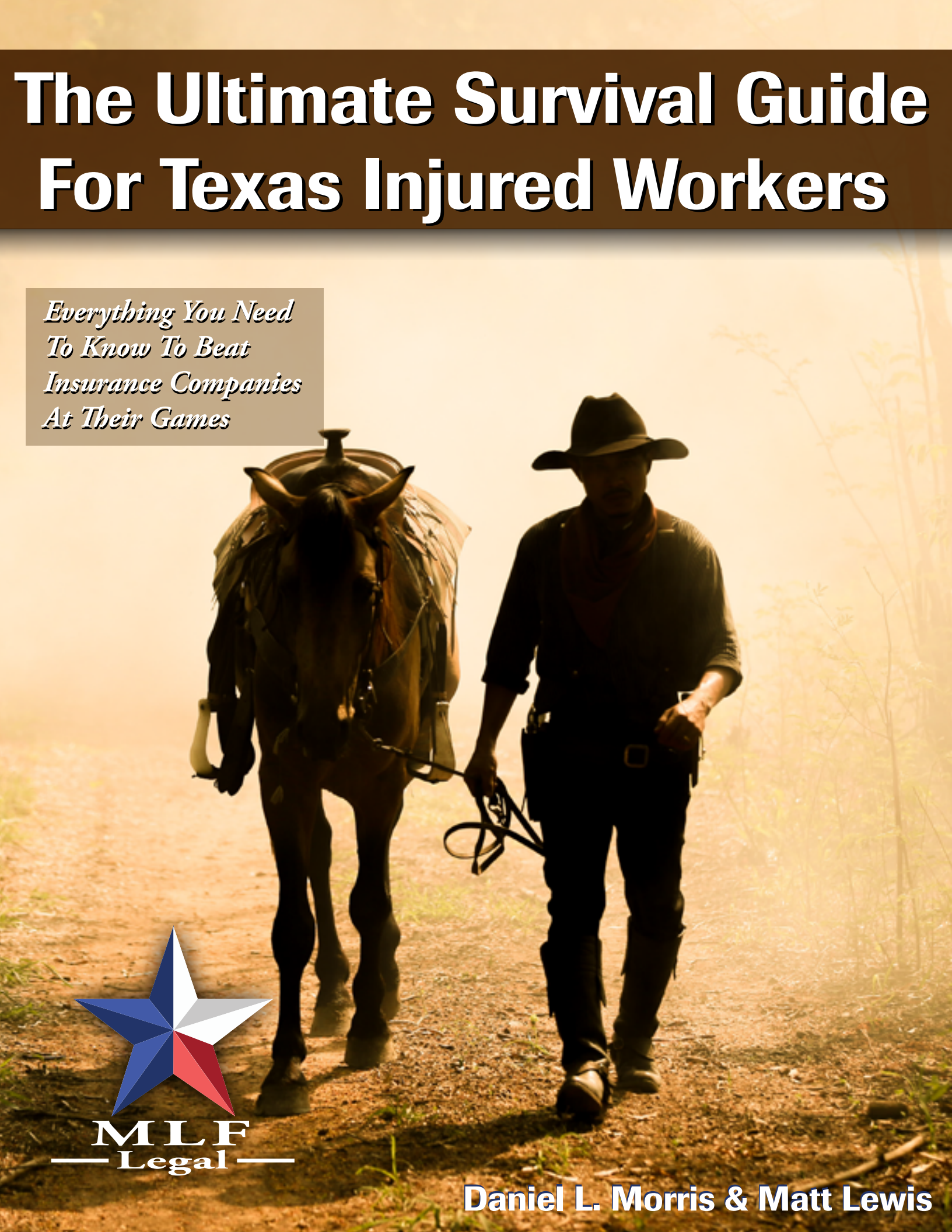
The Ultimate Survival Guide For Texas Injured Workers

Everything You Need To Know To Beat Insurance Companies At Their Games



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Daniel L. Morris & Matt Lewis

THE ULTIMATE SURVIVAL GUIDE FOR TEXAS INJURED WORKERS:

Everything You Need To Know To Beat Insurance Companies At Their Games

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&
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Introduction

It is very likely that everyone in Texas has either had an on the job injury, or has a close family member or friend who has. Unlike many types of injuries, there are not a lot of resources to learn how to navigate a workers' compensation claim.

Texas is the only state that allows employers to decide if they want to subscribe to the workers' compensation system or become what is generally referred to as a non-subscriber.

These two types of claims are handled very differently. Therefore, the first thing to confirm after a work injury is if your employer is a subscriber or a non-subscriber to the system.
We have written this guide to assist injured workers in handing a workers compensation claim. We explain the types of benefits and hearings that can arise as a result of an injury at work.

Abraham Lincoln is credited as saying, "He who represents himself has a fool for a client." We would never advise a person to represent them self, but everyone needs to understand what is happening in their claim. This guide provides the terminology and information you will need to navigate the beauracratic process.

CONTENTS

Authors

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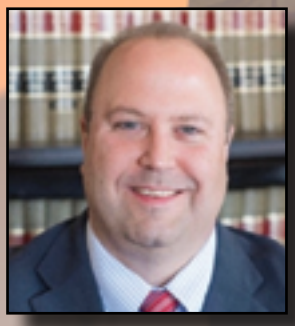
Daniel has represented injured workers in Texas since 1996. He is fluent in Spanish and has lived in Argentina and Mexico.He has been involved in the Texas Workers' Compensation Bar Section since its inception and has served as a workers' representative for the board. He has lectured numerous me at the Texas Bar Advanced Workers' Compensation Seminar for over the last ten years and has spoken on subjects from "How to Handle Your First Workers' Compensation Claim" to the "Legislative Update."

He lives with his wife, five of his seven children and one grandchild. He is active in his church and Boy Scouts, where he serves as the District Activities Chairperson.



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Matt has represented injured workers pursuing Texas workers' compensation claims since 1998. Additionally, he helps those that can't return to work obtain social security disability benefits.

Currently, Matt serves on the board of the State Bar's Workers' Compensation Section representing injured workers, and speaks annually at the Bar's Workers' Compensation Seminar. He is board certified in Workers' Compensation Law by the Texas Board of Legal Specialization, and has been named a Texas Super Lawyer in Texas Monthly Magazine every year since 2012.

Matt lives in Tarrant County with his wife and two kids. He is active in his community and serves as Chairman of the City of Saginaw's Planning & Zoning Commission.

CHAPTER 1

History of Texas Workers' Compensation

Texas enacted its first workers compensation laws in 1913. The law stayed pretty consistent until 1991, when the Texas Legislature enacted what is referred to as the new law.
Insurance carriers claimed that workers compensation in our great State of Texas was a "run away train" driven by the plaintiffs bar. They argued that injured workers were not getting the care they needed and attorneys were getting rich off of peoples' injuries.

The "New Law" Separated the indemnity (compensation) and the medical benefits owed to the injured worker. The argument for this was that if they were determined at the same time, workers would give up medical benefits to increase their indemnity benefits. The idea was that the insurance companies would cooperate with the medical providers to get injured workers the care they needed and get them back to work.
Unfortunately, it appears that we have left the wolf to guard the hen house. The Texas Workers' Compensation system has been in almost constant change from 1991 through thepresent. However, almost none of these changes are for the benefit of the injured worker.

