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FOLIO

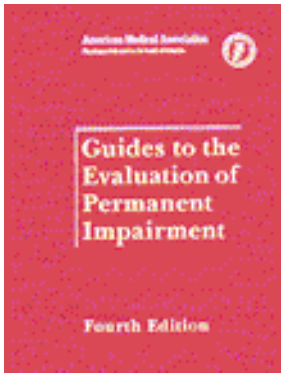
Client Newsletter by Flahive, Ogden & Latson

Fourth Edition of *AMA Guides* Takes Effect

The Fourth Edition of the *Guides to the Evaluation of Permanent Impairment* will now be applicable to all but a handful of impairment ratings issued in the future. Moreover, a new form TWCC-69 form is in the works and should be released shortly. The Commission issued Advisory 2001-08 clarifying procedures to be followed during this transition between the old version of the Guides and the new version.

The appropriate edition of the *Guides* to use for certifying examinations conducted on or after October 15, 2001 is the Fourth Edition (1st, 2nd, 3rd, or 4th printing including corrections and changes issued before May 16, 2000), per the Commission. The American Medical Association publishes the *Guides*, and the book's use in preparing impairment ratings is mandated by statute and Commission rule.

One exception exists in which the old version of the *Guides* will still be applicable. If at the time of the certifying examination, there is a certification of MMI made by a doctor prior to October 15, 2001 which has not been withdrawn through agreement of the parties or overturned by a final decision, the appropriate edition of the *AMA Guides* is the Third Edition, Second Printing, dated February, 1989.



Only impairment ratings assigned using the appropriate edition of the *AMA Guides* shall be considered valid. If the impairment rating is disputed, the letter from the Commission assigning the designated doctor will indicate which edition of the *Guides* will be used in the designated doctor impairment rating examination.

The new TWCC-69 form should be issued soon. Rule 130.1 is currently proposed for

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Supreme Court Hears *Downs* Argument

The Supreme Court of Texas heard arguments in *Downs v. Continental Casualty Company* on Wednesday, October 24, 2001. The court's acceptance of the case lends hope that it will reverse a controversial lower court ruling which held that a carrier's failure to file a Notice of Refusal within seven days of the first written notice waives the carrier's right to contest compensability. A decision by the Supreme Court could come at any time after argument, but is not expected until early 2002.

In *Downs*, the San Antonio Court of Appeals construed §409.021(c) TEX. LAB. CODE. The statute clearly provides 60 days to contest a claim. Review by the Supreme Court is discretionary, and the decision to hear the case signals the court's possible concern that the San Antonio court incorrectly decided the case.

During the 77th Legislative Session, legislators responded to the lower court opinion by filing bills in both the Senate and the House to reverse the ruling. Both bills would have clarified that a carrier has a full

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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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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 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.

New Threats for Provider Interest Payments

Texas Comp Carriers have become targets in two kinds of litigation over late paid interest on medical bills. Both situations seek damages against carriers who fail to pay interest to health care providers at the proper rate and in a timely manner.

Carriers are required to pay or dispute medical bills within forty-five days of the date of receipt. Rule 133.304 (o). For medical bills not in dispute, if the carrier fails to pay the bill before the sixtieth day, the carrier must pay interest "without order of the Commission." Rule 133.304 (q).

A recent case filed in Jefferson County (Beaumont) seeks damages for the failure to pay interest in a class action type of complaint. Although the complaint was filed on behalf of two plaintiffs and identifies seven insurance companies and one TPA, FO&L believes that the plaintiffs will seek to expand the litigation to include all Texas providers and every Texas comp carrier.

On an entirely different front, Dr. Robert Howell, a chiropractor in the Brownsville area, has begun to file Justice of the Peace Court suits on each case in which carriers failed to pay interest on one of his bills. Although the complaints generally allege less than $10 in damages in each case, Dr. Howell requests court costs and attorney's fees. Dr. Howell's attorney has been able to obtain attorney's fees in excess of $1,000 on a similar complaint.

The justice of the peace was not persuaded that the fees were unnecessary inasmuch as a phone call would have accomplished the purpose of the lawsuit, nor did he believe the fees to be unreasonable in amount, inasmuch as the fees awarded were clearly unrelated to the actual time spent on the individual case. One may easily anticipate that cases filed in the same justice court, before the same justice of the peace would be similarly adjudicated. The judge may order several dollars in interest and several thousand dollars in attorney's fees on each case.

Our lawfirm urges carrier to be very attentive to its obligation to pay interest on a medical bill paid on or after the sixtieth day following receipt. The rule requires that interest be paid. Failure to pay interest is a potential administrative violation. It may become the subject of a class action suit in a case pending in Beaumont. Finally, it may be the subject of an enforcement suit by an aggressive provider.

NCCI Considers Comp Fallout from September 11th Terrorist Attack

Following the September 11, 2001 attacks on the World Trade Center and the Pentagon, the National Commission on Compensation Insurers answered general coverage questions that may be applicable to workers' compensation claims.

The questions and answers are not state specific. As such, any actual or potential claim must be reviewed in light of the applicable state statute and case authorities. However, the questions provide a solid background from which to begin to analyze such claims.

The NCCI questions and answers follow.

What coverage is available for victims under workers compensation and employers liability policies?

Workers compensation and employers liability policies will likely provide statutory workers' compensation benefits for workers injured or survivors of workers injured in the course and scope of their employment. There is no standard policy exclusion that applies in this circumstance.

Workers' compensation and employers liability policies do not apply to affected federal government employees who are eligible for benefits under the Federal Employees' Compensation Act (FECA) or other applicable federal laws.

Affected individuals may also qualify for assistance under the Disaster Unemployment Assistance Program, addressed briefly below.

Is there a standard exclusion in workers' compensation and employers liability policies for acts of war or similar events?

The standard workers compensation and employers liability policy was first filed in 1922. The standard policy did not then, and still does not, contain an exclusion for acts of war or terrorism committed in the United States. The prospect of war or terrorism so close to home, and in the employment context, simply did not occur to those that drafted the original and later versions of the workers compensation and employer liability policies.

What kinds of policies typically contain war exclusions? Do these exclusions apply to the types of acts we witnessed this week?

Property insurance is one line that generally excludes acts of war. With the recent increase in terrorist activities at home and abroad, there has been discussion about whether terrorist activity falls within "war exclusions" contained in insurance policies. Although this is an area that will continue to be addressed by the courts, there has been at least one case in which a court in New York decided that property loss resulting from a hijacking was covered.

What is the Disaster Unemployment Assistance (DUA) Program and how do affected workers qualify for DUA benefits?

The Disaster Unemployment Assistance Program is a program funded by the Federal Emergency Management Agency that provides temporary income assistance to both workers and self-employed individuals whose work has been lost or interrupted as a direct result of a major disaster. Individuals may qualify for assistance under this program if: they worked in or were scheduled to begin work in a county that has been federally declared a disaster area; they cannot work as the direct result of a major disaster; the work they are prevented from performing by the disaster is their primary source of income and livelihood; and they do not qualify for regular state unemployment insurance benefits.

NCCI is the nation's largest single source for workers' compensation data and statistical and research information.

Travel Reimbursement Rates Rise

Reimbursement rates for mileage and other travel related expenses have gone up. The commission has issued an advisory that affects the payment of meals, mileage and lodging to claimants under the workers' compensation system. Those rates are governed by the rate applicable for reimbursement to state employees who engage in business-related travel within Texas.

Effective September 1, 2001, the new travel rates for state employees traveling within Texas are as follows:

Mileage: 34.5 cents a mile

Meal Rate: $30.00 a day

Lodging Rate: $80.00 a day

Accordingly, any mileage or other applicable reimbursements paid to claimants after September 1, 2001 should be paid at the same rate.

