§§126.5 - 126.7

1. INTRODUCTION. The Commissioner of the Division of Workers' Compensation, Texas Department of Insurance, adopts amendments to §126.5 and §126.6 and new §126.7, concerning required medical evaluations, entitlement and procedures for requesting a designated doctor. The new and amended sections are adopted with changes to the proposed text as published in the February 3, 2006 issue of the *Texas Register* (31 TexReg 664).

2. REASONED JUSTIFICATION. The new and amended sections are necessary to implement changes to the Labor Code §§408.004, 408.0041, and 408.151 as a result of House Bill (HB) 7, enacted by the 79th Legislature, Regular Session. HB 7 amended Labor Code §408.004 to limit the use of a required medical examination (RME) prior to a designated doctor examination to only the resolution of issues regarding the appropriateness of the health care received by an injured employee (employee). HB 7 also amended Labor Code §408.0041 by expanding the scope of issues a designated doctor may be requested to address. The amendments to §126.5 and §126.6 and new §126.7 are necessary to implement amendments to Labor Code §§408.004, 408.0041 and 408.151 which establish the requirements and processes for requesting and scheduling an RME and designated doctor examination. These adopted rules reflect the Division's efforts to implement the statutory requirements of HB 7 with stakeholder

input and public comment. The Division has made changes to the sections based on public comment and for clarification purposes. The Division added notification to the employee's representative, if any, where appropriate in §126.6 and §126.7 as suggested by commenters. The other changes are more fully discussed below in this preamble.

3. <u>HOW THE SECTIONS WILL FUNCTION.</u> Section 126.5 provides procedural direction and guidance regarding the reasons and timeframes an RME may be requested and granted. Consistent with Labor Code §§408.004, 408.0041 and 408.151, §126.5 specifies the reasons and times during the lifetime of the claim an insurance carrier or the Commissioner of Workers' Compensation may require an RME. The Division has made changes to §126.5 as a result of public comment to clarify that it's the requesting party's responsibility to ensure that an RME doctor does not have a disqualifying association and to change the number of days from 10 to 15 for an employee to agree to an examination. Other changes have been made for clarification purposes.

Section 126.6 provides procedural direction and guidance regarding scheduling RMEs, rescheduling RME appointments when there is a scheduling conflict, filing of reports by the RME doctor, suspending of temporary income benefits (TIBs) when the employee fails to attend, without good cause, a required medical examination following

a designated doctor examination, and the reinstating of TIBs when the employee submits to a rescheduled examination.

Subsection (a) provides that the Division will grant or deny the requests for an RME within seven days of receipt of the request. The Division will provide a copy of the notice for the RME to the injured employee, employee's representative, if any, and the insurance carrier. Subsection (a) also requires the notice to provide information that failure to attend the examination may result in the loss of benefits and an administrative penalty. Subsection (b) requires a rescheduled examination resulting from a schedule conflict be rescheduled within seven days of the originally scheduled exam unless the employee and RME doctor agree to an extension. Based on public comment, the Division has added language to limit the amount of time for an extension to 30 days from the originally scheduled exam. Subsection (e) requires a report to be filed regarding the findings of the RME by the RME doctor who performed an examination regarding the appropriateness of medical care received by the injured employee pursuant to §408.004. It also provides with whom the report shall be filed and the manner in which the report is to be filed. Based on comments received, the Division has added a description of when a notice is considered verifiable. The Division has also made changes to subsections (f), (h), and (j) as a result of public comments. The changes include notice to the employee and employee's representative, if any, of the MMI or impairment rating; require an RME to file a narrative report within seven days of the exam if it addresses issues other than those in subsections (f) and (g); require an

RME doctor to reschedule an exam as soon as possible but no later than 30 days after contact from the employee if TIBs have been suspended; reinstate TIBs as of the date the employee submits to the exam; and reinitiate TIBs when the carrier is notified that the employee had good cause for not attending the exam.

New §126.7 provides procedural direction and guidance regarding the request for, and selection of, a designated doctor consistent with the amendments to Labor Code §408.0041. The section also provides procedural direction and guidance regarding the scheduling of the designated doctor examination, the suspension of TIBs for failure to attend the examination without good cause, the reinstatement of TIBs when the injured employee submits to the examination, and the responsibilities of the designated doctor. As a result of public comment, the Division made changes to subsection (e)(5) to clarify that the Division will appoint a new designated doctor if an exam cannot be rescheduled with the existing designated doctor within 21 days. In subsection (g) in response to comments, the Division has changed the requirement for reinstatement of TIBs to submission to the exam rather than rescheduling the exam. The Division also added that TIBs is reinstated when the carrier is notified that the employee had good cause for not attending the exam. The Division has changed subsection (i) to clarify that when using the same designated doctor only those records not previously submitted have to be provided for a subsequent exam and deleted the requirement that original records be left intact. The Division made changes to subsection (j) to clarify that a medical history should be obtained from the employee. In

subsection (k), the testing completion requirement of seven days has been changed to 10 days as well as changing the trigger for filing the report from utilizing another health care provider to the need for additional testing. Subsections (n), (o) and (p) specify the required reports for the designated doctor to file pertaining to the type of examination conducted. The Division has changed subsection (u) based on public comments to clarify that the designated doctor must be currently on the list at the time a request is received and that the designated doctor shall respond within five days to a letter of clarification. The Division has also changed the requirements when a reexamination is necessary.

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

General: A commenter states the rules need to be rewritten to eliminate the worthless and meaningless definitions of the various types of physicians and the restrictions on the examinations. A commenter believes that the independent review process becomes meaningless by changing the definitions and authority of the different physicians in the system. A commenter contends that networks will make sure these rules don't apply to them so that they may have as many RMEs and designated doctors as they want.

Agency Response: The Division disagrees that the rules need to be rewritten. The Division believes the rules provide clarification to doctors who perform RMEs and information regarding when they may appropriately perform an examination on an injured employee based on new statutory requirements and restrictions enacted under

HB 7. Labor Code §408.004(f) is clear regarding the applicability of RMEs for injured employees receiving care through a network. An injured employee who receives care through a network may not be required to attend an RME regarding appropriateness of medical care. However, in accordance with §408.0041, an injured employee receiving care through a network may be required to attend an RME that addresses MMI/IR, return-to-work, extent of injury or causation after a designated doctor examination on the same issue.

§126.5: A commenter states that there should only be "treating doctor" and "independent medical examination physicians." He contends the designated doctor process has been destroyed over the years.

Agency Response: The Division disagrees that there should only be two types of doctors in the system, and no designated doctors. Labor Code §404.0041 requires designated doctors to be in the system.

Comment: A commenter questions who determines what is "unbiased," and states that Hearing Officers and Appeal Panel Decisions cannot be used.

Agency Response: The Division determines what is an unbiased report. The Contested Case Hearing Officers and Appeals Panel judges make determinations as to the appropriateness, accuracy and applicability of the differing medical opinions during the dispute resolution process.

Comment: A commenter states the rule allows for too many "opinions," and that special training and medical literature should be used to clarify controversies.

Agency Response: The Division disagrees. The statute provides for opinions by treating doctors, required medical exam doctors, and designated doctors. Additionally, medical literature may be a resource to doctors in the system, but it does not take the place of a physical examination of the employee regarding the specific issues in question or dispute.

Comment: A commenter states that it is horrible that an RME doctor could become a treating doctor or take over the injured employee's care and that this should only happen when there is a predetermined special medical need.

Agency Response: The Division disagrees. The employee may choose the RME doctor as the employee's treating doctor. However, the workers' compensation healthcare networks may prohibit this type of practice since injured employees receiving treatment through a network can only be treated by a doctor authorized/approved by the network.

Comment: A commenter states that networks and employees should be allowed to request RMEs.

Agency Response: The Division disagrees. Labor Code §408.004 does not allow a network or an injured employee to request an RME. Only the Commissioner of Workers' Compensation or the insurance carrier may request or require an RME.

Comment: A commenter states there should not be a limit on the number of physicians per claim that can perform an RME, and that any number of RME physicians per claim could be agreed on and used.

Agency response: The Division disagrees. Labor Code §408.004(b) requires the use of the same doctor for subsequent exams unless otherwise approved by the Commissioner.

Comment: A commenter states RME doctors should be required to have the same level of Division approved training as designated doctors, and that their decisions should be tracked.

Agency Response: The Division agrees in part and disagrees in part. The Division agrees that an RME doctor that performs MMI/IR certifications must be trained and certified by the Division in the same manner as a designated doctor. They are currently required to meet the same training requirements for this type of exam as the designated doctor, and this requirement will continue. The Division disagrees that an RME doctor is required to have the same level of training across the board as a designated doctor. Not every RME doctor will be requested to perform the types of exams that designated

doctors will perform. Labor Code §408.1225 requires the designated doctor to meet specified requirements. There are no equivalent requirements regarding RME doctors.

