House Bill 2600 Makes Waves

Every legislative session, one or two bills attract the focused attention of participants in the workers’ compensation system. This session, it is HB 2600, and it proposes more changes to workers compensation than any bill considered by the legislature since 1989. Rep. Kim Brimer, Chairman of the House Business & Industries Committee, is the sponsor of this comprehensive bill. It was favorably reported by the House B&I Committee on Tuesday, April 3.

HB 2600 establishes a medical network of providers, directs the TWCC to adopt Medicare reimbursement rules, abolishes the current second opinion for spinal surgery, changes carriers rights to required medical examinations, changes trial of disputes by requiring designated doctor exams for many issues, provides for significant physician disclosure, requires payment of claimants attorneys fees when the carrier appeals to judicial review, enlarges LIBs entitlement, and provides for “stacking” of wages for multiple employments.

A committee substitute has already been drafted incorporating changes based upon discussions of industry groups. In spite of the sweeping changes that it proposes, the bill is on a fast track and stands an excellent chance of favorable consideration if industry groups sustain a consensus. A brief article-by-article summary follows. The full current version of the committee substitute can be located on our web site in the Resource Center under “HB 2600.”

House Bill 2600 is divided into ten sections, each of which has a specific area of concern and proposed solution. (See An Analysis of HB 2600) Because HB 2600 has such a strong sponsorship, it has become the refuge for bills having less political support. Separate bills providing for lifetime income benefits, claimant’s attorneys fees, and stacking of wages for multiple employments have been folded into HB 2600.

The deadline for filing any new, non-emergency, legislation has expired. The focus throughout the remainder of the session will be on the committee process and final floor action. The 77th Texas Legislature adjourns May 28, 2001.

Non-subscriber Waivers Ruled Valid
Senate Bill Would Reverse Court’s Ruling

The Texas Supreme Court, in a 6-2 ruling, has cleared the way for employers to avoid the workers’ compensation system while insulating themselves from lawsuits by injured employees. The decision may be remembered as the spark that lit the Legislature’s fuse on workers’ compensation issues this session. The court’s ruling drew outrage from veteran legislators.

Leading Republican lawmakers joined organized labor in criticizing the ruling, saying it encourages employers to leave the workers’ compensation system—where the rates that employers pay already are on the rise. That would leave thousands of workers without coverage and with little recourse if they get hurt on the job.

The majority ruling, written by Justice Harriet O’Neill, said the Legislature has never specifically barred employers who don’t carry the insurance from asking employees to sign waivers giving up their right to sue in exchange for other benefits if they are hurt or killed. Whether such waivers should be barred, the court said, is a question “best resolved by the Legislature, not the judiciary.”

Justice James Baker, joined by Chief Justice Tom Phillips, wrote in the dissent that it was clear the

continued on p. 27
Governor Appoints Defense Lawyer to Supreme Court

Gov. Rick Perry has nominated Wallace Jefferson, a San Antonio insurance defense lawyer and appellate specialist, to the Texas Supreme Court. The Texas Senate still must confirm him. Jefferson fills a slot left open by Alberto “Al” Gonzales, who left the bench in January for a job as White House counsel to President George W. Bush.

In remarks accepting the nomination, Mr. Jefferson declined to classify himself as a moderate or a conservative. “It’s not a judge’s role to make law but to interpret it,” Jefferson said. “If that’s the way you use that term [strict constructionist], that’s what I am.”

A 1988 graduate of the University of Texas School of Law, Mr. Jefferson will be the first African-American member of the Texas Supreme Court. He worked at San Antonio’s Groce, Locke & Hebdon prior to starting his own firm in 1991. He is board-certified in appellate law.

Mr. Jefferson comes to the court with a solid appellate pedigree. A founding member of San Antonio’s Crofts, Callaway & Jefferson, he joins Priscilla Owen as the only current justice who arrived at the court straight from a private practice.

Like Mr. Gonzales, who never served as a judge prior to his appointment by then-Gov. Bush, Mr. Jefferson brings the point of view of a practitioner to the court, Supreme Court Justice Greg Abbott said. “He brings to the court probably more appellate experience than anyone else I’ve seen from the lawyer perspective,” Justice Abbott said. “Although those who have come to the court from the trial court or the court of appeals have a lot of experience, I don’t think there’s anyone on our court who has gone before the U.S. Supreme Court.”

Mr. Jefferson made a name for himself in the appellate world following his 1998 U.S. Supreme Court victory in Gebser v. Lago Vista Independent School District, a 5-4 decision that kept school districts from being held liable for teacher-student harassment when school authorities don’t know of an alleged incident.

In 1997, Mr. Jefferson won a reversal before the high court in another 5-4 decision in Bryan County v. Jill Brown, in which he successfully argued that the county was not responsible for the alleged violent conduct of a deputy just because it did not adequately check his record.

If confirmed, Mr. Jefferson will serve until 2002. He intends to run in that year’s general election.
Ergonomic Rule Repealed
Businesses claim rule was too costly

In a swift victory for many U.S. businesses, President Bush this month signed a repeal of the OSHA ergonomic rule issued late in the Clinton administration. Unions and public-health advocates said the overturned rule would have reduced painful and debilitating repetitive motion injuries for millions of American workers. Business groups said the rules were needlessly costly and burdensome. The White House said the rule would have offered “uncertain benefits” and “cost both large and small employers billions of dollars and presented employers with overwhelming compliance challenges.”

The repeal throws rule proponents into disarray. Mr. Bush said his administration will revisit the issue, but the repeal casts doubt on the Department of Labor’s latitude in issuing revised rules. Experts on both sides of the debate acknowledge a potential for common ground, but few predict rapid compromise.

“We really don’t know what room there is because right now everybody is so angry and so mad at what has happened,” Mohammad Akhter, Executive Director of the American Public Health Association told reporters. “The labor unions and the medical community are up in arms and somewhat shocked at the speed and the way in which things were done.”

Republican congressional leaders used a previously untested legislative procedure to repeal the regulations, which had been set in motion a decade ago when Republican Elizabeth Dole was Labor secretary. The Congressional Review Act gives Congress 60 days to kill final regulations and precludes federal agencies from reissuing substantially similar rules.

Labor Secretary Elaine L. Chao said she would consider issuing new ergonomics rules, likely to be less far-reaching and expensive than the Clinton rules. Ms. Chao could face resistance from business lobbyists who oppose any mandates, although some corporate groups say they could go along with limited ones.

Nevertheless, union officials say they are sure that many business groups will fight to kill new ergonomics rules that contain any mandates or teeth. “They will oppose any meaningful regulation,” said Peg Seminario, the A.F.L.-C.I.O. Director of Occupational Safety. “They have opposed every regulatory initiative on ergonomics for the past 10 years, and I don’t see them suddenly changing now.”

Wrong-Site Surgery
Prevention Studied

Hundreds of cases of wrong-site surgery occur in the United States each year. There were 28 cases in New York State alone last year, up from 20 cases in 1999, according to that state’s Department of Health. In many cases, the surgeon is punished, either by losing his license or the right to practice in the hospital where the error occurred.

However, the New York Times notes that wrong-site surgery is rarely the fault of a single person. By the time the wrong body part is actually removed, several factors have almost certainly come into play, ranging from a series of small but crucial mistakes by several people who dealt with the patient, to flaws in a hospital’s operating procedures, to the very culture of American medicine.

Dr. Elise Becher, an assistant professor of pediatrics and health policy at Mount Sinai School of Medicine, divides the conditions that lead to wrong-site surgery into two categories, “environmental” and “latent.” Latent conditions, she explains, are holes in presurgical procedures and problems with the way staff members communicate during an operation. For instance, a set number of people should be required to verify that the correct limb, and yes, the correct patient, have been prepared for surgery.

In a study of 15 wrong-site surgery cases, the Joint Commission on Accreditation of Healthcare Organizations, a national group, found several common factors, including the involvement of more than one surgeon, the performance of several different procedures during one surgery and pressure from hospital administrators on surgical teams to speed things up.

Besides reforming the culture of medicine, what can be done to continued on p. 27
New Classification System Impacts Statistics – Part 3

The Texas Workforce Commission has published a report that outlines a uniform system of industry classifications. The new industry standard will apply across North America. It is designed to permit a more accurate analysis of job classifications. In a three part-series, FOLIO describes the new classification system. This month, in the final installment of this series, we conclude our examination of the major classification changes by sector.

Many of the new classification sectors reflect recognizable parts of SIC divisions. Conversely, the SIC Division for Service industries has been subdivided to form several new sectors. Other sectors represent combinations of pieces from more than one SIC division. Professional, Scientific, and Technical Services

Those businesses whose major input is human capital are grouped together in this new Sector. The industries within this Sector are each defined by the expertise and training of the service provider. The Sector includes such industries as offices of lawyers, engineering services, architectural services, veterinary services, advertising services, and interior design services.

Health and Social Assistance

Nine new service sectors and 250 new service industries are recognized in the U.S. NAICS system. The new Health and Social Assistance Sector recognizes that it is sometimes difficult to distinguish between the boundaries of health care and social assistance. These industries are grouped in order from those providing the most intensive type of health care to those providing minimal health care with social assistance to those providing only social assistance. Some of the new industries include HMO medical centers, family planning centers, blood and organ banks, diagnostic imaging centers, continuing care retirement communities, and community food services. The Sector also includes ambulance services which was transferred from the Transportation, Communications, and Public Utilities Division under the SIC system.

Auxiliary Establishments

Auxiliary establishments are those establishments that primarily produce support services for other establishments of the enterprise. Generally, these support services are not intended for use outside of the enterprise. In the SIC system, these separate service establishments were classified according to the primary activity of the establishments they served. NAICS classifies auxiliary establishments based on what they do, not on whom they serve. This would mean that a warehousing facility of a large manufacturing establishment would be classified under warehousing, not under manufacturing. While the new NAICS system provides a more precise depiction of the U.S. economy, it will also mean that data users will be confronted with time-series breaks and new data products. The Texas Workforce Commission will continue to provide assistance in interpreting the data and will make efforts to educate users about NAICS, its benefits, implementation schedule, and any future changes to the system.

Unemployment Rate Drops

Texas’ seasonally adjusted unemployment rate decreased to 3.7 percent in February, according to figures released in March by the Texas Workforce Commission.

