By: Solomons, Giddings, Hamric, Dunnam H.B. No. 7

Substitute the following for H.B. No. 7:

By: Elkins C.S.H.B. No. 7

A BILL TO BE ENTITLED

AN ACT

relating to the continuation and operation of the workers' compensation system of this state and to the abolition of the Texas Workers' Compensation Commission, the establishment of the office of injured employee counsel, and the transfer of the powers and duties of the Texas Workers' Compensation Commission to the Texas Department of Insurance and the office of injured employee counsel; providing administrative violations.

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

ARTICLE 1. AMENDMENTS TO SUBTITLE A, TITLE 5, LABOR CODE

PART 1. AMENDMENTS TO CHAPTER 401, LABOR CODE

SECTION 1.001. The heading to Subchapter A, Chapter 401, Labor Code, is amended to read as follows:

SUBCHAPTER A. GENERAL PROVISIONS [~~SHORT TITLE; APPLICATION OF SUNSET ACT~~]

SECTION 1.002. Section 401.003(a), 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 department's [~~commission's~~]:

(1) structure and internal controls;

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

(3) implementation of statutory mandates;

(4) employee turnover;

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

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

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

SECTION 1.003. Section 401.011, Labor Code, is amended by amending Subdivisions (1), (8), (14), (15), (19), (28), (30), (37), (39), (42), and (44) and adding Subdivisions (2-a), (4-a), (5-a), (5-b), (5-c), (11-a), (11-b), (12-a), (13-a), (16-a), (17-a), (17-b), (25-a), (25-b), (29-a), (31-a), (31-b), (31-c), (31-d), (34-a), (34-b), (34-c), (34-d), (35-a), (35-b), (35-c), (38-a), (38-b), (39-a), (39-b), (42-a), (42-b), (42-c), and (42-d) to read as follows:

(1) "Adjuster" means a person licensed under Chapter 4101, Insurance Code [~~407, Acts of the 63rd Legislature, Regular Session, 1973 (Article 21.07-4, Vernon's Texas Insurance Code)~~].

(2-a) "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 injured employee are not reasonable and necessary health care services or are not appropriate.

(4-a) "Appeal process" means the formal process by which an insurance carrier addresses adverse determinations.

(5-a) "Carrier-network contract" means a written

agreement between a provider network and an insurance carrier that meets the requirements of Section 408B.152 and under which the provider network:

(A) agrees to undertake to arrange for or to provide, by itself or through subcontracts with one or more entities, health care services on a non-capitated basis to participants through participating providers; and

(B) accepts responsibility to perform certain delegated functions on behalf of the insurance carrier.

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

(5-c) "Certified provider network" means a network of participating health care providers using care management procedures that is certified by an insurance carrier in accordance with Subchapter C, Chapter 408B, and is used by the carrier to provide health care services to participants. A certified provider network may include one or more provider networks and individual providers.

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

(11-a) "Complainant" means a person who files a complaint under this subtitle. 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.

(11-b) "Complaint" means any dissatisfaction expressed orally or in writing by a complainant to a provider network regarding any aspect of the network's operation. The term includes dissatisfaction relating to medical fee disputes, 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.

(12-a) "Credentialing" means the insurance carrier's processes, established in accordance with Section 408B.301, for review of qualifications and of other relevant information relating to a health care provider who seeks a participating provider contract.

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

(14) "Dependent" means an individual who receives a regular or recurring economic benefit that contributes substantially to the individual's welfare and livelihood if the individual is eligible for distribution of benefits under this

subtitle [~~Chapter 408~~].

(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.

(16-a) "Dispute" means a disagreement related to review or appeal of an adverse determination, the denial, reduction, or termination of services for reasons not related to whether the services were reasonable and necessary health care services, or 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.

(17-a) "Emergency care" means services provided in a hospital emergency facility or a comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health care to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

(A) serious jeopardy to the person's health;

(B) serious impairment to bodily functions;

(C) serious dysfunction of any bodily organ or

part;

(D) serious disfigurement; or

(E) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

(17-b) "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.

(19) "Health care" means only medically [~~includes all reasonable and~~] necessary medical aid, medical examinations, medical treatments, medical diagnoses, medical evaluations, and medical services. The term does not include vocational rehabilitation. The term includes:

(A) medical, surgical, chiropractic, podiatric, optometric, dental, nursing, and physical therapy services provided by or at the direction of, or that are the subject of a referral by, a treating doctor;

(B) physical rehabilitation services performed by a licensed [~~occupational~~] therapist and provided by or at the direction of, or that are the subject of a referral by, a treating doctor;

(C) psychological services provided by or at the direction of, or that are the subject of a referral by, a treating [~~prescribed by a~~] doctor;

(D) the services of a hospital or other health care facility provided by or at the direction of, or that are the subject of a referral by, a treating doctor;

(E) a prescription drug, medicine, or other

remedy provided by or at the direction of, or that is the subject of a referral by, a treating doctor; and

(F) a medical or surgical supply, appliance, brace, artificial member, or prosthesis, including training in the use of the appliance, brace, member, or prosthesis, provided by or at the direction of, or that is the subject of a referral by, a treating doctor.

(25-a) "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.

(25-b) "Independent review organization" means an entity that is certified by the commissioner to conduct independent review under Article 21.58C, Insurance Code, and rules adopted by the commissioner.

(28) "Insurance company" means a person authorized and admitted by the department [~~Texas Department of Insurance~~] to engage in the business of [~~do~~] insurance [~~business~~] in this state under a certificate of authority that includes authorization to write workers' compensation insurance.

(29-a) "Life threatening" has the meaning assigned by Section 2, Article 21.58A, Insurance Code.

(30) "Maximum medical improvement" means the earlier of:

(A) the earliest date after which, based on reasonable medical probability, further material recovery from or

lasting improvement to an injury can no longer reasonably be anticipated;

(B) the expiration of 104 weeks from the date on which income benefits begin to accrue; or

(C) the date determined as provided by Section 408D.054 [~~408.104~~].

(31-a) "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) serious jeopardy to the patient's health or bodily functions; or

(B) serious dysfunction of any body organ or part.

(31-b) "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.

(31-c) "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.

(31-d) "Nurse" has the meaning assigned by Section 2, Article 21.58A, Insurance Code.

(34-a) "Participating health care provider" and "participating provider" mean a health care provider that:

(A) participates in a certified provider network by entering into a participating provider contract to provide

health care services to participants in accordance with this subtitle; and

(B) has been credentialed by the insurance carrier or provider network in the manner described by Section 408B.301.

(34-b) "Participating provider contract" means the written agreement entered into by a health care provider with an insurance carrier or provider network under which the health care provider agrees to, by itself or through subcontracts with one or more entities, provide or arrange for health care services to injured employees under Chapter 408B.

(34-c) "Pattern of practice of under-utilization or over-utilization" means repetition of instances of under-utilization or over-utilization within a specific medical case or multiple cases by a participating health care provider.

(34-d) "Pattern of practice review" means an evaluation, conducted by two or more health care providers licensed under the same authority and with the same or similar specialty as the participating provider under review, that includes an evaluation of:

(A) the appropriateness of both the level and the quality of health care services provided to an injured employee;

(B) the appropriateness of treatment, hospitalization, or office visits consistent with nationally recognized, scientifically valid, outcome-based treatment standards and guidelines;

(C) utilization control; and

(D) the existence of a pattern of practice of under-utilization or over-utilization.

(35-a) "Preauthorization" means the process required to request approval from a provider network to provide a specific treatment or service before the treatment or service is provided.

(35-b) "Provider network" means an entity, including a preferred provider organization, a health maintenance organization, or a nonprofit health corporation certified under Section 162.001, Occupations Code, that has entered into a carrier-network contract under Chapter 408B.

(35-c) "Quality improvement program" means a system designed to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions in accordance with Section 408B.203.

(37) "Representative" means a person, including an attorney, authorized by the department [~~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-a) "Retrospective review" means the process of reviewing whether services that have been provided to an injured employee are reasonable and necessary services.

(38-b) "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.

(39) "Sanction" means a penalty or other punitive action or remedy imposed by the department [~~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 of the commissioner [~~commission~~].

(39-a) "Screening criteria" means the written policies, decision rules, medical protocols, and treatment guidelines used by a provider network as set forth in Section 408B.352(c) as part of utilization review and retrospective review.

(39-b) "Service area" means a geographic area within which health care services from network providers are available and accessible to employees who live or work within that geographic area.

(42) "Treating doctor" means the doctor who is primarily responsible for the employee's health care for an injury. Within a provider network, the term includes a participating provider who is primarily responsible for:

(A) the efficient management of health care services for an injured employee;

(B) return-to-work outcomes; and

(C) all referrals to other health care providers.

(42-a) "Utilization control" means a systematic process of implementing measures that assure overall quality, management and cost containment of services delivered, including compliance with nationally recognized, scientifically valid, outcome-based treatment standards and guidelines.

(42-b) "Utilization review" has the meaning assigned by Section 2, Article 21.58A, Insurance Code.

(42-c) "Utilization review agent" means any entity with which a provider network contracts or subcontracts to provide utilization review under Article 21.58A, Insurance Code.

(42-d) "Utilization review plan" means the screening criteria, retrospective review procedures, and utilization review procedures of an insurance carrier, provider network, or utilization review agent.

(44) "Workers' compensation insurance coverage" means coverage to secure the payment of compensation provided through:

(A) an approved insurance policy [~~to secure the payment of compensation~~];

(B) [~~coverage to secure the payment of compensation through~~] self-insurance, as provided by this subtitle; or

(C) [~~coverage provided by~~] a governmental entity, as provided by Subtitle C [~~to secure the payment of compensation~~].

SECTION 1.004. 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 under this title 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 under this title is governed by Subchapters A and B, Chapter 2002, Government Code, excluding Sections 2002.001(3) [~~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;

(B) [~~(C) an appeals panel proceeding;~~

[~~(D)~~] arbitration; or

(C) [~~(E)~~] another proceeding involving a determination on a workers' compensation claim; and

(4) Chapter 552, Government Code, applies to a workers' compensation record of the department or the office of injured employee counsel [~~commission or the research center~~].

SECTION 1.005. Section 401.023(b), 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 1.006. Sections 401.024(b)-(d), 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 commissioner [~~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 1.007. The following laws are repealed:

(1) Section 401.002, Labor Code; and

(2) Section 401.011(38), Labor Code.

PART 2. AMENDMENTS TO CHAPTER 402, LABOR CODE

SECTION 1.011. The heading to Chapter 402, Labor Code, is amended to read as follows:

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

SECTION 1.012. The heading to Subchapter A, Chapter 402, Labor Code, is amended to read as follows:

SUBCHAPTER A. GENERAL ADMINISTRATION OF SYSTEM [~~ORGANIZATION~~]

SECTION 1.013. Section 402.001, Labor Code, is amended to read as follows:

Sec. 402.001. ADMINISTRATION OF SYSTEM: TEXAS DEPARTMENT OF INSURANCE. Except as provided by Section 402.002, the Texas Department of Insurance is the state agency designated to oversee and operate the workers' compensation system of this state. [~~MEMBERSHIP REQUIREMENTS. (a) The Texas Workers' Compensation Commission is composed of six members appointed by the governor with the advice and consent of the senate.~~

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

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

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

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

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

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

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

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

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

SECTION 1.014. Section 402.002, Labor Code, is amended to read as follows:

Sec. 402.002. ADMINISTRATION OF SYSTEM: OFFICE OF INJURED EMPLOYEE COUNSEL. The office of injured employee counsel established under Chapter 404 shall perform the functions regarding the provision of workers' compensation benefits in this state designated by this subtitle as under the authority of that office.

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

~~on February 1 of each year.~~

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

SECTION 1.015. The heading to Subchapter B, Chapter 402, Labor Code, is amended to read as follows:

SUBCHAPTER B. SYSTEM GOALS [~~ADMINISTRATION~~]

SECTION 1.016. Section 402.021, Labor Code, is renumbered as Section 402.051, Labor Code, and amended to read as follows:

Sec. 402.051 [~~402.021~~]. GOALS; LEGISLATIVE INTENT. (a) The basic goals of the workers' compensation system of this state are as follows:

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

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

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

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

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

(1) promote safe and healthy workplaces through

appropriate incentives, education, and other actions;

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

(3) provide appropriate income benefits and medical benefits in a manner that is timely and cost-effective;

(4) provide timely, appropriate, and high-quality medical care supporting restoration of the injured employee's physical condition and earning capacity;

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

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

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

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

(9) take maximum advantage of technological advances to provide the highest levels of service possible to system participants and to promote communication among system participants. [~~COMMISSION DIVISIONS. (a) The 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 commission for effective administration and performance of commission functions. The executive director may allocate and reallocate functions among the divisions.~~

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

SECTION 1.017. Subchapter B, Chapter 402, Labor Code, is amended by adding Section 402.052 to read as follows:

Sec. 402.052. GENERAL WORKERS' COMPENSATION MISSION OF DEPARTMENT. As provided by this subtitle, the department shall work to promote and help ensure the safe and timely return of injured employees to productive roles in the workforce.

SECTION 1.018. The heading to Subchapter C, Chapter 402, Labor Code, is amended to read as follows:

SUBCHAPTER C. DEPARTMENT WORKFORCE EDUCATION AND SAFETY FUNCTIONS [~~EXECUTIVE DIRECTOR AND PERSONNEL~~]

SECTION 1.019. Subchapter C, Chapter 402, Labor Code, is amended by adding Sections 402.101 and 402.102 to read as follows:

Sec. 402.101. GENERAL DUTIES; FUNDING. (a) The department shall perform the workforce education and safety functions of the workers' compensation system of this state.

(b) The operations of the department under this subtitle are

funded through the maintenance tax assessed under Section 403.002.

Sec. 402.102. EDUCATIONAL PROGRAMS. (a) The department shall provide education on best practices for return-to-work programs and workplace safety.

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

SECTION 1.020. Section 402.082, Labor Code, is transferred to Subchapter C, Chapter 402, Labor Code, renumbered as Section 402.103, Labor Code, and amended to read as follows:

Sec. 402.103 [~~402.082~~]. INJURY INFORMATION MAINTAINED BY DEPARTMENT [~~COMMISSION~~]. (a) 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.

(b) The department shall provide information maintained under Subsection (a) to the office of injured employee counsel. The confidentiality requirements imposed under Section 402.202 apply to injury information maintained by the department.

SECTION 1.021. The heading to Subchapter D, Chapter 402, Labor Code, is amended to read as follows:

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

SECTION 1.022. Section 402.042, Labor Code, is transferred

to Subchapter D, Chapter 402, Labor Code, renumbered as Section 402.151, Labor Code, and amended to read as follows:

Sec. 402.151 [~~402.042~~]. GENERAL POWERS AND DUTIES OF COMMISSIONER AND DEPARTMENT [~~EXECUTIVE DIRECTOR~~]. (a) The commissioner [~~executive director~~] shall conduct the [~~day-to-day~~] operations of the department under this subtitle [~~commission in accordance with policies established by the commission and otherwise implement commission policy~~].

(b) The commissioner or the commissioner's designee, acting under this subtitle, [~~executive director~~] may:

(1) investigate misconduct;

(2) hold hearings;

(3) issue subpoenas to compel the attendance of witnesses and the production of documents in accordance with Subchapter C, Chapter 36, Insurance Code;

(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 department [~~commission~~]; and

(12) delegate all powers and duties as necessary.

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

(d) The department shall operate regional offices throughout this state as necessary to implement the duties of the department under this subtitle.

SECTION 1.023. Section 402.061, Labor Code, is renumbered as Section 402.152, Labor Code, and amended to read as follows:

Sec. 402.152 [~~402.061~~]. ADOPTION OF RULES. The commissioner [~~commission~~] shall adopt rules as necessary for the implementation and enforcement of this subtitle.

SECTION 1.024. Section 402.062, Labor Code, is renumbered as Section 402.153, Labor Code, and amended to read as follows:

Sec. 402.153 [~~402.062~~]. ACCEPTANCE OF CERTAIN GIFTS, GRANTS, OR [~~AND~~] DONATIONS. [~~(a)~~] The department [~~commission~~] may accept gifts, grants, or donations for the operation of this subtitle as provided by rules adopted by the commissioner [~~commission~~].

[~~(b) Notwithstanding Chapter 575, Government Code, the commission may accept a grant paid by the Texas Mutual Insurance Company established under Article 5.76-3, Insurance Code, to implement specific steps to control and lower medical costs in the workers' compensation system and to ensure the delivery of quality medical care. The commission must publish the name of the grantor and the purpose and conditions of the grant in the Texas Register~~

~~and provide for a 20-day public comment period before the commission may accept the grant. The commission shall acknowledge acceptance of the grant at a public meeting. The minutes of the public meeting must include the name of the grantor, a description of the grant, and a general statement of the purposes for which the grant will be used.~~]

SECTION 1.025. Section 402.064, Labor Code, is renumbered as Section 402.154, Labor Code, and amended to read as follows:

Sec. 402.154 [~~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 under this subtitle [~~commission~~], including services provided under Subchapter E.

SECTION 1.026. Section 402.065, Labor Code, is renumbered as Section 402.155, Labor Code, and amended to read as follows:

Sec. 402.155 [~~402.065~~]. EMPLOYMENT OF COUNSEL. Notwithstanding Article 1.09-1, Insurance Code, or any other law, the commissioner [~~The commission~~] may employ counsel to represent the department [~~commission~~] in any legal action the department [~~commission~~] is authorized to initiate under this subtitle.

SECTION 1.027. Section 402.066, Labor Code, is renumbered as Section 402.156, Labor Code, and amended to read as follows:

Sec. 402.156 [~~402.066~~]. RECOMMENDATIONS TO LEGISLATURE. (a) The commissioner [~~commission~~] shall consider and recommend to the legislature changes to this subtitle, including any statutory changes required by an evaluation conducted under Section 402.162.

(b) The commissioner [~~commission~~] shall forward the

recommended changes to the legislature not later than December 1 of each even-numbered year.

SECTION 1.028. Section 402.067, Labor Code, is renumbered as Section 402.157, Labor Code, and amended to read as follows:

Sec. 402.157 [~~402.067~~]. ADVISORY COMMITTEES. The commissioner [~~commission~~] may appoint advisory committees under this subtitle as the commissioner [~~it~~] considers necessary.

SECTION 1.029. Section 402.068, Labor Code, is renumbered as Section 402.158, Labor Code, and amended to read as follows:

Sec. 402.158 [~~402.068~~]. DELEGATION OF RIGHTS AND DUTIES. Except as expressly provided by this subchapter, the commissioner [~~commission~~] may not delegate rulemaking and policy-making functions [~~rights and duties~~] imposed on the commissioner and the department [~~it~~] by this subchapter.

SECTION 1.030. Section 402.022, Labor Code, is transferred to Subchapter D, Chapter 402, Labor Code, renumbered as Section 402.159, Labor Code, and amended to read as follows:

Sec. 402.159 [~~402.022~~]. PUBLIC INTEREST INFORMATION. (a) The department [~~executive director~~] shall prepare information of public interest describing the functions of the commissioner and the department under this subtitle [~~commission~~] and the procedures by which complaints are filed with and resolved by the department under this subtitle [~~commission~~].

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

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

(1) is written in plain language;

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

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

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

SECTION 1.031. Section 402.023, Labor Code, is transferred to Subchapter D, Chapter 402, Labor Code, renumbered as Section 402.160, Labor Code, and amended to read as follows:

Sec. 402.160 [~~402.023~~]. COMPLAINT INFORMATION. (a) The commissioner shall:

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

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

(b) The rules adopted under this section must, at a minimum:

(1) ensure that the department clearly defines in rule the method for filing a complaint; and

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

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

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

(2) information regarding the complaint filing process.

(d) The department [~~executive director~~] shall keep an information file about each written complaint filed with the department under this subtitle [~~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.

(e) [~~(b)~~] For each written complaint that is unrelated to a specific workers' compensation claim that the department [~~commission~~] has authority to resolve, the department [~~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 under this subtitle relating to complaint investigation and resolution. The department [~~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 1.032. Subchapter D, Chapter 402, Labor Code, is

amended by adding Sections 402.161-402.166 to read as follows:

Sec. 402.161. PRIORITIES FOR COMPLAINT INVESTIGATIONS. (a) The department shall assign priorities to complaint investigations under this subtitle based on risk. In developing priorities under this section, the department shall develop a formal, risk-based complaint investigation system that considers:

(1) the severity of the alleged violation;

(2) whether the alleged violator showed continued or wilful noncompliance; and

(3) whether a commissioner order has been violated.

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

Sec. 402.162. STRATEGIC MANAGEMENT; EVALUATION. (a) The commissioner shall implement a strategic management plan that:

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

(A) the statutory goals adopted under Section 402.051, particularly goals established to encourage the safe and timely return of injured employees to productive work roles; and

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

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

(b) The department shall conduct research regarding the system as provided by Chapter 405 to obtain the necessary data and

analysis to perform the evaluations required by this section.

Sec. 402.163. INFORMATION TO EMPLOYERS. (a) The department shall provide employers with information on methods to enhance the ability of an injured employee to return to work. The information may include access to available research and best practice information regarding return-to-work programs for employers.

(b) The department shall augment return-to-work program information provided to employers to include information regarding methods for an employer to appropriately assist an injured employee to obtain access to doctors who:

(1) provide high-quality care; and

(2) use effective occupational medicine treatment practices that lead to returning employees to productive work.

(c) The information provided to employers under this section must help to foster:

(1) effective working relationships with local doctors and with insurance carriers or provider networks to improve return-to-work communication; and

(2) access to return-to-work coordination services provided by insurance carriers and provider networks.

(d) The department shall develop and make available the information described by this section.

Sec. 402.164. INFORMATION TO EMPLOYEES. The department shall provide injured employees with information regarding the benefits of early return to work. The information must include information on how to receive assistance in accessing high-quality

medical care through the workers' compensation system.

Sec. 402.165. SINGLE POINT OF CONTACT. To the extent determined feasible by the commissioner, the department shall establish a single point of contact for injured employees receiving services from the department.

Sec. 402.166. INCENTIVES; PERFORMANCE-BASED OVERSIGHT. (a) The commissioner by rule shall adopt requirements that:

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

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

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

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

self-reporting by insurance carriers, provider networks, and health care providers.

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

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

(f) The department shall:

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

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

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

SECTION 1.033. Section 402.071, Labor Code, is renumbered

as Section 402.167, Labor Code, and amended to read as follows:

Sec. 402.167 [~~402.071~~]. REPRESENTATIVES. (a) The commissioner by rule [~~commission~~] shall establish qualifications for a representative and shall adopt rules establishing procedures for authorization of representatives.

(b) A representative may receive a fee for providing representation under this subtitle only if the representative [~~is~~]:

(1) is an adjuster representing an insurance carrier; or

(2) is licensed to practice law.

SECTION 1.034. Section 402.072, Labor Code, is renumbered as Section 402.168, Labor Code, and amended to read as follows:

Sec. 402.168 [~~402.072~~]. SANCTIONS. Only the commissioner [~~commission~~] may impose:

(1) a sanction that deprives a person of the right to practice before the department under this subtitle [~~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 certificate of authority, license, certification, or permit required for practice in the field of workers' compensation.

SECTION 1.035. Section 402.073, Labor Code, is renumbered as Section 402.169, Labor Code, and amended to read as follows:

Sec. 402.169 [~~402.073~~]. COOPERATION WITH STATE OFFICE OF ADMINISTRATIVE HEARINGS. (a) The commissioner [~~commission~~] and the chief administrative law judge of the State Office of Administrative Hearings by rule shall adopt a memorandum of

understanding governing administrative procedure law hearings under this subtitle conducted by the State Office of Administrative Hearings in the manner provided for a contested case hearing under Chapter 2001, Government Code [~~(the administrative procedure law)~~].

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

[~~(c)~~] In a case in which a hearing is conducted in conjunction with Section 402.168 or [~~402.072,~~] 407.046, [~~or 408.023,~~] and in other cases under this subtitle other than cases subject to Subchapter C, Chapter 413 [~~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 1.036. Section 402.081, Labor Code, is renumbered as Section 402.201, Labor Code, and amended to read as follows:

Sec. 402.201 [~~402.081~~]. WORKERS' COMPENSATION [~~COMMISSION~~] RECORDS. (a) The commissioner [~~executive director~~] is the custodian of the department's [~~commission's~~] records under this subtitle and shall perform the duties of a custodian required by law, including providing copies and the certification of records.

(b) The department shall comply with records retention schedules as provided by Section 441.185, Government Code

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

(c) A record maintained by the department under this subtitle [~~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 1.037. Section 402.083, Labor Code, is renumbered as Section 402.202, Labor Code, and amended to read as follows:

Sec. 402.202 [~~402.083~~]. CONFIDENTIALITY OF INJURY INFORMATION. (a) Information in or derived from a claim file regarding an employee is confidential and may not be disclosed by the department or the State Office of Risk Management [~~commission~~] except as provided by this subtitle.

(b) Information concerning an employee who has been finally adjudicated of wrongfully obtaining payment under Section 415.008 is not confidential.

SECTION 1.038. Section 402.084, Labor Code, is renumbered as Section 402.203, Labor Code, and amended to read as follows:

Sec. 402.203 [~~402.084~~]. RECORD CHECK; RELEASE OF INFORMATION. (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 commissioner [~~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.

(c) The requirements of Subsection (a)(1) do not apply to a request from a third-party litigant described by Subsection (b)(7).

(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 1.039. Section 402.085, Labor Code, is renumbered as Section 402.204, Labor Code, and amended to read as follows:

Sec. 402.204 [~~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;~~

[~~(2)~~] a legislative committee for legislative purposes;

(2) [~~(3)~~] a state or federal elected official requested in writing to provide assistance by a constituent who qualifies to obtain injury information under Section 402.203(b) [~~402.084(b)~~], if the request for assistance is provided to the department [~~commission~~];

(3) [~~(4)~~] the workers' compensation research and evaluation group [~~Research and Oversight Council on Workers' Compensation~~] for research purposes; [~~or~~]

(4) [~~(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; or

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

(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 1.040. Section 402.086, Labor Code, is renumbered as Section 402.205, Labor Code, to read as follows:

Sec. 402.205 [~~402.086~~]. TRANSFER OF CONFIDENTIALITY. (a) Information relating to a claim that is confidential under this subtitle remains confidential when released to any person, except when used in court for the purposes of an appeal.

(b) This section does not prohibit an employer from releasing information about a former employee to another employer with whom the employee has applied for employment, if that information was lawfully acquired by the employer releasing the information.

SECTION 1.041. Section 402.087, Labor Code, is renumbered as Section 402.206, Labor Code, and amended to read as follows:

Sec. 402.206 [~~402.087~~]. INFORMATION AVAILABLE TO [~~PROSPECTIVE~~] EMPLOYERS. (a) A prospective employer who has workers' compensation insurance coverage and who complies with this subchapter is entitled to obtain information from the department on the prior injuries of an applicant for employment if the employer obtains written authorization from the applicant before making the request.

(b) A current employer who has workers' compensation insurance and who complies with this subchapter is entitled to obtain information from the department on the prior injuries of an employee, without authorization from the employee, if the employer requests the information from the department not later than the 30th day after the date of hire of the employee.

(c) The employer must make a [~~the~~] request for information under Subsection (a) by telephone or file the request in writing not later than the 14th day after the date on which the application for employment is made.

(d) A [~~(c) The~~] request under this section must include the applicant's or employee's name, address, and social security number.

(e) [~~(d)~~] If a [~~the~~] request under Subsection (a) is made in writing, the authorization must be filed simultaneously. If the request is made by telephone, the employer must file the authorization not later than the 10th day after the date on which the request is made.

(f) An employer may not use information obtained under this section in a manner that violates the Americans with Disabilities Act (42 U.S.C. Section 12101 et seq.).

SECTION 1.042. Section 402.088, Labor Code, is renumbered as Section 402.207, Labor Code, and amended to read as follows:

Sec. 402.207 [~~402.088~~]. REPORT OF PRIOR INJURY. (a) In this section, "general injury" means an injury other than an injury limited to one or more of the following:

(1) an injury to a digit, limb, or member;

(2) an inguinal hernia; or

(3) vision or hearing loss.

(b) On receipt of a valid request made under and complying with Section 402.206 [~~402.087~~], the department [~~commission~~] shall review its records.

(c) [~~(b)~~] If the department [~~commission~~] finds that an

[~~the~~] applicant or an employee has made any [~~two or more~~] general injury claims in the preceding five years, the department [~~commission~~] shall release the date and description of each injury regarding:

(1) the applicant, to the prospective employer; and

(2) the employee, to the current employer.

(d) [~~(c)~~] The information may be released in writing or by telephone.

(e) [~~(d)~~] If a prospective [~~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.

[~~(e) In this section, "general injury" means an injury other than an injury limited to one or more of the following:~~

[~~(1) an injury to a digit, limb, or member;~~

[~~(2) an inguinal hernia; or~~

[~~(3) vision or hearing loss.~~]

SECTION 1.043. Section 402.089, Labor Code, is renumbered as Section 402.208, Labor Code, and amended to read as follows:

Sec. 402.208 [~~402.089~~]. FAILURE TO FILE AUTHORIZATION; ADMINISTRATIVE VIOLATION. (a) A prospective [~~An~~] employer who receives information by telephone from the department [~~commission~~] under Section 402.207 [~~402.088~~] and who fails to file the necessary authorization in accordance with Section 402.206 [~~402.087~~] commits a Class C administrative violation.

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

SECTION 1.044. Section 402.090, Labor Code, is renumbered as Section 402.209, Labor Code, and amended to read as follows:

Sec. 402.209 [~~402.090~~]. STATISTICAL INFORMATION. The department [~~commission~~], the workers' compensation research and evaluation group [~~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 1.045. Section 402.091, Labor Code, is renumbered as Section 402.210, Labor Code, and amended to read as follows:

Sec. 402.210 [~~402.091~~]. FAILURE TO MAINTAIN CONFIDENTIALITY; OFFENSE; PENALTY. (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~~].

(b) A person commits an offense if the person knowingly, intentionally, or recklessly receives information that is confidential under this subchapter and that the person is not authorized to receive.

(c) An offense under this section is a Class A misdemeanor.

(d) An offense under this section may be prosecuted in a court in the county where the information was unlawfully received, published, disclosed, or distributed.

(e) A district court in Travis County has jurisdiction to enjoin the use, publication, disclosure, or distribution of confidential information under this section.

SECTION 1.046. Section 402.092, Labor Code, is renumbered

as Section 402.211, Labor Code, and amended to read as follows:

Sec. 402.211 [~~402.092~~]. INVESTIGATION FILES CONFIDENTIAL; DISCLOSURE OF CERTAIN INFORMATION. (a) In this section, "investigation file" means any information compiled or maintained by the department with respect to a department investigation authorized under this subtitle or other workers' compensation law. The term does not include information or material acquired by the department that is relevant to an investigation by the insurance fraud unit and subject to Section 701.151, Insurance Code.

(b) Information maintained in the investigation files of the 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; or

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

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

(d) [~~(c)~~] Information in an investigation file that is

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

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

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

SECTION 1.047. Chapter 402, Labor Code, is amended by adding Subchapter F to read as follows:

SUBCHAPTER F. COOPERATION WITH OFFICE OF INJURED EMPLOYEE COUNSEL

Sec. 402.251. COOPERATION; FACILITIES. (a) The department

shall cooperate with the office of injured employee counsel in providing services to claimants under this subtitle.

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

SECTION 1.048. Effective March 1, 2006, the following laws are repealed:

(1) Section 402.0015, Labor Code;

(2) Sections 402.003-402.012, Labor Code;

(3) Sections 402.024 and 402.025, Labor Code;

(4) Section 402.041, Labor Code;

(5) Sections 402.043-402.045, Labor Code;

(6) Section 402.063, Labor Code;

(7) Section 402.0665, Labor Code; and

(8) Sections 402.069 and 402.070, Labor Code.

SECTION 1.049. (a) The commissioner of insurance shall conduct a review of the rules, policies, and practices of the Texas Department of Insurance regarding the operation of the workers' compensation system of this state. The review must include analysis of the rules, policies, and practices of the Texas Workers' Compensation Commission, as that commission existed before abolishment under this Act, that are continued as rules, policies, and practices of the Texas Department of Insurance until replaced by the commissioner of insurance. In the review, the commissioner shall:

(1) analyze the effectiveness of the rules, policies,

and practices in implementing the goals of the workers' compensation system as described by Section 402.051, Labor Code, as added by this Act, especially the return-to-work goals; and

(2) evaluate the existence of any statutory barriers to the implementation of those goals.

(b) The commissioner of insurance shall report the results of the review, together with any recommendations for statutory changes, to the governor, the lieutenant governor, the speaker of the house of representatives, and the members of the 80th Legislature not later than December 1, 2006.

PART 3. AMENDMENTS TO CHAPTER 403, LABOR CODE

SECTION 1.051. The heading to Chapter 403, Labor Code, is amended to read as follows:

CHAPTER 403. [~~COMMISSION~~] FINANCING OF WORKERS' COMPENSATION SYSTEM

SECTION 1.052. Section 403.001, Labor Code, is amended to read as follows:

Sec. 403.001. [~~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 Texas Department of Insurance operating account. Notwithstanding Section 202.101, Insurance Code, or any other law, money deposited in the account under this section may be appropriated only for the use and benefit of the department and the office of injured employee counsel as provided by the General

Appropriations Act to pay salaries and other expenses arising from and in connection with the duties under this title of the department and the office [~~commission~~].

(b) The money may be spent as authorized by legislative appropriation on warrants issued by the comptroller under requisitions made by the commissioner [~~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 1.053. 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 and evaluation group [~~oversight council on workers' compensation~~]; or

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

SECTION 1.054. 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 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 1.055. 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 Texas Department of Insurance operating account. Notwithstanding Section 202.101, Insurance Code, or any other law, money deposited in the account under this section may be appropriated only for the use and benefit of the department as provided by the General Appropriations Act to pay salaries and other expenses arising from and in connection with the department's duties under this title [~~commission~~].