A system, that when created was to always look at issues in the best light for the injured worker, has morphed into a bureaucratic nightmare that promotes form over substance. Most of the attorneys who provided representation to injured workers left the system after the 1991 changes. This left injured workers to rely upon the medical proders to be their advocates in resolving disputes. In 2005. the medical providers began to leave, as employer networks took away the injured employee's ability to select their own choice of treating doctor.

Most injured workers' interaction in the workers compensation arena are with the employer's HR department, insurance claims handlers, and clinics who contract with insurance companies for cost containment. However, there are still attorneys and medical providers who assist injured workers: you just need to do a little research to find them.

CHAPTER 2

I Got Hurt At Work, What Do I Do Now?

Injured workers often feel like they face a dilemma following an injury. They probably know they need to say something so they can get medical attention, but they often either fear for their job or have the mindset that they want to be a good "company man." But the worst thing any claimant can do is fail to do anything at all.

The most common thing we hear from injured workers with Texas workers' compensation claims is that they thought the injury was no big deal and it would go away. And then when it didn't, they figured out why waiting to say something was the wrong thing to do. Once an injury occurs, there are two things all Texas injured workers must do immediately: report the injury to a supervisor, and get medical treatment as soon as possible.

Reporting An Injury To Your Employer

Any time you get hurt at work, you need to report that injury to your employer. In Texas, if your employer has workers' compensation insurance, then you have thirty days to report the injury. If you don't, your claim can be denied and you can lose the right to benefits forever.

When does the thirty-day deadline start? If you sustained an injury in a one-time event, what we call a specific incident, like falling off of a ladder, then you have thirty days to report that injury from the day it happened.

If you have an occupational disease, like cancer, or a repetitive trauma injury that occurs over time, like carpal tunnel syndrome, then you have thirty days to report the injury from the day you knew, or should have known, that you have a work related injury.

- Report your injury to a supervisor
- Report what happened and what body parts are hurt. State that your injuries happened at work
- Email the same report to your supervisor and print a copy so that you will have proof later if the company says you never reported
- Make the doctor write down all of the body partsthat you injured
- Do not continue to treat with the company doctor
- Choose your own doctor as soon as possible

CHAPTER 2

You must report your injury to someone with a management or supervisory position. This could be your supervisor, the foreman or the HR manager. You must tell them the nature of your injury and that it is work related. This puts them on notice and allows them to investigate what happened.

Once the employer receives your report of injury, they should call their workers' compensation insurance company to report the claim. After that, you should hear from an adjuster with the insurance company who will probably have some questions for you about what happened.

Get Medical Treatment ASAP

Because so many injured workers try to wait and see if the injury will go away like most regular aches and pains do, they often fail to get immediate medical attention, This means that in many cases, there will not be any evidence of an actual injury on the date that the employee sustained the injury. That is not an ideal situation if the claim has to be litigated later.

Get to the doctor as soon as possible. That way, all of the acute injuries can be documented. Make sure the doctor documents every injury that you think you have. If your low back is the most significant injury, don't fail to have the doctor document your other injuries too.

Your company might have a doctor they want you to see. That is fine, but remember who they work for. Your employer is the one that hired them, not you. You will need to follow up on the same day, or the next day at the latest, with the emergency room or your own choice of doctor so that you can make sure you get the right diagnosis and treatment.

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CHAPTER 3

Do I Have A Workers' Compensation Claim?

If you have an injury at work, that doesn't always mean that you can get compensation. In Texas, we do not require all employers to have workers' comp insurance. If your employer does have workers' comp insurance, only injuries sustained in the course and scope of employment are covered. Here's what you need to know about establishing a claim for benefits.

Subscribers & Non-Subscribers

In Texas, employers are not required to have workers' compensation insurance. The ones that do have workers' comp insurance are known as subscribers. Those that don't are known as non-subscribers.

Subscribers have coverage, so injured employees get all of the benefits provided by the workers' compensation system. Non-subscribers do not have coverage, so those injured employees will usually not get their medical treatment and lost wages paid for by the employer. Some of the non-subscribers will provide limited treatment and benefits, but it usually doesn't compare to what the workers' comp system provides.

In order to induce employers into buying workers' comp insurance, the legislature has passed laws stating that if the employer does not have workers' comp insurance, then that employer can be sued for negligence. However, if the employer does have workers' comp insurance, then the only remedy you have is collecting the workers' comp benefits.

The Division of Workers' Compensation has a website with a tool to search for your employer so you can find out if it is a subscriber or a nom-subscriber,From the "topics A-Z" section, select "TXCOMP", and then select "claims and coverage systems" and you can then do a search under "locate covered employer."

Injury In The Course & Scope Of Employment

One of the most common questions we get asked when people come into the office is, "Do I have a worker's comp case," and the answer is, "Well, did you have an injury, and did that injury occur in the course and scope of your employment?" Now, an injury is defined as damage or harm to the physical structure of your body. These injuries might be verified by something like a diagnosis from a doctor, or an x-ray, or it might show up on an MRI. The next question is whether or not the injury occurred in the course and scope of your employment. Course and scope of employment means an activity that occurred while you were at work, and in the furtherance of your employer's affairs. Something such as stacking boxes on a pallet to send out a shipment for your employer would be in the course and scope of employment. However, if you were driving to work, or driving home from work, those generally are not activities that are helping your employers business, so they would not be in the course and scope of your employment.

When you have an injury, and that injury arises out of your employment, then you probably have a workers' comp case.

CHAPTER 4

How To File A Texas Workers' Comp Claim?

When you have a work-related injury in Texas, you have to file notice of your injury with the Division of Workers' Compensation within one year from the date of your injury. There is a form to fill out — it's called a DWC-41. It asks for your contact info and a description of how you got hurt and where you work.

Failure to file this document within one year of your date of injury can result in your claim being denied. Have you heard of people losing legal claims due to a technicality? This is one of those types of deadlines. Don't miss it!

The instructions on the form will tell you to fax it to an Austin number. The Division loses paperwork all the time, so don't take a chance and hope that your fax gets logged into the system. In addition to faxing it, we would recommend you take it to your local field office of the Division of Workers' Compensation and file it in person. When you do that, they will stamp it for you showing the date it was received, and they can give you a copy. Then you will have the evidence you need to show that you filed it if that becomes a question later.

Texas Department Of Insurance

Division of Workers' Compensation
Records Processing
7551 Metro Center Dr, Ste.100 • MS-94
Austin, TX 78744-1609
(800) 252-7031 (512) 804-4378 fax www.tdi.texas.gov

DWC Claim#

Carrier Claim#

← Send the completed form to this address.

Employee's Claim for Compensation for a Work-Related Injury or Occupational Disease (DWC Form-041)

Claim for workers' compensation must be filed by the injured employee or by a person acting on the injured employee's behalf **within one year** of the date of injury or within one year from the date the injured employee knew or should have known the injury or disease may be work-related.