February marks the third month in a row that the state’s unemployment rate has stayed under 4 percent, which has not occurred since 1974. Over the past year, the state agency reports that Texas’ unemployment rate has dropped by eight-tenths of a percentage point and has been lower than the national rate for three months running.

A breakdown of the jobs report shows that nonagricultural employment increased by some 33,200 jobs during February, including 5,200 construction jobs and 8,800 retail jobs.

Among metropolitan statistical areas, the lowest unemployment rate was in Bryan-College Station (1.4 percent); followed by Austin-San Marcos, at 2.2 percent. The highest unemployment rates were in McAllen-Edinburg-Mission, 12.7 percent; and Brownsville-Harlingen, 7.7 percent.
The United States Supreme Court decided a case this month that strengthens the ability of employers to enforce arbitration agreements in employment discrimination cases. The decision in Circuit City v. Adams, No. 99-1379, will affect workplace relationships as well as civil rights class actions against employers.

By a 5-4 vote, the court said that the Federal Arbitration Act requires enforcement of arbitration agreements in all employment categories except for a narrow class of seamen and other transportation workers exempted by the law in 1925. Employee and civil rights groups, as well as several states, had sought a broader definition of that exception that would have allowed any workers involved in interstate commerce to circumvent arbitration and pursue employment claims in court. According to the briefs in the case, eleven other federal appeals courts had interpreted the exception narrowly, but the U.S. Court of Appeals for the 9th Circuit disagreed, ruling the other way in the Circuit City case.

In the case before the court, Circuit City employee Saint Clair Adams signed an arbitration agreement when he joined the company in 1995. Nevertheless, after he resigned in 1996 Mr. Adams went to California state court to sue the company for employment discrimination and wrongful discharge. Circuit City fought the case, arguing that it was foreclosed by the arbitration agreement. The 9th Circuit sided with Mr. Adams, ruling that the exception in the arbitration law covered his dispute with the company, thereby allowing him to file suit.

As it reached the high court, the case took on major significance as a test of the scope of arbitration agreements, in use in an increasing number of workplaces. Employers favor arbitration’s efficiency and generally lower cost in resolving workplace disputes.

The Circuit City case was also cast as a federalism case, testing whether federal arbitration law preempted state court remedies. However, the justices who usually side with the states in federalism disputes embraced a broader view of federal power in the Circuit City case.

Justice Anthony Kennedy, writing for the majority, said a long line of precedents dictated the outcome, as well as the necessity for a consistent rule nationwide. Allowing litigation to overcome arbitration agreements, Justice Kennedy said, would introduce “considerable complexity and uncertainty . . . into the enforceability of arbitration agreements in employment contracts [and] would call into doubt the efficacy of alternative dispute resolution procedures adopted by many of the Nation’s employers.”

Chief Justice William Rehnquist and Justices Sandra Day O’Connor, Antonin Scalia and Clarence Thomas joined Justice Kennedy.

Justice John Paul Stevens dissented, arguing that Congress plainly did not intend for the arbitration law to cover employment contracts. “There is little doubt that the Court’s interpretation of the Act has given it a scope far beyond the expectations of the Congress that enacted it.” Also dissenting were Justices David Souter, Ruth Bader Ginsburg and Stephen Breyer.

Interest Rate Declines

The Commission has announced that the second quarter interest and discount rate will be 7.74 percent. The rate will be effective on all payments made between April 1, 2001 and June 30, 2001.

The rate dropped dramatically from the first quarter rate of 9.21 percent. The rate was computed by taking the auction rate quoted at a discount basis for 52-week treasury bills on February 27, 2001 (4.24 percent) plus 3.5 percent as required by Labor Code 401.023.
Section 408.203(b) of the Texas Labor Code defines when a child support lien must be paid “as required by law.” This section refers to Orders of Withholding under Subchapter A, Chapter 158, Family Code and a Writ of Withholding under Subchapter D, Chapter 158, Family Code. There are also Administrative Writs of Withholding under Subchapter F, Chapter 158, Family Code which are considered “non-judicial writs.” The question arises as to whether these Administrative Writs of Withholding are enforceable pursuant to Section 408.203(b) of the Labor Code, since these writs are administrative, not judicial.

In the situation of an Administrative Writ of Withholding issued against the wages of an injured worker who had a compensable death, the Appeals Panel in AP 002112 has approved of the argument that this Administrative Writ of Withholding is a non-judicial writ that was not enforceable against the death benefits owed to the beneficiaries.

However, when the question is whether these administrative writs are enforceable against an injured worker’s workers’ compensation income benefits, the answer is “yes.” Pursuant to Section 101.012 of the Family Code, the carrier is defined as the claimant’s “employer” for purposes of these writs and orders. Certainly the Workers’ Compensation Act appears, on its face, to limit the liens to those orders or writs issued pursuant to Subchapters A and D, Chapter 158, Family Code.

Subchapter A, Chapter 158, Family Code deals with when income withholding is required. Under Subchapter A, Section 158.001 states: “In a proceeding in which periodic payments of child support are ordered, modified, or enforced, the court or the Title IV-D agency shall order that income be withheld from the disposable earnings of the obligor as provided by this chapter.” (Emphasis added). As a result of this language, Subchapter F, referring to Administrative Writs of Withholding, is probably incorporated into Subchapter A through language contained in Section 158.001.

The effect of this incorporation is that Administrative Writs of Withholding issued pursuant to Subchapter F would be enforceable against the injured workers’ income benefits, just as the Orders of Withholding under Subchapter A and the Writs of Withholding under Subchapter D are enforceable. Although Texas Labor Code Section 408.203(b) does not specifically refer to writs issued under Subchapter F, Chapter 158, Family Code, Subchapter F is incorporated by the language contained in the Subchapter A Section 158.001.

So, if you receive any sort of Order of Withholding, Writ of Withholding, or Administrative Writ of Withholding issued pursuant to Subchapters A, D or F, Chapter 158, Family Code, these liens are enforceable and must be paid as indicated in Section 408.203(b) of the Texas Labor Code. If the carrier fails to follow such an order that it was otherwise required to pay, the carrier would be required to pay the beneficiary of the writ or order the amount that should have been paid, with no apparent credit against other income benefits. Accordingly, failure to obey an order or administrative writ subjects the carriers to a double payment liability. While an administrative fine under the Workers’ Compensation Act is unlikely, this could be a substantial penalty for non-compliance. Additionally, the carrier is required to pay attorney fees, court costs, and a fine of up to $200.00 for each occurrence for a knowing violation.
Offender Information Available by Telephone

The Texas Department of Criminal Justice can run a status search on an offender currently incarcerated or on parole within the TDCJ system. Currently, this information is not online but TDCJ is investigating making this information available on the TDCJ website.

To find out an offender’s status you may call the following numbers.

**Offender Status Line**
800-535-0283 (toll free only for calls made from within Texas)

**Offender Status Line—Austin**
512-406-5202

**Offender Status Line—Huntsville**
936-437-6371

You will need to know the offender’s 6-digit TDCJ number or their full name, date of birth (or approximate age), and county of conviction.

Inquiries concerning previous convictions and sex offender registration should be directed to the Texas Department of Public Safety (main headquarters: 5805 North Lamar, Austin, TX 78752 telephone (512) 424-2000). The DPS website is located at http://txdps.state.tx.us/

If you are unable to use the Offender Status Line you may e-mail the TDCJ webmaster at webmaster@tdcj.state.tx.us and make sure to provide the offender’s 6-digit TDCJ number or their full name, date of birth (or approximate age), and county of conviction. Please state if your questions are parole-related. Do not use the Feedback Form for offender questions.

Texas soon will move into the ranks of states providing physician profile information to consumers as a result of action by the 76th Legislature. HB 110, sponsored by Rep. Glen Maxey of Austin, requires the Board to gather and make public certain information about physicians.

The bill became effective September 1, 1999, and requires the data to be available to the public by September 1, 2001. During that period, the Board must gather the additional data and develop the technology to make the information available via the Internet as well as on paper. Data will be gathered as part of the renewal process over the next year.

A pilot project will begin with renewal forms to be mailed September 1, 2001. Renewal forms will request new profile information in addition to the mandatory information now required. Provision of the additional data will be optional until September 2001, when the program becomes fully operational and compliance is mandatory. After that date, failure to return the completed form to the Board will be considered non-compliance, resulting in non-renewal of the physician’s license.

Rules were adopted by the Board effective March 5, specifying the information to be collected from physicians and provided to the public. The list includes name, date and place of birth, gender, ethnic origin, name of medical school(s) and date of graduation, a full description of graduate medical education, any specialty certification, number of years in practice, date of Texas licensure and expiration date, CME information, disciplinary history and other information designated by HB 110. Physicians may also provide brief descriptions of a maximum of five awards, honors, publications or academic appointments. A complete list of the requirements can be viewed on the Board’s web site (www.tsbme.state.tx.us, click on the Board Rules, then Chapter 173, Physician Profiles).

A Profile Update and Correction Form is being developed for physicians to revise and update their data. Physicians will have opportunities to correct or dispute information in their Profile before it is published.

HB 110 also allows the Board to raise licensure fees to fund the profile program by no more than $20 for each fiscal year in the 2000-2001 biennium and $10 each fiscal year in the 2002-2003 biennium. There will be a further reduction in fees within two years of full program implementation.

HB 110 also required other Texas health licensing boards to develop cost estimates to establish a profile program for their licensees. Agencies required to submit cost estimates by January 1 were the Texas Board of Chiropractic Examiners, State Board of Dental Examiners, Texas Board of Occupational Therapy Examiners, Texas Optometry Board, Texas State Board of Pharmacy, Texas Board of Physical Therapy Examiners, Texas State Board of Podiatric Medical Examiners, and Texas State Board of Examiners of Psychologists.

At least 10 other states now have legislation requiring development of physician profiles, following the lead of Massachusetts, which began providing physician profiles in 1996. Massachusetts has offered the information via the Internet since 1997.
An Analysis of HB 2600

House Bill 2600 is divided into ten different articles, each of which proposes a major substantive revision to the Workers’ Compensation Act. **Article 1.** Amends the approved doctors’ list by adding a registration requirement. Unless the healthcare provider is registered, he or she cannot perform services as a treating doctor, RME doctor, peer review, or utilization review doctor. TWCC may sanction a doctor or utilization review agent, including but not limited to deletion from the list of approved doctors, thereby effectively barring the doctor from a workers’ compensation practice. This may be based upon a single determination of misconduct (an evaluation or impairment that is not fair and reasonable). The TWCC is permitted to establish a medical quality review panel of healthcare providers as “an advisory body” to the medical advisor. They would be independent of the Medical Advisory Committee and the Network Advisory Committee established in Article 2, and would act as a peer review panel recommending sanctions for physicians including removal from the approved doctor list or designated doctor list.  

