitioner shall make the disclosure in the manner provided by commissioner [~~commission~~] rule.

(b) The commissioner [~~commission~~] shall require by rule that a doctor disclose financial interests in other health care providers as a condition of registration for the approved doctor list established under Section 408.023 and shall define "financial interest" for purposes of this subsection as provided by analogous federal regulations. The commissioner [~~commission~~] by rule shall

adopt the federal standards that prohibit the payment or acceptance of payment in exchange for health care referrals relating to fraud, abuse, and antikickbacks.

(d) The department [~~commission~~] shall publish all final disclosure enforcement orders issued under this section on the department's [~~commission's~~] Internet website.

SECTION 3.245. Subsection (b), Section 413.042, Labor Code, is amended to read as follows:

(b) A health care provider commits a violation if the provider violates Subsection (a). [~~A violation under this subsection is a Class B administrative violation.~~]

SECTION 3.246. Section 413.044, Labor Code, is amended to read as follows:

Sec. 413.044. SANCTIONS ON DESIGNATED DOCTOR. (a) In addition to or in lieu of an administrative penalty under Section 415.021 or a sanction imposed under Section 415.023, the commissioner [~~commission~~] may impose sanctions against a person who serves as a designated doctor under Chapter 408 who, after an evaluation conducted under Section 413.002(c), is determined by the division to be out of compliance with this subtitle or with rules adopted by the commissioner [~~commission~~] relating to:

(1) medical policies, fee guidelines, and impairment ratings; or

(2) the quality of decisions made under Section 408.0041 or Section 408.122.

(b) Sanctions imposed under Subsection (a) may include:

(1) removal or suspension from the department list of designated doctors; or

(2) restrictions on the reviews made by the person as a designated doctor.

SECTION 3.247. Subsections (a) through (d), Section 413.051, Labor Code, are amended to read as follows:

(a) The department [~~commission~~] may contract with a health care provider, health care provider professional review organization, or other entity to develop, maintain, or review medical policies or fee guidelines or to review compliance with the medical policies or fee guidelines.

(b) For purposes of review or resolution of a dispute as to compliance with the medical policies or fee guidelines, the department [~~commission~~] may contract with a health care provider, health care provider professional review organization, or other entity that includes in the review process health care practitioners who are licensed in the category under review and are of the same field or specialty as the category under review.

(c) The department [~~commission~~] may contract with a health care provider, health care provider professional review organization, or other entity for medical consultant services, including:

(1) independent medical examinations;

(2) medical case reviews; or

(3) establishment of medical policies and fee guidelines.

(d) The commissioner [~~commission~~] shall establish standards for contracts under this section.

SECTION 3.248. Section 413.0511, Labor Code, is amended to read as follows:

Sec. 413.0511. MEDICAL ADVISOR. (a) The department [~~commission~~] shall employ or contract with a medical advisor, who must be a doctor as that term is defined by Section 401.011.

(b) The medical advisor shall make recommendations regarding the adoption of rules and policies to:

(1) develop, maintain, and review guidelines as provided by Section 413.011, including rules regarding impairment ratings;

(2) review compliance with those guidelines;

(3) regulate or perform other acts related to medical benefits as required by the commissioner [~~commission~~];

(4) impose sanctions or delete doctors from the 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

this subsection does not constitute a waiver of privilege or confidentiality as established by law.

(c) Information that is received by the department [~~commission~~] from the Texas State Board of Medical Examiners or by the Texas State Board of Medical Examiners from the department [~~commission~~] remains confidential, may not be disclosed by the department [~~commission~~] except as necessary to further the investigation, and shall be exempt from disclosure under Sections 402.092 and 413.0513.

(d) The department [~~commission~~] and the Texas Board of Chiropractic Examiners on request or on its own initiative, may share with each other confidential information or information to which access is otherwise restricted by law. The department [~~commission~~] and the Texas Board of Chiropractic Examiners shall cooperate with and assist each other when either agency is conducting an investigation by providing information to each other that is relevant to the investigation. Except as provided by this section, confidential information that is shared under this section remains confidential under law and legal restrictions on access to the information remain in effect unless the agency sharing the information approves use of the information by the receiving agency for enforcement purposes. Furnishing information by the Texas Board of Chiropractic Examiners to the department [~~commission~~] or by the department [~~commission~~] to the Texas Board of Chiropractic Examiners under this subsection does not constitute a waiver of privilege or confidentiality as established by law.

(e) Information that is received by the department [~~commission~~] from the Texas Board of Chiropractic Examiners or by the Texas Board of Chiropractic Examiners remains confidential and may not be disclosed by the department [~~commission~~] except as necessary to further the investigation unless the agency sharing the information and the agency receiving the information agree to use of the information by the receiving agency for enforcement purposes.

(f) The department [~~commission~~] and the Texas State Board of Medical Examiners shall provide information to each other on all disciplinary actions taken.

(g) The department [~~commission~~] and the Texas Board of Chiropractic Examiners shall provide information to each other on all disciplinary actions taken.

SECTION 3.252. Section 413.0515, Labor Code, is amended to read as follows:

Sec. 413.0515. REPORTS OF PHYSICIAN AND CHIROPRACTOR VIOLATIONS. (a) If the department [~~commission~~] or the Texas State Board of Medical Examiners discovers an act or omission by a physician that may constitute a felony, a misdemeanor involving moral turpitude, a violation of state or federal narcotics or controlled substance law, an offense involving fraud or abuse under the Medicare or Medicaid program, or a violation of this subtitle, the agency shall report that act or omission to the other agency.

(b) If the department [~~commission~~] or the Texas Board of Chiropractic Examiners discovers an act or omission by a chiropractor that may constitute a felony, a misdemeanor involving moral turpitude, a violation of state or federal narcotics or controlled substance law, an offense involving fraud or abuse under the Medicare or Medicaid program, or a violation of this subtitle, the agency shall report that act or omission to the other agency.

SECTION 3.253. Section 413.052, Labor Code, is amended to read as follows:

Sec. 413.052. PRODUCTION OF DOCUMENTS. The commissioner [~~commission~~] by rule shall establish procedures to enable the department [~~commission~~] to compel the production of documents.

SECTION 3.254. Section 413.053, Labor Code, is amended to read as follows:

Sec. 413.053. STANDARDS OF REPORTING AND BILLING. The commissioner [~~commission~~] by rule shall establish standards of reporting and billing governing both form and content.

SECTION 3.255. Subsection (a), Section 413.054, Labor Code, is amended to read as follows:

(a) A person who performs services for the department [~~commission~~] as a designated doctor, an independent medical examiner, a doctor performing a medical case review, or a member of a peer review panel has the same immunity from liability as the commissioner [~~a commission member~~] under Section 402.011 [~~402.010~~].

SECTION 3.256. Subsections (a) and (b), Section 413.055, Labor Code, are amended to read as follows:

(a) The department [~~executive director~~], as provided by commissioner [~~commission~~] rule, may enter an interlocutory order for the payment of all or part of medical benefits. The order may address accrued benefits, future benefits, or both accrued benefits and future benefits.

(b) The subsequent injury fund shall reimburse an insurance carrier for any overpayments of benefits made under an order entered under Subsection (a) if the order is reversed or modified by final arbitration, order, or decision of the commissioner [~~commission~~] or a court. The commissioner [~~commission~~] shall adopt rules to provide for a periodic reimbursement schedule, providing for reimbursement at least annually.

SECTION 3.257. Subsection (a), Section 414.002, Labor Code, is amended to read as follows:

(a) The division shall monitor for compliance with commissioner [~~commission~~] rules, this subtitle, and other laws relating to workers' compensation the conduct of persons subject to this subtitle, other than persons monitored by the division of medical review. Persons to be monitored include:

(1) persons claiming benefits under this subtitle;

(2) employers;

(3) insurance carriers; and

(4) attorneys and other representatives of parties.

SECTION 3.258. Section 414.003, Labor Code, is amended to read as follows:

Sec. 414.003. COMPILATION AND USE OF INFORMATION. (a) The division shall compile and maintain statistical and other information as necessary to detect practices or patterns of conduct by persons subject to monitoring under this chapter that:

(1) violate this subtitle, commissioner [~~or commission~~] rules, or a commissioner order or decision; or

(2) otherwise adversely affect the workers' compensation system of this state.

(b) The department [~~commission~~] shall use the information compiled under this section to impose appropriate penalties and other sanctions under Chapters 415 and 416.

SECTION 3.259. Section 414.005, Labor Code, is amended to read as follows:

Sec. 414.005. INVESTIGATION UNIT. The division shall maintain an investigation unit to conduct investigations relating to alleged violations of this subtitle, commissioner [~~or commission~~] rules, or a commissioner order or decision, with particular emphasis on violations of Chapters 415 and 416.

SECTION 3.260. Section 414.007, Labor Code, is amended to read as follows:

Sec. 414.007. REVIEW OF REFERRALS FROM DIVISION OF MEDICAL REVIEW. The division shall review information and referrals received from the division of medical review concerning alleged violations of this subtitle, commissioner rules, or a commissioner order or decision, and, under Sections 414.005 and 414.006 and Chapters 415 and 416, may conduct investigations, make referrals to other authorities, and initiate administrative violation proceedings.

SECTION 3.261. Section 415.001, Labor Code, is amended to read as follows:

Sec. 415.001. ADMINISTRATIVE VIOLATION BY REPRESENTATIVE OF EMPLOYEE OR LEGAL BENEFICIARY. A representative of an employee or legal beneficiary commits an administrative violation if, regardless of the person's mental state, the person [~~wilfully or intentionally~~]:

(1) fails without good cause to attend a dispute

resolution proceeding within the department [~~commission~~];

(2) attends a dispute resolution proceeding within the department [~~commission~~] without complete authority or fails to exercise authority to effectuate an agreement or settlement;

(3) commits an act of barratry under Section 38.12, Penal Code;

(4) withholds from the employee's or legal beneficiary's weekly benefits or from advances amounts not authorized to be withheld by the department [~~commission~~];

(5) enters into a settlement or agreement without the knowledge, consent, and signature of the employee or legal beneficiary;

(6) takes a fee or withholds expenses in excess of the amounts authorized by the department [~~commission~~];

(7) refuses or fails to make prompt delivery to the employee or legal beneficiary of funds belonging to the employee or legal beneficiary as a result of a settlement, agreement, order, or award;

(8) violates the Texas Disciplinary Rules of Professional Conduct of the State Bar of Texas;

(9) misrepresents the provisions of this subtitle to an employee, an employer, a health care provider, or a legal beneficiary;

(10) violates a commissioner [~~commission~~] rule; or

(11) fails to comply with this subtitle.

SECTION 3.262. Section 415.002, Labor Code, is amended to read as follows:

Sec. 415.002. ADMINISTRATIVE VIOLATION BY AN INSURANCE CARRIER. (a) An insurance carrier or its representative commits an administrative violation if, regardless of the person's mental state, that person [~~wilfully or intentionally~~]:

(1) misrepresents a provision of this subtitle to an employee, an employer, a health care provider, or a legal beneficiary;

(2) terminates or reduces benefits without substantiating evidence that the action is reasonable and authorized by law;

(3) instructs an employer not to file a document required to be filed with the department [~~commission~~];

(4) instructs or encourages an employer to violate a claimant's right to medical benefits under this subtitle;

(5) fails to tender promptly full death benefits if a legitimate dispute does not exist as to the liability of the insurance carrier;

(6) allows an employer, other than a self-insured employer, to dictate the methods by which and the terms on which a claim is handled and settled;

(7) fails to confirm medical benefits coverage to a person or facility providing medical treatment to a claimant if a legitimate dispute does not exist as to the liability of the insurance carrier;

(8) fails, without good cause, to attend a dispute resolution proceeding within the department [~~commission~~];

(9) attends a dispute resolution proceeding within the department [~~commission~~] without complete authority or fails to exercise authority to effectuate agreement or settlement;

(10) adjusts a workers' compensation claim in a manner contrary to license requirements for an insurance adjuster, including the requirements of Chapter 4101, Insurance Code [~~407, Acts of the 63rd Legislature, Regular Session, 1973 (Article 21.07-4, Vernon's Texas Insurance Code)~~], or the rules of the commissioner [~~State Board~~] of insurance [~~Insurance~~];

(11) fails to process claims promptly in a reasonable and prudent manner;

(12) fails to initiate or reinstate benefits when due if a legitimate dispute does not exist as to the liability of the insurance carrier;

(13) misrepresents the reason for not paying benefits or terminating or reducing the payment of benefits;

(14) dates documents to misrepresent the actual date of the initiation of benefits;

(15) makes a notation on a draft or other instrument indicating that the draft or instrument represents a final settlement of a claim if the claim is still open and pending before the department [~~commission~~];

(16) fails or refuses to pay benefits from week to week as and when due directly to the person entitled to the benefits;

(17) fails to pay an order awarding benefits;

(18) controverts a claim if the evidence clearly indicates liability;

(19) unreasonably disputes the reasonableness and necessity of health care;

(20) violates a commissioner [~~commission~~] rule; [~~or~~]

(21) makes a statement denying all future medical care for a compensable injury; or

(22) fails to comply with a provision of this subtitle.

(b) An insurance carrier or its representative does not commit an administrative violation under Subsection (a)(6) by allowing an employer to:

(1) freely discuss a claim;

(2) assist in the investigation and evaluation of a claim; or

(3) attend a proceeding of the department [~~commission~~] and participate at the proceeding in accordance with this subtitle.

SECTION 3.263. Section 415.003, Labor Code, is amended to read as follows:

Sec. 415.003. ADMINISTRATIVE VIOLATION BY HEALTH CARE PROVIDER. A health care provider commits an administrative violation if, regardless of the person's mental state, the person [~~wilfully or intentionally~~]:

(1) submits a charge for health care that was not furnished;

(2) administers improper, unreasonable, or medically unnecessary treatment or services;

(3) makes an unnecessary referral;

(4) violates the department's [~~commission's~~] fee and treatment guidelines;

(5) violates a commissioner [~~commission~~] rule; or

(6) fails to comply with a provision of this subtitle.