Comment: A commenter states it is too much to see another doctor, and that she loses time getting well waiting on what her primary doctor wants to do.

Agency Response: The Labor Code specifically permits an insurance carrier to require an exam with a doctor of its choice. If the commenter is unhappy with the treatment received from the treating doctor, the commenter should discuss treatment concerns with the treating doctor and consider requesting a change of treating doctor.

Comment: A commenter requests the Division to specifically state the effective date of the rule as the effective date for a carrier is on or after the date provided by the rule.

Agency Response: The effective date of the rules is January 1, 2007. The Division has specified the date that a request for an RME may be made in §§126.5 - 126.7 and 130.6 as on or after January 1, 2007.

§126.5 & §126.7: A commenter states that the rules lay out a cumbersome process that many doctors may not want to participate in. The commenter also believes the rules are positive because they place responsibilities on the injured employee.

Agency Response: The Division disagrees in part and agrees in part. The Division disagrees that the rules lay out a cumbersome process and feels that the rules as

written lay out reasonable procedural guidance regarding the request for and performance of an RME and designated doctor exam. The Division agrees that the rules place requirements on the injured employee.

§126.5(a): A commenter states there is no Labor Code provision that prohibits a doctor from performing as an RME doctor because he belongs to the same network as the employee's treating doctor.

Agency Response: Although there is no provision in the Labor Code for this prohibition, the Insurance Code §1305.101(b) prohibits a doctor from performing as a designated doctor or required medical exam doctor on an employee that is receiving care through a network with which the doctor is employed or contracted.

Comment: A commenter suggests clarifying up front that prior to a designated doctor exam an RME may only be used to evaluate the appropriateness of health care.

Agency Response: The Division has structured the rule in subsection (c)(1), (2) and (3) to provide clarification as to when an RME may be requested and scheduled.

§126.5(b): A commenter states the carrier is entitled to an RME under specified circumstances. The commenter also states that "similar issues" should not be deleted, and that the proposed language does not track the statute. Another commenter asserts that Labor Code §408.004(a) and (b) are parallel provisions. The commenter states

that the Division's ability to require an RME under subsection (a) is "on its own motion," and limited to only the issue of appropriateness of medical care; however, under subsection (b), the insurance carrier may request an RME for any reason set forth in §408.004, including an exam on the issue of "whether treatment should be extended to another body part or system" and "a change in the employee's condition and whether it is necessary to change the employee's diagnosis."

Agency Response: The Division disagrees that the insurance carrier is entitled to an RME under specified circumstances. The Division's interpretation is that the Division's ability to order an RME, on its own motion or at the request of the carrier, is restricted to only the issue of appropriateness of medical care. There is no statutory provision in subsection (a) that an RME may be ordered only at the Division's own motion. The Division also interprets subsection (b) to restrict the Division's ability to require an employee to attend an RME until after the insurance carrier has first attempted to seek the employee's agreement to attend. The statutory provision the commenter references regarding exams on issues other than appropriateness of medical care is permissive based on the Commissioner of Workers' Compensation adopting rules to allow the additional exams. The Division has determined that the use of additional RME exams as previously allowed by §408.004 is not a tool that has been widely used. Division records indicate that in FY2004, only 151 requests for additional exams were received with 91 being approved. In FY2005, 150 requests were received with 81 being approved. Additionally, the "similar issues" provision of Labor Code §408.0041 would

seem logical for the types of exams to which the commenter referred. Labor Code §408.004(b) provides that the Commissioner of Workers' Compensation may adopt rules that allow up to three medical examinations in a 180-day period for specific circumstances. The Division is not adopting rules to allow the additional exams. The Division has determined that this provision is not necessary, as the designated doctor process will handle the need for the additional exams.

The Division disagrees that "similar issues" should not be deleted. The provision for an RME on "similar issues" was removed from Labor Code §408.004 by HB 7 and replaced in §408.0041 regarding designated doctor exams.

§126.5(c)(1) & §126.7(t): Several commenters question why the additional reasons for requesting an RME more frequently than 180 days are being deleted. The commenters contend that an RME should be allowed as often as necessary, not once every 180 days or once a year. Several commenters recommend amending the section to allow for one RME for return to work every 180 days, rather than once per year, after the second anniversary of SIBs.

Agency Response: The reason for the deletion of the additional RMEs is due to previous non-use of the rule to request additional RMEs. The reasons for the additional RMEs provided in Labor Code §408.004 can be handled appropriately under the "similar issues" provision of Labor Code §408.0041. Additionally, by handling the reasons for additional RMEs as a "similar issue" under §408.0041, the carrier could

request the designated doctor exam on these issues every 60 days rather than every 180 days as allowed by §408.004. Labor Code §408.004(b) restricts the carrier's ability to obtain an RME to once every 180 days. The Division disagrees that the insurance carrier should be able to request an RME for return to work every 180 days. Labor Code §408.151(a) limits the insurance carrier's ability to require the injured employee to attend an RME more than once per year after the second anniversary of entitlement to SIBs.

§126.5(c)(3): Several commenters recommend amending subsection (c)(3) to allow for one RME for return to work every 180 days, rather than once per year, after the second anniversary of SIBs. The commenter also states the insurance carrier should be able to request an RME if the injured employee's condition worsens after MMI has been certified and the injured employee applies for lifetime income benefits (LIBs).

Agency Response: The Division disagrees that the insurance carrier should be able to request an RME for return to work every 180 days. Labor Code §408.151(a) limits the insurance carrier's ability to require the injured employee to attend an RME more than once per year after the second anniversary of entitlement to SIBs.

The Division agrees in part and disagrees in part regarding the comment that the insurance carrier should be able to request an RME if the injured employee's condition worsens after MMI has been certified and the injured employee applies for LIBs. In the situation provided it appears this would be an extent of injury issue. The Division

disagrees that the carrier can proceed directly to an RME. The Division agrees the insurance carrier should be able to have a doctor review the extent of the injured employee's injury in an effort to determine if the injured employee's injury meets the requirement for LIBs. An examination by the designated doctor under Labor Code §408.0041 is available for this purpose. After the designated doctor's examination, the insurance carrier will be entitled to an RME on the issue. Additionally, since entitlement to LIBs is based on the severity of the injury, not on the injured employee's ability to work, a request for an exam regarding return to work is not appropriate.

§126.5(d): Several commenters recommend removing the requirement that an RME doctor to be on the Division's approved doctor list (ADL). Some commenters also state that many good doctors became unavailable after the ADL went into effect in 2003 and removing the restriction would make more doctors available, particularly specialists, such as urologists and psychiatrists.

Agency Response: The Division disagrees. Labor Code §408.023 requires RME doctors to be on the ADL and thus, these doctors should have the same training as other doctors practicing within the system. Additionally, an RME doctor has to be on the ADL to be able to certify MMI/IR. However, pursuant to Labor Code §408.023(k) the requirements of the ADL expire on September 1, 2007 and this requirement will no longer be in effect.

Comment: A commenter recommends adding language to clarify that the MMI/IR exam is after a designated doctor exam.

Agency Response: The Division agrees and has changed the language.

§126.5(e): A commenter recommends amending the reference to "subsection (b)(2) and (3)" to "subsection (c)(2) and (3)" since there is no (b)(2) and (3).

Agency Response: The Division agrees and has corrected the cite. Additionally, the Division changed the reference to "subsection (g)" to the appropriate cite.

§126.5(e)(2): Several commenters recommend deleting "on the fifth day after," as the time allowed under the current rule is sufficient.

Agency Response: The intent of the proposal was to provide the injured employee 10 days to reach agreement with the insurance carrier. The outcome of this intent is that the injured employee has 15 days after the request is sent, considering §102.5, to reach agreement with the insurance carrier. The Division has clarified that the injured employee has 15 days to agree to the insurance carrier's request.

Comment: A commenter states that the injured employee rarely agrees to attend the RME. The commenter further states there is no legitimate reason to extend the timeframe for the injured employee to agree to the exam from 10 days to 15 days since the Division almost always approves the carrier's request. A commenter states that

some parties will wait until the 10th day only to not agree to the exam, prolonging the time required to get approval for the RME.

Agency Response: The Division disagrees. The employee should be allowed a sufficient amount of time to make a decision. Additionally, the rule provides that the adjuster may contact the employee, or the employee's representative, by telephone to obtain the employee's response.

§126.5(f)(2): A commenter agrees with the deletion of this subsection from the existing rule. He states the provision created confusion regarding whether a carrier is allowed a different doctor when the request is pursuant to Labor Code §408.004 or §408.0041.

Agency Response: The Division acknowledges the comment and agrees that the carrier may request a different doctor to perform the exam pursuant to Labor Code §408.004 or §408.0041. The Division does not agree that the carrier may request different doctors for post-designated doctor exams based on the multiple issues addressed by the designated doctor. The RME doctor selected by the carrier for the post-designated doctor exam should be qualified to address all the issues addressed by the designated doctor.

