STATE BAR *of* TEXAS

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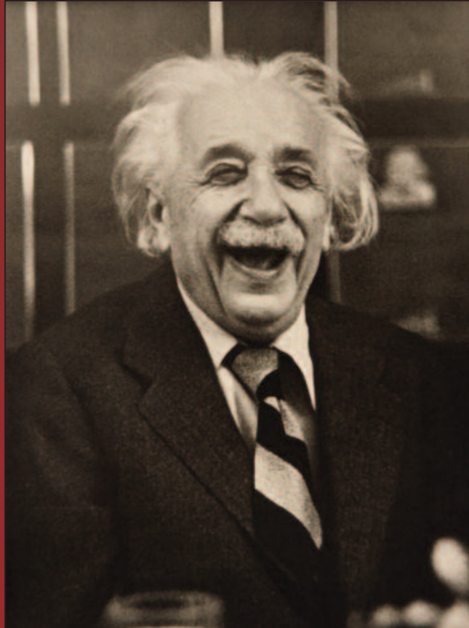

"I consider it important, indeed urgently necessary, for intellectual workers to get together, both to protect their own economic status and, also, generally speaking, to secure their influence in the political field."

What's Going on in Our Comp World?

- Extra–Contractual Exposure
- Closed Formulary
- Overview of the 2011 Sunset Bill
- A Look Back at the 2011 Workers' Compensation Seminar

Section President's Letter

I was not able to attend the Eighth Annual Advanced Workers' Compensation Seminar and related festivities this past August of 2011. As many of you know, I had an unexpected foray into our healthcare system, so I experienced the conference vicariously through the many text messages and e-mails, including photos that were sent to me while I was "in the hangar for repairs." I appreciate the many visitors I had, and it reinforces the longstanding notion which many of us share that our section, while relatively small compared to other sections, is a very tight-knit group.

I would like to thank the immediate Past President of the Section, Barbara Lombrano-Williamson, for all she did in her tenure as Section Chair, specifically, getting the website up and running. It is one of my goals to build upon this website.

One of the changes to the section is that we have a new editor of the newsletter, Ken Wrobel, a Hearing Officer with the TDI/DWC in Fort Worth. Mr. Wrobel has kindly agreed to serve as our section's editor. Assistant editors are John Gibson of Lubbock, a claimant's attorney, and Leeanna Gainer Mask of San Antonio, a carrier's attorney. They have kindly agreed to provide their sharply-honed editing skills to our newsletter. It is my goal to publish at least three newsletters a year. Hopefully, everyone will find these letters informative and occasionally entertaining.

If you have any questions, input, comments, criticism, praise, or ideas in general, please do not hesitate to contact me or Vice Chair, the talented Michael Sprain of Houston. I look forward to serving you for this term and seeing you out in the field.

Your friend and colleague,
Joe R. Anderson

Editor's Note:

I did not work on the junior high school newspaper. I did not work on the high school newspaper. I did not even work for the college newspaper. I certainly was not asked to be on my law school's law journal. Yet somehow, someway, here I am — first time editor editing for a newsletter that has an effect or is effected by one of the most important, most contentious and most controversial areas of law in Texas. Cool.

Joe Anderson called me one day and asked if I could do him a favor. I should have known it was not as menial a favor as, say, watching his dog for the weekend (which in itself would have been quite a favor with him in Austin and me in Arlington). Joe asked me to be the editor of the newsletter and I said, "Sure." I then added, "So, what do I do?" I think LeeAnna Mask Gainer and John Gibson had the same responses when asked to be the assistant editors.

So, here it is. Our first attempt at a newsletter. We will try to make it a regular event. We will try to provide articles of interest. We will try to provide information you can use in your daily practice. And we will come to you for contributions because I can't write all this stuff working in my windowless room in Fort Worth, secluded from most of the happenings and events that make up our world of work comp. This is a big, complicated, morphing area of law in a big state and we need all of you to help make this newsletter work.

I tried to find stories for this newsletter that impact us all and I tried to get people who could write about the effects and applications of these stories to your practice. I also try to send out through the Listserve bulletins, cases and other information as I get them. I didn't duplicate many of those in the newsletter figuring you already had them. I try not to send anything that I don't think is important, so look at them before you delete them. They may apply to your practice or let you know of opportunities to make our opinions known to the Division.

I think I did a pretty good job on this newsletter, with a lot of help, for this first go-around. If you want to contribute a story or have an idea for a story but are not able to write it, send it to me – **ken.wrobel@tdi.state.tx.us**. If you have comments, questions or suggestions, let me know. All I can say is I'll do my best and if it stays as fun and intriguing as this first attempt, I'll stay on for a while.

Respectfully,

Ken Wrobel
Workers' Compensation Section's
Newsletter Editor

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LEGAL UPDATE

Extra–Contractual Exposure After *Ruttiger*

By David Brenner

On August 26, 2011, the Texas Supreme Court concluded that the unfair claims settlement practices contained in Texas Insurance Code section 541.060, 542.003 and the Texas Deceptive Trade Practices Act are inconsistent with the Texas Labor Code in its current structure and, thus, a workers' compensation claimant may not assert such causes of action. The Court concluded that the provisions of Texas Insurance Code section 541.061, which regulate the misrepresentation of an insurance policy, are not inconsistent with the Labor Code. However, two days after the *Ruttiger* decision, the Fifth Circuit Court of Appeals concluded that one must have privity of contract to bring a 541.061, because a workers' compensation claimant lacks such privity, no standing to bring the claim exists. Finally, because the Supreme Court in *Ruttiger* could not reach a majority as to whether the common law duty of good faith and fair dealing should continue to remain a viable cause of action, that issue was remanded to the court of appeals for further proceedings. This paper is intended to evaluate extra-contractual exposure in Texas workers' compensation claims in light of *Ruttiger*.

The Historical Adoption Of The Common Law Duty OF Good Faith And Fair Dealing.

In 1987, the Texas Supreme Court perceived an inherently unequal bargaining power between an insurer and its policyholders. In an effort to balance the power between the insured and the insurer, the Court concluded that a "special relationship" exists between an insurer and its insured that forms the foundation of the insurance contract.[1] Due to the special relationship, the Court created a duty, owed by an insurer to its insured, to deal fairly and in good faith when investigating, adjusting, and settling claims.[2]

Although there is no insurer/insured relationship between a workers' compensation claimant and a workers' compensation insurer, in 1989, the Supreme Court extended the duty of good faith and fair dealing to the relationship between a workers' compensation claimant and the workers' compensation carrier providing coverage of his claim. In *Aranda vs. Ins. Co. of North America*,[3] the Supreme Court concluded that the Workers' Compensation Act in effect at that time did not provide injured workers with an immediate recourse to address an arbitrary and unjust denial of benefits. Because the lack of recourse could result in economic calamity to the injured worked, the *Aranda* court chose to extend the duty of good faith and fair dealing to a workers' compensation carrier in favor of injured workers. To avoid running afoul of the exclusive remedy provision of the Workers' Compensation Act, *Aranda* also concluded that in order to prevail, the injured worker must prove the breach of the duty of good faith and fair dealing caused an injury that is separate and independent from the workers' compensation injury.

1 *Arnold vs. National County Mutual Fire Ins. Co*, 725 S.W.2d 165 (Tex. 1987).
2 *Id*.
3 *Aranda vs. Ins. Co. of North America*,3 748 S.W.2d 210 (Tex. 1988).

Enter The Insurance Code

As the effects of *Arnold* and *Aranda* began to percolate through the judicial system, the Texas Legislature adopted insurance regulations relating to unfair claims settlement practices. Now contained within Insurance Code section 541.060, the provisions prohibited an insurer from, among other things, failing to effect a prompt and fair settlement of a claim for which liability was reasonably clear or refusing to pay a claim without conducting a reasonable investigation.[4] Two significant Supreme Court cases set the stage for evaluating the Insurance Code's unfair claims settlement practices applicability to workers' compensation claims.

In *Aetna Cas. & Sur. Co. v. Marshall*,[5] the Supreme Court addressed whether a workers' compensation claimant was granted standing to pursue an Insurance Code claim for violations of the DTPA. The workers' compensation claimant did not sue Aetna for refusal to timely pay benefits owed under the Workers' Compensation Act but, instead, sued Aetna for misrepresentations that their agreed judgment conferred rights that it did not.[6] Marshall claimed that despite Aenta's agreement in the judgment to pay medical expenses, it delayed payment of such expenses for some times as long as seventeen months and also refused to pay for a prescription. Marshall argued that because of this, physicians refused to provide medical treatment, hospitals refused to discharge him, and pharmacies refused to extend him credit. The Court concluded there was evidence that Aetna misrepresented the terms of the settlement agreement.[7] In his dissenting opinion, Chief Justice Gonzales argued that the Legislature never intended for court judgments, particularly in workers' compensation cases, to be the basis of a DTPA. In a footnote to his dissent, Justice Gonzales notes that "The irony is that in the long run, the majority opinion will hurt rather than help consumers. Cases will be more difficult to settle and we may have seen the end of agreed judgment in workers' compensation cases that leave future medical open."[8]

In 1994 the Court issued two decisions relating to Insurance Code claims handling exposure. First, in *Allstate v. Watson*, the Court limited private causes of action to the insured and those fully aligned with the insured, holding that a third-party claimant lacks standing to sue under section 16 of Article 21.21.[9] The Court explained that to permit any other statutory construction would create conflicting duties and compromise the insurer's loyalties and obligations owed to the insured.[10]

Then, in *Stewart Title v. Aiello*, the Court explained and distinguished its *Marshall* holding, explaining that in *Marshall*, Aetna faced liability to Marshall based upon an agreed judgment to which both Aetna and Marshall were parties, and in which Aetna agreed to investigate the claim and serve in the capacity of Marshall's insurer, paying future medical bills as they were incurred.[11] Absent this agreement, the claim would have sounded in contract and not in tort.[12]

Of significance is that a compromise settlement agreement, of the nature entered into in *Marshall*, is no longer viable in workers' compensation claims in Texas.