SECTION 1.056. 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 [~~general revenue~~] account in the general revenue fund [~~in the state treasury~~]. Money in the account may be appropriated only for the purposes of this section or as provided by other law. The subsequent injury fund is not subject to any provision of law that makes dedicated revenue available for general governmental purposes and available for the purpose of certification under Section 403.121, Government Code. [~~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 408D.202 [~~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 department [~~commission~~] may make partial payment of insurance carrier claims under Subsection (b)(3).

SECTION 1.057. 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 department [~~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 department [~~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 department's [~~commission's~~] actuary or financial advisor shall report biannually to the workers' compensation research and evaluation group [~~Research and Oversight Council on~~

~~Workers' Compensation~~] on the financial condition and projected assets and liabilities of the subsequent injury fund. The department [~~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.

PART 4. ADOPTION OF CHAPTER 404, LABOR CODE

SECTION 1.061. Subtitle A, Title 5, Labor Code, is amended by adding Chapter 404 to read as follows:

CHAPTER 404. OFFICE OF INJURED EMPLOYEE COUNSEL

SUBCHAPTER A. OFFICE; GENERAL PROVISIONS

Sec. 404.001. DEFINITIONS. In this chapter:

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

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

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

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

(c) The department shall provide the staff and facilities necessary to enable the office to perform the duties of the office

under this subtitle, including:

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

(2) personnel services; and

(3) computer equipment and support.

(d) The public counsel and the commissioner may enter into interagency contracts and other agreements as necessary to implement this chapter.

Sec. 404.003. SUNSET PROVISION. The office of injured employee counsel is subject to Chapter 325, Government Code (Texas Sunset Act). Unless continued in existence as provided by that chapter, the office is abolished and this chapter expires September 1, 2019.

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

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

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

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

Sec. 404.006. RULEMAKING. (a) The public counsel shall adopt rules as necessary to implement this chapter.

(b) Rulemaking under this section is subject to Chapter

2001, Government Code.

[Sections 404.007-404.050 reserved for expansion]

SUBCHAPTER B. INJURED EMPLOYEE PUBLIC COUNSEL

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

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

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

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

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

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

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

(3) have management experience;

(4) possess knowledge and experience with the workers' compensation system; and

(5) have experience with legislative procedures and administrative law.

Sec. 404.053. BUSINESS INTEREST; SERVICE AS PUBLIC COUNSEL. (a) A person is not eligible for appointment as public counsel if

the person or the person's spouse:

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

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

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

(b) A person is not eligible for appointment as public counsel if the person or the person's spouse has been an employee of an insurance company in the five years preceding the date of appointment.

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

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

(1) does not have at the time of appointment or maintain during service as public counsel the qualifications required by Section 404.052;

(2) violates a prohibition established by Section

404.053, 404.054, 404.056, or 404.057; or

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

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

Sec. 404.056. PROHIBITED REPRESENTATION OR EMPLOYMENT. (a) A former public counsel may not make any communication to or appearance before the department, the commissioner, or an employee of the department before the second anniversary of the date the person ceases to serve as public counsel if the communication or appearance is made:

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

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

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

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

(d) A former employee of the office may not:

(1) be employed by an insurance carrier regarding a

matter that was in the scope of the employee's official responsibility while the employee was associated with the office; or

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

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

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

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

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

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

(b) A person may not serve as public counsel if the person is:

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

(2) the spouse of an officer, manager, or paid consultant of a trade association in the field of workers'

compensation.

[Sections 404.058-404.100 reserved for expansion]

SUBCHAPTER C. GENERAL POWERS AND DUTIES OF OFFICE

Sec. 404.101. GENERAL DUTIES. (a) The office shall:

(1) provide representation to workers' compensation claimants as provided by this subtitle; and

(2) advocate on behalf of the public regarding rulemaking by the commissioner relating to workers' compensation.

(b) The office shall accept or reject cases for representation in disputes subject to Chapter 410 or 413 based on standards set by department policy.

(c) To the extent determined feasible by the public counsel, the office shall establish a single point of contact for injured employees receiving services from the office.

(d) In determining how best to provide services for injured employees as required by this subtitle, the public counsel may consider contracting with other legal assistance entities to provide some portion of the services, including contracting for the use of legal aid offices and legal service clinics operated at the law schools in this state.

(e) The office:

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

(2) shall:

(A) monitor the performance and operation of the workers' compensation system, with a focus on the system's effect on

the return to work of injured employees;

(B) assist injured employees with the resolution of complaints against system participants, including state regulatory agencies;

(C) provide assistance to injured workers in the administrative dispute resolution system; and

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

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

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

(b) The office shall coordinate services provided by the ombudsman program with services provided by the Department of Assistive and Rehabilitative Services.

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

(1) may appear or intervene, as a party or otherwise, as a matter of right before the commissioner or department on behalf of injured employees as a class in matters involving rates, rules, and forms affecting workers' compensation insurance for which the commissioner promulgates rates or adopts or approves rules or

forms;

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

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

(4) may appear or intervene before the commissioner or department, as a party or otherwise, on behalf of injured employees as a class in a matter involving rates, rules, or forms affecting injured employees as a class in any proceeding in which the public counsel determines that injured employees are in need of representation.

Sec. 404.105. AUTHORITY TO REPRESENT INJURED EMPLOYEES IN ADMINISTRATIVE PROCEDURES. (a) The office may appear before the commissioner or department on behalf of an individual injured employee during an administrative dispute resolution process.

(b) The office may represent injured employees either through attorney representation or by an ombudsman whose representation will be under the direction of an attorney.

(c) The public counsel shall adopt rules and polices for representation of individual injured employees before the

department. The rules must include:

(1) mandatory representation of an injured employee who requests representation and who is unrepresented by private counsel;

(2) a process for determining which cases need direct attorney involvement, that takes into consideration the complexity of the case and of the issue in dispute; and

(3) representation at the request of an injured employee in a case in which compensability or extent of injury is in dispute.

(d) A determination of an injured employee's need for direct attorney representation does not constitute a fact determination on the validity of the claim.

(e) The office is prohibited from representing an injured employee in:

(1) an informal dispute resolution process before an insurance carrier or certified provider network;

(2) a judicial review; or

(3) a hearing before the department alleging an administrative violation or fraud.

Sec. 404.106. RESOLUTION OF COMPLAINTS. (a) The office shall receive and attempt to resolve complaints from injured employees against system participants, including state agencies. The office shall:

(1) work with various state agencies to assist in resolving complaints, including coordination of communications among various state agencies;

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

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

(b) The office, at least quarterly and until final disposition of the complaint, shall notify the injured employee of the status of the complaint unless the notice would jeopardize an investigation by law enforcement or the fraud units of an individual insurance company or a state or federal regulatory body.

Sec. 404.107. LEGISLATIVE REPORT. (a) The office shall report to the governor, lieutenant governor, speaker of the house of representatives, and the chairs of the legislative committees with appropriate jurisdiction not later than December 31 of each even-numbered year. The report must include:

(1) a description of the activities of the office;

(2) identification of any problems in the workers' compensation system from the perspective of injured employees as considered by the public counsel, with recommendations for regulatory and legislative action; and

(3) an analysis of the ability of the workers' compensation system to provide adequate, equitable, and timely benefits to injured employees at a reasonable cost to employers.

(b) The office shall coordinate with the workers' compensation research and evaluation group to obtain needed

information and data to make the evaluations required for the report.

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

Sec. 404.108. ACCESS TO INFORMATION BY PUBLIC COUNSEL. The public counsel:

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

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

Sec. 404.109. LEGISLATIVE RECOMMENDATIONS. The public counsel may recommend proposed legislation to the legislature that the public counsel determines would positively affect the interests of injured employees.

Sec. 404.110. INJURED EMPLOYEE RIGHTS; NOTICE. The public counsel shall submit to the department for adoption by the commissioner a notice of injured employee rights and responsibilities to be distributed as provided by commissioner rules on first report of injury.

Sec. 404.111. PROHIBITED INTERVENTIONS OR APPEARANCES. The public counsel may not intervene or appear in:

(1) any proceeding or hearing before the commissioner or department, or any other proceeding, that relates to approval or consideration of an individual charter, license, certificate of authority, acquisition, merger, or examination; or

(2) any proceeding concerning the solvency of an individual insurer, a financial issue, a policy form, advertising, or another regulatory issue affecting an individual insurer or agent.

Sec. 404.112. APPLICABILITY OF CONFIDENTIALITY REQUIREMENTS. Confidentiality requirements applicable to examination reports under Article 1.18, Insurance Code, and to the commissioner under Section 3A, Article 21.28-A, Insurance Code, apply to the public counsel.

Sec. 404.113. ACCESS TO INFORMATION. (a) The office is entitled to information that is otherwise confidential under a law of this state, including information made confidential under:

(1) Section 843.006, Insurance Code;

(2) Chapter 108, Health and Safety Code; and

(3) Chapter 552, Government Code.

(b) On request by the public counsel, the department and the Texas Health Care Information Council shall provide any information or data requested by the office in furtherance of the duties of the office under this chapter.

(c) The office shall use information collected or received under this chapter for the benefit of the public.

Sec. 404.114. CONFIDENTIALITY AND USE OF INFORMATION. (a) Except as provided by this section, information collected under

this subchapter is subject to Chapter 552, Government Code. The office shall make determinations on requests for information in favor of access.

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

(1) could reasonably be expected to reveal the identity of a doctor or an injured employee;

(2) reveals the zip code of an injured employee's primary residence;

(3) discloses a provider discount or a differential between a payment and a billed charge; or

(4) relates to an actual payment made by a payer to an identified provider.

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

(1) Section 81.103, Health and Safety Code;

(2) Section 311.037, Health and Safety Code; and

(3) Chapter 159, Occupations Code.

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

(1) subject to discovery, subpoena, or other means of legal compulsion for release to any individual or entity; or

(2) admissible in any civil, administrative, or criminal proceeding.

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

Sec. 404.115. LITERACY AND BASIC SKILLS CURRICULUM. (a) The office shall coordinate with the Texas Workforce Commission and local workforce development boards to develop a workplace literacy and basic skills curriculum designed to eliminate the skills gap between employees and current and emerging jobs.

(b) The public counsel may enter into memoranda of understanding or other agreements with the Texas Workforce Commission and local workforce development boards as necessary to implement Subsection (a).

SECTION 1.062. Subchapter C, Chapter 409, Labor Code, is redesignated as Subchapter D, Chapter 404, Labor Code, and Sections 409.041-409.044, Labor Code, are renumbered as Sections 404.151-404.154, Labor Code, and amended to read as follows:

SUBCHAPTER D [~~C~~]. OMBUDSMAN PROGRAM

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

(b) An ombudsman shall:

(1) meet with or otherwise provide information to

injured employees [~~workers~~];

(2) investigate complaints;

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

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

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

Sec. 404.152 [~~409.042~~]. DESIGNATION AS OMBUDSMAN; ELIGIBILITY AND TRAINING REQUIREMENTS; CONTINUING EDUCATION REQUIREMENTS. (a) At least one specially qualified employee in each department workers' compensation [~~commission~~] office shall be an ombudsman designated by the office [~~an ombudsman~~] who shall perform the duties under this subchapter [~~section~~] as the person's primary responsibility.

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

(1) demonstrate satisfactory knowledge of the requirements of:

(A) this subtitle and the provisions of Subtitle C that relate to claims management;

(B) other laws relating to workers' compensation; and

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

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

(3) possess strong interpersonal skills; and

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

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

(1) include education regarding this subtitle and[~~,~~] 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.

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

(b) An employer commits a violation if the employer fails to comply with this section. A violation under this section is a Class C administrative violation.

Sec. 404.154 [~~409.044~~]. PUBLIC INFORMATION. The office [~~commission~~] shall widely disseminate information about the ombudsman program.

SECTION 1.063. The ombudsman program operated by the office of injured employee counsel under Subchapter D, Chapter 404, Labor Code, as added by this Act, shall begin providing services under

that subchapter not later than March 1, 2006.

PART 5. AMENDMENTS TO CHAPTER 405, LABOR CODE

SECTION 1.071. Section 405.001, Labor Code, is amended to read as follows:

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

SECTION 1.072. Section 405.002, Labor Code, is amended to read as follows:

Sec. 405.002. WORKERS' COMPENSATION RESEARCH DUTIES OF DEPARTMENT; RESEARCH AND EVALUATION GROUP. (a) The workers' compensation research and evaluation group is located within the department and serves as a resource for the commissioner on workers' compensation issues [~~shall conduct professional studies and research related to:~~

[~~(1) the delivery of benefits;~~

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

[~~(3) insurance rates and rate-making procedures;~~

[~~(4) rehabilitation and reemployment of injured workers;~~

[~~(5) workplace health and safety issues;~~

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

[~~(7) other matters relevant to the cost, quality, and operational effectiveness of the workers' compensation system~~].

(b) The department may apply for and spend grant funds to implement this chapter.

(c) The department shall ensure that all research reports prepared under this chapter or by the former Research and Oversight Council on Workers' Compensation are accessible to the public through the Internet to the extent practicable.

SECTION 1.073. Chapter 405, Labor Code, is amended by adding Sections 405.0025, 405.0026, and 405.0027 to read as follows:

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

(1) the delivery of benefits;

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

(3) insurance rates and ratemaking procedures;

(4) rehabilitation and reemployment of injured employees;

(5) the quality and cost of medical benefits;

(6) employer participation in the workers' compensation system;

(7) employment health and safety issues; and

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

(b) The group shall:

(1) objectively evaluate the impact of the workers' compensation health care networks certified under this subtitle on the cost and the quality of medical care provided to injured employees; and

(2) report the group's findings to the governor, the

lieutenant governor, the speaker of the house of representatives, and the members of the legislature not later than December 1 of each even-numbered year.

(c) At a minimum, the report required under Subsection (b) must evaluate the impact of workers' compensation health care networks on:

(1) the average medical and indemnity cost per claim;

(2) access and utilization of health care;

(3) injured employee return-to-work outcomes;

(4) injured employee, health care provider, and insurance carrier satisfaction;

(5) injured employee health-related functional outcomes; and

(6) the frequency, duration, and outcome of disputes regarding medical benefits.

Sec. 405.0026. RESEARCH AGENDA. (a) The group 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.

Sec. 405.0027. REPORT CARD. (a) The group shall develop and issue an annual informational report card that identifies and compares, on an objective basis, the quality, costs, provider availability, and other analogous factors of provider networks

operating under the workers' compensation system of this state.

(b) The group may procure services as necessary to produce the report card. The report card must include a risk-adjusted evaluation of:

(1) employee access to care;

(2) return-to-work outcomes;

(3) health-related outcomes;

(4) employee satisfaction with care; and

(5) health care costs and utilization of health care.

(c) The report cards may be based on information or data from any person, agency, organization, or governmental entity that the group considers reliable. The group may not endorse or recommend a specific provider network or plan, or subjectively rate or rank provider networks or plans, other than through comparison and evaluation of objective criteria.

(d) The commissioner shall ensure that consumer report cards issued by the group under this section are accessible to the public on the department's Internet website and available to any person on request. The commissioner by rule may set a reasonable fee for obtaining a paper copy of report cards.

SECTION 1.074. Sections 405.003(a) and (e), Labor Code, are amended to read as follows:

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

(e) Amounts received under this section shall be deposited in the general revenue fund [~~state treasury~~] in accordance with Section 251.004 [~~Article 5.68(e)~~], Insurance Code, to be used:

(1) for the operation of the group's [~~department's~~] duties under this chapter; and

(2) to reimburse the general revenue fund in accordance with Section 201.052 [~~Article 4.19~~], Insurance Code.

SECTION 1.075. Section 405.004, Labor Code, is amended by amending Subsections (a), (b), and (d) and adding Subsections (e) and (f) to read as follows:

(a) As required to fulfill the group's [~~department's~~] objectives under this chapter, the group [~~department~~] is entitled to access to the files and records of:

(1) [~~the commission;~~

[~~(2)~~] the Texas Workforce Commission;

(2) [~~(3)~~] the [~~Texas~~] Department of Assistive and Rehabilitative [~~Human~~] Services;

(3) the office of injured employee counsel;

(4) the State Office of Risk Management; and

(5) other appropriate state agencies.

(b) A state agency shall assist and cooperate in providing information to the group [~~department~~].

(d) Except as provided by this subsection, the [~~The~~] identity of an individual or entity selected to participate in a [~~department~~] survey conducted by the group or who participates in such a survey is confidential and is not subject to public disclosure under Chapter 552, Government Code. This subsection

does not prohibit the identification of a provider network in a report card issued under Section 405.0027, provided that the report card may not identify any injured employee or other individual.

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

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

PART 6. AMENDMENTS TO CHAPTER 406, LABOR CODE

SECTION 1.081. Section 406.005(c), Labor Code, is 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.

SECTION 1.082. Sections 406.006(a)-(c), 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, 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, certified self-insurer, or 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 1.083. Sections 406.007(a)-(c), 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 1.084. 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 1.085. Sections 406.009(a)-(d), Labor Code, are amended to read as follows:

(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:

(1) 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; and

(2) [~~. The 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 commissioner [~~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.

SECTION 1.086. Section 406.010(c), Labor Code, is amended to read as follows:

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

SECTION 1.087. Section 406.011(a), Labor Code, is amended to read as follows:

(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 representative [~~agent~~] constitutes notice under this subtitle or the Insurance Code to the insurance carrier.

SECTION 1.088. Section 406.012, Labor Code, is amended to

read as follows:

Sec. 406.012. ENFORCEMENT OF SUBCHAPTER. The department [~~commission~~] shall enforce the administrative penalties established under this subchapter in accordance with Chapter 415.

SECTION 1.089. Subchapter B, Chapter 406, Labor Code, is amended by adding Section 406.0325 to read as follows:

Sec. 406.0325. DETERMINATION OF INTOXICATION; DRUG TESTING. (a) There is a rebuttable presumption that an employee is intoxicated or under the influence of a controlled substance not prescribed by the employee's physician, and that being intoxicated or under the influence of a controlled substance not prescribed by the employee's physician is the proximate cause of an injury, if the employee, through a qualifying chemical test:

(1) administered within eight hours of when an injury occurs, is determined to have an alcohol concentration level equal to or in excess of the levels established in Section 49.01, Penal Code;

(2) administered within 32 hours of when an injury occurs, is determined to have one of the following controlled substances not prescribed by the employee's physician in the employee's system that tests above the following levels in an enzyme multiplied immunoassay technique screening test and above the levels established under Subdivision (3) in a gas chromatography mass spectrometry test:

(A) for amphetamines, 1,000 nanograms per milliliter of urine;

(B) for cannabinoids, 50 nanograms per

milliliter of urine;

(C) for cocaine, including crack cocaine, 300 nanograms per milliliter of urine;

(D) for opiates, 2,000 nanograms per milliliter of urine; and

(E) for phencyclidine, 25 nanograms per milliliter of urine;

(3) administered within 32 hours of when an injury occurs, is determined to have one of the following controlled substances not prescribed by the employee's physician in the employee's system that tests above the following levels in a gas chromatography mass spectrometry test:

(A) for amphetamines, 500 nanograms per milliliter of urine;

(B) for cannabinoids, 15 nanograms per milliliter of urine;

(C) for cocaine, including crack cocaine, 150 nanograms per milliliter of urine;

(D) for opiates, 2,000 nanograms per milliliter of urine; and

(E) for phencyclidine, 25 nanograms per milliliter of urine; or

(4) administered within 32 hours of when an injury occurs, is determined to have barbiturates, benzodiazepines, methadone, or propoxyphene in the employee's system that tests above levels established by laboratories certified by the United States Department of Health and Human Services.

(b) An employee may not be forced to submit to a drug test without consent.

(c) A qualified health care provider that performs a drug test under Subsection (a) shall submit on request the analysis of the drug test to the employee and to the employer or insurance carrier.

SECTION 1.090. Sections 406.051(b) and (c), Labor Code, are amended to read as follows:

(b) The contract for coverage must be written on a policy and endorsements approved by the department [~~Texas Department of Insurance~~].

(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 1.091. Section 406.053, Labor Code, is amended to read as follows:

Sec. 406.053. ALL STATES COVERAGE. The department [~~Texas Department of Insurance~~] shall coordinate with the appropriate agencies of other states to:

(1) share information regarding an employer who obtains all states coverage; and

(2) ensure that the department has knowledge of an employer who obtains all states coverage in another state but fails to file notice with the department.

SECTION 1.092. Section 406.073(b), Labor Code, is amended to read as follows:

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

SECTION 1.093. Sections 406.074(a) and (b), 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 1.094. Section 406.093(b), 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 1.095. Section 406.095(b), 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 1.096. Section 406.098(c), Labor Code, is amended to read as follows:

(c) The commissioner [~~Texas Department of Insurance~~] shall adopt rules governing the method of calculating premiums for workers' compensation insurance coverage for volunteer members who are covered pursuant to this section.

SECTION 1.097. Section 406.123(f), Labor Code, is amended to read as follows:

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

SECTION 1.098. Sections 406.144(c) and (d), 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 1.099. Sections 406.145(a)-(d) and (f), 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 1.0991. Section 406.004, Labor Code, is repealed.

PART 7. AMENDMENTS TO CHAPTER 407, LABOR CODE

SECTION 1.101. Sections 407.001(3) and (5), Labor Code, are 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.

(5) "Qualified claims servicing contractor" means a person who provides claims service for a certified self-insurer, who is a separate business entity from the affected certified self-insurer, and who is:

(A) an insurance company authorized by the department [~~Texas Department of Insurance~~] to write workers' compensation insurance;

(B) a subsidiary of an insurance company that provides claims service under contract; or

(C) a third-party administrator that has on its staff an individual licensed under Chapter 4101, Insurance Code [~~407, Acts of the 63rd Legislature, Regular Session, 1973 (Article 21.07-4, Vernon's Texas Insurance Code)~~].

SECTION 1.102. Subchapter A, Chapter 407, Labor Code, is amended by adding Section 407.002 to read as follows:

Sec. 407.002. CLAIM; SUIT. (a) A claim or suit brought by a claimant or a certified self-insurer shall be styled "in re: [name of employee] and [name of certified self-insurer]."

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

SECTION 1.103. Sections 407.041(a)-(c), 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 commissioner [~~director~~] shall approve

or deny [~~recommend approval or denial of~~] the application [~~to the commission~~].

SECTION 1.104. Section 407.042, Labor Code, is amended to read as follows:

Sec. 407.042. ISSUANCE OF CERTIFICATE OF AUTHORITY. 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 1.105. 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 department [~~commission~~] shall notify the applicant in writing of the [~~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 1.106. Section 407.044, Labor Code, is amended to read as follows:

Sec. 407.044. TERM OF CERTIFICATE OF AUTHORITY; RENEWAL. (a) A certificate of authority to self-insure is valid for one year

after the date of issuance and may be renewed under procedures prescribed by the commissioner [~~commission~~].

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

SECTION 1.107. 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 1.108. Sections 407.046(a), (b), and (d), 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 1.109. Section 407.047(b), 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 1.110. Sections 407.061(a), (c), (e), and (f), 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 department [~~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 department [~~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 1.111. 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 department [~~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 considers [~~commission finds~~] appropriate; and

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

SECTION 1.112. Section 407.063(a), 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 department [~~commission~~] of a total unmodified workers' compensation insurance premium in this state in the calendar year of application of at least $500,000.

SECTION 1.113. Sections 407.064(a), (b), and (e), Labor Code, are amended to read as follows:

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

(1) cash or negotiable securities of the United States or of this state;

(2) a surety bond that names the commissioner [~~director~~] as payee; or

(3) an irrevocable letter of credit that names the commissioner [~~director~~] as payee.

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

(e) If an applicant is granted a certificate of authority to self-insure, any interest or other income that accrues from cash or negotiable securities deposited by the applicant as security under this section while the cash or securities are on deposit with the department [~~director~~] shall be paid to the applicant quarterly.

SECTION 1.114. Sections 407.065(b)-(f), Labor Code, are amended to read as follows:

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

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

(d) On receipt by the department [~~director~~] of a request to renew, submit, or increase or decrease a security deposit, a perfected security interest is created in the certified

self-insurer's assets in favor of the commissioner [~~director~~] to the extent of any then unsecured portion of the self-insurer's incurred liabilities for compensation. That perfected security interest transfers to cash or securities deposited by the self-insurer with the department [~~director~~] after the date of the request and may be released only on:

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

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

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

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

SECTION 1.115. Sections 407.066(a) and (b), Labor Code, are amended to read as follows:

(a) The commissioner [~~director~~], after notice to the concerned parties and an opportunity for a hearing, shall resolve a dispute concerning the deposit, renewal, termination, release, or return of all or part of the security, liability arising out of the submission or failure to submit security, or the adequacy of the security or reasonableness of the administrative costs, including legal fees, that arises among:

(1) a surety;

(2) an issuer of an agreement of assumption and guarantee of workers' compensation liabilities;

(3) an issuer of a letter of credit;

(4) a custodian of the security deposit;

(5) a certified self-insurer; or

(6) the association.

(b) A party aggrieved by a decision of the commissioner [~~director~~] is entitled to judicial review. Venue for an appeal is in Travis County.

SECTION 1.116. Sections 407.067(a)-(c), Labor Code, are amended to read as follows:

(a) Each applicant shall obtain excess insurance or reinsurance to cover liability for losses not paid by the self-insurer in an amount not less than the amount required by the commissioner [~~director~~].

(b) The commissioner [~~director~~] shall require excess insurance or reinsurance in at least the amount of $5 million per occurrence.

(c) A certified self-insurer shall notify the department

[~~director~~] not later than the 10th day after the date on which the certified self-insurer has notice of the cancellation or termination of excess insurance or reinsurance coverage required under this section.

SECTION 1.117. Sections 407.081(a)-(d), (f), and (g), 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 commissioner [~~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 commissioner [~~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 1.118. Sections 407.082(a), (c), and (d), 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.

SECTION 1.119. Section 407.101(b), 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 1.120. 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 1.121. Sections 407.103(a), (b), and (d), 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.

(b) To determine the tax base of a certified self-insurer for purposes of this chapter, the department [~~director~~] shall

multiply the amount of the certified self-insurer's liabilities for workers' compensation claims incurred in the previous year, including claims incurred but not reported, plus the amount of expense incurred by the certified self-insurer in the previous year for administration of self-insurance, including legal costs, by 1.02.

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

SECTION 1.122. Sections 407.104(b), (c), and (e), 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 Texas Department of Insurance operating account. Notwithstanding Section 202.101, Insurance Code, or any other law, money deposited in the account under this section may be appropriated only for the use and benefit of the department as provided by the General Appropriations Act to pay salaries and other expenses arising from and in connection with the department's duties under this title [~~commission~~].

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

SECTION 1.123. Section 407.122(b), Labor Code, is amended to read as follows:

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

(1) four [~~three~~] certified self-insurers;

(2) 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.

SECTION 1.124. Section 407.123(b), Labor Code, is amended to read as follows:

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

SECTION 1.125. Section 407.124, Labor Code, is amended to read as follows:

Sec. 407.124. IMPAIRED EMPLOYER; ASSESSMENTS. (a) On determination by the department [~~commission~~] that a certified self-insurer has become an impaired employer, the commissioner [~~director~~] shall secure release of the security deposit required by this chapter and shall promptly estimate:

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

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

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

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

(c) A certified self-insurer designated as an impaired employer is exempt from assessments beginning on the date of the designation until the department [~~commission~~] determines that the employer is no longer impaired.

SECTION 1.126. Section 407.125, Labor Code, is amended to read as follows:

Sec. 407.125. PAYMENT OF ASSESSMENTS. Each certified self-insurer shall pay the amount of its assessment to the association not later than the 30th day after the date on which the department [~~division~~] notifies the self-insurer of the assessment.

A delinquent assessment may be collected on behalf of the association through suit. Venue is in Travis County.

SECTION 1.127. Section 407.126(d), 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 1.128. Section 407.127(a), 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 department [~~director~~].

SECTION 1.129. Section 407.128, Labor Code, is amended to read as follows:

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

SECTION 1.130. Section 407.132, Labor Code, is amended to read as follows:

Sec. 407.132. SPECIAL FUND. Funds advanced by the association under this subchapter do not become assets of the

impaired employer but are a special fund advanced to the commissioner [~~director~~], trustee in bankruptcy, receiver, or other lawful conservator only for the payment of compensation liabilities, including the costs of claims administration and legal costs.

SECTION 1.131. Section 407.133(a), 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 department [~~director~~].

SECTION 1.132. The following laws are repealed:

(1) Section 407.001(2), Labor Code;

(2) Section 407.122(c), Labor Code; and

(3) Subchapter B, Chapter 407, Labor Code.

PART 8. AMENDMENTS TO CHAPTER 407A, LABOR CODE

SECTION 1.141. Section 407A.053(d), 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 [~~executive director of the commission~~] under a trust document acceptable to the commissioner. 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 1.142. Section 407A.201(c), 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 commission~~] of the cancellation or termination of a membership not later than the 10th day after the date on which the cancellation or termination takes effect and shall maintain coverage of each canceled or terminated member until the 30th day after the date of the notice, at the terminating member's expense, unless before that date the commissioner [~~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 1.143. The heading to Section 407A.301, Labor Code, is amended to read as follows:

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

SECTION 1.144. Sections 407A.301(a) and (c), Labor Code, are amended to read as follows:

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

(1) the administration of the department

[~~commission~~];

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

(3) the workers' compensation research and evaluation group [~~Research and Oversight Council on Workers' Compensation~~].

(c) The tax liability of a group under Subsection (a)(3) is based on gross premium for the group's retention multiplied by the rate assessed insurance carriers under Section 405.003 [~~404.003~~].

SECTION 1.145. Section 407A.303(c), Labor Code, is amended to read as follows:

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

SECTION 1.146. Section 407A.357(b), 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 [~~commission~~] member, designated by the commissioner, who represents wage earners;

(3) one member, designated by the commissioner, who represents employers; and

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

PART 9. AMENDMENTS TO CHAPTER 408, LABOR CODE

SECTION 1.151. The heading to Chapter 408, Labor Code, is amended to read as follows:

CHAPTER 408. WORKERS' COMPENSATION BENEFITS: GENERAL PROVISIONS

SECTION 1.152. Section 408.001, Labor Code, is amended by adding Subsection (d) to read as follows:

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

SECTION 1.153. Sections 408.003(b) and (c), Labor Code, are amended to read as follows:

(b) If an injury is found to be compensable and an insurance carrier initiates compensation, the insurance carrier shall reimburse the employer for the amount of benefits paid by the employer to which the employee was entitled under this subtitle. Payments that are not reimbursed or reimbursable under this section may be reimbursed under Section 408D.107 [~~408.127~~].

(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 1.154. Sections 408.005(a)-(g), Labor Code, are amended to read as follows:

(a) A settlement may not provide for payment of benefits in a lump sum except as provided by Section 408D.108 [~~408.128~~].

(b) An employee's right to medical benefits as provided by Section 408A.001 [~~408.021~~] may not be limited or terminated.

(c) A settlement or agreement resolving an issue of impairment:

(1) may not be made before the employee reaches maximum medical improvement; and

(2) must adopt an impairment rating using the impairment rating guidelines described by Section 408D.104 [~~408.124~~].

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

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

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

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

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

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

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

SECTION 1.155. Section 413.021, Labor Code, is transferred

to Subchapter A, Chapter 408, Labor Code, renumbered as Section 408.009, Labor Code, and amended to read as follows:

Sec. 408.009 [~~413.021~~]. RETURN-TO-WORK COORDINATION SERVICES. (a) An insurance carrier shall, with the agreement of a participating employer, provide each [~~the~~] employer with return-to-work coordination services as necessary to facilitate an injured employee's return to employment.

(b) 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. The carrier shall evaluate a compensable injury in which the injured employee sustains a disability that results in lost time from employment that extends for more than six weeks as early as is practicable to determine if skilled case management is necessary for the injured employee's case.

(c) These services may be offered by insurance carriers in conjunction with the accident prevention services provided under Section 411.061. Nothing in this section:

(1) supersedes the provisions of a collective bargaining agreement between an employer and the employer's employees; or

(2) [~~, 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) [~~(b)~~] Return-to-work coordination services under this section may include:

(1) job analysis to identify the physical demands of a job;

(2) job modification and restructuring assessments as necessary to match job requirements with the functional capacity of an employee; and

(3) medical or vocational case management to coordinate the efforts of the employer, the treating doctor, and the injured employee to achieve timely return to work.

(e) [~~(c)~~] An insurance carrier is not required to provide physical workplace modifications under this section and is not liable for the cost of modifications made under this section to facilitate an employee's return to employment.

(f) [~~(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.

(g) [~~(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 1.156. Section 408.041(c), 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 department [~~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 1.157. Sections 408.042(d), (f), and (g), 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 department [~~commission~~] determines that computing the average weekly wage for an employee as provided by Subsection (c) is impractical or unreasonable, the department [~~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 1.158. Section 408.043(c), 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 department [~~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 1.159. Section 408.0445, Labor Code, is amended to read as follows:

Sec. 408.0445. AVERAGE WEEKLY WAGE FOR MEMBERS OF STATE MILITARY FORCES AND TEXAS TASK FORCE 1. (a) For purposes of computing income benefits or death benefits under Section 431.104, Government Code, the average weekly wage of a member of the state military forces as defined by Section 431.001, Government 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 the member holds in addition to serving as a member of the state military forces, disregarding any period during which the member is not fully compensated for that employment because the member is engaged in authorized military training or duty, and the member's regular

weekly wage as a member of the state military forces, except that the amount may not exceed 130 [~~100~~] percent of the state average weekly wage as determined under Section 408.047.

(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 130 [~~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 department [~~commission~~].

SECTION 1.160. Sections 408.0446(d) and (e), Labor Code, are amended to read as follows:

(d) If the department [~~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 department [~~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 1.161. Section 408.045, Labor Code, is amended to read as follows:

Sec. 408.045. NONPECUNIARY WAGES. The department [~~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 1.162. Section 408.047, Labor Code, is amended to read as follows:

Sec. 408.047. STATE AVERAGE WEEKLY WAGE. The state average weekly wage for a state [~~the~~] fiscal year is the amount computed by the Texas Workforce Commission under Section 207.002 as the average weekly wage in covered employment in this state [~~beginning September 1, 2003, and ending August 31, 2004, is $537, and for the fiscal year beginning September 1, 2004, and ending August 31, 2005, is $539~~].