I. INJURED EMPLOYEE INFORMATION

Name (First, Middle, Last)	**Social Security Number**	**Date of birth** (mm / dd / yyyy)
Address (street, city/town, state, zip code, county, country)		
Phone Number	**E-Mail address**	**Sex** ☐ Male ☐ Female
Race / Ethnicity ☐ White, not of Hispanic Origin ☐ Black, not of Hispanic Origin ☐ Hispanic ☐ Asian or Pacific Islander		
Do you speak English? ☐ Yes ☐ No If no, specify language		
Marital status ☐ Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced		
Do you have an attorney or other representation? ☐ Yes ☐ No **If yes, name of representative**		
Have you returned to work? ☐ Yes ☐ No	**If returned to work, date returned** (mm/dd/yyyy)	**Work status** ☐ Regular ☐ Restricted
Occupation at time of injury		**Date of hire** (mm / dd / yyyy)
Hired or recruited in Texas ☐ Yes ☐ No	**Pre-tax wages** (at the time of injury) $	☐ hourly ☐ weekly ☐ monthly

II. INJURY INFORMATION

I am reporting an ☐ injury or ☐ occupational disease	**Date of injury** (mm / dd / yyyy)	**Time of injury**
First work day missed (mm / dd / yyyy)	**Date injury was reported to the employer** (mm / dd / yyyy)	
Where did the injury occur? County	State	Country
If accident occurred outside of Texas, on what date did you leave Texas? (mm/dd/yyyy)		
Witness(es) to the injury (list by name)		
Describe cause of injury or occupational disease, including how it is work related		
Body part(s) affected by the injury		
If injury is the result of an occupational disease: **1. On what date was the employee last exposed to the cause of the occupational disease?** (mm / dd / yyyy) **2. When did you first know occupational disease was work related?** (mm / dd / yyyy)		

III. EMPLOYER INFORMATION (at the time of injury)

Employer name	**Employer address** (street, city/town, state, zip code, county, country)
Employer phone number	**Supervisor name**

IV. DOCTOR INFORMATION

Name of treating doctor	**Phone number**
Address (street, city/town, state, zip code)	
Name of workers' compensation health care network, if any	

Signature of injured employee or person filling out this form on behalf of injured employee — **Date**

Printed name of injured employee or person filling out form on behalf of injured employee

CHAPTER 5

MEDICAL TREATMENT

When you sustain a work injury in Texas, all medical treatment for that injury is supposed to be covered under the claim. The law specifically states that injured workers are "entitled" to all health care that cures or relieves the effects of the injury, that promotes recovery, or that enhances your ability to return to work. This right to treatment is for your lifetime, as long as the treatment is related to the work injury.

While the law is clear about what treatment injured workers are entitled to receive, the Division adopted a book called a treatment guideline to control and limit the treatment injured workers receive. Currently, the Division uses the Official Disability Guideline to determine what treatment is allowed. This book lists various treatments for specific types of injuries and indicates whether the treatment is recommended or not by the doctors who wrote the book.

PREAUTHORIZATION

Other than initial physical therapy, most treatment prescribed by your doctor will require preauthorization. Preauthorization means that the insurance company has to consider and give permission for the treatment your doctor recommends. Treatment can be delayed while this preauthorization process takes place. Generally, the insurance company has three days to review your doctor's request for treatment and give an answer. Sometimes, though, the delays related to preauthorization disputes can be aggravating.

If the insurance company denies preauthorization, your doctor can appeal that decision. If it's denied again, another appeal can be made to the Division. Most of the time, preauthorization problems are simply communication issues between the reviewing doctor and your treating doctor. other times, the treatment is not recommended by the Official Disability Guidelines and the reviewing doctor doesn't allow for an exception. In these circumstances, medical dispute resolution may be necessary.

NETWORK OR NON-NETWORK CLAIMS

In Texas, a workers' comp claim is either a network claim or a non-network claim. A network claim is when your employer has signed up with the insurance company to have its employees get treatment in that insurance company's network of doctors. This is similar to regular health insurance where if you have Aetna as your insurance, you have to treat with a doctor who has contracted with Aetna to treat their patients. What this means, is that if you have a network claim, you have to treat with a doctor who is approved to be in the insurance company's network of doctors. Sometimes, this list is fairly limited and full of insurance company doctors, or employer friendly doctors, rather than patient advocate doctors. In a non-network claim, the injured worker is free to treat with any doctor that is willing to see them and bill through the workers' comp system. The choice of doctors

- Choosing a treating doctor is one of the most imortant decisions you will make
- Do not treat with the company doctor
- Ask potential doctors if they write causation letters
- Even if you do not want to hire an attorney, use the free consult to get advice on a treating doctor

in a non-network claim is a much larger pool, and contains many of the doctors known to be good doctors, as well as doctors who fight for necessary preauthoñzation approvals and help injured workers prove their injuries. There is a cear advantage for injured workers who have a non network claim.

Choosing A Treating Doctor

Most injured workers receive medical attention first from either an emergency room doctor or the company doctor. But these are not viable options for long term care. The emergency room doctor won't treat beyond that first visit, and the company doctor is often more concerned about taking care of the employer and not the patient. Once initial care has been obtained, it is time to consider who should be selected as the treating doctor. The "treating doctor" in a Texas workers' comp claim has a very large role. That doctor is responsible for making sure that the injured worker gets appropriate treatment and is referred to any necessary specialists. Everything goes through the treating doctor. And if the claim (or any portion of the claim) is denied, the treating doctor helps to establish what the injuries are, prove how they were caused by the work accident, and establish the claimant's work abilities. Any and all benefits that an injured worker might possibly collect are established through the treating doctor. So, you can see why treating with a company doctor is not the best idea.

If you are still treating with a company doctor, you can change to a doctor of your choice, The adjuster and the Division of Workers' Compensation might tell you different, but they are wrong. You might need the help of an attorney, but you can change doctors in most situations. Sometimes changing treating doctors requires some litigation, but in the vast majority of all situations, there is a way to change doctors. In a non-network claim, all you have to do is file form DWC-53. In order to file the form, you will need to get the new treating doctor to sign the form indicating their agreement to be your new treating doctor. Once filed, the Division reviews the request for approval.

If you are told that your claim is a network claim, then the procedure is different, but a change can still be made. You will have to call the adjuster and ask for approval to change doctors.

Beware of the adjuster trick where they give you a list of network doctors to choose from, but it is a list of only the doctors the insurance company likes and not the complete list. If you have a network claim, you will need to research the choices to see whether the doctors you can pick from are patient friendly, or insurance friendly. This might be a good reason to seek a free consultation with an attorney.

CHAPTER 6

Lost Wages

Lost wages in a workers' comp claim are covered beginning on the eighth day of lost time from work, and ending when you are able to earn your full wages or you reach maximum medical improvement, whichever comes first. The benefits that are paid for lost wages are called Temporary Income Benefits (TIBs). In order to get TIBs, you have to prove that you have disability under the workers compensation law.

Disability

Texas workers' compensation law defines disability as the inability, because of a workplace injury, to earn your pre-injury wage. This means that if your injury results in a loss of earnings, then you meet the definition of disability. This might be because you cannot work at all after your injury. Maybe you can work but not full time, so you get paid less than before your injury. Sometimes injured workers are given different job duties after an injury, and it comes with less pay. In all of these situations, you would have disability.

