SUBCHAPTER A. GENERAL RULES FOR ENFORCEMENT
28 TAC §§180.1-180.3, and 180.8

SUBCHAPTER B. MEDICAL BENEFIT REGULATION
28 TAC §§180.22, 180.24-180.28, and 180.50

1. INTRODUCTION. The Commissioner of Workers' Compensation (Commissioner), Texas Department of Insurance (Department), Division of Workers' Compensation (Division) adopts amendments to §§180.1 - 180.3, 180.8, 180.22, 180.24, 180.25, 180.27 and 180.28 of this title (relating to Definitions; Filing a Complaint; Compliance Audits; Notices of Violation; Notices of Hearing; Default Judgments; Health Care Provider Roles and Responsibilities; Financial Disclosure; Improper Inducements, Influence and Threats; Sanctions Process/Appeals/Restoration; Peer Review Requirements, Reporting, and Sanctions; respectively) and adopts new §180.26 of this title (relating to Criteria for Imposing, Recommending, and Determining Sanctions; Other Remedies) and §180.50 of this title (relating to Severability). Sections 180.1, 180.2, 180.8, 180.22, and 180.24 - 180.28 are adopted with changes to the proposed text published in the August 27, 2010, issue of the *Texas Register* (35 TexReg 7645) and will be republished. Sections 180.3 and 180.50 are adopted without changes and will not be republished.*****

The adopted rules conform the rules with various statutory amendments and generally concern the regulation and duties of system participants and provide an overall description of certain enforcement procedures such as filing a complaint. The adopted rules are necessary to implement and enforce statutory provisions of House Bill 7 (HB 7), enacted by the 79th Legislature, Regular Session, effective September 1, 2005; House Bill 34 (HB 34), House Bill 1003 (HB 1003), House Bill 1006 (HB 1006), and House Bill 2004 (HB 2004) enacted by the

80th Legislature, Regular Session, effective September 1, 2007; and House Bill 4290 (HB 4290), enacted by the 81st Legislature, Regular Session, effective September 1, 2009. The adopted rules are necessary to implement amendments to existing statutes and update existing rules, such as the rules that pertain to the approved doctor list that expired on September 1, 2007. The Division has also adopted the simultaneous repeal of existing §§180.6, 180.7, 180.10 - 180.18, 180.20, and 180.26 of this title (relating to guidelines for establishing evidence of patterns of practice, the schedule of administrative penalties for violations, and the Approved Doctors List (ADL)) which are published elsewhere in this issue of the *Texas Register.*

In accordance with Government Code §2001.033(a)(1), the Division's reasoned justification for these rules is set out in this order, which includes the preamble, which in turn includes the rules. The preamble contains a summary of the factual basis of the rules, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were in support of or in opposition to adoption of the rules, and the reasons why the Division agrees or disagrees with some of the comments and recommendations.

The public hearing was held and the public comment period closed on September 27, 2010.

2. REASONED JUSTIFICATION. Changes to the Labor Code by HB 7 amended the Labor Code to enhance the enforcement authority of the Division. Labor Code §401.011 expanded the definition of "sanction" to include penalties (fines) or other punitive actions or remedies imposed by the Commissioner of Workers' Compensation (Commissioner) for violations of decisions of the Commissioner. Labor Code §401.011 added the definition of "violation" to

mean an administrative violation subject to penalties and sanctions as provided by the Texas Workers' Compensation Act, Labor Code, Title 5, Subtitle A (Act) and expanded the definition of "administrative violation" to include a violation of an order or decision of the Commissioner that is subject to penalties and sanctions as provided by the Act. Labor Code §401.011 replaced the definition of "commission" with a definition for "commissioner" to mean "the commissioner of workers' compensation." Labor Code §401.011 added a definition for "department" to mean "the Texas Department of Insurance." Labor Code §401.011 added a definition for "division" to mean "the division of workers' compensation of the department." Labor Code §401.011 added a definition for "health care reasonably required" to mean "health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices consistent with evidence-based medicine; or if that evidence is not available, generally accepted standards of medical practice recognized in the medical community." Labor Code §401.021 was amended to apply to the Division. Labor Code §402.001 was amended to provide that except as provided by Labor Code §402.002, the Texas Department of Insurance is the state agency designated to oversee the workers' compensation system of this state and the Division of Workers' Compensation is established as a division within the Texas Department of Insurance to administer and operate the workers' compensation system as provided by Labor Code, Title 5.

Labor Code §402.00111 was added and describes the relationship between the Commissioner of Insurance and the Commissioner of Workers' Compensation, the separation of authority, and rulemaking authority. Labor Code §402.00128 was added and provides the general powers and duties of the Commissioner. Labor Code §402.0016 was added and describes the duties and powers of the Commissioner as the Division's chief executive and

administrative officer. Labor Code §402.023 was amended and states that the Commissioner shall adopt rules regarding the filing of a complaint under the Act against an individual or entity subject to regulation under the Act; and ensure that information regarding the complaint process is available on the Division's Internet website. The Division is required to, at a minimum, ensure that the rules adopted by the Division clearly define the method for filing a complaint; and define what constitutes a frivolous complaint under the Act. The Division is also required to develop and post on the Division's Internet website a simple standardized form for filing complaints under the Act and information regarding the complaint filing process. Labor Code §402.0235 requires the Division to assign priorities to complaint investigations under the Act based on risk. In developing priorities, the Division is required to develop a formal, risk-based complaint investigation system that considers the severity of the alleged violation; whether the alleged violator showed continued or willful noncompliance; and whether a Commissioner's order has been violated. Labor Code §402.0235 also provides that the Commissioner may develop additional risk-based criteria as determined necessary.

Labor Code §402.024(b) requires the Division to comply with federal and state laws related to program and facility accessibility. Labor Code §402.061 requires the Commissioner to adopt rules as necessary for the implementation and enforcement of the Act. Labor Code §402.072 provides that the Division may impose sanctions against any person regulated by the Division under the Act and a sanction imposed by the Commissioner is binding pending appeal. Labor Code §402.073 requires that in a case in which a hearing is conducted in conjunction with Labor Code §§402.072, 407.046, or 408.023, and in other cases under the Act that are not subject to Labor Code §402.073(b), the administrative law judge who conducts the hearing for

the State Office of Administrative Hearings shall propose a decision to the Commissioner for final consideration and decision by the Commissioner.

Labor Code §402.075 was added and provides the requirements for rules that pertain to incentives and performance-based oversight.

Labor Code §408.0041 provides additional requirements related to designated doctor examinations. Labor Code §408.023 applies to the Division and provides requirements for doctors who contract with workers' compensation health care networks certified under Insurance Code Chapter 1305; for the expiration of the approved doctor list effective September 1, 2007; for requirements that the Commissioner may establish by rule for doctors and other health care providers; and for requirements that doctors and insurance carriers must comply with. Labor Code §408.0231 has been amended to apply to the Division and requires the Commissioner to adopt rules regarding doctors who perform peer review functions under the Act. Labor Code §408.0231(g) authorizes the Commissioner to adopt rules regarding doctors who perform peer review functions for insurance carriers, such as, standards for peer review, sanctions against doctors performing peer review functions (including restriction, suspension, or removal of the doctor's ability to perform peer reviews) and other issues important to the quality of peer review. Labor Code §408.1225 was amended and provides the Commissioner with additional authority to ensure the quality of designated doctor decisions and reviews through active monitoring of decisions and reviews and to take action as necessary to restrict the participation of a designated doctor or remove a doctor from inclusion on the Division's list of designated doctors. Labor Code §408.1225(a) requires the Division to develop qualification standards and administrative policies pertaining to the doctors who serve on the designated doctor list. Labor Code §408.1225(d) requires the Division to develop rules to ensure that a

designated doctor has no conflict of interest in serving as a designated doctor in performing examinations.

Labor Code §413.002 requires the Division to monitor health care providers, insurance carriers, independent review organizations, and workers' compensation claimants who receive medical services, to ensure the compliance of those persons with rules adopted by the Division relating to health care, including medical policies and fee guidelines. Labor Code §413.002(b) requires that in monitoring designated doctors under Labor Code, Chapter 408, and Independent Review Organizations (IRO) who provide services described by Labor Code, Chapter 413, the Division is to evaluate compliance with the Act and with rules adopted by the Commissioner relating to medical policies, fee guidelines, treatment guidelines, return-to-work guidelines, and impairment ratings and the quality and timeliness of decisions made under Labor Code §§408.0041, 408.122, or 413.031. Labor Code §413.022 has been added and provides requirements for the return-to-work reimbursement pilot program for small employers. Labor Code §413.031 pertains to medical dispute resolution and was amended to require that the decision of an IRO under Labor Code §413.031(d) is binding during the pendency of a dispute. Labor Code §413.032 provides requirements regarding the content of IRO decisions for reviews conducted under Labor Code, Chapter 413. Labor Code §413.041 requires the Commissioner to define "financial interest" for the purpose of the section as provided by analogous federal regulations and to adopt the federal standards that prohibit the payment or acceptance of payment in exchange for health care referrals relating to fraud, abuse, and anti-kickbacks. Labor Code §413.044 provides additional sanctions that may be imposed on designated doctors. Labor Code §413.0511 requires that the Medical Advisor shall make recommendations regarding the adoption of rules and policies to monitor the quality and

timelines of decisions made by designated doctors and independent review organizations, and the imposition of sanctions regarding those decisions. Labor Code §413.0512 requires that the medical quality review panel shall recommend to the Medical Advisor appropriate action regarding independent review organizations. Labor Code §413.052 requires the Commissioner to establish by rule procedures to enable the Division to compel production of documents.

Labor Code §§414.002 - 414.003 and 414.005 - 414.007 pertain to the Division's monitoring duties, compilation and maintenance of statistical and other information, investigative duties, referral of persons to appropriate authorities, medical review, and investigation of alleged violations. Labor Code §414.002 includes health care providers as persons to be monitored by the Division. Labor Code §414.003 includes the provision that the Division shall also compile and maintain statistical and other information as necessary to detect practices or patterns of conduct by persons subject to monitoring under Labor Code, Chapter 414 that violate a rule, order or decision of the Commissioner. Labor Code §414.005 includes the provision that the Division shall maintain an investigation unit to conduct investigations relating to alleged violations of a rule, order, or decision of the Commissioner. HB 7 amendments to Labor Code §414.006 deleted the provision that the Division may refer persons involved in a case subject to investigation to the division of hearings. Labor Code §414.007 includes the provision that the Division shall review information concerning an alleged violation regarding the provision of medical benefits, or a rule, order or decision of the Commissioner.

The HB 7 amendments to §§415.001 - 415.0035 modified various provisions related to violations under the Act. The HB 7 amendments to Labor Code §§415.005, 415.006, and 415.024 delete the classification of the violations as either class A, B, or C violations. Labor Code §415.021 was amended to delete the provision which stated an administrative penalty

should not exceed $10,000, and Labor Code §415.021 now permits the Division to assess administrative penalties of up to $25,000 per violation in addition to any other sanctions authorized by the Act. Labor Code §415.021 also states that each day of noncompliance constitutes a separate violation and subsection (c) lists the factors the Division must use when determining penalty amounts. Labor Code §415.025 provides that a reference in the Labor Code or other law, or in rules of the former Texas Workers' Compensation Commission or the Commissioner, to a particular class of violation, administrative violation, or penalty shall be construed as a reference to an administrative penalty and, except as otherwise provided by Labor Code, Title 5, Subtitle A, an administrative penalty may not exceed $25,000 per day per occurrence and each day of noncompliance constitutes a separate violation. One example of other sanctions that may be imposed under Labor Code, Title 5, are found in Labor Code §408.0231(b). Labor Code §415.023(b) and §402.072 also provide authority for the Division to impose sanctions. HB 7 amended Labor Code §415.024 by deleting the classification of the penalty to be imposed as a Class A violation and now provides that a violation of the statute is an administrative violation. Labor Code §415.031 and §415.032 were amended to delete "director", "compliance and practices" and "commission." Labor Code §415.032 also requires that not later than the 20th day after the date on which notice of violation is received by a charged party, the charged party shall remit the amount of the penalty to the Division or submit to the Division a written request for a hearing. Labor Code §415.033 requires that if without good cause a charged party fails to respond as required under Labor Code §415.032, the penalty is due and the Division shall initiate enforcement proceedings. Labor Code §504.053 was amended to provide requirements for political subdivisions that self-insure that relate to workers' compensation.

House Bill 34 added Labor Code §415.0036 which applies to an insurance adjustor, case manager, or other person who has authority under Labor Code, Title 5 to request the performance of a service affecting the delivery of benefits to an injured employee or who actually performs such a service, including peer reviews, performance of required medical examinations, or case management. A person described by this statute commits an administrative violation if the person offers to pay, pays, solicits, or receives an improper inducement relating to the delivery of benefits to an injured employee or improperly attempts to influence the delivery of benefits to an injured employee, including through the making of improper threats.

House Bill 1003 added Labor Code §413.031(e-2) to require that IROs that use doctors to perform reviews of health care services provided under Labor Code, Title 5 only use doctors licensed to practice in this state.

House Bill 1006 amended Labor Code §408.023(h) to require that a utilization review agent or an insurance carrier that uses a doctor to perform reviews of health care services provided under Labor Code, Title 5, Subtitle A, including utilization review, only use doctors licensed to practice in this state.

House Bill 2004 added Labor Code §408.0043. Labor Code §408.0043(a) applies to doctors, other than chiropractors or dentists, who perform health care services under Labor Code, Title 5 as doctors performing peer reviews, utilization reviews, independent reviews, required medical examinations, or who serve on the medical quality review panel or as designated doctors for the Division. Labor Code §408.0043(b) requires that a doctor described by Labor Code §408.0043(a), other than a chiropractor or dentist, 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.

House Bill 2004 added Labor Code §408.0044 which pertains to dentists who perform dental services under Labor Code, Title 5 for peer reviews, utilization reviews, independent reviews, or required dental examinations. Labor Code §408.0044(b) requires that a dentist who reviews a dental service in conjunction with a specific workers' compensation case must be licensed to practice dentistry. House Bill 2004 added Labor Code §408.0045 which pertains to chiropractors who perform chiropractic services under Labor Code, Title 5 for peer reviews, utilization reviews, independent reviews, required medical examinations, or who serve on the medical quality review panel or as designated doctors providing chiropractic services for the Division. Labor Code §408.0045(b) requires that a chiropractor who reviews a chiropractic service in conjunction with a specific workers' compensation case must be licensed to engage in the practice of chiropractic.

House Bill 2004 added Labor Code §408.0046 and states that the Commissioner may adopt rules as necessary to determine which professional health practitioner specialties are appropriate for treatment of certain compensable injuries and must require an entity requesting a peer review to obtain and provide to the doctor providing the peer review services all relevant and updated medical records.

House Bill 4290 amended Insurance Code §4201.002(13) which provides that "utilization review" includes a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services; the term does not include a review in response to an elective request for

clarification of coverage. Insurance Code §4201.002(1) was amended by HB 4290 and provides that "adverse determination" means a determination by a utilization review agent that health care services provided or proposed to be provided to a patient are not medically necessary or are experimental or investigational. Additionally, Labor Code §413.014 requires a determination of medical necessity for experimental or investigational services. Insurance Code §1305.004 was amended to include within the meaning of independent review, a final review by an independent review organization of the experimental or investigational nature of health care services provided, proposed to be provided, or that have been provided to an injured employee. Insurance Code §1305.351, as amended by HB 4290, provides that a utilization review agent or insurance carrier that uses doctors to perform reviews of health care services provided under Insurance Code, Chapter 1305, including utilization review, or peer reviews under Labor Code §408.0231(g), may only use doctors licensed to practice in this state.

The Division has changed some of the proposed language in the text of the rule as adopted in response to public comments received. The Division has also made some changes for clarification and editorial reasons. The changes, however, do not materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

The Division received comments recommending that the Division should delete the language "shall have the following meaning, unless the context clearly indicates otherwise" because it may be confusing. In response, the Division has not adopted the language in §180.1(a).

The Division received comments recommending that the Division should modify the definition for peer review in §180.1 because it is overly broad and inconsistently used by the Division. In response the Division adopted the revised definition for peer review in §180.1(a)(19) of this title to mean an administrative review by a health care provider performed at the insurance carrier's request without a physical examination of the injured employee.

The Division received a comment recommending that the Division should not include a definition for utilization review in §180.1 because it is redundant and unnecessary since Insurance Code Chapter 4201 defines utilization review. In response the Division has not adopted the definition in these rules because the definition in Labor Code §401.011(42-a), which references Insurance Code Chapter 4201, will be utilized.

The Division received a comment recommending that the Division should delete §180.1(b) because it is confusing. In response, the Division has not adopted subsection (b) of adopted §180.1.

The Division received comments recommending that the Division should modify §180.2 to remove the provisions for anonymous complaints. In response the Division has modified §180.2 of this title and removed provisions for anonymous complaints.

The Division received comments recommending that the Division should clarify §180.8 and the statutory authority and jurisdiction of the Division to review or modify decisions issued by an ALJ from SOAH. In response the Division has clarified §180.8(f) of this title by adding the language "or the entity having the final decision making power" and also clarified §180.8(g) and (h) of this title by adding the language "the entity having the final decision making power." Each determination will be made on a case by case basis.

The Division received a comment requesting that the Division change §180.22(a) to clarify that subsection (a) pertains to health care providers "as defined in subsections (c) - (e)." In response, the Division has adopted the language in §180.22(a).

The Division received a comment requesting that the Division change §180.22(c) to clarify that among the duties and responsibilities of treating doctors is the duty to perform examinations on injured employee to determine a date of maximum medical improvement and to assign impairment ratings. In response, the Division has clarified adopted §180.22(c) to include that a duty and responsibility of the treating doctor is to examine an injured employee to determine a date of maximum medical improvement and assign impairment ratings when appropriate.

The Division received a comment requesting that the Division change §180.22(e) so that it synchronizes with the timeframe for referral doctors to submit a timely report in §129.5(d) - (f) and §133.20(h) of this title. In response the Division has clarified §180.22(e)(2) of this title to require that the referral doctor shall timely report the injured employee's status to the treating doctor and insurance carrier as required by applicable Division rules.

The Division received comments recommending that the Division modify and strike portions of §180.22 (g)(1) - (2). In response the Division has clarified §180.22(g) of this title to mean that a peer reviewer is a health care provider who performs an administrative review at the insurance carrier's request without a physical examination of the injured employee.

The Division received comments recommending that the Division clarify §180.22(i) because it was confusing. In response the Division clarified §180.22(i) of this title by including dentists and deleting the citation to Labor Code §413.0512.