SECTION 3.264. Subsections (a), (b), (e), and (f), Section 415.0035, Labor Code, are amended to read as follows:

(a) An insurance carrier or its representative commits an administrative violation if, regardless of the person's mental state, that person:

(1) fails to submit to the department [~~commission~~] a settlement or agreement of the parties;

(2) fails to timely notify the department [~~commission~~] of the termination or reduction of benefits and the reason for that action; or

(3) denies preauthorization in a manner that is not in accordance with rules adopted by the commissioner [~~commission~~] under Section 413.014.

(b) A health care provider commits an administrative violation if, regardless of the person's mental state, that person:

(1) fails or refuses to timely file required reports or records; or

(2) fails to file with the department [~~commission~~] the annual disclosure statement required by Section 413.041.

(e) An insurance carrier or health care provider commits an administrative violation if that person violates this subtitle or a rule, order, or decision of the commissioner [~~commission~~].

(f) A subsequent administrative violation under this section, after prior notice to the insurance carrier or health care provider of noncompliance, is subject to penalties as provided by Section 415.021. Prior notice under this subsection is not required [~~if the violation was committed wilfully or intentionally, or~~] if the violation was of a decision or order of the commissioner

[~~commission~~].

SECTION 3.265. The heading to Section 415.005, Labor Code, is amended to read as follows:

Sec. 415.005. OVERCHARGING BY HEALTH CARE PROVIDERS PROHIBITED[~~, ADMINISTRATIVE VIOLATION~~].

SECTION 3.266. Subsection (b), Section 415.005, Labor Code, is amended to read as follows:

(b) A violation under this section is an [~~a Class B~~] administrative violation. A health care provider may be liable for an administrative penalty regardless of whether a criminal action is initiated under Section 413.043.

SECTION 3.267. The heading to Section 415.006, Labor Code, is amended to read as follows:

Sec. 415.006. EMPLOYER CHARGEBACKS PROHIBITED[~~, ADMINISTRATIVE VIOLATION~~].

SECTION 3.268. Subsection (c), Section 415.006, Labor Code, is amended to read as follows:

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

SECTION 3.269. Subsection (a), Section 415.007, Labor Code, is amended to read as follows:

(a) An attorney who represents a claimant before the department [~~commission~~] may not lend money to the claimant during the pendency of the workers' compensation claim.

SECTION 3.270. Subsection (e), Section 415.008, Labor Code, is amended to read as follows:

(e) If an administrative violation proceeding is pending under this section against an employee or person claiming death benefits, the department [~~commission~~] may not take final action on the person's benefits.

SECTION 3.271. Subsection (a), Section 415.009, Labor Code, is amended to read as follows:

(a) A person commits a violation if, regardless of the person's mental state, the person [~~knowingly~~] brings, prosecutes, or defends an action for benefits under this subtitle or requests initiation of an administrative violation proceeding that does not have a basis in fact or is not warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law.

SECTION 3.272. Subsection (a), Section 415.010, Labor Code, is amended to read as follows:

(a) A party to an agreement approved by the department [~~commission~~] commits a violation if, regardless of the person's mental state, the person [~~knowingly~~] breaches a provision of the agreement.

SECTION 3.273. Section 415.021, Labor Code, is amended to read as follows:

Sec. 415.021. ASSESSMENT OF ADMINISTRATIVE PENALTIES. (a) In addition to any other provisions in this subtitle relating to violations, a person commits an administrative violation if the person violates, fails to comply with, or refuses to comply with this subtitle or a rule, order, or decision of the department. In addition to any sanctions, administrative penalty, or other remedy authorized by this subtitle, the commissioner [~~The commission~~] may assess an administrative penalty against a person who commits an administrative violation. The administrative penalty shall not exceed $25,000 per day per occurrence. Each day of noncompliance constitutes a separate violation. The commissioner's authority under this chapter is in addition to any other authority to enforce a sanction, penalty, fine, forfeiture, denial, suspension, or revocation otherwise authorized by law [~~Notwithstanding Subsection (c), the commission by rule shall adopt a schedule of specific monetary administrative penalties for specific violations under this subtitle~~].

(b) The commissioner [~~commission may assess an administrative penalty not to exceed $10,000 and~~] may enter a cease and desist order against a person who:

(1) commits repeated administrative violations;

(2) allows, as a business practice, the commission of repeated administrative violations; or

(3) violates an order or decision of the commissioner [~~commission~~].

(c) In assessing an administrative penalty:

(1) [~~,~~] the commissioner [~~commission~~] shall consider:

(A) [~~(1)~~] the seriousness of the violation, including the nature, circumstances, consequences, extent, and gravity of the prohibited act;

(B) [~~(2)~~] the history and extent of previous administrative violations;

(C) [~~(3)~~] the demonstrated good faith of the violator, including actions taken to rectify the consequences of the prohibited act;

(D) [~~(4) the economic benefit resulting from the prohibited act;~~

[~~(5)~~] the penalty necessary to deter future violations; and

(E) [~~(6)~~] other matters that justice may require; and

(2) the commissioner shall, to the extent reasonable, consider the economic benefit resulting from the prohibited act.

(d) A penalty may be assessed only after the person charged with an administrative violation has been given an opportunity for a hearing under Subchapter C.

SECTION 3.274. Subsection (b), Section 415.023, Labor Code, is amended to read as follows:

(b) The commissioner [~~commission~~] may adopt rules providing for:

(1) a reduction or denial of fees;

(2) public or private reprimand by the commissioner [~~commission~~];

(3) suspension from practice before the commissioner [~~commission~~];

(4) restriction, suspension, or revocation of the right to receive reimbursement under this subtitle; or

(5) referral and petition to the appropriate licensing authority for appropriate disciplinary action, including the restriction, suspension, or revocation of the person's license.

SECTION 3.275. Section 415.024, Labor Code, is amended to read as follows:

Sec. 415.024. BREACH OF SETTLEMENT AGREEMENT; ADMINISTRATIVE VIOLATION. A material and substantial breach of a settlement agreement that establishes a compliance plan is an [~~a Class A~~] administrative violation. In determining the amount of the penalty, the commissioner [~~commission~~] shall consider the total volume of claims handled by the insurance carrier.

SECTION 3.276. Subsection (b), Section 415.032, Labor Code, is amended to read as follows:

(b) Not later than the 20th day after the date on which notice is received, the charged party shall:

(1) remit the amount of the penalty to the department [~~commission~~]; or

(2) submit to the department [~~commission~~] a written request for a hearing.

SECTION 3.277. Section 415.033, Labor Code, is amended to read as follows:

Sec. 415.033. FAILURE TO RESPOND. If, without good cause, a charged party fails to respond as required under Section 415.032, the penalty is due and the department [~~commission~~] shall initiate enforcement proceedings.

SECTION 3.278. Subsection (a), Section 415.034, Labor Code, is amended to read as follows:

(a) On the request of the charged party or the commissioner [~~executive director~~], the State Office of Administrative Hearings shall set a hearing. The hearing shall be conducted in the manner provided for a contested case under Chapter 2001, Government Code (the administrative procedure law).

SECTION 3.279. Subsections (b) and (d), Section 415.035,

Labor Code, are amended to read as follows:

(b) If an administrative penalty is assessed, the person charged shall:

(1) forward the amount of the penalty to the commissioner [~~executive director~~] for deposit in an escrow account; or

(2) post with the commissioner [~~executive director~~] a bond for the amount of the penalty, effective until all judicial review of the determination is final.

(d) If the court determines that the penalty should not have been assessed or reduces the amount of the penalty, the commissioner [~~executive director~~] shall:

(1) remit the appropriate amount, plus accrued interest, if the administrative penalty was paid; or

(2) release the bond.

SECTION 3.280. Section 416.001, Labor Code, is amended to read as follows:

Sec. 416.001. CERTAIN CAUSES OF ACTION PRECLUDED. An action taken by an insurance carrier under an order of the commissioner [~~commission~~] or recommendations of a benefit review officer under Section 410.031, 410.032, or 410.033 may not be the basis of a cause of action against the insurance carrier for a breach of the duty of good faith and fair dealing.

SECTION 3.281. Subsections (c) and (d), Section 417.001, Labor Code, are amended to read as follows:

(c) If a claimant receives benefits from the subsequent injury fund, the department [~~commission~~] is:

(1) considered to be the insurance carrier under this section for purposes of those benefits;

(2) subrogated to the rights of the claimant; and

(3) entitled to reimbursement in the same manner as the insurance carrier.

(d) The department [~~commission~~] shall remit money recovered under this section to the comptroller for deposit to the credit of the subsequent injury fund.

SECTION 3.282. Subsection (b), Section 417.003, Labor Code, is amended to read as follows:

(b) An attorney who represents the claimant and is also to represent the subrogated insurance carrier shall make a full written disclosure to the claimant before employment as an attorney by the insurance carrier. The claimant must acknowledge the disclosure and consent to the representation. A signed copy of the disclosure shall be furnished to all concerned parties and made a part of the department [~~commission~~] file. A copy of the disclosure with the claimant's consent shall be filed with the claimant's pleading before a judgment is entered and approved by the court. The claimant's attorney may not receive a fee under this section to which the attorney is otherwise entitled under an agreement with the insurance carrier unless the attorney complies with the requirements of this subsection.

SECTION 3.283. Subdivisions (1) and (5), Section 501.001, Labor Code, are amended to read as follows:

(1) "Department" [~~"Commission"~~] means the Texas Department of Workers' Compensation [~~Commission~~].

(5) "Employee" means a person who is:

(A) in the service of the state pursuant to an election, appointment, or express oral or written contract of hire;

(B) paid from state funds but whose duties require that the person work and frequently receive supervision in a political subdivision of the state;

(C) a peace officer employed by a political subdivision, while the peace officer is exercising authority granted under:

(i) Article 2.12 [~~12~~], Code of Criminal Procedure; or

(ii) Articles 14.03(d) and (g), Code of Criminal Procedure;

(D) a member of the state military forces, as defined by Section 431.001, Government Code, who is engaged in

authorized training or duty; or

(E) a Texas Task Force 1 member, as defined by Section 88.301, Education Code, who is activated by the governor's division of emergency management or is injured during any training session sponsored or sanctioned by Texas Task Force 1.

SECTION 3.284. Subsection (d), Section 501.026, Labor Code, is amended to read as follows:

(d) A person entitled to benefits under this section may receive the benefits only if the person seeks medical attention from a doctor for the injury not later than 48 hours after the occurrence of the injury or after the date the person knew or should have known the injury occurred. The person shall comply with the requirements of Section 409.001 by providing notice of the injury to the department [~~commission~~] or the state agency with which the officer or employee under Subsection (b) is associated.

SECTION 3.285. Subsection (a), Section 501.050, Labor Code, is amended to read as follows:

(a) In each case appealed from the department [~~commission~~] to a county or district court:

(1) the clerk of the court shall mail to the department [~~commission~~]:

(A) not later than the 20th day after the date the case is filed, a notice containing the style, number, and date of filing of the case; and

(B) not later than the 20th day after the date the judgment is rendered, a certified copy of the judgment; and

(2) the attorney preparing the judgment shall file the original and a copy of the judgment with the clerk.

SECTION 3.286. The heading to Chapter 502, Labor Code, is amended to read as follows:

CHAPTER 502. WORKERS' COMPENSATION INSURANCE COVERAGE FOR EMPLOYEES OF THE TEXAS A&M UNIVERSITY SYSTEM AND EMPLOYEES OF INSTITUTIONS OF THE TEXAS A&M UNIVERSITY SYSTEM

SECTION 3.287. Subdivision (1), Section 502.001, Labor Code, is amended to read as follows:

(1) "Department" means the Texas Department of Workers' Compensation [~~"Commission" means the Texas Workers' Compensation Commission~~].

SECTION 3.288. Subsection (b), Section 502.002, Labor Code, is amended to read as follows:

(b) For the purpose of applying the provisions listed by Subsection (a) to this chapter, "employer" means "the institution," and "system" means the insurance carrier under Section 502.022.

SECTION 3.289. Subsection (a), Section 502.021, Labor Code, is amended to read as follows:

(a) The system [~~institution~~] shall pay benefits as provided by this chapter to an employee with a compensable injury.

SECTION 3.290. Section 502.041, Labor Code, is amended to read as follows:

Sec. 502.041. EXHAUSTION OF ANNUAL AND SICK LEAVE. (a) An employee may elect to use accrued sick leave before receiving income benefits. If an employee elects to use sick leave, the employee is not entitled to income benefits under this chapter until the employee has exhausted the employee's accrued sick leave [~~institution may provide that an injured employee may remain on the payroll until the employee's earned annual and sick leave is exhausted~~].

(b) An employee may elect to use all or any number of weeks of accrued annual leave after the employee's accrued sick leave is exhausted. If an employee elects to use annual leave, the employee is not entitled to income benefits under this chapter until the elected number of weeks of leave have been exhausted [~~While an injured employee remains on the payroll under Subsection (a), medical services remain available to the employee, but workers' compensation benefits do not accrue or become payable to the injured employee~~].

SECTION 3.291. Subsections (a) and (c), Section 502.061, Labor Code, are amended to read as follows:

(a) The system [~~Each institution~~] shall administer this

chapter.

(c) The system [~~institution~~] may:

(1) adopt and publish rules and prescribe and furnish forms necessary for the administration of this chapter; and

(2) adopt and enforce rules necessary for the prevention of accidents and injuries.

SECTION 3.292. Section 502.063, Labor Code, is amended to read as follows:

Sec. 502.063. CERTIFIED COPIES OF DEPARTMENT [~~COMMISSION~~] DOCUMENTS. (a) The department [~~commission~~] shall furnish a certified copy of an order, award, decision, or paper on file in the department's [~~commission's~~] office to a person entitled to the copy on written request and payment of the fee for the copy. The fee is the same as that charged for similar services by the secretary of state's office.

(b) The system or an [~~An~~] institution may obtain certified copies under this section without charge.

(c) A fee or salary may not be paid to an [~~a member or~~] employee of the department [~~commission~~] for making a copy under Subsection (a) that exceeds the fee charged for the copy.