Exit The Insurance Code

On August 26, 2011, the Texas Supreme Court revisited the applicability of the Insurance Code claims handling practices to workers' compensation claims. What is clear is that based on the *Ruttiger*[13] decision, a workers' compensation claimant cannot recover for violations of Insurance Code sections 541.060 and 542.003, and also may not recover for violations of the Texas

4 TEX. INS. CODE § 541.060.
5 *Aetna Cas. & Sur. Co. v. Marshall*, 72 S.W.2d 770 (Tex. 1987).
6 *Id*. at 771.
7 *Id*. at 772.
8 *Id*. at 774, footnote 2.
9 *See Allstate Ins. Co. v. Watson*, 876 S.W.2d 145, 150 (Tex. 1994).
10 *Id*.
11 *Stewart Title v. Aiello*, 941 S.W.2d 68, 71 (Tex. 1994).
12 *Id*.
13 *Texas Mut. Ins. Co. v. Ruttiger*, 08-0751, 2011 WL 3796353 (Tex. Aug. 26, 2011).

Deceptive Trade Practices Act. Distinguishing its prior decision in *Marshall*, the Court notes that the workers' compensation landscape changed since *Marshall*. Differences between the dispute resolution processes under the old law and new Act are stark. Under the old Industrial Accident Board (IAB) prehearing process, no testimony was taken and the only discernible result was a recommendation. The formal hearing was more formality than hearing. Under the old law, IABs were no more than a "way station" on the way to the courthouse.[14]

The majority opinion noted that in contrast to the Act in effect at the time of *Marshall*, the current Act provides significantly more meaningful proceedings at the administrative level so as to reduce the number and cost of judicial trials, speed up the time for the entire dispute resolution process, and facilitate interlocutory payment of benefits pending final resolution of disputes. To achieve these purposes, the amended Act contains detailed procedures and penalties for failures of the various interested parties to comply with the statutory and regulatory requirements.[15] After evaluating the mechanics of the dispute resolution process, the Court concluded that the Act has multiple, and sometimes redundant, additive penalty and sanction provisions for enforcing compliance with its requirements. Permitting a workers' compensation claimant to additionally recover by simply suing under general provisions of Insurance Code section 541.060 or 542.003 would be inconsistent with the structure and detailed processes of the Act. Not only would such recovery be inconsistent with the Act … it could also result in rewarding an employee who is dilatory in utilizing the Act's detailed resolution process.[16]

Misrepresentations And Insurance Code Section 541.061

Not only does the *Ruttiger* opinion address whether a claim can be brought for unfair claims settlement practices, but it also addresses whether the Workers' Compensation Act conflicts with a claim for making misrepresentations under the policy. In this respect, the Court concluded that section 541.061 is not at odds with the dispute resolution process of the workers' compensation system.[17] However, the Court noted that although recovery based upon section 541.061 may not be precluded by the Act, there was legally insufficient evidence to support a finding based upon misrepresentation.

While the question of whether the Workers' Compensation Act precludes a section 541.061 claim is answered, the Supreme Court did not address the standing of a workers' compensation claimant, as a non-party to the insurance contract, to bring such a claim. The 5th Circuit Court of Appeals, in an unpublished opinion issued on August 30, 2011, in Cause No 10-20630, *Effinger v. Cambridge Int. Serv., et al.*, concluded that such claims may only be brought by one in privity of contract with the insurer. Since a workers' compensation claimant does not have privity with the insurer, no standing exists to bring such a claim.

Thus, it does not appear Texas Insurance Code section 541.061 provides a fertile ground for future workers' compensation claimants' extra-contractual claims. Texas Insurance Code section 541.061 provides:

> It is an unfair method of competition or an unfair or deceptive act or practice in the business of insurance to misrepresent an insurance policy by:
>
> (1) making an untrue statement of material fact;
> (2) failing to state a material fact necessary to make other statements made not misleading, considering the circumstances under which the statements were made;
> (3) making a statement in a manner that would mislead a reasonably prudent person to a false conclusion of a material fact;
> (4) making a material misstatement of law; or
> (5) failing to disclose a matter required by law to be disclosed, including failing to make a disclosure in accordance with another provision of this code.[18]

14 *Ruttiger*, 08-0751, 2011 WL 3796353 (slip opinion, page 15).
15 *Id*.
16 *Ruttiger*, 08-0751, 2011 WL 3796353 (slip opinion, page 21).
17 *Ruttiger*, 08-0751, 2011 WL 3796353 (Slip opinion, page 26).
18 TEX. INS. CODE § 541.061.

While workers' compensation policies can be complex and include many endorsements, from a claimant's perspective, the terms of the standard Texas policy providing coverage for workers compensation claims generally provide:

Part One — Workers' Compensation Insurance

A. How This Insurance Applies

This workers' compensation insurance applies to bodily injury by accident or bodily injury by disease. Bodily injury includes resulting death.

1. Bodily injury by accident must occur during the policy period.
2. Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period.

B. We Will Pay

We will pay promptly when due the benefits required of you by the workers' compensation law

C. We Will Defend

We have the right and duty to defend at our expense any claim, proceeding or suit against you for benefits payable by this insurance. We have the right to investigate and settle these claims, proceedings or suits.

We have no duty to defend a claim, proceeding or suit that is not covered by this insurance.

D. We Will Also Pay

We will also pay these costs, in addition to other amounts payable under this insurance, as part of any claim, proceeding or suit we defend:

1. reasonable expenses incurred at our request, but not loss of earnings;
2. premiums for bonds to release attachments and for appeal bonds in bond amounts up to the amount payable under this insurance;
3. ligitation costs taxed against you;
4. interest on a judgment as required by law until we offer the amount due under this insurance; and
5. expenses we incur.

E. Other Insurance.

We will not pay more than our share of benefits and costs covered by this insurance and other insurance of self-insurance. Subject to any limits of liability that may apply, all shares will be equal until the loss is paid. If any insurance or self-insurance is exhausted, the shares of all remaining insurance will be equal until the loss is

It is the statutory framework and rules, and not the policy language, that generally forms the evaluation of compensability, the entitlement to benefits, and the basis for plain language notices required to dispute entitlement to benefits. Thus, despite absence of privity, it is unlikely that a workers' compensation claimant will find that misrepresentations relating to the terms of the policy will ever formulate a basis for recovery.

The Common Law Duty Of Good Faith And Fair Dealing

At issue in *Ruttiger* was whether, through the enactment of the current Workers' Compensation Act, the Legislature intended to abrogate the common law duty of good faith and fair dealing and, if not, whether *Aranda* should be overturned because it interferes with the administrative processes and goals of the Workers' Compensation Act. As it pertains to the common law duty of good faith and fair dealing, the Supreme Court could not arrive at a majority decision and thus remanded the issue to the court of appeals for further proceedings.

On this specific issue three opinions are written. Justice Johnson wrote the first opinion and was joined by Justices Hecht, Wainwright, and Medina. Justice Willet filed a concurring opinion and was joined by Guzman. The final opinion was issued by Chief Justice Jefferson and joined by Justices Green and Lehrmann.

While the Court could not reach a majority on whether *Aranda* should be overturned, seven of the nine justices did agree that it could not be concluded that the Legislature intended to abrogate the common law duty of good faith and fair dealing through the enactment of the current Workers' Compensation Act. In his dissenting opinion, Justice Jefferson wrote that the question before the Court was whether the Legislature intended to abrogate the common law duty of good faith and fair dealing. Justice Jefferson concludes that given the existence of Texas Labor Code chapter 416, it is impossible to conclude the Legislature had such an intent. Thus, according to Justice Jefferson's dissenting opinion, the inquiry ends there. If the Legislature limited certain *Aranda*-type claims, it could not have logically have also intended to eliminate them.

In contrast, Justice Johnson writes "the essential question is not whether the Legislature intended to abrogate entirely a common law bad faith act… I believe it did not."[19] Rather, the question is to what extent the judiciary will respect the Legislature's function of addressing concerns and adjusting the rights of parties to the workers' compensation system as part of its policy-making function. In this respect, Justice Johnson concludes that the Act effectively eliminates the need for a judicially imposed cause of action outside the administrative processes and other remedies in the Act. Thus, Justice Johnson concludes Aranda should be overturned.[20]

Justices Willett and Guzman concluded that the Court should await addressing *Aranda* until the court of appeals first considers the *Ruttiger*'s claims that Texas Mutual breached the duty of good faith and fair dealing.

