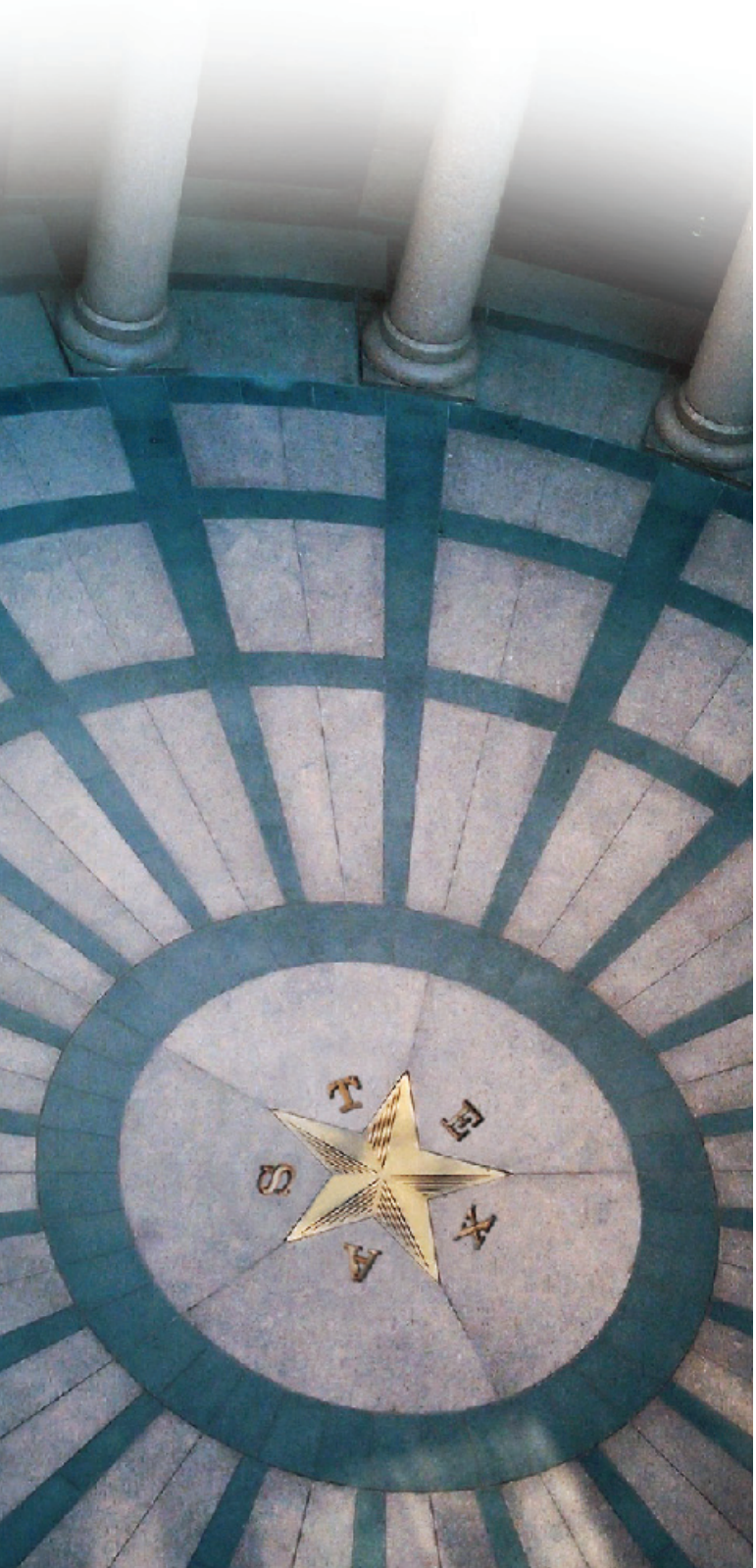
Sunset Advisory Commission

Final Report



Division of Workers' Compensation – Texas Department of Insurance

Office of Injured Employee Counsel

July 2011

Sunset Advisory Commission

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In 1977, the Texas Legislature created the Sunset Advisory Commission to identify and eliminate waste, duplication, and inefficiency in government agencies. The 12-member Commission is a legislative body that reviews the policies and programs of more than 130 government agencies every 12 years. The Commission questions the need for each agency, looks for potential duplication of other public services or programs, and considers new and innovative changes to improve each agency's operations and activities. The Commission seeks public input through hearings on every agency under Sunset review and recommends actions on each agency to the full Legislature. In most cases, agencies under Sunset review are automatically abolished unless legislation is enacted to continue them.

Division of Workers' Compensation
Texas Department of Insurance

Office of Injured Employee Counsel

Sunset Final Report

July 2011

This document is intended to compile all recommendations and action taken by the Sunset Advisory Commission for an agency under Sunset review. The following explains how the document is expanded and reissued to include responses from agency staff and the public.

- *Sunset Staff Report, April 2010* – Contains all Sunset staff recommendations on an agency, including both statutory and management changes, developed after extensive evaluation of the agency.

- *Hearing Material, May 2010* – Summarizes all responses from agency staff and the public to Sunset staff recommendations, as well as new policy issues raised for consideration by the Sunset Commission at its public hearing.

- *Decision Material, July 2010* – Includes additional responses, testimony, or new policy issues raised during and after the public hearing for consideration by the Sunset Commission at its decision meeting.

- *Commission Decisions, July 2010* – Contains the decisions of the Sunset Commission on staff recommendations and new policy issues. Statutory changes adopted by the Commission are presented to the Legislature in the agency's Sunset bill.

- *Final Report, July 2011* – Summarizes action taken by the Legislature on Sunset Commission recommendations and new provisions added by the Legislature to the agency's Sunset bill.

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Summary

Summary

Among growing concerns of high utilization and increasing medical costs, limited access to high-quality medical care, and poor return-to-work rates, the 79th Legislature made sweeping changes to the workers' compensation system. These extensive reforms included abolishing the standing regulatory agency and splitting its functions between the Texas Department of Insurance (TDI) and a newly created injured employee advocacy agency. Nearly five years later, the Sunset reviews of the Division of Workers' Compensation (DWC) and the Office of Injured Employee Counsel (Office) found both agencies, and the system as a whole, still in the wake of incredible transition. Overall the system seems to be healthier, with stabilizing medical costs, fewer claims and disputes, lower insurance rates, fewer lost days of work, and better return-to-work outcomes.[1] In addition, the structural transition of both the Division and the Office has worked, although many aspects of the reforms are still very much in the implementation phase.

Nearly five years after sweeping reforms, Texas' workers' compensation agencies are still in the wake of incredible transition.

The timing of the current Sunset reviews presented both challenges and opportunities. Since not enough time has passed to allow for evidence of long-term, concrete outcomes, many of the system-wide changes are not yet ripe for evaluation. As a result, Sunset staff did not make recommendations on most of the recent reforms. For example, in 2005 the Legislature authorized the use of certified workers' compensation networks, and preliminary indications seem to show that networks have higher medical costs and utilization but yield better patient satisfaction and return-to-work outcomes than non-network care.[2] However, because network claims account for only 16 percent of the market and DWC has just three years' worth of data relating to network performance, Sunset staff chose not to assess the need for potential changes until the agency and industry have had time to fully adjust to the new model.

Also, Sunset staff determined that wholesale changes to the system, such as benefit level changes, were outside the scope of staff reviews aimed at evaluating the continuing need for the functions and the effectiveness, efficiency, fairness, and accountability of statutory programs. Given these challenges, Sunset staff focused on identifying possibilities to fine-tune past reform efforts, improve major program areas, and address lingering statutory questions needing further directive.

The material on the following pages summarizes the Sunset staff recommendations on the Division of Workers' Compensation and the Office of Injured Employee Counsel.

Issues and Recommendations

Division of Workers' Compensation – Texas Department of Insurance

Issue 1

The Division's Complicated Dispute Resolution Process Often Fails to Provide a Quicker, More Accessible Alternative to the Courts.

An effective administrative dispute resolution process is vital to a well-functioning workers' compensation system. The Division's dispute resolution process allows dissatisfied parties, particularly injured employees, the opportunity to appeal the denial or reduction of services through low-cost, accessible means, instead of through the formal and costly court system. The review assessed the dispute resolution process as a whole, as well as the impact of recent legislative changes.

Different dispute resolution paths exist depending on the type of dispute, the amount of the dispute, and how the employee received medical care. The Sunset review found that these differences create inequities within the dispute resolution process, unfairly subjecting system participants to varied levels of formality during hearings, and ultimately depriving participants of a quick, accessible means to resolution.

Changes to the dispute resolution process would make it less formal, confusing, and costly, consistent with the design and purpose of having an administrative process at DWC. Such changes would make it more likely for system participants to have their disputes resolved promptly and fairly, receiving more consistent decisions.

Key Recommendations

- Require parties to a dispute to prove preparedness as a prerequisite to a Benefit Review Conference.
- Require parties to a non-network medical fee dispute to attempt a low-level mediation, through a Benefit Review Conference, before appealing to the Contested Case Hearing level.
- Establish an administrative appeal mechanism for network medical necessity disputes.
- Streamline the process for resolving non-network medical disputes, by removing SOAH's involvement in conducting Contested Case Hearings.
- Authorize the Division's Appeals Panel to issue written affirmations in limited circumstances.
- Extend the timeframe allowed for appeals of DWC decisions regarding medical necessity and non-network medical fee disputes to district court.
- Clarify the venue for district court appeals of agency decisions regarding medical disputes.

Issue 2

The Division's Medical Quality Review Process Needs Improvement to Ensure Thorough and Fair Oversight of Workers' Compensation Medical Care.

The medical quality review process is a key part of DWC's efforts to ensure system participants make appropriate decisions regarding the type, level, and quality of medical care needed by an injured employee. The Division's Medical Advisor, along with a Panel of outside health care providers, play significant roles in this review process. The Sunset review identified several inadequacies in the process that threaten the meaningfulness of the Division's review efforts, potentially compromising the impartiality of review outcomes.

Shifting the Division's oversight of the medical quality review process to depend more on multiple agency staff, instead of on solely the Medical Advisor and contracted Panel members, would reduce the appearance of any impropriety. Increasing qualification and training requirements for Panel members and providing an opportunity for input at various review stages would result in a more transparent process and allow for solid decisions regarding recommended enforcement actions.

Key Recommendations

- Require Division staff, rather than the Medical Advisor, to manage and oversee the medical quality review process.
- Require the Division to develop guidelines to strengthen the medical quality review process.
- Establish a more streamlined medical review process by removing the Quality Assurance Panel's involvement.
- Require the Commissioner to develop additional qualification and training requirements for Medical Quality Review Panel members.
- Require the Division to work with health licensing boards to expand the pool of Medical Quality Review Panel members.

Issue 3

The Division Cannot Always Take Timely and Efficient Enforcement Actions to Protect Workers' Compensation System Participants.

The Division monitors the activities of all system participants and takes enforcement action against violators of law, rule, and order using a variety of administrative sanctions. However, the Division lacks some enforcement tools that would allow for meaningful enforcement actions and ensure that TDI, as a whole, has an efficient agency-wide enforcement process. In addition, some Labor Code provisions that govern the Division's enforcement are confusing and outdated. Providing DWC with additional enforcement tools and clarifying its existing authority will enable it to better ensure compliance in the workers' compensation system by taking appropriate, consistent, and swift action, and eliminate confusion about the scope of DWC's enforcement authority.

Key Recommendations

- Clarify that the Division can conduct announced and unannounced inspections.
- Authorize DWC to refuse to renew Designated Doctor certifications.
- Authorize the Commissioner to issue emergency cease-and-desist orders.
- Specify that the judicial review standard for appeals of DWC enforcement cases is substantial evidence.
- Authorize the Commissioner to make final decisions on enforcement cases involving monetary penalties.
- Remove outdated and confusing enforcement provisions in the Labor Code.

Issue 4

The Division's Oversight of Designated Doctors Does Not Effectively Ensure Meaningful Use of Expert Medical Opinions in Dispute Resolution.

Designated Doctors provide a neutral assessment of an injured employee's medical condition that DWC uses to resolve disputes, especially in circumstances in which an insurance carriers' doctor and an injured employee's treating doctor disagree. The presumptive weight of Designated Doctor opinions in legal disputes necessitates that Designated Doctors are able to consistently provide high-quality, independent medical assessments. However, the way that the Division certifies and schedules Designated Doctors lacks sufficient parameters to ensure that applicants can adequately perform the specific statutory duties required. Additional guidance to strengthen the Division's processes for selecting, training, and assigning Designated Doctors would help ensure that the best qualified doctors serve in this important role, while fortifying the goal of providing neutral expert opinions that DWC may use to resolve disputed claims.

Key Recommendations

- Require the Commissioner to develop qualification requirements for Designated Doctors.
- Direct the Commissioner to adopt rules requiring Designated Doctors remain with case assignments, unless otherwise authorized.
- Authorize the Commissioner to establish a certification fee in rule for Designated Doctors.
- The Division should remove the Designated Doctor scheduling data from its website.

Issue 5

The Division's Responsibility for Making Some Individual Claims Decisions Conflicts with Its Oversight and Dispute Resolution Duties.

The overall structure of Texas' workers' compensation system contemplates insurance carriers paying for and managing individual claims, and DWC overseeing and resolving disputes in the system. As a limited exception to this general approach, statute charges DWC with making certain individual claims decisions. The Sunset review found that DWC's involvement in eight types of decisions is unnecessary

and conflicts with the Division's regulatory role. Transferring responsibility for these decisions from DWC to insurance carriers that are well-positioned to manage individual claims would allow DWC to focus on its oversight duties and ensure DWC's neutrality when adjudicating disputes.

Key Recommendation

- Transfer the responsibility for certain claims decisions from DWC to insurance carriers.

Issue 6

Employers Outside the Workers' Compensation System Are Failing to Report Information the Legislature Needs to Evaluate the Health of the System.

While state law does not require private Texas employers to offer workers' compensation coverage to their employees, it does require all employers to report their decision to DWC, as well as information about any injuries, illnesses, or deaths at the workplace. This information gives the Legislature a better understanding of the system and all workplace safety in Texas. However, despite increased education and compliance efforts by DWC, only an estimated 10 percent of nonsubscribing employers report this information. Working with other state agencies that have interactions with Texas employers would benefit DWC's data collection efforts and potentially increase reporting, giving the Legislature a broader picture of the system as a whole.

Key Recommendation

- The Division should closely coordinate with other state agencies to include nonsubscription reporting requirements in their print and electronic publications.

Issue 7

Texas Has a Continuing Need for the Division of Workers' Compensation.

Sunset staff evaluated DWC's functions and structure as a division within the Texas Department of Insurance, led by a separate Commissioner of Workers' Compensation, and concluded that the Division fulfills an important role in ensuring the fair treatment of all system participants. In addition, the review found that, while the merger with TDI is still being implemented, the integration works well. As a result, DWC no longer needs to have a separate Sunset date from TDI in statute. Sunset staff also found that without an effective way to track and manage complaints against the Division, DWC misses an opportunity to systematically analyze complaint trends that would allow it to address broader problems with the system.

Key Recommendations

- Continue the Division of Workers' Compensation for 12 years, and remove its separate Sunset date from statute.

- Require the Division to develop standard procedures for documenting complaints and for tracking and analyzing complaint data.

Office of Injured Employee Counsel

Issue 1

Texas Has a Continuing Need for the Office of Injured Employee Counsel.

Sunset staff found that Texas has a continuing need to help injured employees navigate the complex workers' compensation system and ensure access to medical and income benefits promised by state law. The Office fulfills this need by providing beneficial education and assistance to individuals with workers' compensation claims and promoting the interests of injured employees in the system. Sunset staff found no significant benefit to altering the Office's current organizational structure. The review also found that the Office is well-positioned to positively affect the efficiency of DWC's dispute resolution process by increasing the preparedness of injured employees it is assisting as parties to informal mediations.

Key Recommendations

- Continue the Office of Injured Employee Counsel for 12 years.
- Direct the Office to work with DWC to ensure injured employees are fully prepared by Ombudsmen before attending a DWC Benefit Review Conference.

Issue 2

The Office Has Inappropriate Access to Claims Information Held by the Division of Workers' Compensation.

The Office performs two of its primary roles – assisting injured employees in dispute resolution hearings and advocating for injured employees as a class – in adversarial proceedings in which the Office acts as one of several interested parties before a neutral regulator, such as DWC. The Sunset review found that the Office's administrative attachment to DWC, and statutory language allowing the Office to obtain otherwise confidential information, gives the Office access to information that other parties cannot receive. This situation places the Office in a potentially more favorable position than other parties in the workers' compensation system. Limiting this access would remove the appearance of impropriety, as well as solidify the Office's independence from DWC without preventing the Office from fulfilling its statutory duties.

Key Recommendation

- Limit the Office's authority to access claim files for injured employees the Office is not directly assisting.

Fiscal Implication Summary

None of the recommendations in this report would have an overall fiscal impact to the State's General Revenue Fund, since both the Division of Workers' Compensation – Texas Department of Insurance and the Office of Injured Employee Counsel are funded through taxes and assessments on workers' compensation insurers. However, two recommendations would have a fiscal implication on TDI's appropriations pattern, including one recommendation that would result in a biennial savings of nearly $190,000, as described below.

Division of Workers' Compensation – Texas Department of Insurance

- ***Issue 1*** – Removing all workers' compensation dispute resolution hearings from the State Office of Administrative Hearings would result in an annual savings of approximately $94,000, as the Division would no longer reimburse SOAH for costs associated with conducting hearings. Although DWC would be responsible for an increased caseload as a result of this change, the Division would be able to assume this duty using existing resources.

- ***Issue 4*** – Authorizing the Commissioner of Workers' Compensation to collect a certification and renewal fee from Designated Doctors would result in a gain in revenue, which would depend on the fee level and number of Designated Doctors, and cannot be estimated. Gains would be offset by costs associated with the certification process, and ultimately result in a decrease in maintenance taxes assessed on workers' compensation insurance carriers.

Texas Department of Insurance

Fiscal Year	Savings to the General Revenue Fund Account 36	Loss to the General Revenue Fund Account 36	Net Effect to the General Revenue Fund Account 36
2012	$94,000	($94,000)	0
2013	$94,000	($94,000)	0
2014	$94,000	($94,000)	0
2015	$94,000	($94,000)	0
2016	$94,000	($94,000)	0

Office of Injured Employee Counsel

None of the recommendations on the Office of Injured Employee Counsel in this report would have a fiscal impact to the State.

[1] Texas Department of Insurance, *Setting the Standard: An Analysis of the Impact of the 2005 Legislative Reforms on the Texas Workers' Compensation System, 2008 Results*. Online. Available: http://www.tdi.state.tx.us/reports/wcreg/documents/settingthestandard201.pdf. Accessed: April 15, 2010.

[2] Texas Department of Insurance, *2009 Workers' Compensation Network Report Card Results*. Online. Available: http://www.tdi.state.tx.us/reports/wcreg/documents/2009reportcard2.pdf. Accessed: March 30, 2010.

Summary of Legislative Action
Division of Workers' Compensation –
Texas Department of Insurance
H.B. 2605 L. Taylor (Huffman)

House Bill 2605 continues the Division of Workers' Compensation, which has a separate Sunset date from TDI, for six years. The Legislature adopted the majority of the Sunset Commission's recommendations and added other statutory modifications to help ensure injured employees receive prompt, high-quality medical care and all entitled benefits. The list below summarizes the major provisions of H.B. 2605, and more detailed discussion is located in each issue.

Sunset Provisions

1. Streamline the dispute resolution process to provide a quicker, more accessible alternative to the courts.
2. Improve the medical quality review process to ensure thorough and fair oversight of workers' compensation medical care.
3. Strengthen the Division's ability to take timely and efficient enforcement actions to protect workers' compensation system participants.
4. Increase the Division's oversight of Designated Doctors to ensure meaningful use of expert medical opinions in dispute resolution.
5. Continue the Division of Workers' Compensation for six years.

Provisions Added by Legislature

1. Expedite medical claims for certain seriously injured first responders.
2. Authorize injured employees to obtain a second opinion for certain medical determinations.

Fiscal Implication Summary

House Bill 2605 contains one provision that will provide a positive fiscal impact to the State. Depositing all administrative penalties assessed and collected by the Division in the General Revenue Fund, instead of the Texas Department of Insurance operating account, will result in a gain to the General Revenue Fund of $1.2 million annually.

Fiscal Year	Gain to the General Revenue Fund
2012	$1,200,000
2013	$1,200,000
2014	$1,200,000
2015	$1,200,000
2016	$1,200,000

Summary of Legislative Action
Office of Injured Employee Counsel
H.B. 1774 L. Taylor (Huffman)

House Bill 1774 continues the Office of Injured Employee Counsel for six years to coincide with the next review of DWC. The Legislature adopted all of the Sunset Commission's recommendations and added two other provisions to H.B. 1774. The list below summarizes the major provisions of H.B. 1774, and more detailed discussion is located in each issue.

Sunset Provisions

1. Continue the Office of Injured Employee Counsel for six years.
2. Limit the Office's authority to access claim files for injured employees the Office is not directly affecting.

Provisions Added by Legislature

1. Allow the Office of Injured Employee Counsel an additional month in preparing its legislative report.
2. Allow the Office of Injured Employee Counsel to seek and receive grants to fulfill the agency's mission.

Fiscal Implication Summary

House Bill 1774 will not have a significant fiscal impact to the State.

Division of Workers' Compensation

Agency at a Glance

(April 2010)

Division at a Glance

As a division of the Texas Department of Insurance (TDI), the Division of Workers' Compensation (DWC) regulates and administers the workers' compensation system in Texas. Workers' compensation insurance provides employees injured on the job with medical care and income replacement benefits, as described in the textbox *Workers' Compensation Benefits*. While mandatory for governmental entities and companies that contract with the government, purchasing a workers' compensation insurance policy is optional for private employers in Texas. However, in most circumstances, state law gives employers who choose to provide these benefits immunity from further liability related to a workplace injury.

Workers' Compensation Benefits

Workers' compensation coverage provides four categories of benefits for injuries or illness determined to have occurred on the job.

Medical benefits pay for necessary medical care to treat the injury or illness.

Income benefits replace a portion of lost wages as a result of missing work for more than seven days, or becoming disabled or permanently impaired due to the injury or illness. Four types of income benefits exist: temporary, impairment, supplemental, and lifetime.

Death benefits pay eligible family members a portion of lost income due to a family member's work-related death.

Burial benefits reimburse eligible family members for a deceased employee's funeral expenses.

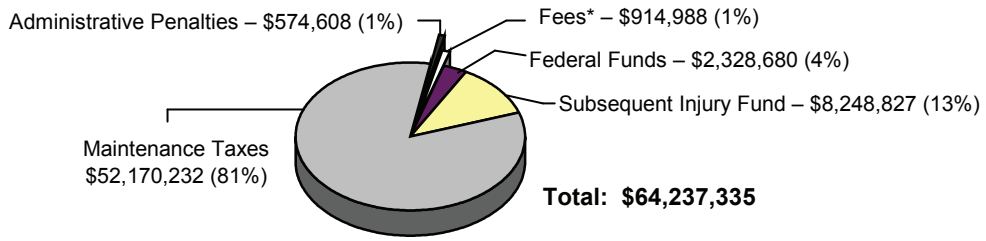
The Division's regulation of the workers' compensation system aims to accomplish four basic goals established by the Legislature, including ensuring that each employee: is treated with dignity and respect when injured on the job; has access to a fair and accessible dispute resolution process; has access to prompt, high-quality medical care; and returns to employment as soon as considered safe and appropriate.

Key Facts

- **Commissioner and Staff**. State law designates TDI as the agency to oversee workers' compensation, and establishes DWC as a division within TDI. The Commissioner of Workers' Compensation, appointed by the Governor and confirmed by the Senate, oversees DWC's regulatory functions and works in conjunction with the Commissioner of Insurance, who is also appointed by the Governor. The Commissioner of Workers' Compensation has executive and rulemaking authority over workers' compensation. Of TDI's 1,572 staff, 697 are dedicated to workers' compensation-related functions within the agency, and 240 operate from DWC's 24 field offices across the state.

- **Funding**. The Division is primarily funded from a maintenance tax assessed on all workers' compensation insurance carriers writing policies in Texas. Of TDI's total budget of $164 million, about 39 percent, or $64 million, was dedicated to workers' compensation-related functions at the Department in fiscal year 2009. The pie chart on the next page, *TDI Workers' Compensation-Related Revenue*, details TDI's sources of revenue related to workers' compensation regulation.

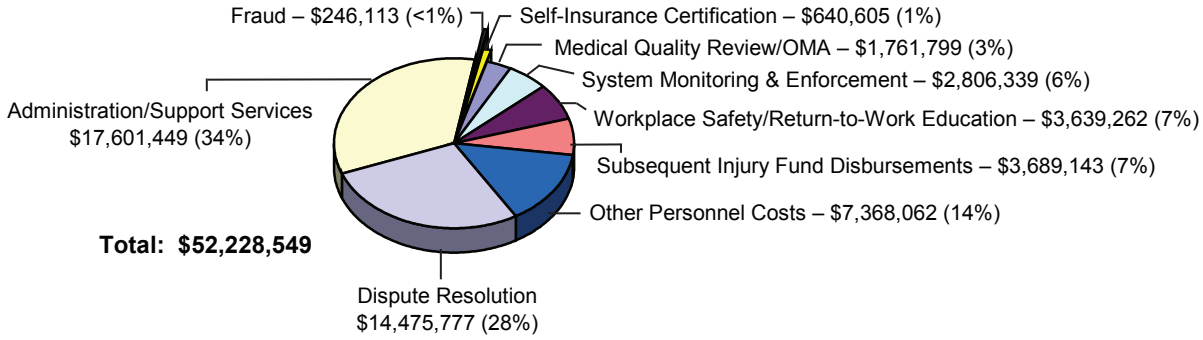
TDI Workers' Compensation-Related Revenue
Appropriation Year 2009



*Includes examination reimbursements, as well as other assessments and allocations.

In 2009, TDI expended about $52 million on the regulation of workers' compensation. The pie chart, *TDI Workers' Compensation-Related Expenditures*, breaks down the Department's expenditures on workers' compensation regulation.

TDI Workers' Compensation-Related Expenditures
Appropriation Year 2009



- **Dispute Resolution**. Most workers' compensation claims are filed and paid without question. However, in cases where an insurance carrier denies a claim, injured employees and other system participants may dispute that denial. In fiscal year 2009, only about 6 percent of claims reported to DWC were disputed, and DWC facilitated resolution of a vast majority of those disputes outside of the court system.

  The Division oversees disputes involving income benefits, medical care, or payment for medical treatment. Within each type of dispute, the Division attempts to facilitate early, informal resolution, but parties can appeal to a more formal contested case proceeding, and eventually to court. In fiscal year 2009, the Division received more than 25,000 disputes regarding income benefits, more than 540 disputes about medical care, and approximately 12,000 disputes regarding payment for medical care. For information on the full resolution process for each type of dispute – indemnity, medical necessity, and medical fee – refer to Appendices A, B, and C of this report.

- **System Monitoring**. Compliance monitoring plays a critical role in DWC's oversight of the workers' compensation system as a whole. The Division oversees the activities of more than 270 insurance companies that actively write workers' compensation insurance, the 67 percent of Texas employers that offer workers' compensation coverage to their employees, and more than 96,000 health care providers who operate in the workers' compensation system. Through the following agency programs, the Division evaluates system participant behavior to ensure compliance with rules and regulations unique to the workers' compensation system, referring violations for enforcement action.