SECTION 3.293. Subsection (a), Section 502.065, Labor Code, is amended to read as follows:

(a) In addition to a report of an injury filed with the department [~~commission~~] under Section 409.005(a), an institution shall file a supplemental report that contains:

(1) the name, age, sex, and occupation of the injured employee;

(2) the character of work in which the employee was engaged at the time of the injury;

(3) the place, date, and hour of the injury; and

(4) the nature and cause of the injury.

SECTION 3.294. Subsections (a), (b), (d), and (e), Section 502.066, Labor Code, are amended to read as follows:

(a) The department [~~commission~~] may require an employee who claims to have been injured to submit to an examination by the department [~~commission~~] or a person acting under the department's [~~commission's~~] authority at a reasonable time and place in this state.

(b) On the request of an employee or the system [~~institution~~], the employee, [~~or~~] the institution, or the system is entitled to have a physician or chiropractor selected by the employee, [~~or~~] the institution, or the system, as appropriate, present to participate in an examination under Subsection (a) or Section 408.004.

(d) The system or the institution may have an injured employee examined at a reasonable time and at a place suitable to the employee's condition and convenient and accessible to the employee by a physician or chiropractor selected by the system or the institution. The system or the institution shall pay for an examination under this subsection and for the employee's reasonable expenses incident to the examination. The employee is entitled to have a physician or chiropractor selected by the employee present to participate in an examination under this subsection.

(e) The system or the institution shall pay the fee set by the department [~~commission~~] of a physician or chiropractor selected by the employee under Subsection (b) or (d).

SECTION 3.295. Subsection (a), Section 502.067, Labor Code, is amended to read as follows:

(a) The commissioner of the Texas Department of Workers' Compensation [~~commission~~] may order or direct the system or the institution to reduce or suspend the compensation of an injured employee who:

(1) persists in insanitary or injurious practices that tend to imperil or retard the employee's recovery; or

(2) refuses to submit to medical, surgical, chiropractic, or other remedial treatment recognized by the state that is reasonably essential to promote the employee's recovery.

SECTION 3.296. Section 502.068, Labor Code, is amended to read as follows:

Sec. 502.068. POSTPONEMENT OF HEARING. If an injured employee is receiving benefits under this chapter and the system or the institution is providing hospitalization, medical treatment, or chiropractic care to the employee, the department [~~commission~~] may postpone the hearing on the employee's claim. An appeal may not be taken from a department [~~commission~~] order under this section.

SECTION 3.297. Subsection (a), Section 502.069, Labor Code, is amended to read as follows:

(a) In each case appealed from the department [~~commission~~] to a county or district court:

(1) the clerk of the court shall mail to the department [~~commission~~]:

(A) not later than the 20th day after the date the case is filed, a notice containing the style, number, and date of filing of the case; and

(B) not later than the 20th day after the date the judgment is rendered, a certified copy of the judgment; and

(2) the attorney preparing the judgment shall file the original and a copy of the judgment with the clerk.

SECTION 3.298. The heading to Chapter 503, Labor Code, is amended to read as follows:

CHAPTER 503. WORKERS' COMPENSATION INSURANCE COVERAGE FOR EMPLOYEES OF THE UNIVERSITY OF TEXAS SYSTEM AND EMPLOYEES OF INSTITUTIONS OF THE UNIVERSITY OF TEXAS SYSTEM

SECTION 3.299. Section 503.001, Labor Code, is amended by amending Subdivision (1) and by adding Subdivision (1-a) to read as follows:

(1) "Commissioner" means the commissioner of the Texas Department of Workers' Compensation [~~"Commission" means the Texas Workers' Compensation Commission~~].

(1-a) "Department" means the Texas Department of Workers' Compensation.

SECTION 3.300. Subsection (b), Section 503.002, Labor Code, is amended to read as follows:

(b) For the purpose of applying the provisions listed by Subsection (a) to this chapter, "employer" means "the institution," and "system" means the insurance carrier under Section 503.022.

SECTION 3.301. Subsection (a), Section 503.021, Labor Code, is amended to read as follows:

(a) The system [~~institution~~] shall pay benefits as provided by this chapter to an employee with a compensable injury.

SECTION 3.302. Section 503.022, Labor Code, is amended to read as follows:

Sec. 503.022. AUTHORITY TO SELF-INSURE. An institution may self-insure as part of a system insurance plan.

SECTION 3.303. Section 503.041, Labor Code, is amended to read as follows:

Sec. 503.041. EXHAUSTION OF ANNUAL AND SICK LEAVE. (a) An employee may elect to use accrued sick leave before receiving income benefits. If an employee elects to use sick leave, the employee is not entitled to income benefits under this chapter until the employee has exhausted the employee's accrued sick leave [~~An institution may provide that an injured employee may remain on the payroll until the employee's earned annual and sick leave is exhausted~~].

(b) An employee may elect to use all or any number of weeks of accrued annual leave after the employee's accrued sick leave is exhausted. If an employee elects to use annual leave, the employee is not entitled to income benefits under this chapter until the elected number of weeks of leave have been exhausted [~~While an injured employee remains on the payroll under Subsection (a), the employee is entitled to medical benefits but income benefits do not accrue~~].

SECTION 3.304. Subsections (a) and (c), Section 503.061, Labor Code, are amended to read as follows:

(a) The system [~~Each institution~~] shall administer this chapter.

(c) The system [~~institution~~] may:

(1) adopt and publish rules and prescribe and furnish

forms necessary for the administration of this chapter; and

(2) adopt and enforce rules necessary for the prevention of accidents and injuries.

SECTION 3.305. Section 503.063, Labor Code, is amended to read as follows:

Sec. 503.063. CERTIFIED COPIES OF DEPARTMENT [~~COMMISSION~~] DOCUMENTS. (a) The department [~~commission~~] shall furnish a certified copy of an order, award, decision, or paper on file in the department's [~~commission's~~] office to a person entitled to the copy on written request and payment of the fee for the copy. The fee is the same as that charged for similar services by the secretary of state's office.

(b) The system or the institution may obtain certified copies under this section without charge.

(c) A fee or salary may not be paid to an [~~a member or~~] employee of the department [~~commission~~] for making a copy under Subsection (a) that exceeds the fee charged for the copy.

SECTION 3.306. Subsection (a), Section 503.065, Labor Code, is amended to read as follows:

(a) In addition to a report of an injury filed with the department [~~commission~~] under Section 409.005(a), an institution shall file a supplemental report that contains:

(1) the name, age, sex, and occupation of the injured employee;

(2) the character of work in which the employee was engaged at the time of the injury;

(3) the place, date, and hour of the injury; and

(4) the nature and cause of the injury.

SECTION 3.307. Subsections (a), (b), (d), and (e), Section 503.066, Labor Code, are amended to read as follows:

(a) The department [~~commission~~] may require an employee who claims to have been injured to submit to an examination by the department [~~commission~~] or a person acting under the department's [~~commission's~~] authority at a reasonable time and place in this state.

(b) On the request of an employee, the system, or the institution, the employee, the system, or the institution is entitled to have a physician selected by the employee, the system, or the institution, as appropriate, present to participate in an examination under Subsection (a) or Section 408.004.

(d) The system or the institution may have an injured employee examined at a reasonable time and at a place suitable to the employee's condition and convenient and accessible to the employee by a physician selected by the system or the institution. The system or the institution shall pay for an examination under this subsection and for the employee's reasonable expenses incident to the examination. The employee is entitled to have a physician selected by the employee present to participate in an examination under this subsection.

(e) The system or the institution shall pay the fee, as set by the department [~~commission~~], of a physician selected by the employee under Subsection (b) or (d).

SECTION 3.308. Subsection (a), Section 503.067, Labor Code, is amended to read as follows:

(a) The commissioner [~~commission~~] may order or direct the system or the institution to reduce or suspend the compensation of an injured employee who:

(1) persists in insanitary or injurious practices that tend to imperil or retard the employee's recovery; or

(2) refuses to submit to medical, surgical, or other remedial treatment recognized by the state that is reasonably essential to promote the employee's recovery.

SECTION 3.309. Section 503.068, Labor Code, is amended to read as follows:

Sec. 503.068. POSTPONEMENT OF HEARING. If an injured employee is receiving benefits under this chapter and the system or the institution is providing hospitalization or medical treatment to the employee, the department [~~commission~~] may postpone the hearing on the employee's claim. An appeal may not be taken from a

commissioner [~~commission~~] order under this section.

SECTION 3.310. Subsection (a), Section 503.069, Labor Code, is amended to read as follows:

(a) In each case appealed from the department [~~commission~~] to a county or district court:

(1) the clerk of the court shall mail to the department [~~commission~~]:

(A) not later than the 20th day after the date the case is filed, a notice containing the style, number, and date of filing of the case; and

(B) not later than the 20th day after the date the judgment is rendered, a certified copy of the judgment; and

(2) the attorney preparing the judgment shall file the original and a copy of the judgment with the clerk.

SECTION 3.311. Subsection (a), Section 503.070, Labor Code, is amended to read as follows:

(a) A party who does not consent to abide by the final decision of the commissioner [~~commission~~] shall file notice with the department [~~commission~~] as required by Section 410.253 and bring suit in the county in which the injury occurred to set aside the final decision of the commissioner [~~commission~~].

SECTION 3.312. Section 504.001, Labor Code, is amended by amending Subdivision (1) and adding Subdivision (4) to read as follows:

(1) "Department" means the Texas Department of Workers' Compensation [~~"Commission" means the Texas Workers' Compensation Commission~~].

(4) "Pool" means two or more political subdivisions collectively self-insuring under an interlocal contract under Chapter 791, Government Code.

SECTION 3.313. Subsection (a), Section 504.002, Labor Code, is amended to read as follows:

(a) The following provisions of Subtitles A and B apply to and are included in this chapter except to the extent that they are inconsistent with this chapter:

(1) Chapter 401, other than Section 401.011(18) defining "employer" and Section 401.012 defining "employee";

(2) Chapter 402;

(3) Chapter 403, other than Sections 403.001-403.005;

(4) Sections 406.006-406.009 and Subchapters B and D-G, Chapter 406, other than Sections 406.033, 406.034, 406.035, 406.091, and 406.096;

(5) Chapter 408, other than Sections 408.001(b) and (c);

(6) Chapters 409-412 [~~409-417~~]; [~~and~~]

(7) Chapter 413, except as provided by Section 504.053;

(8) Chapters 414-417; and

(9) Chapter 451.

SECTION 3.314. The heading to Section 504.018, Labor Code, is amended to read as follows:

Sec. 504.018. NOTICE TO DEPARTMENT [~~COMMISSION~~] AND EMPLOYEES; EFFECT ON COMMON-LAW OR STATUTORY LIABILITY.

SECTION 3.315. Subsection (a), Section 504.018, Labor Code, is amended to read as follows:

(a) A political subdivision shall notify the department [~~commission~~] of the method by which its employees will receive benefits, the approximate number of employees covered, and the estimated amount of payroll.

SECTION 3.316. Subchapter C, Chapter 504, Labor Code, is amended by adding Section 504.053 to read as follows:

Sec. 504.053. ELECTION. (a) A political subdivision that self-insures either individually or collectively shall provide workers' compensation medical benefits to the injured employees of the political subdivision or the injured employees of the members of a pool:

(1) in the manner provided by Chapter 1305, Insurance Code;

(2) in the manner provided by Chapter 408, other than

Sections 408.001(b) and (c) and Section 408.002, and by Subchapters B and C, Chapter 413; or

(3) by direct contracting with health care providers or by contracting through a health benefits pool established under Chapter 172, Local Government Code.

(b) Chapter 1305, Insurance Code, and the provisions of Chapter 408 relating to medical benefits and Chapter 413 of this code, do not apply if the political subdivision or pool provides medical benefits in the manner authorized under Subsection (a)(3).

(c) If the political subdivision or pool provides medical benefits in the manner authorized under Subsection (a)(3), the following standards apply:

(1) the political subdivision or pool must ensure that workers' compensation medical benefits are reasonably available to all injured workers of the political subdivision or the injured workers of the members of the pool within a designed service area;

(2) the political subdivision or pool must ensure that all necessary health care services are provided in a manner that will ensure the availability of and accessibility to adequate health care providers, specialty care, and facilities;

(3) the political subdivision or pool must have an internal review process for resolving complaints relating to the manner of providing medical benefits, including an appeal to the governing body or its designee and appeal to an independent review organization;

(4) the political subdivision or pool must establish reasonable procedures for the transition of injured workers to contract providers and for the continuity of treatment, including notice of impending termination of providers and a current list of contract providers;

(5) the political subdivision or pool shall provide for emergency care if an injured worker cannot reasonably reach a contact provider and the care is for medical screening or other evaluation that is necessary to determine whether a medical emergency condition exists, necessary emergency care services including treatment and stabilization, and services originating in a hospital emergency facility following treatment or stabilization of an emergency medical condition;

(6) prospective or concurrent review of the medical necessity and appropriateness of health care services must comply with Article 21.58A, Insurance Code;

(7) the political subdivision or pool shall continue to report data to the appropriate agency as required by Title 5 of this code and Chapter 1305, Insurance Code; and

(8) a political subdivision or pool is subject to the requirements under Sections 1305.501, 1305.502, and 1305.503, Insurance Code.

(d) Nothing in this chapter waives sovereign immunity or creates a new cause of action.

SECTION 3.317. The heading to Section 505.053, Labor Code, is amended to read as follows:

Sec. 505.053. CERTIFIED COPIES OF TEXAS DEPARTMENT OF WORKERS' COMPENSATION [~~COMMISSION~~] DOCUMENTS.

SECTION 3.318. Subsections (a) and (c), Section 505.053, Labor Code, are amended to read as follows:

(a) The Texas Department of Workers' Compensation [~~commission~~] shall furnish a certified copy of an order, award, decision, or paper on file in that department's [~~the commission's~~] office to a person entitled to the copy on written request and payment of the fee for the copy. The fee shall be the same as that charged for similar services by the secretary of state's office.

(c) A fee or salary may not be paid to a person in the Texas Department of Workers' Compensation [~~commission~~] for making the copies that exceeds the fee charged for the copies.