SECTION 1.163. Sections 408.061(a), (b), (c), (d), (e), and (f), Labor Code, are amended to read as follows:

(a) A weekly temporary income benefit may not exceed 130 [~~100~~] percent of the state average weekly wage under Section 408.047 rounded to the nearest whole dollar.

(b) A weekly impairment income benefit may not exceed 100 [~~70~~] percent of the state average weekly wage rounded to the nearest whole dollar.

(c) A weekly supplemental income benefit may not exceed 100 [~~70~~] percent of the state average weekly wage rounded to the nearest whole dollar.

(d) A weekly death benefit may not exceed 130 [~~100~~] percent of the state average weekly wage rounded to the nearest whole dollar.

(e) A weekly lifetime income benefit may not exceed 130 [~~100~~] percent of the state average weekly wage rounded to the nearest whole dollar.

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

SECTION 1.164. Section 408.062(b), Labor Code, is amended to read as follows:

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

SECTION 1.165. Section 408.063(a), Labor Code, is 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.

SECTION 1.166. 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 department [~~commission~~] approval, assign the right to death benefits.

SECTION 1.167. Sections 408.221(a), (b), (d)-(g), and (i), 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 department [~~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 408D.159(c) [~~408.147(c)~~], the attorney's fee shall be paid from the claimant's recovery.

(d) In approving an attorney's fee under this section, the department [~~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~~].

(i) Except as provided by Subsection (c) or Section 408D.159(c) [~~408.147(c)~~], an attorney's fee may not exceed 25 percent of the claimant's recovery.

SECTION 1.168. 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 department [~~commission~~] or court and determined by the department [~~commission~~] or court to be reasonable and necessary.

(b) In determining whether a fee is reasonable under this section, the department [~~commission~~] or court shall consider issues analogous to those listed under Section 408.221(d). The defense counsel shall present written evidence to the department [~~commission~~] or court relating to:

(1) the time spent and expenses incurred in defending the case; and

(2) other evidence considered necessary by the

department [~~commission~~] or court in making a determination under this section.

PART 10. ADOPTION OF CHAPTERS 408A, 408B, AND 408C, LABOR CODE

SECTION 1.201. The heading to Subchapter B, Chapter 408, Labor Code, and Sections 408.004, 408.0041, 408.006-408.008, 408.021, 408.026, and 408.028-408.030, Labor Code, are designated as Chapter 408A, Labor Code, and that chapter is amended to read as follows:

CHAPTER 408A. WORKERS' COMPENSATION

[~~SUBCHAPTER B. MEDICAL~~] BENEFITS: GENERAL PROVISIONS REGARDING MEDICAL BENEFITS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 408A.001 [~~408.021~~]. ENTITLEMENT TO MEDICAL BENEFITS. (a) An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that:

(1) cures or relieves the effects naturally resulting from the compensable injury;

(2) promotes recovery; or

(3) enhances the ability of the employee to return to or retain employment.

(b) Medical benefits are payable from the date of the compensable injury.

(c) Except in an emergency, all health care must be approved or recommended by the employee's treating doctor.

(d) An insurance carrier's liability for medical benefits

may not be limited or terminated by agreement or settlement.

Sec. 408A.002 [~~408.004~~]. REQUIRED MEDICAL EXAMINATIONS; ADMINISTRATIVE VIOLATION. (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, 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~~].

(c) The insurance carrier shall pay for:

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

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

(d) An injured employee is entitled to have a doctor of the employee's choice present at an examination required by the commissioner [~~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 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 that the commissioner [~~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) 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 department [~~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 commissioner [~~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 department [~~commission~~] makes a reasonable attempt to obtain the treating doctor's opinion before the commissioner or a hearings officer [~~commission~~] makes a determination regarding the entry of an interlocutory order under this subtitle requiring continuation of benefits; and

(3) the commissioner [~~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.

Sec. 408A.003 [~~408.0041~~]. DESIGNATED DOCTOR EXAMINATION. (a) At the request of an insurance carrier or an employee, the commissioner [~~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.

(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. 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 department [~~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 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 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 great weight of the evidence is to the contrary. An employer may make a bona fide offer of employment subject to Sections 408D.053(e) [~~408.103(e)~~] and 408D.156(c) [~~408.144(c)~~] based on the designated doctor's report.

(f) 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 commissioner [~~commission~~] shall allow the insurance carrier reasonable time to obtain and present the opinion of the doctor selected under this subsection before the commissioner [~~commission~~] makes a decision on the merits of the

issue in question.

(g) 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.

(h) An employee is not entitled to 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 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.

(i) If the report of a designated doctor indicates that an employee has reached maximum medical improvement, the insurance carrier may suspend or reduce the payment of temporary income benefits immediately.

Sec. 408A.004 [~~408.006~~]. MENTAL TRAUMA INJURIES. (a) It is the express intent of the legislature that nothing in this subtitle shall be construed to limit or expand recovery in cases of

mental trauma injuries.

(b) A mental or emotional injury that arises principally from a legitimate personnel action, including a transfer, promotion, demotion, or termination, is not a compensable injury under this subtitle.

Sec. 408A.005 [~~408.007~~]. DATE OF INJURY FOR OCCUPATIONAL DISEASE. For purposes of this subtitle, the date of injury for an occupational disease is the date on which the employee knew or should have known that the disease may be related to the employment.

Sec. 408A.006 [~~408.008~~]. COMPENSABILITY OF HEART ATTACKS. A heart attack is a compensable injury under this subtitle only if:

(1) the attack can be identified as:

(A) occurring at a definite time and place; and

(B) caused by a specific event occurring in the course and scope of the employee's employment;

(2) the preponderance of the medical evidence regarding the attack indicates that the employee's work rather than the natural progression of a preexisting heart condition or disease was a substantial contributing factor of the attack; and

(3) the attack was not triggered solely by emotional or mental stress factors, unless it was precipitated by a sudden stimulus.

Sec. 408A.007 [~~408.028~~]. PHARMACEUTICAL SERVICES. (a) A physician providing care to an injured employee under this subtitle [~~subchapter~~] shall prescribe for the employee any necessary prescription drugs, and order over-the-counter alternatives to prescription medications as clinically appropriate and applicable,

in accordance with applicable state law and as provided by Subsection (b). A doctor providing care may order over-the-counter alternatives to prescription medications, when clinically appropriate, in accordance with applicable state law and as provided by Subsection (b).

(b) The commissioner [~~commission~~] by rule shall develop a closed [~~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.

(c) Except as otherwise provided by this subtitle, an insurance carrier may not require an injured employee to use pharmaceutical services designated by the carrier.

(d) The commissioner [~~commission~~] shall adopt rules to allow an injured 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 injured 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.

Sec. 408A.008 [~~408.029~~]. NURSE FIRST ASSISTANT SERVICES. An insurance carrier may not refuse to reimburse a health care practitioner solely because that practitioner is a nurse first assistant, as defined by Section 301.1525, Occupations Code, for a covered service that a physician providing health care services under this subtitle has requested the nurse first assistant to perform.

Sec. 408A.009 [~~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 commissioner [~~commission~~] shall immediately report that act or omission to the Texas State Board of Medical Examiners.

Sec. 408A.010 [~~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.

Sec. 408A.011. UNDERSERVED AREAS. The commissioner by rule shall identify areas of this state in which access to health care providers is less available and shall adopt appropriate standards and guidelines regarding health care, including any use of provider networks, in those areas.

Sec. 408A.012. 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 who are not able to accept medical bills electronically.

Sec. 408A.013. PEER REVIEW. (a) 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.

(b) A doctor who performs peer review under this section must hold the appropriate professional license issued by this state.

SUBCHAPTER B. PAYMENT OF CLAIMS TO HEALTH CARE PROVIDERS

Sec. 408A.051. CARRIER NOTICE. (a) An insurance carrier shall simultaneously notify the department, the injured employee, any representative of the injured employee, and the injured employee's treating doctor of any disputes regarding compensability or extent of injury.

(b) An insurance carrier may not deny payment on the ground of compensability for health care services provided before the date of the notification required under Subsection (a).

(c) If the insurance carrier successfully contests compensability, the carrier is liable for a maximum of $7,000.

Sec. 408A.052. RECOVERY FROM HEALTH INSURER. (a) If the injury is finally determined to be non-compensable, the health care provider is entitled to recover from the injured employee's group health insurance company, if any.

(b) A health care provider may not file a claim with the injured employee's group health insurance company plan until final adjudication under the workers' compensation system of the compensability under Subtitle A of the services provided by the health care provider.

Sec. 408A.053. SUBMISSION OF CLAIM BY PROVIDER. (a) A health care provider must submit a claim for payment to the

insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely remit a claim constitutes a forfeiture of the provider's right to reimbursement on the claim.

(b) The insurance carrier shall review the provider's claim not later than the 65th day after the date on which the claim is received by the carrier. The carrier may request further documentation necessary to clarify the provider's charges at any time during the 65-day period. If the insurance carrier requests clarification under this subsection, the provider must provide the requested clarification not later than the 15th day after the date of receipt of the carrier's request.

(c) An insurance carrier may change the American Medical Association Current Procedural Terminology (CPT) code assigned to the services provided based on the additional documentation provided by the health care provider.

Sec. 408A.054. DEADLINE FOR CARRIER ACTION. (a) The insurance carrier must pay, reduce, deny, or determine to audit the health care provider's claim not later than the 65th day after the date of receipt by the carrier of the provider's claim.

(b) If the insurance carrier elects to audit the claim, the carrier must complete the audit not later than the 160th day after the date of receipt by the carrier of the provider's claim, and, not later than the 160th day after the receipt of the claim, must make a determination regarding:

(1) the relationship of the health care services

provided to the compensable injury;

(2) the extent of the injury; and

(3) the medical necessity of the services provided.

(c) If the insurance carrier chooses to audit the claim, the insurance carrier must pay to the health care provider 85 percent of:

(1) if the health care service is not provided through a provider network under Chapter 408B, the amount for the health care service established under the fee guidelines; or

(2) if the health care service is provided through a provider network under Chapter 408B, the amount of the contracted rate for that health care service.

(d) If the health care services provided are determined to be appropriate, the insurance carrier shall pay the health care provider the remaining 15 percent of the claim not later than the 160th day after the receipt of the claim.

(e) The failure of the insurance carrier under Subsection (a) to pay, reduce, deny, or notify the health care provider of the intent to audit the claim by the 65th day after the date of receipt by the carrier of the provider's claim constitutes a Class C administrative violation.

(f) The failure of the insurance carrier under Subsection (b) to pay, reduce, or deny an audited claim by the 160th day after the date of receipt of the claim constitutes a Class C administrative violation.

Sec. 408A.055. REIMBURSEMENT BY HEALTH CARE PROVIDER. (a) If the health care services provided are determined to be

inappropriate, the insurance carrier shall:

(1) notify the health care provider in writing of the carrier's decision; and

(2) demand a refund by the provider of the portion of payment on the claim that was received by the provider for the inappropriate services.

(b) The health care provider may appeal the insurance carrier's determination under Subsection (a). The provider must file an appeal under this subsection with the insurance carrier not later than the 45th day after the date of the insurance carrier's request for the refund. The insurance carrier must act on the appeal not later than the 45th day after the date on which the provider files the appeal.

(c) A health care provider must reimburse the insurance carrier for payments received by the provider for inappropriate charges not later than the 65th day after the date of the carrier's notice. The failure by the health care provider to timely remit payment to the carrier constitutes a Class D administrative violation.

SECTION 1.202. Subtitle A, Title 5, Labor Code, is amended by adding Chapter 408B to read as follows:

CHAPTER 408B. WORKERS' COMPENSATION BENEFITS: REQUIREMENTS FOR INSURANCE CARRIERS THAT USE PROVIDER NETWORKS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 408B.001. USE OF PROVIDER NETWORK: GENERAL REQUIREMENTS FOR INSURANCE CARRIER. An insurance carrier may arrange for health care services for injured employees through a

provider network certified under this chapter. The obligations and requirements imposed under this chapter apply only to:

(1) an insurance carrier that arranges for health care services for injured employees through a certified provider network; and

(2) services provided for compensable injuries for which the insurance carrier is liable under this chapter.

Sec. 408B.002. USE OF PROVIDER NETWORK PROVIDERS. (a) If an insurance carrier elects to use a certified provider network, an injured employee who is covered by that insurance carrier is required to obtain treatment for a compensable injury within the provider network if the injured employee lives or works within the provider network's service area.

(b) Except for emergencies and out-of-network referrals, a provider 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 provider network.

(c) A network provider who has treated an employee may not serve as a designated doctor or perform a required medical examination for that employee for the compensable injury for which the provider provided treatment.

Sec. 408B.003. GENERAL PROVIDER NETWORK REQUIREMENTS. (a) Each provider network certified under this chapter must be a fee-for-service network designed to improve the quality and reduce the cost of health care provided to injured employees.

(b) Insurance carriers and the provider networks are prohibited from using capitation as a form of payment for

contracted providers.

(c) Except as provided by Subsection (d), a provider network is not an insurer and may not use in the provider network's name, contracts, 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.

(d) A provider network is subject to Articles 21.28 and 21.28-A, Insurance Code, and is considered to be an insurer or insurance company, as applicable, for purposes of those laws.

Sec. 408B.004. INSURANCE CARRIER LIABILITY FOR OUT-OF-NETWORK HEALTH CARE. An insurance carrier that establishes or contracts with a provider network is not liable for all or part of the cost of a health care service, other than emergency services, if the employee obtains the health care service without provider network approval from:

(1) a network provider other than the employee's treating doctor or a specialist to whom the employee is referred by the treating doctor; or

(2) a non-network provider.

Sec. 408B.005. RESTRAINT OF TRADE. (a) A provider 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 or the Insurance 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.

Sec. 408B.006. AUTHORITY OF COMMISSIONER. Except as expressly provided by this chapter, the powers and duties created by Chapter 36, Insurance Code, Article 21.58D, Insurance Code, and Sections 843.080, 843.082, 843.102, and 843.151, Insurance Code, do not apply to this chapter.

Sec. 408B.007. RULES. The commissioner may adopt rules as necessary to implement this chapter.

SUBCHAPTER B. GENERAL POWERS AND DUTIES OF INSURANCE CARRIER AND PROVIDER NETWORK

Sec. 408B.051. NOTICE TO EMPLOYEES REQUIRED. (a) An insurance carrier that uses a certified provider network shall provide to the employer, and shall ensure that the employer provides to the employer's employees, notice of the provider network requirements, including all information required by Section 408B.052. The insurance 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 provider network and the provider network's requirements; and

(2) post notice of the provider network's requirements at each place of employment.

(b) The insurance carrier shall ensure that an employer provides to each employee hired after the date notice is given under Subsection (a) the notice and information required under that subsection not later than the third day after the date of hire.

(c) The insurance carrier shall require the employer to notify an injured employee of the provider network requirements at the time the employer receives actual or constructive notice of an injury.

(d) An injured employee is not required to comply with the provider network requirements until the employee receives the notice required under Subsection (a).

(e) Each self-insured employer, employer group, and governmental entity that qualifies as an insurance carrier and establishes a certified provider network shall also comply with the notice obligations established under Subsection (a).

Sec. 408B.052. CONTENTS OF NOTICE. (a) The written notice required under Section 408B.051(a) must be written in plain language and in a readable and understandable format, and must be provided in English, Spanish, and any additional language common to an employer's employees.

(b) The notice must include, in a clear, complete, and accurate format:

(1) a statement that, for workers' compensation

purposes, the employer participates in a certified provider network and that employees must receive health care services through the certified provider network;

(2) the insurance carrier's toll-free telephone number and address for obtaining additional information about the certified provider network, including information about participating providers;

(3) a statement that in the event of an injury, an employee must select a treating doctor from a list of all the treating doctors within the certified provider network that are located within:

(A) 30 miles of the employee's place of residence if the employee resides in an urban area; or

(B) 60 miles of the employee's place of residence if the employee resides in a rural area;

(4) a statement that, except for emergency services, an employee must obtain all health care and specialist referrals through the employee's treating doctor;

(5) an explanation that participating providers have agreed to look only to the insurance carrier and not to employees for payment of health care services related to the compensable injury, except as provided by Section 408B.304;

(6) a statement that, except for emergency services, if the employee obtains health care from non-participating providers without a referral from the employee's treating doctor, the carrier may not be liable, and the employee may be liable, for payment for that health care;

(7) information about how to obtain emergency services, including emergency care outside the certified provider network's service area, and after-hours care;

(8) an explanation regarding continuity of care in the event of the termination of a treating doctor from participation in the certified provider network;

(9) a description of the complaint system, including a statement that the insurance carrier is prohibited from retaliating against:

(A) an employee if the employee files a complaint against the carrier or appeals a decision of the carrier; or

(B) a health care provider if the provider, on behalf of an employee, reasonably filed a complaint against the carrier or appeals a decision of the carrier;

(10) a summary of the insurance carrier's procedures relating to adverse determinations and the availability of the independent review process;

(11) a description of where and how to obtain a list of participating providers that includes:

(A) the names and addresses of the participating providers;

(B) a statement of limitations of accessibility and referrals to specialists; and

(C) a disclosure of which treating doctors are accepting new patients; and

(12) a description of the certified provider network's service area.

Sec. 408B.053. ACCESS TO CARE; APPLICABILITY TO CLAIMS. (a) If the insurance carrier has opted to offer workers' compensation benefits through a certified provider network, all claims, including claims with a date of injury before, on, or after September 1, 2005, shall be administered under the provisions of this subchapter.

(b) Except as provided by Section 408B.054, if the insurance carrier is responsible for a claim and provides benefits through a certified provider network, the carrier shall notify an injured employee at the time a claim is filed that the injured employee must select a treating doctor and obtain health care services from participating providers in accordance with the requirements of Subchapter G.

(c) Except as provided by Section 408B.054, if the insurance carrier responsible for the claim does not arrange for health care services through a certified provider network on the date of injury, but arranges for health care services through a certified provider network at a later date, the carrier shall notify the injured employee that, not later than the 30th day after the date on which the notice is sent, the injured employee must select a treating doctor and obtain health care services from participating providers in accordance with the requirements of Subchapter G. If the injured employee fails to select a treating doctor on or before the 14th day after the date of receipt of the notice, the carrier may assign the injured employee a treating doctor within the certified provider network.

Sec. 408B.054. PRE-EXISTING RELATIONSHIPS; CONTINUITY OF

CARE. (a) In this section:

(1) "Acute condition" means a medical condition that:

(A) involves a sudden onset of symptoms because of an illness, injury, or other medical problem that requires prompt medical attention; and

(B) has a duration of, and corresponding treatment for, not more than 30 days.

(2) "Terminal illness" means an incurable or irreversible condition that has a high probability of causing death within one year or less.

(b) This section applies to medical benefits regarding an existing claim in which:

(1) the insurance carrier has decided to offer coverage solely through a workers' compensation certified provider network; or

(2) treatment is being provided by the insurance carrier through a workers' compensation certified provider network and the network contract with the injured employee's treating doctor is being terminated.

(c) The insurance carrier shall provide for completion of treatment by non-participating providers for injured employees who are being treated by a treating doctor for:

(1) an acute condition;

(2) a terminal illness; or

(3) performance of a surgical procedure or other procedure that:

(A) is authorized by the insurance carrier as

part of a documented course of treatment; and

(B) has been recommended and documented by the health care provider to occur not later than the 30th day after the date the carrier begins to arrange for health care services through a certified provider network.

(d) Completion of treatment shall be provided for the duration of a terminal illness.

(e) Following the determination of the injured employee's medical condition in accordance with Subsection (c), the insurance carrier shall notify the injured worker of the determination regarding the completion of treatment. The notification must be sent to the injured employee's residence, with a copy of the letter sent to the non-participating provider.

(f) If the injured employee disputes the medical determination under Subsection (c), the injured employee shall request a report from the injured employee's non-participating provider that addresses whether the injured employee falls within any of the conditions set forth in Subsection (c).

(g) If the employer or injured employee objects to the medical determination by the non-participating provider, the dispute regarding the medical determination made by the non-participating provider shall be resolved by use of the carrier's internal reconsideration process, to be followed, if necessary, by review by an independent review organization. The non-participating provider shall have the burden of proving that one of the conditions set forth in Subsection (c) exists.

(h) The independent review organization shall order

transfer of the care to a treating doctor and other participating providers in accordance with Subchapter G if the documented evidence fails to establish that one of the conditions set forth in Subsection (c) exists.

(i) If the non-participating provider agrees with the carrier's determination that the injured employee's medical condition does not meet the conditions set forth in Subsection (c), the transfer of care shall go forward during the dispute resolution process.

(j) If the non-participating provider does not agree with the carrier's determination that the injured employee's medical condition does not meet the conditions set forth in Subsection (c), the transfer of care may not go forward until the dispute is resolved. The non-participating provider's performed and prescribed medical services are subject to carrier preauthorization while the dispute is pending.

Sec. 408B.055. ACCESSIBILITY AND AVAILABILITY REQUIREMENTS. (a) All services provided under this chapter must be provided by a provider who holds an appropriate license, unless the provider is exempt from license requirements. Each provider network shall ensure that the provider network's provider panel includes a broad choice of health care providers, including 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 provider network's service area. An adequate number of the treating doctors and specialists must have admitting privileges at one or more provider network hospitals located within

the provider network's service area to ensure that any necessary hospital admissions are made.

(b) Hospital services must be available and accessible 24 hours a day, seven days a week, within the provider network's service area. The provider network shall provide for the necessary hospital services by contracting with general, special, and psychiatric hospitals.

(c) Emergency care must be available and accessible 24 hours a day, seven days a week, without restrictions as to where the services are rendered.

(d) Except for emergencies, a provider 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.

(e) Each provider network shall provide that provider network services are sufficiently accessible and available as necessary to ensure that the distance from any point in the provider 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. For portions of the service area in which the provider network identifies noncompliance with this subsection, the provider network must file an access plan with the department in accordance with Subsection (f).

(f) The provider 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 provider network provider is not available to an

employee within the distance specified by Subsection (e) because:

(1) providers are not located within that distance;

(2) the provider network is unable to obtain provider contracts after good faith attempts; or

(3) providers meeting the provider network's minimum quality of care and credentialing requirements are not located within that distance.

(g) The provider network may make arrangements with providers outside the service area to enable employees to receive a higher level of skill or specialty not available within the provider network service area.

(h) The provider network may not be required to expand services outside the provider network's service area to accommodate employees who live and work outside the service area.

Sec. 408B.056. TELEPHONE ACCESS. (a) Each provider 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 provider network must have a telephone system capable of accepting, recording, or providing instructions to incoming calls during other than normal business hours. The provider network shall respond to those calls not later than two business days after the date:

(1) the call was received by the provider network; or

(2) the details necessary to respond were received by the provider network from the caller.

SUBCHAPTER C. CERTIFICATION OF PROVIDER NETWORKS

Sec. 408B.101. APPLICATION FOR CERTIFICATION. (a) An insurance carrier that seeks to offer workers' compensation benefits through a certified provider network shall apply to the department for a certificate to determine the adequacy of the provider network to provide benefits under this subtitle.

(b) A certificate application must be:

(1) filed with the department in the form prescribed by the commissioner;

(2) verified by an authorized agent of the insurance carrier; and

(3) accompanied by a nonrefundable fee set by commissioner rule.

Sec. 408B.102. CONTENTS OF APPLICATION. Each certificate application must include:

(1) a description and a map of the insurance carrier's service area or areas, with key and scale, that identifies each county or part of a county to be served;

(2) a list of all contracted provider network providers that demonstrates the adequacy of the provider 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 are met;

(3) a description of the types of compensation

arrangements made or to be made between the provider network and its contracted providers in exchange for the provision of, or an arrangement to provide, health care services to employees;

(4) a description of programs and procedures to be used, including:

(A) a complaint system, as required under Subchapter I; and

(B) a quality improvement program, as required under Section 408B.203; and

(5) any other information determined to be necessary by the commissioner to establish the adequacy and economic stability of the provider network.

Sec. 408B.103. COMMISSIONER ACTION ON APPLICATION. (a) The commissioner shall approve or disapprove an application for certification of a provider 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.

Sec. 408B.104. TERM OF CERTIFICATE. A certificate issued under this subchapter is valid until revoked or suspended by the commissioner.

SUBCHAPTER D. GENERAL REQUIREMENTS RELATING TO CONTRACTS

Sec. 408B.151. GENERAL CONTRACT REQUIREMENTS. (a) Each carrier-network contract or participating provider contract must comply with this subchapter, as applicable.

(b) Before entering into a carrier-network contract, an insurance carrier shall make a reasonable effort to evaluate the provider network's current and prospective ability to provide or arrange for health care services through participating providers, and to perform any functions delegated to the provider network in accordance with the provisions of this section.

(c) An insurance carrier and a provider network may negotiate the functions to be delegated to the provider network. A carrier may not, through a contract with a provider network, transfer risk.

(d) A provider network is not required to accept an

application for participation in the provider network from a health care provider who otherwise meets the requirements specified in this chapter for participation if the provider network determines that the provider network has contracted with a sufficient number of qualified health care providers.

(e) An insurance carrier or certified provider network is not liable for any damages or losses alleged by the health care provider arising from a decision to withhold designation as a participating provider. No cause of action related to a refusal to include a provider in a certified provider network may be maintained against an insurance carrier or the certified provider network.

(f) A provider network that employs health care providers shall obtain from each participating provider network provider a written agreement that the provider acknowledges and agrees to the contractual provisions under this subchapter.

Sec. 408B.152. CARRIER NETWORK CONTRACT REQUIREMENTS. A carrier network contract must include:

(1) a statement that the provider network's role is to provide the services described under this chapter that have been delegated by the carrier, subject to the carrier's oversight and monitoring of the provider network's performance;

(2) a description of the functions that the carrier delegates to the provider network, consistent with the requirements of this chapter, and the reporting requirements for each function;

(3) to the extent the carrier delegates one or more of the functions to the provider network, a statement that the

provider network will perform the obligations of the carrier in:

(A) arranging for the provision of health care through participating provider contracts that comply with the requirements of this section;

(B) managing the selection of treating doctors in accordance with the requirements of Section 408B.302;

(C) complying with the requirements related to termination of provider contracts under Section 408B.306;

(D) operating a utilization review plan in accordance with Subchapter H;

(E) operating a quality improvement program in accordance with the requirements of Section 408B.203; and

(F) performing credentialing functions in accordance with the requirements of Section 408B.301;

(4) a provision that requires the provider network to make available to the carrier participating provider contracts;

(5) a statement that the provider network and any third party to which the provider network subdelegates any function delegated by the carrier to the provider network will perform delegated functions in compliance with the requirements of this subtitle;

(6) a statement that the carrier retains ultimate responsibility for ensuring that all delegated functions are performed in accordance with this subchapter and that the contract may not be construed to limit in any way the carrier's responsibility to comply with applicable statutory and regulatory requirements;

(7) a contingency plan under which the carrier would, in the event of termination of the carrier-network contract or a failure to perform, reassume one or more functions of the provider network under the contract, including functions related to:

(A) notification to employees;

(B) quality of care; and

(C) continuity of care, including a plan for identifying and transitioning injured employees to new providers;

(8) a provision that requires that any agreement by which the provider network subdelegates to a third party any function delegated by the carrier to the provider network be in writing and be approved by the carrier, and that such an agreement require the delegated third party to be subject to all the requirements of this subchapter;

(9) a provision that requires the provider network to provide to the department the license number of any delegated third party who performs a function that requires a license as a utilization review agent under Article 21.58A, Insurance Code, or any other license under the Insurance Code or another insurance law of this state;

(10) an acknowledgment that:

(A) any third party to which a provider network subdelegates any function delegated by the carrier to the provider network must perform in compliance with this subchapter, and that the third party is subject to the carrier's and the provider network's oversight and monitoring of its performance; and

(B) if the third party fails to meet monitoring

standards established to ensure that functions delegated to the third party under the delegation contract are in full compliance with all statutory and regulatory requirements, the carrier or the provider network may cancel the delegation of one or more delegated functions; and

(11) a provision for a quality improvement committee that shall have the responsibility of:

(A) promoting the delivery of health care services for employees;

(B) developing and overseeing the implementation of programs aimed at promoting participating providers' understanding and application of nationally recognized, scientifically valid, outcome-based treatment and disability standards and guidelines applicable to the treatment of injuries;

(C) recommending specific actions, including provider education and training, for improving the quality of care provided to employees; and

(D) complying with Section 408B.203.

Sec. 408B.153. CONTRACTS WITH PARTICIPATING PROVIDERS. A carrier network contract and a participating provider contract must include:

(1) a provision that the insurance carrier shall monitor the acts of the provider network or participating provider through a monitoring plan that must contain, at a minimum, the requirements set forth in Section 408B.201;

(2) a provision that the contract:

(A) may not be terminated without cause by either

party without 90 days' prior written notice; and

(B) may be terminated immediately if cause exists;

(3) requirements related to termination of, and appeal rights of, participating providers in accordance with Section 408B.306;

(4) a continuity of care clause that states that if a health care provider's status as a participating provider terminates, the carrier is obligated to continue to reimburse the provider 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 if the provider requests continued care;

(5) billing and reimbursement provisions in accordance with Sections 408B.154-408B.156;

(6) utilization review requirements in accordance with Subchapter H;

(7) if the carrier uses a preauthorization process, a list of health care services that require preauthorization and information concerning the preauthorization process;

(8) a hold-harmless clause stating that participating providers may not under any circumstances bill or attempt to collect any amounts from employees for health care services rendered for a compensable injury, including the insolvency of the carrier, except if an employee obtains services from a participating provider that is not the employee's treating doctor without a referral from the treating doctor, or a non-participating

provider without approval from the carrier, or the carrier is not liable for the cost of services because they do not qualify as compensable benefits under this subtitle;

(9) a statement that the participating provider agrees to follow treatment guidelines, return-to-work guidelines, and individual treatment protocols adopted by the insurance carrier under this subtitle, as applicable to an employee's injury;

(10) a requirement that the participating provider or provider network provide all necessary information to allow the insurance carrier or the employer to provide information to employees as required by Sections 408B.051 and 408B.052;

(11) a requirement that the participating provider or provider network provide the carrier, in a form usable for audit purposes, the data necessary for the carrier to comply with regulatory reporting requirements with respect to any services provided under the contract;

(12) a provision that any failure by the provider network or participating provider to comply with this subchapter or monitoring standards shall allow the carrier to terminate all or any part of the carrier-network contract or participating provider contract;

(13) a provision that requires the provider network or participating provider to provide documentation, except for information, documents, and deliberations related to peer review for credentialing purposes that are confidential or privileged under state or federal law, that relates to:

(A) any regulatory agency's inquiry or

investigation of the provider network or participating provider that relates to an employee covered by the carrier's workers' compensation policy; and

(B) the final resolution of any regulatory agency's inquiry or investigation;

(14) a provision relating to complaints that requires the provider network or participating provider to ensure that on receipt of a complaint, a copy of the complaint shall be sent to the carrier and the department within two business days, except that in a case in which a complaint involves emergency care, the provider network or participating provider shall forward the complaint immediately to the carrier, and provided that nothing in this paragraph prohibits the provider network or participating provider from attempting to resolve a complaint;

(15) a statement that a carrier may not engage in retaliatory action, including limiting coverage, against an employee because the employee or a person acting on behalf of the employee has filed a complaint against the carrier or appealed a decision of the carrier, and a carrier may not engage in retaliatory action, including refusal to renew or termination of a contract, against a participating provider because the provider has, on behalf of an employee, reasonably filed a complaint against the carrier or appealed a decision of the carrier;

(16) a requirement that a complaint notice be posted in accordance with Section 408B.405;

(17) a mechanism for the resolution of complaints initiated by complainants that complies with Subchapter I;

(18) a statement that a provider network or participating provider may not engage in any of the prohibited practices listed under Subchapter J;

(19) a statement that the carrier may not use any financial incentive or make a payment to a health care provider or certified provider network that acts directly or indirectly as an inducement to limit medically necessary services;

(20) a clause regarding appeal by the provider of termination of provider status and applicable written notification to employees regarding such a termination, including any provisions required by the commissioner; and

(21) any other provisions required by the commissioner by rule.

Sec. 408B.154. APPLICATION OF PROMPT PAY REQUIREMENTS. The prompt payment of health care services provided by the carrier or certified provider network is subject to Subchapter B, Chapter 408A.

Sec. 408B.155. REIMBURSEMENT. (a) The amount of reimbursement for services provided by a provider network provider is determined by the contract between the provider network and the provider or group of providers.

(b) If a provider network has preauthorized a health care service, the insurance carrier or provider network or the provider network's agent or other representative may not deny payment to a provider except for reasons other than medical necessity.

(c) A provider network shall reimburse out-of-network providers who provide emergency care or whose referral by a

provider network provider has been approved by the provider network either at a rate that is agreed to by both the provider network and the out-of-network provider, or in accordance with Section 413.011.

(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 this subtitle and applicable rules of the commissioner, as consistent with this subtitle. This subsection may not be construed to require application of rules of the commissioner regarding reimbursement if application of those rules would negate reimbursement amounts negotiated by the provider network.

(e) An insurance carrier shall notify in writing a provider 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 provider network provider before that notification on the grounds that the injury was not compensable. The carrier is liable for a maximum of $7,000 for health care services that were provided before the notice required in this subsection was given.

Sec. 408B.156. RESTRICTIONS ON PAYMENT AND REIMBURSEMENT. (a) An insurance carrier or third-party administrator may not reimburse a doctor or other health care practitioner, an institutional provider, or an organization of doctors and health care providers on a discounted fee basis for services that are provided to an injured employee unless:

(1) the carrier or third-party administrator has contracted with either:

(A) the doctor or other practitioner, institutional provider, or organization of doctors and health care providers; or

(B) a preferred provider organization that has a network of preferred providers and that has contracted with the doctor or other practitioner, institutional provider, or organization of doctors and health care providers;

(2) the doctor or other practitioner, institutional provider, or organization of doctors and health care providers has agreed to the contract and has agreed to provide health care services under the terms of the contract; and

(3) the carrier or third-party administrator has agreed to provide coverage for those health care services under this chapter.

