APPEAL NO. 080416-s
FILED MAY 19, 2008

This appeal arises pursuant to the Texas Workers' Compensation Act, TEX. LAB. CODE ANN. § 401.001 *et seq*. (1989 Act). A contested case hearing was held on February 11, 2008. With regard to the only issue before her, the hearing officer determined that the first certification of maximum medical improvement (MMI) and impairment rating (IR) assessed by Dr. E on June 8, 2007, did not become final because Dr. E was not a doctor authorized to make an impairment determination under 28 TEX. ADMIN. CODE § 130.1(a) (Rule 130.1(a)).

The appellant (claimant) appealed, contending that Dr. E was authorized to certify MMI and the assigned IR. The respondent (carrier) responded, urging affirmance.

DECISION

Reversed and remanded.

It is undisputed that the claimant sustained a compensable low back and left hand/wrist injury on _____. The claimant began treating with Dr. E on _____.

In March 2007, the employer joined a Health Care Network (HCN). The employer's risk manager testified that notices were sent out to all the employees on March 29, 2007, advising them that the employer was joining a HCN on March 31, 2007. Although the claimant contends that she did not get this notice until November 15, 2007, there is evidence from the risk manager that the claimant's packet of information regarding the HCN was sent on March 29, 2007. There is no signed acknowledgment of the notice by the claimant in evidence. The hearing officer made a finding of fact that "[o]n March 29, 2007, Employer notified Claimant that it would be joining a health care network as of March 31, 2007." *See* Rule 102.4 for the general rules for non-Texas Department of Insurance (Department), Division of Workers' Compensation (Division) communications.

The claimant continued to see Dr. E and in a Report of Medical Evaluation (DWC-69) and narrative, both dated June 8, 2007, Dr. E certified clinical MMI on that date and assigned a 13% IR. The hearing officer, in an unappealed finding, determined that Dr. E's DWC-69 "was the first such certification issued with respect to claimant's compensable injury of _____." There is evidence that the carrier received Dr. E's certification of MMI/IR by acknowledged receipt by August 1, 2007, when the carrier filed a Notification of MMI/First Impairment Income Benefit Payment (PLN-3) on August 1, 2007, disputing the 13% IR. (*See* Appeals Panel Decision (APD) 080301-s, decided April 16, 2008). Pursuant to Rule 130.12(b)(1), a first certification of MMI and/or IR can be disputed by requesting a benefit review conference or by requesting appointment of

a designated doctor, if one has not been appointed. The hearing officer made an unappealed finding of fact that the carrier did not dispute Dr. E's MMI and IR certification within 90 days of receiving it.

Section 408.123(e) provides that except as otherwise provided by Section 408.123, an employee's first valid certification of MMI and the first valid assignment of an IR is final if the certification or assignment is not disputed before the 91st day after the date written notification of the certification or assignment is provided to the employee and the carrier by verifiable means. Rule 130.12(b) provides, in part, that the first MMI/IR certification must be disputed within 90 days of delivery of written notice through verifiable means, including IRs related to extent-of-injury disputes; that the notice must contain a copy of a valid DWC-69, as described in Rule 130.12(c); and that the 90-day period begins on the day after the written notice is delivered to the party wishing to dispute the certification of MMI or IR assignment, or both.

The carrier argued that the certification from Dr. E did not become final because Dr. E was not affiliated with the HCN, and therefore, was no longer the treating doctor after March 31, 2007, and could not provide a valid MMI and IR. The hearing officer made findings that the claimant resided within the service area of the HCN; that Dr. E was not affiliated with the HCN on June 8, 2007; and that on June 8, 2007, Dr. E "was not a treating doctor, a doctor to whom Claimant was referred by her treating doctor, a designated doctor, or a Carrier-selected doctor for a Required Medical Examination." *See* Rules 130.1(a) and 130.12(c)(3).

Both the carrier and the hearing officer reference Rules 130.12(c)(3) and 130.1(a) and Texas Insurance Code § 1305.005(b). Rule 130.12(c)(3) provides that to be valid, a DWC-69 must have the signature of the certifying doctor who is authorized under Rule 130.1(a) to make the assigned impairment determination. In the Discussion Section of the decision, the hearing officer commented:

> Employer's decision to join a network and Section 1305.005(b) of the Texas Insurance Code required Claimant to choose a treating doctor from among the available network providers; Claimant's apparent failure to fully comprehend that obligation does not diminish her responsibility to comply with it. Since Claimant did not select a network provider as her treating doctor, but instead continued to consult [Dr. E], who was not affiliated with the network, it is proper to conclude that Claimant had no treating doctor in June of 2007, when [Dr. E] issued his purported certification.

Section 1305.005(b) of the Insurance Code provides:

> (b) An insurance carrier may establish or contract with networks certified under this chapter to provide health care services under the Texas Workers' Compensation Act. If an employer elects to contract with an insurance company for the provision of health care services through a network, . . . the employer's employees who live within the network's service area are required to obtain medical treatment for a compensable injury within the network, except as provided by Section 1305.006(1) and (3).

