

TITLE 28. INSURANCE
Part 2. Texas Department of Insurance
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Chapter 180. Monitoring and Enforcement

SUBCHAPTER B. MEDICAL BENEFIT REGULATION
§§180.21, 180.22, and 180.28

1. **INTRODUCTION.** The Commissioner of the Division of Workers' Compensation, Texas Department of Insurance, adopts amendments to §180.21 and §180.22 and new §180.28 concerning peer reviewers and designated doctors. 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 683).

2. **REASONED JUSTIFICATION.** The amendments and new sections are necessary to implement new statutory provisions contained in House Bill (HB) 7, enacted by the 79th Legislature, Regular Session. These rules are written to clarify qualifications and functions of designated doctors and peer reviewers. Adopted amendments to §§180.21 and 180.22 implement the expanded role of designated doctors and define the role of peer reviewer under HB 7. New §180.28 establishes standards for peer review reports.

The Labor Code §§408.0041 and 408.1225 address new requirements for a designated doctor and these have been added to §180.21. The requirements to be on the Division's Designated Doctor List (DDL) include additional training and testing to ensure proficiency in determining the injured employee's (employee) extent of injury, ability to return to work, and whether the employee's disability is the direct result of a work-related injury. Other changes to §180.21 include provisions to eliminate the appearance of bias by prohibiting a designated doctor from rendering an opinion if the

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doctor has a contract with, or is employed by, the workers' compensation health care network responsible for providing medical care to the employee, or if he has any other association with the employee, employer, or insurance carrier (carrier) that may give the appearance of preventing the designated doctor from rendering an unbiased opinion.

Adopted §180.22 contains health care provider roles and responsibilities, including peer reviewers. It also specifies the authority under which a required medical exam (RME) may be conducted and lists issues the RME doctor may not address unless there has been a prior designated doctor exam on the specific issue.

HB 7 requires standards for a carrier to use peer reviews to determine the appropriateness of treatment related to an employee's compensable or job-related injury. The new and amended sections are applicable to medical benefits provided in the workers' compensation system including medical benefits provided to employees subject to a workers' compensation health care network established under Insurance Code Chapter 1305. The changes to §§180.21 and 180.22 and new §180.28 are necessary to implement Labor Code §408.0231, which sets forth the requirements for the Commissioner to adopt rules regarding providers performing peer review functions for carriers, peer review standards, imposition of sanctions on doctors performing peer review functions, and other issues related to the quality of peer reviews. These adopted rules reflect the Division's efforts to address the following objectives regarding benefits of peer reviews as a result of stakeholder input as well as public comment: ensure the use of peer reviews for health care services provided in connection with a workers'

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compensation claim; curtail the carrier's ability to request multiple peer reviews of the same health care services or issues for a favorable decision; require the use of current, evidence-based treatment parameters; facilitate timely and appropriate medical treatments and services; control utilization of medical treatments and services; and control medical costs where appropriate. The intent of these rules is to improve the quality of health care provided to employees and to monitor peer review activities in the workers' compensation system. The implementation of peer review standards helps to ensure that health care providers performing peer reviews consider evidence-based medicine prior to making any determinations related to the review of medical care. The implementation of peer review standards may reduce excessive or inappropriate medical care while safeguarding the delivery of necessary medical care by requiring the treating doctor to identify, prescribe, and provide only appropriate health care.

As a result of public comments, changes have been made to §§180.21, 180.22 and 180.28 and are described more fully in Sections 3 and 4. Additionally, the adopted amendments to §§180.21 and 180.22 remove unnecessary language to increase the clarity of the sections, reduce confusion, and address new statutory requirements of HB 7.

The Division will be issuing a bulletin to remind health care providers of the requirements of Labor Code §§408.023 and 408.0231 and these rules.

3. HOW THE SECTIONS WILL FUNCTION. These sections are intended to clarify the functions of and standards for designated doctors and peer review doctors.

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Section 180.21 lays out the process for application to the Division's DDL, the requirements for admission to the DDL, and the process for notification to the doctor of admission, denial, suspension, or deletion from the DDL. The appeals process for a doctor who is suspended or deleted from the DDL is described in this section.

Subsection (a) provides a list of definitions for terms used in this section. It also identifies two new disqualifying associations that prevent a designated doctor from rendering an opinion: 1) having a contract with the same health care network responsible for providing medical care to the employee; or 2) having any other association with the employee, employer, or insurance carrier that may give the appearance of preventing the designated doctor from rendering an unbiased opinion.

Subsection (c) lays out the requirements for a doctor to be on the Division's DDL prior to January 1, 2007 and subsection (d) lays out the requirements for a doctor to be on the Division's DDL after January 1, 2007. The Division changed the date from September 1, 2006 to provide doctors sufficient time to obtain training and register to be on the DDL. As a result of public comments, changes have been made to subsection (d) to require the doctor to have successfully completed approved training and passed an exam rather than requiring board certification. The doctor must also have had an active practice for at least three years during his or her career. The Division has also changed subsections (d) and (e) to correct the time for renewal to biennial. Subsection (e) requires reapplication to the DDL every two years and completion of 12 additional

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hours of relevant training. Subsection (j) has been changed to provide 15 working days for a doctor to respond to the Commissioner's denial of the application to the DDL.

Subsection (m) provides the reasons a designated doctor may be deleted or suspended from the DDL. It also adds language related to the failure to notify the Division of conflicts caused by the doctor's and employee's association with the same workers' compensation health care network.