SECTION 3.319. Subsection (d), Section 505.054, Labor Code, is amended to read as follows:

(d) A physician designated under Subsection (c) who conducts an examination shall file with the department a complete transcript of the examination on a form furnished by the

department. The department shall maintain all reports under this subsection as part of the department's permanent records. A report under this subsection is admissible in evidence before the Texas Department of Workers' Compensation [~~commission~~] and in an appeal from a final award or ruling of that department [~~the commission~~] in which the individual named in the examination is a claimant for compensation under this chapter. A report under this subsection that is admitted is prima facie evidence of the facts stated in the report.

SECTION 3.320. Section 505.055, Labor Code, is amended to read as follows:

Sec. 505.055. REPORTS OF INJURIES. (a) A report of an injury filed with the Texas Department of Workers' Compensation [~~commission~~] under Section 409.005, in addition to the information required by commissioner of workers' compensation [~~commission~~] rules, must contain:

(1) the name, age, sex, and occupation of the injured employee;

(2) the character of work in which the employee was engaged at the time of the injury;

(3) the place, date, and hour of the injury; and

(4) the nature and cause of the injury.

(b) In addition to subsequent reports of an injury filed with the Texas Department of Workers' Compensation [~~commission~~] under Section 409.005(e), the department shall file a subsequent report on a form obtained for that purpose:

(1) on the termination of incapacity of the injured employee; or

(2) if the incapacity extends beyond 60 days.

SECTION 3.321. Subsections (a) and (d), Section 505.056, Labor Code, are amended to read as follows:

(a) The Texas Department of Workers' Compensation [~~commission~~] may require an employee who claims to have been injured to submit to an examination by that department [~~the commission~~] or a person acting under the [~~commission's~~] authority of that department at a reasonable time and place in this state.

(d) On the request of an employee or the department, the employee or the department is entitled to have a physician selected by the employee or the department present to participate in an examination under Subsection (a) or Section 408.004. The employee is entitled to have a physician selected by the employee present to participate in an examination under Subsection (c). The department shall pay the fee set by the commissioner of the Texas Department of Workers' Compensation [~~commission~~] of a physician selected by the employee under this subsection.

SECTION 3.322. Subsection (a), Section 505.057, Labor Code, is amended to read as follows:

(a) The commissioner of the Texas Department of Workers' Compensation [~~commission~~] may order or direct the department to reduce or suspend the compensation of an injured employee if the employee:

(1) persists in insanitary or injurious practices that tend to imperil or retard the employee's recovery; or

(2) refuses to submit to medical, surgical, or other remedial treatment recognized by the state that is reasonably essential to promote the employee's recovery.

SECTION 3.323. Section 505.058, Labor Code, is amended to read as follows:

Sec. 505.058. POSTPONEMENT OF HEARING. If an injured employee is receiving benefits under this chapter and the department is providing hospitalization or medical treatment to the employee, the Texas Department of Workers' Compensation [~~commission~~] may postpone the hearing of the employee's claim. An appeal may not be taken from an [~~a commission~~] order of the commissioner of the Texas Department of Workers' Compensation under this section.

SECTION 3.324. Subsection (a), Section 505.059, Labor Code, is amended to read as follows:

(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

orally or in writing by a complainant to a network regarding any aspect of the network's operation. The term includes dissatisfaction relating to medical fee disputes and the network's administration and the manner in which a service is provided. The term does not include:

(A) a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the complainant; or

(B) an oral or written expression of dissatisfaction or disagreement with an adverse determination.

(6) "Credentialing" means the review, under nationally recognized standards to the extent that those standards do not conflict with other laws of this state, of qualifications and other relevant information relating to a health care provider who seeks a contract with a network.

(7) "Emergency" means either a medical or mental health emergency.

(8) "Employee" has the meaning assigned by Section 401.012, Labor Code.

(9) "Fee dispute" means a dispute over the amount of payment due for health care services determined to be medically necessary and appropriate for treatment of a compensable injury.

(10) "Health care facility" means a general or specialty hospital, emergency clinic, outpatient clinic, or other facility providing health care.

(11) "Health care provider" or "provider" means:

(A) a doctor or other person licensed to practice one or more of the healing arts within the scope of the license of the license holder;

(B) a health care facility; or

(C) an entity providing health care that is covered under this chapter.

(12) "Independent review" means a system for final administrative review by an independent review organization of the medical necessity and appropriateness of health care services being provided, proposed to be provided, or that have been provided to an employee.

(13) "Independent review organization" means an entity that is certified by the commissioner to conduct independent review under Article 21.58C and rules adopted by the commissioner.

(14) "Life-threatening" has the meaning assigned by Section 2, Article 21.58A.

(15) "Medical emergency" means the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the patient's health or bodily functions in serious jeopardy; or

(B) serious dysfunction of any body organ or part.

(16) "Medical records" means the history of diagnosis and treatment for an injury, including medical, dental, and other health care records from each health care practitioner who provides care to an injured employee.

(17) "Mental health emergency" means a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person.

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

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

(B) certified in accordance with this chapter and commissioner rules; and

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

(19) "Nurse" has the meaning assigned by Section 2, Article 21.58A.

(20) "Person" means any natural or artificial person,

including an individual, partnership, association, corporation, organization, trust, hospital district, community mental health center, mental retardation center, mental health and mental retardation center, limited liability company, or limited liability partnership.

(21) "Preauthorization" means the process required to request approval from the network to provide a specific treatment or service before the treatment or service is provided.

(22) "Quality improvement program" means a system designed to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions.

(23) "Retrospective review" means the process of reviewing the medical necessity and reasonableness of health care that has been provided to an injured employee.

(24) "Rural area" means:

(A) a county with a population of 50,000 or less;

(B) an area that is not designated as an urbanized area by the United States Census Bureau; or

(C) any other area designated as rural under rules adopted by the commissioner.

(25) "Screening criteria" means the written policies, decision rules, medical protocols, and treatment guidelines used by a network as part of utilization review or retrospective review.

(26) "Service area" means a geographic area within which health care services from network providers are available and accessible to employees who live within that geographic area.

(27) "Texas Workers' Compensation Act" means Subtitle A, Title 5, Labor Code.

(28) "Transfer of risk" means, for purposes of this chapter only, an insurance carrier's transfer of financial risk for the provision of health care services to a network through capitation or other means.

(29) "Utilization review" has the meaning assigned by Section 2, Article 21.58A.

(30) "Utilization review agent" has the meaning assigned by Article 21.58A.

(31) "Utilization review plan" means the screening criteria and utilization review procedures of a workers' compensation health care network or utilization review agent.

(b) In this chapter, the following terms have the meanings assigned by Section 401.011, Labor Code:

(1) "compensable injury";

(2) "doctor";

(3) "employer";

(4) "health care";

(5) "injury";

(6) "insurance carrier"; and

(7) "treating doctor."

Sec. 1305.005. PARTICIPATION IN NETWORK; NOTICE OF NETWORK REQUIREMENTS. (a) An employer that elects to provide workers' compensation insurance coverage under the Texas Workers' Compensation Act may receive workers' compensation health care services for the employer's injured employees through a workers' compensation health care network.

(b) An insurance carrier may establish or contract with networks certified under this chapter to provide health care services under the Texas Workers' Compensation Act. If an employer elects to contract with an insurance company for the provision of health care services through a network, or if a self-insured employer under Chapter 407, Labor Code, a group of employers certified to self-insure under Chapter 407A, Labor Code, or a public employer under Subtitle C, Title 5, Labor Code, elects to establish or contract with a network, the employer's employees who live within the network's service area are required to obtain medical treatment for a compensable injury within the network, except as provided by Section 1305.006(a)(1) and (3).

(c) The insurance carrier shall provide to the employer, and shall ensure that the employer provides to the employer's

employees, notice of network requirements, including all information required by Section 1305.451. The carrier shall require the employer to:

(1) obtain a signed acknowledgment from each employee, written in English, Spanish, and any other language common to the employer's employees, that the employee has received information concerning the network and the network's requirements; and

(2) post notice of the network requirements at each place of employment.

(d) The insurance carrier shall ensure that an employer provides to each employee hired after the notice is given under Subsection (c) the notice and information required under that subsection not later than the third day after the date of hire.

(e) An injured employee who has received notice of network requirements but refuses to sign the acknowledgment form required under Subsection (c) remains subject to the network requirements established under this chapter.

(f) The insurance carrier shall require the employer to notify an injured employee of the network requirements at the time the employer receives actual or constructive notice of an injury.

(g) An injured employee is not required to comply with the network requirements until the employee receives the notice under Subsection (c) or (d).

(h) The commissioner may adopt rules as necessary to implement this section.

Sec. 1305.006. INSURANCE CARRIER LIABILITY FOR OUT-OF-NETWORK HEALTH CARE. (a) An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:

(1) emergency care;

(2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and

(3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103.

(b) If an accident or health insurance carrier or other person obligated for the cost of health care services has paid for health care services for an employee for an injury for which a workers' compensation insurance carrier denies compensability, and the injury is later determined to be compensable, the accident or health insurance carrier or other person may recover the amounts paid for such services from the workers' compensation insurance carrier.

Sec. 1305.007. RULES. The commissioner may adopt rules as necessary to implement this chapter.

[Sections 1305.008-1305.050 reserved for expansion]

SUBCHAPTER B. CERTIFICATION

Sec. 1305.051. CERTIFICATION REQUIRED. (a) A person may not operate a workers' compensation health care network in this state unless the person holds a certificate issued under this chapter and rules adopted by the commissioner.

(b) A person may not perform any act of a workers' compensation health care network except in accordance with the specific authorization of this chapter or rules adopted by the commissioner.

(c) A health maintenance organization regulated under Chapter 843 or an organization of physicians and providers that operates as a preferred provider benefit plan, as defined by Chapter 1301, may obtain a certification as a workers' compensation health care network in the same manner as any other person if that entity meets the requirements of this chapter and rules adopted by the commissioner under this chapter.

Sec. 1305.052. CERTIFICATE APPLICATION. (a) A person who seeks to operate as a workers' compensation health care network shall apply to the department for a certificate to organize and operate as a network.

(b) A certificate application must be:

(1) filed with the department in the form prescribed by the commissioner;

(2) verified by the applicant or an officer or other authorized representative of the applicant; and

(3) accompanied by a nonrefundable fee set by commissioner rule.

Sec. 1305.053. CONTENTS OF APPLICATION. Each certificate application must include:

(1) a description or a copy of the applicant's basic organizational structure documents and other related documents, including organizational charts or lists that show:

(A) the relationships and contracts between the applicant and any affiliates of the applicant; and

(B) the internal organizational structure of the applicant's management and administrative staff;

(2) biographical information regarding each person who governs or manages the affairs of the applicant, accompanied by information sufficient to allow the commissioner to determine the competence, fitness, and reputation of each officer or director of the applicant or other person having control of the applicant;

(3) a copy of the form of any contract between the applicant and any provider or group of providers, and with any third party performing services on behalf of the applicant under Subchapter D;

(4) a copy of the form of each contract with an insurance carrier, as described by Section 1305.154;

(5) a financial statement, current as of the date of the application, that is prepared using generally accepted accounting practices and includes:

(A) a balance sheet that reflects a solvent financial position;

(B) an income statement;

(C) a cash flow statement; and

(D) the sources and uses of all funds;

(6) a statement acknowledging that lawful process in a legal action or proceeding against the network on a cause of action arising in this state is valid if served in the manner provided by Chapter 804 for a domestic company;

(7) a description and a map of the applicant's service area or areas, with key and scale, that identifies each county or part of a county to be served;

(8) a description of programs and procedures to be utilized, including:

(A) a complaint system, as required under Subchapter I;

(B) a quality improvement program, as required under Subchapter G; and

(C) the utilization review and retrospective review programs described in Subchapter H;

(9) a list of all contracted network providers that demonstrates the adequacy of the network to provide comprehensive health care services sufficient to serve the population of injured employees within the service area and maps that demonstrate that the access and availability standards under Subchapter G are met; and

(10) any other information that the commissioner requires by rule to implement this chapter.

Sec. 1305.054. ACTION ON APPLICATION; RENEWAL OF CERTIFICATION. (a) The commissioner shall approve or disapprove an application for certification as a network not later than the 60th day after the date the completed application is received by the department. An application is considered complete on receipt of all information required by this chapter and any commissioner rules, including receipt of any additional information requested by the commissioner as needed to make the determination.

(b) Additional information requested by the commissioner under Subsection (a) may include information derived from an on-site quality-of-care examination.

(c) The department shall notify the applicant of any

deficiencies in the application and may allow the applicant to request additional time to revise the application, in which case the 60-day period for approval or disapproval is tolled. The commissioner may grant or deny requests for additional time at the commissioner's discretion.

(d) An order issued by the commissioner disapproving an application must specify in what respects the application does not comply with applicable statutes and rules. An applicant whose application is disapproved may request a hearing not later than the 30th day after the date of the commissioner's disapproval order. The hearing is a contested case hearing under Chapter 2001, Government Code.

(e) A certificate issued under this subchapter is valid until revoked or suspended.

Sec. 1305.055. USE OF CERTAIN INSURANCE TERMS BY NETWORK PROHIBITED. A network is not an insurer and may not use in the network's name or informational literature the word "insurance," "casualty," "surety," or "mutual" or any other word that is:

(1) descriptive of the insurance, casualty, or surety business; or

(2) deceptively similar to the name or description of an insurer or surety corporation engaging in the business of insurance in this state.

Sec. 1305.056. RESTRAINT OF TRADE; APPLICATION OF CERTAIN LAWS. (a) A network that contracts with a provider or providers practicing individually or as a group is not, because of the contract or arrangement, considered to have entered into a conspiracy in restraint of trade in violation of Chapter 15, Business & Commerce Code.

(b) Notwithstanding any other law, a person who contracts under this chapter with one or more providers in the process of conducting activities that are permitted by law but that do not require a certificate of authority or other authorization under this code is not, because of the contract, considered to have entered into a conspiracy in restraint of trade in violation of Chapter 15, Business & Commerce Code.

(c) A network is subject to Articles 21.28 and 21.28-A and is considered an insurer or insurance company, as applicable, for purposes of those laws.