Supreme Court Rejects Redistricting Ruling

Months after lawmakers failed to come up with a new congressional map for Texas, an Austin judge who drew new districts also failed to come up with a legal map, the Texas Supreme Court ruled late this month. Now, a federal court has taken up the issue without any official map as a guide.

The Supreme Court ruled that District Court Judge Paul Davis, a Democrat, violated the state constitution by drawing a map based on plans that were never in evidence before his court and by not giving Gov. Rick Perry, Attorney General John Cornyn, the state's political parties and others involved in a state lawsuit over redistricting a chance to testify about his map.

"Thus, the parties not only had little time to object to the new changes, they were deprived of a meaningful opportunity to present a motion for new trial," Justice James Baker wrote in the majority opinion. He was one of six justices who ruled in favor of sending the map back to district court.

The Texas Supreme Court heard the Attorney General's plea to adopt his redistricting plan for state congressional seats in oral arguments October 18, 2001. The court's ruling will affect whether the majority of Texas congressional seats go with the Democrats or the Republicans in 2002. Democrats currently control the congressional delegation 17-13, but the state is getting two new seats because of growth. The Courts are equalizing the state's population into 32 new districts because the Legislature deadlocked on the issue.

Justice James Baker

Attorney General Cornyn, a former member of the Court, made only his second appearance before his former colleagues. The Republican attorney general argued that a plan crafted after a two-week trial by State District Judge Paul Davis, a Democrat, is invalid. The proposal by Judge Davis, a Democrat, would have given Democrats 18 of the state's congressional seats and Republicans 14, analysts said.

Mr. Cornyn said he was pleased the Court did not accept Davis' map. "Because the federal court's deadline for the state court has expired, congressional redistricting will be determined by a three-judge panel in a trial beginning Monday," he said. "We intend to move forward in federal court to secure a fair congressional redistricting plan for all Texans." A panel of three federal judges began hearing evidence the week after the Supreme Court argument in a congressional redistricting case in Austin.

The federal court's decision will undoubtedly tilt the political dynamics of the state's 32 congressional districts. For example, in 1996, when the federal courts ruled three congressional districts illegal, the judges ordered changes in those districts. Ten neighboring districts also were affected by the domino effect of the court's changes. But the rest of the state was left untouched.

Austin attorney Renea Hicks, who represented Democrats at the Supreme Court, said the federal judges probably would use the existing districts as a starting point as they work to

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Injured Worker's First Visit To Provider Is Key In Reducing Costs

A new study of workers' compensation medical networks found that an initial non-emergency visit to a network medical provider by an injured worker plays a significant role in managing workers' compensation costs.

Both this study and an earlier study by the Workers Compensation Research Institute reported treatment by network health care providers reduced medical costs without increasing income benefit costs. This study also finds that the likelihood of continued network care is much greater if the injured worker's first non-emergency visit is with a network doctor.

"The initial non-emergency visit plays an important role in determining the extent of network/non-network cost differences," said Dr. Richard Victor, executive director of WCRI, who co-authored the study. "That first visit is key because it is the single largest factor that determines continued care by network providers."

The WCRI study reaffirmed earlier studies that found workers' compensation networks generally are associated with lower medical costs – 16 percent to 46 percent lower if the patient is treated exclusively by network providers and up to 11 percent lower for similar claims if the treatment is predominately, but not exclusively,

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New Study "Follows the (WC) Money"

A new study from the Massachusetts-based Workers' Compensation Research Institute has concluded that Texas medical expenses paid in comp cases are too high. The researchers found, however, that claim costs, litigation expenses and adjusting expenses in the Texas system are low.

The study considered the following questions in its formulation. "Where does the workers' compensation dollar go? What share goes to workers? What share to medical providers for medical treatment? What share is spent for the expenses to deliver benefits?"

Researchers answered those questions for claims in 8 large states representing about 40 percent of the nation's benefits: California, Connecticut, Florida, Georgia, Massachusetts, Pennsylvania, Texas and Wisconsin. These states are diverse, both geographically and in the designs of their workers' compensation systems.

Among the major findings are:

- Massachusetts gets a much greater share (53% vs. 40%) of the total claim cost to injured workers in the form of income benefits, compared to most states studied.
- Benefit delivery expenses absorb a higher share of claim costs in California (12%) and Massachusetts (11%).
- Texas and Wisconsin pay a higher share of claim costs for medical treatment.
- Vocational rehabilitation services in California (3%) account for triple the share of the next highest state.
- California pays a higher share (7%) of total claim costs in litigation and claims adjusting expenses.
- In most states studied, medical cost containment services account for 3.5% to 4.5% of total claim costs.

The study analyzed the adequacy of income benefits, the affordability of benefit delivery expenses and the cost of medical care. Researchers also examined litigation and adjusting expenses, the cost of vocational rehabilitation and the expenses related to medical cost containment in the eight states studied.

Income Benefits. Massachusetts gets a greater share of the total claim cost to injured workers in the form of income benefits. In five of the eight states, income benefits comprise a remarkably consistent 39-42% of total claim costs. In Massachusetts, income benefits are 53%. By contrast, in Wisconsin, income benefits comprise 33% of total claim costs.

Expenses. Benefit delivery expenses absorb a higher share of claim costs in California (12%) and Massachusetts (11%) than the other states – and compare to 6% in Texas and Wisconsin. The California expense driver is litigation and claims adjusting expenses (7%) that are the highest among the eight states.

Medical Treatment. Texas and Wisconsin pay a higher share of claim costs for medical treatment (54% and 61% respectively) than the majority of states studied. Four of the eight states studied pay 49-52% of claim costs. Massachusetts and California pay the smallest share of claim costs – 36% and 41% respectively.

Rehabilitation. Vocational rehabilitation services in California (3%) account for triple the share of the next highest state (1%). In five of the eight states, vocational rehabilitation services comprise less than one-half of one percent of total claim costs.

Litigation and adjusting. Litigation and claims adjusting expenses comprise an unusually high share of claim costs in California (7%) – roughly double the typical state (3-4%). These costs represent less than 2% in Texas. Payments for defense attorneys comprise 2-3% of claim costs in California, Florida and Georgia.

Medical cost containment. In five of the eight states, medical cost containment expenses are 3.5% to 4.6% of total claim costs. Notable exceptions are:

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Coverage Information Available Online

The Texas Workers' Compensation Commission has launched an initiative allowing the public to confirm Workers' Compensation insurance coverage for employers via the Internet. The application provides a searchable database of the most recent 18 months of workers' compensation coverage information as reported to the Commission. No fees are required to use the service.

The data is current as of Friday night and is updated on Monday night. FO&L staff has been using this new function as part of a Commission pilot project for several months. The system works well for recent coverage information, although historical coverage information is not accessible.

Interested persons can link to the search engine on either the TWCC web site or at TexasOnline, the state portal. The direct URL is www.texasonline.state.tx.us/NASApp/twcc/TwccInsuranceCoverageManager.

Fake Workers Assigned to 12,000 Disability Cases

About 12,000 sick and injured people who applied to the Texas Rehabilitation Commission this year for Social Security disability benefits had their cases assigned to workers who don't exist and whose names are actually codes. The code is part of a system where these cases are set aside and handled by disability examiners on an overtime basis on Fridays and Saturdays, the Houston Chronicle reported last month.

The 12,000 Texans who applied for benefits got letters showing their cases were assigned to 25 examiners whose names began with the initial "W." But no disability examiners with such names, including "W. Jackson" whose signature was in one letter, exist.