Section 180.22 specifies the authority under which an RME may be conducted and provides the list of issues the RME doctor may not address unless there has been a prior designated doctor exam on the specific issue. It also adds the employees' representative to the list of parties with whom the treating doctor communicates regarding the employee's ability to work or any work restrictions for the employee. Subsection (f) provides the responsibilities of an RME doctor and restrictions on the type and timing of examinations the RME doctor may perform.

Section 180.22 also contains health care provider roles and responsibilities, including peer reviewers, as required by Labor Code §§408.023(h) and 408.0231(g). Subsection (g) provides the responsibilities of a peer review doctor and has been changed to define a peer review as an administrative review of the health care of a workers' compensation claim. Labor Code §408.023(h) allows an out of state doctor to perform utilization review but requires it to be performed under the direction of a doctor licensed in this state. Labor Code §408.0231(g) requires peer reviews to be performed by a doctor that holds the appropriate professional Texas license. The subsection has

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been changed to be consistent with both of these provisions of the Labor Code. Subsection (g) defines a peer reviewer, addresses any known conflicts of interest with the injured employee or the health care provider who rendered any health care being reviewed, and establishes the licensing requirements. If a health care provider, including a health care provider not licensed in Texas, does not comply with the statute and these rules, the Division may impose sanctions which include the following: restriction, suspension, or removal of the provider's ability to perform peer review on behalf of insurance carriers in the workers' compensation system, and other issues related to the quality of peer review. The Division will be monitoring health care providers to ensure they are in compliance with Labor Code §§408.023 and 408.0231 and these rules to ensure proper licensing or performing actions under the direction of a licensed Texas doctor.

New §180.28 contains the additional requirements of Labor Code §408.0231(g) and sets forth the peer review requirements, reporting, record keeping and sanctions, which includes parameters for the request and use of peer review reports. Subsection (a) has been changed and addresses the components of the peer reviewer's report. Additional language has been added to require a list of all medical records and other documents reviewed by the peer reviewer, including the dates of the documents reviewed. Language has been changed in subsection (b) to provide for situations where a subsequent peer review would be appropriate. Language has been added to subsection (c) to include the injured employee and injured employee's representative, if

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any, to the parties that receive a copy of the peer review report. Additionally, the term, “negatively impact” has been removed from the rules because this language is unnecessary, and use of the phrase “reduce income or medical benefits of an injured employee” is a sufficiently broad explanation. Subsection (d) has been changed to clarify the requirements that peer reviewers and carriers maintain requests, reports, and results for peer reviews so that the Division may monitor peer review use, activity and decisions. Subsection (e)(2) has been changed to reflect that the Commissioner may prohibit a doctor from conducting peer reviews for failure to consider all records provided for their review, as peer reviewers can only respond based on records that have been provided to them for review. As a result of public comment, a change has also been made to allow for an appeals mechanism through §180.27 for a doctor who has received a Division order prohibiting further peer reviews.

4. SUMMARY OF COMMENTS AND AGENCY’S RESPONSE.

General: 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 the exam available is online.

Agency response: The Division understands the commenter’s concern about people taking exams for other people. This is not how the system is intended to work. There are protocols in place to ensure that the appropriate person is taking the exam. The Division is revising training and testing requirements to comply with duties given to

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designated doctors by HB 7. A part of the revision will be to select training and testing vendors with adequate security protocols to ensure that the doctor being trained and/or tested is the person he or she claims for either personal or on-line testing.

§180.21(a): Several commenters agree with definition of “active practice.”

Agency Response: The Division appreciates the comment.

§180.21(a)(2): A few commenters recommend adding language to specify that the influence be “improper influence” and to define “whose perception” is necessary to trigger the perception of improper influence as not all attempts to influence are improper. A commenter feels the definition of disqualifying association is too broad. The commenter provides an example of the state medical association trying to influence the conduct of its members as “influence” but not “improper influence.”

Agency Response: The Division disagrees. The rule addresses any influence on a designated doctor that may be perceived based on the factual circumstances illustrated in the rule without consideration by Division staff as to its effect on a decision. A determination of a disqualifying association is not based on a belief, but facts as determined by Division staff.

Comment: A commenter questions whether a disqualifying association exists between a designated doctor and an RME doctor who has previously examined the employee if

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the two doctors share an affiliated practice. The commenter requests clarifying language that a mere association between a designated doctor and a doctor who has previously examined the employee is not a disqualifying association. The commenter also presents an example of a three doctor practice.

Agency Response: The Division disagrees. The role of the designated doctor is to provide an unbiased opinion on the topics required by the Labor Code. The disqualifying associations stated in the rules are general situations in which the ability of the designated doctor to provide an unbiased opinion could be reasonably questioned. In the example where three doctors share a medical practice and have a business relationship, if one doctor performed the RME for the employee, it could easily be argued that another doctor in the three doctor practice would have difficulty finding fault in the opinion given by the first doctor and should be treated as a disqualifying association.

In addition, the commenter requests clarifying language that a mere association between a designated doctor and a doctor who has previously examined the employee is not a disqualifying association. As previously stated, disqualifying associations are situations in which the ability of the designated doctor to provide an unbiased opinion could be reasonably questioned. It is not possible to list every situation in which the ability of a designated doctor to provide an unbiased opinion based on a business, social, or family association could be questioned. The language in the rule is broad enough to advise the designated doctor to be alert to situations in which the designated

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doctor's ability to provide an unbiased opinion could be questioned and to avoid those situations.

Comment: A commenter questions why an employee's treating doctor from a previous work related, or non-work related injury, is not disqualified from acting as a designated doctor and why there is only a 12-month restriction.

Agency Response: Section 126.7(h)(1) specifies that the Division shall select the next available doctor who 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. The 12-month restriction was set 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 designated doctors.