[Sections 1305.057-1305.100 reserved for expansion]

SUBCHAPTER C. GENERAL POWERS AND DUTIES OF WORKERS' COMPENSATION HEALTH CARE NETWORKS

Sec. 1305.101. PROVIDING OR ARRANGING FOR HEALTH CARE. (a) Except for emergencies and out-of-network referrals, a network shall provide or arrange for health care services only through providers or provider groups that are under contract with or are employed by the network.

(b) A network doctor may not serve as a designated doctor or perform a required medical examination, as those terms are used under the Texas Workers' Compensation Act, for an employee receiving medical care through a network with which the doctor contracts or is employed.

(c) Notwithstanding any other provision of this chapter, prescription medication or services, as defined by Section 401.011(19)(E), Labor Code, may not be delivered through a workers' compensation health care network. Prescription medication and services shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of the Texas Department of Workers' Compensation.

Sec. 1305.102. MANAGEMENT CONTRACTS. (a) A network may not enter into a contract with another entity for management services unless the proposed contract is first filed with the department and approved by the commissioner.

(b) The commissioner shall approve or disapprove the contract not later than the 30th day after the date the contract is filed, or within a reasonable extended period that the commissioner specifies by notice given within the 30-day period.

(c) The contract must state that:

(1) the contract may not be canceled without cause

without at least 90 days' prior written notice;

(2) notice of any cancellation must be sent simultaneously to the commissioner by certified mail; and

(3) the network is responsible for ensuring that all functions delegated by the contract are performed in accordance with applicable statutes and rules, subject to the carrier's oversight and monitoring of the network's performance.

(d) The management contractor proposing to contract shall provide to the commissioner information sufficient to allow the commissioner to determine the competence, fitness, or reputation of each of the contractor's officers and directors or other person having control of the contractor, including criminal history information demonstrating that none of those individuals has been convicted of a felony involving moral turpitude or breach of fiduciary duty.

(e) The commissioner shall disapprove the proposed contract if the commissioner determines that the contract authorizes a person who is not sufficiently trustworthy, competent, experienced, and free from conflict of interest to manage the network with due regard for the interests of employers, employees, creditors, or the public.

(f) The commissioner may not approve a proposed management contract unless the management contractor has in force in the management contractor's own name a fidelity bond on the contractor's officers and employees in the amount of $250,000 or a greater amount prescribed by the commissioner.

(g) The fidelity bond must be issued by an insurer authorized to engage in business in this state and must be filed with the department. If the commissioner determines that a fidelity bond is not available from an insurer authorized to engage in business in this state, the management contractor may obtain a fidelity bond procured by a surplus lines agent under Chapter 981.

(h) The fidelity bond must obligate the surety to pay any loss of money or other property or damage that the network sustains because of an act of fraud or dishonesty by an employee or officer of the management contractor during the period that the management contract is in effect.

(i) In lieu of a fidelity bond, and at the commissioner's discretion, the management contractor may deposit with the comptroller cash or readily marketable liquid securities acceptable to the commissioner. The deposit must be maintained in the amount of, and is subject to the same conditions required for, a fidelity bond under this section.

(j) A management contract approved by the commissioner under this section may not be assigned to any other entity.

(k) A management contract filed with the department under this section is confidential and is not subject to disclosure as public information under Chapter 552, Government Code.

Sec. 1305.103. TREATING DOCTOR; REFERRALS. (a) A network shall determine the specialty or specialties of doctors who may serve as treating doctors.

(b) For each injury, an injured employee shall select a treating doctor from the list of all treating doctors under contract with the network in that service area.

(c) An employee being treated by a non-network provider for an injury that occurred before the employer's insurance carrier contracted with the network shall select a network treating doctor on notification by the carrier that health care services are being provided through the network. The carrier shall provide to the employee all information required by Section 1305.451. If the employee fails to select a treating doctor on or before the 14th day after the date of receipt of the information required by Section 1305.451, the network may assign the employee a network treating doctor.

(d) Each network shall, by contract, require treating doctors to provide, at a minimum, the functions and services for injured employees described by this section.

(e) A treating doctor shall provide health care to the employee for the employee's compensable injury and shall make

referrals to other network providers, or request referrals to out-of-network providers if medically necessary services are not available within the network. Referrals to out-of-network providers must be approved by the network. The network shall approve a referral to an out-of-network provider not later than the seventh day after the date on which the referral is requested, or sooner if circumstances and the condition of the employee require expedited approval. If the network denies the referral request, the employee may appeal the decision through the network's complaint process under Subchapter I.

(f) The treating doctor shall participate in the medical case management process as required by the network, including participation in return-to-work planning.

Sec. 1305.104. SELECTION OF TREATING DOCTOR. (a) An injured employee is entitled to the employee's initial choice of a treating doctor from the list provided by the network of all treating doctors under contract with the network who provide services within the service area in which the injured employee lives. The following does not constitute an initial choice of treating doctor:

(1) a doctor salaried by the employer;

(2) a doctor providing emergency care; or

(3) any doctor who provides care before the employee is enrolled in the network, except for a doctor selected under Section 1305.105.

(b) An employee who is dissatisfied with the initial choice of a treating doctor is entitled to select an alternate treating doctor from the network's list of treating doctors who provide services within the service area in which the injured employee lives by notifying the network in the manner prescribed by the network. The network may not deny a selection of an alternate treating doctor.

(c) An employee who is dissatisfied with an alternate treating doctor must obtain authorization from the network to select any subsequent treating doctor. The network shall establish procedures and criteria to be used in authorizing an employee to select subsequent treating doctors. The criteria must include, at a minimum, whether:

(1) treatment by the current treating doctor is medically inappropriate;

(2) the employee is receiving appropriate medical care to reach maximum medical improvement or medical care in compliance with the network's treatment guidelines; and

(3) a conflict exists between the employee and the current treating doctor to the extent that the doctor-patient relationship is jeopardized or impaired.

(d) Denial of a request for any subsequent treating doctor is subject to the appeal process for a complaint filed under Subchapter I.

(e) For purposes of this section, the following do not constitute the selection of an alternate or any subsequent treating doctor:

(1) a referral made by the treating doctor, including a referral for a second or subsequent opinion;

(2) the selection of a treating doctor because the original treating doctor:

(A) dies;

(B) retires; or

(C) leaves the network; or

(3) a change of treating doctor required because of a change of residence by the employee to a location outside the service area distance requirements, as described by Section 1305.302(g).

(f) A network shall provide that an injured employee with a chronic, life-threatening injury or chronic pain related to a compensable injury may apply to the network's medical director to use a nonprimary care physician specialist that is in the network as the injured employee's treating doctor.

(g) An application under Subsection (f) must:

(1) include information specified by the network, including certification of the medical need provided by the nonprimary care physician specialist; and

(2) be signed by the injured employee and the nonprimary care physician specialist interested in serving as the injured employee's treating doctor.

(h) To be eligible to serve as the injured employee's treating doctor, a physician specialist must agree to accept the responsibility to coordinate all of the injured employee's health care needs.

(i) If a network denies a request under Subsection (f), the injured employee may appeal the decision through the network's established complaint resolution process under Subchapter I.

Sec. 1305.105. TREATMENT BY A PRIMARY CARE PROVIDER UNDER CHAPTER 843. (a) Notwithstanding any other provision of this chapter, an injured employee required to receive health care services within a network may select as the employee's treating doctor a doctor who the employee selected, prior to injury, as the employee's primary care provider under Chapter 843.

(b) A doctor serving as an employee's treating doctor under Subsection (a) must agree to abide by the terms of the network's contract and comply with the provisions of this subchapter and Subchapters D and G. Services provided by such a doctor are considered to be network services and are subject to Subchapters H and I.

(c) Any change of doctor requested by an employee being treated by a doctor under Subsection (a) must be to a network doctor and is subject to the requirements of this chapter.

Sec. 1305.106. PAYMENT OF HEALTH CARE PROVIDER. (a) A health care provider shall submit a charge to an insurance carrier not later than the 95th day after the date the provider provides the service for which the charge relates. In the case of a workers' compensation health care network, the parties may agree by contract to extend the 95-day period.

(b) Not later than 45th day after the date on which an insurance carrier receives a charge for services rendered by a health care provider, the carrier shall:

(1) pay the fee allowed under Section 413.011, Labor Code, or, in the case of a provider contracted with a workers' compensation health care network, the amount agreed to by contract;

(2) if the carrier disputes the amount charged by the health care provider and intends to audit the services or the charge, notify the provider and pay 85 percent of the amount or, in the case of a provider contracted with a workers' compensation health care network, 85 percent of the contracted rate;

(3) if the carrier determines that a portion of the charge is payable, pay the portion that is not in dispute and notify the health care provider why the remaining amount will not be paid; or

(4) if the carrier determines that the charge is not payable, notify the provider in writing why the claim will not be paid.

(c) If the insurance carrier denies liability for a claim, the carrier may not deny payment for health care services on the grounds that the injury was not compensable until the carrier notifies the health care provider in writing that the carrier has contested compensability.

(d) If the insurance carrier denies liability or the health care provider's entitlement to payment and an accident or health insurance company provides benefits to the employee for medical or other health care services, the right to recover that amount may be assigned by the employee to the accident or health insurance company.

(e) If an insurance carrier disputes the amount of the charge or the health care provider's entitlement to payment, the carrier shall send to the health care provider and the injured employee a report that sufficiently explains the reasons for the reduction or denial of payment for health care services provided to the employee. The insurance carrier is entitled to a hearing as

provided by Section 413.031(d), Labor Code.

(f) An insurance carrier shall complete the audit under Subsection (b)(2) not later than the 180th day after the date it receives the charge. Following completion of an audit, any additional payment due a health care provider or any refund due the carrier shall be made not later than the 30th day after the date the health care provider receives notice of the audit results.

(g) An insurance carrier that does not comply with Subsection (b) is liable to the health care provider for the fee allowed under Section 413.011, Labor Code, or, if the provider is contracted with a workers' compensation health care network, for the contracted amount, plus a penalty in the amount of 18 percent a year.

Sec. 1305.107. TELEPHONE ACCESS. (a) Each network shall have appropriate personnel reasonably available through a toll-free telephone service at least 40 hours per week during normal business hours, in both time zones in this state if applicable, to discuss an employee's care and to allow response to requests for information, including information regarding adverse determinations.

(b) A network must have a telephone system capable of accepting or recording or providing instructions to incoming calls during other than normal business hours. The network shall respond to those calls not later than two business days after the date:

(1) the call was received by the network; or

(2) the details necessary to respond were received by the network from the caller.

[Sections 1305.108-1305.150 reserved for expansion]

SUBCHAPTER D. CONTRACTING PROVISIONS

Sec. 1305.151. TRANSFER OF RISK. A contract under this subchapter may not involve a transfer of risk.

Sec. 1305.152. NETWORK CONTRACTS WITH PROVIDERS. (a) A network shall enter into a written contract with each provider or group of providers that participates in the network. A provider contract under this section is confidential and is not subject to disclosure as public information under Chapter 552, Government Code.

(b) A network is not required to accept an application for participation in the network from a health care provider who otherwise meets the requirements specified in this chapter for participation if the network determines that the network has contracted with a sufficient number of qualified health care providers.

(c) Provider contracts and subcontracts must include, at a minimum, the following provisions:

(1) a hold-harmless clause stating that the network and the network's contracted providers are prohibited from billing or attempting to collect any amounts from employees for health care services under any circumstances, including the insolvency of the insurance carrier or the network, except as provided by Section 1305.451(b)(6);

(2) a statement that the provider agrees to follow treatment guidelines adopted by the network under Section 1305.304, as applicable to an employee's injury;

(3) a continuity of treatment clause that states that if a provider leaves the network, the insurance carrier or network is obligated to continue to reimburse the provider for a period not to exceed 90 days at the contracted rate for care of an employee with a life-threatening condition or an acute condition for which disruption of care would harm the employee;

(4) a clause regarding appeal by the provider of termination of provider status and applicable written notification to employees regarding such a termination, including provisions determined by the commissioner; and

(5) any other provisions required by the commissioner by rule.

(d) Continued care as described by Subsection (c)(3) must be requested by a provider. A dispute involving continuity of care is subject to the dispute resolution process under Subchapter I.

(e) An insurance carrier and a network may not use any financial incentive or make a payment to a health care provider that acts directly or indirectly as an inducement to limit medically necessary services.

Sec. 1305.153. PROVIDER REIMBURSEMENT. (a) The amount of reimbursement for services provided by a network provider is determined by the contract between the network and the provider or group of providers.

(b) If a network has preauthorized a health care service, the insurance carrier or network or the network's agent or other representative may not deny payment to a provider except for reasons other than medical necessity.

(c) Out-of-network providers who provide care as described by Section 1305.006(a) shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of the Texas Department of Workers' Compensation.

(d) Subject to Subsection (a), billing by, and reimbursement to, contracted and out-of-network providers is subject to standard reimbursement requirements as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of the Texas Department of Workers' Compensation, as consistent with this chapter. This subsection may not be construed to require application of rules of the commissioner of the Texas Department of Workers' Compensation regarding reimbursement if application of those rules would negate reimbursement amounts negotiated by the network.

(e) An insurance carrier shall notify in writing a network provider if the carrier contests the compensability of the injury for which the provider provides health care services. A carrier may not deny payment for health care services provided by a network provider before that notification on the grounds that the injury was not compensable.

(f) If an insurance carrier contests the compensability of an injury and the injury is determined not to be compensable, the carrier may recover the amounts paid for health care services from the employee's accident or health insurance carrier or any other person who may be obligated for the cost of the health care services.

Sec. 1305.154. NETWORK-CARRIER CONTRACTS. (a) Except for emergencies and out-of-network referrals, a network may provide services to employees only through a written contract with an insurance carrier. A network-carrier contract under this section is confidential and is not subject to disclosure as public information under Chapter 552, Government Code.

(b) A carrier and a network may negotiate the functions to be provided by the network, except that the network shall contract with providers for the provision of health care functions related to the operation of a quality improvement program, and credentialing in accordance with the requirements of this chapter.

