BILL ANALYSIS

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Engrossed

DIGEST AND PURPOSE

Currently, the Texas Workers' Compensation Commission (commission) requires an employee who sustains a compensable injury to receive medical treatment from a doctor chosen from a list of doctors approved by the commission. Currently, each doctor licensed in Texas on January 1, 1993, is on the list, unless subsequently deleted for any conduct the commission considers relevant. A study by the Research and Oversight Council on Workers' Compensation (council) showed that medical costs for workers' compensation services in Texas exceeds the costs of other states in the study, but that the additional expenditures did not result in better return-to-work outcomes or an increase in workers' satisfaction with their medical services. The council found that over one-third of workers had not returned to work more than two years after their injury, and that many health care providers were frustrated with the workers' compensation system as well.

H.B. 2600 expands regulation, training and monitoring for doctors and insurance carriers in the workers' compensation system, allows for the creation of health care delivery networks in the workers' compensation system, expands notification requirements about return-to-work issues, changes medical regulation and medical dispute resolution processes, provides new benefits for injured workers, and alters current law relating to the payment of attorney's fees in disputes, among other provisions.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the Texas Workers' Compensation Commission in SECTION 1.01 (Sections 408.023 and 408.0231, Labor Code), SECTION 2.01 (Section 408.0222, Labor Code), SECTION 3.02 (Section 413.021, Labor Code), SECTION 4.03 (Section 413.0141, Labor Code), SECTION 5.02 (Section 408.0041, Labor Code), SECTION 6.01 (Section 408.028, Labor Code), SECTION 6.02 (Section 413.011, Labor Code), SECTION 6.03 (Section 413.031, Labor Code), SECTION 6.04 (Section 413.041, Labor Code), SECTION 6.06 (Section 415.021, Labor Code), SECTION 6.07 (Section 415.023, Labor Code), and SECTION 10.03 (Section 408.042, Labor Code).

SECTION BY SECTION ANALYSIS

ARTICLE 1. APPROVED DOCTORS; MEDICAL REVIEW

SECTION 1.01. Amends Chapter 408B, Labor Code, by amending Section 408.023 and adding Section 408.0231, as follows:

Sec. 408.023. New heading: LIST OF APPROVED DOCTORS; DUTIES OF TREATING DOCTORS. (a) Requires the Texas Workers' Compensation Commission (commission) to develop a list of doctors licensed in this state who are approved to provide health care services under this subtitle. Provides that each doctor licensed in this state on September 1, 2001, is eligible to be included on the commission's list of approved doctors under certain conditions.

(b) Requires the commission by rule to establish reasonable requirements for doctors

and health care providers financially related to those doctors regarding training, impairment rating testing, and disclosure of financial interests as required by Section 413.041, and for monitoring of those doctors and health care providers as provided by Sections 408.0231 and 413.0512. Requires the commission by rule to provide a reasonable period, not to exceed 18 months after the adoption of rules under this section, for doctors to comply with the registration and training requirements of this subchapter. Sets forth those doctors and health care providers to which the requirements under this subsection apply.

(c) Requires the commission to issue to a doctor who is approved by the commission a certificate of registration. Authorizes the commission, in determining whether to issue a certificate of registration, to consider and condition its approval on any practice restrictions applicable to the applicant that are relevant to services provided under this subtitle. Authorizes the commission to consider the practice restrictions of an applicant when determining appropriate sanctions under Section 408.0231.

(d) Provides that a certificate of registration issued under this subsection is valid, unless revoked or revised, for the period provided by commission rule, and may be renewed on application to the commission. Requires the commission to provide notice to each doctor on the approved doctor list of the pending expiration of the doctor's certificate of registration not later than the 60th day before the date of expiration of the certificate. Deletes existing text relating to doctors being placed on the list of approved doctors.

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

(f) Sets forth certain requirements for a doctor to be able to perform services or receive payment for services performed under this subtitle.

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

(h) Sets forth certain requirements for a utilization review agent that uses doctors to perform reviews of certain health care services.

(i) Authorizes the commission to grant exceptions to the requirement imposed under Subsection (f) as necessary to ensure that employees have access to health care and that insurance carriers have access to evaluations of an employee's health care and income benefit eligibility as provided by this subtitle.

(j) Provides that the injured employee's treating doctor is responsible for the efficient management of medical care as required by Section 408.025(c) and commission rules. Requires the commission to collect certain information.

(k) Authorizes the commission to adopt rules to define the role of the treating doctor and to specify outcome information to be collected for a treating doctor.