**Article 2.** Establishes a nine member Health Care Network Advisory Committee. This committee will consist of employee representatives, public and private sector employers, the Fund, TWCC’s Medical Advisor, and representatives from state agencies. The HCNAC will contract with outside organizations to develop workers’ compensation healthcare delivery networks. The networks must comply with Article 3.70-3C Insurance Code having to do with minimum standards for reasonable healthcare delivery networks. The committee may recommend additional standards having to do with twelve different criteria. The HCNAC and ROC will develop evaluation standards and produce a report card addressing things like employee access, return to work outcomes, appropriate clinical care, etc. Insurance carriers will have reasonable rights to conduct audits of the network. The cost of establishing the network, up to $1.5 million, will be assessed against the Subsequent Injury Find.

Insurance carrier participation in the network is voluntary. An insurance carrier may limit its election to participate in a network to a particular employer or particular region. Public employers must participate.

**Article 3.** Encourages modified duty. It requires the employer to notify the employee of modified duty availability upon written request by the employee, a doctor, or TWCC. If modified duty exists, the employer must identify a contact person and provide information to the treating doctor to facilitate return to work. Failure to comply subjects the employer to a $500 fine.

Carriers are obligated to provide “return to work coordination services.” With the agreement of the employer, these services must be provided “as necessary” to facilitate an employee’s return to work. Return to work coordination includes job analysis, job modification assessments and other reasonable services. Carriers are not required to pay for job modification.

**Article 4.** Abolishes the spinal surgery second opinion procedure. It substitutes a preauthorization procedure for approving spinal surgery. It provides “at a minimum” that TWCC adopt rules providing for preauthorization of spinal surgery, work hardening, in-patient hospitalization, and newer investigational procedures. The bill does not include physical medicine, home healthcare, and psychiatric services, all of which are currently covered under the TWCC preauthorization rule. It does not require preauthorization for chiropractic manipulations.

Additionally, the article requires carriers to prospectively certify coverage for healthcare services not requiring preauthorization. Carriers retain the right to retrospectively review “precertified” services.

**Article 5.** Substantially modifies current insurance carrier rights to a required medical exam and limits those to exams regarding appropriateness of medical care. It enlarges the designated doctor process to issues of impairment, MMI, disability, compensability and extent of injury, or “similar issues.” If the insurance carrier disagrees with the
designated doctor, the carrier may request an RME. Benefits may be suspended if an employee fails to attend the designated doctor examination unless TWCC determines the employee had good cause. The carrier may suspend based upon an RME opinion after fourteen days, subject to Interlocutory Order by the TWCC. If the order is reversed, the carrier is reimbursed by the Subsequent Injury Fund. It removes the requirement that the designated doctors be of the same “discipline” and licensed by the same “board of examiners” as the employee’s doctor.

**Article 6.** Changes medical fee guidelines. TWCC is directed to adopt Medicare requirements and related rules, including billing and coding requirements, for medical fees. TWCC is currently mandated to establish treatment guidelines. That would be made discretionary. It establishes a pharmaceutical formulary requiring the pharmacy to provide generic drugs unless otherwise specified by the treating doctor and permits a doctor to prescribe over the counter “alternatives” as well as prescription drugs. Disputes about medical necessity will be decided by independent review organizations. Costs will be paid by the prevailing party.

TWCC is directed to publish its’ decisions resolving disputes over medical. The employee’s name must be redacted. Presumably, other information will be available, including the identity of the carrier and the provider. Subsequent decisions by SOAH will be published.

Physicians will be required to disclose all financial interests, as defined by federal regulations. TWCC shall adopt federal standards prohibiting the payment or acceptance of healthcare referrals. Providers failing to comply are subject to penalties, including forfeiture of the right to reimbursement during any period of non-compliance. The Commission shall publish all final disclosure enforcement orders on the Internet web site.

Violations of the medical provisions of the Act by an insurance carrier or healthcare provider subjects the violator to a $1,000 fine. Any subsequent administrative violation subjects the violator to a $10,000 fine. TWCC is directed to adopt a schedule of specific monetary administrative penalties for specific violations.

**Article 7.** TWCC was subject to a Sunset Act review as of 2007. That is accelerated to 2005. The state auditor is directed to audit TWCC’s compliance with the statute, employee turnover, adoption and implementation of rules, assessment of administrative violations, etc.

**Article 8.** If an insurance carrier seeks judicial review of a final decision of the Appeals Panel, and the claimant prevails on “an issue” on which judicial review is sought by the carrier, the insurance carrier must pay the reasonable and necessary attorney’s fees incurred by the claimant’s attorney. Those attorney’s fees are not capped or limited to a percentage of the employee’s recovery.

**Article 9.** Extends the entitlement to lifetime income benefits to injuries resulting in “third degree burns over 40% of the body.”

**Article 10.** Establishes a priority for reimbursement of claims by the Subsequent Injury Fund:
1) Payment of lifetime income benefits to claimants;
2) Reimbursement payments pursuant to Interlocutory Order;
3) Multiple employment payments and pharmacy payments due to TWCC orders which are later reversed; and
4) Funding of Workers’ Compensation Health Care Delivery Network.

If funding is inadequate to meet the obligations, the fund shall be supplemented by an additional maintenance tax sufficient to meet 120% of the projected unfunded liability.

Stacks average weekly wages of employees working in multiple employments. Provides that the insurance carrier may apply for and receive reimbursement from the Subsequent Injury Fund for the amount of the income benefits paid as a result of the noninsured employment.

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**Senator Ends Talk of Governor’s Run**

Sen. Kay Bailey Hutchison announced this month that she would not be a candidate for Texas governor in 2002. The move put an end to weeks of speculation and rumor that the Junior Senator would challenge Republican Gov. Rick Perry in a primary fight.

“I will not be a candidate for governor in the Republican primary of 2002 with Rick Perry and I wish him well,” Sen. Hutchison said in a prepared statement. The senator’s announcement was made, she said to end statewide conjecture about her possible candid-acy, which she said had become a distraction. “Preoccupation over my plans for the 2002 election cycle has reached that stage and should end,” Sen. Hutchison said. “The interests of our state at the federal level require that I devote my time and energy to protect and advance the interests of all Texans,” she said.

Hutchison was re-elected to the Senate last year, after winning more than 60 percent of the vote. During her campaign she said she was considering a governor’s race. ■
Interest Calculator
Second Quarter

Interest Rate Effective from 04/1/2001 through 06/30/2001: 7.74%

1. Determine number of weeks of continuous payment owed. Find corresponding “X” value on chart.
2. Multiply “X” by weekly compensation rate. This is the approximate amount of interest owed on the ending date of benefits.
3. Determine number of weeks between ending date of payments and date benefits are to be paid. Find corresponding “Y” value on chart.
4. Multiply “Y” by the total benefits owed (not including interest determined in steps 1 and 2 above). This is the approximate amount of interest owed from benefit ending date to payment date.
5. Determine total benefits plus interest owed by adding interest from steps 2 and 4, and adding total benefits to be paid.

TIBs: Calculate interest from the 7th day after first day benefits began, or the 7th day after the first notice, whichever is LATER.

IIBs: Calculate interest from the 5th day after notice of the certification of MMI and impairment, or the date of a CARRIER dispute of MMI or impairment, whichever is EARLIER.

NOTE: For partial weeks, round up to next week (8 2/7ths weeks = 9 weeks).

| Accumulated Interest from Beginning to End of Continuous Payment | Accumulated Interest from End of Payment Period to Date Paid |
|---|---|---|
| **Weeks** | **"X" Value** | **Weeks** | **"X" Value** | **Weeks** | **"Y" Value** |
| 1 | 0.0020 | 27 | 0.5616 | 1 | 0.0015 | 27 | 0.0402 |
| 2 | 0.0050 | 28 | 0.6032 | 2 | 0.0030 | 28 | 0.0417 |
| 3 | 0.0094 | 29 | 0.6462 | 3 | 0.0045 | 29 | 0.0432 |
| 4 | 0.0153 | 30 | 0.6907 | 4 | 0.0060 | 30 | 0.0447 |
| 5 | 0.0228 | 31 | 0.7368 | 5 | 0.0074 | 31 | 0.0461 |
| 6 | 0.0317 | 32 | 0.7843 | 6 | 0.0089 | 32 | 0.0476 |
| 7 | 0.0421 | 33 | 0.8332 | 7 | 0.0104 | 33 | 0.0491 |
| 8 | 0.0539 | 34 | 0.8837 | 8 | 0.0119 | 34 | 0.0506 |
| 9 | 0.0673 | 35 | 0.9357 | 9 | 0.0134 | 35 | 0.0521 |
| 10 | 0.0821 | 36 | 0.9891 | 10 | 0.0149 | 36 | 0.0536 |
| 11 | 0.0985 | 37 | 1.0440 | 11 | 0.0164 | 37 | 0.0551 |
| 12 | 0.1163 | 38 | 1.1004 | 12 | 0.0179 | 38 | 0.0566 |
| 13 | 0.1356 | 39 | 1.1583 | 13 | 0.0194 | 39 | 0.0581 |
| 14 | 0.1564 | 40 | 1.2177 | 14 | 0.0208 | 40 | 0.0595 |
| 15 | 0.1786 | 41 | 1.2786 | 15 | 0.0223 | 41 | 0.0610 |
| 16 | 0.2024 | 42 | 1.3409 | 16 | 0.0238 | 42 | 0.0625 |
| 17 | 0.2276 | 43 | 1.4047 | 17 | 0.0253 | 43 | 0.0640 |
| 18 | 0.2543 | 44 | 1.4700 | 18 | 0.0268 | 44 | 0.0655 |
| 19 | 0.2825 | 45 | 1.5368 | 19 | 0.0283 | 45 | 0.0670 |
| 20 | 0.3122 | 46 | 1.6051 | 20 | 0.0298 | 46 | 0.0685 |
| 21 | 0.3434 | 47 | 1.6749 | 21 | 0.0313 | 47 | 0.0700 |
| 22 | 0.3760 | 48 | 1.7461 | 22 | 0.0327 | 48 | 0.0714 |
| 23 | 0.4102 | 49 | 1.8189 | 23 | 0.0342 | 49 | 0.0729 |
| 24 | 0.4458 | 50 | 1.8931 | 24 | 0.0357 | 50 | 0.0744 |
| 25 | 0.4829 | 51 | 1.9688 | 25 | 0.0372 | 51 | 0.0759 |
| 26 | 0.5215 | 52 | 2.0460 | 26 | 0.0387 | 52 | 0.0774 |
## FLAHIVE, OGDEN & LATSON DIRECTORY

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<th>Direct Dial (512)</th>
<th>Direct Fax* (512)</th>
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*Attorney's direct dial fax no. is directed to his/her paralegal.

