LABOR CODE

TITLE 5. WORKERS' COMPENSATION

SUBTITLE A. TEXAS WORKERS' COMPENSATION ACT

CHAPTER 408. WORKERS' COMPENSATION BENEFITS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 408.001. EXCLUSIVE REMEDY; EXEMPLARY DAMAGES. (a) Recovery of workers' compensation benefits is the exclusive remedy of an employee covered by workers' compensation insurance coverage or a legal beneficiary against the employer or an agent or employee of the employer for the death of or a work-related injury sustained by the employee.

(b) This section does not prohibit the recovery of exemplary damages by the surviving spouse or heirs of the body of a deceased employee whose death was caused by an intentional act or omission of the employer or by the employer's gross negligence.

(c) In this section, "gross negligence" has the meaning assigned by Section 41.001, Civil Practice and Remedies Code.

(d) A determination under Section 406.032, 409.002, or 409.004 that a work-related injury is noncompensable does not adversely affect the exclusive remedy provisions under Subsection (a).

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.077, eff. September 1, 2005.

Sec. 408.002. SURVIVAL OF CAUSE OF ACTION. A right of action survives in a case based on a compensable injury that results in the employee's death.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1991.

Sec. 408.003. REIMBURSABLE EMPLOYER PAYMENTS; SALARY CONTINUATION; OFFSET AGAINST INCOME BENEFITS; LIMITS. (a) After an injury, an employer may:

(1) initiate benefit payments, including medical

benefits; or

(2) on the written request or agreement of the employee, supplement income benefits paid by the insurance carrier by an amount that does not exceed the amount computed by subtracting the amount of the income benefit payments from the employee's net preinjury wages.

(b) If an injury is found to be compensable and an insurance carrier initiates compensation, the insurance carrier shall reimburse the employer for the amount of benefits paid by the employer to which the employee was entitled under this subtitle. Payments that are not reimbursed or reimbursable under this section may be reimbursed under Section 408.127.

(c) The employer shall notify the division and the insurance carrier on forms prescribed by the commissioner of the initiation of and amount of payments made under this section.

(d) Employer payments made under this section:

(1) may not be construed as an admission of compensability; and

(2) do not affect the payment of benefits from another source.

(e) If an employer does not notify the insurance carrier of the injury in compliance with Section 409.005, the employer waives the right to reimbursement under this section.

(f) Salary continuation payments made by an employer for an employee's disability resulting from a compensable injury shall be considered payment of income benefits for the purpose of determining the accrual date of any subsequent income benefits under this subtitle.

(g) If an employer is subject to a contractual obligation with an employee or group of employees, such as a collective bargaining agreement or a written agreement or policy, under which the employer is required to make salary continuation payments, the employer is not eligible for reimbursement under this section for those payments.

(h) Payments made as salary continuation or salary supplementation do not affect the exclusive remedy provisions of Section 408.001.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 1999, 76th Leg., ch. 954, Sec. 5, eff. Sept. 1, 1999; Acts 1999, 76th Leg., ch. 1003, Sec. 1, 2, eff. Sept. 1, 1999.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.078, eff. September 1, 2005.

Sec. 408.004. REQUIRED MEDICAL EXAMINATIONS; ADMINISTRATIVE VIOLATION.

(a) The commissioner may require an employee to submit to medical examinations to resolve any question about the appropriateness of the health care received by the employee.

(a-1) A doctor, other than a chiropractor, who performs a required medical examination under this section is subject to Section 408.0043. A chiropractor who performs a required medical examination under this section is subject to Section 408.0045.

(b) The commissioner may require an employee to submit to a medical examination at the request of the insurance carrier, but only after the insurance carrier has attempted and failed to receive the permission and concurrence of the employee for the examination. Except as otherwise provided by this subsection, the insurance carrier is entitled to the examination only once in a 180-day period. The commissioner may adopt rules that require an employee to submit to not more than three medical examinations in a 180-day period under specified circumstances, including to determine whether there has been a change in the employee's condition and whether it is necessary to change the employee's diagnosis. The commissioner by rule shall adopt a system for monitoring requests made under this subsection by insurance carriers. That system must ensure that good cause exists for any additional medical examination allowed under this subsection that is not requested by the employee. A subsequent examination must be performed by the same doctor unless otherwise approved by the commissioner.

(c) The insurance carrier shall pay for:

(1) an examination required under Subsection (a) or (b); and

(2) the reasonable expenses incident to the employee in submitting to the examination.

(d) An injured employee is entitled to have a doctor of the employee's choice present at an examination required by the division at the request of an insurance carrier. The insurance carrier shall pay a fee set by the commissioner to the doctor selected by the employee.

(e) An employee who, without good cause as determined by the commissioner, fails or refuses to appear at the time scheduled for an examination under Subsection (a) or (b) commits an administrative violation. The commissioner by rule shall ensure that an employee receives reasonable notice of an examination and that the employee is provided a reasonable opportunity to reschedule an examination missed by the employee for good cause.

(f) This section does not apply to health care provided through a workers' compensation health care network established under Chapter 1305, Insurance Code.

(g) An insurance carrier who makes a frivolous request for a medical examination under Subsection (b), as determined by the commissioner, commits an administrative violation.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 1997, 75th Leg., ch. 1133, Sec. 1, 2, eff. Sept. 1, 1999; Acts 1999, 76th Leg., ch. 1426, Sec. 8, eff. Jan. 1, 2000; Acts 2001, 77th Leg., ch. 1456, Sec. 5.01, eff. June 17, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.079, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 1218 (H.B. 2004), Sec. 2, eff. September 1, 2007.

Sec. 408.0041. DESIGNATED DOCTOR EXAMINATION. (a) At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about:

(1) the impairment caused by the compensable injury;

(2) the attainment of maximum medical improvement;

(3) the extent of the employee's compensable injury;

(4) whether the injured employee's disability is a direct result of the work-related injury;

(5) the ability of the employee to return to work; or

(6) issues similar to those described by Subdivisions (1)-(5).

(b) Except as provided by Section 408.1225(f), a medical examination requested under Subsection (a) shall be performed by the next available doctor on the division's list of certified designated doctors whose credentials are appropriate for the area of the body affected by the injury and the injured employee's diagnosis as determined by commissioner rule. The division shall assign a designated doctor not later than the 10th day after the date on which the request under Subsection (a) is approved, and the examination must be conducted not later than the 21st day after the date on which the commissioner issues the order under Subsection (a). An examination under this section may not be conducted more frequently than every 60 days, unless good cause for more frequent examinations exists, as defined by commissioner rules.

(b-1) A designated doctor, other than a chiropractor, is subject to Section 408.0043. A designated doctor who is a chiropractor is subject to Section 408.0045. To the extent of a conflict between this section and Section 408.0043 or 408.0045, this section controls.

(c) The treating doctor and the insurance carrier are both responsible for sending to the designated doctor all of the injured employee's medical records relating to the issue to be evaluated by the designated doctor that are in their possession. The treating doctor and insurance carrier may send the records without a signed release from the employee. The designated doctor is authorized to receive the employee's confidential medical records to assist in the resolution of disputes. The treating doctor and insurance carrier may also send the designated doctor an analysis of the injured employee's medical condition, functional abilities, and return-to-work opportunities.

(d) To avoid undue influence on a person selected as a designated doctor under this section, and except as provided by Subsection (c), only the injured employee or an appropriate member

of the division's staff may communicate with the designated doctor about the case regarding the injured employee's medical condition or history before the examination of the injured employee by the designated doctor. After that examination is completed, communication with the designated doctor regarding the injured employee's medical condition or history may be made only through appropriate division staff members. The designated doctor may initiate communication with any doctor or health care provider who has previously treated or examined the injured employee for the work-related injury or with peer reviewers identified by the insurance carrier.

(e) The designated doctor shall report to the division. The report of the designated doctor has presumptive weight unless the preponderance of the evidence is to the contrary. An employer may make a bona fide offer of employment subject to Sections 408.103(e) and 408.144(c) based on the designated doctor's report.

(f) Unless otherwise ordered by the commissioner, the insurance carrier shall pay benefits based on the opinion of the designated doctor during the pendency of any dispute. If an insurance carrier is not satisfied with the opinion rendered by a designated doctor under this section, the insurance carrier may request the commissioner to order an employee to attend an examination by a doctor selected by the insurance carrier.

(f-1) The subsequent injury fund shall reimburse an insurance carrier for any overpayment of benefits made by the insurance carrier under Subsection (f) based on an opinion rendered by a designated doctor if that opinion is reversed or modified by a final arbitration award or a final order or decision of the commissioner or a court. The commissioner shall adopt rules to provide for a periodic reimbursement schedule, providing reimbursement at least annually.

(f-2) An employee required to be examined by a designated doctor may request a medical examination to determine maximum medical improvement and the employee's impairment rating from the treating doctor or from another doctor to whom the employee is referred by the treating doctor if:

(1) the designated doctor's opinion is the employee's first evaluation of maximum medical improvement and impairment rating; and

(2) the employee is not satisfied with the designated doctor's opinion.

(f-3) The commissioner shall provide the insurance carrier and the employee with reasonable time to obtain and present the opinion of a doctor selected under Subsection (f) or (f-2) before the commissioner makes a decision on the merits of the issue.

(f-4) The commissioner by rule shall adopt guidelines prescribing the circumstances under which an examination by the employee's treating doctor or another doctor to whom the employee is referred by the treating doctor to determine any issue under Subsection (a), other than an examination under Subsection (f-2), may be appropriate.

(g) Except as otherwise provided by this subsection, an injured employee is entitled to have a doctor of the employee's choice present at an examination requested by an insurance carrier under Subsection (f). The insurance carrier shall pay a fee set by the commissioner to the doctor selected by the employee. If the injured employee is subject to a workers' compensation health care network under Chapter 1305, Insurance Code, the doctor must be the employee's treating doctor.

(h) The insurance carrier shall pay for:

(1) an examination required under Subsection (a), (f), or (f-2), unless otherwise prohibited by this subtitle or by an order or rule of the commissioner; and

(2) the reasonable expenses incident to the employee in submitting to the examination.

(i) An employee who, without good cause as determined by the commissioner, fails or refuses to appear at the time scheduled for an examination under Subsection (a) or (f) commits an administrative violation. An injured employee may not be fined more than $10,000 for a violation of this subsection.

(j) An employee is not entitled to temporary income benefits, or to lifetime income benefits under Section 408.1615, if applicable to the employee, and an insurance carrier is authorized

to suspend the payment of those benefits, during and for a period in which the employee fails to submit to an examination required by Subsection (a) or (f) or, if applicable, Section 408.1615(h), unless the commissioner determines that the employee had good cause for the failure to submit to the examination. The commissioner may order temporary income benefits or lifetime income benefits under Section 408.1615, as applicable, to be paid for the period for which the commissioner determined that the employee had good cause. The commissioner by rule shall ensure that:

(1) an employee receives reasonable notice of an examination and the insurance carrier's basis for suspension; and

(2) the employee is provided a reasonable opportunity to reschedule an examination for good cause.

(k) If the report of a designated doctor indicates that an employee has reached maximum medical improvement or is otherwise able to return to work immediately, the insurance carrier may suspend or reduce the payment of temporary income benefits immediately.

(k-1) If the report of a designated doctor indicates that an employee receiving lifetime income benefits under Section 408.1615 is no longer entitled to those benefits, the insurance carrier may suspend the payment of lifetime income benefits as provided by that section.

(l) A person who makes a frivolous request for a medical examination under Subsection (a) or (f), as determined by the commissioner, commits an administrative violation.

Added by Acts 2001, 77th Leg., ch. 1456, Sec. 5.02, eff. June 17, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.080, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 1150 (S.B. 1169), Sec. 1, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 1218 (H.B. 2004), Sec. 3, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 1162 (H.B. 2605), Sec. 11, eff. September 1, 2011.

Acts 2023, 88th Leg., R.S., Ch. 721 (H.B. 2468), Sec. 1, eff. September 1, 2023.

Sec. 408.0042. MEDICAL EXAMINATION BY TREATING DOCTOR TO DEFINE COMPENSABLE INJURY. (a) The division shall require an injured employee to submit to a single medical examination to define the compensable injury on request by the insurance carrier.

(b) A medical examination under this section shall be performed by the employee's treating doctor. The insurance carrier shall pay the costs of the examination.

(c) After the medical examination is performed, the treating doctor shall submit to the insurance carrier a report that details all injuries and diagnoses related to the compensable injury, on receipt of which the insurance carrier shall:

(1) accept all injuries and diagnoses as related to the compensable injury; or

(2) dispute the determination of specific injuries and diagnoses.

(d) Any treatment for an injury or diagnosis that is not accepted by the insurance carrier under Subsection (c) as compensable at the time of the medical examination under Subsection (a) must be preauthorized before treatment is rendered. If the insurance carrier denies preauthorization because the treatment is for an injury or diagnosis unrelated to the compensable injury, the injured employee or affected health care provider may file an extent of injury dispute.

(e) Any treatment for an injury or diagnosis that is accepted by the insurance carrier under Subsection (c) as compensable at the time of the medical examination under Subsection (a) may not be reviewed for compensability, but may be reviewed for medical necessity.

(f) The commissioner may adopt rules relating to requirements for a report under this section, including requirements regarding the contents of a report.

(g) This section does not limit an injured employee or insurance carrier's ability to request an examination under Section 408.004 or 408.0041, as provided by those sections.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.0805, eff. September 1, 2005.

Sec. 408.0043. PROFESSIONAL SPECIALTY CERTIFICATION REQUIRED FOR CERTAIN REVIEW. (a) This section applies to a person, other than a chiropractor or a dentist, who performs health care services under this title as:

(1) a doctor performing peer review;

(2) a doctor performing a utilization review of a health care service provided to an injured employee;

(3) a doctor performing an independent review of a health care service provided to an injured employee;

(4) a designated doctor;

(5) a doctor performing a required medical examination; or

(6) a doctor serving as a member of the medical quality review panel.

(b) A person described by Subsection (a) who reviews a specific workers' compensation case must hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving.

(c) Notwithstanding Subsection (b), if a health care service is requested, ordered, provided, or to be provided by a physician, a person described by Subsection (a)(1), (2), or (3) who reviews the service with respect to a specific workers' compensation case must be of the same or a similar specialty as that physician.

Added by Acts 2007, 80th Leg., R.S., Ch. 1218 (H.B. 2004), Sec. 1, eff. September 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 14, eff. September 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.10, eff. September 1, 2019.

Sec. 408.0044. REVIEW OF DENTAL SERVICES. (a) This section applies to a dentist who performs dental services under this title

as:

(1) a doctor performing peer review of dental services;

(2) a doctor performing a utilization review of a dental service provided to an injured employee;

(3) a doctor performing an independent review of a dental service provided to an injured employee; or

(4) a doctor performing a required dental examination.

(b) A person described by Subsection (a) who reviews a dental service provided in conjunction with a specific workers' compensation case must be licensed to practice dentistry.

Added by Acts 2007, 80th Leg., R.S., Ch. 1218 (H.B. 2004), Sec. 1, eff. September 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 15, eff. September 1, 2009.