(b) A party to a preferred provider contract, including a contract with a preferred provider organization, may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority of and prior adequate notification to the other contracting parties. This subsection does not affect the authority of the commissioner under this code to request and obtain information.

(c) An insurance carrier or third-party administrator who violates this section:

(1) commits an unfair claim settlement practice in violation of Subchapter A, Chapter 542, Insurance Code; and

(2) is subject to administrative penalties under Chapters 82 and 84, Insurance Code.

SUBCHAPTER E. MONITORING PLAN; QUALITY IMPROVEMENT

Sec. 408B.201. MONITORING PLAN REQUIRED. (a) Each insurance carrier, or entity contracting with a carrier, that enters into carrier-network contracts or participating provider contracts shall monitor the acts of provider networks and participating providers through a monitoring plan.

(b) The monitoring plan must be set forth in each carrier-network contract and participating provider contract, and must contain, at a minimum:

(1) requirements for review of the provider network's compliance with the requirements for participating provider contracts as set forth in Subchapter D;

(2) provisions for review of the provider network's or participating provider's compliance with the terms of the carrier-network contract or participating provider contract, respectively, as well as with this chapter affecting the functions delegated by the carrier under the carrier-network contract;

(3) provisions for review of the provider network's and participating provider's compliance with the process for terminating contracts with participating providers, as described by Section 408B.306;

(4) provisions for review of the provider network's and participating provider's compliance with the utilization review processes set forth in Subchapter H;

(5) periodic certification by the provider network on request by the carrier that the quality improvement program of the provider network and any third parties contracted with the provider

network to perform quality improvement complies with the standards under Section 408B.203 to the extent delegated to the provider network by the carrier;

(6) periodic signed statements provided by the provider network on request from the carrier, certifying that the credentialing standards of the provider network and any third parties contracted with the provider network to perform delegated credentialing functions comply with the standards under Section 408B.301 to the extent delegated to the provider network by the carrier;

(7) a process to objectively evaluate the cost of health care services provided to employees by participating providers under this chapter;

(8) policies and procedures for conducting a pattern of practice review;

(9) processes to provide the carrier, in a standard electronic format agreed to by the parties, the following information:

(A) the average medical cost per claim for health care services provided by a participating provider to employees;

(B) the utilization by employees of health care services provided by a participating provider;

(C) employee release to return-to-work outcomes;

(D) employee satisfaction and health-related functional outcomes; and

(E) the frequency, duration, and outcome of disputes regarding medical benefits;

(10) a program of education and training aimed at ensuring that participating providers are knowledgeable and skilled in the treatment of occupational injuries and illnesses and the use of disability guidelines, and familiar with the requirements and procedures of the workers' compensation system; and

(11) policies and procedures for protecting the privacy and confidentiality of patient information.

Sec. 408B.202. COMPLIANCE WITH MONITORING PLAN. (a) An insurance carrier that becomes aware of any information that indicates that a provider network or participating provider, or any third party to which the provider network or participating provider delegates a function, is not operating in accordance with the monitoring plan as described by Section 408B.201 or is operating in a condition that renders the continuance of the carrier's relationship with the provider network or participating provider hazardous to employees shall:

(1) notify the provider network or participating provider in writing of those findings; and

(2) request in writing a written explanation, with documentation supporting the explanation, of:

(A) the provider network's or participating provider's apparent noncompliance with the contract; or

(B) the existence of the condition that apparently renders the continuance of the carrier's relationship with the provider network or participating provider hazardous to employees.

(b) A provider network or participating provider 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. The carrier shall reasonably assist the participating provider or provider network in its efforts to correct any failure to comply with the monitoring plan or any hazardous condition that forms the basis of the carrier's findings.

(c) If a carrier does not believe that a provider network or participating provider has corrected its failure to comply with the monitoring plan or any hazardous condition by the 90th day after the date the request under Subsection (a) is received, the carrier shall notify the commissioner and provide the department with copies of all notices and requests submitted to the provider network or participating provider and the responses and other documentation the carrier generates or receives in response to the notices and requests.

(d) On receipt of a notice under Subsection (c), or on receipt of a complaint filed with the department only, 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 provider network's or participating provider's ability to meet its responsibilities in connection with any function performed by the provider network or participating provider.

(e) On completion of the examination, the department shall report to the provider network or participating provider and the carrier the results of the examination and any action the

department determines is necessary to ensure that the carrier and provider network or participating provider meets its responsibilities under this chapter, and that the provider network can meet its responsibilities in connection with any function delegated by the carrier or performed by the provider network or any third party to which the provider network delegates a function.

(f) 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) In connection with an examination and report as described by Subsections (d)-(f), the commissioner may order a carrier to take any action the commissioner determines is necessary to ensure that the carrier can provide health care services under a workers' compensation insurance policy, including:

(1) reassuming the functions performed by or delegated to the provider network;

(2) temporarily or permanently ceasing arranging for services to employees through the noncompliant provider network;

(3) complying with the contingency plan required by Section 408B.152; or

(4) terminating the carrier's contract with the provider network or participating provider.

(h) A carrier-network contract or participating provider contract that is provided to the department in connection with an examination under this section is confidential and is not subject to disclosure as public information under Chapter 552, Government Code.

Sec. 408B.203. QUALITY IMPROVEMENT PROGRAM. (a) A carrier 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 carrier is ultimately responsible for the quality improvement program. The carrier shall:

(1) appoint a quality improvement committee that includes participating 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;

(5) review the annual written report on the quality improvement program; and

(6) report the results of the quality improvement program to the department.

(c) The quality improvement committee or committees shall evaluate the overall effectiveness of the quality improvement program.

(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 carrier shall dedicate adequate resources, including adequate personnel and information systems, to the quality improvement program.

(e) The carrier shall develop a written description of the quality improvement program that outlines the organizational structure of the program, including functional responsibilities and design.

(f) Each carrier shall implement a documented process for the credentialing of participating providers, in accordance with Section 408B.301.

(g) The quality improvement program must provide for an effective peer review procedure for participating providers.

SUBCHAPTER F. EXAMINATIONS

Sec. 408B.251. EXAMINATION OF PROVIDER NETWORK. (a) As often as the commissioner considers necessary, the commissioner or the commissioner's designated representative may review the operations of a provider network to determine compliance with this chapter. The review may include on-site visits to the provider network's premises.

(b) During on-site visits, the provider network shall make available to the department all records relating to the provider network's operations.

Sec. 408B.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 provider network has contracted to provide health care services or any other services delegated to the provider 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 provider network of the provider, provider group, or third party.

SUBCHAPTER G. NETWORK PROVIDERS

Sec. 408B.301. CREDENTIALING. Each insurance carrier shall have processes for credentialing participating providers that appropriately assess and validate the qualifications and other relevant information relating to the providers.

Sec. 408B.302. TREATING DOCTORS. (a) An insurance carrier shall, by contract, require treating doctors to provide, at a minimum, the functions and services for employees described by this section.

(b) For each injury, an injured employee shall notify the employee's employer or carrier under Section 408B.053 of the employee's selection of a treating doctor from the list of treating doctors within the certified provider network that are located within the provider network's service area.

(c) The following doctors do not constitute an initial choice of treating doctor:

(1) a doctor salaried by the employer;

(2) a doctor recommended by the insurance carrier or the employer;

(3) any doctor who provides care before the employee is enrolled in the provider network; or

(4) a doctor providing emergency care.

(d) The participating employer, or the injured employee in a claim described under Section 408B.053, shall provide notice to the carrier or the carrier's designee of the selection of a treating

doctor not later than the fifth business day after the date of the employee's selection.

(e) A treating doctor shall participate in the medical case management process as required by the carrier or provider network, including participation in return-to-work planning.

Sec. 408B.303. CHANGE IN TREATING DOCTOR. (a) An employee who is dissatisfied with the initial choice of a treating doctor is entitled to select an alternate treating doctor from the provider network's list of treating doctors whose practice is located within 30 miles of the employee's place of residence if the employee resides in an urban area or within 60 miles of the employee's place of residence if the employee resides in a rural area. The provider network may not deny an initial selection of an alternate treating doctor.

(b) If the employee is dissatisfied with the employee's second choice of treating doctor, the employee may notify the carrier and request permission to select an alternate treating doctor.

(c) The carrier shall establish procedures and criteria to be used in authorizing an employee to select an alternate treating doctor. The criteria must include, at a minimum, whether:

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

(2) a conflict exists between the employee and the current treating doctor to the extent that the doctor-patient relationship is jeopardized or impaired; or

(3) the employee is receiving appropriate medical care

to reach maximum medical improvement in accordance with the carrier's or provider network's treatment guidelines.

(d) A change of treating doctor may not be made to secure a new impairment rating or medical report.

(e) Denial of a request for a change of treating doctor is subject to the appeal process for a complaint filed under Subchapter C, Chapter 413.

(f) For purposes of this section, the following does not constitute the selection of an alternate treating doctor:

(1) a referral made by the treating doctor for health care services;

(2) the receipt of services ancillary to surgery;

(3) the obtaining of a second or subsequent opinion only on the appropriateness of the diagnosis or treatment;

(4) the selection of a new treating doctor because the original treating doctor:

(A) dies;

(B) retires;

(C) changes location outside the service area distance requirements, as described by Section 408B.055(e); or

(D) terminates the doctor's contract with the carrier or provider network; or

(5) 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 408B.055(e).

Sec. 408B.304. DESIGNATION OF SPECIALIST AS TREATING

DOCTOR. (a) A provider network shall ensure that an injured employee with chronic pain or a disabling or life-threatening illness may apply to the network's medical director to use a non-primary care specialist as the injured employee's treating doctor.

(b) The application must:

(1) include information specified by the provider network, including certification of the medical need for care by a specialist; and

(2) be signed by the injured employee and the non-primary care specialist interested in serving as the injured employee's treating doctor.

(c) To be eligible to serve as the injured employee's treating doctor, a specialist doctor must:

(1) meet the provider network's requirements for participation; and

(2) agree to accept the responsibility to coordinate all of the injured employee's health care needs.

(d) If a provider network denies a request under this section, the injured employee may appeal the decision through the network's established complaint and appeals process.

Sec. 408B.305. REFERRALS. (a) A treating doctor shall provide health care services to an injured employee for the employee's compensable injury and shall make referrals to other participating providers, or request from the carrier referrals to non-participating providers if a health care service is not available within the certified provider network.

(b) If a medically necessary health care service is not available within the certified provider network, a carrier shall allow referral to a non-participating provider on the request of the treating doctor and within the time appropriate to the circumstances related to the delivery of the services and the condition of the employee, but not later than the seventh day after the date of the treating doctor's request.

(c) Health care services by a non-participating provider must be arranged by the carrier or certified provider network.

(d) Health care services by a non-participating provider must be preauthorized by the carrier or certified provider network and may not be retrospectively reviewed for medical necessity.

(e) If the provider network denies the referral request, the employee may appeal the decision to an independent review organization as provided by this subtitle.

Sec. 408B.306. TERMINATION OF CONTRACT. (a) A certified provider network may decline to renew a contract with a participating provider for any reason. Before terminating a participating provider contract, a carrier must provide to the participating provider 90 days' prior written notice of the termination.

(b) A certified provider network may terminate a contract with a participating provider for cause in the case of imminent harm to patient health, an action taken against the provider's license to practice, or reasonable cause to suspect fraud or malfeasance, in which case termination may be immediate.

(c) On request, before the effective date of the termination

and within a period not later than the 60th day after the date the carrier gave written notice under Subsection (a), a participating provider is entitled to a review by an advisory review panel of the carrier's proposed termination, except in a case involving:

(1) imminent harm to patient health;

(2) an action by a state medical or dental board, another medical or dental licensing board, or another licensing board or government agency that effectively impairs the participating provider's ability to provide health care services; or

(3) reasonable cause to suspect fraud or malfeasance.

(d) On request by the health care provider whose participation in a certified provider network is being terminated or who is deselected, the health care provider is entitled to an expedited review process by the carrier.

Sec. 408B.307. ADVISORY REVIEW PANEL. (a) An advisory review panel must:

(1) be composed of participating providers who are appointed to serve on the standing quality improvement committee or utilization review committee of the carrier; and

(2) include, if available, at least one representative of the participating provider's specialty or a similar specialty.

(b) The carrier must consider, but is not bound by, the recommendation of the advisory review panel.

(c) On request, the carrier shall provide to the affected participating provider a copy of the recommendation of the advisory review panel and the carrier determination.

Sec. 408B.308. NOTIFICATION OF INJURED EMPLOYEE. (a) Except as provided by Subsection (b), the carrier must provide notification of the termination of a participating provider to each injured employee currently receiving care from the provider being terminated at least 30 days before the effective date of the termination.

(b) Notification of termination of a participating provider for reasons related to imminent harm may be given immediately.

SUBCHAPTER H. UTILIZATION REVIEW

Sec. 408B.351. UTILIZATION REVIEW AGENT. An entity performing utilization review, including an insurance carrier or a certified provider network, must be a certified utilization review agent under Article 21.58A, Insurance Code.

Sec. 408B.352. GENERAL STANDARDS FOR UTILIZATION REVIEW; UTILIZATION REVIEW PLAN; SCREENING CRITERIA. (a) An entity performing utilization review shall use a utilization review plan. The plan must be reviewed and approved by a physician and be conducted in accordance with standards developed with input from appropriate providers, including doctors engaged in active practice.

(b) The utilization review plan must include:

(1) a list of the health care services that require preauthorization in addition to those in Section 413.014; and

(2) written procedures for:

(A) identification of injured employees whose injuries or circumstances may not fit the screening criteria and who thus may require flexibility in the application of screening

criteria through utilization review decisions;

(B) notification of the provider network's determinations provided in accordance with Section 408B.355;

(C) informing appropriate parties of the process for reconsideration of an adverse determination, as required by Section 408B.356;

(D) receiving or redirecting toll-free normal business hours and after-hours telephone calls, either in person or by recording, and assurance that a toll-free telephone number is maintained 40 hours a week during normal business hours;

(E) review, including review of any form used during the review process and the time frames that must be met during the review;

(F) ensuring that providers used by the provider network to perform utilization review:

(i) meet the provider network's credentialing standards; and

(ii) are appropriately trained to perform utilization review in accordance with Section 408B.354;

(G) ensuring that any employee-specific information obtained during the process of utilization review is kept confidential in accordance with applicable federal and state laws; and

(H) screening criteria that meet the requirements of Subsection (c).

(c) Each provider network shall use written medically acceptable screening criteria and review procedures that are

established and periodically evaluated and updated with appropriate involvement from providers, including providers engaged in active practice. Utilization review decisions must be made in accordance with currently accepted medical or health care practices, taking into account any special circumstances of a case that may require deviation from the norm stated in the screening criteria. The screening criteria may be used only to determine whether to approve the requested treatment and must be:

(1) objective;

(2) clinically valid;

(3) compatible with established principles of health care; and

(4) flexible enough to allow deviations from the norm when justified on a case-by-case basis.

(d) The utilization review plan must provide that denials of care be referred to an appropriate doctor to determine whether health care is medically reasonable and necessary.

(e) The written screening criteria and review procedures must be available for review and inspection as determined necessary by the commissioner or the commissioner's designated representative. However, any information obtained or acquired under the authority of this subtitle related to the screening criteria and the utilization review plan is confidential and privileged and is not subject to disclosure under Chapter 552, Government Code, or to subpoena except to the extent necessary for the commissioner to enforce this chapter.

Sec. 408B.353. GENERAL STANDARDS FOR RETROSPECTIVE REVIEW;

SCREENING CRITERIA. An entity performing retrospective review shall use written screening criteria established and periodically updated with appropriate involvement from physicians, including practicing physicians, and other health care providers. Except as provided by this subtitle, the insurance carrier or provider network's system for retrospective review must be under the direction of a physician.

Sec. 408B.354. PERSONNEL. (a) Personnel employed by or under contract with a carrier or a certified provider network to perform utilization review or retrospective review must be appropriately trained and qualified and, if applicable, appropriately licensed. Personnel who obtain information regarding an injured employee's specific medical condition, diagnosis, and treatment options or protocols directly from the treating doctor or other health care provider, either orally or in writing, and who are not doctors must be nurses, physician assistants, or other health care providers qualified to provide the service requested by the provider. This subsection may not be interpreted to require personnel who perform only clerical or administrative tasks to have the qualifications prescribed by this subsection.

(b) A carrier or a provider network may not permit or provide compensation or any thing of value to an employee or agent of the carrier or provider network, condition employment of a carrier or provider network employee or agent evaluation, or set the carrier or provider network's employee or agent performance standards based, in a manner inconsistent with the requirements of this subchapter, on:

(1) the amount or volume of adverse determinations;

(2) reductions in or limitations on lengths of stay, duration of treatment, medical benefits, services, or charges; or

(3) the number or frequency of telephone calls or other contacts with health care providers or injured employees.

(c) Utilization review conducted by either a carrier or a provider network must be under the direction of a physician licensed to practice medicine in this state. The physician may be employed by or under contract to the carrier or provider network.

Sec. 408B.355. NOTICE OF ADVERSE DETERMINATIONS; PREAUTHORIZATION REQUIREMENTS. (a) Each carrier, or provider network if the carrier has delegated utilization review or retrospective review functions to the provider network, 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 by the provider network 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) The insurance carrier, or the provider network if the carrier has delegated utilization review functions to the provider network, shall specify which health care treatments or services provided in the provider network require preauthorization or concurrent review by the insurance carrier or the provider network. At a minimum, those treatments must include the preauthorization requirements in Section 413.014. Treatments and services for a medical emergency do not require preauthorization. On receipt of a preauthorization request from a provider for proposed services that require preauthorization, the carrier, or the provider network if utilization review functions have been delegated to the provider network, shall issue and transmit a determination indicating whether the proposed health care services are preauthorized. The provider network shall respond to requests for preauthorization within the periods prescribed by this section.

(d) For services not described by 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 by the provider network.

(e) If the proposed services are for concurrent hospitalization care, the carrier or the provider network 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 carrier or the provider network 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 carrier or the provider network issues an adverse determination in response to a request for poststabilization treatment or a request for treatment involving a life-threatening condition, the carrier or the provider network 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. 408B.356. RECONSIDERATION OF ADVERSE DETERMINATION. (a) Each carrier, or provider network if the carrier has delegated utilization review or retrospective review functions to the provider network, shall maintain and make available a written description of the carrier's or provider network's reconsideration procedures involving an adverse determination. The reconsideration procedures must be reasonable and must include:

(1) a provision stating that reconsideration shall 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 provider network shall send to the requesting party a letter acknowledging the date of the receipt of the request and that includes a reasonable list of documents the requesting party is required to submit;

(4) a provision that, after the carrier or provider network completes the review of the request for reconsideration of the adverse determination, the carrier or provider network 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 must 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. 408B.357. DISPUTE RESOLUTION. Fee disputes are subject to the provider network complaint process under Subchapter I. Disputes regarding medical necessity are subject to Subchapter C, Chapter 413.

SUBCHAPTER I. COMPLAINT RESOLUTION

Sec. 408B.401. COMPLAINT SYSTEM REQUIRED. (a) Each

provider network shall implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint.

(b) The provider 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. 408B.402. COMPLAINT INITIATION AND INITIAL RESPONSE; DEADLINES FOR RESPONSE AND RESOLUTION. (a) If a complainant notifies a provider network of a complaint, the provider network, not later than the seventh calendar day after the date the provider network receives the complaint, shall respond to the complainant, acknowledging the date of receipt of the complaint and providing a description of the provider network's complaint procedures and deadlines.

(b) The provider network shall investigate and resolve a complaint not later than the 30th calendar day after the date the provider network receives the complaint.

Sec. 408B.403. RECORD OF COMPLAINTS. (a) Each provider network shall maintain a complaint and appeal log regarding each complaint. The commissioner shall adopt rules designating the classification of provider network complaints under this section.

(b) Each provider 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 provider network's record regarding the complaint and any proceeding relating to that complaint.

(d) The department, during any investigation or examination of a provider network, may review documentation maintained under this subchapter, including original documentation, regarding a complaint and action taken on the complaint.

Sec. 408B.404. RETALIATORY ACTION PROHIBITED. A provider 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 provider network.

Sec. 408B.405. POSTING OF INFORMATION ON COMPLAINT PROCESS REQUIRED. (a) A contract between a provider 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 provider network.

(b) The notice required under Subsection (a) must include the department's toll-free telephone number for filing a complaint.

SUBCHAPTER J. PROHIBITED PRACTICES

Sec. 408B.451. NO INDUCEMENT TO LIMIT SERVICES. An insurance carrier 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 services.

Sec. 408B.452. INDEMNIFICATION; LIABILITY. (a) An

insurance carrier may not require participating providers, by contract or otherwise, to indemnify the carrier for any liability in tort resulting from an act or omission of the carrier.

(b) A carrier-network contract or participating provider contract may not transfer liability for acts of one or more parties to any other parties. Each entity shall only be responsible for its own acts, omissions, and decisions relative to the providing of health care services to employees.

Sec. 408B.453. NO LIMITATION ON PROVIDER COMMUNICATION. An insurance carrier may not, as a condition of contract with a participating provider, or in any other manner, prohibit, attempt to prohibit, or discourage a participating provider from discussing with or communicating to an employee under the participating provider's care, information or opinions regarding that employee's medical condition or treatment options.

Sec. 408B.454. MISLEADING INFORMATION. An employer, insurance carrier, or agent or representative of an employer or carrier may not cause or permit the use or distribution to employees of information that is intentionally untrue or intentionally misleading.

SUBCHAPTER K. DISCIPLINARY ACTIONS

Sec. 408B.501. DETERMINATION OF VIOLATION; NOTICE. (a) If the commissioner determines that a provider network, insurance carrier, or any other person or third party operating under this chapter, including a third party to which a provider network delegates a function, is in violation of this chapter, rules adopted by the commissioner under this chapter, or applicable

provisions of the Insurance Code or rules adopted under that code, the commissioner or a designated representative may notify the provider 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. 408B.502. DISCIPLINARY ACTIONS. If under Section 408B.501 the commissioner determines that a provider network, insurance carrier, or other person or third party described under Section 408B.501 has violated or is violating this chapter, rules adopted by the commissioner under this chapter, or the Insurance Code or rules adopted under that code, the commissioner may:

(1) suspend or revoke a certificate issued under this subtitle;

(2) impose sanctions under Chapter 82, Insurance Code;

(3) issue a cease and desist order under Chapter 83, Insurance Code; or

(4) impose administrative penalties under Chapter 84, Insurance Code.

CHAPTER 408C. REQUIREMENTS FOR INSURANCE CARRIERS THAT DO NOT USE PROVIDER NETWORKS

Sec. 408C.001. APPLICABILITY OF CHAPTER. This chapter applies only to medical benefits provided through an insurance

carrier that does not use a provider network.

Sec. 408C.002 [~~408.022~~]. SELECTION OF DOCTOR. (a) An [~~Except in an emergency, the commission shall require an employee to receive medical treatment from a doctor chosen from a list of doctors approved by the 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 as provided by this section [~~from the commission's list~~]. The injured employee shall notify the employer, who shall notify the insurance carrier, of the employee's choice of treating doctor not later than the later of:

(1) the date on which the employee notifies the employer of the injury; or

(2) the date of the first non-emergency visit to a health care provider.

(b) If an employee is dissatisfied with the initial choice of a doctor [~~from the 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.

(d) A change of doctor may not be made to secure a new impairment rating or medical report.

(e) For purposes of this section, the following is not a selection of an alternate doctor:

(1) a referral made by the doctor chosen by the employee if the referral is medically reasonable and necessary;

(2) the receipt of services ancillary to surgery;

(3) the obtaining of a second or subsequent opinion only on the appropriateness of the diagnosis or treatment;

(4) the selection of a doctor because the original doctor:

(A) dies;

(B) retires; or

(C) becomes unavailable or unable to provide medical care to the employee; or

(5) a change of doctors required because of a change of residence by the employee.

Sec. 408C.003. TREATING DOCTOR DUTIES. (a) 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 those reviews

must be performed under the direction of a doctor licensed to practice in this state.

(b) The injured employee's treating doctor is responsible for the efficient management of medical care as required by Section 408C.005(c) and commissioner rules. The department 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.

(c) The commissioner may adopt rules to define the role of the treating doctor and to specify outcome information to be collected for a treating doctor.

(d) A doctor who provides health care services under this chapter may perform only those procedures that are within the scope of the practice for which the doctor is licensed.

Sec. 408C.004. MEDICAL EXAMINATION BY TREATING DOCTOR TO DEFINE COMPENSABLE INJURY. (a) The department shall require an injured employee to submit to a single medical examination to define the compensable injury on request by the insurance carrier.

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

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

injuries and diagnoses as related to the compensable injury or shall dispute the determination of specific injuries and diagnoses.

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

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

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

Sec. 408C.005 [~~408.025~~]. REPORTS AND RECORDS REQUIRED FROM HEALTH CARE PROVIDERS. (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.

(c) The treating doctor is responsible for maintaining efficient utilization of health care.

(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.

Sec. 408C.006 [~~408.027~~]. PAYMENT OF HEALTH CARE PROVIDER. (a) An insurance carrier shall pay the fee allowed under Section 413.011 for a service rendered by a health care provider not later than the 45th day after the date the insurance carrier receives the charge unless the amount of the payment or the entitlement to payment is disputed.

(b) If an insurance carrier disputes the amount charged by a health care provider and requests an audit of the services rendered, the insurance carrier shall pay 50 percent of the amount charged by the health care provider not later than the 45th day after the date the insurance carrier receives the statement of charge.

(c) If an 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.

(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)~~].

Sec. 408C.007. PREAUTHORIZATION; UTILIZATION REVIEW FOR OUT-OF-NETWORK CARE. (a) The preauthorization requirements of Section 413.014 apply to out-of-network care.

(b) For out-of-network care, an insurance carrier may:

(1) perform utilization review itself if the carrier is a certified utilization review agent under Article 21.58A, Insurance Code; or

(2) contract for utilization review services with a certified utilization review agent.

Sec. 408C.008. DISPUTE RESOLUTION FOR OUT-OF-NETWORK CARE. The medical dispute resolution requirements of Subchapter C, Chapter 413, apply to a dispute regarding out-of-network care.

SECTION 1.203. The following laws are repealed:

(1) Sections 408.0221-408.0223, Labor Code;

(2) Section 408.023, Labor Code;

(3) Section 408.0231, Labor Code; and

(4) Section 408.024, Labor Code.

SECTION 1.204. Notwithstanding the repeal by this Act of Sections 408.023 and 408.0231, Labor Code, a doctor who was removed from the list of approved doctors by the Texas Workers' Compensation Commission before the effective date of this Act for a reason described by Section 408.0231(a), Labor Code, as that section existed prior to repeal by this Act, is ineligible to provide professional services under Subtitle A, Title 5, Labor Code, as amended by this Act, except as otherwise provided by rules adopted under Subtitle A, Title 5, Labor Code, as amended by this Act, by the commissioner of insurance.

PART 11. ADOPTION OF CHAPTERS 408D AND 408E, LABOR CODE

SECTION 1.251. Subchapters E, F, G, H, and I, Chapter 408, Labor Code, are redesignated as Chapter 408D, Labor Code, and that chapter is amended to read as follows:

CHAPTER 408D. WORKERS' COMPENSATION BENEFITS: INCOME BENEFITS

SUBCHAPTER A [~~E~~]. INCOME BENEFITS: [~~IN~~] GENERAL PROVISIONS

Sec. 408D.001 [~~408.081~~]. INCOME BENEFITS. (a) An employee is entitled to income benefits as provided by [~~in~~] this subtitle [~~chapter~~].

(b) Except as otherwise provided by this section or this subtitle, income benefits shall be paid as required under Section 409.021(a) 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~~].

(d) An employee's entitlement to income benefits under this chapter terminates on the death of the employee. An interest in future income benefits does not survive after the employee's death.

Sec. 408D.002 [~~408.082~~]. ACCRUAL OF RIGHT TO INCOME BENEFITS. (a) Income benefits may not be paid under this subtitle for an injury that does not result in disability for at least one week.

(b) If the disability continues for longer than one week, weekly income benefits begin to accrue on the eighth day after the date of the injury. If the disability does not begin at once after the injury occurs or within eight days of the occurrence but does result subsequently, weekly income benefits accrue on the eighth day after the date on which the disability began.

(c) If the disability continues for 14 days [~~four weeks~~] or longer after the date the disability [~~it~~] begins, compensation shall be computed from the date the disability begins.

(d) This section does not preclude the recovery of medical benefits as provided by this subtitle [~~Subchapter B~~].

Sec. 408D.003 [~~408.083~~]. TERMINATION OF RIGHT TO TEMPORARY

INCOME, IMPAIRMENT INCOME, AND SUPPLEMENTAL INCOME BENEFITS. (a) Except as provided by Subsection (b), an employee's eligibility for temporary income benefits, impairment income benefits, and supplemental income benefits terminates on the expiration of 401 weeks after the date of injury.

(b) If an employee incurs an occupational disease, the employee's eligibility for temporary income benefits, impairment income benefits, and supplemental income benefits terminates on the expiration of 401 weeks after the date on which benefits began to accrue.

Sec. 408D.004 [~~408.084~~]. CONTRIBUTING INJURY. (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 department [~~commission~~] shall consider the cumulative impact of the compensable injuries on the employee's overall impairment in determining a reduction under this section.

(c) If the combination of the compensable injuries results in an injury compensable under Section 408D.201 [~~408.161~~], the benefits for that injury shall be paid as provided by Section 408D.202 [~~408.162~~].

Sec. 408D.005 [~~408.085~~]. ADVANCE OF BENEFITS FOR HARDSHIP. (a) If there is a likelihood that income benefits will be paid, the department [~~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 under [~~in~~] Section 408.061. The department [~~commission~~] may not grant more than three advances to a particular employee based on the same injury.

(d) The department [~~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 408D.109 [~~408.129~~].

Sec. 408D.006 [~~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 department [~~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 department [~~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 department's duties [~~its duty~~] under this section and Subchapter D [~~H~~].

SUBCHAPTER B [~~F~~]. TEMPORARY INCOME BENEFITS

Sec. 408D.051 [~~408.101~~]. TEMPORARY INCOME BENEFITS. (a) An employee is entitled to temporary income benefits if the employee has a disability and has not attained maximum medical improvement.

(b) On the initiation of compensation as provided by Section 409.021, the insurance carrier shall pay temporary income benefits as provided by this subchapter.

Sec. 408D.052 [~~408.102~~]. DURATION OF TEMPORARY INCOME BENEFITS. (a) Temporary income benefits continue until the employee reaches maximum medical improvement.

(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.

Sec. 408D.053 [~~408.103~~]. AMOUNT OF TEMPORARY INCOME BENEFITS. (a) Subject to Sections 408.061 and 408.062, the amount of a temporary income benefit is equal to:

(1) 70 percent of the amount computed by subtracting the employee's weekly earnings after the injury from the employee's average weekly wage; or

(2) for the first 26 weeks, 75 percent of the amount computed by subtracting the employee's weekly earnings after the injury from the employee's average weekly wage if the employee earns less than $8.50 an hour.

(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 department [~~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 department [~~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.

(c) A presumption under Subsection (b) may be rebutted by other credible evidence of the employee's actual earnings.

(d) The Texas Workforce [~~Employment~~] Commission shall provide information required under this section in the manner most efficient for transferring the information.

(e) For purposes of Subsection (a), if an employee is offered a bona fide position of employment that the employee is reasonably capable of performing, given the physical condition of

the employee and the geographic accessibility of the position to the employee, the employee's weekly earnings after the injury are equal to the weekly wage for the position offered to the employee.

Sec. 408D.054 [~~408.104~~]. MAXIMUM MEDICAL IMPROVEMENT AFTER SPINAL SURGERY. (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 408A.010 [~~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 department [~~commission~~].

(b) Either the employee or the insurance carrier may dispute an application for extension made under this section. A dispute under this subsection is subject to Chapter 410.

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

Sec. 408D.055 [~~408.105~~]. SALARY CONTINUATION IN LIEU OF TEMPORARY INCOME BENEFITS. (a) In lieu of payment of temporary income benefits under this subchapter, an employer may continue to pay the salary of an employee who sustains a compensable injury under a contractual obligation between the employer and employee, such as a collective bargaining agreement, written agreement, or policy.

(b) Salary continuation may include wage supplementation if:

(1) employer reimbursement is not sought from the carrier as provided by Section 408D.107 [~~408.127~~]; and

(2) the supplementation does not affect the employee's eligibility for any future income benefits.

SUBCHAPTER C [~~G~~]. IMPAIRMENT INCOME BENEFITS

Sec. 408D.101 [~~408.121~~]. IMPAIRMENT INCOME BENEFITS. (a) An employee's entitlement to impairment income benefits begins on the day after the date the employee reaches maximum medical improvement and ends on the earlier of:

(1) the date of expiration of a period computed at the rate of three weeks for each percentage point of impairment; or

(2) the date of the employee's death.

(b) The insurance carrier shall begin to pay impairment income benefits not later than the fifth day after the date on which the insurance carrier receives the doctor's report certifying maximum medical improvement. Impairment income benefits shall be paid for a period based on the impairment rating, unless that rating is disputed under Subsection (c).

(c) If the insurance carrier disputes the impairment rating used under Subsection (a), the carrier shall pay the employee impairment income benefits for a period based on the carrier's reasonable assessment of the correct rating.

Sec. 408D.102 [~~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.

(b) To be eligible to serve as a designated doctor, a doctor must meet specific qualifications, including training in the determination of impairment ratings. The department [~~executive director~~] shall develop qualification standards and administrative policies to implement this subsection, and the commissioner [~~commission~~] may adopt rules as necessary. If medical benefits are provided through a provider network, the designated doctor must be a health care practitioner under the provider network. 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 great weight of the other medical evidence is to the contrary.

Sec. 408D.103 [~~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 408D.104 [~~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 department [~~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 408D.054 [~~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).