## KEY TASK DIRECTORY

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<td>Joel Ogden</td>
<td>435-2256</td>
<td>472-9160</td>
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**Alternative e-mail address: first initial+last name@fol.com (Example: aprovosty@fol.com)}
Here are several of the most significant general questions (and answers) asked of FO&L attorneys this month.

I have recently taken over the handling of the above claim. The treating doctor assigned maximum medical improvement of 15%. The previous adjuster had assessed statutory maximum medical improvement with an 11% impairment rating. The treating physician is now in agreement with maximum medical improvement of 0% due to surveillance video of claimant. Since the 90 days have passed and no one disputed the 15%, do I have any options at this time? Do I have to pay out the IIBs on the 15%? Is there anything I can do?

The correct answer to your question depends upon the date of the certification and the date that the 90 days expired. Specifically, on March 13, 2000, a new version of Rule 130.5(e) (the 90-day rule) was passed. If the claimant’s certification did not become final before March 13, 2000, then this version of the rule applies. Under this version of the rule, the 90-day period does not even start to run until the Commission issues written notification of the maximum medical improvement/impairment rating certification to all parties. If the Commission has not issued such notice, the 90-day period has not started and you may dispute the maximum medical improvement and 15% impairment rating originally issued by the treating doctor. This will result in the appointment of a designated doctor to resolve the dispute. In addition, your assessment of 11% impairment rating at statutory maximum medical improvement would be valid and you would not owe additional benefits, if at all, until you received the designated doctor’s certification.

On the other hand, if no union contract or “plant policy” applies, you have extremely limited options to assert that the first certification of maximum medical improvement and impairment rating did not become final. If we received proper written notice and did not contact the TWCC to dispute, the claimant will be able to assert that the certification became final under Rule 130.5(e). If it has become final, then you would be required to pay the 15% impairment rating.

If we have a written plant policy requiring an employee (out on medical leave) to come in person to the medical department and present a status report from doctor are we required to pay them for the time? (They are already receiving either weekly indemnity from WC or disability pay.)

This is not a workers' compensation question. It is a question of the employee's rights under the contract of employment. If you have a union contract or other “plant policy” that requires you to pay the Claimant for the time he comes to the employer’s offices, then you may be required to pay him wages for the time he is there. If he receives such wages, then the wages can be taken into account in calculating his temporary income benefits for the week in which those wages were received. Generally, those wages can be deducted from his temporary income benefit amount pursuant to the Commission’s designated formula.

On the other hand, if no union contract or “plant policy” requires payment for his visit, you do not have to pay him. He will remain entitled to weekly temporary income benefits for the time he has lost from work as the result of his injury until disability ends or he reaches MMI.

Do you have the interest rates that are to be paid? I received an order to pay benefits that date back 52 weeks and need to figure out the interest amount to be paid.

Interest rates can be found at our web site — www.fol.com, and in each issue of FOLIO. If you have trouble using the site or calculating interest, give our office a call at 512-477-4405 to speak to the General Question attorney.
Where would I find the interest rate calculator on your web site?

Go to our web site at: fol.com. Above the firm picture, you will see a section entitled “Resource Center.” Click on Resource Center and it should bring up a “prompt” menu requesting a name and password. Enter the appropriate name and password that has been assigned to your group and it should take you to the Resource Center menu. The second item listed on the menu is an interest rate calculator for weekly benefits. Click on that menu item and it will bring up the calculator. The initial screen in the interest calculator asks for a series of information regarding benefit amount, time periods for payment, date of payment, etc. Make sure to provide all of the requested information or you will not get an accurate calculation.

If you have not been given a password to access the Resource Center, you will need to call our main number @ (512) 477-4405 and ask for Patsy Shelton or Frank Cleary. Either Patsy or Frank should be able to set you up to access the Resource Center.

Who’s responsibility is it to get records to the DD? I have always copied records for DD appointments however, doesn’t the treating physician bear some responsibility to provide records as well? I have a DD’s office calling and harassing me for these records.

You are correct. Pursuant to Rule 130.6(a)(7), upon the appointment of the designated doctor, the Commission is required to send a notice to the parties identifying the designated doctor and, among other things, “requir[ing] the treating doctor and insurance carrier to forward all medical records in compliance with subsection (h) of this section.” Rule 130.6(h) mandates that “the treating doctor and insurance carrier are both responsible for sending to the designated doctor all the employee’s medical records relating to the medical condition to be evaluated by the designated doctor that are in their possession without a signed release from the employee.” These records must be received by the designated doctor at least three days prior to the scheduled exam. Failure to comply with this section is an administrative violation. Accordingly, both you and the treating doctor are required to forward all records in your possession to the designated doctor at least three days before the exam.

I have an employer whose employees are frequently restricted from overtime, thus creating a potential liability for partial TIBs. Is there any reason I should not pay the “waiting period” if the employee is only owed two weeks partial TIBs? The employer wants me to pay starting with week 1. The claimant was restricted starting 1/2/01 and returned to regular work duties at full wages on 1/15/01.

The law does not require that you pay the waiting period until there are four weeks of disability. Section 408.082. Accordingly, under your fact scenario, you first owe benefits from 1/9/01 to 1/15/01, payable on 1/16/01.

I got on the Internet and printed Rule 134.801. I also printed the preamble. What is a preamble? Is it the discussions and negotiations prior to the rule being adopted? I am looking for confirmation of the timely filing deadline by providers to the carriers of bills. I see the rule states 11 months, but the preamble states “the health care provider’s incentive for timely billing is early collection of reimbursement. Therefore, subsections (c), (d) and (e) as proposed have been deleted, leaving the responsibility of timely billing to the health care provider.” Could you please clarify which we go by?

The preamble to a rule is used to assist in its interpretation according to relevant case law. It is a history—of sorts—of how the rule developed. You go by the rule. If it is unclear or subject to more than one interpretation, you look to the preamble for clarification. That said, the clear language of the rule would control over the language in the preamble.
How Bills Become Law – Part Four

The House Calendars

The Texas Legislature meets in regular session for 140 days every two years, putting the legislative process on display. The process by which a bill becomes law can be complex. Nevertheless, the rules governing lawmaking are well established. On The Lege will feature a component of the legislative process each month of the session.

After a bill or resolution has been reported favorably by a standing committee and the committee report has been printed, the chief clerk forwards the measure to the appropriate calendars committee for placement on a calendar. The house rules provide for four types of calendars:

1. **The Daily House Calendar**, which contains a list of new bills and resolutions scheduled by the Committee on Calendars for consideration by the house and which must be distributed to the members 36 hours before the house convenes during regular sessions and 24 hours before the house convenes during special sessions;

2. **The Supplemental House Calendar** (prepared by the Committee on Calendars), which must be distributed two hours before the house convenes and which may contain: (a) measures passed to third reading on the previous day; (b) measures on the Daily House Calendar for a previous day that were not reached for consideration; (c) measures on the Daily House Calendar for the current day; (d) postponed business from a previous day; and (e) notice to call from the table a measure laid on the table subject to call on a previous day;

3. **The Local, Consent, and Resolutions Calendar**, which must be distributed to the members 48 hours before the house convenes and which contains a list of local or noncontroversial bills scheduled by the Committee on Local and Consent Calendars for consideration by the house; and

4. **The Congratulatory and Memorial Calendar**, which must be distributed 24 hours before the house convenes and which contains a list of congratulatory and memorial resolutions and motions scheduled by the Committee on Rules and Resolutions for consideration by the house.

The Supplemental House Calendar, because it includes the measures listed on the Daily House Calendar, is the primary agenda followed by the house during its deliberations. The Local, Consent, and Resolutions Calendar and the Congratulatory and Memorial Calendar are special calendars that are prepared approximately once a week during the last half of a regular session. In addition to the four calendars listed above, the house rules provide for seven categories continued on p. 17
# Status of Workers’ Compensation Bills Pending in the 77th Legislature