  Complaint Resolution – The Division receives complaints regarding system participants and successfully resolves the vast majority of them without formal action. If DWC is unable to resolve a justified complaint, it forwards it on to be investigated to determine whether a violation of workers' compensation rules or law occurred. In fiscal year 2009, DWC received 6,794 complaints and resolved 7,369 complaints, some of which DWC received in a previous fiscal year. Most complaints relate to communication between system participants, medical bill processing, medical reimbursement, quality of care, and income benefit payment.

  Audits and Investigations – The Division investigates complaints and conducts performance and compliance audits, according to an annual audit plan. In fiscal year 2009, DWC completed 2,442 investigations, as well as 77 audits focused on the initial payment of benefits, timeliness of payments and form filings, and data accuracy.

  Performance-Based Oversight – The Division examines the performance of randomly selected system participants and ranks outcomes, with the goal of providing incentives for good conduct in the system. In 2009, DWC assessed the performance of 138 insurance carriers, finding 30 to be high performers and eight to be in the poor performer category. The Division also assessed the performance of 274 health care providers, four of whom were high performers and 219 of whom were deemed poor performers. To follow up and ensure future compliance, DWC audits poor performers.

  Medical Quality Reviews – Overseen by the Division's Medical Advisor, the medical quality review process uses outside health care providers as expert reviewers to determine if a violation of the Division's act or rules occurred. In fiscal year 2009, DWC initiated 124 medical quality reviews, resulting in four enforcement actions.

- **Enforcement**. The Department takes enforcement actions against system participants, including insurance carriers, employers, health care providers, and injured employees, for violations of the Labor Code and DWC rules. In fiscal year 2009, DWC investigated 571 enforcement cases, closed 414 cases, and assessed more than $1 million in administrative penalties. The Department's fraud division investigates workers' compensation fraud, referring 28 workers' compensation-related fraud cases for prosecution in fiscal year 2009, which resulted in 20 convictions and $4.2 million in ordered restitution.

- **Certified Self-Insured Employers**. If an employer chooses to provide workers' compensation insurance, it typically gets insurance through a policy purchased from an insurance carrier, or it can self-insure, providing coverage to its employees but retaining the financial risk of potential claims instead of transferring that risk to the carrier. In fiscal year 2009, DWC regulated the solvency of 214 individual self-insured companies, and TDI regulated the solvency of six self-insured groups.

- **Certified Workers' Compensation Networks**. When purchasing a workers' compensation policy, an employer can choose a policy that provides medical care either through non-network health care providers or through managed care networks, which are certified by TDI. At the end of fiscal year 2009, 33 certified networks operated in the workers' compensation system, accounting for about 16 percent of total workers' compensation medical claims.

- **Workplace Safety**. To help ensure Texans work in safe and healthy environments, DWC provides employers with a variety of safety-related training materials and information. Division staff also audit insurance carriers that write workers' compensation coverage to ensure they give employers required assistance in creating safe workplaces. In fiscal year 2009, DWC distributed about 138,000 educational materials on workplace safety, held 59 training seminars regarding workplace safety, and audited 115 insurance carriers' accident prevention services. As part of a federal grant program, the Division also assisted more than 2,600 small employers in complying with federal safety standards.

- **Customer Assistance**. Division staff assist injured employees and other system participants in navigating the complex workers' compensation system. Staff, located across the state in DWC's 24 field offices, answer questions about filing a claim or disputing the denial of a claim, and host educational seminars. In fiscal year 2009, DWC provided system participants with approximately 1.5 million informational publications.

- **Subsequent Injury Fund**. The Subsequent Injury Fund (SIF) provides payments to injured employees who qualify for Lifetime Income Benefits as a result of a subsequent work-related injury and reimbursements to insurance carriers for benefit overpayment. In fiscal year 2009, the Division made about $3.6 million in SIF payments. To fund the SIF, workers' compensation insurance carriers contribute any unexpended death benefit payments for covered employees without beneficiaries. At the end of fiscal year 2009, the fund had a balance of $60.2 million.

Issues

Issue 1

The Division's Complicated Dispute Resolution Process Often Fails to Provide a Quicker, More Accessible Alternative to the Courts.

Background

Workers' compensation insurance provides injured employees with needed medical care and partial replacement of lost wages due to a work-related injury or illness. Although most workers' compensation claims are processed and benefits are provided without question, system participants may dispute an insurance carrier's denial of claim liability or medical care, as well as the level of income benefits paid or amount reimbursed for medical treatment provided.

The Legislature established an administrative dispute resolution process as an alternative to resolving workers' compensation disputes through costly and time-consuming litigation. Parties to a dispute seek resolution through a number of different low-level processes and more formal administrative proceedings. In recent years, the Legislature made significant changes to the dispute resolution process, and also introduced health care networks to the workers' compensation system. Workers' compensation networks function similarly to group health networks, allowing an employer to manage health care provided to injured employees by contracting with providers of their choice for a fee separate and apart from fee guidelines developed by the Division of Workers' Compensation (DWC).

Currently, each type of dispute – Indemnity, Medical Necessity, and Medical Fee – is subject to different resolution processes. The chart on the next page, *Workers' Compensation Dispute Resolution Process*, details the types of disputes that arise in the workers' compensation system, the typical parties involved, and the path those parties take to seek resolution. Appendices A, B, and C provide a more detailed description of the steps involved in each dispute resolution process.

Findings

Unprepared parties to a mediation waste valuable time and staff resources and hamper opportunities for early dispute resolution.

Despite a legislative directive to make the informal mediation process more productive – including limiting the number of Benefit Review Conferences (BRC) held to two, and requiring participants to document an initial attempt to resolve the dispute themselves – system participants continue to request BRCs without fully developing documentation to support the dispute. In fact, the Division does not require parties to demonstrate preparedness or submit any documentation supporting the dispute when requesting a BRC. In fiscal year 2009, the agency rescheduled 13,421 BRCs, more than 3,000 of which were based on parties needing additional time to prepare or lacking necessary documentation, such as medical records.

DWC had to reset more than 3,000 mediations because parties were not prepared.

Workers' Compensation Dispute Resolution Process

Dispute Description		Dispute Process
Indemnity		
Arises when a carrier denies claim liability stating that an injury or illness is not work-related; or that an injured employee is not eligible for payment of lost wages or other monetary compensation. Typically raised by an injured employee when an insurance carrier denies liability for a claim or denies payment of income benefits.		**Informal Resolution**: Mediation, called a Benefit Review Conference (BRC), before the Division. **Appeal 1**: Contested Case Hearing (CCH), similar to a hearing in a court of law, before the Division. **Appeal 2**: Review by the Division's Appeals Panel. **Appeal to district court.**
Medical Necessity		
Arises when a carrier denies medical care for an injured employee as not medically necessary. Typically raised by an injured employee, or a health care provider on behalf of an injured employee, whose medical care has been denied authorization by an insurance carrier.	**Network**	**Appeal 1**: Independent Review Organization (IRO), certified by the Texas Department of Insurance, provides an expert medical evaluation of the carrier's reason for denial. **Appeal to district court.**
	Non-Network	**Appeal 1**: IRO provides an expert medical evaluation of the carrier's reason for denial. **Appeal 2**: CCH, similar to a hearing in a court of law, before the Division or State Office of Administrative Hearings (SOAH). **Appeal to district court.**
Medical Fee		
Arises when an insurance carrier denies or reduces payment for a medical treatment or service provided. Typically raised by a health care provider, however disputes can also be raised by the injured employee or a subclaimant.	**Network**	The terms of the network contract prescribe the resolution of medical fee disputes outside of an administrative appeal process.
	Non-Network	**Appeal 1**: Division staff evaluate the dispute against DWC-adopted fee guidelines and issue a decision. **Appeal 2:** CCH, similar to a hearing in a court of law, before the Division or SOAH. **Appeal to district court.**

Parties to a dispute may request to reschedule a BRC for any number of reasons and with virtually no notice given. In fiscal year 2009, DWC rescheduled more than half of the number of initial requests received by the agency. This significant number of rescheduled BRCs disrupts the hearings process, leaving gaps in the BRC docket which staff cannot fill on short notice, and takes staff away from conducting other mediations.

The process for resolving non-network medical fee disputes lacks a mechanism for encouraging parties to attempt resolution through mediation before proceeding to a Contested Case Hearing.

The lack of opportunity for mediation for certain disputes clogs DWC's hearing docket.

The Division resolves nearly all non-network medical fee disputes through its initial staff-level review process.[1] However, unlike the BRC process, this staff-level review does not include mediated communication between the parties before proceeding to a CCH. In fiscal year 2009, 44 percent of the non-network fee disputes appealed were resolved during the pre-hearing conference, indicating that given the opportunity, parties are able to resolve differences before formal action is taken. Without a low-level mediation process, after the initial staff decision, the first time parties must discuss the particular matters of the dispute is at the pre-hearing conference, which clogs the CCH docket and postpones resolution.

Having two different dispute resolution processes for medical necessity disputes treats injured employees inequitably.

Medical necessity disputes are subject to different appeals processes depending on whether or not an injured employee receives network or non-network medical care. The flowchart on the next page, *Medical Necessity Dispute Resolution*, shows the complete dispute resolution process for questions of medical necessity provided both in- and out-of-network.

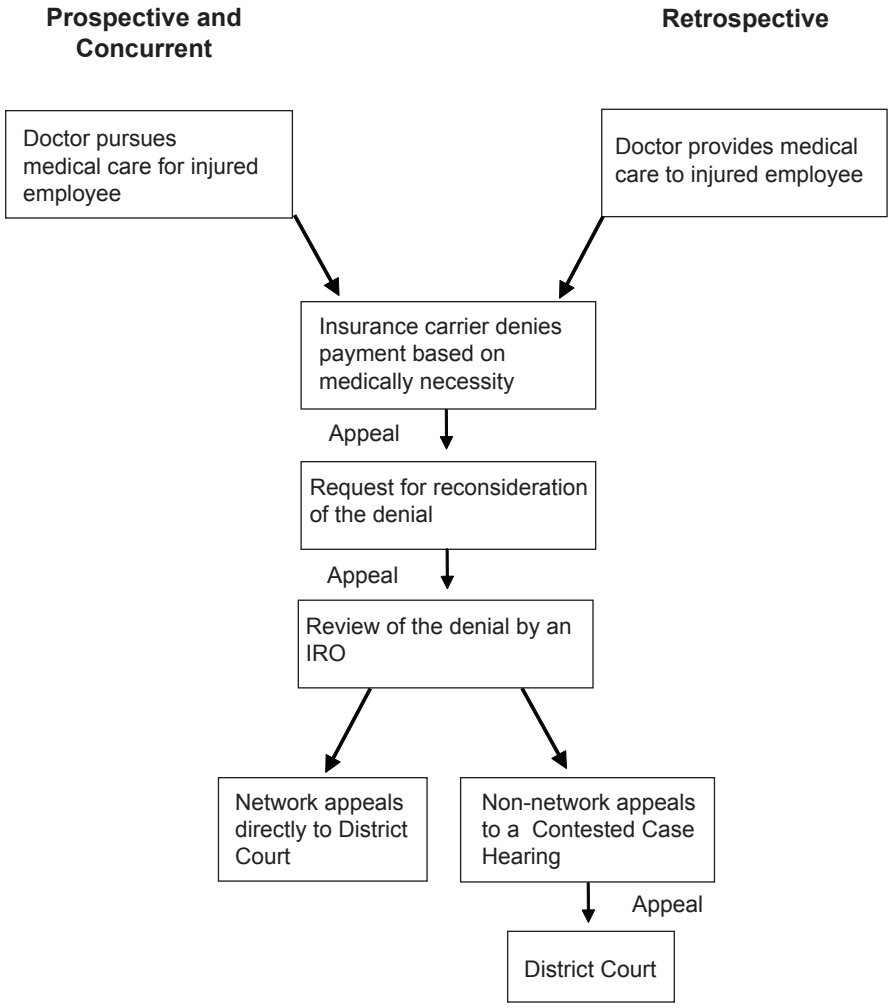
Injured employees receiving medical care in-network do not have access to low-cost dispute resolution.

Statute entitles injured employees, regardless of how they receive medical care, to quality treatment and a fair and accessible dispute resolution process.[2] Injured employees receiving treatment through a network must appeal denials of medical care to district court, whereas employees receiving non-network medical care appeal to a CCH – a low-cost, administrative process. Having two different resolution processes places injured employees pursuing a medical necessity dispute on unequal footing. Injured employees disputing in-network medical care denials have a much more difficult time overcoming an improper denial of care than those injured employees receiving care outside of a network.

The Legislature established the network system to provide a streamlined approach to health care delivery in the workers' compensation system, similar to that of group health. The existence of networks, however, does not create a different entitlement to care – injured employees receiving medical treatment in-network or out-of-network should receive the same level of care. Although both dispute resolution options offer advantages and disadvantages, the appeals

process for non-network medical necessity disputes better incorporates the Legislature's broader intent to afford injured employees with the right to a fair and accessible dispute resolution system.

Medical Necessity Dispute Resolution



Having two different agencies conduct non-network medical dispute hearings yields inconsistent decisions and increases costs to system participants, with no added benefit.

In 2007, to address constitutionality issues, the Legislature modified the appeals process for non-network medical necessity and medical fee disputes to involve both DWC and SOAH in conducting Contested Case Hearings. The table, *Formal Non-network Medical Appeal Process*, provides additional information on the types of cases subject to this bifurcated system.

Formal Non-network Medical Appeal Process

Type of Appeal	Venue	Number of Appeals FY 09
Non-network Medical Necessity		
Prospective and Concurrent	DWC	367
Spinal Surgeries	DWC	166
Retrospective – Less than $3,000	DWC	2
Retrospective – More than $3,000	SOAH	5
Non-network Medical Fee		
Fee Dispute - Less than $2,000	DWC	63
Fee Dispute - More than $2,000	SOAH	175

- **Differences in the agencies' rules of procedures make SOAH hearings more formal and potentially lead to inconsistencies**. The Division conducts Contested Case Hearings and issues decisions using a precedent manual. In contrast, the State Office of Administrative Hearings uses its own rules of procedure that contain different standards for admitting evidence into the record than the Division's rules of procedure. These differences require parties to the case to provide a higher level of case preparation for disputes before SOAH, which is contrary to the overall system goal of providing an easily accessible administrative appeal process, and could potentially lead to inconsistencies in decisions. In addition, SOAH only conducts hearings in Austin, requiring participants to travel to Austin for the hearing. In contrast, the Division holds hearings in 24 field offices across the state and will even travel to employees who reside in extremely rural areas.[3]

The Division provides the same type of expertise and neutral review as SOAH.

- **SOAH's involvement in workers' compensation disputes is unnecessary to ensure independent case resolution**. Historically, the Legislature has placed contested case proceedings for administrative actions, such as agency enforcement cases, before SOAH to provide a high level of legal expertise and a wholly independent review of issues at hand. However, the Legislature created a separate administrative process at the Division to provide that same type of expertise and neutral review in workers' compensation disputes. Because the Division is not a party to dispute proceedings but is an independent judge, unlike many agencies that have Contested Case Hearings before SOAH, the agency is able to fulfill the role of neutral adjudicator.

Further, the Division has procedures in place, comparable to SOAH, to ensure that contested case decisions are fair, accurate, and consistent amongst field office staff, as shown in the table, *Quality Assurance of Contested Case Hearing Decisions*.

Quality Assurance of Contested Case Hearing Decisions

Type of Quality Assistance	DWC	SOAH
Written Decision and Order Peer Review	√	√
Contested Case Hearing Observations by Management	√	√
Ongoing Supplemental Training	√	√

- **Contested Case Hearings before SOAH are more costly to the Division than hearings conducted in-house**. The Division reimburses SOAH $100 per hour for Administrative Law Judge time and $50 per hour for legal assistant time spent on all workers' compensation cases. In fiscal year 2009, the Division spent $94,000 reimbursing SOAH for 180 medical dispute hearings. The Division, however, conducts hearings at a lower cost. Also, the Division anticipates an increased volume of appeals that fall within SOAH's jurisdiction in the near future, necessitating even higher reimbursement costs.

The Appeals Panel cannot adequately voice the Division's stance on important indemnity cases.

The Appeals Panel cannot always communicate precedent on cases.

The Division's Appeals Panel acts as the final agency-level administrative appeal for indemnity disputes and oftentimes issues decisions that become precedent for future cases. Parties dissatisfied with the outcome of a Contested Case Hearing may appeal to the Division's Appeals Panel, which is composed of three administrative law judges who perform a desk review of the record and Hearing Officer's decision, and issue a final administrative-level decision on the case.

As part of efforts to streamline the Appeals Panel review process, the Legislature created the unintended consequence of prohibiting the Appeals Panel from weighing in on significant decisions not previously affirmed or reversed by the Appeals Panel, as well as other cases that may affect future precedent such as incorrect application of the law. Prohibiting the Appeals Panel from issuing affirmations on certain cases of high significance precludes important statements regarding precedent from communicating feedback to Division Hearing Officers in the field and reaching all system participants.

Inconsistencies in the judicial review appeal process lead to system participant confusion.

Differences in judicial appeal timeframes may unfairly disadvantage system participants who appeal an insurance carrier denial. In 2009, the Legislature

extended the statutory timeframe for an injured employee to file an appeal to district court of an administrative decision regarding an indemnity dispute to 45 days. This change ensures all parties have an opportunity for timely notification of decisions before the timeframe for appealing that decision begins. However, the Legislature did not extend the statutory timeframe for appeals of medical necessity and non-network medical fee disputes. Thus, system participants must follow a confusing system of different timeframes depending on the type of dispute decision being appealed.

The timeframes and venue for judicial appeal are unclear.

Statute does not clearly specify the required venue for filing appeals for judicial review of Contested Case Hearing decisions regarding medical disputes. Statute outlines a process for filing appeals for judicial review, however, this process only clearly applies to indemnity disputes and is not clearly linked with appeals of medical necessity and non-network fee disputes. Without aligning the statutory venue for medical and indemnity appeals, which court has jurisdiction may be unclear.

Recommendations

Change in Statute

1.1 Require parties to a dispute to prove preparedness as a prerequisite to a Benefit Review Conference.

This recommendation would require injured employees, employers, health care practitioners, insurance carriers, and other parties to a dispute to obtain information necessary to facilitate resolution of the dispute as part of the initial request for a BRC. In evaluating a BRC request, Division staff would be authorized to deny the request for a BRC if participants have failed to attest to having necessary documentation, such as medical records. Under this recommendation, the Division would be required to adopt rules outlining what types of documents would be needed to approve a request for a BRC, as well as the process used by Division staff for evaluating submitted information.

Under this recommendation, parties to a dispute would also be required to provide notice to the Division before rescheduling a Benefit Review Conference. The Division would develop circumstances, by rule, in which rescheduling a BRC would be authorized for good cause, as well as the timeframes by which a request to reschedule must occur. Rescheduled Benefit Review Conferences would not automatically be reset on the agency's docket; rather the participant requesting the reset would be required to re-submit a request for a Benefit Review Conference for Division approval, and comply with all requirements of an initial request for a BRC.

Failure to abide by the Division-approved system for rescheduling would result in forfeiting an opportunity to attend a Benefit Review Conference. Parties to a dispute who reach the statutory two-BRC limit could resolve the dispute themselves or proceed to a formal Contested Case Hearing. This recommendation would also work in conjunction with Recommendation 1.3 in the Office of Injured Employee Counsel section of this report to better prevent wasted time and efforts of all BRC participants, including Division staff.

1.2 Require parties to a non-network medical fee dispute to attempt a low-level mediation, through a Benefit Review Conference, before appealing to the Contested Case Hearing level.

This recommendation would require parties to a non-network medical fee dispute to participate in a BRC administered by DWC as a prerequisite to filing an appeal for a Contested Case Hearing. Non-network medical fee disputes would remain subject to an initial staff review and decision process, however, parties dissatisfied with the staff decision would file an appeal for mediation as a prerequisite to proceeding to a Contested Case Hearing.

Under this recommendation, the mediation process for non-network medical fee disputes would mirror the structure for BRCs held on indemnity disputes. As part of the mediation process, parties to the dispute would be able to resolve issues, such as billing discrepancies. However, parties would not be authorized to negotiate fees outside of the Division's adopted fee guidelines. As part of this recommendation, parties would be subject to fulfilling the BRC requirements outlined in Recommendation 1.1.

If adopted, this recommendation would only affect appeals of staff-level medical fee dispute decisions issued on or after the effective date of the Sunset bill.

1.3 Establish an administrative appeal mechanism for network medical necessity disputes.

This recommendation would augment the current appeal process for network medical necessity disputes by restructuring appeals of IRO determinations to include a CCH before the Division, instead of a direct appeal to district court. Contested Case Hearings held on *network* medical necessity disputes would conform to the same procedures outlined in the Labor Code as those CCHs conducted on appeals of *non-network* medical necessity disputes. Division Hearings Officers would be required to weigh a network's adopted evidence-based treatment guidelines, in adjudicating the appeal just as they currently weigh Division-adopted treatment guidelines for medical care delivered by a non-network health care provider.

Because IROs conduct desk reviews of medical records that are not formal, recorded proceedings, under this recommendation, the Contested Case Hearing process would produce a record admissible to court during an appeal for judicial review. As a result, under this recommendation, network medical necessity disputes would no longer be subject to a *trial de novo* standard of judicial review. Instead, network medical necessity disputes would be subject to a substantial evidence review, allowing the judge to review the formal record resulting from a Contested Case Hearing before the Division.

If adopted, this recommendation would only affect appeals of IRO medical necessity decisions issued on or after the effective date of the Sunset bill.

1.4 Streamline the process for resolving non-network medical disputes, by removing SOAH's involvement in conducting Contested Case Hearings.

Under this recommendation the State Office of Administrative Hearings would no longer have a role in performing Contested Case Hearings for workers' compensation disputes. Specifically, this would eliminate SOAH's role in adjudicating retrospective medical necessity cases valued at more than $3,000 or medical fee disputes involving reimbursements in excess of $2,000. Instead, Contested Case Hearings for both types of disputes would be held before the Division and conducted in the same manner as other medical necessity and medical fee Contested Case Hearings. Also, as part of

this recommendation, medical necessity Contested Case Hearing decisions, including spinal surgery cases, and medical fee disputes would not be subject to the Division's Appeals Panel review. As a result of this recommendation, because the Division would no longer reimburse SOAH for conducting workers' compensation dispute hearings, the Texas Department of Insurance, Division of Workers' Compensation would save about $94,000 annually.

If adopted, this recommendation would only affect appeals of IRO medical necessity decisions and staff-level medical fee dispute decisions issued on or after the effective date of the Sunset bill.

1.5 Authorize the Division's Appeals Panel to issue written affirmations in limited circumstances.

This recommendation would allow the Division's Appeals Panel to issue written decisions affirming Contested Case Hearing decisions on only the following types of cases:

- cases of first impression;
- cases that are impacted by a recent change in law; and
- cases that include inappropriate findings of fact, conclusions of law, or other legal errors.

If adopted, this recommendation would only affect appeals of CCH decisions issued on or after the effective date of the Sunset bill. This recommendation would ensure all system participants are well apprised of precedent set by the Division, as well as allow the Division to better ensure consistency amongst its Hearing Officers.

1.6 Extend the timeframe allowed for appeals of DWC decisions regarding medical necessity and non-network medical fee disputes to district court.

This recommendation would extend the amount of time, from 30 to 45 days, parties to a medical necessity or medical fee dispute have to file an appeal of an agency decision for judicial review. This change would only apply to medical necessity and fee disputes subject to an administrative appeals process before the Division.

If adopted, this recommendation would only affect appeals to district court of CCH decisions issued on or after the effective date of the Sunset bill.

1.7 Clarify the venue for district court appeals of agency decisions regarding medical disputes.

This recommendation would clarify that appeals of medical necessity and non-network medical fee disputes should be filed and held in the county where the employee resided at the time of injury, or at the time disability associated with a work-related illness began. Parties to a dispute would also be authorized to file district court appeals in a mutually agreed upon county. Appeals misfiled in the incorrect county would follow the resolution process established in statute for indemnity dispute district court appeals.[4] This recommendation would only apply to appeals of agency decisions regarding medical necessity and fee disputes.

If adopted, this recommendation would only affect appeals to district court of CCH decisions issued on or after the effective date of the Sunset bill.

Management Action

1.8 The Division should require a review of all Contested Case Hearing decisions to ensure consistency amongst field office staff.

Under this recommendation, the Division would require a review of all Hearing Officers' contested case decisions before releasing the final order. By practice, all Hearing Officers are already requesting this review, however, the Division should ensure that this practice continues in the future.

Fiscal Implication Summary

These recommendations would not have an overall fiscal impact to the State. The recommendations would result in an appropriations reduction of approximately $94,000 per year reflected in the Texas Department of Insurance appropriations pattern. However, due to the self-regulating nature of the Department's funding, any savings would result in a reduction of maintenance taxes on workers' compensation insurers, but would be revenue neutral to the State.

Recommendation 1.1 – Requiring an early resolution mediation for non-network medical fee disputes as a prerequisite to a Contested Case Hearing would increase the number of Benefit Review Conferences held by approximately 238 per year, based on fiscal year 2009 data. However, these additional BRCs could be conducted using existing hearings staff.

Recommendations 1.3 and 1.4 – Removing the State Office of Administrative Hearings jurisdiction in conducting Contested Case Hearings for non-network medical disputes would result in a biennial savings to the Texas Department of Insurance, Division of Workers' Compensation of approximately $188,000.

Holding non-network medical dispute hearings at DWC and establishing an administrative appeal process for network medical necessity disputes would increase the number of CCHs at the Division by about 500 additional cases per year. However, the Division would be able to handle this increased workload with existing resources. According to DWC, Hearing Officers can complete a caseload of up to 200 hearings each year. Currently, each of the Division's 34 Hearing Officers conducts approximately 133 hearings each year, leaving additional room for growth in their caseload.

Recommendation 1.5 – Authorizing the Appeals Panel to write affirmations of significant cases would only increase the Panel's workload by about 30 cases, which can be handled using existing resources.

Texas Department of Insurance

Fiscal Year	Savings to the General Revenue Fund Account 36	Loss to the General Revenue Fund Account 36	Net Effect to the General Revenue Fund Account 36
2012	$94,000	($94,000)	0
2013	$94,000	($94,000)	0
2014	$94,000	($94,000)	0
2015	$94,000	($94,000)	0
2016	$94,000	($94,000)	0

[1] In fiscal year 2009, the Division's staff-level review resolved 96 percent of all non-network medical fee disputes before appeal.

[2] Texas Labor Code, sec. 402.021(a)(2) and (3).

[3] Texas Labor Code, sec. 410.005.

[4] Texas Labor Code, sec. 410.252.

Responses to Issue 1

Recommendation 1.1

Require parties to a dispute to prove preparedness as a prerequisite to a Benefit Review Conference.