Sec. 408D.104 [~~408.124~~]. IMPAIRMENT RATING GUIDELINES. (a) An award of an impairment income benefit, whether by the department [~~commission~~] or a court, must be based [~~shall be made~~] on an impairment rating determined using the impairment rating guidelines described by [~~in~~] this section.

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

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

Sec. 408D.105 [~~408.125~~]. DISPUTE AS TO IMPAIRMENT RATING; ADMINISTRATIVE VIOLATION. (a) If an impairment rating is disputed, the department [~~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 great weight of the other medical evidence is to the contrary. If the 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.

(e) Notwithstanding Subsection (d), the treating doctor and the insurance carrier are both responsible for sending to the designated doctor all the injured employee's medical records that are in their possession and that relate to the issue to be evaluated by the designated doctor. The treating doctor and the 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 the insurance carrier may also send the designated doctor an analysis of the injured employee's medical condition, functional abilities, and return-to-work opportunities.

(f) A violation of Subsection (d) is a Class C administrative violation.

Sec. 408D.106 [~~408.126~~]. AMOUNT OF IMPAIRMENT INCOME BENEFITS. Subject to Sections 408.061 and 408.062, an impairment income benefit is equal to 70 percent of the employee's average weekly wage.

Sec. 408D.107 [~~408.127~~]. REDUCTION OF IMPAIRMENT INCOME BENEFITS. (a) An insurance carrier shall reduce impairment income benefits to an employee by an amount equal to employer payments made under Section 408.003 that are not reimbursed or reimbursable under that section.

(b) The insurance carrier shall remit the amount of a reduction under this section to the employer who made the payments.

(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.

Sec. 408D.108 [~~408.128~~]. COMMUTATION OF IMPAIRMENT INCOME BENEFITS. (a) An employee may elect to commute the remainder of the impairment income benefits to which the employee is entitled if the employee has returned to work for at least three months, earning

at least 80 percent of the employee's average weekly wage.

(b) An employee who elects to commute impairment income benefits is not entitled to additional income benefits for the compensable injury.

Sec. 408D.109 [~~408.129~~]. ACCELERATION OF IMPAIRMENT INCOME BENEFITS. (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.

(c) The duration of the impairment income benefits to which the employee is entitled shall be reduced to offset the increased payments caused by the acceleration taking into consideration the discount for present payment computed at the rate provided under Section 401.023.

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

SUBCHAPTER D [~~H~~]. SUPPLEMENTAL INCOME BENEFITS

Sec. 408D.151 [~~408.141~~]. AWARD OF SUPPLEMENTAL INCOME BENEFITS. An award of a supplemental income benefit, whether by the department [~~commission~~] or a court, shall be made in accordance with this subchapter.

Sec. 408D.152 [~~408.142~~]. SUPPLEMENTAL INCOME BENEFITS. (a) An employee is entitled to supplemental income benefits if on the expiration of the impairment income benefit period computed under Section 408D.101(a)(1) [~~408.121(a)(1)~~] the employee:

(1) has an impairment rating of 15 percent or more as determined by this subtitle from the compensable injury;

(2) has not returned to work or has returned to work earning less than 80 percent of the employee's average weekly wage as a direct result of the employee's impairment;

(3) has not elected to commute a portion of the impairment income benefit under Section 408D.108 [~~408.128~~]; and

(4) has complied with the requirements adopted under Section 408D.153 [~~attempted in good faith to obtain employment commensurate with the employee's ability to work~~].

(b) If an employee is not entitled to supplemental income benefits at the time of payment of the final impairment income benefit because the employee is earning at least 80 percent of the employee's average weekly wage, the employee may become entitled to supplemental income benefits at any time within one year after the date the impairment income benefit period ends if:

(1) the employee earns wages for at least 90 days that are less than 80 percent of the employee's average weekly wage;

(2) the employee meets the requirements of Subsections (a)(1), (3), and (4); and

(3) the decrease in earnings is a direct result of the employee's impairment from the compensable injury.

Sec. 408D.153. WORK SEARCH COMPLIANCE STANDARDS. (a) The

commissioner by rule shall adopt compliance standards for supplemental income benefit recipients that require each recipient to demonstrate an active effort to obtain employment. To be eligible to receive supplemental income benefits under this chapter, a recipient must provide evidence satisfactory to the department of:

(1) active participation in a vocational rehabilitation program conducted by the Department of Assistive and Rehabilitative Services or a private vocational rehabilitation provider;

(2) active participation in work search efforts conducted through the Texas Workforce Commission; or

(3) active work search efforts documented by job applications submitted by the recipient.

(b) In adopting rules under this section, the commissioner shall:

(1) establish the level of activity that a recipient should have with the Texas Workforce Commission and the Department of Assistive and Rehabilitative Services;

(2) define the number of job applications required to be submitted by a recipient to satisfy the work search requirements; and

(3) consider factors affecting the availability of employment, including recognition of access to employment in rural areas, economic conditions, and other appropriate employment availability factors.

(c) The commissioner may consult with the Texas Workforce

Commission, the Department of Assistive and Rehabilitative Services, and other appropriate entities in adopting rules under this section.

Sec. 408D.154. RETURN-TO-WORK GOALS AND ASSISTANCE. (a) The department shall assist recipients of supplemental income benefits to return to the workforce. The department shall develop improved data sharing, within the standards of federal privacy requirements, with all appropriate state agencies and workforce programs to inform the department of changes needed to assist supplemental income benefit recipients to successfully reenter the workforce.

(b) The department shall train staff dealing with supplemental income benefits to respond to questions and assist injured employees in their effort to return to the workforce. If the department determines that an injured employee is unable to ever return to the workforce, the department shall inform the employee of possible eligibility for other forms of benefits, such as social security disability income benefits.

(c) As necessary to implement the requirements of this section, the department shall:

(1) attempt to remove any barriers to successful employment that are identified at the department, the Texas Workforce Commission, the Department of Assistive and Rehabilitative Services, and private vocational rehabilitation programs;

(2) ensure that data is tracked among the department, the Texas Workforce Commission, the Department of Assistive and

Rehabilitative Services, and insurance carriers, including outcome data;

(3) establish a mechanism to refer supplemental income benefit recipients to the Texas Workforce Commission and local workforce development centers for employment opportunities; and

(4) develop a mechanism to promote employment success that includes post-referral contacts by the department with supplemental income benefit recipients.

Sec. 408D.155 [~~408.143~~]. EMPLOYEE STATEMENT. (a) After the department's [~~commission's~~] initial determination of supplemental income benefits, the employee must file a statement with the insurance carrier stating:

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

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

(3) that the employee has complied with the requirements adopted under Section 408D.153 [~~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 department [~~commission~~]. The department [~~commission~~] may modify the filing period as appropriate to an individual case.

(c) Failure to file a statement under this section relieves the insurance carrier of liability for supplemental income benefits for the period during which a statement is not filed.

Sec. 408D.156 [~~408.144~~]. COMPUTATION OF SUPPLEMENTAL INCOME BENEFITS. (a) Supplemental income benefits are calculated quarterly and paid monthly.

(b) Subject to Section 408.061, the amount of a supplemental income benefit for a week is equal to 80 percent of the amount computed by subtracting the weekly wage the employee earned during the reporting period provided by Section 408D.155(b) [~~408.143(b)~~] from 80 percent of the employee's average weekly wage determined under Section 408.041, 408.042, 408.043, [~~or~~] 408.044, 408.0445, or 408.0446.

(c) For the purposes of this subchapter, if an employee is offered a bona fide position of employment that the employee is capable of performing, given the physical condition of the employee and the geographic accessibility of the position to the employee, the employee's weekly wages are considered to be equal to the weekly wages for the position offered to the employee.

Sec. 408D.157 [~~408.145~~]. PAYMENT OF SUPPLEMENTAL INCOME BENEFITS. An insurance carrier shall pay supplemental income benefits beginning not later than the seventh day after the expiration date of the employee's impairment income benefit period and shall continue to pay the benefits in a timely manner.

Sec. 408D.158 [~~408.146~~]. TERMINATION OF SUPPLEMENTAL INCOME BENEFITS; REINITIATION. (a) If an employee earns wages that are at least 80 percent of the employee's average weekly wage for at least 90 days during a time that the employee receives supplemental income benefits, the employee ceases to be entitled to supplemental income benefits for the filing period.

(b) Supplemental income benefits terminated under this section shall be reinitiated when the employee:

(1) satisfies the conditions of Section 408D.152(b) [~~408.142(b)~~]; and

(2) files the statement required under Section 408D.155 [~~408.143~~].

(c) Notwithstanding any other provision of this section, an employee who is not entitled to supplemental income benefits for 12 consecutive months ceases to be entitled to any additional income benefits for the compensable injury.

Sec. 408D.159 [~~408.147~~]. CONTEST OF SUPPLEMENTAL INCOME BENEFITS BY INSURANCE CARRIER; ATTORNEY'S FEES. (a) An insurance carrier may request a contested case hearing [~~benefit review conference~~] to contest an employee's entitlement to supplemental income benefits or the amount of supplemental income benefits.

(b) If an insurance carrier fails to [~~make a~~] request [~~for~~] a contested case hearing [~~benefit review conference~~] within 10 days after the date of the expiration of the impairment income benefit period or within 10 days after receipt of the employee's statement, the insurance carrier waives the right to contest entitlement to supplemental income benefits and the amount of supplemental income benefits for that period of supplemental income benefits.

(c) If an insurance carrier disputes a department [~~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).

Sec. 408D.160 [~~408.148~~]. EMPLOYEE DISCHARGE AFTER TERMINATION. The department [~~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 408D.158(c) [~~408.146(c)~~] if the department [~~commission~~] finds that the employee was discharged at that time with the intent to deprive the employee of supplemental income benefits.

Sec. 408D.161 [~~408.149~~]. STATUS REVIEW; HEARING [~~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 department [~~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. The department shall conduct the review not later than the 10th day after the date on which the department receives the request.

(b) Either party may request a contested case hearing [~~benefit review conference~~] to contest a determination of the department [~~commission~~] at any time, subject only to the limits placed on the insurance carrier by Section 408D.159 [~~408.147~~].

Sec. 408D.162 [~~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.

Sec. 408D.163 [~~408.151~~]. MEDICAL EXAMINATIONS FOR SUPPLEMENTAL INCOME BENEFITS. (a) On or after the second anniversary of the date the department [~~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 department [~~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 great weight of the other medical evidence is to the contrary.

(c) The department [~~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.

SUBCHAPTER E [~~I~~]. LIFETIME INCOME BENEFITS

Sec. 408D.201 [~~408.161~~]. LIFETIME INCOME BENEFITS. (a) Lifetime income benefits are paid until the death of the employee for:

(1) total and permanent loss of sight in both eyes;

(2) loss of both feet at or above the ankle;

(3) loss of both hands at or above the wrist;

(4) loss of one foot at or above the ankle and the loss of one hand at or above the wrist;

(5) an injury to the spine that results in permanent and complete paralysis of both arms, both legs, or one arm and one leg;

(6) a physically traumatic injury to the brain resulting in an incurable mental disability or impairment [~~insanity or imbecility~~]; or

(7) third degree burns that cover at least 40 percent of the body and require grafting, or third degree burns covering the majority of either both hands or one hand and the face.

(b) For purposes of Subsection (a), the total and permanent loss of use of a body part is the loss of that body part.

(c) Subject to Section 408.061, the amount of lifetime income benefits is equal to 75 percent of the employee's average weekly wage. Benefits being paid shall be increased at a rate of three percent a year notwithstanding Section 408.061.

(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.

Sec. 408D.202 [~~408.162~~]. SUBSEQUENT INJURY FUND BENEFITS. (a) If a subsequent compensable injury, with the effects of a previous injury, results in a condition for which the injured employee is entitled to lifetime income benefits, the insurance carrier is liable for the payment of benefits for the subsequent injury only to the extent that the subsequent injury would have entitled the employee to benefits had the previous injury not existed.

(b) The subsequent injury fund shall compensate the employee for the remainder of the lifetime income benefits to which the employee is entitled.

SECTION 1.252. Subchapter J, Chapter 408, Labor Code, is redesignated as Chapter 408E, Labor Code, and amended to read as follows:

CHAPTER 408E. WORKERS' COMPENSATION BENEFITS:

[~~SUBCHAPTER J.~~] DEATH AND BURIAL BENEFITS

Sec. 408E.001 [~~408.181~~]. DEATH BENEFITS. (a) An insurance carrier shall pay death benefits to the legal beneficiary if a compensable injury to the employee results in death.

(b) Subject to Section 408.061, the amount of a death benefit is equal to 75 percent of the employee's average weekly wage.

(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.

Sec. 408E.002 [~~408.182~~]. DISTRIBUTION OF DEATH BENEFITS. (a) In this section:

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

(A) is a minor;

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

(C) is 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 preceding the death without good cause, as determined by the department.

(b) If there is an eligible child or grandchild and an eligible spouse, half of the death benefits shall be paid to the eligible spouse and half shall be paid in equal shares to the eligible children. If an eligible child has predeceased the employee, death benefits that would have been paid to that child shall be paid in equal shares per stirpes to the children of the deceased child.

(c) [~~(b)~~] If there is an eligible spouse and no eligible child or grandchild, all the death benefits shall be paid to the eligible spouse.

(d) [~~(c)~~] If there is an eligible child or grandchild and no eligible spouse, the death benefits shall be paid to the eligible children or grandchildren.

(e) [~~(d)~~] If there is no eligible spouse, no eligible child, and no eligible grandchild, the death benefits shall be paid in equal shares to surviving dependents of the deceased employee who are parents, stepparents, siblings, or grandparents of the deceased.

(f) [~~(e)~~] If an employee is not survived by legal beneficiaries, the death benefits shall be paid to the subsequent injury fund under Section 403.007.

[~~(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 commission.~~]

Sec. 408E.003 [~~408.183~~]. DURATION OF DEATH BENEFITS. (a) Entitlement to death benefits begins on the day after the date of an employee's death.

(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.

(c) A child who is eligible for death benefits because the child is a minor on the date of the employee's death is entitled to receive benefits until the child attains the age of 18.

(d) A child eligible for death benefits under Subsection (c) who at age 18 is enrolled as a full-time student in an accredited educational institution or a child who is eligible for death benefits because on the date of the employee's death the child is enrolled as a full-time student in an accredited educational institution is entitled to receive or to continue to receive, as appropriate, benefits until the earliest of:

(1) the date the child ceases, for a second consecutive semester, to be enrolled as a full-time student in an accredited educational institution;

(2) the date the child attains the age of 25; or

(3) the date the child dies.

(e) A child who is eligible for death benefits because the child is a dependent of the deceased employee on the date of the employee's death is entitled to receive benefits until the earlier of:

(1) the date the child dies; or

(2) if the child is dependent:

(A) because the child is an individual with a physical or mental disability, the date the child no longer has the disability; or

(B) because of a reason other than a physical or mental disability, the date of the expiration of 364 weeks of death benefit payments.

(f) An eligible grandchild is entitled to receive death benefits until the earlier of:

(1) the date the grandchild dies; or

(2) if the grandchild is:

(A) a minor at the time of the employee's death, the date the grandchild ceases to be a minor; or

(B) not a minor at the time of the employee's death, the date of the expiration of 364 weeks of death benefit payments.

(g) Any other person entitled to death benefits is entitled to receive death benefits until the earlier of:

(1) the date the person dies; or

(2) the date of the expiration of 364 weeks of death benefit payments.

(h) Section 401.011(16) does not apply to the use of the term "disability" in this section.

Sec. 408E.004 [~~408.184~~]. REDISTRIBUTION OF DEATH BENEFITS. (a) If a legal beneficiary dies or otherwise becomes ineligible for death benefits, benefits shall be redistributed to the remaining legal beneficiaries as provided by Sections 408E.002 [~~408.182~~] and

408E.003 [~~408.183~~].

(b) If a spouse ceases to be eligible because of remarriage, the benefits payable to the remaining legal beneficiaries remain constant for 104 weeks. After the 104th week, the spouse's share of benefits shall be redistributed as provided by Sections 408E.002 [~~408.182~~] and 408E.003 [~~408.183~~].

(c) If all legal beneficiaries, other than the subsequent injury fund, cease to be eligible and the insurance carrier has not made 364 weeks of full death benefit payments, including the remarriage payment, the insurance carrier shall pay to the subsequent injury fund an amount computed by subtracting the total amount paid from the amount that would be paid for 364 weeks of death benefits.

Sec. 408E.005 [~~408.185~~]. EFFECT OF BENEFICIARY DISPUTE; ATTORNEY'S FEES. On settlement of a case in which the insurance carrier admits liability for death benefits but a dispute exists as to the proper beneficiary or beneficiaries, the settlement shall be paid in periodic payments as provided by law, with a reasonable attorney's fee not to exceed 25 percent of the settlement, paid periodically, and based on time and expenses.

Sec. 408E.006 [~~408.186~~]. BURIAL BENEFITS. (a) If the death of an employee results from a compensable injury, the insurance carrier shall pay to the person who incurred liability for the costs of burial the lesser of:

(1) the actual costs incurred for reasonable burial expenses; or

(2) $6,000.

(b) If the employee died away from the employee's usual place of employment, the insurance carrier shall pay the reasonable cost of transporting the body, not to exceed the cost of transporting the body to the employee's usual place of employment.

Sec. 408E.007 [~~408.187~~]. AUTOPSY. (a) If in a claim for death benefits based on an occupational disease an autopsy is necessary to determine the cause of death, the department [~~commission~~] may, after opportunity for hearing, order the legal beneficiaries of a deceased employee to permit an autopsy.

(b) A legal beneficiary is entitled to have a representative present at an autopsy ordered under this section.

(c) The department [~~commission~~] shall require the insurance carrier to pay the costs of a procedure ordered under this section.

PART 12. AMENDMENTS TO CHAPTER 409, LABOR CODE

SECTION 1.301. 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 department [~~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 1.302. 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 1.303. Section 409.004, Labor Code, is amended to read as follows:

Sec. 409.004. EFFECT OF FAILURE TO FILE CLAIM FOR COMPENSATION. Failure to file a claim for compensation with the 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 1.304. Sections 409.005(d)-(f) and (h)-(k), 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 department [~~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.

SECTION 1.305. Sections 409.006(b) and (c), 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.

SECTION 1.306. Section 409.007(a), 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 1.307. 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 1.308. 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:

(A) the department; and

(B) the office of injured employee counsel [~~commission~~], including the services of the ombudsman program;

(2) the department's [~~commission's~~] procedures under this subtitle; and

(3) the person's rights and responsibilities under this subtitle.

SECTION 1.309. Sections 409.011(a) and (c), 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 and the office of injured employee counsel [~~commission~~];

(2) the department's [~~commission's~~] procedures under this subtitle; 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 1.310. Section 409.012, Labor Code, is amended to read as follows:

Sec. 409.012. SKILLED CASE MANAGEMENT; VOCATIONAL REHABILITATION [~~INFORMATION~~]. (a) The department shall require an insurance carrier to evaluate a compensable injury in which the injured employee sustains an injury that results in lost time from employment as early as is practicable to determine if skilled case management is necessary for the injured employee's case.

(b) The department [~~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 department [~~commission~~] determines that an injured employee would be assisted by vocational rehabilitation, the department [~~commission~~] shall notify:

(1) the injured employee in writing of the services and facilities available through the Department of Assistive and Rehabilitative Services [~~Texas Rehabilitation Commission~~] and private providers of vocational rehabilitation; and

(2) [~~. The commission shall notify~~] the Department of Assistive and Rehabilitative Services [~~Texas Rehabilitation Commission~~] and the affected insurance carrier that the injured employee has been identified as one who could be assisted by

vocational rehabilitation.

(c) The department [~~commission~~] shall cooperate with the office of injured employee counsel, the Department of Assistive and Rehabilitative Services, [~~Texas Rehabilitation Commission~~] and private providers of vocational rehabilitation in the provision of services and facilities to employees by the Department of Assistive and Rehabilitative Services [~~Texas Rehabilitation Commission~~].

(d) A private provider of vocational rehabilitation services may register with the 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.

SECTION 1.311. Section 409.013, Labor Code, is amended to read as follows:

Sec. 409.013. PLAIN LANGUAGE INFORMATION; NOTIFICATION OF INJURED EMPLOYEE [~~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 office of injured employee counsel or the department [~~commission~~] for public dissemination

that relates to the employee's situation, such as information relating to back injuries or occupational diseases.

SECTION 1.312. Section 409.021, Labor Code, is amended to read as follows:

Sec. 409.021. INITIATION OF BENEFITS; DUTIES OF INSURANCE CARRIER [~~CARRIER'S REFUSAL~~]; ADMINISTRATIVE VIOLATION. (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 contested case hearing [~~benefit review conference~~]; and

(B) the means to obtain additional information from the department [~~commission~~].

(b) [~~(a-1)~~] An insurance carrier that fails to comply with Subsection (a) does not waive the carrier's right to contest the compensability of the injury as provided by Subsection (e) [~~(c)~~] but commits an administrative violation subject to Subsection (g) [~~(e)~~].

(c) [~~(a-2)~~] An insurance carrier is not required to comply with Subsection (a) if the insurance carrier has accepted the claim as a compensable injury and income or death benefits have not yet

accrued but will be paid by the insurance carrier when the benefits accrue and are due.

(d) [~~(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.

(e) [~~(c)~~] If an insurance carrier does not contest the compensability of an injury on or before the 60th day after the date on which the insurance carrier is notified of the injury, the insurance carrier waives its right to contest compensability. The initiation of payments by an insurance carrier does not affect the right of the insurance carrier to continue to investigate or deny the compensability of an injury during the 60-day period.

(f) [~~(d)~~] An insurance carrier may reopen the issue of the compensability of an injury if there is a finding of evidence that could not reasonably have been discovered earlier.

(g) [~~(e)~~] An insurance carrier commits a violation if the insurance carrier does not initiate payments or file a notice of refusal as required by this section. A violation under this subsection shall be assessed at $500 if the carrier initiates compensation or files a notice of refusal within five working days of the date required by Subsection (a), $1,500 if the carrier initiates compensation or files a notice of refusal more than five and less than 16 working days of the date required by Subsection (a), $2,500 if the carrier initiates compensation or files a notice of refusal more than 15 and less than 31 working days of the date required by Subsection (a), or $5,000 if the carrier initiates

compensation or files a notice of refusal more than 30 days after the date required by Subsection (a). The administrative penalties are not cumulative.

(h) [~~(f)~~] For purposes of this section, "written notice" to a certified self-insurer occurs only on written notice to the qualified claims servicing contractor designated by the certified self-insurer under Section 407.061(c).

(i) [~~(f)~~] For purposes of this section:

(1) a certified self-insurer receives notice on the date the qualified claims servicing contractor designated by the certified self-insurer under Section 407.061(c) receives notice; and

(2) a political subdivision that self-insures under Section 504.011, either individually or through an interlocal agreement with other political subdivisions, receives notice on the date the intergovernmental risk pool or other entity responsible for administering the claim for the political subdivision receives notice.

(j) Each insurance carrier shall establish a single point of contact in the carrier's office for an injured employee for whom the carrier receives a notice of injury.

SECTION 1.313. Section 409.023(a), Labor Code, is 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.

SECTION 1.314. Section 409.0231(b), 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 1.315. 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 department [~~commission~~]. A violation under this subsection is a Class B administrative violation.

PART 13. AMENDMENTS TO CHAPTER 410, LABOR CODE

SECTION 1.351. 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 1.352. Section 410.005, Labor Code, is amended by amending Subsections (a) and (c) and adding Subsection (d) to read as follows:

(a) Unless the department [~~commission~~] determines that good cause exists for the selection of a different location, a prehearing [~~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.

(c) An injured employee who is a party to a prehearing conference may select the department field office at which the prehearing conference [~~All appeals panel proceedings~~] shall be conducted [~~in Travis County~~].

(d) Notwithstanding Subsections (a) and (c), if determined appropriate by the commissioner, the department may conduct a prehearing conference telephonically on agreement by the injured employee.

SECTION 1.353. Section 410.006(a), Labor Code, is amended to read as follows:

(a) A claimant may be represented at a prehearing [~~benefit review~~] conference, a contested case hearing, or arbitration by an attorney or may be assisted by an individual of the claimant's choice who does not work for an attorney or receive a fee. An employee of an attorney may represent a claimant if that employee:

(1) is a relative of the claimant; and

(2) does not receive a fee.

SECTION 1.354. Subchapter A, Chapter 410, Labor Code, is amended by adding Sections 410.007 and 410.008 to read as follows:

Sec. 410.007. INFORMATION LIST. (a) The department shall determine the type of information that is most useful to parties to help resolve disputes regarding income benefits. That information may include:

(1) reports regarding the compensable injury;

(2) medical information regarding the injured employee; and

(3) wage records.

(b) The department shall publish a list developed of the information under Subsection (a) in appropriate media, including the department's Internet website, to provide guidance to parties to a dispute on the type of information they should have available at a prehearing conference or a contested case hearing.

(c) At the time a prehearing conference is scheduled, the department shall provide a copy of the list under Subsection (b) to each party to the dispute.

Sec. 410.008. PRECEDENT MANUAL. (a) The commissioner by rule shall adopt a precedent manual for workers' compensation disputes to establish better and more consistent decisions at each level of the dispute resolution process. In developing the precedent manual, the commissioner shall use as a model the precedent manual developed by the Texas Workforce Commission for appealed unemployment insurance cases.

(b) The commissioner may adopt key contested case decisions and court decisions as precedent decisions.

(c) The department shall:

(1) publish the decisions adopted under Subsection (b)

in the precedent manual by subject areas; and

(2) make the precedent manual available on the department's Internet website.

(d) The department shall instruct each department employee involved in dispute resolution under this subtitle in the use of the manual and ensure that decisions at each stage of the dispute resolution process are made based on the precedents, as appropriate.

SECTION 1.355. The heading to Subchapter B, Chapter 410, Labor Code, is amended to read as follows:

SUBCHAPTER B. INITIAL DISPUTE RESOLUTION

[~~BENEFIT REVIEW CONFERENCE~~]

SECTION 1.356. Subchapter B, Chapter 410, Labor Code, is amended by adding Sections 410.051, 410.052, and 410.053 to read as follows:

Sec. 410.051. INFORMAL BENEFIT DISPUTE RESOLUTION. (a) Before filing a dispute regarding income benefits with the department, the parties to the dispute, including the claimant, employer, and insurance carrier, must demonstrate a good faith effort to resolve the dispute among themselves.

(b) The commissioner shall adopt rules that specify:

(1) the requirements for documentation of attempts under Subsection (a) to resolve the dispute, including documentation of telephone calls or written correspondence; and

(2) the standards by which an insurance carrier is required to reconsider the issue being disputed by the claimant, including:

(A) the identification of additional information or explanations necessary to resolve the dispute;

(B) the name of the insurance carrier and information as to how to contact the insurance carrier representative who has the authority to resolve income benefit disputes informally; and

(C) the timeframe and method by which the insurance carrier representative will contact the claimant to discuss a possible resolution of the dispute.

(c) If a claimant notifies an insurance carrier of an issue requiring dispute resolution under this subchapter, the carrier, not later than the fifth business day after the date of receipt of the notice, shall notify the claimant acknowledging receipt of the request for reconsideration.

(d) An insurance carrier shall acknowledge, investigate, and resolve a request for reconsideration under this section not later than the 15th calendar day after the date on which the carrier receives notice of the request for reconsideration from the claimant.

(e) A claimant may request a contested case hearing under this subchapter if the claimant has requested reconsideration and:

(1) after reconsideration, the claimant is dissatisfied with the insurance carrier's proposed resolution; or

(2) the claimant has not received the insurance carrier's response to the request for reconsideration by the 15th calendar day after the date the insurance carrier received notice of the request for reconsideration.

(f) Failure to comply with the requirements of this section and rules adopted by the commissioner may result, after notice and hearing, in the determination of an administrative violation and imposition of sanctions and administrative penalties as provided by Chapters 82 and 84, Insurance Code.

Sec. 410.052. REQUEST FOR ARBITRATION OR CONTESTED CASE HEARING. If the parties are unable to timely resolve a dispute regarding income benefits through the informal dispute resolution process required under Section 410.051, the claimant may file with the department a request for:

(1) arbitration under Subchapter C; or

(2) a contested case hearing under Subchapter D.

Sec. 410.053. PAYMENT OF BENEFITS UNDER INTERLOCUTORY ORDER. If the parties to a dispute regarding income benefits have filed a request with the department under Section 410.052, the commissioner may issue an interlocutory order for the payment of all or part of the benefits during the pendency of the dispute. The order may address accrued benefits, future benefits, or both accrued benefits and future benefits.

SECTION 1.357. 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 by rule [~~commission~~] shall establish procedures to carry out this subsection.

SECTION 1.358. 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 1.359. Section 410.104, Labor Code, is amended to read as follows:

Sec. 410.104. ELECTION OF ARBITRATION; EFFECT. (a) If issues remain unresolved after the informal dispute resolution process required under Section 410.051 [~~a benefit review conference~~], the parties, by agreement, may elect to engage in arbitration in the manner provided by this subchapter. Arbitration

may be used only to resolve disputed benefit issues and is an alternative to a contested case hearing. [~~A contested case hearing scheduled under Section 410.025(b) is canceled by an election under this subchapter.~~]

(b) To elect arbitration, the parties must file the election with the department on a form prescribed by the commissioner [~~commission~~] not later than the 20th day after the date the insurance carrier is required to resolve the complaint under Section 410.051(d) [~~last day of the benefit review conference. The 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 regarding income benefits under this subtitle arising out of the claims that are under the jurisdiction of the department [~~commission~~].

(d) An agreement to elect arbitration binds the parties to the provisions of Chapters 408-408E [~~Chapter 408~~] relating to income benefits, and any award, agreement, or settlement after arbitration is elected must comply with those chapters [~~that chapter~~].

SECTION 1.360. 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 department [~~commission~~] shall review the lists of arbitrators annually and determine if each arbitrator is fair and impartial and makes awards that are consistent with and in accordance with this subtitle and the rules of the commissioner [~~commission~~]. The commissioner [~~commission~~] shall remove an arbitrator if, after the review, the commissioner determines that the arbitrator is not fair and impartial or does not make awards consistent with this subtitle and the commissioner's rules [~~arbitrator does not receive an affirmative vote of at least two commission members representing employers of labor and at least two commission members representing wage earners~~].

(c) The 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 1.361. Section 410.106, Labor Code, is amended to read as follows:

Sec. 410.106. SELECTION OF ARBITRATOR. (a) 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.

(b) 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 1.362. Section 410.107(a), 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 1.363. Section 410.108(a), 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 1.364. 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 1.365. Section 410.110, Labor Code, is amended to read as follows:

Sec. 410.110. CONTINUANCE. (a) A request by a party for a continuance of the arbitration to another date must be directed to the department [~~director~~]. The department [~~director~~] may grant a continuance only if the department [~~director~~] determines, giving due regard to the availability of the arbitrator, that good cause for the continuance exists.

(b) If the department [~~director~~] grants a continuance under this section, the rescheduled date may not be later than the 30th day after the original date of the arbitration.

(c) Without regard to whether good cause exists, the department [~~director~~] may not grant more than one continuance to each party.

SECTION 1.366. 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 1.367. Section 410.114(b), Labor Code, is amended to read as follows:

(b) The department [~~commission~~] shall make an electronic recording of the proceeding.

SECTION 1.368. Section 410.118(d), 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 1.369. Section 410.119(b), Labor Code, is amended to read as follows:

(b) An arbitrator's award is a final order of the commissioner [~~commission~~].

SECTION 1.370. Sections 410.121(a) and (b), 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 1.371. Section 410.151, Labor Code, is amended to read as follows:

Sec. 410.151. CONTESTED CASE HEARING; PREHEARING CONFERENCE REQUIRED [~~SCOPE~~]. (a) If arbitration is not elected under Section 410.104, a party to a claim [~~for which a benefit review conference is held or a party eligible to proceed directly to a contested case hearing as provided by Section 410.024~~] is entitled to obtain a contested case hearing by filing a request with

the department in the manner prescribed by the commissioner by rule not later than the 90th day after the date the insurance carrier is required to resolve the complaint under Section 410.051(d).

(b) On receipt of a request for a contested case hearing, the department shall:

(1) direct the parties to meet in a prehearing conference to establish the disputed issues involved in the claim;

(2) schedule the prehearing conference to be held not later than the 30th day after the date of receipt of the claimant's request;

(3) schedule the contested case hearing to be held not later than the 60th day after the date of receipt of the claimant's request; and

(4) notify the office of injured employee counsel that a request for administrative resolution of the dispute has been filed with the department.

(c) The department shall send written notice of the prehearing conference and the contested case hearing to the parties to the claim.

(d) An issue that was not raised at a prehearing [~~benefit review~~] conference [~~or that was resolved at a benefit review conference~~] may not be considered at a contested case hearing under this subchapter unless:

(1) the parties consent; or

(2) [~~if the issue was not raised,~~] the department [~~commission~~] determines that good cause existed for not raising the issue at the conference.

(e) Notwithstanding Subsection (a), the department may extend the 90-day period for filing a request for a contested case hearing if the party to the claim applies for an extension in the manner prescribed by the commissioner and presents evidence satisfactory to the department of good cause for the failure to comply with the 90-day requirement.

SECTION 1.372. 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 determines [~~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 1.373. 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 410.151 [~~410.024 or 410.025(b)~~].

SECTION 1.374. 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 department [~~commission~~].

(b) The department [~~commission~~] may grant a continuance only if the department [~~commission~~] determines that there is good cause for the continuance.

SECTION 1.375. 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 1.376. Section 410.158(a), 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 1.377. 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 1.378. 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 1.379. 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 1.380. Sections 410.168(c)-(f), Labor Code, are amended to read as follows:

(c) The hearing officer may enter an interlocutory order for

the payment of all or part of medical benefits or income benefits. The order may address accrued benefits, future benefits, or both accrued benefits and future benefits. The order is binding unless a party seeks judicial review as provided by this chapter [~~during the pendency of an appeal to the appeals panel~~].