You can see, then, that disability is not what people generally consider the word "disabled" to mean. Disability in a Texas workers' comp claim is different than disability in a social security claim. It is not necessarily about functional ability, but more about earning ability. It is an economic issue, not a medical opinion. There are many scenarios that result in disability. The majority of disability cases involve an inability to work at all (like the traditional concept of disability) or a release to return to work on light duty. If you cannot work at all, then you obviously can't earn wages that's disability. If your employer won't let you work light duty, then your injury is the reason why you aren't earning wages - that's disability.

You will have to prove that you have disability in order to be entitled to temporary income benefits, Generally, injured workers can prove disability by providing a DWC-73 — a work status report — from a doctor. This form documents your functional ability. If it says you can not work at all, that is evidence of disability. The same is true if it documents the various restrictions you might have that would keep you from being able to do your regular job duties. Other evidence that might be considered would be diagnostic test results (MRI, EMG, x-rays), surgical records and other medical opinions about your physical condition and functional ability, as well as your job description.

- If you can't work or have restrictions and are not getting benefits, something is wrong
- Make sure your work status reports are faxed to your adjuster
- Don't miss doctor appointments

CHAPTER 7

Extent of Injury

Insurance companies will often accept liability for minor injuries like a contusion or a sprain. Those injuries are not too expensive to treat and don't keep people off of work very long. Then when you get diagnosed with a herniated disc, or a pinched nerve or a tear in your shoulder or knee, they dispute those conditions and refuse to provide treatment or benefits. When insurance companies dispute your injuries like that, it is called an extent of injury dispute. We use that name because now you have to prove the extent of your injuries.

You might have an MRI that shows that you definitely have a rotator cuff tear or a herniated disc in your low back, but so long as the insurance company says "we dispute this," you won't be able to get treatment for it. You won't get paid benefits if that condition is the one that limits your ability to work. You won't get paid for any permanent impairment you have that results from it. You have to go get that condition covered under the claim.

Proving your extent of injury requires more than proving that you have the condition. You have to prove that it was caused by the work accident. In most cases, you will have to obtain expert medical evidence of the diagnosis and the cause of the condition. This is done by getting a doctor to write a report explaining how the work accident caused the diagnosis in dispute. We call this a "causation letter." Once you get the causation letter, you can litigate liability and ask the Division to rule that your extent of injury includes the diagnosis the insurance company disputed.

A causation letter should include:

- Mechanism of Injury
- Diagnosis
- What forces were caused by the mechanism of injury
- How did those forces act on the body to cause the diagnosis

Causation

Causation is a fancy legal word that covers everything related to proving that your injuries were caused by your work accident. It's usually easy to prove that you have the injury that shows up on an MRI. It's much harder to prove the cause. There are two ways to do this. One option is to request a designated doctor by filing form DWC-32 and asking the designated doctor to determine your extent of injury. The problem here is that you don't know who the designated doctor is going to be (it could end up being an insurance company doctor), and you don't know what they will say. If they are against you on the cause of your injury and think it is age-related or pre-existing, then that makes it harder to prove your case because now you have to overcome the opinion of the State's doctor.

is hard for doctors to do because they treat injuries, they don't argue legal cases. But here it is in a nutshell: When the doctor writes the causation letter, she needs to explain the mechanism of injury (what happened to you) in detail. Then she can explain what forces those actions placed upon your body. These forces are usually something like an axial load from lifting, rotational forces from twisting, or blunt force trauma from being hit by something or falling to the ground. Finally, the doctor should explain how those forces acted upon your body to cause your specific diagnosis.

It's always best if the doctor bolsters her opinion with medical journal articles or some treatise that affirms her position. Ask the doctor to include a sentence that says she has provided her opinion within reasonable medical probability. Then you should have a causation letter that can be considered by the judge.

CHAPTER 8

Maximum Medical Improvement & Impairment Rating

When you finish your medical teatment and recover from your injuries as much as possible, you have reached maximum medical improvement (MMI). The law defines MMI as the earliest date after which further material recovery f rom, or lasting improvement to, an injury can no longer reasonably be anticipated. This means that if your doctors are providing treatment to you that they expect to help you get some improvement in your condition, then you are not at MMI.

Maximum medical improvement is an important date in your claim. First, it ends the time period that you are eligible to get temporary income benefits. Second, the attainment of MMI requires that you be given an impairment rating. The fact that reaching MMI ends your benefits for lost wages makes it one of the most sigrnficant factors in your claim.

When a doctor performs an exam to determine if you have reached MMI, the doctor is supposed to consider at what point in your claim there was no further expectation of recovery from your injury. Many doctors do not do this correctly. They look back through your records and they figure out at what point you failed to make any additional improvement, and then they write a report saying that is the day you reached MMI. Wouldn't it be crazy to say that you reached MMI before you had your surgery just because the surgery didn't work?

The correct way for the doctor to look at the question of MMI, is to determine at what point there was no reasonable expectation of further recovery. This is not before a failed surgery, but after the post-surgery therapy. Your doctor expected the surgery to help you. He expected the post-surgery therapy to help you. The fact that the doctor expected the treatment to help you is what defines MMI. The actual outcome of the treatment is not relevant to the question of MMI.

Why is this distinction so important? Because so many doctors are back-dating MMI. This means that they are picking a day months in the past to say that you reached MMI. When this happens, your benefits are cut off immediately, and you may not even be owed benefits for your permanent impairment.

One final note about MMI. If it has been two years since the eighth day you missed from work, then you are at MMI automatically by law. This is called statutory MMI. When the Legislature wrote the statute, they picked a two year time period for injured workers to be eligible to receive lost wages. Once you reach the two year mark, you are automatically placed at MMI and get an impairment rating.

Impairment Ratings

An impairment rating is a measurement of the permanent impairment to your body resulting from your work injuries. It is certified when you reach MMI, and it is supposed to be based upon your condition on the date of MMI. The law requires impairment ratings to be based on the 4th Edition of The AMA Guides To The Evaluation of Permanent Impairment, a book put out by the American Medical Association. The doctor who certifies your impairment rating must do a physical examination and review your medical records.

At the impairment rating exam:

- Do not exagerate your symptoms
- Give a full effort on all testing
- Be aware that you are watched from the parking lot into the office and back to the parking lot.
- Know your current treatment plan and explain it to the doctor

For most joints, the impairment rating is based on range of motion loss and the type of surgery you may have had. For neck and low back injuries, the book provides impairment ratings based on your diagnosis or the type of symptoms you may have had during your claim. For instance, if you have had muscle spasms in your back as a result of your injury, then you should receive an impairment rating. If you have a loss of reflexes or atrophy due to your neck or low back injury, then you may qualify for a higher impairment rating.

The Ninety Day Rule, A Deadline For Impairment Rating Disputes

As in many areas of law, the Texas Workers' Compensation system has hard deadlines. You have a limited amount of time to report your injury to your employer or file a claim with the Division of Workers' Compensation, and you only have 90 days to dispute a certification of MMI and impairment rating.

The ninety-day period to file a dispute of your impairment rating begins on the day you receive a copy of the certification by "verifiable means." Verifiable means refers to a way to prove that you received the report. This can be established through certified mail receipt, fax or email verification, or by your testimony that you received it on a certain date.

If nobody can prove when you received a copy of the report, then nobody can say that you failed to dispute your impairment rating before the end of the deadline period.
Failure to dispute your first impairment rating by the end of the ninety-day period results in that impairment rating becoming your final impairment rating. Your ability to dispute it at that point becomes much more difficult. Before the deadline passes, simply filing a dispute keeps the rating from becoming final against you. Missing the deadline means that the only way around it is to prove that you meet an exception to the rule.