Agency Response to 1.1

The Division agrees that requiring parties to prove preparedness as a prerequisite to the scheduling of a BRC will streamline the dispute resolution process. The Division has rules in development to address this issue, but believes statutory clarification is appropriate. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 1.1

Susan Rudd-Bailey, MD, President and David Teuscher, MD – Texas Medical Association, Austin

Against 1.1

Lee Ann Alexander – Liberty Mutual Group, Austin

Cathy DeWitt, Vice President – Texas Association of Business, Austin

Jo Betsy Norton, Vice President, Public Affairs and Kristi Guerrero, Sr. Administrative Specialist, Public Affairs – Texas Mutual Insurance Company, Austin

Frank Weedon, Attorney – Mayfield Weedon, LLP, Longview

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Modification

1. Once a BRC hearing request is granted and the hearing is set, this setting should count against the party's entitlement to a maximum of two BRCs. (Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin and Lee Ann Alexander – Liberty Mutual Group, Austin)

Recommendation 1.2

Require parties to a non-network medical fee dispute to attempt a low-level mediation, through a Benefit Review Conference, before appealing to the Contested Case Hearing level.

Agency Response to 1.2

The Division agrees that allowing the parties the opportunity to discuss their dispute resolution prior to a formal CCH reduces the number of CCHs scheduled to resolve medical fee disputes. The Division has no objection to including a BRC as long as the BRC's purpose is to allow parties to exchange information and discuss the dispute and not allow parties to negotiate a medical fee for health care services that differs from the Division's adopted medical fee guidelines. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 1.2

None received.

Against 1.2

Lee Ann Alexander – Liberty Mutual Group, Austin

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Modifications

2. Allow parties to a BRC on non-network medical fee dispute the ability to agree on a monetary level other than the Division's adopted fee guidelines. (Jo Betsy Norton, Vice President, Public Affairs and Kristi Guerrero, Sr. Administrative Specialist, Public Affairs – Texas Mutual Insurance Company, Austin)

3. Authorize parties to mutually agree to depart from the Division's fee guidelines in settling a dispute. (Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin)

Recommendation 1.3

Establish an administrative appeal mechanism for network medical necessity disputes.

Agency Response to 1.3

The network appeal process could be aligned with the non-network process pending statutory change, as recommended by Sunset Staff. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 1.3

None received.

Against 1.3

Lee Ann Alexander – Liberty Mutual Group, Austin

Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin

Against 1.3 (continued)

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Modification

4. Clarify how Hearings Officers will "weigh" a network's adopted evidence-based guidelines. (Jo Betsy Norton, Vice President, Public Affairs and Kristi Guerrero, Sr. Administrative Specialist, Public Affairs – Texas Mutual Insurance Company, Austin)

Recommendation 1.4

Streamline the process for resolving non-network medical disputes, by removing SOAH's involvement in conducting Contested Case Hearings.

Agency Response to 1.4

The Division agrees that designating a single agency to adjudicate workers' compensation medical necessity and medical fee disputes will bring consistency to the process. The Division has the expertise and is equipped to handle these disputes as recommended by Sunset Staff. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

Affected Agency Response to 1.4

If the Sunset Commission or the Legislature should decide not to go forward with the return of the medical dispute resolution cases to the Division, we would continue to bring our role and our experience to bear. We also have enjoyed an amicable and collaborative relationship with the Division and TWCC, which we look forward to continuing under any scenario. (Cathleen Parsley, Chief Administrative Law Judge – State Office of Administrative Hearings)

For 1.4

None received.

Against 1.4

Lee Ann Alexander – Liberty Mutual Group, Austin

Joe R. Anderson, Attorney – Burns Anderson Jury & Brenner, LLP, Austin

Susan Rudd-Bailey, MD, President and David Teuscher, MD – Texas Medical Association, Austin

Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin

Cathy DeWitt, Vice President – Texas Association of Business, Austin

Thomas Daniel Hollaway, Attorney – Hollaway & Gumbert, Houston

Against 1.4 (continued)

Jo Betsy Norton, Vice President, Public Affairs and Kristi Guerrero, Sr. Administrative Specialist, Public Affairs – Texas Mutual Insurance Company, Austin

Jane Lipscomb Stone – Stone Loughlin & Swanson, LLP, Austin

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Modification

5. Remove all Contested Case Hearings from the Division and place all hearings at the State Office of Administrative Hearings. (Jane Lipscomb Stone – Stone Loughlin & Swanson, LLP, Austin)

Staff Comment: The Division held more than 5,000 CCHs in FY 2009, all across the state.

Recommendation 1.5

Authorize the Division's Appeals Panel to issue written affirmations in limited circumstances.

Agency Response to 1.5

The Division agrees with the recommendation to reinstate the Appeals Panel's ability to write affirmations of Hearings Officers' decisions in certain circumstances in order to provide guidance to system participants and correct legal errors that do not affect the outcome of the case at hand but may be used inappropriately in future cases. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 1.5

Lee Ann Alexander – Liberty Mutual Group, Austin

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Against 1.5

None received.

Modifications

6. Clarify how the Appeals Panel will review "inappropriate findings of fact." (Jo Betsy Norton, Vice President, Public Affairs and Kristi Guerrero, Sr. Administrative Specialist, Public Affairs – Texas Mutual Insurance Company, Austin)

7. Clarify that the Appeals Panel is not authorized to modify or change findings of fact made by the Hearing Officer. (Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin)

Recommendation 1.6

Extend the timeframe allowed for appeals of DWC decisions regarding medical necessity and non-network medical fee disputes to district court.

Agency Response to 1.6

The Division agrees with this recommendation and believes that aligning timeframes for medical appeals with those for indemnity appeals would eliminate any confusion for system participants. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 1.6

None received.

Against 1.6

Lee Ann Alexander – Liberty Mutual Group, Austin

Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin

Jo Betsy Norton, Vice President, Public Affairs and Kristi Guerrero, Sr. Administrative Specialist, Public Affairs – Texas Mutual Insurance Company, Austin

Jane Lipscomb Stone – Stone Loughlin & Swanson, LLP, Austin

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Recommendation 1.7

Clarify the venue for district court appeals of agency decisions regarding medical disputes.

Agency Response to 1.7

The Division agrees with this recommendation. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 1.7

Lee Ann Alexander – Liberty Mutual Group, Austin

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Against 1.7

Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin

Jo Betsy Norton, Vice President, Public Affairs and Kristi Guerrero, Sr. Administrative

Specialist, Public Affairs – Texas Mutual Insurance Company, Austin

Jane Lipscomb Stone – Stone Loughlin & Swanson, LLP, Austin

Recommendation 1.8

The Division should require a review of all Contested Case Hearing decisions to ensure consistency amongst field office staff.

Agency Response to 1.8

The Division agrees and has recently implemented this recommendation effective April 13, 2010. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation).

For 1.8

Lee Ann Alexander – Liberty Mutual Group, Austin

Jo Betsy Norton, Vice President, Public Affairs and Kristi Guerrero, Sr. Administrative Specialist, Public Affairs – Texas Mutual Insurance Company, Austin

Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Against 1.8

None received.

Commission Decision

Adopted Recommendations 1.1 through 1.3.

Adopted a modification as an alternative to Recommendation 1.4 to improve the process for resolving medical disputes by holding all medical necessity hearings before the Division and all fee dispute hearings before SOAH.

The modification also:

- retains the staff recommendation to remove the statutory provisions requiring spinal surgery cases to go through the DWC Appeals Panel, and instead treats these cases like all other medical necessity disputes;

- eliminates SOAH costs paid by DWC for fee disputes by requiring the losing party to pay SOAH hearing costs;
- authorizes the Division to intervene in SOAH hearings that involve significant issues of fee guideline interpretation; and
- only affects appeals of IRO medical necessity decisions and staff-level medical fee decisions issued on or after the effective date of the Sunset bill.

Adopted Recommendation 1.5, which authorizes the Division's Appeals Panel to issue written affirmations in limited circumstances, with a modification to apply only to the following types of cases:

- cases of first impression;
- cases that are impacted by a recent change in law; and
- cases involving errors which require correction but which do not affect the outcome of the dispute, including:
  - findings of fact for which there is insufficient evidence;
  - incorrect conclusions of law;
  - findings of fact or conclusions of law which were not properly before the hearing officer; or
  - other legal errors.

Adopted Recommendation 1.8.

Legislative Action

House Bill 2605 requires injured employees, employers, health care practitioners, insurance carriers, and other parties to a dispute to obtain information necessary to facilitate resolution of the dispute as part of the initial request for a Benefit Review Conference (BRC). The bill authorizes DWC staff to deny the request for a BRC if participants have failed to attest to having necessary documentation, such as medical records. The bill also requires parties to a dispute to provide notice to DWC before rescheduling a BRC. Failure to abide by the DWC-approved system for rescheduling would result in forfeiting an opportunity to attend a Benefit Review Conference. Parties to a dispute who reach the statutory two-BRC limit could resolve the dispute themselves or proceed to a formal Contested Case Hearing. (Recommendation 1.1)

House Bill 2605 requires parties to a non-network medical fee dispute to participate in a BRC administered by DWC as a prerequisite to filing an appeal for a Contested Case Hearing. Non-network medical fee disputes will remain subject to an initial staff review and decision process. However, parties dissatisfied with the staff decision would file an appeal for mediation as a prerequisite to proceeding to a Contested Case Hearing. As part of the mediation process, parties to the dispute will be able to resolve issues, such as billing discrepancies, but will not be authorized to negotiate fees outside of the Division's adopted fee guidelines. (Recommendation 1.2)

The bill also augments the current appeal process for network medical necessity disputes by restructuring appeals of Independent Review Organization determinations to include a Contested Case Hearing before the Division, instead of a direct appeal to district court. Contested Case Hearings held on network medical necessity disputes will conform to the same procedures outlined in the Labor Code as those Contested Case Hearings conducted on appeals of non-network medical necessity disputes. The Legislature modified the Sunset provision to clarify that medical necessity disputes arising between injured employees and their political subdivision employer are subject to the same Contested Case Hearing process as other network medical necessity and fee disputes. House Bill 2605 also adjusts the standard of review in district court for these cases to a substantial evidence review, allowing the judge to review the formal record resulting from a Contested Case Hearing before the Division. (Recommendation 1.3)

House Bill 2605 shifts the dispute resolution process for medical necessity and medical fee cases. All Contested Case Hearings for medical necessity cases will be held before the Division, with appeals of medical necessity Contested Case Hearing decisions, including those decisions related to spinal surgery cases, no longer subject to the Division's Appeals Panel review before appealing to district court. All medical fee Contested Case Hearings will be held before the State Office of Administrative Hearings (SOAH). Also, the bill requires the losing party appealing DWC's staff-level medical fee decision to pay all associated hearing costs at SOAH. Because medical fee cases involve DWC-adopted fee guidelines, the bill authorizes the Commissioner of Workers' Compensation to intervene in cases sent to SOAH that involve issues of fee guideline interpretation. (Commission alternative to Recommendation 1.4)

Finally, the bill allows the Division's Appeals Panel to issue written decisions affirming Contested Case Hearing decisions on only the following types of cases:

- cases of first impression;
- cases that are impacted by a recent change in law; and
- cases involving errors which require correction but which do not affect the outcome of the dispute. (Recommendation 1.5 as modified)

As a management recommendation not needing statutory change, Recommendation 1.8 did not result in legislative action.

Issue 2

The Division's Medical Quality Review Process Needs Improvement to Ensure Thorough and Fair Oversight of Workers' Compensation Medical Care.

Background

In structuring the State's oversight of the workers' compensation system, the Legislature established a broad goal of ensuring injured employees have access to high-quality medical care.[1] As part of this mission, the Legislature charged the Division of Workers' Compensation (DWC) to monitor the appropriate delivery of medical care – both decisions to provide or deny care made by insurance companies and actual treatment given by health care providers – through a variety of different compliance efforts. Although other regulatory agencies, like the Texas Medical Board, conduct compliance efforts to evaluate standard of care and ensure public protection, DWC's efforts focus on the unique statutory requirements for medical care provided in the workers' compensation system. Statute directs the Division to employ a Medical Advisor, who provides medical expertise in regulatory matters.

The Legislature specifically charged DWC with monitoring the legitimacy of insurance carrier denials for medical care and reimbursement for care provided; the accuracy of reviews performed by Utilization Review Agents, Independent Review Organizations, Designated Doctors, and peer review doctors; and the quality of care provided in the workers' compensation system by health care professionals.[2] The Medical Advisor oversees this medical quality review process and appoints a Medical Quality Review Panel (MQRP), composed of health care professionals who serve as expert reviewers in conducting medical quality case reviews and evaluating potential violations of the Texas Workers' Compensation Act. The table, *MQRP Membership*, shows the Panel's current composition.

MQRP Membership

Type of Provider	Number of Panelists
Physician	27
Chiropractor	6
Psychologist	1
Occupational Therapist	1
Physical Therapist	1
Total	**36**

Medical quality reviews fall into two main categories – audit-based cases, selected by the Division as part of a broad system-monitoring effort, and complaint-based cases, which are referred from a variety of different sources. The Commissioner approves an annual plan formulated by the Medical Advisor, in consultation with MQRP members, outlining selection priorities for audit-based reviews. The audit plan focuses on medical procedures that involve a high level of risk or are high cost drivers in the workers' compensation system. The 2009 audit priorities included a focus on insurance carriers' inappropriate denial of medically necessary treatment, physicians who have a high rate of prescribing narcotics, and the outcome of previously performed spinal fusions and implanted pain management devices. Once the Medical Advisor determines the subject areas for audit-based reviews, the Medical Advisor works with Division staff to randomly select specific entities and providers to review. The Medical Advisor also reviews all complaint-based cases, and determines whether the case should be investigated further through the MQRP quality review process or whether a case is egregious enough to be referred directly to enforcement.

In their role as expert reviewers, Panel members evaluate case documentation through a desk review process, determine whether a violation occurred, and make recommendations to the Medical Advisor regarding appropriate sanctions. A subset of the MQRP, called the Quality Assurance Panel (QAP), provides a second review of each case by meeting quarterly with the Medical Advisor in Austin to discuss the facts of the case and the initial MQRP reviewer's recommendation. Although QAP members vote to recommend enforcement action, the Medical Advisor makes the final recommendation regarding case referrals to enforcement.

The Division pays MQRP members $100 per hour of time spent reviewing a case, and reimburses QAP members for expenses incurred when traveling to Austin. In fiscal year 2009, the Division initiated 124 medical quality reviews, as shown in the accompanying table, *Medical Quality Reviews*. Of the 124 reviews, 107 were audit-based reviews and 17 were complaint-based reviews. Payments to MQRP members for case evaluation and travel expenses totaled nearly $51,000.

Medical Quality Reviews – FY 2009

Type of Health Care Provider or Entity Reviewed	Number of Reviews
Insurance Carrier	85
Doctor of Medicine	21
Doctor of Chiropractic	14
Doctor of Osteopathy	2
Physical Therapist	1
Independent Review Organization	1
Total	**124**

Findings

The Medical Advisor's direct involvement in all stages of the medical quality review process threatens its validity and independence.

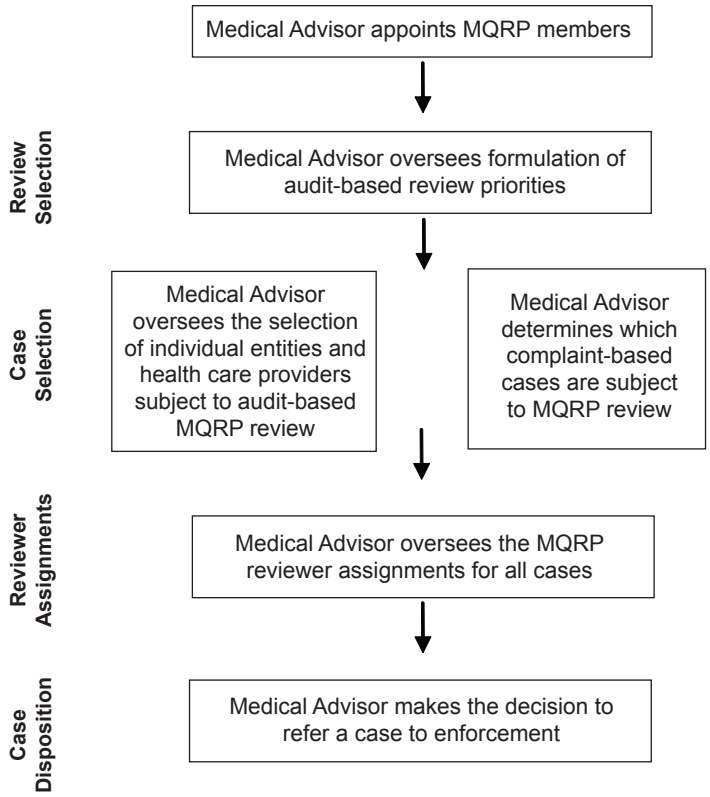
The Division recently discarded eight enforcement cases because of flaws in the review process.

The Medical Advisor guides decisions made at every stage of the review process – from the selection of MQRP members and individual health care providers subject to review, to the decision to recommend enforcement action against those providers. The flowchart, *Medical Advisor's Role In Overseeing MQRP Reviews*, highlights the Medical Advisor's significant influence on the review process. Allowing a single individual to be involved in all aspects of the medical quality review process gives one person too much authority and influence over the process, potentially compromising review outcomes. For example, the Medical Advisor makes the final decision to recommend a case to enforcement, but because of involvement in the case selection and investigation phase, may not be able to make a fully impartial recommendation. In fact, the Division recently discarded eight medical quality review cases referred to enforcement because questions arose regarding the objectivity of the case selection process.

Lack of qualification and training requirements for MQRP members prevent the Division from using the Panel for high-quality review outcomes.

- **Statute does not adequately guide membership qualifications for the Medical Quality Review Panel**. Although statute is virtually silent, the Division, through a contracting process, has developed

Medical Advisor's Role In Overseeing MQRP Reviews



minimal requirements for MQRP membership, as shown in the textbox, *Minimum MQRP Member Qualifications*. However, these minimal requirements do not address more specific qualifications that potentially impact the quality of reviews provided. In contrast, other agencies that perform similar quality-of-care reviews, like the Texas Medical Board, have developed qualifications to serve as an expert reviewer, including holding board certification. The Medical Board also adopted other service requirements important to preserving the integrity of reviews, such as the avoidance of conflicts of interest and grounds for removal of expert panelists who no longer meet requirements to serve or fail to meet expectations in conducting high-quality reviews.

Minimum MQRP Member Qualifications

To qualify to serve on the Medical Quality Review Panel, health care providers must meet the following minimum requirements:

- be eligible to provide medical care in the workers' compensation system;
- show a demonstrated commitment to quality health care and objective diagnosis and treatment; and
- have maintained an active practice in Texas for three years.

The Division relies on a small pool of health care professionals and a limited range of disciplinary backgrounds to perform all reviews. These constraints hinder the Division's ability to match specific case reviews – and the numerous types of health care professionals practicing in

the workers' compensation system – with an expert reviewer who has a similar knowledge-base or specialty training background. For example, physicians review dentistry cases because the Panel lacks a dentist member. Since statute only requires the Division to seek input from the Texas Medical Board and Texas Board of Chiropractic Examiners when selecting MQRP members, DWC may not have formal relationships with other regulatory agencies that have expert reviewer resources, such as the Executive Council of Physical Therapy and Occupational Therapy Examiners.

The Division found that 44 MQRP enforcement recommendations were not actionable.

- **Despite playing a role in the Division's regulatory process, MQRP members do not receive adequate training necessary to effectively evaluate cases and recommend enforcement actions**. In fiscal year 2009, Panel members recommended enforcement action be taken on 113 of 124 cases reviewed. However, the Medical Advisor only referred 69 of those cases to enforcement, discarding 44 recommendations for enforcement action. Of those cases referred, four have resulted in final enforcement action and the remaining are still pending final investigation. These enforcement outcomes may indicate that MQRP members lack sufficient information needed to make effective case recommendations.

  Health care professionals who provide treatment in the workers' compensation system must operate under unique requirements specific to the Labor Code. Unlike serving as an expert reviewer for a regulatory agency such as the Texas Medical Board, MQRP members must apply Division-adopted treatment guidelines to questions of standard of care. However, once appointed by the Medical Advisor, MQRP members do not receive agency training specific to the types of actions that constitute a violation of the Workers' Compensation Act. Also, MQRP members experience a disconnect from their own review recommendations to the Division's final enforcement actions. Although Division staff update a smaller subset of MQRP members, the Quality Assurance Panel, regarding the status of enforcement actions at the quarterly meeting, MQRP members are generally unaware of final case outcomes.

MQRP members must apply information unique to workers' compensation during reviews.

Inadequacies in the process of selecting and conducting medical quality reviews prevent the Division from ensuring the review process is meaningful.

The Division conducts medical quality reviews to ensure injured employees promptly receive needed, high-quality medical treatment, as contemplated by State law. Without a proper system in place to oversee the medical quality review process, the Division cannot adequately assess whether injured employees receive this care, or whether the Division is meeting its statutory oversight charge.

- **The Division does not solicit stakeholder input in the development of audit-based review priorities**. By not actively engaging system participants, the Division overlooks an opportunity to incorporate first-hand knowledge of what is happening in the workers' compensation system at the ground level. Also, because staff develop review priorities internally, system participants potentially subject to review are unaware of the existence of these targeted, audit-based reviews.

QAP meetings include discussions that can taint the process.

- **Quality Assurance Panel meetings do not provide any added value and waste valuable time and agency resources**. In fiscal year 2009, the Division spent more than $13,000 reimbursing QAP members for expenses incurred in traveling to the quarterly meeting. Although the Quality Assurance Panel function provides a needed second review of case findings and recommended actions, the group discussion provided by actually meeting is not necessary to accomplish this goal, and the Division could provide this safeguard through other means. In fact, the Division has not defined clear roles for staff and QAP members in these meetings, inviting an opportunity for outside discussion not appropriate to the specific review that can taint the decision-making process. In contrast, the Texas Medical Board sends all standard-of-care cases through an abbreviated second desk review, performed by an individual expert reviewer, and maintains a third-reviewer process for circumstances where the first and second reviewer disagree on the outcome of a case.

- **The Division does not give system participants subject to medical quality review an adequate opportunity to respond to review findings until enforcement action is already in progress**. The Division notifies participants under review during the initial information gathering stage of the review process. While the Division does allow the subjects of complaint-based reviews an initial opportunity to respond to allegations, subjects of audit-based reviews do not receive the same opportunity. In addition, after initial notification, neither complaint- nor audit-based review subjects receive additional updates or opportunities to formally respond to alleged violations until the case is referred to enforcement. These oversights are not only unfair to system participants under review, but may result in a missed opportunity for the Division to gather information and wasted staff resources pursuing unfounded violations. In contrast, the Texas Medical Board, which performs complaint-based standard-of-care reviews of physicians, provides review subjects written updates regarding review status, as well as an opportunity to provide a formal, written response regarding complaint allegations.

Lack of updates can waste staff resources on unfounded violations.

Recommendations

Change in Statute

2.1 Require Division staff, rather than the Medical Advisor, to manage and oversee the medical quality review process.

This recommendation allows the Medical Advisor to focus on medical matters and not administration of the medical quality review process. Division staff would manage the MQRP membership selection process and the Commissioner would be required to approve all final contracts. Division staff would also oversee all aspects of review selection, including choosing audit-based review priorities and individual cases to review, referring compliant-based cases to MQRP, and assigning MQRP reviewers. Staff involved in the selection of reviews and assignment of expert panelists would not be involved in analyzing the panelists' recommendation or in making the ultimate decision to refer the case to enforcement, to prevent the same type of conflict that exists in the current process.

As a result of this recommendation, the Medical Advisor would no longer hold statutory responsibility for selecting MQRP members. Also, the Medical Advisor would no longer serve as the Chair of MQRP, removing the Medical Advisor's direct role in review selection, MQRP member assignment, and recommending enforcement actions resulting from completed reviews. As part of this recommendation, the Medical Advisor's statutorily defined role in the medical quality review process would be clarified to be purely advisory, allowing Division staff to seek medical expertise from the Medical Advisor as needed.

The Medical Advisor would still provide assistance in the selection of MQRP members and type of reviews conducted, as well as the process by which cases are assessed for possible referral to enforcement, but the Division would make all final decisions.

2.2 Require the Division to develop guidelines to strengthen the medical quality review process.

In conjunction with Recommendation 2.1, this recommendation would require the Division to develop criteria, subject to the Commissioner's approval, to further improve the medical quality review process. In developing these guidelines, the Division should address, at a minimum, the following areas:

- criteria for assessing whether complaint-based cases should be dismissed, subjected to a quality review by MQRP, or directly referred to enforcement;
- procedures outlining the selection of audit-based review priorities, including the targeted number of reviews to be conducted in a given fiscal year;
- a process for including stakeholder input in the development of audit-based review priorities;
- a formal documented process for the selection of each health care provider and entities subject to an audit-based review;
- criteria for evaluating whether a case contains sufficient cause for recommending enforcement action; and
- procedures to allow system participants under review an opportunity to respond to the MQRP review findings, in writing and to Division staff, before enforcement actions are initiated.

Once developed, the Division should make both the audit-based review priorities and its procedures for conducting medical quality reviews available to stakeholders on its website.

2.3 Establish a more streamlined medical review process by removing the Quality Assurance Panel's involvement.

This recommendation would clarify that the Panel's sole function is to assist the Division in ensuring medical competency in the workers' compensation system. As part of this recommendation, the Division would not hold QAP meetings to provide a second case review and discuss potential violations. Instead, the Division would be required to assign two MQRP members to each medical quality review before pursuing enforcement action. Division staff would randomly assign MQRP members to each case, taking into account the need to match practice area specialties and avoid any potential conflicts of interest.

Under this recommendation, the second assigned MQRP member would provide a summary review of the initial reviewers' findings and recommendation, in place of conducting a second full-scale review of the case. If the second panelist agreed with the first panelist, a duplicate report would not need to be issued. In cases where the two assigned reviewers disagree, a third MQRP member would be available to provide a tie-breaking case review. Division staff would use each case report submitted to guide the decision to dismiss the case or pursue enforcement action.

2.4 Require the Commissioner to develop additional qualification and training requirements for Medical Quality Review Panel members.

This recommendation would require the Commissioner to adopt rules outlining clear prerequisites to serve as a MQRP expert reviewer. The Division's policy should govern the composition of the Panel, qualifications for membership on the Panel, the length of time a member may serve on the Panel, grounds for removal from the Panel, and the avoidance of conflicts of interest, such as if a member knows a health care provider under review. The policy should also address the process for removing Panel members who are repeatedly delinquent in completing case reviews and submitting recommendations to the Division. In developing these service requirements, the Division could use the Texas Medical Board's rules defining its expert reviewer process as a guide.

Once appointed, MQRP members would also be required to fulfill training requirements, as developed by the Division, to ensure panel members are fully aware of the goals associated with the Division's medical quality review process and what constitutes a violation under the Texas Workers' Compensation Act. As part of this recommendation, the Division would also work to better educate MQRP members about the enforcement outcomes of cases under review, providing Panel members with a working knowledge of what constitutes a violation of the Labor Code and resulting in a better focused, more educated panel of expert reviewers.

2.5 Require the Division to work with health licensing boards to expand the pool of Medical Quality Review Panel members.