The Division received comments requesting that the Division modify §180.24(b) to require a 30 day deadline for filing disclosures outside of those required annually. In response the Division has kept the current rule language in this subsection unchanged which requires the health care practitioner to file a disclosure with the division within 30 days of the date the first referral is made unless the disclosure was previously made.

The Division has made a non-substantive change to adopted §180.25(a) by adding "examinations by designated doctors." Labor Code §415.0036 applies to persons who have authority under Labor Code, Title 5 to request the performance of a service affecting the delivery of benefits to an injured employee or who actually perform such a service. Labor Code §415.0036(a) contains a list that is not an exhaustive list of those persons to whom the section applies. Designated doctors perform examinations of injured employees that affect the delivery of benefits to injured employees and therefore must comply with the statute.

The Division received comments requesting that the Division modify §180.26(a) to clarify that workers' compensation insurance carriers do not render medical treatment in the Medicare or Medicaid programs nor do they bill for medical services within the Medicare or Medicaid programs and therefore cannot be sanctioned for adverse findings by the Medicare or Medicaid programs. In response the Division has modified adopted §180.26(a) by deleting the list of acts in that subsection. The Division has, for clarity, replaced that list with a statutory reference in adopted §180.26(b) to Labor Code §408.0231(c) which is the statute upon which the list in proposed §180.26(a) was based.

The Division received comments recommending that the Division delete or modify §180.26(e). In response, the Division has modified §180.26(e)(6) to provide that evidence of heightened awareness of the person's legal duty to comply with the Act and Division rules shall

be considered when the Division determines which sanction and the severity of the sanction to impose.

The Division received comments recommending that the Division delete or modify §180.26(g) relating to warning letters. In response, the Division has modified §180.26(g) to state that as an alternative to imposing a sanction such as an administrative penalty on a charged system participant, the division may, at its discretion, provide formal notice of the violation through a Warning Letter and the Warning Letter shall include a summary of the duty that the division believes that the charged system participant failed to fulfill or timely fulfill; identify the facts that establish that a violation occurred; and inform the charged system participant that subsequent noncompliance of the same sort may be deemed to be a repeated administrative violation or matter of practice any of which will be subject to sanction. The language has been recodified from prior rule §180.8(f). The term "pattern of practice" has been replaced with the term "matter of practice" because the term "matter of practice" appears in Labor Code §415.023 and is defined in adopted §180.26(c) to implement that statute.

The Division received a comment that the Division should more closely track the language from Labor Code §408.0231(d)(2) in §180.27(d). In response to the comment, the Division has clarified adopted §180.27(d) to provide that in accordance with Labor Code §408.0231(d)(2) a doctor, other than a doctor to which Labor Code §408.023(r) applies may apply for the restoration of a doctor privilege removed under Labor Code §408.0231 by sending a letter of consideration to the Medical Advisor.

The Division received comments recommending that the Division remove or modify the requirement in §180.28(a) that the peer reviewer's report shall include the name and professional license number of all health care providers related to the treatment under review,

the requirement to list all documents reviewed related to the claim, and a full clinical history. In response the Division modified §180.28(a) of this title by deleting §180.28(a)(7) and (a)(8) which required "the name and professional license number of all health care providers whose treatment, review, or any other service related to the claim is the subject of the review" and "for return-to-work, compensability, extent of injury, or other related issues, the name and professional license number of the injured employee's treating doctor."

3. HOW THE SECTION(S) WILL FUNCTION. Section 180.1 of this title sets forth the definitions of the terms used in the rules. Section 180.2 outlines the method for filing a complaint with the Division and explains what constitutes a frivolous complaint. Section 180.3 sets out the Division's process for compliance audits. Section 180.8 establishes the Division's procedures for issuing notices of violation, notices of hearing, and processing default judgments. Section 180.22 describes and sets forth health care provider roles and responsibilities. Section 180.24 sets forth the Division's financial disclosure requirements for health care providers and defines terms that are used within the section. Section 180.25 sets forth the acts that the Division deems to be improper inducements, attempts to influence or threat, and violations of applicable federal standards by system participants that are administrative violations. Section 180.26 sets forth the criteria for imposing, recommending and determining sanctions or other remedies, and establishes the use and purpose of warning letters. Section 180.27 sets forth the procedure for the Commissioner to modify, amend, or change a recommended finding of fact or conclusion of law or order of the ALJ and the procedure for doctors to apply for restoration of practice privileges removed by the Division. Section 180.28 sets forth requirements for peer review reports, requests for peer review,

maintenance of records related to peer reviews by insurance carriers and peer reviewers, sanctions against health care providers performing peer review, submission of peer review reports, and submission of medical records to doctors providing peer review. Section 180.50 is the severability clause for the chapter.

4. SUMMARY OF COMMENTS AND AGENCY'S RESPONSE TO COMMENTS.

Comment: A commenter is concerned that the proposed rule amendments do not incorporate the PBO concept into each element of the Division's and Department's workers' compensation compliance and enforcement processes. It is the commenter's position that the Division's compliance monitoring and audit programs along with the Department's workers' compensation enforcement programs must incorporate the PBO concept. It is also the commenter's opinion that regulatory oversight efforts should solely focus on insurance carriers and health care providers identified as poor performers through the PBO process; and that efforts to bring action against insurance carriers and health care providers not identified as poor performers through the PBO process should be discontinued.

Agency Response: The Division disagrees. The Act allows for sanctions against insurance carriers and health care providers regardless of whether the system participant is a poor performer through the PBO process. PBO performance is one of many factors considered when taking enforcement action and is included in adopted §180.26(e). PBO performance does not excuse improper conduct but will be considered when determining administrative actions to be taken and sanctions.

Comment: A commenter states "…rule changes with regard to doctor lists, licensed in the state only approvals, and Title 5 with regard to approved doctors to conduct peer reviews, utilization reviews, IRO appears to be increasingly difficult to manage."

Agency Response: The Division acknowledges commenter's concerns, however, the Division is required to implement statutory changes.

Comment: A commenter summarizes that changes to the complaint process includes a formal, risk-based complaint investigation system which appears to be more comprehensive than in the past. The commenter is unsure how this may impact insurance carriers.

Agency Response: The language of the adopted rule conforms with the statutory changes made by HB 7 that took effect in 2005 and continues to fulfill the legislative intent.

Comment: A commenter states the Division is authorized to collect, compile and maintain statistical and other information as necessary to detect patterns and practices under Labor Code §414.003, but that it is unclear if this includes additional reporting requirements for insurance carriers. The commenter further states that the proposal preamble describes data collection for the possible use of evaluating patterns and practices and the repeals remove guidelines to establish patterns of practices along with the resulting schedule of penalties. The commenter is of the opinion that the repeal of guidelines to establish patterns of practices along with the resulting schedule of penalties may be a favorable change to insurance carriers. However, the commenter finds it unclear if new data requirements offset the benefits from the repeal of guidelines that establishes patterns of practices along with the resulting schedule of penalties. The commenter also asks what type of new data may be required.

Agency Response: The Division cannot speculate on data that may be required in the future; however, nothing in this adopted rule is intended to limit the Division's ability to collect data.

Comment: A commenter states that the description of Labor Code §402.075 in the preamble does not make clear the statutory requirements for the rules for performance based oversight (PBO) or if there will be any changes to the current Division rules for PBO.

Agency Response: Section 180.19 of this title was not a rule proposed to be amended and is beyond the scope of these rules. Adopted §180.26(e) provides that a PBO assessment is a factor the Division shall consider when determining which sanction to impose against a system participant and the severity of that sanction.

Comment: A commenter states the initial description of Labor Code §402.072 in the preamble is not clear in its application to the proposed amendments.

Agency Response: The Division disagrees with the comment but offers more clarification. Pursuant to Labor Code §402.072 the Division may impose sanctions against any person regulated by the Division under the Act. Only the Commissioner of Workers' Compensation may impose a sanction that deprives a person of the right to practice before the Division or of the right to receive remuneration under the Act for a period exceeding 30 days; or another sanction suspending for more than 30 days or revoking a license, certification, or permit required for practice in the field of workers' compensation. A sanction by the Division is binding pending appeal. This chapter applies to monitoring and enforcement and contains Division regulations related to sanctions of "persons regulated by the Division under the Act."

Comment: A commenter summarizes that in the preamble it is explained that HB 7 expanded the definition of sanctions in Labor Code §401.011 and that the definition of sanctions references violations. The commenter states that there is concern over fines, sanctions and violations, increasing from $10,000 to $25,000 per violation with each day of non-compliance constituting a separate violation. The commenter is unsure how this may impact insurance carriers.

Agency Response: The language of the adopted rule conforms with the statutory changes made by HB 7 that took effect in 2005 and continues to fulfill the legislative intent.

§180.1(a)

Comment: A Commenter states that language in proposed §180.1(a) "shall have the following meanings, unless the context clearly indicates otherwise" is inappropriate and should be removed. The commenter states such a concept could lead to confusion about the regulatory definitions of specific terms. The commenter also asks why the Division would include a definition of a term in this section if it was not going to have a specific meaning as defined.

Agency Response: The Division agrees and has clarified adopted §180.1; however, the general rules of statutory and rule construction still apply.

Comment: A commenter suggests the addition of a definition for injured employee stating that many individuals initiate workers' compensation claims that are neither an employee and/or injured. The commenter suggests "injured employee" be defined as "any person who makes a claim for benefits pursuant to Labor Code, Title 5, because of an allegation that he or she has sustained a compensable injury."

Agency Response: The Division disagrees because it is unnecessary to add a definition for injured employee. The Act and Division rules provide regulation for claims.

§180.1(a) and §180.26(a)

Comment: Commenter states that the definition for "pattern of practice" was removed resulting in it not being defined for Chapter 180 of this title; however, the term is still used in the proposed rules. One commenter states that it appears that "a pattern of practice" will be equivalent to a single violation and requests the subsection be clarified to ensure a single action is not considered a "pattern of action". Commenter suggests the following language: "The division shall take into account in determining whether and the extent to which to impose sanctions whether there has been a willful violation of any law and may take into account whether there has been a pattern of practice of violations."

Agency Response: Agency Response: The Division disagrees with this comment and declines to define pattern of practice. Because HB 7 removed the mental state requirements that the Division was required to demonstrate in order to establish administrative violations under Chapter 415 of the Labor Code, the Division no longer needs a definition of "pattern of practice." Furthermore, Labor Code §415.021 provides that in addition to any other sanction, administrative penalty (fine), or other remedy authorized by Labor Code, Title 5, the Division may assess an administrative penalty against a person who commits an administrative violation. The Division also notes that the reference to "pattern of practice" referred to by the commenter has been deleted from adopted rule §180.26 and replaced with a statutory reference to Labor Code §408.0231(c), the statute upon which the proposed language was based. Labor Code §408.0231 does not, however, require the Division to find a "pattern of

practice" as a threshold to demonstrating an administrative violation under that section and, therefore, a definition of the term is unnecessary.

§180.1 (a)(4), (23) and (25)

Comment: Commenters request a modification to the definition for "agent" in §180.1. One commenter states that definition is overly vague because insurance carriers are already required to pay penalties due to mistakes and/or errors of third party administrators (TPAs).

One commenter states that language should be removed because it could cause an agent to be assessed a fine or penalty two times; once by the principle and a second time by the Division.

Agency Response: The Division disagrees. The definition of "agent" is intentionally broad and includes any party that the system participant utilizes or contracts with. Labor Code §415.0036(b) broadens who may be viewed as a system participant and the agent may be held responsible for the agent's own violations pursuant to the statute. Labor Code §402.072(a) also states the Division may impose sanctions against any person regulated by the Division under the Act.

§180.1 (a)(5), §180.22(f) - (h), and §180.28(e)(5)

Comment: Commenters request clarification and modification of the definition for "appropriate credentials."

One commenter states that the proposed definition is inconsistent with language previously adopted in §133.308(d) of this title relating to medical dispute resolution by

independent review organizations related to HB 2004 specialty certification requirements, and suggests two alternative definitions as follows:

"Pursuant to Labor Code §408.0046, a doctor must be one who would typically manage the medical or dental condition, procedure, or treatment under consideration for review and be qualified by the appropriate certification(s), education, training and experience to provide the health care reasonably required by the nature of the specific injury to treat the condition until further material recovery from or lasting improvement to the injury can no longer reasonably be anticipated."

Or, in the alternative: "Pursuant to Labor Code §408.0046, a doctor must be one who would typically manage the medical or dental condition, procedure, or treatment under consideration for review and be qualified by the appropriate licensure, certification(s), and the same or similar education, training and experience to provide the health care reasonably required by the nature of the specific injury including to both generally treat the condition and to provide expertise on the specific procedure and treatment being requested until further material recovery from or lasting improvement to the injury can no longer reasonably be anticipated."

One commenter states that the definition for appropriate credentials, as proposed, is subjective and suggests the addition of "scope of practice" to the proposed definition.

One commenter asks that the section be modified to remove the application of appropriate credentials to peer reviews, RMEs, and DD exams. The commenter states the proposed rule amendments in this subsection are an incorrect interpretation and application of the statutory amendments enacted by HB 2004. The commenter reasons that the Division does not have the statutory authority to apply the requirement of appropriate credentials to those reviewing health care for reasons other than medical necessity.

One commenter states that Labor Code §408.0046 is cited as the reason for this amendment; however, that peer reviewers do not provide treatment; and as such, the statutory authority for the Division to require peer reviewers to have appropriate credentials is not evident in Labor Code §408.0046. The commenter states the amendment needs to be clarified or removed.

One commenter summarizes that HB 2004 added Labor Code §408.0046 directing that the Commissioner may adopt rules to determine which professional health practitioner specialties are appropriate for treatment. The commenter has the opinion that "…this could create somewhat of a moving target and prove to be unmanageable."

Agency Response: The Division disagrees. The Division disagrees that the adopted definition of "appropriate credentials" conflicts with §133.308(d) of this title regarding professional specialty requirements, because the provisions serve different purposes. The definition of "appropriate credentials" is a general definition that applies to many health care providers as described by these adopted rules. The professional specialty requirements of §133.308(d) of this title apply specifically to doctors performing reviews under that section and are in addition to the "appropriate credentials" requirements in Chapter 180 of this title. The Division also disagrees with commenters' concerns regarding the scope of application for the definition of "appropriate credentials." Labor Code §408.0043 requires that a peer review doctor, utilization review doctor, IRO doctor, designated doctor, RME doctor, or MQRP doctor that 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; therefore, the Division's definition of "appropriate credentials" must apply to all doctors described by that section to health care providers as described by these adopted rules. Furthermore, nothing in

Labor Code §408.0043 limits its application to reviews of medical necessity, and, moreover, that section also includes designated doctors, who do not review medical necessity. The Division also disagrees that its definition of "appropriate credentials" definition should include a "scope of practice" requirement, because this requirement is sufficiently covered by the Division's adopted definition. Finally, the Division acknowledges the commenter's concerns regarding Labor Code §408.0046 but notes that the Division must comply with the statute.

§180.1(a)(11)

Comment: A commenter recommends that the definition of the term "conviction or convicted" in §180.1 be changed by deleting any reference to a "system participant entering a first-offender or other program and judgment of conviction has been withheld". This commenter is concerned with rule language that considers a person convicted when a court has withheld a conviction judgment.

Agency Response: The Division disagrees that subsection (a)(11) should be deleted because under Labor Code §408.0231(c) the criteria for recommending or imposing sanctions against a doctor or insurance carrier may include anything the Commissioner considers relevant.

§180.1(a)(19)

Comment: Several commenters request modification of the definition for peer review in §180.1 because it is overly broad and inconsistently used by the Division. Some commenters state that a health care provider cannot "provide treatment" without a physical examination; consequently, a health care provider that is providing treatment is not a peer review doctor. Some commenters state that the definition goes beyond the definition of UR found in Insurance

Code Chapter 4201 and HB 4290. Some commenters also state that the Insurance Code and associated Department rules apply to UR in the workers' compensation system.

One commenter suggests that the proposed definition may lead to any consultation by the insurance carrier with a medical professional being defined as "peer review". One commenter states that current §180.22(g) contains an appropriately scope-restricted definition of peer review.

One commenter states that the proposed definition is different from the definition of the term recommended by the Department's Utilization Review Agent Advisory Committee to be included in the soon to be proposed §19.2003 definitions rule that is part of the planned overhaul of the utilization review agent rules. With the exception of the reference to IROs in the Department's Utilization Review Agent Advisory Committee draft rule, the definition of the term "peer review" should be the same in both sets of rules so as to avoid confusion among system stakeholders.

Some commenters suggest that the "for any issue" language be removed from the proposed definition because the relevant statutes address the administrative review "*of the medical necessity and appropriateness of health care services".* The relevant statutes do not apply to any issue related to health care.

Other commenters provide additional language options to restrict the definition's scope.

Agency Response: The Division disagrees but recognizes that the proposed definition of "peer review" caused confusion among system participants. In particular, the Division recognizes that the provision that stated health care providers were not required to perform treatment to perform peer review was confusing and did not communicate the Division's intended meaning, which is that the Labor Code definitions of "health care provider" and "health

care practitioner" cannot be used to imply that health care providers that perform peer review must also render treatment. Therefore, the adopted definition of "peer review" is consistent with the peer review rule language in previous §180.22(g). Adopted §180.1 defines "peer review" as "An administrative review by a health care provider performed at the insurance carrier's request without a physical examination of the injured employee." The adopted definition continues to meet the intent of the previous rule which established that peer reviews were also performed for issues other than medical necessity and clarifies that the scope of the adopted rule applies to medical opinions rendered regarding any aspect of an injury claim as a result of an administrative review without a physical examination of the injured employee. The division agrees that the definition of "peer review" is broader than the definition of "utilization review" found in Insurance Code Chapter 4201. Chapter 4201 defines "utilization review" as "includes a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. The term does not include a review in response to an elective request for clarification of coverage." Adopted §180.22(g) establishes that there are two types of peer reviews, those performed for the review of medical necessity and those performed for issues other than medical necessity. Only peer reviews performed for the review of medical necessity are utilization review. Therefore, the definition of "peer review" is broader than the definition of "utilization review." The Division also agrees that the definition of "peer review" in these adopted rules should be consistent with the Department's utilization review rules currently being amended and will take necessary steps to ensure this consistency.

§180.1(a)(26)

Comment: A commenter states that the definition for "utilization review" in §180.1 is redundant and unnecessary since Insurance Code Chapter 4201 defines "utilization review." The commenter alludes to the Legislature's amendment of the UR definition during the 2007 and 2009 sessions and reflects that the Department has, at this time, not incorporated Legislative amendments to §19.2003(33) of this title. Commenter suggests that defining UR in this rule may require that this rule be reopened to update the definition in the future. Commenter suggests, to the extent that a definition is required, that a reference to Labor Code §401.011(42-a) should be sufficient.