(c) A network's contract with a carrier must include:

(1) a description of the functions that the carrier delegates to the network, consistent with the requirements of Subsection (b), and the reporting requirements for each function;

(2) a statement that the network and any management contractor or third party to which the network delegates a function will perform all delegated functions in full compliance with all requirements of this chapter, the Texas Workers' Compensation Act, and rules of the commissioner of insurance or the commissioner of the Texas Department of Workers' Compensation;

(3) a provision that the contract:

(A) may not be terminated without cause by either party without 90 days' prior written notice; and

(B) must be terminated immediately if cause exists;

(4) a hold-harmless provision stating that the network, a management contractor, a third party to which the network delegates a function, and the network's contracted providers are prohibited from billing or attempting to collect any amounts from employees for health care services under any

circumstances, including the insolvency of the carrier or the network, except as provided by Section 1305.451(b)(6);

(5) a statement that the carrier retains ultimate responsibility for ensuring that all delegated functions and all management contractor functions are performed in accordance with applicable statutes and rules and that the contract may not be construed to limit in any way the carrier's responsibility, including financial responsibility, to comply with all statutory and regulatory requirements;

(6) a statement that the network's role is to provide the services described under Subsection (b) as well as any other services or functions delegated by the carrier, including functions delegated to a management contractor, subject to the carrier's oversight and monitoring of the network's performance;

(7) a requirement that the network provide the carrier, at least monthly and in a form usable for audit purposes, the data necessary for the carrier to comply with reporting requirements of the department and the Texas Department of Workers' Compensation with respect to any services provided under the contract, as determined by commissioner rules;

(8) a requirement that the carrier, the network, any management contractor, and any third party to which the network delegates a function comply with the data reporting requirements of the Texas Workers' Compensation Act and rules of the commissioner of the Texas Department of Workers' Compensation;

(9) a contingency plan under which the carrier would, in the event of termination of the contract or a failure to perform, reassume one or more functions of the network under the contract, including functions related to:

(A) payments to providers and notification to employees;

(B) quality of care;

(C) utilization review;

(D) retrospective review; and

(E) continuity of care, including a plan for identifying and transitioning employees to new providers;

(10) a provision that requires that any agreement by which the network delegates any function to a management contractor or any third party be in writing, and that such an agreement require the delegated third party or management contractor to be subject to all the requirements of this subchapter;

(11) a provision that requires the network to provide to the department the license number of a management contractor or any delegated third party who performs a function that requires a license as a utilization review agent under Article 21.58A or any other license under this code or another insurance law of this state;

(12) an acknowledgment that:

(A) any management contractor or third party to whom the network delegates a function must perform in compliance with this chapter and other applicable statutes and rules, and that the management contractor or third party is subject to the carrier's and the network's oversight and monitoring of its performance; and

(B) if the management contractor or the third party fails to meet monitoring standards established to ensure that functions delegated to the management contractor or the third party under the delegation contract are in full compliance with all statutory and regulatory requirements, the carrier or the network may cancel the delegation of one or more delegated functions;

(13) a requirement that the network and any management contractor or third party to which the network delegates a function provide all necessary information to allow the carrier to provide information to employees as required by Section 1305.451; and

(14) a provision that requires the network, in contracting with a third party directly or through another third party, to require the third party to permit the commissioner to examine at any time any information the commissioner believes is relevant to the third party's financial condition or the ability of

the network to meet the network's responsibilities in connection with any function the third party performs or has been delegated.

(d) An insurance carrier, a network, and any management contractor or third party to which the network delegates a function may not use any financial incentive or make a payment to a health care provider that acts directly or indirectly as an inducement to limit medically necessary services.

Sec. 1305.155. COMPLIANCE REQUIREMENTS. (a) An insurance carrier that becomes aware of any information that indicates that the network, any management contractor, or any third party to which the network delegates a function is not operating in accordance with the contract or is operating in a condition that renders the continuance of the network's business hazardous to employees shall:

(1) notify the network in writing of those findings;

(2) request in writing a written explanation, with documentation supporting the explanation, of:

(A) the network's apparent noncompliance with the contract; or

(B) the existence of the condition that apparently renders the continuance of the network's business hazardous to employees; and

(3) notify the commissioner and provide the department with copies of all notices and requests submitted to the network and the responses and other documentation the carrier generates or receives in response to the notices and requests.

(b) A network shall respond to a request from a carrier under Subsection (a) in writing not later than the 30th day after the date the request is received.

(c) The carrier shall cooperate with the network to correct any failure by the network to comply with any regulatory requirement of the department.

(d) On receipt of a notice under Subsection (a), or if a complaint is filed with the department, on receipt of that complaint, the commissioner or the commissioner's designated representative shall examine the matters contained in the notice or complaint as well as any other matter relating to the financial solvency of the network or the network's ability to meet its responsibilities in connection with any function performed by the network or delegated to the network by the carrier.

(e) Except as provided by this subsection, on completion of the examination, the department shall report to the network and the carrier the results of the examination and any action the department determines is necessary to ensure that the carrier meets its responsibilities under this chapter, this code, and rules adopted by the commissioner, and that the network can meet the network's responsibilities in connection with any function delegated by the carrier or performed by the network, any management contractor, or any third party to which the network delegates a function. The department may not report to the carrier any information regarding fee schedules, prices, cost of care, or other information not relevant to the monitoring plan.

(f) The network and the carrier shall respond to the department's report and submit a corrective plan to the department not later than the 30th day after the date of receipt of the report.

(g) The commissioner may order a carrier to take any action the commissioner determines is necessary to ensure that the carrier can provide all health care services under the Texas Workers' Compensation Act, including:

(1) reassuming the functions performed by or delegated to the network, including claims payments for services previously provided to injured employees;

(2) temporarily or permanently ceasing coverage of employees through the network;

(3) complying with the contingency plan required by Section 1305.154(c)(9), including permitting an injured employee to select a treating doctor in the manner provided by Section 408.022, Labor Code; or

(4) terminating the carrier's contract with the network.

(h) The carrier retains ultimate responsibility for ensuring that all delegated functions and all management contractor functions are performed in accordance with applicable statutes and rules and nothing in this section may be construed to limit in any way the carrier's responsibility, including financial responsibility, to comply with all statutory and regulatory requirements.

[Sections 1305.156-1305.200 reserved for expansion]

SUBCHAPTER E. FINANCIAL REQUIREMENTS

Sec. 1305.201. NETWORK FINANCIAL REQUIREMENTS. (a) Each network shall prepare financial statements in accordance with generally accepted accounting standards, which must include adequate provisions for liabilities, including incurred but not reported obligations relating to providing benefits or services.

(b) Each network shall file the financial statement under Subsection (a) with the department in the manner prescribed by commissioner rule.

[Sections 1305.202-1305.250 reserved for expansion]

SUBCHAPTER F. EXAMINATIONS

Sec. 1305.251. EXAMINATION OF NETWORK. (a) As often as the commissioner considers necessary, the commissioner or the commissioner's designated representative may review the operations of a network to determine compliance with this chapter. The review may include on-site visits to the network's premises.

(b) During on-site visits, the network must make available to the department all records relating to the network's operations.

Sec. 1305.252. EXAMINATION OF PROVIDER OR THIRD PARTY. If requested by the commissioner or the commissioner's representative, each provider, provider group, or third party with which the network has contracted to provide health care services or any other services delegated to the network by an insurance carrier shall make available for examination by the department that portion of the books and records of the provider, provider group, or third party that is relevant to the relationship with the network of the provider, provider group, or third party.

[Sections 1305.253-1305.300 reserved for expansion]

SUBCHAPTER G. PROVISION OF SERVICES BY NETWORK; QUALITY IMPROVEMENT PROGRAM

Sec. 1305.301. NETWORK ORGANIZATION; SERVICE AREAS. (a) The chief executive officer, operations officer, or governing body of a network is responsible for:

(1) the development, approval, implementation, and enforcement of:

(A) administrative, operational, personnel, and patient care policies; and

(B) network procedures; and

(2) the development of any documents necessary for the operation of the network.

(b) Each network shall have a chief executive officer or operations officer who:

(1) is accountable for the day-to-day administration of the network; and

(2) shall ensure compliance with all applicable statutes and rules pertaining to the operation of the network.

(c) Each network shall have a medical director, who must be an occupational medicine specialist or employ or contract with an occupational medicine specialist, and who must be licensed to practice medicine in the United States. The medical director shall:

(1) be available at all times to address complaints, clinical issues, and any quality improvement issues on behalf of the network;

(2) be actively involved in all quality improvement activities; and

(3) comply with the network's credentialing requirements.

(d) The network shall establish one or more service areas within this state. For each defined service area, the network must:

(1) demonstrate to the satisfaction of the department

the ability to provide continuity, accessibility, availability, and quality of services;

(2) specify the counties and zip code areas, or any parts of a county or zip code area, included in the service area; and

(3) provide a complete provider directory to all employers in the service area.

Sec. 1305.302. ACCESSIBILITY AND AVAILABILITY REQUIREMENTS. (a) All services specified by this section must be provided by a provider who holds an appropriate license, unless the provider is exempt from license requirements.

(b) The network shall ensure that the network's provider panel includes an adequate number of treating doctors and specialists, who must be available and accessible to employees 24 hours a day, seven days a week, within the network's service area. An adequate number of the treating doctors and specialists must have admitting privileges at one or more network hospitals located within the network's service area to ensure that any necessary hospital admissions are made.

(c) Hospital services must be available and accessible 24 hours a day, seven days a week, within the network's service area. The network shall provide for the necessary hospital services by contracting with general, special, and psychiatric hospitals.

(d) Physical and occupational therapy services and chiropractic services must be available and accessible within the network's service area.

(e) Emergency care must be available and accessible 24 hours a day, seven days a week, without restrictions as to where the services are rendered.

(f) Except for emergencies, a network shall arrange for services, including referrals to specialists, to be accessible to employees on a timely basis on request, but not later than the last day of the third week after the date of the request.

(g) Each network shall provide that network services are sufficiently accessible and available as necessary to ensure that the distance from any point in the network's service area to a point of service by a treating doctor or general hospital is not greater than 30 miles in nonrural areas and 60 miles in rural areas and that the distance from any point in the network's service area to a point of service by a specialist or specialty hospital is not greater than 75 miles in nonrural areas and 75 miles in rural areas. For portions of the service area in which the network identifies noncompliance with this subsection, the network must file an access plan with the department in accordance with Subsection (h).

(h) The network shall submit an access plan, as required by commissioner rules, to the department for approval at least 30 days before implementation of the plan if any health care service or a network provider is not available to an employee within the distance specified by Subsection (g) because:

(1) providers are not located within that distance;

(2) the network is unable to obtain provider contracts after good faith attempts; or

(3) providers meeting the network's minimum quality of care and credentialing requirements are not located within that distance.

(i) The network may make arrangements with providers outside the service area to enable employees to receive a skill or specialty not available within the network service area.

(j) The network may not be required to expand services outside the network's service area to accommodate employees who live outside the service area.

Sec. 1305.303. QUALITY OF CARE REQUIREMENTS. (a) A network shall develop and maintain an ongoing quality improvement program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services and to pursue opportunities for improvement. The quality improvement program must include return-to-work and medical case management programs.

(b) The network's governing body is ultimately responsible

for the quality improvement program. The governing body shall:

(1) appoint a quality improvement committee that includes network providers;

(2) approve the quality improvement program;

(3) approve an annual quality improvement plan;

(4) meet at least annually to receive and review reports of the quality improvement committee or group of committees, and take action as appropriate; and

(5) review the annual written report on the quality improvement program.

(c) The quality improvement committee or committees shall evaluate the overall effectiveness of the quality improvement program as determined by commissioner rules.

(d) The quality improvement program must be continuous and comprehensive and must address both the quality of clinical care and the quality of services. The network shall dedicate adequate resources, including adequate personnel and information systems, to the quality improvement program.

(e) The network shall develop a written description of the quality improvement program that outlines the organizational structure of the program, the functional responsibilities of the program, and the frequency of committee meetings.

(f) The network shall develop an annual quality improvement work plan designed to reflect the type of services and the populations served by the network in terms of age groups, disease or injury categories, and special risk status, such as type of industry.

(g) The network shall prepare an annual written report to the department on the quality improvement program. The report must include:

(1) completed activities;

(2) the trending of clinical and service goals;

(3) an analysis of program performance; and

(4) conclusions regarding the effectiveness of the program.

(h) Each network shall implement a documented process for the selection and retention of contracted providers, in accordance with rules adopted by the commissioner.

(i) The quality improvement program must provide for a peer review action procedure for providers, as described by Section 151.002, Occupations Code.

(j) The network shall have a medical case management program with certified case managers. Case managers shall work with treating doctors, referral providers, and employers to facilitate cost-effective care and employee return-to-work.

Sec. 1305.304. GUIDELINES AND PROTOCOLS. Each network shall adopt treatment guidelines, return-to-work guidelines, and individual treatment protocols. The treatment guidelines and individual treatment protocols must be evidence-based, scientifically valid, and outcome-focused and be designed to reduce inappropriate or unnecessary health care while safeguarding necessary care.

[Sections 1305.305-1305.350 reserved for expansion]

SUBCHAPTER H. UTILIZATION REVIEW; RETROSPECTIVE REVIEW

Sec. 1305.351. UTILIZATION REVIEW AND RETROSPECTIVE REVIEW IN NETWORK. (a) The requirements of Article 21.58A apply to utilization review conducted in relation to claims in a workers' compensation health care network. In the event of a conflict between Article 21.58A and this chapter, this chapter controls.

(b) Any screening criteria used for utilization review or retrospective review related to a workers' compensation health care network must be consistent with the network's treatment guidelines.

Sec. 1305.352. GENERAL STANDARDS FOR RETROSPECTIVE REVIEW. (a) Retrospective review of a health care service shall be based on written screening criteria established and periodically updated with appropriate involvement from doctors, including actively practicing doctors, and other health care providers.

(b) Retrospective review must be performed under the direction of a physician.