§126.6: A commenter states it is a waste of time going to the insurance carrier's doctor. She believes that is why employees don't get well and states that the insurance carriers think the injured employees are faking.

Agency Response: The Division disagrees. Labor Code §§408.004, 408.0041 and 408.151 entitle an insurance carrier to an exam performed by a doctor of its choice. Section 408.004 requires an employee to submit to medical examinations to resolve any question about the appropriateness for health care received by the employee. Section 408.0041(a) authorizes the Commissioner to order a medical examination to resolve any questions about (1) the impairment caused by the compensable injury; (2) the attainment of maximum medical improvement; (3) the extent of the employee's compensable injury; (4) whether the injured employee's disability is the direct result of the work-related injury; (5) the ability of the employee to return to work; or (6) other issues similar to those described in subdivisions (1) - (5). Section 408.151(b) states that if a dispute exists as to whether the employee's medical condition has improved sufficiency to allow the employee to return to work, the Commissioner shall direct the employee to be examined by a designated doctor chosen by the Division.

Comment: A commenter contends that RMEs are occurring prior to the designated doctor exam rather than after as required by statute. The commenter recommends that a statistical analysis of RME doctors' exams be compared with an analysis of designated doctor exams.

Agency Response: The Division has structured the rule to be consistent with the statute, which does not authorize or allow this. If the commenter is aware of violations

of the statute and rule occurring, then he should report these violations to the Division so that appropriate action can be taken.

Comment: A commenter states that since this rule pertains to carrier-selected and Division-appointed RMEs, it should be noted that the authority to order exams under Labor Code §408.004 does not apply to health care provided pursuant to a workers' compensation health care network (WCHCN).

Agency Response: The Division disagrees. Section 126.6 addresses RMEs for issues other than appropriateness of medical care. It also addresses RMEs allowed by Labor Code §408.0041, which may be requested by the employee in addition to the insurance carrier. Section 126.5(c)(1)provides the requested clarification that RMEs to address appropriateness of medical care may not be performed on employees receiving medical care through a workers' compensation health care network.

Comment: A commenter states that since the Division has not repealed §134.650 regarding Prospective Review of Medical Exams (PRME), it should be stated in the rule that the Division may not require an RME for employees covered by a WCHCN.

Agency Response: The Division disagrees. The Division intends to adopt treatment guidelines in the near future. The adoption of the treatment guidelines, along with the expanded role of the designated doctor, is anticipated to eliminate the need for the PRME rule. The Division intends to repeal §134.650 when the treatment guidelines

have been implemented. An exception to the PRME rule in this rule would be inappropriate at this time. Additionally, the restriction on the use of a PRME for an injured employee receiving care through a network can be addressed through procedural guidance and training of Division staff.

Comment: A commenter states that the rules lay out a cumbersome process that many doctors may not want to participate in. The commenter also believes the rules are positive because they place responsibilities on the injured employee.

Agency Response: The Division disagrees in part and agrees in part. The Division disagrees that the rules lay out a cumbersome process and feels that the rules as written lay out reasonable procedural guidance regarding the request for and performance of an RME and designated doctor exam. The Division agrees that the rules place requirements on the injured employee.

§126.6(a): A commenter questions whether "notice" carries the same compliance weight as "order," and whether there is a difference between the two words.

Agency Response: The Division assures the commenter that notice does carry the same compliance requirement as order. If an injured employee does not comply with the requirements of the notice, the carrier can still take the same action that it previously could take for non-compliance. The Division has merely clarified what its practice has been by changing the word. The Division was providing notice to the employee but was

referring to that notice as an order. No change has occurred in any of the requirements of the parties or the need to comply with any of the provisions of the rules. The change was made to be consistent with the actual practices of the Division and with those of the Department.

§126.6(a), (b) & (k): Several commenters state that the Division notice requiring the injured employee to attend an RME should also include notice that a party may not ignore the order because of some perceived fault by the Division in approving the request. A commenter states that some attorneys are advising their injured employee clients not to attend the RME because the attorney believes the Division should not have approved the request.

Agency Response: The Division disagrees. The Division does not believe that clarification needs to be provided to advise participants in the workers' compensation system that failure of one party to comply with statute or rules does not negate the other party's obligation to comply with statutory or rule requirements. Failure of a system participant to comply with a requirement of the Division or the Commissioner of Workers' Compensation may result in the issuance of an administrative penalty.

§126.6(b): A commenter states the requirement for the exam to be conducted within 30 days from receipt of the notice, with 10 days notice to the employee, is unreasonable. Even when scheduling the exam in advance, delays by the Division make it impossible

to meet the required timeframes. The commenter also states some attorneys are advising their injured employee clients to not attend the exam if the employee does not receive 10 days notice of the scheduled examination. A commenter states there is no statutory authority for limiting the amount of time the order is valid.

Agency Response: The Division disagrees. According to agency records, a request for an RME is processed, on average, in less than three days from receipt by the Division. Taking into consideration distribution to the insurance carrier through the Austin Rep Box, the request for an RME is processed and a response provided to the carrier within seven days of receipt by the Division. Failure of one party to comply with statutory or rule provisions does not negate the other party's obligation to comply with statutes or rules. Failure of a system participant to comply with a requirement of the Division or the Commissioner of Workers' Compensation may result in the issuance of an administrative penalty. The Division is not limiting the amount of time the notice is valid. The notice of required attendance does not become invalid due to noncompliance by one of the parties. If the carrier does not meet the requirement to schedule the exam timely, the carrier may be assessed an administrative penalty. The injured employee is still required to attend the exam. If the employee does not attend the exam, the employee is subject to an administrative penalty and/or suspension of temporary income benefits.

Comment: A commenter states there needs to be a limit on how far out and how many times an appointment may be rescheduled.

Agency Response: The Division agrees in part and disagrees in part. The Division disagrees that there needs to be a specific number of times an appointment can be rescheduled based on scheduling conflicts between the doctor and the employee as long as communication between the doctor and employee is taking place. The Division agrees that a limit should be set on how far out the exam may be rescheduled. Based on the requirement that the exam be initially scheduled within 30 days, the Division requires the exam to be rescheduled within 30 days of the originally scheduled exam.

§126.6(e) & (g): Several commenters state the rule does not define "verifiable means" and believe the phrase will be read in context and construed according to rules of grammar and common usage. A commenter provided definition language for consideration.

Agency Response: The Division agrees and has added a description of "verifiable means" to subsection (e) and it is to be used as direction to ensure that delivery is verifiable. The goal of this requirement is not to regulate how a system participant makes delivery of a report or other information to another system participant, but to ensure that the system participant filing the report or providing the information has verifiable proof that it was delivered.

Comment: A commenter states the doctor should be required to describe how he believes the injury occurred and that the credibility and persuasiveness of the doctor is dependent upon what he understands the history of the injury to be.

Agency Response: The Division disagrees, as making this a requirement would be very subjective and would call for speculation on the part of the doctor. The medical information provided to the doctor should contain an objective history and description of the injury.

§§126.6(f) & 126.7(u) & (v): Several commenters state that "the employee's representative, if any" needs to be added to the report distribution list, notice of designated doctor appointment distribution list and rescheduled appointment distribution list.

Agency response: The Division agrees. The language has been added to the rule. It should be noted that §102.4(b) provides for notification to the injured employee's representative if the health care provider has been notified of the representation. If the provider has not been notified of the representation, the provider has no obligation to provide notice to the representative.

Comment: Several commenters state the rule as written appears to allow an RME doctor to certify MMI/IR merely after a designated doctor exam, even if the designated doctor determines the injured employee is not at MMI. They state the true purpose is to

allow an RME doctor to certify MMI/IR only after the designated doctor has certified MMI/IR.

Agency Response: The Division disagrees that an RME doctor should only be allowed to certify MMI/IR after the designated doctor has certified MMI/IR. Labor Code §408.0041(f) allows the insurance carrier to request an RME if it is not satisfied with the opinion of the designated doctor, not just when the designated doctor certified MMI/IR. Additionally, refusing to allow the insurance carrier to seek the opinion of an RME would prevent the carrier from being able to gather medical evidence to dispute the determination of the designated doctor.

§126.6(h)(1)(B): A commenter is concerned about the elimination of subparagraph (B) and believes that injured employees will not attend rescheduled exams because the deterrent has been removed.

Agency Response: The injured employee is still required to attend a rescheduled exam and TIBS can still be suspended if an injured employee does not attend the exam without having good cause. This situation is addressed in §126.6(j)(3).

§126.6(j): A commenter recommends missing an RME required under Labor Code §408.004(a) should result in suspension of TIBs to the injured employee.

Agency Response: The Division disagrees. Labor Code §408.004(a) addresses RME exams for appropriateness of medical care. Labor Code §408.004(e) provides that an

employee's failure to attend an RME required under §408.004(a) constitutes an administrative violation not suspension of TIBs.