Agency Response: The Division agrees and the definition of "utilization review" as proposed is not included in adopted §180.1. The definition in Labor Code §401.011(42-a), which references Insurance Code Chapter 4201, will be utilized.

§180.1(b)

Comment: Commenters request that §180.1(b) be removed.

One commenter questions the inclusion of this subsection in a section that specifically provides definitions for Chapter 180 of this title and suggests that it would be more appropriate to include this subsection in a section that addresses the scope of the chapter.

One commenter states the subsection is "…somewhat unusual and strange" and that the language is entirely unnecessary and may only result in confusion.

Agency Response: The Division agrees and has not adopted §180.1(b).

§180.2

Comment: Commenters request §180.2 be modified to remove the provision for anonymous complaints. Commenters state that the Division does not have the statutory authority to provide for anonymous complaint filing. Commenters cite Labor Code Chapter 418 and §§402.023, 409.009, 411.082, 415.009, and 451.001 in support of the request to remove the provision for anonymous complaints. Commenters opine that the acceptance of anonymous complaints raises due process concerns since one of the fundamental principles of due process is to allow the accused to confront and cross-examine the accuser and allowance of anonymous complaints removes this due process protection.

One commenter states that the rule appears to be inconsistent with *GuideOne Ins. Co. v. Cupps*, 207 S.W.3d 900 (Tex. App. - Ft. Worth 2006, pet. denied) which held that a party is entitled to seek a hearing to determine whether an administrative violation has occurred based on allegedly fraudulent conduct and must do so prior to seeking judicial review over such conduct.

One commenter states that there is concern that anonymous complainants will be reviewed and may only be further pursued if the complaint has merit based on the subjective judgment of an investigator. The commenter states this process may lead to arbitrariness against system participants.

Agency Response: The Division agrees in part and disagrees in part. The Division has changed the adopted rule to remove language regarding the submission of anonymous complaints. However, Labor Code §402.092 requires investigation files maintained by the Division to remain confidential and provides the exceptions that apply. Division investigation files are not open records for the purposes of Government Code Chapter 552 and are governed by applicable statutory confidentially provisions.

§180.2(h)

Comment: A commenter has concern with the term "other risk-based criteria." The commenter is concerned that the lack of definition to this term will lead to rule making not subject to public comment.

Agency Response: The Division disagrees. Labor Code §402.0235 provides that the Division may develop risk based criteria. The statute does not require the Division to define "other risk-based criteria." The Division uses many indicators to determine the priority of complaint investigations, including new legislation.

§180.2(i)

Comment: A commenter recommends that this subsection be modified to specify that a person commits an administrative violation if a person "knowingly" submits a frivolous complaint. This modification is recommended to ensure that no one is discouraged from filing complaints in fear of being penalized for unknowingly filing an improper complaint, particularly those not familiar with the system.

Agency Response: The Division disagrees. Adding the word "knowingly" would be inconsistent with Labor Code §402.023.

§180.3(h)

Comment: A commenter disagrees with §180.3(h) and the decision to make publishing of the final audit report on the Division Internet website discretionary, particularly those that reflect non-compliance. The commenter states that making information public on system participants

that are not in compliance with standards is a primary reason for conducting compliance audits and that the educational benefit to the system of audits exposing non-compliance will be muted if the non-compliance information is not provided publically. Commenter appreciates that posting the results of a follow-up audit permits a system participant to demonstrate its efforts to come into compliance. However, commenter does not believe that taking corrective action should result in excusing the original noncompliance, which will be the result if the findings of the original audit are not made public. Commenter believes that the system works best when system participants have access to complete information and that goal will be undermined if the results of the original audit demonstrating noncompliance are not published.

Agency Response: The Division disagrees. The language is not newly proposed language and is the current language in the rule with the exception of changing the word "commission" to "division." Final audit reports are releasable under the Texas Public Information Act with confidential information redacted and these reports have been released when requested. The Division believes that publishing final audit reports on the Internet will have a positive impact on compliance rates by motivating system participants and providing an incentive to perform better. The Division places public information on its website when it believes the information is of value to system participants.

§180.8

Comment: Commenters request clarification and modification of §180.8. Commenters question the non-response to the Notice of Violation (NOV) triggering the setting of a hearing at SOAH, the jurisdiction between the Division and SOAH once a hearing has been set, the statutory authority and jurisdiction that allows the Division to issue a default finding upon a non-

response to the Notice of Hearing (NOH), the statutory authority and jurisdiction of the Division to review or modify decisions issued by an ALJ from SOAH, and the statutory authority and jurisdiction of the Division for the process to set aside findings. Commenters state that it is unclear if Chapters 415 and 402 of the Labor code apply to the processes and proceedings. Commenters go on to state that there is no authority for the Division or the Department to collect a penalty through typical judicial types of means and that the only enforceable recourse is through revocation to practice within the system, suspension of the right to receive payments within the system, or suspension of a license, certification, or permit issued by TDI. Commenters cite Labor Code §§415.032, 415.033, 402.072, 402.073, 1 TAC Chapter 155, and Chapter 149 of this title in support of comments that request clarification and modification of proposed language around the Division's statutory authority and jurisdiction in this section.

Agency Response: The Division agrees in part and disagrees in part. The Division agrees that, pursuant to Labor Code §402.073, SOAH has jurisdiction to issue penalties upon a default; therefore, the Division has made a change to reflect this agreement. The Division disagrees, however, with the commenters' statement that the Division does not have the statutory authority to set a hearing at SOAH if the charged party does not respond to the NOV, because Labor Code §415.033 states that if, without good cause, a charged party fails to respond to an NOV as required under Labor Code §415.032, the Division shall initiate enforcement proceedings. The Division also disagrees with the assertion that it does not have the statutory authority to issue a default if a party fails to respond to an NOH. Government Code §2001.056, which applies to enforcement hearings pursuant to Labor Code §415.034, permits contested cases to be disposed of informally by default, and, therefore, this rule implements that authority. Lastly, the Division disagrees with commenters' concern that these default provisions conflict with the

Division's memorandum of understanding with the State Office of Administrative Hearings, because these requirements are necessary to comply with the Labor Code and Government Code and supplement the MOU for the purposes of enforcement hearings.

§180.8(b)

Comment: Commenter requests that the cautionary language be included in the Notice of Violation (NOV) by rule to ensure that individuals clearly understand that a State Office of Administrative Hearings (SOAH) hearing will be set if there is not a response to the NOV.

Agency Response: The Division disagrees that any cautionary language need appear in the rule because it is not necessary. Stakeholders are on notice that a hearing will be set through adopted §180.8(c). Cautionary language will also appear in the NOV.

§180.8(c)

Comment: A commenter asks if the intent of §180.8(c) is to prohibit insurance carriers from requesting an extension beyond the 20 days.

Agency Response: Pursuant to Labor Code §415.032(b) not later than the 20th day after the date on which notice is received, the charged party shall remit the amount of the penalty to the Division or submit to the Division a written request for a hearing.

Comment: Commenters request a longer amount of time to respond to a Notice of Violation (NOV). One commenter states that 20 days is, at times and with certain state approved third party vendors, not enough time to coordinate responses in order to comply with §180.8.

Agency Response: The Division disagrees with the comment because Labor Code §415.032 requires that not later than the 20th day after the date on which the notice is received, the charged party shall remit the amount of the penalty to the division or submit to the division a written request for a hearing. However, the Division may negotiate an informal case disposition with charged parties prior to issuing a NOV and may negotiate a possible informal resolution if the charged party requests a hearing.

§180.8(c) and (d)

Comment: Commenter requests that the cautionary language be included in the Notice of Hearing (NOH) by rule to ensure that individuals clearly understand that a default judgment will occur if there is not a response to the NOH.

Agency Response: The Division disagrees because it is not necessary that cautionary language appear in the rule. However, cautionary language will appear in the NOH.

§180.8 (e) and (f)

Comment: Commenter requests that the subsections be clarified to ensure individuals understand that a party will not receive a default judgment due to not responding to an NOV as long as the party attends the SOAH hearing that is triggered by the non-response to the NOV.

Agency Response: The Division disagrees because it is not necessary that cautionary language appear in the rule. Non-response to the NOV will trigger a hearing at SOAH and issuance of the Notice of Hearing. A party may be subject to a default judgment if the party does not file a written response to a Notice of Hearing or does not appear at the hearing.

§180.8(h)

Comment: Commenter recommends that this subsection clearly state the deadline for a party to file a motion to set aside a default order rather than stating that a party is required to file such a motion "prior to the time that the order of the commissioner becomes final pursuant to the provisions of the Government Code Chapter 2001" in order to limit the impact of the default provisions and to minimize the number of instances where administrative penalties are imposed without the benefit of a hearing.

Agency Response: The Division disagrees because it is not necessary that the rule specifically state a deadline. The APA generally sets out these requirements. Currently, several of these requirements are located in Government Code §§2001.144 - 2001.147.

§180.22(a)

Comment: A commenter states that there needs to be clarification around the term health care providers as it relates to RMEs, peer reviewers, designated doctors, members of the MQRP, and IROs in this subsection. The commenter states the need for clarification stems from the fact that none of the above health care providers provide treatment and the definition of a health care provider is to provide treatment. Commenter suggests the language be changed in §180.22(a) to state "…health care providers as defined in subsections (c) - (e) shall provide ….".

Agency Response: The Division agrees to the change and has clarified adopted §180.22(a).

Comment: Commenters recommend that the language in this subsection track the precise statutory language in Labor Code §408.021.

Agency Response: The Division disagrees with the change because the language comports with Labor Code §408.021 and is not in conflict with the statutory language. The Division notes, however, that, for other reasons, a change has been made to this subsection that limits its application to particular health care providers under §180.22 and that this may address the commenter's concerns.

§180.22(c)

Comment: Commenter requests an addition to this subsection. The commenter asks that a requirement for the treating doctor to examine the injured employee to certify a date of maximum medical improvement and assign an impairment rating or refer the injured employee to another authorized doctor to do so be clearly included in the responsibilities of the treating doctor. The commenter cites §130.2 of this title to support the request for the addition to this subsection and suggests that insurance carriers often take the position that this provision is only mandatory if there is not already a certification of MMI and IR from a designated doctor. Commenter states that if §180.22(c) were modified to establish that the treating doctor is required to perform this examination for the injured employee or refer the patient to another doctor, whether or not there is a certification from a designated doctor, then the rule language could be emphasized to either a treating doctor or an insurance carrier to demonstrate that the certification examination is required and, as such, the carrier is liable for the cost of that examination. Commenter recommends the addition of the following language to §180.22(c) and the treating doctor's responsibilities "examine an injured employee to determine a date of maximum medical improvement and to assign an impairment rating for any permanent impairment resulting from a compensable injury or refer the injured employee to another

authorized doctor to perform the certification examination. The requirement that the treating doctor perform the certification examination or refer the injured employee to another authorized doctor for a certification examination continues even if the certification examination will occur after a designated doctor has already certified MMI and IR."

Agency Response: The Division disagrees because the specific concerns of the comment are beyond the scope of these rules and may be more appropriately addressed in other rules. However, in response to the comment, the Division clarifies in adopted §180.22(c), which describes the general duties and responsibilities of treating doctors, that a duty and responsibility of the treating doctor is to examine an injured employee to determine a date of maximum medical improvement and to assign impairment ratings when appropriate.

§180.22(e)

Comment: Commenters state that the proposed timeframe for referral doctors to submit a timely report contradicts requirements in §129.5(d) - (f) and §133.20(h) of this title and ask that the language in this subsection be synchronized with the cited sections.

Agency Response: The Division agrees and has clarified the language in the rule.

§180.22(g)

Comment: Commenters request the term "conflicts of interest" be defined because left undefined it is open to vastly different interpretations.

Agency Response: The Division disagrees because a potential conflict of interest will depend on individual facts and cannot be defined for every possible conflict.

Comment: Commenters recommend rule language be modified and striking portions of paragraphs (1) and (2) of subsection (g). Commenters state that the concepts of "peer review" and "peer reviewer" apply to administrative reviews of medical necessity and appropriateness of medical care for health care services that are under review and do not apply to all other issues in a workers' compensation claim. Commenters state the proposed rule language applies to reviews made by health care providers regardless of whether or not the health care provider is providing treatment and that a health care provider cannot "provide treatment" without a physical examination; consequently, a health care provider that is providing treatment is not a peer review doctor. Commenters further state that such an expansive definition could potentially endanger the health of the worker, undermine the handling of claims, and undermine the dispute resolution process administered by the Division. Commenters also state that the Insurance Code and associated Department rules apply to utilization review in the workers' compensation system. Commenters state that the definition goes beyond the definition of utilization review found in Insurance Code Chapter 4201 and HB 4290.

One commenter states that the proposed use of the term may lead to any consultation by the insurance carrier with a medical professional being defined as a "peer review".

One commenter states that the use of the term as proposed turns all treating doctors into peer review doctors.

One commenter states that the proposed definition is different from the definition of the term recommended by the Department's Utilization Review Agent Advisory Committee to be included in the soon to be proposed §19.2003 definitions rule that is part of the planned overhaul of the utilization review agent rules.

One commenter points to Labor Code §408.0044 and states that it applies to the review of dental services; and that Labor Code §408.0045 applies to the review of chiropractic services and that these statutes do not apply to "any issue other than medical necessity" and do not apply to "compensability" or "ability to return to work".

One commenter states that the Texas Labor Code does not require that this rule address the specialty of the peer review doctor nor does it require a specialist to specialist review.

Agency Response: The Division agrees that proposed subsection (g) created confusion among system participants. The Division clarifies that it was the intent of the proposed rule to follow the standards established by previous §180.22(g), which provided for two types of peer reviews. Previous §180.22(g)(1) established requirements for peer reviews for the "review of the medical necessity or reasonableness of health care"; and, previous §180.22(g)(2) established requirements for peer reviews for the "review for any issue other than medical necessity." The intent of the proposed language was to provide further clarification and not change the peer review process in place in the workers' compensation system. However, due to comments received adopted §180.22(g) is more consistent with previous rule language. Adopted §180.22(g) establishes that "A peer reviewer is a health care provider who performs an administrative review at the insurance carrier's request without a physical examination of the injured employee." The adopted rule continues to apply to all medical opinions rendered regarding any aspect of an injury claim as a result of an administrative review without a physical examination of the injured employee. The Division agrees that the Insurance Code and associated Department rules apply to utilization review in the workers' compensation system and adopted §180.22(g)(1) establishes that peer reviews for the "review of the medical necessity or reasonableness of health care services" is utilization review and is subject to

applicable provisions of Insurance Code Chapter 4201. The Division also agrees that the definition of "peer review" is broader than the definition of "utilization review" found in Chapter 4201. Chapter 4201 defines "utilization review" as "includes a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. The term does not include a review in response to an elective request for clarification of coverage." Adopted §180.22(g) establishes that there are two types of peer reviews, those performed for the review of medical necessity and those performed for issues other than medical necessity. Only peer reviews performed for the review of medical necessity are utilization review. Therefore, the definition of "peer review" is broader than the definition of "utilization review." The Division also agrees that the definition of "peer review" in these adopted rules should be consistent with the Department's utilization review rules currently being amended and will take necessary steps to ensure this consistency. The Division disagrees that Labor Code §408.0044 and Labor Code §408.0045 do not apply to "any issue other than medical necessity", for example, Labor Code §408.0045(a)(6) applies to a chiropractor who serves as a member of the MQRP. Labor Code §408.0044 and §408.0045 establish that the provisions are applicable to "a doctor performing peer review." The Division also disagrees that the Labor Code does not require that this adopted rule address the specialty of the peer review doctor nor require a specialist-to-specialist review. Labor Code §408.0043 establishes that a doctor performing a peer review of 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. Labor Code §408.0044 and §408.0045 establish similar provisions for dentists and chiropractors.

§180.22(i)

Comment: Commenters state this subsection is potentially confusing and request clarification. The commenters state that the first sentence of this subsection, taken out of context, suggests that chiropractors can serve on the MQRP without being subject to Labor Code §413.0512.

Agency Response: The Division has clarified adopted §180.22(i).

§180.24(a)

Comment: Commenter recommends a review of Government Code Chapter 573 to ensure statutory continuity.

Agency Response: The Division disagrees that Government Code, Chapter 573 is relevant to the adopted rule since it pertains to nepotism prohibitions applicable to public officials, candidates, district judges, and trading.

§180.24(b)

Comment: Commenters request clarification of when a disclosure must be filed apart from the annual filing requirement as new situations may arise in any given annual cycle. The commenters also request that a deadline for filing disclosures, outside of those required annually, be established by rules and suggest a 30 day deadline.

One commenter suggests that the proposed rule would not provide sufficient notice for the information to be useful and therefore is of no value since the purpose of the disclosure is, in important part, so that the carrier may evaluate the information on the question of medical necessity. Commenter believes the rule is based on the federal rules and the federal rules are

concerned with unnecessary over-referrals to providers in which the doctor has financial interests. Commenter suggests a carrier may not learn of the financial interest for some 300+ days (because of newly acquired interests) if the reporting is annual and that may be too late for the carrier to request a refund if the information affected the appropriateness of the payment and cites §133.260 of this title (carrier shall request a refund *within 240 days* from date of service). Commenter recommends requiring an annual disclosure requirement of all interests and a "within 30-day requirement" for any new referrals to providers (in which there is a financial interest) not included in the original disclosure.

Agency Response: The Division agrees to keep the current language of this subsection unchanged which requires the health care practitioner to file a disclosure with the division within 30 days of the date the first referral is made unless the disclosure was previously made.

§180.24(c)(2)

Comment: A commenter requests clarification in the rule that timely submission of refunds is due and payable after a 45 day period from the day that the health care provider fails to file the required disclosure and requests additional information regarding interest calculations and deadlines.

Agency Response: The Division disagrees because the change is not necessary.

§180.25(b)

Comment: A commenter questions why the terms intentionally, knowingly, and willfully have been removed from rule language when the division is required to develop a formal, risk-based

complaint investigation system that considers the severity of the alleged violation which includes determining if there was continued or willful non-compliance.

Agency Response: The Division disagrees. HB 7, 79th Legislature, Regular Session (2005) generally removed the requirement that the Division prove particular mental states in order for it to establish that an administrative violation occurred. Furthermore, Labor Code §415.0036, which was added by HB 34, 80th Legislature, Regular Session (2007), does not include a requirement that the Division prove that violations described in that section were performed intentionally, knowingly, or willfully. However, the Division notes that it may still consider factors such as whether the person remains in continued or willful noncompliance with the Act or a rule, order, or decision of the Commissioner when evaluating a complaint.