(d) On a form prescribed by rule by the commissioner [~~that the 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 shall [~~must~~] file the decisions with the department after the date the contested case hearing is concluded. The commissioner may issue an order for payment of benefits on receipt of the decision [~~division~~].

(f) The department [~~division~~] shall send a copy of the decision to each party.

SECTION 1.381. Section 410.169, Labor Code, is amended to read as follows:

Sec. 410.169. EFFECT OF DECISION. A decision of a hearing officer regarding benefits is final unless [~~in the absence of a timely appeal by~~] a party seeks judicial review as provided by this chapter [~~and is binding during the pendency of an appeal to the appeals panel~~].

SECTION 1.382. Subchapter D, Chapter 410, Labor Code, is amended by adding Sections 410.170-410.173 to read as follows:

Sec. 410.170. CLERICAL ERROR. The commissioner may revise a decision in a contested case hearing on a finding of clerical error.

Sec. 410.171. CONTINUATION OF DEPARTMENT JURISDICTION. During judicial review of a hearing officer's decision on any disputed issue relating to a workers' compensation claim, the department retains jurisdiction of all other issues related to the claim.

Sec. 410.172. 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 department under this subtitle, the department 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, final order, or decision of the department under this subtitle, 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 brings suit to enforce an interlocutory order, final order, or decision, the department 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 department under this subtitle 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 department before the 21st day after the date the order or decision becomes final. A violation under this subsection is a Class A administrative violation.

Sec. 410.173. REIMBURSEMENT FOR CERTAIN OVERPAYMENTS. The subsequent injury fund shall reimburse an insurance carrier for any overpayment 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 or a court.

SECTION 1.383. Section 410.251, Labor Code, is amended to read as follows:

Sec. 410.251. EXHAUSTION OF REMEDIES. A party that has exhausted the party's [~~its~~] administrative remedies under this subtitle and that is aggrieved by a final decision of the department [~~appeals panel~~] may seek judicial review under this subchapter and Subchapter G, if applicable.

SECTION 1.384. Section 410.252, Labor Code, is amended by amending Subsections (a) and (b) and adding Subsection (e) to read as follows:

(a) A party may seek judicial review by filing suit not later than the 40th day after the date on which the decision of the hearings officer [~~appeals panel~~] was filed with the department [~~division~~].

(b) The party bringing suit to appeal the decision must file a petition in district [~~with the appropriate~~] court in:

(1) the county where the employee resided at the time of the injury or death, if the employee is deceased; or

(2) in the case of an occupational disease, in the county where the employee resided on the date disability began or any county agreed to by the parties.

(e) A district court described by Subsection (b) has exclusive jurisdiction of a suit described by this section.

SECTION 1.385. 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 1.386. Section 410.254, Labor Code, is amended to read as follows:

Sec. 410.254. DEPARTMENT [~~COMMISSION~~] INTERVENTION. On timely motion initiated by the commissioner [~~executive director~~], the department may [~~commission shall be permitted to~~] intervene in any judicial proceeding under this subchapter or Subchapter G.

SECTION 1.387. Sections 410.256(a), (c), (d), and (f),

Labor Code, are amended to read as follows:

(a) A claim or issue may not be settled contrary to the provisions of the contested case hearing [~~an appeals panel~~] decision issued on the claim or issue unless a party to the proceeding has filed for judicial review under this subchapter or Subchapter G. The trial court must approve a settlement made by the parties after judicial review of an award is sought and before the court enters judgment.

(c) A settlement may not provide for:

(1) payment of any benefits in a lump sum except as provided by Section 408D.108 [~~408.128~~]; or

(2) limitation or termination of the claimant's right to medical benefits under Section 408A.001 [~~408.021~~].

(d) A settlement or agreement that resolves an issue of impairment may not be made before the claimant reaches maximum medical improvement and must adopt one of the impairment ratings under Subchapter C [~~G~~], Chapter 408D [~~408~~].

(f) Settlement of a claim or issue under this section does not constitute a modification or reversal of the decision awarding benefits for the purpose of Section 410.173 [~~410.209~~].

SECTION 1.388. Sections 410.257(a), (b), (c), and (e), Labor Code, are amended to read as follows:

(a) A judgment entered by a court on judicial review of a [~~an appeals panel~~] decision of a hearing officer under this subchapter or Subchapter G must comply with all appropriate provisions of the law.

(b) A judgment under this section may not provide for:

(1) payment of benefits in a lump sum except as provided by Section 408D.108 [~~408.128~~]; or

(2) the limitation or termination of the claimant's right to medical benefits under Section 408A.001 [~~408.021~~].

(c) A judgment that resolves an issue of impairment may not be entered before the date the claimant reaches maximum medical improvement. The judgment must adopt an impairment rating under Subchapter C [~~G~~], Chapter 408D [~~408~~], except to the extent Section 410.307 applies.

(e) A judgment under this section based on default or on an agreement of the parties does not constitute a modification or reversal of a decision awarding benefits for the purpose of Section 410.173 [~~410.209~~].

SECTION 1.389. 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 1.390. Sections 410.258(a)-(e), 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 department [~~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 commissioner [~~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 1.3905. Section 410.301(a), Labor Code, is amended

to read as follows:

(a) Judicial review [~~of a final decision of a 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 1.391. Section 410.302, Labor Code, is amended to read as follows:

Sec. 410.302. ADMISSIBILITY OF RECORDS; LIMITATION OF ISSUES. (a) The records of a prehearing conference or contested case hearing conducted under this chapter are admissible in a trial under this subchapter.

(b) A trial under this subchapter is limited to issues decided by the hearing officer at the contested case hearing [~~commission appeals panel~~] and on which judicial review is sought. The pleadings must specifically set forth the determinations of the hearing officer [~~appeals panel~~] by which the party is aggrieved.

SECTION 1.392. 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 hearing officer's [~~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 hearing officer [~~commission~~

~~appeals panel~~].

SECTION 1.393. Sections 410.306(b) and (c), 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 C [~~C~~], Chapter 408D [~~408~~].

SECTION 1.394. Sections 410.307(a) and (d), 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 commission~~] under Section 408C.103 [~~408.123~~].

SECTION 1.395. Section 410.308(a), 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 1.396. The following laws are repealed:

(1) Section 410.001, Labor Code;

(2) Section 410.004, Labor Code;

(3) Sections 410.021-410.034, Labor Code; and

(4) Subchapter E, Chapter 410, Labor Code.

PART 14. AMENDMENTS TO CHAPTER 411, LABOR CODE

SECTION 1.401. Section 411.003(a), Labor Code, is amended to read as follows:

(a) An insurance company, the agent, servant, or employee of the insurance company, or a safety consultant who performs a safety consultation under this chapter [~~Subchapter D or E~~] has no liability for an accident, injury, or occupational disease based on an allegation that the accident, injury, or occupational disease was caused or could have been prevented by a program, inspection, or

other activity or service undertaken by the insurance company for the prevention of accidents in connection with operations of the employer.

SECTION 1.402. Section 411.011, Labor Code, is amended to read as follows:

Sec. 411.011. COORDINATION AND ENFORCEMENT OF STATE LAWS AND RULES. The department [~~division~~] shall coordinate and enforce the implementation of state laws and rules relating to workers' health and safety issues.

SECTION 1.403. Section 411.012, Labor Code, is amended to read as follows:

Sec. 411.012. COLLECTION AND ANALYSIS OF INFORMATION. (a) The department [~~division~~] shall collect and serve as a repository for statistical information on workers' health and safety. The department [~~division~~] shall analyze and use that information to:

(1) identify and assign priorities to safety needs; and

(2) better coordinate the safety services provided by public or private organizations, including insurance carriers.

(b) The department [~~division~~] shall coordinate or supervise the collection by state or federal entities of information relating to job safety, including information collected for the supplementary data system and the annual survey of the Bureau of Labor Statistics of the United States Department of Labor.

SECTION 1.404. Section 411.013, Labor Code, is amended to read as follows:

Sec. 411.013. FEDERAL CONTRACTS AND PROGRAMS. The

department [~~With the approval of the commission, the division~~] may:

(1) enter into contracts with the federal government to perform occupational safety projects; and

(2) apply for federal funds through any federal program relating to occupational safety.

SECTION 1.405. Section 411.014, Labor Code, is amended to read as follows:

Sec. 411.014. EDUCATIONAL PROGRAMS; COOPERATION WITH OTHER ENTITIES. (a) The department [~~division~~] shall promote workers' health and safety through educational and other innovative programs developed by the department or other state agencies [~~division~~].

(b) The department [~~division~~] shall cooperate with other entities in the development and approval of safety courses, safety plans, and safety programs.

(c) The department [~~division~~] shall cooperate with business and industry trade associations, labor organizations, and other entities to develop means and methods of educating employees and employers concerning workplace safety.

SECTION 1.406. Sections 411.015(a), (d), and (e), Labor Code, are amended to read as follows:

(a) The department [~~division~~] shall publish or procure and issue educational books, pamphlets, brochures, films, videotapes, and other informational and educational material.

(d) The department [~~division~~] shall make specific decisions regarding the issues and problems to be addressed by the educational materials after assigning appropriate priorities based on frequency of injuries, degree of hazard, severity of injuries,

and similar considerations.

(e) The educational materials provided under this section must include specific references to:

(1) the requirements of state and federal laws and regulations;

(2) recommendations and practices of business, industry, and trade associations; and

(3) if needed, recommended work practices based on recommendations made by the department [~~division~~] for the prevention of injury.

SECTION 1.407. Section 411.016, Labor Code, is amended to read as follows:

Sec. 411.016. PEER REVIEW SAFETY PROGRAM. The department [~~division~~] shall certify safe employers to provide peer review safety programs.

SECTION 1.408. Section 411.017, Labor Code, is amended to read as follows:

Sec. 411.017. ADVISORY SERVICE TO INSURANCE CARRIERS. The department [~~division~~] shall advise insurance carrier loss control service organizations of safety needs and priorities developed by the department [~~division~~] and of:

(1) hazard classifications, specific employers, industries, occupations, or geographic regions to which loss control services should be directed; or

(2) the identity and types of injuries or occupational diseases and means and methods for prevention of those injuries or diseases to which loss control services should be directed.

SECTION 1.409. Section 411.018, Labor Code, is amended to read as follows:

Sec. 411.018. FEDERAL OSHA COMPLIANCE. In accordance with Section 7(c), Occupational Safety and Health Act of 1970 (29 U.S.C. Section 656), the department [~~division~~] shall:

(1) consult with employers regarding compliance with federal occupational safety laws and rules; and

(2) collect information relating to occupational safety as required by federal laws, rules, or agreements.

SECTION 1.410. Section 411.031, Labor Code, is amended to read as follows:

Sec. 411.031. JOB SAFETY INFORMATION SYSTEM; COOPERATION WITH OTHER AGENCIES. (a) The department [~~division~~] shall maintain a job safety information system.

(b) The department [~~division~~] shall obtain from any appropriate state agency, including the Texas Workforce Commission [~~Department of Insurance~~], the [~~Texas~~] Department of State Health Services, and the Department of Assistive and Rehabilitative Services [~~Texas Employment Commission~~], data and statistics, including data and statistics compiled for rate-making purposes.

(c) The department [~~division~~] shall consult with the Texas Workforce [~~Department of Insurance and the Texas Employment~~] Commission in the design of data information and retrieval systems to accomplish the mutual purposes of the department [~~those agencies~~] and [~~of~~] the commission [~~division~~].

SECTION 1.411. 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 1.412. Section 411.064, Labor Code, is amended to read as follows:

Sec. 411.064. INSPECTIONS. (a) The department, in conjunction with the audits conducted under Section 402.166(g), may [~~division shall~~] conduct inspections [~~an inspection at least every two years~~] to determine the adequacy of the accident prevention services required by Section 411.061 for each insurance company writing workers' compensation insurance in this state.

(b) If, after an inspection under Subsection (a), an insurance company's accident prevention services are determined to be inadequate, the department [~~division~~] shall reinspect the accident prevention services of the insurance company not earlier than the 180th day or later than the 270th day after the date the accident prevention services were determined by the department [~~division~~] to be inadequate.

(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 1.413. Section 411.065, Labor Code, is amended to read as follows:

Sec. 411.065. ANNUAL INFORMATION SUBMITTED BY INSURANCE COMPANY. (a) Each insurance company writing workers' compensation insurance in this state shall submit to the department [~~division~~] at least once a year detailed information on the type of accident prevention facilities offered to that insurance company's policyholders.

(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;

(3) [~~(4)~~] accident prevention services for which the insurance company contracts;

(4) [~~(5)~~] a breakdown of the premium size of the risks to which services were provided;

(5) [~~(6)~~] evidence of the effectiveness of and accomplishments in accident prevention; and

(6) [~~(7)~~] any additional information required by the department [~~commission~~].

SECTION 1.414. Section 411.067, Labor Code, is amended to read as follows:

Sec. 411.067. DEPARTMENT [~~COMMISSION~~] PERSONNEL. [~~(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.

[~~(b) A safety inspector must have the qualifications required for a field safety representative by Section 411.062.~~]

SECTION 1.415. Section 411.081(a), Labor Code, is amended to read as follows:

(a) The department [~~division~~] shall maintain a 24-hour toll-free telephone service for reports of violations of occupational health or safety law.

SECTION 1.416. Section 411.104, Labor Code, is amended to read as follows:

Sec. 411.104. ADMINISTRATION BY DEPARTMENT. [~~DIVISION DUTIES. (a)~~] The department [~~division~~] shall administer this subchapter.

[~~(b) In addition to the duties specified in this chapter, the division shall perform other duties as required by the commission.~~]

SECTION 1.417. The following laws are repealed:

(1) Section 411.001(1), Labor Code;

(2) Subchapters D and G, Chapter 411, Labor Code;

(3) Section 411.062, Labor Code;

(4) Section 411.063(b), Labor Code; and

(5) Section 411.102(1), Labor Code.

PART 15. AMENDMENTS TO CHAPTER 412, LABOR CODE

SECTION 1.451. Sections 412.041(g), (i), and (l), 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 commission;~~

[~~(2)~~] the commissioner [~~of the Texas Department of Insurance~~]; and

(2) [~~(3)~~] the administrative heads of all state agencies affected by this chapter and Chapter 501.

PART 16. AMENDMENTS TO CHAPTER 413, LABOR CODE

SECTION 1.501. The heading to Subchapter A, Chapter 413, Labor Code, is amended to read as follows:

SUBCHAPTER A. GENERAL PROVISIONS [~~DIVISION OF MEDICAL REVIEW~~]

SECTION 1.502. Section 413.001, Labor Code, is amended to read as follows:

Sec. 413.001. APPLICABILITY. This chapter applies to the provision of health care services by insurance carriers who use provider networks and to insurance carriers who do not use provider networks. [~~DEFINITION. In this chapter, "division" means the division of medical review of the commission.~~]

SECTION 1.503. Section 413.002, Labor Code, is amended to read as follows:

Sec. 413.002. [~~DIVISION OF~~] MEDICAL REVIEW. (a) [~~The commission shall maintain a division of medical review to ensure compliance with the rules and to implement this chapter under the~~

~~policies adopted by the commission.~~

[~~(b)~~] The department [~~division~~] shall monitor health care providers, insurance carriers, and workers' compensation claimants who receive medical services to ensure the compliance of those persons with rules adopted by the commissioner [~~commission~~] relating to health care, including medical policies and fee guidelines.

(b) [~~(c)~~] In monitoring health care providers who serve as designated doctors under this subtitle [~~Chapter 408~~], the department [~~division~~] shall evaluate the compliance of those providers with this subtitle and with rules adopted by the commissioner [~~commission~~] relating to medical policies, fee guidelines, and impairment ratings.

(c) The department may monitor independent review organizations to ensure the compliance of those organizations with rules adopted by the commissioner. In monitoring independent review organizations who provide services described by this chapter, the department shall evaluate:

(1) the compliance of those organizations with this subtitle and with rules adopted by the commissioner relating to medical policies, fee guidelines, and impairment ratings; and

(2) the quality and timeliness of decisions made under Section 408.0041, 408D.102, or 413.031.

SECTION 1.504. Section 413.003, Labor Code, is amended to read as follows:

Sec. 413.003. AUTHORITY TO CONTRACT. The commissioner [~~commission~~] may contract with a private or public entity to

perform a duty or function of the department under this chapter [~~division~~].

SECTION 1.505. Section 413.004, Labor Code, is amended to read as follows:

Sec. 413.004. COORDINATION WITH PROVIDERS. The department [~~division~~] shall coordinate the department's [~~its~~] activities with health care providers as necessary to perform the department's [~~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 1.506. Section 413.007, Labor Code, is amended to read as follows:

Sec. 413.007. INFORMATION MAINTAINED BY DEPARTMENT [~~DIVISION~~]. (a) The department [~~division~~] shall maintain a statewide data base of medical charges, actual payments, and treatment protocols that may be used by:

(1) the commissioner [~~commission~~] in adopting [~~the~~] medical policies and fee guidelines; and

(2) the department [~~division~~] in administering [~~the~~] medical policies, fee guidelines, or rules.

(b) The department [~~division~~] shall ensure that the data base:

(1) contains information necessary to detect practices and patterns in medical charges, actual payments, and treatment protocols; and

(2) may [~~can~~] be used in a meaningful way to allow the [~~commission to~~] control of medical costs as provided by this subtitle.

(c) The department [~~division~~] shall ensure that the data base is available for public access for a reasonable fee established by the department [~~commission~~]. The identities of injured employees [~~workers~~] and beneficiaries may not be disclosed.

(d) The department [~~division~~] shall take appropriate action to be aware of and to maintain the most current information on developments in the treatment and cure of injuries and diseases common in workers' compensation cases.

SECTION 1.507. Sections 413.008(a) and (b), Labor Code, are amended to read as follows:

(a) On request from the department [~~commission~~] for specific information, an insurance carrier shall provide to the department [~~division~~] any information in the carrier's [~~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 maintain the confidentiality of information received under this section [~~keep confidential information~~] that is confidential by law.

SECTION 1.508. Section 413.011, Labor Code, is amended to

read as follows:

Sec. 413.011. REIMBURSEMENT POLICIES FOR NON-NETWORK HEALTH CARE; FEE [~~AND~~] GUIDELINES; MEDICAL POLICIES; TREATMENT GUIDELINES AND PROTOCOLS. (a) The commissioner [~~commission~~] shall adopt [~~use~~] health care reimbursement policies and fee guidelines for health care that is not provided through a provider network under Chapter 408B that reflect the standardized reimbursement structures found in other health care delivery systems, with minimal modifications to those reimbursement methodologies as necessary to meet occupational injury requirements. To achieve standardization, the commissioner may [~~commission shall~~] adopt the most current reimbursement methodologies, models, and values or weights used by the federal Centers for Medicare & 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 department [~~commission~~] shall also provide for reasonable fees for the evaluation and management of care as required by Section 408C.005(b) [~~408.025(c)~~] and commissioner [~~commission~~] rules. This section does not adopt the Medicare fee schedule, and the commissioner [~~commission~~] shall not adopt conversion factors or other payment adjustment factors based solely on those factors as

developed by the federal Centers for Medicare & 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) Fee guidelines [~~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 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 one or more sets of treatment guidelines, including return-to-work guidelines, and individual treatment protocols, including protocols for pharmacy benefits. Except as otherwise provided by this subsection, the treatment guidelines and protocols must be nationally recognized, scientifically valid, and 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 commissioner [~~commission~~], the commissioner [~~commission~~] may adopt another treatment guideline or protocol as long as it is scientifically valid and outcome-based.

(f) The commissioner [~~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.

SECTION 1.509. Section 413.013, Labor Code, is amended to read as follows:

Sec. 413.013. PROGRAMS. The commissioner [~~commission~~] by rule shall establish:

(1) for health care that is not provided through a provider network under Chapter 408B:

(A) a program for prospective, concurrent, and retrospective review and resolution of a dispute regarding health care treatments and services; and

(B) [~~(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 commissioner [~~commission~~] to ensure that the medical policies or guidelines are not exceeded;

(2) [~~(3)~~] a program to detect practices and patterns by insurance carriers, including carriers who use provider networks, in unreasonably denying authorization of payment for medical services requested or performed if authorization is required by the medical policies of the commissioner [~~commission~~]; and

(3) [~~(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 1.510. Section 413.014, Labor Code, is amended by amending Subsections (b)-(e) and adding Subsection (f) to read as follows:

(b) The commissioner [~~commission~~] by rule shall specify which health care treatments and services provided by an insurance carrier who does not use a provider network under Chapter 408B 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 [~~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 408A.010 [~~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 department [~~commission~~].

(e) If a specified health care treatment or service is preauthorized as provided by this section, that treatment or service is not subject to retrospective review of the medical necessity of the treatment or service.

(f) The department [~~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 1.511. Section 413.0141, Labor Code, is amended to read as follows:

Sec. 413.0141. INITIAL PHARMACEUTICAL COVERAGE. (a) The commissioner [~~commission may~~] by rule shall provide that an insurance carrier, including a carrier who provides health care services through a provider network, 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~~].

(b) The commissioner rules must [~~adopted by the 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 1.512. Sections 413.015(a) and (b), Labor Code, are amended to read as follows:

(a) Insurance carriers who do not provide health care services through a provider network under Chapter 408B shall make appropriate payment of charges for medical services provided under this subtitle. An insurance carrier may contract with a separate entity to forward payments for medical services. Any payment due

the insurance carrier from the separate entity must be made in accordance with the contract. The separate entity is subject to the direction of the insurance carrier, and the insurance carrier is responsible for the actions of the separate entity under this subsection. An insurance carrier who provides health care services through a provider network under Chapter 408B is subject to the provisions of that chapter.

(b) The commissioner [~~commission~~] shall provide by rule for the review and audit of the payment by insurance carriers subject to this section 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 1.513. 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 commissioner [~~commission~~] and that are authorized by an insurance carrier.

SECTION 1.514. Section 413.018, Labor Code, is amended to read as follows:

Sec. 413.018. REVIEW OF MEDICAL CARE; RETURN TO WORK

PROGRAMS [~~IF GUIDELINES EXCEEDED~~]. (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.

(b) The commissioner [~~division~~] shall review the medical treatment provided in a claim that exceeds the guidelines and may take appropriate action to ensure that necessary and reasonable care is provided.

(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 commissioner [~~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.

(e) 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 commissioner [~~commission~~] to be a bona fide job offer is subject to Section 408D.053(e) [~~408.103(e)~~].

(f) [~~(e)~~] The commissioner [~~commission~~] may adopt rules and forms as necessary to implement this section.

SECTION 1.515. 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 1.516. Subchapter C, Chapter 413, Labor Code, is amended to read as follows:

SUBCHAPTER C. DISPUTE RESOLUTION REGARDING MEDICAL BENEFITS

Sec. 413.031. MEDICAL DISPUTE: RIGHT TO REVIEW [~~RESOLUTION~~]. (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.

Sec. 413.032. INFORMAL DISPUTE RESOLUTION AT CARRIER. (a) Before bringing a dispute regarding medical benefits to the department, the parties to the dispute must try to resolve the dispute among themselves through an informal process conducted by the insurance carrier.

(b) If a claimant notifies an insurance carrier of a complaint requiring dispute resolution under this subchapter, the carrier, not later than the fifth business day after the date of receiving the notice, shall send to the claimant a letter acknowledging receipt of the complaint.

(c) An insurance carrier shall acknowledge, investigate, and resolve a complaint under this section not later than the 30th calendar day after the date the carrier receives a written statement of the complaint from the claimant.

(d) The commissioner shall adopt rules that specify the requirements for documentation of the initial attempt under Subsection (a) to resolve the dispute, including documentation of telephone calls or written correspondence.

Sec. 413.033. FEE DISPUTES. [~~(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 employee [~~worker~~].

Sec. 413.034. REVIEW BY INDEPENDENT REVIEW ORGANIZATION. (a) If the parties are unable to resolve a dispute regarding medical benefits through the informal dispute resolution process required under Section 413.032, either party may file with the department a request for review by an independent review organization certified under Article 21.58C, Insurance Code.

(b) An [~~(d) A review of the medical necessity of a health care service requiring preauthorization under Section 413.014 or commission rules under that section shall be conducted by an~~] independent review organization shall conduct a review of the medical necessity of a health care service:

(1) requiring preauthorization under Section 413.014 or commissioner rules under that section; or

(2) provided under this chapter or Chapter 408 or 408A.

(c) An independent review organization shall conduct a review under this section [~~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.

(d) In performing a review of medical necessity, the independent review organization shall consider the department's health care reimbursement policies adopted under Section 413.011 if those policies are raised by one of the parties to the dispute. If the independent review organization's decision is contrary to the department's policies 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.

(e) In performing a review of medical necessity, an independent review organization may request that the department order an examination by a designated doctor.

Sec. 413.035. INDEPENDENT REVIEW ORGANIZATION DECISION; APPEAL. (a) An independent review organization that conducts a

review under this subchapter shall specify the elements on which the decision of the organization is based. At a minimum, the decision must include:

(1) a list of all medical records and other documents reviewed by the organization;

(2) a description and the source of the screening criteria or clinical basis used in making the decision;

(3) an analysis of and explanation for the decision, including the findings and conclusions used to support the decision; and

(4) a description of the qualifications of each physician or other health care provider who reviews the decision.

(b) The independent review organization shall certify that each physician or other health care provider who reviews the decision certifies that no known conflicts of interest exist between that provider and the injured employee, the injured employee's employer, and any of the treating doctors or insurance carrier health care providers who reviewed the case for decision before referral to the independent review organization.

(c) Either party may appeal the decision of the independent review organization to district court for judicial review. Judicial review under this section shall be conducted in the manner provided for judicial review of contested cases under Subchapter G, Chapter 2001, Government Code.

Sec. 413.036. ALTERNATIVE PROCESS. [~~(e) Except as provided by Subsections (d), (f), and (m), a review of the medical necessity of a health care service provided under this chapter or~~

~~Chapter 408 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 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 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 may prescribe an alternative [~~shall specify the appropriate~~] dispute resolution process for disputes:

(1) in which a claimant has paid for medical services and seeks reimbursement; or

(2) 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.

Sec. 413.037. PAYMENT OF COSTS. (a) [~~(g) In performing a review of medical necessity under Subsection (d) or (e), an independent review organization may request that the commission order an examination by a designated doctor under Chapter 408.~~]

[~~(h)~~] The insurance carrier shall pay the cost of [~~the~~] review by an independent review organization if the dispute arises in connection with a request for health care services:

(1) provided through a provider network; or

(2) that require preauthorization under Section 413.014 or commissioner [~~commission~~] rules under that section.

(b) [~~(i)~~] Except as provided by Subsection (a) [~~(h)~~], the cost of the review shall be paid by the nonprevailing party.

(c) [~~(j)~~] Notwithstanding Subsections (a) and (b) [~~(h) and (i)~~], an employee may not be required to pay any portion of the cost of a review.

(d) The cost of a review under an alternative dispute resolution process under Section 413.036 shall be paid by the nonprevailing party.

[~~(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. 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.~~

[~~(l) A party to a medical dispute regarding spinal surgery that remains unresolved after a review by an independent review organization as provided by Subsections (d) and (e) is entitled to dispute resolution as provided by Chapter 410.~~

[~~(m) The 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 1.517. Sections 413.041(a), (b), and (d), 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 1.518. Section 413.042(a), Labor Code, is amended to read as follows:

(a) A health care provider may not pursue a private claim against a workers' compensation claimant for all or part of the cost of a health care service provided to the claimant by the provider unless:

(1) the injury is finally adjudicated not compensable under this subtitle; or

(2) the employee violates Section 408C.002 [~~408.022~~] relating to the selection of a doctor and the doctor did not know of the violation at the time the services were rendered.

SECTION 1.519. Section 413.044, Labor Code, is amended to read as follows:

Sec. 413.044. SANCTIONS ON DESIGNATED DOCTOR. In addition to or in lieu of an administrative penalty under Section 415.021 or a sanction imposed under Section 415.023, the department [~~commission~~] may impose sanctions against a person who serves as a designated doctor under this subtitle, including a designated doctor who serves under a provider network, [~~Chapter 408~~] who, after an evaluation conducted under Section 413.002(b)

[~~413.002(c)~~], is determined by the department [~~division~~] to be out of compliance with this subtitle or with rules adopted by the commissioner [~~commission~~] relating to medical policies, fee guidelines, and impairment ratings.

SECTION 1.520. The heading to Subchapter E, Chapter 413, Labor Code, is amended to read as follows:

SUBCHAPTER E. IMPLEMENTATION OF DEPARTMENT [~~COMMISSION~~]
POWERS AND DUTIES

SECTION 1.521. Section 413.051, Labor Code, is amended to read as follows:

Sec. 413.051. CONTRACTS WITH REVIEW ORGANIZATIONS AND HEALTH CARE PROVIDERS. (a) In this section, "health care provider professional review organization" includes an independent review organization.

(b) The 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.

(c) [~~(b)~~] For purposes of review or resolution of a dispute with an insurance carrier that does not use a provider network under Chapter 408B, 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.

(d) [~~(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.

(e) [~~(d)~~] The commissioner [~~commission~~] shall establish standards for contracts under this section.

[~~(e) For purposes of this section, "health care provider professional review organization" includes an independent review organization.~~]

SECTION 1.522. 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 physician [~~doctor as that term is defined by Section 401.011~~].

(b) The medical advisor shall make recommendations regarding the adoption of rules 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 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 commission on the list of approved doctors~~]; and

(6) [~~(7)~~] determine minimal modifications to the reimbursement methodology and model used by the Medicare system as necessary to meet occupational injury requirements.

SECTION 1.523. Sections 413.0512(a), (c), and (d), Labor Code, are amended to read as follows:

(a) The commissioner, with the advice of the medical advisor, shall establish a medical quality review panel of health care providers to assist the medical advisor in performing the duties required under Section 413.0511. The panel is [~~independent of the medical advisory committee created under Section 413.005 and~~

~~is~~] not subject to Chapter 2110, Government Code.

(c) The medical quality review panel shall recommend to the medical advisor:

(1) appropriate action regarding doctors, other health care providers, insurance carriers, [~~and~~] utilization review agents, independent review organizations, and provider networks; 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 408D.102 [~~408.122~~].

(d) A person who serves on the medical quality review panel is immune from suit and from civil liability for an act performed, or a recommendation made, within the scope of the person's functions as a member of the panel if the person acts without malice and in the reasonable belief that the action or recommendation is warranted by the facts known to that person. In the event of a civil action brought against a member of the panel that arises from the person's participation on the panel, the person is entitled to the same protections afforded the commissioner or a department employee [~~commission member~~] under Section 34.001, Insurance Code [~~402.010~~].

SECTION 1.524. 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 402.211

[~~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 1.525. 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 402.211 [~~402.092~~] and 413.0513.

(d) The department [~~commission~~] and the Texas Board of Chiropractic Examiners, on request or on either agency's [~~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 from the department 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 1.526. 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 1.527. Section 413.052, Labor Code, is amended to read as follows:

Sec. 413.052. PRODUCTION OF DOCUMENTS; SUBPOENA. The commissioner [~~commission~~] by rule shall establish procedures to enable the department [~~commission~~] to compel the production of documents under this subtitle. The commissioner shall exercise subpoena powers under this section in the manner provided by Subchapter C, Chapter 36, Insurance Code.

SECTION 1.528. 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 1.529. Section 413.054(a), 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 or a department employee [~~commission member~~] under Section 34.001, Insurance Code [~~402.010~~].

SECTION 1.530. Sections 413.055(a) and (b), Labor Code, are amended to read as follows:

(a) The commissioner [~~executive director, as provided by 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 1.531. The following laws are repealed:

(1) Section 413.005, Labor Code;

(2) Section 413.006, Labor Code; and

(3) Section 413.016, Labor Code.

PART 17. AMENDMENTS TO CHAPTER 414, LABOR CODE

SECTION 1.551. The heading to Chapter 414, Labor Code, is amended to read as follows:

CHAPTER 414. ENFORCEMENT [~~DIVISION~~] OF COMPLIANCE AND PRACTICE REQUIREMENTS [~~PRACTICES~~]

SECTION 1.552. Section 414.002, Labor Code, is amended to

read as follows:

Sec. 414.002. MONITORING DUTIES. (a) The department [~~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 under this chapter include:

(1) persons claiming benefits under this subtitle;

(2) employers;

(3) insurance carriers; [~~and~~]

(4) attorneys and other representatives of parties;

(5) health care providers;

(6) independent review organizations; and

(7) provider networks.

(b) The department [~~division~~] shall monitor conduct described by Sections 415.001, 415.002, and 415.003 and refer persons engaging in that conduct for [~~to the division of~~] hearings.

(c) The department [~~division~~] shall monitor payments made to health care providers on behalf of workers' compensation claimants who receive medical services to ensure that the payments are made on time as required by Section 408C.006 [~~408.027~~].

SECTION 1.553. Section 414.003, Labor Code, is amended to read as follows:

Sec. 414.003. COMPILATION AND USE OF INFORMATION. (a) The department [~~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 or commissioner [~~commission~~] rules; or

(2) otherwise adversely affect the workers' compensation system of this state.

(b) The commissioner [~~commission~~] shall use the information compiled under this section to impose appropriate penalties and other sanctions under Chapters 415 and 416.

SECTION 1.554. Section 414.004, Labor Code, is amended to read as follows:

Sec. 414.004. PERFORMANCE REVIEW OF INSURANCE CARRIERS. (a) The department [~~division~~] shall review regularly the workers' compensation records of insurance carriers as required to ensure compliance with this subtitle.

(b) Each insurance carrier, the carrier's agents, and those with whom the carrier has contracted to provide, review, or monitor services under this subtitle shall:

(1) cooperate with the department [~~division~~];

(2) make available to the department [~~division~~] any records or other necessary information; and

(3) allow the department [~~division~~] access to the information at reasonable times at the person's offices.

(c) The insurance carrier, other than a governmental entity, shall pay the reasonable expenses, including travel expenses, of an auditor who audits for the department an insurance carrier's workers' compensation records at the office of the insurance carrier.