§126.6(j)(1)(B): Several commenters recommend deleting the proposed language and replacing it with the previous language. They state that the entitlement to TIBs should occur when the employee submits to the exam, not when he contacts the doctor's office. A commenter states it is unclear how the carrier will be notified of the date the injured employee contacted the doctor's office to reschedule the examination and suggested language.

Agency Response: The Division disagrees that the original language should be replaced as suggested. However, the requirement for reinstatement of TIBs effective the date the injured employee contacts the doctor's office has been removed and clarifying language added regarding the rescheduling of the missed appointment and the reinstatement of TIBs once the injured employee has submitted to the exam.

§126.6(j)(2): A commenter states there is no statutory provision for the suspension of TIBs for a missed appointment. The statute provides for an administrative penalty.

Agency Response: The Division disagrees that there is no statutory provision for the suspension of TIBs. This section addresses an RME after a designated doctor exam. Labor Code §408.0041(j) allows for the suspension of TIBs for failure to attend a

designated doctor exam or an RME after the designated doctor exam. The administrative penalty is in addition to the suspension of TIBs.

§126.7: A commenter questions if everything in §130.6 has been moved to this rule, and suggests it should all be in one place. A commenter recommends that §130.6(d), (e), and (f) be moved to §126.7 to avoid confusion.

Agency Response: The Division clarifies that not all the requirements of §130.6 have been moved to this rule. The Division disagrees that all designated doctor language should be in one place. Chapter 126 addresses general provisions applicable to all benefits. Section 126.7 provides general direction regarding the request for a designated doctor during any benefit period. Chapter 130, Subchapter A, specifically addresses issues regarding the certification of MMI/IR and impairment income benefits. Section 130.6 provides direction specific to an exam performed for the purpose of certifying MMI by a designated doctor

Comment: A commenter objects to online exams for designated doctors and wants the practice eliminated. The commenter believes that doctors pay other individuals to take the exam for them when it is online.

Agency Response: The Division understands the commenter's concern about people taking exams for other people. There are protocols in place to ensure that the appropriate person is taking the exam.

Comment: A commenter objects to required medical exams performed by carrier paid physicians as biased and believes that designated doctors should only perform RMEs.

Agency Response: The statute permits a carrier to select an RME doctor. An injured employee's provider may attend an RME with the employee. It is necessary for a carrier to be able to request an RME to ensure that appropriate care is being provided to the injured employee. This ability ensures that there are checks and balances in the system.

Comment: A commenter states that there should be a provision for reimbursement from the Subsequent Injury Fund (SIF) when the insurance carrier makes an overpayment of income benefits based on a designated doctor's report.

Agency Response: The Division understands the commenter's concern about reimbursement of an overpayment. Labor Code §403.006 provides for the reimbursement from the SIF when there has been an overpayment of benefits made under an interlocutory order or decision of the Commissioner. The Division will review the applicable provisions of the Labor Code and rules and make a determination if this is a matter that can possibly be addressed at a future date.

§126.7(c)(4) & (5): A commenter feels the designated doctor should be evaluating the employee's ability to return to any type of work at any employer, not just the employer at

the time of the injury, and suggests changing the language in paragraphs (4) and (5) to reflect this concept. The commenter also recommends deleting "similar issues" and further defining other reasons for examinations by the designated doctor such as "the effects of any intervening injury or illness on the ability to work or on the impairment rating."

Agency Response: The Division agrees in part and disagrees in part. The Division disagrees regarding "similar issues" because this is from Labor Code §408.0041(a). The reasons for requesting a designated doctor exam provided in the rule are statutory provisions. Only reasons for the exam provided by statute will be included here.

The Division agrees that the designated doctor should be evaluating the injured employee's ability to return to any type of work. Neither the statute nor this rule is intended to limit the exam to the ability to return to work at the same employer, or the same type of work being performed, at the time of the injury.

§126.7(d): A commenter requests the Division to define the legal term "presumptive weight."

Agency Response: The Division declines to define the term "presumptive weight" because it is a well recognized, commonly understood legal term. Additionally, the term should be read in conjunction with the remainder of the sentence in which it is contained, as well as other uses of the term in Labor Code §§408.0041, 408.1225, 408.125, and 408.151. The Division will determine whether the report of the designated

doctor is to be given "presumptive weight" by comparing it to other evidence. If other evidence exists that counters the report, the Division may decide not to resolve questions about the employee's injury based upon the report of the designated doctor.

§126.7(e) & (i)(3): A commenter states that a 14 – 21 day timeframe to schedule an appointment is unwieldy. He recommends "no earlier than 21 days and no later than 28 days" from the date the exam is set.

Agency Response: The Division disagrees. Labor Code §408.0041(b) requires the Division to assign a designated doctor not later than the 10th day after the date under which the request under §408.0041(a) is approved and the exam to be scheduled no later than the 21st day after the Commissioner issues the order. The Division expects the medical records to be delivered prior to the exam to ensure they are there in time for the examination.

Comment: A commenter states the subsection requires the assigning of the designated doctor but does not articulate standards as to the doctor's qualifications. The commenter states the statute requires the credentials to be established by rule and they are not present.

Agency Response: The Division has addressed the qualifications to be selected as a designated doctor in §180.21, and it is not necessary for the qualifications to be restated.

Comment: A commenter requests that the rule be amended to prohibit Division staff from rejecting a request for a designated doctor because the request is incomplete or contains incorrect information that the commenter feels is available through the Division's records. The commenter provides recommended language.

Agency Response: The Division disagrees. The reason the Division requires the information on the request for a designated doctor is because the insurance carrier or the injured employee has not always provided the required information to the Division. There have been many occasions where the request for the designated doctor exam was the first notice the Division had of the injury and claims had to be created from the information contained on the request. Additionally, the carrier and the employee are parties that should have immediate access to and knowledge of the information required.

§126.7(f): A commenter recommends requiring the rescheduled exam to occur in seven days, rather than the proposed 14 days.

Agency Response: The Division disagrees. However, the Division has changed the language to be consistent with the requirement under Labor Code §408.0041 to schedule the initial examination within 21 days. A new designated doctor may need to be selected by requiring the exam to be rescheduled within seven days. This change will allow some leeway in facilitating use of the same designated doctor.

§126.7(g)(2): Several commenters recommend that the precondition to reinstated TIBs be submitting to the exam, not contacting the doctor's office to reschedule. Another commenter states that reinstating TIBs when the employee calls to reschedule the exam will encourage missed appointments. The commenter also states that the statute allows for suspension of TIBs until the employee submits to the exam. As such, the rule conflicts with the statute.

Agency Response: The Division agrees. The requirement for reinstatement of TIBs effective the date the injured employee contacts the doctor's office to reschedule has been removed. Language has been added regarding the rescheduling of the missed appointment and the reinstatement of TIBs based on the injured employee's submitting to the exam.

§126.7(h): A commenter recommends adding a requirement for staff to document why an alternate designated doctor was selected in DRIS logs or similar diary system.

Agency Response: The Division disagrees that it is necessary to change the rule. Generally, Division staff already record this information. This requirement will be addressed by internal Division procedure.

Comment: A commenter recommends deleting the language "if the doctor is still qualified and available" from the rule. He recommends that the same doctor be required to be used, and that common sense can dictate if a new doctor is needed.

Agency response: The Division disagrees. The language provides that the same designated doctor shall be used unless there is a reason to select a different doctor. The language allows the Division to take appropriate action based on the qualifications or availability of the designated doctor.

Comment: A commenter questions what the timeframe is for a rescheduled examination. The commenter states a new designated doctor should not be appointed just because the designated doctor is not readily available, and believes there should be reasonable leeway for repeat examinations.

Agency Response: The Division notes that an exam rescheduled due to a scheduling conflict is addressed in §126.7(f), which requires the examination to be rescheduled within 21 days of the originally scheduled examination. For a subsequent examination pursuant to subsection (h), the required timeframe is between the 14th and 21st days after the Division's receipt, as required by §126.7(e). This change will allow some leeway in facilitating use of the same designated doctor.

§126.7(h)(1): A commenter states that the 12-month treatment restriction is insufficient and should be extended to five years.

Agency Response: The Division disagrees. The 12-month restriction was established to prevent a doctor from examining an employee with whom the doctor has had a recent relationship. Additionally, imposing a longer restriction may have an adverse impact on the pool of eligible doctors.

§126.7(h)(3): A commenter suggests defining "credentials appropriate" and provides recommended language.

Agency Response: The Division has addressed the qualifications to be selected as a designated doctor in §180.21 which includes meeting certain training requirements as well as being on the approved doctor's list (ADL). It is not necessary to define the term as the meaning is understood when the rule is read as a whole.

§126.7(i): Several commenters request that sanctions be imposed against insurance carriers that provide the designated doctor with an analysis of the employee's medical condition that is false, misleading, or contains a misrepresentation.

Agency Response: The Division agrees. There are processes in place to deal with these types of activities and commenters are urged to report evidence of wrongdoing to the Division for review and possible follow-up action.