Under this recommendation, the Division would be required to work with health licensing boards, beyond just the Texas Medical Board and the Texas Board of Chiropractic Examiners, to expand the health care provider pool of available expert reviewers. The Division should work with the Texas Medical Board to increase the pool of specialists available, enabling the Division to better match a an MQRP member's expertise to a physician under review's specialty. The Division should develop a method to partner with these agencies to access outside expertise not immediately available on MQRP on an as-needed basis.

Fiscal Implication Summary

These recommendations would not have a fiscal implication to the State. Requiring the Division to expand the pool of MQRP members would not result in any additional costs to the agency, as expert reviewers would continue to be paid on an as-needed basis. Altering the medical quality review process to include a summary review by a second MQRP member instead of conducting a Quality Assurance Panel meeting would save the Division nearly $20,000 annually, including travel reimbursements for QAP members, staff time, and agency materials. However, this savings would be used to pay MQRP members for their time spent performing a second case review.

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1 Texas Labor Code, sec. 402.021(a)(3) and (b)(4).

2 Texas Labor Code, sec. 413.002.

Responses to Issue 2

Recommendation 2.1

Require Division staff, rather than the Medical Advisor, to manage and oversee the medical quality review process.

Agency Response to 2.1

The Division agrees that the role of the Medical Advisor should be restructured and has taken steps to accomplish many of the objectives contained in this recommendation, including changing its procedures to have Division staff manage the Medical Quality Review Panel process and directing the Medical Advisor to focus on statutory duties as laid out in the Labor Code. However, because statute directs the Medical Advisor to establish a Medical Quality Review Panel, to fully implement this recommendation, additional statutory guidance is required. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 2.1

Allen W. Burton, MD, President; Roy Durrett, MD, PhD, Workers' Comp Committee Chair; and C.M. Schade, MD, PhD, TMA Delegate and TPS Board Emeritus – Texas Pain Society, Austin

Against 2.1

Representative Rafael Anchia, Member – Sunset Advisory Commission

Lee Ann Alexander – Liberty Mutual Group, Austin

Luke Bellsnyder – Texas Association of Manufacturers

Susan Rudd-Bailey, MD, President and David Teuscher, MD – Texas Medical Association, Austin

Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin

Cathy DeWitt, Vice President – Texas Association of Business, Austin

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Modifications

1. Authorize staff to make recommendations regarding audit-based review priorities for the medical quality review process, but retain the Medical Advisor's final decision-making authority over the issues that are chosen for review. (Susan Rudd-Bailey, MD, President and David Teuscher, MD – Texas Medical Association, Austin)

2. Require the Medical Advisor, as the Chair of MQRP, to review all MQRP findings and make the final decision to recommend or not recommend referral for enforcement. (Susan Rudd-Bailey, MD, President – Texas Medical Association, Austin)

Recommendation 2.2

Require the Division to develop guidelines to strengthen the medical quality review process.

Agency Response to 2.2

The Division agrees that the medical quality review process needs improvement and has taken steps to accomplish many of the objectives contained within this recommendation.

Agency Modification

3. The statute should specify that the Commissioner makes the final determination regarding audit-based priorities and should provide the necessary flexibility to implement the provision as determined to be appropriate.

(Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 2.2

Susan Rudd-Bailey, MD, President and David Teuscher, MD – Texas Medical Association, Austin

Allen W. Burton, MD, President; Roy Durrett, MD, PhD, Workers' Comp Committee Chair; and C.M. Schade, MD, PhD, TMA Delegate and TPS Board Emeritus – Texas Pain Society, Austin

Against 2.2

Representative Rafael Anchia, Member – Sunset Advisory Commission

Lee Ann Alexander – Liberty Mutual Group, Austin

Luke Bellsnyder – Texas Association of Manufacturers

Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin

Cathy DeWitt, Vice President – Texas Association of Business, Austin

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Modifications

4. Require the Division to develop criteria for expanding reviews to assess known risk, including assessing health care providers suspected of committing fraud or causing patient harm. (Senator Glenn Hegar, Chairman – Sunset Advisory Commission)

5. Require the Division to establish time limits from start to completion of the review. (Sherri Giorgio, Senior Manager, State Government Affairs – Medtronic Spinal and Biologics, Memphis, Tennessee; N. William Fehrenbach, Director, Government Affairs – Medtronic Neurological, Minneapolis, Minnesota)

6. Require the Division to establish deadlines to respond to an initial complaint or review. (Sherri Giorgio, Senior Manager, State Government Affairs – Medtronic Spinal and Biologics, Memphis, Tennessee; N. William Fehrenbach, Director, Government Affairs – Medtronic Neurological, Minneapolis, Minnesota)

Recommendation 2.3

Establish a more streamlined medical review process by removing the Quality Assurance Panel's involvement.

Agency Response to 2.3

The Division agrees with the recommendation to replace the Quality Assurance Panel process with additional case reviews and recommendations by individual Medical Quality Review Panel members. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 2.3

Susan Rudd-Bailey, MD, President and David Teuscher, MD – Texas Medical Association, Austin

Allen W. Burton, MD, President; Roy Durrett, MD, PhD, Workers' Comp Committee Chair; and C.M. Schade, MD, PhD, TMA Delegate and TPS Board Emeritus – Texas Pain Society, Austin

Against 2.3

Representative Rafael Anchia, Member – Sunset Advisory Commission

Lee Ann Alexander – Liberty Mutual Group, Austin

Luke Bellsnyder – Texas Association of Manufacturers

Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin

Cathy DeWitt, Vice President – Texas Association of Business, Austin

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Modification

7. Remove final decisions from the Medical Advisor or Division staff. The staff should only have a hands on approach in that they would compile the reports given by three qualified reviewers, specifically qualified in the field at issue, out of the three reports, the majority of the reports revealing prevailing conclusions of the standard being met or not would then be attached to a decision form. The CVs and reports should be on letterhead of the reviewers and should be attached to the file. (Allen W. Burton, MD, President; Roy Durrett, MD, PhD, Workers' Comp Committee Chair; and C.M. Schade, MD, PhD, TMA Delegate and TPS Board Emeritus – Texas Pain Society, Austin)

Recommendation 2.4

Require the Commissioner to develop additional qualification and training requirements for Medical Quality Review Panel members.

Agency Response to 2.4

The Division agrees with this recommendation and has taken steps to develop additional qualification and training requirements for Medical Quality Review Panel members. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 2.4

Susan Rudd-Bailey, MD, President and David Teuscher, MD – Texas Medical Association, Austin

Allen W. Burton, MD, President; Roy Durrett, MD, PhD, Workers' Comp Committee Chair; and C.M. Schade, MD, PhD, TMA Delegate and TPS Board Emeritus – Texas Pain Society, Austin

Against 2.4

Lee Ann Alexander – Liberty Mutual Group, Austin

Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Modifications

8. Authorize the Medical Advisor to make the final determination as to who is and who is not a MQRP member; require the Medical Advisor to serve as an integral part of developing the qualification and training requirements; and grant the Medical Advisor final approval authority over such requirements. (Susan Rudd-Bailey, MD, President and David Teuscher, MD – Texas Medical Association, Austin)

Staff Comment: Although the Medical Advisor currently recommends individuals to serve on the Medical Quality Review Panel, the Commissioner of Workers' Compensation has the ultimate authority to approve a Request for Qualification and contract. The Medical Advisor is a statutorily-required employee of the Division

9. Require reviewers to be licensed in the same specialty as the health care provider being reviewed and have actual experience in the treatment under review. Require the Division to adopt guidelines on the procedure for informal hearings. (Sherri Giorgio, Senior Manager, State Government Affairs – Medtronic Spinal and Biologics, Memphis, Tennessee; N. William Fehrenbach, Director, Government Affairs – Medtronic Neurological, Minneapolis, Minnesota)

Recommendation 2.5

Require the Division to work with health licensing boards to expand the pool of Medical Quality Review Panel members.

Agency Response to 2.5

The Division agrees with this recommendation and is currently working with multiple health care licensing boards to identify qualified Medical Quality Review Panel applicants. This recommendation could enhance the Division's ability to work with other agencies if those agencies are also specifically instructed in statute to provide information regarding potential Medical Quality Review Panel members to the Division. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 2.5

Susan Rudd-Bailey, MD, President and David Teuscher, MD – Texas Medical Association, Austin

Allen W. Burton, MD, President; Roy Durrett, MD, PhD, Workers' Comp Committee Chair; and C.M. Schade, MD, PhD, TMA Delegate and TPS Board Emeritus – Texas Pain Society, Austin

Against 2.5

Lee Ann Alexander – Liberty Mutual Group, Austin

Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin

Cathy DeWitt, Vice President – Texas Association of Business, Austin

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Modification

10. Require the Division to work with licensing boards, the Texas Medical Association and medical societies (stakeholders) throughout the state in an effort to display fairness and inclusiveness to the medical licensees and healthcare providers who share an interest in a strong and fair process. (Allen W. Burton, MD, President; Roy Durrett, MD, PhD, Workers' Comp Committee Chair; and C.M. Schade, MD, PhD, TMA Delegate and TPS Board Emeritus – Texas Pain Society, Austin)

Commission Decision

The following provisions were adopted by the Sunset Commission to replace the Sunset staff recommendations contained in Issue 2.

Change in Statute

2.1 Require the Division to develop guidelines to strengthen the medical quality review process.

Require the Division to develop criteria, subject to the Commissioner's approval, to further improve the medical quality review process. In developing such guidelines, require the Division required to consult with the Medical Advisor and consider input from key stakeholders. The Division should also define, at a minimum, a fair and transparent process for the:

- handling of complaint-based cases; and
- selection of health care providers and other entities for review.

Require the Division to make the adopted process for conducting both complaint-based and audit-based reviews available to stakeholders on its website.

Change in Statute

2.2 Establish the Quality Assurance Panel in statute.

This recommendation would establish the Quality Assurance Panel (QAP) in statute and require the Division to hold QAP meetings as a means to assist the Medical Advisor and the Medical Quality Review Panel, while providing a second level evaluation of all reviews.

Management Action

2.3 Improve the medical quality review process by clarifying the Quality Assurance Panel's involvement.

In conjunction with Recommendation 2.2, but as a management action, the Commissioner should adopt procedures, subject to input from the Medical Advisor, to further define the QAP's role in the medical quality review process and establish the frequency of QAP meetings. At a minimum, such procedures should include:

- a process for selecting QAP members from the pool of appointed MQRP members, including health care professionals from diverse health care specialty backgrounds and individuals with expertise in utilization review and quality assurance;

- a policy outlining the length of time a member may serve on the QAP;
- procedures to ensure QAP members are kept informed of enforcement outcomes of cases under review; and
- procedures to clarify the roles and responsibilities of QAP members and Division staff at QAP meetings.

This recommendation would ensure that the QAP is properly structured and managed to maximize its value in the review process. This recommendation would also ensure that all participants in QAP meetings are aware of their required tasks and do not compromise the decision-making process for reviews that become active investigations in the enforcement process.

Change in Statute

2.4 Require the Division to develop additional qualification and training requirements for Medical Quality Review Panel members.

Require the Commissioner, subject to input from the Medical Advisor, to adopt rules outlining clear prerequisites to serve as a MQRP expert reviewer, including necessary qualifications and training requirements. In developing these policies, the Division could use the Texas Medical Board's expert reviewer process as a guide. At a minimum, rules on qualifications should include:

- a policy outlining the composition of expert reviewers serving on MQRP, including the number of reviewers and all health care specialties represented;
- a policy outlining the length of time a member may serve on MQRP;
- procedures defining areas of potential conflicts of interest between MQRP members and subjects under review and the avoidance of such conflicts; and
- procedures governing the process and grounds for removal from the Panel, including instances when members are repeatedly delinquent in completing case reviews or submitting review recommendations to the Division.

As part of this recommendation, the Division would also develop rules on training. Under this recommendation, MQRP members would be required to fulfill training requirements to ensure panel members are fully aware of the goals of the Division's medical quality review process and the Texas Workers' Compensation Act. Training topics should include, at a minimum, the following areas:

- administrative violations affecting the delivery of appropriate medical care;
- confidentiality of the review process and the qualified immunity from suit granted to MQRP members under the Labor Code; and
- medical quality review process guidelines adopted under Recommendation 2.1.

The Division would also be authorized to include training on other topic areas such as the Division's adopted treatment and return-to-work guidelines, other evidence-based medicine resources, and the impairment rating process.

The Division would also be required to better educate Panel members about the status and enforcement outcomes of cases resulting from the medical quality review process.

Change in Statute

2.5 Require the Division to work with health licensing boards to expand the pool of Medical Quality Review Panel members.

Under this recommendation, the Division, in consultation with the Medical Advisor, would be required to work with health licensing boards, beyond just the Texas Medical Board and the Texas Board of Chiropractic Examiners, as necessary, to expand the pool of health care providers available as expert reviewers. The Division should also work with the Texas Medical Board to increase the pool of specialists available, as necessary, enabling the Division to better match an MQRP member's expertise to the specialty of a physician under review.

As part of this recommendation, when selecting the composition of expert reviewers serving on MQRP, the Medical Advisor should advise the Division by identifying areas of medical expertise that may not require ongoing representation on the MQRP. In such circumstances, the Division should develop a method to partner with these other agencies to access outside expertise on an as-needed basis.

Legislative Action

House Bill 2605 requires the Division to develop criteria, subject to the Commissioner's approval, to further improve the medical quality review process. In developing such guidelines, the bill requires the Division to consult with the Medical Advisor and consider input from key stakeholders. The Division is also required to define, at a minimum, a fair and transparent process for the handling of complaint-based cases, and selection of health care providers and other entities for review. Once developed, the bill requires the Division to make the adopted process for conducting both complaint-based and audit-based reviews available to stakeholders on its website. (Commission Recommendation 2.1)

The bill also establishes the Quality Assurance Panel in statute, providing a second level of evaluation for all medical case reviews. The Legislature modified the Sunset provision to require members of the panel to evaluate medical care and recommend enforcement actions to the Medical Advisor; and for the panel to meet periodically to discuss issues and offer assistance to the Medical Advisor. (Commission Recommendation 2.2)

As a management requirement not needing statutory change, Commission Recommendation 2.3 did not result in legislative action.

House Bill 2605 requires the Commissioner, subject to input from the Medical Advisor, to adopt rules outlining clear prerequisites to serve as a medical quality review process expert reviewer, including necessary qualifications and training requirements. In developing these policies, the bill requires the Division to include:

- a policy outlining the composition of expert reviewers serving on the Medical Quality Review Panel (MQRP), including the number of reviewers and all health care specialties represented;
- a policy outlining the length of time a member may serve on MQRP;
- procedures defining areas of potential conflicts of interest between MQRP members and subjects under review and the avoidance of such conflicts; and
- procedures governing the process and grounds for removal from the Panel, including instances when members are repeatedly delinquent in completing case reviews or submitting review recommendations to the Division.

The bill also requires the Division to develop rules on training, including educating MQRP members about the status and enforcement outcomes of cases resulting from the medical quality review process, and requires MQRP members to fulfill training requirements to ensure panel members are fully aware of the goals of the Division's medical quality review process and the Texas Workers' Compensation Act. (Commission Recommendation 2.4)

Finally, H.B. 2605 requires the Division, in consultation with the Medical Advisor, to work with health licensing boards, beyond just the Texas Medical Board and the Texas Board of Chiropractic Examiners, as necessary, to expand the pool of health care providers available as expert reviewers. The bill also requires the Division to work with the Texas Medical Board to increase the pool of specialists available, as necessary, enabling the Division to better match a MQRP member's expertise to the specialty of a physician under review. (Commission Recommendation 2.5)

Issue 3

The Division Cannot Always Take Timely and Efficient Enforcement Actions to Protect Workers' Compensation System Participants.

Background

The Division of Workers' Compensation (DWC) oversees the workers' compensation system to ensure that injured employees fairly receive entitled benefits and that the system functions well, offering accessible care at reasonable costs. State law charges DWC with promptly detecting and addressing acts or practices of noncompliance in the system.[1] To do this, DWC monitors the activities of system participants, which are governed by the Texas Workers' Compensation Act. Key system participants include injured employees, employers, workers' compensation insurance carriers, health care providers, and attorneys.

Unlike many regulatory agencies, DWC monitors the compliance of system participants that may be licensed and regulated by another state agency, such as the Texas Medical Board or the State Bar of Texas. In these cases, DWC's regulation focuses on potential violations of specific requirements for the workers' compensation system as laid out in law and rule.

To enforce these provisions, DWC has a variety of administrative sanctions available, as detailed in the textbox, *Administrative Sanctions*. In fiscal year 2009, DWC closed 414 enforcement cases, which resulted in about $1 million in administrative penalties. Of those actions, 85 percent were taken against insurance carriers or health care providers.

Administrative Sanctions

To take enforcement action against violators of law and rule, statute gives DWC the following sanctioning authority over all system participants:

- monetary penalties of up to $25,000 per day, per violation;
- cease-and-desist orders;
- reduction or denial of fees or reimbursements for services provided in the system;
- restriction, suspension, or revocation of the right to practice in the system;
- revocation of a license, certificate, or permit required to practice in the system;
- referral to a jurisdictional agency for license restriction, suspension, or revocation; and
- reprimand.

In addition to the above, DWC may impose the following sanctions on doctors practicing in the system:

- mandatory preauthorization or utilization review of services;
- supervision or peer review monitoring, reporting, or audit;
- restriction on the type of services, appointments, or reviews a doctor may provide in the system;
- mandatory education; and
- suspension or removal from the Designated Doctor List.

Finally, DWC also has the authority to deny the application of or revoke a certificate of authority for a certified self-insurer.

Findings

The Division lacks standard enforcement tools, limiting DWC's ability to take timely enforcement actions to protect system participants' welfare.

Staff compared DWC enforcement tools to model standards.

Ineffective licensing programs served as an impetus behind the creation of Sunset in 1977. As a result, Sunset has a long history of evaluating regulatory agencies, having completed more than 93 certification and licensing agency reviews, and has documented standards to serve as a guide for evaluating agencies with regulatory responsibilities. These licensing programs share many of the same regulatory concepts as those used in the oversight of the workers' compensation system. Staff evaluated DWC's statutory enforcement tools to determine whether they include model standards and found that the Division could benefit from conforming agency practices to the standards that follow.

- **Inspections**. An agency should have clear statutory authority to conduct inspections to help ensure timely compliance of regulated entities, including the use of announced and unannounced inspections. An agency should also have clear procedures in place governing the use of inspections and ensuring the standard treatment of regulated entities.

  State law gives DWC the authority to conduct investigations relating to alleged violations of law, rule, or order, but does not specify how or under what circumstances DWC may enter into the premises of a system participant.[2] Many of the system activities that DWC monitors directly relate to the welfare, health, and safety of injured employees. As result, violations can result in significant and immediate harm to an injured employee's health and safety through the quality and timeliness of medical treatment, or to an employee's financial wellbeing through the nonpayment of benefits.

  Violations can result in immediate harm to an injured employee's welfare, health, and safety.

  In addition, the Texas Department of Insurance (TDI) conducts announced and unannounced on-site inspections of regulated entities, including certified workers' compensation networks. To ensure that the Division and the Department are able to work in concert to investigate potential violations of both the Insurance and Labor Codes and to prevent harm, DWC should have the authority to immediately enter a system participant's place of business to determine if violations are occurring.

- **Refusal to renew**. A regulatory agency's statute should authorize a full range of penalties. The Division certifies few types of individuals, mostly concentrating its compliance monitoring on the actions of individuals and entities licensed under different statutory authority. However, DWC does have regulatory purview over Designated Doctors, who are doctors certified by the Division to provide an assessment of an injured employee's medical condition for use in DWC's dispute resolution system.

The Division certifies Designated Doctors and renews their certifications every two years. Although statute gives DWC the authority to suspend or revoke a designation, law is silent regarding the Division's authority to refuse to renew the certification. Expressly authorizing DWC to refuse to renew a Designated Doctor's certification, with an opportunity for the doctor to contest the decision, would allow the Division to take timely action against a doctor who does not meet continuing qualification requirements or commits repeated violations. In fiscal year 2009, DWC took enforcement action against 22 Designated Doctors for violations of law or rule.

- **Emergency cease-and-desist authority**. A regulatory agency should have the means to stop unlicensed or harmful activity immediately. Although statute currently gives DWC cease-and-desist authority over an entity that commits repeated administrative violations, allows repeated administrative violations to occur, or violates a Commissioner order or decision, the Division cannot take immediate action against a violator who does not already have a history of violations with DWC. In contrast, TDI has statutory authority to issue emergency cease-and-desist orders against violators of the Insurance Code.

  The Division cannot take immediate action against a violator without a history of violations.

  Instead, DWC must start an enforcement investigation, give notice to the violator, and provide an opportunity for a hearing before the agency can issue a cease-and-desist order. The Division only used its current cease-and-desist authority once in fiscal year 2009, taking most enforcement action through consent or final order. Without being able to take timely action against violators, DWC cannot adequately protect system participants from immediate threats to their health and safety.

- **Judicial review**. State agency enforcement actions should be subject to review in district court under the substantial evidence rule, to take advantage of the record built under the State's administrative enforcement proceeding, saving time and money during appeals. The Labor Code does not specify the judicial review standard for actions taken by DWC. In contrast, the Insurance Code provides that the judicial review standard for enforcement cases taken by TDI is substantial evidence. Aligning the judicial review standards in statute for both the Labor and Insurance Codes would ensure that the agency builds consistent and efficient enforcement cases.

The Commissioner of Workers' Compensation's lack of authority to finalize enforcement cases involving monetary penalties creates inefficiencies and potentially inconsistent results.

Depending on the type of sanction, DWC has to follow different procedures.

State law requires two different procedures for deciding DWC enforcement cases that are appealed to the State Office of Administrative Hearings (SOAH). For enforcement cases relating to non-monetary administrative sanctions, such as revocation, suspension, or other reprimand, statute provides that SOAH hears the case and enters into a proposal for decision for the

Unlike DWC, the Commissioner of Insurance has final order authority over all insurance violations.

Commissioner of Workers' Compensation's (Commissioner) consideration. In these cases, the Commissioner takes the final action. Alternatively, for enforcement cases involving monetary penalties, SOAH makes the final decision.[3] As a result, DWC must meet differing statutory notice and Administrative Procedure Act requirements depending on what type of sanction it is pursuing. In contrast, the Commissioner of Insurance has final order authority over all violations of the Insurance Code, including both monetary and non-monetary penalties.

To safeguard against conflicts of interest and improprieties in cases in which either Commissioner may end up making the final decision on an enforcement case, both Commissioners have procedures in place to prevent ex parte communication and preserve their decision-making independence. Currently, for cases in which the Commissioners make final decisions on a proposal for decision, staff does not discuss the enforcement cases with the Commissioners after the agency has issued notice of the violation.

The bifurcated way in which DWC enforcement actions go through the SOAH process creates inefficiencies in that DWC must maintain two different enforcement processes with different notice requirements. In addition, giving SOAH final decision-making authority over cases with monetary penalties reduces the Department's ability to ensure that sanctions – pursued by either TDI or DWC – are consistent agency-wide for like violations, no matter what type of sanction.

Outdated provisions in the Labor Code create confusion about DWC's enforcement authority.

Overly specific statutory provisions conflict with DWC's broad enforcement authority.

As a result of significant workers' compensation system reform efforts that span 20 years, the Legislature has amended the Division's enforcement authority many times. Most recently, the merger of the Texas Workers' Compensation Commission (TWCC) with TDI and the creation of a single Workers' Compensation Commissioner resulted in establishing new enforcement authority comparable to that of the Commissioner of Insurance. Such authority includes the ability for the Commissioner of Workers' Compensation to issue administrative penalties of up to $25,000 per violation, per day for any violation of the Labor Code, rule, or order. However, provisions throughout statute continue to reference outdated language related to TWCC's enforcement authority, which is at odds with the Commissioner's new authority. For example, statute still defines specific classes and types of violations, linked with corresponding administrative penalties, as well as certain notice requirements for subsequent administrative violations. Because DWC now has general administrative penalty authority for any violation and associated notice requirements, such outdated language creates confusion.

Finally, statutory provisions outlining what action DWC can take against a violator are spread throughout the Code. Without having the Division's full range of administrative sanctions in one place, system participants may be confused about what DWC's authority really is.

Recommendations

Change in Statute

3.1 Clarify that the Division can conduct announced and unannounced inspections.

This recommendation would amend the Division's current investigative authority to clarify that it can conduct onsite inspections in investigating potential violations of the law, rule, or order. In addition, the recommendation would authorize DWC to perform both announced and unannounced inspections. To ensure that all regulated entities are treated fairly and consistently, the Division would develop clear procedures defining the entities and records subject to inspection, and how it will use its unannounced inspection authority.

3.2 Authorize DWC to refuse to renew Designated Doctor certifications.

This recommendation would clarify the Division's authority to refuse to renew a Designated Doctor's biennial certification. Under the recommendation, doctors disagreeing with DWC's decision to refuse to renew would be entitled to a hearing at the State Office of Administrative Hearings.

3.3 Authorize the Commissioner to issue emergency cease-and-desist orders.

Under this recommendation, the Commissioner of Workers' Compensation would be able to issue cease-and-desist orders in emergency situations. The Division could use this authority if a system participants' actions were violations of law, rule, or order, and would result in harm to the health, safety, or welfare of other participants. The recommendation would provide for notice and opportunities for expedited hearings, similar to the Insurance Code's provisions relating to emergency cease-and-desist authority.

In addition, DWC would be authorized to assess administrative penalties against persons or entities violating cease-and-desist orders. Although this penalty authority could result in a gain to General Revenue, the fiscal impact cannot be estimated because the number of violations and their seriousness cannot be predicted.

3.4 Specify that the judicial review standard for appeals of DWC enforcement cases is substantial evidence.

This recommendation would add language to the Labor Code specifying that any appeal of a Commissioner order is subject to the substantial evidence rule.

3.5 Authorize the Commissioner to make final decisions on enforcement cases involving monetary penalties.

This recommendation would remove final decision authority from SOAH in cases involving monetary penalties, and require the Commissioner of Workers' Compensation to enter in final orders upon consideration of a proposal for decision from SOAH. As part of this recommendation, the Commissioner would adhere to provisions in the Administrative Procedures Act governing how an agency may consider, adopt, or change proposals for decision. The Division would also amend its current memorandum of understanding with SOAH to include procedures for handling SOAH proposals for decision for monetary penalties, as it is already generally required to do by statute.

As part of this recommendation, the Commissioner of Workers' Compensation should adopt internal policies to prevent any ex parte communication within the Division on enforcement cases as TDI and DWC have already done for SOAH proposals for decision that return to the agency for final decision currently. These procedures would preserve the Commissioner's independence in issuing final orders and prevent any potential conflicts of interest.

3.6 Remove outdated and confusing enforcement provisions in the Labor Code.

Under this recommendation, statute would be amended to remove outdated language referencing specific classes of violations or penalty amounts. The recommendation would also remove language relating to notice requirements for subsequent violations under the Code that suggest conflict with DWC's broader administrative penalty authority. As part of this recommendation, statute would be changed to clarify what DWC's full range of administrative sanctions are for all system participants, and locate all sanctioning authority in the same piece of statute, to ensure that system participants are aware of DWC's complete enforcement authority.

Fiscal Implication Summary

These recommendations would not have a fiscal impact to the State.

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1 Texas Labor Code, sec. 402.021(b)(7).

2 Texas Labor Code, sec. 414.005.

3 Texas Labor Code, sec. 402.073(b) and (c).

Responses to Issue 3

Recommendation 3.1

Clarify that the Division can conduct announced and unannounced inspections.

