

# FOLIO

Client Newsletter by Flahive, Ogden & Latson

## PROPOSED PRE-AUTHORIZATION RULES FAIL ON 3-3 VOTE

The Workers' Compensation Commissioners failed to pass proposed pre-authorization rules in a deadlocked vote this month. The vote came as Commissioners reconsidered proposed changes designed to reduce overutilization of medical care. The rules were stridently opposed by chiropractic interests. The proposed rules included substantive and technical changes to both the original drafted proposal and the rules now in place.

The TWCC staff that presented the proposed changes included Tom Hardy (Director of Medical Review,) Dr. Bill Nemeth (TWCC Medical Advisor) and Nancy Crawley (Rules Team Leader.) The proposed changes were intended to increase the quality of care and lower the cost of delivery for the system participants. According to the TWCC Staff, the proposed rules would improve quality of care and cost effectiveness by a more efficient process of determining medical necessity.

The Staff noted that there are currently some 300,000 requests

for pre-authorization each year. The Staff also noted that, according to the WCRI's recent survey, the primary cost drivers in the Texas comp system can be found in over-utilization and excessive treatment, particularly within the

realm of chiropractic manipulation. The new rules would limit non-authorized manipulation to 18 visits or less. The Texas Chiropractic Association vehemently opposed

*"Commissioners voted 3 for and 3 against the changes to the rules — a straight employer/employee split."*

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## Martin Case Raises Questions

A recent decision from the Texarkana Court of Appeals has created a stir in the claimant's bar. In the case, *The Travelers Insurance Company v. Wilson*, No. 06-99-00175-CV (Tex. App. Texarkana – 2000) the carrier's expert witness was allowed to testify about his treatment of the claimant and his injury, but not

about whether Mr. Wilson's chiropractic care was reasonable or necessary. The Court held that Travelers did not prove how the doctor's medical training and experience as an orthopedic surgeon qualified him to opine about the reasonableness and necessity of chiropractic treatment.

This case received a lot of attention. It was summarized in the September 2000 *FOLIO*. The TWCC has received copies of this case from plaintiffs' lawyers and are being encouraged to follow it. The case should be distinguishable for a number of reasons.

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Flahive, Ogden & Latson, a 25 lawyer firm, defends contested workers' compensation cases statewide every day. The firm has represented insurance companies and employers before the Texas Workers' Compensation agency for more than 50 years.

For general questions concerning the newsletter call (512) 435-2225. *FOLIO's* Editor-in-Chief is Jack W. Latson.

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## Payroll Limits Announced for Seasonal Workers

The Texas Workers' Compensation Commission has determined the adjusted annual payroll requirement of an employer for the coverage of seasonal workers is \$39,826. This gross payroll amount will be used in the year 2001 to apply against an agricultural employer's 2000 gross payroll, and to determine whether a farm or ranch worker is covered by workers' compensation.

The Texas Comptroller of Public Accounts has calculated that in Texas the inflation rate was 3.4 percent between September 1, 1999 through August 31, 2000. The new payroll threshold was determined pursuant to Texas Labor Code, Section 406.162.

## Eleven Indicted for Comp Fraud

The Texas Workers' Compensation Commission joined other state and federal agencies at a press conference in Dallas on September 28, 2000 to announce the results of an investigation that resulted in indictments of health care providers.

Len Riley, TWCC Executive Director, who participated in the press conference, affirmed that TWCC's involvement in investigations such as this will continue as part of the Commission's enhanced efforts to weed out fraudulent activity in the workers' compensation system. He emphasized, "If you are defrauding the Texas workers' compensation system, we are putting you on notice."

Federal grand juries in Dallas and Austin returned three indictments earlier this month, charging nine defendants with health care fraud and other related fraudulent, criminal activity. In addition to the defendants charged in these indictments, two other Dallas residents have been charged by a federal criminal complaint with participating in a health care fraud scheme. The defendants include seven health care professionals including six chiropractors and one licensed physical therapist. All eleven defendants were arrested by federal agents.

These charges are the result of a two-year undercover multi-agency operation which was initiated to identify and build criminal cases against dishonest health care providers, and other individuals, working together to submit fictitious and fraudulent insurance claims, submit claims for services that were not rendered, inflate fees to maximize insurance reimbursements, or bill for services that were not medically necessary.

The 11 individuals who were charged in the three indictments and one criminal complaint submitted more than \$750,000 in fraudulent medical claims to the Texas Workers' Compensation Insurance Fund, who participated in the investigation. The Fund is a Texas governmental corporation that provides workers' compensation coverage to employers, including small employers and those with high risk.

Jesus Villarreal, also known as Alex Villarreal, the Senior Vice President for Imaging with Associated Medical Providers of Dallas, Texas, was charged in an 18-count indictment with health care fraud, mail fraud, and money laundering. Mr. Villarreal was also indicted

*continued on p. 12*

## Downs Still at the Court of Appeals

The San Antonio Court of Appeals will have a second opportunity to reconsider its opinion in *Downs v. Continental Casualty Insurance*. Attorneys for the carrier have filed a second motion for rehearing with the San Antonio Court of Appeals. The Court has ordered that any responses must be filed on or before October 31, 2000.

The second motion for rehearing was prompted by the Court's revised decision, which was issued on August 16, 2000. In its revised decision, the Court held that the Act requires a carrier to complete and file a TWCC-21 on or before the seventh day after the date on which the carrier receives written notice of an injury. According to the Court's interpretation of the Act, a carrier must state on the TWCC-21 that it is either refusing to pay any benefits because it denies compensability of the injury or that it will pay benefits as required by the Act if, as, and when a benefit accrues. Thus, in order to avoid a potential waiver pursuant to *Downs*, a carrier must file a TWCC-21 on all claims on or before the seventh day after the date written notice is received. The Court's initial decision held that a carrier waived its defenses by failing to deny or pay benefits within seven days. A discussion of the initial decision was featured in "Court Finds Waiver", *FOLIO* January 2000.

Attorneys for the carrier in *Downs* say they do not anticipate expedient action by the Court given the impending judicial election. Moreover, some observers question

whether the carrier can obtain any relief in the San Antonio Court and have advocated pushing the case forward to the Texas Supreme Court. The second motion for rehearing means that the case will remain pending at the Court of Appeals level for at least several more months. Attorneys for the carrier do not anticipate that this case will reach the Supreme Court until mid-year 2001. A decision by the Supreme Court is not anticipated for at least another full year.

The Commission has issued an advisory (Advisory 2000-07) staying agency implementation of the *Downs* decision. (See "Downs Update" *FOLIO*, September 2000) The Commission, after consulting with the office of the Attorney General, is of the opinion that the August 16, 2000 *Downs* decision "should not be considered precedent at least until it becomes final upon completion of the judicial process." Accordingly, the Commission has instructed its personnel not to enforce *Downs*

while the case remains pending in the Texas Court system. While the Commission declines to recognize *Downs* as controlling in cases currently pending at the administrative level, Claimants' attorneys are routinely raising the "Downs waiver" issue and pursuing that issue through the dispute resolution process in order to preserve the right to take that issue into district court.

FO&L has recommended that carriers file a TWCC-21 within seven days of written notification on all cases in which there is a possibility that the investigation will support a basis for denial. If a good faith investigation conducted within the first seven days results in a determination that the claim should be denied, carriers should deny liability. If the investigation is incomplete, then the carrier should state: The carrier will pay all income and medical benefits if, as, and when they accrue subject to the carrier's further investigation of compensability.

### FO&L OFFICE HOURS

Our regular office hours are 8:15 a.m. to 4:45 p.m.. If you need to call after 4:45, please call Patsy Shelton at (512) 435-2234. She will be on duty until 6:00 p.m. daily.

**DON'T WAIT UNTIL THE LAST HOUR OF THE DAY FOR DEADLINE FILING. ANY FAXES WITH INFORMATION DUE MUST BE RECEIVED BY 3:30 p.m.** for any deadline handling for same day delivery to the Commission, and faxed according to the fax directory listed on the last page of *FOLIO*. Furthermore, if you have a last minute deadline call our office by 3:00 p.m. and speak with Joyce Reagan, Tillie Aguirre, or Patsy Shelton to advise that a last minute filing is necessary to meet a deadline. We will be watching and waiting for the fax. Otherwise, last minute faxes could delay receipt. Our last daily run to the Commission will be at 4:00 p.m., in order to get across town to meet their 5:00 closing time.

# Dr. Scheffey's Malpractice Payments Published

Dr. Eric Scheffey, a Houston area orthopedic surgeon, has treated many workers' compensation patients in the last two decades. His treatment of patients has attracted the attention of the Texas Board of Medical Examiners in the past. See "Board Refuses to Modify Doc's Suspension", *FOLIO* April 2000. Now a newspaper has published a list outlining a decade of medical malpractice payments made on behalf of Dr. Scheffey.