Because of the lack of a majority on whether the common law duty of good faith and fair dealing should remain viable, the claim was remanded to the court of appeals to address Texas Mutual's challenge to the breach of the common law duty of good faith and fair dealing claim.

Will The Common Law Duty Of Good Faith And Fair Dealing In Workers' Compensation Claims Survive Remand?

There is much speculation in the legal community as to how the court of appeals will address the viability of the common law duty of good faith and fair dealing. However, what we do know is that as of today, the Supreme Court has not reversed *Aranda*. Texas jurisprudence is also clear that it is not the function of a court of appeals to abrogate or modify established precedent.[21] That function lies exclusively with the Supreme Court.[22] Considering such limitations, this writer believes it is unlikely the court of appeals, on remand, will conclude it has the authority to overrule *Aranda*. Perhaps in light of this, Texas Mutual or *Ruttiger* may seek rehearing with the Supreme Court.*Ruttiger* leaves open the following questions for a later date:

1. Is the common law duty of good faith and fair dealing still viable in the workers' compensation context?
2. Is pain and suffering, mental anguish and impairment caused by an alleged aggravation to a compensable injury as a result of alleged bad-faith conduct separate and independent injury?

I have often heard the phrase "May he live in interesting times." There is no question we do. I always assumed living in interesting times was positive. However, in his "Day of Affirmation" address in Cape Town, South Africa, Robert F. Kennedy suggested this phrase is a Chinese curse. Like this phrase, whether the *Ruttiger* analysis is a blessing or curse will depend on one's perspective. However, time will ultimately allow us to evaluate *Ruttiger*'s impact on the Texas workers' compensation system.

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19 *Ruttiger*, 08-0751, 2011 WL 3796353 (slip opinion, page 35).

20 *Id*. (slip opinion at 37).

21 *Lubbock County v. Trammel's Lubbock Bail Bonds*, 80 S.W.3d 580, 585 (Tex. 2002).

22 *Lubbock County*, 80 S.W.3d 580.

Supreme Court of Texas: LIBs Eligibility Requires Injury to Enumerated Body Part

The basic framework of Lifetime Income Benefits (LIBs) is found in Texas Labor Code §408.161. The Act enumerates various "losses" and residua of injury that would allow a claimant to recover indemnity benefits for the rest of her life. These situations include the loss of two extremities. In this section, the only definition provided by the Legislature for the term "loss" (as in loss of both feet at or above the ankle) is a notation in subsection (b) that "the total and permanent loss of use of a body part is the loss of that body part."

Loss of use of a body part in the LIBs context has long been evaluated under the criteria established in *Travelers Ins. Co. v. Seabolt*, 361 S.W.2d 204 (Tex. 1962). In that case, the Supreme Court of Texas established two different methods for an injured worker to meet the requirement of loss of use. Loss of use could be established through proving the absence of any utility in the body part or, alternatively, that the claimant cannot obtain and retain employment requiring the use of the enumerated body part. In essence, there was both an impairment-related test and a disability-related test, either of which was sufficient to establish loss of use for LIBs purposes.

Over time, the Division awarded LIBs for injuries to non-enumerated body parts that affected enumerated body parts, such as back injuries that affected the functional use of the legs (See Appeals Panel Decision 070063-S). This was brought on as a natural progression of the *Burdine* case, *Hartford Underwriters Ins. Co. v. Burdine,* 34 S.W.3d 700, (Tex. App.—Fort Worth 2000, no pet.). In *Burdine*, the claimant's back injury resulted in radiculopathy that affected the nerve roots that went down the leg and "into the foot" resulting in footdrop. This case helped establish the concept that LIBs could be obtained even if the claimant's initial and direct injuries were not to an enumerated body part.

Carmen Muro took this line of thought a bit further. Mrs. Muro had bilateral hip injuries that developed into necrosis. She had multiple surgeries complicated by recalls of the hip replacement hardware used on her, and the failure of another hip replacement hardware device. While she never lost the complete utility of her legs, she did reach a point where she could no longer perform any work that required the use of her legs. She sought LIBs on this basis even though the hips are not an enumerated body part in §408.161 and won at the CCH and Appeals Panel levels. At trial, the evidence showed that she had not lost the functional use of her feet, but that she had lost the ability to obtain and retain employment requiring the use of her feet at or above the ankle. The jury agreed that she met the disability prong of the *Seabolt* test. This decision was affirmed by the Court of Appeals in Dallas. However, it was reversed by the Supreme Court of Texas.

In its review of the case, *Insurance Co. of the State of Pennsylvania v. Muro*, Cause No. 09-0340 (Tex. 2011), the Supreme Court took issue with Seabolt and its application to current §408.161. The main question in *Muro* was whether or not a claimant had to have an injury to an enumerated body part in order to qualify for LIBs under §408.161. The court stated that §408.161 defines LIBs eligibility in terms of specific impairments rather than general disabilities. Therefore, there must be an injury or impairment to the enumerated body part in order to qualify for LIBs. The disjunctive *Seabolt* test for loss of use does not apply until there is evidence of a direct or indirect injury to the enumerated body part. The Court specifically stated that an injury such as that described in *Burdine* (radiculopathy) would satisfy this requirement as an indirect injury resulting in impairment to an enumerated body part. There was no suggestion in the decision that "impairment" means a "ratable impairment." "Impairment" was clearly used to suggest the enumerated body part was itself affected by the compensable injury in some way.

From this point on, LIBs will not be evaluated as a disability issue until there is first a showing of impairment to an enumerated body part. Claimants must satisfy *Muro* before satisfying *Seabolt*.

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DWC IMPLEMENTS THE LONG–AWAITED "CLOSED FORMULARY"

Jane Lipscomb Stone
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In response to growing concerns about over-utilization of dangerous drugs by injured workers, the Division of Workers' Compensation is making an attempt to address these concerns. It was almost three years ago, in December 2008, that the Division published the first working draft of a rule to address the crisis. Finally adopted in 2011, DWC is implementing what it considers to be a solution – the "Closed Formulary Rule." Although the rule inexplicably exempts the application of the closed formulary to the overwhelming majority of workers' compensation claims for the next two years, and excuses health care providers from the requirement to seek preauthorization for drugs excluded from the formulary for these claims during that time, ultimately the rule could have a positive effect on the health of Texas' injured workers.

September 1, 2011 – A Wake-up Call

Although DWC's new rule governing prescription medications for Texas' injured workers was adopted on January 17, 2011, it did not begin to affect Texas claims until September 1st for dates of injury on or after September 1, 2011. The rule includes a new "closed formulary" for prescription medications. Before the adoption of the rule, prescription drugs for all workers' compensation claims, regardless ofthe date of injury, were under an "open formulary" model. Under the "open formulary" model, allFDA approved prescription and nonprescription drugs may be provided to injured workers.[1] Claimswith dates of injury before September 1, 2011, are referred to as "legacy claims" under the new rules.2 The open formulary continues to apply to these claims until September 1, 2013 for certified network and non-network legacy claims.[3]

What Is The Closed Formulary?

The closed formulary is the list of drugs at Appendix A to the Official Disability Guideline (ODG), the DWC's officially adopted treatment guideline.[4] Appendix A, like the rest of the ODG, is subject to periodic revision.

Until September 1, 2013, the Closed Formulary Applies Only to Dates of Injury On or After 9/1/2011

The new closed formulary applies to claims with dates of injury occurring *on or after September 1, 2011*.[5] The closed formulary includes all FDA approved prescription and nonprescription drugs, but unlike the open formulary, it excludes: (1) "N" drugs; (2) any compound containing an "N" drug; and (3) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted (Excluded Drugs).[6] "N" drugs are those drugs identified with a status of "N" in the current edition of Appendix A of the ODG.[7] With the adoption of the closed formulary come some important changes to preauthorization and retrospective review rules.

New Rules for Preauthorization and Retrospective Review Effective 9/1/2011

For claims with dates of injury *on or after September 1, 2011*, only Excluded Drugs and drugs provided through an intrathecal drug delivery system are subject to preauthorization.[8] One exception to this rule is that Excluded Drugs are not subject to preau-

1 28 TEX. ADMIN. CODE §134.500(9).
2 28 TEX. ADMIN. CODE §134.506(a).
3 28 TEX. ADMIN. CODE §134.510(d)(4).
4 28 TEX. ADMIN. CODE §137.100
5 28 TEX. ADMIN. CODE §134.520.
6 28 TEX. ADMIN. CODE §134.500(3).
7 28 TEX. ADMIN. CODE §134.500(3)(A).
8 On August 1, 2011 TDI/DWC issued a Memorandum stating that drugs included in the open formularyprescribed and dispensed for non-network legacy claims do not require preauthorization, except for investigational andexperimental drugs, but are subject to retrospective review. However, at the time the memo was written this pronouncementdid not appear to be within the DWC's statutory authority. Since that time, the DWC has proposed an amendment to DWC Rule134.600 which it hopes will clear up any ambiguity about whether preauthorization is required.

thorization if prescribed within the first seven days of injury. If a carrier denies a preauthorization request for an Excluded Drug, the denial is subject to appeal through medical dispute resolution under Rule 133.308, or through a medical interlocutory order (Rule 133.306) if the doctor believes there to be an "unreasonable risk of medical emergency."[9]

Drugs included on the closed formulary are *not* subject to preauthorization, but they *are subject to retrospective review* for medical necessity. However, when prescribed within the first seven days of injury, closed formulary drugs are *not* subject to retrospective review. To deny payment on retrospective review, there must be documentation of evidence-based medicine that outweighs the presumption of reasonableness as provided in TEX. LAB. CODE §413.017 (for non-certified network claims) or outweighs the certified treatment guidelines for certified network claims, if applicable.[10] If the prescription outweighs the applicable treatment guidelines, the rules allow the carrier to request a statement of medical necessity from the prescribing doctor.[11]

Legacy Claims Subject to Closed Formulary Effective September 1, 2013

Effective September 1, 2013, legacy claims become subject to the closed formulary. The open formulary will no longer apply to any claims. To ensure continuity of care, the new rules provide procedures to transition the legacy claims to the closed formulary.