Sec. 408.0231. MAINTENANCE OF LIST OF APPROVED DOCTORS; SANCTIONS AND PRIVILEGES RELATING TO HEALTH CARE. Requires the executive director to

delete certain doctors from the list of approved doctors. Requires the commission to establish certain criteria by rule. Provides that rules adopted under this section are in addition to, and do not affect, the rules adopted under Section 415.023(b). Authorizes the criteria for deleting a doctor from the list or for recommending or imposing sanctions to include certain items. Requires the commissioner, by rule, to establish certain procedures. Requires the commission to act on a recommendation by the medical advisor selected under Section 413.0511, and authorizes the commission, after notice and opportunity for a hearing, to impose sanctions under this section on a doctor or an insurance carrier or to recommend action regarding a utilization review agent. Requires the commission and the Texas Department of Insurance (TDI) to enter into a memorandum of understanding to coordinate the regulation of insurance carriers and utilization review agents. Sets forth certain sanctions the commission is authorized to recommend or impose.

SECTION 1.02. Amends Chapter 413E, Labor Code, by amending Section 413.051 and adding Sections 413.0511, 413.0512, and 413.0513, as follows:

Sec. 413.051. Authorizes the commission to contract with a health care provider to develop, maintain, or review medical policies or fee guidelines or to review compliance with the medical policies or fee guidelines. Requires the commissioner to establish standards for contracts under this section. Defines "health care provider professional review organization." Makes conforming changes.

Sec. 413.0511. MEDICAL ADVISOR. Requires the commission to employ or contract with a medical advisor, who must be a doctor as that term is defined by Section 401.011. Requires the medical advisor to make recommendations regarding the adoption of certain rules.

Sec. 413.0512. MEDICAL QUALITY REVIEW PANEL. Requires the medical advisor to establish a medical quality review panel of health care providers to assist the medical advisor in performing the duties required under Section 413.0511. Provides that the panel is independent of the medical advisory committee created under Section 413.005 and is not subject to Chapter 2110, Government Code. Requires the Texas State Board of Medical Examiners and the Texas Board of Chiropractic Examiners, with input from their respective professional associations, to develop lists of physicians and chiropractors licensed by those agencies who have demonstrated experience in workers' compensation or utilization review. Requires the medical advisor to consider appointing some of the members of the medical quality review panel from the names on those lists. Authorizes the medical advisor to consider nominations for the panel made by labor, business, and insurance organizations. Requires the medical quality review panel to recommend certain actions to the medical advisor. Provides that a person who serves on the medical quality review panel is not liable in a civil action for an act performed in good faith as a member of the panel and is entitled to the same protections afforded a commission member under Section 402.010. Provides that the actions of a person serving on the medical quality review panel do not constitute utilization review and are not subject to Article 21.58A, Insurance Code.

Sec. 413.0513. CONFIDENTIALITY REQUIREMENTS. Prohibits information maintained by or on behalf of the commission under Section 413.0512, and that is confidential under law, from being disclosed under Section 413.0512 except under certain conditions. Provides that confidential information developed by the commission under Section 413.0512 is not subject to discovery or court subpoena in any action except under certain conditions.

SECTION 1.03. (a) Requires the commission to adopt rules as required by Chapter 408, Labor Code, as amended by this article, not later than February 1, 2002.

(b) Provides that a doctor is not required to hold a certificate of registration issued under Section 408.023, Labor Code, as amended by this article, to perform medical services under

Subtitle A, Title 5, Labor Code, before the date provided by commission rules adopted to implement that section.

ARTICLE 2. MEDICAL NETWORK PARTICIPATION OPTION

SECTION 2.01. Amends Chapter 408B, Labor Code, by adding Sections 408.0221, 408.0222, and 408.0223, as follows:

Sec. 408.0221. REGIONAL HEALTH CARE DELIVERY NETWORKS; ADVISORY COMMITTEE. (a) Defines “advisory committee” and “regional network.”

(b) Establishes the Health Care Network Advisory Committee (committee) to advise the commission on the implementation of this section and Section 408.0222. Provides that members of the committee are appointed by and serve at the pleasure of the governor and sets forth the membership of the committee.

(c) Requires the commission, on behalf of the committee established under this section, to establish and, through competitive procurement, contract with regional networks for the provision of health care under this subtitle. Requires the commission to, through competitive procurement, contract with one or more organizations to determine the feasibility of, develop, and evaluate the regional networks established under this section. Sets forth certain requirements for these organizations.

(d) Requires the committee to make certain recommendations to the commission.

(e) Requires the committee to gather information from certain other entities.

(f) Provides that the standards adopted for preferred provider networks under Article 3.70-3C, Insurance Code, as added by Chapter 1024, Acts of the 75th Legislature, Regular Session, 1997, apply as minimum standards for regional health care delivery networks created under this section and are adopted by reference in this section except to the extent they are inconsistent with this subtitle. Authorizes the committee to recommend certain additional standards.