§180.21(a)(2)(F): A commenter disagrees that a designated doctor's employment or contract with the workers' compensation health care network that is providing medical care to the injured employee is a disqualifying association. The commenter feels that the restrictions will limit the number of designated doctors.

Agency Response: The Division disagrees. Insurance Code §1305.101(b) restricts a doctor from performing as a designated doctor for an injured employee receiving medical care through a network with which the doctor contracts or is employed.

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§180.21(c): A commenter states the rule is confusing and contradictory. The rule contradicts §180.23(i)(A) regarding a Level 2 Certificate of Registration with no conditions or restrictions. He states the requirement for an active practice in §180.21(c)(2) conflicts with subsection (c)(5) and suggests alternative language.

Agency Response: The Division disagrees. The Division does not believe the rules are confusing or contradictory. Section 180.23(i) lays out the requirements a doctor must meet to be approved to certify maximum medical improvement (MMI) and assign an impairment rating regardless of conditions or restrictions. Section 180.21(c)(1) places the additional burden on the designated doctor to have no conditions or restrictions on the doctor's status as an approved doctor. There is not a conflict between §180.21(c)(2) and (c)(5) as subsection (c)(2) provides that a doctor must have had an active practice sometime in the doctor's career prior to becoming a designated doctor while subsection (c)(5) provides a current requirement to have an active practice or to take Division approved training for continued participation as a designated doctor.

§180.21(d): Several commenters recommend requiring the designated doctor to have a current and active practice.

Agency Response: The Division declines to make this change. The Division believes this change would unduly restrict the pool of doctors available to be designated doctors.

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Comment: A commenter states the rule as written is invalid since it improperly differentiates between medical doctors and doctors of chiropractic, and other doctors as defined in Labor Code §401.011. A commenter states that the Division is incorrectly equating going to chiropractic school and three years of chiropractic practice to attending medical school and completing 4-6 years of American Board of Medical Specialties (ABMS) residency. The commenter states the rule conflicts with §408.1225 by allowing some doctors to be exempt from training and suggest alternative language. Another commenter recommends that doctors of osteopathic medicine be included as a designated doctor.

Agency Response: The Division agrees with the commenters and has eliminated exemptions from training. The Division recognizes that there is a difference between attending medical school and chiropractic school; however, both qualify as doctors under the Labor Code. Further, doctors of osteopathic medicine are not precluded from applying to be designated doctors. Doctors of osteopathic medicine meet the definition of doctor under Labor Code §401.011(17).

Comment: A commenter recommends that the number of years of practice after medical, chiropractic or osteopathic school should be the same.

Agency Response: The Division agrees and has made the standard for an active practice uniform for all doctors.

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§180.21(d)(3): A commenter recommends specifying that a chiropractor may only be a designated doctor on a claim where the injured employee was treated by a chiropractor. Several commenters recommend clarifying language to specify that a doctor of chiropractic may be a designated doctor on injured employees with injuries to the spine only, rather than the musculoskeletal system, based on the chiropractor's scope of practice.

Agency Response: The Division disagrees. The Division believes chiropractors should be allowed to serve as designated doctors on claims where the injured employee has not received medical care that is outside of the scope of practice for a chiropractor. The Division will not limit injuries to the spine because doctors of chiropractic are able to provide treatment to body parts other than the spine.

Comment: A commenter questions why a designated doctor must have previous experience treating an injured employee in Texas as it does not affect the quality of the doctor's opinions. The commenter notes that out-of-state designated doctors do not have to meet this requirement and contends that Texas doctors should not have the requirement.

Agency Response: The Division agrees. Language requiring previous experience treating injured employees in the Texas workers' compensation system has been removed. However, the Division may still waive the training requirements for out-of-state designated doctors to effectuate an examination by a designated doctor.

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§180.21(d)(4)(A): A commenter recommends that fellow status with the American Board of Independent Medical Examiners (ABIME) be added as an alternate qualification to the American Academy of Disability Evaluation Physicians (AADEP). He believes recognizing only AADEP will provide an unfair trade advantage and both organizations perform the same role. Another commenter questions accepting fellowship with AADEP, as the requirements are not in line with that needed for workers' compensation issues, and is fee based rather than training or testing based. He further notes that AADEP is not recognized by the ABMS. Another commenter questions if testing is required to become a fellow of AADEP. Some commenters recommend deleting the AADEP fellow status as a minimal requirement to be a designated doctor. They recommend that all designated doctors should be required to successfully complete Division approved training.

Agency Response: Rather than adding alternative qualifications, the Division has eliminated exemptions from training. Also, Division approved testing will be required.

§180.21(e): A commenter requests clarification regarding the training requirement every two years even if an AADEP fellow. The commenter advises re-training on the same guides every two years is not effective, and recommends training on workers' compensation rules.

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Agency Response: The Division refers the commenter to the required training in §180.23(i)(3) which provides that a doctor who has not completed the prescribed training under subsection (i)(2) but who has had similar training in the AMA Guides from an approved vendor within the prior two years may submit the syllabus and training materials from that course to the Division for review. If the Division determines that the training is substantially the same as the prescribed test, the doctor is fully authorized.

Comment: A commenter recommends replacing “biannual” with “biennial.”

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

§180.21(j)(2): A commenter recommends changing “15 days” to “15 working days” in regard to the doctor filing a response to a denial of a DDL application.

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

§180.21(m)(9): A commenter recommends clarifying the designated doctor disqualifying association regarding network affiliation to include “to the extent known by the doctor.”

Agency Response: The Division disagrees. Insurance Code §1305.101(b) prohibits a network doctor from performing as a designated doctor on an employee that receives care from a network that the designated doctor is employed by or with whom the

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designated doctor contracts. Additionally, the Division will check network status during the designated doctor scheduling process to avoid these types of scheduling conflicts.