The Transition Period for Legacy Claims from September 1, 2011 through September 1, 2013

Beginning by at least September 1, 2012, carriers should begin identifying which of their legacy claims have been prescribed Excluded Drugs.[12] The rules require carriers or their agents to notify each injured employee, the employee's prescribing doctor, and pharmacy (if known) that: (1) the closed formulary will apply to legacy claims effective September 1, 2013; and (2) the insurance carrier's name, address, phone number together with a date and time to discuss the ongoing pharmacological management of the injured employee's claim.[13] The notices have to be provided no later than March 1, 2013.

During the transition period, prescribing doctors "*should*" provide the carrier with a statement of medical necessity if they are prescribing Excluded Drugs to legacy claims.[14] In addition, the same rule provides that the doctor and carrier may contact each other to discuss "ongoing pharmacological management of the injured employee's claim."[15] When one of the parties contacts the other, the parties must provide to each other a name, phone number, and a date and time to discuss the subject claim.[16]

The idea behind these transition rules is to encourage the doctor and the carrier to communicate and transition the worker to drugs on the closed formulary. But in practice there is no way for the Division or a carrier to force the doctor to provide a statement of medical necessity or to communicate at all, much less come up with a plan to transition medications. There is no penalty to the doctor if he refuses to respond to the carrier, or to cooperate in the transition.

Carriers May Enter Into Agreements With Doctors to Transition to Closed Formulary on Case-by-Case Basis

Before September 1, 2013, the carrier or its agent may enter into an agreement with a prescribing doctor to transition the legacy claims from Excluded Drugs to closed formulary drugs.[17] The agreement may allow legacy claims to continue receiving Excluded Drugs after September 1, 2013. Drugs prescribed in accordance with agreements with doctors under the new rules are *not subject* to retrospective review.[18] If no agreement is reached, the closed formulary will apply to the legacy claims effective September 1, 2013.

9 *See* 28 TEX. ADMIN. CODE §134.550.
10 28 TEX. ADMIN. CODE §§134.530(g)(1), 134.540(g)(1).
11 28 TEX. ADMIN. CODE §§134.530(g)(2), 134.540(g)(2).
12 28 TEX. ADMIN CODE §134.510(b)(2)(A).
13 28 TEX. ADMIN. CODE §134.510(b)(2)(B).
14 28 TEX. ADMIN. CODE §134.510(b)(1)(A).
15 28 TEX. ADMIN. CODE §134.510(b)(1)(B).
16 28 TEX. ADMIN. CODE §134.510(b)(1)(C).
17 28 TEX. ADMIN. CODE §134.510(c).
18 28 TEX. ADMIN. CODE §134.510(d)(4).

A Doctor May Seek Preauthorization to Prescribe Excluded Drugs to Legacy Claims after September 1, 2013, and Obtain a Medical Interlocutory Order Following Denial

A prescribing doctor (or pharmacist) may seek preauthorization to continue prescribing an Excluded Drug to a legacy claim *after* September 1, 2013. If the carrier denies preauthorization, the new rules provide the doctors with a virtually automatic reversal of the denial through a medical interlocutory order (MIO) where the doctor alleges that an "unreasonable risk of medical emergency" exists.[19] The Division will issue the MIO if the doctor's request contains the information listed in Rule 134.550(c).[20] If the Division issues the MIO it will be effective retroactively to the date the completed MIO request was submitted to the Division.[21] The carrier may appeal the MIO by requesting a hearing in accordance with TEX. LAB. CODE §413.055, and Rule 148.3.

Overview of the 2011 Sunset Bill: "Enter the Sandman."[1]

By Robert R. Graves, Jr.[2]

In July of 2010, the Sunset Advisory Commission issued its report regarding the Texas Department of Insurance, Division of Workers' Compensation. The report made recommendations for the Texas workers' compensation system. The 2011 Legislature, in House Bill 2605, also referred to as the "Sunset Bill," attempted to incorporate some of those suggestions. The scope of the 2011 Sunset Legislation and other legislative acts exceed the breadth of this article. However, this article will attempt to highlight the changes implemented by the Sunset Bill.

I. Benefit Review Conferences

The Commissioner is required to adopt rules establishing a process through which the Division can evaluate this efficiency of the documentation provided in a request for a benefit review conference (BRC). The Division may deny such a request if the party has failed to provide sufficient documentation. Additionally, if the party requests that a BRC be rescheduled, the party must submit the request in the same manner as the initial request was made and the Division must evaluate the request. If a party fails to request that a BRC be rescheduled in the time required or fails to attend the BRC without good cause, the party forfeits his or her entitlement to attend the BRC on the issue in dispute unless the benefit review officer is authorized to schedule an additional BRC.

II. Designated Doctors

A designated doctor examination must be performed by the next available designated doctor on the Division's list of "certified" designated doctors. The designated doctor's credentials must be appropriate for the "area of the body affected by the injury" and the employee's "diagnosis."

In order to be eligible to serve as a designated doctor, a doctor is now required to "maintain an active certification by the Division." The Commissioner is also required to adopt rules regarding the process for certification of designated doctors. Those rules must: (1) require the Division to evaluate the qualification of the designated doctor for certification using eligibility requirements, including: education experience, previous training, and demonstrated ability to perform the specific designated doctor duties; and (2) require standard training and testing to be completed in accordance with the policy and guidelines developed by the Division. To that end, the Division is required to develop guidelines for certification training programs and is required to develop and implement a procedure to periodically review and update those guidelines. The Division now may authorize an independent training or testing to conduct such certifications. The Division has the explicit authority to deny renewal of a designated doctor's certification or revoke a designated doctor's certification.

A designated doctor is required to continue providing services related to a case to which he is assigned, including performing subsequent examinations or acting as a resource for Division disputes, unless the Division authorizes the designated doctor to discontinue providing services. The Commissioner is required to adopt rules addressing when a designated doctor is permitted to discontinue services and under what circumstances a designated doctor may discontinue providing services, including: (1) the doctor decides to stop practicing in the workers' compensation system; or (2) the doctor relocates his/her residence or practice.

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1 "Enter the Sandman" was the first song written by Metallica for their 1991 eponymous album, "Metallica." The song's lyrics include "Sleep with one eye open, gripping your pillow tight. Exit light, enter night, take my hand, we're off to never never-land."

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If an employee disagrees with a designated doctor's first evaluation of maximum medical improvement (MMI) or impairment, the employee may now request a medical examination to determine MMI and impairment from his treating doctor or from another doctor to whom the employee is referred by the treating doctor.

III. Appeals Panel Review

The Appeals Panel now has the authority to issue a decision where it affirms the decision of a hearing officer if the case is significant, in that it is: (1) a case of first impression; (2) involves a recent change in the law; or (3) involves errors at the contested case hearing that require correction, but do not affect the outcome of the hearing, including: (a) finding a fact for which insufficient evidence exists; (b) incorrect conclusions of law; (c) finding the facts or conclusions of law regarding matters that were not properly before the hearing officer; and (d) legal errors not otherwise described above.

IV. Medical Disputes

House Bill 2605 made changes to the medical dispute resolution process for non-network, network and political subdivision claims. It also imposes additional requirements for first responders.

A. Medical Dispute Process for Medical Necessity (IRO) disputes and Medical Fee disputes

Texas Labor Code section 413.0311, now requires all appeals of an independent review organization (IRO) decision to go to a medical contested case hearing in a local Division field office. A new procedure has been adopted for medical fee disputes.

If a medical fee dispute remains unresolved after review by the Division, the party may request a BRC. At the BRC, the parties may not resolve the dispute by negotiating fees that are inconsistent within the applicable fee guideline. If the issue remains unresolved after the BRC, the parties may elect to engage in arbitration or, if arbitration is not elected, the parties can proceed to a contested case hearing. Such a contested case hearing will be held before the State Office of Administrative Hearings (SOAH). The Division is given the option to participate in the proceeding, although they are not parties. With a few exceptions, the non-prevailing party at the SOAH will be required to reimburse the Division for the cost of the SOAH's services. However, if the injured employee is the non-prevailing party, the carrier must reimburse the Division for the cost of the SOAH's services. Additionally, if a party does not pay for the services, interest will begin to accrue on the amount of reimbursement owed beginning on the 45th day after the Division submits a bill or statement to the party. Texas Labor Code section 402.073 was amended to require that the Memorandum of Understanding between the Commission and Chief Administrative Law Judge of the State Office of Administrative Hearings addresses the payment of costs by the parties in medical fee disputes.