Sec. 408.0045. REVIEW OF CHIROPRACTIC SERVICES. (a) This section applies to a chiropractor who performs chiropractic services under this title as:

(1) a doctor performing peer review of chiropractic services;

(2) a doctor performing a utilization review of a chiropractic service provided to an injured employee;

(3) a doctor performing an independent review of a chiropractic service provided to an injured employee;

(4) a designated doctor providing chiropractic services;

(5) a doctor performing a required medical examination; or

(6) a chiropractor serving as a member of the medical quality review panel.

(b) A person described by Subsection (a) who reviews a chiropractic service provided in conjunction with a specific workers' compensation case must be licensed to engage in the practice of chiropractic.

Added by Acts 2007, 80th Leg., R.S., Ch. 1218 (H.B. 2004), Sec. 1,

eff. September 1, 2007.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 16, eff. September 1, 2009.

Sec. 408.0046. RULES. The commissioner may adopt rules as necessary to determine which professional health practitioner specialties are appropriate for treatment of certain compensable injuries. The rules adopted under this section must require an entity requesting a peer review to obtain and provide to the doctor providing peer review services all relevant and updated medical records.

Added by Acts 2007, 80th Leg., R.S., Ch. 1218 (H.B. 2004), Sec. 1, eff. September 1, 2007.

Sec. 408.005. SETTLEMENTS AND AGREEMENTS. (a) A settlement may not provide for payment of benefits in a lump sum except as provided by Section 408.128.

(b) An employee's right to medical benefits as provided by Section 408.021 may not be limited or terminated.

(c) A settlement or agreement resolving an issue of impairment:

(1) may not be made before the employee reaches maximum medical improvement; and

(2) must adopt an impairment rating using the impairment rating guidelines described by Section 408.124.

(d) A settlement must be signed by the commissioner and all parties to the dispute.

(e) The commissioner shall approve a settlement if the commissioner is satisfied that:

(1) the settlement accurately reflects the agreement between the parties;

(2) the settlement reflects adherence to all appropriate provisions of law and the policies of the division; and

(3) under the law and facts, the settlement is in the best interest of the claimant.

(f) A settlement that is not approved or rejected before the

16th day after the date the settlement is submitted to the commissioner is considered to be approved by the commissioner on that date.

(g) A settlement takes effect on the date it is approved by the commissioner.

(h) A party to a settlement may withdraw acceptance of the settlement at any time before its effective date.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.081, eff. September 1, 2005.

Sec. 408.006. MENTAL TRAUMA INJURIES. (a) It is the express intent of the legislature that nothing in this subtitle shall be construed to limit or expand recovery in cases of mental trauma injuries.

(b) Notwithstanding Section 504.019, a mental or emotional injury that arises principally from a legitimate personnel action, including a transfer, promotion, demotion, or termination, is not a compensable injury under this subtitle.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 353 (H.B. 1983), Sec. 2, eff. September 1, 2017.

Sec. 408.007. DATE OF INJURY FOR OCCUPATIONAL DISEASE. For purposes of this subtitle, the date of injury for an occupational disease is the date on which the employee knew or should have known that the disease may be related to the employment.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Sec. 408.008. COMPENSABILITY OF HEART ATTACKS. A heart attack is a compensable injury under this subtitle only if:

(1) the attack can be identified as:

(A) occurring at a definite time and place; and

(B) caused by a specific event occurring in the course and scope of the employee's employment;

(2) 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; and

(3) the attack was not triggered solely by emotional or mental stress factors, unless it was precipitated by a sudden stimulus.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

SUBCHAPTER B. MEDICAL BENEFITS

Sec. 408.021. ENTITLEMENT TO MEDICAL BENEFITS. (a) An employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that:

(1) cures or relieves the effects naturally resulting from the compensable injury;

(2) promotes recovery; or

(3) enhances the ability of the employee to return to or retain employment.

(b) Medical benefits are payable from the date of the compensable injury.

(c) Except in an emergency, all health care must be approved or recommended by the employee's treating doctor.

(d) An insurance carrier's liability for medical benefits may not be limited or terminated by agreement or settlement.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Sec. 408.022. SELECTION OF DOCTOR. (a) Except in an emergency, the division shall require an employee to receive medical treatment from a doctor chosen from a list of doctors approved by the commissioner. A doctor may perform only those procedures that are within the scope of the practice for which the doctor is licensed. The employee is entitled to the employee's initial choice of a doctor from the division's list.

(b) If an employee is dissatisfied with the initial choice

of a doctor from the division's list, the employee may notify the division and request authority to select an alternate doctor. The notification must be in writing stating the reasons for the change, except notification may be by telephone when a medical necessity exists for immediate change.

(c) The commissioner shall prescribe criteria to be used by the division in granting the employee authority to select an alternate doctor. The criteria may include:

(1) whether treatment by the current doctor is medically inappropriate;

(2) the professional reputation of the doctor;

(3) whether the employee is receiving appropriate medical care to reach maximum medical improvement; and

(4) whether a conflict exists between the employee and the doctor to the extent that the doctor-patient relationship is jeopardized or impaired.

(d) A change of doctor may not be made to secure a new impairment rating or medical report.

(e) For purposes of this section, the following is not a selection of an alternate doctor:

(1) a referral made by the doctor chosen by the employee if the referral is medically reasonable and necessary;

(2) the receipt of services ancillary to surgery;

(3) the obtaining of a second or subsequent opinion only on the appropriateness of the diagnosis or treatment;

(4) the selection of a doctor because the original doctor:

(A) dies;

(B) retires; or

(C) becomes unavailable or unable to provide medical care to the employee; or

(5) a change of doctors required because of a change of residence by the employee.

(f) This section does not apply to requirements regarding the selection of a doctor under a workers' compensation health care network established under Chapter 1305, Insurance Code, except as provided by that chapter.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.082, eff. September 1, 2005.

Sec. 408.0221. REQUEST FOR DESCRIPTION OF EMPLOYMENT. (a) This section applies only to an employee of an employer who has 10 or more employees.

(b) To facilitate an injured employee's return to employment as soon as it is considered safe and appropriate by the injured employee's treating doctor, the treating doctor may request that the injured employee's employer provide the treating doctor with the information described by Subsection (d) on the form adopted under that subsection.

(c) Information provided to a treating doctor under Subsection (b) does not constitute:

(1) a request by the employer that the injured employee return to the employment;

(2) an offer of employment by the employer for the injured employee to return to employment; or

(3) an admission of the compensability of the injury of the employee.

(d) The commissioner shall prescribe a form to provide information from an employer to a treating doctor concerning the functions and physical responsibilities of an injured employee's job. To the extent possible, the form prescribed under this subsection shall be one page, use a check box format as appropriate, and be compatible with electronic mail. The form must include:

(1) the name and address of the employer and the contact information and availability of the individual representing the employer who has knowledge of the injured employee's job;

(2) the scope of the injured employee's employment, including any specific tasks, job duties, or work activities that the injured employee was required to perform at the time the employee sustained the injury; and

(3) an area for additional comments or information by

the employer or individual representing the employer concerning:

(A) the injured employee's job; or

(B) the availability, if any, of other jobs that the employer may have that the employer would like the treating doctor to consider in determining whether an injured employee is able to return to work.

(e) The commissioner may adopt rules as necessary to implement this section and to facilitate communication between the employer and the treating doctor regarding return-to-work opportunities.

Added by Acts 2009, 81st Leg., R.S., Ch. 456 (H.B. 2547), Sec. 1, eff. September 1, 2009.

Sec. 408.023. LIST OF APPROVED DOCTORS; DUTIES OF TREATING DOCTORS. (a) The division shall develop a list of doctors licensed in this state who are approved to provide health care services under this subtitle. A doctor is eligible to be included on the division's list of approved doctors if the doctor:

(1) registers with the division in the manner prescribed by commissioner rules; and

(2) complies with the requirements adopted by the commissioner under this section.

(b) The commissioner by rule shall establish reasonable requirements for training for doctors as a prerequisite for inclusion on the list. Except as otherwise provided by this section, the requirements adopted under this subsection apply to doctors and other health care providers who:

(1) provide health care services as treating doctors;

(2) provide health care services as authorized by this chapter;

(3) perform medical peer review under this subtitle;

(4) perform utilization review of medical benefits provided under this subtitle; or

(5) provide health care services on referral from a treating doctor, as provided by commissioner rule.

(c) The division shall issue to a doctor who is approved by the commissioner a certificate of registration. In determining

whether to issue a certificate of registration, the commissioner may consider and condition approval on any practice restrictions applicable to the applicant that are relevant to services provided under this subtitle. The commissioner may also consider the practice restrictions of an applicant when determining appropriate sanctions under Section 408.0231.

(d) A certificate of registration issued under this section is valid, unless revoked, suspended, or revised, for the period provided by commissioner rule and may be renewed on application to the division. The division shall provide notice to each doctor on the approved doctor list of the pending expiration of the doctor's certificate of registration not later than the 60th day before the date of expiration of the certificate.

(e) Notwithstanding other provisions of this section, a doctor not licensed in this state but licensed in another state or jurisdiction who treats employees or performs utilization review of health care for an insurance carrier may apply for a certificate of registration under this section to be included on the division's list of approved doctors.

(f) Except in an emergency or for immediate post-injury medical care as defined by commissioner rule, or as provided by Subsection (h), (i), or (j), each doctor who performs functions under this subtitle, including examinations under this chapter, must hold a certificate of registration and be on the division's list of approved doctors in order to perform services or receive payment for those services.

(g) The commissioner by rule shall modify registration and training requirements for doctors who infrequently provide health care or who perform utilization review or peer review functions for insurance carriers as necessary to ensure that those doctors are informed of the regulations that affect health care benefit delivery under this subtitle.

(h) A utilization review agent or an insurance carrier that uses doctors to perform reviews of health care services provided under this subtitle, including utilization review, may only use doctors licensed to practice in this state.

(i) The commissioner may grant exceptions to the

requirement imposed under Subsection (f) as necessary to ensure that:

(1) employees have access to health care; and

(2) insurance carriers have access to evaluations of an employee's health care and income benefit eligibility as provided by this subtitle.

(j) A doctor who contracts with a workers' compensation health care network certified under Chapter 1305, Insurance Code, is not subject to the registration requirements of Subsections (a)-(i) for the purpose of providing health care services under that network contract. The doctor is subject to the requirements of Subsections (l)-(p), and Subsection (q) applies to health care services and functions provided by a doctor who contracts with a certified workers' compensation health care network.

(k) The requirements of Subsections (a)-(g) and Subsection (i) expire September 1, 2007. Before that date, the commissioner may waive the application of the provisions of Subsections (a)-(g) and Subsection (i) that require doctors to hold a certificate of registration and to be on the list of approved doctors if the commissioner determines that:

(1) injured employees have adequate access to health care providers who are willing to treat injured employees for compensable injuries through workers' compensation health care networks certified under Chapter 1305, Insurance Code; or

(2) injured employees who are not covered by a workers' compensation health care network certified under Chapter 1305, Insurance Code, do not have adequate access to health care providers who are willing to treat injured employees for compensable injuries.

(l) The injured employee's treating doctor is responsible for the efficient management of medical care as required by Section 408.025(c) and commissioner rules. The division shall collect information regarding:

(1) return-to-work outcomes;

(2) patient satisfaction; and

(3) cost and utilization of health care provided or authorized by a treating doctor on the list of approved doctors.

(m) The commissioner may adopt rules to define the role of the treating doctor and to specify outcome information to be collected for a treating doctor.

(n) The commissioner by rule shall establish reasonable requirements for doctors, and health care providers financially related to those doctors, regarding training, impairment rating testing, and disclosure of financial interests as required by Section 413.041, and for monitoring of those doctors and health care providers as provided by Sections 408.0231, 413.0511, and 413.0512.

(o) A doctor, including a doctor who contracts with a workers' compensation health care network, shall:

(1) comply with the requirements established by commissioner rule under Subsections (l) and (m) and with Section 413.041 regarding the disclosure of financial interests; and

(2) if the doctor intends to provide certifications of maximum medical improvement or assign impairment ratings, comply with the impairment rating training and testing requirements established by commissioner rule under Subsection (n).

(p) A person required to comply with Subsection (o), including a doctor who contracts with a workers' compensation health care network, who does not comply with that section commits an administrative violation.

(q) An insurance carrier may not use, for the purpose of suspending temporary income benefits or computing impairment income benefits, a certification of maximum medical improvement or an impairment rating assigned by a doctor, including a doctor who contracts with a workers' compensation health care network certified under Chapter 1305, Insurance Code, who fails to comply with Subsection (o)(2).

(r) Notwithstanding the waiver or expiration of Subsections (a)-(g) and (i), there may be no direct or indirect provision of health care under this subtitle and rules adopted under this subtitle, and no direct or indirect receipt of remuneration under this subtitle and rules adopted under this subtitle by a doctor who:

(1) before September 1, 2007:

(A) was removed or deleted from the list of

approved doctors either by action of the Texas Workers' Compensation Commission or the division or by agreement with the doctor;

(B) was not admitted to the list of approved doctors either by action of the Texas Workers' Compensation Commission or the division or by agreement with the doctor;

(C) was suspended from the list of approved doctors either by action of the Texas Workers' Compensation Commission or the division or by agreement with the doctor; or

(D) had the doctor's license to practice suspended by the appropriate licensing agency, including a suspension that was stayed, deferred, or probated, or voluntarily relinquished the license to practice; and

(2) was not reinstated or restored by the Texas Workers' Compensation Commission or the division to the list of approved doctors before September 1, 2007.

(s) The waiver or expiration of Subsections (a)-(g) and (i) do not limit the division's ability to impose sanctions as provided by this subtitle and commissioner rules.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 1995, 74th Leg., ch. 980, Sec. 1.25, eff. Sept. 1, 1995; Acts 2001, 77th Leg., ch. 1456, Sec. 1.01, eff. Sept. 1, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.083, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 134 (H.B. 1006), Sec. 2, eff. September 1, 2007.

Acts 2009, 81st Leg., R.S., Ch. 1330 (H.B. 4290), Sec. 17, eff. September 1, 2009.

Acts 2019, 86th Leg., R.S., Ch. 1218 (S.B. 1742), Sec. 3.13, eff. September 1, 2019.

Sec. 408.0231. MAINTENANCE OF LIST OF APPROVED DOCTORS; SANCTIONS AND PRIVILEGES RELATING TO HEALTH CARE. (a) The commissioner shall delete from the list of approved doctors a doctor:

(1) who fails to register with the division as

provided by this chapter and commissioner rules;

(2) who is deceased;

(3) whose license to practice in this state is revoked, suspended, or not renewed by the appropriate licensing authority; or

(4) who requests to be removed from the list.

(b) The commissioner by rule shall establish criteria for:

(1) deleting or suspending a doctor from the list of approved doctors;

(2) imposing sanctions on a doctor or an insurance carrier as provided by this section;

(3) monitoring of utilization review agents, as provided by a memorandum of understanding between the division and the Texas Department of Insurance; and

(4) authorizing increased or reduced utilization review and preauthorization controls on a doctor.