## Bills With No Action

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<th>Bill</th>
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<tr>
<td>HB 49</td>
<td>Relating to the release of certain workers’ compensation records to certain persons.</td>
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<td>HB 159</td>
<td>Relating to the computation of certain workers’ compensation income benefits.</td>
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<td>HB 463</td>
<td>Relating to mandatory workers’ compensation insurance coverage for certain employees; providing penalties.</td>
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<tr>
<td>HB 980</td>
<td>Relating to workers’ compensation lifetime income benefits for certain compensable injuries.</td>
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<td>HB 1399</td>
<td>Relating to workers’ compensation insurance coverage for employees placed through a staff leasing company.</td>
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<tr>
<td>HB 1526</td>
<td>Relating to the selection of a doctor for workers’ compensation benefits.</td>
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<td>HB 1577</td>
<td>Relating to medical dispute resolution in certain workers’ compensation cases.</td>
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<td>HB 1578</td>
<td>Relating to medical evidence introduced by a workers’ compensation claimant in a contested case hearing.</td>
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<td>HB 1774</td>
<td>Relating to the use of sick or annual leave before receiving workers’ compensation benefits by an employee of the Texas Department of Transportation.</td>
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<td>HB 1895</td>
<td>Relating to the prohibition of certain waivers by employers and employees under the workers’ compensation system.</td>
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<td>HB 1980</td>
<td>Relating to the workers’ compensation insurance coverage requirements for certain construction contracts with governmental entities.</td>
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<td>HB 2445</td>
<td>Relating to lifetime workers’ compensation benefits for certain employees who suffer catastrophic burns.</td>
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<td>HB 2449</td>
<td>Relating to the certification of maximum medical improvement and the assignment of impairment ratings in workers’ compensation cases.</td>
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<td>HB 2566</td>
<td>Relating to certain requirements for the appeal of a hearing officer’s decision in a workers’ compensation proceeding.</td>
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<td>HB 2641</td>
<td>Relating to administrative penalties assessed for certain unmeritorious challenges to workers’ compensation claims.</td>
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<td>HB 2836</td>
<td>Relating to indemnification in construction contracts.</td>
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<td>HB 2976</td>
<td>Relating to the funding of the State Office of Risk Management.</td>
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<td>HB 3102</td>
<td>Relating to reimbursement of insurers in workers’ compensation third-party actions.</td>
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<td>HB 3128</td>
<td>Relating to the adoption of a drug-free workplace program by employers and to a discount on workers’ compensation insurance premiums for employers who elect to participate in the program.</td>
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<td>Relating to status as an employer under a workers’ compensation insurance policy or certificate of authority to self-insure.</td>
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<td>SB 66</td>
<td>Relating to the creation and operation of a telemedicine pilot program to provide certain workers’ compensation medical benefits.</td>
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<td>SB 453</td>
<td>Relating to the use of sick or annual leave before receiving workers’ compensation benefits by an employee of the Texas Department of Transportation.</td>
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<td>SB 851</td>
<td>Relating to changing the name of the Texas Workers’ Compensation Commission to the Texas Department of Workers’ Compensation, and to the powers and duties of the governing authority of that department.</td>
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<td>SB 902</td>
<td>Relating to administrative adjudication by the State Office of Administrative Hearings of disputes</td>
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Bills Pending in the 77th Legislature Continued

regarding workers’ compensation claims.

SB 942 Relating to insurance carrier reimbursement regarding benefit overpayments on certain workers’ compensation claims.

SB 943 Relating to monitoring of the conduct of insurers that engage in the business of workers’ compensation insurance in this state; providing penalties.

SB 1151 Relating to the duties of employers and insurance carriers in a workers’ compensation proceeding.

SB 1153 Relating to the regulation of certain insurance adjusters by the Texas Commission on Private Security.

SB 1395 Relating to the right of an insurance carrier to contest the compensability of an injury in a workers’ compensation case.

SB 1476 Relating to medical and income benefits, return to work coordination, and regulation of doctors and insurance carriers under the workers’ compensation system.

SB 1489 Relating to indemnification in construction contracts.

SB 1514 Relating to the use of health care delivery networks to provide workers’ compensation medical benefits to employees of the Texas Department of Transportation.

SB 1633 Relating to the approval of attorneys’ fees for defending an insurance company in a workers’ compensation claim.

SB 1634 Relating to the approval of attorney’s fees for defending an insurance company in a workers’ compensation claim.

Keep Your Eyes On

HB 1049 Relating to eligibility to act as a designated doctor under the workers’ compensation system.

HB 1203 Relating to the purchase of certain insurance coverage by state agencies.

HB 1204 Relating to the provision of risk management services and the administration of a workers’ compensation insurance program by the State Office of Risk Management for certain state agencies, including certain institutions of higher education.

HB 1324 Relating to attorney’s fees paid in certain workers’ compensation cases.

HB 1382 Relating to certain insurance carrier information required in workers’ compensation proceedings.

HB 1579 Relating to the medical determination of, and disputes regarding, workers’ compensation impairment income benefits; providing penalties.

HB 2126 Relating to the computation of the average weekly wage of a school district employee.

HB 2527 Relating to certificates of insurance used to evidence the existence of workers’ compensation insurance coverage.

HB 2600 Relating to medical and income benefits, return to work coordination, and regulation of doctors and insurance carriers under the workers’ compensation system.

HB 2612 Relating to the payment and funding of workers’ compensation benefits for certain claimants who work part-time or have multiple employment.

HB 2613 Relating to the payment and funding of workers’ compensation benefits for certain claimants who work part-time or have multiple employment.

HB 2642 Relating to prohibiting an employer who does not provide workers’ compensation insurance coverage from engaging in certain discrimination against an employee who sustains an employment-related injury.

HB 2644 Relating to payment procedures for charges assessed for certain workers’ compensation medical benefits.

HB 3120 Relating to status as an employer under a workers’ compensation insurance policy or certificate of authority to self-insure.

HB 3151 Relating to the right of an insurance carrier to contest the compensability of an injury in a workers’ compensation case.
H B 694 Relating to eligibility for unemployment compensation benefits of certain sheltered workshop employees who are blind.

H B 1192 Relating to a gateway physician pilot program for the provision of medical benefits to certain state employees who sustain compensable injuries.

H B 1202 Relating to the medical review of health care provided under the workers’ compensation insurance system.

H B 1205 Relating to changing the name of the Texas Workers’ Compensation Commission to the Texas Department of Workers’ Compensation, and to the powers and duties of the governing authority of that department.

H B 2537 Relating to the recovery of exemplary damages by the surviving spouse or heirs of the body of a deceased employee.

S B 624 Relating to the prohibition of certain waivers by employers and employees under the workers’ compensation system.

As of March 25, 2001
Source: Texas Legislature Website

(How Bills Become Law, from p. 14)

Except during the latter part of the regular session, when calendars become especially lengthy, the House normally considers all measures listed on its calendars before adjourning or recessing for the day. Toward the end of the session, however, the House calendars committee becomes the choke point for legislation to reach the floor. As such, the members of the House calendars committee hold sway over whether legislation will reach the floor of the House for a vote, or die in the House calendars committee.

List of Items Eligible for Consideration. This list is prepared by the chief clerk of the House, upon request of the speaker, when the volume of legislation warrants (normally during the last few weeks of a regular session). The list must be distributed six hours before it may be considered and contains: (1) house bills with senate amendments eligible to be considered; (2) senate bills for which the senate has requested the appointment of a conference committee; and (3) conference committee reports eligible to be considered.
Spotlight on... Robert Junell

State Representative Robert Junell has sponsored only one comp bill this session. But his influence on workers’ compensation matters stretches far beyond sponsoring legislation. He is a key player in comp reform and Commission budget matters.

The San Angelo Democrat was first elected to the Texas Legislature in 1988. The next year the Legislature took up workers’ comp reform in a big way. The 1989 Act erased decades of comp law and procedure, did away with the Industrial Accident Board, and created the Texas Workers’ Compensation Commission. Business leaders were pleasantly surprised over Rep. Junell’s support of comp reform. Trial lawyers were outraged.

Since taking office, Rep. Junell has quickly and meticulously consolidated his power base. He is currently serving his fourth term as Chairman of the House Appropriations Committee. He also serves on the Legislative Budget Board and the Legislative Audit Committee. Several years ago, Rep. Junell served a stint on the Research and Oversight Commission for Workers’ Compensation.

From his post as head of the Appropriations Committee, Rep. Junell holds life or death sway over state spending matters. With House and Senate budget-writers preparing this month to hash out their differences in a conference committee, he compares the legislative process to reality television. “It’s like being on ‘Survivor,’” he says. “We’re the House tribe, and they’re the Senate tribe, and we’re going to try to vote them off the island.”

For the past two months, each of the two legislative tribes has worked to set priorities, fine-tune the state’s nearly $110 billion spending plan for 2002-03 and figure out just how much Medicaid, the Commission’s wish list of legislation and other priorities will cost. As the final days of the session near, Rep. Junell’s “power of the purse” will grow. And that power will influence other representative’s votes.

He is not predictable. Although he is a Democrat, Rep. Junell endorsed Gov. Bush during his run for president. He even went so far as to travel around the country to stump for him.

He also enjoys a challenge. In 1999, he and then-Sen. Bill Ratliff, R-Mount Pleasant proposed an amendment to cut the state constitution to 1/5 its current size, strip it of obsolete language, and give the governor more power. The restructuring would have established a state salary commission to set legislative pay, imposed term limits on legislators and the governor, and ended judicial elections. This ambitious proposal was heard in the Senate State Affairs Committee, but never made it to the full House or Senate.

Rep. Junell is of counsel in the Litigation section of Jackson Walker, a national law firm. However, he cut his teeth trying comp cases – from the plaintiff’s side of the docket. He switched sides, placing an emphasis on personal injury defense in the late 1980s. Now his practice consists of defending personal injury, products liability, employment discrimination, sexual harassment, and various tort matters. He is certified by the Texas Board of Legal Specialization in Personal Injury Law.

Did you know...?

The number of work related injuries and illnesses per 100 workers declined from 7.1 to 5.6 between 1993 and 1997 (the most recent years available).

CLIENT NEWSLETTER BY FLAHIVE, OGDEN & LATSON
Rep. Delwin Jones, R-Lubbock, Chairman of the House Redistricting Committee, met for several days in March with representatives from the state’s biggest counties. Rep. Jones asked the congressional representatives to carve out their own political districts, rather than submit the redistricting puzzle to his committee.

Mr. Jones told the Dallas Morning News that he intends to encourage legislators from the six counties – Dallas, Tarrant, Harris, Travis, Bexar and El Paso – that have at least five House members each to draw plans for their counties and get them out as quickly as possible. Those counties account for 72 districts out of 150. “Those members know better than I [know] the minute details of their county,” he said.

The toughest plans to draw could stem from Bexar and possibly Harris County. Bexar is represented by 11 House members. Census figures show only 10 representatives will be needed. Harris County is on the verge of losing one of its 25 House members. Each House district should have about 139,000 people, but Houston’s inner-city growth has not kept up with the suburban areas.

Congressional redistricting occurs every ten years, in connection with the national census. State houses nationwide are reviewing and redrawing the congressional lines – making, and in some cases breaking, political futures. As the Texas legislative session draws toward its May 28, 2001 conclusion more and more attention will be drawn toward redistricting issues and away from other areas of legislation.

A bill that would establish state rules to protect the confidentiality of medical records has passed the Senate and been sent to the Texas House of Representative. The bill cleared the Senate March 21, 2001 and was received in the House the next day.

Senate Bill 11, sponsored by Sen. Jane Nelson, R-Flower Mound, would prevent the release of medical information to advertising or marketing entities without the patient’s permission. It would also give patients the right to know how their health information is being used, give them the right to sue to stop release of data and allow them to inspect and amend their medical histories.