B. Medical disputes for Network Claims

Insurance Code Chapter 1305 has been amended and now specifically explains that a party is entitled to seek a hearing regarding an independent review organization (IRO) decision and if the party is still unsatisfied following the IRO's decision, seek judicial review under Chapter 2001 of the Government Code just as IRO disputes are handled for non-network claims. Before this change, Chapter 1305 simply provided for an undefined right to judicial review with no prior hearing.

C. Medical Disputes associated with Political Subdivisions and Chapter 504 agreements

Under Labor Code Chapter 504, political subdivisions are permitted to directly contract with health care providers and require an injured worker to receive care form those providers with whom the political subdivision has contracted. However, there were no provisions regarding how medical disputes under such agreements would be resolved. This has now been clarified. Regarding Chapter 504 political subdivision healthcare agreements, there is now a statutory medical dispute resolution process required

for disputes regarding a decision by an IRO. A party who is dissatisfied with an IRO decision may seek a medical contested case hearing. If a party is dissatisfied after the medical contested case hearing, they may seek judicial review under Texas Government Code Chapter 2001.

D. First Responders

If a first responder suffers a serious bodily injury, the political subdivision or applicable carrier is required to accelerate and give priority to the first responder's claim for medical benefits and the Division is required to accelerate a contested case hearing requested by, or an appeal submitted by, a first responder regarding a denial of a claim for medical benefits. These provisions are intended to ensure that an injured first responder's claim for medical benefits is accelerated to the full extent authorized by current law.

V. The Medical Quality Review Panel (MQRP)

Agencies that regulate health care professionals who provide care in the workers' compensation system must develop a list of healthcare providers who have demonstrated experience in workers' compensation or utilization review. The medical advisor is now required to consider appointing members of the MQRP from the names of those lists and, when appointing members in MQRP, must select specialists from various healthcare specialty fields to serve on the panel to ensure the membership of the panel has expertise in a wide variety of special healthcare specialty fields.

The Division is required to develop criteria concerning the medical case review process. The medical director must establish a quality assurance panel within the MQRP to: (1) provide an additional level of evaluation in medical case reviews; and (2) assist the medical director with performing the advisor's duties in the MQRP and performing the panel's duties. The Commissioner is required to adopt the rules concerning the operation of the MQRP, as well as rules concerning the training of the members of the MQRP.

VI. Compliance

House Bill 2605 touches on numerous compliance aspects.

A. Policies and Procedures

The Division is required to adopt a policy outlining its complaint process from receipt of an initial complaint to the complaint's disposition. The Division is required to develop procedures to formally document and analyze complaints, including compiling statistics on complaints, and report the information compiled to the Commissioner at regular intervals.

B. Where the Penalties go

Texas Labor Code section 403.008 was adopted and provides that administrative penalties collected under the Workers' Compensation Act will be deposited into the General Revenue Fund.

C. Penalties for failure to Timely initiate benefits

Texas Labor Code section 409.021(e) has been amended. This section provides that a carrier commits an administrative violation if it does not timely initiate payments or files a notice of refusal. The section used to provide specific statutory penalties. Those specific statutory penalties have been deleted.

D. The Investigation Unit

Texas Labor Code section 414.005 has been amended to provide that, as often as the Commissioner feels necessary, the Commissioner or the investigations units may review the operations of a person regulated by the Division in order to determine compliance. The review may include onsite visits. The Commissioner is not required to announce an onsite visit. During an onsite visit, a person must make available to the Division all records related to the person's participation in the workers' compensation system.

E. Cease and Desist Orders

The Commissioner is now authorized to issue an emergency cease and desist order if the Commissioner believes that a person is engaged in conduct violating a law, rule or order and believes that the alleged conduct will result in harm to the health, safety or welfare of another person. There is a process by which a person affected by such an order may request a hearing.

VII. Other Legislation

In addition to the Sunset Legislation, there were numerous other bills that impact the workers' compensation system. The bills include:

- House Bill 2089, requiring the Division to adopt rules regarding the recoupment of overpayment and the payment of underpayments.
- House Bill 528, addressing fee schedules for pharmaceutical services, as well as the ability to negotiate informal network agreements regarding pharmaceutical services.
- House Bill 1774, addressing changes to the Office of Injured Employee Counsel (OIEC).
- House Bill 625, amending the Staff Leasing Act.
- House Bill 2093, making changes regarding certain consolidated insurance programs.
- Senate Bill 800, allowing the Division to enter into contracts with private agencies to collect data.
- Senate Bill 809, addressing time frames regarding seeking judicial review.
- Senate Bill 1714, addressing non-subscriber plans, as well as an employee's waiver of the right to sue.

The above is intended as a general overview of the Sunset Legislation and highlights some of the other legislative changes of 2011. House Bill takes effect on September 1, 2011. However, the changes to the medical dispute resolution process for network claims take apply to IRO decisions issued on or after June 1, 2012. Similarly, the non-network medical dispute resolution changes apply to reviews conducted on or after June 1, 2012. The changes related to certification of designated doctors do not take effect until January 1, 2013. It will be interesting to see how these provisions are implemented.

The HIPAA Privacy Rule and Texas Workers' Compensation: Correcting the Record

Many participants and stakeholders in the Texas Workers Compensation system believe that HIPAA applies directly to system participants. HIPPA does not directly apply to workers' compensation, but the evolution of the law, including adoption of HITECH, indicate that similar standards of privacy and non-disclosure should obtain, if only to comply with Texas state law concerning workers' compensation confidentiality.

The HIPAA Privacy Rule ("the Rule") mandates that "covered entities" and their "business associates" (which terms are each defined below) maintain and protect the confidentiality of defined health information (termed "protected health information")("PHI") in keeping with federal regulations.[1] These federal regulations were intended to foster the confidentiality of PHI while in the possession or constructive possession of covered entities or business associates. Failure to meet the terms of the Privacy Rule may expose covered entities and their business associates to monetary penalties and/or imprisonment. Recent developments, including adoption of the HITECH Act, have increased the potential monetary liability for non-compliance or accidental disclosure.

A covered entity is any entity for which compliance with the Privacy Rule is mandatory. Covered entities consist of: (1) health plans, (2) health care clearinghouses, (3) and health care providers who transmit health information in connection with an electronic transaction.[2] A business associate is defined as a person or entity that arranges, performs, or assists a covered entity in an activity involving the use or disclosure of protected health information.[3] A covered entity, such as a health plan, may use and disclose protected health information for treatment, payment, or health care operations without requesting an authorization for such disclosures.

HIPAA's Federal Privacy Rule preempts the state law. If the state law, however, is more rigorous and provides more safeguards for the patient, the state privacy rule controls.[4] This means that to the extent that workers' compensation participants are excepted from the requirements of the Rule (as discussed below), and the Texas workers' compensation laws mandate that health information be protected, then such laws do not conflict with, and provide more protection than HIPAA, and these Texas laws are not preempted.

A. Texas Workers' Compensation Privacy Statutes and Federal Law:

We have seen above that to be covered directly by the HIPAA Privacy Rule, a workers' compensation participant would have to be a covered entity. A workers' compensation participant is not a healthcare clearinghouse or health care provider, but may be considered a health plan. However, a participant in the workers' compensation system is excepted from the definition

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1 Protected health information is defined under the Federal Privacy Rule to include health information that identifies or can be reasonably used to ascertain the identity of an individual that is maintained or transferred in written, electronic or any other form. 45 C.F.R. § 164.501.

2 *See id*. at § 160.103. The Privacy Rule defines a transaction as the transmission of information between two parties to carry out financial or administrative activities. *Id*. These transactions include transmissions in connection with health care claims, payment, enrollment, dis-enrollment, coordination of benefits, remittance advice, eligibility, health plan premium payments, first report of injury, and other transactions the Secretary of Health and Human Services prescribes by regulation. *Id*. These activities include claims processing, claims administration, data analysis, utilization review, quality assurance, benefit management, and any other similar activities covered by the Privacy Rule. *See id*.
Id. at § 160.203.

3 These activities include claims processing, claims administration, data analysis, utilization review, quality assurance, benefit management, and any other similar activities covered by the Privacy Rule. *See id*.

4 *Id*. at § 160.203.

of a health plan and is not defined as a covered entity.[5] So, the Privacy Rule does not apply directly to workers' compensation insurers, workers' compensation administrative agencies or employers when disclosing health information as required by state law for workers' compensation system purposes – such as to process or adjudicate claims or to coordinate care.[6]

In the author's opinion, the HIPAA Privacy Rule will continue to apply to group health insurers and their business associates acting as subclaimants within the system to the extent they are required to maintain PHI in the ordinary course of their business. *See* footnote 2. However, assuming these entities comply with existing federal law and regulation regarding the maintenance of PHI, the use of PHI in workers' compensation proceedings will be permitted.