According to The Hartford (CT) Courant, \$8.5 million in malpractice payments have been made on behalf of Dr. Scheffey, between 1984 and 1993. The Courant obtained the data from the National Practitioner Data Bank. (See Table) Most payments listed represent a separate allegation of malpractice, although it is possible for multiple allegations to involve the same patient.

In April 2000, the Texas Board of Medical Examiners refused to modify Dr. Scheffey's probated license suspension, rejecting his attempt to loosen restrictions on the nature of his practice. Dr. Scheffey had been suspended from the practice of medicine in May 1995 based on allegations that he engaged in billing and other irregularities in his practice. The Board's order became effective in October 1997 following the Texas Supreme Court's rejection of Dr. Scheffey's request for a stay. However, the suspension was probated for five years and Dr. Scheffey has been permitted to continue to practice medicine subject to certain terms and conditions.

The Hartford Courant has detailed Dr. Scheffey's malpractice claims history as well as his troubles with the Board of Medical Examiners in an online article,

"Patients Bleed, Practice Thrives". The article, and a link to the payment table, is published on the Courant's website at [www.ctnow.com](http://www.ctnow.com).

Malpractice Payments on Behalf of Dr. Eric Sheffey		
Record No.	Malpractice Year	Payment
167744	1993	\$160,000
50400	1992	\$175,000
50408	1992	\$200,000
185344	1992	\$45,000
31926	1991	\$7,500
50405	1991	\$200,000
50406	1991	\$25,000
50409	1991	\$200,000
50414	1991	\$50,000
50398	1990	\$100,000
50402	1990	\$200,000
50411	1990	\$200,000
50403	1989	\$150,000
50413	1989	\$200,000
70283	1989	\$1,000
50401	1988	\$125,000
50412	1988	\$199,000
30957	1987	\$510,000
50407	1987	\$50,000
50410	1987	\$110,955
50415	1987	\$187,500
58737	1987	\$462,500
72233	1987	\$750,000
30958	1986	\$25,000
50399	1986	\$186,500
50404	1986	\$100,000
58738	1986	\$462,500
72228	1986	\$750,000
72235	1986	\$750,000
58678	1985	\$40,000
72217	1985	\$25,000
51011	1984	\$55,000
51012	1984	\$1,536,045
84520	1984	\$225,000

Source: The Hartford Courant ([www.ctnow.com](http://www.ctnow.com))

# How to Use the New Medical Benefit Rules

## Part Three

*The Commission held its first seminar regarding the new medical benefits rules in August 2000. In a series of articles, FOLIO is summarizing the important changes, as noted in the seminar. This is the final installment of a series of articles in which FOLIO has summarized the important changes, as noted in the seminar. This month, we examine how the new rules affect medical dispute resolution.*

Under new Rule 133.305, there will be no more abatement of medical disputes pending the outcome of compensability disputes. This means that all medical disputes will be addressed, regardless of whether the service is related to the compensable injury.

A request for medical dispute resolution regarding fee reimbursement may not be filed earlier than the sixtieth day after the date the carrier received the bill, unless the carrier took final action on the bill before the sixty days elapsed. The cutoff for fee reimbursement and medical necessity disputes is one year from the date of service. A carrier must request medical dispute resolution on a refund dispute within one year from the date of service. If the Commission orders a refund, the appealing party must request medical dispute resolution within 20 days of receipt of the order. Requests for medical dispute resolution for preauthorization disputes must be filed within 45 days of the denial of the request for reconsideration.

The Commission has adopted a new TWCC-60 form, which incorporates both the request for medical dispute resolution and the response. Use of this form by all parties is mandatory as of January 15, 2001.

The request for medical dispute resolution must include all relevant medical bills, all relevant EOBs, all TWCC-62 forms, all

relevant peer review reports, all medical records, and documentation of the request for reconsideration. It must include a table of disputed services (found on the TWCC-60). It must also contain a statement of disputed issues, which must address the specific services in dispute, why they should be preauthorized or reimbursed, how the statute and rules affect the disputed issues, and how the documentation submitted supports the requestor's position. If the dispute involves fair and reasonable reimbursement, the requestor must document that the payment sought is fair and reasonable and that it will not exceed the payment for a non-workers' compensation claim. If the dispute involves preauthorization of DME, the request for medical dispute resolution must include product literature and a copy of the retail invoice.

The response to request for medical dispute resolution must include all the documentation listed above, but no duplicates. For disputes involving fair and reasonable reimbursement, the respondent must document that the paid amount is fair and reasonable. Any documentation submitted in support of this contention becomes subject to the Public Information Act. The respondent must include a table of the disputed services. If the dispute involves pre-authorization, the respondent must include copies of the written denials

of preauthorization, copies of the relevant peer review/physician advisor's reports, the reviewer's name and specialty, and the reviewer's clinical rationale for the denial.

The respondent has **14 days** to respond to disputes regarding medical necessity or fee reimbursement. The respondent has **7 days** to respond to preauthorization disputes.

It is important to note that if the response to request for medical dispute resolution is not filed in the prescribed form and format, with all of the required information, within the deadline, it will not be considered by the Medical Review Division. FO&L requests that you respond to our notices regarding medical dispute resolution promptly to ensure that your documentation is considered.

These new rules place additional burdens on both health care providers and carriers. You must review them carefully. Call FO&L if you have any questions.

Interest Rates	
Quarter /Year	Interest Rate
4 <sup>th</sup> /2000	9.38%
3 <sup>rd</sup> /2000	9.50
2 <sup>nd</sup> /2000	9.34
1 <sup>st</sup> /2000	8.85



## Practice Pointer

# Out of State Spinal Surgery

From time to time, a Texas claimant moves out of state and continues her medical treatment with an out of state doctor. If the employee develops a problem requiring spinal surgery, the physician must comply with the Spinal Surgery Rule. Failure to comply with the rule may relieve the carrier from the obligation to pay for the surgery.

It is an obvious problem to transport the claimant back to Texas and coordinate with a very tight schedule of a surgeon, who may or may not have an emergency requiring the physician to be out of the office at the time that the claimant attends. Because of those scheduling difficulties, multiple trips or an overnight stay may be necessary. Carriers do have a right to require the claimant to return to Texas for an examination. If a carrier insists on that right, it has the obligation to pay for the transportation, and reasonable costs that may be necessary because of the claimant's condition or the circumstances of the travel.

A carrier can avoid this problem by agreeing upon a doctor located in the area where the claimant resides. To exercise this option, which is entirely discretionary with the Commission, the carrier must accommodate the Commission's needs for the information. Accordingly, it must obtain TWCC approval to vary from the general rule. We suggest the following procedure to accommodate the claimant and the Commission.

- ❖ Discuss with the employee your interest in having a local examination. If the employee is

agreeable to the exam, complete a TWCC-24 (Benefit Dispute Agreement) and note that the disputed issue is "Selection of doctor to perform spinal surgery second opinion." For the resolution, state "Carrier and Claimant agree that Dr. \_\_\_\_\_ shall serve as the Carrier's Second Opinion Doctor on the question of spinal surgery."

- ❖ Remember, if the second-opinion physician does not concur, a third doctor must be chosen by the employee and his or her surgeon. There will be no commission sub-list limiting that choice.
- ❖ With the exception of the method of selecting a doctor through a sub-list, you must otherwise comply with the TWCC procedure. You must provide the name of the proposed doctor within the fourteen (14) days

from our firm's receipt of the TWCC-63, set up the appointment within thirty days of the TWCC 63 receipt, timely notify all parties, etc.

- ❖ The physician must agree to comply with the TWCC reporting requirements! TWCC will not approve the Benefit Dispute Agreement if the surgeon will not agree to comply. You must qualify the doctor on his/her willingness to report findings to the Division, the treating doctor, the surgeon, and the carrier within ten (10) days of the exam.

The spinal surgery second opinion process determines carrier liability for spinal surgery. The spinal surgery rule was implemented to reduce the cost associated with unnecessary surgical procedures and to protect injured workers from the effects of unneeded surgery.



## Practice Pointer

# Disputing Mileage Reimbursement

Rule 134.6 provides that a claimant who travels more than 20 miles one way for reasonable and necessary medical treatment is entitled to reimbursement for the mileage at the state rate. Some confusion exists regarding the proper method of disputing a claimant's entitlement to mileage reimbursement. Two rules exist on mileage reimbursement. The date the travel took place controls which rule to use.