(c) Rules adopted under Subsection (b) are in addition to, and do not affect, the rules adopted under Section 415.023(b). The criteria for deleting a doctor from the list or for recommending or imposing sanctions may include anything the commissioner considers relevant, including:

(1) a sanction of the doctor by the commissioner for a violation of Chapter 413 or Chapter 415;

(2) a sanction by the Medicare or Medicaid program for:

(A) substandard medical care;

(B) overcharging;

(C) overutilization of medical services; or

(D) any other substantive noncompliance with requirements of those programs regarding professional practice or billing;

(3) evidence from the division's medical records that the applicable insurance carrier's utilization review practices or the doctor's charges, fees, diagnoses, treatments, evaluations, or impairment ratings are substantially different from those the commissioner finds to be fair and reasonable based on either a single determination or a pattern of practice;

(4) a suspension or other relevant practice restriction of the doctor's license by an appropriate licensing authority;

(5) professional failure to practice medicine or provide health care, including chiropractic care, in an acceptable manner consistent with the public health, safety, and welfare;

(6) findings of fact and conclusions of law made by a court, an administrative law judge of the State Office of Administrative Hearings, or a licensing or regulatory authority; or

(7) a criminal conviction.

(d) The commissioner by rule shall establish procedures under which a doctor may apply for:

(1) reinstatement to the list of approved doctors; or

(2) restoration of doctor practice privileges removed by the commissioner based on sanctions imposed under this section.

(e) The commissioner shall act on a recommendation by the medical advisor selected under Section 413.0511 and, after notice and the opportunity for a hearing, may impose sanctions under this section on a doctor or an insurance carrier or may recommend action regarding a utilization review agent. The commissioner and the commissioner of insurance shall enter into a memorandum of understanding to coordinate the regulation of insurance carriers and utilization review agents as necessary to ensure:

(1) compliance with applicable regulations; and

(2) that appropriate health care decisions are reached under this subtitle and under Chapter 4201, Insurance Code.

(f) The sanctions the commissioner may recommend or impose under this section include:

(1) reduction of allowable reimbursement;

(2) mandatory preauthorization of all or certain health care services;

(3) required peer review monitoring, reporting, and audit;

(4) deletion or suspension from the approved doctor list and the designated doctor list;

(5) restrictions on appointment under this chapter;

(6) conditions or restrictions on an insurance carrier

regarding actions by insurance carriers under this subtitle in accordance with the memorandum of understanding adopted under Subsection (e); and

(7) mandatory participation in training classes or other courses as established or certified by the division.

(g) The commissioner shall adopt rules regarding doctors who perform peer review functions for insurance carriers. Those rules may include standards for peer review, imposition of sanctions on doctors performing peer review functions, including restriction, suspension, or removal of the doctor's ability to perform peer review on behalf of insurance carriers in the workers' compensation system, and other issues important to the quality of peer review, as determined by the commissioner. A doctor who performs peer review under this subtitle must hold the appropriate professional license issued by this state. A doctor, other than a chiropractor or a dentist, who performs peer review is subject to Section 408.0043. A dentist who performs a peer review of a dental service provided to an injured employee is subject to Section 408.0044. A chiropractor who performs a peer review of a chiropractic service provided to an injured employee is subject to Section 408.0045.

Added by Acts 2001, 77th Leg., ch. 1456, Sec. 1.01, eff. June 17, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.084, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 134 (H.B. 1006), Sec. 3, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 1218 (H.B. 2004), Sec. 4, eff. September 1, 2007.

Sec. 408.024. NONCOMPLIANCE WITH SELECTION REQUIREMENTS. Except as otherwise provided, and after notice and an opportunity for hearing, the commissioner may relieve an insurance carrier of liability for health care that is furnished by a health care provider or another person selected in a manner inconsistent with the requirements of this subchapter.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.085, eff. September 1, 2005.

Sec. 408.025. REPORTS AND RECORDS REQUIRED FROM HEALTH CARE PROVIDERS. (a) The commissioner by rule shall adopt requirements for reports and records that are required to be filed with the division or provided to the injured employee, the employee's attorney, or the insurance carrier by a health care provider.

(a-1) A treating doctor may delegate to a physician assistant who is licensed to practice in this state under Chapter 204, Occupations Code, or an advanced practice registered nurse who is licensed to practice in this state under Chapter 301, Occupations Code, the authority to complete and sign a work status report regarding an injured employee's ability to return to work. The delegating treating doctor is responsible for the acts of the physician assistant or advanced practice registered nurse under this subsection.

(b) The commissioner by rule shall adopt requirements for reports and records that are to be made available by a health care provider to another health care provider to prevent unnecessary duplication of tests and examinations.

(c) The treating doctor is responsible for maintaining efficient utilization of health care.

(d) On the request of an injured employee, the employee's attorney, or the insurance carrier, a health care provider shall furnish records relating to treatment or hospitalization for which compensation is being sought. The division may regulate the charge for furnishing a report or record, but the charge may not be less than the fair and reasonable charge for furnishing the report or record. A health care provider may disclose to the insurance carrier of an affected employer records relating to the diagnosis or treatment of the injured employee without the authorization of the injured employee to determine the amount of payment or the entitlement to payment.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended

by Acts 1999, 76th Leg., ch. 1426, Sec. 9, eff. Sept. 1, 1999.
Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.086, eff. September 1, 2005.

Acts 2017, 85th Leg., R.S., Ch. 483 (H.B. 2546), Sec. 1, eff. June 9, 2017.

Acts 2019, 86th Leg., R.S., Ch. 723 (H.B. 387), Sec. 1, eff. September 1, 2019.

Sec. 408.0251. ELECTRONIC BILLING REQUIREMENTS. (a) The commissioner, by rule and in cooperation with the commissioner of insurance, shall adopt rules regarding the electronic submission and processing of medical bills by health care providers to insurance carriers.

(b) Insurance carriers shall accept medical bills submitted electronically by health care providers in accordance with commissioner rule.

(c) The commissioner shall by rule establish criteria for granting exceptions to insurance carriers and health care providers who are unable to submit or accept medical bills electronically.

(d) On or after January 1, 2008, the commissioner may adopt rules regarding the electronic payment of medical bills by insurance carriers to health care providers.
Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.087, eff. September 1, 2005.

Sec. 408.0252. UNDERSERVED AREAS. The commissioner by rule may identify areas of this state in which access to health care providers is less available and may adopt appropriate standards, guidelines, and rules regarding the delivery of health care in those areas.
Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.087, eff. September 1, 2005.

Sec. 408.026. SPINAL SURGERY. Except in a medical emergency, an insurance carrier is liable for medical costs related to spinal surgery only as provided by Section 413.014 and

commissioner rules.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 2001, 77th Leg., ch. 1456, Sec. 4.01, eff. June 17, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.088, eff. September 1, 2005.

Sec. 408.027. PAYMENT OF HEALTH CARE PROVIDER. (a) A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.

(b) The insurance carrier must pay, reduce, deny, or determine to audit the health care provider's claim not later than the 45th day after the date of receipt by the carrier of the provider's claim. The carrier may request additional documentation necessary to clarify the provider's charges at any time during the 45-day period. If the insurance carrier requests additional documentation under this subsection, the health care provider must provide the requested documentation not later than the 15th day after the date of receipt of the carrier's request. If the insurance carrier elects to audit the claim, the carrier must complete the audit not later than the 160th day after the date of receipt by the carrier of the health care provider's claim, and, not later than the 160th day after the receipt of the claim, must make a determination regarding the relationship of the health care services provided to the compensable injury, the extent of the injury, and the medical necessity of the services provided. If the insurance carrier chooses to audit the claim, the insurance carrier must pay to the health care provider not later than the 45th day after the date of receipt by the carrier of the provider's claim 85 percent of:

(1) the amount for the health care service established under the fee guidelines authorized under this subtitle if the health care service is not provided through a workers' compensation

health care network under Chapter 1305, Insurance Code; or

(2) the amount of the contracted rate for that health care service if the health care service is provided through a workers' compensation health care network under Chapter 1305, Insurance Code.

(c) If the health care services provided are determined to be appropriate, the insurance carrier shall pay the health care provider the remaining 15 percent of the claim not later than the 160th day after the date of receipt by the carrier of the health care provider's documentation of the claim. An insurance carrier commits an administrative violation if the carrier, in violation of Subsection (b), fails to:

(1) pay, reduce, deny, or notify the health care provider of the intent to audit the claim by the 45th day after the date of receipt by the carrier of the health care provider's claim; or

(2) pay, reduce, or deny an audited claim by the 160th day after the date of receipt of the claim.

(d) If an insurance carrier contests the compensability of an injury and the injury is determined not to be compensable, the carrier may recover the amounts paid for health care services from the employee's accident or health benefit plan, or any other person who may be obligated for the cost of the health care services. If an accident or health insurance carrier or other person obligated for the cost of health care services has paid for health care services for an employee for an injury for which a workers' compensation insurance carrier denies compensability, and the injury is later determined to be compensable, the accident or health insurance carrier or other person may recover the amounts paid for such services from the workers' compensation insurance carrier. If an accident or health insurance carrier or other person obligated for the cost of health care services has paid for health care services for an employee for an injury for which the workers' compensation insurance carrier or the employer has not disputed compensability, the accident or health insurance carrier or other person may recover reimbursement from the insurance carrier in the manner described by Section 409.009 or 409.0091, as

applicable.

(e) If an insurance carrier disputes the amount of payment or the health care provider's entitlement to payment, the insurance carrier shall send to the division, the health care provider, and the injured employee a report that sufficiently explains the reasons for the reduction or denial of payment for health care services provided to the employee. The insurance carrier is entitled to a hearing as provided by Section 413.031(d).

(f) Except as provided by Section 408.0281 or 408.0284, any payment made by an insurance carrier under this section shall be in accordance with the fee guidelines authorized under this subtitle if the health care service is not provided through a workers' compensation health care network under Chapter 1305, Insurance Code, or at a contracted rate for that health care service if the health care service is provided through a workers' compensation health care network under Chapter 1305, Insurance Code.

(g) Notwithstanding any other provision in this subtitle or Chapter 1305, Insurance Code, this section and Section 408.0271 apply to health care provided through a workers' compensation health care network established under Chapter 1305, Insurance Code. The commissioner shall adopt rules as necessary to implement the provisions of this section and Section 408.0271.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 1999, 76th Leg., ch. 1426, Sec. 10, eff. Sept. 1, 1999.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.089, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 1007 (H.B. 724), Sec. 4, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 705 (H.B. 528), Sec. 1, eff. June 17, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 1202 (S.B. 1322), Sec. 1, eff. September 1, 2013.

Sec. 408.0271. REIMBURSEMENT BY HEALTH CARE PROVIDER. (a) If the health care services provided to an injured employee are determined by the insurance carrier to be inappropriate, the

insurance carrier shall:

(1) notify the health care provider in writing of the carrier's decision; and

(2) demand a refund by the health care provider of the portion of payment on the claim that was received by the health care provider for the inappropriate services.

(b) The health care provider may appeal the insurance carrier's determination under Subsection (a). The health care provider must file an appeal under this subsection with the insurance carrier not later than the 45th day after the date of the insurance carrier's request for the refund. The insurance carrier must act on the appeal not later than the 45th day after the date on which the provider files the appeal.

(c) A health care provider shall reimburse the insurance carrier for payments received by the provider for inappropriate charges not later than the 45th day after the date of the carrier's notice. The failure by the health care provider to timely remit payment to the carrier constitutes an administrative violation.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.0895, eff. September 1, 2005.

Sec. 408.0272. CERTAIN EXCEPTIONS FOR UNTIMELY SUBMISSION OF CLAIM. (a) In this section:

(1) "Group accident and health insurance" has the meaning assigned by Chapter 1251, Insurance Code.

(2) "Health maintenance organization" has the meaning assigned by Chapter 843, Insurance Code.

(b) Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

(1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:

(A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a

covered insured;

(B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or

(C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or

(2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

(c) Notwithstanding Subsection (b), a health care provider who erroneously submits a claim for payment to an entity described by Subdivision (1) of that subsection forfeits the provider's right to reimbursement for that claim if the provider fails to submit the claim to the correct workers' compensation insurance carrier within 95 days after the date the provider is notified of the provider's erroneous submission of the claim.

(d) Notwithstanding any other provision of this section or Section 408.027, the period for submitting a claim for payment may be extended by agreement of the parties.

Added by Acts 2007, 80th Leg., R.S., Ch. 459 (H.B. 1005), Sec. 1, eff. September 1, 2007.

Sec. 408.028. PHARMACEUTICAL SERVICES. (a) A physician providing care to an employee under this subchapter shall prescribe for the employee any necessary prescription drugs, and order over-the-counter alternatives to prescription medications as clinically appropriate and applicable, in accordance with applicable state law and as provided by Subsection (b). A doctor providing care may order over-the-counter alternatives to prescription medications, when clinically appropriate, in accordance with applicable state law and as provided by Subsection (b).

(b) The commissioner by rule shall require the use of generic pharmaceutical medications and clinically appropriate over-the-counter alternatives to prescription medications unless otherwise specified by the prescribing doctor, in accordance with

applicable state law. The commissioner by rule shall adopt a closed formulary under Section 413.011. Rules adopted by the commissioner shall allow an appeals process for claims in which a treating doctor determines and documents that a drug not included in the formulary is necessary to treat an injured employee's compensable injury.

(c) Except as otherwise provided by this subtitle, an insurance carrier may not require an employee to use pharmaceutical services designated by the carrier.

(d) The commissioner shall adopt rules to allow an employee to purchase over-the-counter alternatives to prescription medications prescribed or ordered under Subsection (a) or (b) and to obtain reimbursement from the insurance carrier for those medications.

(e) Notwithstanding Subsection (b), the commissioner by rule shall allow an employee to purchase a brand name drug rather than a generic pharmaceutical medication or over-the-counter alternative to a prescription medication if a health care provider prescribes a generic pharmaceutical medication or an over-the-counter alternative to a prescription medication. The employee shall be responsible for paying the difference between the cost of the brand name drug and the cost of the generic pharmaceutical medication or of an over-the-counter alternative to a prescription medication. The employee may not seek reimbursement for the difference in cost from an insurance carrier and is not entitled to use the medical dispute resolution provisions of Chapter 413 with regard to the prescription. A payment described by this subsection by an employee to a health care provider does not violate Section 413.042. This subsection does not affect the duty of a health care provider to comply with the requirements of Subsection (b) when prescribing medications or ordering over-the-counter alternatives to prescription medications.

(f) Notwithstanding any other provision of this title, the commissioner by rule shall adopt a fee schedule for pharmacy and pharmaceutical services that will:

(1) provide reimbursement rates that are fair and

reasonable;

(2) assure adequate access to medications and services for injured workers;

(3) minimize costs to employees and insurance carriers; and

(4) take into consideration the increased security of payment afforded by this subtitle.

(g) Section 413.011(d) and the rules adopted to implement that subsection do not apply to the fee schedule adopted by the commissioner under Subsection (f).

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 2001, 77th Leg., ch. 1456, Sec. 6.01, eff. June 17, 2001; Acts 2003, 78th Leg., ch. 468, Sec. 1, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.090, eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 705 (H.B. 528), Sec. 2, eff. June 17, 2011.

Sec. 408.0281. REIMBURSEMENT FOR PHARMACEUTICAL SERVICES; ADMINISTRATIVE VIOLATION. (a) In this section:

(1) "Informal network" means a network that:

(A) is established under a contract between an insurance carrier or an insurance carrier's authorized agent and a health care provider for the provision of pharmaceutical services; and

(B) includes a specific fee schedule.