The Rehabilitation Commission, stuck with a shortage of trained employees and a growing backlog of cases, told the Chronicle the use of code names is a way of preventing the cases from being delayed further. "Without overtime, 12,000 more claimants would currently be waiting to be served," spokesperson Glenn Neal told the newspaper.

The agency said the "W" in each of the 25 names stands for "a management information system tracking method." The last names in the code words come from supervisors, who will eventually have one of the agency's nearly 300 disability examiners handle the cases.

The use of code names started in January because the Social Security Administration approved overtime pay to reduce a backlog of about 78,000 disability applications. But when asked why disability applicants are unknowingly supplied with a code name rather than informed that their cases have been assigned to future overtime work, the agency said: "The process of informing claimants is the same for all cases."

Calls from applicants are routed to workers who handle a variety of questions about the cases. Mr. Neal emphasized that the use of code words does not prevent the disability applicants from eventually getting through to someone who can help them.

In Texas, it takes an average of 103 days after a disability case arrives in the mail for it to be assigned to a caseworker and decided, compared to the national average of 88 days, state records show. State and national officials with the Social Security Administration said they didn't know the state agency was using code names.

Group Health Providers Accused of "Theft"

An Austin lawyer has filed suit against the group health provider, Cigna Healthcare, claiming that "Texas physicians are being robbed blind." The case is *Rogers v. Cigna Healthcare of Texas, Inc.*

Robert Provan of Austin's Provan & Associates, and Jim George have teamed up and filed the suit under the Texas Theft Liability Act. To establish a cause of action, the physicians must prove that they are victims of "theft" as defined by the Texas Penal Code. The suit alleges that Cigna took services from the physician with the intent of not paying of the full value for the services.

Apparently, the suit complains about

1. Software programs used;
2. Down coding by substituting a lower reimbursement code; and
3. Bundling of various services or procedures and paying for only the combined bundled service. The suit seeks class action status.

Interest Rate Continues to Drop

The interest rate applicable for payments made to claimants and health care providers continued its yearlong slide. The TWCC announced that the fourth quarter interest rate would be 6.22 percent. The rate will be effective on all payments made between October 1, 2001 and December 31, 2001.

The interest rate applicable to workers' comp cases this year has plunged from a first quarter high of 9.21 percent. The third quarter rate was 7.03 percent. The rate also applies to discounts for advanced payments made during the fourth quarter.

The workers' compensation interest rate is computed by using the treasury constant maturity rate for one-year treasury bills issued by the United States Government, as published by the Federal Reserve Board on September 17, 2001 (3.53 percent) plus 3.5 percent as required by Section 401.023.

The HIPAA Privacy Standard Clearing up the Confusion

Privacy of patient medical records has become an industry watchword over the last five years. Congress and individual states have enacted or debated legislation to protect confidentiality, while permitting payors and administrators reasonable access to needed information. The federal law governing these transactions is the Health Insurance Portability and Accountability Act of 1996, which is known as "HIPAA". In a series of articles, we will examine why HIPAA was created, look at what it is designed to accomplish, and consider its potential effect on workers' compensation.

HHS Guidance

On July 6, 2001, the Department of Health and Human Services issued the first in a series of guidance materials on new federal privacy protections for medical records and other personal health information. The guidelines explain and clarify key provisions of the medical privacy regulation. Providing this guidance is part of an ongoing process to help health care providers and health plans come into compliance with the regulation by April 14, 2003.

"The patient privacy rule will provide strong protections for personal health information while maintaining the high quality of care that Americans expect," HHS Secretary Tommy G. Thompson said. "This guidance is an opening step in helping physicians, healthcare providers and health plans understand their obligations to patients under the rule."

The guidance – available on the Web at www.hhs.gov/ocr/hipaa – answers common questions about the new protections for consumers and requirements for doctors, hospitals, other providers, health plans and health insurers, and health care clearinghouses. It also clarifies some of the confusion regarding the meaning of key provisions of the rule.

For example, the guidance makes clear that hospitals do not have to build private, soundproof rooms to prevent overheard conversations about a patient's condition, as some mistakenly believed. Rather, the rule simply requires that hospitals provide reasonable safeguards to protect confidential information – such as using curtains, screens or similar barriers, which are often already used. The guidance also indicates that the rule allows a friend or relative to pick up a patient's prescription at the pharmacy, as often occurs today.

The guidance addresses many key issues of concern. Topics include patient consent, parental rights, marketing, medical research and governmental access issues.

Most covered entities have until April 14, 2003, to comply with the patient privacy rule; small health plans have an additional year to comply. HHS' Office for Civil Rights will conduct extensive outreach to consumers and healthcare providers

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Fraud Detection and Prevention in the Texas Workers' Compensation System--part one

The Research and Oversight Council on Workers' Compensation recently conducted a study of fraud detection and prevention in Texas and in other states. The comprehensive report analyzes common perceptions of fraud and identifies opportunities to prevent fraud within the Texas workers' compensation system. *FOLIO* will, for the next several months, present the ROC's findings. This month, the study introduces and defines the problem.

I. INTRODUCTION

The detection and prevention of fraud has been an issue of concern in the Texas workers' compensation system for some time. In addition, its implications are not limited to one, easily-defined category of fraud. Perceptions of the severity of fraud in the system, and of what types of activities should be the focus of fraud prevention efforts, vary among stakeholders including insurance carriers, employers, workers, attorneys and health care providers.

In order to identify opportunities to improve workers' compensation insurance fraud detection and prevention in Texas, the ROC conducted a review of systems in place here and in other states. The background information for this review was gathered during the fall of 2000 and involved interviews with both the key workers' compensation and insurance regulatory agencies in Texas and selected insurance fraud experts here and in other states, along with a review of published and Internet-supported information.

It attempts to provide answers to three basic questions:

1. What is the extent of fraud in workers' compensation and other

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GQ Corner

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

Q *I received a SIBs application for 3rd quarter, the claimant listed 66 job searches (he lives in El Paso). On all these searches, he went "in person," did not file an application or resume, and no one was hiring. Would this constitute a good faith effort?*

A What constitutes a good faith effort is a fact question. In some cases 66 contacts is sufficient and in some cases, it is not. Sixty-six contacts are a considerable number, but no set number is necessarily a good faith effort. The cases generally focus on the amount of time the claimant is putting in to the job search. You should examine the application closely to determine if the claimant did search each week of the qualifying period. If he did not he will probably not qualify for SIBs. You should also look at the types of business and the addresses. Often a claimant lists a lot of businesses that are very close together geographically, yet asserts that they went to each business on a separate date. That artificial spreading of the contacts does not look like a good faith effort. If the claimant is unduly restricting his search to a particular specific business, then that may be a factor that shows a lack of good faith.

Q *We have received several claims where a nurse accidentally sticks herself with a needle. Sometimes the patient is HIV positive - sometimes they are not. The nurses are tested. The results (so far) have been negative for HIV. Should we be filing a dispute on these claims to protect us if the claimant tests positive at a later date?*

A Yes, you should most definitely deny the claim to preserve your rights. Note also Sec. 81.050(j) of the Texas Health Code, which we include in the appendix of our FOL Manual. If you have the 2001 edition (green cover), it's on page 544. It mandates that, for the purpose of qualifying for workers' comp or any other benefits, an employee who claims a possible work-related exposure to a reportable disease, including HIV, must provide the employer with a sworn affidavit of the date and circumstances of the exposure. The employee must also document that no later than the 10th day after exposure, the employee had a test result that indicated an absence of the reportable disease, including HIV infection.