Comment: Several commenters state the employee or the employee's representative should be able to send a response to the designated doctor if the insurance carrier sends an analysis.

Agency Response: The Division disagrees. There is no statutory provision allowing this type of communication. The injured employee's treating doctor has the ability to provide records and an analysis to the designated doctor.

§126.7(i)(1): A commenter states that the treating doctor and insurance carrier should only be required to submit medical records to the designated doctor for the initial examination. He recommends that for repeat examinations, only the medical records not previously provided should be sent.

Agency Response: The Division agrees and has changed the language.

§126.7(i)(2): Several commenters recommend allowing the carrier and treating doctor to submit one set of medical records that may contain an analysis of the injured employee's medical condition, functional abilities, return-to-work opportunities, video-taped activities as this would help reduce the amount of paper used and save the designated doctor valuable storage space.

Agency Response: The Division agrees and has changed the language.

Comment: Some commenters state that requiring the medical records to be received by the designated doctor no later than the fifth working day is unreasonably short. A commenter provides a scenario where the appointment is scheduled to occur on the 14th day. Given five days mail time and delivery five days prior to the exam, there are only four days to process the medical information and mail it. The commenter recommends amending the language to require the medical records be mailed no later that the fifth working day prior to the exam. Another commenter provides a scenario in which the carrier may not be able to get the medical records to the designated doctor in time. A commenter states there are other means of verifying delivery, and that repeal of §102.5(d) will still require a method of verifying the designated doctor's receipt of a letter of clarification. The commenter also asserts that doctors are out of their offices and that adequate time should be allowed for them to respond.

Agency Response: The Division agrees with the commenters' recommendation to extend the time and the language has been changed to "mailed" to allow extra time. The Division disagrees that §102.5(d) should be repealed. Section 102.5(d) provides a date certain for determining the date of receipt when there is no verification of delivery required.

§126.7(i)(4)(A): Several commenters recommend changing "shall" to "may" since the designated doctor should be able to use his discretion when reporting that a carrier has not timely provided the medical records prior to the exam.

Agency Response: The Division disagrees. Without this notice the Division will not have a ready mechanism to identify potential violations and take appropriate actions.

§126.7(j): A commenter suggests that the type of information provided to the designated doctor for review by the injured employee should be specified, and provides recommended language.

Agency Response: The Division agrees and has made the change.

Comment: A commenter recommends replacing "feels appropriate" with language that is more objective such as "determines to be appropriate."

Agency Response: The Division agrees and has made the change.

§126.7(k): A commenter states that ordering additional tests should extend the designated doctor's time to file the report by seven days regardless of whether another doctor is used or the designated doctor performs the test. A few commenters recommend changing seven days to 14 days to allow sufficient time to locate a doctor and schedule the testing.

Agency response: The Division agrees and has changed the length of time to obtain the additional testing from seven to 10 days. The time to file the report when additional testing is required was also changed to 10 days. The time to locate a doctor and get the testing performed has been extended to 10 working days.

§126.7(k): A commenter states that it makes no sense to limit subsequent examinations to the same designated doctor for subsequent issues if those issues are different than those previously determined by a designated doctor. The commenter states that he should not be tied to the notion that one doctor should be assigned for all issues.

Agency Response: The Division disagrees that there should be multiple designated doctors based on subsequent issues being raised. Subsection (k) of this rule allows a designated doctor to refer the employee to other health care providers when necessary to determine the issue in question.

§126.7(n)(1): A commenter recommends substituting "used" in place of "reviewed" as some records are so large it would take multiple pages to list them all.

Agency Response: The Division disagrees. Use of "reviewed" is helpful in dispute resolution when issues arise regarding the medical evidence/information used to make the determination. This type of information may also be critical in reducing the number of letters for clarification regarding whether specific medical records were considered when making the determination.

§126.7(s): A commenter states this section is unnecessary and that all designated doctor exam requests are based on good cause. He feels the Division should not impose a 60-day hurdle for a carrier to get a subsequent designated doctor exam.

Agency Response: The Division disagrees. The 60-day prohibition, unless good cause for more frequent exams exist, is statutorily required by Labor Code §408.0041(b).

Comment: A commenter questions the statutory authority to limit the carrier's ability to request a designated doctor exam after the second anniversary of entitlement to SIBs. The commenter states the carrier is prohibited from requesting an RME under Labor Code §408.151 but not from requesting a designated doctor.

Agency Response: As the commenter stated, Labor Code §408.151 prohibits the carrier from requesting an RME after the second anniversary of entitlement to SIBs. Since a carrier is entitled by Labor Code §408.0041 to an RME if the carrier is not satisfied with the opinion of the designated doctor, allowing the carrier to request a designated doctor on the issue of the employee's ability to return to work more often that once per year would allow the carrier the opportunity and ability to request or require an RME on return to work more often that once annually. By restricting the carrier's access to the designated doctor on the issue of the ability of the employee to return to work after the second anniversary of entitlement to SIBs, the Division is

restricting the carrier's ability to request/require an RME on return to work pursuant to §408.151.

§126.7(u): Several commenters recommend striking "This procedure may only be used to schedule one additional examination" as there is no statutory basis. Another commenter recommends deleting the last sentence as it is unclear whether the "one additional examination" is for the life of the claim or for the particular examination.

Agency Response: The Division has deleted subsections (u) and (v) which require the designated doctor to reschedule the exam when the doctor determines the employee is not able to return to work, or has not reached MMI, respectively as unnecessary.

Comment: A commenter requests clarification that the designated doctor should evaluate the employee regarding any type of return to work with any employer, not just the employer at the time of the injury.

Agency Response: The Division disagrees the clarification needs to made. Since neither the statute or the Division specified that the ability to return to work was with the pre-injury employer, the designated doctor should be determining the injured employee's ability to return to work in any capacity.

§126.7(w): A commenter recommends requiring the Division to notify the requesting party, within 10 days, if the Division elects to not request clarification and the specific reason for not doing so.

Agency Response: The Division disagrees that it needs to add this requirement to the rule. The Division currently has a process in place to perform this function and will continue to utilize this process.

Comment: A commenter questions the authority of the Division to request clarification from the designated doctor on issues the Division deems appropriate and believes there is no authority for letters of clarification.

Agency Response: The Division disagrees. Pursuant to Labor Code §402.021(b)(5) and Chapter 410, the Division has statutory authority to perform dispute resolution activities to resolve disputes. Requesting letters of clarification is one way for the Division to try and expedite dispute resolution.

Comment: A commenter states the Division does not have the authority to compel a designated doctor to be available to conduct another examination within 10 days of when the designated doctor receives the request.

Agency Response: The Division agrees in part and disagrees in part. Labor Code §408.0041(a) provides that the Commissioner may order, on his own motion, a designated doctor exam. Section 408.0041(b) provides that the exam shall be

conducted with 21 days of the Commissioner's order. The language has been changed to require the rescheduled exam to be conducted within 21 days of the request by the Division.

Comment: A commenter states the rule is ambiguous and confusing. The commenter contends the requirement to respond to the letter of clarification within five days of receipt of the request, or within 10 days if the doctor requires a repeat examination, is impossible. Another commenter states that while there is a required response time when the doctor needs to reexamine the injured employee, there is no required timeframe for response when there is no need for a reexamination.

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

Comment: A commenter states that not only should the opposing party be provided a copy of the request for clarification, but also it should have the opportunity to respond to the request, and suggested language.

Agency Response: The Division disagrees. Allowing the opposing party time to respond to the request for a letter of clarification will only prolong the dispute resolution process. Each party has the ability to request a letter of clarification. Also, each party has the ability to question/dispute the response provided from the designated doctor's response to the letter of clarification.

Comment: A commenter states that the Division's Appeals Panel has held that presumptive weight is given to an amended report regardless of whether the doctor amended the report for a proper reason, and that the "proper reason" criterion must continue. The commenter recommends that amended reports for improper reasons should be deemed invalid and not be considered.

Agency Response: The Division disagrees. If a party feels the report has been amended for an improper reason, the party should request dispute resolution. Evidence of wrongdoing (amending for improper reasons) should be submitted to the Division for review and appropriate action.

Comment: A commenter states that the Appeals Panel is split regarding whether a designated doctor who is no longer on the list is authorized to respond to a letter of clarification. The commenter recommends that a designated doctor need not be on the list to respond to the letter of clarification, but must be on the list to perform an examination.

Agency Response: The Division disagrees. There are several reasons why a designated doctor may no longer be on the designated doctor list (DDL). The reasons include, but are not limited to, the doctor being removed from the DDL or ADL by action of the Division, or the doctor retiring and closing the doctor's practice. Based on the fact that the designated doctor is a doctor selected by the Division to provide resolution to numerous issues, the Division expects designated doctors to comply with all

requirements to be a designated doctor, including not being removed from the DDL or removing himself or herself voluntarily. To respond to a request for clarification regarding the doctor's report, the doctor must be on the DDL at the time of the request for clarification.