SECTION 1.555. Section 414.005, Labor Code, is amended to

read as follows:

Sec. 414.005. WORKERS' COMPENSATION INVESTIGATION UNIT; FRAUD INVESTIGATIONS. (a) The department [~~division~~] shall maintain an investigation unit to conduct investigations relating to alleged violations of this subtitle or commissioner [~~commission~~] rules adopted under this subtitle[~~, with particular emphasis on violations of Chapters 415 and 416~~].

(b) The department shall conduct investigations of fraud involving participants in the workers' compensation system. In conducting investigations under this subsection, the department may operate under the insurance fraud unit established under Chapter 701, Insurance Code.

(c) The department's duties in conducting and prosecuting fraud investigations under this section are funded through the maintenance tax assessed under Section 403.002.

SECTION 1.5551. Chapter 414, Labor Code, is amended by adding Section 414.0055 to read as follows:

Sec. 414.0055. DUTY TO REPORT; ADMINISTRATIVE VIOLATION. (a) This section applies only to a person who is:

(1) an injured employee or other claimant under this subtitle;

(2) an insurance carrier;

(3) a doctor or other health care provider who provides health care services regarding a claim for workers' compensation benefits; or

(4) an employer.

(b) A person subject to this section who determines that a

fraudulent act has been or is about to be committed by another in conjunction with a workers' compensation claim shall report the information in writing to the department not later than the 30th day after the date the person makes the determination.

(c) A person subject to this section commits a violation if the person violates Subsection (b). A violation under this subsection is a Class B administrative violation.

(d) The identity of a person who reports to the department under Subsection (b) is confidential and is not public information under Chapter 552, Government Code.

SECTION 1.556. Section 414.006, Labor Code, is amended to read as follows:

Sec. 414.006. REFERRAL TO OTHER AUTHORITIES. For further investigation or the institution of appropriate proceedings, the department [~~division~~] may refer the persons involved in a case subject to an investigation to [~~:~~

[~~(1) the division of hearings; or~~]

[~~(2)~~] other appropriate authorities, including licensing agencies, district and county attorneys, or the attorney general.

SECTION 1.557. Section 414.007, Labor Code, is amended to read as follows:

Sec. 414.007. [~~REVIEW OF REFERRALS FROM DIVISION OF~~] MEDICAL REVIEW. The department [~~division~~] shall review information [~~and referrals received from the division of medical review~~] concerning alleged violations of this subtitle regarding the provision of medical benefits 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 1.558. Section 414.001, Labor Code, is repealed.

PART 18. AMENDMENTS TO CHAPTER 415, LABOR CODE

SECTION 1.601. Section 415.001, Labor Code, is amended to read as follows:

Sec. 415.001. ADMINISTRATIVE VIOLATION BY REPRESENTATIVE OF EMPLOYEE OR LEGAL BENEFICIARY. A representative of an employee or legal beneficiary commits an administrative violation if the person wilfully or intentionally:

(1) fails without good cause to attend a dispute resolution proceeding under this subtitle [~~within the commission~~];

(2) attends a dispute resolution proceeding under this subtitle [~~within the 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 1.602. Section 415.002, Labor Code, is amended to read as follows:

Sec. 415.002. ADMINISTRATIVE VIOLATION BY [~~AN~~] INSURANCE CARRIER. (a) An insurance carrier or its representative commits an administrative violation if that person wilfully or intentionally:

(1) misrepresents a provision of this subtitle to an employee, an employer, a health care provider, or a legal beneficiary;

(2) terminates or reduces benefits without substantiating evidence that the action is reasonable and authorized by law;

(3) instructs an employer not to file a document required to be filed with the 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 under this subtitle [~~within the commission~~];

(9) attends a dispute resolution proceeding under this subtitle [~~within the 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 commissioner [~~the~~] rules [~~of the State Board of 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) 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 commission~~] and participate at the proceeding in accordance with this subtitle.

SECTION 1.603. Section 415.003, Labor Code, is amended to read as follows:

Sec. 415.003. ADMINISTRATIVE VIOLATION BY HEALTH CARE

PROVIDER. A health care provider commits an administrative violation if the person wilfully or intentionally:

(1) submits a charge for health care that was not furnished;

(2) administers improper, unreasonable, or medically unnecessary treatment or services;

(3) makes an unnecessary referral;

(4) violates the 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 1.604. Sections 415.0035(a), (b), (e), and (f), Labor Code, are amended to read as follows:

(a) An insurance carrier or its representative commits an administrative violation if that person:

(1) fails to submit to the 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 Chapter 408B or Section 413.014 or with commissioner rules adopted [~~by the commission~~] under Section 413.014.

(b) A health care provider commits an administrative violation if that person:

(1) fails or refuses to timely file required reports

or records; or

(2) fails to file with the 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 1.605. Section 415.007(a), 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 1.606. Section 415.008(e), 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 1.607. Sections 415.021(a)-(c), Labor Code, are amended to read as follows:

(a) The department [~~commission~~] may assess an

administrative penalty against a person who commits an administrative violation. Notwithstanding Subsection (c), the commissioner [~~commission~~] by rule shall adopt a schedule of specific monetary administrative penalties for specific violations under this subtitle.

(b) The department [~~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, the department [~~commission~~] shall consider:

(1) the seriousness of the violation, including the nature, circumstances, consequences, extent, and gravity of the prohibited act;

(2) the history and extent of previous administrative violations;

(3) the demonstrated good faith of the violator, including actions taken to rectify the consequences of the prohibited act;

(4) the economic benefit resulting from the prohibited act;

(5) the penalty necessary to deter future violations; and

(6) other matters that justice may require.

SECTION 1.608. Section 415.023(b), 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 department [~~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 1.609. 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 a Class A administrative violation. In determining the amount of the penalty, the department [~~commission~~] shall consider the total volume of claims handled by the insurance carrier.

SECTION 1.610. Section 415.031, Labor Code, is amended to read as follows:

Sec. 415.031. INITIATION OF ADMINISTRATIVE VIOLATION PROCEEDINGS. Any person may request the initiation of

administrative violation proceedings by filing a written allegation with the department [~~director of the division of compliance and practices~~].

SECTION 1.611. Section 415.032, Labor Code, is amended to read as follows:

Sec. 415.032. NOTICE OF POSSIBLE ADMINISTRATIVE VIOLATION; RESPONSE. (a) If investigation by the department [~~division of compliance and practices~~] indicates that an administrative violation has occurred, the department [~~division~~] shall notify the person alleged to have committed the violation in writing of:

(1) the charge;

(2) the proposed penalty;

(3) the right to consent to the charge and the penalty; and

(4) the right to request a hearing.

(b) Not later than the 20th day after the date on which notice is received, the charged party shall:

(1) remit the amount of the penalty to the department [~~commission~~]; or

(2) submit to the department [~~commission~~] a written request for a hearing.

SECTION 1.612. 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 1.613. Section 415.034(a), 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 1.614. Sections 415.035(b) and (d), 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 department [~~executive director~~] for deposit in an escrow account; or

(2) post with the department [~~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 department [~~executive director~~] shall:

(1) remit the appropriate amount, plus accrued interest, if the administrative penalty was paid; or

(2) release the bond.

PART 19. AMENDMENT TO CHAPTER 416, LABOR CODE

SECTION 1.651. 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.

PART 20. AMENDMENTS TO CHAPTER 417, LABOR CODE

SECTION 1.701. Sections 417.001(c) and (d), 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 1.702. Section 417.003(b), 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.

PART 21. ADOPTION OF CHAPTER 419, LABOR CODE

SECTION 1.751. Subtitle A, Title 5, Labor Code, is amended by adding Chapter 419 to read as follows:

CHAPTER 419. MISUSE OF DEPARTMENT NAME

Sec. 419.001. DEFINITIONS. (a) In this chapter:

(1) "Representation of the department's logo" includes a nonexact representation that is deceptively similar to the logo used by the department.

(2) "Representation of the state seal" has the meaning assigned by Section 17.08(a)(2), Business & Commerce Code.

(b) A term or representation is "deceptively similar" for purposes of this chapter if:

(1) a reasonable person would believe that the term or representation is in any manner approved, endorsed, sponsored, authorized by, the same as, or associated with the department, this state, or an agency of this state; or

(2) the circumstances under which the term is used could mislead a reasonable person as to its identity.

Sec. 419.002. MISUSE OF DEPARTMENT'S NAME OR SYMBOLS PROHIBITED IN RELATION TO WORKERS' COMPENSATION DUTIES OF DEPARTMENT. (a) Except as authorized by law, a person, in

connection with any impersonation, advertisement, solicitation, business name, business activity, document, product, or service made or offered by the person regarding workers' compensation coverage or benefits, may not knowingly use or cause to be used:

(1) the words "Texas Department of Insurance," "Department of Insurance," or "Texas Workers' Compensation";

(2) any term using both "Texas" and "Workers' Compensation" or any term using both "Texas" and "Workers' Comp";

(3) the initials "T.D.I."; or

(4) any combination or variation of the words or initials, or any term deceptively similar to the words or initials, described by Subdivisions (1)-(3).

(b) A person subject to Subsection (a) may not knowingly use or cause to be used a word, term, or initials described by Subsection (a) alone or in conjunction with:

(1) the state seal or a representation of the state seal;

(2) a picture or map of this state; or

(3) the official logo of the department or a representation of the department's logo.

Sec. 419.003. RULES. The commissioner may adopt rules relating to the regulation of the use of the department's name and other rules as necessary to implement this chapter.

Sec. 419.004. CIVIL PENALTY. (a) A person who violates Section 419.002 or a rule adopted under this chapter is liable for a civil penalty not to exceed $5,000 for each violation.

(b) The attorney general, at the request of the department,

shall bring an action to collect a civil penalty under this section in a district court in Travis County.

Sec. 419.005. ADMINISTRATIVE PENALTY. (a) The department may assess an administrative penalty against a person who violates Section 419.002 or a rule adopted under this chapter.

(b) An administrative penalty imposed under this section:

(1) may not exceed $5,000 for each violation; and

(2) is subject to the procedural requirements adopted for administrative penalties imposed under Section 415.021.

Sec. 419.006. INJUNCTIVE RELIEF. (a) At the request of the commissioner, the attorney general or a district attorney may bring an action in district court in Travis County to enjoin or restrain a violation or threatened violation of this chapter on a showing that a violation has occurred or is likely to occur.

(b) The department may recover the costs of investigating an alleged violation of this chapter if an injunction is issued.

Sec. 419.007. REMEDIES NOT EXCLUSIVE. The remedies provided by this chapter are not exclusive and may be sought in any combination determined by the department as necessary to enforce this chapter.

ARTICLE 2. AMENDMENTS TO SUBTITLE C, TITLE 5, LABOR CODE

PART 1. AMENDMENTS TO CHAPTER 501, LABOR CODE

SECTION 2.001. Section 501.001(1), Labor Code, is amended to read as follows:

(1) "Department" [~~"Commission"~~] means the Texas Department of Insurance [~~Workers' Compensation Commission~~].

SECTION 2.002. Section 501.002, Labor Code, is amended by

amending Subsections (a) and (c) and adding Subsection (a-1) to read as follows:

(a) The following provisions of Subtitles A and B apply to and are included in this chapter except to the extent that they are inconsistent with this chapter:

(1) Chapter 401, other than Section 401.012 defining "employee";

(2) Chapter 402;

(3) Chapter 403, other than Sections 403.001-403.005;

(4) Chapters 404 and [~~Chapter~~] 405;

(5) Subchapters B and D through H, Chapter 406, other than Sections 406.071(a), 406.073, and 406.075;

(6) Chapter 408, other than Sections 408.001(b) and (c);

(7) Chapters 408A, 408C, 408D, and 408E, except as provided by Subsection (a-1);

(8) Chapters 409 and 410;

(9) [~~(8)~~] Subchapters A and G, Chapter 411, other than Sections 411.003 and 411.004;

(10) [~~(9)~~] Chapters 412-417; and

(11) [~~(10)~~] Chapter 451.

(a-1) Each state agency shall provide workers' compensation medical benefits for the agency's employees through a provider network under Chapter 408B if the commissioner of insurance determines that provision of those benefits through a network is available to the employees and practical for the state. To that extent, Chapter 408B applies to this chapter.

(c) For the purpose of applying the provisions listed by Subsections [~~Subsection~~] (a) and (a-1) to this chapter, "insurer" or "employer" means "state," "office," "director," or "state agency," as applicable.

SECTION 2.003. Section 501.026(d), 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 2.004. Sections 501.050(a), (b), and (d), Labor Code, are 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.

(b) An attorney's failure to comply with Subsection (a)(2) does not excuse the failure of a [~~county or~~] district clerk to comply with Subsection (a)(1)(B).

(d) A [~~county or~~] district clerk who violates this section commits an offense. An offense under this subsection is a misdemeanor punishable by a fine not to exceed $250.

PART 2. AMENDMENTS TO CHAPTER 502, LABOR CODE

SECTION 2.051. Section 502.001(1), Labor Code, is amended to read as follows:

(1) "Department" [~~"Commission"~~] means the Texas Department of Insurance [~~Workers' Compensation Commission~~].

SECTION 2.052. Section 502.002, Labor Code, is amended by amending Subsections (a) and (b) and adding Subsection (a-1) to read as follows:

(a) The following provisions of Subtitle A apply to and are included in this chapter except to the extent that they are inconsistent with this chapter:

(1) Chapter 401, other than Section 401.012 defining "employee";

(2) Chapter 402;

(3) Chapter 403, other than Sections 403.001-403.005;

(4) Chapters 404 and [~~Chapter~~] 405;

(5) Sections 406.031-406.033; Subchapter D, Chapter 406; Sections 406.092 and 406.093;

(6) Chapter 408, other than Sections 408.001(b) and (c);

(7) Chapters 408A, 408C, 408D, and 408E, except as

provided by Subsection (a-1);

(8) Chapters 409 and 410;

(9) [~~(8)~~] Subchapters A and G, Chapter 411, other than Sections 411.003 and 411.004; and

(10) [~~(9)~~] Chapters 412-417.

(a-1) Each institution shall provide workers' compensation medical benefits for the institution's employees through a provider network under Chapter 408B if the commissioner of insurance determines that provision of those benefits through a network is available to the employees and practical for the state. To that extent, Chapter 408B applies to this chapter.

(b) For the purpose of applying the provisions listed by Subsections [~~Subsection~~] (a) and (a-1) to this chapter, "employer" means "the institution."

SECTION 2.053. 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 2.054. The heading to Section 502.063, Labor Code, is amended to read as follows:

Sec. 502.063. CERTIFIED COPIES OF [~~COMMISSION~~] DOCUMENTS.

SECTION 2.055. Sections 502.063(a) and (c), Labor Code, are amended to read as follows:

(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.

(c) A fee or salary may not be paid to a department [~~member or~~] employee [~~of the commission~~] for making a copy under Subsection (a) that exceeds the fee charged for the copy.

SECTION 2.056. Section 502.065, Labor Code, is amended to read as follows:

Sec. 502.065. REPORTS OF INJURIES. (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.

(b) The institution shall file the supplemental report on a form prescribed by the commissioner of insurance [~~obtained for that purpose~~]:

(1) on the termination of incapacity of the injured employee; or

(2) if the incapacity extends beyond 60 days.

SECTION 2.057. Sections 502.066(a) and (e), 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.

(e) The institution shall pay the fee set by the department for the services [~~commission~~] of a physician or chiropractor selected by the employee under Subsection (b) or (d).

SECTION 2.058. Section 502.067(a), Labor Code, is amended to read as follows:

(a) The commissioner of insurance [~~commission~~] may order or direct 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 2.059. 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 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 an [~~a commission~~] order of the commissioner of insurance under this section.

SECTION 2.060. Section 502.069, Labor Code, is amended to read as follows:

Sec. 502.069. NOTICE OF APPEAL; NOTICE OF TRIAL COURT JUDGMENT; OFFENSE. (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.

(b) An attorney's failure to comply with Subsection (a)(2) does not excuse the failure of a [~~county or~~] district clerk to comply with Subsection (a)(1)(B).

(c) The duties of a [~~county or~~] district clerk under Subsection (a)(1) are part of the clerk's ex officio duties, and the clerk is not entitled to a fee for the services.

(d) A [~~county or~~] district clerk who violates this section commits an offense. An offense under this section is a misdemeanor punishable by a fine not to exceed $250.

PART 3. AMENDMENTS TO CHAPTER 503, LABOR CODE

SECTION 2.101. Section 503.001(1), Labor Code, is amended to read as follows:

(1) "Department" [~~"Commission"~~] means the Texas Department of Insurance [~~Workers' Compensation Commission~~].

SECTION 2.102. Section 503.002, Labor Code, is amended by amending Subsections (a) and (b) and adding Subsection (a-1) to read as follows:

(a) The following provisions of Subtitle A apply to and are included in this chapter except to the extent that they are inconsistent with this chapter:

(1) Chapter 401, other than Section 401.012 defining "employee";

(2) Chapter 402;

(3) Chapter 403, other than Sections 403.001-403.005;

(4) Chapters 404 and [~~Chapter~~] 405;

(5) Sections 406.031-406.033; Subchapter D, Chapter 406; Sections 406.092 and 406.093;

(6) Chapter 408, other than Sections 408.001(b) and (c);

(7) Chapters 408A, 408C, 408D, and 408E, except as provided by Subsection (a-1);

(8) Chapters 409 and 410;

(9) [~~(8)~~] Subchapters A and G, Chapter 411, other than Sections 411.003 and 411.004; and

(10) [~~(9)~~] Chapters 412-417.

(a-1) Each institution shall provide workers' compensation medical benefits for the institution's employees through a provider network under Chapter 408B if the commissioner of insurance determines that provision of those benefits through a network is available to the employees and practical for the state. To that extent, Chapter 408B applies to this chapter.

(b) For the purpose of applying the provisions listed by Subsections [~~Subsection~~] (a) and (a-1) to this chapter, "employer" means "the institution."

SECTION 2.103. 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 2.104. The heading to Section 503.063, Labor Code, is amended to read as follows:

Sec. 503.063. CERTIFIED COPIES OF [~~COMMISSION~~] DOCUMENTS.

SECTION 2.105. Sections 503.063(a) and (c), Labor Code, are amended to read as follows:

(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.

(c) A fee or salary may not be paid to a department [~~member or~~] employee [~~of the commission~~] for making a copy under Subsection (a) that exceeds the fee charged for the copy.

SECTION 2.106. Section 503.065, Labor Code, is amended to read as follows:

Sec. 503.065. REPORTS OF INJURIES. (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.

(b) The institution shall file the supplemental report on a form prescribed by the commissioner of insurance [~~obtained for that purpose~~]:

(1) on the termination of incapacity of the injured employee; or

(2) if the incapacity extends beyond 60 days.

SECTION 2.107. Sections 503.066(a) and (e), 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.

(e) The institution shall pay the fee, as set by the department [~~commission~~], for the services of a physician selected by the employee under Subsection (b) or (d).

SECTION 2.108. Section 503.067(a), Labor Code, is amended to read as follows:

(a) The commissioner of insurance [~~commission~~] may order or direct 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 2.109. 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 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 an [~~a commission~~] order of the commissioner of insurance under this section.

SECTION 2.110. Section 503.069, Labor Code, is amended to read as follows:

Sec. 503.069. NOTICE OF APPEAL; NOTICE OF TRIAL COURT JUDGMENT; OFFENSE. (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.

(b) An attorney's failure to comply with Subsection (a)(2) does not excuse the failure of a [~~county or~~] district clerk to comply with Subsection (a)(1)(B).

(c) The duties of a [~~county or~~] district clerk under Subsection (a)(1) are part of the clerk's ex officio duties, and the clerk is not entitled to a fee for the services.

(d) A [~~county or~~] district clerk who violates this section commits an offense. An offense under this section is a misdemeanor punishable by a fine not to exceed $250.

SECTION 2.111. Section 503.070(a), Labor Code, is amended to read as follows:

(a) A party who does not consent to abide by the final decision of the department [~~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 department [~~commission~~].

PART 4. AMENDMENTS TO CHAPTER 504, LABOR CODE

SECTION 2.151. Section 504.001, Labor Code, is amended by amending Subdivision (1) and adding Subdivision (4) to read as follows:

(1) "Department" [~~"Commission"~~] means the Texas Department of Insurance [~~Workers' Compensation Commission~~].

(4) "Pool" means two or more political subdivisions that collectively self-insure under an interlocal contract entered into under Chapter 791, Government Code.

SECTION 2.152. Section 504.002, Labor Code, is amended by amending Subsections (a) and (b) and adding Subsection (a-1) 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 408A, 408C, 408D, and 408E, except as provided by Subsection (a-1);

(7) Chapters 409-412 [~~417~~]; [~~and~~]

(8) Chapter 413, except as provided by Section 504.011;

(9) Chapters 414-417; and

(10) [~~(7)~~] Chapter 451.

(a-1) Chapter 408B applies to this chapter as provided by Section 504.011.

(b) For the purpose of applying the provisions listed by Subsections [~~Subsection~~] (a) and (a-1) to this chapter, "employer" means "political subdivision."

SECTION 2.153. Section 504.011, Labor Code, is amended to read as follows:

Sec. 504.011. METHOD OF PROVIDING COVERAGE. (a) A political subdivision shall provide [~~extend~~] workers' compensation benefits to its employees by:

(1) becoming a self-insurer;

(2) providing insurance under a workers' compensation insurance policy; or

(3) entering into an interlocal agreement with other political subdivisions providing for self-insurance.

(b) A political subdivision shall provide workers' compensation medical benefits for the political subdivision's employees through a provider network under Chapter 408B if the governing body of the political subdivision determines that provision of those benefits through a network is available to the employees and practical for the political subdivision. A political subdivision may enter into interlocal agreements and other agreements with other political subdivisions to establish or contract with provider networks under this section.

(c) If a political subdivision or a pool determines that a provider network under Chapter 408B is not available or practical for the political subdivision or pool, the political subdivision or pool may provide medical benefits to its injured employees or to the injured employees of the members of the pool:

(1) in the manner provided by Chapter 408, other than Sections 408.001(b) and (c) and Section 408.002, and by Subchapters B and C, Chapter 413; or

(2) by directly contracting with health care providers or by contracting through a health benefits pool established under Chapter 172, Local Government Code.

(d) The provisions of Chapters 408 and 408A relating to medical benefits, Chapter 408B, and Chapter 413, do not apply if the political subdivision or pool provides medical benefits under Subsection (c)(2).

(e) If the political subdivision or pool provides medical benefits under Subsection (c)(2), the following standards apply:

(1) the political subdivision or pool must ensure that workers' compensation medical benefits are reasonably available to all injured employees of the political subdivision within a designated 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 numbers of health care providers, specialty care providers, and health care 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 review by an independent review organization;

(4) the political subdivision or pool must establish reasonable procedures for transition of injured employees to contracting health care providers and for continuity of treatment, including:

(A) notice of impending termination of a provider's contract; and

(B) maintenance of a current list of contracting providers;

(5) the political subdivision or pool shall provide for emergency care, as defined by Section 401.011, if:

(A) an injured employee is not able to reasonably reach a contracting provider; and

(B) the care is for:

(i) medical screening or another evaluation that is necessary to determine whether a medical emergency condition exists;

(ii) necessary emergency care services including treatment and stabilization; and

(iii) 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; and

(7) the political subdivision or pool shall continue to report data to the appropriate agency as required by Subtitle A.

(f) This section may not be construed as waiving sovereign immunity or creating a new cause of action.

SECTION 2.154. Sections 504.016(d) and (e), Labor Code, are amended to read as follows:

(d) A joint insurance fund created under this section may

provide to the department [~~Texas Department of Insurance~~] loss data in the same manner as an insurance company writing workers' compensation insurance. The department [~~State Board of Insurance~~] shall use the loss data as provided by Subchapter D, Chapter 5, Insurance Code.

(e) Except as provided by Subsection (d), a joint insurance fund created under this section is not considered insurance for purposes of any state statute and is not subject to [~~State Board of Insurance~~] rules adopted by the commissioner of insurance.

SECTION 2.155. Section 504.017, Labor Code, is amended to read as follows:

Sec. 504.017. FEDERAL AND STATE FUNDED TRANSPORTATION ENTITIES. An entity is eligible to participate under Section 504.016 or Chapter 791 or 2259, Government Code, if the entity provides transportation subsidized in whole or in part by and provided to clients of:

(1) the [~~Texas~~] Department of [~~on~~] Aging and Disability Services;

(2) the Department of Assistive and Rehabilitative Services [~~Texas Commission on Alcohol and Drug Abuse~~];

(3) the Department of State Health Services [~~Texas Commission for the Blind~~];

(4) the Texas Cancer Council;

(5) the Department of Family and Protective Services [~~Texas Commission for the Deaf and Hard of Hearing~~];

(6) the Texas Department of Housing and Community Affairs;

(7) the Health and Human Services Commission [~~Texas Department of Human Services~~]; or

(8) [~~the Texas Department of Mental Health and Mental Retardation;~~

[~~(9) the Texas Rehabilitation Commission; or~~

[~~(10)~~] the Texas Youth Commission.

SECTION 2.156. 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 2.157. Section 504.018(a), Labor Code, is amended to read as follows:

(a) A political subdivision shall notify the department [~~commission~~] of the method by which the [~~its~~] employees of the political subdivision will receive benefits, the approximate number of employees covered, and the estimated amount of payroll.

PART 5. AMENDMENTS TO CHAPTER 505, LABOR CODE

SECTION 2.201. Section 505.002, Labor Code, is amended by amending Subsections (a) and (b) and adding Subsection (a-1) to read as follows:

(a) The following provisions of Subtitles A and B apply to and are included in this chapter except to the extent that they are inconsistent with this chapter:

(1) Chapter 401, other than Section 401.012, defining "employee";

(2) Chapter 402;

(3) Chapter 403, other than Sections 403.001-403.005;

(4) Chapters 404 and [~~Chapter~~] 405;

(5) Subchapters B, D, E, and H, Chapter 406, other than Sections 406.071-406.073, and 406.075;

(6) Chapter 408, other than Sections 408.001(b) and (c);

(7) Chapters 408A, 408C, 408D, and 408E, except as provided by Subsection (a-1);

(8) Chapters 409 and 410;

(9) [~~(8)~~] Subchapters A and G, Chapter 411, other than Sections 411.003 and 411.004;

(10) [~~(9)~~] Chapters 412-417; and

(11) [~~(10)~~] Chapter 451.

(a-1) The department shall provide workers' compensation medical benefits for the department's employees through a provider network under Chapter 408B if the commissioner of insurance determines that provision of those benefits through a network is available to the employees and practical for the state. To that extent, Chapter 408B applies to this chapter.

(b) For the purpose of applying the provisions listed by Subsections [~~Subsection~~] (a) and (a-1) to this chapter, "employer" means "department."

SECTION 2.202. The heading to Section 505.053, Labor Code, is amended to read as follows:

Sec. 505.053. CERTIFIED COPIES OF [~~COMMISSION~~] DOCUMENTS.

SECTION 2.203. Sections 505.053(a) and (c), Labor Code, are amended to read as follows:

(a) The Texas Department of Insurance [~~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 an employee of the Texas Department of Insurance [~~a person in the commission~~] for making the copies that exceeds the fee charged for the copies.

SECTION 2.204. Section 505.054(d), 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 Insurance [~~commission~~] and in an appeal from a final award or ruling of the Texas Department of Insurance [~~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 2.205. 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 Insurance [~~commission~~] under Section 409.005, in addition to the information required by

[~~commission~~] rules of the commissioner of insurance, 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 Insurance [~~commission~~] under Section 409.005(i) [~~409.005(e)~~], the department shall file a subsequent report on a form prescribed by the commissioner of insurance [~~obtained for that purpose~~]:

(1) on the termination of incapacity of the injured employee; or

(2) if the incapacity extends beyond 60 days.

SECTION 2.206. Sections 505.056(a) and (d), Labor Code, are amended to read as follows:

(a) The Texas Department of Insurance [~~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 the commissioner of insurance 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 Texas Department of Insurance for the services [~~commission~~] of a physician selected by the employee under this subsection.

SECTION 2.207. Section 505.057(a), Labor Code, is amended to read as follows:

(a) The Texas Department of Insurance [~~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 2.208. 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 Insurance [~~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 insurance under this section.

SECTION 2.209. Section 505.059, Labor Code, is amended to read as follows:

Sec. 505.059. NOTICE OF APPEAL; NOTICE OF TRIAL COURT JUDGMENT; OFFENSE. (a) In each case appealed from the Texas

Department of Insurance [~~commission~~] to a [~~county or~~] district court:

(1) the clerk of the court shall mail to the Texas Department of Insurance [~~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.

(b) An attorney's failure to comply with Subsection (a)(2) does not excuse the failure of a [~~county or~~] district clerk to comply with Subsection (a)(1)(B).

(c) The duties of a [~~county or~~] district clerk under Subsection (a)(1) are part of the clerk's ex officio duties, and the clerk is not entitled to a fee for the services.

(d) A [~~county or~~] district clerk who violates this section commits an offense. An offense under this section is a misdemeanor punishable by a fine not to exceed $250.

SECTION 2.210. Section 505.001(a)(1), Labor Code, is repealed.

ARTICLE 3. CONFORMING AMENDMENTS

PART 1. CONFORMING AMENDMENTS--GOVERNMENT CODE

SECTION 3.001. Section 23.101(a), Government Code, is amended to read as follows:

(a) The trial courts of this state shall regularly and

frequently set hearings and trials of pending matters, giving preference to hearings and trials of the following:

(1) temporary injunctions;

(2) criminal actions, with the following actions given preference over other criminal actions:

(A) criminal actions against defendants who are detained in jail pending trial;

(B) criminal actions involving a charge that a person committed an act of family violence, as defined by Section 71.004, Family Code; and

(C) an offense under:

(i) Section 21.11, Penal Code;

(ii) Chapter 22, Penal Code, if the victim of the alleged offense is younger than 17 years of age;

(iii) Section 25.02, Penal Code, if the victim of the alleged offense is younger than 17 years of age; or

(iv) Section 25.06, Penal Code;

(3) election contests and suits under the Election Code;

(4) orders for the protection of the family under Subtitle B, Title 4, Family Code;

(5) appeals of final rulings and decisions of the Texas Department of Insurance regarding workers' compensation claims [~~Workers' Compensation Commission~~] and claims under the Federal Employers' Liability Act and the Jones Act; and

(6) appeals of final orders of the commissioner of the General Land Office under Section 51.3021, Natural Resources Code.

SECTION 3.002. Section 25.0003(c), Government Code, is amended to read as follows:

(c) In addition to other jurisdiction provided by law, a statutory county court exercising civil jurisdiction concurrent with the constitutional jurisdiction of the county court has concurrent jurisdiction with the district court in[~~:~~

[~~(1)~~] civil cases in which the matter in controversy exceeds $500 but does not exceed $100,000, excluding interest, statutory or punitive damages and penalties, and attorney's fees and costs, as alleged on the face of the petition[~~; and~~

[~~(2) appeals of final rulings and decisions of the Texas Workers' Compensation Commission, regardless of the amount in controversy~~].

SECTION 3.003. Section 25.0222(a), Government Code, is amended to read as follows:

(a) In addition to the jurisdiction provided by Section 25.0003 and other law, a statutory county court in Brazoria County has concurrent jurisdiction with the district court in:

(1) civil cases in which the matter in controversy exceeds $500 but does not exceed $100,000, excluding interest, statutory damages and penalties, and attorney's fees and costs, as alleged on the face of the petition; and

(2) [~~appeals of final rulings and decisions of the Texas Workers' Compensation Commission, regardless of the amount in controversy; and~~

[~~(3)~~] family law cases and proceedings and juvenile jurisdiction under Section 23.001.

SECTION 3.004. Section 25.0862(i), Government Code, is amended to read as follows:

(i) The clerk of the statutory county courts and statutory probate court shall keep a separate docket for each court. The clerk shall tax the official court reporter's fees as costs in civil actions in the same manner as the fee is taxed in civil cases in the district courts. The district clerk serves as clerk of the county courts in a cause of action arising under the Family Code [~~and an appeal of a final ruling or decision of the Texas Workers' Compensation Commission~~], and the county clerk serves as clerk of the court in all other cases.

SECTION 3.005. Section 25.2222(b), Government Code, as amended by Chapter 22, Acts of the 72nd Legislature, Regular Session, 1991, is amended to read as follows:

(b) A county court at law has concurrent jurisdiction with the district court in:

(1) civil cases in which the matter in controversy exceeds $500 and does not exceed $100,000, excluding mandatory damages and penalties, attorney's fees, interest, and costs;

(2) nonjury family law cases and proceedings;

(3) [~~final rulings and decisions of the Texas Workers' Compensation Commission, regardless of the amount in controversy;~~

[~~(4)~~] eminent domain proceedings, both statutory and inverse, regardless of the amount in controversy;

(4) [~~(5)~~] suits to decide the issue of title to real or personal property;

(5) [~~(6)~~] suits to recover damages for slander or

defamation of character;

(6) [~~(7)~~] suits for the enforcement of a lien on real property;

(7) [~~(8)~~] suits for the forfeiture of a corporate charter;

(8) [~~(9)~~] suits for the trial of the right to property valued at $200 or more that has been levied on under a writ of execution, sequestration, or attachment; and

(9) [~~(10)~~] suits for the recovery of real property.

SECTION 3.006. Section 551.044(b), Government Code, is amended to read as follows:

(b) Subsection (a) does not apply to:

(1) the Texas Department of Insurance, as regards proceedings and activities of the department or commissioner of insurance under Title 5, Labor Code [~~Workers' Compensation Commission~~]; or

(2) the governing board of an institution of higher education.

SECTION 3.007. Section 2001.003(7), Government Code, is amended to read as follows:

(7) "State agency" means a state officer, board, commission, or department with statewide jurisdiction that makes rules or determines contested cases. The term includes the State Office of Administrative Hearings for the purpose of determining contested cases. The term does not include:

(A) a state agency wholly financed by federal money;

(B) the legislature;

(C) the courts;

(D) the Texas Department of Insurance, as regards proceedings and activities of the department or commissioner of insurance under Title 5, Labor Code [~~Workers' Compensation Commission~~]; or

(E) an institution of higher education.

