Title 28. Insurance
Part 2. Texas Department of Insurance, Division of Workers' Compensation
Chapter 124 Insurance Carriers: Required Notices and Mode of Payment
§124.2 Insurance Carrier Reporting and Notification Requirements, and
§124.3 Investigation of an Injury and Notice of Denial/Dispute

The Texas Department of Insurance, Division of Workers' Compensation (DWC) proposes amendments to Texas Administrative Code, Title 28, §124.2 and §124.3, to implement Senate Bill (SB) 2551, 86th Legislature (2019). The proposed amendments to §124.2 define the process through which an insurance carrier may provide an injured employee, who may qualify for a presumption under Texas Government Code Chapter 607, Subchapter B with a 15-day notice that describes all steps taken by the insurance carrier to investigate the injury and the evidence that the insurance carrier reasonably believes is necessary to complete its investigation of the compensability of the injury. The proposed amendments to §124.3 describe an insurance carrier's obligation to investigate each element of a presumption claim. Additional editorial corrections are made throughout these rules to align them with current style and usage. Concurrent with this rulemaking, DWC is proposing amendments to Chapter 180 that are also necessary to implement SB 2551.

BACKGROUND AND PURPOSE

Senate Bill 2551 amended both the Workers' Compensation Act, Labor Code Title 5, and Government Code Chapter 607, Subchapter B, relating to diseases and illnesses suffered by firefighters, peace officers, and emergency medical technicians (EMTs) (collectively "first responders"). A separate bill, SB 1582, added peace officers to the list of first responders covered by Subchapter B. As these proposed rules will apply uniformly to all first responders covered by Subchapter B, no additional rulemaking is required to implement SB 1582. The proposed amendments to Chapters 124 and 180 address both an insurance

carrier's obligation to investigate and how a presumption claim is to be investigated. The proposed amendments also address the notification process for such claims.

Subchapter B applies to certain occupational diseases or illnesses suffered by first responders who meet the qualifications set forth under its provisions. Subchapter B applies to first responders who received a physical examination upon or during employment that did not reveal evidence of the illness or disease for which benefits or compensation is sought, who have been employed for five years or more as a first responder, and who seek benefits or compensation for a disease or illness covered by the subchapter that is discovered during employment as a first responder. Gov't Code §607.052(a). The diseases and illnesses covered by Subchapter B are reactions to vaccinations for smallpox or other diseases, tuberculosis or other respiratory illness, cancer (firefighters and EMTs only), and acute myocardial infarction or stroke. §§607.053-607.056. The presumptions under Subchapter B do not apply to a determination of a survivor's eligibility for benefits under Government Code Chapter 615 (relating to Financial Assistance to Survivors of Certain Law Enforcement Officers, Fire Fighters, and Others), in a cause of action brought in court except for judicial review of a grant or denial of employment-related benefits or compensation, to a determination regarding benefits or compensation under a life or disability insurance policy, or if the disease or illness for which benefits or compensation is sought is known to be caused by the use of tobacco and if either the first responder is or has been a user of tobacco or if their spouse has, during the marriage, smoked tobacco. §607.052(b). The presumptions under Subchapter B apply to a determination of whether a first responder's disability or death resulted from a disease or illness contracted in the course and scope of employment for purposes of benefits or compensation. §607.057.

Senate Bill 2551 amended Subchapter B to direct that four specified types of cancer and cancers originating in seven specified organs might trigger the presumption under Government Code §607.055. Senate Bill 2551 also amended the requirements for rebutting a presumption. A presumption can be rebutted through showing, by a preponderance of the evidence, that a risk factor, accident, hazard, or other cause not associated with an individual's service as a first responder was a substantial factor in bringing about the individual's disease or illness, without which the disease or illness would not have occurred. §607.058(a). A rebuttal must include a statement that describes, in detail, the evidence that the person reviewed before making the determination that a cause not associated with the individual's service as a first responder was a substantial factor in bringing about the individual's disease or illness, without which the disease or illness would not have occurred. §607.058(b).

Senate Bill 2551 also amended the Workers' Compensation Act (Act) to provide that an insurance carrier is not required to initiate compensation or deny a claim within 15 days after first receiving written notice of an injury if the claim results from an employee's disability or death for which a presumption is claimed under Subchapter B. In that circumstance, an insurance carrier must provide the claimant and DWC with a notice, referred to in these rules as a "Notice of Continuing Investigation," that describes all steps taken by the insurance carrier to investigate the injury before notice was given and the evidence the insurance carrier reasonably believes is necessary to complete its investigation of the compensability of the injury. The insurance carrier must issue a Notice of Continuing Investigation no later than 15 days after first receiving written notice of the injury. Labor Code §409.021.

The bill also amended Labor Code §415.021 to require that the DWC commissioner consider whether the employee cooperated with the insurance carrier's investigation of the claim and whether the

employee timely authorized access to relevant medical records when determining whether to assess an administrative penalty involving a claim in which the insurance carrier provided a Notice of Continuing Investigation. The commissioner shall also consider whether the insurance carrier conducted an investigation of the claim, applied the statutory presumptions under Subchapter B, and expedited medical benefits under Labor Code §504.055 (relating to Expedited Provision of Medical Benefits for Certain Injuries Sustained by First Responder in Course and Scope of Employment by a political subdivision).

An insurance carrier's existing duty to investigate a claim is described under the Act. Labor Code 409.021 establishes the foundation for an insurance carrier's duty to investigate a claim prior to a refusal to pay benefits. Section 409.021(a-3) specifically provides that a Notice of Continuing Investigation must "describe all steps taken by the insurance carrier to investigate the injury before the notice was given and the evidence that the carrier reasonably believes is necessary to complete its investigation of the compensability of the injury." Section 409.021(c) provides that an insurance carrier has a right to continue to investigate the compensability of an injury during the 60-day period. Section 409.021(d) provides that an insurance carrier may reopen the issue of compensability if evidence is later found that could not be reasonably discovered earlier. This language plainly reflects a recognized obligation to reasonably investigate a claim in a timely manner. Upon receipt of written notice of injury, an insurance carrier shall conduct an investigation relating to the compensability of the injury, the insurance carrier's liability for the injury, and the accrual of benefits. A notice of refusal to pay benefits must specify the reasonable grounds for the refusal. Labor Code §409.022(a) and (c).

Furthermore, if an insurance carrier intends to rely on evidence discovered after the denial of a claim, the insurance carrier must show that the evidence could not have been reasonably discovered at an earlier date. Labor Code §409.022(b). When reviewing a health care provider's claim, an insurance carrier can request additional documentation necessary to clarify the provider's charges and, when disputing payment, an insurance carrier must submit a report that sufficiently explains the reasons for the reduction or denial of payment. §408.027(b) and (e). An insurance carrier commits an administrative violation for any of 22 specified actions, including failing to process claims promptly and in a reasonable and prudent manner, misrepresenting the reason for not paying benefits or terminating or reducing payments of benefits, controverting a claim if the evidence clearly indicates liability, and failing to comply with the Act. §415.002(a). Conversely, an insurance carrier is authorized to allow an employer to assist in the investigation and evaluation of a claim. §415.002(b)(2). The unambiguous command of these statutory provisions is that an insurance carrier is expected to conduct a reasonable investigation to establish grounds for refusing to pay benefits. Rule 124.3(a) sets forth the procedures for carrying out these statutory requirements for investigating claims.