The exceptions in Section 1305.006 of the Insurance Code are for emergency care, an employee who lives outside the service area of the network, or for a referral from the network treating doctor to an out-of-network provider that has been approved by the network. Insurance Code Section 1305.005(d) provides that the insurance carrier shall provide to the employer, and the employer shall provide to the employer's employees, notice of network requirements including all information required by Section 1305.451 and the employer shall "obtain a signed acknowledgment from each employee . . . that the employee has received information concerning the network and the network's requirements." Section 1305.005(h) provides that an injured employee is not required to comply with the network requirements until the employee receives the notice under Subsections (d), (e), or (g).[1] We further note that Section 1305.103(c) of the Insurance Code addresses the situation we have in the instant case. Section 1305.103(c) provides:

> (c) An employee who lives within the service area of a network and who is being treated by a non-network provider for an injury that occurred before the employer's insurance carrier established or contracted with the network, shall select a network treating doctor on notification by the carrier that health care services are being provided through the network. The carrier shall provide to the employee all information required by Section 1305.451. If the employee fails to select a treating doctor on or before the 14th day after the date of receipt of the information required by Section 1305.451, the network may assign the employee a network treating doctor. (Emphasis added.)

Section 1305.401(a) of the Insurance Code, pertaining to Complaint Resolution provides that each network shall implement and maintain a complaint system that provides reasonable procedures to resolve an oral or written complaint. Sections 1305.401(c) and (d) provide that the complaint system must include a process for the

[1] Subsection (e) of Section 1305.005 pertains to employees hired after notice is given under Subsection (d) and Subsection (g) pertains to notifying an injured employee of the network requirements at the time the employer receives actual or constructive notice of an injury.

notice and appeal of a complaint and that the Commissioner of Insurance may adopt rules as necessary to implement Section 1305.401.

The threshold question, in this case, is whether the claimant received notification from the employer that health care services are going to be provided through the HCN. The claimant contends that she did not receive the required notice until November 15, 2007. There was conflicting evidence on this point.

Rule 10.60(a) provides that an insurance carrier that establishes or contracts with a network shall deliver to the employer, and the employer shall deliver to the employer's employees notice of network requirements and information required by Insurance Code Sections 1305.005 and 1305.451, to include the employee acknowledgment form described in Insurance Code Section 1305.005 and Rule 10.60. Rule 10.62 entitled Dispute Resolution for Employee Requirements Related to In-Network Care establishes a dispute resolution process whereby the employee can assert that he or she does not live in the network's service area.[2] Rule 10.62 does not address dispute resolution regarding whether an employee was provided notification of health care network requirements.

The Appeals Panel Decision Manual, Other Procedural Issues (P00), located on the Division's internet website under Dispute Decisions, states:

> **NOTICE OF NETWORK REQUIREMENTS**. Proper notice of network requirements under Insurance Code Section 1305.005 (Participation In Network; Notice of Network Requirements) is a matter for the Workers' Compensation Health Care Networks to determine. This is not an issue for the Hearings Division.

This is a case of first impression. Insurance Code Section 1305.401 provides for a health care network complaint system. Rule 10.122, entitled Submitting Complaints to the Department, provides that any person, including a person who has attempted to resolve a complaint through a network's complaint system process, or attempted to resolve a dispute regarding whether the employee lives within the network's service area through the insurance carrier, who is dissatisfied with the resolution of the complaint, may submit a complaint to the Department. Rule 10.122(b) sets out how complaint forms may be obtained.

In this particular case, the threshold question of whether the claimant received notification from the employer that health care services are being provided through the HCN pursuant to Insurance Code Sections 1305.005 and 1305.103(c) was a matter to be decided by the HCN and Department as set out in Insurance Code Chapter 1305 and the implementing rules, in particular Section 1305.401 and Rule 10.122. The hearing officer, in this case, was not authorized to make a determination regarding whether the claimant received proper notification from the employer that health care services are going to be provided through the HCN. There is no indication that anyone

[2] The claimant does not assert that she does not live in the health care network's service area.

else made a determination regarding when the claimant received notice the employer was joining the HCN.

Further consideration and development of the evidence is necessary to resolve the issue of whether the first MMI and IR certification, issued by Dr. E on June 8, 2007, has become final as discussed herein. *See* Albertson's Inc. v. Ellis, 131 S.W.3d 245 (Tex. App.-Fort Worth 2004, pet. denied). Accordingly, we reverse the hearing officer's determination that the certification of MMI and IR assessed by Dr. E on June 8, 2007, was not valid and that certification did not become final. We remand the case back to the hearing officer for further development of the evidence to include a determination by the HCN and/or the Department regarding whether the claimant received the proper notification that health care services are to be provided by the HCN and when that notice was provided to the claimant. After determinations have been made on these points the hearing officer is to reconsider the case based on those determinations.

Pending resolution of the remand, a final decision has not been made in this case. However, since reversal and remand necessitate the issuance of a new decision and order by the hearing officer, a party who wishes to appeal from such new decision must file a request for review not later than 15 days after the date on which such new decision is received from the Division, pursuant to Section 410.202 which was amended June 17, 2001, to exclude Saturdays and Sundays and holidays listed in Section 662.003 of the Texas Government Code in the computation of the 15-day appeal and response periods. *See* APD 060721, decided June 12, 2006.

The true corporate name of the insurance carrier is **ZURICH AMERICAN INSURANCE COMPANY** and the name and address of its registered agent for service of process is

LEO F. MALO
12222 MERIT DRIVE, SUITE 700
DALLAS, TEXAS 75251-2237.

_____
Thomas A. Knapp
Appeals Judge

CONCUR:

_____
Veronica L. Ruberto
Appeals Judge

_____
Margaret L. Turner
Appeals Judge