(g) Requires the committee and the Research and Oversight Council on Workers' Compensation (council) to develop evaluation standards and specifications as necessary to implement a workers' compensation medical regional network report card. Requires the commission to ensure that the report card is published and available for inspection. Authorizes the commission to procure services as necessary to produce the report card. Sets forth certain minimum requirements of the report card.

(h) Requires the regional network administrators to report quarterly to the commission and the committee on the progress of implementing the regional networks and to submit consolidated annual reports. Requires the council to report to the legislature by January 1 of each odd-numbered year on the status of the implementation of regional networks under this section.

(i) Requires the commission to ensure that regional network contracts provide that insurance carriers have reasonable rights to conduct audits under this subsection. Requires insurance carriers participating in the regional network to be allowed the opportunity for consolidated audits of the regional networks.

(j) Requires the cost of assessing the feasibility of, developing, and evaluating the regional networks created under this section to be funded through an assessment on the subsequent injury fund established under Section 403.006. Prohibits this cost from

exceeding $250,000 per regional network or a total of $1.5 million for up to six regional networks. Requires the cost of ongoing regional network administration and management services to be included in the fees for health care services paid by insurance carriers participating in the regional network.

Sec. 408.0222. PARTICIPATION IN REGIONAL NETWORK; SELECTION OF DOCTOR WITHIN REGIONAL NETWORK; BENEFIT INCENTIVES. (a) Authorizes an insurance carrier or a self-insurer certified to provide workers' compensation coverage in this state to elect to participate, by contract, in a regional network established under Section 408.0221. Provides that a public employer covered under Subtitle C of this title, other than an employer covered under Chapter 504, is required to participate in a regional network established under Section 408.0221. Provides that an insurance carrier who elects to participate in regional networks agrees to abide by the terms of the regional network contracts between the commission and the regional networks.

(b) Authorizes an insurance carrier to limit its election to participate in a regional network established under Section 408.0221 to a particular employer or a particular region of this state. Provides that this subsection expires January 1, 2006.

(c) Authorizes a doctor participating in a regional network established under Section 408.0221 to perform only those procedures that are within the scope of the practice for which the doctor is licensed.

(d) Authorizes an employee to elect to participate or not participate in a regional network established under Section 408.0221. Authorizes only an employee covered by an insurance carrier who has elected to participate in a regional network established under Section 408.0221 to elect to participate in that regional network. Requires the commission, by rule, to establish the form and manner by which an employee receives notice of the employee's rights under this section. Authorizes an employee, except as provided by Subsection (e), to make the election described by this subsection at the time of employment or to make that election or rescind an election made under this subsection at any later time before certain dates.

(e) Authorizes an employee to elect to participate in a regional network established under Section 408.0221 at any time with the insurance carrier's permission. Provides that an employee is not bound by an election to participate in a regional network made under Subsection (d) or this subsection under certain conditions

(f) Requires an insurance carrier who elects to participate in a regional network established under Section 408.0221 to provide each employer who obtains coverage through the insurance carrier with adequate information about the regional network to share with the employer's employees. Requires the employer to provide an employee with certain information before the employee makes an election under this section to participate in a regional network.

(g) Requires an employer to not discharge, subject to disciplinary action, or take an adverse employment action against an employee who elects not to participate in a regional network created under Section 408.0221 if the employer's action would not have occurred in the absence of the employee's election not to participate.

(h) Authorizes an employee to bring suit against an employer for violation of Subsection (g) under certain conditions.

(i) Requires the employee to bring suit for an employer's violation of Subsection (g) within 120 days of the alleged violation. Authorizes a suit under this section to be

brought in certain counties.

(j) Sets forth certain items the employee is authorized to recover if the employee prevails in an action under Subsection (h) .

(k) Provides that a suit under this section is the exclusive remedy for violation of Subsection (g) and the provisions of Chapter 451 do not apply to such a violation. Prohibits parties from maintaining an action under Rule 42, Texas Rules of Civil Procedure.

(l) Requires an employee who elects to participate in a regional network created under Section 408.0221 to receive certain benefits.

(m) Requires an employee who elects to participate in a regional network to receive, except for emergency care, or as otherwise provided by this section, medical treatment, including referrals, from health care providers within the regional network. Authorizes an employee or an employee's treating doctor to use a health care provider outside of the regional network with the approval of the regional network for good cause consistent with the regional network contract. Requires the regional network, if medically necessary services are not available through regional network health care providers, on the request of a regional network health care provider, to within a reasonable time period allow a referral to a nonregional network health care provider and to fully reimburse the nonregional network physician or provider at an agreed rate. Defines "emergency care."

(n) Requires a health care provider who participates in a regional network created under Section 408.0221 to be reimbursed and be subject to utilization review as provided by the regional network contract. Provides that the insurance carrier is responsible for payment of regional network providers as provided by the contract between the regional network and the insurance carrier. Prohibits a nonregional network provider who does not obtain the approval of the regional network from providing services from being reimbursed by the insurance carrier.