Agency Response to 3.1

The Division agrees that its authority to conduct on-site inspections should be clarified in statute by aligning with the authority the Commissioner has in the Insurance Code. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 3.1

None received.

Against 3.1

Lee Ann Alexander – Liberty Mutual Group, Austin

Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Recommendation 3.2

Authorize DWC to refuse to renew Designated Doctor certifications.

Agency Response to 3.2

The Division agrees with this recommendation. The Division's authority to determine eligibility for the Designated Doctor List and to suspend or delete a doctor from the list is currently specified in statute. The Division believes non-renewal is encompassed within the current statutory authority and has initiated a rulemaking process to utilize non-renewal in the future. To avoid any challenge to the rules, the Division believes statutory clarification is appropriate. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 3.2

Lee Ann Alexander – Liberty Mutual Group, Austin

Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Against 3.2

None received.

Recommendation 3.3

Authorize the Commissioner to issue emergency cease-and-desist orders.

Agency Response to 3.3

The Division agrees with this recommendation and believes the cease-and-desist authority of the Commissioner of Workers' Compensation should be aligned with that of the Commissioner of Insurance. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 3.3

Susan Rudd-Bailey, MD, President and David Teuscher, MD – Texas Medical Association, Austin

Staff Comment: The Texas Medical Association agrees with Recommendation 3.3 if the normal due process protections contained within the standard process for excluding a physician are initiated simultaneously with the emergency order.

Against 3.3

Lee Ann Alexander – Liberty Mutual Group, Austin

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Modification

1. Require the Medical Advisor to advise the Commissioner in cease-and-desist cases involving a breach of the standard of medical care. (Susan Rudd-Bailey, MD, President – Texas Medical Association, Austin and David, Teuscher, MD – Texas Medical Association, Austin)

Recommendation 3.4

Specify that the judicial review standard for appeals of DWC enforcement cases is substantial evidence.

Agency Response to 3.4

The Division agrees with the recommendation to align workers' compensation judicial review standards with similar provisions in the Insurance Code. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 3.4

None received.

Against 3.4

None received.

Modification

2. Judicial review and the qualification for that review should be decided and determined to be substantial by an outside judging entity such as arbitration at the State Office of Administrative Hearings. (Allen W. Burton, MD, President; Roy Durrett, MD, PhD, Workers' Comp Committee Chair; and C.M. Schade, MD, PhD, TMA Delegate and TPS Board Emeritus – Texas Pain Society, Austin)

Recommendation 3.5

Authorize the Commissioner to make final decisions on enforcement cases involving monetary penalties.

Agency Response to 3.5

The Division agrees that the Commissioner of Workers' Compensation should be authorized to make final decisions on enforcement cases involving monetary penalties. The current system may result in inconsistent penalties and create administrative inefficiencies for the Division due to maintaining two different enforcement procedures. The current system also makes it difficult to pursue monetary and non-monetary sanctions simultaneously on individual cases. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

Affected Agency Response to 3.5

The State Office of Administrative Hearings writes proposals for decision in most of the types of cases it hears, so this change, if adopted, will not have a great impact on either the hearings or the decision and writing process undertaken by the Administrative Law Judges. (Cathleen Parsley, Chief Administrative Law Judge – State Office of Administrative Hearings)

For 3.5

None received.

Against 3.5

Lee Ann Alexander – Liberty Mutual Group, Austin

Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin

Jonathan D. Bow, JD, Executive Director – State Office of Risk Management

Cathy DeWitt, Vice President – Texas Association of Business, Austin

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Modification

3. Remove the State Office of Administrative Hearings and allow the Commissioners of Insurance and Workers' Compensation to be responsible for assessing fines and penalties, but with the requirement that neither Commissioner may allow third or first parties to be involved in this process. (Andrew Patterson, Houston)

Recommendation 3.6

Remove outdated and confusing enforcement provisions in the Labor Code.

Agency Response to 3.6

The Division agrees with this recommendation. In some cases parties attempt to refer to these provisions although they no longer apply. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 3.6

Lee Ann Alexander – Liberty Mutual Group, Austin

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Against 3.6

None received.

Commission Decision

Adopted Recommendations 3.1 through 3.6.

Legislative Action

House Bill 2605 amends the Division's current investigative authority to clarify that it can conduct onsite inspections in investigating potential violations of the law, rule, or order. In addition, the bill authorizes DWC to perform both announced and unannounced inspections. To ensure that all regulated entities are treated fairly and consistently, the bill also requires the Division to develop clear procedures defining the entities and records subject to inspection, and how it will use its unannounced inspection authority. (Recommendation 3.1)

The bill clarifies the Division's authority to refuse to renew a Designated Doctor's biennial certification. Doctors disagreeing with DWC's decision to refuse to renew are entitled to a hearing at the State Office of Administrative Hearings. (Recommendation 3.2)

The bill authorizes the Commissioner of Workers' Compensation to issue cease-and-desist orders in emergency situations. The Division can use this authority if a system participant's actions are

violations of law, rule, or order, and would result in harm to the health, safety, or welfare of other participants. The bill provides for notice and opportunities for expedited hearings, similar to the Insurance Code's provisions relating to emergency cease-and-desist authority, and authorizes DWC to assess administrative penalties against persons or entities violating cease-and-desist orders. (Recommendation 3.3)

The bill adds language to the Labor Code specifying that any appeal of a Commissioner enforcement order is subject to the substantial evidence rule. (Recommendation 3.4)

House Bill 2605 removes final decision authority from SOAH in enforcement cases involving monetary penalties, and requires the Commissioner of Workers' Compensation to enter final orders upon consideration of a proposal for decision from SOAH. The bill requires the Commissioner to adhere to provisions in the Administrative Procedure Act governing how an agency may consider, adopt, or change proposals for decision, and requires the Division to amend its current memorandum of understanding with SOAH to include procedures for handling SOAH proposals for decision for monetary penalties, as it is already generally required to do by statute. (Recommendation 3.5)

House Bill 2605 removes outdated language referencing specific classes of violations or penalty amounts. The bill also removes language relating to notice requirements for subsequent violations under the Labor Code that suggest conflict with DWC's broader administrative penalty authority. The bill clarifies what DWC's full range of administrative sanctions are for all system participants, and locates all sanctioning authority in the same piece of statute, to ensure that system participants are aware of DWC's complete enforcement authority. (Recommendation 3.6)

Issue 4

The Division's Oversight of Designated Doctors Does Not Effectively Ensure Meaningful Use of Expert Medical Opinions in Dispute Resolution.

Background

To address a problem facing the Division of Workers' Compensation (DWC) of having to weigh differing medical opinions from multiple doctors in a single dispute, the Legislature created the Designated Doctor program. A Designated Doctor acts on behalf of the State in providing a neutral, expert assessment of an injured employee's medical condition that holds presumptive weight in the Division's dispute resolution process.[1] Statute authorizes Designated Doctors to provide assessments of injured employees in several circumstances, as shown in the textbox, *Designated Doctor Duties*. Designated Doctors receive a fee for their work, prescribed by the Division's medical fee guidelines and paid by insurance carriers. The Division certifies eligible doctors – including health care professionals such as chiropractors, dentists, and physicians – and schedules Designated Doctor examination appointments.

Designated Doctor Duties

Designated Doctors assess an injured employee's condition in the following circumstances.

Causation – whether the impairment or disability exists as the result of a specific injury or illness.

Maximum Medical Improvement – the earliest date after which further recovery from an injury is unlikely.

Impairment Rating – the percentage of whole body impairment resulting from a compensable injury.

Extent of Injury – the extent of the injured employee's work-related injury or illness.

Return to Work – whether the injured employee is safely able to return to work.

Certifying Designated Doctors. The Division uses a combination of eligibility, training, and testing requirements to determine if Designated Doctors are qualified to give medical opinions on behalf of the State. To become a certified Designated Doctor, applicants must meet specific requirements, developed in rule, including maintaining eligibility to practice in the workers' compensation system and having maintained an active practice for at least a three-year period in the doctor's career. In addition to these eligibility requirements, DWC relies on a Division-approved training and end-of-course test to demonstrate a doctor's proficiency to perform the five statutorily authorized duties. In this way, doctors with different practice backgrounds can be certified by DWC to perform examinations for dispute resolution purposes.

The Division's Medical Advisor and Medical Quality Review Panel evaluate applications and recommend doctors for certification or denial, which are ultimately approved by Division staff. Designated Doctors must biennially renew their certification, a process that requires doctors to complete an additional 12 hours of Division-approved training, but does not include an additional test. In fiscal year 2009, DWC oversaw 1,436 certified Designated Doctors.

Scheduling Designated Doctor Examination Appointments. Both injured employees and insurance carriers may request a Designated Doctor examination. The Division may also order a Designated Doctor examination to help resolve an issue in dispute. The Division schedules examination appointments using criteria detailed in the textbox, *Designated Doctor Selection Criteria*. To keep the dispute resolution process accessible to injured employees, statute does not require injured employees to travel for Designated Doctor examination appointments. As a result, DWC allows each Designated Doctor to register to see injured employees in as many as 20 Texas counties at one time. Because doctors do not typically have offices in each area they serve, many Designated Doctors rely on outside entities to arrange space in out of town areas. In fiscal year 2009, DWC scheduled 48,158 Designated Doctor examination appointments.

Designated Doctor Selection Criteria

To assign a Designated Doctor to a case, DWC considers the following:

- the injured employee's county of residence;
- the best possible match between the Designated Doctor's self-reported medical background and the employee's injury; and
- the existence of a conflict of interest or disqualifying association, as reported by the doctor, at the time the appointment is scheduled.

Findings

Flaws in the Division's certification and scheduling of Designated Doctors prevent the optimum and consistent use of expertise needed to resolve medical questions in the dispute resolution process.

The workers' compensation dispute resolution process relies heavily on the need for high-quality medical assessments made by Designated Doctors. Injured employees, insurance carriers, and their respective doctors often have differing opinions regarding an employee's medical condition, yielding claim disputes. A Designated Doctor's assessment, however, guides the dispute resolution process by providing one medical opinion that holds presumptive weight, unless proven otherwise. Although the Division has developed a process to certify and schedule Designated Doctors, DWC's efforts in these areas lack sufficient detail to ensure a level of expertise and consistency needed for resolving differing medical opinions in the dispute resolution process.

A Designated Doctor's opinion holds presumptive weight in the dispute resolution process.

- **Certification**. Taken as a whole, the combination of eligibility, training, and testing standards DWC uses to determine an applicant's qualifications is insufficient to adequately ensure the applicant has the specific skill-set necessary to serve as a Designated Doctor assessing injuries common

in the workers' compensation system. Simply because doctors are well-qualified to practice in their given professions does not mean that they are capable, without demonstrating additional skills, to perform the specific functions required of a Designated Doctor, or have the appropriate credentials to assess a specific issue or medical condition in question.

For example, a chiropractor, family practice physician, or neurosurgeon could qualify to serve as a Designated Doctor evaluating back injuries if the applicant has the certification or experience in treating or diagnosing these types of injuries. Although DWC uses a matrix to match Designated Doctors' practice areas to injuries in assignments, the Division lacks an effective process on the front-end to verify the specific areas that a doctor is qualified in for the purposes of resolving medical disputes. Instead, DWC relies on self-reported information from doctors regarding their areas of expertise when making such assignments.

Simply because doctors are well-qualified to practice does not mean they are qualified to perform specific Designated Doctor duties.

Another concern regards the training and testing that DWC depends on to ensure doctors are able to perform the statutory duties required of a Designated Doctor. The Division's current training course, administered by an outside entity, does not focus on providing training specific to the responsibilities of a Designated Doctor. While the course includes some Designated Doctor duties, such as impairment ratings, it insufficiently covers topics related to other Designated Doctor's statutory responsibilities, such as determining extent of injury or evaluating whether an injured employee is able to return to work. Likewise, the end-of-course test to determine certification does not fully evaluate an applicant's knowledge in such areas. The Division also relies on this same course to satisfy ongoing training requirements as a prerequisite to certification renewal. Finally, because the certification renewal process does not include completing an end-of-training test, the Division must inefficiently rely on a retrospective case review to evaluate a doctor's continued competency in Designated Doctor duties, such as extent of injury exams or return-to-work evaluations.

- **Scheduling**. Designated Doctors are not required to perform subsequent exams on the same injured employee throughout the life of the claim. When a Designated Doctor makes the decision to no longer work in a certain county, all the doctor's existing cases in that county needing additional or new assessments are assigned to a new doctor. For those cases in need of a Designated Doctor opinion in an ongoing dispute, allowing multiple doctors to provide assessments on the same issue can yield different decisions, each of which holds presumptive weight in the dispute resolution process. In these circumstances, Hearing Officers, who are not medical professionals, must weigh the medical opinions of multiple doctors, including Designated Doctors, the employee's treating doctor, and the insurance carrier's expert physician. The end result recreates the problem that the Legislature tried to solve in creating the Designated Doctor role.

Multiple Designated Doctors opinions muddle the dispute resolution process.

Designated Doctors can stop seeing injured employees at any time.

Because DWC provides scheduling data online, Designated Doctors, or companies that assist them with scheduling appointments, may use this information about available doctors in particular counties to jump in and out of counties to gain additional examination appointments. Although DWC cannot provide a full picture of how often disputes receive multiple Designated Doctor opinions, the Division has identified at least 906 instances in which at least two Designated Doctors were assigned to a dispute set for mediation before the Division in fiscal year 2009. One major factor contributing to this problem is that the Division's process for scheduling examination appointments allows Designated Doctors to remove themselves from seeing an injured employee at any time, disrupting the continuity of the dispute resolution process and diluting the presumptive weight of a Designated Doctor's opinion. For example, Designated Doctors may alter the number of counties in which they see patients at any time, for any reason, and without obtaining Division-approval.

The Division does not assess a fee to cover the cost of certifying Designated Doctors.

Sunset has documented standards for regulatory activities to serve as a guide for evaluating agencies with regulatory responsibilities, as discussed in Issue 3 of this report. Those standards provide that a regulatory agency should have clear statutory authority to set reasonable fees in rule for licensing-related functions, like certification and renewal. Fee authority for an agency such as DWC should allow cost recovery for administrative expenses directly related to certification-related services provided. Although the Division administers a program to certify Designated Doctors, and such doctors receive a fee for service, DWC does not have statutory authority to require a certification fee. Allowing DWC to set a reasonable certification fee in rule would enable the Division to recover a portion of the direct cost it incurs to regulate Designated Doctors, instead of the insurance industry as a whole covering this cost.

The Texas Department of Insurance's certification of Independent Review Organizations offers a comparison for certifying organizations that give medical opinions in the dispute resolution process.

The Texas Department of Insurance (TDI) certifies IROs, which review insurance company decisions to deny medical care. While IROs and Designated Doctors serve different purposes in DWC's dispute resolution process, in both cases, through the certification process, the State determines if the doctor or entity can provide independent, quality reviews. For example, TDI requires certified Independent Review Organizations to maintain information regarding each expert reviewer's credentials, including licensure status, education level, and physician board certification. Certified IROs may only employ health care providers who maintain an active practice and meet certain conflict-of-interest provisions. Finally, to become certified, IROs

must also provide all expert reviewers with an orientation and training on the review process. In addition to these qualifications for certification, TDI charges a fee to recover the cost of the IRO certification process, which is set at $800 for an initial application and $200 for certification renewal.

Recommendations

Change in Statute

4.1 Require the Commissioner to develop qualification requirements for Designated Doctors.

This recommendation would require the Commissioner of Workers' Compensation to develop a certification process, in rule, that effectively uses the spectrum of eligibility, training, and testing to assess the general proficiency of Designated Doctors. This recommendation would require the Division to revisit the current minimal requirements and adopt any changes in rule. Under this recommendation, the Division should develop a process that ensures doctors have either the appropriate specialty qualification, through educational experience or previous training, or demonstrated proficiency, through additional training and testing, to serve as a Designated Doctor. The recommendation would ensure that however DWC chooses to use the interaction of qualification requirements, every Designated Doctor would show the ability to perform the five specific Designated Doctor duties authorized in statute.

This recommendation would give the Division the flexibility it needs to determine how to best combine qualification requirements to ultimately ensure that Designated Doctors have the ability to perform the examinations required by state law. At a minimum, the Division should develop standard course materials and testing for initial and renewed Designated Doctor certification. If the Division chooses to continue to rely on an outside provider, Division staff should be involved in the development of course materials and tests, and all final products should be Commissioner-approved. Training and any associated end-of-course tests developed to serve as part of a certification renewal process should include topics that allow the Division to ensure a doctor's continued competency in providing assessments.

Finally, as part of this recommendation, the Division should formulate a process for maintaining and regularly updating course materials, regardless of whether training and testing materials are developed in-house or by an outside provider.

4.2 Direct the Commissioner to adopt rules requiring Designated Doctors remain with case assignments, unless otherwise authorized.

As part of this recommendation, the Commissioner of Workers' Compensation would develop, by rule, certain circumstances permissible for a Designated Doctor to discontinue service in a particular area of the state or with a particular case. Such circumstances could include the decision to stop practicing in the workers' compensation system, relocation, or other instances where the doctor is no longer available. Designated Doctors choosing to no longer practice in a county would be expected to remain available as a resource and to perform subsequent exams for the same injured employee throughout the life of the claim for any cases previously assigned, unless the Division authorizes otherwise.

4.3 Authorize the Commissioner to establish a certification fee in rule for Designated Doctors.

This recommendation would authorize the Commissioner to assess a reasonable certification fee. The Division would develop an appropriate fee structure, by rule, taking into account the approximate staff time needed to evaluate initial and renewal applications, as well as staff time needed to pursue enforcement action against noncompliant Designated Doctors. In calculating the fee amount, the Division would not assess the amount of time needed to schedule Designated Doctor exam appointments, as this function is a component of the agency's dispute resolution program and is accounted for in the Texas Department of Insurance's general appropriations.

Fee authority would result in additional funds collected for initial certification applications and renewals. Designated Doctors already certified would not be required to reapply as a first-time applicant, but would be grandfathered under their pre-existing approved application. However, under this recommendation, those Designated Doctors already certified would be required to pay a fee for certification renewal. Although a certification fee would generate additional revenue for Texas Department of Insurance, Division of Workers' Compensation, because Recommendation 4.1 would require DWC to restructure the certification process, possibly increasing the amount of time needed to evaluate an applicant, the amount of revenue cannot be estimated at this time.

Establishing this authority in rule would allow DWC the needed flexibility to make adjustments to the certification fee structure as aspects of the Designated Doctor certification process change, as well as provide an opportunity for the public, specifically doctors, an opportunity to comment on proposed fees.

Management Action

4.4 The Division should remove the Designated Doctor scheduling data from its website.

Under this recommendation, the Division would still be required to maintain a list of certified Designated Doctors and make that list public on its website, however, data regarding actual Designated Doctor assignments serves no public purpose and should be removed.

Fiscal Implication Summary

These recommendations would not have a fiscal impact to the State. Authorizing the Commissioner of Workers' Compensation to collect a certification fee for Designated Doctors would result in additional generated revenue for the Texas Department of Insurance, Division of Workers' Compensation, but, due to the self-leveling nature of the agency's funding, any additional revenue would result in a reduction in maintenance taxes paid by insurers and not affect the State's General Revenue Fund.

[1] Texas Labor Code, sec. 408.0041(e).

Responses to Issue 4

Recommendation 4.1

Require the Commissioner to develop qualification requirements for Designated Doctors.

Agency Response to 4.1

The Division agrees with the recommendation to enhance qualification requirements for Designated Doctors and to adopt those requirements by rule. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 4.1

Lee Ann Alexander – Liberty Mutual Group, Austin

Susan Rudd-Bailey, MD, President and David Teuscher, MD – Texas Medical Association, Austin

Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Against 4.1

None received.

Modifications

1. Reduce the number of designated doctors substantially based on performance. (Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin and Lee Ann Alexander – Liberty Mutual Group, Austin)

2. Require training and proven competency in the Official Disability Guidelines for Designated Doctors, in addition to AMA Guides to the Evaluation of Permanent Impairment. (Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin and Lee Ann Alexander – Liberty Mutual Group, Austin)

3. Provide proper training of the Designated Doctor candidate to properly and accurately answer the questions asked by DWC. (Mark A. Ritchie and C. Wayne Hebert – Texas Independent Evaluators, LLC, Southlake)

Recommendation 4.2

Direct the Commissioner to adopt rules requiring Designated Doctors remain with case assignments, unless otherwise authorized.

Agency Response to 4.2

The Division agrees with the recommendation and had proposed and received informal stakeholder input on rules that address a variety of issues in the Designated Doctor process. With regard to case assignments, the rule proposal states that the Division may require a Designated Doctor previously assigned to a claim to conduct all subsequent examinations on that claim in the same county as the previous examinations were performed as long as that Designated Doctor is still qualified to perform the examination. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 4.2

Lee Ann Alexander – Liberty Mutual Group, Austin

Susan Rudd-Bailey, MD, President and David Teuscher, MD – Texas Medical Association, Austin

Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Against 4.2

None received.

Modifications

4. Change the policy for "best match" based on "compensable condition or accepted diagnosis" regardless of the level of treatment performed and select one qualified and available designated doctor which is recognized by his licensing authority to "evaluate" the condition based on his past experience with such conditions, and his level of training, verified by his credentials and testing through the state mandated curriculum. (Wayne Hebert, Co-Owner – Texas Independent Evaluators, LLC, Southlake)

5. Regardless of which county the designated doctor is registered in, require the doctor to evaluate the injured employee if he is still certified and an active designated doctor in the state of Texas system. Require the designated doctor to remain available regardless of his home location and be required to travel to see the injured employee in the county of their residence again if a subsequent or letter of clarification is ordered. (Wayne Hebert, Co-Owner – Texas Independent Evaluators, LLC, Southlake)

6. Clearly define the selection of the Designated Doctor, which is currently done by using the matrix on the DWC #032 form. (Mark A. Ritchie and C. Wayne Hebert – Texas Independent Evaluators, LLC, Southlake)

7. Remove treatment as the basis for selecting a Designated Doctor. (Mark A. Ritchie and C. Wayne Hebert – Texas Independent Evaluators, LLC, Southlake)

8. Change the matrix selection process to be based on injury area or condition, instead of treatment-based. (Mark A. Ritchie and C. Wayne Hebert – Texas Independent Evaluators, LLC, Southlake)

9. Allow all Designated Doctors to participate in all counties desired, rather than the current 20 county maximum service area, and require each doctor to remain available in that county unless authorized to leave by DWC. (Mark A. Ritchie and C. Wayne Hebert – Texas Independent Evaluators, LLC, Southlake)

Recommendation 4.3

Authorize the Commissioner to establish a certification fee in rule for Designated Doctors.

Agency Response to 4.3

The Division would be able to establish a certification fee for Designated Doctors. Consideration should be given to maintaining the Commissioner's authority to non-renew applications, including those for which a fee is paid, should other requirements not be met. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 4.3

Lee Ann Alexander – Liberty Mutual Group, Austin

Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Against 4.3

Susan Rudd-Bailey, MD, President and David Teuscher, MD – Texas Medical Association, Austin

Recommendation 4.4

The Division should remove the Designated Doctor scheduling data from its website.

Agency Response to 4.4

The Division agrees with this recommendation. However, the Division requests flexibility to determine the appropriate level of information necessary to serve the public purpose. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

Staff Comment: The recommendation is intended to give the Division the flexibility to determine the appropriate level of information to be made available on the agency's website, provided that current scheduling data is not on the website.

For 4.4

Lee Ann Alexander – Liberty Mutual Group, Austin

Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin

Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin

Against 4.4

Susan Rudd-Bailey, MD, President and David Teuscher, MD – Texas Medical Association, Austin

Mark A. Ritchie and C. Wayne Hebert – Texas Independent Evaluators, LLC, Southlake

Commission Decision

Adopted Recommendations 4.1 and 4.2.

Legislative Action

House Bill 2605 requires the Commissioner of Workers' Compensation to develop a certification process, in rule, that effectively uses the spectrum of eligibility, training, and testing to assess the general proficiency of Designated Doctors. The bill requires DWC to develop a process that ensures doctors have either the appropriate specialty qualification, through educational experience or previous training, or demonstrated proficiency, through additional training and testing, to serve as a Designated Doctor. If the Division chooses to continue to rely on an outside provider, the bill requires Division staff be involved in the development of course materials and tests, and all final products should be Commissioner approved. Finally, the bill requires the Division to formulate a process for maintaining and regularly updating course materials, regardless of whether training and testing materials are developed in-house or by an outside provider. (Recommendation 4.1)

The bill also requires the Commissioner of Workers' Compensation to develop, by rule, certain circumstances permissible for a Designated Doctor to discontinue service in a particular area of the state or with a particular case. Such circumstances could include the decision to stop practicing in the workers' compensation system, relocation, or other instances where the doctor is no longer available. Designated Doctors choosing to no longer practice in a county are expected to remain available as a resource and to perform subsequent exams for the same injured employee throughout the life of the claim for any cases previously assigned, unless the Division authorizes otherwise. (Recommendation 4.2)

Issue 5

The Division's Responsibility for Making Some Individual Claims Decisions Conflicts with Its Oversight and Dispute Resolution Duties.

Background

Workers' compensation insurance provides income and medical benefits to employees with a work-related injury or illness. The Texas workers' compensation system's structure contemplates insurance carriers paying and managing individual claims while the Division of Workers' Compensation (DWC) provides oversight and resolves disputes for the system as a whole. The Texas Workers' Compensation Act specifically lays out the types of and eligibility for benefits that injured employees are entitled to, as well as the specific criteria that insurance carriers must adhere to in providing these benefits. Once an injury occurs, and an injured employee files a claim with an insurance carrier, the carrier makes the initial decision about the compensability of the injury, and provides benefits to the injured employee according to requirements in state law and rule.

Most workers' compensation claims are filed and paid without problem. However, if a carrier denies a claim or if there is a dispute about the benefits provided, employees and other system participants can appeal to DWC. As the state agency charged with overseeing the workers' compensation system, DWC is not typically involved in individual claims except to adjudicate disputes, or conduct investigations or audits.

Findings

The Division's involvement in making decisions on individual claims conflicts with its oversight role.

Although generally not responsible for the management of individual claims not under dispute, statute charges DWC and the Commissioner of Workers' Compensation (Commissioner) with making certain specific claims decisions. Involvement in specific claims management activities could pose conflicts with DWC's broader monitoring and oversight role. Further, in the majority of cases, insurance carriers make initial determinations of eligibility, without DWC's involvement.

Sunset staff analyzed all of the claims decisions DWC makes and identified certain decisions in which the Division is unnecessarily involved, as summarized in the chart on the next page, *DWC Claims Decisions*. In each of these instances, the injured employee or beneficiary already meets statutory eligibility requirements for certain benefits, and the claims decision is related to a change in the benefits' frequency, type, or timeframe of payment.