§180.21(m)(12): A commenter recommends leaving “significant” in the rule to prevent the Commissioner from taking an extreme action regarding a minor violation.

Agency Response: The Division disagrees. “Significant” is a determination made on a case-by-case basis and cannot be defined across all situations. The Commissioner of Workers’ Compensation has the ability to review the severity/significance of the violation(s) when making a determination and extreme action will not be taken when it is a minor violation.

§180.22(a): A commenter recommends that “reasonable and necessary” should be defined using the American Medical Association (AMA) definition.

Agency Response: The Division disagrees. The Division believes that the rule outlines what is considered reasonable and necessary in subsection (a)(1), (2) and (3).

§180.22(c)(3): Several commenters request that “the injured employee’s representative, if any,” be added to the list of persons that the treating doctor should communicate with regarding the employee’s ability to return to work.

Agency Response: The Division agrees and has added the language. It should be noted that §102.4(b) provides for notification to the injured employee’s representative if

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the health care provider had been notified of the representation. If the doctor has not been notified of the representation, the doctor has no requirement to provide notice to the representative.

§180.22(f)(4): Several commenters recommend removing “or as otherwise directed by the Division” because the requirements for this type of exam is established by statute and the Division does not have the authority to set the exam without a prior designated doctor exam.

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

Comment: A commenter feels the Division is improperly limiting the use of a carrier’s use of an RME. The commenter contends the Division is limited in what type of exam it can order on its own motion, however, the carrier has no restrictions on what type of exam it can request.

Agency Response: The Division disagrees that the carrier is entitled to an RME without restriction. 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 Labor Code §408.004(a) to an RME being ordered only on the Division’s own motion. Subsection (b) restricts the Division’s ability to require an employee to attend an RME until the insurance carrier has first attempted to seek the employee’s agreement to attend. The statutory provision the commenter

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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. 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.

§180.22(g): Some commenters request clarification as to whether prospective medical necessity review services subsequent to a preauthorization/concurrent review under §134.600 is a health care provider role as defined in this rule. The commenters are concerned that the review requirements may be duplicative of other requirements.

Agency Response: The Division clarifies that §134.600 (Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) does not establish the role of a health care provider reviewing the requests under that rule. The role of a health care provider referenced in subsection (g) could include prospective medical necessity

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review services and is subject to the requirements of Insurance Code Article 21.58A but is not duplicative of other responsibilities.

§180.22(g): A few commenters state the proposed rule is a reasonable attempt to improve the peer review system.

Agency Response: The Division appreciates the comment.

§180.22(g): A commenter recommends a different definition of peer review such as that used in the Medical Practice Act.

Agency Response: The Division declines to change the definition as suggested because the definition authorizes peer reviews to be performed by all health care providers, not just physicians. If the Division chose to utilize the recommended peer review definition in the Medical Practice Act, which is predominantly for physicians, this would prevent peer reviews from being performed by all health care providers, which is not the intent of the rules.

§180.22(g)(1): A commenter recommends clearly stating which provisions of Insurance Code Article 21.58A, Chapter 1305, and the Labor Code apply to peer review by insurance carriers to avoid potential conflict or overlap. Additionally, a commenter asks if medical necessity determination is made as part of an overall review of a claim, or if the term "peer reviewer" applies to utilization review doctors as defined in §180.20(c)(7).

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Agency Response: Section 180.22(g) adds the roles and responsibilities of peer reviewers, a category of health care providers previously undefined. If a utilization review agent is performing utilization review activities, including retrospective review of medical necessity, then the requirements of Insurance Code Article 21.58A and Labor Code §408.023(h) apply. For performance of utilization review activities, the provider must be certified or registered as a utilization review agent (URA) or employed by a URA and licensed to practice in Texas or perform utilization review under a licensed Texas doctor. Peer reviewer activities for any issue other than medical necessity are governed by the Labor Code and these rules and require the provider to hold the appropriate professional license in this state.

§180.22(g)(2): A commenter recommends the phrase “in Texas” be checked against the terminology used in §180.20(c)(7) to clarify whether the phrase includes both holding a Texas medical license and residing in Texas.

Agency Response: The Division verified the terminology used in §180.20(c)(7) and disagrees that it is necessary to change the rule. Neither §180.20 nor §180.22 requires a peer review doctor to reside in Texas; however, a peer review doctor must be licensed in Texas.

§§180.22(g)(2) and 180.28(b): A commenter asks if the definition of a peer reviewer means a doctor reviewing a doctor or a physical therapist reviewing a physical therapist,

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etc. Additionally, a commenter recommends that the "same or similar specialty" language be added to the subsection to indicate that "the peer reviewer hold an appropriate, same or similar professional license in Texas, to conduct the peer review."

A commenter states that honest physicians have no problem with another physician reviewing or performing the action of peer review of patient care, regardless of the reviewer's specialty, type of practice, etc. as long as the review is based on the normal standard of care.

Agency Response: The Division declines to stipulate in the rule that a peer reviewer be of the same or similar specialty as the health care provider whose services are being reviewed to maintain consistency with Insurance Code Article 21.58A rules. However, the Division clarifies that health care providers are required to be appropriately trained and qualified to provide the service requested by the provider. A peer reviewer must hold the appropriate Texas license and to perform utilization review must either be licensed in this state or acting under the direction of a Texas licensed doctor. The Division generally agrees with the commenter's statements that the need for peer review is not necessarily for the majority of Texas physicians in the system, and when a peer review is performed it should be based on the normal standard of care. The Division notes that pre-proposal drafts of disability management rules are available on the Division's website at <http://www.tdi.state.tx.us/wc/rules/planning/dmtp/tpppd.html>. These pre-proposal draft rules pertaining to treatment guidelines and treatment planning are currently being shared with system participants and will be followed by a formal

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proposal. These rule development activities should further enable the parties to better understand the expected standard of care.