Furthermore, as noted in 2012 by the Texas Supreme Court in *Texas Mutual Insurance Company v. Ruttiger*, an insurance "carrier has statutory and regulatory duties to promptly conduct adequate investigations and reasonably evaluate and expeditiously pay workers' legitimate claims or face administrative penalties." 381 SW3d 430 (Tex. 2012). The Court further noted, "The Act's requirements include time limits for payment of benefits, giving notice of a compensability contest and the specific reason for the contest, and necessarily subsume the requirement of proper investigation and claims processing." *Id.* at 445 (citing Labor Code §409.021(a)). The court held that "[k]ey parts of the [workers' compensation] system are the amount and types of benefits, the delivery systems for benefits, the dispute resolution processes for inevitable disputes that arise among participants, the penalties imposed

for failing to comply with legislatively mandated rules, and the procedures for imposing such penalties." *Id.* at 449. The court recognized that DWC's pervasive authority to regulate and penalize insurance carriers for inadequate investigations eliminated the need for private causes of action.

Insurance carriers have additional investigative responsibilities specific to designated claims advanced by first responders or their beneficiaries. As provided by SB 2551, an insurance carrier is relieved of the duty to either initiate payment or provide notice of its refusal to pay within 15 days of receiving written notice of a qualifying injury to a first responder, if it provides a Notice of Continuing Investigation "that describes all steps taken by the insurance carrier to investigate the injury before notice was given and the evidence that the carrier reasonably believes is necessary to complete its investigation of the compensability of the injury." Labor Code §409.021(a-3). An insurance carrier's notice of refusal to pay benefits must explain why a presumption under Government Code, Chapter 607, Subchapter B, does not apply and must describe the evidence that the carrier reviewed in making that determination. §409.022(d). In determining whether to assess an administrative penalty for a claim involving a first responder, the commissioner must consider whether "the insurance company conducted an investigation of the claim [and] applied the statutory presumption under Subchapter B." §415.021(c-2).

For claims concerning first responders, Subchapter B provides elements necessary to qualify for a presumption under the subchapter, as well as a disqualification for tobacco use. Gov't Code §607.052(a) and (b)(4). An insurance carrier may rebut any presumption established under Subchapter B "through a showing by a preponderance of the evidence that a risk factor, accident, hazard, or other cause not associated with the individual's service as a firefighter, peace officer, or [EMT] was a substantial factor in bringing about the individual's disease or illness, without which the disease or illness would not have

occurred." §607.058. These provisions establish the evidentiary standard applicable to rebuttal of the presumption and require that an insurance carrier investigate a first responder's qualification for a presumption under Subchapter B.

The Legislature has required that DWC adopt rules necessary to implement SB 2551 no later than January 1, 2020. The implementation will include the amended process for claim notification including an amendment in which the insurance carrier is not required to comply with the 15-day deadline to either give notice or refuse or start benefit payments on claims through issuance of a Notice of Continuing Investigation. Upon issuance of a Notice of Continuing Investigation, an insurance carrier will have more time to investigate a claim before taking action. The proposed amendments also describe an insurance carrier's obligation to investigate when it receives notice of an injury for which a presumption may apply on a claim and the process the carrier must follow when investigating a presumption claim under Government Code, Chapter 607, Subchapter B.

The changes in law made by SB 2551 apply to a claim for benefits filed on or after June 10, 2019, the effective date of SB 2551. Section 8 of SB 2551 provides that the amendments to Government Code §607.055 and §607.058 apply only to a claim for benefits filed on or after June 10, 2019. Section 10 of SB 2551 provides that Labor Code §504.053(e)(1) applies only to a claim for benefits filed on or after June 10, 2019. These proposed amendments will not apply to a claim for benefits filed before June 10, 2019.

DWC posted an informal draft of these rules on its website for comment and hosted a stakeholder workshop on Wednesday, August 21, 2019. DWC revised the proposed amendments in response to the comments received during informal rulemaking.

Labor Code §409.021(a-3), as amended by SB 2551, directs that an insurance carrier need not comply with the established 15-day pay or deny obligation if it issues a described notice. Proposed Rule 124.2 identifies this notice as a Notice of Continuing Investigation and requires that insurance carriers use a plain language format. DWC has posted a draft of the Notice of Continuing Investigation on its website at www.tdi.texas.gov/wc/rules/drafts.html.

The proposed amendments to Rule 124.2 add subsections (f)-(h) to establish the notice requirements provided for under Labor Code §409.021(a-3) (Notice of Continuing Investigation). Subsection (f) details the choice of actions that an insurance carrier may take during the first 15 days following receipt of a written notice of injury. Subsection (f)(3) provides that notice must be provided to both the claimant and DWC, as required under §409.021(a-3). This requirement is also consistent with DWC's responsibility to monitor the workers' compensation system, as set forth in Labor Code Chapter 414 (relating to Enforcement of Compliance and Practice Requirements).

The new subsection (g) clarifies that a "claim for benefits" means the first written notice of injury as provided in Rule 124.1 (concerning Notice of Injury). A written notice of injury can include DWC Form-001, *Employer's First Report of Injury or Illness*, or if that form has not been filed, any other written communication, regardless of the source, which informs the carrier of the name of the injured employee, the identity of the employer, the approximate date of the injury, and information which asserts the injury is work related. The filing of a DWC Form-041, *Employee's Claim for Compensation for a Work-related Injury or Occupational Disease,* or a DWC Form-042, *Claim for Workers' Compensation Death Benefits*, by an injured employee or their beneficiary would fulfill this requirement if it is the first written notice of injury.

Subsection (h) describes what must be included in a Notice of Continuing Investigation. The elements of a Notice of Continuing Investigation provide an outline for what constitutes a reasonable investigation and relevant and necessary information for that investigation. An insurance carrier may request that an injured employee provide specified information or documents within their custody or control and releases required to obtain evidence reasonably believed to be necessary to complete its investigation of the compensability of an injury. An insurance carrier must still pursue its own investigation, seeking to obtain information directly from health care providers, employers, and other sources. This is consistent with an insurance carrier's existing duty under law to investigate a claim as discussed above. Senate Bill 2551 did not create any additional duty for an injured employee to respond to production requests from an insurance carrier.

Subsection (h)(3) provides a description of information or documents that may not be identified by the insurance carrier as reasonably necessary to complete its investigation through a Notice of Continuing Investigation, such as a request for additional diagnostic testing, mental health records, generic requests, or requests for records that are not directly related to either the disease or illness or eligibility for a statutory presumption under Government Code, Chapter 607, Subchapter B. The workers' compensation system provides other opportunities for an insurance carrier to obtain additional diagnostic testing. Mental health records have no apparent relevance to an investigation involving any of the diseases or illnesses identified under Subchapter B. As described under Labor Code §409.021(a-3), the Notice of Continuing Investigation provides an insurance carrier with the opportunity to identify the claim-specific evidence that the insurance carrier reasonably believes is necessary to complete its investigation of the compensability of an injury.

The new subsection (j) describes additional requirements for an insurance carrier when issuing a denial notice on a claim where the insurance carrier issued a Notice of Continuing Investigation. These requirements are consistent with Labor Code §409.022. Subsection (j)(2) clarifies that the showing of evidence to rebut a presumption must be done as part of a denial notice. Gov't Code §§607.057-607.058 and Labor Code §409.022(d). These requirements are consistent with Labor Code §415.021, as amended by SB 2551.