I would suggest the following wording for a dispute: The claimant has alleged a needle stick. The carrier denies that the alleged incident caused a compensable injury or occupational disease. Additionally the carrier denies that the claimant contracted a communicable disease as a result of the alleged incident. The carrier further relies upon the provisions of section 81.050 of the Texas Health Code to the extent the claimant has failed to comply with the requirements of that section of the Health Code.

Q *I have a claim where an employee was on a 15-minute break and she went to her car. On her way out there, she tripped and fell on the garage stairs. Would this be a compensable workers' compensation injury in your opinion.*

A It depends on what she was going to her car to do. If she was going for some "personal need," it could be compensable under the personal comfort and convenience doctrine. If not, it would probably not be compensable. Similar facts were considered in AP 992215:

Where a claimant goes to the employer's parking lot on a break to determine if her car windows are closed, and suffers an injury, such injury is not compensable as outside of the course and scope of employment. Personal activities are divided into two categories, one addresses the personal needs of the employee, such as eating or using a restroom and comes within the scope of the personal comfort doctrine. The other deals with activities of an employee on a break to do personal business, chores, or errands, and falls outside of the personal comfort doctrine. While the injury originated in the workplace, it did not occur while the claimant was furthering the affairs of the employer.

Q *The claimant was found to be at maximum medical improvement on 1/4/01 with 6% impairment rating given by the treating doctor. The claimant disputed and was sent to a designated doctor. The designated doctor gave maximum medical improvement on 7/19/01(date he saw claimant) and an 8% impairment rating.*
I am filing a TWCC-45 disputing the change in maximum medical improvement date. The claimant has seen the

treating doctor one time since 1/4/01 and the doctor stated nothing seems to have changed since the maximum medical improvement date. He has not been receiving any therapy or treatment of any kind. I am requesting that the Designated explain the MMI date he gave. Question: Do I need to file anything besides the TWCC-45? Do I pay TIBs now from the original date of maximum medical improvement to this new date—the claimant's only work restriction is an 8 hr day and the insured works 12-hour days and the additional IIBs, or can I wait until I get the Designated doctor's review?

A I assume that the designated doctor was specifically appointed for both MMI and IR. If this is correct, you must pay TIBs for any disability that occurred since you suspended them until the date certified by the designated doctor. You can redesignate any IIBs paid during that period to TIBs, and take the overpayment against any future IIBs. If the designated doctor was not appointed for the issue of maximum medical improvement (look at the appointment letter), then he is not entitled to presumptive weight on that issue, and you are not required to pay for that date of maximum medical improvement (only the impairment rating). I would also write to the Texas Workers' Compensation Commission and ask them to contact the designated doctor regarding the date of maximum medical improvement, to see if he can indicate any evidence of additional material improvement in the claimant's condition between the date he certified and the date originally given by the treating doctor.

Q *When a claimant reaches statutory maximum medical improvement and the treating doctor has not given any impairment rating, do I make a reasonable assessment and begin paying IIBs on that assessment? Is there any form or anything to be filed? How does anyone know what assessment I gave?*

A This scenario is governed by Rule 130.8(b)(2). Failure to make a reasonable assessment and initiate IIBs timely will subject you to a potential administrative violation. File a TWCC-21, noting the suspension of TIBs (if any) and the initiation of IIBs, and the fact that you are making a reasonable assessment. You may make an assessment of 0%, if it is reasonable. If your assessment is not reasonable, you are subject to an administrative penalty. You must do this in all cases where the claimant has reached statutory MMI, even where the period of lost time has already ended.

Q *Claimant was in the employer's parking lot and was returning from lunch when she tripped and fell and injured her left elbow and knee. Would the injuries be covered under access doctrine?*

A This would likely be compensable if the claimant parked in an employer-owned lot. Assuming the employees were expected to use this lot for parking and that this was in fact a trip to and from lunch, the incident would fall within the access doctrine.

Q *Our insured is forming a softball team, the company is going to supply uniforms, with the company logo on the jersey, the company is going to pay the league entry fees. The practice field will be on the insured's premises. It is not mandatory to join the team. If an employee should get injured while practicing, will it be considered within course and scope? What if the employee is injured while playing in a game?*

A There is some split of authority. However, the cases look to Sec. 406.032(1)D, for the answer. The AP will look at whether the activity arose out of a voluntary participation in an off duty activity that did not constitute part of the claimant's work-related duties. Second, they look to whether there was a reasonable expectation that the activity was expressly or impliedly required by the employment. The leading cases are mostly school cases. They are AP 941269, 981313, 980600, and 992077. Most of the cases favor the carriers, but it depends on the facts of each case. The AP has increased the claimant's burden somewhat by adopting the view that it is the employer's expectancy that matters. See AP 960515 and 981313. Keep in mind that these cases are to be distinguished from the cases in which the employee is injured during a break while during his work hours such as from throwing a football. In those cases, the claim is almost certainly compensable. However, anytime an employer sponsors an athletic activity, there are generally going to be injuries and regardless of whether the carrier can ultimately prevail, an employee who is injured may very likely file a comp claim.

Q *Do you have a copy of the letter we are required to send claimants, informing them that SIBs will end soon? Is there a commission approved form letter for this notification or do we just write our own letter?*

A See FOL Advisory #242 and TWCC Advisory 98-05.

Q *The claimant was in an auto accident and obtained an attorney for the third party claim. The lien has been resolved and the disbursement is as follows: Settlement (at policy limit) $20,000 WC lien recovered $5,500. Attorney fees: $6,800. Client expenses: $363.38. Outstanding medical bill: $2,592.95 NET CLAIMANT RECOVERY: $4,743.67 She is currently in the IIBs phase of the workers' compensation claim and designated doctor assessed 28%. Do I have a choice on which line (indemnity vs. medical) to recover the claimant's net settlement?*

A Under Texas Labor Code § 417.002, any amount recovered that exceeds what has already been paid by the carrier shall be treated as an advance against future benefits, including medical benefits, that the claimant is entitled to receive. Thus, under the statute, there is no preference of which benefits to use to recover the remaining amount.

Q *If a claimant has an attorney, are we required to send a copy of the pre-authorization letter to the attorney (whether the medical procedure was approved or denied)?*

A Yes. Rule 134.600 (e) requires it.

Q *TWCC-52 is submitted on last day for filing Claimant returned to work but did not send all his paycheck stubs for qualifying period. An adjuster called and advised he had to send further paycheck stubs. He submitted the remaining paycheck stubs required except for one week. Even without the one week's paycheck, he made over 80% of his pre-injury earnings. The adjuster will now indicate on TWCC-52 that claimant does not qualify for SIBs as he made over 80% of pre-injury earnings. Even though I am past the 10 day deadline to dispute, carrier does not have to file TWCC 45 as entitlement to SIBs is not disputed just the amount, (which is zero), right?*

A The Rules do not expressly cover this situation. However, under Rule 130.104(g), a question of how much you owe for a quarter (i.e., a change of monthly amount) is not subject to the Rule 130.108 requirement of filing a TWCC-45 to dispute entitlement. You could argue this is not an entitlement dispute, only a question of amount owed. Since the information ultimately means the claimant is entitled to zero, you could return the TWCC-52 and indicate the amount owed is zero.

The better alternative may be to argue that an application for SIBs is defined in Rule 130.101(1) as requiring supporting payroll documentation and the amount of wages earned in the qualifying period. Take the position the TWCC-52 is not filed until that information is completed. Since you just received it, you have ten days from the completed TWCC-52 to now file your TWCC-45.

Q *Are we still using 3rd Edition or has 4th Edition been adopted?*

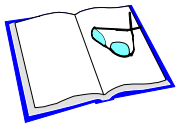
A Under Rule 130.1, the 4th Edition is to be used for exams on or after 10/15/01, unless there is a prior unwithdrawn impairment rating using the 3rd Edition.