Exceptions To The Ninety Day Rule

The first exception to the ninety day rule is when you received improper or inadequate medical care. If there is compelling medical evidence that you had improper or inadequate medical care before the date of MMI that you were assigned, then you have a chance of getting around the ninety day rule. The fact that you haven't fully recovered yet isn't evidence of inadequate medical treatment. Failing to receive the ODG recommended medical treatment could be evidence of inadequate medical care. The second exception is when you have a mistaken diagnosis or develop a previously undiagnosed medical condition. An example of this would be when you have an MRI after the impairment rating exam that shows you have a serious injury that the doctors had not diagnosed yet.

The last exception is when the doctor makes a significant error in applying the AMA Guides, which is the book used to determine your impairment rating. When the doctor makes a mistake, or uses the wrong methods to determine your impairment rating, you can pursue a dispute even if you missed the deadline.

These are the only three exceptions to the rule. So, you can see how important it is to file a dispute on time. But if you didn't know about the deadline, see if one of these exceptions will work to get you out of the wrong impairment rating.

- Do not refuse delivery of the certified mailing of the impairment rating report.
- Talk to your doctor about the impairment rating to see if there is a reason to dispute the MMI or impairment certification.
- If you miss the deadline to file a dispute, consider exceptions to the rule.

How To Dispute An Impairment Rating

There are two ways to dispute an impairment rating: one is to request a designated doctor, and the second is to request a benefit review conference. The hard part is figuring out which method to use, and when.

First, you must determine whether or not a designated doctor has ever been appointed on your claim by the Division of Workers' Compensation. A designated doctor is a state-appointed doctor who may have been asked to determine your impairment rating, or she may have been asked to determine your work ability, extent of your injury, etc. If a designated doctor has ever been appointed on your case, the only way you can dispute the impairment rating is by requesting a benefit review conference.

Impairment Rating BENEFITS

When you receive an impairment rating, you should be paid impairment income benefits (IIBs) if you have any permanent impairment. Impairment income benefits begin on the date selected to be your MMI date. You should be paid three weeks of benefits for every percentage of impairment you were awarded. So, if you got a 5% impairment rating, you should be paid 15 weeks of IIBs.

When you get paid IIBs, you should receive 70% of your average weekly wage. However, these benefits currently cap out at $853.00. Once IIBs are paid out, that will be the end of your monetary benefits unless you get at least a 15% impairment rating.

Hearing Process

When there are disputes that cannot be resolved through communication between the parties, the issues in dispute can be resolved through the Texas Department of Insurance, Division of Workers' Compensation. The hearing process starts with a party completing a DWC-45 form (Request for a Benefit Review Conference).

A notice will be sent to the involved parties to attend a Benefit Review Conference at the nearest field office. You should take whatever information/ evidence that will support your position to the benefit Review Conference.

Texas Department Of Insurance
Division of Workers' Compensation
Records Processing
7551 Metro Center Dr. Ste.100 • MS-94
Austin, TX 78744-1609
(800) 252-7031 (512) 804-4378 fax www.tdi.texas.gov

DWC Claim#
Carrier Claim#

← Send the completed form to this address.

Employee's Claim for Compensation for a Work-Related Injury or Occupational Disease (DWC Form-041)

Claim for workers' compensation must be filed by the injured employee or by a person acting on the injured employee's behalf **within one year** of the date of injury or within one year from the date the injured employee knew or should have known the injury or disease may be work-related.

I. INJURED EMPLOYEE INFORMATION

Name (First, Middle, Last)	**Social Security Number**	**Date of birth** (mm / dd / yyyy)
Address (street, city/town, state, zip code, county, country)		
Phone Number	**E-Mail address**	**Sex** ☐ Male ☐ Female
Race / Ethnicity ☐ White, not of Hispanic Origin ☐ Black, not of Hispanic Origin ☐ Hispanic ☐ Asian or Pacific Islander		
Do you speak English? ☐ Yes ☐ No If no, specify language		
Marital status ☐ Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced		
Do you have an attorney or other representation? ☐ Yes ☐ No **If yes, name of representative**		
Have you returned to work? ☐ Yes ☐ No	**If returned to work, date returned** (mm/dd/yyyy)	**Work status** ☐ Regular ☐ Restricted
Occupation at time of injury		**Date of hire** (mm / dd / yyyy)
Hired or recruited in Texas ☐ Yes ☐ No	**Pre-tax wages** (at the time of injury) $	☐ hourly ☐ weekly ☐ monthly

II. INJURY INFORMATION

I am reporting an ☐ injury or ☐ occupational disease	**Date of injury** (mm / dd / yyyy)	**Time of injury**
First work day missed (mm / dd / yyyy)	**Date injury was reported to the employer** (mm / dd / yyyy)	
Where did the injury occur? County	State	Country
If accident occurred outside of Texas, on what date did you leave Texas? (mm/dd/yyyy)		
Witness(es) to the injury (list by name)		
Describe cause of injury or occupational disease, including how it is work related		
Body part(s) affected by the injury		
If injury is the result of an occupational disease: **1. On what date was the employee last exposed to the cause of the occupational disease?** (mm / dd / yyyy) **2. When did you first know occupational disease was work related?** (mm / dd / yyyy)		

III. EMPLOYER INFORMATION (at the time of injury)

Employer name	**Employer address** (street, city/town, state, zip code, county, country)
Employer phone number	**Supervisor name**

IV. DOCTOR INFORMATION

Name of treating doctor	**Phone number**
Address (street, city/town, state, zip code)	
Name of workers' compensation health care network, if any	

Signature of injured employee or person filling out this form on behalf of injured employee — **Date**

Printed name of injured employee or person filling out form on behalf of injured employee

DWC041 Rev. 03/07

Page 1 of 1

BENEFIT REVIEW CONFERENCE (BRC)

A BRC is an informal hearing between the parties to see if the issues in dispute can be resolved without a formal hearing. A Benefit Review Officer (BRO) conducts the hearing which can last up to 45 minutes. The parties appear virtually using the Zoom application. During the BRC, parties may ask to caucus privately with the BRO or with their representative. The BRO will introduce the parties and then will allow the parties to state their positions and ask questions to help the parties reach a resolution. There can be four possible outcomes:

1. Resolution, the parties sign a DWC-24 (Benefit Dispute Agreement), which resolves the issues in dispute;
2. The parties set the issues for a Benefit Contest Case Hearing (CCH), to have the issues determined by a judge;
3. Reset the BRC (maximum of two BRCs), to allow the parties an opportunity to further develop their evidence;
4. Withdraw the disputed issue.

- Make sure that you have all the evidence you need by the time you attend the BRC.
- If you have an attorney, have a discussion before you are in the BRC. You don't want to share information that may hurt your case during the hearing.
- You only have 15 days to exchange your evidence after the BRC if you set a date for a CCH.

Benefit Contested Case Hearing (CCH)

The CCH is an administrative trial. An Administrative Law Judge (ALJ) presides over the hearing. The hearings are scheduled to last up to two hours. However, if it is not completed within that time, the hearing may be reset to finish the hearing at a future date.