### **NEW Rule (for dates of travel 07/15/2000 or later)**

The claimant is to submit form TWCC-48. At the bottom there is a space for the carrier to explain any denial or reduction in mileage. The form states that the claimant is to request a BRC to resolve a carrier's denial or reduction. Therefore, the carrier is to use this

*continued on next page*

# How are Comp Premiums Calculated?

## Part Four

*In a series of articles, FOLIO is examining the evolving history and process of premium assessment in workers' compensation. The articles rely, in large part, on a study performed by the National Council on Compensation Insurance. This month, the series continues with an examination of the strengths and weaknesses of proposals to calculate premium based on the number of hours worked.*

The proposal to use hours worked to determine premiums has been raised by those who believe that there is an inequity inherent in the use of total payroll. These groups most often point to differences in the premiums paid by high-wage paying and low-wage paying employers within a single classification as evidence of the perceived inequity.

However, policymakers must consider that aggregate system costs will not change under an hours-worked program. Sufficient

premium must be generated to pay claims, no matter how its collection is determined.

Under an hours-worked program, the great majority (small and mid-sized) of employers will see their premiums increase to offset the loss of premium from the higher wage employers, and the higher losses they generate.

Supporters of hours-worked proposals sum up the basic thrust of their arguments this way:

By paying workers compensation premiums

based on wages, employers that hire at higher wages are penalized in relation to those that hire at lower wages. Workers at both job sites do the same job and are exposed to the same risks. If they both have the same injury, it is reasonable to think they will have the same medical bills. Using hours worked is a more accurate representation of the exposure to hazard on the job.

The arguments may also include a plea to "level the playing field" between high- and low-wage paying contractors that bid on the same project. Other arguments include the idea that high-wage paying employers are put at a competitive disadvantage for paying a "living wage" and the idea that in-state contractors have to compete with out-of-state contractors who pay little if anything towards workers' compensation.

Finally, there may be arguments that unscrupulous contractors may intentionally misclassify workers to defraud the system and all contractors then have to make up the difference.

### ***Mileage Reimbursement Cont'd***

form; no other form is necessary.

#### **OLD Rule (for dates of travel prior to 07/15/2000)**

The source of the confusion appears to be Appeals Panel Decision 93952, which states that a carrier who wants to dispute entitlement to mileage must file a TWCC-21 when the change of treating doctors is filed. Most carriers took this decision to mean that the proper form for disputing mileage is always the TWCC-21. At least one decision indicates that disputes of mileage filed on TWCC-21s were considered valid (e.g., 950835 Carrier disputed mileage on a TWCC-21 but did not dispute the change of doctor) although these disputes were not necessarily decided in the carrier's favor.

Then, in Appeals Panel Decisions 990071 and 991176, the Appeals Panel stated that a TWCC-21 is not required, and that in fact, there is no particular required format for a mileage dispute.

While a TWCC-21 is not required to dispute entitlement to mileage reimbursement under the old rule, a dispute of mileage filed on a TWCC-21 is not invalid. Because no particular format is required under the old rule, using a TWCC-62 makes sense, as mileage is technically a medical benefit.

In conclusion, under the old rule there is no particular format required for a dispute of mileage. Under the new rule, use the comment box on form TWCC-48.

*Next month, the series analyzes whether the total payroll method or the hours-worked method is more reliable for workers' compensation purposes.*



## **Practice Pointer**

# **Phonophoresis and Whirlpool**

Phonophoresis (97139-PH) is a procedure that uses ultrasound as the method of application of medication. It is a DOP procedure, meaning there is no set reimbursement rate. Therefore, reimbursement is at a fair and reasonable rate, based on the documentation of the procedure.

One chiropractor who regularly bills this procedure argues that because his patients could have allergic reaction to the lidocaine applied by this method, he must have all his personnel trained in CPR and he must have a defibrillator ready. He alleges that additional training is required to perform this procedure, and that it is dangerous. Therefore, he reasons, he is entitled to reimbursement at a rate higher than that of regular ultrasound.

The Medical Review Division has held that reimbursement at the same rate as for ultrasound is fair and reasonable, if the provider does not document otherwise. The Commission will accept evidence of what other carriers have paid as evidence of fair and reasonable reimbursement, although arguably it is only evidence that the provider is billing his usual and customary charges.

When you face this issue, keep these points in mind. Chiropractors are not licensed to prescribe or dispense medication. In order to be entitled to bill for this procedure, the provider must document that the procedure was performed under the supervision of a medical doctor. In addition, the only fact that differentiates between phonophoresis and ultrasound is the

application of medication, which is billed and reimbursed separately.

Sterile whirlpool is billed at \$40.00; regular whirlpool is billed at \$20.00. The Medical Review Division has determined that the mere fact that the whirlpool must be cleaned between uses is not enough to justify a sterile whirlpool charge. Therefore, make sure you have documentation as to the medical necessity of the sterile whirlpool charge; otherwise, the proper reimbursement is for regular whirlpool.



## **Practice Pointer**

# **IDET: Spinal Surgery or Medical Dispute?**

Intradiscal Electrothermal Therapy (IDET) is a controversial new treatment, which involves inserting a catheter into the vertebra and running electric current through it. It is touted as an alternative to spinal surgery. Our firm has received requests for second opinions for spinal surgery and requests for medical dispute resolution on this procedure, so we inquired of the Medical Review Division as to the correct venue.

According to the Medical Review Division, the correct dispute

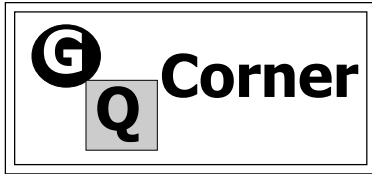
resolution procedure is the spinal surgery second opinion process. Therefore, when you get a request for second opinion on an IDET procedure, we recommend that you do not waive it. This procedure was not approved for inclusion in the new Spine Treatment Guideline because there are no scientific studies to support its long-term effectiveness. Carriers should continue fighting use of this procedure, as the current data indicates it is not effective, and in some cases, may be harmful.

## **TWCC Fraud Unit Created**

The Commission has created a fraud investigation division and appointed a director of the new division. Linda Bayless, a former assistant district attorney and associate commissioner with the Texas Department of Insurance, will direct the new division, known as the Enforcement Initiatives Division.

Ms. Bayless pledged to “go after workers’ compensation fraud” and solicited carriers to report suspected fraud to her division or to the TWCC’s Office of Investigations. The new unit will target large dollar fraud cases, many of which involve attorneys and health care providers allegedly working in concert.

The new division will work closely with federal and local law enforcement agencies, as well as the special investigation units of insurance carriers.



**Here are several of the most significant questions (and answers) asked of FO&L attorneys this month.**

*Q. Has there been a change to how we dispute a claimant's request for mileage reimbursement?*

A. Yes. For mileage incurred after July 15, 2000, the TWCC is using new form TWCC-48 for requests for mileage reimbursement. There is a section at the bottom of the form for the adjuster to indicate whether the request is accepted or rejected, and to provide the basis of any objection. Completing and returning that form to the claimant is the proper way to dispute a mileage request. You should not file a TWCC-21. The claimant must submit a mileage request within one year of the travel date. The carrier has 45 days to respond to claimant's request. Claimant may appeal a reduction or denial by requesting a Benefit Review Conference.

*Q. Our insured is an employee leasing company. They sent the claimant to work for their client company, and the claimant was injured while working. Our insured, the leasing company, had nobody at the job site and did not control the details of the claimant's work. The client company told the claimant what to do when he was working. Can we dispute liability on the basis that the claimant was a*

*"borrowed servant" of the client company at the time of his injury?*

A. No. The carrier for a leasing company may not avoid liability with a "borrowed servant" argument. "Right of control" issues do not make the client company, or its carrier, liable in this situation. This has been most recently explained in AP 000599.

*Q. Claimant was in the course and scope of employment when he was in a bad car wreck. He filed a third party claim against the party responsible for the wreck and received a \$1,000,000 settlement. Do we now have a \$1,000,000 credit against any additional workers' compensation liability in this case?*

A. No. The subrogation credit is for the claimant's "net recovery" only. That net recovery excludes attorney's fees and litigation costs that the claimant had to pay out of the gross recovery. In a typical personal injury case, the attorney fee alone can take one third of the gross recovery. Consequently, you can expect that your credit will be much closer to \$660,000 rather than \$1,000,000. These issues were discussed in *Insurance Company of North America v. Wright*, 886 S.W.2d 337 (Tex. App. – Houston [1<sup>st</sup> Dist] 1994).