§180.28(a): A commenter suggests that if the desire is to harmonize the network and non-network processes, then the list of elements to be required in a peer review report should be identical to those required by Insurance Code §1305.353(b) for an adverse determination.

Agency Response: The Division declines to make the requested changes because Insurance Code §1305.353(b) specifically applies to networks in determining prospective/utilization review requirements and does not encompass non-network utilization review requirements. The Division instead has chosen to pattern the elements of the peer reviewer's reports after the more accepted terminology used in the Chapters 133 and 134 rules.

§180.28(b): Several commenters recommend allowing insurers to request subsequent peer reviews of dates of service already reviewed for medical necessity as long as the review is to address an issue other than medical necessity (e.g., quality of treatment, patterns of practice, fraud investigation, disability management, etc.). The commenters object to limiting a peer review to one review for the same dates of service as this will unnecessarily hamper the ability of a carrier to use a peer review to address other pertinent issues. A commenter questions if there is a limit to the number of peer

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reviews a carrier may request during the life of a claim. Some commenters recommend adding language that permits a review if it is for a different service by a different specialty or for situations, such as changes in diagnosis, treatment, or conditions, where a second peer review would be appropriate.

Agency Response: The Division recognizes that there may be instances where an additional peer review is necessary and has changed §180.28(b) to provide for situations where a subsequent peer review would be appropriate which include: 1) review for different service; 2) carrier needs clarification of the peer review opinion; 3) the peer reviewer failed to address the questions submitted by the carrier; and 4) for purposes other than determining the medical necessity of health care. There is not a limit to the number of peer reviews a carrier may request during the life of a claim.

§180.28(b): A commenter expresses concern that peer reviews are not allowed to address future treatment, which limits and restricts doctors from expressing their medical opinions. The commenter contends that this creates an atmosphere of over treatment or unnecessary treatment.

Agency Response: The Division clarifies that the peer review is an administrative review of health care in a workers' compensation claim. A peer review as defined in §180.22(g) permits a prospective review as long as there is a specific request for treatment. A peer review cannot be a review for all future treatment. The Division notes that for a doctor to express a medical opinion, as in the commenter's concern about

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future care and possible over-treatment, the carrier has the option of requesting a required medical examination, instead of a peer review, to resolve any questions about the appropriateness of the health care.

§180.28(b): A commenter questions whether “peer review” and “peer review report” apply to utilization review determinations if they do not contain compensability or return to work considerations. The commenter believes that the peer review report is in conflict with §134.600. The commenter also questions if a peer review report is provided with a utilization review determination.

Agency Response: It appears that the commenter is asking, “Is a utilization review determination of medical necessity synonymous with a peer review?” Based on this interpretation, the Division clarifies that the terms “peer review” and “peer review report” do apply for items not specifically addressed in §134.600. Treatments and services governed by §134.600 follow that rule’s process, including the request for reconsideration. Section 134.600 does not require that the peer review report accompany a denial of a preauthorization request. However, §180.28(b) requires the peer review report be sent to the treating doctor when the carrier uses the report to reduce benefits.

§180.28(c): Several commenters recommend redacting the name and license number of the peer reviewers by the carrier, and listing the peer reviewer’s specialty and board

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certification, if applicable. The commenters suggest the carriers provide the Division a copy of the report with the peer reviewer's name and license, if requested, in the same manner that anonymity is maintained for Independent Review Organizations.

Agency Response: The Division declines to make the requested change. One of the primary purposes of HB 7 modifications to Labor Code §408.0231(g) was to set forth the requirements for the Commissioner to adopt rules regarding: providers performing peer review functions for carriers, peer review standards, imposition of sanctions on doctors performing peer review functions, and other issues related to the quality of peer reviews. The Division notes that since July 15, 2000 there has been a requirement in the Chapter 133 rules to provide the name and license number of the peer reviewer. The Division continues to support the ability of the subject of a review to know the peer reviewer's identity, which would not be possible if the information is redacted.

§180.28(c): A commenter inquires if the term "health care provider who rendered the health care" is the same as the referral doctor.

Agency Response: Referral doctor is defined in §180.22(e) and it is possible that a referral doctor who examines and treats the employee can be considered the same as the health care provider who rendered the health care.

§180.28(c): Some commenters recommend the carrier submit a copy of the peer review report to the employee and employee's representative.

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Agency Response: The Division agrees and has modified §180.28(c) to include this provision.

§180.28(c): A commenter observes that the peer review report would need to be provided to the treating doctor, as well as the health care provider who rendered the health care for each time a peer review report is used. The commenter suggests that the rule proposes an excessive paper flow for the treating doctor to receive if it involves treatment the treating doctor did not directly perform or provide. A commenter asks if the peer review report must be provided with all utilization review determinations.

Agency Response: The Division notes that the treating doctor, as gatekeeper in the workers' compensation system, must receive all pertinent information regarding his patient's (injured employee's) care, regardless of whether the care was performed directly or referred. Section 180.28(c) further provides that the carrier shall submit a copy of a peer review report to the treating doctor and health care provider who rendered the health care when the carrier uses the report to reduce income or medical benefits (which includes a denial) of an employee. Copies of a peer review report are not required for all utilization review determinations but are required any time it results in the carrier taking an action that reduces income or medical benefits (which includes a denial) of an employee.