The proposed new subsection (s) establishes minimum standards for plain language notices including a minimum font size of 12-point be used in all plain language notices and that notices be printed on an insurance carrier's letterhead. The requirement for a 12-point font is consistent with other guidelines and requirements for readability and plain language. For example, the Texas Department of Insurance requires that a notice of network requirements and employee information form must "be printed in not less than 12-point type." 28 TAC §10.63; *see also* Federal Plain Language Guidelines (May 2011), available at plainlanguage.gov. The requirements for 12-point font and letterhead will apply to all plain language notices, and DWC proposes that they go into effect on April 1, 2020, to provide insurance carriers with additional time to update their automated systems.

Throughout Rule 124.2, additional non-substantive editorial changes are proposed to correct errors of grammar and punctuation, clarify wording, and to conform to the agency's style guidelines.

The amendments to Rule 124.3(a)(1-4) address the use of the Notice of Continuing Investigation as now allowed under Labor Code §409.021(a-3). As provided by SB 2551, by issuing a timely Notice of Continuing Investigation, an insurance carrier is allowed additional time to investigate a claim before deciding to pay or deny a claim on or before the 60th day from written notice of injury. §409.021(a-3). Under subsection

(a)(4), if a Notice of Continuing Investigation is issued after the 15th day from receipt of written notice of injury, the insurance carrier is liable for accrued or payable income and medical benefits prior to a timely denial.

The proposed amendments to 124.3 delete penalty provisions in subsection (a)(4)(A-C) in order to conform with House Bill (HB) 7, enacted by the 79th Legislature, Regular Session, effective September 1, 2005. House Bill 7 amended Labor Code §415.021 to delete a limitation that an administrative penalty should not exceed $10,000. Section 415.021 permits DWC to assess administrative penalties of up to $25,000 per violation in addition to any other sanctions authorized by the Act. Section 415.021 also states that each day of noncompliance constitutes a separate violation and lists the factors that DWC must use when determining penalty amounts. Additionally, Labor Code §415.025 provides that a reference in the Labor Code or other law to a particular class of violation or administrative penalty must be construed as a reference to an administrative penalty, and except as otherwise provided in the Act, an administrative penalty may not exceed $25,000 per day per occurrence, and each day of noncompliance constitutes a separate violation in accordance with §415.021.

The proposed amendments to subsection (d) and proposed subsection (e) are required to provide for the use of a Notice of Continuing Investigation in claims involving death or burial benefits. Subsection (d) is amended to clarify, for purposes of death benefits, when an insurance carrier may issue a Notice of Continuing Investigation in accordance with the provisions of §124.2(f) and §124.3. Subsection (e) is proposed to provide that, notwithstanding the requirements of §132.13 (concerning Burial Benefits), when an insurance carrier issues a Notice of Continuing Investigation, the insurance carrier must either pay or deny a claim for burial benefits within seven days from the initiation of benefits or the issuance of a notice of denial.

The transition language in existing subsection (f) is now obsolete and proposed for deletion as all claims prior to September 1, 2003, have exceeded the 15 days provided in subsection (a).

A new subsection (g) is proposed to provide that if an insurance carrier receives written notice of injury for a disease or illness identified by Government Code Chapter 607, Subchapter B, it is required to investigate each element of the applicable statutory presumption in addition to investigating the compensability of the injury, liability for the injury, and the accrual of benefits. Subsection (g)(1) provides that a claimant is not required to expressly claim the applicability of a statutory presumption in order for the statutory presumption to apply.

As described in subsection (g)(2), a presumption under Subchapter B is claimed to be applicable upon a first responder's written notice of injury for a disease or illness identified by Subchapter B. As a written notice of injury constitutes a claim for any presumption under Subchapter B, an insurance carrier has the duty of investigating whether a presumption does or does not apply to an individual claim. This is consistent with the provisions of Government Code §607.057 and §607.058 and Labor Code §409.021 and §415.021, as well as with an insurance carrier's duty to investigate a claim as discussed above. Subsection (g)(2) is also consistent with the Legislature's intent that DWC "effectively educate and clearly inform each person who participates in the system as a claimant, employer, insurance carrier, health care provider, or other participant of the person's rights and responsibilities under the system and how to appropriately interact within the system." Labor Code §402.021 (relating to Goals; Legislative Intent; General Workers' Compensation Mission of Department).

As described in subsection (g)(3), whether a presumption does or does not apply has no direct bearing on issues relating to compensability, liability for the injury, and the accrual of benefits. For instance, if an employee is a smoker, the employee nonetheless may have suffered a compensable injury even if the presumption under Government Code §607.054 does not apply. Accordingly, as set forth in subsection (g)(3), an insurance carrier has a continuing obligation to conduct a reasonable investigation even when a presumption does not apply or is rebutted.

Throughout Rule 124.3, additional non-substantive editorial changes are proposed to correct errors of grammar and punctuation, clarify wording, renumber subsections, and to conform to the agency's style guidelines.

FISCAL NOTE

Debra Knight, Deputy Commissioner for Compliance and investigations, has determined that for each year of the first five years these proposed rules will be in effect, there will be no additional estimated cost to the state and local governments, other than that imposed by the statute. There will not be any estimated reduction in costs to the state and local governments, nor will there be any estimated loss or increase in revenue to the state or local governments as a result of enforcing or administering these rules. DWC does not anticipate that these proposed amendments will require that insurance carriers make significant changes to their current practices and procedures.

While these rules do set forth more detailed procedures for investigating certain claims involving first responders, as required under SB 2551, insurance carriers had a preexisting obligation to investigate these claims. The clarification of an insurance carrier's investigative responsibilities should not result in any

additional costs. As now provided by Labor Code §409.021(a), an insurance carrier is allowed additional time to make a decision on a claim. Thus, these proposed rules do not impose additional costs on an insurance carrier's investigation of a claim.

In addition, the Legislative Budget Board's (LBB's) fiscal note on SB 2551 found that there would be no significant fiscal implication to the state. Based on information provided to the Legislature by the Texas Department of Insurance, State Office of Risk Management, and Texas A&M University System Administration, the LBB assumed that the duties and responsibilities associated with implementing SB 2551 could be accomplished using existing resources. The LBB did note that the Texas Association of Counties (TAC) anticipated a potential fiscal impact on the TAC Risk Management Pool, which covers approximately 1,500 firefighters and EMTs. However, the extent of the impact could not be determined due to uncertainty in predicting the number or severity of future cancer claims. The LBB also noted that the Texas Municipal League Intergovernmental Risk Pool estimated a $6 million annual cost.

Senate Bill 1582 included peace officers among the persons covered under Government Code, Chapter 607, Subchapter B (other than for cancer claims under §607.055). Thus, these proposed amendments will apply to peace officers. However, an increase in costs as the result of the addition of peace officers under SB 1582, if any, cannot be defined with any precision given the inherent uncertainty of events and injuries and is beyond the scope of this rulemaking.