Sec. 1305.353. NOTICE OF CERTAIN UTILIZATION REVIEW DETERMINATIONS; PREAUTHORIZATION REQUIREMENTS. (a) The entity performing utilization review or retrospective review shall notify the employee or the employee's representative, if any, and the requesting provider of a determination made in a utilization review or retrospective review.

(b) Notification of an adverse determination must include:

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

(3) a description of or the source of the screening criteria that were used as guidelines in making the determination;

(4) a description of the procedure for the reconsideration process; and

(5) notification of the availability of independent review in the form prescribed by the commissioner.

(c) On receipt of a preauthorization request from a provider for proposed services that require preauthorization, the utilization review agent shall issue and transmit a determination indicating whether the proposed health care services are preauthorized. The utilization review agent shall respond to requests for preauthorization within the periods prescribed by this section.

(d) For services not described under Subsection (e) or (f), the determination under Subsection (c) must be issued and transmitted not later than the third calendar day after the date the request is received.

(e) If the proposed services are for concurrent hospitalization care, the utilization review agent shall, within 24 hours of receipt of the request, transmit a determination indicating whether the proposed services are preauthorized.

(f) If the proposed health care services involve poststabilization treatment or a life-threatening condition, the utilization review agent shall transmit to the requesting provider a determination indicating whether the proposed services are preauthorized within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, not to exceed one hour from receipt of the request. If the utilization review agent issues an adverse determination in response to a request for poststabilization treatment or a request for treatment involving a life-threatening condition, the utilization review agent shall provide to the employee or the employee's representative, if any, and the employee's treating provider the notification required under Subsection (a).

(g) For life-threatening conditions, the notification of adverse determination must include notification of the availability of independent review in the form prescribed by the commissioner.

Sec. 1305.354. RECONSIDERATION OF ADVERSE DETERMINATION. (a) A utilization review agent shall maintain and make available a written description of the reconsideration procedures involving an adverse determination. The reconsideration procedures must be reasonable and must include:

(1) a provision stating that reconsideration must be performed by a provider other than the provider who made the original adverse determination;

(2) a provision that an employee, a person acting on behalf of the employee, or the employee's requesting provider may, not later than the 30th day after the date of issuance of written notification of an adverse determination, request reconsideration of the adverse determination either orally or in writing;

(3) a provision that, not later than the fifth calendar day after the date of receipt of the request, the network shall send to the requesting party a letter acknowledging the date of the receipt of the request that includes a reasonable list of documents the requesting party is required to submit;

(4) a provision that, after completion of the review of the request for reconsideration of the adverse determination, the utilization review agent shall issue a response letter to the

employee or person acting on behalf of the employee, and the employee's requesting provider, that:

(A) explains the resolution of the reconsideration; and

(B) includes:

(i) a statement of the specific medical or clinical reasons for the resolution;

(ii) the medical or clinical basis for the decision;

(iii) the professional specialty of any provider consulted; and

(iv) notice of the requesting party's right to seek review of the denial by an independent review organization and the procedures for obtaining that review; and

(5) written notification to the requesting party of the determination of the request for reconsideration as soon as practicable, but not later than the 30th day after the date the utilization review agent received the request.

(b) In addition to the written request for reconsideration, the reconsideration procedures must include a method for expedited reconsideration procedures for denials of proposed health care services involving poststabilization treatment or life-threatening conditions, and for denials of continued stays for hospitalized employees. The procedures must include a review by a provider who has not previously reviewed the case and who is of the same or a similar specialty as a provider who typically manages the condition, procedure, or treatment under review. The period during which that reconsideration must be completed shall be based on the medical or clinical immediacy of the condition, procedure, or treatment, but may not exceed one calendar day from the date of receipt of all information necessary to complete the reconsideration.

(c) Notwithstanding Subsection (a) or (b), an employee with a life-threatening condition is entitled to an immediate review by an independent review organization and is not required to comply with the procedures for a reconsideration of an adverse determination.

Sec. 1305.355. INDEPENDENT REVIEW OF ADVERSE DETERMINATION. (a) The utilization review agent shall:

(1) permit the employee or person acting on behalf of the employee and the employee's requesting provider whose reconsideration of an adverse determination is denied to seek review of that determination within the period prescribed by Subsection (b) by an independent review organization assigned in accordance with Article 21.58C and commissioner rules; and

(2) provide to the appropriate independent review organization, not later than the third business day after the date the utilization review agent receives notification of the assignment of the request to an independent review organization:

(A) any medical records of the employee that are relevant to the review;

(B) any documents used by the utilization review agent in making the determination;

(C) the response letter described by Section 1305.354(a)(4);

(D) any documentation and written information submitted in support of the request for reconsideration; and

(E) a list of the providers who provided care to the employee and who may have medical records relevant to the review.

(b) A request for independent review under Subsection (a) must be timely filed by the requestor as follows:

(1) for a request for preauthorization or concurrent review by an independent review organization, not later than the 45th day after the date of denial of a reconsideration for health care requiring preauthorization or concurrent review; or

(2) for a request for retrospective medical necessity review, not later than the 45th day after the denial of reconsideration.

(c) The insurance carrier shall pay for the independent review provided under this subchapter.

(d) The department shall assign the review request to an independent review organization.

(e) A party to a medical dispute that remains unresolved after a review under this section may seek judicial review of the decision. The department is not considered a party to the medical dispute.

(f) A determination of an independent review organization related to a request for preauthorization or concurrent review is binding during the pendency of any appeal, and the carrier and network shall comply with the determination.

(g) If judicial review is not sought under this section, the carrier and network shall comply with the independent review organization's determination.

[Sections 1305.356-1305.400 reserved for expansion]

SUBCHAPTER I. COMPLAINT RESOLUTION

Sec. 1305.401. COMPLAINT SYSTEM REQUIRED. (a) Each network shall implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint.

(b) The network may require a complainant to file the complaint not later than the 90th day after the date of the event or occurrence that is the basis for the complaint.

(c) The complaint system must include a process for the notice and appeal of a complaint.

(d) The commissioner may adopt rules as necessary to implement this section.

Sec. 1305.402. COMPLAINT INITIATION AND INITIAL RESPONSE; DEADLINES FOR RESPONSE AND RESOLUTION. (a) If a complainant notifies a network of a complaint, the network, not later than the seventh calendar day after the date the network receives the complaint, shall respond to the complainant, acknowledging the date of receipt of the complaint and providing a description of the network's complaint procedures and deadlines.

(b) The network shall investigate and resolve a complaint not later than the 30th calendar day after the date the network receives the complaint.

Sec. 1305.403. RECORD OF COMPLAINTS. (a) Each network shall maintain a complaint and appeal log regarding each complaint. The commissioner shall adopt rules designating the classification of network complaints under this section.

(b) Each network shall maintain a record of and documentation on each complaint, complaint proceeding, and action taken on the complaint until the third anniversary of the date the complaint was received.

(c) A complainant is entitled to a copy of the network's record regarding the complaint and any proceeding relating to that complaint.

(d) The department, during any investigation or examination of a network, may review documentation maintained under this subchapter, including original documentation, regarding a complaint and action taken on the complaint.

Sec. 1305.404. RETALIATORY ACTION PROHIBITED. A network may not engage in any retaliatory action against an employer or employee because the employer or employee or a person acting on behalf of the employer or employee has filed a complaint against the network.

Sec. 1305.405. POSTING OF INFORMATION ON COMPLAINT PROCESS REQUIRED. (a) A contract between a network and a provider must require the provider to post, in the provider's office, a notice to injured employees on the process for resolving complaints with the network.

(b) The notice required under Subsection (a) must include the department's toll-free telephone number for filing a complaint.

[Sections 1305.406-1305.450 reserved for expansion]

SUBCHAPTER J. EMPLOYEE INFORMATION AND RESPONSIBILITIES

Sec. 1305.451. EMPLOYEE INFORMATION; RESPONSIBILITIES OF EMPLOYEE. (a) An insurance carrier that establishes or contracts

with a network shall provide to employers, and ensure that the employer provides to its employees, an accurate written description of the terms and conditions for obtaining health care within the network's service area.

(b) The written description required under Subsection (a) must be in English, Spanish, and any additional language common to an employer's employees, must be in plain language and in a readable and understandable format, and must include, in a clear, complete, and accurate format:

(1) a statement that the entity providing health care to employees is a workers' compensation health care network;

(2) the network's toll-free number and address for obtaining additional information about the network, including information about network providers;

(3) a statement that in the event of an injury, the employee must select a treating doctor:

(A) from a list of all the network's treating doctors who have contracts with the network in that service area; or

(B) as described by Section 1305.105;

(4) a statement that, except for emergency services, the employee shall obtain all health care and specialist referrals through the employee's treating doctor;

(5) an explanation that network providers have agreed to look only to the network or insurance carrier and not to employees for payment of providing health care, except as provided by Subdivision (6);

(6) a statement that if the employee obtains health care from non-network providers without network approval or as provided by Section 1305.006(a), the insurance carrier may not be liable, and the employee may be liable, for payment for that health care;

(7) information about how to obtain emergency care services, including emergency care outside the service area, and after-hours care;

(8) a list of the health care services for which the network requires preauthorization;

(9) an explanation regarding continuity of treatment in the event of the termination from the network of a treating doctor;

(10) a description of the network's complaint system, including a statement that the network is prohibited from retaliating against:

(A) an employee if the employee files a complaint against the network or appeals a decision of the network; or

(B) a provider if the provider, on behalf of an employee, reasonably files a complaint against the network or appeals a decision of the network;

(11) a summary of the network's procedures relating to adverse determinations and the availability of the independent review process;

(12) a list of network providers updated at least quarterly, including:

(A) the names and addresses of the providers;

(B) a statement of limitations of accessibility and referrals to specialists; and

(C) a disclosure of which providers are accepting new patients; and

(13) a description of the network's service area.

(c) The network and the network's representatives and agents may not cause or knowingly permit the use or distribution to employees of information that is untrue or misleading.

(d) A network that contracts with an insurance carrier shall provide all the information necessary to allow the carrier to comply with this section.

[Sections 1305.452-1305.500 reserved for expansion]

SUBCHAPTER K. EVALUATION OF NETWORKS; CONSUMER REPORT CARD

Sec. 1305.501. EVALUATION OF NETWORKS. (a) In accordance with the research duties assigned to the department under Chapter 405, Labor Code, the department shall:

(1) objectively evaluate the cost and the quality of

medical care provided by networks certified under this chapter; and

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

(b) At the minimum, the report required under Subsection (a) must evaluate:

(1) the average medical and indemnity cost per claim for health care services provided through networks;

(2) the access to care and utilization by injured employees of health care provided through networks;

(3) injured employee return-to-work outcomes;

(4) injured employee satisfaction and health-related functional outcomes; and

(5) the frequency, duration, and outcome of disputes regarding medical benefits.

(c) The department shall include in the report a comparison of the administrative burdens incurred by health care providers who provide workers' compensation medical benefits through networks with those incurred by providers who provide analogous medical benefits outside the network structure.

Sec. 1305.502. CONSUMER REPORT CARDS. (a) The department shall annually issue consumer report cards that identify and compare, on an objective basis, the networks certified by the department under this chapter.

(b) The department shall ensure that consumer report cards issued by the department under this section are accessible to the public on the department's Internet website and available to any person on request. The commissioner, by rule, may set a reasonable fee to obtain a paper copy of consumer report cards.

Sec. 1305.503. CONFIDENTIALITY REQUIREMENTS. (a) As necessary to implement this subchapter, the department is entitled to information that is otherwise confidential under any law of this state, including the Texas Workers' Compensation Act.

(b) Confidential information provided to or obtained by the department under this section remains confidential and is not subject to disclosure under Chapter 552, Government Code. The department may not release, and a person may not gain access to, any information that:

(1) could reasonably be expected to reveal the identity of an injured employee; or

(2) discloses provider discounts or differentials between payments and billed charges for individual providers or networks.

(c) Information that is in the possession of the department and that relates to an individual injured employee, and any compilation, report, or analysis produced from the information that identifies an individual injured employee, are not:

(1) subject to discovery, subpoena, or other means of legal compulsion for release to any person; or

(2) admissible in any civil, administrative, or criminal proceeding.

[Sections 1305.504-1305.550 reserved for expansion]

SUBCHAPTER L. DISCIPLINARY ACTIONS

Sec. 1305.551. DETERMINATION OF VIOLATION; NOTICE. (a) If the commissioner determines that a network, insurance carrier, or any other person or third party operating under this chapter, including a third party to which a network delegates a function, or any third party with which a network contracts for management services, is in violation of this chapter, rules adopted by the commissioner under this chapter, or applicable provisions of the Labor Code or rules adopted under that code, the commissioner or a designated representative may notify the network, insurance carrier, person, or third party of the alleged violation and may compel the production of any documents or other information as necessary to determine whether the violation occurred.

(b) The commissioner's designated representative may initiate the proceedings under this section.

(c) A proceeding under this section is a contested case

under Chapter 2001, Government Code.

Sec. 1305.552. DISCIPLINARY ACTIONS. If under Section 1305.551 the commissioner determines that a network, insurance carrier, or other person or third party described under Section 1305.551 has violated or is violating this chapter, rules adopted by the commissioner under this chapter, or the Labor Code or rules adopted under that code, the commissioner may:

(1) suspend or revoke a certificate issued under this code;

(2) impose sanctions under Chapter 82;

(3) issue a cease and desist order under Chapter 83;

(4) impose administrative penalties under Chapter 84; or

(5) take any combination of these actions.

ARTICLE 5. RATES AND UNDERWRITING REQUIREMENTS

SECTION 5.01. Section 1, Article 5.55, Insurance Code, is amended by amending Subdivision (2) and adding Subdivision (2-a) to read as follows:

(2) "Insurer" means a person authorized and admitted by the department [~~Texas Department of Insurance~~] to engage in the [~~do insurance~~] business of insurance in this state under a certificate of authority that includes authorization to write workers' compensation insurance. The term includes:

(A) the Texas Mutual Insurance Company;

(B) a Lloyd's plan under Chapter 941 of this code;

(C) a reciprocal and interinsurance exchange under Chapter 942 of this code; and

(D) a workers' compensation self-insurance group required to file rates under Chapter 407A, Labor Code.