(o) Authorizes an employee or an employee's treating doctor to request a review by an independent review organization under Section 413.031(c) to resolve an issue regarding the necessity or the appropriateness of care, or referrals to nonregional network physicians or providers.

(p) Requires an employee who elects to participate in a regional network established under Section 408.0221 to select an initial treating doctor within the regional network as provided by the regional network contract. Authorizes an employee to change treating doctors within the regional network in accordance with Sections 408.022(d) and (e). Provides that an employee who requests to change treating doctors within the regional network is not subject to Section 408.022(b) or (c). Authorizes an employee, at the sole discretion of the regional network, to select a treating doctor outside of the regional network under certain conditions.

(q) Sets forth the conditions under which an employee is subject to the selection of doctor, change of doctor, and other medical benefit and income benefit requirements established under Chapters 408 and 413.

(r) Authorizes an employee to change treating doctors within the regional network established under Section 408.0221 in which the employee is participating in accordance with the regional network contract and sets forth certain entitlements of the employee.

Sec. 408.0223. INSURANCE CARRIER NETWORKS. Defines "insurance carrier network." Provides that this subtitle does not prohibit an insurance carrier, whether doing business as an individual carrier or as a group, from participating in or maintaining voluntary insurance carrier networks if those voluntary insurance carrier networks allow selection of doctors as provided by Section 408.022. Provides that this subtitle does not prohibit an insurance carrier from concurrently participating in an insurance carrier network and a regional network established under Section 408.0221.

SECTION 2.02. (a) Requires the commission to adopt rules as required by Chapter 408, Labor Code, as amended by this article, not later than October 1, 2002.

(b) Requires the commission to convene the first meeting of the Health Care Network Advisory Committee established under Section 408.0221, Labor Code, as added by this article, not later than October 1, 2001.

(c) Require the commission, unless determined to be unfeasible, to contract for regional workers' compensation health care delivery networks under Section 408.0221, Labor Code, as added by this article, not later than December 31, 2002.

(d) Provides that Section 408.0222, Labor Code, as added by this article, as that section affects workers' compensation benefits an employee may receive for participating in a regional network under Section 408.0221, Labor Code, as added by this article, takes effect on the certification by the Texas Workers' Compensation Commission that the regional network is operational.

ARTICLE 3. RETURN-TO-WORK REPORTING AND SERVICES

SECTION 3.01. Amends Section 409.005, Labor Code, as follows:

Sec. 409.005. New heading: REPORT OF INJURY; MODIFIED DUTY PROGRAM NOTICE; ADMINISTRATIVE VIOLATION. Requires the employer, on the written request of the employee, a doctor, the insurance carrier, or the commission, to notify the employee, the employee's treating doctor if known to the employer, and the insurance carrier of the existence or absence of opportunities for modified duty or a modified duty return-to-work program available through the employer. Requires the employer, if those opportunities or that program exists, to identify the employer's contact person and provide other information to assist the treating doctor, the employee, and the insurance carrier to assess modified duty or return-to-work options.

SECTION 3.02. Amends Chapter 413B, Labor Code, by adding Section 413.021, as follows:

Sec. 413.021. RETURN-TO-WORK COORDINATION SERVICES. (a) Requires an insurance carrier, with the agreement of a participating employer, to provide the employer with return-to-work coordination services as necessary to facilitate an employee's reintegration to employment. Requires the insurance carrier to notify the employer of the availability of return-to-work coordination services. Requires the insurance carriers and the commission, in offering the services, to target employers without return-to-work programs and shall focus return-to-work efforts on workers who begin to receive temporary income benefits. Authorizes these services to be offered by insurance carriers in conjunction with the accident prevention services provided under Section 411.061. Provides that nothing in this section supersedes the provisions of a collective bargaining agreement between an employer and the employer's employees, and nothing in this section authorizes or requires an employer to engage in conduct that would otherwise be a violation of the employer's obligations under the National Labor Relations Act (29 U.S.C. Section 151 et seq.), and its subsequent amendments.

(b) Authorizes return-to-work coordination services under this section to include certain items.

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

(d) Requires the commission to use certified rehabilitation counselors or other appropriately trained or credentialed specialists to provide training to commission staff regarding the coordination of return-to-work services under this section.

(e) Requires the commission to adopt rules necessary to collect data on return-to-work outcomes to allow full evaluations of successes and of barriers to achieving timely return to work after an injury.

(f) Requires the commission to report twice annually to the council regarding the implementation and outcome of the return-to-work initiatives required by this section.

SECTION 3.03. Authorizes the commission to adopt rules as necessary to implement Sections 409.005(j) and 413.021, Labor Code, as added by this article, not earlier than January 1, 2004.