DWC's data on claims from first responders from January 1, 2012, to September 3, 2019, shows approximately 85 heart attack claims, 209 cancer claims (firefighters and EMTs only), and 7,208 claims for all other occupational diseases, including diseases and illnesses not identified under Government Code, Chapter 607, Subchapter B. As these claims will be dispersed among first responders working for

political subdivisions across Texas, DWC does not anticipate that these proposed amendments will have more than a nominal effect on the Texas workers' compensation system as a whole.

It is not anticipated that the new requirements for plain language notices will result in increased costs. While it is possible that the larger font size could require additional pages for a plain language notice, that would be a claim-specific occurrence. Even with additional pages, this requirement is not likely to result in additional mailing costs. Any additional costs due to the requirement of providing a plain language notice on company letterhead, as DWC has long recommended, should be nominal.

PUBLIC BENEFITS AND COSTS

Ms. Knight has determined that for each of the first five years that these proposed rules will be in effect there will be a more efficient provision of benefits to injured employees under the Workers' Compensation Act, Labor Code, Title 5, and that the probable economic costs to insurance carriers required to comply with the rule will be minimal. The primary benefit of the adoption of these rules will be description and implementation of an insurance carrier's opportunity to suspend a decision while it conducts its investigation of a claim covered by Government Code Chapter 607, Subchapter B. Insurance carriers may now process presumption claims in accordance with the rule changes to §124.2 and §124.3 since SB 2551 became effective on June 10, 2019. The proposed rules also describe the responsibilities of an insurance carrier when investigating a claim with a presumption identified in Subchapter B.

These proposed rules are also designed to maintain the balance under the Act as described in the Texas Supreme Court's decision in *Texas Mutual Insurance Company v. Ruttiger*. In that case the court stated that an insurance "carrier has statutory and regulatory duties to promptly conduct adequate

investigations and reasonably evaluate and expeditiously pay workers' legitimate claims or face administrative penalties." 381 SW3d 430 (Tex. 2012). The Court further noted, "The Act's requirements include time limits for payment of benefits, giving notice of a compensability contest and the specific reason for the contest, and necessarily subsume the requirement of proper investigation and claims processing." *Id.* at 445 (citing Labor Code §409.021(a)).

Participants in the workers' compensation system will also benefit from the clarifications to roles and responsibilities provided in these proposed rules. The new requirement that all plain language notices must be provided on the insurance carrier's letterhead and written in plain language and in 12-point font will benefit injured employees by improving the readability of such notices, and promoting a clearer understanding of what actions an insurance carrier is taking on their claims.

Firefighters and EMTs suffering from cancer will benefit from the clearer rights and responsibilities in the workers' compensation system provided by SB 2551 and these proposed amendments. The list of specific cancers in Government Code §607.055(b) will provide injured first responders and insurance carriers with greater certainty as to which injured employees qualify for the presumption that the cancer developed during the course and scope of their employment. This will likely reduce the dispute and litigation of such claims.

GOVERNMENT GROWTH IMPACT STATEMENT

Ms. Knight has determined that during the first five years that these rules are in effect, the proposed rules do not create nor eliminate a government program. The implementation of the proposed rules does not require the creation of new employee positions or the elimination of existing employee positions. The

implementation of the proposed rules does not require an increase or decrease in future legislative appropriations. The proposed rules do not require an increase or decrease in fees paid to the agency. Beyond the requirements imposed by SB 2551, the proposed amendments do not create a new regulation. Proposed Rule 124.2(s) does expand upon existing requirements for plain language notices by requiring that all such notices be issued on an insurance carrier's letterhead and set in no less than 12-point font. Previously, both proposed requirements have been recommendations for plain language notices as authorized by Labor Code §409.013 (relating to Plain Language Information; Notification of Injured Employee) and as required by DWC rules. The proposed rules do not increase or decrease the number of individuals subject to the rule's applicability. The proposed rules do not positively or adversely affect the state economy.

STATEMENT ON COSTS TO REGULATED PERSONS

DWC has determined that the proposed amendments do not impose a cost on regulated persons as they align the requirements of the rules with the authorizing statutes. As discussed above in the Fiscal Note, DWC does not anticipate that the requirements of proposed Rule 124.2(s) will impose costs on the Texas workers' compensation system. Therefore, an examination of costs under Government Code §2001.0045 is not required.

LOCAL EMPLOYMENT IMPACT

For each of the first five years that these rules will be in effect, the rules will not have an impact on local employment beyond a benefit of providing injured employees covered by workers' compensation

insurance greater certainty that an insurance carrier will have additional time to investigate their presumption claims under Government Code Chapter 607, Subchapter B.

ECONOMIC EFFECT ON SMALL BUSINESS AND RURAL COMMUNITIES

DWC does not anticipate that these rules will have an adverse economic effect on micro-businesses. These rules primarily impact insurance carriers, and as of 2016, DWC had identified 10 insurance carriers writing workers' compensation and excess workers' compensation business in Texas that met the definition of a small business under Government Code §2006.001(2). These entities had total national premiums of less than $6 million from all lines of business. Political subdivisions that self-insure their workers' compensation responsibilities, including rural political subdivisions, will be impacted by these rules. However, the proposed rules should not impose any new costs on self-insured political subdivisions. While there may be additional costs as a result of producing plain language notices on an insurance carrier's letterhead in 12-point font, such costs would be nominal and cannot be determined with any accuracy as they would be influenced by the specific nature of individual claims.

REGULATORY FLEXIBILITY ANALYSIS

DWC does not find that it would be practicable to establish separate compliance or reporting requirements or to exempt either insurance carriers that qualify as small businesses or self-insured rural political subdivisions from these rules. The proposed amendments merely conform the rules to the requirements of the authorizing statutes. In addition, DWC found that the practical benefits of having uniform notice and investigation requirements significantly outweighed any potential impacts to insurance carriers that qualify as small businesses or to self-insured rural political subdivisions.

Consequently, in accordance with Government Code §2006.002(c), DWC is not required to prepare a regulatory flexibility analysis.

TAKINGS IMPACT ASSESSMENT

DWC has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action. As a result, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR COMMENTS

Comments may be submitted by email to RuleComments@tdi.texas.gov or by mailing or delivering your comments to Cynthia Guillen, Office of General Counsel, MS-4D, Texas Department of Insurance, Division of Workers' Compensation, 7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645. To be considered, comments must be received by 5 p.m., Central Time, on November 25, 2019.

DWC will hold a public hearing to discuss these proposed rules on November 20, 2019 at 10 a.m. at the DWC central office located at 7551 Metro Center Drive, Suite 100, in Austin. DWC provides reasonable accommodations for persons attending meetings, hearings, or educational events as required by the Americans with Disability Act. If you need accommodations, please contact Cynthia Guillen at 512-804-4275 or at RuleComments@tdi.texas.gov before noon, Central Time, on November 18, 2019.

STATUTORY AUTHORITY for §124.2

The proposed amendments are authorized by Texas Labor Code §§402.00111, 402.00116, 402.00128, 402.021, 402.061, 409.013, 409.021, 409.022, 414.002, and 415.021, Government Code §607.052 and §607.058, and SB 2551 §9.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority under Title 5 of the Labor Code. Section 402.00116 provides that the commissioner is the chief executive and administrative officer of the agency with all the powers and duties vested under the Workers' Compensation Act (Act).

Section 402.00128 describes the general powers and duties of the DWC Commissioner, including assessing and enforcing penalties and prescribing the form, manner, and procedure for the transmission of information to DWC.