*Q. Claimant was a security guard who was shot in the head during an attempted robbery. He is now in a vegetative state. He has a home health care aide. Due to a mistake made by a prior third party administrator on the claim, the carrier has overpaid that health care provider by about \$100,000. The provider*

*acknowledges the overpayment, and initially said he would begin repaying the carrier. The provider has not followed through on that promise. Can the carrier start recovering some of that overpayment by reducing the amount paid to the provider for continuing services?*

A. Given the sensitive nature of the claim, and the serious injury sustained by the claimant, you need to act cautiously. We would advise against any unilateral action by the carrier to try to recover the overpayment. If you reduce current payments to the health care provider and that provider, in turn, stops providing services to the claimant, you could quickly be facing a dangerous claims handling lawsuit. The best way to proceed is to involve the TWCC in resolution of this dispute. You can do that by filing a request for medical dispute resolution, pursuant to TWCC Rule 133.305, for all dates of service that are no more than one year old. Medical review has the authority to issue orders requiring repayment. In fact, in most instances, we would argue that repayment is mandatory, even if the overpayment happened as the result of the carrier's error. We have a Medical Review team at FO & L who can help you with these questions.

*Q. Claimant had a compensable injury to her left hip. She was at home, recovering after surgery to that hip, when she fell and broke her right hip. Now she needs surgery on the right hip. Are we liable for the costs of the surgery to the right hip, as well as any additional disability that results from that injury?*

*continued on next page*

**GQ Cont'd**

A. Probably not. The test is whether the new injury to the other hip is a "direct and natural result" of the original compensable injury. Several factors are relevant to making that determination. When the alleged new injury happens at home, and involves a different body part, it is usually found not to be compensable. Some recent cases on this point are AP 991193, AP 982962, and AP 971849.

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*Q. The claimant was a home health aide for a patient who is HIV-positive. She was accidentally exposed to possibly contaminated body fluids. She is taking anti-HIV medication now, but has not yet tested positive. The claimant says she cannot work because the medications make her nauseous. Does she have a compensable injury? Do we owe her temporary income benefits now? Do we have to pay for continued, periodic HIV testing in the future?*

A. This is a challenging area, and all such cases have to be handled carefully. The facts you describe would support a finding of compensable injury. Consequently, if the claimant is legitimately losing time because of her medical treatment for that compensable injury, she has compensable disability. Regarding future testing, there is certainly an argument that we would not owe for continued testing to see if the claimant has contracted the disease. However, since these cases must be handled with extreme sensitivity, the carrier may well want to consider paying for such tests, at least for a reasonable period of time. Keep in

mind that if the claimant does test positive, and can establish by credible medical evidence that she contracted the disease during the compensable event, early detection and treatment will likely reduce the carrier's overall exposure. It is a good idea to contact us immediately if you have a case involving these issues.

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*Q. Claimant gave a urine sample for a pre-employment drug test and was hired on May 15, 2000, before the results were known. Claimant alleged that he was injured in the course and scope of employment on May 17, 2000. A few days later, the results of the pre-employment drug test came back and they were positive for marijuana. Based upon the positive pre-employment drug screen, the claimant was fired the next day. No drug test was done on the date of the accident. Can we dispute compensability of claim based upon intoxication?*

A. Probably not successfully. The intoxication defense applies only if the claimant was intoxicated at the time of the injury [Tex. Labor Code 406.032(1)(A)]. There is a legal presumption of sobriety. The carrier can rebut the presumption of sobriety by providing credible evidence that the claimant may have been intoxicated at the time of the injury. However, a positive drug test from a sample taken two days prior to the injury has little, if any, probative value concerning whether the claimant was intoxicated two days later. Based upon your facts, we probably would not have enough evidence to shift the burden of proof to the claimant.

It is important that employers perform a drug test based upon a sample taken as soon as possible after the injury.

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*Q. A claimant is seeking reimbursement for his out-of-pocket costs for some prescription medications. The claimant says that his chiropractor prescribed the medications. Do I have to reimburse the claimant?*

A. No. Chiropractors are not authorized to write prescriptions for pharmaceuticals. Perhaps the claimant is mistaken. Ask him provide a copy of the prescriptions in question.

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*Q: Are we supposed to be offering electronic transfer of funds to claimants yet, or has that rule not gone into effect?*

A: As of September 1, 2000, all carriers must be equipped to offer a claimant electronic transfer of funds. Moreover, the TWCC expects all carriers to notify claimants of the availability of electronic deposit of benefits.

There is no set form for providing such notice. FOLIO published a sample notice on page 7 of the July 2000 issue. FO&L Advisory No. 287 outlines the latest requirements for electronic fund transfer from the Commission. Contact our office if you need a copy of that Advisory.

### ***Martin Case Cont'd***

First of all, it is important to remember that this case is an old law case. That is significant because juries don't hear medical disputes anymore. The Medical Review Division of the TWCC now hears those cases, followed by an appeal to the State Office of Administrative Hearings. If there is any right to an appeal at that point (an unanswered question in the state of Texas), the appeal will be conducted under the substantial evidence rule. In other words, the case is probably limited to facts that will never again occur.

Moreover, under the new law, health care providers will always bill usual and customary and audit companies will always reduce the bill because that is the way the system is set up. What the *Martin* case does not consider is the effect of the new law on cost containment. Medical cost containment was one of the driving considerations of the 1989 Reform.

The Commission is required to establish guidelines for fees charged and use of medical services. The statute provides "guidelines for medical service fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control." §413.011. Thus, the Commission has an affirmative duty under the statute to develop a treatment guideline that would not only provide for quality treatment, but also "achieve effective medical cost control." For that reason, the Commission has more than sufficient authority to develop utilization guidelines.

Furthermore, §408.021 requires carriers to pay for all health care "reasonably required" by the nature of the injury. In the *Martin* case, the claimant received \$120,000 worth of chiropractic care. Generally, it will never be reasonable for a claimant to receive that amount of chiropractic care. In every case, this will be a fact

issue. However, under the dispute resolution system presently in place, with the current emphasis placed by the TWCC on medical cost containment, such figures will rarely, if ever be approved.

During the *Martin* case, there was no evidence other than the chiropractor's testimony. There was no guideline, no expert whose opinion was admitted into evidence, and nothing on the question of "reasonableness" (if in fact it was part of the theory that was tried), other than the testimony of the self-interested chiropractor. A trial of the case under the new law would be different.

Lastly, in the event a chiropractor cites the *Wilson* case as evidence of a reasonable standard of care, and suggests that it is bad faith to audit chiropractic billings, remember that in Texas, an insurance company owes no duty of good faith and fair dealing to a health care provider. *CNA v. Scheffey*, 828 S.W.2d 785 (Tex. App. – Texarkana 1992, writ denied). Therefore, a healthcare provider in Texas cannot set up a Texas Workers' Compensation carrier concerning a Texas bad faith cause of action. For the same reason, it would be unlikely for a chiropractor to prevail *against an* independent claims reviewer. There is no duty owed.

The basic premise that an orthopedic "cannot testify" against a chiropractor was anticipated by the Commission and incorporated into the new retrospective medical review rule effective July 15<sup>th</sup>. Rule 133.304(g). If your medical vendor is complying with the TWCC rules, you are consistent with the holding in the *Martin* case.

If you have questions concerning the case, please contact Jack Latson in our office.

## **Hospital Fee Test Cases Selected**

The administrative law judge overseeing the hospital fee litigation has selected five "test cases" for adjudication. These cases will move through the discovery and dispute resolution process at the State Office of Administrative Hearings.

Hank Card, the SOAH judge assigned to resolve the consolidated hospital fee cases, selected the five cases from among 221 disputes pending on his consolidated docket. The cases selected involve four workers' comp carriers and four hospitals. The judge selected them as representative cases of all disputed issues in the litigation. Judge Card has abated the remaining cases

pending further dispute resolution.

The hospital fee cases arose following challenges to the Commission's authority to oversee the reasonableness and necessity of hospital fees charged in workers' compensation cases. The Austin Court of Appeals declared an earlier Commission rule setting out the methodology of oversight invalid. The Court ruled that the TWCC failed to provide a "reasoned justification" for the rule. While invalidating the rule on this technicality, the Court did not do away with the overall authority of the Commission to regulate hospital fees. The fees in dispute total more than \$100 million.

### ***Eleven Indicted Cont'd***

by an Austin, Texas grand jury for mail fraud and health care fraud, and conspiracy to commit health care fraud and mail fraud.

Dallas residents, Aftab Qureshi, supervisor for Golden Cab Company of Dallas, and Abdullah Abdulle, were both charged with mail fraud and health care fraud, and conspiracy to commit health care fraud and mail fraud.