DWC Claims Decisions

Individual Claim Decision	Description	Number Processed FY 09	By Statute or Practice
Acceleration of Impairment Income Benefits[1]	Statute requires the Commissioner to order carriers to accelerate impairment income benefit payments to employees, if they meet certain requirements.	80	Statute
Advancement of Income Benefits[2]	Statute authorizes the Commissioner to order carriers to advance the payment of income benefits to employees, if they meet certain requirements.	1,552	Statute
Initial Determination of Supplemental Income Benefits[3]	Statute specifically prescribes when and how an employee is entitled to supplemental income benefits and requires the Commissioner to make the initial determination of eligibility for payment. The law allows carriers to make subsequent determinations without DWC involvement.	1,637	Statute
Change of Treating Doctor[4]	Statute requires the Division to approve requests by employees to change treating doctors. The Commissioner prescribes the criteria by which a change is appropriate.	15,840	Statute
MMI Extension After Spinal Surgery[5]	Statute authorizes the Commissioner to extend the amount of time for an employee who will have spinal surgery to reach Medical Maximum Improvement (MMI), which triggers the end of temporary income benefits. The Commissioner prescribes the criteria for which an extension is appropriate.	116	Statute
Distribution of Lifetime Income and Death Benefits[6]	Upon an agreement by the parties, statute authorizes carriers to pay lifetime income benefits and death benefits through an annuity if the annuity meets criteria prescribed by Commissioner rule. Statute also requires the Commissioner to establish criteria for agreements in rule to allow carriers to pay death benefits monthly instead of weekly. Although not specifically required to do so by law, the Division has interpreted statute to mean that DWC must approve these agreements.	75	Practice
Lump Sum Impairment Income Benefits[7]	Statute authorizes employees to elect to receive their impairment income benefits in a lump sum, if they meet certain statutory requirements. Although statute does not require DWC to be involved in this decision, historically, DWC has interpreted statute to mean that it must review the employee's request and order carriers to give benefits in a lump sum.	272	Practice
Total		19,572	

Requiring DWC to make a decision on an individual claim, and to adjudicate a dispute of the same decision, creates a potential conflict of interest.

One of the Division's primary functions is to administer a dispute resolution process to resolve contested claims decisions in the workers' compensation system. When DWC makes a decision on an individual claim, as occurs for the decisions listed in the chart, a party to that claim may dispute that decision through the Division's dispute resolution process. This situation creates a conflict of interest in which DWC is adjudicating its own decisions. Requiring DWC to make these decisions compromises its neutrality and prevents it from maintaining the independence needed to make fair decisions and resolve disputes between parties. In fiscal year 2009, of the 19,572 claims decisions made by DWC described in the chart, 385 were disputed.

The Division cannot maintain its neutrality when judging the appropriateness of its own decisions in disputes.

While insurance carriers are well-positioned to manage individual claims, the Division's involvement in these claims decisions wastes state resources.

If DWC has no previous involvement with a claim, which is generally the case for claims not under dispute, it may not have the necessary information to make an informed decision. Unlike DWC, insurance carriers have complete access to and keep detailed claim information for each individual claim they manage. An insurance carrier can consider the individual claim in its entirety, enabling it to make informed decisions on individual claims. For example, although statute and rule outline criteria an employee must meet to change treating doctors, DWC may not have information about an employee's specific medical claim, including the identity of the employee's initial treating doctor. However, the insurance carrier, with up-to-date and complete access to the injured employee's medical file, can readily make an informed decision, which an employee could later dispute at the Division.

Because DWC does not have this information, Division staff must spend time contacting the insurance carrier, health care provider, or injured employee to request additional information to make a decision. Staff spend anywhere from 30 minutes to two hours to investigate an individual claim before making a decision, which takes up a substantial amount of time that could be spent performing other tasks, including stakeholder education and preparing for official proceedings. In fiscal year 2009, Division staff estimate spending more than 28,987 hours on these decisions.

In fiscal year 2009, DWC staff spent almost 29,000 hours on these claims decisions.

Recommendations

Change in Statute

5.1 Transfer the responsibility for certain claims decisions from DWC to insurance carriers.

This recommendation would remove the Division and the Commissioner from making decisions on individual claims, transferring responsibility for these decisions to insurance carriers. As a result, DWC would only be involved in an individual claim if a dispute arises or for system monitoring and oversight purposes. Any disputes arising from these claims decisions made by insurance carriers would be resolved through the Division's existing dispute resolution process. This recommendation would not impact the Commissioner's statutory requirements to prescribe criteria by which carriers make these claims decisions. Additionally, DWC should amend its current rules regarding these claims decisions to reflect carrier responsibility, consistent with statute, rule, and internal processes already established. This recommendation would affect the following claims decisions:

- Acceleration of Impairment Income Benefits;
- Advancement of Income Benefits;
- Initial Determination of Supplemental Income Benefits;
- Change of Treating Doctor; and
- Maximum Medical Improvement Extension After Spinal Surgery.

Management Action

5. 2 Direct DWC to require insurance carriers to make decisions on certain individual claims.

Under this recommendation, the Division would adjust its practices to ensure carriers make individual claims decisions. Although statute does not specifically require DWC to be involved in these decisions, historically DWC has approved changing the way that employees and beneficiaries receive their benefits. As part of this recommendation, DWC would amend rules and internal processes to clarify insurance carriers' responsibility for making these decisions, as well as any necessary requirements the carrier should adhere to when making decisions. The Division would only be involved in an individual claim through its current dispute resolution processes if a dispute arises based on one of these decisions, or for system monitoring and oversight purposes. This recommendation would affect the following decisions:

- Distribution of Death Benefits;
- Annuities for Lifetime Income Benefits; and
- Lump Sum Impairment Income Benefits.

Fiscal Implication Summary

These recommendations would not have a fiscal impact to the State. Because many DWC staff within the 24 field offices across the state make these claims decisions, the time saved by transferring responsibility for the decisions to insurance carriers would not result in a reduction of staff.

1 Texas Labor Code, sec. 408.129.

2 Texas Labor Code, sec. 408.085.

3 Texas Labor Code, sec. 408.143.

4 Texas Labor Code, sec. 408.022.

5 Texas Labor Code, sec. 408.104.

6 Texas Labor Code, secs. 408.161 and 408.181.

7 Texas Labor Code, sec. 408.128.

Responses to Issue 5

Recommendation 5.1

Transfer the responsibility for certain claims decisions from DWC to insurance carriers.

Agency Response to 5.1

The Division agrees with this recommendation. Requiring insurance carriers who have direct access to the entire claim file to make these claim decisions would result in greater efficiency and allow the Division to be involved only when the injured employees disputes the insurance carrier's decisions. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 5.1

None received.

Against 5.1

Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin

Recommendation 5.2

Direct DWC to require insurance carriers to make decisions on certain individual claims.

Agency Response to 5.2

The Division agrees with this recommendation and has initiated a process to review rules associated with these claims decisions. In each case, modifications to the rules would result in greater efficiency and allow the Division to be involved only when the injured employee disputes the insurance carrier's decision. Since the volume of these actions is low and eligibility requirements for these types of claims are already specified by rule, the system impact would be minimal. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 5.2

None received.

Against 5.2

Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin

Commission Decision

Adopted Recommendations 5.1 and 5.2.

Legislative Action

The Legislature did not adopt the provisions that would have transferred the responsibility for certain claims decisions from DWC to insurance carriers. (Recommendations 5.1 and 5.2)

Issue 6

Employers Outside the Workers' Compensation System Are Failing to Report Information the Legislature Needs to Evaluate the Health of the System.

Background

In Texas, state law does not require private employers to provide workers' compensation coverage to their employees. The Division of Workers' Compensation (DWC) estimates that 33 percent of Texas employers choose not to subscribe to the workers' compensation system. However, the law does require employers that choose not to subscribe to report that decision to DWC annually and to notify their employees of that choice. In addition, statute requires all employers, regardless of whether they subscribe, to notify DWC of any deaths that occur on-the-job and of illnesses or injuries that result in more than one day of lost time by the injured employee.

The Legislature uses information about employer participation in the workers' compensation system to evaluate the efficacy of system programs and to determine whether aspects of the system are encouraging or discouraging employer participation. Information about injuries and deaths allows the Legislature to monitor the safety of Texas employees and to determine whether workers' compensation initiatives, such as workplace safety programs, are effective. The Legislature has noted the importance of this information and, beginning in 2007, has included a rider in the General Appropriations Act requiring TDI to report information about employers' compliance with reporting requirements to the Legislature.

State law charges DWC with collecting and maintaining this information and monitoring compliance with these provisions. To do so, DWC has information about the reporting requirement on its website. DWC has the authority to contract with the Texas Workforce Commission (TWC) or the Comptroller of Public Accounts for assistance in collecting this information. The Division receives information from TWC about Texas employers with unemployment insurance and cross references it with its own subscription information to identify and contact employers that are failing to report. Employers that fail to report their choice not to subscribe and information about work-related injuries or deaths to DWC commit an administrative violation and may be fined by DWC.

Findings

Only 10 percent of nonsubscribing employers make required reports to DWC, including information on workplace injuries.

DWC receives statutorily required information regarding subscription choice and on-the-job injuries from very few nonsubscribing employers.[1] Due to the voluntary nature of workers' compensation in Texas, employers may not understand that, even though they do not provide workers' compensation coverage, the law still requires them to report that choice to DWC. Further, an employer that fails to report its choice to not subscribe to DWC is more likely to similarly fail to report workplace injuries and deaths. This lack of information negatively impacts the Legislature's ability to evaluate the workers' compensation system and to monitor the safety of Texas employees.

DWC's efforts to identify noncompliant employers and increase reporting have not been effective.

The Division's compliance efforts have shown little impact on overall reporting.

Despite stepped up efforts to identify noncompliant employers and encourage reporting, compliance is still low. Through its own data and its data share agreement with TWC, the Division identifies employers that have not reported and attempts to gain voluntary compliance. The Division initiates administrative enforcement proceedings only after an employer refuses to comply after multiple contacts. The Division levied no fines in fiscal year 2009, despite pursuing 44 enforcement actions, since the employers ultimately complied with the reporting requirement. While such compliance is good, this extensive process targets individual employers only after they have failed to report and has so far shown little impact on overall reporting compliance by nonsubscribing employers.

Other state agencies that regularly provide information to Texas employers are well-positioned to help DWC increase awareness about employers' reporting requirements.

Several state agencies interact with Texas employers on a regular basis, as highlighted in the textbox, *State Agency Employer Contacts*. These agencies provide new and existing employers with publications and online information regarding an employer's responsibilities under state law.

State Agency Employer Contacts

Texas Department of Information Resources – The Department manages the Texas Online Business Portal, which includes a four-step guide for employers starting new businesses.

The Governor's Office for Economic Development and Tourism – The Governor's Office provides information to employers starting new businesses.

Texas Workforce Commission – In addition to its contact with employers on unemployment insurance, TWC provides online and print information to employers about their responsibilities under state law.

Secretary of State – The Secretary's Office interacts with employers who file to organize as a limited liability corporation. In addition, the Secretary's website includes links to information for starting a business and to other state agencies' websites.

Comptroller of Public Accounts – The Comptroller's Office works with employers that must file various business taxes. In addition, the Comptroller's website has information for new businesses, including links to other state agencies' websites.

Of these agencies, only TWC's website prominently features a link to DWC's website. Although the Department of Information Resources and the Office for Economic Development and Tourism both mention the existence of workers' compensation on their website, neither have further information or links to DWC's website. None of the agencies have specific information

regarding the voluntary nature of workers' compensation or a nonsubscribing employer's reporting requirements.

To make reporting easier and encourage compliance, DWC has begun work on an online system for employers to report their choice regarding workers' compensation subscription. As DWC works on the creation of its online reporting form, opportunities exist both to coordinate education efforts with these agencies and to provide links to this form electronically through these agencies' websites.

Recommendation

Management Action

6.1 The Division should closely coordinate with other state agencies to include nonsubscription reporting requirements in their print and electronic publications.

This recommendation would direct DWC to coordinate with other state agencies about nonsubscription reporting, including the Comptroller of Public Accounts, the Secretary of State, the Governor's Office of Economic Development and Tourism, and the Department of Information Resources, as well as further coordination with the Texas Workforce Commission. Coordination should include efforts such as adding information about workers' compensation reporting requirements to the other agencies' websites, including links to DWC's online reporting form as it develops. Coordination could also include adding workers' compensation information to other relevant agency publications. If beneficial, DWC might also explore further data sharing of employer information with these agencies to identify nonreporting employers. Under this recommendation, DWC and these other agencies would have the flexibility to determine the most useful and cost effective ways to coordinate, as conditions change.

Fiscal Implication Summary

This recommendation would have no fiscal impact to the State. The agencies will have the flexibility to determine the most effective way to coordinate and should be able to do so using existing resources.

[1] The Division estimates that only 10 percent of nonsubscribers report based on a 2008 biennial survey of Texas employers. The Division will send out the survey again in the summer of 2010. Although DWC believes that the recent increased focus on reporting has likely caused this percentage to go up, it does not expect that number to be a majority of nonsubscribers.

Responses to Issue 6

Recommendation 6.1

The Division should closely coordinate with other state agencies to include nonsubscription reporting requirements in their print and electronic publications.

Agency Response to 6.1

The Division agrees with the recommendation that its ongoing efforts to identify non-subscribing employers should include further coordination with the agencies identified by Sunset Staff. The Division has initiated contact with several of these agencies to discuss coordination efforts. The addition of an online reporting system, currently in development, will enhance the Division's ability to involve other agencies in the process as well as make the process easier for Texas employers. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

Affected Agency Response to 6.1

The Texas Comptroller of Public Accounts reviewed Issue 6 and Recommendation 6.1 and does not have any comments, and will work with DWC with linking to our Window on State Government website. (The Honorable Susan Combs, Comptroller of Texas – Texas Comptroller of Public Accounts)

The Texas Department of Information Resources concurs with the recommendation for management action and is working with DWC to add new electronic links and modify existing links between DWC's website and relevant pages on TexasOnline, including the Business Portal. (Karen W. Robinson, Interim Executive Director – Texas Department of Information Resources)

The Texas Workforce Commission has no concerns with the information contained in Issue 6 and is supportive of the recommendation. Presently, DWC is receiving information from TWC on Texas employers with unemployment insurance and TWC's website includes a prominent link to DWC's website. (Larry Temple, Executive Director – Texas Workforce Commission)

For 6.1

Cathy DeWitt, Vice President – Texas Association of Business, Austin

Emily Timm, Policy Advocate – Workers Defense Project, Austin

Against 6.1

None received.

Modifications

1. Request further review by the Sunset Commission of the lack of reporting of critical data on workplace injuries of employees not covered by workers' compensation. (Letter signed

by the following members of the Texas House of Representatives – Alma A. Allen, Roberto Alonzo, Carol Alvarado, Valinda Bolton, Lon Burnam, Garnet F. Coleman, Joe Deshotel, Dawnna Dukes, Jim Dunnam, Al Edwards, Kirk England, Joe Farias, Jessica Farrar, Ana Hernandez, Abel Herrero, Carol Kent, Barbara Mallory Caraway, Robert Miklos, Elliott Naishtat, Paula Pierson, Eddie Rodriguez, Chris Turner, Marc Veasey, and Armando Walle)

2. Require additional critical workplace injury data be reported by subscriber and non-subscriber alike to ensure Texas can adequately evaluate injury outcomes in all workplaces across the state. (Richard Levy, Legal Director – Texas AFL-CIO)

3. Establish incentives and penalties to ensure nonsubscribers report required information. (Emily Timm, Policy Advocate – Workers Defense Project, Austin)

Commission Decision

Adopted Recommendation 6.1.

Legislative Action

As a management recommendation not needing statutory change, Recommendation 6.1 did not result in legislative action.

Issue 7

Texas Has a Continuing Need for the Division of Workers' Compensation.

Background

The Texas Workers' Compensation Act provides income replacement and medical benefits for employees who are injured or contract an illness on the job. In Texas, workers' compensation policies are elective for non-governmental employers. In exchange for providing workers' compensation benefits, subscribing employers are immune in most circumstances from liability relating to an employee's work-related injury or illness. To ensure these statutory benefits are delivered timely and fairly, the Texas Department of Insurance (TDI), Division of Workers' Compensation (DWC) oversees, regulates, and ensures benefit delivery for Texas workers' compensation participants.

Organizationally, statute establishes DWC as a division within TDI and designates TDI as the agency to oversee workers' compensation.[1] The Commissioner of Insurance, appointed by the Governor with the advice and consent of the Senate, leads TDI. At the same time, statute provides that the Commissioner of Workers' Compensation, also appointed by the Governor, administers DWC and has executive and rulemaking authority over workers' compensation.[2] The Division has a separate Sunset date from TDI in statute.[3]

The textbox, *Workers' Compensation System Participants*, gives information on the number and type of participants DWC oversees. To regulate workers' compensation, DWC and TDI perform the following key functions.

Workers' Compensation System Participants

Injured Employees. More than 97,000 job-related injuries or illnesses occurred in Texas in 2009, following a downward trend in both the state and nation. Of those, 422 Texans died as a result of a work-related injury.

Employers. About 67 percent of Texas employers subscribe to the DWC-regulated workers' compensation insurance system, covering about three-quarters of Texas' workforce, or eight million employees.

Insurance Carriers. Of the more than 600 companies licensed to write workers' compensation in Texas, about 270 actively write policies.

Health Care Providers. Nearly 96,000 health care providers practice in the workers' compensation system.

- Oversee the workers' compensation benefit delivery system through audits and complaint resolution.
- Provide a low-cost administrative dispute resolution process for contested claims.
- Certify workers' compensation networks, and entities that make decisions about medical treatment in the system.
- Review medical care utilization and the quality of medical care given in the system.
- Certify employers that choose to self-insure and retain the financial risk of a policy.
- Take enforcement action against violators as necessary and investigate workers' compensation fraud.

In 2005, the Legislature passed House Bill 7, the Sunset bill for the Texas Workers' Compensation Commission, which included comprehensive reforms to the system. Among these, the bill abolished the Texas Workers' Compensation Commission and transferred most of its functions to the Texas Department of Insurance, Division of Workers' Compensation; created certified workers' compensation healthcare networks to improve the quality and cost of medical care given in the system; and required the adoption of evidence-based medicine treatment guidelines.

Findings

Texas has a clear and continuing interest in regulating workers' compensation.

Because state law prohibits an employee from suing a covered employer for compensation related to an on-the-job injury or illness, the State has an interest in ensuring that the benefits promised by state law are delivered appropriately. The Division oversees the system to ensure fair treatment of injured employees and other system participants, and to ultimately help injured workers return to work.

The State continues to need a neutral third-party to resolve claims disputes.

The complicated delivery of benefits often leads to disputes about the compensability of a claim or the medical treatment given. The State has created an administrative, neutral, third-party dispute resolution process, outside of the court system, to resolve these disputes and has designated DWC as the lead entity responsible for resolving disputes. Although other entities may be able to perform this function, the State continues to need a neutral third-party to resolve disputes and ensure injured employees are timely paid benefits. System participants filed more than 38,000 disputes in fiscal year 2009, including indemnity, medical necessity, and medical fee disputes. The chart, *Dispute Resolution Performance,* details the resolution of disputes in fiscal year 2009. Once filed, system participants may choose not to pursue a dispute, or resolve the dispute independently from DWC.

Dispute Resolution Performance – FY 2009

Number of Indemnity Dispute Benefit Review Conferences Held	10,886
Number of Indemnity Disputes Resolved Informally Before a Hearing	6,531
Number of Indemnity Dispute Hearings Held	4,906
Number of Medical Dispute Hearings Held*	778

* This number includes medical dispute hearings held at both DWC and the State Office of Administrative Hearings.

State law gives companies the option of self-insuring their employees and retaining the financial risk of the policies, and requires companies to meet certain solvency requirements. The regulation of certified self-insurers

continues to be of interest to the State to verify that companies that self-insure are able to pay future claims for injured employees. In fiscal year 2009, DWC-issued certificates covered 214 self-insured entities, comprising 14 percent of the Texas workers' compensation market.

Ongoing oversight of the workers' compensation system continues to be needed to ensure that the system works well and to minimize overall costs to the system. The Division takes enforcement action against those who violate statute or rule to ensure system compliance. In fiscal year 2009, DWC opened 571 enforcement cases and assessed about $1 million in administrative penalties. That same year, TDI's fraud division referred 28 workers' compensation fraud cases for prosecution, which resulted in 20 convictions, and $4.2 million in ordered restitution.

The merger of DWC with TDI has resulted in administrative improvements.

TDI is the most appropriate agency to regulate workers' compensation in Texas.

Organizationally, DWC's functions could be severed from TDI and returned to a separate agency as it was before the 2005 reforms, but Sunset staff concluded that no significant benefit would result from splitting the functions apart. The Department and DWC are still implementing the organizational changes made by House Bill 7, including the merger of the agencies. Sunset staff examined the consolidation and determined that it has resulted in some administrative improvements, as well as opportunities for the agency to identify efficiencies and functional benefits as integration continues. For example, the State has been able to improve its overall approach to network certification, and the regulation of utilization review agents and independent review organizations, by having all functions at one agency for both workers' compensation and group health insurance.

Before the 2005 reforms, workers' compensation was not only regulated by a separate agency, but it also operated under a six-member Commission rather than a single Commissioner. Sunset staff examined the structure of having a single Workers' Compensation Commissioner within the context of having two separate Commissioners for Insurance and Workers' Compensation, both appointed by the Governor. While this structure is unique in a state agency, and has the potential to create some confusion, the review found no compelling reason to alter it. The Commissioners have made good use of their statutory authority to delegate authority to each other in writing, having signed seven delegation orders.[4]

While unique, no compelling reason exists to alter the two-Commissioner structure.

While organizational structures vary, all 50 states regulate workers' compensation.

All states regulate workers' compensation, though the structure and administration of workers' compensation systems vary significantly from state to state. Texas is the only state that does not require workers' compensation insurance for private employers. Several states have set up independent bodies

to regulate workers' compensation, but most have workers' compensation divisions attached to a larger state agency regulating insurance or employment, as Texas does.

The Division does not have an effective system to track or manage complaints against DWC.

Without additional complaint information, DWC may not identify larger problems.

System participants only filed three formal complaints against DWC in fiscal year 2009. However, given the adversarial system that DWC oversees, system participants informally complain to DWC on a much more frequent basis, on issues ranging from the quality of assistance given by customer service representatives to the consistency and fairness of a dispute proceeding before DWC.

The Division reports that staff receive and resolve these complaints at the program level. While staff may be appropriately handling complaints and taking action when needed, the informality of the system prevents this information from being recorded, tracked, or communicated to executive staff in a systematic way. Functionally, DWC does much of its work in its 24 field offices, exacerbating the disconnect between problems occurring on the ground and an overall look at potential agency weaknesses. Without complete information about the complaints that it receives, the final disposition of those complaints, and the areas that produce the most complaints, DWC cannot use those valuable tools to analyze trends that may indicate larger problems.

Recommendations

Change in Statute

7.1 Continue the Division of Workers' Compensation for 12 years, and remove its separate Sunset date from statute.

This recommendation would continue DWC for 12 years as a division within TDI. The recommendation would also remove DWC's separate Sunset date from statute, merging the Sunset date with TDI. The Division's role and responsibilities in regulating the workers' compensation system would be subject to review as part of future Sunset reviews of TDI, allowing the Legislature to take a full look at the entire workings of the agency.

7.2 Require the Division to develop standard procedures for documenting complaints and for tracking and analyzing complaint data.

This recommendation would require DWC to develop standard procedures to formally document and analyze complaints. The recommendation would apply to all complaints made to the Division, including both formal and informal complaints. The Division would be required to clearly lay out policies for all phases of the complaint process, from receipt to disposition. The recommendation would also require DWC to compile statistics, including the number, source, type, length of resolution time, and disposition of complaints. The Division would analyze complaint information trends to get a clearer picture of system participants' concerns about the Division and allow DWC to make improvements. The Division should track this information by field office and by program, and report to the Commissioner of Workers' Compensation on a regular basis.

Fiscal Implication Summary

If the Legislature continues DWC, the amount of funds appropriated to related strategies within TDI's appropriations pattern, totaling about $64 million, would need to be continued. Those appropriations are covered by assessments on workers' compensation insurance carriers.

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1 Texas Labor Code, sec. 402.001.

2 Texas Labor Code, sec. 402.00111.

3 Texas Insurance Code, sec. 31.004(a) and sec. 31.004(b).

4 Texas Labor Code, sec. 402.00111(b).

Responses to Issue 7

Recommendation 7.1

Continue the Division of Workers' Compensation for 12 years, and remove its separate Sunset date from statute.

Agency Response to 7.1

The Division agrees that there is a continuing need to regulate workers' compensation and has no objections to aligning the Division's Sunset date with that of the Texas Department of Insurance. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 7.1

Susan Rudd-Bailey, MD, President and David Teuscher, MD – Texas Medical Association, Austin

Richard Levy, Legal Director – Texas AFL-CIO

Against 7.1

None received.

Modification

1. Do not remove the separate Sunset date for DWC from statute. (Jonathan D. Bow, JD, Executive Director – State Office of Risk Management)

Recommendation 7.2

Require the Division to develop standard procedures for documenting complaints and for tracking and analyzing complaint data.

Agency Response to 7.2

The Division agrees with this recommendation and had taken steps to improve its tracking and analysis of complaints against the Division. (Rod Bordelon, Commissioner of Workers' Compensation and Mike Geeslin, Commissioner of Insurance – Texas Department of Insurance, Division of Workers' Compensation)

For 7.2

Susan Rudd-Bailey, MD, President and David Teuscher, MD – Texas Medical Association, Austin

Against 7.2

None received.

Modifications

2. Require the Division to make complaint data open to the public to ensure all Texans are adequately informed of all aspects of DWC. (Susan Rudd-Bailey, MD, President – Texas Medical Association, Austin and David Teuscher, MD – Texas Medical Association, Austin)

3. Remove the Division's matrix system of categorizing complaints and require the Division to create a simple and transparent method to be used instead. (Andrew Patterson)

Commission Decision

Adopted Recommendation 7.1, with a modification to continue the Division for six years instead of the standard 12-year period and to retain the agency's separate Sunset date.

Adopted Recommendation 7.2.

Legislative Action

House Bill 2605 continues DWC for six years, as a division within TDI, instead of the standard 12-year period. This shortened Sunset date will give the Legislature the opportunity to re-evaluate the continued implementation of reforms passed in previous legislative sessions. (Recommendation 7.1 as modified)

In addition, the bill requires DWC to develop standard procedures to formally document and analyze complaints, including both formal and informal complaints. The bill requires DWC to compile statistics, including the number, source, type, length of resolution time, and disposition of complaints, and to analyze complaint information trends. (Recommendation 7.2)

New Issues

New Issues

The following issues were raised in addition to the issues in the staff report. These issues are numbered sequentially to follow the staff's recommendations.

Medical Quality Review Process and Office of the Medical Advisor

8. Except for administrative matters, prohibit the Commissioner of Workers' Compensation and Division staff from communicating with the subject under review or the subject's representatives, including elected officials and attorneys, from the time the notification letter is sent from the Division to a subject identified for review as part of the medical quality review process. (Representative Rafael Anchia, Member – Sunset Advisory Commission; Luke Bellsnyder – Texas Association of Manufacturers; Cathy Stoebner DeWitt – Texas Association of Business; and Joe Woods – Property Casualty Insurers, Inc.)

9. Require a member of the Office of the Medical Advisor's office or a MQRP member who initiates a complaint against a doctor to recuse themselves from any further activity on that doctor's review case. (Representative Rafael Anchia, Member – Sunset Advisory Commission; Luke Bellsnyder – Texas Association of Manufacturers; Cathy Stoebner DeWitt – Texas Association of Business; and Joe Woods – Property Casualty Insurers, Inc.)