Section 402.021 provides that a basic goal of the Texas workers' compensation system is that each employee shall be treated with dignity and respect when injured on the job and that it is the intent of the Legislature that the workers' compensation system must minimize the likelihood of disputes and resolve them promptly and fairly when identified and effectively educate and clearly inform each system participant of their rights and responsibilities under the system and how to appropriately interact within the system.

Section 402.061 provides that the commissioner shall adopt rules as necessary for the implementation and enforcement of the Act.

Section 409.013 authorizes DWC to develop plain language information to provide the public with information on the benefit process and compensation procedures.

Section 409.021(a) sets forth the general rule that not later than the 15th day after receipt of written notice of injury, an insurance carrier must either begin payment of benefits or notify DWC and the injured employee in writing of its refusal to pay and their procedural rights. Section 409.021(a-3) provides that an insurance carrier is not required to comply with subsection (a) if the claim results from an injured employee's disability or death for which the presumption is claimed to be applicable under Subchapter B, Chapter 607, Government Code, and not later than the 15th day after the date on which the insurance carrier received written notice of the injury, the insurance carrier has provided the employee and DWC with a notice describing all steps taken by the insurance carrier to investigate the injury. Section 409.021(a-3) also requires the commissioner to adopt rules as necessary to implement that subsection. Section 409.021(d) provides that an insurance carrier may reopen the issue of the compensability of an injury if there is a finding of evidence that could not reasonably have been discovered earlier.

Section 409.022(c) provides that an insurance carrier commits an administrative violation if the insurance carrier does not have reasonable grounds for a refusal to pay benefits, as determined by the commissioner. Section 409.022(d) provides that if an insurance carrier's notice of refusal to pay benefits under Section 409.021 is sent in response to a claim for compensation resulting from an EMT's, peace officer's, or a firefighter's disability or death for which a presumption is claimed to be applicable under Subchapter B, Chapter 607, Government Code, the notice must include a statement by the carrier that explains why the insurance carrier determined a presumption under that subchapter does not apply to

the claim for compensation; and describes the evidence that the carrier reviewed in making the determination.

Section 414.002 provides that DWC shall monitor the system for compliance with the Act and rules as well as other laws relating to workers' compensation.

Section 415.021(c-2) provides that in determining whether to assess an administrative penalty involving a claim in which the insurance carrier provides notice under Section 409.021(a-3), the commissioner shall consider whether the injured employee cooperated with the insurance carrier's investigation and whether the injured employee authorized access to the applicable medical records.

Government Code Section 607.052(a) provides that notwithstanding any other law, this subchapter applies only to a firefighter, peace officer, or EMT who on becoming employed or during employment as a firefighter, peace officer, or EMT, received a physical examination that failed to reveal evidence of the illness or disease for which benefits or compensation are sought using a presumption established by this subchapter; is employed for five or more years as a firefighter, peace officer, or EMT; and seeks benefits or compensation for a disease or illness covered by this subchapter that is discovered during employment as a firefighter, peace officer, or EMT.

Section 607.052(b) provides that a presumption under this subchapter does not apply to a determination of a survivor's eligibility for benefits under Chapter 615; in a cause of action brought in a state or federal court except for judicial review of a proceeding in which there has been a grant or denial of employment-related benefits or compensation; to a determination regarding benefits or compensation under a life or disability insurance policy purchased by or on behalf of the firefighter,

peace officer, or EMT that provides coverage in addition to any benefits or compensation required by law; or if the disease or illness for which benefits or compensation is sought is known to be caused by the use of tobacco and the firefighter, peace officer, or EMT is or has been a user of tobacco, or their spouse has, during the marriage, been a user of tobacco that is consumed through smoking.

Section 607.058 provides that a presumption under §§607.053, 607.054, 607.055, or 607.056 may be rebutted through a showing by a preponderance of the evidence that a risk factor, accident, hazard, or other cause not associated with the individual's service as a firefighter, peace officer, or EMT was a substantial factor in bringing about the individual's disease or illness, without which the disease or illness would not have occurred. A rebuttal offered under Section 607.058 must include a statement by the person offering the rebuttal that describes, in detail, the evidence that the person reviewed before making the determination that a cause not associated with the individual's service as a firefighter, peace officer, or EMT was a substantial factor in bringing about the individual's disease or illness without which the disease or illness would not have occurred.

Finally, §9 of SB 2551 requires that the commissioner adopt rules as required by or necessary no later than January 1, 2020. The proposed amendments support implementation of the Workers' Compensation Act, Labor Code Title 5, Subtitle A.

Chapter 124. Insurance Carriers: Required Notices and Mode of Payment

§124.2. Insurance Carrier Reporting and Notification Requirements

(a) An insurance carrier shall notify the division [~~Commission~~] and the claimant of actions taken on[~~,~~] or events occurring in a claim as required by this title.

(b) The division [~~Commission~~] shall prescribe the form, format, and manner of required electronic submissions through publications such as advisory(ies), instructions, specifications, the Texas Electronic Data Interchange Implementation Guide, and trading partner agreements. Trading partners will be responsible for obtaining a copy of the International Association of Industrial Accident Boards and Commissions (IAIABC) Electronic Data Interchange Implementation Guide.

(c) The insurance carrier shall electronically file, as that term is used in §102.5(e) of this title (concerning [~~relating to~~] General Rules for Written Communications to and from the Commission), with the division [~~Commission~~]:

(1) the information from the original Employer's First Report of Injury; the insurance carrier's Federal Employer Identification Number (FEIN); and the policy number, policy effective date, and policy expiration date reported under §110.1 of this title (concerning [~~relating to~~] Insurance Carrier Requirements for Notifying the Division [~~Commission of Insurance Coverage~~]) for the employer associated with the claim, not later than the seventh day after the later of:

(A) receipt of a required report where there is lost time from work or an occupational disease; or

(B) notification of lost time if the employer made the Employer's First Report of Injury prior to the employee experiencing absence from work as a result of the injury;

(2) any correction of division [~~Commission~~] -identified errors in a previously accepted electronic record as provided in §102.5(e) of this title. (Correction);

(3) information regarding a compensable death with no beneficiary (Compensable Death No Beneficiaries/Payees) not later than the 10th [~~tenth~~] day after determining that an employee whose injury resulted in death had no legal beneficiary; and

(4) a change in an electronic record initiated by the insurance carrier (Change), the coverage information required by paragraph (1) of this subsection if not available when the First Report of

Injury was submitted to the division [~~commission~~] and any change in a claimant or employer mailing address within seven [~~7~~] days of receipt of the new address.

(d) The insurance carrier shall notify the division [~~Commission~~] and the claimant of a denial of a claim (Denial) based on non-compensability or lack of coverage in accordance with this section and as otherwise provided by this title.