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§180.28(e): Some commenters recommend that this section, or a new rule, is required for an appeal process for a doctor who has received a Division order prohibiting further peer reviews for any reasons set forth in paragraphs (1) through (3) of this subsection.

Agency Response: The Division agrees and has added the appeal mechanisms in §180.27 to the subsection.

§180.28(e)(2): Some commenters are concerned that the review requirements may be excessive and unfair (e.g., requirement to review all records available for the life of a claim vs. applicable documentation to substantiate the review) or duplicative of utilization review agent rules or other documentation requirements for prospective medical necessity review services provided by §134.600.

Agency Response: The Division notes that where pertinent, other Division rules need to be followed. However, to alleviate some of the concerns regarding excessive review of all records available and potential sanctions imposed on a peer review doctor, the rule has been changed to “failure to consider all records provided for review.”

§180.28(e)(3): Some commenters recommend requiring the Medical Quality Review Panel to determine medical necessity of health care reviewed, and not a member of the Division staff.

Agency Response: The Division disagrees. The rule parallels Labor Code §408.0231, which establishes the authority for the Commissioner to act on the recommendation of

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the medical advisor, or another member of the Division's staff. The Commissioner has the prerogative to seek input from the Medical Quality Review Panel, if needed.

§180.28(e)(4): Some commenters recommend deletion of this paragraph, or otherwise change it to limit the application to violations of Division rules and the Labor Code that are related to performing peer reviews.

Agency Response: The Division disagrees. The Commissioner has the authority through Labor Code §408.0231 and other provisions of the Labor Code to delete a doctor from the list, recommend or impose sanctions, and consider anything else relevant.

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

For, with changes: TIRR Systems; Association of Fire and Casualty Insurers of Texas; Texas Medical Association; American Insurance Association; Medtronic, Inc.; Texas Mutual Insurance Company; Fair Isaac Corporation; The Insurance Council of Texas; Property Casualty Insurers of America; HealthSouth Corporation; Rehab for Workers; Lockheed Martin Aeronautics Company; The Boeing Company; Texas Lobby Solutions; and various individuals.

Neither for or Against: HDM Group.

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6. STATUTORY AUTHORITY. The amendments to §§180.21 and 180.22 and new §180.28 are adopted under the Labor Code §§408.023, 408.0231, 408.004, 408.0041, 408.1225, 408.025, 402.00111, and 402.061. Section 408.023 governs the Division's Approved Doctor List (ADL) and requires the Division to establish criteria for sanctions and removal of doctors from the ADL. Section 408.0231 requires the Commissioner of Workers' Compensation to adopt rules regarding doctors who perform peer review functions for insurance carriers, which may include standards for peer reviews, imposition of sanctions on doctors performing peer reviews, and other issues important to the quality of peer reviews. Section 408.004 provides for required medical examinations to resolve questions about the appropriateness of health care received by injured employees. Section 408.0041 sets out requirements for designated doctors and their examinations and requires the Division to order a medical examination to resolve any question about an injured employee's impairment caused by the compensable injury or the attainment of maximum medical improvement at the request of an insurance carrier or injured employee. Section 408.1225 requires the Commissioner of Workers' Compensation to develop qualification standards and administrative policies regarding eligibility to serve as a designated doctor. Section 408.025 requires the Commissioner to adopt requirements for reports and records filed by health care providers and provides that the treating doctor is responsible for efficient utilization of health care. Section 402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority,

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under the Labor Code and other laws of this State. Section 402.061 provides the Commissioner the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

7. TEXT.

§180.21. Division Designated Doctor List.

(a) The following words and terms when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise:

(1) Active practice--A doctor has an active practice if the doctor maintains routine office hours of at least 20 hours per week for the treatment of patients.

(2) Disqualifying association--Any association that may reasonably be perceived as having potential to influence the conduct or decision of a doctor, which may include:

(A) receipt of income, compensation, or payment of any kind not related to health care provided by the doctor;

(B) shared investment or ownership interest;

(C) contracts or agreements that provide incentives, such as referral fees, payments based on volume or value, and waiver of beneficiary coinsurance and deductible amounts;

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(D) contracts or agreements for space or equipment rentals, personnel services, management contracts, referral services, or warranties, or any other services related to the management of the doctor's practice;

(E) personal or family relationships;

(F) a contract with the same workers' compensation health care network that is responsible for the provision of medical benefits to the injured employee; or

(G) any other financial arrangement that would require disclosure under the Labor Code or applicable Division rules, the Insurance Code or applicable Department rules, or any other association with the injured employee, the employer, or insurance carrier that may give the appearance of preventing the designated doctor from rendering an unbiased opinion.

(b) In order to serve as a designated doctor, a doctor must be on the Designated Doctor List (DDL).

(c) To be on the DDL prior to January 1, 2007, the doctor shall at a minimum:

(1) be currently active on the Division's Approved Doctor List (ADL) with a Level 2 Certificate of Registration with no condition(s) or restriction(s) or have a temporary exception to the requirement to be on the ADL as set forth in Labor Code §408.023 and §180.20 of this title (relating to Commission Approved Doctor List);

(2) have had an active practice for one year during their career;

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(3) be fully authorized to assign impairment ratings and certify maximum medical improvement (MMI) under §180.23(i) of this title (relating to Commission Required Training for Doctors/Certificate of Registration Levels);

(4) have filed a request in the form and manner prescribed by the Division and have been approved by the Commissioner to be included on the DDL; and

(5) either maintain an active practice or successfully complete Division-approved supplemental training on medical issues relevant to workers' compensation and/or serving as a designated doctor. Supplemental training shall be completed between 18 and 30 months following the doctor's passing the test required to obtain and retain full MMI/impairment authorization.