While the Privacy Rule does not apply to certain types of insurance entities and workers' compensation participants;[7] insurers, who are covered entities, would be subject to the provisions of the Privacy Rule[8] with respect to all of the protected health information they provide and receive due to (a) the Privacy Rule applying to the insurer as a covered entity, and (b) the state workers' compensation confidentiality laws.

Although the TDI/DWC is not subject to the requirements of the Privacy Rule, the TDI/DWC is statutorily mandated to protect injured workers' medical information.[9] The DWC rules require the DWC to keep confidential an injured worker's claim file information, including information that could be used to identify an injured worker.[10] Information in, or derived from, a claim file regarding an employee is confidential, and may not be disclosed by the DWC except as permitted by law.[11] Confidential information that is related to a claim remains confidential when released to any person, except when used in court for the purposes of an appeal.[12] A person's failure to maintain confidentiality by knowingly, intentionally, or recklessly publishing, disclosing, or distributing information that is confidential to a person not authorized to receive such information will result in a Class A misdemeanor.[13]

B: Important changes implemented by HITECH

The implementation of HITECH ("Health Information Technology for Economic and Clinical Health Act") has significantly expanded HIPAA, extending PHI obligations and protections to business associates:

> ….the HITECH Act now directly regulates business associates of covered entities and has made business associates subject to and directly responsible for full compliance with the relevant requirements of the HIPAA and HITECH Act privacy and security regulations.

Brown, *THE IMPACT OF RECENT HEALTH CARE LAW DEVELOPMENTS, 2009 WL* 4023553, Aspatore (Nov. 2009).

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5 According to the Privacy Rule, a health plan's definition excludes any policy, plan, or program to the extent that it provides, or pays for the cost of, excepted benefits that are listed in 42 United States Code 300gg-91(c)(1). In other words, the Privacy Rule definition of health plan excludes certain entities that are described in the United States Code definition of "excepted benefits," which include workers' compensation or similar insurance. 42 U.S.C. 300gg-91(c)(1)(d)(excepting " Workers' compensation or similar insurance."). In addition, a covered entity may disclose protected health information as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without fault. 45 C.F.R. § 164.512 (2004).

6 Clarification on the HIPAA Privacy Rule and Disclosures to the Texas Workers' Compensation Commission, effective May 6, 2003, TWCC Advisory 2003-05.

7 *Id*. at § 160.103; see also, 64 Fed. Reg. 59932 (November 3, 1999).

8 For example, the Privacy Rule requires that in most cases only the minimum amount of information necessary be disclosed for each particular purpose. 45 C.F.R. § 164.514.

9 *Clarification on the HIPAA Privacy Rule and Disclosures to the Texas Workers' Compensation Commission, effective May 6, 2003*, TWCC Advisory 2003-05.

10 *See* Tex. Labor Code Ann. §§ 402.083- 402.092.

11 *See id*. at § 402.083.

12 *See id*. at § 402.086.

13 *See id*. at § 402.091.

Thus covered entities may also be vicariously liable if business associates (as defined by Federal law) of covered entities breach their duties to safeguard PHI.

C: Conclusion:

The Privacy Rule excludes most workers' compensation participants from its definition of a health plan. Consequently, a workers' compensation participant is not a covered entity and not directly covered by the requirements of the Privacy Rule. An exception is a health plan acting as subclaimant in a workers' compensation matter, which will be subject to the maintenance of PHI requirements, but excepted due to the permitted use of PHI for reimbursement.

A covered entity, including a healthcare insurer, may disclose PHI as necessary to comply with the workers' compensation laws.

In Texas the workers' compensation laws require that health information, whether in the possession of the TDI/DWC or others, remain confidential when being used for workers' compensation purposes. These state laws do not conflict with the Privacy Rule, due to the Privacy Rule exempting workers' compensation participants from having to comply with its requirements. All workers' compensation health information used, disclosed and maintained by any insurer should nonetheless remain confidential in compliance with Texas workers' compensation laws.

—Caldwell Fletcher

(The author acknowledges the significant contribution of Pati McCandless and Melissa Eason and their associates to this article)

Office of Injured Employee Counsel Legislative Recommendations Adopted into Law

Sunset Advisory Commission recommends the agency continue for at least six years

By Brian White

The Office of Injured Employee Counsel (OIEC) is the state agency which was established by the Texas Legislature to represent the interests of and provide assistance to injured employees in the Texas workers' compensation system. OIEC assists individuals with workers' compensation claims and advocates on behalf of injured employees as a class by carrying forward legislation that has a positive impact on injured employee workers' compensation benefits and on the system as a whole.

During the 82nd Legislative Session OIEC recommended nine pieces of legislation, five of which passed and became effective on September 1, the first day of the state's 2012 fiscal year. The following changes have taken place based on the passage of OIEC's legislative recommendations to the 82nd Texas Legislature:

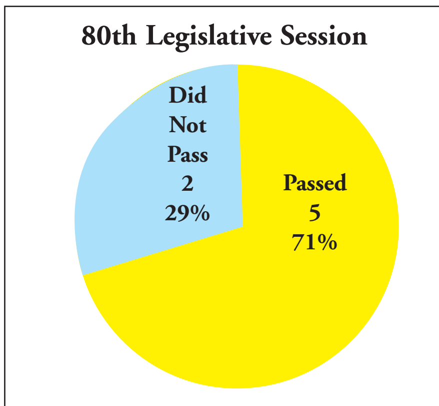
- Labor Code §§408.0041(f)(2), 408.0041(f)(3), and 408.0041(h): An injured employee will have the opportunity to seek the opinion of a treating doctor if not satisfied by the designated doctor's opinion regarding maximum medical improvement and impairment rating, and will require the insurance carrier to pay the cost of such examination;
- Insurance Code §1305.103(c): The Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) will be the appropriate venue for failure to provide information from the carrier or employer to the injured employee in Workers' Compensation Healthcare Network disputes;
- Labor Code §504.054: A medical benefit dispute involving a political subdivision is now adjudicated at DWC;
- Labor Code §404.252(d): A party will be allowed 45 days to appeal a medical dispute decision into district court, which is the same timeframe as an appeal of an indemnity dispute decision;
- Labor Code §404.106(a): OIEC will have the authority to seek and accept grant funding to enable the office to perform its duties; and
- Labor Code §404.101(b)(1): OIEC's Legislative Reports will be due on January 1 instead of December 1.

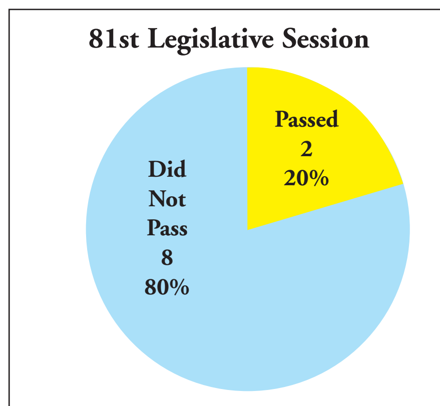
Since OIEC's creation in Fiscal Year 2006, the agency has obtained legislative sponsors for 100% of its proposed legislation. OIEC has made a total of 21 recommendations to the Texas Legislature for the benefit of injured employees and 13 of those recommendations have passed into law. Successful recommendations by the agency in past legislative sessions include:

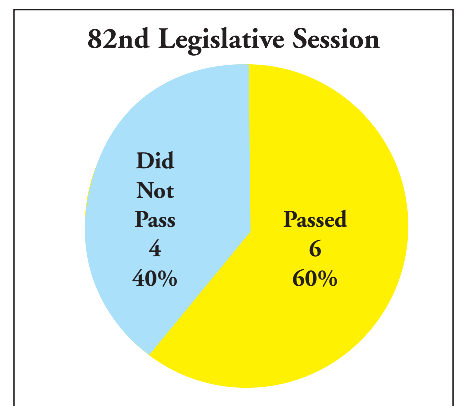
- *House Bill (HB) 886, 80th Session*: Guarantees that an approved small employer would be reimbursed for expenses incurred during modifications made by the employer to accommodate an injured employee's return to work.
- *HB 1003, 80th Session*: Requires that an independent review organization (IRO) that uses doctors to perform reviews of health care services may only use doctors licensed to practice in Texas and must be of the same specialty.
- *HB 1006, 80th Session*: Requires that Utilization Review Agents (URAs) and insurance carriers use doctors licensed to practice in Texas for performing a utilization review.
- *Senate Bill 1169, 80th Session*: Grants authority to a Benefit Review Officer to consider a request and issue an interlocutory order if determined to be appropriate.