(e) The insurance carrier shall notify the division [~~Commission~~] and the claimant of the following:

(1) first payment of indemnity benefits on a claim (Initial Payment) within 10 days of making the first payment;

(2) change in the net benefit payment amount caused by a change in the employee's post-injury earnings (Reduced earnings) within ten days of making the first payment reflecting the change;

(3) change in the net benefit payment amount that was not caused by a change in employee's post-injury earnings, this includes but is not limited to subrogation, attorney fees, advances, and contribution (Change in Benefit Amount), and the notice must be made within 10 days of making the first payment which reflects [~~reflecting~~] the change;

(4) change from one income benefit type to another or to death benefits (Change in Benefit Type) within 10 days of making the first payment reflecting the change;

(5) resumption of payment of income or death benefits (Reinstatement of Benefits) within 10 days of making the first payment;

(6) termination or suspension of income or death benefits (Suspension) within 10 days of making the last payment for the benefits[~~.~~] ; or

(7) employer continuation of salary equal to or exceeding the employee's Average Weekly Wage as defined by this title (Full Salary) within:

(A) seven days of receipt of the Employer's First Report of Injury or a Supplemental Report of Injury (if the report included information that salary would be continued) if the insurance carrier has not initiated temporary income benefits; or

(B) 10 [~~ten~~] days of making the last payment of temporary income benefits due to the employer's continuation of full salary.

(f) If an insurance carrier receives a written notice of injury for a disease or illness identified by Texas Government Code, Chapter 607, Subchapter B (relating to Diseases or Illnesses Suffered by Firefighters, Peace Officers, or Emergency Medical Technicians), the insurance carrier shall take one of the following actions no later than the 15th day following receipt of the notice of injury:

(1) initiate benefits as required by the Workers' Compensation Act and the division's rules;

(2) file a notice of denial as described in this section; or

(3) provide the claimant and the division with notice as required under Labor Code §409.021(a-3) (Notice of Continuing Investigation) for a claim for benefits received on or after June 10, 2019.

(g) When applying subsection (f) of this section and Government Code, Chapter 607, Subchapter B, a "claim for benefits" means the first written notice of injury as provided in §124.1 of this title (concerning Notice of Injury).

(h) The insurance carrier shall issue a Notice of Continuing Investigation as a plain language notice in the form and manner prescribed by the division. The notification requirements of this section are not considered complete until a copy of the notice provided to the claimant is received by the division.

(1) A Notice of Continuing Investigation shall include the following:

(A) a statement describing all steps taken by the insurance carrier to investigate the disease or illness before the notice was given;

(B) a list of any claim-specific evidence, releases, or documentation the insurance carrier reasonably believes is both relevant and necessary to complete its investigation; and

(C) contact information for the adjuster, including the adjuster's email address, facsimile number, and telephone number.

(2) An insurance carrier shall provide a reasonable amount of time for a claimant to respond to the notice.

(3) The notice may not include a request for additional diagnostic testing, mental health records, generic requests (such as "the claimant's medical records"), or requests for records that are not directly related to either the disease or illness or eligibility for application of a statutory presumption.

(4) Notwithstanding the issuance of a Notice of Continuing Investigation, an insurance carrier must continue taking reasonable steps to acquire claim-specific evidence and documentation necessary to complete its investigation of the claim.

(i) [~~(f)~~] Notification to the claimant as required by subsections (d)-(h) [~~and (e)~~] of this section requires the insurance carrier to use plain language notices in the form and manner [~~with language and content~~] prescribed by the division [~~Commission~~]. These notices shall provide a full and complete statement describing the insurance carrier's action and rationale [~~its reason(s) for such action~~]. The statement must contain sufficient claim-specific substantive information to enable the claimant [~~employee / legal beneficiary~~] to understand the insurance carrier's position or action taken on the claim. A generic statement that simply states the insurance carrier's position with phrases such as "employee returned to work," "adjusted for light duty," "liability is in question," "compensability in dispute," "under investigation," or other similar phrases with no further description of the factual basis for the action taken does not satisfy the requirements of this section.

(j) In addition to the denial notice requirements in subsection (i), if the insurance carrier receives a written notice of injury for a disease or illness identified by Texas Government Code, Chapter 607, Subchapter B (relating to Diseases or Illnesses Suffered by Firefighters, Peace Officers, or Emergency Medical Technicians), the denial must also include the following:

(1) If the insurance carrier asserts that a statutory presumption does not apply, a detailed statement explaining why and describing the claim-specific evidence or documentation that the insurance carrier reviewed.

(2) If the insurance carrier asserts that the statutory presumption has been rebutted, as provided under Government Code §607.058 (relating to Presumption Rebuttable), a detailed statement explaining why and describing the claim-specific evidence the insurance carrier reviewed in making the assertion that a risk factor, accident, hazard, or other cause not associated with the individual's service as a firefighter, peace officer, or emergency medical technician was a substantial factor in bringing about the individual's disease or illness without which the disease or illness would not have occurred.

(3) If the insurance carrier provided a timely Notice of Continuing Investigation as permitted by law, the denial notice must also include a statement describing whether the claimant provided a timely response to the notice.

(k) [~~(g)~~] Notification to the division [~~Commission~~] as required by subsections (c)~~–~~(h) [~~, (d) and (e)~~] of this section requires the insurance carrier to use electronic filing, as that term is used in §102.5(e) of this title (concerning General Rules for Written Communications to and from the Commission).

(1) In addition to the electronic filing requirements of this subsection, when an insurance [~~a~~] carrier notifies the division [~~Commission~~] of a denial as required by [~~subsections (b) and (c) of~~] this section, it must provide the division [~~Commission~~] a written copy of the notice provided to the claimant as described under subsections (i) – (j) [~~(f)~~] of this section, as applicable.

(2) The notification requirements of this section are not considered completed until the copy of the notice provided to the claimant is received by the division [~~Commission~~].

(l) [~~(h)~~] Notification to the division [~~Commission~~] and the claimant of a dispute of disability, extent of injury, or eligibility of a claimant to receive death benefits shall be made as otherwise prescribed by this title and requires the insurance carrier to use plain language notices in the form and manner [~~with language and content~~] prescribed by the division [~~Commission~~]. These notices shall provide a full and complete statement describing the insurance carrier's action and its reason(s) for such action. The statement must contain sufficient claim-specific substantive information to enable the claimant [~~employee/legal beneficiary~~] to understand the insurance carrier's position or action taken on the claim. A generic statement that simply states the insurance carrier's position with phrases such as "no medical evidence to support disability," "not part of compensable injury," "liability is in question," "under investigation," "eligibility questioned," or other similar phrases with no further description of the factual basis for the action taken does not satisfy the requirements of this section.

(m) [~~(i)~~] The division [~~Commission~~] shall send an acknowledgment to the transmitting trading partner detailing whether an electronically submitted record was accepted, accepted with errors, or rejected. The acknowledgment shall be provided directly to the trading partner submitting the transmission, not through the Austin representative box identified in §102.5 of this title. If the record was accepted with errors in conditional elements, the insurance carrier must correct the errors in accordance with §102.5 of this title.

(n) [~~(j)~~] Except as otherwise provided by this title, insurance carriers shall not provide notices to the division [~~Commission~~] that explain that:

(1) – (3) (no change).

(4) the insurance carrier is disputing some or all medical treatment as not reasonable or necessary;

(5) compensability is not denied but the insurance carrier disputes the existence of disability (if there are no indications of lost time or disability and the employee is not claiming disability); or

(6) future medical benefits are disputed (notices of which shall not be provided to anyone in the system).

(o) [~~(k)~~] Written requests for a waiver of the electronic filing requirement for the Employer's First Report of Injury may be submitted to the commissioner [~~Commission's executive director~~] or their [~~his/her~~] designee for consideration. Waivers must be requested at least annually, and the requests must include[~~,~~] a justification for the waiver, the volume of the insurance carrier's claims and total premium amounts, current automation capabilities, Electronic Data Interchange (EDI) programming status, and a specific target date to implement EDI. Waivers require written approval [~~from the executive director~~] and shall be granted at the discretion of and for the time frame noted by the commissioner [~~Executive Director~~] or their [~~his/her~~] designee.