10. Amend statute to ensure a strong, independent, and aggressive Office of the Medical Advisor that remains separate from the other administrative aspects of the Division and answers only to the Commissioner. (Donald A. Abrams, PA, President – Medical Equation, Inc., Austin)

11. Require the Division to adopt guidelines on the procedures for informal hearings resulting from the medical quality review process, including assurance that evidence submitted will be reviewed and considered. (Sherri Giorgio, Senior Manager, State Government Affairs – Medtronic Spinal and Biologics, Memphis, Tennessee; N. William Fehrenbach, Director, State Government Affairs – Medtronic Neurological, Minneapolis, Minnesota)

12. Establish a 60-day notice requirement for hearings that result from a review performed as part of the medical quality review process. (Sherri Giorgio, Senior Manager, State Government Affairs – Medtronic Spinal and Biologics, Memphis, Tennessee; N. William Fehrenbach, Director, State Government Affairs – Medtronic Neurological, Minneapolis, Minnesota)

13. Require the Division to make public the names and credentials of the MQRP reviewers to ensure the Panel is comprised of a fair and balanced review team. (Sherri Giorgio, Senior Manager, State Government Affairs – Medtronic Spinal and Biologics, Memphis, Tennessee; N. William Fehrenbach, Director, State Government Affairs – Medtronic Neurological, Minneapolis, Minnesota)

14. Allow for Notice of Violations and Informal Settlement Conferences along with strictly enforced time limits and guidelines for procedure and rebuttal evidence submission that will be reviewed and considered. Allow for the Panels sitting or presiding over these settlement conferences to be of the specialty at issue and not be on the initial review committee or among the three Medical Quality Review Panel doctors initially reviewing the medical case. Include

statutory language to require reviewers to be physicians of like specialty, licensed in to practice in Texas and currently treating Texas workers' comp patients a minimum of 20 hours per week. (Allen W. Burton, MD, President; Roy Durrett, MD, PhD, Workers' Comp Committee Chair; and C.M. Schade, MD, PhD, TMA Delegate and TPS Board Emeritus – Texas Pain Society, Austin)

Benefit Levels

15. Request the Sunset Commission further review the inadequate levels of benefits received by injured workers. (Letter signed by the following members of the Texas House of Representatives – Alma A. Allen, Roberto Alonzo, Carol Alvarado, Valinda Bolton, Lon Burnam, Garnet F. Coleman, Joe Deshotel, Dawnna Dukes, Jim Dunnam, Al Edwards, Kirk England, Joe Farias, Jessica Farrar, Ana Hernandez, Abel Herrero, Carol Kent, Barbara Mallory Caraway, Robert Miklos, Elliott Naishtat, Paula Pierson, Eddie Rodriguez, Chris Turner, Marc Veasey, and Armando Walle; and Richard Levy, Legal Director – Texas AFL-CIO)

Networks

16. Request further review by the Sunset Commission of the inadequacy of certified workers' compensation networks. (Letter signed by the following members of the Texas House of Representatives – Alma A. Allen, Roberto Alonzo, Carol Alvarado, Valinda Bolton, Lon Burnam, Garnet F. Coleman, Joe Deshotel, Dawnna Dukes, Jim Dunnam, Al Edwards, Kirk England, Joe Farias, Jessica Farrar, Ana Hernandez, Abel Herrero, Carol Kent, Barbara Mallory Caraway, Robert Miklos, Elliott Naishtat, Paula Pierson, Eddie Rodriguez, Chris Turner, Marc Veasey, and Armando Walle)

17. Resolve statutory inconsistencies to avoid requiring Pharmacy Benefit Managers to obtain a network certification. (Kevin Tribout – CompPharma, Madison, Connecticut)

18. More clearly define the concept of network adequacy as it applies to network certification. (Richard Levy, Legal Director – Texas AFL-CIO)

The Entergy Case

19 Request the Sunset Commission further review the effects of the Entergy decision. (Letter signed by the following members of the Texas House of Representatives – Alma A. Allen, Roberto Alonzo, Carol Alvarado, Valinda Bolton, Lon Burnam, Garnet F. Coleman, Joe Deshotel, Dawnna Dukes, Jim Dunnam, Al Edwards, Kirk England, Joe Farias, Jessica Farrar, Ana Hernandez, Abel Herrero, Carol Kent, Barbara Mallory Caraway, Robert Miklos, Elliott Naishtat, Paula Pierson, Eddie Rodriguez, Chris Turner, Marc Veasey, and Armando Walle)

20. Recommend legislative action that would overturn the wrongly decided Entergy v. Summers decision. (Richard Levy, Legal Director – Texas AFL-CIO)

Dispute Resolution

21. Require every hearing officer, at every level, to undergo periodic review of a sample of their decisions, by a wholly independent review source, with failure to meet standards, developed in accordance with the Attorney General and the State Office of Administrative Hearings, resulting in appropriate re-training or termination from the position held. (Donald A. Abrams, PA, President – Medical Equation, Inc., Austin)

22. Remove the alternative resolution process and instead allow parties to seek District Court review of the issues by authorizing discovery, interrogatories, deposition and one or two delays before a judge or jury hears the issues. (Andrew Patterson, Houston)

23 Authorize the Division to develop a cost-effective, simple dispute resolution process for small dollar amount bills, grant the Commissioner explicit authority to aggregate disputes involving a single payer and single provider or agent in cases where the Division can determine a pattern of inappropriate behavior, and require disputes to be decided within prescribed timeframes. (Tristan "Tris" Castaneda, Jr., Manager, Legislative and Government Relations – Workers' Compensation Pharmacy Alliance, Austin)

Designated Doctors

24. Require the Division to create a contract for Designated Doctors, limited to 400, that outlines all requirements to serve as a Designated Doctor, including knowledge base, system participation, statutory requirements, and acknowledgement of published standards. Require the Division to terminate the contract of any Designated Doctor who violates the contract more than three times. (Donald A. Abrams, PA, President – Medical Equation, Inc., Austin)

25. Require the Division to outsource to two entities responsiility for completing the first-level QA review, the process of receiving the Designated Doctor requests, making the assignment of the request to the appropriate contracted Designated Doctor, and ensuring that the medical records are obtained and are properly formatted and reflected in the Designated Doctor report. (Donald A. Abrams, PA, President – Medical Equation, Inc., Austin)

Treatment Guidelines

26. Establish an oversight process to ensure the Division updates and modifies adopted treatment guidelines based on medical literature and best medical standards-of-care and not other factors. (Sherri Giorgio, Senior Manager, State Government Affairs – Medtronic Spinal and Biologics, Memphis, Tennessee; N. William Fehrenbach, Director, State Government Affairs – Medtronic Neurological, Minneapolis, Minnesota)

Fee Guidelines

27. Require the Division, in developing the closed formulary, to ensure that injured employees are not placed at risk, for example, by allowing implantable drug infusion pump refills to be authorized on an annual basis. (Sherri Giorgio, Senior Manager, State Government Affairs – Medtronic Spinal and Biologics, Memphis, Tennessee; N. William Fehrenbach, Director, State Government Affairs – Medtronic Neurological, Minneapolis, Minnesota)

Medical Necessity Review Process

28. Remove the medical review board and Independent Review Organization process and require the Division to make arrangements directly with the various medical agencies and allow them to determine the medical issues being raised. (Andrew Patterson, Houston)

29. Eliminate all Utilization Review and other opinion doctors for treatment preauthorization, and instead require live, second opinions from practicing, qualified doctors in the same specialty by equally or greater certified specialists. (Marianne Bogel, RN, BSN, Helotes)

30. Require the Division to address the denial by carriers of treatments that are specifically authorized in the Official Disability Guidelines. (Bubba Klostermann OT, CVE/R; CEAS – West Texas Rehabilitation Center, Austin)

Workplace Safety and Accident Prevention Services

31. Require that all safety managers be bonded. (Samuel Meeks, Belton)

32. Merge the DWC Accident Prevention Services program with the TDI Inspections/Loss Control division and significantly refocus workers' compensation Accident Prevention Services to more meaningful safety services. (Joe Woods, Vice President, State Government Relations – Property and Casualty Insurers Association of America, Austin and Lee Ann Alexander – Liberty Mutual Group, Austin)

33. Consolidate the Department's and the Division's loss control services program. (Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin)

Miscellaneous

34. Amend statute to ensure carriers, Third Party Administrators, and adjusters are held professionally liable for their actions, whether they reside in Texas or outside the state, through legal action brought by parties to the insurance contract and employees under the Workers' Compensation Act. (Andrew Patterson, Houston)

35. Allow the Division to make unannounced investigations of carriers' and Third Party Administrators' offices to review claims, underwriting, and other activities. Require such investigations to be done on a regular basis and when allegations are made of a carrier's or Third Party Administrator's misconduct, including failure to comply with judicial process, withholding information, and providing false information to the Court. (Andrew Patterson, Houston)

36. Require the Texas Department of Insurance to be subject to twice yearly external audits by entities that are not part of Texas state government, the Legislature, or Governor's Office, but using standards developed by members of Legislature and the Sunset Advisory Commission. Audits should revolve around the agency's performance and how well it responds to Texas citizens' needs regarding insurance issues. (Andrew Patterson, Houston)

37. Require the Department of Insurance, including the Division of Workers' Compensation, to develop a culture where laws, statutes, and regulations they enforce are viewed as living documents with the need for changes when indicated, and provide such issues to the Governor and the Legislature. (Andrew Patterson, Houston)

38. Require spine surgeon board certification to treat injured workers. (Marianne Bogel, RN, BSN, Helotes)

39. Amend statute to require that injured workers be treated first and all bills paid; authorize the carrier to seek opinions and dispute care after treatment is compete and all bills are paid; carrier will not be reimbursed for acceptable outcomes. (Marianne Bogel, RN, BSN, Helotes)

40. Clarify when a pharmacy contract rate can be lawfully applied and to whom. (Tristan "Tris" Castaneda, Jr., Manager, Legislative and Government Relations – Workers' Compensation Pharmacy Alliance, Austin)

41. Require a three-doctor panel to have injured employees qualify for medicine. (Anthony Mason, Grand Prairie)

42. Focus DWC's oversight functions on current performance so that ongoing errors can be identified and corrected in a timely matter, instead of focusing on punishing system participants for errors. (Jonathan D. Bow, JD, Executive Director – State Office of Risk Management)

43. Exempt Pharmacy Benefit Managers from the statute that requires Third Party Administrators to be licensed. (Kyle Frazier – CompPharma, Madison, Connecticut)

44. Allow for an appeals process and notice before a doctor is taken off the list before removal. (Allen W. Burton, MD, President; Roy Durrett, MD, PhD, Workers' Comp Committee Chair; and C.M. Schade, MD, PhD, TMA Delegate and TPS Board Emeritus – Texas Pain Society, Austin)

Commission Decision

The Commission adopted the following new issues.

- Amend statute to deposit all administrative penalties assessed and collected by the Division in the General Revenue Fund, instead of the Texas Department of Insurance operating account.
- Amend statute to modify the Designated Doctor matrix selection process to be based on diagnosis and injury area, instead of a treatment-based selection process.
- As a management action, direct the Division, through the rulemaking process, to allow all Designated Doctors to participate in any county desired, rather than the current 20 county maximum service area.
- As a management action, direct the Division, as part of the rulemaking process adopted in the Recommendations contained in Issue 2, to develop an ex parte communication policy that extends to any case under investigation in which the Commissioner of Workers' Compensation would be the ultimate arbiter in a final enforcement action. The adopted policy should prohibit ex parte communication before the minimum timeframes outlined in the Administrative Procedures Act and should aim to preserve the agency's enforcement process.

Legislative Action

House Bill 2605 amends the Labor Code to require that all administrative penalties assessed and collected by the Division be deposited into the General Revenue Fund, aligning the administrative penalty collection process with other state agencies and resulting in a gain to General Revenue. (First bulleted new issue)

The bill also modifies the Designated Doctor matrix selection process to be based on diagnosis and injury area, instead of a treatment-based selection process. (Second bulleted new issue)

The last two issues are management recommendations not needing statutory change. (Third and Fourth bulleted new issues)

Provisions Added by Legislature

Provisions Added by Legislature

1. Expedite medical claims for certain seriously injured first responders.

House Bill 2605 establishes a process for expediting claims and benefits for first responders employed by or volunteering for political subdivisions. The bill requires DWC to expedite a Contested Case Hearing or appeal request submitted by a first responder who has sustained a work-related, serious bodily injury. The bill also requires a political subdivision, insurance carrier, and DWC to accelerate and give priority to a first responder's claim for medical benefits.

2. Authorize injured employees to obtain a second opinion for certain medical determinations.

House Bill 2605 authorizes an employee who is required to be examined by a Designated Doctor for an initial determination of Maximum Medical Improvement or an Impairment Rating to request a re-examination from either their treating doctor or another doctor if they are dissatisfied with the Designated Doctor's opinion. The bill also guarantees payment for these exams. Finally, the bill requires the Division to adopt guidelines prescribing the situations where a treating doctor exam is appropriate after a Designated Doctor exam for all issues that the Designated Doctor can review.

Office of Injured Employee Counsel

Agency at a Glance

(April 2010)

Agency at a Glance

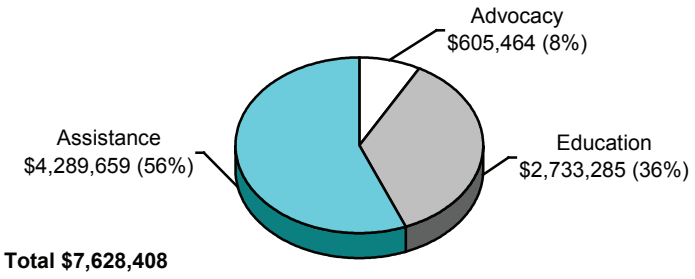
The Office of Injured Employee Counsel (Office) was created in 2005, when the Legislature abolished the Texas Workers' Compensation Commission (TWCC), transferred its regulatory duties to the Texas Department of Insurance (TDI), and moved its employee assistance functions to this newly established state agency. The Office represents the interests of workers' compensation claimants. To achieve its mission, the Office carries out the following key activities.

- Assists unrepresented injured employees in navigating the Division of Workers' Compensation's (DWC) dispute resolution process.
- Advocates on behalf of injured employees as a class in rulemaking and judicial proceedings.
- Educates injured employees regarding the Texas workers' compensation system.

Key Facts

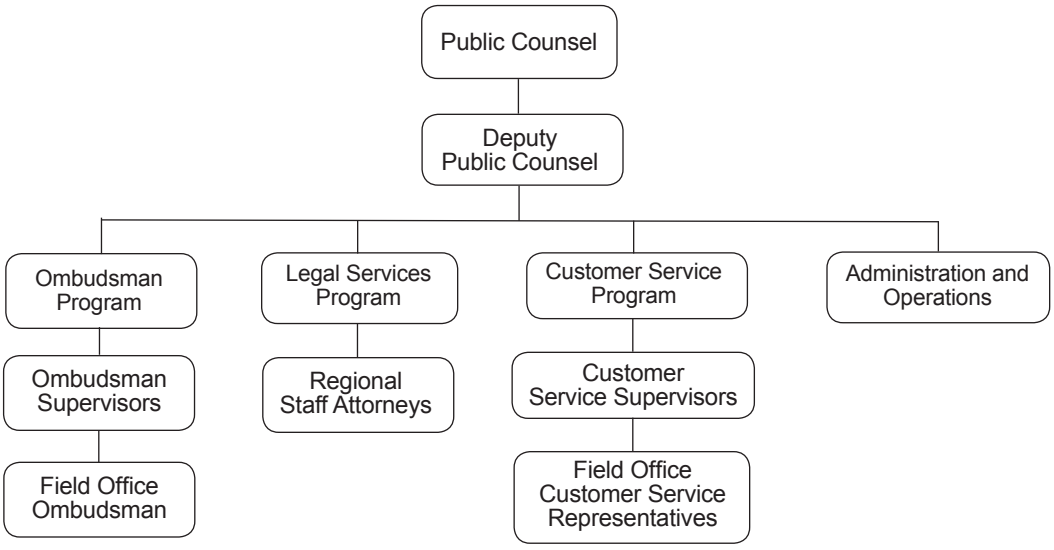
- **Public Counsel**. The Office is headed by a Public Counsel appointed by the Governor with the advice and consent of the Senate for two-year terms. Among other requirements, the Public Counsel must be licensed to practice law in Texas and must have demonstrated a strong commitment to the rights of the working public.
- **Funding**. The Office expended approximately $7.6 million in fiscal year 2009, as shown in the pie chart, *Office of Injured Employee Counsel Expenditures*. The Office is funded through a dedicated General Revenue account that draws funding from a maintenance tax paid by insurance carriers writing workers' compensation policies in Texas. The Office is administratively attached to TDI, which provides the Office budget, human resources, and technical support, as well as office space.

Office of Injured Employee Counsel Expenditures – FY 2009



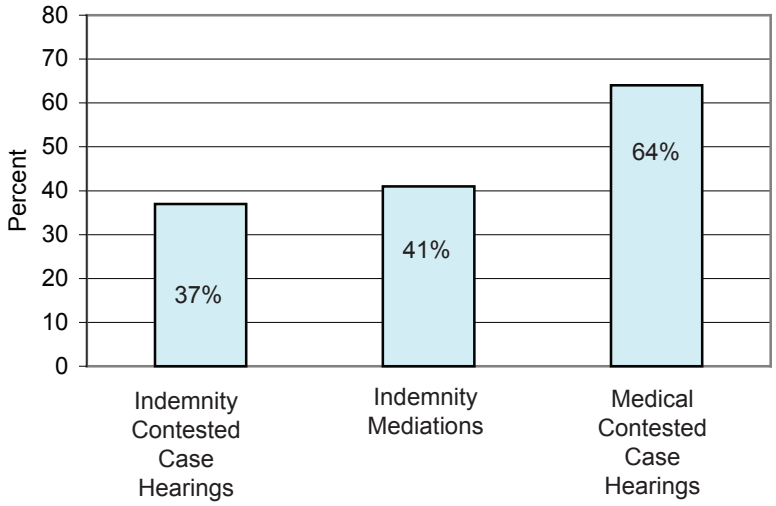
- **Staff**. In fiscal year 2009, the Office employed 158.5 staff, most of whom assisted injured employees in the 24 field offices that the Office shares with DWC. The Office's structure is shown in the organizational chart.

Office of Injured Employee Counsel
Organizational Chart



- **Assistance**. The Office's primary function is to assist injured employees to resolve disputes in the workers' compensation system. The Office prepares injured employees for and often assists injured employees to present their case at informal dispute resolution mediations, contested case hearings, and administrative appeals. During fiscal year 2009, the Office provided assistance to injured employees in, on average, 38 percent of all dispute resolution proceedings held by DWC. The bar chart, *Office of Injured Employee Counsel Participation in DWC Proceedings*, shows this participation for specific types of DWC proceedings.

Office of Injured Employee Counsel
Participation in DWC Proceedings – FY 2009



- **Advocacy**. The Office advocates for injured employees as a class by analyzing and providing comments to workers' compensation rules proposed by DWC. The Office analyzed and commented on all four rulemakings proposed by DWC in fiscal year 2009. The Office also files amicus curiae briefs before courts on issues of importance to injured employees as a class. Since its creation, the Office has filed five amicus briefs.

- **Education**. The Office informs injured employees and beneficiaries of deceased employees about the workers' compensation system and assists them in obtaining workers' compensation benefits. These efforts include publishing information about employees' rights and responsibilities in the system, as well as making outreach calls to injured employees and beneficiaries. During fiscal year 2009, the Office provided educational materials to more than 197,000 injured employees, handled more than 15,000 walk-in visits at DWC field offices, and made more than 30,000 outreach calls.

Issues

Issue 1

Texas Has a Continuing Need for the Office of Injured Employee Counsel.

Background

The Office of Injured Employee Counsel (Office) promotes the interests of injured employees and beneficiaries of deceased employees in various formal and informal proceedings before the Division of Workers' Compensation (DWC), Texas Department of Insurance (TDI) and the Legislature, working to ensure that these parties have a voice in the workers' compensation system and receive benefits promised under the Texas Workers' Compensation Act. The Office fulfills this mission through education, assistance at dispute resolution proceedings, and advocacy on behalf of injured employees as a class.

Many of the Office's functions were originally created in 1991 under the Texas Workers' Compensation Commission (TWCC). In 2005, House Bill 7 abolished TWCC and transferred most of its functions to DWC within TDI. However, H.B. 7 split off TWCC's injured employee assistance functions and placed them in the newly created Office. Although an independent agency, the Office is administratively attached to TDI, which provides support to the Office. The Governor, with the advice and consent of the Senate, appoints the Public Counsel for two-year terms to oversee the Office.

Findings

Texas has a continuing interest in aiding injured employees navigating the workers' compensation system.

The aid the Office provides is needed to help ensure injured employees' access to the medical and income benefits promised by state law. Despite legislative reforms over the last 20 years that simplified the workers' compensation system, the system remains complicated and injured employees continue to need help when problems arise with their claims. The Office provides education needed to inform these injured employees about their rights and responsibilities under the workers' compensation system. In addition, Office staff work to resolve any problems with claims early – within the first seven days of contact by an injured employee – coordinating with insurance adjusters and health care providers to avoid the need for dispute resolution proceedings before DWC.

The Office provides free assistance to injured employees.

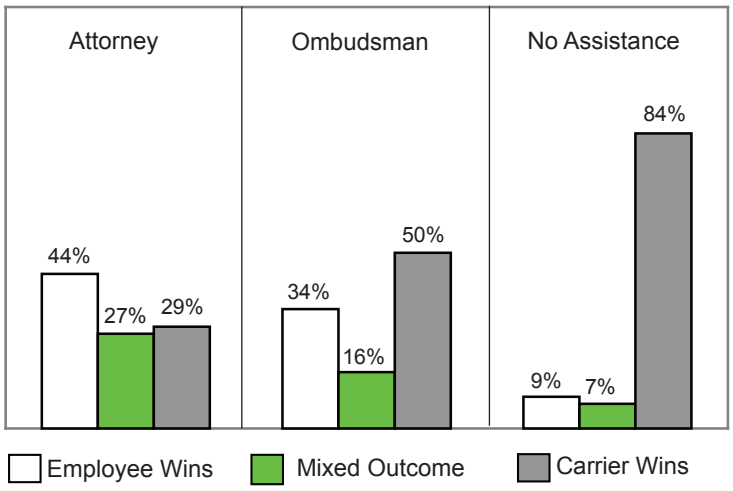
For dispute resolution proceedings that do occur, the Office provides easily accessible and free assistance to injured employees. Few injured employees pursue a disputed claim without some assistance or legal representation. However, injured employees may have difficulty finding legal representation for disputes, in part because state law limits the amount of fees an attorney may earn when representing an injured employee in a workers' compensation dispute. The Office fills this gap.

In a hearing, an injured employee is four times more likely to prevail with Ombudsman assistance than appearing alone.

The Office's Ombudsmen are familiar with the workers' compensation system and trained to provide assistance to any injured employee seeking it. During fiscal year 2009, the Office provided assistance in 38 percent of dispute proceedings held by DWC. That percentage jumped to more than 60 percent in disputes regarding the need for medical care, for which state law does not allow attorneys' fees.

The Office focuses on resolving disputes as quickly and informally as possible to avoid the need for more formal proceedings. When the Office assists injured employees at DWC's initial mediation proceedings, 70 percent of the issues being disputed are resolved without being sent on to a contested case hearing. If a contested case hearing occurs, an injured employee is nearly four times more likely to win a dispute with Ombudsman assistance than without any legal representation or assistance, as illustrated by the bar chart, *Outcomes of DWC Contested Case Hearings*.

Outcomes of DWC Contested Case Hearings by Type of Assistance



Finally, the Legislature has shown a continued interest in providing a voice for injured employees and their beneficiaries when considering changes to the laws and rules within the workers' compensation system. Compared to workers' compensation insurance carriers, health care providers, and employers, who generally have more resources available to represent their own interests, injured employees are often at a disadvantage. No other entity provides the perspective of injured employees as a class.

While other organizational structures exist, the Office's independent structure places it in a unique position to aid injured employees.

While DWC could absorb the Office's assistance functions, Sunset staff found no compelling benefits to justify altering the Office's current structure.

Independence from DWC helps ensure the Office can focus on the interests of injured employees. In addition, because the Office provides assistance for individual employees in dispute resolution proceedings in DWC field offices across the state, administrative attachment to DWC provides cost savings and administrative efficiencies and does not significantly infringe on the Office's independence.

A number of other state public counsel offices represent the interests of consumers as a class before agencies regulating insurance, public utilities, and environmental quality. While the Office similarly advocates for injured employees, its predominant function is to assist individual employees within the workers' compensation dispute resolution system, a function unlike any of these other counsels. For this reason, and because these agencies lack subject-matter expertise in workers' compensation, Sunset staff found no justification for merging the functions into one public counsel agency.

The Office assists individual employees, a function unlike those of other public counsel offices.

While many other states provide aid to injured employees involved in workers' compensation disputes, the organizational structure and type of assistance provided varies greatly.

Twenty other states provide some form of aid targeted at injured employees within a larger regulatory agency. However, that aid varies widely from simply providing information to actually assisting injured employees in administrative proceedings. Only two other states, Nevada and Ohio, have an Ombudsman-type program that, like Texas, exists as separate body from the state's workers' compensation regulatory agency. However, other states' approaches to workers' compensation vary widely in complexity and in attorney involvement.

The Office is well-positioned to increase the preparedness of injured employees for informal mediation proceedings at DWC, decreasing unnecessary delays in the process overall.

For indemnity disputes, DWC offers an informal mediation called a Benefit Review Conference (BRC) as the initial dispute resolution proceeding. During fiscal year 2009, system participants scheduled more than 21,000 BRCs at DWC, while less than 11,000 were ultimately held. For more than 3,000 of these resets, participants needed more time to prepare or to obtain medical records.

State law charges the Office with preparing injured employees for hearings before DWC.

The large number of BRC resets disrupts DWC's hearings process and wastes DWC staff and other participants' time. In addition, other participants are denied the opportunity for earlier resolution of their claims as staff and docket time cannot be used for other mediations.

Because the Office assists with a large number of disputes, it is in a good position to affect the frequency of hearing resets. When providing assistance, the Office is statutorily charged with preparing an injured employee for a proceeding, including meeting with an injured employee for 15 minutes before any informal or formal hearing. The Office could use its contact with

injured employees to better ensure injured employees are fully prepared and ready for a hearing before it occurs.

The Office's statute does not reflect standard language typically applied across the board during Sunset reviews.

Although the Office has an internal complaint resolution process, statute does not include standard language relating to complaint information that the Sunset Commission routinely applies in across-the-board fashion to agencies under review. This language ensures that the agency maintains proper documentation on all complaints received by the agency, that the agency has a system for complaint resolution, and that the agency informs all parties to a complaint about the status of the complaint until resolution.

The Office's statute also does not include a standard provision relating to alternative rulemaking and dispute resolution for dealing with internal and external complaints made to the agency. The purpose of the standard is to improve the resolution of agency disputes and is not intended to affect the way the Office assists injured employees in DWC's dispute resolution process. Without this provision, the agency could miss ways to improve rulemaking and dispute resolution through more open, inclusive, and conciliatory processes designed to solve problems by building consensus rather than through contested proceedings.