Comment: Commenters state that the proposed language of "any remuneration" goes beyond the statutory intent of Labor Code §413.0036 which contains language of "improper inducement" and ask that the language "any remuneration" be replaced with "improper inducement". Commenters state that many Texas workers' compensation carriers contract with outside vendors to assist in performing certain claim services including utilization review, case management, peer reviews, required medical examinations, and medical bill reviews. Commenters state that contracting for these services always involves solicitation to provide services and an offering to pay remuneration for services. Commenters suggest that the statute does not prohibit soliciting or receiving any remuneration and does not prohibit offering or paying any remuneration. Commenters also suggest that the statute does prohibit offering or soliciting improper inducements for the delivery of those claims services. Commenters opine that the term "improper inducement" is not defined in the statute but it is reasonable to interpret

that term to mean "kickback, bribe, or rebate" as found elsewhere in the rule and it is not reasonable to interpret "improper inducement" to mean "any remuneration" which would prohibit any payment for the services rendered.

Agency Response: The Division disagrees. Adopted subsection (a) pertains to Labor Code §415.0036 and Labor Code §413.041(b). Labor Code §415.0036(b) requires the Division to adopt the federal standards relating to fraud, abuse, and antikickbacks that prohibit the payment or acceptance of payment in exchange for health care referrals. An injured employee is entitled to all health care reasonably required. Providing fees for referrals creates an incentive to over-prescribe care and unnecessarily add costs to the workers' compensation system. Adopted subsections (b) - (d) generally adopts the federal provisions in Title 42, United States Code §1320a-7b (Antikickback Statute). Subsection (b) sets out the specific conduct that will be deemed to be an improper inducement, influence or threat. Subsection (b)(1) and (2) relate to the federal standards. They cover soliciting, receiving, offering, or paying any remuneration for referrals. The language is constructed in such a way that a third party is not permitted to engage in these activities either. The subsections focus on medical benefits. Subsection (b)(3) and (4) prohibit attempts to influence where an injured employee seeks medical care by offering financial or other incentives such as favorable medical opinions that could impact the injured employee's benefits or offering to keep the injured employee off of work. Subsection (b)(3) also prohibits providing such incentives to attempt to influence the injured employee to comply with the health care provider's treatment plans. It is just as improper to attempt to be selected as an RME doctor by promising reports that are favorable to the insurance carrier. In addition, the subsection prohibits threatening adverse actions as well. For example, doctors cannot threaten the injured employee with a low impairment rating if the

injured employee refuses to comply with treatment. Subsection (b)(5) prohibits attempting to influence the opinion of a health care provider or insurance carrier by threatening to file a complaint or embroil them in other legal action. Medical benefit delivery is to be based solely upon the health care that is reasonably required by the nature of the injury as and when needed to cure or relieve the effects naturally resulting from the compensable injury, promote recovery, or enhance the ability of the injured employee to return to or retain employment.

§180.26(a)

Comment: Commenters ask that this subsection be modified to clarify that workers' compensation insurance carriers do not render medical treatment in the Medicare or Medicaid programs nor do they bill for medical services within the Medicare or Medicaid programs and therefore cannot be sanctioned for adverse findings by the Medicare or Medicaid programs.

One commenter states that there is no statutory authority to provide for this rule language under Labor Code §408.0231.

One commenter also suggests §180.26(a)(2) be "tweaked" to include all health care providers.

Agency Response: The Division agrees in part and disagrees in part. The Division has clarified proposed §180.26(a) by removing the list of sanctionable acts and replaced the list with a reference in §180.26(b) to the list of sanctionable acts in Labor Code §408.0231(c). Moreover, this change will clarify the possibly misleading outcome with regard to sanctions imposed against insurance carriers due to findings by Medicaid or Medicare. The Division disagrees that adopted §180.26(a)(2) must include all health care providers because Labor Code §408.0231(c)(3), the statute upon which the adopted language is based, only applies to

doctors; however, proposed §180.26(a)(2) is part of the deleted language described above that the Division has replaced with a statutory reference in §180.26(b).

Comment: Commenters request this subsection be modified to clarify the "fair and reasonable" standard that may be utilized by the Commissioner in this subsection, particularly in relation to utilization review. Commenters state that there is no statutory authority that allows the Commissioner to individually make findings of "fair and reasonable" based on a single determination or a pattern of practice. Commenters also state that the proposed rule essentially makes the Commissioner the ultimate fact-finder, which would undermine the authority of the State Office of Administrative Hearings (SOAH) to make the final decision in enforcement cases pursuant to Labor Code §402.073(b). Commenters also cite Labor Code Chapter 413 to support the request for modification in this subsection. Commenters go on to state that the subsection does not explain how or why a utilization review practice might differ from those the Commissioner finds "fair and reasonable".

One commenter suggests that this subsection is ambiguous because it is not clear what the Division is attempting to regulate since the Department, not the Division, regulates utilization review agents (URAs).

Agency Response: The Division disagrees but has made a change for other reasons. Specifically, the Division has deleted the entire list of acts in §180.26(a) and replaced that list with a statutory reference in §180.26(b) to Labor Code §408.0231(c), the statute upon which the proposed language was based. The Division has made this change for reasons described in the response to another comment on this subsection. Though it has made a change, the Division disagrees with these comments. With regard to the "fair and reasonable" language,

guidelines may not apply to all situations. Some flexibility is needed by the Division. The Commissioner has the discretion in Labor Code §408.0231(c)(3) to recommend or impose sanctions against an insurance carrier if evidence from the Division's medical records shows that the insurance carrier's utilization review practices are substantially different from those the Commissioner finds to be fair and reasonable based on either a single determination or a pattern of practice or against a doctor if 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. The Division agrees that the Department regulates URAs; however, the Act also requires regulation by the Division of health care providers that perform utilization review, insurance carrier's utilization review practices, and the practices or omissions of agents of insurance carriers with relation to utilization review. For example, Labor Code §415.0035 states an insurance carrier or its representative commits an administrative violation if that person denies preauthorization in a manner that is not in accordance with rules adopted by the Commissioner under Labor Code §413.014 and a health care provider commits an administrative violation if that person fails or refuses to timely file required reports or records; further, an insurance carrier or health care provider commits an administrative violation if that person violates the Act or a rule, order, or decision of the Commissioner. Labor Code §415.003 states that a health care provider commits an administrative violation if the person violates a Commissioner rule or fails to comply with a provision of the Act. Labor Code §415.0036 applies to sanctions against insurance adjusters, case managers, or other persons who have the authority under the Act to request the performance of a service affecting the delivery of benefits to an injured employee or who

actually performs such a service, including peer reviews, performance of required medical examinations, or case management - and to their agents.

§180.26(e) and (g)

Comment: Commenters request that this subsection be deleted or modified. Commenters cite Labor Code §415.021 for the factors that are to be used when the Commissioner considers sanctions and state that warning letters are not sanctions and do not constitute documentation that a violation occurred at any time. Some commenters also state that there is no statutory authority for the Commissioner to elevate warning letters to the level of a sanction by rule. Commenters go on to state that warning letters only document that there have been allegations that an administrative violation may have occurred, not that one did occur. Once commenter states concerns over "due process" if the language is adopted as proposed.

One commenter asks that a procedure for recipients to respond to warning letters be codified, along with a provision that the Division must maintain responses to warning letters on file. One commenter asks that if warning letters are to be used as part of the formula to assess sanctions that a "finding" of a violation must be included in the warning letter; the commenter alternatively suggests the use of educational letters if the Division is not going to find that a violation did occur. This commenter states that the use of warning letters for the proposed purpose is a large departure from the current use of warning letters.

One commenter suggests that a possible alternative is to issue a zero dollar fine which would make the "finding" of a violation concrete, but would still allow the Division flexibility to not issue a fine. The commenter notes that this would turn the warning letter into an NOV. This

commenter also suggests the possible use of educational letters or some other type of letter in place of warning letters as they are proposed.

Agency Response: The Division agrees and disagrees in part. The Division has clarified the language in the rule. Adopted Subsection (e) lays out "other matters that justice may require" pursuant to Labor Code §415.021(c) and includes "evidence of heightened awareness of the legal duty to comply with the Act and Division rules." Warning letters are evidence that the Division made a system participant aware of the participant's noncompliance and its responsibilities under the Act and Division rules. The system participant may respond to the Division following receipt of a warning letter. In response to comments, adopted Subsection (g) has been modified to state that as an alternative to imposing a sanction such as an administrative penalty on a charged system participant, the division may, at its discretion, provide formal notice of the violation through a Warning Letter and the Warning Letter shall include a summary of the duty that the division believes that the charged system participant failed to fulfill or timely fulfill; identify the facts that establish that a violation occurred; and inform the charged system participant that subsequent noncompliance of the same sort may be deemed to be a repeated administrative violation or matter of practice any of which will be subject to sanction. Most of the language has been recodified from prior rule §180.8(f).

§180.27(a)

Comment: Commenters request that this subsection be modified to clarify what is meant by "the commissioner shall review the proposed decision of the administrative law judge". Commenters have concern that the proposed wording may be misleading as the Commissioner

cannot alter a final decision issued by SOAH. Commenters site Labor Code §402.073 and §149.8 and §149.9 of this title to support the request to clarify this subsection.

Agency Response: The Division disagrees that any clarification is needed. Adopted §180.27 only states that the Commissioner may modify proposed decisions, not final orders, issued by SOAH. This language is consistent with the provisions of Labor Code §402.073(c). The Division does recognize, however, that the Commissioner may not modify the final orders issued by SOAH.

§180.27(d)

Comment: Commenter suggests that the rule proposes that the Commissioner may lift any sanction imposed under Labor Code §408.0231; however, the statute only provides for reinstatement to the approved doctor's list or restoration of a doctor's practice privileges under §408.0231(d) and nowhere provides for the lifting of the list of sanctions imposed under §408.0231(f) other than those also provided for under §408.0231(d).

Agency Response: The Division agrees in part and disagrees in part; however, the Division has clarified adopted §180.27(d) to more closely track the language of the statute. Labor Code §408.0231(d)(2) provides that the Commissioner by rule shall establish procedures under which a doctor may apply for restoration of doctor practice privileges removed by the Commissioner based on sanctions imposed under Labor Code §408.0231. Labor Code §408.0231(f) lists some of the sanctions that the Commissioner may recommend or impose against a doctor under Labor Code §408.0231 and is clearly a subsection of §408.0231 and falls within the meaning of those practice privileges to which §408.0231(d)(2) applies.

§180.28

Comment: Commenter states that most of the orthopedic physicians in the state of Texas are not seeing injured employees. Commenter also states that the Texas Orthopedic Association (TOA) statistics reflect a decrease of 50 percent in physician participation in the system since the late 90's. Also that TOA polling of members reflects a concern that orthopedic physicians are being brought into the system in a marginal fashion; meaning that their services are being brought into the surgical arena without consideration for the whole practice of orthopedic surgery. Commenter provides several examples of how adverse determinations affect injured employee care and RTW. Commenter recommends encouraging orthopedic surgeon participation in the system, UR and peer review on orthopedic surgery only be completed by orthopedic surgeons, and that the URs or peer reviewers have access to all necessary medical records.

One commenter suggests that the preeminent specialty in the musculoskeletal field of injuries is the orthopedic surgeon; musculoskeletal injuries comprised approximately 90% of all injured workers claims and the opinion of the orthopedic surgeon carries the predominant weight of professional authority. Commenter recommends adding language to §180.28(g) that "a denial of any recommendation by an orthopedic surgeon should be made only by a peer orthopedic surgeon licensed and practicing in the State of Texas" and add to §180.28(h) that "any quality-of-care oversight at the MQRP level be similarly performed only by respected-peer-orthopedic surgeons, licensed and practicing in the State of Texas."

Agency Response: The Division disagrees and clarifies that increasing orthopedic physician participation in the workers' compensation system is outside the scope of these rules, which address medical benefit regulation. The Division also clarifies that these adopted rules address

commenter's concern regarding utilization review and peer review of orthopedic surgeries by implementing Labor Code §408.0043, which requires a doctor (other than a chiropractor or a dentist) that performs peer review or utilization review of a health care service provided to an injured employee or serves on the MQRP hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving. In addition, adopted §180.1(5) includes a definition for "appropriate credentials" to mean "the certification(s), education, training and experience to provide the health care that an injured employee is receiving or is requesting to receive."

§180.28(a)

Comment: Commenters state that the Division does not have the statutory authority to apply the requirement of appropriate credentials to peer reviewers reviewing health care for reasons other than medical necessity. That the rule proposed amendments in this subsection are an incorrect interpretation and application of the statutory amendments enacted by HB 2004 and should be removed. One commenter recommends §180.28(a)(2) be struck.

Agency Response: The Division disagrees that the Division does not have the statutory authority to apply the requirement of appropriate credentials to peer reviewers reviewing health care for reasons other than medical necessity. Labor Code §408.0231(g) authorizes the commissioner "to adopt rules regarding doctors who perform peer review functions" and adopted §180.22(g) establishes the functions of peer reviewers. Labor Code §§408.0043, 408.0044 and 408.0045 establish that the provisions of those sections are applicable to "a doctor performing peer review." Labor Code §408.0043 also establishes that a doctor performing a peer review of 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.

Comment: A commenter recommends that the requirement to provide a peer review report should only apply in the case of retrospective review. The commenter supports the recommendation by citing the response timeframes established in §134.600 of this title for preauthorization and concurrent review and comparing those timeframes to those allowed for under Labor Code §408.027. The commenter also states there will be additional costs incurred for letter programming and postage for URAs if the requirements are not confined only to retrospective reviews.

Agency Response: The Division disagrees that the requirement to provide a peer review report should only apply in the case of retrospective review. Labor Code §§414.002 - 414.005 and 414.007 establish the Division's duties of monitoring, compilation and maintenance of statistical data, review of insurance carrier records, maintenance of an investigation unit, and medical review. Also, Labor Code §408.0231(g) provides that the Commissioner shall adopt rules regarding doctors who perform peer review functions for insurance carriers and those rules may include standards for peer review and imposition of sanctions on doctors performing peer review functions. For these reasons it would not be appropriate to have different reporting requirements for a peer review of retrospective health care services and a peer review of prospective health care services. Further, the Division clarifies that a peer review report and a report to deny preauthorization as required by §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) may be the same report as long as the required elements of adopted §180.28(a) and §134.600 of this title are met.

Comment: A commenter states the inclusion of UR (preauthorization) within the proposed peer review process is not necessary. The commenter goes on to state that the Division has adequate monitoring and enforcement power to provide sufficient oversight to the preauthorization process. The commenter further states that defining utilization review as a peer review with the proposed additional administrative requirements does not increase the clinical value of the review itself; it simply increases URAs administrative costs with no parallel increase in the quality or benefit to the injured employee.

Agency Response: The Division agrees and disagrees in part. The Division clarifies that Insurance Code Chapter 4201, and not the Division, defines utilization review as "a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services…" Therefore, if the peer review is for the review of the medical necessity and appropriateness of health care services the peer reviewer is performing utilization review and must comply with Chapter 4201 and the applicable provisions of the Act and Division rules.

Comment: Commenters state peer review reports are not applicable to issues outside of medical necessity and appropriateness of medical care for health care services that are under review. Commenters state that there is no statutory authority for the requirement. One commenter, additionally, states that the proposal to apply the proposed requirements to return-to-work, compensability, extent of injury, or other related issues is a misinterpretation of the amendments made to the Labor and Insurance Codes by HB 2004. Some commenters state the requirements will discourage requests for peer reviews along with discouraging per

reviewers from accepting requests. Some commenters ask the Division to consider the possible impact on dispute resolution.

Agency Response: The Division disagrees that peer review reports are not applicable to issues outside of medical necessity and appropriateness of care for health care services that are under review. Labor Code §§414.002 - 414.005 and 414.007 establish the Division's duties of monitoring, compilation and maintenance of statistical data, review of insurance carrier records, maintenance of an investigation unit, and medical review. Also, Labor Code §408.0231(g) provides that the Commissioner shall adopt rules regarding doctors who perform peer review functions for insurance carriers and those rules may include standards for peer review and imposition of sanctions on doctors performing peer review functions. For these reasons and to meet statutory requirements, it is necessary for the Division to be able to obtain all types of peer review reports.

Comment: Commenters state the subsection needs to be stricken or modified to align with current or future URA rules.

One commenter states that this subsection as proposed is in conflict with Department's URA Advisory Committee draft rule, another commenter states that the subsection as proposed conflicts with current URA rules.

One commenter states that the requirement for a report upon the denial of preauthorization is not contained within Labor or Insurance Code nor is it in the Division's or Department's rules and that there is no statutory authority for the requirement.

One commenter states that, as proposed the subsection, as written, does not affect peer report generation when there is denial of a preauthorization request. This commenter goes on

to state that the denial of preauthorization must go though the UR process and that the additional requirement of a peer review report is unnecessary and overly burdensome.

One commenter suggests that a URA should not be denied the use of a peer review report because of a technical defect, ie absence of license number, if the given report otherwise provides valuable information; and that ultimately the URA is responsible for the determination and the URA is subject to regulation by the Department, not the Division.

One commenter states that the Legislature used each term, and that each term has a separate definition and that there is nothing in the Labor Code to suggest that the Legislature intended the two terms to be treated the same and neither the terms nor processes are interchangeable.

Agency Response: The Division disagrees that the adopted rule is in conflict with utilization review requirements of Chapter 4201. The Division clarifies that this adopted rule is to be applied in conjunction with the requirements of Chapter 4201 for peer reviews performed for the review of the medical necessity or reasonableness of health care. Labor Code §§414.002 - 414.005 and 414.007 establish the Division's authority and duties of monitoring, compilation and maintenance of statistical data, review of insurance carrier records, maintenance of an investigation unit, and medical review. Also, Labor Code §408.0231(g) provides that the Commissioner shall adopt rules regarding doctors who perform peer review functions for insurance carriers and those rules may include standards for peer review and imposition of sanctions on doctors performing peer review functions. Further, the Division clarifies that a peer review report and a report to deny preauthorization as required by §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care)

may be the same report as long as the required elements of adopted §180.28(a) and §134.600 of this title are met.

Comment: Commenters state the requirements to provide the name and professional license number of all health care providers related to the treatment under review, the requirement to list all documents reviewed related to the claim, and a full clinical history either need to be removed entirely or modified. The commenters state that the requirements in this subsection are overly burdensome and will add cost to the system. Some commenters state that there is no statutory mandate to require this information; that it will be hard to meet; exposes peer reviewers, utilization review companies, and insurance carriers to enforcement situations; and serves no purpose other than to discourage doctors from performing peer reviews in the workers' compensation system which is fraught with over-utilization of medical care. Some commenters acknowledge that the information may be for Medical Quality Review Panel (MQRP) or other purposes, but state that either the information is available via the Division's medical data base or that the information will rarely be reviewed and the burden to provide the information far outweighs any possible benefit. Some commenters state that the requirements to provide the name and professional license number of all health care providers related to the treatment under review and the requirement to list all documents reviewed related to the claim has no beneficial effect on the report because the point is to determine if the peer reviewer has the appropriate credentials to review the health care under review.