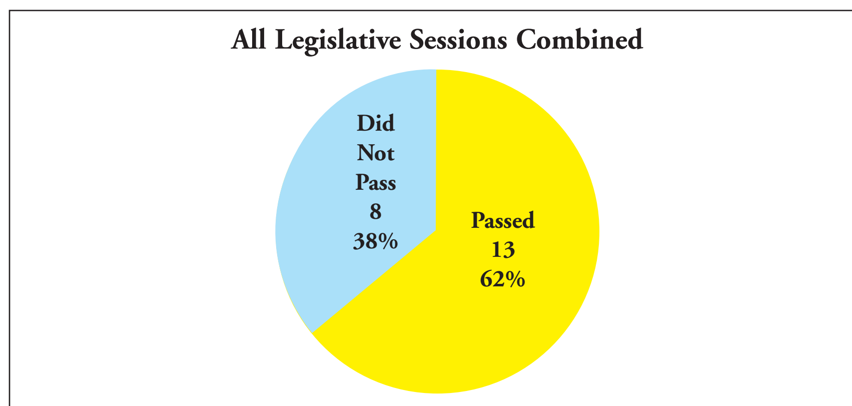
- *HB 888, 80th Session*: Requires a health care provider to provide copies of the injured employee's medical records to an OIEC Ombudsman at no cost.
- *HB 673, 81st Session*: Clarifies an injured employee's right to seek assistance with a dispute before SOAH; holds Ombudsman and injured employee communications confidential; changes the statutory authority to adopt OIEC's notice to injured employees' rights and responsibilities to the Public Counsel; gives OIEC the right to refuse service to threatening or abusive injured employees or injured employees pursuing a criminal act; and limits the agency from being able to access the regulator's attorney-work product to protect the integrity of the agency and the dispute resolution process.
- *HB 1058, 81st Session*: Prohibits total death benefit payments from exceeding 104 weeks regardless of the number of surviving eligible parents; provides that failure to timely file a claim bars the claim unless good cause exists; and redefines "eligible parent."

The following charts illustrate the percentage of OIEC recommendations that became law.









OIEC was also reviewed by the Sunset Advisory Commission during the 82nd Legislative Session. The Sunset Review process requires all state agencies to be evaluated periodically to determine if they should be continued, modified, or abolished. The recommendations that were adopted based on the Sunset Review include:

- Labor Code §404.003: Continues OIEC for six years;
- Labor Code §404.007: Requires the agency to develop and implement negotiated rulemaking and alternative dispute resolution policies and to maintain a system on handling complaints (Note: these were across-the-board recommendations for all agencies going through the Sunset process. OIEC sent draft policies to stakeholders and accepted comments during a period which ended on July 8. The new policies became effective on September 1.);
- Labor Code §410.023: Directs OIEC to work with TDI-DWC to ensure injured employees are fully prepared by Ombudsmen before attending a TDI-DWC Benefit Review Conference;
- Labor Code §402.082(b): Limits OIEC's authority to access claim files for injured employees that OIEC is not directly assisting; and
- Directs OIEC to work with TDI-DWC to complete firewalls in the new database system.

In addition to the eventful legislative session, this year marked OIEC's five year anniversary. The agency celebrated with an open house at OIEC's Central Office in Austin. Following a successful Sunset Review and first five years of operation, OIEC remains determined in its mission to assist, educate, and advocate on behalf of the injured employees of Texas. Should you need any assistance from the agency, please call 1-866-393-6432.

A LOOK BACK AT THE 2011 ADVANCED WORKERS' COMPENSATION SEMINAR

By Barbara Lombrano-Williamson

A cool glass of wine, a summer breeze and great company was a superb way to spend some of the dog days of August. Apparently, the fine workers' comp lawyers of Texas agree with me as the Advanced Workers' Compensation Seminar was once again a huge success. We had over 200 attorneys attendance. We can boast as being one of the few advanced seminars to not decease in attendance. This of course is due to the fine speakers which so generously give of their time.

This year's focus was placed on the practicality of topics in the workers' compensation arena. Topics ranged from a doctor explaining how to read MRIs and other medical evidence to updates in both Supreme Court decisions and Appeal Panel decisions. According to the State Bar the comments received show the seminar was resounding success.

Following the seminar on Thursday night was a social hour and Workers' Compensation Section meeting. A huge "Thank You" goes out to the sponsor of the social hour Work Loss Data Institute, publishers of Official Disability Guidelines. At the end of the meeting, the reins were turned over to our new section chair, Joe Anderson.

While August 2012, seems a long way away, planning is already getting started for next year's seminar. Sooo, leave time in your calendar to attend next year's seminar in August, date to be set, as our new Course Directors, Joe Anderson and Mike Sprain set the course for our next Advanced Worker's Compensation Seminar.

Eight Facts in Honor of the Workers' Comp Centennial (1911 – 2011)

1. Among the pioneers of workers' compensation were 18th century pirates, who offered compensation (paid in pieces of 8) to injured comrades that was based on the body parts affected. There was a limit, however, to the generosity of the "pirate comp" system – only pirates who survived their "work-related" injuries would receive payment; dead men tell no tales and, as it turns out, received no compensation.

2. In the early 1880s, Germany enacted workers' accident insurance (later, "workers' compensation"), which awarded benefits for work-related injuries regardless of fault. The program, along with other social insurance reforms, was supported by the regime (1871 – 1890) of Chancellor Otto von Bismarck. Germany's workers' compensation program was influential in the passage of later laws throughout Europe and the U.S.

3. Author Franz Kafka (1883 – 1924), known for surreal and nightmarish works such as "The Trial", "The Castle", and "The Metamorphosis," worked in Prague as a lawyer for the Workers' Accident Insurance Institute, the state-run workers' compensation insurance carrier for the Kingdom of Bohemia.

4. In its much-maligned decision in Ives. v. S. Buffalo Railway Co., 201 NY 271, 94 NE 431 (NY 1911), the New York Court of Appeals struck down as "plainly revolutionary" a state law requiring workers' compensation coverage for extrahazardous occupations. Within a day of the Ives decision, 146 garment workers, mainly female immigrants from southern and eastern Europe, perished in a fire at the cramped Triangle Shirtwaist Factory in New York City's Greenwich Village section. The "Triangle Fire" is considered to be a turning point in U.S. labor history, particularly in the area of workplace safety.

5. We celebrate the workers' compensation centennial in 2011 in commemoration of Wisconsin's 1911 Act. Wisconsin was the first U.S. state to pass a workers' compensation law found to be constitutional by the courts. The law was signed by Governor Francis McGovern on May 3, 1911 and largely went into effect on September 1st of that year. After Wisconsin's success, workers' comp laws spread rapidly throughout the U.S. and, by the end of 1911, nine states had passed workers' compensation laws.

6. Workers' compensation as an alternative to the fault-based negligence liability system in the U.S. was largely embraced by the three key interest groups involved - labor, business, and insurance companies. In fact, support for workers' compensation laws was found in the platforms of all three major U.S. political parties (Democratic, Republican, and Progressive) in the election of 1912.

7. The last U.S. state to pass workers' compensation into law was Mississippi in 1948.

8. Texas passed its first workers' compensation act, the Texas Workmen's Compensation Act, in 1913. "New law" reforms were passed in 1989 and went into effect for dates of injury on and after January 1, 1991. Texas remains the only U.S. state that allows most employers the option of not subscribing to workers' compensation coverage.

IMPORTANT WORKERS' COMPENSATION WEBSITES AND LINKS

Texas Department of Insurance (note the change in the domain to .gov. All state agencies will be making this change.)
http://www.tdi.texas.gov/

TDI-Division of Workers' Compensation
http://www.tdi.texas.gov/wc/index.html

Administrative decisions including AP decisions and medical contested case decisions
http://www.tdi.texas.gov/wc/admindecisions.html

Advisories and bulletins
http://www.tdi.texas.gov/wc/news/advisories/index.html

Appeals Panel Decision Manuel
http://www.tdi.texas.gov/wc/idr/apdmtoc.html

Medical Contested Case Hearing Manuel
http://www.tdi.texas.gov/wc/idr/mddmtoc.html

Medical Fee Dispute Resolution
http://www.tdi.texas.gov/wc/mfdr/

Workers' compensation forms
http://www.tdi.texas.gov/forms/form20.html

Requests for a Letter of Clarification (LOC) of a Designated Doctor's Report
http://www.tdi.texas.gov/wc/loc/index.html

SIBs Work Requirements per County
http://www.tdi.texas.gov/wc/employee/sibs.html

Carrier's Interrogatories to Claimant
http://www.tdi.texas.gov/wc/rules/documents/car_interr_cla.pdf

Claimant's Interrogatories to Carrier
http://www.tdi.texas.gov/wc/rules/documents/cla_interr_car.pdf

Proposed Rules
http://www.tdi.texas.gov/wc/rules/proposedrules/index.html

Informal Working Drafts
http://www.tdi.texas.gov/wc/rules/drafts.html

TxComp
https://txcomp.tdi.state.tx.us/twccprovidersolution/homehtml

TDI Search for Company's Attorney for Service
https://wwwapps.tdi.state.tx.us/inter/perlroot/consumer/attorney/attorney.html

Information on Networks
http://www.tdi.texas.gov/wc/wcnet/indexinjured.html

Texas Board of Legal Specialization
http://www.tbls.org/Default.aspx

Rule book supplements
http://www.tdi.texas.gov/wc/rules/supplements.html

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Appeals Panel Decisions Update
(July 05, 2011 – October 25, 2011)
http://www.tdi.texas.gov/appeals/2011cases

110622 – Disability, extent, hearing officer exceeded her authority

110624 – 10-day letter sent to wrong address, HO to find if good cause to redo CCH

110670 – MMI/impairment rating/disability, remanded after finding of MMI date for HO to send LOC to Designated Doctor to determine impairment rating.