The parties must bring copies of their exhibits for the other party and the ALJ. After the exhibits are admitted into evidence, the party with the burden of proof may provide their opening statement. The other party may then give their opening statement, or wait until their case in chief.

Then the party with the burden may call their witnesses. Once their witnesses are done, the other party begins their case in chief and may call witnesses to support their position. Usually, the injured worker goes first and the insurance company is second. After both parties have finished with their witnesses, the parties give closing statements to the ALJ. The closing statement should explain how the evidence supports your position. The ALJ will write a Decision & Order after reading through all the evidence and reviewing the testimony of the witnesses. The Decision & Order usually takes about two weeks to get to the parties.

- Know the issues that are dispute and stay on topic. The ALJ hears up to three cases per day. Let them remember your evidence and not other topics.
- Point out in your records the reports that help to establish your position.

APPEAL

The final step of the administrative process is to appeal the Decision & Order to the Division of Workers' Compensation Appeals Panel. The appeal is done in writing and there is no live testimony or argument.

The party appealing the Decision & Order must send copies to both the Appeals Panel and the other party explaining how the ALJ erred in making their decision. The other party then has an opportunity to provide a written response.

An appeal is effective if the ALJ makes an error in applying the law. Appealing arguments about the facts of the case will not result in a reversal. This is because the ALJ is the sole trier of fact. This means that only the ALJ gets to weigh the evidence and decide the truth about what happened or what to believe about the medical evidence. The Appeals Panel looks to make sure that the law was applied correctly to those facts decided by the ALJ.

The Appeals Panel may reverse the ALJ's Decision & Order and render a new one, reverse the Decision & Order and remand the case back to the ALJ to make a new Decision following their instructions, they may affirm the ALJ's Decision & Order, or they may let the Decision & Order become final as a matter of law.

Other Benefits

As explained in previous chapters, other than medical benefits, the most common benefits are Temporary Income Benefits (TIBs) paid for lost wages prior to a finding of Maximum Medical Improvement (MMI) and Impairment Income Benefits (IIBs) which are paid from the Impairment Rating (IR). However, there are other benefits that injured workers may pursue depending upon the circumstances and the level of their injury.

Supplemental Income Benefits

Injured workers who receive at least a 15% IR are eligible to pursue Supplemental Income Benefits (SIBs). The purpose of SIBs is to provide a supplement to the most injured workers while they are attempting to return to the workforce. Many are not able to return to the same type of employment and need to be trained in another profession.

SIBs start when the IIBs are fully paid. SIBs are reviewed on a quarterly basis and are paid monthly. The previous quarter is reviewed to determine the current quarter. As long as the injured worker stays eligible, they may receive SIBs for up to 401 weeks from the date of injury.

Chapter 10

Supplemental Income Benefits

An application (DWC-52 form) is submitted 14 days prior to the beginning of a quarter. The first quarter is determined by the Division of Workers' Compensation (DWC). All subsequent quarters are determined by the insurance company. Either party may dispute a determination of entitlement by requesting a Benefit Review Conference (BRC) within 10 days of receiving notice of a determination.

To qualify for SIBs, an injured worker must show they:

1. have an IR of 15% or more;
2. have not elected to commute a portion of the IIBs under Section 408.128 (taken a lump sum payment);
3. have not returned to work or have returned to work earning less than 80% of the their pre-injury wage as a direct result of their permanent impairment;
4. have completed and filed a DWVC-52; and
5. have not permanently lost entitlement to SIBs.

Each quarter is looked at separately from the other quarters. There are two determinations made when determining the quarter - entitlement and liability.

Entitlement: An injured worker is entitled to a quarter of SIBs If they meet one of the following criteria:

1. Have returned to work in a position which is commensurate with the IW's ability to work and is earning less than 80% of their pre-injury wage;
2. Have actively participated in a Vocational Rehabilitation Program as defined in Section 130.101;
3. Have actively participated in work search efforts conducted through the Texas Workforce Commission (TWC);
4. Have performed active work search efforts documented by job applications; or
5. Have been unable to perform any type of work in any capacity. In this case the injured worker must provide a narrative report from a doctor which specifically explains how the injury causes a total inability to work, and there must not be any other records showing that the injured worker is able to return to work.

- Make sure your Vocational Rehabilitation Program is through the Department of Assistive and Rehabilitation Services (DARs) to qualify easier.
- Even if you are unable to work most jobs, make at least the minimum number of contacts required by the TWC to qualify for unemployment in the county you reside.
- Do your job contacts online. If you do them through a service, you will have copies of the dates and and employers.
- Keep good records of all your efforts. If nothing else seems to work, start your own business.

SIBS APPLICATION

TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation (MS-603)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(800) 252-7031 | F: (512) 804-4378 | TDI.texas.gov | @TexasTDI

Please complete, if known:
DWC Number
Carrier Claim Number

Send **first** quarter SIBs applications to the TDI-DWC field office handling your claim. Send applications for all other quarters to the insurance carrier.

APPLICATION FOR SUPPLEMENTAL INCOME BENEFITS (DWC Form-052)

SECTION 1: EMPLOYEE INFORMATION

1. Employee's Name (Last, First, M.I.)	2. Social Security Number (last 4 digits) XXX-XX-	3. Telephone Number
4. Mailing Address (Street or P.O. Box, City, State, Zip Code)		5. Date of Injury
6. Current Treating Doctor's Name	7. Current Treating Doctor's Telephone Number	

SECTION 2: EMPLOYER / INSURANCE CARRIER INFORMATION

8. Employer's Name	9. Insurance Carrier's Name	
10. Adjuster's Name	11. Adjuster's Telephone Number	Extension

SECTION 3: SIBs QUALIFYING INFORMATION

12. Impairment Rating	13. Date of Maximum Medical Improvement	
14. Quarter Number	15. Filing Deadline	
16. Dates of Quarter	Beginning:	Ending:
17. Dates of Qualifying Period	Beginning:	Ending:
18. County of Residence:	19. Number of minimum weekly work search efforts for your county of residence:	

SECTION 4: WORK SEARCH ACTIVITIES FOR THE QUALIFYING PERIOD

To further document work searches, use the "Detailed Job Search / Employer Contact Log" on page 5 of this form.

Week Number	Check All That Apply		Notes and Type of Documentation Attached (see instructions)
Sample	☐ Unable to Work ☐ Working ☒ Vocational Rehab Program	☒ Work Search Efforts Number of Work Searches Conducted 3	Copy of my rehab plan from ABC Therapy; copies of three job applications. Two jobs found with assistance from staff at Workforce Dev't office, one job vacancy I found in the newspaper
1	☐ Unable to Work ☐ Working ☐ Vocational Rehab Program	☐ Work Search Efforts Number of Work Searches Conducted ____	
2	☐ Unable to Work ☐ Working ☐ Vocational Rehab Program	☐ Work Search Efforts Number of Work Searches Conducted ____	
3	☐ Unable to Work ☐ Working ☐ Vocational Rehab Program	☐ Work Search Efforts Number of Work Searches Conducted ____	
4	☐ Unable to Work ☐ Working ☐ Vocational Rehab Program	☐ Work Search Efforts Number of Work Searches Conducted	

DWC052 Rev. 02/17 Page 1 of 6

Lifetime Income Benefits

Injured workers with extreme injuries may qualify for Lifetime Income Benefits (LIBs). A date is determined as to when the injured worker becomes entitled to LIBs and then the worker receives 75% of their pre-injury wage with a 3% increase each year.