One commenter states that the rule proposed amendments in this subsection are an incorrect interpretation and application of the statutory amendments enacted by HB 2004.

One commenter states that the requirements of §180.28(a)(4) that the report provide "a list of all medical records and other documents reviewed by the peer reviewer, including dates of those documents" unnecessarily drives up the cost of preparation of the report both from a clerical and a peer reviewer perspective due to the requirement of outlining each and every document. Commenter also states that the requirement of §180.28(a)(5) that the peer report contain a summary of the clinical history is unnecessary in most cases, overly burdensome, and needlessly drives up the cost of preparation of the report. Commenter suggests that at best, the rule should require a summary of only that portion of the clinical history relevant to the actual peer review. Commenter recommends that §180.28(a)(4) and §180.28(a)(5) be modified so that only those medical records most relevant to the actual peer review and the clinical history related to the peer review must be listed and summarized.

Agency Response: The Division disagrees and agrees in part. Proposed §180.28(a)(7) and (a)(8) which required "the name and professional license number of all health care providers whose treatment, review, or any other service related to the claim is the subject of the review" and "for return-to-work, compensability, extent of injury, or other related issues, the name and professional license number of the injured employee's treating doctor" have been deleted. However, the Division clarifies that the requirements to list all medical records and other documents reviewed by the peer reviewer, including dates of those documents and a summary of the clinical history are not new requirements and were established by previous §180.28. Labor Code §§414.002 - 414.005 and 414.007 establish the Division's authority and duties of monitoring, compilation and maintenance of statistical data, review of insurance carrier records, maintenance of an investigation unit, and medical review. Also, Labor Code §408.0231(g) provides that the Commissioner shall adopt rules regarding doctors who perform peer review

functions for insurance carriers and those rules may include standards for peer review and imposition of sanctions on doctors performing peer review functions. Further, Labor Code §408.0046 requires the Division to adopt rules that require an entity requesting a peer review to obtain and provide to the doctor providing peer review services all relevant and updated medical records.

§180.28(c)

Comment: A commenter recommends the peer record also be provided to the Office of Injured Employee Counsel (OIEC) Ombudsman, if one is assisting the injured employee. The commenter recommends the language be modified to "person acting on behalf of the injured employee" from "injured employee's representative"

Agency Response: The Division disagrees. The commenter's suggested language is too broad and would include persons far beyond an ombudsman. The adopted language conforms with the language in Labor Code §402.071.

§180.28(e)(1)

Comment: Commenter states that the following standard is vague and requires clarification - the commissioner may impose sanctions on peer reviews and may prohibit a doctor from conducting peer reviews for "applicable provisions of the Act, or a rule, order, or decision of the commissioner."

Agency Response: The Division disagrees. Labor Code §408.0231(g) clearly requires that the Commissioner shall adopt rules regarding doctors who perform peer review functions for insurance carriers. The adopted rule states that the Commissioner may impose sanctions on

doctors performing peer reviews pursuant to Labor Code §408.0231 and §180.26 and §180.27 of this title (relating to Criteria for imposing, Recommending and Determining Sanctions; Other Remedies; and Sanctions Process/Appeals/Restoration, respectively) and other applicable provisions of the Labor Code and Division rules. The adopted rule also provides that the Commissioner may prohibit a doctor from conducting peer reviews for non-compliance with the provisions of §180.22 of this title (relating to Health Care Provider Roles and Responsibilities), this section, or applicable provisions of the Act, or a rule, order or decision of the Commissioner.

§180.28(f)

Comment: A commenter recommends adding injured employees to the list of those that may requests a peer review.

Agency Response: The Division disagrees. The Division does not have the authority to allow injured employees to request peer reviews and does not have the authority to monitor peer reviews requested by an injured employee. Labor Code §408.0231(g) provides that the Commissioner shall adopt rules regarding doctors who perform peer review functions for insurance carriers and those rules may include standards for peer review and imposition of sanctions on doctors performing peer review functions.

Comment: A commenter supports the requirement of this subsection stating it reinforces the need for insurance carriers to have timely access to medical records.

Agency Response: The Division acknowledges and appreciates the comment.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.

For, with changes: Property Casualty Insurers Association of America; Medtronic Spinal & Biologics/Texas Lobby Solutions; Insurance Council of Texas; American Insurance Association; CorVel Corporation; Flahive, Ogden & Latson; State Office of Risk Management; Office of Injured Employee Counsel; ACE Group; Texas Mutual Insurance Company

Against: None

6. STATUTORY AUTHORITY.

SUBCHAPTER A. GENERAL RULES FOR ENFORCEMENT

The amendments are adopted under Labor Code §§401.011, 401.021, 402.001, 402.00128, 402.00111, 402.00116, 402.023, 402.0235, 402.024, 402.061, 402.072, 408.0043 - 408.0046, 408.023, 408.0231, 414.002, 414.007, 415.001 - 415.0036, 415.008 - 415.010, 415.021, 415.023, 415.031, 415.032, 415.034; Government Code §§2001.051, 2001.052, and 2001.056; and Insurance Code §1305.004(a)(10) and §4201.002(13). Labor Code §401.011 defines certain terms that are used under Labor Code, Title 5, Subtitle A (the Act).

Labor Code §401.021(1) provides that except as otherwise provided by Labor Code, Title 5, Subtitle A, a proceeding, hearing, judicial review, or enforcement of a Commissioner order, decision, or rule is governed by the following subchapters and sections of Government Code, Chapter 2001: Subchapters A, B, D, E, G, and H, excluding §2001.004(3) and §2001.005; §§2001.051, 2001.052, and 2001.053; §§2001.056 - 2001.062; and §2001.141(c).

Labor Code §402.001 was amended to provide that except as provided by Labor Code §402.002, the Texas Department of Insurance is the state agency designated to oversee the workers' compensation system of this state and the Division of Workers' Compensation is

established as a division within the Texas Department of Insurance to administer and operate the workers' compensation system as provided by Labor Code, Title 5.

Labor Code §402.00111 provides that except as otherwise provided by Labor Code, Title 5, the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority, under Labor Code, Title 5.

Labor Code §402.00116(a) provides that the Commissioner or Workers' Compensation is the Division's chief executive and administrative officer. The Commissioner shall administer and enforce Labor Code, Title 5, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to the division or the Commissioner, except as otherwise specifically provided by Labor Code, Title 5, a reference in Labor Code, Title 5 to the "commissioner" means the Commissioner of Workers' Compensation.

Labor Code §402.00116(b) provides that the Commissioner has the powers and duties vested in the division by Labor Code, Title 5 and other workers' compensation laws of this state.

Labor Code §402.00128(b) provides that the Commissioner or the Commissioner's designee may investigate misconduct; hold hearings; issue subpoenas to compel the attendance of witnesses and the production of documents; administer oaths; take testimony directly or by deposition or interrogatory; assess and enforce penalties established under this title; enter appropriate orders as authorized by this title; institute an action in the Division's name to enjoin the violation of Labor Code, Title 5; initiate an action under Labor Code §410.254 to intervene in a judicial proceeding; prescribe the form, manner, and procedure for the transmission of information to the Division; correct clerical errors in the entry of errors; and exercise other powers and perform other duties as necessary to implement and enforce Labor Code, Title 5.

Labor Code §402.021(b)(6) states that it is the intent of the legislature that, in implementing the goals described by Subsection (a), the workers' compensation system of this state must promote compliance with this subtitle and rules adopted under this subtitle through performance-based incentives.

Labor Code §402.023(a) provides that "[t]he commissioner shall adopt rules regarding the filing of a compliant under this Labor Code, Title 5, against an individual or entity subject to regulation under this subtitle".

Labor Code §402.035 requires the Division to develop a risk based complaint investigation system and to consider the severity of the alleged violation, whether the alleged violator showed continued or willful noncompliance, whether a Commissioner order has been violated, and other necessary risk based criteria. Labor Code §402.024(b) provides that the Division shall comply with federal and state laws related to program and facility accessibility.

Labor Code §402.061 provides that the Commissioner shall adopt rules as necessary for the implementation and enforcement of Labor Code, Title 5, Subtitle A.

Labor Code §402.072(a) provides that the Division may impose sanctions against any person regulated by the Division under Labor Code, Title 5, Subtitle A.

Labor Code §402.072(b) provides that the Commissioner may impose certain sanctions regarding the right to practice before the division or to suspend for 30 days a license, certification or permit required for practice in the workers' compensation system.

Labor Code §402.072(c) states that a sanction imposed by the Division is binding pending appeal.

Labor Code §408.0043(a) applies to doctors, other than chiropractors or dentists, who perform health care services under Labor Code, Title 5, as doctors performing peer reviews,

utilization reviews, independent reviews, required medical examinations, or who serve on the medical quality review panel or as designated doctors for the Division.

Labor Code §408.0043(b) requires that a doctor described by Labor Code §408.0043(a), other than a chiropractor or dentist, 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.

Labor Code §408.0044 pertains to dentists who perform dental services under Labor Code, Title 5 for peer reviews, utilization reviews, independent reviews, or required dental examinations.

Labor Code §408.0044(b) requires that a dentist who reviews a dental service in conjunction with a specific workers' compensation case must be licensed to practice dentistry.

Labor Code §408.0045 pertains to chiropractors who perform chiropractic services under Labor Code, Title 5 for peer reviews, utilization reviews, independent reviews, required medical examinations, or who serve on the medical quality review panel or as designated doctors providing chiropractic services for the Division.

Labor Code §408.0045(b) requires that a chiropractor who reviews a chiropractic service in conjunction with a specific workers' compensation case must be licensed to engage in the practice of chiropractic.

Labor Code §408.0046 states that the Commissioner may adopt rules as necessary to determine which professional health practitioner specialties are appropriate for treatment of certain compensable injuries and must require an entity requesting a peer review to obtain and provide to the doctor providing the peer review services all relevant and updated medical records.

Labor Code §408.023(h) requires that a utilization review agent or an insurance carrier that uses doctors to perform reviews of health care services provided under Labor Code, Title 5, Subtitle A, including utilization review, only use doctors licensed to practice in this state.

Labor Code §408.023(k) states that Labor Code §408.023(a) - (g) and (i) which developed the approved doctors list will expire September 1, 2007.

Labor Code §408.023(n) and §408.0231(g) require the Commissioner to adopt rules that apply to doctors and health care providers which relate to training, financial disclosure, monitoring, and peer review.

Labor Code §408.0231(g) authorizes the Commissioner to adopt rules regarding doctors who perform peer review functions for insurance carriers, such as, standards for peer review, sanctions against doctors performing peer review functions (including restriction, suspension, or removal of the doctor's ability to perform peer reviews) and other issues important to the quality of peer review.

Labor Code §408.0231(b) authorizes the Commissioner by rule to establish criteria for imposing sanctions on a doctor or an insurance carrier as provided by this section.

Labor Code §408.0231(c) states the criteria for recommending or imposing sanctions that the Commissioner may use (which may include anything the Commissioner considers relevant) including a sanction of the doctor for a violation of Labor Code, Chapter 413 or 415; a sanction by the Medicare or Medicaid program; evidence from the Division's medical records that an 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; professional failure to practice medicine or provide health care, including

chiropractic care, in an acceptable manner consistent with the public health, safety, and welfare; or a criminal conviction.

Labor Code §408.0231(d) requires the Commissioner to establish rules for the restoration of doctor practice privileges removed by the Commissioner for sanctions imposed under Labor Code §408.0231.

Labor Code §408.0231(f) provides the sanctions the Commissioner may recommend or impose under this section which include reduction of allowable reimbursement; mandatory preauthorization of all or certain health care services; required peer review monitoring, reporting, and audit; deletion or suspension from the designated doctor list; restrictions on appointment under this chapter; conditions or restrictions on an insurance carrier regarding actions by insurance carriers and mandatory participation in training classes or other courses as established or certified by the Division under Labor Code, Title 5, Subtitle A, in accordance with a memorandum of understanding adopted under Labor Code §408.0231(e) regarding regulation of insurance carriers and utilization review agents.

Labor Code §413.017 states the following medical services are presumed reasonable: medical services consistent with the medical policies and fee guidelines adopted by the Commissioner; and medical services that are provided subject to prospective, concurrent, or retrospective review as required by the medical policies of the Division and that are authorized by an insurance carrier.

Labor Code §414.002 provides that the Division shall monitor for compliance with Commissioner rules; Labor Code, Title 5, Subtitle A; and other laws relating to workers' compensation the conduct of persons subject to this subtitle. Persons to be monitored include

persons claiming benefits under Labor Code, Title 5, Subtitle A; employers; insurance carriers; attorneys and other representatives of parties; and health care providers.

Labor Code §414.003(a) provides that the Division shall compile and maintain statistical and other information as necessary to detect practices or patterns of conduct by persons subject to monitoring under Labor Code, Chapter 414, that violate Labor Code, Title 5, Subtitle A, Commissioner rules, or a Commissioner order or decision, or otherwise adversely affect the workers' compensation system of this state.

Labor Code §414.003(b) provides that the Commissioner shall use the information compiled under this section to impose appropriate penalties and other sanctions under Labor Code, Chapters 415 and 416.

Labor Code §414.004(a) provides that the Division shall review regularly the workers' compensation records of insurance carriers as required to ensure compliance with Labor Code, Title 5, Subtitle A.

Labor Code §414.004(b) provides that each insurance carrier, the insurance carrier's agents, and those with whom the insurance carrier has contracted to provide, review, or monitor services under Labor Code, Title 5, Subtitle A, shall cooperate with the Division; make available to the Division any records or other necessary information; and allow the Division access to the information at reasonable times at the person's offices.

Labor Code §414.007 provides that the Division shall review information concerning alleged violations of Labor Code, Title 5, Subtitle A regarding the provisions of medical benefits, Commissioner rules, or a Commissioner order or decision, and, under Labor Code §414.005 and §414.006 and Labor Code, Chapters 415 and 416, may conduct investigations, make referrals to other authorities, and initiate administrative violation proceedings.

Amendments to Labor Code §§415.001 - 415.003, 415.0035, 415.009, and 415.010 deleted the requirement that the Division prove that a violation was committed willfully, intentionally, or knowingly in an enforcement action for an administrative violation brought against a system participant under those sections.

Labor Code §415.003 provides that a health care provider commits an administrative violation if the person submits a charge for health care that was not furnished, administers improper, unreasonable, or medically unnecessary treatment or services, makes an unnecessary referral, violates the Division's fee and treatment guidelines, violates a Commissioner rule, or fails to comply with a provision of this subtitle.

Labor Code §415.0035(a)(3) provides that an insurance carrier or its representative commits an administrative violation if that person denies preauthorization in a manner that is not in accordance with rules adopted by the Commissioner under Labor Code §413.014.

Labor Code §415.0035(b) provides that a health care provider commits an administrative violation if that person fails or refuses to timely file required reports or records, or fails to file with the Division the annual disclosure statement required by Labor Code §413.041.

Labor Code §415.0035(e) provides that an insurance carrier or health care provider commits an administrative violation if that person violates Labor Code, Title 5, Subtitle A, or a rule, order, or decision of the Commissioner.

Labor Code §415.0036 applies to an insurance adjustor, case manager, or other person who has authority under Labor Code, Title 5 to request the performance of a service affecting the delivery of benefits to an injured employee or who actually performs such a service, including peer reviews, performance of required medical examinations, or case management; a person described by this section commits an administrative violation if the

person offers to pay, pays, solicits, or receives an improper inducement relating to the delivery of benefits to an injured employee or improperly attempts to influence the delivery of benefits to an injured employee, including through the making of improper threats.

Labor Code §415.0036(b) further provides that the same section applies to each person it describes who is a participant in the workers' compensation system of this state and to an agent of such a person.

Labor Code §415.008(a) provides that a person commits a violation if the person, to obtain or deny a payment of a workers' compensation benefit or the provision of a benefit for the person or another, knowingly or intentionally makes a false or misleading statement, misrepresents or conceals a material fact, fabricates, alters, conceals, or destroys a document, or conspires to commit an act described by Labor Code §415.008(a)(1), (a)(2), or (a)(3).

Labor Code §415.021 states that in addition to any sanctions, administrative penalty, or other remedy authorized by Labor Code, Title 5, Subtitle A, the Commissioner may assess an administrative penalty against a person who commits an administrative violation; the administrative penalty shall not exceed $25,000 per day per occurrence; each day of noncompliance constitutes a separate violation; and the authority of the Commissioner under chapter 415 is in addition to any other authority to enforce a sanction, penalty, fine, forfeiture, denial, suspension, or revocation otherwise authorized by law.

Labor Code §415.023(a) provides that a person who commits an administrative violation under Labor Code §§415.001, 415.002, 415.003, or 415.0035 as a matter of practice is subject to an applicable rule adopted under Labor Code §415.023(b) in addition to the penalty assessed for the violation.

Labor Code §415.023(b) provides that the Commissioner may adopt rules providing for a reduction or denial of fees; public or private reprimand by the Commissioner; suspension from practice before the Division; restriction, suspension, or revocation of the right to receive reimbursement under Labor Code, Title 5, Subtitle A; or referral and petition to the appropriate licensing authority for appropriate disciplinary action, including the restriction, suspension, or revocation of the person's license.

Labor Code §415.031 provides that any person may request the initiation of administrative violation proceedings by filing a written allegation with the Division.

Labor Code §415.032(a) provides that if investigation by the Division indicates that an administrative violation has occurred, the Division shall notify the person alleged to have committed the violation in writing of the charge, the proposed penalty, the right to consent to the charge and the penalty, and the right to request a hearing.

Labor Code §415.032(b) provides that not later than the 20th day after the date on which notice is received by the charged party, the charged party shall remit the amount of the penalty to the Division, or submit to the Division a written request for a hearing. Government Code §2001.051 provides that in a contested case, each party is entitled to an opportunity for hearing after reasonable notice of not less than 10 days and to respond and to present evidence and argument on each issue involved in the case. Government Code §2001.056 provides that unless precluded by law, an informal disposition may be made of a contested case by stipulation, agreed settlement, consent order, or default. Insurance Code §1305.004(a)(10) provides that "independent review" means a system for final administrative review by an independent review organization of the medical necessity and appropriateness, or

the experimental or investigational nature, of health care services being provided, proposed to be provided, or that have been provided to an injured employee.

Insurance Code §4201.002(13) states that "utilization review" includes a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services being provided or proposed to be provided to an individual in this state and the term does not include a review in response to an elective request for clarification of coverage.

Occupations Code §155.001 states that a person may not practice medicine in this state unless the person holds a license issued under Occupations Code, Title 3, Subtitle B (relating to Physicians).