Recommendations

Change in Statute

1.1 Continue the Office of Injured Employee Counsel for 12 years.

This recommendation would continue the Office of Injured Employee Counsel as an independent agency, responsible for aiding injured employees in the workers' compensation system.

1.2 Apply standard Sunset across-the-board requirements to the Office of Injured Employee Counsel.

This recommendation would require the Office to maintain a system to promptly and efficiently act on complaints filed with the Office. The language would require the Office to maintain information on the parties to a complaint, the subject matter, a summary of results, and the disposition. The recommendation also would require the Office to make information about its complaint procedures public and periodically notify the complaint parties of the status of the complaint.

The recommendation would also ensure that the Office develops and implements a policy to encourage alternative procedures for rulemaking and dispute resolution, conforming to the extent possible to model guidelines by the State Office of Administrative Hearings. The agency would also coordinate implementation of the policy, provide training as needed, and collect data concerning the effectiveness of these procedures. Because the recommendation only requires the agency to develop a policy for this alternative approach to solving problems, it would not require additional staffing or other expense. This requirement for alternative dispute resolution would not affect the way the Office participates in

DWC's administrative dispute resolution process. In addition, the required policy would not affect dispute resolution that falls under TDI's authority through the Office's administrative attachment to that agency.

Management Action

1.3 Direct the Office to work with DWC to ensure injured employees are fully prepared by Ombudsmen before attending a DWC Benefit Review Conference.

This recommendation would direct the Office to take steps toward reducing the number of rescheduled proceedings at DWC, through efforts by Ombudsmen to fully prepare injured employees they are assisting. These efforts could include refraining from scheduling proceedings until after an Ombudsman has initially met with an injured employee, scheduling the Ombudsman's initial meeting with an injured employee within a certain timeframe before a proceeding, or ensuring certain important documents are possessed by the injured employee before attending a proceeding. This recommendation would work in concert with Recommendation 1.1 of the DWC staff recommendations, which would require all parties to communicate preparedness before attending a BRC.

Fiscal Implication Summary

If the Legislature continues the current functions of the Office of Injured Employee Counsel using the existing organizational structure, the agency's annual appropriation of $7.6 million would continue to be required for its operation. However, since the agency is funded through maintenance taxes assessed on insurers writing workers' compensation policies in Texas, this recommendation would not affect General Revenue. Applying the Sunset across-the-board requirements would not have a fiscal impact.

Responses to Issue 1

Recommendation 1.1

Continue the Office of Injured Employee Counsel for 12 years.

Agency Response to 1.1

OIEC agrees with the recommendation to continue the agency as an independent enterprise and its functions. (Norman Darwin, Public Counsel – Office of Injured Employee Counsel)

For 1.1

Richard Levy, Legal Director – Texas AFL-CIO

Against 1.1

None received.

Recommendation 1.2

Apply standard Sunset across-the-board requirements to the Office of Injured Employee Counsel.

Agency Response to 1.2

OIEC agrees with this recommendation. OIEC management would like to note that the agency takes internal and external complaints seriously. It is a top priority of agency management to ensure complaints are handled promptly and properly, which is exhibited by the two internal audits conducted in the area of complaint handling at the direction of agency management. OIEC management has taken steps to ensure that the agency is already in compliance with the Sunset Advisory Commission Staff across-the-board recommendation regarding complaints. OIEC management has formed a committee that is currently developing alternative procedures for rulemaking and dispute resolution, which will conform to the State Office of Administrative Hearings model guidelines. (Norman Darwin, Public Counsel – Office of Injured Employee Counsel)

For 1.2

None received.

Against 1.2

None received.

Recommendation 1.3

Direct the Office to work with DWC to ensure injured employees are fully prepared by Ombudsmen before attending a DWC Benefit Review Conference.

Agency Response to 1.3

OIEC agrees with this recommendation and has taken numerous steps to ensure injured employees are fully prepared prior to entering the DWC administrative dispute resolution process. OIEC procedures have been changed to fully implement the agency's early intervention efforts. OIEC notes it is difficult to discourage its customers from entering the dispute resolution process if they are not fully prepared, particularly when those customers are without an income source. However, OIEC also understands the paramount need to ensure State resources are used efficiently and effectively. (Norman Darwin, Public Counsel – Office of Injured Employee Counsel)

For 1.3

None received.

Against 1.3

None received.

Commission Decision

Adopted Recommendation 1.1, with a modification to continue the Office for six years instead of the standard 12-year period.

Adopted Recommendations 1.2 and 1.3.

Legislative Action

House Bill 1774 continues the Office as an independent agency for six years, instead of the standard 12 years. The shorter continuation date coincides with that of the Division of Workers' Compensation, giving the Legislature the opportunity to monitor the ongoing implementation of major reforms from 2005. (Recommendation 1.1 as modified) In addition, the bill applies standard Sunset across-the-board requirements including requiring the Office to develop a policy that encourages the use of negotiated rulemaking and alternative dispute resolution. The bill also adds standard Sunset language requiring the Office to maintain information on all complaints and notify the parties about policies for and status of complaints. (Recommendation 1.2)

As a management recommendation not needing statutory change, Recommendation 1.3 did not result in legislative action.

Issue 2

The Office Has Inappropriate Access to Claims Information Held by the Division of Workers' Compensation.

Background

As an independent advocate for injured employees in the workers' compensation system, the Office of Injured Employee Counsel (Office) wears many hats. At times, the Office generally assists injured employees to obtain their benefits. At other times, the Office acts as one of many parties to an adversarial proceeding, such as when it assists an individual injured employee or death beneficiary in a dispute before the Division of Workers' Compensation (DWC) or when it advocates for injured employees as a class in rulemaking proceedings. Proceedings before DWC, as the state regulatory body, are meant to provide a fair and impartial venue to all system participants.

As part of its administrative attachment to DWC, the Office shares space in DWC field offices and uses DWC's computer systems in its day-to-day operations when assisting injured employees. This situation gives the Office access to all claim files held by DWC. Claim files include injury reports with personal and contact information for all employees that have injuries reported to DWC, communications between the employee and DWC, and, if there is a dispute regarding a claim, documents related to the dispute such as medical records.

State law makes claim files generally confidential, allowing DWC to release aggregate data about workers' compensation claims and only give out specific information to parties to a dispute.[1] However, statute gives the Office broad authority to access information from all executive agencies.[2] Statute also specifically excepts the Office from confidentiality restrictions governing claim files and directs DWC to release claim information to the Office for any statutory or regulatory purpose that relates to the Office's duties.[3]

Findings

The Office's access to all claim files unfairly exceeds that of other parties to DWC proceedings.

For dispute resolution proceedings, statute authorizes the release of a claim file to only a select group of people involved in a dispute – the injured employee or beneficiary, the employer, the insurance carrier, and their representatives. Certain exceptions exist for entities that are not typically a party to a dispute, but that may have an interest in the particular proceeding, as described in the textbox on the next page, *Interested Parties to Dispute Proceedings*. However, statute only allows these parties to access a claim file if they have a relationship with the injured employee. Unlike other parties, statute does not require the Office to have a direct relationship with an injured employee in a dispute before obtaining that injured employee's claim file.

The Office may obtain an injured employee's claim file without having a direct relationship with that employee.

Interested Parties to Dispute Proceedings

In addition to the direct parties to dispute proceedings, the following entities may obtain limited claim information from DWC.

Group Health Insurance Carriers. Authorized to receive information for employees that have insurance policies with them, in order to seek subrogation.

Prospective Employers. Authorized to receive information for prospective employees.

Third-Party Litigants. Authorized to receive information if the litigant is involved in a lawsuit arising from the underlying injury to the workers' compensation claim.

Self-Insurance Guarantee Association. Authorized to receive information if it has assumed the obligations of the self-insured employer.

The Office's increased access to claim files creates the appearance of impropriety in what is supposed to be a level playing field.

For rulemaking, judicial, legislative, and other public proceedings, DWC provides aggregate data about workers' compensation claims for parties to use in advocating for their positions. In addition, any party wishing to advocate in the workers' compensation system may use the Open Records Act to request public information from DWC about workers' compensation claims. However, the Office is able to get more detailed information from claim files rather than relying on aggregate public information that other parties to the same proceeding must use.

Although it does not appear the Office has misused its authority, the Office's blanket exception to statutory confidentiality restrictions on claim files places the Office in a more favorable position than other system participants to the same proceedings. Such increased access creates the appearance of impropriety and unfairness in what is supposed to be a level playing field provided by the state regulatory body. In other comparable regulatory arenas, public counsel offices are not given any greater access to information than another, similarly situated party would have.

Further, the Office does not need access to claim files for injured employees it is not directly assisting in dispute resolution proceedings or to effectively advocate for injured employees as a class. Finally, allowing the Office to access a claim file, which can include medical data, for an injured employee who has not requested the Office's help infringes on that injured employee's privacy.

The Division cannot restrict the Office's access to claim files at this time.

The Division is currently working on a new computer system, which will allow it to restrict specific users' access to information, and has recognized the need to implement restrictions if the Office continues to share DWC's computer system. The transition to the new system, though, will take about

four years to complete. Until that time, DWC is unable to give the Office only partial access to claim file data because of limitations with the current computer system. Because of the Office's day-to-day use, DWC cannot feasibly prohibit the Office from accessing the computer system – barring administrative detachment or the Office receiving a separate computer system, both costly solutions.

Recommendations

Change in Statute

2.1 Limit the Office's authority to access claim files for injured employees the Office is not directly assisting.

This recommendation would remove existing language that excepts the Office from the confidentiality requirements surrounding claim file information and that directs DWC to release such information to the Office. The recommendation would also remove language granting the Office broad access to information from all executive agencies. Instead, the recommendation would clarify that the Office has the same access to information that another, similarly situated party has and is allowed access to a claim file when officially assisting an injured employee.

Until the implementation of DWC's new computer system occurs, the changes made by the recommendation would require the Office to self-enforce the legal limits on its authority to access information. The Office would be required to work with DWC to implement new procedures by which the Office will request information from DWC. These procedures should reflect the practical needs of the Office's day-to-day use of the DWC computer system, yet strive to reflect the manner in which other system participants request and access information. The recommendation is not intended to require the Office to use the Public Information Act to request information from DWC, which would be unnecessarily time consuming.

In addition, the recommendation would not restrict the Office's access to information it uses to generally educate injured employees and death beneficiaries about the existence of the Office and its services, which it does to fulfill its statutory duty to assist them in obtaining workers' compensation benefits. Such information may include the names and contact information of employees whose injuries are reported to DWC, but would not include other information included in the claims files, such as sensitive medical claim information.

Management Action

2.2 Direct the Office to work with DWC to complete firewalls in the new database system.

This recommendation would direct the Office to work with DWC during its development of the new computer system to include proper firewalls restricting information. These firewalls would ensure that the Office has the appropriate access to information needed to perform its duties without receiving information that is statutorily protected.

Fiscal Implication Summary

These recommendations would not have a fiscal impact to the State. The recommendations do not suggest or require the Office to obtain a separate computer system.

[1] Texas Labor Code, secs. 402.083 and 402.084.

[2] Texas Labor Code, sec. 404.111.

[3] Texas Labor Code, secs. 402.082, 402.085, and 404.107.

Responses to Issue 2

Recommendation 2.1

Limit the Office's authority to access claim files for injured employees the Office is not directly assisting.

Agency Response to 2.1

OIEC believes no further changes need to be made in light of both the passage of House Bill 673 (81R) and the severe penalties established by Section 404.111 of the Labor Code for disclosing confidential information. OIEC's management is sensitive to the appearance of impropriety, and as the sole advocacy agency for injured employees, OIEC understands the importance of confidential claim information. The agency accesses individual claimant information only after the injured employee authorizes the release of information and understands the agency's services. Aggregate information is needed to advocate on behalf of injured employees as a class. (Norman Darwin, Public Counsel – Office of Injured Employee Counsel)

For 2.1

None received.

Against 2.1

None received.

Modification

1. Eliminate the Office's authority to access claim files for injured employees the Office is not directly assisting. (Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin)

Recommendation 2.2

Direct the Office to work with DWC to complete firewalls in the new database system.

Agency Response to 2.2

OIEC agrees with this recommendation to work with DWC during its development of the new computer system to include proper firewalls restricting information from field office staff. OIEC has formed a committee that is currently working with DWC staff to develop a new system to ensure appropriate access of information to OIEC staff. OIEC's management is sensitive to the appearance of impropriety and is committed to working with DWC to ensure that all system participants operate on a level playing field in the administrative dispute resolution process. (Norman Darwin, Public Counsel – Office of Injured Employee Counsel)

For 2.2

Fred C. Bosse, Vice President, Southwest Region – American Insurance Association, Austin

Against 2.2

None received.

Commission Decision

Adopted Recommendations 2.1 and 2.2.

Legislative Action

House Bill 1774 removes existing language that excepts the Office from the confidentiality requirements surrounding claim file information and that directs the Division of Workers' Compensation to release such information to the Office. The bill also removes language granting the Office broad access to information from all executive agencies. The Legislature modified these Sunset provisions to clarify that the Office has access to claim information when assisting an injured employee, specify that claim information includes the claim number, and apply these changes in information access to all pending and future claims before the Office. (Recommendation 2.1)

As a management recommendation not needing statutory change, Recommendation 2.2 did not result in legislative action.

New Issue

New Issue

3. Require the Office of Injured Employee Counsel to have the proper oversight and accountability for their actions and require the Office to retain records on injured employees for at least five years. (Janice May, Brenham)

Commission Decision

The Commission did not adopt the new issue relating to the Office.

Legislative Action

No action needed.

Provisions Added by Legislature

Provisions Added by Legislature

1. **Allow the Office of Injured Employee Counsel an additional month in preparing its legislative report.**

House Bill 1774 amends current law to allow the Office an additional month in preparing its legislative report – a document that includes a description of the Office's activities and identifies problems within the workers' compensation system – as the Office is dependent on information compiled by the Division of Workers' Compensation.

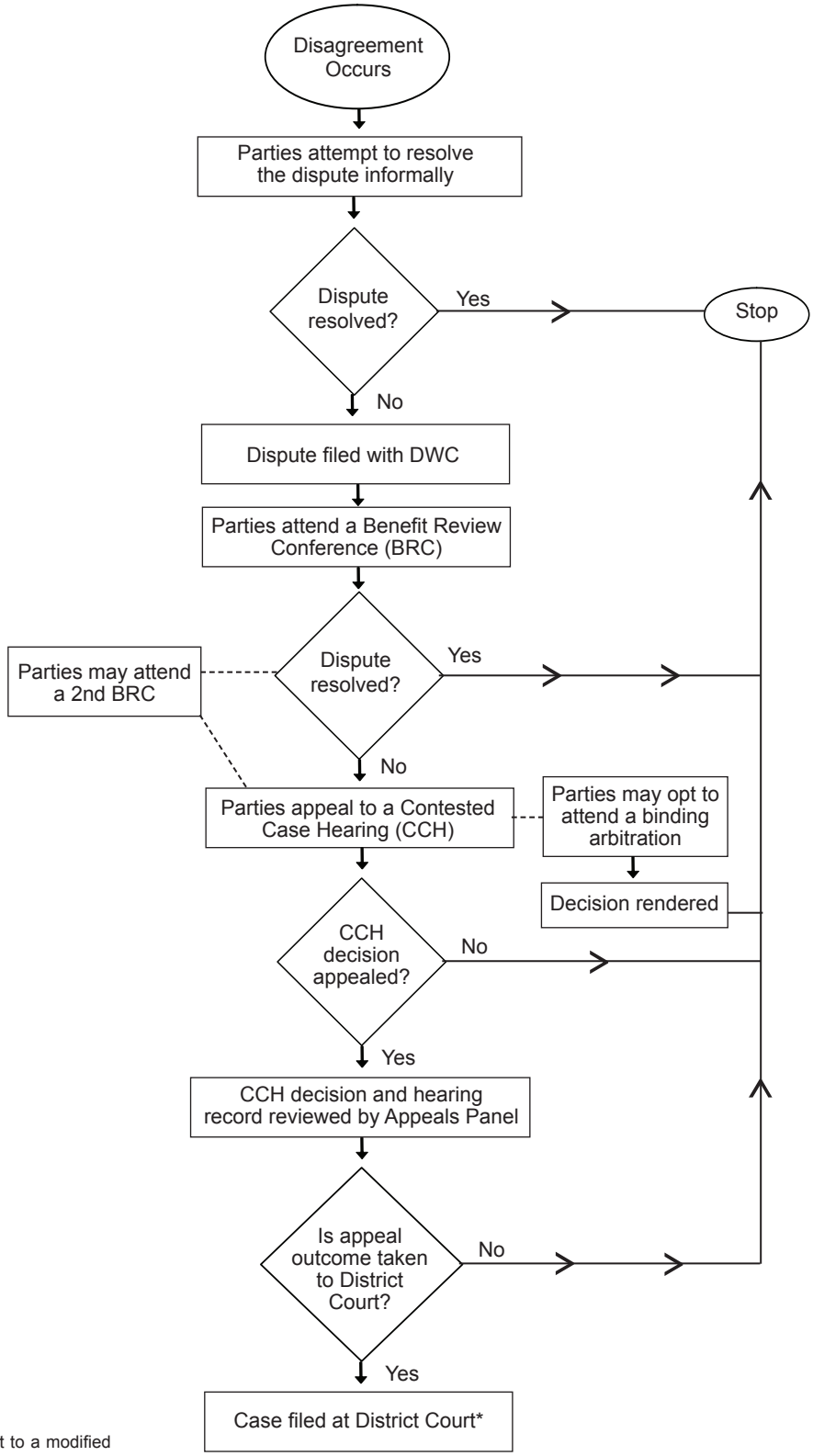
2. **Allow the Office of Injured Employee Counsel to seek and receive grants to fulfill the agency's mission.**

Appendices

Appendices

Appendix A

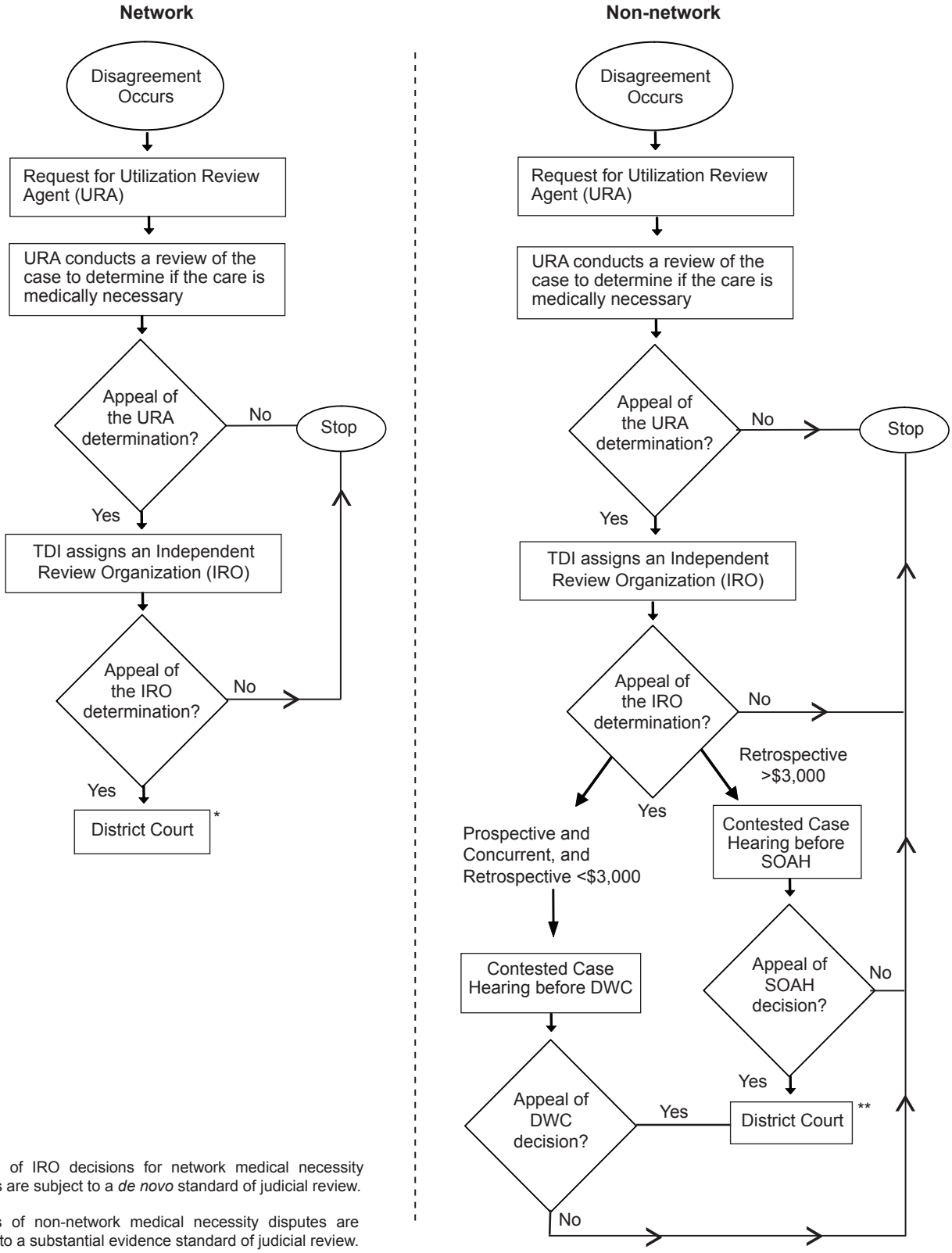
Indemnity Dispute Resolution



* Indemnity disputes are subject to a modified *de novo* judicial review standard.

Appendix B

Medical Necessity Dispute Resolution

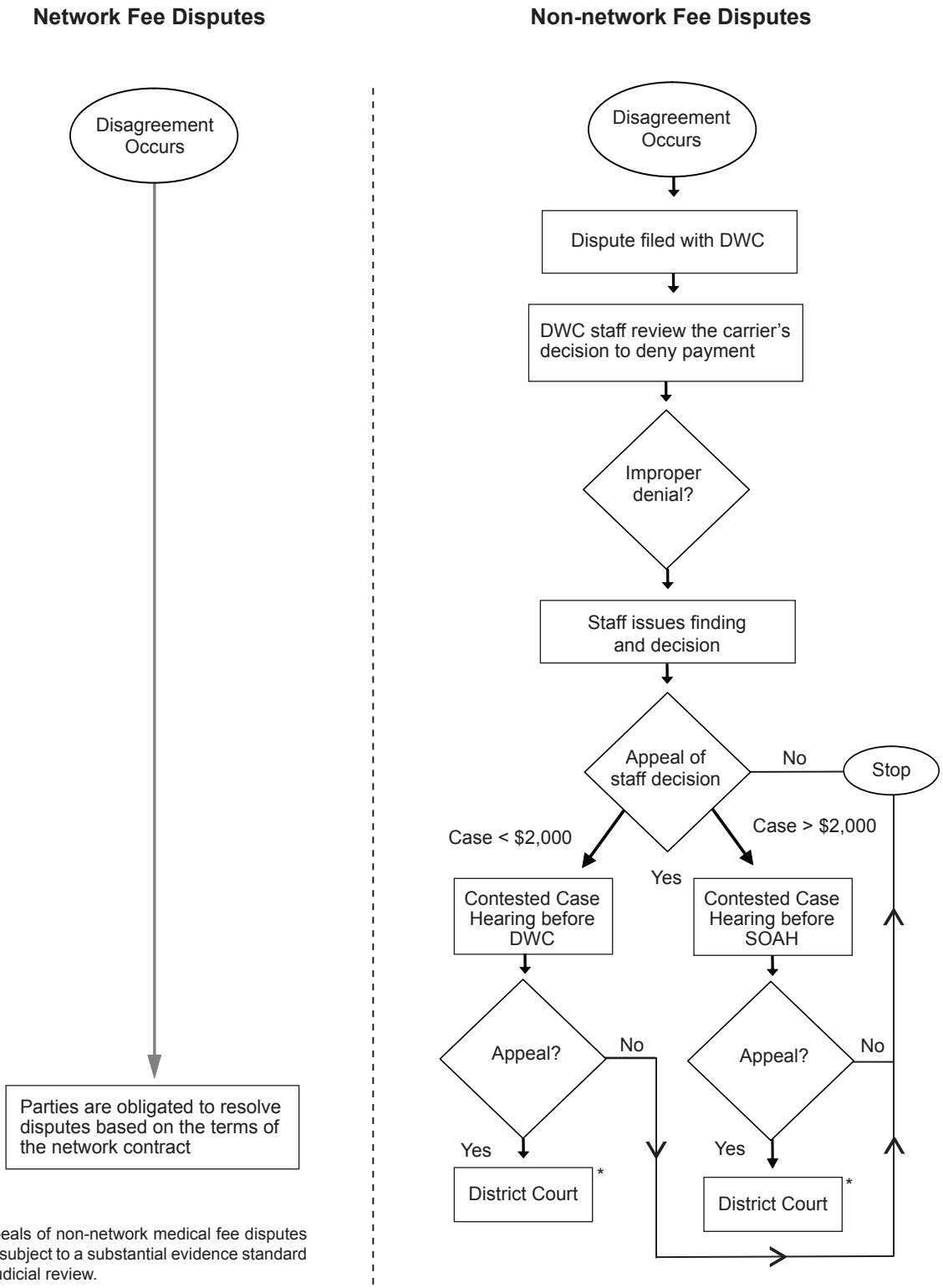


* Appeals of IRO decisions for network medical necessity disputes are subject to a *de novo* standard of judicial review.

** Appeals of non-network medical necessity disputes are subject to a substantial evidence standard of judicial review.

Appendix C

Medical Fee Dispute Resolution



* Appeals of non-network medical fee disputes are subject to a substantial evidence standard of judicial review.

Appendix D

Staff Review Activities

During the reviews of the Division of Workers' Compensation and the Office of Injured Employee Counsel, Sunset staff engaged in the following activities that are standard to all Sunset reviews. Sunset staff worked extensively with agency personnel; met with staff from key legislative offices; conducted interviews and solicited written comments from interest groups and the public; reviewed agency documents and reports, state statutes and rules, federal statutes, legislative reports, previous legislation, and literature; researched the organization and functions of similar state agencies in other states; and performed background and comparative research using the Internet.

In addition, Sunset staff also performed the following activities unique to these agencies.

- Toured Division field offices and observed informal Benefit Review Conferences and formal Contested Case Hearings, including disputes with Office Ombudsman assistance and private attorney representation provided to the injured employee.
- Toured the Office's Fort Worth field office, and observed the operations of its central call center.
- Attended numerous Division stakeholder and working group meetings.
- Met with or interviewed staff from the State Office of Administrative Hearings, the Department of Assistive and Rehabilitative Services, the Texas Workforce Commission, the Secretary of State, the Comptroller of Public Accounts, the Governor's Office of Economic Development and Tourism, the Department of Information Resources, and the State Auditor's Office.
- Attended the 2009 Workers' Compensation Educational Conference held by the Division.
- Interviewed participants of the Division's dispute resolution process.

Sunset Staff Review of the Division of Workers' Compensation Office of Injured Employee Counsel

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