Dr. Charles Dramiga, of Frisco, Texas and owner/operator of

Chirostar Clinics of Dallas, Texas, and Dr. Mark Prii, resident of Coppell, Texas and owner/operator of Chiropractic Arts Center in Coppell, were each charged with mail fraud and health care fraud, and money laundering, and conspiracy to commit health care fraud and mail fraud. Dallas resident, Dr. Rantiola Ogun, owner/operator of Family Care Chiropractic of Dallas, was charged with health care fraud, mail fraud,

and money laundering, and conspiracy to commit health care fraud and mail fraud.

Dr. David Reaume, owner/operator of Organized Healthcare Services, Inc. in Austin, Texas, and Dr. Jonathan Boyd, Houston Regional Manager of Organized Healthcare Services, Inc., and Dr. Steven Descant, owner/operator of a chiropractic facility in San Antonio, Texas, were each charged with health care fraud and mail fraud, and money laundering, and conspiracy to commit health care fraud and mail fraud.

Mehmood "Mark" Fidai, owner/operator of Kwhaja Enterprise, Inc. of Dallas, Texas, and Zonia Elvas Valasco, a licensed physical therapist and owner/operator of Health Prime in Dallas, Texas, were charged with mail fraud, health care fraud, and conspiracy to commit mail fraud and health care fraud.

If convicted of all charges against them, defendants face prison terms ranging from 105 to 290 years, and fines ranging from \$4 million to \$11 million.

TWCC cooperated with the United States Attorney for the Western District of Texas, the FBI, the Dallas Police Department Intelligence Unit, the United States Department of Health and Human Services-Office of Inspector General, the Texas Workers' Compensation Insurance Fund, the National Insurance Crime Bureau, the Texas Department of Insurance, and the United States Postal Service-Office of Inspector General. Assistant United States Attorneys, Phillip C. Umphres and Jodi Rudman are prosecuting the case.

### ***Preauthorization Rules Cont'd***

any changes to the existent rules, particularly to the number of treatment sessions. The Commissioners publicly responded to a letter received from the Texas Chiropractic Association threatening a lawsuit if the rules were passed. Commissioner Jack Abila, who represents employee interests on the Commission, said on the record that he found the letter to be "offensive," and characterized the letter as "an attempt to blackmail" the Commission into voting against the proposed changes.

Throughout the presentation, the Commissioners asked many pointed questions about the proposed changes. Dr. Nemeth opined that the current process does not allow for quality delivery of medical care or cost control. He indicated that an exhaustive review of the literature received during the public comments period was completed prior to the final draft of the rule changes. He noted that the proposed changes would expedite the delivery of care to injured workers, reduce claims administration costs, cut down on

paperwork, reduce over-utilization and excessive treatment, and provide for better clinical outcomes.

In spite of the wide range of arguments for the proposed changes, the Commissioners voted 3 for and 3 against for changes to the rules. The Commissioners voting for the changes include Burt Terrill, Mike Lowrey, and Lonnie Watson. Voting against were Rebecca Olivares, Kenneth Moore, and Jack Abila. This is a straight employer/employee split. The greatest source of contention proved to be whether the TWCC had the necessary infrastructure to administer changes to the rules.

Commissioner Olivares said that the Fee Guidelines should be changed prior to the Pre-Authorization rules. Commissioner Moore thought that the independent study of the proposed rules (conducted by Milliman and Robertson) did not indicate that the current fee guidelines would support the goals of effective cost containment and quality of care if used in conjunction with the proposed changes to the pre-authorization rules.

# Texas Workers' Compensation Commission Question/Resolution Log

*This is a reprint of selected portions of an internal log utilized by the Texas Workers' Compensation Commission to memorialize informal opinions given by the Commission in response to questions from the field. It is a training tool for TWCC personnel. Although these opinions are not binding, they do state current TWCC interpretations and represent Commission policy.*

Date Received	Question/Problem	Resolution
<p>04/06/2000 00-04</p>	<p><b>TIBs</b> Question is from Midland Field Office and the Date of Injury is 10-21-98. Employer has collective bargaining agreement with employees and their union to continue 30% of salary for 13 weeks when employee is out on accident benefits.</p> <p>In this case the carrier began TIBs and at the same time the employer continued to pay full salary for 4 weeks. The employer now wants to recoup the salary from IIBs. QRL 95-149 says some of these payments may be gratuitous.</p> <p>Can a carrier recoup payment from IIBs when an employer continued salary "but" employer didn't file TWCC-2 (voluntary payment form).</p>	<p>No. T.L.C §408.003 provides that after an injury, an employer may: initiate benefit payments, including medical benefits; or supplement income benefits paid by the carrier upon written request or agreement of the employee (total amount may not exceed net preinjury wages).</p> <p>§408.003(b) requires the carrier to pay the employer those benefits to which the employee was entitled but which the employer paid. It also provides that amounts which could not be reimbursed under §408.003(b) are reimbursable out of IIBs under §408.127. However, to be eligible for reimbursement, the employer has to meet two conditions.</p> <p>First, to be eligible for any reimbursement under TLC §408.003, the employer must have timely reported the injury to the insurance carrier. Second, the employer must notify the commission and carrier of the initiation and amount of payments made. Thus, unless these two conditions are met, the employer is not entitled to reimbursement.</p> <p>Assuming these two conditions are met and the claim is compensable, the employer is entitled to reimbursement.</p> <p>Additional reimbursement from IIBs is provided to ensure that an employer's initiation of benefits does not result in the employee receiving more than what the employee is entitled to in income benefits.</p> <p>In the immediate case, the employer is making supplemental payments. These are not the</p>

Date Received	Question/Problem	Resolution
<i>Cont'd</i>	<i>Cont'd</i>	type of payments which the statute anticipated being reimbursed. Since supplemental payments are voluntarily paid by the employer after the carrier has accepted the claim reimbursement under §408.003(b), and thus §408.127, does not apply.
04/13/2000 00-05	<p><b>SIBs</b> Rule 130.106(a) states that an injured employee who is not entitled to SIBs for a period of 4 consecutive quarters permanently loses entitlement to such benefits. If an insurance carrier disputes entitlement to 4 consecutive quarters of SIBs, when do these denials become final under rule 130.106?</p>	The disputes do not become final until they are finally adjudicated before the Commission and/or the Courts. The insurance carrier will need to continue to review entitlement for subsequent quarters as long as the injured employee files for SIBs. In this specific fact situation, the injured employee must initiate the dispute resolution process for filing for a BRC pursuant to rules 130.108 and 141.1.
04/17/2000 00-06	<p><b>MEDICAL RECORDS</b> Who is responsible for sending medical records to the RME doctor? Many insurance carriers are advising injured employees that they are responsible for obtaining and providing the records for an RME.</p>	The insurance carrier should not be requiring the injured employee to obtain records for an RME. Since the request for the examination is made by the insurance carrier, the insurance carrier should notify the treating doctor to share the medical records with the insurance carrier's RME doctor as defined in rule 133.2.
04/19/2000 00-07	<p><b>CONFIDENTIAL CLAIM INFORMATION</b> The agency is starting to receive e-mails from insurance carriers and injured employees containing claim-specific information and questions regarding such. The party is able to satisfy all the requirements to receive and/or discuss confidential claim data (name, social security number, date of injury, employer, etc.)</p> <p>May agency staff respond via e-mail when the response requires providing confidential information, or should the response be provided via telephone calls or hard copy/paper?</p>	TWCC does not have the capability to securely respond to e-mails requesting confidential claim file information. Confidential claim file information should only be released by hard copy/paper or phone call once the appropriate verification has been made.