ARTICLE 4. PREAUTHORIZATION, CONCURRENT REVIEW, AND CERTIFICATION REQUIREMENTS

SECTION 4.01. Amends Section 408.026, Labor Code, as follows:

Sec. 408.026. New heading: SPINAL SURGERY. Provides that, except in a medical emergency, an insurance carrier is liable for medical costs related to spinal surgery only as provided by Section 413.014 and commission rules. Deletes existing text relating to spinal surgery and an examination required under this section.

SECTION 4.02. Amends Section 413.014, Labor Code, as follows:

Sec. 413.014. New heading: PREAUTHORIZATION REQUIREMENTS; CONCURRENT REVIEW AND CERTIFICATION OF HEALTH CARE. Defines "investigational or experimental service or device." Requires the commission by rule to specify which health care treatments and services require concurrent review by the insurance carrier. Requires the commission rules adopted under this section to provide that preauthorization and concurrent review are required at a minimum for certain items. Provides that the insurance carrier is not liable for those specified treatments and services requiring preauthorization unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or ordered by the commission. Requires each insurance carrier to allow health care providers to request that the insurance carrier prospectively or concurrently certify coverage for health care services, including pharmaceutical services, that do not require preauthorization and concurrent review. Provides that regardless of the insurance carrier's response to the request, the carrier retains the right to retrospectively review health care services and supporting records and to contest the certification of those services.

SECTION 4.03. Amends Chapter 413B, Labor Code, by adding Section 413.0141, as follows:

Sec. 413.0141. INITIAL PHARMACEUTICAL COVERAGE. Authorizes the commission by rule to provide that an insurance carrier shall provide for payment of specified pharmaceutical services sufficient for the first seven days following the date of injury if the health care provider requests and receives verification of insurance coverage and a verbal confirmation of an injury from the employer or from the insurance carrier as provided by

Section 413.014. Authorizes the rules adopted by the commission to also provide that an insurance carrier is eligible for reimbursement for pharmaceutical services paid under this section from the subsequent injury fund in the event the injury is determined not to be compensable.

SECTION 4.04. Requires the commission to adopt the rules required under Sections 408.026 and 413.014, Labor Code, as amended or added by this article, not later than February 1, 2002, and authorizes the commission to adopt rules required by Section 413.0141, Labor Code.

ARTICLE 5. REQUIRED MEDICAL EXAMINATIONS; DESIGNATED DOCTORS

SECTION 5.01. Amends Sections 408.004(a) and (c), Labor Code, to delete existing text related to certain medical examinations. Requires the insurance carrier to pay for the reasonable mileage expenses, rather than an expense, incident to the employee in submitting to the examination.

SECTION 5.02. Amends Chapter 408A, Labor Code, by adding Section 408.0041, as follows:

Sec. 408.0041. DESIGNATED DOCTOR EXAMINATION. (a) Requires the commission, at the request of an insurance carrier or an employee, to order a medical examination to resolve certain questions.

(b) Requires a medical examination requested under Subsection (a) to be performed by the next available doctor on the commission's list of designated doctors whose credentials are appropriate for the issue in question and the injured employee's medical condition. Requires the designated doctor doing the review to be knowledgeable and experienced with the treatment and procedures used by the doctor treating the patient's medical condition and the treatments and procedures performed to be within the scope of practice of the designated doctor. Requires the commission to assign a designated doctor not later than the 10th day after the date on which the request under Subsection (a) is received, and requires the examination to be conducted not later than the 21st day after the date on which the commission issues the order under Subsection (a). Prohibits an examination under this section from being held more frequently than every 60 days, unless good cause for more frequent examinations exists, as defined by commission rules.

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

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

(e) Requires the designated doctor to report to the commission. Provides that the report of the designated doctor has presumptive weight unless the great weight of the evidence is to the contrary. Authorizes an employer to make a bona fide offer of employment subject to Sections 408.103(e) and 408.144(c) based on the designated doctor's report.

(f) Authorizes an insurance carrier, if the insurance carrier is not satisfied with the opinion rendered by a designated doctor under this section, to request the commission to order an employee to attend an examination by a doctor selected by the insurance carrier. Requires the commission to allow the insurance carrier reasonable time to obtain and present the opinion of the doctor selected under this subsection before the commission makes a final decision on the merits of the issue in question.

(g) Requires the insurance carrier to pay for certain items.

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

(i) Authorizes the insurance carrier, if the report of a designated doctor indicates that an employee can return to work immediately or has reached maximum medical improvement, to suspend or reduce the payment of temporary income benefits immediately.

(j) Authorizes the insurance carrier, if the report of a doctor selected by the insurance carrier indicates that an employee can return to work immediately or has reached maximum medical improvement, to suspend or reduce the payment of temporary income benefits on the 14th day after the date on which the insurance carrier files a notice of suspension with the commission.