SUBCHAPTER B. MEDICAL BENEFIT REGULATION

The amendments and new sections are adopted under Labor Code §§401.011, 401.021, 402.001, 402.00128, 402.00111, 402.00116, 402.021, 402.024, 402.061, 402.072, 402.073, 402.075, 408.0041, 408.0043 - 408.0046, 408.021, 408.023, 408.0231, 408.1225, 413.002, 413.014, 413.022, 413.031, 413.041, 413.044, 413.051, 413.0511, 413.0512, 414.002 - 414.007, 415.001 - 415.0036, 415.005, 415.006, 415.008 - 415.010, 415.021, 415.023 - 415.025, and 504.053; Government Code, §2001.051 and §2001.056; Insurance Code §§1305.004(a)(10), 1305.351(d), 4201.002(1), and 4201.002(13); and Occupations Code §155.001.

Labor Code §401.011 defines certain terms that are used under Labor Code, Title 5, Subtitle A (the Act). Labor Code §401.021(1) provides that except as otherwise provided by

Labor Code, Title 5, Subtitle A, a proceeding, hearing, judicial review, or enforcement of a Commissioner order, decision, or rule is governed by the following subchapters and sections of Government Code, Chapter 2001: Subchapters A, B, D, E, G, and H, excluding §2001.004(3) and §2001.005; §§2001.051, 2001.052, and 2001.053; §§2001.056 - 2001.062; and Section 2001.141(c).

Labor Code §402.001 was amended to provide that except as provided by Labor Code §402.002, the Texas Department of Insurance is the state agency designated to oversee the workers' compensation system of this state and the Division of Workers' Compensation is established as a division within the Texas Department of Insurance to administer and operate the workers' compensation system as provided by Labor Code, Title 5.

Labor Code §402.00111 provides that except as otherwise provided by Labor Code, Title 5, the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority, under Labor Code, Title 5.

Labor Code §402.00116(a) provides that the Commissioner or Workers' Compensation is the Division's chief executive and administrative officer. The Commissioner shall administer and enforce Labor Code, Title 5, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to the division or the Commissioner, except as otherwise specifically provided by Labor Code, Title 5, a reference in Labor Code, Title 5 to the "commissioner" means the Commissioner of Workers' Compensation.

Labor Code §402.00116(b) provides that the Commissioner has the powers and duties vested in the division by Labor Code, Title 5 and other workers' compensation laws of this state.

Labor Code §402.00128(b) provides that the Commissioner or the Commissioner's designee may investigate misconduct; hold hearings; issue subpoenas to compel the

attendance of witnesses and the production of documents; administer oaths; take testimony directly or by deposition or interrogatory; assess and enforce penalties established under this title; enter appropriate orders as authorized by this title; institute an action in the Division's name to enjoin the violation of Labor Code, Title 5; initiate an action under Labor Code §410.254 to intervene in a judicial proceeding; prescribe the form, manner, and procedure for the transmission of information to the Division; correct clerical errors in the entry of errors; and exercise other powers and perform other duties as necessary to implement and enforce Labor Code, Title 5.

Labor Code §402.021(b)(6) states that it is the intent of the legislature that, in implementing the goals described by Subsection (a), the workers' compensation system of this state must promote compliance with this subtitle and rules adopted under this subtitle through performance-based incentives.

Labor Code §402.024(b) provides that the Division shall comply with federal and state laws related to program and facility accessibility. Labor Code §402.061 provides that the Commissioner shall adopt rules as necessary for the implementation and enforcement of Labor Code, Title 5, Subtitle A.

Labor Code §402.072(a) provides that the Division may impose sanctions against any person regulated by the Division under Labor Code, Title 5, Subtitle A, and Labor Code §402.072(c) states that a sanction imposed by the Division is binding pending appeal.

Labor Code §402.073(b) provides that in a case in which a hearing is conducted by the State Office of Administrative Hearings under Labor Code §§413.031, 413.055, or 415.034, the administrative law judge who conducts the hearing for the State Office of Administrative Hearings shall enter the final decision in the case after completion of the hearing.

Labor Code §402.073(c) provides that in a case in which a hearing is conducted in conjunction with Labor Code §§402.072, 407.046, or 408.023, and in other cases under Labor Code, Title 5, Subtitle A, that are not subject to Labor Code §402.073(b), the administrative law judge who conducts the hearing for the State Office of Administrative Hearings shall propose a decision to the Commissioner for final consideration and decision by the Commissioner.

Labor Code §402.075(a) provides that the Commissioner by rule shall adopt requirement that provide incentives for overall compliance in the workers' compensation system of this state, and emphasize performance-based oversight linked to regulatory outcomes.

Labor Code §402.075(b) provides that the Commissioner shall develop key regulatory goals to be used in assessing the performance of insurance carriers and health care providers. The goals adopted under this subsection must align with the general regulatory goals of the Division under Labor Code, Title 5, Subtitle A, such as improving workplace safety and return-to-work outcomes, in addition to goals that support timely payment of benefits and increased communication.

Labor Code §408.0041(b) requires that a medical examination requested under Labor Code §408.0041(a) be performed by the next available doctor on the Division's list of designated doctors whose credentials are appropriate for the issue in question and the injured employee's medical condition as determined by Commissioner rule.

Labor Code §408.0043(a) applies to doctors, other than chiropractors or dentists, who perform health care services under Labor Code, Title 5, as doctors performing peer reviews, utilization reviews, independent reviews, required medical examinations, or who serve on the medical quality review panel or as designated doctors for the Division.

Labor Code §408.0043(b) requires that a doctor described by Labor Code §408.0043(a), other than a chiropractor or dentist, 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. Labor Code §408.0044 pertains to dentists who perform dental services under Labor Code, Title 5 for peer reviews, utilization reviews, independent reviews, or required dental examinations.

Labor Code §408.0044(b) requires that a dentist who reviews a dental service in conjunction with a specific workers' compensation case must be licensed to practice dentistry.

Labor Code §408.0045 pertains to chiropractors who perform chiropractic services under Labor Code, Title 5 for peer reviews, utilization reviews, independent reviews, required medical examinations, or who serve on the medical quality review panel or as designated doctors providing chiropractic services for the Division.

Labor Code §408.0045(b) requires that a chiropractor who reviews a chiropractic service in conjunction with a specific workers' compensation case must be licensed to engage in the practice of chiropractic. Labor Code §408.0046 states that the Commissioner may adopt rules as necessary to determine which professional health practitioner specialties are appropriate for treatment of certain compensable injuries and must require an entity requesting a peer review to obtain and provide to the doctor providing the peer review services all relevant and updated medical records.

Labor Code §408.021 describes medical benefits and health care that an injured employee is entitled to.

Labor Code §408.023(h) requires that a utilization review agent or an insurance carrier that uses doctors to perform reviews of health care services provided under Labor Code, Title 5, Subtitle A, including utilization review, only use doctors licensed to practice in this state.

Labor Code §408.023(k) states that Labor Code §408.023(a) - (g) and (i) which developed the approved doctors list will expire September 1, 2007. Labor Code §408.023(n) and §408.0231(g) require the Division to monitor and adopt rules regarding doctors who perform peer review.

Labor Code §408.0231(g) authorizes the Commissioner to adopt rules regarding doctors who perform peer review functions for insurance carriers, such as, standards for peer review, sanctions against doctors performing peer review functions (including restriction, suspension, or removal of the doctor's ability to perform peer reviews) and other issues important to the quality of peer review.

Labor Code §408.0231(b) authorizes the Commissioner by rule to establish criteria for imposing sanctions on a doctor or an insurance carrier as provided by this section.

Labor Code §408.0231(c) states the criteria for recommending or imposing sanctions that the Commissioner may use (which may include anything the Commissioner considers relevant) including a sanction of the doctor for a violation of Labor Code, Chapter 413 or 415; a sanction by the Medicare or Medicaid program; evidence from the Division's medical records that an 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; professional failure to practice medicine or provide health care, including

chiropractic care, in an acceptable manner consistent with the public health, safety, and welfare; or a criminal conviction.

Labor Code §408.0231(d) requires the Commissioner to establish rules for the restoration of doctor practice privileges removed by the Commissioner for sanctions imposed under Labor Code §408.0231.

Labor Code §408.0231(f) provides the sanctions the Commissioner may recommend or impose under this section which include reduction of allowable reimbursement; mandatory preauthorization of all or certain health care services; required peer review monitoring, reporting, and audit; deletion or suspension from the designated doctor list; restrictions on appointment under this chapter; conditions or restrictions on an insurance carrier regarding actions by insurance carriers and mandatory participation in training classes or other courses as established or certified by the Division under Labor Code, Title 5, Subtitle A, in accordance with a memorandum of understanding adopted under Labor Code §408.0231(e) regarding regulation of insurance carriers and utilization review agents.

Labor Code §408.1225(a) requires the Division to develop qualification standards and administrative policies pertaining to the doctors who serve on the designated doctor list to implement the subsection and the Division may adopt rules as necessary.

Labor Code §408.1225(b) requires the Commissioner to ensure the quality of designated doctor decisions and reviews by active monitoring of decisions and reviews and to take action as necessary to restrict the participation of a designated doctor or remove a doctor from inclusion on the Division's list of designated doctors.

Labor Code §408.1225(d) requires the Division to develop rules to ensure that a designated doctor has no conflict of interest in serving as a designated doctor in performing examinations.

Labor Code §413.002 requires the Division to monitor health care providers, insurance carriers, independent review organizations, and workers' compensation claimants who receive medical services to ensure the compliance of those persons with rules adopted by the Division relating to health care, including medical policies and fee guidelines. In monitoring designated doctors under Labor Code, Chapter 408, and independent review organizations who provide services described by Labor Code, Chapter 413, Labor Code §413.002(b) requires the Division to evaluate compliance with Labor Code, Title 5, Subtitle A, and with rules adopted by the Commissioner relating to medical policies, fee guidelines, treatment guidelines, return-to-work guidelines, and impairment ratings and the quality and timeliness of decisions made under Labor Code §§408.0041, 408.122, 408.151, or 413.031.

Labor Code §413.014 requires the Commissioner by rule to specify which health care treatments and services require express preauthorization or concurrent review by the insurance carrier.

Labor Code §413.017 states the following medical services are presumed reasonable: medical services consistent with the medical policies and fee guidelines adopted by the Commissioner; and medical services that are provided subject to prospective, concurrent, or retrospective review as required by the medical policies of the Division and that are authorized by an insurance carrier.

Labor Code §413.022 provides requirements for the return-to-work reimbursement program for small employers.

Labor Code §413.031(e-2) requires that independent review organizations that use doctors to perform reviews of health care services provided under Labor Code, Title 5, only use doctors licensed to practice in this state.

Labor Code §413.041(a) provides that each health care practitioner shall disclose to the Division the identity of any health care provider in which the health care practitioner, or the health care provider that employs the health care practitioner, has a financial interest and the health care practitioner shall make the disclosure in the manner provided by Commissioner rule.

Labor Code §413.041(c) provides that a health care provider that fails to comply with this section is subject to penalties and sanctions as provided by Labor Code, Title 5, Subtitle A, including forfeiture of the right to reimbursement for services rendered during the period of noncompliance.

Labor Code §413.044 provides that in addition to or in lieu of an administrative penalty under Labor Code §415.021 or a sanction imposed under Labor Code §415.023, the Commissioner may impose sanctions against a person who serves as a designated doctor under Labor Code, Chapter 408 who, after an evaluation conducted under Labor Code §413.002(b), is determined by the Division to be out of compliance with this subtitle or with the rules adopted by the Commissioner relating to medical policies, fee guidelines, and impairment ratings, or the quality of decision made under Labor Code §408.0041 or Labor Code §408.122.

Labor Code §413.044(b) provides that the sanctions imposed under Labor Code §413.044(a) may include removal or suspension from the designated doctor list, or restrictions on the reviews made by the person as a designated doctor.

Labor Code §413.051(a) provides that in Labor Code §413.051, "health care provider professional review organization" includes an independent review organization. Labor Code §413.0511(b)(8) provides that the medical advisor shall make recommendation regarding the adoption of rules and policies to monitor the quality and timeliness of decision made by designated doctors and independent review organizations, and the imposition of sanctions regarding those decisions.

Labor Code §413.0512(c)(1) provides that the medical quality review panel shall recommend to the medical advisor appropriate action regarding doctors, other health care providers, insurance carriers, utilization review agents, and independent review organization; and the addition or deletion of doctors from the list of approved doctors under Labor Code §408.023 or the list of designated doctors established under Labor Code §408.1225.

Labor Code §414.002 provides that the Division shall monitor for compliance with Commissioner rules; Labor Code, Title 5, Subtitle A; and other laws relating to workers' compensation the conduct of persons subject to this subtitle. Persons to be monitored include persons claiming benefits under Labor Code, Title 5, Subtitle A; employers; insurance carriers; attorneys and other representatives of parties; and health care providers.

Labor Code §414.003(a) provides that the Division shall compile and maintain statistical and other information as necessary to detect practices or patterns of conduct by persons subject to monitoring under Labor Code, Chapter 414, that violate Labor Code, Title 5, Subtitle A, Commissioner rules, or a Commissioner order or decision, or otherwise adversely affect the workers' compensation system of this state.

Labor Code §414.003(b) provides that the Commissioner shall use the information compiled under this section to impose appropriate penalties and other sanctions under Labor Code, Chapters 415 and 416.

Labor Code §414.004(a) provides that the Division shall review regularly the workers' compensation records of insurance carriers as required to ensure compliance with Labor Code, Title 5, Subtitle A.

Labor Code §414.004(b) provides that each insurance carrier, the insurance carrier's agents, and those with whom the insurance carrier has contracted to provide, review, or monitor services under Labor Code, Title 5, Subtitle A, shall cooperate with the Division; make available to the Division any records or other necessary information; and allow the Division access to the information at reasonable times at the person's offices.

Labor Code §414.005 provides that the Division shall maintain an investigation unit to conduct investigations relating to alleged violations of Labor Code, Title 5, Subtitle A; Commissioner rules, or a Commissioner order or decision, with particular emphasis on violations of Labor Code, Chapters 415 and 416.

Labor Code §414.006 provides that for further investigation or the institution of appropriate proceedings, the Division may refer the persons involved in a case subject to an investigation to other appropriate authorities, including licensing agencies, district and county attorneys, or the attorney general.

Labor Code §414.007 provides that the Division shall review information concerning alleged violations of Labor Code, Title 5, Subtitle A regarding the provisions of medical benefits, Commissioner rules, or a Commissioner order or decision, and, under Labor Code §414.005 and §414.006 and Labor Code, Chapters 415 and 416, may conduct investigations, make

referrals to other authorities, and initiate administrative violation proceedings. Amendments to Labor Code §§415.001 - 415.003, 415.0035, 415.009, and 415.010 deleted the requirement that the Division prove that a violation was committed willfully, intentionally, or knowingly in an enforcement action for an administrative violation brought against a system participant under those sections. The amendments to Labor Code §§415.005, 415.006, 415.021, 415.024, and 415.025 deleted the classification system within the sections for administrative violations (Classes A - D) and the authority and requirement that the commission (which pursuant to enactments by HB 7 is now the Texas Department of Insurance, Division of Workers' Compensation), by rule, adopt a schedule of specific monetary administrative penalties for specific violations of the Texas Workers' Compensation Act.

Labor Code §415.003 provides that a health care provider commits an administrative violation if the person submits a charge for health care that was not furnished, administers improper, unreasonable, or medically unnecessary treatment or services, makes an unnecessary referral, violates the Division's fee and treatment guidelines, violates a Commissioner rule, or fails to comply with a provision of this subtitle.

Labor Code §415.0035(a)(3) provides that an insurance carrier or its representative commits an administrative violation if that person denies preauthorization in a manner that is not in accordance with rules adopted by the Commissioner under Labor Code §413.014.

Labor Code §415.0035(b) provides that a health care provider commits an administrative violation if that person fails or refuses to timely file required reports or records, or fails to file with the Division the annual disclosure statement required by Labor Code §413.041.

Labor Code §415.0035(e) provides that an insurance carrier or health care provider commits an administrative violation if that person violates Labor Code, Title 5, Subtitle A, or a rule, order, or decision of the Commissioner.

Labor Code §415.0036 applies to an insurance adjustor, case manager, or other person who has authority under Labor Code, Title 5 to request the performance of a service affecting the delivery of benefits to an injured employee or who actually performs such a service, including peer reviews, performance of required medical examinations, or case management; a person described by this section commits an administrative violation if the person offers to pay, pays, solicits, or receives an improper inducement relating to the delivery of benefits to an injured employee or improperly attempts to influence the delivery of benefits to an injured employee, including through the making of improper threats.

Labor Code §415.0036(b) further provides that the same section applies to each person it describes who is a participant in the workers' compensation system of this state and to an agent of such a person.

Labor Code §415.008(a) provides that a person commits a violation if the person, to obtain or deny a payment of a workers' compensation benefit or the provision of a benefit for the person or another, knowingly or intentionally makes a false or misleading statement, misrepresents or conceals a material fact, fabricates, alters, conceals, or destroys a document, or conspires to commit an act described by Labor Code §415.008(a)(1), (a)(2), or (a)(3).

Labor Code §415.021 states that in addition to any sanctions, administrative penalty, or other remedy authorized by Labor Code, Title 5, Subtitle A, the Commissioner may assess an administrative penalty against a person who commits an administrative violation; the administrative penalty shall not exceed $25,000 per day per occurrence; each day of

noncompliance constitutes a separate violation; and the authority of the Commissioner under chapter 415 is in addition to any other authority to enforce a sanction, penalty, fine, forfeiture, denial, suspension, or revocation otherwise authorized by law.

Labor Code §415.023(a) provides that a person who commits an administrative violation under Labor Code §§415.001, 415.002, 415.003, or 415.0035 as a matter of practice is subject to an applicable rule adopted under Labor Code §415.023(b) in addition to the penalty assessed for the violation.

Labor Code §415.023(b) provides that the Commissioner may adopt rules providing for a reduction or denial of fees; public or private reprimand by the Commissioner; suspension from practice before the Division; restriction, suspension, or revocation of the right to receive reimbursement under Labor Code, Title 5, Subtitle A; or referral and petition to the appropriate licensing authority for appropriate disciplinary action, including the restriction, suspension, or revocation of the person's license.

Labor Code §415.024 provides that a material and substantial breach of a settlement agreement that establishes a compliance plan is an administrative violation. In determining the amount of the penalty, the Commissioner shall consider the total volume of claims handled by the insurance carrier.

Labor Code §415.025 provides that a reference in this code or other law, or in rules of the former Texas Workers' Compensation Commission or the Commissioner, to a particular class of violation, administrative violation, or penalty shall be construed as a reference to an administrative penalty and, except as otherwise provided by Labor Code, Title 5, Subtitle A, an administrative penalty may not exceed $25,000 per day per occurrence and each day of noncompliance constitutes a separate violation.