(2-a) "Premium" means the amount charged for a workers' compensation insurance policy, including any endorsements, after the application of individual risk variations based on loss or expense considerations.

SECTION 5.02. Subsections (b) and (d), Section 2, Article 5.55, Insurance Code, are amended to read as follows:

(b) In setting rates, an insurer shall consider:

(1) past and prospective loss cost experience;

(2) operation expenses;

(3) investment income;

(4) a reasonable margin for profit and contingencies; [~~and~~]

(5) the effect on premiums of individual risk variations based on loss or expense considerations; and

(6) any other relevant factors.

(d) Rates and premiums established under this article may not be excessive, inadequate, or unfairly discriminatory.

SECTION 5.03. Section 3, Article 5.55, Insurance Code, is amended by adding Subsections (e) through (h) to read as follows:

(e) Not later than December 1 of each even-numbered year, the commissioner shall report to the governor, lieutenant governor, and speaker of the house of representatives regarding the impact that legislation enacted during the regular session of the 79th Legislature reforming the workers' compensation system of this state has had on the affordability and availability of workers' compensation insurance for the employers of this state. The report must include an analysis of:

(1) the projected workers' compensation premium savings realized by employers as a result of the reforms;

(2) the impact of the reforms on:

(A) the percentage of employers who provide workers' compensation insurance coverage for their employees; and

(B) to the extent possible, economic development and job creation;

(3) the effects of the reforms on market competition and carrier financial solvency, including an analysis of how carrier loss ratios, combined ratios, and use of individual risk variations have changed since implementation of the reforms; and

(4) the extent of participation in workers'

compensation health care networks by small and medium-sized employers.

(f) If the commissioner determines that workers' compensation rate filings or premium levels analyzed by the department do not appropriately reflect the savings associated with the reforms described by Subsection (e) of this section, the commissioner shall include in the report required under Subsection (e) of this section any recommendations, including any recommended legislative changes, necessary to identify the tools needed by the department to more effectively regulate workers' compensation rates.

(g) At the request of the department, each insurer shall submit to the department all data and other information considered necessary by the commissioner to generate the report required under Subsection (e) of this section. Failure by an insurer to submit the data and information in a timely fashion, as determined by commissioner rule, constitutes grounds for sanctions under Chapter 82 of this code.

(h) In reviewing rates under this article, the commissioner shall consider any state or federal legislation that has been enacted and that may impact rates and premiums for workers' compensation insurance coverage in this state.

SECTION 5.04. Subsection (b), Section 6, Article 5.55, Insurance Code, is amended to read as follows:

(b) The disapproval order must be issued not later than the 15th day after the close of a hearing and must specify how the rate fails to meet the requirements of this article. The disapproval order must state the date on which the further use of that rate is prohibited. [~~A disapproval order does not affect a policy made or issued in accordance with this code before the expiration of the period established in the order.~~]

SECTION 5.05. Section 7, Article 5.55, Insurance Code, is amended to read as follows:

Sec. 7. EFFECT OF DISAPPROVAL; PENALTY. (a) If a policy is issued and the commissioner [~~board~~] subsequently disapproves the rate or filing that governs the premium charged on the policy:

(1) the policyholder may continue the policy at the original rate;

(2) the policyholder may cancel the policy without penalty; or

(3) the policyholder and the insurer may agree to amend the policy to reflect the premium that would have been charged based on the insurer's most recently approved rate; the amendment may not take effect before the date on which further use of the rate is prohibited under the disapproval order.

(b) If a policy is issued and the commissioner subsequently disapproves the rate or filing on which the premium is based, the commissioner, after notice and the opportunity for a hearing, may:

(1) impose sanctions under Chapter 82 of this code;

(2) issue a cease and desist order under Chapter 83 of this code;

(3) impose administrative penalties under Chapter 84 of this code; or

(4) take any combination of these actions [~~If the board determines, based on a pattern of charges for premiums, that an insurer is consistently overcharging or undercharging, the board may assess an administrative penalty. The penalty shall be assessed in accordance with Article 10, Texas Workers' Compensation Act (Article 8308-10.01 et seq., Vernon's Texas Civil Statutes), and set by the board in an amount reasonable and necessary to deter the overcharging or undercharging of policyholders~~].

SECTION 5.06. Subchapter D, Chapter 5, Insurance Code, is amended by adding Article 5.55A to read as follows:

Art. 5.55A. UNDERWRITING GUIDELINES

Sec. 1. DEFINITIONS. In this article:

(1) "Insurer" has the meaning assigned by Section 1(2), Article 5.55, of this code.

(2) "Underwriting guideline" means a rule, standard, guideline, or practice, whether written, oral, or electronic, that

is used by an insurer or its agent to decide whether to accept or reject an application for coverage under a workers' compensation insurance policy or to determine how to classify those risks that are accepted for the purpose of determining a rate.

Sec. 2. UNDERWRITING GUIDELINES. Each underwriting guideline used by an insurer in writing workers' compensation insurance must be sound, actuarially justified, or otherwise substantially commensurate with the contemplated risk. An underwriting guideline may not be unfairly discriminatory.

Sec. 3. ENFORCEMENT. This article may be enforced in the manner provided by Section 38.003(g) of this code.

Sec. 4. FILING REQUIREMENTS. Each insurer shall file with the department a copy of the insurer's underwriting guidelines. The insurer shall update its filing each time the underwriting guidelines are changed. If a group of insurers files one set of underwriting guidelines for the group, the group shall identify which underwriting guidelines apply to each insurer in the group.

Sec. 5. APPLICABILITY OF SECTION 38.003. Section 38.003 of this code applies to this article to the extent consistent with this article.

SECTION 5.07. Subsection (b), Article 5.58, Insurance Code, is amended to read as follows:

(b) Standards and Procedures. For purposes of Subsection (c) of this article, the commissioner shall establish standards and procedures for categorizing insurance and medical benefits reported on each workers' compensation claim. The commissioner shall consult with the Texas Department of Workers' Compensation [~~Commission and the Research and Oversight Council on Workers' Compensation~~] in establishing these standards to ensure that the data collection methodology will also yield data necessary for research and medical cost containment efforts.

ARTICLE 6. REPEALER

SECTION 6.001. The following provisions of the Labor Code are repealed:

(1) Section 402.025;
(2) Subsection (b), Section 402.062;
(3) Sections 402.063 and 402.070;
(4) Subsection (c), Section 402.091;
(5) Section 406.012;
(6) Subsection (g), Section 408.004;
(7) Sections 408.0221, 408.0222, and 408.0223;
(8) Subsection (d), Section 411.034;
(9) Section 413.005;
(10) Subsection (b), Section 413.043;
(11) Subsections (c) and (d), Section 415.0035;
(12) Section 415.004;
(13) Subsection (b), Section 415.008;
(14) Subsection (b), Section 415.009;
(15) Subsection (b), Section 415.010;
(16) Section 415.022; and
(17) Subdivision (1), Section 505.001.

ARTICLE 7. TRANSITION; EFFECTIVE DATE

SECTION 7.001. EFFECT OF CHANGE IN DESIGNATION. The change in designation of the Texas Workers' Compensation Commission to the Texas Department of Workers' Compensation does not affect or impair any act done or taken, any rule, standard, or rate adopted, any order or certificate issued, or any form approved by the Texas Workers' Compensation Commission as a state agency, or any penalty assessed by the Texas Workers' Compensation Commission as a state agency before the change in designation made by this Act.

SECTION 7.002. ABOLITION OF TEXAS WORKERS' COMPENSATION COMMISSION. (a) The Texas Workers' Compensation Commission is abolished on the effective date of this Act. The term of a person who is serving on the Texas Workers' Compensation Commission on the effective date of this Act expires on the date the commissioner of workers' compensation is appointed.

(b) All appropriations made by the legislature for the use and benefit of the Texas Workers' Compensation Commission are available for the use and benefit of the Texas Department of

Workers' Compensation.

(c) The divisions of the Texas Workers' Compensation Commission established under Section 402.021, Labor Code, as that section existed prior to amendment by this Act, are abolished on the effective date of this Act.

SECTION 7.003. COMMISSIONER. The governor shall appoint the commissioner of workers' compensation not later than September 30, 2005.

SECTION 7.004. RULES REGARDING MEDICAL EXAMINATIONS. The commissioner of workers' compensation shall adopt rules to implement the changes in law made to Sections 408.004 and 408.0041, Labor Code, as amended by this Act, on or before February 1, 2006. The changes in law made to Sections 408.004 and 408.0041, Labor Code, are effective on the date provided by commissioner rule.

SECTION 7.005. ELECTRONIC BILLING RULES. The commissioner of workers' compensation shall adopt rules under Section 408.0251, Labor Code, as added by this Act, not later than January 1, 2006.

SECTION 7.006. ACCRUAL OF RIGHT TO INCOME BENEFITS. Subsection (c), Section 408.082, Labor Code, as amended by this Act, applies only to a claim for workers' compensation benefits based on a compensable injury that occurs on or after the effective date of this Act. A claim based on a compensable injury that occurs before that date is governed by the law in effect on the date that the compensable injury occurred, and the former law is continued in effect for that purpose.

SECTION 7.007. ELIGIBILITY FOR PILOT PROGRAM. The pilot program established under Section 413.022, Labor Code, as added by this Act, takes effect January 1, 2006.

SECTION 7.008. REPORTS. (a) Not later than October 1, 2006, the commissioner of workers' compensation shall report to the governor, the lieutenant governor, the speaker of the house of representatives, and the members of the 79th Legislature regarding the implementation of Section 408.1225, Labor Code, as added by this Act.

(b) Not later than October 1, 2008, the commissioner of workers' compensation shall report to the governor, the lieutenant governor, the speaker of the house of representatives, and the members of the legislature regarding the implementation of the pilot program established by Section 413.022, Labor Code, as added by this Act, and the results of the pilot program. The report must include any recommendations regarding the continuation of the pilot program, including any changes required to enhance the effectiveness of the program.

(c) The commissioner of insurance shall submit the initial report required under Subsection (e), Section 3, Article 5.55, Insurance Code, as added by this Act, not later than December 1, 2006.

(d) The commissioner of insurance shall submit to the governor, the lieutenant governor, the speaker of the house of representatives, and the members of the legislature the first report under Subsection (a), Section 1305.501, Insurance Code, as added by this Act, not later than December 1, 2008.

SECTION 7.009. ABOLITION OF MEDICAL ADVISORY COMMITTEE. The medical advisory committee established under Section 413.005, Labor Code, as that section existed prior to repeal by this Act, is abolished on the effective date of this Act.

SECTION 7.010. STATE OFFICE OF ADMINISTRATIVE HEARINGS REVIEW. (a) This section applies to a hearing conducted by the State Office of Administrative Hearings under Subsection (k), Section 413.031, Labor Code, as that subsection existed prior to amendment by this Act.

(b) The State Office of Administrative Hearings shall conclude on or before December 31, 2005, any hearings pending before that office regarding medical disputes that remain unresolved after a review by an independent review organization.

(c) Effective September 1, 2005, the State Office of Administrative Hearings may not accept for hearing a medical dispute that remains unresolved after a review by an independent review organization. A medical dispute that is not pending for a

hearing by the State Office of Administrative Hearings on or before August 31, 2005, is subject to Subsection (k), Section 413.031, Labor Code, as amended by this Act, and is not subject to a hearing before the State Office of Administrative Hearings.

SECTION 7.011. IMPLEMENTATION OF PROVIDER NETWORKS. (a) The commissioner of insurance and the commissioner of workers' compensation shall adopt rules as necessary to implement Chapter 1305, Insurance Code, as added by this Act, not later than December 1, 2005. The Texas Department of Insurance shall accept applications from a network seeking certification under Chapter 1305, Insurance Code, as added by this Act, beginning December 15, 2005.

(b) An insurance carrier may begin to offer workers' compensation medical benefits through a network under Chapter 1305, Insurance Code, as added by this Act, on certification of the network by the commissioner of insurance.

SECTION 7.012. CONSUMER REPORT CARD. The Texas Department of Insurance shall issue the first annual workers' compensation consumer report card under Section 1305.502, Insurance Code, as added by this Act, not later than 18 months after the date on which that department certifies the first workers' compensation health care network under Chapter 1305, Insurance Code, as added by this Act.

SECTION 7.013. APPLICATION TO MEDICAL BENEFITS. (a) Article 4 of this Act applies to a claim for workers' compensation medical benefits based on a compensable injury incurred by an employee whose employer elects to provide workers' compensation insurance coverage if the insurance carrier of the employer enters into a contract to provide workers' compensation medical benefits through a network certified under Chapter 1305, Insurance Code, as added by this Act.

(b) A claim for workers' compensation medical benefits based on a compensable injury that occurs on or after the effective date of a contract described by Subsection (a) of this section is subject to the provisions of Chapter 1305, Insurance Code, as added by this Act.

(c) Notwithstanding Subsection (a) of this section, an injured employee who receives workers' compensation medical benefits based on a compensable injury that occurs before the effective date of this Act is subject to the provisions of Chapter 1305, Insurance Code, as added by this Act, and must receive treatment through a network health care provider if the insurer liable for the payment of benefits on that claim elects to use a workers' compensation health care network to provide medical benefits and the claimant lives in a network service area. The insurer shall notify affected injured employees in writing of the election.

SECTION 7.014. APPLICATION TO SANCTIONS AND VIOLATIONS. (a) The changes in law made by this Act apply only to a penalty or sanction for an offense or violation committed on or after the effective date of this Act.

(b) For purposes of this section, an offense or violation is committed before the effective date of this Act if any element of the offense occurs before that date.

(c) An offense committed before the effective date of this Act is governed by the law in effect when the offense was committed, and the former law is continued in effect for that purpose.

SECTION 7.015. EFFECT OF UPDATE ACT. To the extent of any conflict, this Act prevails over another Act of the 79th Legislature, Regular Session, 2005, relating to nonsubstantive additions to and corrections in enacted codes (the General Code Update bill).

SECTION 7.016. EFFECTIVE DATE. This Act takes effect September 1, 2005.

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