(k) Requires the commission, at the request of the employee or the insurance carrier to dispute a decision under Subsection (i) or (j), to hold an expedited benefit review conference, by personal appearance or by telephone, not later than the 10th day after the date on which the commission receives the request for the conference. Provides that if a benefit review conference is not held by the 14th day after the date on which the commission receives the insurance carrier's notice of suspension, an interlocutory order, effective from the date of the report certifying maximum medical improvement, is automatically entered for the continuation of temporary income benefits until a benefit review conference is held, and the insurance carrier is eligible for reimbursement for any overpayment of benefits as provided by Chapter 410. Provides that the commission is not required to schedule a contested case hearing as required by Section 410.025(b) if a benefit review conference is scheduled under this subsection. Authorizes the commission, if a benefit review conference is held not later than the 14th day, to enter an interlocutory order for the continuation of benefits and the insurance carrier is eligible for reimbursement for any overpayments of benefits as provided by Chapter 410. Requires the commission to adopt certain rules as necessary to implement this subsection.

SECTION 5.03. Amends Sections 408.122(b) and (c), Labor Code, to require the designated doctor doing the review to be knowledgeable and experienced with the treatment and procedures used by the doctor treating the patient's medical condition and the treatments and procedures performed must be within the scope of practice of the designated doctor. Requires a designated doctor's credentials to be appropriate for the issue in question and the injured employee's medical condition. Deletes existing text relating to doctor's being similarly licensed and a dispute regarding maximum medical improvement.

SECTION 5.04. Requires the council to report to the legislature not later than December 31, 2002, regarding issues related to medical examinations conducted under Section 408.0041, Labor Code, as added by this article.

SECTION 5.05. Provides that Section 408.004, Labor Code, as amended by this article, applies only to a request for a medical examination made to the commission by an insurance carrier on or after January 1, 2002.

ARTICLE 6. MEDICAL BENEFIT REGULATION; DISPUTE RESOLUTION

SECTION 6.01. Amends Section 408.028, Labor Code, as follows:

(a) Requires a physician, rather than a health care practitioner, providing care to an employee under this subchapter to prescribe for the employee any necessary prescription drugs, and over-the-counter alternatives to prescription medications as clinically appropriate and applicable, in accordance with applicable state law and as provided by Subsection (b). Authorizes a doctor providing care to order over-the-counter alternatives to prescription medications, when clinically appropriate, in accordance with applicable state law and as provided by Subsection (b).

(b) Requires the commission by rule to develop an open formulary under Section 413.011 that requires the use of generic pharmaceutical medications and clinically appropriate over-the-counter alternatives to prescription medications unless otherwise specified by the prescribing doctor, in accordance with applicable state law.

(c) Prohibits an insurance carrier, except as otherwise provided by this subtitle, from requiring an employee to use pharmaceutical services designated by the carrier.

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

SECTION 6.02. Amends Section 413.011, Labor Code, as follows:

Sec. 413.011. New heading: FEE GUIDELINES; TREATMENT GUIDELINES. Requires the commission by rule to adopt by reference the reimbursement methodology and model used by the Medicare system with minimal modifications to that reimbursement methodology as necessary to meet occupational injury requirements and to allow chiropractors to serve as treating doctors. Prohibits this section from being interpreted in a manner inconsistent with state laws relating to insurance equity regarding parity of payment or fee reimbursement levels based on provider type, license, discipline, or specialty. Requires the commission to calculate conversion factors to set fees for services based on that methodology and to provide for reasonable fees for the evaluation and management of care by treating doctors as required by Section 408.025(c) and commission rules. Requires the commission to adopt other Medicare requirements and related rules, including coding compliance standards, to meet the standards for reporting documentation and billing required by Section 413.053, and guidelines relating to

fees charged or paid for providing expert testimony relating to an issue arising under this subtitle. Deletes existing text relating to certain medical policies and guidelines. Authorizes the commission by rule to adopt treatment guidelines. Sets forth certain guidelines for the guidelines. Deletes existing text relating to medical policies. Authorizes, rather than requires, the commission by rule to establish medical policies relating to necessary treatments for injuries. Sets forth certain requirements for any medical policies or guidelines adopted by the commission.

SECTION 6.03. Amends Section 413.031, Labor Code, as follows:

(a) Provides that a party, including a health care provider or claimant, is entitled to a review of a medical service provided or for which authorization of payment is sought if that party, rather than a health care provider, receives certain information regarding medical service provided.

(c) Provides that the role of the commission, in resolving disputes over the amount of payment due for services determined to be medically necessary and appropriate for treatment of a compensable injury, is to adjudicate the correct payment given the relevant statutory provisions and commission rules. Requires the commission to publish certain information on its Internet website. Requires the commission, before publication, to redact only that information necessary to prevent identification of the injured worker.