(2) "Voluntary network" means a voluntary workers' compensation health care delivery network established under former Section 408.0223, as that section existed before repeal by Chapter 265 (H.B. 7), Acts of the 79th Legislature, Regular Session, 2005, by an insurance carrier for the provision of pharmaceutical services.

(b) Notwithstanding any provision of Chapter 1305, Insurance Code, or Section 504.053 of this code, prescription medication or services, as defined by Section 401.011(19)(E):

(1) may be reimbursed in accordance with the fee

guidelines adopted by the commissioner or at a contract rate in accordance with this section; and

(2) may not be delivered through:

(A) a workers' compensation health care network under Chapter 1305, Insurance Code; or

(B) a contract described by Section 504.053(b)(2).

(c) Notwithstanding any other provision of this title, including Section 408.028(f), or any provision of Chapter 1305, Insurance Code, an insurance carrier may pay a health care provider fees for pharmaceutical services that are inconsistent with the fee guidelines adopted by the commissioner only if the carrier has a contract with the health care provider and that contract includes a specific fee schedule. An insurance carrier or the carrier's authorized agent may use an informal or voluntary network to obtain a contractual agreement that provides for fees different from the fees authorized under the fee guidelines adopted by the commissioner for pharmaceutical services. If a carrier or the carrier's authorized agent chooses to use an informal or voluntary network to obtain a contractual fee arrangement, there must be a contractual arrangement between:

(1) the carrier or authorized agent and the informal or voluntary network that authorizes the network to contract with health care providers for pharmaceutical services on the carrier's behalf; and

(2) the informal or voluntary network and the health care provider that includes a specific fee schedule and complies with the notice requirements of this section.

(d) An informal or voluntary network, or the carrier or the carrier's authorized agent, as appropriate, shall, at least quarterly, notify each health care provider of any person, other than an injured employee, to which the network's contractual fee arrangements with the health care provider are sold, leased, transferred, or conveyed. Notice to each health care provider:

(1) must include:

(A) the contact information for the network, including the name, physical address, and toll-free telephone

number at which a health care provider with which the network has a contract may contact the network; and

(B) in the body of the notice:

(i) the name, physical address, and telephone number of any person, other than an injured employee, to which the network's contractual fee arrangement with the health care provider is sold, leased, transferred, or conveyed; and

(ii) the start date and any end date of the period during which any person, other than an injured employee, to which the network's contractual fee arrangement with the health care provider is sold, leased, transferred, or conveyed; and

(2) may be provided:

(A) in an electronic format, if a paper version is available on request by the division; and

(B) through an Internet website link, but only if the website:

(i) contains the information described by Subdivision (1); and

(ii) is updated at least monthly with current and correct information.

(e) An informal or voluntary network, or the carrier or the carrier's authorized agent, as appropriate, shall document the delivery of the notice required under Subsection (d), including the method of delivery, to whom the notice was delivered, and the date of delivery. For purposes of Subsection (d), a notice is considered to be delivered on, as applicable:

(1) the fifth day after the date the notice is mailed via United States Postal Service; or

(2) the date the notice is faxed or electronically delivered.

(f) An insurance carrier, or the carrier's authorized agent or an informal or voluntary network at the carrier's request, shall provide copies of each contract described by Subsection (c) to the division on the request of the division. Information included in a contract under Subsection (c) is confidential and is not subject to disclosure under Chapter 552, Government Code. Notwithstanding Subsection (c), the insurance carrier may be required to pay fees in

accordance with the division's fee guidelines if:

(1) the contract:

(A) is not provided to the division on the division's request;

(B) does not include a specific fee schedule consistent with Subsection (c); or

(C) does not clearly state that the contractual fee arrangement is between the health care provider and the named insurance carrier or the carrier's authorized agent; or

(2) the carrier or the carrier's authorized agent does not comply with the notice requirements under Subsection (d).

(g) Failure to provide documentation described by Subsection (e) to the division on the request of the division or failure to provide notice as required under Subsection (d) creates a rebuttable presumption in an enforcement action under this subtitle and in a medical fee dispute under Chapter 413 that a health care provider did not receive the notice.

(h) An insurance carrier or the carrier's authorized agent commits an administrative violation if the carrier or agent violates any provision of this section. Any administrative penalty assessed under this subsection shall be assessed against the carrier, regardless of whether the carrier or agent committed the violation.

(i) Notwithstanding Section 1305.003(b), Insurance Code, in the event of a conflict between this section and Section 413.016 or any other provision of Chapter 413 of this code or Chapter 1305, Insurance Code, this section prevails.

Added by Acts 2011, 82nd Leg., R.S., Ch. 705 (H.B. 528), Sec. 3, eff. June 17, 2011.

Sec. 408.0282. REQUIREMENTS FOR CERTAIN INFORMAL OR VOLUNTARY NETWORKS. (a) Each informal or voluntary network described by Section 408.0281 or 408.0284 shall, not later than the 30th day after the date the network is established, report the following information to the division:

(1) the name of the informal or voluntary network and federal employer identification number;

(2) an executive contact for official correspondence for the informal or voluntary network;

(3) a toll-free telephone number by which a health care provider may contact the informal or voluntary network;

(4) a list of each insurance carrier with whom the informal or voluntary network contracts, including the carrier's federal employer identification number; and

(5) a list of, and contact information for, each entity with which the informal or voluntary network has a contract or other business relationship that benefits or is entered into on behalf of an insurance carrier, including an insurance carrier's authorized agent or a subsidiary or other affiliate of the network.

(b) Each informal or voluntary network shall report any changes to the information provided under Subsection (a) to the division not later than the 30th day after the effective date of the change.

(c) An informal or voluntary network shall submit a report required under this section, including a report of changes required under Subsection (b), to the division through the division's online reporting system available through the division's Internet website.

(d) An informal or voluntary network commits an administrative violation if the informal or voluntary network violates any provision of this section.

Added by Acts 2011, 82nd Leg., R.S., Ch. 705 (H.B. 528), Sec. 3, eff. June 17, 2011.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1202 (S.B. 1322), Sec. 2, eff. September 1, 2013.

Sec. 408.0284. REIMBURSEMENT FOR DURABLE MEDICAL EQUIPMENT AND HOME HEALTH CARE SERVICES; ADMINISTRATIVE VIOLATION. (a) In this section:

(1) "Durable medical equipment" includes prosthetics and orthotic devices and related medical equipment and supplies. The term does not include:

(A) an object or device that is surgically

implanted, embedded, inserted, or otherwise applied;

(B) related equipment necessary to operate, program, or recharge the object or device described by Paragraph (A); or

(C) an intrathecal pump.

(2) "Informal network" means a network that:

(A) is established under a contract between an insurance carrier or an insurance carrier's authorized agent and a health care provider for the provision of durable medical equipment or home health care services; and

(B) includes a specific fee schedule.

(3) "Voluntary network" means a voluntary workers' compensation health care delivery network established under former Section 408.0223, as that section existed before repeal by Chapter 265 (House Bill No. 7), Acts of the 79th Legislature, Regular Session, 2005, by an insurance carrier for the provision of durable medical equipment or home health care services.

(b) Notwithstanding any provision of Chapter 1305, Insurance Code, or Section 504.053 of this code, durable medical equipment and home health care services may be reimbursed in accordance with the fee guidelines adopted by the commissioner or at a voluntarily negotiated contract rate in accordance with this section.

(c) Notwithstanding any other provision of this title or any provision of Chapter 1305, Insurance Code, an insurance carrier may pay a health care provider fees for durable medical equipment or home health care services that are inconsistent with the fee guidelines adopted by the commissioner only if the carrier or the carrier's authorized agent has a contract with the health care provider and that contract includes a specific fee schedule. An insurance carrier or the carrier's authorized agent may use an informal or voluntary network to obtain a contractual agreement that provides for fees different from the fees authorized under the fee guidelines adopted by the commissioner for durable medical equipment or home health care services. If a carrier or the carrier's authorized agent chooses to use an informal or voluntary network to obtain a contractual fee arrangement, there must be a

contractual arrangement between:

(1) the carrier or authorized agent and the informal or voluntary network that authorizes the network to contract with health care providers for durable medical equipment or home health care services on the carrier's behalf; and

(2) the informal or voluntary network and the health care provider that includes a specific fee schedule and complies with the notice requirements of this section.

(d) An informal or voluntary network, or the carrier or the carrier's authorized agent shall, at least quarterly, notify each health care provider of any person, other than an injured employee, to which the network's contractual fee arrangements with the health care provider are sold, leased, transferred, or conveyed. Notice to each health care provider:

(1) must include:

(A) the contact information for the network, including the name, physical address, and toll-free telephone number at which a health care provider with which the network has a contract may contact the network; and

(B) in the body of the notice:

(i) the name, physical address, and telephone number of any person, other than an injured employee, to which the network's contractual fee arrangement with the health care provider is sold, leased, transferred, or conveyed; and

(ii) the start date and any end date of the period during which the network's contractual fee arrangement with the health care provider is sold, leased, transferred, or conveyed; and

(2) may be provided:

(A) in an electronic format, if a paper version is available on request by the division; and

(B) through an Internet website link, but only if the website:

(i) contains the information described by Subdivision (1); and

(ii) is updated at least monthly with current and correct information.

(e) An informal or voluntary network, or the carrier or the carrier's authorized agent, as appropriate, shall document the delivery of the notice required under Subsection (d), including the method of delivery, to whom the notice was delivered, and the date of delivery. For purposes of Subsection (d), a notice is considered to be delivered on, as applicable:

(1) the fifth day after the date the notice is mailed via United States Postal Service; or

(2) the date the notice is faxed or electronically delivered.

(f) An insurance carrier, or the carrier's authorized agent or an informal or voluntary network at the carrier's request, shall provide copies of each contract described by Subsection (c) to the division on the request of the division. Information included in a contract under Subsection (c) is confidential and is not subject to disclosure under Chapter 552, Government Code. Notwithstanding Subsection (c), the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if:

(1) the contract:

(A) is not provided to the division on the division's request;

(B) does not include a specific fee schedule consistent with Subsection (c); or

(C) does not clearly state that the contractual fee arrangement is between the health care provider and the named insurance carrier or the carrier's authorized agent; or

(2) the carrier or the carrier's authorized agent does not comply with the notice requirements under Subsection (d).

(g) Failure to provide documentation described by Subsection (e) to the division on the request of the division or failure to provide notice as required under Subsection (d) creates a rebuttable presumption in an enforcement action under this subtitle and in a medical fee dispute under Chapter 413 that a health care provider did not receive the notice.

(h) An insurance carrier or the carrier's authorized agent commits an administrative violation if the carrier or agent violates any provision of this section. Any administrative

penalty assessed under this subsection shall be assessed against the carrier, regardless of whether the carrier or agent committed the violation.

(i) Notwithstanding Section 1305.003(b), Insurance Code, in the event of a conflict between this section and Section 413.016 or any other provision of Chapter 413 of this code or Chapter 1305, Insurance Code, this section prevails.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1202 (S.B. 1322), Sec. 3, eff. September 1, 2013.

Sec. 408.029. NURSE FIRST ASSISTANT SERVICES. An insurance carrier may not refuse to reimburse a health care practitioner solely because that practitioner is a nurse first assistant, as defined by Section 301.1525, Occupations Code, for a covered service that a physician providing health care services under this subtitle has requested the nurse first assistant to perform.

Added by Acts 2001, 77th Leg., ch. 812, Sec. 9, eff. Sept. 1, 2001.

Sec. 408.031. WORKERS' COMPENSATION HEALTH CARE NETWORKS. (a) Notwithstanding any other provision of this chapter, an injured employee may receive benefits under a workers' compensation health care network established under Chapter 1305, Insurance Code, in the manner provided by that chapter.

(b) In the event of a conflict between this title and Chapter 1305, Insurance Code, as to the provision of medical benefits for injured employees, the establishment and regulation of fees for medical treatments and services, the time frames for payment of medical bills, the operation and regulation of workers' compensation health care networks, the regulation of the health care providers who contract with those networks, or the resolution of disputes regarding medical benefits provided through those networks, Chapter 1305, Insurance Code, prevails.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.092, eff. September 1, 2005.

SUBCHAPTER C. COMPUTATION OF AVERAGE WEEKLY WAGE

Sec. 408.041. AVERAGE WEEKLY WAGE. (a) Except as otherwise provided by this subtitle, the average weekly wage of an employee who has worked for the employer for at least the 13 consecutive weeks immediately preceding an injury is computed by dividing the sum of the wages paid in the 13 consecutive weeks immediately preceding the date of the injury by 13.

(b) The average weekly wage of an employee whose wage at the time of injury has not been fixed or cannot be determined or who has worked for the employer for less than the 13 weeks immediately preceding the injury equals:

(1) the usual wage that the employer pays a similar employee for similar services; or

(2) if a similar employee does not exist, the usual wage paid in that vicinity for the same or similar services provided for remuneration.

(c) If Subsection (a) or (b) cannot reasonably be applied because the employee's employment has been irregular or because the employee has lost time from work during the 13-week period immediately preceding the injury because of illness, weather, or another cause beyond the control of the employee, the commissioner may determine the employee's average weekly wage by any method that the commissioner considers fair, just, and reasonable to all parties and consistent with the methods established under this section.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.094, eff. September 1, 2005.

Sec. 408.042. AVERAGE WEEKLY WAGE FOR PART-TIME EMPLOYEE OR EMPLOYEE WITH MULTIPLE EMPLOYMENT. (a) The average weekly wage of a part-time employee who limits the employee's work to less than a full-time workweek as a regular course of that employee's conduct is computed as provided by Section 408.041.

(b) For part-time employees not covered by Subsection (a), the average weekly wage:

(1) for determining temporary income benefits is

computed as provided by Section 408.041; and

(2) for determining impairment income benefits, supplemental income benefits, lifetime income benefits, and death benefits is computed as follows:

(A) if the employee has worked for the employer for at least the 13 weeks immediately preceding the date of the injury, the average weekly wage is computed by dividing the sum of the wages paid in the 13 consecutive weeks immediately preceding the date of the injury by 13 and adjusting that amount to the weekly wage level the employee would have attained by working a full-time workweek at the same rate of pay; or

(B) if the employee has worked for the employer for less than 13 weeks immediately preceding the date of the injury, the average weekly wage is equal to:

(i) the weekly wage that the employer pays a similar employee for similar services based on a full-time workweek; or

(ii) if a similar employee does not exist, the usual wage paid in that vicinity for the same or similar services based on a full-time workweek.

(c) For employees with multiple employment, the average weekly wage for determining temporary income benefits, impairment income benefits, supplemental income benefits, lifetime income benefits, and death benefits, is computed as follows:

(1) the average weekly wage for an employee with multiple employment is equal to the sum of the average weekly wages computed under Subdivisions (2) and (3);

(2) for each of the employers for whom the employee has worked for at least the 13 weeks immediately preceding the date of injury, the average weekly wage is equal to the sum of the wages paid by that employer to the employee in the 13 weeks immediately preceding the injury divided by 13;

(3) for each of the employers for whom the employee has worked for less than the 13 weeks immediately preceding the date of the injury, the average weekly wage is equal to:

(A) the weekly wage that employer pays similar employees for similar services; or

(B) if a similar employee does not exist, the usual weekly wage paid in that vicinity for the same or similar services; and

(4) the average weekly wage of an employee with multiple employment who limits the employee's work to less than a full-time workweek, but does not do so as a regular course of that employee's conduct, is adjusted to the weekly wage level the employee would have attained by working a full-time workweek at the employee's average rate of pay.