Comment: A commenter recommends language that would require the Division to contact the designated doctor if a party requested clarification. The recommended language would remove any discretion on the Division's part in determining if the clarification was appropriate.

Agency Response: The Division disagrees, as the Division's experience has been that all requests for letters of clarification are not valid, or the issues have previously been addressed.

Comment: A commenter requests that "clarification" be defined.

Agency Response: The Division disagrees. Clarification has a clear meaning and common understanding, which is to provide information or response to a question that would remove any confusion, or misunderstanding of what was previously provided or stated.

Comment: A commenter states letters of clarification should be used sparingly when there is true ambiguity about the interpretation/application of the *Guides to the*

Evaluation of Permanent Impairment. Another commenter states that a request for clarification should not result in a reexamination. However, the commenter contends providing new medical evidence for the designated doctor to review and consider may be a good reason for a reexamination.

Agency Response: The Division agrees. The Division will use its discretion when determining when a letter of clarification is needed. A letter of clarification, in and of itself, does not automatically result in a reexamination. The designated doctor's review of the questions or any additional medical evidence determines the need for a reexamination.

§126.7(w)(1): Several commenters recommend amending the 10-day timeframe to 20 or 30 days to prevent the selection of a subsequent designated doctor.

Agency Response: The Division agrees. Labor Code §408.0041(b) provides the exam shall be conducted with 21 days of the Commissioner's order. The language has been changed to require the rescheduled exam to be conducted within 21 days of the Commissioner's order.

§126.7(w)(2): Several commenters recommend adding language that will clarify that selection of an alternate designated doctor is appropriate if the designated doctor refuses to respond to a letter of clarification.

Agency Response: The Division disagrees. The determination to select a subsequent designated doctor needs to be reviewed by the Division on a case-by-case basis due to unforeseen circumstances encountered by the designated doctor, or based on the reason for the non-response. Therefore, the determination to select a subsequent designated doctor will be addressed through internal procedure and training of Division staff.

§126.7(w)(2): A commenter states that there should be reasonable opportunity for repeat examinations to prevent "gaming" of the system by repeatedly asking for letters of clarification in hopes that the designated doctor cannot make the deadline.

Agency Response: The Division agrees. The timeframe to reschedule a repeat examination has been extended to within 21 days from the date of the Commissioner's order in §126.7(w)(2).

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

For, with changes: Rehab for Workers; Texas Association of School Boards; ECAS WC Services; Texas Mutual Insurance Company; Association of Fire & Casualty Insurers of Texas; Insurance Council of Texas; TIRR Systems; Texas Medical Association; Office of Injured Employee Counsel; Lockheed Martin Aeronautics Company; The Boeing Company; Medical Equation, Inc.; HealthSouth Corporation; and Various Individuals.

Against: An individual.

6. STATUTORY AUTHORITY. The sections are adopted under Labor Code §§408.004, 408.0041, 408.151, 402.00111, and 402.061. Section 408.004 provides for required medical examinations. Section 408.0041 provides for designated doctor examinations. Section 408.151 provides for required medical examinations and designated doctor examinations during supplemental income benefits. Section 402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this State. Section 402.061 authorizes the Commissioner to adopt rules necessary to administer the Act.

7. TEXT.

§126.5. Entitlement and Procedure for Requesting Required Medical Examinations.

(a) A doctor who has contracted with or is employed by an authorized workers' compensation health care network established under Insurance Code Chapter 1305, (network doctor) may not perform a required medical examination, as those terms are used under the Texas Workers' Compensation Act (the Act), for an employee receiving medical care through the same network. It is the responsibility of the requesting party to ensure the doctor selected does not have a disqualifying association.

(b) The Division may authorize a required medical examination (RME) for any reason set forth in the Act, Texas Labor Code §408.004, §408.0041, or §408.151 at the request of the insurance carrier (carrier). The request shall be made in the form and manner prescribed by the Division. A carrier is not entitled to take action with respect to benefits based on, and the Division shall not consider, a report of an RME doctor that was not approved or obtained in accordance with this section.

(c) Carriers are entitled to RMEs by a doctor of their choice in accordance with this subsection as follows:

(1) Pursuant to Texas Labor Code §408.004, once every 180 days, to resolve any questions about the appropriateness of the health care received by the injured employee (employee). The carrier's first RME may be requested at any time after the date of injury. A subsequent examination may be requested once every 180 days after the first examination and must be performed by the same doctor unless otherwise approved by the Division. This paragraph only applies to requests for required medical examinations of employees not receiving medical treatment through an authorized workers' compensation health care network.

(2) For the purpose of evaluating a designated doctor's determination on the issues listed under Labor Code §408.0041, a carrier is entitled to an examination under this subsection only after a Designated Doctor exam under §126.7 of this title (relating to Designated Doctor Examinations: Requests and General Procedures).

(3) For the purpose of evaluating a designated doctor's determination pursuant to Texas Labor Code §408.151, to determine if the employee's medical condition resulting from the compensable injury has improved sufficiently to allow the employee to return to work. For the purposes of this paragraph, the carrier may not require an employee to submit to an RME more than once per year if:

(A) an employee is receiving supplemental income benefits on or after the second anniversary of the date of the employee's initial entitlement to supplemental income benefits, and

(B) in the year preceding the request for the RME, the employee's medical condition resulting from the compensable injury had not improved sufficiently to allow the employee to return to work during that year.

(d) The doctor selected to perform an RME must be on the Division's approved doctors list and, if the purpose of the examination is to evaluate maximum medical impairment (MMI) and/or permanent impairment following a designated doctor examination, be authorized to assign impairment ratings under §130.1(a) of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment).

(e) Except for an examination under subsection (c)(2) and (3) of this section, the Division shall not require an employee to submit to a medical examination at the carrier's request until the carrier has made an attempt to obtain the agreement of the employee for the examination as required by this subsection. The carrier shall notify the

Division in the form and manner prescribed by the Division of any agreement or non-agreement by the employee regarding the requested examination. An examination of an employee by a doctor selected by the carrier shall be requested as follows:

(1) Prior to requesting an RME from the Division, the carrier shall send a copy of the request to the employee and the employee's representative (if any) in the manner prescribed by subsection (g) of this section in an attempt to obtain the employee's agreement to the examination.

(2) The carrier shall give the employee 15 days to agree to the examination. The 15 - day period begins on the date the carrier sends the request to the employee and the employee's representative (if any). Though the employee has 15 days to respond to the request, the carrier is not prohibited from contacting the employee or the employee's representative (if any) by telephone to discuss the request and obtain the employee's or the representative's response.

(3) The carrier shall send the request to the Division after either obtaining the employee's answer to the request or when the employee fails to respond after the 15-day period.

(f) The carrier shall send a copy of the request for a required medical examination required by subsection (e) of this section to the employee and the employee's representative (if any) by facsimile or electronic transmission if the carrier has been provided with a facsimile number or email address for the recipient, otherwise, the carrier shall send the request by other verifiable means.

(g) The carrier shall maintain copies of the request for a required medical examination and shall also maintain verifiable proof of successful transmission of the information. For these purposes, verifiable proof includes, but is not limited to, a facsimile confirmation sheet, certified mail return receipt, delivery confirmation from the postal or delivery service, or a copy of the electronic submission.

(h) This section is effective on January 1, 2007 and a request for an RME under this section may be made on or after January 1, 2007.

§126.6. Required Medical Examination.

(a) When a request is made by the insurance carrier (carrier), or the Division, for a medical examination, the Division shall determine if an examination should occur. The Division shall grant or deny the request within seven days of the date the request is received by the Division. A copy of the action of the Division shall be sent to the injured employee (employee), the employee's representative (if any), and the carrier. The notice shall explain the circumstances under which an employee may experience loss of benefits and penalty exposure for failing to attend the examination as well as the need to reschedule a missed examination. An agreement between the parties for an examination under §126.5 of this title (relating to Entitlement and Procedure for Requesting Required Medical Examinations) that the carrier has a right to has the same effect as the action of the Division.

(b) All examinations required under this section must be scheduled to occur within 30 days after receipt of the notice, with at least 10 days notice to the employee and the employee's representative (if any). If a scheduling conflict exists, the employee and the doctor shall contact each other. The doctor or the employee who has the scheduling conflict must make contact at least 24 hours prior to the appointment. The 24-hour requirement will be waived in an emergency situation (such as a death in the immediate family or a medical emergency). The rescheduled examination shall be set for a date within seven days of the originally scheduled examination, unless an extension is agreed upon by the employee and doctor. The extension may not be to a date later than the 30th day after the originally scheduled examination. In this event, the examining doctor shall notify the carrier and the 10 days notice requirement does not apply to a rescheduled examination.