(d) Requires a review of the medical necessity of a health care, rather than medical, service requiring preauthorization under Section 413.014 or commission rules under that, rather than this section to be conducted by an independent review organization under Article 21.58C, Insurance Code, in the same manner as reviews of utilization review decisions by health maintenance organizations. Provides that it is a defense for the insurance carrier if the carrier timely complies with the decision of the independent review organization. Requires the commission by rule to specify the appropriate dispute resolution process for disputes in which a claimant has paid for medical services and is seeking reimbursement. Deletes existing text relating to a health care provider professional review organization.

(e) Requires a review of the medical necessity of a health care service provided under this chapter or Chapter 408, except as provided by Subsection (d), to be conducted by an independent review organization under Article 21.58C, Insurance Code, in the same manner as reviews of utilization review decisions by health maintenance organizations. Provides that it is a defense for the insurance carrier if the carrier timely complies with the decision of the independent review organization.

(f) Requires the insurance carrier to pay the cost of the review under certain circumstances.

(g) Requires the cost of the review, except as provided by Subsection (f), to be paid by the nonprevailing party.

(h) Prohibits an employee, notwithstanding Subsections (f) and (g), from being required to pay any portion of the cost of a review.

SECTION 6.04. Amends Section 413.041, Labor Code, as follows:

Sec. 413.041. (a) Requires each doctor to disclose to the commission the identity of any health care provider in which the doctor, or the health care provider that employs the doctor, has a financial interest. Requires the doctor to make the disclosure in the manner provided by commission rule.

(b) Requires the commission by rule to require that a doctor disclose financial interests in other health care providers as a condition of registration for the approved doctor list established under Section 408.023, and to define "financial interest" for purposes of this subsection as provided by analogous federal regulations. Requires the commission by rule to adopt the federal standards that prohibit the payment or acceptance of payment in exchange for health care referrals.

(c) Provides that a doctor or health care provider that fails to comply with this section is subject to certain penalties and sanctions as provided by this subtitle.

(d) Requires the commission to publish all final disclosure enforcement orders issued under this section on the commission's Internet website. Deletes existing text relating to the financial interest of certain health care providers.

SECTION 6.05. Amends Section 415.0035, Labor Code, to provide that an insurance carrier or health care provider commits an administrative violation if that person violates this subtitle or a rule, order, or decision of the commission. Provides that a subsequent administrative violation under this section, after prior notice to the insurance carrier or health care provider of noncompliance, is subject to penalties as provided by Section 415.021. Provides that prior notice under this subsection is not required if the violation was committed wilfully or intentionally, or if the violation was of a decision or order of the commission.

SECTION 6.06. Amends Section 415.021(a), Labor Code, to require the commission, notwithstanding Subsection (c), by rule to adopt a schedule of specific monetary administrative penalties for specific violations under this subtitle.

SECTION 6.07. Amends Section 415.023, Labor Code, to authorize the commission to adopt rules providing for referral and petition to the appropriate licensing authority for appropriate disciplinary action, including the restriction, suspension, or revocation of the person's license. Makes a conforming change.

SECTION 6.08. (a) Requires the commission to adopt the rules and fee guidelines under Section 413.011, Labor Code, as amended by this article, not later than May 1, 2002. Provides that the treatment guidelines adopted under Chapter 413, Labor Code, in effect immediately before September 1, 2001, are not applicable to health care services provided on or after January 1, 2002 unless subsequently readopted by the commission.

(b) Requires the commission to adopt rules as required by Sections 408.028 and 413.041, Labor Code, as amended by this article, not later than June 1, 2002.

(c) Makes application of the change in law made by this article by the amendment of Section 413.031, Labor Code, prospective.

(d) Provides that Section 413.041(c), Labor Code, as added by this article, applies only to a failure to comply with Section 413.041 that occurs after June 1, 2002.

(e) Provides that Section 415.0035, Labor Code, as amended by this article, applies only to a violation occurring on or after September 1, 2002.

ARTICLE 7. SUNSET REVIEW; AUDIT

SECTION 7.01. Amends Section 401.002, Labor Code, to provide that the commission is abolished September 1, 2005, rather than 2007, unless continued in existence as provided by Chapter 325, Government Code.

SECTION 7.02. Amends Chapter 401A, Labor Code, by adding Section 401.003, as follows:

Sec. 401.003. ACTIVITIES OF THE STATE AUDITOR. Provides that the commission is subject to audit by the state auditor in accordance with Chapter 321, Government Code. Authorizes the state auditor to audit certain aspects of the commission. Provides that nothing in this section limits the authority of the state auditor under Chapter 321, Government Code.