Q *Are we required to pay out-of-state medical providers in full instead of applying the fee schedule? Please advise what rule address this situation, if any.*

A Out-of-state medical providers performing treatment on Texas claimants are subject to the same standards and guidelines as medical providers who are in-state. There is no specific Rule that deals with out of state providers. Fees should be reviewed to determine the reasonableness of the amounts billed. It would be helpful if the fee guidelines were a factor but not the total basis for a dispute (for example, a peer review explaining why the costs are not reasonable)—this is true for both in-state and out-of-state doctors.

Q *I have an 82-year-old gentleman that was involved in a slip and fall at work. The claim seems compensable, however, the gentleman works at the help desk at the hospital and is a volunteer. How does this affect his worker's compensation claim? Per the Act it appears he is not covered. Is there any interpretation or anything I should be aware of?*

A You are correct. Volunteers are generally not covered under the Act. Section 401.012 defines "employee" as someone under a contract of hire. This would not extend to volunteers. It is still necessary to file a TWCC-21 asserting the defense that he was not an employee at the time of the injury.



Practice Pointer

Child Support Liens

Workers' compensation benefits are subject to writs and orders of income withholding issued pursuant the Family Code. The carrier is defined as the claimant's "employer" for purposes of these writs. Section 101.011 defines "earnings" as "payments made under a ... workers' compensation ... program," with no limit on the benefit type. Under §158.009 of the Family Code, an order or writ of withholding shall direct that the carrier (employer) to withhold from the claimant's benefits the amount specified in the order up to a maximum amount of 50 percent of the weekly benefits.

The Family Code provides for certain rights and duties of a carrier subject to an order or writ of withholding. Section 158.206 requires that the claimant's employer shall send a copy of the income withholding order or writ to the carrier in order to continue any ordered withholding of income. The carrier must begin to withhold the benefits not later than the first pay period following the date on which the order or writ was delivered to the carrier, and continue to withhold benefits.

Compliance with the order or writ relieves the carrier of liability to the claimant for the amount withheld. Further, the carrier may deduct an administrative fee of not more than $10.00 each month from the claimant's benefits in addition to the amount withheld as child support.

Failure to comply with the order or writ renders the carrier liable not only to the claimant for the benefits withheld and not paid per the order, but also to the beneficiary of the writ or order for the amount that should have been paid. In addition, the carrier would be liable for reasonable attorney's fees and court costs, as well as a fine not to exceed $200.00.

Although only writs and orders of income withholding issued pursuant to chapter 158 of the Family code are listed in §408.203(b), other portions of the Family Code affect workers' compensation benefits. A child support lien attaches to "a claim for . . . workers' compensation" due to the claimant "from the date the lien notice is filed with" the carrier.

If a child support lien is delivered to the carrier, the carrier must immediately notify the obligee of the last known address of the obligor and notify any other party that has an interest in the benefits that they have been frozen in an amount not to exceed the amount of the child support arrearage identified in the notice. (§157.314). Upon notice of a levy for child support benefits in arrearage, it may not make any payment of benefits to the claimant so that the remaining benefits would be less than the amount of the arrearages identified in the notice. (§157.327). The carrier must then issue payment not earlier than 15 days after the notice is received, but not later than 21 days unless (among others) the carrier is subsequently notified of the claimant's satisfaction of the levy. A carrier that surrenders the benefits to an obligee is not liable to the obligor or other party. (§157.329).

Because the carrier is defined as an "employer" in one provision of the Family Code, and a "financial institution" in another provision, the interplay between the carrier's obligations is not immediately clear. That is, one part of the Family Code seems to limit the amount the carrier withholds to 50 percent of the weekly benefits. Another provision seems to have no such limitation, and in fact requires the "freezing" of the claimant's benefits. These provisions may be reconciled by noting that the 50 percent limitation applies to a continuing obligation under Chapter 158, whereas the Chapter 157 provisions apply to a lien for arrearages. Section 157.312(c) specifically indicates that a child support lien "is in addition to any other lien provided by law."

One surprising result in this area concerns the payment of attorneys' fees. Attorneys' fees, ordered by the Commission, must be paid first in every case. In the event the child support lien order requires reimbursement of accrued child support arrearage, you should pay 100% of the benefits to the child. However, if there are outstanding attorneys' fees that have been ordered to be paid, the fees must be paid first and the remainder then goes to the children. This is specifically mandated by §408.203, which sets the priority of liens.

In other words, the priority of liens runs as follows: attorney fees come first, then court-ordered child support, and finally the carrier's subrogation lien. This brings up an interesting situation in cases involving third-party recovery. When a carrier "takes a holiday" from paying the claimant benefits because of a third-party settlement, it still must make weekly payment of attorney fees.

To summarize, the following rules can be applied to child support lien questions.

- Such liens are valid.
- You should pay such liens out of any income benefits.
- Pay up to 50% of weekly benefits to fund current child support obligation.
- Pay up to 100% of benefits if the order is for the purpose of reimbursing accrued child support arrearage.
- Any order of withholding should direct whether lien is for current or arrearage and if does not, you should assume that you pay no more than 50% of weekly benefit per week.
- If you have a D&O from TWCC, and if you are ordered to pay a lien, and if it does not specify whether it is arrearage or current, then you should assume current, and should withhold 50% of weekly benefits times the number of weeks that you have had order of withholding to the date of payment.

Maximum Weekly Compensation Amount: A Multi-State Comparison – part two

The Texas workers' comp system ranks in the middle nationally, of statewide systems, in capping maximum weekly benefits for workers injured on the job, according to a new study released by the Research and Oversight Council on Workers' Compensation. The study, published in the Texas Monitor, suggests that increases to the maximum rates must be coupled with other system cost controls if the caps are to be increased meaningfully. In a four part series, *FOLIO* examines the ROC study. This month, we examine the Texas maximum TIB rate, and how it ranks against other states nationally.

This article examines the issue of benefit adequacy by comparing the maximum weekly benefits and statutory income replacement rates in other states to those in Texas. For the purposes of this article, income benefit comparisons with other states are based on **Temporary Income Benefits (TIBs—** known as Temporary Total Disability benefits or TTDs in other states), due to definitional similarities and because TTDs are by far the most frequent type of income benefits injured workers receive.

Background: the Texas System Five types of income benefits are currently payable under the Texas Workers' Compensation Act:

Temporary Income Benefits (TIBs) – paid during the period of temporary disability while the worker is recovering from an on-the-job injury.

Impairment Income Benefits (IIBs) – paid to injured workers for permanent impairments (based on the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association).

Supplemental Income Benefits (SIBs) – paid to injured workers for wage loss after all IIBs have been exhausted, up to 401 weeks after the injury occurred.

Lifetime Income Benefits (LIBs) – paid for the life of an injured worker for specific catastrophic injuries (e.g., total and permanent loss of sight in both eyes, total and permanent loss of use in both feet at or above the ankle, certain 3rd degree burns, etc.).

Death benefits and burial benefits – paid to a deceased worker's spouse or eligible dependents as a result of a death from a compensable injury.

Temporary Income Benefits in Texas When an injured worker misses at least seven days of work due to a compensable injury, he or she is eligible for TIBs. TIBs are paid based on 70 percent of the injured workers' average weekly pre-injury wages and capped at the maximum weekly benefit amount (currently $533 per week for a period up to 104 weeks from the date the disability begins). The maximum weekly benefit is defined as 100 percent of the State Average Weekly Wage (SAWW), which is updated annually by the Texas Workforce Commission and based on the average weekly wage of manufacturing production workers in Texas.