(c) The employee's treating doctor may be present at an examination scheduled with a doctor selected by the carrier. The employee's treating doctor may observe the conduct of the examination, and may consult with the examining doctor about the course of the employee's treatment. The employee's treating doctor shall not otherwise participate in, impede, or advise the employee not to cooperate with the examination. In initially scheduling the examination, a reasonable attempt shall be made to accommodate the schedule of the treating doctor if the employee wants the treating doctor to attend the examination and the treating doctor is willing to do so. However, once an examination is scheduled based on the treating doctor's availability, the

examination shall not be delayed, canceled, or rescheduled due to the treating doctor's scheduling conflicts unless:

(1) the required medical examination (RME) doctor agrees to the rescheduling; or

(2) the examination was canceled by the RME doctor.

(d) If the RME doctor, selected by a carrier, refuses to allow the treating doctor to attend the examination, the carrier shall cancel the appointment and request that another doctor be approved for the RME. If reasonable notice is not provided to the employee and the employee's representative (if any), the carrier shall be liable for any reasonable travel expenses incurred by the employee and for the payment for the treating doctor's attendance at a refused appointment. This subsection shall not apply to situations where the treating doctor is not able to attend the examination due to any form of scheduling conflict.

(e) An RME doctor, selected by the carrier or the Division, who conducts an examination regarding the appropriateness of the health care received by the employee, shall complete a medical report that includes objective findings of the examination and an analysis that explains how the medical condition and objective findings lead to the conclusion reached by the doctor. In addition, the RME doctor shall file the report with the insurance carrier by facsimile or electronic transmission, and shall file the report with the employee and the employee's representative (if any) by facsimile or by electronic transmission if the RME doctor has been provided with a facsimile number or email

address for the recipient, otherwise, the RME doctor shall send the report by other verifiable means. Written notice is verifiable when it is provided from any source in a manner that reasonably confirms delivery to the party. This may include an acknowledged receipt by the injured employee or insurance carrier, a statement of personal delivery, confirmed by e-mail, confirmed delivery by facsimile, or some other confirmed delivery to the home or business address. The goal of this requirement is not to regulate how a system participant makes delivery of a report or other information to another system participant, but to ensure that the system participant filing the report or providing the information has verifiable proof that it was delivered.

(f) An RME doctor who, subsequent to a designated doctor's examination, determines the employee has reached maximum medical improvement (MMI) or who assigns an impairment rating, shall complete and file the report as required by §130.1 and §130.3 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment and Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment by Doctor Other than the Treating Doctor). Otherwise, the RME doctor shall not certify MMI or assign an impairment rating. If the RME doctor disagrees with the designated doctor's opinion regarding MMI, the RME doctor's report shall explain why the RME doctor believes the designated doctor was mistaken or why the designated doctor's opinion is no longer valid. Other reports shall be completed in the form and manner prescribed by the

Division and shall be sent to the carrier, the employee, the employee's representative, if any, the treating doctor, and Division no later than 10 days after the examination.

(g) An RME doctor who, subsequent to a designated doctor's examination, determines that the employee can return to work immediately with or without restrictions is required to file a Work Status Report, as described in §129.5 of this title (relating to Work Status Reports) within seven days of the date of the examination of the employee. This report shall be filed with the treating doctor and the carrier by facsimile or electronic transmission. In addition, the RME doctor shall file the report with the employee and the employee's representative (if any) by facsimile or by electronic transmission if the RME doctor has been provided with a facsimile number or email address for the recipient, otherwise, the RME doctor shall send the report by other verifiable means.

(h) An RME doctor who, subsequent to a designated doctor's examination, addresses issues other than those listed in subsections (f) and (g) of this section, shall file a narrative report within seven days of the date of the examination of the employee. This report shall be filed with the treating doctor and the carrier by facsimile or electronic transmission. In addition, the RME doctor shall file the report with the employee and the employee's representative (if any) by facsimile or by electronic transmission if the RME doctor has been provided with a facsimile number or email address for the recipient, otherwise, the RME doctor shall send the report by other verifiable means.

(i) A doctor who conducts an examination solely under the authority of this rule shall not be considered a designated doctor under the Labor Code §408.0041,

§408.122 or §408.125. Examinations with a designated doctor are not subject to any limitations under the provisions for RMEs.

(j) A carrier may suspend temporary income benefits (TIBs) if an employee, without good cause, fails to attend an RME required pursuant to Labor Code §408.0041(f).

(1) In the absence of a finding by the Division to the contrary, a carrier may presume that the employee did not have good cause to fail to attend the examination if by the day the examination was originally scheduled to occur the employee has both:

(A) failed to submit to the examination; and

(B) failed to contact the RME doctor's office to reschedule the examination in accordance with subsection (b) of this section.

(2) If, after the carrier suspends TIBs pursuant to this section, the employee contacts the RME doctor to reschedule the examination, the RME doctor shall reschedule the examination as soon as possible, but not later than the 30th day after the employee contacted the doctor. The insurance carrier shall re-initiate TIBs effective as of the date the employee submitted to the examination. The re-initiation of TIBs shall occur no later than the seventh day following:

(A) the date the carrier was notified that the employee attended the examination; or

(B) the date that the carrier was notified that the Division found that the employee had good cause for not attending the examination.

(3) An employee is not entitled to TIBs for a period during which the carrier was entitled to suspend benefits pursuant to this section unless the employee later submits to the examination and the Division finds or the carrier determines that the employee had good cause to fail to attend the appointment.

(k) An employee who, without good cause, fails or refuses to appear at the time scheduled for an examination authorized by this section may be assessed an administrative penalty under Labor Code §§408.004 and 408.0041. An employee who fails to submit to an examination at the carrier's request when the carrier selected doctor refuses to allow the treating doctor to attend the examination or when the RME doctor cancels the examination does not commit an administrative violation.

(l) The Division shall require examinations requiring travel of up to 75 miles from the employee's residence, unless the treating doctor certifies that such travel may be harmful to the employee's recovery. Travel over 75 miles may be authorized if good cause exists to support such travel. The carrier shall pay reasonable travel expenses incurred by the employee in submitting to any required medical examination, as specified in Chapter 134 of this title (relating to Benefits – Guidelines For Medical Service, Charges, and Payments).

(m) This section is effective on January 1, 2007 and a request for an RME under this section may be made on or after January 1, 2007.

§126.7. Designated Doctor Examinations: Requests and General Procedures.

(a) The Division may require a medical examination by a designated doctor at the request of the insurance carrier, an injured employee (employee), the employee's representative, if any, the medical advisor, or on its own motion. A doctor who has contracted with or is employed by an authorized workers' compensation health care network established under Chapter 1305, Insurance Code, (network doctor) may not perform a designated doctor examination, as those terms are used under the Texas Workers' Compensation Act, for an employee receiving medical care through the same network.

(b) The request shall be made in the form and manner prescribed by the Division.

(c) A designated doctor examination shall be used to resolve questions about the following:

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

(2) the attainment of maximum medical improvement (MMI);

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

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

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

(6) issues similar to those described by paragraphs (1) – (5) of this subsection.

(d) The report of the designated doctor is given presumptive weight regarding the issue(s) in question and/or dispute, unless the preponderance of the evidence is to the contrary.

(e) The Division, within 10 days after approval of a valid request, shall issue a written notice that assign~~ing~~s a designated doctor; requires an exam to be conducted on a date no earlier than 14 days, but no later than 21 days from the date of the written notice; and notify the designated doctor, the employee, the employee's representative, if any, and the insurance carrier that the designated doctor will be directed to examine the employee. The written notice shall:

(1) indicate the designated doctor's name, license number, practice address and telephone number, and the date and time of the examination or the date range for the examination to be conducted;

(2) explain the purpose of the designated doctor examination;

(3) require the employee to submit to an examination by the designated doctor; and

(4) require the treating doctor and insurance carrier to forward all medical records in compliance with subsection (i)(3) of this section.

(f) The designated doctor's office and the employee shall contact each other if there exists a scheduling conflict for the designated doctor appointment. The

designated doctor or the employee who has the scheduling conflict must make the contact at least 24 hours prior to the appointment. The 24-hour requirement will be waived in an emergency situation (such as a death in the immediate family or a medical emergency). The rescheduled examination shall be set to occur within 21 days of the originally scheduled examination. Within 24 hours of rescheduling, the designated doctor shall contact the Division's field office and the insurance carrier with the time and date of the rescheduled examination. If the examination cannot be rescheduled within 21 days, the designated doctor shall notify the Division and the Division shall select a new designated doctor.

(g) An insurance carrier may suspend temporary income benefits (TIBs) if an employee, without good cause, fails to attend a designated doctor examination.

(1) In the absence of a finding by the Division to the contrary, an insurance carrier may presume that the employee did not have good cause to fail to attend the examination if by the day the examination was originally scheduled to occur the employee has both:

(A) failed to submit to the examination; and

(B) failed to contact the designated doctor's office to reschedule the examination in accordance with subsection (f) of this section.