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. for a compensable injury that occurs on or after June 17, 2001, third degree burns that cover at least 40 percent of the body and require grafting, or third degree burns covering the majority of either both hands or one hand and face.

Even if the injured worker recovers and is able to work, the LIBs are paid until death. Insurance carriers are trying to challenge this determination, so be aware of it.

Death Benefits

If a worker is killed in the course and scope of employment, or they die as a result of their compensable injury, their dependents are entitled to beneficiary benefits. The benefit amount is equal to 75% of the deceased workers' Average Weekly Wage (AWW).

The following parties may be determined to be dependents of the deceased worker:

Spouse

The deceased worker's surviving spouse is entitled to receive death benefits unless:

1. the surviving spouse abandoned the deceased worker
2. without good cause
3. for more than one year immediately preceding the deceased worker's death.

All three elements must be met before a spouse can be denied death benefits. An ALJ may also determine that a common law marriage existed between the deceased worker and the dependant.

Child

A child is a son or daughter, an adopted child, or a stepchild who is a dependent of the deceased worker. The term "child" also includes a child that was conceived but unborn at the time of the worker's death.

A child who is eligible to receive death benefits must fall into one of three categories:

1. a minor at the time of the worker's death;
2. a full-time student attending an accredited educational institution under the age of 25; or
3. a dependent of the deceased work at the time of the worker's death.

Grandchild

A deceased worker's grandchild is entitled to receive death benefits if the grandchild was a dependent of the worker at the time of death unless the grandchild's own parent is eligible for benefits. An individual claiming benefits must submit proof of relationship and evidence of a dependency to the deceased worker.

Parent

If there is no eligible spouse, no eligible child, no eligible grandchild, and no surviving dependents of the dead employee who are parents, siblings, or grandparents of the dead employee, death benefits shall be paid in equal shares to the surviving mother or father of the dead employee, including an adoptive parent or stepparent, but not a parent whose parental rights have been terminated.

Third Party Claim

When an employer carries workers' compensation insurance, the employer is not liable for damages due to their negligence or the negligence of their agents or employees. However, if the injury occurred as the result of another person or company, the injured worker may have a claim for damages against the third party.

An example of a third party claim would be a car wreck on the job. For instance, if you are a plumber and you get in a wreck on the way to a customer's house because somebody ran a red light and hit you, then you have both a workers' comp claim and a third party claim against the negligent driver of the vehicle that hit you. The third party claim is handled like any other claim for damages. The Division ofWorkers' Compensation does not have any jurisdiction over the third party claim, except that the workers compensation insurance company will have a subrogation lien. The subrogation lien is against the injured workers' net proceeds and allows the insurance company to be reimbursed for the amount they have paid in benefits (including medical benefits). The insurance carrier also gets a credit against any future benefits it may owe until the owed benefits equal the injured workers' net recovery. This means that when you settle the third party claim, you have to pay back the workers' compensation insurance company, and that insurance company gets to stop paying money on your claim until you exhaust the money you got in the third party settlement on either your lost wages or medical treatment.

Gross Negligence Resulting in Death

The only time that the insured employer is not protected from claims for negligence is when the injuries occur as the result of the employers' gross negligence resulting in the injured workers' death.

The Texas Labor Code defines Gross Negligence as an act or omission:

1. which when viewed objectively from the standpoint of the actor at the time of its occurrence involves an extreme degree of risk, considering the probability and magnitude of the potential harm to others; and
2. of which the actor has actual, subjective awareness of the risk involved, but nevertheless proceeds with conscious indifference to the rights, safety, or welfare of others.

Unlike third party claims, the insurance carrier does not get a subrogation lien against claims for gross negligence resulting in death. The claim is separate from the workers' compensation claim and is not affected by even determinations of compensability.

Get a FREE Consultation Today
(214) 357-1782

- Third party claims usually arise with multiple companies working at the same site, motor vehicle accidents or using machinery that is defective.
- Coordinate with your workers comp attorney to get the best results from your third party claim.
- Use the workers compensation insurance carrier to help increase the value of the third party claim.
- Also use the carrier to help share in your litigation and expert costs.
- Also try to negotiate the subrogation lien.
- The deadline to file a gross negligence claim is different from the workers compensation claim. Most tort actions in Texas have a statute of limitations of two years. However, deppending on the employee the time may vary.
- If your loved one died from a company's gross negligence, consult an attorney immediatley to protect your right to pursue a claim.

WORKERS' COMP AND SOCIAL SECURITY DISABILITY

If you have not been able to return to work following your work injury, there is a fear lurking about happens after workers' compensation benefits run out. If you have been off work for a year, or expect to be off work for a year, then you may be eligible for
social security disability benefits, often referred to as SSDI.
There are a few requirements that you must meet to get social security disability. Here they are:

1. You should be age 65 or younger when you become disabled
2. You should have worked 5 out of the last 10 years
3. You will need to prove that you have a mental or physical condition that keeps you from being able to perform "substantial gainful activity," which means you have a very limited ability to work and earn wages
4. You must not be able to do the kind of work that you have done for the past 15 years
5. You must not be able to perform the physical demand level of work that your age and circumstances would dictate
6. Your inability to work must last for at least one year, or there must be an expectation that your inability to work will continue for at least one year

In too many instances, workers' comp insurance companies are denying their responsibilities to injured workers. As a result, injured workers are not getting the right treatment to recover from their injuries and return to work. And then, when the workers' comp money runs out, how are you supposed to survive? Often, you may qualify for social security disability benefits.

Free Social Security E-Book Download

451 Wrongful Termination

Texas law protects workers who get hurt and have to file a workers' compensation claim. That law prohibits your employer from firing you just because you file a workers' comp claim. It states:
An injured workers' employer may not discharge or in any other manner discriminate against an employee because the employee has:

1. filed a workers' compensation claim in good faith;
2. hired a lawyer to represent the employee in a claim;
3. instituted or caused to be instituted in good faith a workers' compensation proceeding; or
4. testified or is about to testify in a workers' compensation proceeding.

The 451 claim is brought against the employer who may have to reinstate the injured worker to their previous position and pay damages for any harm caused to the injured worker.

Chapter 11

Medical Disputes

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 term "health care" includes all reasonable and necessary medical aid, medical examinations, medical treatments, medical diagnoses, medical evaluations and medical service.

Medical Fee Dispute

A medical fee dispute is usually initiated by one of your doctors. This occurs because the insurance company has failed to pay one of your bills for treatment. When this happens, the doctor can request the Division to review the treatment provided, the bill, and the reason for denial and issue a decision resolving the dispute with the insurance company. Either party can appeal that decision through a Benefit Review Conference and an administrative trial at the State Office of Administrative Hearings.

Preauthorization Denials

Medical treatment in the Texas Workers Compensation system is paid by the insurance carrier directly to your medical provider. As discussed earlier, there are network and non-network claims. For non-network claims, the State determines which types of treatment and diagnostic studies may be done without preauthorization, and which do require preauthorization. In a network claim, the network determines which type of treatment requires preauthorization.