SECTION 3.008. Section 2002.001(3), Government Code, is amended to read as follows:

(3) "State agency" means a state officer, board, commission, or department with statewide jurisdiction that makes rules or determines contested cases other than:

(A) an agency wholly financed by federal money;

(B) the legislature;

(C) the courts;

(D) the Texas Department of Insurance, as regards proceedings and activities of the department or commissioner of insurance under Title 5, Labor Code [~~Workers' Compensation Commission~~]; or

(E) an institution of higher education.

SECTION 3.009. Section 2003.001(4), Government Code, is amended to read as follows:

(4) "State agency" means:

(A) a state board, commission, department, or other agency that is subject to Chapter 2001; and

(B) to the extent provided by Title 5, Labor Code, the Texas Department of Insurance, as regards proceedings and

activities of the department or commissioner of insurance under Title 5, Labor Code [~~Workers' Compensation Commission~~].

SECTION 3.010. Section 2003.021(c), Government Code, is amended to read as follows:

(c) The office shall conduct hearings under Title 5, Labor Code, as provided by that title. In conducting hearings under Title 5, Labor Code, the office shall consider the applicable substantive rules and policies of the Texas Department of Insurance regarding workers' compensation claims [~~Workers' Compensation Commission~~]. The office and the Texas Department of Insurance [~~Workers' Compensation Commission~~] shall enter into an interagency contract under Chapter 771 to pay the costs incurred by the office in implementing this subsection.

SECTION 3.011. Section 2054.021(c), Government Code, is amended to read as follows:

(c) Two groups each composed of three ex officio members serve on the board on a rotating basis. The ex officio members serve as nonvoting members of the board. Only one group serves at a time. The first group is composed of the commissioner of insurance [~~executive director of the Texas Workers' Compensation Commission~~], the executive commissioner of the Health and Human Services Commission [~~health and human services~~], and the executive director of the Texas Department of Transportation. Members of the first group serve for two-year terms that begin February 1 of every other odd-numbered year and that expire on February 1 of the next odd-numbered year. The second group is composed of the commissioner of education, the executive director of the Texas

Department of Criminal Justice, and the executive director of the Parks and Wildlife Department. Members of the second group serve for two-year terms that begin February 1 of the odd-numbered years in which the terms of members of the first group expire and that expire on February 1 of the next odd-numbered year.

PART 2. CONFORMING AMENDMENTS--INSURANCE CODE

SECTION 3.051. Section 31.002, Insurance Code, is amended to read as follows:

Sec. 31.002. DUTIES OF DEPARTMENT. In addition to the other duties required of the Texas Department of Insurance, the department shall:

(1) regulate the business of insurance in this state; [~~and~~]

(2) administer the workers' compensation system of this state as provided by Title 5, Labor Code; and

(3) ensure that this code and other laws regarding insurance and insurance companies are executed.

SECTION 3.052. Section 31.004, Insurance Code, is amended to read as follows:

Sec. 31.004. SUNSET PROVISION. (a) The Texas Department of Insurance is subject to Chapter 325, Government Code (Texas Sunset Act). Unless continued in existence as provided by that chapter, the department is abolished September 1, 2007.

(b) In conducting its review of the Texas Department of Insurance as required by Subsection (a), the Sunset Advisory Commission shall limit its review to the operations of that department under the Insurance Code. Unless continued as provided

by Chapter 325, Government Code, the duties of the Texas Department of Insurance under Title 5, Labor Code, expire September 1, 2019, or another date designated by the legislature.

SECTION 3.053. Section 31.021(b), Insurance Code, is amended to read as follows:

(b) The commissioner has the powers and duties vested in the department by:

(1) this code and other insurance laws of this state; and

(2) Title 5, Labor Code, and other workers' compensation insurance laws of this state.

SECTION 3.054. Section 33.007(a), Insurance Code, is amended to read as follows:

(a) A person who served as the commissioner, the general counsel to the commissioner, or the public insurance counsel, or as an employee of the State Office of Administrative Hearings who was involved in hearing cases under this code, [~~or~~] another insurance law of this state, or Title 5, Labor Code, commits an offense if the person represents another person in a matter before the department or receives compensation for services performed on behalf of another person regarding a matter pending before the department during the one-year period after the date the person ceased to be the commissioner, the general counsel to the commissioner, the public insurance counsel, or an employee of the State Office of Administrative Hearings.

SECTION 3.055. Section 36.104, Insurance Code, is amended to read as follows:

Sec. 36.104. INFORMAL DISPOSITION OF CERTAIN CONTESTED CASES [~~CASE~~]. (a) The commissioner may, on written agreement or stipulation of each party and any intervenor, informally dispose of a contested case in accordance with Section 2001.056, Government Code, notwithstanding any provision of this code that requires a hearing before the commissioner.

(b) This section does not apply to a contested case under Title 5, Labor Code.

SECTION 3.056. Subchapter D, Chapter 36, Insurance Code, is amended by adding Section 36.2015 to read as follows:

Sec. 36.2015. ACTIONS UNDER TITLE 5, LABOR CODE. Notwithstanding Section 36.201, a decision, order, rule, form, or administrative or other ruling of the commissioner under Title 5, Labor Code, is subject to judicial review as provided by Title 5, Labor Code.

SECTION 3.057. Section 40.003(c), Insurance Code, is amended to read as follows:

(c) This chapter does not apply to a proceeding conducted under Chapter 201 [~~Article 1.04D~~] or to a proceeding relating to:

(1) approving or reviewing rates or rating manuals filed by an individual company, unless the rates or manuals are contested;

(2) adopting a rule;

(3) adopting or approving a policy form or policy form endorsement;

(4) adopting or approving a plan of operation for an organization subject to the jurisdiction of the department; [~~or~~]

(5) adopting a presumptive rate under Chapter 1153; or

(6) a workers' compensation claim brought under Title 5, Labor Code [~~Article 3.53~~].

SECTION 3.058. Section 81.001(c), Insurance Code, is amended to read as follows:

(c) This section does not apply to conduct that is:

(1) a violation that is ongoing at the time the department seeks to impose the sanction, penalty, or fine; [~~or~~]

(2) a violation of Subchapter A, Chapter 544 [~~Article 21.21-6 of this code, as added by Chapter 415, Acts of the 74th Legislature, Regular Session, 1995~~], or Section 541.057 [~~4(7)(a), Article 21.21 of this code~~], as those provisions relate to discrimination on the basis of race or color, regardless of the time the conduct occurs; or

(3) a violation of Title 5, Labor Code.

SECTION 3.059. Section 84.002, Insurance Code, is amended by adding Subsection (c) to read as follows:

(c) This chapter applies to a monetary penalty the department or commissioner imposes under Title 5, Labor Code, only as provided by that title.

SECTION 3.060. Section 843.101, Insurance Code, is amended by adding Subsection (e) to read as follows:

(e) A health maintenance organization may serve as a provider network, as defined by Section 401.011, Labor Code, in accordance with Chapter 408B, Labor Code.

SECTION 3.061. Section 1301.056(b), Insurance Code, as effective April 1, 2005, is amended to read as follows:

(b) A party to a preferred provider contract, including a contract with a preferred provider organization, may not sell, lease, or otherwise transfer information regarding the payment or reimbursement terms of the contract without the express authority of and prior adequate notification to the other contracting parties. This subsection does not affect the authority of the commissioner [~~or the Texas Workers' Compensation Commission~~] under this code or Title 5, Labor Code, to request and obtain information.

SECTION 3.062. Subchapter D, Chapter 5, Insurance Code, is amended by adding Articles 5.55A and 5.55D to read as follows:

Art. 5.55A. WORKERS' COMPENSATION COVERAGE WRITTEN BY GROUP HEALTH INSURERS AUTHORIZED. (a) A person authorized by the department to engage in the business of insurance in this state under a certificate of authority that includes authorization to write group health insurance may also write workers' compensation insurance in this state.

(b) A person writing workers' compensation insurance under this article is, with respect to that insurance, subject to each duty imposed on a workers' compensation insurer under this code and under Title 5, Labor Code, including provisions relating to the payment of premium and maintenance taxes and maintenance of reserves, and is a member insurer under Article 21.28-C of this code.

(c) Notwithstanding Subsection (b) of this article, the commissioner by rule may provide that a person writing workers' compensation insurance under this article may instead comply with specified regulatory provisions otherwise applicable to the

person, such as provisions relating to authorized investments and transactions for a life, health, and accident insurance company, if the commissioner finds that those provisions provide at least as much protection to insureds, insurers, creditors, and the public as the comparable provisions otherwise applicable to a workers' compensation insurer.

Art. 5.55D. DISCOUNTS FOR CERTAIN PROGRAMS

Sec. 1. DEFINITION. In this article, "insurer" means a person authorized and admitted by the department to engage in the business of insurance in this state under a certificate of authority that includes authorization to write workers' compensation insurance. The term includes the Texas Mutual Insurance Company.

Sec. 2. REQUIRED FILING OF DISCOUNT INFORMATION. (a) Each insurer shall file with the department in the manner prescribed by the commissioner by rule information regarding any premium discounts offered by the insurer to an employer who is a policyholder under a policy of workers' compensation insurance for the use by the employer of:

(1) return-to-work programs for injured employees; and

(2) employee safety programs.

(b) The insurer shall include in the filing the percentage amount discounted from the premium for each program described under Subsection (a) of this section.

Sec. 3. DEPARTMENT ANALYSIS; RULES. The department shall analyze the information contained in filings made under this

article and shall determine whether the mandatory use of the workers' compensation insurance premium discounts would improve the operation of the workers' compensation system of this state. If the department does so determine, the commissioner by rule may establish a mandatory premium discount program under this article.

SECTION 3.063. Article 5.58(b), 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 Workers' Compensation Commission and the Research and Oversight Council on Workers' Compensation in establishing these standards to~~] ensure that the data collection methodology will also yield data necessary for research and medical cost containment efforts.

SECTION 3.064. Article 5.60A, Insurance Code, is amended to read as follows:

Art. 5.60A. RATE HEARINGS. (a) The commissioner [~~Board~~] shall conduct a public [~~an annual~~] hearing not later than December 1, 2008, to review rates to be charged for workers' compensation insurance written in this state [~~under this subchapter~~]. A public hearing under this article is not a contested case as defined by Section 2001.003, Government Code. [~~The hearing shall be conducted under the contested case provisions of the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes).~~]

(b) Not later than the 30th day before the date of the public hearing required under Subsection (a) of this article, each insurer subject to this subchapter shall file the insurer's rates, supporting information, and supplementary rating information with the commissioner [~~The Board shall conduct a hearing six months prior to the annual hearing to revise rates to establish the methodology and sources of data to be used in reviewing rates. The hearing shall be conducted under the Administrative Procedure and Texas Register Act (Article 6252-13a, Vernon's Texas Civil Statutes)~~].

(c) The commissioner shall review the information submitted under Subsection (b) of this section to determine the positive or negative impact of the enactment of House Bill 7, Acts of the 79th Legislature, Regular Session, 2005, on workers' compensation rates and premiums. The commissioner may consider other factors, including relativities under Article 5.60 of this code, in determining whether a change in rates has impacted the premium charged to policyholders [~~To assist the Board in making rates and to provide additional information on certain trends that may affect the costs of workers' compensation insurance, the executive director of the Texas Workers' Compensation Commission or a person designated by that officer shall testify at any rate hearing conducted under this article. The testimony shall relate to trends in:~~

[~~(1) claims resolution of workers' compensation cases; and~~

[~~(2) cost components in workers' compensation cases~~].

(d) The commissioner may implement rules as necessary to mandate rate reductions or to modify the use of individual risk variations if the commissioner determines that the rates or premiums charged by insurers are excessive, as that term is defined in this code [~~The testimony of the executive director or designee is subject to cross-examination by the Board and any party to the hearing~~].

(e) The commissioner may adopt rules as necessary to mandate rate or premium reductions by insurers for the use of cost-containment strategies that result in savings to the workers' compensation system, including use of a provider network health care delivery system, as described by Chapter 408B, Labor Code [~~The Board shall consider changes in the workers' compensation laws when setting workers' compensation insurance rates~~].

(f) Not later than January 1, 2009, the commissioner shall submit a report to the governor, the lieutenant governor, the speaker of the house of representatives, and the members of the 80th Legislature regarding the information collected from the insurer filings under this article. The commissioner shall recommend proposed legislation that reflects the findings of the report and how that information may be used to lower the rates filed by insurers and the premium charged to policyholders.

(g) The commissioner may schedule a public hearing to review rates and premiums to be charged for workers' compensation insurance each biennium under this article.

(h) This section expires September 1, 2019.

SECTION 3.065. Article 5.65A(a), Insurance Code, is amended

to read as follows:

(a) A company or association that writes workers' compensation insurance in this state shall notify each policyholder of any claim that is filed against the policy. Thereafter a company shall notify the policyholder of any proposal to settle a claim or, on receipt of a written request from the policyholder, of any administrative or judicial proceeding relating to the resolution of a claim[~~, including a benefit review conference conducted by the Texas Workers' Compensation Commission~~].

SECTION 3.066. Sections 8(a), (e), (g)-(i), (k), and (l), Article 5.76-3, Insurance Code, are amended to read as follows:

(a) The company may make and enforce requirements for the prevention of injuries to employees of its policyholders or applicants for insurance under this article. For this purpose, representatives of the company[~~, representatives of the commission,~~] or representatives of the department on reasonable notice shall be granted free access to the premises of each policyholder or applicant during regular working hours.

(e) The policyholder shall obtain the safety consultation not later than the 30th day after the effective date of the policy and shall obtain the safety consultation from the department [~~division of workers' health and safety of the commission~~], the company, or another professional source approved for that purpose by the department [~~division of workers' health and safety~~]. The safety consultant shall file a written report with the department [~~commission~~] and the policyholder setting out any hazardous conditions or practices identified by the safety consultation.

(g) The department [~~division of workers' health and safety of the commission~~] may investigate accidents occurring at the work sites of a policyholder for whom a plan has been developed under Subsection (f) of this section, and [~~the division~~] may otherwise monitor the implementation of the accident prevention plan as it finds necessary.

(h) In accordance with rules adopted by the commissioner [~~commission~~], not earlier than 90 days or later than six months after the development of an accident prevention plan under Subsection (f) of this section, the department [~~division of workers' health and safety of the commission~~] shall conduct a follow-up inspection of the policyholder's premises. The department [~~commission~~] may require the participation of the safety consultant who performed the initial consultation and developed the safety plan. If the commissioner [~~division~~] determines that the policyholder has complied with the terms of the accident prevention plan or has implemented other accepted corrective measures, the commissioner [~~division~~] shall so certify. If a policyholder fails or refuses to implement the accident prevention plan or other suitable hazard abatement measures, the policyholder may elect to cancel coverage not later than the 30th day after the date of the [~~division~~] determination. If the policyholder does not elect to cancel, the company may cancel the coverage or the commissioner [~~commission~~] may assess an administrative penalty not to exceed $5,000. Each day of noncompliance constitutes a separate violation. Penalties collected under this section shall be deposited in the general revenue fund and may be appropriated [~~to the credit of the~~

~~commission or reappropriated~~] to the department [~~commission~~] to offset the costs of implementing and administering this section.

(i) In assessing an administrative penalty, the commissioner [~~commission~~] may consider any matter that justice may require and shall consider:

(1) the seriousness of the violation, including the nature, circumstances, consequences, extent, and gravity of the prohibited act;

(2) the history and extent of previous administrative violations;

(3) the demonstrated good faith of the violator, including actions taken to rectify the consequences of the prohibited act;

(4) any economic benefit resulting from the prohibited act; and

(5) the penalty necessary to deter future violations.

(k) The department [~~commission~~] shall charge the policyholder for the reasonable cost of services provided under Subsections (e), (f), and (h) of this section. The fees for those services shall be set at a cost-reimbursement level including a reasonable allocation of the department's [~~commission's~~] administrative costs.

(l) The department [~~compliance and practices division of the commission~~] shall enforce compliance with this section through the administrative violation proceedings under Chapter 415, Labor Code.

SECTION 3.067. Sections 9(a), (b), and (e), Article 5.76-3,

Insurance Code, are amended to read as follows:

(a) The company shall develop and implement a program to identify and investigate fraud and violations of this code relating to workers' compensation insurance by an applicant, policyholder, claimant, agent, insurer, health care provider, or other person. The company shall cooperate with the department [~~commission~~] to compile and maintain information necessary to detect practices or patterns of conduct that violate this code relating to the workers' compensation insurance or Subtitle A, Title 5, Labor Code (the Texas Workers' Compensation Act).

(b) The company may conduct investigations of cases of suspected fraud and violations of this code relating to workers' compensation insurance. The company may:

(1) coordinate its investigations with those conducted by the department [~~commission~~] to avoid duplication of efforts; and

(2) refer cases that are not otherwise resolved by the company to the department [~~commission~~] to:

(A) perform any further investigations that are necessary under the circumstances;

(B) conduct administrative violation proceedings; and

(C) assess and collect penalties and restitution.

(e) Penalties collected under Subsection (b) of this section shall be deposited in the Texas Department of Insurance operating account [~~general revenue fund to the credit of the~~

~~commission~~] and shall be appropriated to the department [~~commission~~] to offset the costs of this program.

SECTION 3.068. Section 10(a), Article 5.76-3, Insurance Code, is amended to read as follows:

(a) Information maintained in the investigation files of the company is confidential and may not be disclosed except:

(1) in a criminal proceeding;

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

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

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

SECTION 3.069. Section 12(e), Article 5.76-3, Insurance Code, is amended to read as follows:

(e) The company shall file annual statements with the department [~~and the commission~~] in the same manner as required of other workers' compensation insurance carriers, and the commissioner shall include a report on the company's condition in the commissioner's annual report under Section 32.021 of this code.

SECTION 3.070. Section 16(b), Article 5.76-3, Insurance Code, is amended to read as follows:

(b) The company shall file with the department [~~and the commission~~] all reports required of other workers' compensation insurers.

SECTION 3.071. Sections 10(a) and (c), Article 5.76-5,

Insurance Code, are amended to read as follows:

(a) A maintenance tax surcharge is assessed against:

(1) each insurance company writing workers' compensation insurance in this state;

(2) each certified self-insurer under Chapter 407, Labor Code [~~as provided in Chapter D, Article 3, Texas Workers' Compensation Act (Article 8308-3.51 et seq., Vernon's Texas Civil Statutes)~~]; and

(3) the fund.

(c) On determining [~~receiving notice of~~] the rate of assessment [~~set by the Texas Workers' Compensation Commission~~] under Section 403.003, Labor Code [~~2.23, Texas Workers' Compensation Act (Article 8308-2.23, Vernon's Texas Civil Statutes)~~], the commissioner [~~State Board of Insurance~~] shall increase the tax rate to a rate sufficient to pay all debt service on the bonds subject to the maximum tax rate established by Section 403.002, Labor Code [~~2.22, Texas Workers' Compensation Act (Article 8308-2.22, Vernon's Texas Civil Statutes)~~]. If the resulting tax rate is insufficient to pay all costs for the department under this article [~~Texas Workers' Compensation Commission~~] and all debt service on the bonds, the commissioner [~~State Board of Insurance~~] may assess an additional surcharge not to exceed one percent of gross workers' compensation premiums to cover all debt service on the bonds. In this code, the maintenance tax surcharge includes the additional maintenance tax assessed under this subsection and the surcharge assessed under this subsection to pay all debt service of the bonds.

SECTION 3.072. Section 3A, Article 21.28, Insurance Code, is amended to read as follows:

Sec. 3A. WORKERS' COMPENSATION CARRIER: NOTIFICATION [~~OF TEXAS WORKERS' COMPENSATION COMMISSION~~]. (a) The liquidator shall notify the department [~~Texas Workers' Compensation Commission~~] immediately upon a finding of insolvency or impairment upon any insurance company which has in force any workers' compensation coverage in Texas.

(b) The department [~~Texas Workers' Compensation Commission~~] shall, upon said notice, submit to the liquidator a list of active cases pending before the department [~~Texas Workers' Compensation Commission~~] in which there has been an acceptance of liability by the carrier, where it appears that no bona fide dispute exists and where payments were commenced prior to the finding of insolvency or impairment and where future or past indemnity or medical payments are due.

(c) Notwithstanding the provisions of Section 3 of this Article, the liquidator is authorized to commence or continue the payment of claims based upon the list submitted in Subsection (b) above.

(d) In order to avoid undue delay in the payment of covered workers' compensation claims, the liquidator shall contract with [~~the Texas Workers' Compensation Pool or~~] any [~~other~~] qualified organization for claims adjusting. Files and information delivered by the department [~~Texas Workers' Compensation Commission~~] to the liquidator may be delivered to the [~~Texas Workers' Compensation Pool or any~~] organization with which the liquidator has contracted

for claims adjusting services.

[~~(c) The Texas Workers' Compensation Commission shall report to the State Board of Insurance any occasion when a workers' compensation insurer has committed acts that may indicate insurer financial impairment, delinquency or insolvency.~~]

SECTION 3.073. Section 8(d), Article 21.28-C, Insurance Code, is amended to read as follows:

(d) The association shall investigate and adjust, compromise, settle, and pay covered claims to the extent of the association's obligation and deny all other claims. The association may review settlements, releases, and judgments to which the impaired insurer or its insureds were parties to determine the extent to which those settlements, releases, and judgments may be properly contested. Any judgment taken before the designation of impairment in which an insured under a liability policy or the insurer failed to exhaust all appeals, any judgment taken by default or consent against an insured or the impaired insurer, and any settlement, release, or judgment entered into by the insured or the impaired insurer, is not binding on the association, and may not be considered as evidence of liability or of damages in connection with any claim brought against the association or any other party under this Act. Notwithstanding any other provision of this Act, a covered claim shall not include any claim filed with the guaranty association on a date that is later than eighteen months after the date of the order of liquidation, except that a claim for workers' compensation benefits is governed by Title 5, Labor Code, and the applicable rules of the commissioner

[~~Texas Workers' Compensation Commission~~].

SECTION 3.074. Section 4(l), Article 21.58A, Insurance Code, is amended to read as follows:

(l) Unless precluded or modified by contract, a utilization review agent shall reimburse health care providers for the reasonable costs for providing medical information in writing, including copying and transmitting any requested patient records or other documents. A health care provider's charges for providing medical information to a utilization review agent shall not exceed the cost of copying set by rule of the commissioner [~~Texas Workers' Compensation Commission~~] for records regarding a workers' compensation claim and may not include any costs that are otherwise recouped as a part of the charge for health care.

SECTION 3.075. Section 14(c), Article 21.58A, Insurance Code, is amended to read as follows:

(c) Except as otherwise provided by this subsection, this article applies to utilization review of health care services provided to persons eligible for workers' compensation medical benefits under Title 5, Labor Code. The commissioner shall regulate in the manner provided by this article a person who performs review of a medical benefit provided under Title 5 [~~Chapter 408~~], Labor Code. [~~This subsection does not affect the authority of the Texas Workers' Compensation Commission to exercise the powers granted to that commission under Title 5, Labor Code.~~] In the event of a conflict between this article and Title 5, Labor Code, Title 5, Labor Code, prevails. The commissioner [~~and the Texas Workers' Compensation Commission~~] may adopt rules [~~and enter~~

~~into memoranda of understanding~~] as necessary to implement this subsection.

SECTION 3.076. The following laws are repealed:

(1) Section 31.006, Insurance Code; and

(2) Section 1(2), Article 5.76-3, Insurance Code.

PART 3. CONFORMING AMENDMENTS--OTHER CODES

SECTION 3.101. Section 92.009, Health and Safety Code, is amended to read as follows:

Sec. 92.009. COORDINATION WITH TEXAS DEPARTMENT OF INSURANCE [~~WORKERS' COMPENSATION COMMISSION~~]. The department and the Texas Department of Insurance [~~Workers' Compensation Commission~~] shall enter into a memorandum of understanding which shall include the following:

(1) the department and the Texas Department of Insurance [~~commission~~] shall exchange relevant injury data on an ongoing basis notwithstanding Section 92.006;

(2) confidentiality of injury data provided to the department by the Texas Department of Insurance [~~commission~~] is governed by Subtitle A, Title 5, Labor Code;

(3) confidentiality of injury data provided to the Texas Department of Insurance [~~commission~~] by the department is governed by Section 92.006; and

(4) cooperation in conducting investigations of work-related injuries.

SECTION 3.102. Section 91.003(b), Labor Code, is amended to read as follows:

(b) In particular, the Texas Workforce Commission, the

Texas Department of Insurance, [~~the Texas Workers' Compensation Commission,~~] and the attorney general's office shall assist in the implementation of this chapter and shall provide information to the department on request.

SECTION 3.103. Section 160.006(a), Occupations Code, is amended to read as follows:

(a) A record, report, or other information received and maintained by the board under this subchapter or Subchapter B, including any material received or developed by the board during an investigation or hearing and the identity of, and reports made by, a physician performing or supervising compliance monitoring for the board, is confidential. The board may disclose this information only:

(1) in a disciplinary hearing before the board or in a subsequent trial or appeal of a board action or order;

(2) to the physician licensing or disciplinary authority of another jurisdiction, to a local, state, or national professional medical society or association, or to a medical peer review committee located inside or outside this state that is concerned with granting, limiting, or denying a physician hospital privileges;

(3) under a court order;

(4) to qualified personnel for bona fide research or educational purposes, if personally identifiable information relating to any physician or other individual is first deleted; or

(5) to the Texas Department of Insurance [~~Workers' Compensation Commission~~] as provided by Section 413.0514, Labor

Code.

ARTICLE 4. TRANSITION; EFFECTIVE DATE

SECTION 4.001. ABOLITION OF TEXAS WORKERS' COMPENSATION COMMISSION; GENERAL TRANSFER OF AUTHORITY TO TEXAS DEPARTMENT OF INSURANCE. (a) The Texas Workers' Compensation Commission is abolished March 1, 2006.

(b) Except as otherwise provided by this article, all powers, duties, obligations, rights, contracts, funds, unspent appropriations, records, real or personal property, and personnel of the Texas Workers' Compensation Commission shall be transferred to the Texas Department of Insurance not later than February 28, 2006.

SECTION 4.002. OFFICE OF INJURED EMPLOYEE COUNSEL. (a) The office of injured employee counsel created under Chapter 404, Labor Code, as added by this Act, is established September 1, 2005.

(b) The governor shall appoint the injured employee public counsel of the office of injured employee counsel not later than October 1, 2005.

(c) The injured employee public counsel of the office of injured employee counsel shall adopt initial rules for the office under Section 404.006, Labor Code, as added by this Act, not later than March 1, 2006.

(d) The Texas Department of Insurance shall provide, in Austin and in each regional office operated by the department to administer Subtitle A, Title 5, Labor Code, as amended by this Act, suitable office space, personnel, computer support, and other administrative support to the office of injured employee counsel as

required by Chapter 404, Labor Code, as added by this Act. The department shall provide the facilities and support not later than October 1, 2005.

(e) All powers, duties, obligations, rights, contracts, funds, unspent appropriations, records, real or personal property, and personnel of the Texas Workers' Compensation Commission relating to the operation of the workers' compensation ombudsman program under Subchapter C, Chapter 409, Labor Code, as that subchapter existed before amendment by this Act, shall be transferred to the office of injured employee counsel not later than March 1, 2006. An ombudsman transferred to the office of injured employee counsel under this section shall begin providing services under Chapter 404, Labor Code, as added by this Act, not later than March 1, 2006.

SECTION 4.003. INITIAL REPORT OF WORKERS' COMPENSATION RESEARCH AND EVALUATION GROUP. The workers' compensation research and evaluation group shall submit the initial report required under Section 405.0025, Insurance Code, as added by this Act, not later than September 1, 2008.

SECTION 4.004. CONTINUATION OF CERTAIN POLICIES, PROCEDURES, OR DECISIONS. (a) A policy, procedure, or decision of the Texas Workers' Compensation Commission relating to a duty of that commission that is transferred to the authority of the Texas Department of Insurance under Subtitle A, Title 5, Labor Code, as amended by this Act, continues in effect as a policy, procedure, or decision of the commissioner of insurance until superseded by an act of the commissioner of insurance.

(b) A policy, procedure, or decision of the Texas Workers' Compensation Commission relating to a duty of that commission that is transferred to the authority of the office of injured employee counsel established under Chapter 404, Labor Code, as added by this Act, continues in effect as a policy, procedure, or decision of the office of injured employee counsel until superseded by an act of the injured employee public counsel.

(c) Except as otherwise provided by this article, the validity of a plan or procedure adopted, contract or acquisition made, proceeding begun, grant or loan awarded, obligation incurred, right accrued, or other action taken by or in connection with the authority of the Texas Workers' Compensation Commission before that commission is abolished under Section 4.001 of this article is not affected by the abolishment.

SECTION 4.005. RULES. (a) The commissioner of insurance shall adopt rules relating to the transfer of the programs assigned to the Texas Department of Insurance under Subtitle A, Title 5, Labor Code, as amended by this Act, not later than December 1, 2005.

(b) The injured employee public counsel of the office of injured employee counsel established under Chapter 404, Labor Code, as added by this Act, shall adopt rules relating to the transfer of the programs assigned to the office of injured employee counsel under Subtitle A, Title 5, Labor Code, as amended by this Act, not later than March 1, 2006.

(c) A rule of the Texas Workers' Compensation Commission relating to a duty of that commission that is transferred to the authority of the Texas Department of Insurance under Subtitle A,

Title 5, Labor Code, as amended by this Act, continues in effect as a rule of the commissioner of insurance until the earlier of:

(1) December 1, 2006; or

(2) the date on which the rule is superseded by a rule adopted by the commissioner of insurance.

(d) A rule of the Texas Workers' Compensation Commission relating to a duty of that commission that is transferred to the authority of the office of injured employee counsel under Subtitle A, Title 5, Labor Code, as amended by this Act, continues in effect as a rule of the injured employee public counsel of the office of injured employee counsel until the earlier of:

(1) December 1, 2006; or

(2) the date on which the rule is superseded by a rule adopted by the injured employee public counsel.

SECTION 4.006. EFFECT ON ACTION OR PROCEEDING. (a) Except as otherwise provided by this section, any action or proceeding before the Texas Workers' Compensation Commission or to which the commission is a party is transferred without change in status to the Texas Department of Insurance.

(b) Benefit review conferences, as established under Subchapter B, Chapter 410, Labor Code, as that subchapter existed before amendment by this Act, are abolished February 28, 2006. A benefit review officer conducting a benefit review conference that is in progress on February 28, 2006, shall terminate the conference and file with the Texas Department of Insurance the written agreement required under Section 410.034, Labor Code, as that section existed before repeal by this Act, not later than April 1,

2006. A claimant regarding workers' compensation benefits whose claim is not heard by a benefit review officer under Subchapter B, Chapter 410, Labor Code, as that subchapter existed before amendment by this Act, on or before February 27, 2006, is entitled to a contested case hearing or arbitration on the claim without compliance with the informal dispute resolution procedures established under Chapter 410, Labor Code, as amended by this Act. If the claimant elects to proceed to a contested case hearing, the claimant may elect to participate in a prehearing conference under Section 410.151, Labor Code, as amended by this Act, or may proceed directly to a contested case hearing. This subsection expires April 30, 2006.

(c) The workers' compensation appeals panels established under Subchapter E, Chapter 410, Labor Code, as that subchapter existed before repeal by this Act, are abolished April 1, 2006, or on an earlier date specified by the commissioner of insurance. An appeals panel may not accept a new appeal of the decision of a hearing officer under Chapter 410, Labor Code, as that chapter existed before amendment by this Act, on or after February 28, 2006. A party to a dispute regarding the decision of a hearing officer that is filed with the Texas Workers' Compensation Commission or the Texas Department of Insurance on or after February 28, 2006, may seek judicial review under Chapter 410, Labor Code, as amended by this Act.

SECTION 4.007. APPEAL. Section 410.252(e), Labor Code, as added by this Act, and Sections 25.0003, 25.0222, and 25.0862, Government Code, as amended by this Act, apply only to an appeal

filed on or after the effective date of this Act. An appeal filed before the effective date of this Act is governed by the law in effect on the date the appeal was filed, and the former law is continued in effect for that purpose.

SECTION 4.008. STATE OFFICE OF ADMINISTRATIVE HEARINGS REVIEW. (a) This section applies to a hearing conducted by the State Office of Administrative Hearings under Section 413.031(k), Labor Code, as that subsection existed prior to repeal by this Act.

(b) The State Office of Administrative Hearings shall conclude on or before February 28, 2006, 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 February 28, 2006, is subject to Section 413.035, Labor Code, as added by this Act, and is not subject to a hearing before the State Office of Administrative Hearings.

SECTION 4.009. CHANGE IN CRIMINAL PENALTY. (a) The changes in law made by this Act apply only to the punishment for an offense committed on or after the effective date of this Act. For purposes of this section, an offense is committed before the effective date of this Act if any element of the offense occurs before the effective date.

(b) An offense committed before the effective date of this

Act is governed by the law in effect on the date the offense was committed, and the former law is continued in effect for that purpose.

SECTION 4.010. ABOLITION OF HEALTH CARE NETWORK ADVISORY COMMITTEE. (a) The Health Care Network Advisory Committee is abolished on the effective date of this Act.

(b) Except as otherwise provided by this article, all powers, duties, obligations, rights, contracts, funds, records, and real or personal property of the Health Care Network Advisory Committee shall be transferred to the Texas Department of Insurance not later than February 28, 2006.

SECTION 4.011. REFERENCE IN LAW. A reference in law to the Texas Workers' Compensation Commission means the Texas Department of Insurance or the office of injured employee counsel as consistent with the respective duties of those state governmental entities under the Labor Code, the Insurance Code, and other laws of this state, as amended by this Act.

SECTION 4.012. BUDGET EXECUTION AUTHORITY. Notwithstanding Section 317.005(e), Government Code, the Legislative Budget Board may adopt an order under Section 317.005, Government Code, affecting any portion of the total appropriation of the Texas Department of Insurance if necessary to implement the provisions of this Act. This section expires March 31, 2006.

SECTION 4.013. EFFECTIVE DATE. Except as otherwise provided by this article, this Act takes effect September 1, 2005.