<b>Date Received</b>	<b>Question/Problem</b>	<b>Resolution</b>
05/01/2000 00-08	<p><b>TWCC-34</b> When a Dispute Resolution Officer receives a TWCC34 and a designated doctor is assigned to resolve MMI/IR, do we ask the designated doctor to address disability if the RME doctor releases claimant to return to work?</p>	<p>It would not be inappropriate to contact the designated doctor regarding disability in this situation.</p>
05/01/2000 00-09	<p><b>BRC/MMI/IR/DD</b> If a BRC is set on release to return to work and MMI/IR, and at the BRC does the carrier request that the Designated Doctor also address disability? If so, do we contact the Designated Doctor already set or do we assign a different designated doctor?</p>	<p>If the designated doctor has not performed the exam, it would be appropriate to request the designated doctor to address disability also. In most cases the resolution of MMI/IR would also resolve the disability issue. If the insurance carrier continues to dispute disability after the designated doctor has performed his evaluation, the BRO may request a clarification from the designated doctor regarding disability.</p>
05/01/2000 00-10	<p><b>TIBs/DD/TWCC-34</b> When a claimant no-shows for Designated Doctor appointment, can the carrier stop TIBs if the designated doctor was set on the TWCC-34?</p>	<p>Rule 126.6(h) allows for suspension of TIBs if the injured employee fails to attend an RME or designated doctor examination, without good cause. However, such suspension is only permitted as outlined in 126.6(h).</p>
05/01/2000 00-11	<p><b>DD</b> A field office OAO selected a designated doctor (DD) and made an appointment. Claimant missed the appointment because the notice went to the wrong address. Since this DD travels into the area only once a month and it would take several weeks to get another appointment, would it be appropriate to use a different DD?</p>	<p>Generally, no. Selection of a different doctor reduces the impartiality of the selection process.</p> <p>In this specific fact situation the injured employee's failure to attend was because of an incorrect address. Selection of a different designated doctor would be appropriate in this case as the designated doctor would be unavailable.</p>

Date Received	Question/Problem	Resolution
05/23/2000 00-12	<p><b>SIBs</b> If a insurance carrier paid a quarter of SIBs based on a CCH D&amp;O, and the Appeals Panel reversed the HO's decision, is the insurance carrier supposed to recoup the over-payment from future SIBs rather than the SIF?</p>	<p>Rule 116.11(b), effective March 13, 2000, says that an insurance carrier should not seek SIF reimbursement for benefits recoverable or convertible from other income benefits. Insurance carriers seeking to recoup such overpayments (particularly those that don't involve recouping from IIBs) need to attempt to seek the express agreement of the injured employee. If such agreement is not reached, the insurance carrier may request a BRC. If an injured employee is no longer eligible for SIBs, insurance carriers should seek reimbursement from the SIF.</p>

## Court of Appeals Holds RME Physician Subject to Suit

The Court of Appeals reversed a summary judgment granted in favor of Medical Evaluation Specialists, a medical group that frequently performs RMEs for workers' comp carriers. The employee alleged fraud, civil conspiracy, intentional infliction of emotional distress and breach of the duty of good faith and fair dealing. The Court does not address the question of whether the physician owed a duty of good faith and fair dealing to the claimant. If an independent insurance adjuster owes no duty, it is doubtful that an examining physician hired by the insurance carrier would owe a duty.

One of the Defendant's doctors examined the claimant as an appointed designated doctor. The

Commission found that his opinion was not against the great weight of the medical evidence. The finding of the Commission is tantamount to a court finding. Nevertheless, the court concluded that even though Dr. Dozier's findings were not against the great weight of the other medical evidence, it was possible that he was part of the fraudulent scheme to wrongfully deny benefits to the claimant!

Thus, if a carrier requests that the Commission appoint a doctor for a required medical examination, and if the opinion of the doctor is produced in bad faith, the doctor enjoys no immunity from a claim of fraud, civil conspiracy, or intentional infliction of emotional distress. This

opinion merely reverses a summary judgment and remands the case for trial on the issues.

The larger effect will be to deter the willingness of physicians to provide expert testimony. That is bad news. The good news is that if the Court of Appeals' opinion becomes law, it may permit an insurance carrier to sue a claimant's physician for fraud, or civil conspiracy with a claimant to cause the carrier to pay more benefits than the carrier would owe. To support that, the carrier would need to produce evidence similar to the affidavit evidence described in the Court of Appeals case. See *Davis v. Medical Evaluation Specialists*, 2000 WL 1294325 (Tex.App.-Hous. [1 District]).

# TWCC Electronic Information Plan Published

Faced with mounting pressure to control system costs and to become more efficient, the Texas Workers' Compensation Commission has published a plan to develop more effective storage and use of electronic information. The Electronic Information Exchange Plan is a part of the Commission's Business Process Improvement Project.

The 76<sup>th</sup> Legislature appropriated funds for the Agency to begin a business re-engineering project known as the Business Process Improvement Project. Moreover, HB 2511 was enacted to enable the Commission, by rule, to allow or require electronic transmission of information by system participants. Although this legislation

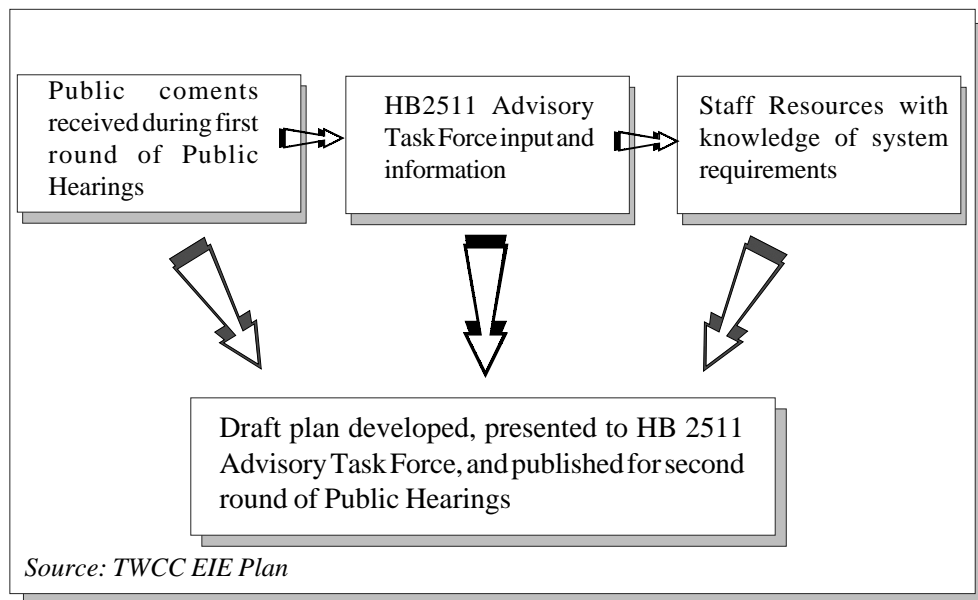
was not funded, it required the TWCC to develop a plan to incorporate electronic reporting of information and financial exchanges between parties in the workers' compensation system.

The Commission notes that, in response to the legislative mandates, it has evaluated its current operations and interactions with system participants. Moreover, the Agency has designed new processes to deliver services, evaluated technical capability, examined new technologies, and

developed an implementation schedule, cost estimates and a cost benefit analysis. Finally, the TWCC notes that it has published the Electronic Information Exchange Plan itself.

The plan notes that several mandated concepts couldn't be implemented without new

making forms available through the Internet. According to the plan, the Commission also intends to increase public access to information on the Commission's website and to require expanded electronic fund payments on a "realistic schedule" for implementation. This will be implemented in connection with the



Source: TWCC EIE Plan

automated systems. Other initiatives are dependent on development, publication and adoption of rules or legislative changes. However, the plan targeted a number of goals deemed necessary in order to meet the requirements of HB 2511.

The goals included a reduction in paper exchange requirements between system participants as well as the elimination of ineffective reporting requirements. Other goals include the development of web-based applications for Commission services and actions, including

imposition of additional requirements for the use of electronic transmission for certain transactions.

The Commission is required to implement a 30 percent reduction of paperwork by January 1, 2002. HB 2511 requires a second 30 percent reduction in paperwork by January 1, 2003. The full Plan may be found on the TWCC website.

# Interest Calculator Fourth Quarter

Interest Rate Effective from 10/1/2000 through 12/30/2000: **9.38%**

- 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			
Weeks	"X" Value	Weeks	"X" Value
1	0.0023	27	0.6805
2	0.0059	28	0.7309
3	0.0113	29	0.7830
4	0.0185	30	0.8370
5	0.0275	31	0.8928
6	0.0383	32	0.9503
7	0.0509	33	1.0097
8	0.0653	34	1.0708
9	0.0815	35	1.1338
10	0.0994	36	1.1986
11	0.1192	37	1.2651
12	0.1408	38	1.3335
13	0.1642	39	1.4036
14	0.1894	40	1.4756
15	0.2164	41	1.5494
16	0.2452	42	1.6249
17	0.2757	43	1.7023
18	0.3081	44	1.7814
19	0.3423	45	1.8624
20	0.3783	46	1.9451
21	0.4160	47	2.0297
22	0.4556	48	2.1160
23	0.4970	49	2.2042
24	0.5402	50	2.2941
25	0.5851	51	2.3858
26	0.6319	52	2.4794