(p) [~~(l)~~] If specifically directed by the division [~~Commission~~], such as through division [~~Commission~~] advisory or the Texas Electronic Data Interchange Guide, the insurance carrier may provide the information required in subsection (c)~~–(g)~~ [~~, (d), or (e)~~] of this section to the division [~~Commission~~] in hardcopy or paper [~~hardcopy/paper~~] format.

(q) [~~(m)~~] Notifications to the claimant and the claimant's representative shall be filed by facsimile or electronic transmission unless the recipient does not have the means to receive such a transmission in which case the notifications shall be personally delivered or sent by mail.

(r) [~~(n)~~] [~~On or after November 1, 2003,~~] Each insurance carrier shall provide to the division [~~commission~~], through its Austin representative in the form and manner prescribed by the division [~~commission~~], the contact information for all workers' compensation claim service administration functions performed by the insurance carrier either directly or through third parties.

(1) The contact information for each function shall include mailing address, telephone number, facsimile number, and email [~~e-mail~~] address as appropriate. This contact information may be provided either in the form of a single [~~World Wide Web (Web)~~] Uniform Resource Locator (URL) for a web [~~Web~~] page created and maintained by the insurance carrier that contains the required information or through an online submission to the division [~~commission~~].

(A) Coverage verification (policy issuance and effective dates of policy);

(B) Claim adjustment;

(C) Medical billing;

(D) Pharmacy billing (if different from medical billing); and

(E) Preauthorization.

(2) If the web [~~Web~~] page option is used the page shall contain the date on which it was last updated and an email [~~e-mail~~] address or other contact information to which a user may report problems or inaccuracies.

(3) The insurance carrier shall update the contact information [~~and /~~] or [~~Web~~] URL within 10 [~~ten~~] working days after any such change is made.

(s) All notices to a claimant required under this section must be stated in plain language, in no less than 12-point font, and provided on the insurance carrier's letterhead. This subsection applies to notices sent on or after April 1, 2020.

STATUTORY AUTHORITY for §124.3

The proposed amendments are authorized by Texas Labor Code §§402.00111, 402.00116, 402.00128, 402.021, 402.061, 409.013, 409.021, 409.022, 414.002, and 415.021, Government Code §607.052 and §607.058, and SB 2551 §9.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority under Title 5 of the Labor Code.

Section 402.00116 provides that the commissioner is the chief executive and administrative officer of the agency with all the powers and duties vested under the Workers' Compensation Act (Act).

Section 402.00128 describes the general powers and duties of the commissioner, including assessing and enforcing penalties and prescribing the form, manner, and procedure for the transmission of information to DWC.

Section 402.021 provides that a basic goal of the Texas workers' compensation system is that each employee shall be treated with dignity and respect when injured on the job and that it is the intent of the Legislature that the workers' compensation system must minimize the likelihood of disputes and resolve them promptly and fairly when identified, and effectively educate and clearly inform each system participant of their rights and responsibilities under the system and how to appropriately interact within the system.

Section 402.061 provides that the commissioner shall adopt rules as necessary for the implementation and enforcement of the Act.

Section 409.013 authorizes DWC to develop plain language information to provide the public with information on the benefit process and compensation procedures.

Section 409.021(a) sets forth the general rule that not later than the 15th day after receipt of written notice of injury, an insurance carrier must either begin payment of benefits or notify DWC and the injured employee in writing of its refusal to pay and their procedural rights. Section 409.021(a-3) provides that an insurance carrier is not required to comply with subsection (a) if the claim results from an employee's disability or death for which the presumption is claimed to be applicable under Subchapter B, Chapter 607, Government Code and not later than the 15th day after the date on which the insurance carrier received written notice of the injury, the insurance carrier has provided the employee and DWC with a notice describing all steps taken by the insurance carrier to investigate the injury. Section 409.021(a-3) also requires the commissioner to adopt rules as necessary to implement that subsection. Section 409.021(d) provides that an insurance carrier may reopen the issue of the compensability of an injury if there is a finding of evidence that could not reasonably have been discovered earlier.

Section 409.022(c) provides that an insurance carrier commits an administrative violation if the insurance carrier does not have reasonable grounds for a refusal to pay benefits, as determined by the commissioner. Section 409.022(d) provides that if an insurance carrier's notice of refusal to pay benefits under Section 409.021 is sent in response to a claim for compensation resulting from an EMT's, peace officer's, or a firefighter's disability or death for which a presumption is claimed to be applicable under Subchapter B, Chapter 607, Government Code, the notice must include a statement by the insurance carrier that explains why the carrier determined a presumption under that subchapter does not apply to the claim for compensation; and describes the evidence that the carrier reviewed in making the determination.

Section 414.002 provides that DWC shall monitor the system for compliance with the Act and rules as well as other laws relating to workers' compensation.

Section 415.021(c-2) provides that in determining whether to assess an administrative penalty involving a claim in which the insurance carrier provides notice under Section 409.021(a-3), the commissioner shall consider whether the employee cooperated with the insurance carrier's investigation and whether the employee authorized access to the applicable medical records.

Government Code §607.052(a) provides that notwithstanding any other law, this subchapter applies only to a firefighter, peace officer, or EMT who on becoming employed or during employment as a firefighter, peace officer, or EMT, received a physical examination that failed to reveal evidence of the illness or disease for which benefits or compensation are sought using a presumption established by Subchapter B; is employed for five or more years as a firefighter, peace officer, or EMT; and seeks benefits or compensation for a disease or illness covered by Subchapter B that is discovered during employment as a firefighter, peace officer, or EMT.

Section 607.052(b) provides that a presumption under Subchapter B does not apply to a determination of a survivor's eligibility for benefits under Chapter 615; in a cause of action brought in a state or federal court except for judicial review of a proceeding in which there has been a grant or denial of employment-related benefits or compensation; to a determination regarding benefits or compensation under a life or disability insurance policy purchased by or on behalf of the firefighter, peace officer, or EMT that provides coverage in addition to any benefits or compensation required by law; or if the disease or illness for which benefits or compensation is sought is known to be caused by the use of tobacco and the firefighter, peace officer, or EMT is or has been a user of tobacco, or if their spouse has, during the marriage, been a user of tobacco that is consumed through smoking.

Section 607.058 provides that a presumption under §§607.053, 607.054, 607.055, or 607.056 may be rebutted through a showing by a preponderance of the evidence that a risk factor, accident, hazard, or other cause not associated with the individual's service as a firefighter or EMT was a substantial factor in bringing about the individual's disease or illness, without which the disease or illness would not have occurred. A rebuttal offered under Section 607.058 must include a statement by the person offering the rebuttal that describes, in detail, the evidence that the person reviewed before making the determination that a cause not associated with the individual's service as a firefighter or EMT was a substantial factor in bringing about the individual's disease or illness without which the disease or illness would not have occurred.

Finally, §9 of SB 2551 requires that the commissioner adopt rules as required by or necessary no later than January 1, 2020. The proposed amendment supports the implementation of the Workers' Compensation Act, Texas Labor Code Title 5, Subtitle A.