(d) The commissioner shall:

(1) prescribe a form to collect information regarding the wages of employees with multiple employment; and

(2) by rule, determine the manner by which the division collects and distributes wage information to implement this section.

(e) For an employee with multiple employment, only the employee's wages that are reportable for federal income tax purposes may be considered. The employee shall document and verify wage payments subject to this section.

(f) If the commissioner determines that computing the average weekly wage for an employee as provided by Subsection (c) is impractical or unreasonable, the commissioner shall set the average weekly wage in a manner that more fairly reflects the employee's average weekly wage and that is fair and just to both parties or is in the manner agreed to by the parties. The commissioner by rule may define methods to determine a fair and just average weekly wage consistent with this section.

(g) An insurance carrier is entitled to apply for and receive reimbursement at least annually from the subsequent injury fund for the amount of income and death benefits paid to a worker under this section that are based on employment other than the employment during which the compensable injury occurred. The commissioner may adopt rules that govern the documentation, application process, and other administrative requirements necessary to implement this subsection.

(h) In this section:

(1) "Employee with multiple employment" means an

employee who has more than one employer.

(2) "Full-time workweek" means a 40-hour workweek.

(3) "Part-time employee" means an employee who, at the time of the injury, was working less than a full-time workweek for the employer for whom the employee was working when the compensable injury occurred.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 2001, 77th Leg., ch. 1456, Sec. 10.03, eff. June 17, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.095, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 1150 (S.B. 1169), Sec. 2, eff. September 1, 2007.

Sec. 408.043. AVERAGE WEEKLY WAGE FOR SEASONAL EMPLOYEE. (a) For determining the amount of temporary income benefits of a seasonal employee, the average weekly wage of the employee is computed as provided by Section 408.041 and is adjusted as often as necessary to reflect the wages the employee could reasonably have expected to earn during the period that temporary income benefits are paid.

(b) For determining the amount of impairment income benefits, supplemental income benefits, lifetime income benefits, or death benefits of a seasonal employee, the average weekly wage of the employee is computed by dividing the amount of total wages earned by the employee during the 12 months immediately preceding the date of the injury by 50.

(c) If, for good reason, the commissioner determines that computing the average weekly wage for a seasonal employee as provided by this section is impractical, the commissioner shall compute the average weekly wage as of the time of the injury in a manner that is fair and just to both parties.

(d) In this section, "seasonal employee" means an employee who, as a regular course of the employee's conduct, engages in seasonal or cyclical employment that does not continue throughout the entire year.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.096, eff. September 1, 2005.

Sec. 408.044. AVERAGE WEEKLY WAGE FOR MINOR, APPRENTICE, TRAINEE, OR STUDENT. (a) For computing impairment income benefits, supplemental income benefits, lifetime income benefits, or death benefits, the average weekly wage of an employee shall be adjusted to reflect the level of expected wages during the period that the benefits are payable if:

(1) the employee is a minor, apprentice, trainee, or student at the time of the injury;

(2) the employee's employment or earnings at the time of the injury are limited primarily because of apprenticeship, continuing formal training, or education intended to enhance the employee's future wages; and

(3) the employee's wages would reasonably be expected to change because of a change of employment during that period.

(b) An adjustment under Subsection (a) may not consider expected wage levels for a period occurring after the third anniversary of the date of the injury.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Sec. 408.0445. AVERAGE WEEKLY WAGE FOR MEMBERS OF STATE MILITARY FORCES, TEXAS TASK FORCE 1, INTRASTATE FIRE MUTUAL AID SYSTEM TEAMS, AND REGIONAL INCIDENT MANAGEMENT TEAMS. (a) For purposes of computing income benefits or death benefits under Section 437.227, Government Code, the average weekly wage of a member of the state military forces as defined by Section 437.001, Government Code, who is engaged in authorized training or duty is an amount equal to the sum of the member's regular weekly wage at any employment the member holds in addition to serving as a member of the state military forces, disregarding any period during which the member is not fully compensated for that employment because the member is engaged in authorized military training or duty, and the member's regular weekly wage as a member of the state military forces, except that the amount may not exceed 100 percent of the

state average weekly wage as determined under Section 408.047.

(b) For purposes of computing income benefits or death benefits under Section 88.303, Education Code, the average weekly wage of a Texas Task Force 1 member, as defined by Section 88.301, Education Code, who is engaged in authorized training or duty is an amount equal to the sum of the member's regular weekly wage at any employment, including self-employment, that the member holds in addition to serving as a member of Texas Task Force 1, except that the amount may not exceed 100 percent of the state average weekly wage as determined under Section 408.047. A member for whom an average weekly wage cannot be computed shall be paid the minimum weekly benefit established by the division.

(c) For purposes of computing income benefits or death benefits under Section 88.126, Education Code, the average weekly wage of an intrastate fire mutual aid system team member or a regional incident management team member, as defined by Section 88.126, Education Code, who is engaged in authorized training or duty is an amount equal to the sum of the member's regular weekly wage at any employment, including self-employment, that the member holds in addition to serving as a member of an intrastate fire mutual aid system team or a regional incident management team, as applicable, except that the amount may not exceed 100 percent of the state average weekly wage as determined under Section 408.047. A member for whom an average weekly wage cannot be computed shall be paid the minimum weekly benefit established by the division.

Added by Acts 1999, 76th Leg., ch. 1205, Sec. 4, eff. Sept. 1, 1999. Amended by Acts 2003, 78th Leg., ch. 644, Sec. 2, eff. June 20, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.097, eff. September 1, 2005.

Acts 2013, 83rd Leg., R.S., Ch. 1217 (S.B. 1536), Sec. 3.14, eff. September 1, 2013.

Acts 2017, 85th Leg., R.S., Ch. 991 (H.B. 919), Sec. 2, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 991 (H.B. 919), Sec. 3, eff. September 1, 2017.

Sec. 408.0446. AVERAGE WEEKLY WAGE; SCHOOL DISTRICT EMPLOYEE. (a) For determining the amount of temporary income benefits of a school district employee under Chapter 504, the average weekly wage is computed on the basis of wages earned in a week rather than on the basis of wages paid in a week. The wages earned in any given week are equal to the amount that would be deducted from an employee's salary if the employee were absent from work for one week and the employee did not have personal leave available to compensate the employee for lost wages for that week.

(b) An insurance carrier may adjust a school district employee's average weekly wage as often as necessary to reflect the wages the employee reasonably could expect to earn during the period for which temporary income benefits are paid. In adjusting a school district employee's average weekly wage under this subsection, the insurance carrier may consider any evidence of the employee's reasonable expectation of earnings.

(c) For determining the amount of impairment income benefits, supplemental income benefits, lifetime income benefits, or death benefits of a school district employee under Chapter 504, the average weekly wage of the employee is computed by dividing the total amount of wages earned by the employee during the 12 months immediately preceding the date of the injury by 50.

(d) If the commissioner determines that computing the average weekly wage of a school district employee as provided by this section is impractical because the employee did not earn wages during the 12 months immediately preceding the date of the injury, the commissioner shall compute the average weekly wage in a manner that is fair and just to both parties.

(e) The commissioner shall adopt rules as necessary to implement this section.

Added by Acts 2001, 77th Leg., ch. 1456, Sec. 10.04, eff. June 17, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.098, eff. September 1, 2005.

Sec. 408.045. NONPECUNIARY WAGES. The division may not include nonpecuniary wages in computing an employee's average weekly wage during a period in which the employer continues to provide the nonpecuniary wages.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.099, eff. September 1, 2005.

Sec. 408.046. SIMILAR EMPLOYEES, SERVICES, OR EMPLOYMENT. For purposes of this subchapter and Subchapter D, the determination as to whether employees, services, or employment are the same or similar must include consideration of:

(1) the training and experience of the employees;

(2) the nature of the work; and

(3) the number of hours normally worked.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Sec. 408.047. STATE AVERAGE WEEKLY WAGE. (a) On and after October 1, 2006, the state average weekly wage is equal to 88 percent of the average weekly wage in covered employment computed by the Texas Workforce Commission under Section 207.002(c).

(b) Expired.

(c) Notwithstanding Subsection (a), the commissioner by rule may increase the state average weekly wage to an amount not to exceed 100 percent of the average weekly wage in covered employment computed by the Texas Workforce Commission under Section 207.002(c).

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 2003, 78th Leg., ch. 963, Sec. 6, eff. June 20, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.100, eff. September 1, 2005.

SUBCHAPTER D. COMPUTATION OF BENEFITS

Sec. 408.061. MAXIMUM WEEKLY BENEFIT. (a) A weekly

temporary income benefit may not exceed 100 percent of the state average weekly wage under Section 408.047 rounded to the nearest whole dollar.

(b) A weekly impairment income benefit may not exceed 70 percent of the state average weekly wage rounded to the nearest whole dollar.

(c) A weekly supplemental income benefit may not exceed 70 percent of the state average weekly wage rounded to the nearest whole dollar.

(d) A weekly death benefit may not exceed 100 percent of the state average weekly wage rounded to the nearest whole dollar.

(e) A weekly lifetime income benefit may not exceed 100 percent of the state average weekly wage rounded to the nearest whole dollar.

(f) The division shall compute the maximum weekly income benefits for each state fiscal year not later than October 1 of each year.

(g) The maximum weekly income benefit in effect on the date of injury is applicable for the entire time that the benefit is payable.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.101, eff. September 1, 2005.

Sec. 408.062. MINIMUM WEEKLY INCOME BENEFIT. (a) The minimum weekly income benefit is 15 percent of the state average weekly wage as determined under Section 408.047, rounded to the nearest whole dollar.

(b) The division shall compute the minimum weekly income benefit for each state fiscal year not later than October 1 of each year.

(c) The minimum weekly income benefit in effect on the date of injury is applicable for the entire time that income benefits are payable.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.102, eff. September 1, 2005.

Sec. 408.063. WAGE PRESUMPTIONS; ADMINISTRATIVE VIOLATION. (a) To expedite the payment of income benefits, the commissioner may by rule establish reasonable presumptions relating to the wages earned by an employee, including the presumption that an employee's last paycheck accurately reflects the employee's usual wage.

(b) Not later than the 30th day after the date the employer receives notice of an injury to the employee, the employer shall file a wage statement showing the amount of all wages paid to the employee.

(c) An employer who fails to file a wage statement in accordance with Subsection (b) commits an administrative violation.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.103, eff. September 1, 2005.

Sec. 408.064. INTEREST ON ACCRUED BENEFITS. (a) An order to pay income or death benefits accrued but unpaid must include interest on the amount of compensation due at the rate provided by Section 401.023.

(b) Accrued but unpaid compensation and interest shall be paid in a lump sum.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

SUBCHAPTER E. INCOME BENEFITS IN GENERAL

Sec. 408.081. INCOME BENEFITS. (a) An employee is entitled to timely and accurate income benefits as provided in this chapter.

(b) Except as otherwise provided by this section or this subtitle, income benefits shall be paid weekly as and when they accrue without order from the commissioner. Interest on accrued

but unpaid benefits shall be paid, without order of the commissioner, at the time the accrued benefits are paid.

(c) The commissioner by rule shall establish requirements for agreements under which income benefits may be paid monthly. Income benefits may be paid monthly only:

(1) on the request of the employee and the agreement of the employee and the insurance carrier; and

(2) in compliance with the requirements adopted by the commissioner.

(d) An employee's entitlement to income benefits under this chapter terminates on the death of the employee. An interest in future income benefits does not survive after the employee's death.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 1999, 76th Leg., ch. 1426, Sec. 11, eff. Sept. 1, 1999.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.104, eff. September 1, 2005.

Acts 2011, 82nd Leg., R.S., Ch. 1153 (H.B. 2089), Sec. 1, eff. September 1, 2011.

Sec. 408.0815. RESOLUTION OF OVERPAYMENT OR UNDERPAYMENT OF INCOME BENEFITS. (a) The commissioner by rule shall establish a procedure by which an insurance carrier:

(1) may recoup an overpayment of income benefits from future income benefit payments that are not reimbursable under Section 410.209; and

(2) shall pay an underpayment of income benefits, including interest on accrued but unpaid benefits, in accordance with this subtitle.

(b) The procedure under Subsection (a) must include:

(1) a process by which an injured employee may notify the insurance carrier of an underpayment;

(2) the time frame and methodology by which an insurance carrier shall pay to an injured employee an underpayment;

(3) a process by which an insurance carrier shall notify an injured employee of an overpayment of income benefits;

(4) the time frame and methodology by which an

insurance carrier may recoup an overpayment through the reduction of a future income benefit payment; and

(5) a method for coordinating overpayments that may be recouped from future income benefits and reimbursements described by Section 410.209.

(c) The procedure for recouping overpayments under Subsection (a)(1) must take into consideration the cause of the overpayment and minimize the financial hardship to the injured employee.

Added by Acts 2011, 82nd Leg., R.S., Ch. 1153 (H.B. 2089), Sec. 2, eff. September 1, 2011.

Sec. 408.082. ACCRUAL OF RIGHT TO INCOME BENEFITS. (a) Income benefits may not be paid under this subtitle for an injury that does not result in disability for at least one week.

(b) If the disability continues for longer than one week, weekly income benefits begin to accrue on the eighth day after the date of the injury. If the disability does not begin at once after the injury occurs or within eight days of the occurrence but does result subsequently, weekly income benefits accrue on the eighth day after the date on which the disability began.

(c) If the disability continues for two weeks or longer after the date it begins, compensation shall be computed from the date the disability begins.

(d) This section does not preclude the recovery of medical benefits as provided by Subchapter B.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.105, eff. September 1, 2005.

Sec. 408.083. TERMINATION OF RIGHT TO TEMPORARY INCOME, IMPAIRMENT INCOME, AND SUPPLEMENTAL INCOME BENEFITS. (a) Except as provided by Subsection (b), an employee's eligibility for temporary income benefits, impairment income benefits, and supplemental income benefits terminates on the expiration of 401 weeks after the date of injury.

(b) If an employee incurs an occupational disease, the employee's eligibility for temporary income benefits, impairment income benefits, and supplemental income benefits terminates on the expiration of 401 weeks after the date on which benefits began to accrue.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 1995, 74th Leg., ch. 980, Sec. 1.26, eff. Sept. 1, 1995.

Sec. 408.084. CONTRIBUTING INJURY. (a) At the request of the insurance carrier, the commissioner may order that impairment income benefits and supplemental income benefits be reduced in a proportion equal to the proportion of a documented impairment that resulted from earlier compensable injuries.

(b) The commissioner shall consider the cumulative impact of the compensable injuries on the employee's overall impairment in determining a reduction under this section.

(c) If the combination of the compensable injuries results in an injury compensable under Section 408.161, the benefits for that injury shall be paid as provided by Section 408.162.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.106, eff. September 1, 2005.

Sec. 408.085. ADVANCE OF BENEFITS FOR HARDSHIP. (a) If there is a likelihood that income benefits will be paid, the commissioner may grant an employee suffering financial hardship advances as provided by this subtitle against the amount of income benefits to which the employee may be entitled. An advance may be ordered before or after the employee attains maximum medical improvement. An insurance carrier shall pay the advance ordered.