Accumulated Interest from End of Payment Period to Date Paid			
Weeks	"Y" Value	Weeks	"Y" Value
1	0.0018	27	0.0487
2	0.0036	28	0.0505
3	0.0054	29	0.0523
4	0.0072	30	0.0541
5	0.0090	31	0.0559
6	0.0108	32	0.0577
7	0.0126	33	0.0595
8	0.0144	34	0.0613
9	0.0162	35	0.0631
10	0.0180	36	0.0649
11	0.0198	37	0.0667
12	0.0216	38	0.0685
13	0.0235	39	0.0704
14	0.0253	40	0.0722
15	0.0271	41	0.0740
16	0.0289	42	0.0758
17	0.0307	43	0.0776
18	0.0325	44	0.0794
19	0.0343	45	0.0812
20	0.0361	46	0.0830
21	0.0379	47	0.0848
22	0.0397	48	0.0866
23	0.0415	49	0.0884
24	0.0433	50	0.0902
25	0.0451	51	0.0920
26	0.0469	52	0.0938

# FLAHIVE, OGDEN & LATSON DIRECTORY

Attorneys	Direct Dial (512)	Direct Fax* (512)	E-Mail ** Initials@FOL.Com	Paralegal	Paralegal (512)
Allain Collins	435-2170	867-1715	APC	Raina Walpole	435-2231
Bobby Stokes	435-2150	867-1705	RDS	Anita Drake	435-2249
Carlos Acosta	435-2177	867-1712	CA1	Sally Stephens	435-2236
Chuck Finch	435-2158	867-1713	CCF	Dayna Dixon	435-2223
Dana Gannon	435-2151	867-1710	DMG	Margo Davis	435-2263
Doug Pruettt	435-2182	867-1721	HDP	Christel Green	435-2238
Erin Allen	435-2181	867-1728	EMA	Lori Goebel	435-2225
Greg Solcher	435-2175	867-1718	GDS	Lisa Black	435-2260
Jack Latson	435-2156	867-1724	JWL	Patsy Shelton	435-2234
James Sheffield	435-2169	867-1703	JRS	Sharissa Karol	435-2224
Katie Flahive	435-2168	867-1702	KMF	Gina Barrow	435-2229
Kevin MacEwan	435-2166	867-1706	KEM	Cynthia Sherman	435-2274
Lynette Phillips	435-2165	867-1708	LLP	Karen Vanloo	435-2240
Pamela Peavy	435-2163	867-1736	PEP	Lisa Anderson	435-2250
Paul Stone	435-2157	867-1716	PBS	Bronna Sanders	435-2269
Paul Warren	435-2159	867-1719	PDW	Debbie Garza	435-2281
Rebecca Strandwitz	435-2160	867-1720	RMS	Raina Walpole	435-2231
Rhett Robinson	435-2154	867-1709	SRR	Jessica Newlin	435-2216
Rob Dollars	435-2164	867-1707	RAD	Eva Hernandez	435-2233
Ron Johnson	435-2178	867-1722	RMJ	Dayna Dixon	435-2223
Roy Leatherberry	435-2179	867-1714	RJL	Kim Harrington	435-2228
Scott Bouton	435-2153	867-1737	SDB	Sally Stephens	435-2236
Steve Tipton	435-2162	867-1704	SMT1	Mary Casebier	435-2275
Susan Veltman	435-2152	867-1717	SRV	Gina Barrow	435-2229
Tricia Blackshear	435-2180	867-1723	PHB	Lisa Black	435-2260

\*Attorney's direct dial fax no. is directed to his/her paralegal.

## KEY TASK DIRECTORY

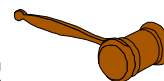
Task	Contact Person	Direct Dial (512)	Direct Fax (512)	E-Mail Initials@FOL.Com
Admin. Violations	Patsy Shelton	435-2234	867-1724	PGS
BRC Settings (FO&L - Req. For Evid.)	Cindi Friedel	435-2244	477-4987	CAF
Disputed Claims (TWCC-21)	Phyllis Devine	435-2271	477-4996	PAD
General Questions	Receptionist	477-4405	867-1700	GQS
Insurance Coverage (TWCC-20)	Phyllis Devine	435-2267	477-4996	PAD
Med Review Disputes	Annette Moffett	435-2266	867-1733	AMM
Records Request/Photostats	Phyllis Devine	435-2267	477-4996	PAD
Request for BRC (TWCC-45)	Kathy McFerrin	435-2217	477-4862	KLM
Spinal Surgery	Dianne Townsend	435-2251	479-5319	DLT
TWCC Manual Sales	Joel Ogden	435-2256	472-9160	JMO

\*\* Alternative e-mail address: first initial+last name@fol.com (Example: aprovosty@fol.com)

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## CASE DECISIONS TEXAS COURTS OF APPEALS

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**Texas Workers' Compensation Commission and Subsequent Injury Fund v. Texas Municipal League Intergovernmental Risk Pool, No. 03-98-00169-CV (Tex. App. - Austin 2000)**

*As applied to the member cities of the Texas Municipal League Intergovernmental Risk Pool ("Risk Pool"), Sections 403.007(a) and 408.184(c) of the Texas Workers' Compensation Act and the TWCC provisions directing their implementation do not violate Article III, Section 52(a) or Article VIII, Section 1-e of the Texas Constitution.*

**Facts:** The Risk Pool sought a declaratory judgment that the Subsequent Injury Fund's ("Fund") mandatory contribution scheme as applied to Risk Pool members violated the Texas Constitution. First, the Risk Pool asserted that the mandatory contribution scheme failed to guarantee that the contributing member cities would benefit from the statewide Fund distribution, thereby forcing the member cities to "lend [their] credit or grant public money" in violation of Article III, Section 52(a). Second, the Risk Pool contended that the city members' payment of unclaimed death benefits into the Fund violated Article VIII, Section 1-e's prohibition against State ad valorem taxes levied upon property within the State. The trial court held Sections 403.007(a) and 408.184(c) of the Texas Workers' Compensation Act and the TWCC rules to be in violation of the Texas Constitution as applicable to Risk Pool members.

**Holding:** Reversed. The Appeals Court reversed the trial court's finding that the statutory scheme violates the Texas Constitution as applied to the Risk Pool members. The Appeals Court explained that under the challenged Labor Code provisions, the Fund only takes custody of the Risk Pool's funds. Thus, Sections 403.007(a) and 408.184(c) do not require the Risk Pool to transfer title of its funds to the Fund. The Appeals Court concluded that Article III, Section 52(a) and Article VIII, Section 1-e of the Texas Constitution apply only to transfers of title. As a consequence, the Appeals Court held that the challenged statutory scheme did not violate the Texas Constitution as applied to Risk Pool members.

**Texas Workers' Compensation Insurance Fund v. Martinez, No. 06-00-00026-CV (Tex. App. Texarkana 2000)**

*A Benefit Dispute Agreement and an agreement signed by the carrier waiving the carrier's right to challenge the compensability of claimant's injury will be enforced unless the carrier can satisfy the requirement set forth in Section 410.029(a) of the Texas Labor Code.*

**Facts:** At a benefit review conference, Martinez, an injured employee, and the carrier signed a Benefit Dispute Agreement. In addition, the carrier signed an agreement waiving its right to challenge Martinez's claim. The carrier later filed a dispute of Martinez's claim contending that Martinez suffered from a congenital heart condition unrelated to his work injury. However, the carrier knew prior to the benefit review conference that Martinez suffered from a heart condition. The carrier argued that Martinez suffered from two different heart conditions, the second condition being unknown at the time the agreements were signed. The hearing officer determined that Martinez suffered from only one heart condition referred to by two different names, and upheld the waiver agreement. After the Appeals Panel affirmed the hearing officer's decision, the carrier sought review in the District Court, and the District Court rendered summary judgment in favor of Martinez.

**Holding:** Affirmed. The Appeals Court explained that the carrier had to satisfy the requirement set forth in Section 410.029(a) of the Texas Labor Code to have the Benefit Dispute Agreement and waiver agreement declared non-binding. Because the carrier failed to prove "a finding of fraud, newly discovered evidence, or other good or sufficient cause" to justify the Court rendering the agreements non-binding, the Appeals Court affirmed the summary judgment.

**Davis v. Medical Evaluation Specialists Inc. No. 01-99-00980-CV (Tex. App. Houston (1<sup>st</sup> Dist.) – 2000)**

*Designated doctors must show they acted in good faith to retain immunity.*

**Facts:** The plaintiff, Ms. Davis, sued MES, two of its physicians, the insurance company (Connecticut Insurance Company) and EBI Companies for not participating in good faith in evaluating workers' compensation claims. Her treating doctor, Dr. Bergeron, gave her an IR of 17%. The insurance carrier then requested an evaluation by a doctor through MES, which markets independent contractor doctors to insurance companies to perform requested medical examinations under the TWCA. That doctor, Dr. DeFrancesco, assigned a 0% IR. TWCC subsequently selected a designated doctor, Dr. Dozier, who was also an MES contractor, and who also assigned a 0% IR. Ms. Davis protested and TWCC assigned a new designated doctor, who assigned an IR of 21%. The claimant sued MES, the physicians, and the insurance company for bad faith in evaluating workers' compensation claims. The doctors and MES moved for summary judgment claiming absolute derived judicial immunity and qualified good faith immunity. The insurance company and EBI sought summary judgment based on the Texas Labor Code and immunity derived from the physicians and MES. The District Court granted all motions without specifying grounds.