Labor Code, Title 5, Subtitle C, §504.053(d)(3) provides that if the political subdivision or pool provides medical benefits in the manner authorized under Labor Code §504.0053(b)(2), the following standards apply - the political subdivision or pool must have an internal review process for resolving complaints relating to the manner of providing medical benefits, including an appeal to the governing body or its designee and appeal to an independent review organization.

Labor Code §504.053(b)(2) provides that if a political subdivision or a pool determines that a workers' compensation health care network certified under Insurance Code, Chapter 1305, is not available or practical for the political subdivision or pool, the political subdivision or pool may provide medical benefits to its injured employees or to the injured employees of the members of the pool by directly contracting with health care providers or by contracting through a health benefits pool established under Local Government Code, Chapter 172.

Government Code §2001.051 provides that in a contested case, each party is entitled to an opportunity for hearing after reasonable notice of not less than 10 days and to respond and to present evidence and argument on each issue involved in the case. Government Code §2001.056 provides that unless precluded by law, an informal disposition may be made of a contested case by stipulation, agreed settlement, consent order, or default. Insurance Code §1305.004(a)(10) provides that "independent review" means a system for final administrative review by an independent review organization of the medical necessity and appropriateness, or the experimental or investigational nature, of health care services being provided, proposed to be provided, or that have been provided to an injured employee. Insurance Code §1305.351(d) provides that notwithstanding Insurance Code §4201.152, a utilization review agent or an insurance carrier that uses doctors to perform reviews of health care services provided under

Insurance Code, Chapter 1305, including utilization review and retrospective review, or peer reviews under Labor Code §408.0231(g) may only use doctors licensed to practice in this state.

Insurance Code §4201.002(1) states an "adverse determination" means a determination by a utilization review agent that health care services provided or proposed to be provided to a patient are not medically necessary or are experimental or investigational.

Insurance Code §4201.002(13) states that "utilization review" includes a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services being provided or proposed to be provided to an individual in this state and the term does not include a review in response to an elective request for clarification of coverage. Occupations Code §155.001 states that a person may not practice medicine in this state unless the person holds a license issued under Occupations Code, Title 3, Subtitle B (relating to Physicians).

7. TEXT.

SUBCHAPTER A. General Rules for Enforcement

§180.1. *Definitions*.

The following words and terms, when used in this chapter, shall have the following meanings.

(1) Accident Prevention Services Inspection--An inspection under Chapter 166 under this title (relating to Workers' Health and Safety Accident Prevention Services) that focuses on insurance carrier's duties to provide accident prevention services under Labor Code Chapter 411, Subchapter E and division rules.

(2) Act--The Texas Workers' Compensation Act, Labor Code, Title 5, Subtitle A.

(3) Administrative violation--A violation, failure to comply with, or refusal to comply with the Act, or a rule order, or decision of the commissioner. This term is synonymous with the terms "violation" or "violate."

(4) Agent--A person with whom a system participant utilizes or contracts with for the purpose of providing claims service or fulfilling duties under Labor Code, Title 5 and rules. The system participant who utilizes or contracts with the agent may also be responsible for the administrative violations of that agent.

(5) Appropriate credentials--The certification(s), education, training, and experience to provide the health care that an injured employee is receiving or is requesting to receive.

(6) Audit Violations--Violations discovered through a census or statistical sampling of the alleged violator.

(7) Commissioner--The commissioner of workers' compensation.

(8) Complaint--A written submission to the division alleging a violation of the Act or rules by a system participant.

(9) Compliance Audit (also Performance Review)--An audit of compliance with one or more duties under the Act and rules other than monitoring or review activities involving the Medical Advisor or the Medical Quality Review Panel. These audits are conducted using a census or statistical sampling to ensure that the findings of the audit are representative of overall performance in the area being audited.

(10) Controlled substances--"Controlled substance" as defined by the Texas Controlled Substances Act (Health and Safety Code, Chapter 481) or its successor and the Federal Controlled Substances Act (21 USCS §801 et seq.) or its successor.

(11) Conviction or convicted--

(A) A system participant is considered to have been convicted when:

(i) a judgment of conviction has been entered against the system participant in a federal, state, or local court;

(ii) the system participant has been found guilty in a federal, state, or local court;

(iii) the system participant has entered a plea of guilty or nolo contendere (no contest) that has been accepted by a federal, state, or local court;

(iv) the system participant has entered a first offender or other program and judgment of conviction has been withheld; or

(v) the system participant has received probation or community supervision, including deferred adjudication.

(B) A conviction is still a conviction until and unless overturned on appeal even if:

(i) it is stayed, deferred, or probated;

(ii) an appeal is pending;

(iii) the judgment of conviction or other record related to the conduct is expunged; or

(iv) the system participant has been discharged from probation or community supervision, including deferred adjudication.

(12) Department--Texas Department of Insurance.

(13) Division--Texas Department of Insurance, Division of Workers' Compensation.

(14) Emergency--As defined in §133.2 of this title (relating to Definitions).

(15) Frivolous--That which does not have a basis in fact or is not warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law.

(16) Frivolous complaint--A complaint that does not have a basis in fact or is not warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law.

(17) Immediate post-injury medical care--That health care provided on the date that the injured employee first seeks medical attention for the workers' compensation injury.

(18) Notice of Violation (NOV)--A notice issued to a system participant by the division when the division has found that the system participant has committed an administrative violation and the division seeks to impose a sanction in accordance with Labor Code, Title 5 or division rules.

(19) Peer Review--An administrative review by a health care provider performed at the insurance carrier's request without a physical examination of the injured employee.

(20) Performance Review--This term is synonymous with Compliance Audit, as defined in this section.

(21) Remuneration--Any payment or other benefit made directly or indirectly, overtly or covertly, in cash or in kind, including, but not limited to, forgiveness of debt.

(22) Rules--The division's rules adopted under Labor Code, Title 5.

(23) Sanction--A penalty or other punitive action or remedy imposed by the commissioner on an insurance carrier, representative, injured employee, employer, or health care provider, or any other person regulated by the division under the Act, for an administrative violation.

(24) SOAH--The State Office of Administrative Hearings.

(25) System Participant--A person or their agent subject to the Act or a rule, order, or decision of the commissioner.

§180.2. *Filing a Complaint*.

(a) Any person may submit a complaint to the division for alleged administrative violations.

(b) A person may submit a complaint to the division:

(1) through the division's website;

(2) through electronic correspondence;

(3) through written correspondence;

(4) through facsimile correspondence; or

(5) in person and the complaint will be reduced to writing.

(c) A complaint submitted on the form provided by the division or in any other written format shall contain the following information as applicable:

(1) complainant's name and contact information;

(2) name and contact information of the subject or parties of the complaint, if known;

(3) name and contact information of witnesses, if known;

(4) claim file information including, but, not limited to, the name, address, and date of injury of the injured employee, if known;

(5) the statement of the facts constituting the alleged violation including the dates or time period the alleged violation occurred;

(6) the nature of the alleged violation, including, the specific sections of the Act and division rules alleged to have been violated, if known;

(7) supporting documentation relevant to the allegation that may include, but, is not limited to, medical bills, Explanation of Benefits Statements, copy of payment invoices or checks, and medical reports as applicable;

(8) supporting documentation for alleged fraud may include photographs, video, audio, and surveillance recordings, and reports; and

(9) other sources of pertinent information, if known.

(d) Contact information may include, but, is not limited to, name, address, telephone number, facsimile number, email address, business name, business address, business telephone number, and websites.

(e) A complaint shall contain sufficient information for the division to investigate the complaint.

(f) Upon receipt of a complaint, the division will review, monitor and may investigate the allegation against a person or entity who may have violated the Act or division rules.

(g) The division will assign priorities to complaints being investigated based on a risk-based complaint investigation system that considers:

(1) the severity of the alleged violation;

(2) continued noncompliance of the alleged violation;

(3) whether a commissioner order has been violated; or

(4) other risk-based criteria the division determines necessary.

(h) A person commits an administrative violation if the person submits a complaint to the division that is:

(1) frivolous, as defined in §180.1 of this title (relating to Definitions);

(2) groundless or made in bad faith; or

(3) done specifically for competitive or economic advantage.

§180.3. *Compliance Audits*.

(a) The division shall conduct Compliance Audits of the workers' compensation records of system participants and their agents for compliance with the Act and division rules.

(b) The division may conduct such audit at the offices of a system participant, an agent, or at any location the division deems appropriate. During an audit, the division may, at its discretion, utilize persons in addition to division staff to provide additional expertise.

(c) The division shall provide reasonable notice in advance of any audit. That notice shall:

(1) be in writing;

(2) be sent at least 10 calendar days before the audit is to be performed;

(3) specify the information that must be made available;

(4) list the name and telephone number of the audit coordinator; and

(5) specify the date, time, location, and conditions of the audit.

(d) The system participant being audited (auditee) shall designate a general contact person and a contact person at each relevant location to coordinate the audit. That contact person shall:

(1) provide reasonable access to requested personnel and information;

(2) respond to reasonable needs of auditors onsite or to inquiries by auditors; and

(3) be familiar with the system participant's procedures and recordkeeping systems related to the scope of the audit.

(e) System participants (which may include those who are not being audited but whose records are necessary to conduct an audit of another system participant), upon request, shall make available for review claim files and other workers' compensation records in the format specified by the division.

(f) Initial findings of the audit will be provided in writing to the auditee.

(g) The auditee may prepare and file with the division a management response to the initial findings. The response may include proposed corrective actions. If such a response is provided, the division shall review the response and shall adjust its findings if deemed appropriate.

(h) Final audit reports may be published on the division's Internet website and shall be redacted to not include any confidential claim file information and shall remain on the division's website until a subsequent audit has taken place. The division may, at its discretion, delay publishing the final audit report until a follow-up audit is performed and, should the subsequent audit find the auditee to have achieved standards, may choose to only publish the subsequent audit report. Such a delay will not be considered if the auditee fails to submit a management response that identifies appropriate corrective actions to be taken to achieve standards.

(i) The division, should it deem it appropriate or upon request of a licensing or certification authority, shall provide the appropriate licensing or certification authority with a copy of all final audit reports (redacted in accordance with subsection (h) of this subsection) and the auditee's response to the final audit report, if any.

(j) To the extent permitted by the Act and/or rule, the division shall submit a bill to the auditee for the actual expenses associated with the audit, including audit staff time, additional expertise, travel and per diem expenses, and copying costs.

(k) The auditee shall submit payment by check, made payable to the order of the Texas Department of Insurance, for the expenses within 25 days after receipt of the bill.

§180.8. *Notices of Violation; Notices of Hearing; Default Judgments*.

(a) A notice of violation (NOV) is a notice issued to a system participant when the division finds that the system participant has committed an administrative violation and the division seeks to impose a sanction under the Act or division rules.

(b) A NOV shall be in writing and include:

(1) the provision(s) of the Act, rule, order, or decision of the commissioner that the system participant violated;

(2) a summary of the facts that establish that the violation(s) occurred;

(3) a description of the proposed sanction that the division intends to impose;

(4) the right to consent to the charge and the proposed sanction(s);

(5) the right to request a hearing; and

(6) other information about the rights, obligations, and procedures for requesting a hearing.

(c) The charged party shall file a written answer to the NOV not later than the twentieth day after the day the notice is received. The answer shall either consent to the proposed sanction, and remit the amount of the penalty, if any, or request a hearing by being filed with the commission's chief clerk of proceedings. If the charged party fails to respond to the NOV within

20 days of receipt of the notice, the division shall schedule a hearing at SOAH and provide notice of hearing to the charged party that meets the requirements of §148.5 of this title (relating to Notice of Hearing).

(d) A charged party that receives a notice of hearing under subsection (c) of this section shall, within 20 days of the date on which the notice of hearing is provided to the party, file a written answer or other responsive pleading. Such response shall be filed in accordance with 1 TAC §155.101 (relating to Filing Documents) and §155.103 (relating to Service of Documents on Parties).

(e) For purposes of this section, events described in paragraphs (1) or (2) of this subsection constitute a default on the part of a charged party who receives a notice of hearing under subsection (c) of this section:

(1) failure of the charged party to file a written response as provided by subsection (d) of this section; or

(2) failure of the charged party to appear in person or by legal representative on the day and at the time set for hearing in a contested case, regardless of whether a written response has been filed.

(f) In the event that a charged party defaults as described by subsection (e) of this section, the division may seek informal disposition by default by the entity having the final decision making power as permitted by Government Code §2001.056.

(g) For purposes of this subchapter, "disposition by default" shall mean the issuance of an order against the charged party in which the allegations against the party in the notice of hearing are deemed admitted as true, upon the offer of proof to the entity having the final decision making power that proper notice was provided to the defaulting party. For purposes of

this section, proper notice means notice sufficient to meet the provisions of the Government Code §2001.051 and §2001.052 and §148.5 of this title (relating to Notice of Hearing).

(h) After informal disposition of a contested case by default, a charged party may file a written motion to set aside the default order and reopen the record. A motion by the charged party to set aside the default order and reopen the record shall be granted if the charged party establishes that the failure to file a written response or to attend the hearing was neither intentional nor the result of conscious indifference, and that such failure was due to a mistake or accident. A motion to set aside the default order and reopen the record shall be filed with the entity having the final decision making power.

SUBCHAPTER B. MEDICAL BENEFIT REGULATION.

§180.22. *Health Care Provider Roles and Responsibilities*.

(a) Health care providers as defined in subsections (c) - (e) of this section shall provide all health care reasonably required by the nature of the injury as and when needed to:

(1) cure or relieve the effects naturally resulting from the compensable injury;

(2) promote recovery; or

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

(b) In addition to the general requirements of this section, health care providers shall timely and appropriately comply with all applicable requirements under the Act and department and division rules, including, but not limited to:

(1) reporting required information;

(2) disclosing financial interests;

(3) impartially evaluating an injured employee's condition;

(4) correctly billing for health care provided;

(5) examine an injured employee to determine a date of maximum medical improvement and design impairment ratings as and when appropriate; and

(6) complying with all applicable provisions of the Americans with Disabilities Act.

(c) The treating doctor is the doctor primarily responsible for the efficient management of health care and for coordinating the health care for an injured employee's compensable injury. The treating doctor shall:

(1) except in the case of an emergency, approve or recommend all health care reasonably required that is to be rendered to the injured employee including, but not limited to, treatment or evaluation provided through referrals to consulting and referral doctors or other health care providers, as defined in this section;

(2) maintain efficient utilization of health care;

(3) communicate with the injured employee, injured employee's representative, if any, employer, and insurance carrier about the injured employee's ability to work or any work restrictions on the injured employee;

(4) make available, upon request, in the form and manner prescribed by the division:

(A) work release data;

(B) cost and utilization data; and/or

(C) patient satisfaction data, including comorbidity, patient outcomes, return-to-work outcomes, functional health outcomes, and recovery expectations; and

(5) examine an injured employee to determine a date of maximum medical improvement and assign impairment ratings when appropriate.

(d) The consulting doctor is a doctor who examines an injured employee or the injured employee's medical record in response to a request from the treating doctor, the designated doctor, or the division. The consulting doctor shall:

(1) perform unbiased evaluations of the injured employee as directed by the requestor including, but not limited to, evaluations of:

(A) the accuracy of the diagnosis and appropriateness of the treatment of the injured employee;

(B) the injured employee's work status, ability to work, and work restrictions;

(C) the injured employee's medical condition; and

(D) other similar issues;

(2) submit a narrative report to the treating doctor, the injured employee, the injured employee's representative (if any), the insurance carrier, and the division (if the requestor was the division);

(3) not make referrals without the approval of the treating doctor and when such approval is obtained, ensure that the health care provider to whom the consulting doctor is making an approved referral knows the identity and contact information of the treating doctor;

(4) initiate or provide treatment only if the treating doctor approves or recommends the treatment; and

(5) become a referral doctor if the doctor begins to prescribe or provide health care to an injured employee.

(e) The referral doctor is a doctor who examines and treats an injured employee in response to a request from the treating doctor. The referral doctor shall:

(1) supplement the treating doctor's care;

(2) timely report the injured employee's status to the treating doctor and the insurance carrier as required by applicable division rules; and

(3) not make referrals without the approval of the treating doctor and when such approval is obtained, ensure that the health care provider to whom the referral doctor is making an approved referral knows the identity and contact information of the treating doctor.

(f) The Required Medical Examination (RME) doctor is a doctor who examines the injured employee's medical condition in response to a request from the insurance carrier or the division pursuant to Labor Code §§408.004, 408.0041, or 408.151. The RME doctor shall:

(1) perform unbiased evaluations of the injured employee as directed by the RME notice issued by the division;

(2) not make referrals without the approval of the treating doctor and when such approval is obtained, ensure that the health care provider to whom the RME doctor is making an approved referral knows the identity and contact information of the treating doctor;

(3) initiate or provide treatment only if the treating doctor approves or recommends the treatment; and

(4) not evaluate, except following an examination by a designated doctor:

(A) the impairment caused by the injured employee's compensable injury;

(B) the attainment of maximum medical improvement;

(C) the extent of the injured employee's compensable injury;

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

(E) the ability of the injured employee to return to work; or

(F) issues similar to those described by subparagraphs (A) - (E) of this paragraph; and

(5) be a doctor licensed to practice medicine in Texas that holds the appropriate credentials as defined in §180.1 of this title (relating to Definitions);

(A) a dentist that performs dental services under the Act may review dental services that may lawfully be performed within the scope of the dentist's license to practice dentistry; or

(B) a chiropractor that performs chiropractic services under the Act may review chiropractic services that may lawfully be performed within the scope of the chiropractor's license to engage in the practice of chiropractic.

(g) A peer reviewer is a health care provider who performs an administrative review at the insurance carrier's request without a physical examination of the injured employee. The peer reviewer must not have any known conflicts of interest with the injured employee or the health care provider who has proposed or rendered any health care being reviewed.

(1) A peer reviewer who performs a prospective, concurrent, or retrospective review of the medical necessity or reasonableness of health care services (utilization review) is subject to the applicable provisions of the Labor Code; Insurance Code, Chapters 1305 and 4201; and department and division rules. A peer reviewer who performs utilization review must:

(A) be certified or registered as a utilization review agent (URA) by the department or be employed by or under contract with a certified or registered URA to perform utilization review;

(B) hold the appropriate professional license issued by this state; and

(C) hold the appropriate credentials as defined in §180.1 of this title.

(2) A peer reviewer who performs a review for any issue other than medical necessity, such as compensability or an injured employee's ability to return to work, must:

(A) hold the appropriate professional license issued by this state; and

(B) hold the appropriate credentials as defined in §180.1 of this title.