(d) To be on the DDL on or after January 1, 2007, the doctor shall at a minimum:

(1) meet the registration requirements, or the exceptions thereto, of subsection (c)(1) of this section or, upon expiration or waiver of the ADL in accordance with Labor Code §408.023(k), comply with all successor requirements, including but not limited to financial disclosure under Labor Code §413.041;

(2) have filed an application to be on the DDL, which must be renewed biennially;

(3) have successfully completed Division-approved training and examination on the assignment of impairment ratings using the currently adopted edition of the American Medical Association Guides, medical causation, extent of injury, functional restoration, return to work, and other disability management topics; and

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(4) have had an active practice for at least three years during the doctor's career.

(e) A doctor shall renew an application status biennially and shall have completed and submitted to the Division information verifying 12 additional credit hours of training in accordance with subsection (d)(3) of this section with each renewal application.

(f) An incomplete application for registration to be admitted to the DDL pursuant to this section and other applicable rules shall be rejected and shall not be processed.

(g) A complete application shall include:

(1) general contact information including, but not limited to: name, mailing address, telephone and facsimile numbers, and an email address;

(2) the training certificate certifying that the doctor applicant has successfully completed the Division-approved training in accordance with subsection (d)(3) of this section;

(3) Impairment Rating Skills Examination score;

(4) verification of licensure;

(5) information on the doctor's training and experience in various types of health care and injury areas;

(6) disciplinary actions or practice restrictions by an appropriate licensing or certification authority, if any; and

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(7) other information required by the Division to confirm the doctor's training and ability to determine:

- (A) the extent of the injured employee's compensable injury;
- (B) whether the injured employee's disability is the direct result of a work-related injury;
- (C) the ability of the injured employee to return to work; or
- (D) issues similar to those described in Labor Code §408.0041(a)(1) - (6).

(h) The Commissioner may utilize members of the Medical Quality Review Panel (MQRP) for evaluating DDL applications and making recommendations to the Medical Advisor to approve or deny admission to the DDL. The Commissioner may also utilize members of the MQRP regarding deletion, suspension, or other sanction of a designated doctor as provided in this section.

(i) Doctors shall be denied admission to the DDL:

- (1) if the doctor does not meet the requirements of subsection (c)(1) of this section prior to January 1, 2007 or subsection (d)(1) of this section on or after January 1, 2007;
- (2) if the doctor has not completed required training in accordance with §180.23(i) of this title and passed the Division approved examination;
- (3) for failing to submit a complete application in accordance with this section;

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(4) for having a relevant restriction on their practice (including, but not limited to, prior deletion from the ADL or DDL, or a prior ADL restriction); or

(5) for other activities that warrant denial of the application to be on the DDL, such as grounds that would require the Medical Advisor to recommend deletion of a doctor from the ADL or other sanction of a doctor as specified in §180.26 of this title (relating to Doctor and Insurance Carrier Sanctions) or other applicable statutes or rules.

(j) The Division shall notify a doctor of the Commissioner's approval or denial of the doctor's application to be on the DDL.

(1) Denials shall include the reason(s) for the denial.

(2) Within 15 working days after receiving the notice, the doctor may file a response, which addresses the reasons given for the denial.

(A) If a response is not received by the 15th working day after the date the doctor received the notice, the denial shall be final effective the following day. No further notice shall be sent.

(B) If a response which disagrees with the denial is timely received, the Division shall review the response and shall notify the doctor of the Commissioner's final decision. If the final decision is a denial, the Division's final notice shall provide the reason(s) why the doctor's response did not convince the Commissioner to admit the doctor to the DDL. The denial shall be effective the day

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following the date the doctor receives notice of the denial unless otherwise specified in the notice.

(3) Notwithstanding other provisions of this subsection, for denials pursuant to subsection (i)(1), (2), (3) and (5) of this section, the doctor may within five working days of receipt of notice, file a response which addresses the reason(s) given for the denial.

(A) If a response is not received by the fifth working day after the date the doctor received the notice, the action shall be final effective the following day. No further notice shall be sent.

(B) If a response which disagrees with the action is timely received, the Division shall review the response and shall notify the doctor of the Commissioner's final decision. A final decision denying the doctor admission to the DDL shall provide the reason(s) why the doctor's response did not convince the Commissioner to grant the doctor admission to the DDL. The denial shall be effective the day following the date the doctor receives notice of the denial unless otherwise specified in the notice.

(4) All notices under this subsection shall be delivered by a verifiable means. Date of receipt for notices shall be determined in accordance with §102.5(d) of this title (relating to General Rules for Written Communication to and from the Commission).

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(5) The fact that the Commissioner did not take action to deny or restrict admission to the DDL does not waive the Commissioner's right to review or further review a doctor and take action at a later date.

(k) When necessary because the injured employee is temporarily located or is residing out-of-state, the Division may waive any of the requirements as specified in this rule for an out-of-state doctor to serve as a designated doctor to facilitate a timely resolution of the dispute.

(l) Doctors on the DDL shall provide the Division with updated information within 30 days of a change in any of the information provided to the Division on the doctor's DDL application.