**Holding:** Reversed and Remanded. The designated doctor, Dr. Dozier, has immunity for acts in good faith, just as the TWCC members would. However, the designated doctor cannot have more immunity than TWCC members, and therefore Dr. Dozier does not have absolute judicial immunity. MES also does not have absolute judicial immunity because they were not acting as an arm of the Court. The doctor chosen by the insurance carrier (Dr. DeFrancesco) to evaluate the claimant has no judicial immunity because he was not selected by the TWCC. Accordingly, CIC and EBI's contention that they derive judicial immunity from Dr. Dozier and Dr. DeFrancesco fail. The treating doctor's (Dr. Bergeron) affidavit created a fact issue as to whether the MES doctors acted in bad faith, and therefore the trial court erred in granting summary judgment for MES and Dr. DeFrancesco and Dr. Dozier.

**Dissent:** J. Wilson. Dr. Bergeron's affidavit was conclusory and did not raise a material fact issue. Bad faith must rest in the process by which the 0% impairment rating was reached, not in the 0% IR itself.

## **CITATION UPDATE**

*The cases below have previously been summarized in FOLIO. However, at the time of printing, they were not yet published in the Southwest 3d Reporter. They have now been released for publication. We have included the citations to the Southwest 3d Reporter below. This update will appear in each edition of FOLIO.*

***The following case appeared in the September 2000 issue of FOLIO.***

***Wolfe v. C.S.P.H., Inc., d/b/a Domino's Pizza, 24 S.W.3d 641 (Tex.App.-Dallas 2000)***

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## APPEALS PANEL DECISIONS



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### Texas Workers' Compensation Commission Appeal No. 000616

*Finding employment that is relatively equal to the injured employee's ability to work during the qualifying period for the quarter at issue can qualify the claimant for supplemental income benefits, even though the claimant may not have looked for work during every week of the qualifying period. Where the claimant left her job at the beginning of the qualifying period for the quarter at issue for reasons unrelated to the compensable injury, the claimant can not establish that her unemployment during the qualifying period was a direct result of the compensable injury.*

**Facts:** The claimant worked as a food service specialist for the self-insured's school district. At issue in the case at hand was her entitlement to supplemental income benefits. The evidence established that the claimant returned to work within a few days of her December 8, 1997 injury at the same rate of pay as prior to the injury. The claimant took a leave of absence to care for her ex-husband in Colorado after he sustained a heart attack. At some point thereafter, she contacted her supervisor to inform the supervisor that she would be returning to work the following Monday. The supervisor explained to her that she thought her leave of absence would expire the day following the contact. The claimant testified that she assumed from this conversation that she was being terminated as it was impossible for her to get back to work from Colorado by the next day. The above events took place at the beginning of the qualifying period for the quarter at issue. The claimant subsequently submitted a TWCC-52 identifying ten job contacts. The claimant did begin working for one of the employers listed on the TWCC-52. The Hearing Officer determined the claimant was entitled to supplemental income benefits for the quarter at issue. The carrier appealed.

**Holding:** Reversed and rendered. The Appeals Panel agrees with the Hearing Officer's conclusion that the fact that the claimant did not search for employment during every week of the qualifying period did not preclude entitlement. The Appeals Panel indicates that the claimant may establish entitlement to supplemental income benefits by proving that he or she, "has returned to work in a position which is relatively equal to the injured employee's ability to work" under Rule 130.102(d)(1). This applies irregardless of the claimant's search for employment during every week of the qualifying period.

However, the Appeals Panel disagrees with the Hearing Officer's conclusion that the claimant's unemployment during the qualifying period was a direct result of her impairment from the compensable injury under the facts as stated above. The claimant clearly left a job paying the equivalent of her preinjury wage for reasons having nothing to do with the compensable injury. Under those circumstances, the claimant's unemployment is not a direct result of her impairment from the compensable injury.

### Texas Workers' Compensation Commission Appeal No. 000433

*The Appeals Panel holds that the carrier's failure to either pay benefits or dispute the claim within seven days of its first receipt of written notification of injury resulted in a waiver of the dispute under the Downs decision.*

**Facts:** In the case at hand, the carrier filed a dispute of compensability within 60 days of its first receipt of written notification of injury, but not within seven days of that date. The Hearing Officer determined that the carrier had not waived its right to dispute compensability. The Hearing Officer specifically discussed the Downs decision. In doing so, the Hearing Officer specifically commented that the decision was incorrectly decided under the law.

**Holding:** Reversed and rendered. In this case, the Appeals Panel disagreed with the Hearing Officer's conclusion that Downs was incorrectly decided under the law. The Appeals Panel follows the reasoning of the Downs decision and holds that the carrier did waive the right to dispute compensability by failing to either initiate benefits or file its dispute within seven days of its receipt of written notification of the injury. Accordingly, the Appeals Panel holds that the claimant's injury became compensable as a matter of law.

**Texas Workers' Compensation Commission Appeal No. 000677**

*A claimant can establish entitlement to supplemental income benefits through proof that he was enrolled in a TRC retraining program on a "fulltime" basis.*

**Facts:** In seeking supplemental income benefits, the claimant contended that he was enrolled in a vocational rehabilitation program through TRC on a fulltime basis entitling him to supplemental income benefits irregardless of whether or not he sought employment during the qualifying period for the quarter at issue. His testimony established that during a majority of the qualifying period he was enrolled in classes requiring his attendance in classes or lab for 14 to 16 hours per week. He further testified that he spent a total of eight to 12 hours per week studying for his classes. The Hearing Officer determined that the claimant was entitled to supplemental income benefits under those facts. The carrier appealed contending that the claimant's schedule was not "fulltime".

**Holding:** Affirmed. The Appeals Panel notes that while Rule 130.102(d)(2), providing for entitlement to supplemental income benefits in the event the claimant is enrolled in a fulltime vocational rehabilitation program through TRC, was not effective at the time of the qualifying period for the quarter at issue, that rule, nonetheless, was "instructive" on the concept of whether or not the claimant was enrolled on a fulltime basis in vocational rehabilitation. The Appeals Panel determines that the evidence was sufficient to support the Hearing Officer's decision and affirmed that decision. In a concurring opinion from Judge Potts, Judge Potts notes that the evidence reflected that the claimant had no classes during the period from August 4<sup>th</sup> through August 29<sup>th</sup>, was in classes or labs thereafter during only 14 to 16 hours per week and studied a maximum of eight to 12 hours a week, Monday through Thursday even according to the claimant's testimony. He notes that this schedule, "contrasts with the widely common work week of 40 hours". Nonetheless, he concludes by noting that he can not say that the Hearing Officer's decision is erroneous as a matter of law.

**Texas Workers' Compensation Commission Appeal No. 001256**

*Where the evidence establishes that the claimant knew or should have known that her hearing loss was work-related well before the effective date of the "1989 Act", the Hearing Officer's finding that the claimant's date of injury was July 21, 1999, was so against the great weight and preponderance of the evidence as to be clearly wrong and manifestly unjust.*

**Facts:** The claimant first discovered that she had a hearing loss during annual hearing examinations that took place in 1987 and 1988. The claimant testified that she first learned that she might have a hearing loss in late 1988 or early 1989, when the company nurse called her into her office to discuss the results of the test. The claimant's testimony further established that the claimant considered her problems to be work-related at this time or soon thereafter. The claimant's testimony as well as the content of her recorded statement provided numerous instances of the claimant saying that she considered her hearing loss to be work-related well before the date of injury found by the Hearing Officer and, in fact, before the effective date of the 1989 Act. In spite of that testimony, the Hearing Officer determined the date of injury was July 21, 1999. The carrier appealed contending that this finding was against the great weight of the evidence and that the Hearing Officer did not have jurisdiction to make a finding concerning a date of injury prior to the effective date of the Act.

**Holding:** Reversed and rendered. The Appeals Panel states that the Hearing Officer's finding concerning the date of injury is contrary to the great weight of the evidence in this case. They discussed the numerous instances where the claimant had either indicated in a statement or testified to facts showing that she considered her condition to be work-related long before the date found by the Hearing Officer. Defining "date of injury" as the date when the claimant knew or should have known her condition was work-related, the Appeals Panel concludes that the date of injury was prior to the effective date of the 1989 Act. As such, the Hearing Officer had no jurisdiction with respect to the claim.

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