ARTICLE 8. ATTORNEY'S FEES

SECTION 8.01. Amends Section 408.221, Labor Code, to provide that an insurance carrier that seeks judicial review under Chapter 410G, of a final decision of a commission appeals panel regarding compensability or eligibility for, or the amount of, income or death benefits is liable for reasonable and necessary attorney's fees incurred by the claimant as a result of the insurance carrier's appeal if the claimant prevails on an issue on which judicial review is sought by the insurance carrier in accordance with the limitation of issues contained in Section 410.302. Provides that this subsection does not apply to attorney's fees for which an insurance carrier may be liable under Section 408.147. Provides that an award of attorney's fees under this subsection is not subject to commission rules adopted under Subsection (f). Provides that Subsection (c) expires September 1, 2005. Makes conforming changes.

SECTION 8.02. Amends Section 408.147(c), Labor Code, to make conforming changes.

SECTION 8.03. Amends Section 408.222(b), Labor Code, to make a conforming change.

ARTICLE 9. LIFETIME INCOME BENEFITS

SECTION 9.01. Amends Section 408.161(a), Labor Code, to provide that lifetime income benefits are paid until the death of the employee for burns that result in at least 40 percent of the body being subject to debriding or grafting, or third degree burns covering the majority of either both hands or one hand and the head.

ARTICLE 10. MULTIPLE EMPLOYMENT; SUBSEQUENT INJURY FUND

SECTION 10.01. Amends Section 403.006, Labor Code, to set forth the liabilities of the subsequent injury fund. Authorizes the commission, based on an actuarial assessment of the funding available under Section 403.007(e), to make partial payment of insurance carrier claims under Subsection (b)(3).

SECTION 10.02. Amends Section 403.007, Labor Code, to require the fund, if the commission determines that the funding under Subsection (a) is not adequate to meet the expected obligations of the subsequent injury fund established under Section 403.006, to be supplemented by the collection of a maintenance tax paid by insurance carriers, other than a governmental entity, as provided by Sections 403.002 and 403.003. Sets forth certain requirements of the rate of assessment. Requires the commission's actuary or financial advisor to report biannually to the council on the financial condition and projected assets and liabilities of the subsequent injury fund. Requires the commission to make the reports available to members of the legislature and the public. Authorizes the commission to purchase annuities to provide for payments due to claimants under this subtitle if the commission determines that the purchase of annuities is financially prudent for the administration of the fund.

SECTION 10.03. Amends Section 408.042, Labor Code, as follows:

Sec. 408.042. New heading: AVERAGE WEEKLY WAGE FOR PART-TIME EMPLOYEE OR EMPLOYEE WITH MULTIPLE EMPLOYMENT. (a) Deletes existing text relating to full-time hours.

(b) Makes nonsubstantive changes.

(c) Sets forth the manner in which the average weekly wage for determining certain benefits is determined for employees with multiple employment.

(d) Requires the commission to take certain actions, including determining, by rule, the manner by which wage information is collected and distributed to implement this section.

(e) Authorizes only an employee's wages that are reportable for federal income tax purposes to be considered for an employee with multiple employment. Requires the employee to document and verify wage payments subject to this section.

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

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

(h) Defines "employee with multiple employment" and "full-time workweek." Redefines "part-time employee."

ARTICLE 11. INSURANCE CARRIER INFORMATION

SECTION 11.01. Amends Section 410.164, Labor Code, to require the insurance carrier, at each contested case hearing, as applicable, to file with the hearing officer and to deliver to the claimant a single document stating the true corporate name of the insurance carrier and the name and address of the insurance carrier's registered agent for service of process. Provides that the document is part of the record of the contested case hearing.

SECTION 11.02. Amends Section 410.204, Labor Code, to set forth specific text required to conclude each final decision of the appeals panel.

SECTION 11.03. Makes application of this article prospective.

ARTICLE 12. APPEAL REQUIREMENTS

SECTION 12.01. Amends Section 410.202, Labor Code, by adding Subsection (d), to provide that Saturdays and Sundays and holidays listed in Section 662.003, Government Code, are not included in the computation of the time in which a request for an appeal under Subsection (a) or a response under Subsection (b) must be filed.

SECTION 12.02. Makes application of this article prospective.

ARTICLE 13. STUDY ON DRUG-FREE WORKPLACE REQUIREMENTS

SECTION 13.01. Amends Chapter 411G, Labor Code, by adding Section 411.093, as follows:

Sec. 411.093. STUDY ON DRUG-FREE WORKPLACE; REPORT. Requires the

commission to study certain items regarding a drug-free workplace. Requires the commission to report not later than February 1, 2003, to the legislature and the council regarding the study conducted under this section. Sets forth certain requirements of the report. Requires TDI, on the request of the commission, to assist the commission in the performance of its duties under this section. Provides that this section expires September 1, 2003.

ARTICLE 14. GENERAL TRANSITION; EFFECTIVE DATE

SECTION 14.01. Makes application of this Act prospective, except as otherwise provided by this Act.

SECTION 14.02. Effective date: September 1, 2001, except as expressly provided.