According to the United States Department of Labor, Office of Workers' Compensation Programs, Texas currently ranks 27th among the fifty states and District of Columbia in the actual maximum weekly benefit amounts for TIBs. This ranking is considerably higher than in 1989 when Texas ranked 41st. However, this ranking does not consider certain economic indicators, such as cost of living differences between states.

Next month, the series continues with a multi-state comparison of TIBs caps.

Gov. Appoints Health Care Committee

House Bill 2600 provided for a Health Care Network Advisory Committee to make recommendations to the TWCC regarding network standards, contracts proposals, feasibility, as well as other issues involving workers' compensation. On Oct 19, Governor Perry's office informally released the names of the members that will serve in this capacity. A formal announcement should follow.

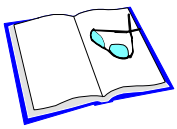
The committee consists of members from the employer's community, representatives of employee's interests, three health care provider members, three representatives of the insurance carrier industry and an actuarial expert. The three employer members are: William Simmons, WC Case Manager for UPS; William Ledbetter, HR Director, Justin Industries; and Norman Berkley, HR for Chevron Phillips Chemical Co.

The three employee members are: John Nash, Retired Kelly-Springfield, a former employee Commissioner at TWCC; David Faith, Chairman of Union, Safety & Health Coordinator for Lockheed Martin; and Katherine D'Aunno of the William & Bailey Law Firm.

The three provider members are George Willeford III, Gastroenterologist; Melissa Tonn, Chair of the Medical Advisory Committee; and Gregory Gilbert, CONCENTRA VP.

The three carrier members are: Jaelene Fayhee, Texas Mutual Insurance Company; Ron Josselet, SORM; and Marianne Caironi, Liberty Mutual Insurance Company.

The actuarial expert is James Daniel, Director of Actuarial Studies at UT.



Practice Pointer

Payment Obligations After Receipt of a TWCC-69

What do you do when you have a claimant to whom you are not paying TIBs (either he's back at work or never missed any time) and you receive a TWCC-69 from someone other than the treating doctor? Do you automatically pay the impairment without having the treating doctor sign off on it? The answer depends upon whether the rating has come from an RME physician or a referral doctor.

While the answer to this question is not immediately clear from the rules, we believe that for all certifications of MMI and assignment of IR, other than from a carrier selected RME doctor, you must act on it in the same manner as a treating doctor's certification.

Rule 130.8 specifically states that IIBs accrue on the day after the claimant reaches MMI. The rule recognizes no distinction between the category of doctors from whom the certification comes. Rule 130.1(a) defines the "certifying doctor" as a doctor defined by §401.011(17) of the Act, without reference to the status of the doctor. Further, Rule 130.5 requires the carrier to either pay or dispute an impairment rating within a certain amount of time, again without reference to the particular type of doctor.

The exception for RME doctors is statutorily based (§ 408.004). This was a 1999 amendment in response to a couple of developments. First, a district court overturned Texas Workers' Compensation Commission Appeal No. 92374, decided August 28, 1992 in *Maximiliano Davis v. Employers Casualty Co.*, No. 92-11978, 134th Judicial District, Dallas County, and held that a carrier could suspend TIBs on the basis of any doctor's certification, including a certification from a carrier selected RME. Utilizing the same rationale, a SOAH decision held that the Commission could not issue an administrative violation against a carrier for suspending TIBs on the basis of an RME certification.

The 1999 Legislature amended §408.004, and set up a specific process for the suspension of TIBs based upon a carrier-selected RME doctor's certification. The fact that no provision prohibits suspension on the basis of any other doctor's certification (i.e., a referral doctor or Commission-selected RME) indicates a legislative intention to allow it, according to the rules of statutory construction.

Rule 133.3(f) states that if a doctor other than the treating doctor is certifying MMI, the treating doctor shall indicate agreement or disagreement with the certification and evaluation of the certifying doctor." The Appeal Panel had determined in Appeal No. 92374 that this language precluded suspension on the basis of carrier-selected RME doctor's certification. However, that decision was overturned, as noted. Further, in Texas Workers' Compensation Commission Appeal No. 941006 the Appeals Panel specifically limited the holding of Appeal No. 92374 to carrier-selected RME doctor certifications.

There is interest on the part of Commission to keep the treating doctor in the loop, and that may explain this requirement of Rule 133.3(f). It does create an opportunity for the treating doctor to object, and many do. It is also important to note that this Rule is contained in Chapter 133 of the Rules, which deal with medical benefits and the responsibilities of the various doctors, as opposed to Chapter 130, which deals with the payment of impairment and supplemental income benefits. Any conflict should be resolved in favor of the rules specifically dealing with IIBs, rather than the treating doctor's responsibilities.

Note, also, that Rule 133.3 is currently proposed for repeal, and in fact the rules proposed to replace it specifically allow suspension of TIBs upon the receipt of a certification of MMI by a referral doctor. This obviously could not be allowed if it were inconsistent with the statute.

Accordingly, we believe that, for the first certification of MMI and assignment of IR received from any doctor other than a carrier-selected RME doctor, you must pay or dispute within 5 days and you must not wait on a response on the treating doctor. Once you have done one or the other, you will have complied with your obligation under the Act.

Did you Know...?

The median number of days for the first benefit payment under the Texas system between 1993 and 1998 is 13 days.

Interest Calculator
Fourth Quarter

Interest Rate Effective from 10/1/2001 through 12/31/2001: **6.22%**

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	Weeks	**"Y"** Value
1	0.0017	27	0.4514	1	0.0012	27	0.0323
2	0.0041	28	0.4848	2	0.0024	28	0.0335
3	0.0077	29	0.5194	3	0.0036	29	0.0347
4	0.0124	30	0.5552	4	0.0048	30	0.0359
5	0.0184	31	0.5922	5	0.0060	31	0.0371
6	0.0256	32	0.6303	6	0.0072	32	0.0383
7	0.0339	33	0.6697	7	0.0084	33	0.0395
8	0.0434	34	0.7103	8	0.0096	34	0.0407
9	0.0542	35	0.7520	9	0.0108	35	0.0419
10	0.0661	36	0.7950	10	0.0120	36	0.0431
11	0.0792	37	0.8391	11	0.0132	37	0.0443
12	0.0935	38	0.8844	12	0.0144	38	0.0455
13	0.1091	39	0.9309	13	0.0156	39	0.0467
14	0.1258	40	0.9787	14	0.0167	40	0.0478
15	0.1436	41	1.0276	15	0.0179	41	0.0490
16	0.1627	42	1.0777	16	0.0191	42	0.0502
17	0.1830	43	1.1290	17	0.0203	43	0.0514
18	0.2045	44	1.1814	18	0.0215	44	0.0526
19	0.2271	45	1.2351	19	0.0227	45	0.0538
20	0.2510	46	1.2900	20	0.0239	46	0.0550
21	0.2761	47	1.3461	21	0.0251	47	0.0562
22	0.3023	48	1.4033	22	0.0263	48	0.0574
23	0.3297	49	1.4618	23	0.0275	49	0.0586
24	0.3584	50	1.5214	24	0.0287	50	0.0598
25	0.3882	51	1.5823	25	0.0299	51	0.0610
26	0.4192	52	1.6443	26	0.0311	52	0.0622

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Disputed Claims (TWCC-21)	Tillie Aguirre	435-2235	477-4996	TAA
General Questions	Receptionist	477-4405	867-1700	GQS
Insurance Coverage (TWCC-20)	Phyllis Devine	435-2267	867-1748	PAD
Med Review Disputes	Annette Moffett	435-2266	867-1733	AMM
Records Request/Photostats	Phyllis Devine	435-2267	867-1748	PAD
Request for BRC (TWCC-45)	Tillie Aguirre	435-2235	477-4996	TAA
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CASE DECISIONS US COURT OF APPEALS

Hathcock v. Acme Truck Lines, Inc., No. 00-20810 (5th Cir. Sept. 6, 2001).