Under the bill, the Attorney General’s office could impose penalties of up to $250,000. National patient privacy rules were passed in December but are now being reconsidered by the Bush Administration. Rep. Glen Maxey, D-Austin, and Rep. Kip Averitt, R-Waco, have filed patient privacy bills in the House that are still pending.

As the Texas Senate passed a $111.7 billion state budget this month, legislative leaders acknowledged that the spending plan won’t meet all of Texas’ needs and called for an overhaul the state’s tax structure. The move could result in a tax increase.

Although House members have recently suggested raising taxes, senators have resisted that approach during this session, which is being dominated by legislative redistricting. However, Lt. Gov. Bill Ratliff and Senate Finance Committee Chairman Rodney Ellis, D-Houston, agreed Monday that the tax system might need to be examined when the Legislature next meets in 2003. “After we draw these new districts and see who’s coming back, some of us are going to have to do what’s right and suffer the consequences,” Mr. Ellis said as the Senate discussed the 2002-2003 budget bill.

The full Senate made no changes to the Senate committee version of the state budget bill, which will be reviewed along with the House budget proposal by a House-Senate conference committee during April. The Senate plan is $10 billion larger than the current 2000-2001 budget and $3.5 billion bigger than the initial legislative plan released in January, which would not have increased any state services. The Senate plan includes $585 million for state worker pay raises.

The Senate bill also includes a provision that would allow the state to spend money from its rainy-day fund.
Neither the Workers’ Compensation Act nor public policy considerations prohibit a non-subscribing employer and employee from entering into an agreement to waive an injured workers’ right to sue his employer at common law.

Facts: In these consolidated cases, employees of nonsubscribers to workers’ compensation insurance under the Texas Workers’ Compensation Act voluntarily elected to participate in employer benefit plans that provide injured employees specified benefits in lieu of common-law remedies. The court decides whether the Workers’ Compensation Act prohibits voluntary pre-injury agreements of this type and, if not, whether it should hold them void on public policy grounds because they undermine the Legislature’s workers’ compensation scheme. In Lawrence v. CDB Services, Inc., the court must also decide whether the waiver signed by the employee meets the express-negligence and fair-notice tests.

CDB Services was a nonsubscriber under the Texas Workers’ Compensation Act. Instead of opting into the statutory workers’ compensation scheme, CDB adopted an employee benefit plan that provides medical disability, dismemberment, and death benefits for its eligible employees who choose to participate in the plan. On his first day of employment with CDB, Gary Lawrence signed an election to participate in the plan. That election provided that Lawrence waived any right to sue CDB for injuries as the result of CDB’s negligence. The election further recites that (1) Lawrence did not sign the election under duress, (2) he received a summary plan description, (3) no person made any representation to him on behalf of CDB or its affiliated employers that influenced him to sign the election, (4) Lawrence signed the election of his own free will, (5) he had the option of seeking professional advice before executing the election and had consulted an attorney to the extent he deemed necessary, and (6) he understood the language in the election.

Less than a month after signing the election, Lawrence was injured on the job. He began receiving benefits under the CDB plan, and the record reflects that those benefits have continued. About seven months after he was injured, Lawrence sued CDB alleging that his injury was caused by CDB’s negligence and negligence per se. CDB moved for summary judgment on the basis of waiver, election of remedies, release, and estoppel by acceptance of benefits. The trial court granted the motion, and the court of appeals affirmed, holding that the employee’s waiver did not violate any public policy expressed in the Workers’ Compensation Act.

Affiliated Foods, Inc., a nonsubscriber to the workers’ compensation insurance program, employed Danny Lee Lambert in May 1992. Although Affiliated did not have workers’ compensation coverage, it had an employee disability plan that provided certain medical, disability, and death benefits to injured employees who agreed to release and waive any claims against their employer. The election also recites that (1) Lambert executed the document voluntarily and without duress, (2) no representation by Affiliated induced him to execute the document, (3) he carefully read and understood the document, (4) he signed the document of his own free will and with knowledge of the consequences, and (5) he had consulted an attorney to the extent he deemed necessary.

Almost nine months after he signed the waiver, Lambert was injured on the job. He received more than $57,000 in benefits before suing Affiliated for negligence and gross negligence. Affiliated moved for summary judgment, arguing that: (1) Lambert had waived and released his claims by signing the election; (2) he had ratified the waiver by accepting benefits under the plan; and (3) he was estopped from suing Affiliated because he had accepted plan benefits. The trial court granted Affiliated’s motion. The court of appeals affirmed, holding that the election was not void as against public policy.

These two cases are not the only ones to present the issue. Wolfe v. C.S.P.H., Inc., 24 S.W.3d 641.

Held: Reversed and rendered. The injured workers argue that section 406.033 of the Workers’ Compensation Act prohibits their nonsubscribing employers from asserting waiver as a defense. They contend that the Act prohibits their employers from asserting waiver as a defense because section 406.033(c) contains an exclusive list of defenses.
available to nonsubscribers and does not mention waiver. By enforcing their waivers, the injured workers contend, that
the court would be adding a defense not allowed by the statute.

Alternatively, they argue that their waivers essentially require them to assume the risk of their own injuries and
thus violate section 406.033(a)(2). Petitioners cite a number of cases to support their positions, but none addresses the
precise situation presented here. In contrast, the statute reveals no clear legislative intent to preclude an employer from
asserting the affirmative defense of waiver. There is, admittedly, some tension between the enumeration of prohibited
defenses in section 406.033(a) and the list of available defenses identified in section 406.033(c); both lists cannot be
exclusive. That the employers also rely on section 406.033 highlights this tension. They emphasize subsection (a), which
lists defenses that are not available to a nonsubscriber. Because the defense of waiver is not specifically prohibited,
they contend that the court’s failure to allow this defense would be adding a prohibited defense to the statute.

The court rejects the argument that the Legislature’s purpose in enacting subsection (c) was to provide an
exhaustive list of defenses available to nonsubscribers. Instead, by enacting subsection (c), the Legislature clearly
indicated that it did not intend subsection (a), which lists defenses based on an employee’s (or fellow employee’s) fault
that would otherwise defeat or diminish recovery, to protect employees injured as a result of their own intoxication or
their own intent to bring about the injury. But for the exceptions expressly identified in subsection (c), subsection (a)’s
prohibition of the contributory negligence defense might arguably prevent an employer from asserting as a defense its
employee’s intoxication or intent to cause the injury. Unlike the comparative-fault issue in Kroger, the contractual
waivers before the court do not implicate the employees’ fault and are therefore not clearly within section 406.033’s
purview. If the Legislature had intended section 406.033(c)’s defenses to be exclusive, or section 406.033(a)’s
prohibited defenses to be broader, it could have easily said so. The waiver defense is simply not addressed in section
406.033, either as a prohibited or a permitted defense. In sum, the court finds that the Act itself does not expressly
prohibit the elections signed by Lawrence and Lambert. Thus, it must enforce them as it would any other contract unless
they should be held void on public policy grounds because they contravene the workers’ compensation scheme.

The employees also argue that enforcing their elections would contravene the workers’ compensation scheme
because their employers would then enjoy the benefits the Act bestows upon subscribers without having to provide their
employees equivalent statutory benefits. The courts of appeals in Reyes and Castellow agreed, holding that such
waivers violate public policy when the employer-provided benefits are more limited than those provided by workers’
compensation insurance. Reyes, 995 S.W.2d at 729; Castellow, 33 S.W.3d at 901. Those courts engaged in a
substantive comparison of the respective benefits and concluded that the employer-provided benefits were inferior to
those provided under the Act and were therefore void.

The court believes that courts engaging in such a qualitative, plan-by-plan evaluation is ill-advised, pointing to
the difficulties inherent in quantifying and measuring such intangible benefits. Hinging the validity of employer-provided
plans upon a comparative-equivalency analysis fosters unpredictability of outcome and undermines judicial economy.
But more importantly, weighing the substantive equivalency of employer-provided benefits involves competing policy
considerations that courts are ill-equipped to address. Because the Act itself provides no clear guidance on this issue,
the court believes the balance must be drawn by the Legislature.

The injured workers argue that the court should declare these waivers void because they undermine the Act’s
general scheme; if employee waivers such as these are not prohibited, they argue, employers will have no incentive
to subscribe to workers’ compensation insurance and the system established under the Act will be crippled. The court
recognizes that the Legislature designed the workers’ compensation scheme to encourage employer participation. See,
e.g., Kroger, 23 S.W.3d at 350; Garcia, 893 S.W.2d at 511. It also recognizes that enforcing waivers like those presented
today might discourage employer participation in the workers’ compensation system and present the problems
articulated by some of the amici. But, while the Legislature has created statutory incentives to encourage participation,
participation remains voluntary. As a judicial body, the court writes that it is ill-equipped to evaluate the likely real-world
consequences of invalidating the agreements before it.

Given the lack of any clear legislative intent to prohibit agreements like the ones before it, and absent any claim
by the employees of fraud, duress, accident, mistake, or failure or inadequacy of consideration, the court declines to
declare them void on public policy grounds. The court believes the factually intensive, competing public policy concerns
raised by the parties and by amici in these cases are not clearly resolved by the statute and are best resolved by the
Legislature, not the judiciary.
An injury sustained by an employee on the employer’s private property will be deemed to have occurred within the course and scope of employment, if the work performed benefited the employer.

**Facts:** Kenneth Burkett suffered injuries while performing work ordered by his employer, Electro-Motor. Although Burkett received workers’ compensation benefits, he filed a negligence action against Electro-Motor’s sole shareholder, president and employee, Rosalie Welborn. Burkett alleged that because he sustained injuries while performing work on Welborn’s private property, he was injured outside the scope of his employment. The trial court granted Welborn’s motion for summary judgment, explaining that Burkett’s receipt of workers’ compensation benefits barred him from seeking tort recovery.

**Holding:** Summary judgement of negligence action affirmed. The court set forth the general rule that an employee’s injury is sustained within the course and scope of his employment if the injury stems from the employment, and the employee’s work furthers the employer’s business. Although Burkett performed the work that resulted in his injuries on Welborn’s private property, the court found this fact to be irrelevant because Burkett received compensation for performing the work for his employer, Electro-Motor.

Although the Texas Labor Code fails to define “party” as used in Section 410.252(a), Section 406.031(a) provides that only the insurance carrier can be held liable for an employee’s compensation for a work-related injury. As a consequence, the employee and the insurance carrier are the only parties that may appeal an Appeals Panel decision to the district court.