(2) If, after the insurance carrier suspends TIBs pursuant to this subsection, the employee contacts the designated doctor to reschedule the examination, the designated doctor shall schedule the examination to occur as soon as

possible, but not later than the 21st day after the employee contacted the doctor. The insurance carrier shall reinstate TIBs effective as of the date the employee submitted to the examination unless the report of the designated doctor indicates that the employee has reached MMI or is otherwise not eligible for income benefits. The re-initiation of TIBs shall occur no later than the seventh day following:

(A) the date the insurance carrier was notified that the employee submitted to the examination; or

(B) the date that the carrier was notified that the Division found that the employee had good cause for not attending the examination.

(3) An employee is not entitled to TIBs for a period during which the insurance carrier suspended benefits pursuant to this subsection unless the employee later submits to the examination and the Division finds or the insurance carrier determines that the employee had good cause for failure to attend the examination.

(h) If at the time the request is made, the Division has previously assigned a designated doctor to the claim, the Division shall use that doctor again, if the doctor is still qualified and available. Otherwise, the Division shall select the next available doctor on the Division's Designated Doctor List (DDL) who:

(1) has not previously treated or examined the employee within the past 12 months and has not examined or treated the employee with regard to a medical condition being evaluated in the designated doctor examination;

(2) does not have any disqualifying associations as described in §180.21 of this title (relating to Division Designated Doctor List); and

(3) has credentials appropriate to the issue in question and the employee's medical condition.

(i) The designated doctor is authorized to receive the employee's confidential medical records to assist in the resolution of a dispute under this section without a signed release from the employee.

(1) The treating doctor and insurance carrier shall provide to the designated doctor copies of all the employee's medical records in their possession relating to the medical condition to be evaluated by the designated doctor. For subsequent examinations with the same designated doctor, only those medical records not previously sent must be provided.

(2) The treating doctor and insurance carrier may also send the designated doctor an analysis of the employee's medical condition, functional abilities, and return-to-work opportunities. The analysis may include supporting information such as videotaped activities of the employee, as well as marked copies of medical records. If the insurance carrier sends an analysis to the designated doctor, the insurance carrier shall send a copy to the treating doctor, the employee, and the employee's representative, if any. If the treating doctor sends an analysis to the designated doctor, the treating doctor shall send a copy to the insurance carrier, the employee, and the employee's representative, if any.

(3) The treating doctor and insurance carrier shall ensure that the required records and analyses (if any) are mailed to the designated doctor no later than the fifth working day prior to the date of the designated doctor examination.

(4) If the designated doctor has not received the medical records or any part thereof at least one working day prior to the examination, the designated doctor shall:

(A) report this violation to the Division's Compliance and Practices section; and

(B) reschedule the examination in accordance with subsection (f) of this section. The doctor shall conduct the rescheduled examination regardless of whether or not the complete medical record has been timely received.

(j) The designated doctor shall review the employee's medical records, including an analysis of the employee's medical condition, functional abilities and return to work opportunities provided by the insurance carrier and treating doctor, as well as the employee's medical condition and history as provided by the injured employee, and shall perform a complete physical examination. The designated doctor shall give the medical records reviewed the weight the doctor determines to be appropriate.

(k) The designated doctor shall perform additional testing or refer an employee to other health care providers when necessary to determine the issue in question. Any additional testing required for the evaluation is not subject to preauthorization requirements in accordance with the Labor Code §413.014 or Insurance Code, Chapter

1305. Any additional testing must be completed within 10 working days of the designated doctor's physical examination of the employee. The need for additional testing under this subsection extends the amount of time the designated doctor has to file the report by 10 working days.

(l) To avoid undue influence on the designated doctor:

(1) except as provided by subsection (i) of this section, only the employee or appropriate Division staff may communicate with the designated doctor prior to the examination of the employee by the designated doctor regarding the employee's medical condition or history;

(2) after the examination is completed, communication with the designated doctor regarding the employee's medical condition or history may be made only through appropriate Division staff; and

(3) the designated doctor may initiate communication with any doctor who has previously treated or examined the employee for the work-related injury or with a peer review doctor identified by the insurance carrier who examined the employee's claim.

(m) The insurance carrier, treating doctor, employee, or employee's representative, if any, may contact the designated doctor's office to ask about administrative matters such as whether the designated doctor received the records, whether the exam took place, or whether the report has been filed, or similar matters.

(n) A designated doctor who determines the employee has reached maximum medical improvement (MMI) or who assigns an impairment rating, or who determines the employee has not reached MMI, shall complete and file the report as required by §§130.1 and 130.3 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment and Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment by Doctor Other than the Treating Doctor). The report shall be completed in the form and manner prescribed by the Division and shall be sent to the carrier, the employee, the employee's representative, if any, the treating doctor, and Division.

(o) A designated doctor who determines that the employee can return to work immediately with or without restrictions is required to file a Work Status Report, as described in §129.5 of this title (relating to Work Status Reports) within seven days of the date of the examination of the employee. This report shall be filed with the treating doctor and the carrier by facsimile or electronic transmission. In addition, the designated doctor shall file the report with the employee and the employee's representative (if any) by facsimile or by electronic transmission if the designated doctor has been provided with a facsimile number or email address for the recipient, otherwise, the designated doctor shall send the report by other verifiable means.

(p) A designated doctor who addresses issues other than those listed in subsections (n) and (o) of this section, shall file a narrative report within seven days of the date of the examination of the employee. This report shall be filed with the treating

doctor and the carrier by facsimile or electronic transmission. In addition, the designated doctor shall file the report with the employee and the employee's representative (if any) by facsimile or by electronic transmission if the designated doctor has been provided with a facsimile number or email address for the recipient, otherwise, the designated doctor shall send the report by other verifiable means.

(q) The designated doctor shall maintain accurate records, including the employee records, analysis (including supporting information), and narratives provided by the insurance carrier and treating doctor, to reflect:

(1) the date and time of any designated doctor appointments scheduled with an employee;

(2) the circumstances regarding a cancellation, no-show or other situation where the examination did not occur as initially scheduled or rescheduled;

(3) the date of the examination;

(4) the date medical records were received from the treating doctor or any other person or organization;

(5) the date the medical evaluation report, including the narrative report described in subsection (n) of this section, was submitted to all parties;

(6) the name of all referral health care providers, date of appointments and reason for referral by the designated doctor; and

(7) the date the doctor contacted the Division for assistance in obtaining medical records from the insurance carrier or treating doctor.

(r) The insurance carrier shall pay any accrued income benefits, and shall begin or continue to pay weekly income benefits, in accordance with the designated doctor's report for the issue(s) in dispute, no later than five days after receipt of the report or five days after receipt of notice from the Division, whichever is earlier.

(s) The insurance carrier, the employee, and the employee's representative (if any) is not entitled to a subsequent designated doctor examination until the earlier of:

(1) the 60th day after the prior designated doctor examination was held; or

(2) the date the insurance carrier or the employee is found by the Division to have good cause, such as the inclusion of additional body parts (extent of injury).

(t) On or after the second anniversary of the initial award of Supplemental Income Benefits (SIBs), the insurance carrier may not require an employee who is receiving SIBs to submit to a designated doctor examination more than annually, if in the preceding year, the employee's medical condition resulting from the compensable injury has not improved sufficiently to allow the employee to return to work.

(u) Parties may file a request with the Division for clarification of the designated doctor's report. A copy of the request must be provided to the opposing party. The Division may contact the designated doctor if it determines that clarification is necessary to resolve an issue regarding the designated doctor's report. The Division, at its discretion, may request clarification from the designated doctor on issues the Division deems appropriate. To respond to the request for clarification, the designated doctor

must be on the Division's DDL at the time the request is received by the Division. The designated doctor shall respond to the letter of clarification within five days of receipt. If, in order to respond to the request for clarification, the designated doctor has to reexamine the injured employee, the doctor shall:

(1) respond to the request for clarification advising of the need for an additional examination within five days of receipt and provide copies of the response to the parties specified in subsection (p) of this section; and

(2) conduct the reexamination within 21 days from the request by the Division at the location of the original examination.

(v) Upon receipt of a request for a benefit review conference, the Division shall resolve a dispute of the opinion of a designated doctor through the dispute resolution processes outlined in Chapters 140 - 147 of this title (relating to Dispute Resolution).

(w) This section is effective on January 1, 2007 and a request for a designated doctor under this section may be made on or after January 1, 2007.

CERTIFICATION. This agency certifies that the adopted 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 _____, 2006.

_____
Norma Garcia
General Counsel
Division of Workers' Compensation
Texas Department of Insurance

IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that amendments to §§126.5 and 126.6 and new §126.7, concerning required medical evaluations, entitlement and procedures for requesting a designated doctor, are adopted.

AND IT IS SO ORDERED.

_____
ALBERT BETTS
COMMISSIONER OF WORKERS' COMPENSATION
TEXAS DEPARTMENT OF INSURANCE

ATTEST:

_____

Norma Garcia
General Counsel

COMMISSIONER'S ORDER NO. DWC-06-0032