Truck owner who leased his truck to a company and selected himself to drive the truck for the company is an employee of lessee company in his capacity as a truck driver.

Facts: Plaintiff Hathcock leased his truck to Acme. As part of the lease agreement, Acme agreed to pay Hathcock a certain percentage of revenue earned from the use of the truck minus the driver's wages, payroll taxes, and various other costs. Acme also accorded Hathcock the option of choosing and designating the driver of the truck, or to let Acme supply the driver. Hathcock selected himself as the driver. Eventually, Hathcock terminated the lease agreement and sued Acme asserting various causes, such as fraud, breach of contract, conversion and unjust enrichment. The case was removed by Acme to federal district court. The district court granted Acme's motion for summary judgment. Hathcock appealed, arguing that (1) Acme's deductions from his rental check to defray tax costs were unlawful because he argues he was an independent contractor at all times and was never Acme's employee, and (2) in the alternative, that Acme violated federal and state law when it deducted money from a lessor-driver's rental check to defray the employer's tax expenses.

Holding: The Fifth Circuit affirmed the district court's granting of summary judgment for Acme. The Court first held that Acme can treat Hathcock the same way when he drives the truck that he leased to Acme as it would treat a third-party driver chosen by Hathcock. Thus, Acme may simultaneously treat him as an owner-lessor and as a driver-employee. Hathcock wears two "hats" in the relationship.

The Court disagreed with Hathcock's argument that he was an independent contractor and not an employee, and looked at five factors from case law in analyzing whether one is an independent contractor or employee. The facts here mandated a clear conclusion that Hathcock was an employee. Hathcock did not dispute these facts but argued that his subjective belief that he was an independent contractor and his treatment as such by his CPA should be considered. The Court rejected this argument.

With respect to Hathcock's second argument, the Court found that Acme's tax withholding practices were perfectly legitimate and that Hathcock's argument had no merit.

CASE DECISIONS TEXAS COURTS OF APPEALS

Alayon v. Delta Air Lines, Inc., No. 10-99-297-CV (Tex. App.—Dallas 2001).

Court of Appeals reversed and remanded the trial court's granting of summary judgment for Delta in a claim of discharge for filing a WC claim because there was a fact issue as to whether Delta had a retaliatory motive and filed Alayon for filing a WC claim.

Facts: Claimant Alayon sustained an elbow injury in 1995. Alayon's job required the employee to be able to lift a minimum of 70 pounds. After the injury, Alayon was restricted to lifting only 50 pounds. Alayon filed a workers' compensation claim. Eighteen months later Delta discharged Alayon. Delta claimed it discharged Alayon because he was discovered working for Gold's Gym as a personal trainer. Alayon filed a retaliation lawsuit; Delta filed for summary judgment. The trial court granted Delta's motion, and Alayon appealed.

Holding: The Court of Appeals reversed and remanded the trial court's granting of summary judgment to Delta because it found a fact issue as to whether Delta had a retaliatory motive and fired Alayon for filing a workers' compensation claim.

The Court looked at the factors for determining whether there exists a causal link between the discharge and the workers' compensation claim as set out in Continental Coffee. The Court noted that when reviewing a summary judgment for the defendant, it must be shown that there is no genuine issue of material fact when all evidence is viewed in a light most favorable to the plaintiff. Here, the Court found that the evidence did raise a fact issue as to whether Delta had a retaliatory motive and fired Alayon for filing a workers' compensation claim. Specifically, the Court took note of evidence produced by Alayon of a memo in which Delta claimed Alayon was not injured, and of alleged contradictory reasons for termination. Accordingly, the Court reversed the summary judgment in favor of Delta and remanded the cause to the trial court for a determination on the specific fact issues.

Bryan v. Zenith Ins. Co., No. 03-00-00573-CV (Tex. App.—Austin 2001).
Court of Appeal affirms, among other things, that decedent's heart attack was not a compensable injury.

Facts: Decedent Bryan worked for Colcom, Inc. as a cable locator. After inspecting one work site, Bryan suffered a fatal heart attack driving to his next inspection site. It was customary, to protect against liability for damaged lines, and for inspectors to videotape the markings made at work sites. Bryan's widow and children filed for survival benefits after they were told by an employee of Colcom that Colcom had a videotape of Bryan breathing laboriously while working the day before the heart attack. The tapes delivered by Colcom after subpoena did not include heavy breathing by Bryan. The Bryans' claim for survival benefits was denied at a benefit review conference, and subsequently at a contested case hearing and appeal. The Bryans then filed suit for judicial review. The district court rendered judgment for Zenith, finding that Bryan's heart attack was not compensable under the labor code. Bryan's family appeals, arguing: (1) that exclusion of the Colcom employee's testimony about Bryan's labored breathing was harmful error; (2) that exclusion of evidence of the spoliation of the videotape was harmful error; and (3) that the district court's judgment that Bryan's heart attack was not compensable was against contrary to the great weight and preponderance of the evidence.

Holding: The Court of Appeals affirmed the decision of the district court and overruled all of the Bryans' arguments.

With respect to the issue of whether the heart attack was a compensable injury, the Court found sufficient evidence to support the district court's finding that Bryan's heart attack was not a compensable injury. The Court noted that in order for a heart attack to be compensable, the claimant must prove that the preponderance of the medical evidence regarding the attack indicates that the employee's work rather than the natural progression of a preexisting heart condition or disease was a substantial contributing factor of the attack. Here, the Court noted medical evidence that Bryan had a significantly enlarged heart and a history of heart disease before the heart attack; that he had a ninety-percent blockage in one artery; that he smoked regularly; and that both medical experts agreed that Bryan's heart disease was a major factor in the heart attack.

Downs Agreement
Continued from p. 1

60 days to investigate a claim before waiver could apply to prevent its defenses. Neither bill, however, was passed into law, leaving it up to the Supreme Court to determine whether a carrier has seven or 60 days before waiver applies.

The San Antonio 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. On motion for rehearing the San Antonio 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 Commission has issued an advisory (Advisory 2000-07) staying agency implementation of the *Downs* decision. (See "Downs Update" FOLIO, September 2000) That advisory notified all interested parties 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 instructed its personnel not to enforce *Downs* while the case remains pending in the Texas court system.

AMA Guides
Continued from p. 1

amendment. Due to the proposed amendments to Rule130.1 and the change to the fourth edition of the *AMA Guides*, the TWCC-69, Report of Medical Evaluation (Rev. 5/94), will soon be revised.

Until the revised TWCC Form-69 is available, doctors who certify MMI and use the fourth edition of the *AMA Guides* to assign an impairment rating must strike through the words "third edition, second printing, February 1989" in block 18 of the current TWCC-69 form and write by hand the "fourth edition" in block 18. If the TWCC-69 form does not have the required change to block 18, but the narrative report clearly indicates that the Fourth Edition was used, it shall be assumed that the Fourth Edition was used in the assignment of that impairment rating.

First Visit
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within network, according to the study, The Impact of Initial Treatment by Network Providers on Workers' Compensation Medical Costs and Disability Payments.

The study also found that lower network medical costs do not raise indemnity benefit costs among claims treated in networks. Indemnity benefits are paid to compensate injured workers for wages lost while they are away from their jobs.

The quality and accessibility of medical care are not directly measured in this study. WCRI is undertaking studies that will examine the affect of medical networks on worker satisfaction, health and functioning, and return to work – important dimensions of medical care for injured workers.