§124.3. Investigation of an Injury and Notice of Denial or [/] Dispute

(a) Except as provided in subsection (b) of this section, upon receipt of written notice of injury as provided in §124.1 of this title (relating to Notice of Injury) the insurance carrier shall conduct an investigation relating to the compensability of the injury, the insurance carrier's liability for the injury, and the accrual of benefits. If the insurance carrier believes that it is not liable for the injury or that the injury was not compensable, the insurance carrier shall file the notice of denial of a claim (Notice of Denial [~~notice of denial~~]) in the form and manner required by Labor Code §409.022 (relating to Refusal to Pay Benefits; Notice; Administrative Violation) and §124.2 of this title (concerning [~~relating to~~] Insurance Carrier Reporting and Notification Requirements).

(1) If the insurance carrier does not file a Notice of Denial [~~notice of denial~~] by the 15th day after receipt of the written notice of injury or does not file a Notice of Continuing Investigation as described under Labor Code §409.021(a-3) (relating to Initiation of Benefits; Insurance Carrier's Refusal; Administrative Violation), the insurance carrier is liable for any benefits that accrue and shall initiate benefits in accordance with this section.

(2) If the insurance carrier files a Notice of Denial [~~notice of denial~~] after the 15th day but on or before the 60th day after receipt of written notice of the injury:

(A) The insurance carrier is liable for and shall pay all income benefits that had accrued and were payable prior to the date the insurance carrier filed the Notice of Denial [~~notice of denial~~] and only then is it permitted to suspend payment of benefits; and

(B) The insurance carrier is liable for and shall pay for all medical services, in accordance with the Act and rules, provided prior to the filing of the Notice of Denial [~~notice of denial~~].

(3) The insurance carrier shall not file notice with the division [~~commission~~] that benefits will be paid as and when they accrue with the division.

(4) An insurance [~~A~~] carrier's failure to file a Notice of Denial or a Notice of Continuing Investigation [~~notice of denial of a claim~~] by the 15th day after it receives written notice of an injury constitutes the insurance carrier's acceptance of the claim as a compensable injury, subject to the insurance carrier's ability to contest compensability on or before the 60th day after receipt of written notice of the injury. In the event of such a failure, the insurance carrier is liable for and shall pay all income and medical benefits that have accrued or become payable, subject to the insurance carrier's right to contest compensability on or before the 60th day.

(5) [~~(4)~~] The insurance carrier commits an administrative [~~a~~] violation if, not later than the 15th day after it receives written notice of the injury, it does not begin to pay benefits as required, [~~or~~]

file a Notice of Denial [~~notice of denial~~] of the compensability of a claim or file a Notice of Continuing Investigation in the form and manner required by §124.2 of this title.

[~~(A) An administrative penalty under this subsection shall be assessed at:~~

~~(i) $500 if the carrier initiates compensation or files a notice of refusal within five working days of the date required by subsection (a);~~

~~(ii) $1,500 if the carrier initiates compensation or files a notice of refusal more than five and less than 16 working days of the date required by subsection (a);~~

~~(iii) $2,500 if the carrier initiates compensation or files a notice of refusal more than 15 and less than 31 working days of the date required by subsection (a); or~~

~~(iv) $5,000 if the carrier initiates compensation or files a notice of refusal more than 30 working days after the date required by subsection (a).~~

~~(B) The administrative penalties provided for in this subsection are not cumulative and a violation occurs only with respect to the initial late payment of benefits.~~]

[~~(C)~~] The division [~~commission~~] will send periodic notifications to all insurance carriers regarding the amount of penalties owed and the proper way to submit and document the payments.

(b) Except as provided by subsection (c), the insurance carrier waives the right to contest compensability of or liability for the injury, if it does not contest compensability on or before the 60th day after the date on which the insurance carrier receives written notice of the injury.

(c) If the insurance carrier wants to deny compensability of or liability for the injury after the 60th day after it received written notice of the injury:

(1) the insurance carrier must establish that it is basing its denial on evidence that could not have reasonably been discovered earlier; and

(2) the insurance carrier is liable for and shall pay all benefits that were payable prior to and after filing the Notice of Denial [~~notice of denial~~] until the division [~~Commission~~] has made a finding that the evidence could not have been reasonably discovered earlier.

(d) If the claim involves the death of an injured employee, investigations, denials of compensability or liability, and disputes of the eligibility of a potential beneficiary to receive death benefits are governed by §132.17 of this title (concerning [~~relating to~~] Denial, Dispute, and Payment of Death Benefits). Notwithstanding §132.17(f)(1) and (2) of this title, the insurance carrier may issue a Notice of Continuing Investigation in accordance with the provisions of §124.2(f) and this section.

(e) Notwithstanding §132.13 of this title (concerning Burial Benefits), if an insurance carrier has issued a Notice of Continuing Investigation in accordance with the provisions of §124.2(f) and this section, the insurance carrier shall either pay or deny a claim for burial benefits within seven days from the date the insurance carrier either initiated benefits or filed a notice of denial in accordance with §124.2(f) of this title.

(f) [~~(e)~~] [~~Texas~~] Labor Code[~~,~~] §409.021 and subsection (a) of this section do not apply to disputes of extent of injury. If an insurance [~~a~~] carrier receives a medical bill that involves treatment(s) or service(s) that the insurance carrier believes is not related to the compensable injury, the insurance carrier shall file a notice of dispute of extent of injury (notice of dispute). The notice of dispute shall be filed in accordance with §124.2 of this title and be filed not later than the earlier of:

(1) the date the insurance carrier denied the medical bill; or

(2) the due date for the insurance carrier to pay or deny the medical bill as provided in Chapter 133 of this title (concerning [~~relating to~~] General Medical Provisions).

([~~(f) The 15-day time frame provided for in subsection (a) and the administrative penalty provisions of subsection (a)(4) apply to a claim for benefits based on a compensable injury occurring on or after September 1, 2003. For claims based on a compensable injury occurring prior to September 1, 2003,~~

~~the applicable time frame is seven days and the administrative penalty provisions of subsection (a)(4) are inapplicable.~~]

(g) If the insurance carrier receives a written notice of injury for a disease or illness identified by Texas Government Code, Chapter 607, Subchapter B (relating to Diseases or Illnesses Suffered by Firefighters, Peace Officers, and Emergency Medical Technicians), it shall investigate each element of the applicable statutory presumption as well as compensability of the injury, liability for the injury, and the accrual of benefits.

(1) A claimant is not required to expressly claim the applicability of a statutory presumption in order for the statutory presumption to apply.

(2) A presumption under Government Code, Chapter 607, Subchapter B, is claimed upon an insurance carrier's receipt of a written notice of injury which identifies:

(A) the injured or deceased employee's occupation as a firefighter, peace officer, or emergency medical technician, and

(B) the injured or deceased employee's disease or illness is a medical condition identified by Subchapter B.

(3) A determination that the statutory presumption does not apply does not relieve the insurance carrier of its continuing obligation to conduct a reasonable investigation relating to the compensability of the injury, liability for the injury, and accrual of benefits.

DWC certifies that the proposed rule has been reviewed by legal counsel and found to be within the agency's statutory authority to adopt.

Nicholas Canaday III
General Counsel

1 Texas Department of Insurance, Division of Workers' Compensation