110687 – Designated Doctor and disqualifying association

110692 – MMI date and overpayment of TIBs

110701 – extent of injury; attenuation factor

110703 – clerical error or inconsistent finding

110706 – extent of injury

110719 – extent of injury without attendant explanation

110741 – MMI/impairment rating, no provision in the Act or Rules that adopts the AMA Guides Casebook

110854 – have to know extent of injury before can determine impairment rating.

110871 – LOC appropriately not sent; unclear which impairment rating the hearing officer chose

110878 – AWW with multiple employers; claimant's evidence did not comply with the statutory requirements of Section 408.042 and Rule 122.5

110896 – Designated Doctor did not properly apply definition of MMI

110903 – Issue of finality of impairment rating needed before can determine if designated doctor should have been appointed.

110911 – 90-day rule, claimant's testimony did not constitute an acknowledged receipt to begin the 90-day period

111006-s addresses important requirements for disputing a first valid MMI/IR certification. Essentially it says, "The Division's preamble to Rule 141.1 states that only after a complete request is submitted, approved, and a BRC scheduled has a party established a dispute of the first valid certification of MMI and/or IR, effective the date the party filed the request, in accordance with Section 408.123(e)."

111095 – The hearing officer erred in the addition of an issue that had not been raised as an issue at the BRC nor reported by the benefit review officer in the BRC report

111136 – Doctor's narrative insufficient for SIBs entitlement

111169 – The Individual Plan for Employment was not in effect for each week of the SIBs qualifying period.

111177 – The Designated Doctor and RME impairment ratings were invalid because they did not certify an MMI date or assign an IR based on the entire compensable injury.

111188 – For SIBs, a narrative report from a doctor which specifically explains how the injury causes a total inability to work must come from one doctor.

111189-s The hearing officer found the carrier received the DWC-52 (for the second quarter) on April 1, 2011. A Request for a BRC (DWC-45) from the carrier was with the Division on April 11, 2011. The Division denied the DWC-45 requested by the carrier on April 13, 2011. The denial noted all claim information was not provided in Section II. Although a DWC-45 was filed on April 11, 2011, it was incomplete and was denied and therefore, did not constitute a dispute proceeding. The AP noted the carrier did not request an expedited CCH under Rule 141.1(g). Since the DWC-45 was denied and a complete DWC-45 was not filed within 10 days after receiving the application for SIBs, the hearing officer erred in deciding the carrier did not waive the right to contest the claimant's entitlement to SIBs for the second quarter by failing to timely request a BRC.

111191 – On extent of injury, the hearing officer included the "and/or" language in the conclusion. The Appeals Panel reversed and rendered to "and" based upon how the rest of the decision was written. On bona fide offer of employment, because the duties assigned to the claimant exceeded the restrictions of the DWC-73 the self-insured did not make a bona fide offer of employment.

111227 – The failure to rate the entire compensable injury constitutes compelling medical evidence of a significant error by the certifying doctor in applying the appropriate AMA Guides or in calculating the impairment rating.

111238 – Follows the holding in 111189-s for SIBs

111244 – Designated Doctor did not certify the entire injury

"ONLY IN THE WC"

With reverence to Judge Buckmeyer, this section will be about those times we can laugh at ourselves (and others) while doing our best to represent our clients and apply the Act and rules the best we can. If you have a story you want to share, please send it to Ken Wrobel at **ken.wrobel@tsi.state.tx.us**.

From Ellen Vannah, Hearing Officer in Beaumont:

The injured employee had failed his post-injury drug test, so the carrier was disputing compensability of the injury on the basis of intoxication, and was relying on the drug test to rebut the presumption of sobriety and to require the claimant to prove that he was not intoxicated at the time of the injury. The injured employee's position was that the carrier had not adequately raised the intoxication defense, and that he therefore bore no burden of proof, because the specimen that was tested could not possibly have been his specimen, since it **did not** test positive for the drugs he was **really using** at the time!

Another from Ellen Vannah:

The injured employee was a seriously smart computer systems type in his 60's, which made the whole exchange all the stranger/funnier.

> Claimant's attorney: . . . Why did you use marijuana?
>
> Claimant: Actually, I believe that was a secondhand experience. That is to say that I didn't necessarily – I didn't go out and buy any and do that – I was just at a party where either the cookies or the smoking was a secondhand exposure – if you look at the dosage [on the test result] it's pretty low.
>
> Claimant's attorney: Ok, so you believe that at a social occasion, you inhaled somebody else's marijuana?
>
> Claimant: Yes.
>
> Claimant's attorney (sounding slightly incredulous): What kind of social occasions do you go to?
> (laughter erupted from all in attendance!)

This from Patrice Squirewell-Jean, a hearing officer in Houston

The issue was SIBs, and the claimant had sustained a compensable physical injury. He also had a significant mental condition, but I can't recall whether it was part of the compensable injury. On direct examination, his attorney asked him about his course of treatment, which the claimant could recall included surgery, physical therapy and a chronic pain management program. I got the picture — I knew it was a serious injury because it was undisputed that his IR was 15% or greater — but still, the claimant's attorney continued to the point of redundancy in asking the claimant if there was any other treatment he'd been provided for the injury. After stating the above treatments, the claimant could not recall anything else, but alas, after being pressed by his attorney one more time, the claimant stated as he looked up at the ceiling as though it had just come to him: "That's right...I think my doctor wants me to be electrocuted. In fact, I think I'm supposed to *be electrocuted* next week."

Finally, from Ken Wrobel, a hearing officer in Fort Worth:

The video surveillance showed the claimant outside a mom and pop store with a cigarette in one hand and an ice cream cone in the other. The video then showed the claimant smoking that cigarette and then licking his ice cream cone. I asked the claimant if that was him smoking a cigarette and then licking on an ice cream cone. He said, "Yes, sir." I said in disdain, "Ewwww. There's a reason they don't make nicotine flavored ice cream." And a good laugh was had by all in an otherwise sorely contested case hearing.

Community News

John Howie Award

Kay Goggin and her client, Von Phathong, were presented the Dallas Trial Lawyer Association's "John Howie Award" which is awarded annually to a DTLA member and his or her clients for "the courageous pursuit of justice in the face of adversity" in a particular case. The late John Howie was such an inspiration to DTLA members and a true champion of fighting the good fight. From DTLA: "The "pursuit of justice in the face of adversity" need not necessarily have resulted in a favorable outcome because the award honors the courageous pursuit of justice. Some fights just have to be fought, regardless of the probable or eventual outcome." Von Phathong filed for judicial review after DWC determined that his oil-rig compensable accident did not extend to and include a neck injury. A Dallas County jury in February reversed the DWC and now Von is receiving full workers compensation benefits for his on the job injury.

Law Firm of Harris and Harris

Alisha Darden (formerly a hearing officer in the Fort Worth field office), **Roy Horton, Abby Lee** and **James Howard** have joined the law firm of Harris and Harris.

White Espey, PLLC

Timothy White, Camille Espey, and **Katie Sacra** went on their own and started White Espey, PLLC. They handle workers' compensation and employment law defense.

WORK COMP SECTION WEBSITE

How many of you knew we have a website?

Well, here's the link: **http://www.texasworkerscompensationsection.com/index.php**. It's kinda sad really. Especially for such a vibrant, energetic, passionate group like ours. We need someone to step up and mold, massage and manipulate this into a website that is representative of a conglomeration of such a great-looking, inspirational folk like us. What's great is you don't even have to be a techie – the State Bar has people like that. All you need to do is read stuff, look at stuff, and decide on stuff you think should be stuffed onto our website. And you don't have to do it alone – get your best friend or worst enemy to nurture our website and watch it grow under your SIMs green thumb. Contact Joe Anderson. He'll introduce you to the knowledgeable people at the State Bar who will make you look great as editor of the section website. Thanks.

Congratulations!

3rd Annual Advanced Workers' Compensation Golf Tournament

This year's pre-seminar golf event was a great success despite the heat. Although the number of participants was down from last year, the average donations and sponsorships increased substantially. Due to the generous contribution from players, volunteers, and sponsors, the Workers' Compensation Section will be donating over $4,000 towards the following charities:

- American Heart Association in memory of W.J. "Bill" Morris
- Town Lake Animal Shelter in memory of Madeline Anderson
- Aplastic Anemia & MDS Intl. Foundation benefiting Matthew Lee Sprain
- Dallas Intergroup Association in memory of Robert Rogers
- East 19th Street Baptist Church in memory of Joe Phillips

Congratulation needs to be given to this year's awards winners:

1st Place Team
Darryl Silvera
Matt Lewis
Steven Stamps
Dave Joeckel

2nd Place Team
Avery Bingston
Bradley Bingston
Brad McClelland

3rd Place Team
J.A. Davis
Mike Doyle
Chad Lee
Scott Wiedeback

Closest to the Pin
Chad Lee (twice)
Bradley Bingston

Long Drive
Kevin McGillicuddy

Finally, special recognition needs to be given to those that made substantial donations to this year's event. Lynette Phillips received an outstanding donor award for her generous contribution. A special Lifetime Donor award was created to recognize the remarkable donations given by Larry Trimble and James Grantham over the last 3 years.

If you are interested in playing, donating, sponsoring, or volunteering at next year's event, look for the registration form on the Advanced Workers' Compensation Seminar brochure or email Kyle Morris at **kyle.morris@wjbillmorris.com**.