**Facts:** Johnson pursued benefits under the Texas Worker’s Compensation Act after he sustained injuries while employed by UPS. Disagreeing with the hearing officer’s findings, Johnson appealed his case to the Appeals Panel. The Appeals Panel affirmed the hearing officer’s findings, and Johnson filed suit in district court. Johnson named UPS as the defendant, not Liberty Mutual Fire Insurance Company, the insurance carrier. In its answer, UPS asserted a plea to jurisdiction. UPS argued that Johnson should have filed suit against the insurance carrier. The trial court dismissed Johnson’s case for lack of jurisdiction, stating that he filed suit against the wrong defendant.

**Holding:** Affirmed. Although the Texas Labor Code does not define “party” as used in Section 410.252(a), Section 406.031(a) states that only the insurance carrier can be held liable for an employee’s compensation for a work-related injury. The court explained that as a consequence, only Johnson and the insurance carrier could be parties to the litigation. In addition, the court explained that the time limit for filing an appeal to the district court continues to run until the proper parties are named in the suit. Although Johnson timely filed his appeal against UPS, the time limit had expired for Johnson to amend his pleading naming the carrier as the defendant.

An “additional insured endorsement” covers the additional insured for claims involving injuries to employees of the named insured. Thus, insurer owes a defense and indemnity to the additional insured in a negligence suit brought by the injured employee.

**Facts:** Ward Brothers provided plumbing services for Highland Park Shopping Village. Trinity Universal Insurance Company issued a commercial general liability policy to Ward Brothers, with Ward Brothers as the named insured. An “additional insured endorsement” to the policy listed Highland Park and its owners as insured with respect to liability arising out of the named insured’s work.

A plumber employed by Ward Brothers injured himself on the Highland Park premises while working in the Highland Park parking garage. The plumber recovered worker’s compensation benefits and then brought, with his wife, a third-party action against Highland Park and its owners. Highland Park demanded that Trinity defend the suit and indemnify them for any liability. Trinity refused because the claim alleged negligence on the part of Highland Park and not on the part of Ward Brothers, the named insured.

**Holding:** The court of appeals affirmed the trial court’s granting of summary judgment for appellants.
(Highland Park) declaring that Trinity had a duty to defend appellants in the negligence suit. The court of appeals also reversed the trial court’s granting of Trinity’s summary judgment declaring that Trinity had no duty to indemnify appellants, and rendered judgment that appellants were entitled to be indemnified for the negligence suit. The court of appeals noted two cases with very similar facts: McCarthy Bros. Co. v. Continental Lloyds Ins. Co., 7 S.W.3d 725 (Tex. App.—Austin 1999, no pet.); and, Admiral Ins. Co. v. Trident NGL, Inc., 988 S.W.2d 451 (Tex. App.—Houston 1st Dist. 1999, no pet.). In both cases the courts concluded that “additional insured endorsements” covered the additional insured for claims involving injuries to employees of the named insured. Relying on these cases, the court of appeals here found that the injury in question occurred while the injured party was on the premises to do the work of his employer, Ward Brothers; that his injury arose out of Ward Brothers’ work; and that appellants were covered as additional insureds.


The Temporary Common Worker Employers Act (Chapter 92 of the Texas Labor Code) does not supersede the common law “borrowed servant doctrine.” Accordingly, an injured “borrowed servant” is limited to recovery under the Texas Workers’ Compensation Act.

Facts: Richmond was an employee of Pacesetter, a licence holder under the Temporary Common Worker Employer Act. Pacesetter assigned Richmond to work for Brinkman (a “user of common workers”). While working for Brinkman, Richmond was severely injured in a work-related fall, and received workers’ compensation benefits from Pacesetter's carrier. Richmond and Pacesetter sued Brinkman for negligence. Brinkman filed a motion for summary judgment, contending that because Richmond was working as Brinkman’s “borrowed servant” at the time of the accident, it was protected by the “exclusive remedy” provision of the Texas Workers’ Compensation Act. Richmond and Pacesetter responded that the Temporary Common Worker Employer Act superseded the borrowed servant doctrine, as the Act defines the license holder (Pacesetter) as the employer with right of control; therefore, the user of common workers (Brinkman) could be sued for negligence. The trial court granted summary judgment for Brinkman.

Holding: The Court of Appeals affirmed the summary judgment and held that the Temporary Common Worker Employer Act does not supersede the common law borrowed servant doctrine. Richmond and Pacesetter attempted to draw an analogy between the Temporary Common Worker Employer Act and the Staff Leasing Services Act (Chapter 91 of the Texas Labor Code). However, unlike the Temporary Common Worker Employer Act, the Staff Leasing Services Act specifically defines its relationship with the Workers’ Compensation Act. Because the legislature failed to similarly define such a relationship with respect to the Temporary Common Worker Employer Act, the inference is that the issue continues to be resolved through the common law application of the right-of-control test. To hold otherwise, the court noted, would expose every user of common workers to common law personal injury claims of their workers, and would devastate the temporary employment industry. Note that although the user of common workers is entitled to the protections of the exclusive remedy provision of the Workers’ Compensation Act, according to Attorney General Opinion DM-242, the primary responsibility for the provision of workers’ compensation insurance remains with the license holder.


Because the University of Texas System is a workers’ compensation carrier, it is entitled to contest attorney’s fees.

Facts: Wynynthia Cheatum, an attorney, obtained supplemental income benefits (SIBS) for an injured employee of the University of Texas System (UTS). Cheatum was awarded attorney’s fees for her representation, and UTS paid the fees to Cheatum. However, UTS challenged these fees, and the Texas Workers’ Compensation Commission (TWCC) reduced the fees by more than half. Cheatum then billed for defending her attorney’s fees, and TWCC awarded additional fees. However, these awards were eliminated after UTS successfully disputed them. TWCC ordered Cheatum to reimburse UTS, but Cheatum did not. Rather, Cheatum sued, attacking the constitutionality of certain statutory provisions and claiming an abuse of process for UTS’ disputing the awarded attorney’s fees. The trial court granted summary judgment in favor of TWCC and UTS.

Holding: The Court of Appeals dismissed Cheatum’s constitutional claims for lack of jurisdiction and affirmed the remainder of the trial court’s judgment. Because Cheatum chose to accept benefits under the workers’ compensation laws and rules and labor code, she had no standing to contest the constitutionality of provisions of these laws and regulations. Standing is an element of subject matter jurisdiction. Thus, the court did not have jurisdiction over Cheatum’s constitutional challenges because of Cheatum’s lack of standing. Second, the court held that because UTS was a workers’ compensation carrier it was clearly entitled to contest the attorney’s fees granted to Cheatum.
Texas Workers’ Compensation Commission Appeal No. 992790

The appointment of a psychiatrist as the designated doctor where the treating doctor is a medical doctor specializing in the treatment of upper extremity injuries requires a determination by the Hearing Officer of whether or not a psychiatrist is of the “same discipline” as a medical doctor specializing in the treatment of upper extremity injuries.

Facts: The claimant sustained bilateral wrist injuries. She treated with a medical doctor specializing in the treatment of upper extremity injuries. This doctor eventually provided a 25% impairment rating that was disputed. The Commission appointed a psychiatrist as the designated doctor. The psychiatrist awarded an 8% impairment rating. At the Contested Case Hearing, the claimant objected to the appointment of a psychiatrist and requested the appointment of a second designated doctor contending that a psychiatrist was not of the “same discipline” as the treating doctor. The Hearing Officer found the impairment rating was 8%. The claimant appealed raising the contention noted above.

Holding: Reversed and remanded with instructions for the Hearing Officer to make a determination as to whether or not a psychiatrist is of the same discipline as a medical doctor specializing in the treatment of upper extremity injuries. The Appeals Panel notes that Rule 130.6(b)(4) requires that to the extent possible, the doctor appointed as the designated doctor be in the same discipline and licensed by the same board of examiners as the employee’s choice of doctor. While a psychiatrist is licensed by the same board of examiners as any other medical doctor, the Appeals Panel remains concerned about whether or not the doctor is of the “same discipline” as the treating doctor. The term “discipline” is defined in Black’s Law Dictionary as an act in accordance with rules and order. In Webster’s Collegiate Dictionary “discipline” is defined as “instruction” and “a field of study”. The Appeals Panel remands the case to the Hearing Officer for a determination as to whether or not the designated doctor was of the same discipline as the treating doctor in the case at hand.

Texas Workers’ Compensation Commission Appeal No. 992161

Where the weight of the medical evidence supports accumulative impact from two separate injuries, the claimant’s testimony that he had fully recovered from the initial injury is insufficient to preclude an award of contribution.

Facts: The claimant initially sustained a cervical injury in December of 1990. He was able to return to work in 1992 and continued through 1997, when he sustained a second cervical injury. Dr. R treated the claimant for both injuries. As part of her impairment evaluation for the 1990 injury, Dr. R took cervical range of motion measurements in December of 1990 and January and August of 1991.

Following the second injury in 1997, the claimant again underwent cervical range of motion testing pursuant to impairment evaluations. The measurements obtained were only slightly more restricted than those obtained in 1990 and 1991. Based upon those measurements, the carrier contended that it should be entitled to contribution based upon the range of motion deficiencies. The claimant contended that he had fully recovered from the initial injury and argued against the award of any contribution for range of motion deficiencies. Dr. R testified at the Contested Case Hearing that, “In clinical practice in the real world, patients that work on it may/can easily get 90, 95% of their range of motion back of what is normal.” Dr. P also testified at the Contested Case Hearing indicating that the percentages obtained in 1990 and 1991 would have resulted in a 7% whole person impairment, and that it was improbable that the claimant’s range of motion would have drastically improved over a two, three or four month period prior to his return to work.

The Hearing Officer concluded that the carrier was not entitled to contribution under the circumstances relying upon the testimony from Dr. R and the claimant. The carrier appealed.

Holding: Reversed and rendered. The Appeals Panel points out that the Hearing Officer improperly relied upon Dr. R’s testimony that a person could, with work, reacquire 90 to 95 percent of their prior range of motion in the event of a two-level cervical fusion to support a finding that the claimant had “fully recovered” prior to returning to work in 1992. That finding was contrary to the evidence. The totality of the evidence in this case clearly
supported an award of contribution. Under circumstances where the overwhelming medical evidence supports
an award of contribution, the claimant’s testimony that he had fully recovered is insufficient to support a decision
of no contribution.