(b) An employee must apply to the division for an advance on a form prescribed by the commissioner. The application must describe the hardship that is the grounds for the advance.

(c) An advance under this section may not exceed an amount equal to four times the maximum weekly benefit for temporary income benefits as computed in Section 408.061. The commissioner may not

grant more than three advances to a particular employee based on the same injury.

(d) The commissioner may not grant an advance to an employee who is receiving, on the date of the application under Subsection (b), at least 90 percent of the employee's net preinjury wages under Section 408.003 or 408.129.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.107, eff. September 1, 2005.

SUBCHAPTER F. TEMPORARY INCOME BENEFITS

Sec. 408.101. TEMPORARY INCOME BENEFITS. (a) An employee is entitled to temporary income benefits if the employee has a disability and has not attained maximum medical improvement.

(b) On the initiation of compensation as provided by Section 409.021, the insurance carrier shall pay temporary income benefits as provided by this subchapter.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Sec. 408.102. DURATION OF TEMPORARY INCOME BENEFITS. (a) Temporary income benefits continue until the employee reaches maximum medical improvement.

(b) The commissioner by rule shall establish a presumption that maximum medical improvement has been reached based on a lack of medical improvement in the employee's condition.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.109, eff. September 1, 2005.

Sec. 408.103. AMOUNT OF TEMPORARY INCOME BENEFITS. (a) Subject to Sections 408.061 and 408.062, the amount of a temporary income benefit is equal to:

(1) 70 percent of the amount computed by subtracting the employee's weekly earnings after the injury from the employee's

average weekly wage; or

(2) for the first 26 weeks, 75 percent of the amount computed by subtracting the employee's weekly earnings after the injury from the employee's average weekly wage if the employee earns less than $10 an hour.

(b) A temporary income benefit under Subsection (a)(2) may not exceed the employee's actual earnings for the previous year. It is presumed that the employee's actual earnings for the previous year are equal to:

(1) the sum of the employee's wages as reported in the most recent four quarterly wage reports to the Texas Workforce Commission divided by 52;

(2) the employee's wages in the single quarter of the most recent four quarters in which the employee's earnings were highest, divided by 13, if the commissioner finds that the employee's most recent four quarters' earnings reported in the Texas Workforce Commission wage reports are not representative of the employee's usual earnings; or

(3) the amount the commissioner determines from other credible evidence to be the actual earnings for the previous year if the Texas Workforce Commission does not have a wage report reflecting at least one quarter's earnings because the employee worked outside the state during the previous year.

(c) A presumption under Subsection (b) may be rebutted by other credible evidence of the employee's actual earnings.

(d) The Texas Employment Commission shall provide information required under this section in the manner most efficient for transferring the information.

(e) For purposes of Subsection (a), if an employee is offered a bona fide position of employment that the employee is reasonably capable of performing, given the physical condition of the employee and the geographic accessibility of the position to the employee, the employee's weekly earnings after the injury are equal to the weekly wage for the position offered to the employee.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.110, eff.

September 1, 2005.

Acts 2015, 84th Leg., R.S., Ch. 54 (S.B. 901), Sec. 1, eff. September 1, 2015.

Sec. 408.104. MAXIMUM MEDICAL IMPROVEMENT AFTER SPINAL SURGERY. (a) On application by either the employee or the insurance carrier, the commissioner by order may extend the 104-week period described by Section 401.011(30)(B) if the employee has had spinal surgery, or has been approved for spinal surgery under Section 408.026 and commissioner rules, within 12 weeks before the expiration of the 104-week period. If an order is issued under this section, the order shall extend the statutory period for maximum medical improvement to a date certain, based on medical evidence presented to the commissioner.

(b) Either the employee or the insurance carrier may dispute an application for extension made under this section. A dispute under this subsection is subject to Chapter 410.

(c) The commissioner shall adopt rules to implement this section, including rules establishing procedures for requesting and disputing an extension.

Added by Acts 1997, 75th Leg., ch. 1443, Sec. 5, eff. Jan. 1, 1998.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.111, eff. September 1, 2005.

Sec. 408.105. SALARY CONTINUATION IN LIEU OF TEMPORARY INCOME BENEFITS. (a) In lieu of payment of temporary income benefits under this subchapter, an employer may continue to pay the salary of an employee who sustains a compensable injury under a contractual obligation between the employer and employee, such as a collective bargaining agreement, written agreement, or policy.

(b) Salary continuation may include wage supplementation if:

(1) employer reimbursement is not sought from the carrier as provided by Section 408.127; and

(2) the supplementation does not affect the employee's eligibility for any future income benefits.

Added by Acts 1999, 76th Leg., ch. 1003, Sec. 3, eff. Sept. 1, 1999.

SUBCHAPTER G. IMPAIRMENT INCOME BENEFITS

Sec. 408.121. IMPAIRMENT INCOME BENEFITS. (a) An employee's entitlement to impairment income benefits begins on the day after the date the employee reaches maximum medical improvement and ends on the earlier of:

(1) the date of expiration of a period computed at the rate of three weeks for each percentage point of impairment; or

(2) the date of the employee's death.

(b) The insurance carrier shall begin to pay impairment income benefits not later than the fifth day after the date on which the insurance carrier receives the doctor's report certifying maximum medical improvement. Impairment income benefits shall be paid for a period based on the impairment rating, unless that rating is disputed under Subsection (c).

(c) If the insurance carrier disputes the impairment rating used under Subsection (a), the carrier shall pay the employee impairment income benefits for a period based on the carrier's reasonable assessment of the correct rating.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Sec. 408.122. ELIGIBILITY FOR IMPAIRMENT INCOME BENEFITS. A claimant may not recover impairment income benefits unless evidence of impairment based on an objective clinical or laboratory finding exists. If the finding of impairment is made by a doctor chosen by the claimant and the finding is contested, a designated doctor or a doctor selected by the insurance carrier must be able to confirm the objective clinical or laboratory finding on which the finding of impairment is based.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 1995, 74th Leg., ch. 980, Sec. 1.27, eff. Sept. 1, 1995; Acts 2001, 77th Leg., ch. 1456, Sec. 5.03, eff. June 17, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.112, eff. September 1, 2005.

Sec. 408.1225. DESIGNATED DOCTOR. (a) To be eligible to serve as a designated doctor, a doctor must maintain an active certification by the division.

(a-1) The commissioner by rule shall develop a process for the certification of a designated doctor.

(a-2) The rules adopted by the commissioner under Subsection (a-1) must:

(1) require the division to evaluate the qualification of designated doctors for certification using eligibility requirements, including:

(A) educational experience;

(B) previous training; and

(C) demonstrated ability to perform the specific designated doctor duties described by Section 408.0041; and

(2) require standard training and testing to be completed in accordance with policies and guidelines developed by the division.

(a-3) The division shall develop guidelines for certification training programs for certification of a designated doctor under Subsection (a-1) to ensure a designated doctor's competency and continued competency in providing assessments, including:

(1) a standard curriculum;

(2) standard course materials; and

(3) testing criteria.

(a-4) The division shall develop and implement a procedure to periodically review and update the guidelines developed under Subsection (a-3).

(a-5) The division may authorize an independent training and testing provider to conduct the certification program for the division under the guidelines developed under Subsection (a-3).

(b) The commissioner shall ensure the quality of designated doctor decisions and reviews through active monitoring of the decisions and reviews, and may take action as necessary to:

(1) restrict the participation of a designated doctor;

(2) deny renewal of a designated doctor's

certification; or

(3) revoke a designated doctor's certification under Section 413.044.

(c) The report of the designated doctor has presumptive weight, and the division shall base its determination of whether the employee has reached maximum medical improvement on the report unless the preponderance of the other medical evidence is to the contrary.

(d) The commissioner shall develop rules to ensure that a designated doctor called on to conduct an examination under Section 408.0041 has no conflict of interest in serving as a designated doctor in performing any examination.

(e) A designated doctor, other than a chiropractor, is subject to Section 408.0043. A designated doctor who is a chiropractor is subject to Section 408.0045. To the extent of a conflict between this section and Section 408.0043 or 408.0045, this section controls.

(f) A designated doctor shall continue providing services related to a case assigned to the designated doctor, including performing subsequent examinations or acting as a resource for division disputes, unless the division authorizes the designated doctor to discontinue providing services. The commissioner by rule shall prescribe the circumstances under which a designated doctor is permitted to discontinue providing services, including:

(1) the doctor decides to stop practicing in the workers' compensation system; or

(2) the doctor relocates the doctor's residence or practice.

(g) On request of the division, a designated doctor shall provide the division with a copy of any contract that is:

(1) between the designated doctor and an authorized agent of the doctor; and

(2) for services provided by the agent related to the designated doctor's duties, including scheduling, billing, and organizing medical records.

(h) A contract provided to the division under Subsection (g) is not subject to disclosure under Chapter 552, Government Code.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.112, eff. September 1, 2005.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 1218 (H.B. 2004), Sec. 5, eff. September 1, 2007.

Acts 2011, 82nd Leg., R.S., Ch. 1162 (H.B. 2605), Sec. 12, eff. September 1, 2011.

Acts 2017, 85th Leg., R.S., Ch. 158 (H.B. 2056), Sec. 1, eff. September 1, 2017.

Sec. 408.123. CERTIFICATION OF MAXIMUM MEDICAL IMPROVEMENT; EVALUATION OF IMPAIRMENT RATING. (a) After an employee has been certified by a doctor as having reached maximum medical improvement, the certifying doctor shall evaluate the condition of the employee and assign an impairment rating using the impairment rating guidelines described by Section 408.124. If the certification and evaluation are performed by a doctor other than the employee's treating doctor, the certification and evaluation shall be submitted to the treating doctor, and the treating doctor shall indicate agreement or disagreement with the certification and evaluation.

(b) A certifying doctor shall issue a written report certifying that maximum medical improvement has been reached, stating the employee's impairment rating, and providing any other information required by the commissioner to:

(1) the division;

(2) the employee; and

(3) the insurance carrier.

(c) The commissioner shall adopt a rule that provides that, at the conclusion of any examination in which maximum medical improvement is certified and any impairment rating is assigned by the treating doctor, written notice shall be given to the employee that the employee may dispute the certification of maximum medical improvement and assigned impairment rating. The notice to the employee must state how to dispute the certification of maximum medical improvement and impairment rating.

(d) If an employee is not certified as having reached

maximum medical improvement before the expiration of 102 weeks after the date income benefits begin to accrue, the division shall notify the treating doctor of the requirements of this subchapter.

(e) Except as otherwise provided by this section, an employee's first valid certification of maximum medical improvement and first valid assignment of an impairment rating 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.

(f) An employee's first certification of maximum medical improvement or assignment of an impairment rating may be disputed after the period described by Subsection (e) if:

(1) compelling medical evidence exists of:

(A) a significant error by the certifying doctor in applying the appropriate American Medical Association guidelines or in calculating the impairment rating;

(B) a clearly mistaken diagnosis or a previously undiagnosed medical condition; or

(C) improper or inadequate treatment of the injury before the date of the certification or assignment that would render the certification or assignment invalid; or

(2) other compelling circumstances exist as prescribed by commissioner rule.

(g) If an employee has not been certified as having reached maximum medical improvement before the expiration of 104 weeks after the date income benefits begin to accrue or the expiration date of any extension of benefits under Section 408.104, the impairment rating assigned after the expiration of either of those periods is final if the impairment rating 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. A certification or assignment may be disputed after the 90th day only as provided by Subsection (f).

(h) If an employee's disputed certification of maximum medical improvement or assignment of impairment rating is finally modified, overturned, or withdrawn, the first certification or

assignment made after the date of the modification, overturning, or withdrawal becomes final if the certification or assignment is not disputed before the 91st day after the date notification of the certification or assignment is provided to the employee and the carrier by verifiable means. A certification or assignment may be disputed after the 90th day only as provided by Subsection (f).

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 2003, 78th Leg., ch. 278, Sec. 1, eff. June 18, 2003; Acts 2003, 78th Leg., ch. 1190, Sec. 1, eff. June 20, 2003; Acts 2003, 78th Leg., ch. 1323, Sec. 2, eff. June 21, 2003.

Reenacted and amended by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.113, eff. September 1, 2005.

Sec. 408.124. IMPAIRMENT RATING GUIDELINES. (a) An award of an impairment income benefit, whether by the commissioner or a court, must be based on an impairment rating determined using the impairment rating guidelines described by this section.

(b) For determining the existence and degree of an employee's impairment, the division shall use "Guides to the Evaluation of Permanent Impairment," third edition, second printing, dated February 1989, published by the American Medical Association.

(c) Notwithstanding Subsection (b), the commissioner by rule may adopt the fourth edition of the "Guides to the Evaluation of Permanent Impairment," published by the American Medical Association, or a subsequent edition of those guides, for determining the existence and degree of an employee's impairment.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 1999, 76th Leg., ch. 1426, Sec. 12, eff. Sept. 1, 1999.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.114, eff. September 1, 2005.

Sec. 408.125. DISPUTE AS TO IMPAIRMENT RATING. (a) If an impairment rating is disputed, the commissioner shall direct the employee to the next available doctor on the division's list of designated doctors, as provided by Section 408.0041.

(b) The designated doctor shall report in writing to the division.

(c) The report of the designated doctor shall have presumptive weight, and the division shall base the impairment rating on that report unless the preponderance of the other medical evidence is to the contrary. If the preponderance of the medical evidence contradicts the impairment rating contained in the report of the designated doctor chosen by the division, the division shall adopt the impairment rating of one of the other doctors.

(d) To avoid undue influence on a person selected as a designated doctor under this section, only the injured employee or an appropriate member of the staff of the division may communicate with the designated doctor about the case regarding the injured employee's medical condition or history before the examination of the injured employee by the designated doctor. After that examination is completed, communication with the designated doctor regarding the injured employee's medical condition or history may be made only through appropriate division staff members. The designated doctor may initiate communication with any doctor who has previously treated or examined the injured employee for the work-related injury.

(e) Notwithstanding Subsection (d), the treating doctor and the insurance carrier are both responsible for sending to the designated doctor all the injured employee's medical records that are in their possession and that relate to the issue to be evaluated by the designated doctor. The treating doctor and the insurance carrier may send the records without a signed release from the employee. The designated doctor is authorized to receive the employee's confidential medical records to assist in the resolution of disputes. The treating doctor and the insurance carrier may also send the designated doctor an analysis of the injured employee's medical condition, functional abilities, and return-to-work opportunities.

(f) A violation of Subsection (d) is an administrative violation.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 1995, 74th Leg., ch. 980, Sec. 1.28, eff. Sept. 1, 1995;

Acts 2001, 77th Leg., ch. 1456, Sec. 5.04, eff. June 17, 2001.
Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.115, eff. September 1, 2005.

Sec. 408.126. AMOUNT OF IMPAIRMENT INCOME BENEFITS. Subject to Sections 408.061 and 408.062, an impairment income benefit is equal to 70 percent of the employee's average weekly wage.
Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Sec. 408.127. REDUCTION OF IMPAIRMENT INCOME BENEFITS. (a) An insurance carrier shall reduce impairment income benefits to an employee by an amount equal to employer payments made under Section 408.003 that are not reimbursed or reimbursable under that section.

(b) The insurance carrier shall remit the amount of a reduction under this section to the employer who made the payments.