The study is based on nearly 300,000 workers' compensation claims in eight states and 20 different workers' compensation networks.

The Workers Compensation Research Institute is a nonpartisan, not-for-profit, membership organization conducting public policy research on workers' compensation, health care and disability issues. Its members include employers, insurers, insurance regulators and state regulatory agencies in the U.S., Canada, Australia, and New Zealand, as well as several state labor organizations.

New Study
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- Florida (5.1%) – the former managed care mandate
- Massachusetts (6.0%) – low medical costs
- Wisconsin (2.9%) – less frequent use of medical cost containment services.

The study collected data from more than 450,000 claims between 1997 and mid-1999. The researchers used comparable definitions across states and adjusted its analysis to standardize for interstate differences in industry mix, injury mix and wage levels.

The measures of benefit delivery expenses are akin to what insurers call "allocated loss adjustment expenses" and understate the total benefit delivery expenses in two ways. First, they do not include "unallocated" expenses – those that are incurred to handle claims, but not charged to individual claim files (e.g. claim adjusters' salaries, rent, etc). Second, they include payments to defense attorneys, but not fees and expenses paid for workers' attorneys.

The study, Where The Workers' Compensation Dollar Goes, was authored by Richard A. Victor and Carol A. Telles. The Workers Compensation Research Institute published it in August 2001. It is available at www.wcrinet.org.

Redistricting Ruling
Continued from p. 4

draw the two new congressional seats. "Our position all along has been: You have to start with that plan and make the least changes you have to make from that plan to fix the current legal problems," he said, referring to making sure the new map fairly represents the changes and shifts in population.

Meanwhile, U.S. Rep. Tom DeLay of Sugar Land, the Republican majority whip, asked the Texas secretary of state's office to refuse to submit Judge Davis' plan to the Department of Justice for pre-clearance. "Politics, not the law, was foremost in the mind of this judge," Mr. DeLay said.

All Texas redistricting plans must be submitted to the Department of Justice, where officials determine whether the proposals violate the federal Voting Rights Act. The plans redrawing districts for seats in the Texas House are pending before the Justice Department. A Justice Department letter to the state this month indicated that the state Senate redistricting plan has passed an initial Voting Rights compliance check. State officials have been notified that the Justice Department has asked for more time to determine the legality of the 150 proposed House districts.

The state House and Senate districts were drawn by three GOP members of the Legislative Redistricting Board: Mr. Cornyn, Comptroller Carole Keeton Rylander, and Land Commissioner David Dewhurst. The plans would give the GOP strong majorities in the state House and Senate, analysts have said. Democrats are contesting those plans in state and federal courts.

To view redistricting maps, go to www.tlc.state.tx.us/tlc/research/redist/redist.htm. The attorney general's map is 01044 C, and Judge Paul Davis' map is 01089 C.

HIPPA
Continued from p. 7

to explain what the rule means for them. HHS also will provide technical assistance and further guidance to healthcare providers and other covered entities to help them comply.

As permitted under the HIPAA law itself, HHS also expects to propose appropriate changes to the rule in order to ensure that it does not adversely affect patients' access to quality health care. For example, Secretary Thompson has said he intends to propose modifications to ensure that a pharmacist can fill a phoned-in prescription for a new patient, even when the pharmacist does not first have the patient's signed consent on file.

A fact sheet summarizing the privacy rule's rights and protections is available on the Web at www.hhs.gov/news/press/2001pres/01fsprivacy.html. More detailed information about the rule, including the initial guidance, is available at www.hhs.gov/ocr/hipaa.

Fraud Detection
Continued from p. 7

insurance lines, and what are Texas' current efforts to detect and prevent fraud?

2. How does fraud detection and prevention in the workers' compensation system, or in insurance generally in Texas, compare to that in other states?
3. What policy options exist to improve insurance fraud prevention programs in Texas?

Following this introduction is a discussion of the extent of fraud in the workers' compensation system. This is followed by an overview of current programs and recent regulatory efforts in Texas, and an examination of programs in six other states, chosen because they utilize comparatively aggressive approaches to fraud.

II. DEFINITION AND EXTENT OF THE FRAUD PROBLEM

There is no one, clear label that can be placed on the various activities in the workers' compensation system that could be construed as fraud. Stakeholders in the system often carry different perceptions of the activities that constitute fraud, as well as the responses that constitute effective anti-fraud efforts.

For example, insurance carriers and employers have historically viewed fraud by workers' compensation claimants as a major problem. Conversely, workers, attorneys and health care providers often contend that employer and insurance carrier actions to deny or delay benefits constitute fraud, and that regulatory agencies should investigate such allegations.

In the workers' compensation system, broad categories of fraud can be defined as follows:

- workers who receive improper benefits through intentional deception;
- health care providers, attorneys, and others who bill for services not rendered, misrepresent their services, receive kickbacks for referrals and/or contribute to a worker receiving improper benefits;
- employers who avoid payment of proper insurance premiums, often to gain a competitive advantage in the marketplace;
- employers, carriers, and medical agents/experts who knowingly act to deny or dispute legitimate claims by workers; and
- officers and agents who market illegal insurance products and those who raid the assets of insurance companies, creating financial distress.

Efforts have been made to assess public sentiment about insurance fraud, and these have also revealed divergent views. A recent survey of public attitudes found that 90 percent of respondents believed that fraud increases insurance costs – by an average estimated increase of 37 percent – but that only a slight majority, or 57 percent of those responding, believed that a person should be prosecuted for falsifying insurance-related information. Historically, the public has often viewed fraud as a "victimless" crime, and prosecutors have made violent crime a higher priority for prosecution.

A review of literature reveals that no solid method exists to quantify the extent of fraud that occurs in workers' compensation – or, for that matter, in any other insurance line. Devices such as claim audits and fraud indicators are commonly used in private and public insurance programs to identify suspicious patterns that could point to fraud. However, most regulatory efforts, including those by workers' compensation regulators, account for fraud in the system by tracking fraud referrals and the prosecution of those referrals, a process that only accounts for reported cases. In addition, many of these regulatory programs include processes that are useful as auditing tools but not necessarily for detecting fraud. Undetected fraud cannot, of course, be factored into an assessment of the extent of the problem in Texas or in any other state.

With these caveats and limitations, there are indications from existing fraud programs and other data that point to both the extent of the fraud problem and the cost savings to be realized by addressing it. For example, the Coalition Against Insurance Fraud, a non-profit, nationwide anti-fraud organization, in 1997 estimated the annual cost of insurance fraud in all lines nationwide at $79.7 billion, a figure that on a per capita basis would suggest about $6 billion in annual fraud-related losses in Texas that year.

Other estimates specific to health care fraud place its cost at between 3 and 10 percent of the country's annual health expenditure of $1 trillion. The National Insurance Crime Bureau, a non-profit organization supported by about 1,000 insurance companies, recently called workers' compensation fraud the fastest-growing segment of insurance fraud, and estimates that it costs the insurance industry nationwide about $5 billion a year.

There are obvious implications in these estimates for fraud in the workers' compensation system. More than half of workers' compensation benefit payments are for medical services, so the connection to health care-related fraud is clear. In addition, the experience of other medical benefit programs suggests that the implementation of aggressive fraud and abuse prevention programs in workers' compensation medical services may pay significant rewards. As an example, a U.S. Department of Health and Human Services Medicare/Medicaid fraud hotline generated 450,000 callers in five years, and Operation Restore Trust, a multi-faceted national Medicare/Medicaid fraud and abuse detection effort, recovered $23 for every $1 expended for fraud and abuse detection and prosecution during a two-year demonstration period.

Next month, this series continues with an examination of current workers' compensation fraud prevention efforts in Texas.

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