(m) In addition to the grounds for deletion or suspension from the ADL or for issuing other sanctions against a doctor under §180.26 of this title, the Commissioner shall delete or suspend a doctor from the DDL, or otherwise sanction a designated doctor for noncompliance with requirements of this section or any of the following:

(1) four refusals within a 90-day period, or four consecutive refusals to perform within the required time frames, a Division requested appointment for which the doctor is qualified;

(2) misrepresentation or omission of pertinent facts in medical evaluation and narrative reports;

(3) having a pattern of practice of unnecessary referrals to other health care providers for the assignment of an impairment rating or determination of MMI;

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(4) submission of inaccurate or inappropriate reports as a pattern of practice due to insufficient examination and analysis of medical records;

(5) failure to timely respond as a pattern of practice to a request for clarification from the Division regarding an examination;

(6) assignments of MMI and/or impairment ratings overturned in a contested case hearing, appeals panel decision and/or court decision;

(7) any of the factors listed in subsection (i) of this section that would allow for denial of admission to the DDL;

(8) failure to successfully complete training and testing requirements as specified in subsections (c) or (d) of this section;

(9) failure to notify the Division of any disqualifying association, including conflicts caused by the doctor's and the injured employee's association with the same workers' compensation health care network, within 48 hours of receiving notice of being selected as a designated doctor as a pattern of practice or conducting an examination when there is a disqualifying association;

(10) failure to maintain an active practice or failure to maintain the alternate training requirements outlined in subsection (c)(5) of this section;

(11) self-referring, including referral to another health care provider with whom the designated doctor has a disqualifying association, for treatment or becoming the employee's treating doctor for the medical condition evaluated by the designated doctor; or

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(12) other violation of applicable statutes or rules while serving as a designated doctor.

(n) The process for notification and opportunity for appeal of a sanction is governed by §180.27 of this title (relating to Sanctions Process/Appeals) except that suspension, deletion, or other sanction relating to the DDL shall be in effect during the pendency of any appeal.

(o) The Division shall make available through its website the names of:

(1) doctors on the DDL;

(2) doctors deleted or suspended from the list or otherwise sanctioned by the Commissioner (including a description of the sanction); and

(3) doctors reinstated to the list or whose sanctions were lifted by the Commissioner.

(p) When a doctor is added to the DDL or readmitted following a suspension or deletion, the doctor shall be placed at the bottom of the list for rotation purposes under Labor Code §408.0041.

§180.22. Health Care Provider Roles and Responsibilities.

(a) Health care providers shall provide reasonable and necessary health care that:

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

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(2) promotes recovery; and/or

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

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

(1) reporting required information;

(2) disclosing financial interests;

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

(4) correctly billing for health care provided.

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

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

(2) maintain efficient utilization of health care;

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

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

- (A) work release data;
- (B) cost and utilization data;
- (C) patient satisfaction data, including comorbidity, "Short Form 12"

outcome information (sf 12), and recovery expectations.

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

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

- (A) the accuracy of the diagnosis and appropriateness of the treatment of the injured employee;
- (B) the employee's work status, ability to work, and work restrictions;
- (C) the employee's medical condition; and
- (D) other similar issues;

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

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

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

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

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

(1) supplement the treating doctor's care;

(2) report the employee's status to the treating doctor and the carrier at least every 30 days; and

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

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

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

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

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

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

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

(B) the attainment of maximum medical improvement;

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

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

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

(F) similar issues.

(g) A peer reviewer is a health care provider who, at the insurance carrier's request, performs an administrative review of the health care of a workers' compensation claim. The peer reviewer must not have any known conflicts of interest with the injured employee or the health care provider who rendered any health care being reviewed.

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(1) A peer reviewer who performs a prospective, concurrent, or retrospective review of the medical necessity or reasonableness of health care services (utilization review) is subject to the requirements of Insurance Code Article 21.58A and Chapter 1305 and applicable provisions of the Labor Code. A peer reviewer who performs utilization review must be:

(A) certified or registered as a utilization review agent (URA) by the Texas Department of Insurance or be employed by or under contract with a certified or registered URA to perform utilization review; and

(B) licensed to practice in Texas or perform utilization reviews under the direction of a doctor licensed to practice in Texas.

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

(h) The designated doctor is a doctor assigned by the Division to recommend a resolution of a dispute as to the medical condition of an employee. The qualifications and responsibilities of a designated doctor are governed by §180.21 of this title (relating to Division Designated Doctor List) and other rules providing for use of a designated doctor.

(i) A member of the Medical Quality Review Panel (MQRP) is a health care provider chosen by the Division's Medical Advisor under Texas Labor Code §413.0512. All eligibilities, terms, responsibilities, and prohibitions shall be prescribed by contract,

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and the MQRP members shall serve on the MQRP as prescribed by contract. A provider must meet the performance standards specified in the contract to be eligible for selection by the Medical Advisor to serve on the MQRP. Doctors seeking membership on the MQRP are required to be on the Division's Approved Doctor List.

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

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

- (1) the peer reviewer's name and professional license number;
- (2) a summary of the reviewer's qualifications;
- (3) a list of all medical records and other documents reviewed by the peer reviewer, including dates of those documents;
- (4) a summary of the clinical history; and
- (5) an analysis and explanation for the peer review recommendation, including the findings and conclusions used to support the recommendations.

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

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

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

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

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

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

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

(e) The Commissioner may impose sanctions on doctors performing peer reviews pursuant to Labor Code §408.0231 and §180.27 of this title (relating to Sanctions Process/Appeals/Restoration/Reinstatement) and other applicable provisions of the Labor Code and Division rules. The Commissioner may prohibit a doctor from conducting peer reviews for any of the following:

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- (1) non-compliance with the provisions of §180.22 of this subchapter (relating to Health Care Provider Roles and Responsibilities);
- (2) failure to consider all records provided for review;
- (3) a history of improper or unjustified decisions regarding the medical necessity of health care reviewed; or
- (4) any other violation of the Labor Code or Division rules.

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 §§180.21 and 180.22 and new §180.28, concerning peer reviewers and designated doctors, are adopted.

DWC-06-0036

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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-06-0036