(c) The commissioner shall adopt rules and forms to ensure the full reporting and the accuracy of reductions and reimbursements made under this section.
Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.
Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.116, eff. September 1, 2005.

Sec. 408.128. COMMUTATION OF IMPAIRMENT INCOME BENEFITS. (a) An employee may elect to commute the remainder of the impairment income benefits to which the employee is entitled if the employee has returned to work for at least three months, earning at least 80 percent of the employee's average weekly wage.

(b) An employee who elects to commute impairment income benefits is not entitled to additional income benefits for the compensable injury.
Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Sec. 408.129. ACCELERATION OF IMPAIRMENT INCOME BENEFITS. (a) On approval by the commissioner of a written request received

from an employee, an insurance carrier shall accelerate the payment of impairment income benefits to the employee. The accelerated payment may not exceed a rate of payment equal to that of the employee's net preinjury wage.

(b) The commissioner shall approve the request and order the acceleration of the benefits if the commissioner determines that the acceleration is:

(1) required to relieve hardship; and

(2) in the overall best interest of the employee.

(c) The duration of the impairment income benefits to which the employee is entitled shall be reduced to offset the increased payments caused by the acceleration taking into consideration the discount for present payment computed at the rate provided under Section 401.023.

(d) The commissioner may prescribe forms necessary to implement this section.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.117, eff. September 1, 2005.

SUBCHAPTER H. SUPPLEMENTAL INCOME BENEFITS

Sec. 408.141. AWARD OF SUPPLEMENTAL INCOME BENEFITS. An award of a supplemental income benefit, whether by the commissioner or a court, shall be made in accordance with this subchapter.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.118, eff. September 1, 2005.

Sec. 408.1415. WORK SEARCH COMPLIANCE STANDARDS. (a) The commissioner by rule shall adopt compliance standards for supplemental income benefit recipients that require each recipient to demonstrate an active effort to obtain employment. To be eligible to receive supplemental income benefits under this chapter, a recipient must provide evidence satisfactory to the

division of:

(1) active participation in a vocational rehabilitation program conducted by the Department of Assistive and Rehabilitative Services or a private vocational rehabilitation provider;

(2) active participation in work search efforts conducted through the Texas Workforce Commission; or

(3) active work search efforts documented by job applications submitted by the recipient.

(b) In adopting rules under this section, the commissioner shall:

(1) establish the level of activity that a recipient should have with the Texas Workforce Commission and the Department of Assistive and Rehabilitative Services;

(2) define the number of job applications required to be submitted by a recipient to satisfy the work search requirements; and

(3) consider factors affecting the availability of employment, including recognition of access to employment in rural areas, economic conditions, and other appropriate employment availability factors.

(c) The commissioner may consult with the Texas Workforce Commission, the Department of Assistive and Rehabilitative Services, and other appropriate entities in adopting rules under this section.

Added by Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.119, eff. September 1, 2005.

Sec. 408.142. SUPPLEMENTAL INCOME BENEFITS. (a) An employee is entitled to supplemental income benefits if on the expiration of the impairment income benefit period computed under Section 408.121(a)(1) the employee:

(1) has an impairment rating of 15 percent or more as determined by this subtitle from the compensable injury;

(2) has not returned to work or has returned to work earning less than 80 percent of the employee's average weekly wage as a direct result of the employee's impairment;

(3) has not elected to commute a portion of the impairment income benefit under Section 408.128; and

(4) has complied with the requirements adopted under Section 408.1415.

(b) If an employee is not entitled to supplemental income benefits at the time of payment of the final impairment income benefit because the employee is earning at least 80 percent of the employee's average weekly wage, the employee may become entitled to supplemental income benefits at any time within one year after the date the impairment income benefit period ends if:

(1) the employee earns wages for at least 90 days that are less than 80 percent of the employee's average weekly wage;

(2) the employee meets the requirements of Subsections (a)(1), (3), and (4); and

(3) the decrease in earnings is a direct result of the employee's impairment from the compensable injury.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.1195, eff. September 1, 2005.

Sec. 408.143. EMPLOYEE STATEMENT. (a) After the commissioner's initial determination of supplemental income benefits, the employee must file a statement with the insurance carrier stating:

(1) that the employee has earned less than 80 percent of the employee's average weekly wage as a direct result of the employee's impairment;

(2) the amount of wages the employee earned in the filing period provided by Subsection (b); and

(3) that the employee has complied with the requirements adopted under Section 408.1415.

(b) The statement required under this section must be filed quarterly on a form and in the manner provided by the commissioner. The commissioner may modify the filing period as appropriate to an individual case.

(c) Failure to file a statement under this section relieves

the insurance carrier of liability for supplemental income benefits for the period during which a statement is not filed.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.120, eff. September 1, 2005.

Sec. 408.144. COMPUTATION OF SUPPLEMENTAL INCOME BENEFITS. (a) Supplemental income benefits are calculated quarterly and paid monthly.

(b) Subject to Section 408.061, the amount of a supplemental income benefit for a week is equal to 80 percent of the amount computed by subtracting the weekly wage the employee earned during the reporting period provided by Section 408.143(b) from 80 percent of the employee's average weekly wage determined under Section 408.041, 408.042, 408.043, 408.044, 408.0445, or 408.0446.

(c) For the purposes of this subchapter, if an employee is offered a bona fide position of employment that the employee is capable of performing, given the physical condition of the employee and the geographic accessibility of the position to the employee, the employee's weekly wages are considered to be equal to the weekly wages for the position offered to the employee.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.1205, eff. September 1, 2005.

Sec. 408.145. PAYMENT OF SUPPLEMENTAL INCOME BENEFITS. An insurance carrier shall pay supplemental income benefits beginning not later than the seventh day after the expiration date of the employee's impairment income benefit period and shall continue to pay the benefits in a timely manner.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Sec. 408.146. TERMINATION OF SUPPLEMENTAL INCOME BENEFITS; REINITIATION. (a) If an employee earns wages that are at least 80 percent of the employee's average weekly wage for at least 90 days

during a time that the employee receives supplemental income benefits, the employee ceases to be entitled to supplemental income benefits for the filing period.

(b) Supplemental income benefits terminated under this section shall be reinitiated when the employee:

(1) satisfies the conditions of Section 408.142(b); and

(2) files the statement required under Section 408.143.

(c) Notwithstanding any other provision of this section, an employee who is not entitled to supplemental income benefits for 12 consecutive months ceases to be entitled to any additional income benefits for the compensable injury.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Sec. 408.147. CONTEST OF SUPPLEMENTAL INCOME BENEFITS BY INSURANCE CARRIER; ATTORNEY'S FEES. (a) An insurance carrier may request a benefit review conference to contest an employee's entitlement to supplemental income benefits or the amount of supplemental income benefits.

(b) If an insurance carrier fails to make a request for a benefit review conference within 10 days after the date of the expiration of the impairment income benefit period or within 10 days after receipt of the employee's statement, the insurance carrier waives the right to contest entitlement to supplemental income benefits and the amount of supplemental income benefits for that period of supplemental income benefits.

(c) If an insurance carrier disputes the commissioner's determination that an employee is entitled to supplemental income benefits or the amount of supplemental income benefits due and the employee prevails on any disputed issue, the insurance carrier is liable for reasonable and necessary attorney's fees incurred by the employee as a result of the insurance carrier's dispute and for supplemental income benefits accrued but not paid and interest on that amount, according to Section 408.064. Attorney's fees awarded under this subsection are not subject to Sections 408.221(b), (f), and (i).

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 1995, 74th Leg., ch. 76, Sec. 9.53, eff. Sept. 1, 1995; Acts 2001, 77th Leg., ch. 1456, Sec. 8.02, eff. June 17, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.121, eff. September 1, 2005.

Sec. 408.148. EMPLOYEE DISCHARGE AFTER TERMINATION. The commissioner may reinstate supplemental income benefits to an employee who is discharged within 12 months of the date of losing entitlement to supplemental income benefits under Section 408.146(c) if the commissioner finds that the employee was discharged at that time with the intent to deprive the employee of supplemental income benefits.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.122, eff. September 1, 2005.

Sec. 408.149. STATUS REVIEW; BENEFIT REVIEW CONFERENCE. (a) Not more than once in each period of 12 calendar months, an employee and an insurance carrier each may request the commissioner to review the status of the employee and determine whether the employee's unemployment or underemployment is a direct result of impairment from the compensable injury.

(b) Either party may request a benefit review conference to contest a determination of the commissioner at any time, subject only to the limits placed on the insurance carrier by Section 408.147.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.123, eff. September 1, 2005.

Sec. 408.150. VOCATIONAL REHABILITATION. (a) The division shall refer an employee to the Texas Workforce Commission with a recommendation for appropriate services if the division determines

that an employee could be materially assisted by vocational rehabilitation or training in returning to employment or returning to employment more nearly approximating the employee's preinjury employment. The insurance carrier may provide vocational rehabilitation or training services through a private provider of vocational rehabilitation services.

(b) An employee who refuses services or refuses to cooperate with services provided under this section by the Texas Workforce Commission or a private provider loses entitlement to supplemental income benefits.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 1999, 76th Leg., ch. 956, Sec. 1, eff. Sept. 1, 1999; Acts 1999, 76th Leg., ch. 1426, Sec. 13, eff. Sept. 1, 1999.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.124, eff. September 1, 2005.

Acts 2017, 85th Leg., R.S., Ch. 467 (H.B. 2112), Sec. 6, eff. June 9, 2017.

Sec. 408.151. MEDICAL EXAMINATIONS FOR SUPPLEMENTAL INCOME BENEFITS. (a) On or after the second anniversary of the date the commissioner makes the initial award of supplemental income benefits, an insurance carrier may not require an employee who is receiving supplemental income benefits to submit to a medical examination more than annually if, in the preceding year, the employee's medical condition resulting from the compensable injury has not improved sufficiently to allow the employee to return to work.

(b) If a dispute exists as to whether the employee's medical condition has improved sufficiently to allow the employee to return to work, the commissioner shall direct the employee to be examined by a designated doctor chosen by the division. The designated doctor shall report to the division. The report of the designated doctor has presumptive weight, and the division shall base its determination of whether the employee's medical condition has improved sufficiently to allow the employee to return to work on that report unless the preponderance of the other medical evidence

is to the contrary.

Added by Acts 1999, 76th Leg., ch. 850, Sec. 1, eff. Sept. 1, 1999.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.125, eff. September 1, 2005.

SUBCHAPTER I. LIFETIME INCOME BENEFITS

Sec. 408.161. LIFETIME INCOME BENEFITS. (a) Lifetime income benefits are paid until the death of the employee for:

(1) total and permanent loss of sight in both eyes;

(2) loss of both feet at or above the ankle;

(3) loss of both hands at or above the wrist;

(4) loss of one foot at or above the ankle and the loss of one hand at or above the wrist;

(5) an injury to the spine that results in permanent and complete paralysis of both arms, both legs, or one arm and one leg;

(6) a physically traumatic injury to the brain that, as determined using evidence-based medicine, results in a permanent major neurocognitive disorder:

(A) for which the employee requires occasional supervision in the performance of routine daily tasks of self-care; and

(B) that renders the employee permanently unemployable; or

(7) third degree burns that cover at least 40 percent of the body and require grafting, or third degree burns covering the majority of:

(A) both hands;

(B) one hand and one foot; or

(C) one hand or one foot and the face.

(b) For purposes of Subsection (a), the total and permanent loss of use of a body part is the loss of that body part.

(c) Subject to Section 408.061, the amount of lifetime income benefits is equal to 75 percent of the employee's average weekly wage. Benefits being paid shall be increased at a rate of

three percent a year notwithstanding Section 408.061.

(d) An insurance carrier may pay lifetime income benefits through an annuity if the annuity agreement meets the terms and conditions for annuity agreements adopted by the commissioner by rule. The establishment of an annuity under this subsection does not relieve the insurance carrier of the liability under this title for ensuring that the lifetime income benefits are paid.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 1997, 75th Leg., ch. 1443, Sec. 7, eff. Sept. 1, 1997; Acts 1999, 76th Leg., ch. 1426, Sec. 14, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 1456, Sec. 9.01, eff. June 17, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.126, eff. September 1, 2005.

Acts 2023, 88th Leg., R.S., Ch. 721 (H.B. 2468), Sec. 2, eff. September 1, 2023.

Sec. 408.1615. LIFETIME INCOME BENEFITS FOR CERTAIN FIRST RESPONDERS. (a) In this section:

(1) "First responder" means an individual who is:

(A) a peace officer under Article 2.12, Code of Criminal Procedure;

(B) certified under Chapter 773, Health and Safety Code, as an emergency care attendant, advanced emergency medical technician, emergency medical technician-paramedic or a licensed paramedic;

(C) a firefighter subject to certification by the Texas Commission on Fire Protection under Chapter 419, Government Code, whose principal duties are aircraft crash and rescue or fire fighting; or

(D) an individual covered under Section 504.012 who is providing volunteer services as:

(i) a volunteer firefighter, regardless of whether the individual is certified under Chapter 419, Government Code; or

(ii) an emergency medical services volunteer, as defined by Section 773.003, Health and Safety Code.

(2) "Serious bodily injury" has the meaning assigned by Section 1.07, Penal Code.

(b) This section applies only to an employee who sustains a serious bodily injury, other than an injury described by Section 408.161, in the course and scope of the employee's employment or volunteer service as a first responder that renders the employee permanently unemployable.

(c) Except as otherwise provided by this section, an employee to which this section applies is entitled to receive lifetime income benefits paid until the employee's death for the employee's injury. Sections 408.161(c) and (d) apply to the payment of lifetime income benefits under this section.

(d) The division shall accelerate any dispute, including a contested case hearing or appeal requested by the employee, regarding an employee's continuing entitlement to lifetime income benefits under this section. The employee shall provide notice to the division that the dispute involves a first responder.

(e) An employee receiving lifetime income benefits under this section shall annually certify to the insurance carrier, in the form and manner prescribed by the division, that the employee was not employed in any capacity during the preceding year.

(f) Notwithstanding Sections 410.169 and 410.205, an insurance carrier may periodically review an employee's continuing entitlement to lifetime income benefits under this section, but not more than once during any five-year period.

(g) Notwithstanding Subsection (f), an insurance carrier may review an employee's continuing entitlement to lifetime income benefits under this section regardless of the date on which the insurance carrier most recently reviewed the employee's continuing entitlement, if:

(1) the employee certifies to the insurance carrier under Subsection (e) that the employee was not employed in any capacity during the preceding year;

(2) the insurance carrier provides evidence to the commissioner that the certification provided by the employee under Subsection (e) is not accurate; and

(3) the commissioner notifies the insurance carrier

that the commissioner has determined that the evidence provided by the insurance carrier is sufficient to show that the certification provided by the employee under Subsection (e) may not be accurate.

(h) An insurance carrier reviewing an employee's continuing entitlement under Subsection (f) or (g) shall request the commissioner to order a medical examination conducted by a designated doctor under Section 408.0041. Except as otherwise provided by this section, the requirements of Section 408.0041 apply to an examination ordered under this subsection to the same extent as if the examination were ordered under Section 408.0041(a).