To get preauthorization, the medical provider will turn in a request to the insurance carrier. The insurance carrier will have the request reviewed by their Utilization Review Agent (URA). If the insurance carrier denies that request, your medical provider can appeal that decision by turning in a request for reconsideration within 15 days of receiving the denial from the insurance carrier.

If the insurance carrier maintains their denial after a second review, you or your medical provider can appeal this decision again. However, this time, the decision is taken away from the insurance company and it goes through an independent review organization (IRO). This appeal is through the Managed Care Quality Assurance Office, at the Texas Department of Insurance.

No later than 45 calendar days after receiving the denial for reconsideration, you or your health care provider can submit the request for an IRO review of the dispute. Then, the carrier or their URA submits a request for assignment to an IRO.

When you receive the second denial of preauthorization from the insurance company, there is a form near the back of that dispute that is the request for an IRO. There is a notation in

the dispute letter, usually buried in the paragraphs of information that mean nothing, telling you where the request for an IRO must be sent.

The IRO receives all of the relevant documentation from the insurance company, along with the request for IRO that you or your doctor files. You can expect a decision back in 20 to 30 days, depending on the type of preauthorization dispute that is filed. For those with life threatening conditions, the IRO decision must come back within 8 days.

Once the IRO decision comes out, all parties have to abide by that decision. Either party can appeal the IRO decision by requesting a contested case hearing on the medical necessity

of the proposed treatment. A request for a CCH must be submitted to the Chief Clerk of Proceedings, in writing, no later than 20 days after the IRO decision is sent to the parties. This will be a hearing in front of an administrative law judge for a determination of whether or not you get to have the treatment requested. You will need your doctor's help to prove that you need the requested treatment. After all, that's who ordered it.

- Third party claims usually arise with multiple companies working at the same site, motor vehicle accidents or using machinery that is defective.
- Coordinate with your workers comp attorney to get the best results from your third party claim.
- Use the workers compensation insurance carrier to help increase the value of the third party claim.
- Also use the carrier to help share in your litigation and expert costs.
- Also try to negotiate the subrogation lien.
- The deadline to file a gross negligence claim is different from the workers compensation claim. Most tort actions in Texas have a statute of limitations of two years. However, deppending on the employee the time may vary.
- If your loved one died from a company's gross negligence, consult an attorney immediatley to protect your right to pursue a claim.

Conclusion

As explained throughout this guide, workers' compensation laws in Texas are always changing. What may be good law today, may no longer be valid in the near future. Our strong advice is that anyone who has suffered a work related injury at least consult with an attorney to understand all their rights and the different claims that they may have.

APPENDIX

DWC Offices

Division of Workers' Compensation Central Office
7551 Metro Center Drive, Suite 100
Austin, TX, 78744-1645
800-252-7031

Abilene
1290 S. Willis, Suite 102
Abilene, TX 79605-4064
800-252-7031
325-695-9789

Amarillo
7112 IH-40, West, Bldg. D
Amarillo, TX 79106-2503
800-252-7031
806-351-1444

Austin
Barbara Jordan Building
1601 Congress Ave.
Austin, TX 78701
800-252-7031
512-928-4875

Beaumont
Concord Square Office Park
6430 Concord Rd.
Beaumont, TX 77708-4315
800-252-7031
409-899-5207

Corpus Christi
5155 Flynn Parkway, Suite 218
Corpus Christi, TX 78411-4 316
800-252-7031
361-881-8631

dallas
1250 W. Mockingbird Lane, Suite 200
Dallas, TX 75247-6952
800-252-7031
214-350-3750

Denton
Dallas Dr. Tech Center
625 Dallas Dr., Suite 475
Denton, TX 76205-5299
800-252-7031
940-380-1408

El Paso
El Paso State Office Building
401 East Franklin Avenue, Ste 330
El Paso, TX 79901-1250
800-252-7031
915-351-5272

Fort Worth
150 Westpark Way, Suite 345
Euless, TX 76040-3708
800-252-7031
817-446-5060

Houston West
350 N. Sam Houston Pkwy. E. # 110
Houston, TX 77060-3318
800-252-7031
281-272-1089

Lubbock
22 Briercroft Office Park, Suite A
Lubbock, TX 79412-3089
800-252-7031
806-7 40-0092

Midland/ Odessa
Executive Office Park
4500 West Illinois Avenue, # 315
Midland, TX 79703-5486
800-252-7031
432-699-7309

San Antonio
The Brownwood Building
4440 S Piedras Drive, Suite 205
San Antonio, Texas 78228-1217
800-252-7031
210-593-0062

Waco
Raleigh Building
801 Austin Ave., Suite 840
Waco, TX 76701-1937
800-252-7031
254-755-7499

Houston East
Elias Ramirez Building
5425 Polk Street, Suite 130
Houston, TX 77023-1454
800-252-7031
713-514-0713

Laredo
500 E Mann Road, Suite B2
Laredo, TX 78041-2630
800-252-7031
956-725-8771

lufkin
310 Harmony Hill Drive, Suite 100
Lufkin, TX 75901-5953
800-252-7031
936-639-6406

San Angelo
State ofTexas Services Center
622 S. Oakes, Suite M
San Angelo, TX 76903-7035
800-252-7031
325-659-8536

Tyler
3800 Paluxy Drive, Suite 570
Tyler, TX 75703-1665
800-252-7031
903-534-5276

Weslaco
1108 West Pike Blvd.
Weslaco, TX 78596-4651
800-252-7031
956-447-4775

An injured Ombudsman hired the attorneys at MLF Legal and had this to say:

I was an Ombudsman who sustained a head injury while on the job. After researching several attorneys, I felt MLF Legal had the best experience and track record to help me win my case. I was right!

I had nowhere to turn, except an attorney, and I am completely confident that I chose the best one to represent me. When I started my dispute, I did not even have a doctor to assist me with my dispute and through a concerted effort, MLF Legal was able to help me see four doctors that all supported my position. While no case is guaranteed, as a prior Ombudsman I know that the medical evidence is a critical piece of the puzzle to ensure a positive outcome. With their help, I was able to see physicians who provided professional, unbiased opinions and ultimately I received the victory.

It was necessary in my particular case to proceed to a Contested Case Hearing which is time consuming and difficult to orchestrate. However, the lawyers at MLF Legal were by my side every step of the way. I never felt alone. If I ever had any question or concern, they would take my calls. I cannot say enough about how MLF Legal went above and beyond what I would have ever expected from an attorney to assist me throughout the entire dispute process. They are kind, compassionate yet highly educated and exceedingly knowledgeable attorneys with regard to the Worker's Compensation system. This is a tricky process and as a prior Ombudsman I am fully aware of all the intricacies and details involved in preparing for and setting up a case to present to an Administrative Law Judge who ultimately holds the key to your victory or defeat. Never did I ever regret hiring MLF Legal.

Thanks to MLF Legal, I am now currently being paid the benefits that were previously denied to me, all thanks to my attorneys, and I can look forward to continued weekly payments while I proceed with my rehabilitation that was only made possible because of MLF Legal. I will never be able to express the gratitude that I have for their assistance and representation. Without hesitation, I highly recommend MLF Legal to anyone needing assistance.

Valerie
Previously an Ombudsman at the Division of Workers' Compensation