(h) The designated doctor is a doctor assigned by the division to recommend a resolution of a dispute as to the medical condition of an injured employee. At the request of an insurance carrier or an injured employee, or on the commissioner's own order, the commissioner may order a medical examination by a designated doctor in accordance with Labor Code §408.0041 and §408.1225. The credentials, qualifications, and responsibilities of a designated doctor are governed by §180.21 of this title (relating to Division Designated Doctor List), §180.1 of this title that defines "appropriate credentials", applicable provisions of the Act, and other rules providing for use of a designated doctor.

(i) A member of the MQRP is a health care provider chosen by the division's Medical Advisor under Labor Code §413.0512. All eligibilities, terms, responsibilities, and prohibitions shall be prescribed by contract, and the MQRP members shall serve on the MQRP as prescribed by contract. A health care provider must meet the performance standards specified in the contract to be eligible for selection by the Medical Advisor to serve on the MQRP. A member of the medical quality review panel, other than a chiropractor or dentist, who reviews a specific workers' compensation case is subject to Labor Code §408.0043. Doctors seeking membership on the MQRP must hold appropriate credentials as defined in §180.1 of this title. A chiropractor who serves on the MQRP and that reviews a chiropractic service under the Act must be licensed to engage in the practice of chiropractic pursuant to Labor Code §408.0045.

A health care provider that serves on the MQRP may only review health care services or treatment that may lawfully be performed within the scope of the health care provider's license.

(j) Independent review organizations (IROs) must comply with the applicable provisions of Insurance Code, Chapter 4201; Labor Code, Title 5; and Chapters 12, 133 and 180 of this title (relating to Independent Review Organizations; General Medical Provisions; and Monitoring and Enforcement, respectively). The division or the department may initiate appropriate proceedings under applicable provisions of the Insurance Code, Chapter 4201; Labor Code, Title 5; and Chapters 12, 133 and 180 of this title.

§180.24. *Financial Disclosure*.

(a) Definitions. The following words and terms when used in this section shall have the following meanings unless the context clearly indicates otherwise.

(1) Compensation arrangement--Any arrangement involving any remuneration between a health care practitioner (or a member of a health care practitioner's immediate family) and a health care provider.

(2) Financial interest means:

(A) an interest of a health care practitioner, including an interest of the health care provider who employs the health care practitioner, or an interest of an immediate family member of the health care practitioner, which constitutes a direct or indirect ownership or investment interest in a health care provider; or

(B) a direct or indirect compensation arrangement between the health care practitioner, the health care provider who employs the referring health care practitioner, or an immediate family member of the health care practitioner and a health care provider.

(3) Immediate family member--Immediate family member or member of a doctor's immediate family means husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

(b) Submission of Financial Disclosure Information to the division.

(1) If a health care practitioner refers an injured employee to another health care provider in which the health care practitioner, or the health care provider that employs the health care practitioner, has a financial interest, the health care practitioner shall file a disclosure with the division within 30 days of the date the first referral is made unless the disclosure was previously made. This annual disclosure shall be filed for each health care provider to whom an injured employee is referred and shall include the information in paragraph (2) of this subsection.

(2) The health care practitioner's disclosures in paragraph (1) of this subsection shall at a minimum include:

(A) the disclosing health care practitioner's name, business address, federal tax identification number, professional license number, and any other unique identification number;

(B) the name(s), business address(es), federal tax identification number(s), professional license number(s), and any other unique identification number of the health care provider(s) in which the disclosing health care practitioner has a financial interest as defined in subsection (a)(2) of this section; and

(C) the nature of the financial interest including, but not limited to, percentage of ownership, type of ownership (e.g., direct or indirect, equity, mortgage), type of compensation arrangement (e.g., salary, contractual arrangement, stock as part of a salary payment) and the entity with the ownership (disclosing health care practitioner, the health care provider who employs the health care practitioner, or an immediate family member of the health care practitioner).

(c) Failure to disclose. In addition to any sanctions provided by the Act and rules, failure to disclose a financial interest by a health care provider is an administrative violation and is subject to a penalty of forfeiture of the right to reimbursement for any services rendered on the claim during the period of noncompliance, regardless of whether the circumstances of the services themselves were subject to disclosure, and regardless of whether the services were medically necessary.

(1) Limitations on billing. A health care practitioner who rendered services on a claim during a period in which the practitioner was out of compliance with the disclosure requirements under this section for that claim, regardless of whether the circumstances of the services themselves were subject to disclosure, shall not present or cause to be presented a claim or bill to any individual, third party payer, or other entity for those services (regardless of whether the services were medically necessary).

(2) Refunds. If a health care practitioner collects any amounts that were billed for services on a claim provided during a period in which the practitioner was in noncompliance with the disclosure requirements of this section for that claim, regardless of whether the circumstances of the services themselves were subject to disclosure, the practitioner shall be

liable to the individual or entity for, and shall timely refund, any amounts collected (regardless of whether the services were medically necessary).

(3) Rebuttable Presumption. A referral for services to a health care provider by a health care practitioner under circumstances which required a disclosure under this section, but which was not timely disclosed as required, creates a rebuttable presumption that the services were not medically necessary unless one of the statutory and regulatory exceptions that apply to referrals in Title 42, United States Code §1395nn(b)-(e) applies to the referral in question. Whenever one of these exceptions is revised and effective, the revised exception shall be effective for referrals made on or after the effective date of the revision.

§180.25. *Improper Inducements, Influence and Threats*.

(a) Pursuant to Labor Code §415.0036, offering, paying, soliciting, or receiving an improper inducement relating to the delivery of benefits to an injured employee is prohibited. Improper attempts to influence the delivery of benefits to an injured employee, including the making of improper threats. This section applies to all system participants in the workers' compensation system who have authority under Labor Code, Title 5 to request the performance of a service affecting the delivery of benefits to an injured employee or who actually performs such a service, including peer reviews, performance of designated doctor examinations, performance of required medical examinations, or case management.

(b) The following specific acts will be deemed to be an improper inducement, attempt to influence or threat:

(1) Soliciting or receiving any remuneration (including, but not limited to, any kickback, bribe, or rebate) in return for referring an injured employee to a person (either the person soliciting or receiving the inducement or another person):

(A) for the furnishing or arranging for the furnishing of any item, treatment, or service constituting a medical benefit for which payment may be made in whole or in part under Labor Code, Title 5 or rules; or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, treatment or item constituting a medical benefit for which payment may be made in whole or in part under Labor Code, Title 5 or rules.

(2) Offering or paying any remuneration (including, but not limited to, any kickback, bribe, or rebate) in return for referring an injured employee to a person (either the person offering or paying the inducement or another person):

(A) for the furnishing or arranging for the furnishing of any item, treatment or service constituting a medical benefit for which payment may be made in whole or in part under the Labor Code, Title 5 or rules; or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, treatment, or item constituting a medical benefit for which payment may be made in whole or in part under Labor Code, Title 5 or rules.

(3) Providing any financial incentive or promising or threatening to provide injured employee evaluation reports or other medical opinions that could enhance or reduce the injured employee's income benefits or affect the injured employee's work release status as an

inducement to have the injured employee treat with or be evaluated by the health care provider or comply with the health care provider's proposed treatment.

(4) Offering or soliciting an inducement in return for selecting a particular health care provider for the furnishing or arranging for the furnishing of any item, treatment, or service (including purchasing or leasing) for which payment may be made in whole or in part under Labor Code, Title 5 or rules; or offering or soliciting an inducement which may reasonably tend to cause a particular health care provider to be selected (excluding a convenience necessary to allow for the provision of health care, such as transportation to and from the health care provider's facility, translator services related to evaluation and treatment, providing claim filing forms or information on rights and responsibilities under the Labor Code, Title 5 and rules, if generally available to all patients). Such inducement is improper whether offered directly or indirectly, overtly or covertly, in cash or in kind.

(5) Making, presenting, filing, or threatening to make, present, or file any frivolous claim or assertion against a system participant, medical peer reviewer, or any other person performing duties arising under Labor Code, Title 5 or rules, with the division or any licensing, certifying, regulatory, or investigatory body.

(6) Making or causing to be made a threat against life, safety, or property directed to a system participant related to their performance of duties arising under Labor Code, Title 5 or rules.

(c) The exceptions that apply to subsection (b)(1) and (2) of this section are those that apply to analogous provisions in Title 42, United States Code §1320a-7b(3). The exceptions shall apply to subsection (b)(1) and (2) of this section.

(d) A violation of applicable federal standards that prohibit the payment or acceptance of payment in exchange for health care referrals relating to fraud, abuse, and antikickbacks is an administrative violation.

§180.26. *Criteria for Imposing, Recommending and Determining Sanctions; Other Remedies*.

(a) The division may impose sanctions on any system participant if that system participant commits an administrative violation.

(b) The division may impose the following sanctions against a doctor or insurance carrier for any reason listed in Labor Code §408.0231(c) or any other criteria the commissioner considers relevant:

(1) reduction of allowable reimbursement to a doctor (such as an automatic percentage reduction on all or some types of health care);

(2) mandatory preauthorization or utilization review of all or certain health care treatments and services (such as mandatory treatment plans);

(3) required supervision or peer review monitoring, reporting, and audit (by the insurance carrier, the division, or an independent auditor/reviewer);

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

(5) restrictions on appointments or reviews;

(6) conditions or restrictions on a insurance carrier regarding actions by insurance carriers under the Act and rules, that are not inconsistent with a memorandum of understanding adopted between the commissioner and the commissioner of insurance regarding the regulation of insurance carriers and utilization review agents as necessary to

ensure that appropriate health care decisions are reached under applicable regulations by the department and the division, the Act, and Chapter 4201, Insurance Code; and

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

(c) In addition to a penalty or the other sanctions that may be imposed in accordance with other applicable provisions of the Act, the division may also impose the following sanctions pursuant to Labor Code §415.023(b) against an insurance carrier or its representative, a health care provider, or a representative of an injured employee or legal beneficiary if any of those parties commit an administrative violation as a matter of practice, meaning a repeated violation of the Act or a rule, order, or decision of the commissioner:

(1) a reduction or denial of fees;

(2) public or private reprimand by the commissioner;

(3) suspension from practice before the division;

(4) restriction, suspension, or revocation of the right to receive reimbursement under the Act; and

(5) referral and petition to the appropriate licensing authority for appropriate disciplinary action, including the restriction, suspension, or revocation of the person's license.

(d) In addition to, or in lieu of, the sanctions in subsections (b) and (c) of this section, the division may impose any other sanction or remedy allowed under the Act or division rules, including but not limited to assessing an administrative penalty of up to $25,000 per violation against a person who commits an administrative violation.

(e) When determining which sanction to impose against a system participant and the severity of that sanction, the division shall consider the factors listed in Labor Code §415.021(c) and other matters that justice may require, including but not limited to:

(1) Performance Based Oversight (PBO) assessment;

(2) the promptness and earnestness of actions to prevent future violations;

(3) self-report of the violation;

(4) the size of the company or practice;

(5) the effect of a sanction on the availability of health care; and

(6) evidence of heightened awareness of the legal duty to comply with the Act and Division rules.

(f) In an investigation where both an administrative violation and a criminal prosecution are possible, the division may, at its discretion, postpone action on the administrative violation until the related criminal prosecution is completed.

(g) As an alternative to imposing a sanction such as an administrative penalty on a charged system participant, the division may, at its discretion, provide formal notice of the violation through a Warning Letter. A Warning Letter shall:

(1) include a summary of the duty that the division believes that the charged system participant failed to fulfill or timely fulfill;

(2) identify the facts that establish that a violation occurred; and

(3) inform the charged system participant that subsequent noncompliance of the same sort may be deemed to be a repeated administrative violation or matter of practice any of which will be subject to sanction.

(h) The division may, at its discretion, enter into a consent order with the system participant. A consent order may be entered into before or after issuance of a NOV is issued under §180.8 of this title (relating to Notices of Violation; Notices of Hearing; Default Judgments).

§180.27. *Sanctions Process/Appeals/Restoration*.

(a) If a hearing was conducted in conjunction with Labor Code §§402.072, 407.046, 408.023, and in other cases under the Act that are not subject to Labor Code §402.073(b), the commissioner shall review the proposed decision of the administrative law judge (ALJ). If the commissioner modifies, amends, or changes a recommended finding of fact or conclusion of law, or order of the ALJ, the commissioner's final order shall state the legal basis and the specific reasons for the change.

(b) The division shall notify the person by issuing an order that describes the effects of the sanction. This order shall be delivered by verifiable means with a copy to the appropriate licensing or certification authority and, if the sanction is against a doctor, copies shall be delivered to those injured employees the division is aware are being treated by that doctor.

(c) Failure to comply with the sanction may result in further sanctioning by the division.

(d) In accordance with Labor Code §408.0231(d)(2) a doctor, other than a doctor to which Labor Code §408.023(r) applies, may apply for the restoration of a doctor privilege removed under Labor Code §408.0231 by sending a letter of consideration to the Medical Advisor.

(1) The request shall be evaluated by the Medical Advisor and /or members of the Medical Quality Review Panel. The requestor shall be liable for the cost of the review, which may include an audit of the records of the requestor.

(A) If, in the Medical Advisor's opinion, the doctor:

(i) has all the appropriate unrestricted licenses/certifications;

(ii) has overcome the conditions that resulted in the sanction;

(iii) meets all the division's qualification standards and conditions for restoration of some or all of the practice privileges removed; and

(iv) is not out of compliance with the Labor Code, Insurance Code, a department rule, or a rule, order, or decision of the commissioner the Medical Advisor may recommend that the commissioner lift the sanction(s) or restore some or all of the privileges removed or restricted by the sanction(s).

(B) If in the Medical Advisor's opinion, the doctor has not met all the requirements for restoration of privileges, the Medical Advisor shall notify the doctor by verifiable means of the intent to recommend to the commissioner that the sanctions not be lifted or that the privileges removed or restricted by the sanction(s) not be restored in whole or in part and the reasons for that recommendation. Within 15 days after receiving the notice, a doctor may file a response that addresses the reasons given in the recommendation to deny lifting the sanction(s) or restoration of some or all of the privileges removed or restricted by the sanction(s). The Medical Advisor shall review the response and make a final recommendation to the commissioner. A copy of the requestor's response to the division shall be provided to the commissioner for consideration.

(2) The commissioner shall consider the matter and shall notify the requestor of the final decision by verifiable means, and may send a copy to the appropriate licensing or certification authority. If the commissioner does not lift the sanction, the commissioner may include in the final decision the conditions that the doctor must meet before the division will reconsider lifting the sanctions including, but not limited to, the amount of time that the doctor must wait prior to re-requesting lifting the sanction(s) or restoration of some or all of the privileges removed or restricted by the sanction(s).

§180.28. *Peer Review Requirements, Reporting, and Sanctions*.

(a) A peer reviewer's report, including a report used to deny preauthorization, shall document the objective medical findings and evidence-based medicine that supports the opinion and include:

(1) the peer reviewer's name and professional Texas license number;

(2) certification that the peer reviewer holds the appropriate credentials as defined in §180.1 of this title (relating to Definitions);

(3) a summary of the reviewer's qualifications;

(4) a list of all medical records and other documents reviewed by the peer reviewer, including dates of those documents;

(5) a summary of the clinical history; and

(6) an analysis and explanation for the peer review recommendation, including the findings and conclusions used to support the recommendations.

(b) The insurance carrier shall not request subsequent peer reviews regarding the medical necessity of health care for dates of services for which a peer review report has already been issued unless:

(1) the review is for a different health care service requiring review by a different peer review specialty;

(2) the insurance carrier needs clarification of the peer review opinion based on new medical evidence that has not been presented to the peer reviewer;

(3) the peer reviewer failed to fully address the questions submitted by the insurance carrier; or

(4) for purposes other than determining medical necessity of the health care.

(c) The insurance carrier shall submit a copy of a peer review report to the treating doctor and the health care provider who rendered or requested the health care, as well as the injured employee and injured employee's representative, if any, when the insurance carrier uses the report to deny the compensability or extent of the compensable injury or reduce or deny income or medical benefits of an injured employee.

(d) A peer reviewer and insurance carrier shall maintain accurate records to reflect information regarding requests, reports, and results for peer reviews. The insurance carrier and peer reviewer shall submit such information at the request of the division in the form and manner proscribed by the division. The division will monitor peer review use, activity, and decisions which may result in the initiation of a medical quality review or other division action.

(e) The commissioner may impose sanctions on health care providers performing peer reviews pursuant to §180.26 and §180.27 of this title (relating to Criteria for Imposing, Recommending and Determining Sanctions; Other Remedies; and Sanctions

Process/Appeals/Restoration, respectively) and other applicable provisions of the Labor Code and division rules. The commissioner may prohibit a doctor from conducting peer reviews for any of the following:

(1) non-compliance with the provisions of §180.22 of this title (relating to Health Care Provider Roles and Responsibilities), this section, or applicable provisions of the Act, or a rule, order, or decision of the commissioner;

(2) failure to consider all records provided for review;

(3) a history of improper or unjustified decisions regarding the medical necessity of health care reviewed;

(4) failure to hold the appropriate professional license issued by this state;

(5) review of health care without holding the appropriate credentials, as defined in §180.1 of this title, in a health care specialty appropriate to the type of health care reviewed; or

(6) any other violation of the Labor Code or division rules.

(f) In accordance with Labor Code §408.0046, an entity requesting a peer review must obtain and provide to the doctor providing peer review services all relevant and updated medical records.

§180.50. *Severability*.

Where any provisions of this chapter are determined by a court of competent jurisdiction to be inconsistent with any statutes of this state, or to be unconstitutional, the remaining provisions of this chapter shall remain in effect.

8. CERTIFICATION. This agency certifies that the adopted amendments and new sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on December 20, 2010.

_____
Dirk Johnson
General Counsel
Texas Department of Insurance,
Division of Workers' Compensation

IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that §§180.1-180.3, 180.8, 180.22, 180.24, 180.25, 180.26, 180.27, 180.28, and 180.50 concerning definitions; filing a complaint; compliance audits; notices of violation; notices of hearing; default judgments; health care provider roles and responsibilities; financial disclosure; improper inducements, influence and threats; sanctions process/appeals/restoration; peer review requirements, reporting, and sanctions; criteria for imposing, recommending, and determining sanctions; other remedies; and severability are adopted.

AND IT IS SO ORDERED:

_____
ROD BORDELON
COMMISSIONER OF WORKERS' COMPENSATION

ATTEST:

_____
Dirk Johnson
General Counsel

COMMISSIONER ORDER NO _____

***** Section 180.3 and §180.50 were not republished by the Texas Register due to both sections being adopted without changes from proposal; however as a convenience to system participants, the Division has provided the text of both sections in this adoption document.