(i) An employee is not entitled to lifetime income benefits under this section, and an insurance carrier is authorized to suspend the payment of lifetime income benefits, during and for a period in which the employee fails to complete the annual certification required by Subsection (e), the employee is employed in any capacity, or as provided under Section 408.0041(j) or (k-1), unless the commissioner determines that there is good cause. The commissioner by rule shall ensure that an employee receives reasonable notice of the insurance carrier's basis for the suspension and is provided a reasonable opportunity to complete the annual certification under Subsection (e) or otherwise respond to the notice.

(j) The commissioner shall adopt rules necessary to implement this section, including rules:

(1) prescribing the deadline for the submission and the form and the manner of the submission of the annual certification required by Subsection (e); and

(2) establishing procedures for:

(A) the review of an employee's continuing entitlement to lifetime income benefits under this section;

(B) the suspension and reinstatement of lifetime income benefits under this section; and

(C) the termination of lifetime income benefits under this section on a final determination that an employee is no longer entitled to the benefits.

Added by Acts 2023, 88th Leg., R.S., Ch. 721 (H.B. 2468), Sec. 3,

eff. September 1, 2023.

Sec. 408.162. SUBSEQUENT INJURY FUND BENEFITS. (a) If a subsequent compensable injury, with the effects of a previous injury, results in a condition for which the injured employee is entitled to lifetime income benefits, the insurance carrier is liable for the payment of benefits for the subsequent injury only to the extent that the subsequent injury would have entitled the employee to benefits had the previous injury not existed.

(b) The subsequent injury fund shall compensate the employee for the remainder of the lifetime income benefits to which the employee is entitled.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

SUBCHAPTER J. DEATH AND BURIAL BENEFITS

Sec. 408.181. DEATH BENEFITS. (a) An insurance carrier shall pay death benefits to the legal beneficiary if a compensable injury to the employee results in death.

(b) Subject to Section 408.061, the amount of a death benefit is equal to 75 percent of the employee's average weekly wage.

(c) The commissioner by rule shall establish requirements for agreements under which death benefits may be paid monthly. Death benefits may be paid monthly only:

(1) on the request of the legal beneficiary and the agreement of the legal beneficiary and the insurance carrier; and

(2) in compliance with the requirements adopted by the commissioner.

(d) An insurance carrier may pay death benefits through an annuity if the annuity agreement meets the terms and conditions for annuity agreements adopted by the commissioner by rule. The establishment of an annuity under this subsection does not relieve the insurance carrier of the liability under this title for ensuring that the death benefits are paid.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 1999, 76th Leg., ch. 1426, Sec. 15, eff. Sept. 1, 1999.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.127, eff. September 1, 2005.

Sec. 408.182. DISTRIBUTION OF DEATH BENEFITS. (a) If there is an eligible child or grandchild and an eligible spouse, half of the death benefits shall be paid to the eligible spouse and half shall be paid in equal shares to the eligible children. If an eligible child has predeceased the employee, death benefits that would have been paid to that child shall be paid in equal shares per stirpes to the children of the deceased child.

(b) If there is an eligible spouse and no eligible child or grandchild, all the death benefits shall be paid to the eligible spouse.

(c) If there is an eligible child or grandchild and no eligible spouse, the death benefits shall be paid to the eligible children or grandchildren.

(d) If there is no eligible spouse, no eligible child, and no eligible grandchild, the death benefits shall be paid in equal shares to surviving dependents of the deceased employee who are parents, stepparents, siblings, or grandparents of the deceased.

(d-1) If there is no eligible spouse, no eligible child, and no eligible grandchild, and there are no surviving dependents of the deceased employee who are parents, siblings, or grandparents of the deceased, the death benefits shall be paid in equal shares to surviving eligible parents of the deceased. A payment of death benefits made under this subsection may not exceed one payment per household. Total payments under this section may not exceed 104 weeks regardless of the number of surviving eligible parents.

(d-2) Except as otherwise provided by this subsection, to be eligible to receive death benefits under Subsection (d-1), an eligible parent must file with the division or insurance carrier a claim for those benefits not later than the first anniversary of the date of the injured employee's death from the compensable injury. The claim must designate all eligible parents and necessary information for payment to the eligible parents. The insurance carrier is not liable for payment to any eligible parent

not designated on the claim. Failure to file a claim in the time required bars the claim unless good cause exists for the failure to file a claim under this section.

(e) If an employee is not survived by legal beneficiaries or eligible parents, the death benefits shall be paid to the subsequent injury fund under Section 403.007.

(f) In this section:

(1) "Eligible child" means a child of a deceased employee if the child is:

(A) a minor;

(B) enrolled as a full-time student in an accredited educational institution and is less than 25 years of age; or

(C) a dependent of the deceased employee at the time of the employee's death.

(2) "Eligible grandchild" means a grandchild of a deceased employee who is a dependent of the deceased employee and whose parent is not an eligible child.

(3) "Eligible spouse" means the surviving spouse of a deceased employee unless the spouse abandoned the employee for longer than the year immediately preceding the death without good cause, as determined by the division.

(4) "Eligible parent" means the mother or the father of a deceased employee, including an adoptive parent or a stepparent. The term does not include a parent whose parental rights have been terminated.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.128, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 1007 (H.B. 724), Sec. 5, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 1007 (H.B. 724), Sec. 6, eff. September 1, 2007.

Acts 2009, 81st Leg., R.S., Ch. 344 (H.B. 1058), Sec. 1, eff. September 1, 2009.

Acts 2023, 88th Leg., R.S., Ch. 502 (H.B. 2314), Sec. 1, eff.

Sec. 408.183. DURATION OF DEATH BENEFITS. (a) Entitlement to death benefits begins on the day after the date of an employee's death.

(b) An eligible spouse is entitled to receive death benefits for life or until remarriage. On remarriage, the eligible spouse is entitled to receive 104 weeks of death benefits, commuted as provided by commissioner rule.

(b-1) Notwithstanding Subsection (b), an eligible spouse who remarried is eligible for death benefits for life if the employee was a first responder, as defined by Section 504.055, or an individual described by Section 615.003(1), Government Code, or Section 501.001(5)(F), who suffered death in the course and scope of employment or while providing services as a volunteer. This subsection applies regardless of the date on which the death of the first responder or other individual occurred.

(c) A child who is eligible for death benefits because the child is a minor on the date of the employee's death is entitled to receive benefits until the child attains the age of 18.

(d) A child eligible for death benefits under Subsection (c) who at age 18 is enrolled as a full-time student in an accredited educational institution or a child who is eligible for death benefits because on the date of the employee's death the child is enrolled as a full-time student in an accredited educational institution is entitled to receive or to continue to receive, as appropriate, benefits until the earliest of:

(1) the date the child ceases, for a second consecutive semester, to be enrolled as a full-time student in an accredited educational institution;

(2) the date the child attains the age of 25; or

(3) the date the child dies.

(e) A child who is eligible for death benefits because the child is a dependent of the deceased employee on the date of the employee's death is entitled to receive benefits until the earlier of:

(1) the date the child dies; or

(2) if the child is dependent:

(A) because the child is an individual with a physical or mental disability, the date the child no longer has the disability; or

(B) because of a reason other than a physical or mental disability, the date of the expiration of 364 weeks of death benefit payments.

(f) An eligible grandchild is entitled to receive death benefits until the earlier of:

(1) the date the grandchild dies; or

(2) if the grandchild is:

(A) a minor at the time of the employee's death, the date the grandchild ceases to be a minor; or

(B) not a minor at the time of the employee's death, the date of the expiration of 364 weeks of death benefit payments.

(f-1) An eligible parent who is not a surviving dependent of the deceased employee is entitled to receive death benefits until the earlier of:

(1) the date the eligible parent dies; or

(2) the date of the expiration of 104 weeks of death benefit payments.

(g) Any other person entitled to death benefits is entitled to receive death benefits until the earlier of:

(1) the date the person dies; or

(2) the date of the expiration of 364 weeks of death benefit payments.

(h) Section 401.011(16) does not apply to the use of the term "disability" in this section.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.129, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 1007 (H.B. 724), Sec. 7, eff. September 1, 2007.

Acts 2015, 84th Leg., R.S., Ch. 1018 (H.B. 1094), Sec. 1, eff. September 1, 2015.

Acts 2017, 85th Leg., R.S., Ch. 468 (H.B. 2119), Sec. 1, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 821 (H.B. 2503), Sec. 1, eff. September 1, 2019.

Sec. 408.184. REDISTRIBUTION OF DEATH BENEFITS. (a) If a legal beneficiary dies or otherwise becomes ineligible for death benefits, benefits shall be redistributed to the remaining legal beneficiaries as provided by Sections 408.182 and 408.183.

(b) If a spouse ceases to be eligible because of remarriage, the benefits payable to the remaining legal beneficiaries remain constant for 104 weeks. After the 104th week, the spouse's share of benefits shall be redistributed as provided by Sections 408.182 and 408.183.

(c) If all legal beneficiaries, other than the subsequent injury fund, cease to be eligible and the insurance carrier has not made 364 weeks of full death benefit payments, including the remarriage payment, the insurance carrier shall pay to the subsequent injury fund an amount computed by subtracting the total amount paid from the amount that would be paid for 364 weeks of death benefits.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Sec. 408.185. EFFECT OF BENEFICIARY DISPUTE; ATTORNEY'S FEES. On settlement of a case in which the insurance carrier admits liability for death benefits but a dispute exists as to the proper beneficiary or beneficiaries, the settlement shall be paid in periodic payments as provided by law, with a reasonable attorney's fee not to exceed 25 percent of the settlement, paid periodically, and based on time and expenses.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Sec. 408.186. BURIAL BENEFITS. (a) If the death of an employee results from a compensable injury, the insurance carrier shall pay to the person who incurred liability for the costs of burial the lesser of:

(1) the actual costs incurred for reasonable burial

expenses; or

(2) $10,000.

(b) If the employee died away from the employee's usual place of employment, the insurance carrier shall pay the reasonable cost of transporting the body, not to exceed the cost of transporting the body to the employee's usual place of employment.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 1999, 76th Leg., ch. 1426, Sec. 16, eff. Sept. 1, 1999.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 192 (S.B. 653), Sec. 1, eff. September 1, 2015.

Sec. 408.187. AUTOPSY. (a) If in a claim for death benefits based on an occupational disease an autopsy is necessary to determine the cause of death, the commission may, after opportunity for hearing, order the legal beneficiaries of a deceased employee to permit an autopsy.

(b) A legal beneficiary is entitled to have a representative present at an autopsy ordered under this section.

(c) The commissioner shall require the insurance carrier to pay the costs of a procedure ordered under this section.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.130, eff. September 1, 2005.

SUBCHAPTER K. PROTECTION OF RIGHTS TO BENEFITS

Sec. 408.201. BENEFITS EXEMPT FROM LEGAL PROCESS. Benefits are exempt from:

(1) garnishment;

(2) attachment;

(3) judgment; and

(4) other actions or claims.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Sec. 408.202. ASSIGNABILITY OF BENEFITS. Benefits are not

assignable, except a legal beneficiary may, with the commissioner's approval, assign the right to death benefits.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.131, eff. September 1, 2005.

Sec. 408.203. ALLOWABLE LIENS. (a) An income or death benefit is subject only to the following lien or claim, to the extent the benefit is unpaid on the date the insurance carrier receives written notice of the lien or claim, in the following order of priority:

(1) an attorney's fee for representing an employee or legal beneficiary in a matter arising under this subtitle;

(2) court-ordered child support; or

(3) a subrogation interest established under this subtitle.

(b) A benefit that is subject to a lien or claim for payment of court-ordered child support shall be paid as required by an order or writ of income withholding under Chapter 158, Family Code.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 1997, 75th Leg., ch. 165, Sec. 7.53, eff. Sept. 1, 1997; Acts 2003, 78th Leg., ch. 610, Sec. 22, eff. Sept. 1, 2003.

SUBCHAPTER L. ATTORNEY'S FEES IN WORKERS' COMPENSATION BENEFIT MATTERS

Sec. 408.221. ATTORNEY'S FEES PAID TO CLAIMANT'S COUNSEL. (a) An attorney's fee, including a contingency fee, for representing a claimant before the division or court under this subtitle must be approved by the commissioner or court.

(b) Except as otherwise provided, an attorney's fee under this section is based on the attorney's time and expenses according to written evidence presented to the division or court. Except as provided by Subsection (c) or Section 408.147(c), the attorney's fee shall be paid from the claimant's recovery.

(c) An insurance carrier that seeks judicial review under

Subchapter G, Chapter 410, of a final decision of the appeals panel regarding compensability or eligibility for, or the amount of, income or death benefits is liable for reasonable and necessary attorney's fees as provided by Subsection (d) incurred by the claimant as a result of the insurance carrier's appeal if the claimant prevails on an issue on which judicial review is sought by the insurance carrier in accordance with the limitation of issues contained in Section 410.302. If the carrier appeals multiple issues and the claimant prevails on some, but not all, of the issues appealed, the court shall apportion and award fees to the claimant's attorney only for the issues on which the claimant prevails. In making that apportionment, the court shall consider the factors prescribed by Subsection (d). This subsection does not apply to attorney's fees for which an insurance carrier may be liable under Section 408.147. An award of attorney's fees under this subsection is not subject to commissioner rules adopted under Subsection (f).

(d) In approving an attorney's fee under this section, the commissioner or court shall consider:

(1) the time and labor required;

(2) the novelty and difficulty of the questions involved;

(3) the skill required to perform the legal services properly;

(4) the fee customarily charged in the locality for similar legal services;

(5) the amount involved in the controversy;

(6) the benefits to the claimant that the attorney is responsible for securing; and

(7) the experience and ability of the attorney performing the services.

(e) The commissioner by rule or the court may provide for the commutation of an attorney's fee, except that the attorney's fee shall be paid in periodic payments in a claim involving death benefits if the only dispute is as to the proper beneficiary or beneficiaries.

(f) The commissioner by rule shall provide guidelines for

maximum attorney's fees for specific services in accordance with this section.

(g) An attorney's fee may not be allowed in a case involving a fatal injury or lifetime income benefit if the insurance carrier admits liability on all issues and tenders payment of maximum benefits in writing under this subtitle while the claim is pending before the division.

(h) An attorney's fee shall be paid to the attorney by separate draft.

(i) Except as provided by Subsection (c) or Section 408.147(c), an attorney's fee may not exceed 25 percent of the claimant's recovery.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 2001, 77th Leg., ch. 1456, Sec. 8.01, eff. June 17, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.132, eff. September 1, 2005.

Sec. 408.222. ATTORNEY'S FEES PAID TO DEFENSE COUNSEL. (a) The amount of an attorney's fee for defending an insurance carrier in a workers' compensation action brought under this subtitle must be approved by the division or court and determined by the division or court to be reasonable and necessary.

(b) In determining whether a fee is reasonable under this section, the division or court shall consider issues analogous to those listed under Section 408.221(d). The defense counsel shall present written evidence to the division or court relating to:

(1) the time spent and expenses incurred in defending the case; and

(2) other evidence considered necessary by the division or court in making a determination under this section.

Acts 1993, 73rd Leg., ch. 269, Sec. 1, eff. Sept. 1, 1993. Amended by Acts 2001, 77th Leg., ch. 1456, Sec. 8.03, eff. June 17, 2001.

Amended by:

Acts 2005, 79th Leg., Ch. 265 (H.B. 7), Sec. 3.133, eff. September 1, 2005.