**Texas Workers’ Compensation Commission Appeal No. 002211-S**

*Contribution does not apply to any income benefit payments, which accrue prior to the filing of a request
for contribution.*

**Facts:** The claimant sustained an initial low back injury in 1998 resulting in a 20% disability rating. That
injury was followed by three back surgeries, the last of which occurred in 1992. After being released to full duty
employment on June 23, 1995, the claimant returned to the job of a truck driver. He sustained a second low back
injury on June 9, 1998. The claimant eventually received an 18% impairment rating from a designated doctor on
the second injury.

At issue in this hearing was the amount of contribution for the prior compensable injury and the carrier’s
right to recoup the overpayment resulting from the payment of both impairment income benefits and supplemental
income benefits at the full rate rather than a reduced rate. The carrier did not pursue the issue of contribution until
all impairment income benefits had been paid and the claimant was receiving supplemental income benefits. The
carrier estimated an overpayment of $14,000.00.

The Hearing Officer found the carrier entitled to contribution and further determined that the carrier could
further reduce payable supplemental income benefits by 50% in order to recoup the existing overpayment. The
carrier appealed essentially contending that it should be entitled to further reduce payable benefits to assure full
recoupment of the past overpayment.

**Holding:** Affirmed as reformed. The Appeals Panel affirms the Hearing Officer’s determination that the
carrier was not entitled to completely suspend benefits in order to recoup the past overpayment. The Appeals Panel
went further with respect to the issue of the date on which contribution would apply. Relying on the suggestion,
“that carrier delays in requesting contribution result in overpayment of impairment income benefits and supplemental
income benefits at no fault of the claimant”, the Appeals Panel held that contribution does not apply

**Texas Workers’ Compensation Commission Appeal No. 001121**

*As the AMA Guides require rating impairment based upon body regions as opposed to specific lumbar discs
the fact that two separate injuries may have affected primarily two separate disc levels does not preclude
an award of contribution.*

**Facts:** The claimant’s initial injury occurred on June 12, 1996. An MRI following that injury revealed a
large herniation at L5-S1 and a smaller herniation at the L4-5 level. The claimant underwent emergency surgery
at the L5-S1 level. Afterwards he received a 14% impairment rating that included 2% for range of motion
deficiencies. The claimant sustained a second injury on September 11, 1997 followed by a second surgery on July
29, 1998. The surgery was primarily directed at the L4-5 level, where a large herniated disc was discovered. The
claimant also had a laminectomy at the L3-4 level with removal of hardware and re-exploration of the disc at the
L5-S1 level. Afterwards, the claimant was given a 20% impairment rating. The rating consisted of 10% under
Table 49, 1% for loss of sensation and 10% for loss of strength.

The Hearing Officer determined that the carrier was not entitled to contribution. In doing so the Hearing
Officer suggested that there was no “financial connection” between the two injuries justifying contribution. The
Hearing Officer further relied upon the fact that the surgeries were primarily directed at different levels. The carrier
appealed.

**Holding:** Affirmed. The Appeals Panel affirms the Hearing Officer’s decision because of the lack of any
evidence presented by the carrier to justify the 35% contribution requested. Nonetheless, the Appeals Panel does
disapprove of the Hearing Officer’s comment that there must be a financial connection between the two injuries
in order for contribution to be allowed. They further disagree with the contention that the occurrence of surgery
at different levels following the two injuries involved precludes an award of contribution. The Appeals Panel

**CLIENT NEWSLETTER BY FLAHIVE, OGDEN & LATSON**
notes that contribution is based upon the cumulative impact of the two injuries on the claimant’s overall condition. They point to the fact that the claimant had a small herniation at L4-5 following the first injury, that the claimant was awarded impairment at the nerve root level that lies between his two surgical sites and the fact that the peer review doctor explained that surgery at one level generally has an impact on other levels as evidence that the cumulative impact of the two injuries together contributed to the claimant’s existing condition.

Texas Workers’ Compensation Commission Appeal No. 000638

An FCE report indicating only that a claimant is functioning at a sedentary level for some of the activities tested does not “show” an ability to work for purposes of Rule 130.102(d)(3).

Facts: At issue were the fourth and fifth quarters of supplemental income benefits. The claimant injured her back on December 18, 1995 after working 38 years for an orthopedic surgeon. The injury was followed by back surgery. The back surgery was followed by surgery for lung cancer in 1997 followed by 13 weeks of chemotherapy and radiation treatment. The claimant underwent an FCE on November 9, 1999 at the end of the fifth quarter qualifying period. The report suggested that the claimant would need considerable accommodation to return to work. The report also noted that the claimant considered herself to have retired. The claimant, in fact, testified that her original intention was to retire at age 65. She was 66 years old during the qualifying periods for the two quarters at issue.

The Hearing Officer determined the issues in favor of the claimant. In doing so, the Hearing Officer made the comment that he interpreted the requirement that a medical report “show” an ability to work to mean that the report must “prove” an ability to work in order to obligate the claimant to search for employment. The carrier appealed.

Holding: Affirmed. The Appeals Panel points to the fact that there were three medical doctors who provided testimony that the claimant had no ability to work at all including a doctor designated by the Commission for the purpose of determining an ability to work. More importantly, the Appeals Panel states that the FCE did not show an ability to work. Instead, the FCE indicated only that the claimant was functioning at a sedentary level with respect to some of the activities tested. The Panel does disapprove of the Hearing Officer’s suggestion that the report must “prove” an ability to work. “Had the FCE in question evaluated the claimant’s overall demonstrated abilities, rather than certain functions in isolation, a further insistence that it also ‘prove’ her ability would not be well-taken.”

With respect to the carrier’s argument that the claimant’s retirement precluded a finding of direct result, the Appeals Panel indicated that the claimant’s situation was different from one in which a worker has some ability to work but chooses retirement over returning to work. In the case at hand, the claimant had no ability to work due to a compensable injury. As such, the fact that she may have intended to retire at age 65 does not preclude qualification for supplemental income benefits after she reaches that age.

Citation Update

The following case appeared in the September 2000 issue of FOLIO:

The following case appeared in the December 2000 issue of FOLIO:

The following cases appeared in the January 2001 issue of FOLIO:
Legislature did not approve of the waivers and that the majority ruling “allows employers an end-run” around the law.

The ruling triggered immediate and strong criticism, and not just from labor groups. Sen. Robert Duncan, R-Lubbock, interrupted the Senate’s routine business to announce that, thanks to the ruling, “The employers get their cake and eat it, too.” Unless the Legislature reverses the court’s decision, he said, employers will “flock out of the system” and it will collapse, leading to demands in the 2003 legislative session to make workers’ compensation coverage mandatory — “and I may be leading the charge.”

Senator Duncan is the author of SB 624, which would prohibit waivers by employers and employees of non-subscribers. The bill passed the Senate days before the Supreme Court’s ruling and is pending in the House Business and Industry Committee at press time. Rep. Kim Brimer, R-Fort Worth, will carry Duncan’s bill in the House but said he had not scheduled a hearing because there’s “plenty of time.” The Legislature must adjourn May 28.

Sen. David Sibley, R-Waco, chairman of the Senate Business and Commerce Committee, said “amen” to Duncan’s remarks and warned that employers outside the workers’ compensation system will make such waivers mandatory, not voluntary. The Texas AFL-CIO said the ruling was “a death warrant” for the workers’ compensation system in Texas. “The court issued an engraved invitation to unscrupulous companies to drop workers’ compensation coverage and at the same time demand that employees who are injured in the workplace give up their valuable right to sue employers for negligence,” said Joe Gunn, Texas AFL-CIO president.

Texas is one of only two states that do not require employers to carry workers’ compensation coverage, and an estimated 35 percent to 40 percent do not, leaving about 20 percent of the state’s workers uncovered. The statutory scheme in New Jersey, the other state in which comp is voluntary, effectively forces employers into the system.

Employer groups applauded the ruling. “We think it was the correct decision, given the current law,” said Bill Hammond, president of the Texas Association of Business and Chambers of Commerce. Hammond said his group was neutral on Duncan’s bill but would “strongly oppose any effort to make the compensation system mandatory, especially in light of the out-of-control medical costs.”

Budget Items
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savings account if lawmakers declare a fiscal emergency. Comptroller Carole Keeton Rylander has blasted that provision, which she calls fiscally irresponsible and Gov. Rick Perry also expressed his concerns. Senators have described it as a safety net. The rainy-day fund, meant to be used in emergencies, is expected to grow from $197 million to $1 billion in 2002-03, “Now is the time to replenish the rainy-day fund, not raid it,” Ms. Rylander wrote in a letter to senators in late March.

Meanwhile, a handful of state jobs and offices would be moved out of Austin under the 2002-03 budget proposal that is expected to be approved by the House Appropriations Committee. Although the immediate impact will be small, lawmakers say the proposals are the start of a long-term strategy to move some jobs and offices to the outskirts of Austin — or elsewhere around the state — to reduce local congestion and air pollution, save state money and limit employee turnover.

An informal survey by the General Services Commission, the state’s landlord, suggested that Texas could save almost $1 million a year if it stopped leasing the 137,000 square feet of office space it has in downtown Austin and leased instead in Round Rock, Georgetown and other Central Texas communities. That figure does not include moving costs.

The idea of relocating offices has been building over the past decade. Several areas of the state have already picked up government functions that were moved out of Austin. Rep. Robert Junell’s hometown of San Angelo, for example, now hosts the backup computer system for much of state government, including the Texas Workers’ Compensation Commission’s system.

Wrong-site Surgery
Continued from p. 3

make sure that the proper arm, designated knee or correct brain lobe is operated on? There is universal agreement that a patient can do her part by trying to have conversations about what she is about to undergo with every health care worker who touches her before the procedure.

The American Academy of Orthopedic Surgeons recently urged members to sign their initials directly on the site to be operated on. Medical error experts also agree that the stigma of reporting mistakes has to be removed. “Wrong-site is a extremely serious problem whose rate of occurrence should be zero,” says Dr. Donald M. Berwick, a clinical professor of health care policy at Harvard Medical School. “But many errors in health care are a derivative of normal human properties such as failing to notice the mistakes of everyday life, like adding salt instead of sugar in your coffee.”
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